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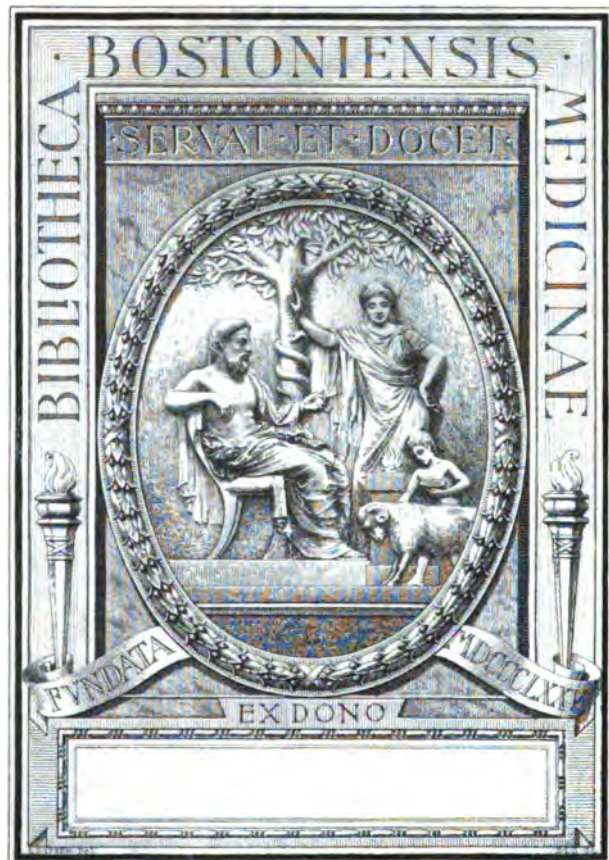
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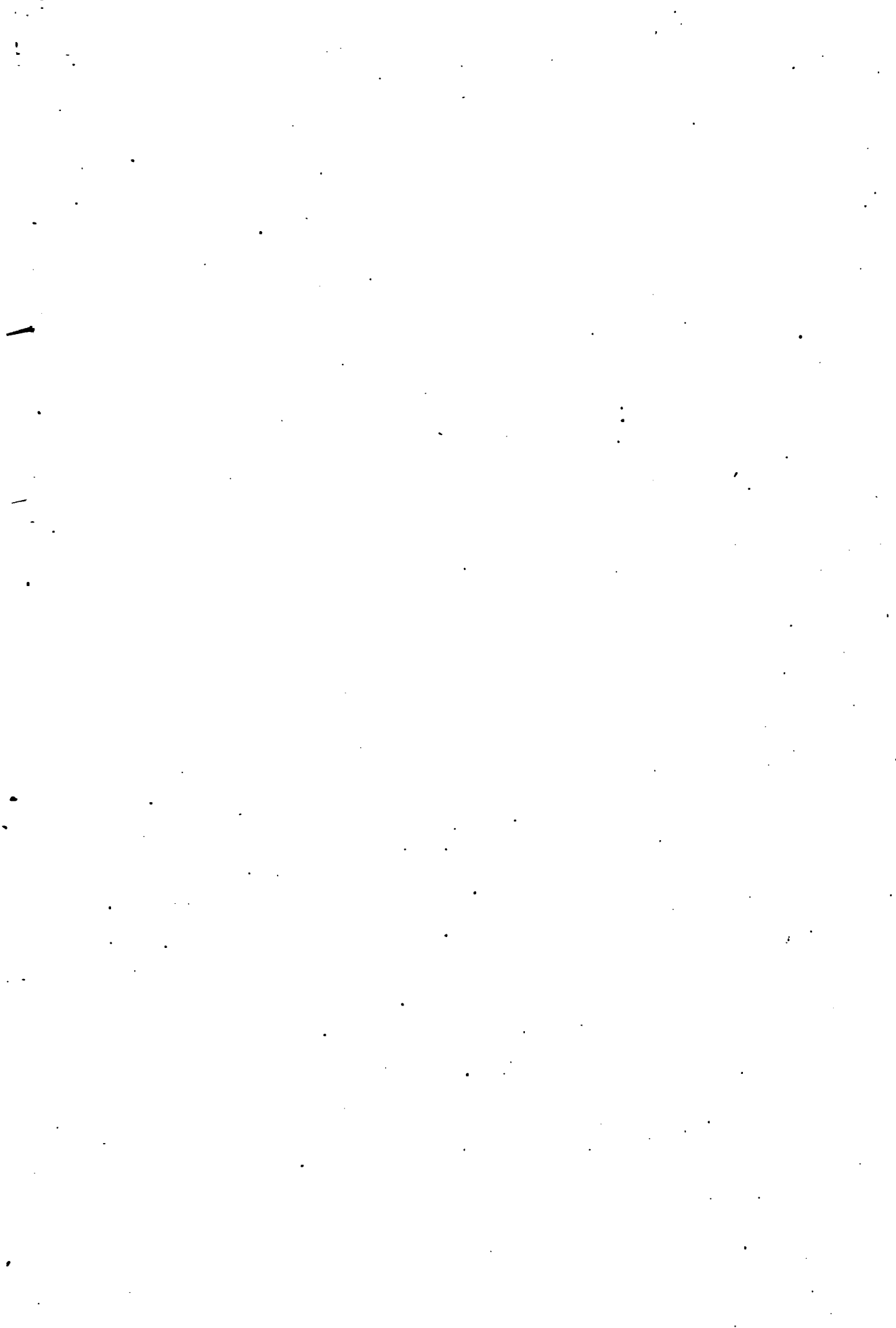
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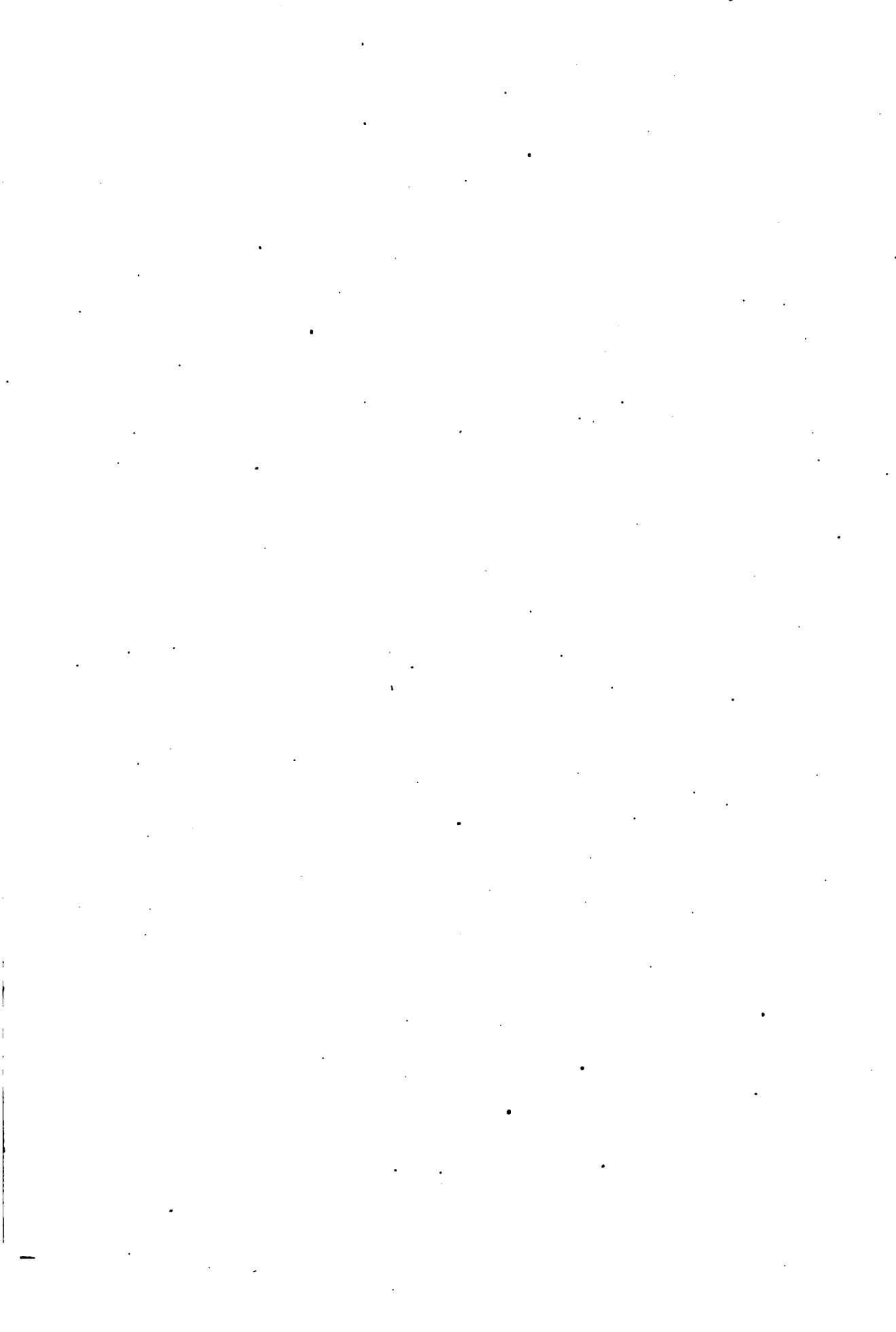
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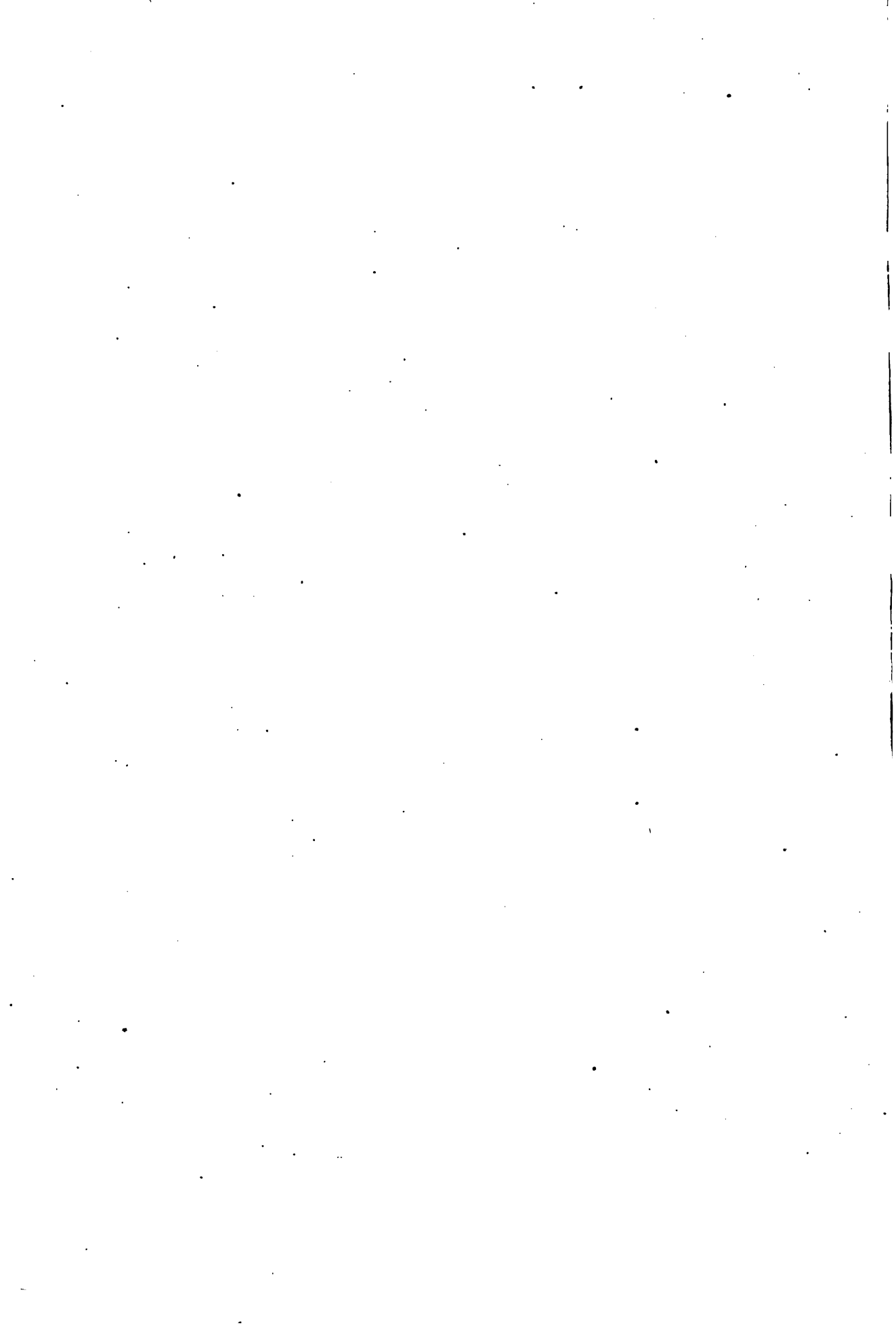
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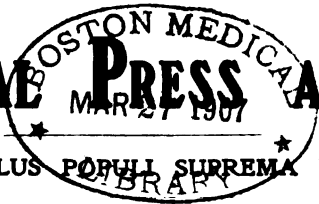
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THE MEDICAL PRESS AND CIRCULAR.



VOL. CXXXII.

WEDNESDAY, JANUARY 3, 1906.

No. 1.

NOTES AND COMMENTS.

Our Programme for 1906. Mr. GLADSTONE is reported to have said on a certain occasion, "I am a regular old Conservative. I never like change unless I know the reason." That, we venture to think, is the true spirit of progress. To-day a change has been made in THE MEDICAL PRESS AND CIRCULAR, and as it is a change dictated by reason, and we believe one in the direction of progress, we should like to place before our subscribers the motives by which it was dictated.

Our Past. But first of all let us examine what are and have been the features which have distinguished THE MEDICAL PRESS AND CIRCULAR from other organs of professional opinion. The chief of these is its brevity. While other journals have been vying with each other to produce a monster sixpennyworth, we of this journal have held on our way untempted to follow in their wake. If we were concerned with the management of a ladies' weekly or a review for idle people, we might be disposed to enter into this competition; but as it is our business to cater for a profession of busy men, we feel otherwise. It is not infrequently our lot when calling on our professional brothers to find piles of "monster sixpennyworths" lying in a corner of the consulting room clad in their original postal wrappers. We have marked the lesson of those piles, and we have remained fixed in our resolve to produce a journal that will be read.

Our Future. A journal that is to be read by medical men as a whole must be brief, pithy, and practical. The tendency of the medical journal of the day is to become more and more ponderous, like a work of reference, and less and less a sheet of news; and though we have nothing but admiration for the enterprise of our contemporaries and the results that they have achieved, we are convinced that our policy in medical journalism meets a distinct want. And this for the most practical reasons. The demand for THE MEDICAL PRESS AND CIRCULAR steadily increases every year, and advertisers also look to it more and more as a medium for making their wares known. With this tangible evidence before us we see every reason to develop our policy; none to change it. The

other claim that we make for our journal is that it is crisp, or, if we may use the expression, peptonised. Our work is to separate the husk from the wheat, to remove the shell from the nut, and to give our readers what we have to give in its most readily assimilable form. It is, we believe, to our having kept these objects steadily in view that we owe the fact that after nearly sixty-eight years of existence, far from showing any signs of senility, THE MEDICAL PRESS AND CIRCULAR takes a firmer grip on life every year.

Clinical Lectures. We have been seeking for some time past to develop our principles still further, and the changes which we make with the New Year are the result of much thought on the subject of the production of a useful, bright, and readable paper. Perhaps the most important innovation is that we propose to present each week a Clinical Lecture on a practical topic by a well-known teacher, in Great Britain or on the Continent. The clinical lecture has been growing in popularity as a medium for instruction, and we feel it will be a strong and acceptable feature if we bind ourselves to include one such lecture in each number of the journal. Arrangements are well in hand, and besides the lecture by Professor Mayo Robson which we give this week we have others by Sir Christopher Nixon, Professor Schüller, of Vienna, and Mr. R. C. B. Maunsell, F.R.C.S., ready for production in the succeeding numbers of January.

Abstracts of Practical Papers. Next we have determined to publish each week a carefully-selected abstract of important papers published in contemporary journals. We have secured the collaboration of an experienced staff for this purpose, and we propose to make it our object primarily to summarise those papers that have a direct practical bearing on the work of the practitioner, rather than those which have a nebulous scientific value that may or may not stand the test of time. Finally, a new arrangement of our columns and a fresh allocation of our space has been undertaken, so that proper prominence may be given to the several features, and a well-balanced whole result. What these arrangements are will be obvious to the readers of the present number.

Our old subscribers will find that though we have changed our dress we have in no wise changed our views, which we flatter ourselves are their views, on the purity of medical practice and the honour of medicine as a calling. We are bound to no section or segment of the profession; we serve no clique; we are entirely independent of outside influence or pressure. As such, we are free to speak our mind without let or hindrance, and we intend to continue to do so. What we believe to be right we shall continue to praise, and what we believe to be wrong we shall continue to denounce. Our motto still is, "Salus populi suprema lex," and in the belief that the health of the people is only attainable by a high standard of medical knowledge and medical conduct, we shall continue to use that motto as our touchstone. We trust that our journal in its rejuvenated form will do something to add to the happiness which we heartily wish all our readers in 1906.

LEADING ARTICLE.

THE MEDICAL MAN, ANNO DOMINI 1906

THE rapid evolution of scientific medicine presents us with an ever-shifting kaleidoscope of professional knowledge. The practitioner of to-day, no matter what his standing or his peculiar bent, must keep abreast of main advances, or in a few years he will find himself lagging hopelessly in the race. In so wide a field he cannot hope to know particularly more than one or two branches and to have a general acquaintance with the rest of the multitudinous subjects that fall within the range of modern medicine. Indeed, it seems almost hopeless for the general practitioner, burdened as he is with incessant calls upon his energy, to keep himself well-educated from the professional point of view. Even where post-graduate education is at hand, it requires no little determination to find the necessary time to attend classes and demonstrations. The medical diplomate or graduate is turned out from school or university a highly finished educational product, charged with a vast amount of information that will be simply an encumbrance to him when called upon to discharge the end and aim of his adopted career, namely, to comfort and heal the sick. There are several saving clauses, however, in the compact between general practice and medical science. The first is that while great, and in some cases enormous, strides have been made in the various branches of medical science and art, that of therapeutics has for the most part lagged behind with slow and halting steps. A lecturer will discourse eloquently upon the etiology, the pathology, the symptomatology and the diagnosis

of some condition, while the therapeutic aspect is disposed of in the last two or three minutes of his allotted hour. Yet treatment is the all-important thing for the future practitioner, not to mention the patient, an interested person of whom we are apt to lose sight at times in the excitement of our scientific ardour. Of what use is it to the medical attendant when sitting at the bedside of a sick person to ransack his mind as to Professor So-and-So's refinements and subtleties of diagnosis? Sick-room practice and laboratory research are for the most part poles asunder, and in the rough and ready tumble of general practice the advance has been made at a few points here and there rather than all along the line. So the general practitioner treats symptoms, trusts to a few approved remedies and throws advanced science to the winds—at any rate, until its advocates can furnish a convincing as well as a plausible case. In fact, he has been taught the lesson that much so-called knowledge is not really knowledge when tested in the crucible of experience. An amusing instance of misapplied high standard smartness recently occurred in a provincial centre of light and leading. A country surgeon sent a lad to the hospital of a neighbouring town for the purpose of having a deep-seated abscess opened. The patient was placed under the care of a Professor of world-wide fame, but he was sent back home without operation because an examination of his blood did not afford the evidence deemed necessary for the diagnosis of internal abscess. Thereupon the country surgeon called in a brother practitioner to give chloroform, and speedily relieved his long-suffering patient of his dangerous burden. The truth of this story, however much it may be suggestive of science run mad, is vouched for on the best authority. It illustrates one of the more disquieting sides of professional life nowadays, namely, the decay of skilled clinical observation, and the exaltation of laboratory methods that are in not a few cases complicated, fallacious, and technical to a degree. But from the mists of theory and of speculation now and then emerges the established fact or the reasoned conclusion which every educated medical man should know. This necessity has led to many attempts on the part of teachers, of authors, and of medical journals to fill the gap. So far as the MEDICAL PRESS AND CIRCULAR is concerned the re-casting of the form of the journal has been framed with that object clearly in view. By means of a careful abstract from the medical literature of all countries, it is hoped to supply readers with the solid information they require in a compact and readily assimilable form. The medical man of 1906 has an increasingly hard task to compass in his endeavour to keep up with the times. So far as lies in our power, we hope to furnish him with matter that he will find refreshing, stimulating, and nourishing, and in this way to proffer him a real assistance in what must ever be a laborious and self-sacrificing career.

The Bennett Testimonial Fund.

WE have been glad to learn that the movement among the old pupils of Mr. Edward H. Bennett, of Dublin, to commemorate in suitable form his services to surgery during his long professional career has received a widespread support. The committee charged with the execution of the wishes of the subscribers are now in a position to decide on the form the testimonial is to take, and we understand that it is intended to ask Mr. Bennett to give sittings for a portrait medallion, the original to be placed in the School of Physic in Ireland, and a copy in Sir Patrick Dun's Hospital. Medals are to be struck, of which a proof in gold is to be presented to Mr. Bennett, while a bronze medal is to be presented biennially to the winner of the Surgical Travelling Prize in Trinity College. Any funds remaining are to be invested, the interest being devoted to a prize to be presented to the candidate who obtains second place in the examination for the Surgical Travelling Prize. The decision of the Committee as to the disposal of the moneys subscribed will give universal satisfaction, as in no way could the memory of a great teacher be better perpetuated. We understand that any of Mr. Bennett's pupils, who, through inadvertence or other cause, have not yet subscribed can send their subscriptions to either of the honorary secretaries, Mr. H. R. Swanzy, 23, Merrion Square, or Mr. C. A. Ball, 12, Lower Mount Street, Dublin.

The Aliens Act.

THE Aliens Act passed last session comes into operation with the New Year, and it may therefore be presumed that the Home Office, under whose auspices its administration is to be carried out, have organised the necessary machinery for the purpose. As is usual with Government departments, when dealing with public health questions, no official place was given to a medical representative on the Committee that sat to advise the Home Secretary as to the necessary steps to be taken and regulations to be made under the Act, and consequently no medical officer has been appointed at head-quarters to supervise its administration. The three classes it is desired to exclude are the criminal, the pauper, and the diseased alien, and it is the last-named only that will provide real difficulty. The only country that has had much practical experience of the exclusion of undesirables is America, and the authorities there have discovered how difficult it is to construct a net whose meshes are sufficiently small to keep out all the rubbish. Each year in the States the medical tests become more stringent. The fact is that the aliens become as experienced as the medical inspectors, and they evolve all sorts of counter-weapons with which to fight their examiners. For instance, they know the astringent powers of adrenalin, and insert it into their eyes to mask the congestion produced by granular lids. The diseased alien is a serious menace to the public health of the low quarters of shipping and indus-

trial towns, and if the Act is not to become a by-word and a farce its administration must be carefully watched.

Sanitary Zeal.

THE tests which the Sanitary Institute applies to would-be inspectors do not apparently include one to prove the sense of humour possessed by candidates. At least so one would judge from an incident that occurred in the Harrow Road last week. A sanitary inspector of the Paddington Borough Council espied in passing the headquarters of the Paddington Liberal Association, a string of German sausages, labelled "Sevenpence half a pound." Here was a clear case of violation of the Horseflesh Act, 1889, which provides that in places where horseflesh is sold, the fact must be indicated over the door of the shop in letters not less than four inches deep. The inspector stepped inside, interviewed the secretary (whose name aptly enough is Mr. W. Jacobs), and complained of the infringement of the law. The secretary was obstinate. He explained that the sausages were not articles for sale, but munitions of war wherewith to fight the coming election, not—as the inspector might suppose—in the same way that sausages are used on the pantomime policeman, but as an object lesson of the future diet of the "rude mechanical" if the tariff-reform candidate got in. But the inspector was not to be fobbed off with such transparent excuses, and a summons was served in due course. Fortunately the case came before the right man—Mr. Plowden, and the inspector departed with a flea in his ear for his stupidity. When sanitary zeal doth outrun discretion it cuts a poor figure indeed.

A Thirty-Three Hours' Day for Carmen.

To secure an eight hours day is the dream of many labour reformers. There are some occupations, however, such as those of railway-men, pilots, fishermen, dairymen, publicans, market gardeners, printers, carmen, cab-drivers, and so on that by reason of their essential nature it would be difficult to subject to an arbitrary time-limit. On the other hand it seems clear that the State should intervene at some given point in the interests both of workmen and of the community. A great element of public danger is introduced when the hours of labour are stretched to an unreasonable length, as witness the familiar railway smash due to the lapse of a signalman who has been on continuous duty for twenty or thirty hours or more. Last week a carman was brought before a London magistrate on a charge of being drunk. He pleaded that he had been in the employment of the same firm for over thirty years, that he had never before been charged with drunkenness, that he had been on duty for thirty-three hours continuously, and that for the past eleven weeks he had never been in bed. Under these circumstances the magistrate very justly refused to fine him, and communicated

with the employer. If Parliament cannot guarantee an eight hours day, it can make anything beyond a twelve hours day illegal. The carman's drunkenness in the above case was not improbably the outcome of a physiological attempt to stimulate a brain exhausted by prolonged insomnia. Anyway, a social matter of this kind deserves the careful consideration of our legislators.

A Chemist's Fatal Error.

LAST week an inquest was held at Sheffield upon the body of a Harrogate lady visitor who died after taking a dose of physic made up by a local chemist. It was found that in dispensing the medicine, the unfortunate chemist, owing to a mistake in the label on one of the bottles, had substituted a solution of nitrate of mercury. The explanation given was that during the removal of the business on a wet day the label was rubbed off, and that in some way or other the label was replaced on the wrong bottle. Such a state of matters is hardly satisfactory, however, inasmuch as a drug of the deadly kind in question should have a permanent label indelibly affixed to the bottle. Indeed, so far as that goes, every stock bottle on a chemist's shelves should obviously be labelled in such a way as to withstand the wear and tear clearly inseparable from the business of dispensing. Then, again, there is no particular reason why chemists should not keep their poisons in distinctive bottles and locked away in special cupboards. That something of the kind is imperatively needed is shown by the occurrence from time to time of such tragedies as that recorded last week at Sheffield. It is by no means clear that chemists have hitherto taken all the precautions necessary to reduce the margin of poisoning accidents to its unavoidable minimum.

What is a Successful Operation?

It often happens that in the newspaper account of some heroic surgical procedure that has ended in the death of the patient it is stated that the operation was perfectly successful. The situation thus displayed tickles the humour of the public, and every medical man must have had the problem laid before him scores of times by intelligent patients. The answer lies in the ultimate meaning attached to the word "successful." If the term be limited to the restoration of life or limb by surgical intervention, then the untimely death of the person operated upon within a few hours or days would indicate the use of its opposite—"unsuccessful" as the proper epithet. The surgeon is naturally eager to escape the stigma of non-success, and has accordingly adopted the plan of claiming a successful result so far as his operation has been concerned, while death is attributed to contributory unavoidable causes. This subtle distinction is readily accepted by coroners' courts and by journalists, who as a rule fully recognise the necessity of protecting the reputation of the conscientious and responsible

men engaged in the practice of modern operative surgery, which, unhappily, has not yet been reduced to the position of an exact science. Any surgeon who reckoned as "recoveries" or "successes" cases in which post-operative death followed at a short interval would infallibly lay himself open to the charge of "cooking" his statistics.

"Signed by Fifteen Eminent Medical Men."

It is a well recognised fact that in infancy and childhood, and throughout the growing stages more sleep is needed than in adult life. Starting on this obvious ground, a manifesto has been drawn up in the form of a letter "signed by fifteen eminent medical men" and published in a London newspaper. It points out the danger that under modern methods school children are often unable to get sufficient sleep, to the consequent damage of the brain and the danger of a nervous breakdown in after life. So far as the matter of this manifesto is concerned there can be little doubt that it falls within the legitimate sphere of the medical profession to educate the public upon a subject so vital to the welfare of future generations. But why append the names of the "fifteen eminent medical men"? It is either ethically right or ethically wrong to send a signed communication to a public newspaper, dealing with a professional subject. Of late years Presidents, and would-be presidents of Royal Colleges—not to mention shoals of smaller fry—have not hesitated to send signed letters upon all sorts of medical topics to lay editors. Possibly medical opinion is undergoing a revolution upon this, as upon many other points. Again, the idea seems to prevail in some quarters that two or three men may sign their names with impunity where it would be wrong for one to do so. By a simple extension of this curious principle any possible ethical offence might be thereby diluted to any required degree. Fifty names, for instance, would be calculated to silence the most captious layman, if only by hopelessly confusing him as to the identity of individual signatures.

Red Light and Scarletina.

THERE is little understood up to the present of the influences of light upon the chemistry of the body, and any facts which we know are purely empirical. It is right and natural, therefore, that those who believe strongly in the therapeutic action of red light in small-pox should test actinic therapy in the case of other acute exanthemata. It is in this attitude of mind that Croff of Nürnberg has studied the influence of red light on the course of scarlet fever, and it may be admitted that his results are encouraging. His method was to exclude white light and to admit only a limited amount of red light. In his opinion this treatment brought about an early disappearance of the rash, as well as a rapid return to normal temperature. Instead of the seven or eight days usually required to get rid

of the fever, Croff found that temperature came down, sometimes by crises, on the third or fourth day. The treatment had to be strictly maintained, as even a few minutes' exposure to daylight was in some cases sufficient to cause a recrudescence of the rash. On the complications of the disease the treatment had no effect.

Libraries and Infectious Disease.

THE prevention of communicable diseases unquestionably forms one of the great aims of sanitary science. In many directions, however, its achievements fall hopelessly short of its ideals. There are many rocks ahead, not less in the inherent character of the various zymotics than in the complex environment of modern life. Library books have always provided sanitarians with a hard nut to crack. Reading is a great solace and recreation to the sick, so that a certain proportion of library books are bound to get into the hands of persons suffering from some form or other of infectious malady. From the circumstances of the case it is impossible for the library authorities to be aware of the facts, and were it possible the books would have to be destroyed, for it is hardly practicable to subject bound volumes to any efficient process of disinfection without rendering them useless for library purposes. The remedy against the spread of infection by this particular agency is not easy to discover. While human nature is constituted on present lines, it is likely that library books will continue to find their way to fever-stricken bedrooms. Perhaps the simplest way out of the difficulty would be to make a general appeal to medical men to instruct their patients as to the risks incurred by selfish exposures of the kind. Another practical step would be to place libraries in close touch with public sanitary departments, so that the whereabouts of every notified infectious case might be kept in full view of the library officials. Lastly, an offence of the kind might be made punishable by fine.

PERSONAL.

THE Prince of Wales has opened a native Medical School at Lucknow.

THE Princess of Wales has sent a Christmas present of toys from her Royal Highness' children and the children of Kew to the little patients in the London Hospital.

SIR DONALD CURRIE's conditional offer of £20,000 to Belfast Queen's College has resulted in a net sum of no less than £70,000 for that fortunate body.

SIR ROBERT FINLAY, K.C., who has a medical qualification, is a Parliamentary candidate at the forthcoming election.

A PRIZE of £100 and a silver cup offered by Mr. Edgar Speyer for the best essay on the economical management of an efficient voluntary hospital has been awarded to Mr. Godfrey H. Hamilton, secretary of the National Hospital for the Paralysed and Epileptic, London.

DR. MARK ANTONY MACDONNELL, M.P., brother of Sir Antony MacDonnell, formerly in practice in Harley

Street, will not contest the Leix Division of Queen's County at the next election.

SIR HENRY BURDETT, it is stated, will contest North Paddington as an Independent Unionist.

THE name of Dr. F. W. Suberton has been placed upon the Commission of the Peace for the City of Manchester.

DR. J. W. BEATTIE was recently presented in the Mayor's Parlour, Town Hall, Sunderland, with a gold watch, bearing the following inscription:—"Presented to J. Walker Beattie (with a cheque for £200) as some recognition of 25 years' work in Sunderland, freely given in the cause of humanity, December 21, 1905."

PROFESSOR KOCH is about to take charge of an expedition to investigate sleeping sickness in German East Africa. He will co-operate with the expedition sent out by the Liverpool School of Tropical Medicine, and is expected to remain in the district about eighteen months.

SIR HALLIDAY MACARTNEY, who is about to retire from the responsible post of English Secretary to the Chinese Legation in London, was educated for the medical profession in Edinburgh University, and served in the Army Medical Department from 1858 to 1862, when he saw much active service in China.

MR. J. F. OBREE, J.P., a well-known Southampton shipbroker, has recently been restored to health after a serious illness, and as a thank offering, has intimated his intention of dividing the sum of £2,850 among the hospitals and charitable institutions of the town.

AT a recent meeting of the board of the Selby Cottage Hospital on Saturday, Miss Standerling, of Selby, expressed her wish, through Dr. Todd, the medical officer, to defray the cost of building a surgical ward for women and an operating-room for the hospital. Miss Standerling also proposed to give £2,000 towards the endowment of the institution.

SIR HENRY LITTLEJOHN has resigned the chair of Forensic Medicine, which he has held for the past eight years. The main part of his professional career has been identified with the Royal College of Surgeons of Edinburgh. He is now in his 78th year, and still gets through a great amount of hard work.

MRS. ADA LEWIS HILL, widow of the late Samuel Lewis, has forwarded for the year 1905 her annual gift of £10,000 to King Edward's Hospital Fund.

THE Hon. Stephen Coleridge has telegraphed the Lord Mayor of London to impound all tickets presented at the door of the recent Hospital Sunday meeting until he has obtained legal advice as to future action.

IN a recent issue we announced that Mr. Edgar Speyer had presented the magnificent sum of £100,000 for the benefit of certain medical charities. The securities to the value of this amount he placed in the hands of Mr. E. J. Bawden, who has now completed the terms of the Trust Fund, Lord Hillingdon, Lord Revelstoke, and Mr. Bawden being the trustees.

MRS. UMFREVILLE PICKERING has generously given one thousand guineas to the West London Hospital, through Dr. D. W. C. Hood, C.V.O. (as a steward of the festival dinner now being organised), for the purpose of endowing and naming one of the beds in perpetuity.

DR. R. R. RENTOUL, author of "Proposed Sterilization of Certain Degenerates," has been asked to give evidence on January 19th before the Royal Commission on the Care and Control of the feeble-minded.

A CLINICAL LECTURE

ON

THE DIAGNOSIS AND TREATMENT OF CANCER OF THE STOMACH.

BY

A. W. MAYO ROBSON, F.R.C.S.

Hunterian Professor in the Royal College of Surgeons of England.

CANCER in itself has no definite symptomatology, and the later symptoms of gastric cancer depend almost entirely on the site of the disease.

If the body of the stomach is the starting point, all localising symptoms may be entirely absent until the loss of strength and wasting compel the patient to seek advice, when a tumour can often be felt.

If the growth invades the pylorus, it tends before long to interfere with the escape of the stomach contents, and so to give rise to retention of food products, to dilatation and to visible peristalsis, associated with pain, and when the obstruction is becoming more complete it leads to vomiting with rapid emaciation. When the growth is at or near the cardiac orifice a difficulty is experienced in the entry of food into the stomach, giving rise to a suspicion of œsophageal obstruction. Wasting is often a marked symptom before pain directs attention to the affected part, though pain is usually present at an early stage.

It will thus be seen that at the outset, in nearly all cases of gastric cancer before the orifices have been interfered with there may be no local symptoms to draw attention to the stomach as the seat of the disease. It has therefore not infrequently happened that a patient has died from another illness and at the autopsy an unsuspected gastric carcinoma has been found.

This early condition is the important stage of the disease from the point of view of radical treatment, for at this time the cancer is localised, and if it can be widely removed either cure or long continued relief may be looked for in a large proportion of cases.

In order that the best results may be attained, the physician and surgeon must act in concert, so that by a timely diagnosis an operation may be undertaken at the earliest possible date. There is ample evidence to show that for some length of time the cancer is a purely local disease; and, just as in the breast, the tongue, and the uterus, we can point to patients living comfortable and happy lives years after the removal of the disease, so in gastric cancer it is reasonable to assume, and in fact can now be proved by positive evidence, that a like result may be hoped for. Here, however, we are faced with the difficulty of a sufficiently early diagnosis being made, and it is not only necessary for us to appeal for an early, exhaustive, and persistent investigation into suspicious stomach cases, but that when the suspicions are becoming confirmed an early surgical consultation may be held and, if needful, an exploratory operation carried out to complete the diagnosis. 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 in the stomach should be recognised, and in a suspected case, if no improvement takes place in a few weeks at most, an exploratory operation is more than justified. As Professor Osler says, the important aid of an exploratory operation should be more frequently advised.

Diagnosis.

Although cancer of the stomach may occur in early life, yet it usually comes on at or after middle age, from 40 to 60 being the most frequent age. I have operated for cancer of the pylorus at 21 and for cancer of the bowel at 14. Men are more frequently affected than women. Osler observed 126 in men to 24 in women. In the Leeds Infirmary the proportion was for ten years 36 males to 23 females. The usual clinical manifestations are loss of appetite and wasting with loss of strength coming on in a patient otherwise well, and with nothing to account for

the dyspepsia. Two features are prominent—acuteness of course and abruptness of onset. Perhaps the friends first notice the change in the patient, who, from being active and well, becomes tired, listless and anæmic, without any symptom pointing to the stomach. Or the first symptom may be pain after food or flatulent distension and great discomfort, leading to limitation of the intake so as to save after effects. Vomiting may be entirely absent, and is frequently not seen until the outlet of the stomach is becoming narrowed or the cavity encroached on. If early, the vomit consists of food with mucus, later of altered blood in the shape of coffee-ground material, and at times, though more rarely than in ulcer, of pure blood. Loss of flesh is well-marked, and may be the only symptom beyond loss of appetite and discomfort after food. Even loss of appetite may be absent at the beginning when loss of weight is already showing itself.

Pain is usually felt at the epigastrium, but, unlike ulcer, there is generally an absence of tenderness on pressure, until the peritoneal coat becomes involved, when local peritonitis may give rise to tenderness.

Professor Osler's analysis of symptoms at onset gives pain as present in 48, dyspepsia in 46, vomiting in 21, of which 2 were vomiting of blood; anorexia in 4, dysphagia in 3, tumour in 1, jaundice in 1, while in 13 there were no symptoms at the outset.

The three most constant symptoms are pain, vomiting, and tumour.

In 86.6 per cent. pain is present.

In 85.3 per cent. vomiting is present.

In 76.6 per cent. tumour is present.

The pain varies from slight attacks to constant, severe, and disabling distress. It may be made worse by food or it may be continuous and not much influenced by diet. My experience is that the nearer the pylorus the more severe the pain, this being apparently due to obstructed outlet and in some cases to painful peristalsis. On several occasions I have found tumour to be the first evidence of the disease.

An examination of the stomach contents obtained after a test meal should not be neglected. While free HCl in good quantity is against a diagnosis of cancer, the absence of free HCl is decidedly in favour of it, as in 80 to 90 per cent. of cases of cancer of the stomach free HCl is absent, or if present is in very small quantity. An excess of free HCl is decidedly in favour of ulcer, just as the presence of lactic acid is of cancer. A microscopic examination of the stomach contents may show blood cells and portions of growth which are of course of the greatest importance, as though blood may be present in case of gastric ulcer, portions of growth and cancer cells are absolutely pathognomonic of cancer.

I would not advise under any circumstances forcible lavage and curettage as recommended by some authorities, in order to obtain material for microscopic examination.

The presence of the Oppler-Boas bacillus has been given importance by some authors, who speak of its being present in 90 per cent. of all cases of gastric cancer.

In many cases—Fenwick says in one-third—a rise of temperature at some period will be found, but in the greater number of cases there is a low or even a sub-normal temperature.

Anæmia, resembling in appearance the pernicious form, is a striking feature of gastric cancer; it is dependent on absorption from the diseased stomach, and from the growth, leading to blood destruction, and on the loss of blood from repeated small hæmorrhages into the stomach.

Laache states that there is a notable diminution in the number of red corpuscles present in the blood. Fenwick says that the corpuscular richness seldom increases under treatment; but at the same time, the number of red cells rarely falls below 1,500,000 per cubic millimetre. The former peculiarity serves to distinguish the disease from many other forms of secondary anæmia, and the latter from the pernicious form, where, according to Henry, the cells always number less than 1,000,000 per cubic millimetre before death occurs. Leucocytosis usually occurs, especially if there is perigastritis or pyrexia, but its diagnostic importance is not great. Tedeschi (*Gaz. degli Osped.*, Jan. 23rd, 1905) states that in cancer of the stomach blood can always be found in the motions on adopting the Guaiacum test.

As an element of prognosis, Fenwick lays stress on the total disappearance from the saliva of potassium sulphocyanide. He says that he has never known a patient to live more than a month after the observance of the phenomenon. Cammidge lays stress on the diminished excretion of chlorides in the urine in cancer, which may afford a help in the diagnosis.

Rommelaere believes that the elimination of less than 180 gr. of urea per diem, by a patient who suffers from chronic indigestion is pathognomonic of cancer, but this is probably, though suspicious, not absolutely true; though it may be permissible to assume that where 450 gr. of urea are excreted, carcinoma does not exist. The presence of ascites and of œdema of the feet are seen in cases too advanced to merit consideration from a purely surgical point of view.

Physical Examination of the Patient.

Where the cardiac end of the stomach is involved, there may be difficulty in deglutition, and in such cases a bougie may be arrested at the entrance to the stomach.

A palpable tumour is discoverable in from 70 to 80 per cent. of all cases of cancer of the stomach.

Inspection of the abdomen may show a perceptible tumour in the epigastrium, or in the left or right hypochondrium, and if the patient is thin it is often easy to manipulate the tumour and to ascertain its relation to the rest of the stomach and to neighbouring organs, especially as the recti are usually free from rigidity, a condition which is quite different in chronic ulcer. It is usually hard, nodular, and irregular, and often free from tenderness, except when peristalsis occurs, or where there is perigastritis. Peristalsis from left to right can often be seen when the tumour is at or near the pylorus, and on palpation the organ is felt to harden under the hand.

The tumour may be very movable, and may be capable of displacement down into the pelvis and upward under cover of the ribs; this from a surgical point of view being, of course, very favourable. Tumour of the pylorus due to chronic ulcer is generally fixed under cover of the liver, and cannot, as a rule, be well defined, especially if, as often is the case, the right rectus is rigid and resists pressure. Retraction and fixation of the navel is an important sign of advanced disease, the growth having involved the round ligament or the subperitoneal tissue near the umbilicus. Ascites, as shown by a thrill on flicking the abdomen in the flanks with the finger-nail, and as evidenced by other well-known signs, is a very unfavourable symptom, as showing the disease is very advanced and probably diffuse.

The position of the growth in the stomach may be shown, as also the shape of the stomach, either by inflating the stomach through a tube or by giving the patient a teaspoonful of sodium carbonate dissolved in water; if there is free acid in the stomach, it will decompose the sodium carbonate, and CO₂ will be evolved, but if there is no free acid in the stomach, about 30 grains of tartaric acid dissolved in water can be given and this will immediately cause the stomach to be distended and its outline and relation to the tumour will be made manifest. In cases of ulcer, the sodium carbonate dose alone is often sufficient; but in cancer the absence of free acid usually necessitates

the tartaric acid dose also, thus affording some help in diagnosis. The presence of enlarged veins on the surface of the abdomen (indicating obstruction of the venous return) of enlarged glands in the groin, of nodules on the skin, of enlarged glands over the left clavicle (indicating diaphragmatic extension) or of other secondary signs of growth in the liver, bowels or peritoneum must all be taken into account in considering the case from a surgical standpoint.

Enlargement of the glands above the left clavicle in my experience occurs in from 5 to 10 per cent. of all cases of cancer of the stomach; the gland between the roots of the left sterno-mastoid, as well as glands behind that muscle, may be involved, and as pointed out by Dr. Newton Pitt may sometimes be more readily felt by making the patient cough.

For the surgeon to be able to perform his best work, the disease should be recognised before a tumour is perceptible, though as can readily be shown, very successful operations may exceptionally be undertaken even when the tumour is visible through the abdominal wall.

Of the tumours of the stomach that can be palpated—some of which may be visible—according to Fenwick, 81 per cent. are situated in the body of the organ, 71 per cent. at the pylorus, and only 55 per cent. at the cardiac end or fundus.

Nearly all tumours of the stomach move downwards on deep inspiration.

The size and shape of the tumour may vary considerably, and the position, though usually above the umbilicus, may in pyloric growth be in the hypogastrium though I have seen and operated on a cancer of the pylorus that formed a tumour in the left hypochondrium and which on expiration disappeared under the left costal margin.

A small tumour of the pylorus, barely perceptible to palpation, may lead to enormous dilatation of the stomach, and in nearly all cases of cancer of the pylorus a stomach splash may be elicited.

When the disease involves the middle of the stomach an hour-glass shape results, and the proximal cavity as a rule becomes considerably dilated.

Treatment.

This may be considered under two heads—medical and surgical. Medical treatment cannot cure, and can do very little even to prolong life; it therefore applies only to cases too advanced for surgical treatment or where operation is declined. It aims at nourishing the patient as much as possible, and at relieving pain or other symptoms as they arise.

Surgical treatment offers the only chance of real relief, and the only possible chance of cure.

Having made the diagnosis, if necessary by an exploratory operation, it will be generally advisable to have everything ready to follow up the exploratory procedure by whatever further operation may be called for. It may be discovered that the disease is manifestly not malignant and that some curative operation can be done, as in a number of cases in which I have found ulcers surrounded by inflammatory thickening in which I was able either to excise the ulcer or to perform a gastro-enterostomy and thus to cure the patient.

Or it may be discovered that the disease resembles malignancy both in its history and physical signs and in the form of the tumour, and is yet, if we may judge from results, apparently not malignant, as in a number of cases under my care, which were at the time of operation supposed to be suffering from cancer of the stomach and in which, as the disease appeared to be beyond removal, a gastro-enterostomy was performed in order to short-circuit the obstruction and so to give relief, but which patients, as the result of surgical treatment, are now not simply relieved, but apparently quite well.

Now, I would lay particular stress on this class of cases, for I think it serves to explain some misconception about cancer generally. It would be easy for anyone, looking at the subject from a one-sided point of view, to raise a claim to having cured a number of

cases of cancer of the stomach by gastro-enterostomy; but I do not for one moment believe that any of these cases were more than inflammatory tumours formed around chronic gastric ulcers; nevertheless I have no doubt that they would have proved fatal, just as certainly as if they had been cancer, had no operation been done. This brings me to another interesting point, and that is the alleged increase of cancer; for I feel sure that many cases like those related above would have been certified as deaths from cancer of the stomach had no operation been done or, in case of death, no necropsy or microscopic investigation made, and I think we must take such cases into account before hastily deciding that this disease is on the increase.

The cases also illustrate another point, and that is, even though a tumour be present, and even though it be probably too large for removal, it may be quite worth while advocating an exploration, to be followed up by gastro-enterostomy if that be practicable, in the hope that the disease may prove to be wholly or partially inflammatory, which the physiological rest secured by gastro-enterostomy will either cure or materially relieve.

Now, to pass to the genuine cancer cases, what can we do for them when diagnosed at an early stage? This will depend (1) on the position of the growth; (2) on its extent; (3) on the presence of adhesions; and (4) on glandular invasion or secondary growths.

First, as to position. In irremovable growths at the cardiac end, if it involve the cardiac orifice and adjacent portion of the stomach, gastrostomy should be performed in order that starvation may be staved off. The view that gastrostomy is both a dangerous and useless operation is, I know, held by some surgeons as well as physicians, but I feel convinced that such views are mistaken ones. When these cases, either of cancer of the cardiac end of the stomach or of the oesophagus, were handed over to the surgeon in a moribund condition the mortality of gastrostomy was, of course, terrible, and the short survival, even if successful from an operative point of view, made the surgical treatment useless; but when I myself can point to a series of gastrostomies performed since 1897 not only without any mortality, but with comfort to all and great prolongation of life to some, I feel that I have good grounds for saying that the operation is well worth doing. In several cases the patients have lived a year or more, have gained considerably in weight, even up to 2½ st., and have lost their pain and the distressing sense of starvation.

The next class of cases is that in which the disease involves a great part or the whole of the stomach, the disease being irremovable and gastro-enterostomy impracticable, and in which any attempt at taking food brings on pain and vomiting, so that the patient must rapidly die in great distress if not relieved; here a jejunostomy can be performed by a very simple and similar procedure to that of gastrostomy, and through a Jacques catheter sufficient food can be given to ward off starvation and relieve the pain caused by attempts at taking food by the mouth. This operation can be done through the small exploratory incision, and need involve very little longer time. It may prolong life for months and make the end much easier and certainly less painful. I reported a case of jejunostomy in 1891 in which the patient lived three months. On November 4th, 1904, I read a paper before the Royal Medical and Chirurgical Society on a new method of performing the operation and gave the notes of a case in which the patient lived for a year after jejunostomy. Although the operation is rarely called for, it is one, nevertheless, which should be borne in mind, as in appropriate cases it may confer a great boon upon the patient and render tolerable an otherwise comfortless existence.

The third class of cases to be considered is where the disease involves the pylorus and is producing obstruction to the passage onwards of the gastric contents, but where, on account of the extreme feebleness of the patient or because of extensive adhesions, secondary

growths or involvement of glands, it is considered unwise to attempt pylorotomy, or partial gastrectomy, though there is sufficient free stomach wall left to enable a gastro-enterostomy to be performed. In such cases a gastro-enterostomy, if performed with proper expedition and adequate precautions, affords the greatest relief to the sufferer, who not only loses the distress due to painful peristalsis and to the irritation of retained secretion, but also becomes freed from the toxæmia due to absorption of the poisonous fermenting stomach contents, which are drained away into the intestine and there disposed of. Thus life is prolonged and made more comfortable, flesh and colour are regained, and even in cases of cancer the patient may have a new lease of life; moreover in some cases where the condition of the patient and not simply the extent of the growth has prevented a radical operation the speedy restoration to health enables a radical operation to be subsequently undertaken. The following cases serve to illustrate what I mean:—

CASE 1.—Mr. B., æt. 62. Symptoms for a year. Epigastric tumour noticed for a month. No free HCl in vomit. Exploratory operation, November 13th, 1900. Ring of cancer found, forming hour-glass shaped stomach. Patient too ill for gastrectomy; posterior gastro-enterostomy performed. Good recovery. December 20th, a month later, partial gastrectomy performed, the ring of growth being removed, and the cut ends of the stomach being fixed together over a large bone bobbin. Good recovery, returned home within the month. Quite well a year later. Letter, Nov., 1902, to say that Mr. B., had put on flesh, gained colour, and been able to take food well for over a year, but had succumbed to exhaustion from secondary growths in the omentum, March 30th, 1902, about eighteen months after operation.

CASE 2.—Miss B., æt. 24. Five years' history of stomach symptoms with great loss of flesh and recently coffee-ground vomit with tumour at epigastrium. Exploratory operation April 17th, 1902. Large tumour found involving the pylorus and anterior wall of stomach. Enlarged glands rendered gastrectomy inadvisable. Posterior gastro-enterostomy performed. Good recovery and returned home on the nineteenth day. Seven months later Dr. — wrote to say that patient, who weighed 4st. 5lb. at the time of operation, on September 1st weighed 8st. 1½lb., thus nearly doubling her weight in five months, but that she had recently developed jaundice, possibly due to extension of the growth to the common bile duct.

CASE 3.—Mr. B., æt. 36, seen with manifest tumour of the stomach, October 26th, 1901, and with a history of stomach trouble extending over several years, with vomiting of blood and passage of mæna on two occasions within the preceding four months. At the operation a large tumour involving the duodenum and pyloric end of the stomach, too adherent for removal, was found and gastro-enterostomy performed. After the operation he went abroad and for six months he rapidly gained weight and felt very well. He then began to get thinner and lose strength, and without any pain he gradually lost strength and succumbed in September, 1902, eleven months after operation.

CASE 4.—The patient was a married woman, æt. 37. Cancer of the body of the stomach and pylorus with dilatation was diagnosed. Gastro-enterostomy was performed on December 21st, 1899. She made a good recovery, and was so well that gastrectomy was advised, but cancer of the uterus supervened, and prevented further operation. She lived for nine months in comfort and was able to take ordinary food.

CASE 5.—The patient, a man, æt. 63 years, had symptoms for five years, at first those of chronic ulcer, with tumour associated with hæmatemesis. Gastro-enterostomy was performed on March 22nd, 1901. He made a good recovery and returned home at the end of the month, having gained 4lbs. in weight during the fourth week. He ultimately gained about 2st., and lived for a time in great comfort, but the growth progressed and he succumbed to exhaustion

about a year later, having been able to enjoy life for some months.

CASE 6.—Mr. W., æt. 68, operated on July 18th, 1902, for pyloric tumour with dilatation of the stomach, the patient being extremely feeble, and suffering great pain. The disease appeared to be cancer and the glands were extensively involved, so that gastro-entrostomy only could be performed. A letter a year later from Dr. — says the patient gained 10lbs. up to November and is now 14lbs. heavier than before he fell ill last June. He is able to take regular exercise and has never felt any pain after taking any meals whatever since the operation. He was well three years later.

Other cases could be given, but these will suffice to show the beneficial effects of gastro-entrostomy even in advanced cases of cancer of the stomach, for, as will be seen immediately, it is only in the cases too advanced for removal that the short-circuiting operation should be performed.

The operation can be done with little risk, for including all my cases of posterior gastro-entrostomy for cancer, the mortality is under 5 per cent., a great contrast to the death rate of these cases a few years ago, when only the anterior operation was a rule performed.

The remaining class of cases is of great interest and includes those where the disease is limited to the stomach, and where the lymphatic glands and adjoining organs have not been seriously invaded, the patient being in a sufficiently good condition to permit of the radical operation being done.

At first sight it would appear hopeless to expect that eradication of the disease could be performed 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 are the intestines; moreover the disease, if caught, early, can be as completely removed as cancer of the colon. The following are examples:—

CASE 7.—Mrs. J., æt. 30. Symptoms five months, tumour noticed three weeks. Operation January 1st, 1901. Tumour found, involving the whole circumference of the pyloric end of the stomach, a short distance from the pylorus. After the growth had been widely excised, the distal and proximal ends of the stomach were brought together over a large bone bobbin. Glands were excised from the lesser and also from the greater omentum. Smooth recovery. The patient enjoyed good health for over four years before there were any signs of recurrence of disease in the abdomen.

CASE 8.—Mrs. S., æt. 54. Loss of flesh, and pain, with failing health for eight months; slight jaundice and tumour in epigastrium and right hypochondrium for a shorter period. Operation August 8th, 1900. The gall bladder, containing gall stones and the site of tumour, was removed. As the adjoining portion of the liver was involved, a wedge-shaped partial hepatectomy was performed, and as the pylorus was also involved in the growth a partial gastrectomy including the pylorus was done, the cut section of stomach being united to the duodenum by two continuous sutures over a bone bobbin. The removed tumour examined microscopically after operation proved to be cancer. That part of the abdominal wall to which the tumour had been adherent was also excised. The patient was in good health five years later.

CASE 9.—Mr. A., middle-aged, who had been ailing for a year and had had stomach symptoms for three months and a noticeable tumour for six weeks, was supposed to be too ill and anæmic for operation, but as the tumour, which was situated in the left hypochondrium and epigastrium was freely movable, I decided to operate. On May 23rd, 1900, I found a mass of cancer involving the centre of the stomach, which I removed along with some glands adjoining it. Recovery was uninterrupted. The patient was in good health over two years later.

CASE 10.—In the *British Medical Journal* for November 8th, 1902, I reported a case in *extenso* where I

had removed the whole of the stomach, except a small portion of the dome adjoining the œsophagus, for malignant disease, on March 18th, 1901. I am glad to say that this patient, nearly five years later, remains in absolutely good health; he has a good appetite, enjoys his food, and is able to attend to his business, as usual. These cases will be sufficient to show that removal of even a considerable portion of the stomach may be something more than a palliative operation, and I think it justifies me in saying that although it is better to have cases of cancer diagnosed and operated on early, yet we need not take the pessimistic view which has been given by some surgeons that if a tumour be manifest it is too late to perform a radical operation.

I hope I have advanced sufficient evidence to prove:

1.—How desirable it is to make an early diagnosis of cancer of the stomach in order that a radical operation may be performed at the earliest possible moment.

2.—That it may be needful to perform an exploratory operation in order to complete or confirm the diagnosis.

3.—That such an exploration may be done with little or no risk in the early stages of the disease.

4.—That even where the disease is more advanced and a tumour perceptible, an exploratory operation is as a rule still advisable in order to carry out radical or palliative treatment.

5.—That where the disease is too extensive for any radical operation to be done the palliative operation of gastro-entrostomy, which can be done with very small risk, may considerably prolong life and make the remainder of it much more comfortable and happy.

6.—That some cases, thought at the time to be cancer, too extensive for removal, may, after gastro-entrostomy, clear up completely and get quite well.

7.—That in cases of disease of the cardiac end of the stomach too extensive for removal, the operation of gastrotomy may considerably prolong life and prove of great comfort to the patient by preventing death from starvation.

8.—That even where the disease is too extensive for removal or even for a gastro-entrostomy being performed with a fair chance of success, the operation of jejunostomy may occasionally prove of service to the patient.

9.—That where a radical operation can be performed the thorough removal of the disease may bring about as much relief to the patient as does the operation for the removal of cancer of the breast, uterus and other organs of the body, and that in some cases a complete cure may follow. Prevention is, however, better than cure, and certainly much better than mere relief. I think, therefore, the fact should not be lost sight of that cancer is predisposed to by chronic ulcer, and in no less than 59.3 per cent. of the cases of cancer of the stomach on which I have operated the history had pointed to antecedent ulcer.

The origin of carcinoma in an ulcer of the stomach is only another instance, added to many of which we have knowledge, of the effect of persisting irritation in establishing malignant disease. 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 of those that prove rebellious, either by gastro-entrostomy or excision, would do much to lessen the amount of cancer in the stomach.

NOTE.—A clinical lecture by a well-known teacher appears in each number of the journal. The lecture in next week's number will be by Sir Christopher Nixon, entitled, "The Diagnostic Value of Alterations of the Pulmonary Second Sound."

CLINICAL LECTURES FOR 1906.

We have already been favoured by promises of Clinical Lectures from the following teachers:—

- JOHN H. ABRAM, M.D., Lond., M.R.C.P., Lecturer on Clinical Medicine University of Liverpool
- WM. ALEXANDER, M.D., R.U.I., F.R.C.S., Eng., Lecturer on Clinical Medicine, University of Liverpool.
- PROF. CLIFFORD ALLBUTT, M.D., F.R.C.P., Lond., F.R.S., Regius Professor of Physic, University of Cambridge.
- SIR C. BALL, F.R.C.S.I., Regius Professor of Surgery, Dublin University.
- SIR JAMES BARR, M.D., F.R.C.P., Lond., Physician, Royal Infirmary, Liverpool.
- H. T. BRAWLEY, M.D., F.R.C.P.I., Lecturer on Public Health, School of Physic, Dublin.
- LEONARD A. BIDWELL, F.R.C.S., Eng., Surgeon to the West London Hospital.
- SIR LAUDER BRUNTON, Bart., M.D., F.R.C.P., F.R.S., Cons. Phys., St. Bartholomew's Hospital.
- JAMES CANTLIE M.B., C.M., F.R.C.S., Surgeon, Seaman's Hospital Society.
- ALBERT CARLESS, M.B., Lond., F.R.C.S., Eng., Surgeon to King's College Hospital.
- PROF. WM. CARTER, M.D., F.R.C.P., Lond., Prof. Mat. Med., University of Liverpool.
- SIR ARTHUR CHANCE, F.R.C.S.I., President Roy College Surgeons, Ireland.
- ANDREW CLARK, D.Sc., Oxon., F.R.O.S., Surgeon to the Middlesex Hospital.
- THOMAS S. CLOUSTON, M.D., F.R.C.P., Ed., Lecturer on Mental Diseases, University of Edinburgh.
- JAMES CRAIG, M.D., F.R.C.P.I., Physician to the Meath Hospital.
- SIR J. HALLIDAY CROOM, M.D., Ed., F.R.C.P., Cons. Gynaecologist, Royal Inf., Edinburgh.
- W. J. DAROGAN, M.D., Physician to St. Vincent's Hospital.
- GEORGE A. GIBSON, M.D., F.R.C.P., F.R.S.E., Examiner in Clin. Med., University of Edinburgh.
- ARTHUR E. GILES, B.Sc., Lond., M.D., F.R.C.S.E., Surgeon, Chelsea Hospital for Women.
- T. E. GORDON, F.R.C.S.I., Surgeon to the Adelaide Hospital.
- A. PEARCE GOULD, M.B., Lond., F.R.C.S., Surgeon, Middlesex Hospital.
- W. S. HAUGHTON, M.D., Surgeon to Steevens Hospital, Dublin.
- O. O. HAWTHORNE, M.D., M.R.C.P., Lond., Phys. Cent. Lond. Ophthalmic Hospital.
- A. J. HOENE, F.R.C.P.I., Master of the National Lying-in Hospital.
- ROBERT HUTCHISON, M.D., F.R.C.P., Lond., Asst. Phys. London Hospital.
- ALEXANDER JAMES, M.D., Ed., F.R.C.P., Phys. to the Edin. Royal Infirmary.
- H. LEWIS JONES, M.D., Cantab., F.R.C.P., Lond., Phys. Electrical Department, St. Bartholomew's Hospital.
- ROBERT JONES, F.R.C.S., Ed., Surgeon to the Liverpool Royal Southern Hospital.
- CHARLES R. B. KEETLEY, F.R.C.S., Eng., Senior Surgeon, West London Hospital.
- J. A. LINDSAY, F.R.C.P., Professor of Medicine, Queen's College, Belfast.
- JOHN MACINTYRE, M.B., C.M., F.R.M.S., Surgeon for Diseases of the Throat and Nose, Glasgow Royal Infirmary.
- R. C. B. MACNELL, F.R.C.S.I., Surgeon to Mercer's Hospital.
- A. B. MITCHELL, F.R.C.S.I., Surgeon Royal Victoria Hospital, Belfast.
- THOS. K. MONRO, M.D., M.Ch., F.F.P.S., Glas., Physician and Clinical Lecturer, Glasgow Royal Infirmary.
- ALEX. MORISON, M.D., F.R.C.P., Lond., Physician, Gt. Northern Central Hospital.
- WM. MURRELL, M.D., F.R.C.P., Lond., Physician to the Westminster Hospital.
- SIR C. NIXON, M.D., F.R.C.P.I., Prof. of Practice of Medicine, Cath. Univ. School of Medicine.
- J. F. O'CARROLL, M.D., F.R.C.P.I., Physician to the Richmond, Whitworth and Hardwick Hospitals.
- FRANK THOS. PAUL, F.R.C.S., Eng., Surgeon, Liverpool Royal Infirmary.
- R. W. PHILIP, M.D., F.R.C.P., Ed., Examiner in Clin. Med., Edinburgh University.
- F. J. POINTON, M.D., F.R.C.P., Lond., Asst. Phys., Hospital for Sick Children.
- A. MAITLAND RAMSAY, M.D., F.F.P.S., Glas., Surgeon, Ophthalmic Inst., Glasgow.
- PROF. A. W. MATO ROBSON, F.R.C.S., Hunterian Professor R. C. Surgeons, Eng.
- E. MARKHAM SHERRITT, M.D., F.R.C.P., Lond., Professor of Medicine, Univ. College, Bristol.
- R. SINGLETON SMITH, M.D., F.R.C.P., Lond., Cons. Physician, Bristol Royal Infirmary.
- WALTER SMITH, M.D., F.R.C.P.I., King's Professor of Mat. Med., Trinity College, Dublin.
- SYDNEY STEPHENSON, M.B., C.M., F.R.O.S.E., Ophth. Surgeon, Evelina Hospital.
- J. LINDSAY STEVEN, M.D., F.F.P.S., Glas., Physician and Lecturer on Clinical Medicine, Glasgow Royal Infirmary.
- H. R. SWANZ, F.R.S.S.I., Surgeon, Royal Victoria Eye and Ear Hospital.
- J. ODERY SYMES, M.D., Lond., D.P.H., Bacteriologist, Bristol General Hospital.

- W. TAYLOR, F.R.C.S.I., Surgeon to the Meath Hospital, Dublin.
- J. LYNN THOMAS, C.B., F.R.S.S., Eng., Surgeon to the Cardiff Infirmary.
- R. F. TOBIN, F.R.C.S.I., Surgeon to St. Vincent's Hospital, Dublin.
- E. H. TWEEDY, F.R.C.P.I., Master of the Rotunda Hospital, Dublin.
- HENRY WALDO, M.D., Aberd., M.R.C.P., Lond., Physician, Bristol Royal Infirmary.
- H. F. WATERHOUSE, M.D., Ed., F.R.C.S., Eng., Surgeon, Charing Cross Hospital.
- SIR JOHN B. TURK, M.D., F.R.C.P., F.R.S.E., Morison Lecturer on Insanity.

ORIGINAL PAPERS.**PARALYSIS OF THE ABDOMINAL MUSCLES FROM ACUTE ANTERIOR POLIOMYELITIS.**

By J. S. FOWLER, M.D. F.R.C.P.Ed.

Extra Physician, Royal Hospital for Sick Children, Edinburgh.

PARALYSIS of the abdominal muscles is unquestionably a rare occurrence in acute anterior poliomyelitis. It is unmentioned even in recent text books, and very few examples are recorded in neurological literature. No doubt the presence of the more conspicuous and incapacitating palsy of the limbs has to some extent contributed to this less obvious paralysis having escaped notice, and, like many other symptoms, it will probably be found to be more common than has been supposed when once its existence is more generally realised, and it is in view of this that I am induced to report the following case.

The patient was a girl, *æt.* 2 11-12, of satisfactory personal and hereditary antecedents. When she was two years and three months old she was suddenly seized with what is described as a "stomach attack," in which she lay drowsy and listless for a couple of days; this was followed by a day or two of good health, after which she was again taken ill and became almost completely paralysed, the only movements remaining possible being those of the head and eyes. There was no fever, unconsciousness, or convulsion. The paralysis persisted without change for a fortnight and then power was gradually regained in the right arm and left leg, so that in about six weeks she could move them fairly well. The left arm and right leg remained weak and almost useless, though latterly they too have improved somewhat, and the child can now stand and walk a little, though only with support. Within the past two months spinal curvature has developed. On examination the patient was found to be healthy in all respects save as regards the nervous system. She can neither walk nor stand without assistance; as a rule she rolls about the floor and cannot rise to a sitting posture without pulling herself up by her hands. She can flex both thighs on the abdomen, and the legs on the thighs, and can extend both legs; all these movements are fairly well carried out by the left leg, but decidedly feebly by the right. The greatest degree of paralysis is shown by the extensors of the right foot, which hangs in a position of foot-drop, and cannot be dorsiflexed voluntarily. Both knee jerks are slightly present; the plantar reflexes are doubtful. The muscles of the right leg below the knee are wasted, and the limb is cold. In both arms gross movements are well executed, but the finer movements of the hands and fingers (as in picking up small objects) are clumsy. The grip is good in the right hand, feeble in the left, which is in the position of *main en griffe*, the lumbricals and interossei being wasted.

The most remarkable feature of the case, however, is the condition of the abdomen. When the child is quiet little abnormal is noticeable, except that the abdomen bulges forward unduly with the descent of the diaphragm, but when she strains as in crying, this bulging becomes much more evident, the whole belly swelling up like that of a frog. On palpating the abdomen there is none of the usual resistance of the muscles, which

feel soft and relaxed. When the child tries to sit up she falls in the attempt, and the hand placed on the abdomen detects no contraction of the muscles. The abdominal reflexes are absent. The umbilicus is not displaced to either side. There is also paralysis of the dorsal muscles, causing well marked scoliosis.

The electrical reactions could not be satisfactorily tested (indeed, in children these can seldom be determined accurately except under general anaesthesia, which was impracticable in the present case), but the small muscles of the left hand, and the extensors of the right foot, showed marked diminution in excitability to the faradic current.

The case may be summarised as one in which the original loss of power was exceptionally widespread, and the residual paralysis, after 8 months, was chiefly localised in the extensors of the right foot, the abdominal and trunk muscles, and the small muscles of the left hand.

Even apart from anterior poliomyelitis, very little attention had been paid to the clinical features of paralysis of the abdominal muscles until Oppenheim's paper (1) on "The Abdominal Symptom-complex" appeared in 1902. Palsy of the muscles of the abdominal walls, he found, might arise from neuritis or from a cord lesion, such as a tumour, the chief symptoms being (1) inability to strain effectually, and bulging of the abdominal walls on attempting to do so; (2) displacement of the umbilicus to the sound side, when the lesion was unilateral; (3) inability to sit up without the help of the hands in bilateral cases; and (4) absence of the abdominal reflexes over the paralysed area. The paralysis in Oppenheim's cases was neither circumscribed nor limited to any one muscle, but affected all the muscles of the abdominal parietes, including the recti, either unilaterally or bilaterally, as the case might be. The segments of the cord which supply the muscles in question are the 8th to the 11th dorsal. Two papers on abdominal paralysis from anterior poliomyelitis have recently appeared, the more important being that of Ibrahim and Hermann (2), which is a study of four cases, while Cornell (3) also reports a case.

As might be expected, it is usual to find that the muscles of the back are affected along with those of the abdomen, but no other grouping is specially characteristic. The case reported above is the only one in which a residual crossed paralysis of the limbs was present. As has been mentioned, Oppenheim states that in neuritis or tumour of the cord, &c., the whole of one or both sides of the abdomen are paralysed or paretic. Ibrahim and Hermann find, on the other hand, that in infantile palsy a more limited paralysis is the rule, leading ultimately as in one or two other cases previously recorded, to a circumscribed atrophy with hernial protrusion of the viscera. A point on which these writers also lay stress is that, in contra-distinction to Oppenheim's cases, the recti are spared. The above cases conform more closely to the abdominal symptom-complex of Oppenheim than to the cases described by Ibrahim, Hermann, and Cornell, in respect of the wide distribution of the paralysis. As far as could be determined, all the abdominal muscles were paralysed, including the recti; the bulging was no greater on the one side than on the other, and the abdominal walls were everywhere equally flaccid. It should, however, be said that the child was very well nourished, and it must be borne in mind that owing to the uniform distribution of the palsy one was deprived of the advantage of being able to compare a sound with a paralysed part. It is quite possible, therefore, that the paralysis was not absolutely complete throughout all the muscles, and that as time goes partial recovery may take place, leaving a more or less circumscribed area of local atrophy. Ibrahim's third case, when examined two months after the onset, showed a state of matters not very dissimilar to that in mine, both sides of the abdomen being paralysed and having their reflexes abolished, though the right was the more severely affected. Six years later, however, the

paralysis had become circumscribed, and gave rise only to a globular protrusion of the viscera on straining.

Although rare, the condition is not destitute of practical importance. We are so habituated to regarding infantile paralysis as devoid of danger to life, that a favourable prognosis is usually given in this respect; at least after the acute onset is over. But when extensive paresis of the abdominal and trunk muscles is present, the risk to the patient should he be attacked by any acute pulmonary affection must be considerable. On the other hand, there is evidently a fair prospect that the function of the abdominal muscles will, partly at least, be restored, for in two of Ibrahim's cases considerable improvement was manifest after some years had elapsed.

(1) *Deutsche Zeitschrift f. Nervenheilkunde*, 1902, Bd. xxiv., Heft 5-6.

(2) *Ibid.*, 1905, Bd. xxviii., Heft 1-2.

(3) *Johns Hopkins Hospital Bulletin*, 1905 January.

THE SUBCUTANEOUS INJECTION OF SEA WATER IN THE TREATMENT OF INFANTILE DEBILITY.

By M. O. MACE,

Obstetrical Physician to the Paris Hospitals;

AND DR. R. QUINTON,

Assistant in the Laboratory of Physiology and Pathology of the College of France.

THE success that has attended the subcutaneous injection of artificial serum in prematurely born and feeble infants is now generally known. For some time past attention has been directed to the results obtained by the use of salt (sea) water with the same object in view. In view of the manifest superiority of sea water over ordinary artificial serum it occurred to us to make use of it as a substitute for the serum in the same class of cases. We therefore undertook a series of observations in order to test this hypothesis, and although in the space at our disposal we cannot go into detail we can at any rate give the general results which may conceivably induce others to follow our example.

Our investigations were carried out in the wards allotted to feeble infants at the Paris Maternity Hospital. They bore on 40 infants, and we wish to lay special stress on the fact that they were 40 feeble infants, peculiarly weak or presenting some hereditary taint, brought to the hospital in an extremely precarious state of health, as evidenced by the very trifling gain in weight prior to the commencement of the treatment—viz., an average of 25 grains per day per infant.

The majority of these prematurely born and feeble infants were suffering from the usual infantile diseases—bronchitis, diarrhoea, icterus, athrepsia, etc. We may lay it down, to begin with, that sea water, far from proving injurious in any possible way, appeared to us to considerably curtail the duration and diminish the gravity of the morbid phenomena. It caused the disappearance of jaundice usually in a comparatively short space of time. On no occasion did we see enteritis persist beyond five days under the sea water treatment even when originally severe. Respiratory affections were also favourably influenced thereby.

Lastly, in the subjects who were purely feeble without other morbid complication the subcutaneous injection of sea water yielded excellent results, rapidly causing the subsidence of all manifestation of debility, such as chilliness, cyanosis, digestive troubles and the like.

Even more convincing than these considerations was the prompt gain in body weight under the influence of the injections as compared with that following the employment of artificial serum, so largely used at the present time. We mentioned above that the average daily increase of weight in our little patients was 25 grains. With injections of artificial serum the gain per day per infant rose to 85 grains, whereas with sea water injections the daily gain amounted to 140 grains,

the other circumstances and conditions being exactly the same.

It follows that the gain in weight, which affords us such a trustworthy indication of functional activity, is double under sea water injections of that which follows the injection of artificial serum and ten times greater than during the "expectant" period. These averages are based on 2,132 days' experience, a fact that will give a good idea of their relative value. No œdema has ever been observed to follow the treatment.

Technical Details—Doses—Intervals. In conclusion we will describe the precise mode in which the treatment was carried out. With infants of an average weight of four pounds we injected every second day 10 cc. (about 180 minims) of isotonic sea water, preferably just below the scapula. We attach great importance to the dose and the interval. Recent researches, indeed, seem to point to a certain timidity in the use of sea water on the part of some practitioners, timidity which there is nothing to justify; indeed on the contrary, when administered in homeopathic doses, sea water gives no results worth mentioning. Nothing less than the quantity specified can be trusted to bring about an improvement.

This dose of 10 cc. every second day, though sufficient for prematurely born infants weighing four or five pounds, is inadequate when we have to deal with older children weighing from eight to twelve pounds. The injections should not be given oftener than every second day, but the dose may advantageously be increased to 30 cc. and upwards.

It has been pointed out that sea water is the culture medium for organic cells. It is absolutely devoid of toxicity and the white corpuscles thrive therein as if to the manner born. An animal may be injected with more than its body weight of sea water (Hallion) without causing the least sign of injury. Doses of 10 cc. for infants represent a minimum below which it is undesirable to descend if we wish to obtain tangible results.

A CASE OF RAYNAUD'S DISEASE.*

By S. T. LIGHTFOOT, L.R.C.S., L.R.C.P.ED.,
L.F.P.S.GLASG.

THE following case of Raynaud's disease, which came under my notice in private practice, presents some features of somewhat unusual interest. The diagnosis was confirmed in consultation both by a physician and by a surgeon. The result of the operative removal of the three affected fingers by the Bilton-Pollard method is extremely good.

History.—Mrs. A. H., widow, æt. 62, came to me on February 17th, 1903, complaining of severe pain and tingling in fingers of both hands. Some five or six years before the patient came under notice, she was suffering from albuminuria, which was cured with some difficulty. In the early spring of 1901, she had severe bronchitis and pleurisy, which left her in a nervous, irritable state. In July, 1901, she left London for Watford, and at first greatly improved in health. But her health fluctuated, a little albumin appearing occasionally in the urine. In the winter of 1902, she was in a very run-down and nervous state. Complained greatly of cold hands on rising. They ached and looked white and bloodless after washing, but regained normal appearance and feeling after a short time. Patient got worse in general health.

Patient was confined to the room and was in a depressed state, with frequent fits of crying. Took to her bed. Complained that everything looked strange and distorted, and appeared edged with bright beads, and seemed in a yellow mist. Wandered somewhat in mind and talk, but was conscious of the strangeness of her fancies, and would frequently laugh at their absurdity.

Patient now began to complain greatly of pain and tenderness in finger-tips of right hand, but no change

was visible in them. Pain changed to acute stabbing. Several times appeared in both hands at once, then in left hand alone; finally in right hand alone, where it remained.

History of Attack.—A faint purple tinge afterwards appeared in the fleshy parts of the right finger-tips. It looked as if the bone were purple, and the flesh sufficiently transparent to allow a slight indication of the colour to be seen. Agonising pain at frequent intervals for half-an-hour or so at a time. Finger tips began to darken, particularly round the nails, which developed a black spot in the centre of each. Thumb swelled up and joints swelled. Under surface of finger tips became harsh to the touch and turned a dirty brown, which colour extended nearly to second joint. Backs of fingers varied somewhat in colour. Sometimes they were mottled with dark, angry red and purple; sometimes only a little redder than normal, down to second joint. First joints steadily got worse, and did not vary save to get blacker. Fingers generally were discoloured for greater distance on palmar than on dorsal aspect.

After this had lasted a few days I noticed the appearance of a network of purplish red mixed with bluish capillaries, which increased gradually, until the tips of the fingers looked more like a dark blue stain, ultimately resembling on both hands the fingers of a person who had been picking blackberries. The patient suffered for some time agonising pain in the fingers, which nothing would relieve. I applied a variety of stimulating anodyne liniments, and kept both hands well covered with cotton wool. Under this treatment the left hand slowly recovered, but the right became gradually worse, and was not amenable to the same treatment. Neither hand could endure exposure to cold air, as it produced intense pain, which was temporarily relieved by hot fomentations and poultices. With regard to the duration of pain in the



* Shown at a Clinical Meeting of the Association of Medical Diplomates of Scotland, Dec. 12th, 1905.

right hand, it was never entirely absent for three months. The pain was always greater in the evening and night.

Dr. C. Herbert Hall, of Watford, saw the patient in consultation on two occasions, April 11th and 16th, and confirmed the diagnosis of Raynaud's disease. We agreed to advise amputation of three fingers. After this the hand was photographed, showing the exact condition of the fingers at that time. You will see that all five fingers were involved. Fortunately the thumb and fore-finger recovered completely.

On May 5th the patient was seen by Mr. Bilton Pollard at University College Hospital. He also confirmed the diagnosis recommending amputation of three-fingers as the others had begun to recover. On May 8th Mr. Bilton Pollard removed the fingers at the metacarpo-phalangeal joints. He noticed that there was very little bleeding during the operation, which he said was usual in Raynaud's disease. Since the operation, now two and a half years ago, the patient has had no return of the symptoms and finds the remaining thumb and fore-finger very useful.

CLINICAL RECORDS.

NOTES ON THREE CASES OF CONGENITAL DISLOCATION OF THE HIP*

By ANDREW FULLERTON, M.D., F.R.C.S.

Hon. Assistant Surgeon Royal Victoria Hospital, and Belfast Hospital for Sick Children, Examiner in Surgery R.C.S.I.

CASE 1.—S.T., female, æt. 2 years and 1 month, was admitted to the Royal Victoria Hospital on account of a "lurching" in her gait. There was no history of injury to mother or child either before or after birth. No deformity of any kind was known to have been present in any member of patient's family. The mother noticed that when the child began to walk its gait was peculiar, and she brought it to hospital to ascertain the cause. On examination the patient was found to be a healthy female child. On walking, she rolled over to the right side and had a very distinct limp. The trochanter on the affected side stood out prominently, and rode on the ilium with each step. The right leg was an inch and a half shorter than the left, but was not wasted. The trochanter of affected side could be felt below and behind the anterior superior iliac spine, and was about $1\frac{1}{2}$ inches above Nélaton's line. It could, however, by traction be brought down to the extent of $\frac{3}{4}$ inch. The head of the femur was freely movable on the ilium. The displacement was upwards and backwards.

Operation.—On May 13th, 1904, the following procedure was carried out under chloroform: (1) Forcible abduction with kneading and percussion to stretch or lacerate the tense adductors. (2) Maximal flexion, with pushing of the head of bone downwards towards perineum to stretch glutei and other muscles tending to draw femur up. (3) Extension and counter-extension to stretch the above muscles with the iliopsoas and hamstrings; also to bring the head of the bone towards the acetabular cavity. (4) Abduction and external rotation assisted by the hand of the operator guiding head towards articular cavity. A sudden snap, audible and easily felt, indicated reduction. At this moment the leg became somewhat flexed on the thigh owing to the shortness of the hamstrings. The head was bored into the acetabular cavity by firm pressure so as to fix it more securely by making a deeper bed for its reception. The limb was put up in the fully abducted position with flexion at hip and knee joints and retained in that position by plaster of Paris bandages. The bandages were changed in a month owing to being soiled, and head of bone slipped out. It was, however, easily reduced. Fresh plaster was applied, and changed first monthly and later at rarer intervals for a period of nine months altogether. At each change the limb

was brought more and more into the normal position, until finally it was quite straight. The child was after the first few weeks allowed to walk, so as to push the head of the femur against the shallow acetabulum and deepen it. The patient was examined on December 14th by the members of the Ulster Medical Society—that is one year and seven months after operation—and the limb was found to be anatomically and functionally perfect. The skiagraphs taken before and after reduction show the characteristic deformity and its complete reduction.

CASE 2.—W.M., male, æt. 8. No history of injury, was noticed to limp when he began to walk, which he did not do till he was æt. 3.

On Examination.—The boy walked lame and had a huge thick sole on his right boot to make up for a very obvious shortening of his right leg. The limb was not so well developed as the left, but there was no loss of power but rather considerable facility of movement. The affected leg was $2\frac{1}{2}$ inches shorter than its fellow, and the trochanter raised above Nélaton's line. The limb could be lengthened to the extent of $\frac{1}{2}$ inch by traction. The movements of the head of the bone at the false joint were very free and painless. The head of femur could be felt almost on a level with the anterior superior spine, and was set further back than on the sound side. The trochanter was prominent. The skiagraph showed the femur to be considerably smaller in diameter than its fellow of the opposite side. The head and trochanter were also attenuated; the former looked like the truncated end of the neck. The acetabulum was shallow and ill-developed. From the skiagraph it would appear that the angle between the neck and shaft is increased on the affected side. No treatment has yet been adopted.

CASE 3.—J.R., æt. 12, was seen on May 9th, 1904. She was a typical example of double congenital dislocation at the hip-joints. Walked with a marked waddling gait. Trochanters could be felt high up on ilium, $2\frac{1}{2}$ inches above Nélaton's line, and posterior to acetabulum. On placing the hands on hips and asking the patient to walk, the up and down movement of the trochanters could be plainly felt. The hips were broad and the trochanters projected in a characteristic manner. The thighs were separated by about an inch at the perineum. There was marked lordosis. The femoral neck on both sides was short and thick as seen by skiagraph, the upper end of the bone resembling that of a humerus rather than that of a femur. There was no indication of an acetabulum on either side in the skiagraph. On traction, the heads of the femora could be drawn down to the extent of about an inch when the patient was lying down. As the girl can get about very comfortably her parents have decided not to submit her to operation.

THE OUT-PATIENTS' ROOM.

THE CANCER HOSPITAL.

Two Cases of Melanotic Sarcoma Commencing in Pigmented Moles.

Under the care of R. H. JOCELYN SWAN,
M.S.LOND., F.R.C.S.
Assistant Surgeon to the Hospital.

Case I.—M.A.W., female, æt. 56, was sent to the Cancer Hospital in May, 1905, for tumours in the abdominal wall, right inguinal region, right breast, and axillary glands. She has had slightly raised, pigmented mole on the right side of the abdominal wall in the mammary line at the level of the umbilicus as long as she could remember. It caused her no inconvenience, but about two years ago she noticed that it had gradually increased in size, forming a raised, rounded boss, covered by thin purple skin, which finally ulcerated, leaving a surface from which bleeding was easily provoked on touching. Twelve months later

* Shown at a meeting of the Ulster Medical Society, Dec. 14th, 1905.

this was removed by a doctor by an elliptical incision, and the wound healed well, but in November, 1904 (six months later), she noticed, under the outer end of the scar, a thickening which progressively increased in size, and extended into the subcutaneous tissues on either side of the scar. About the same time the patient also noticed a tumour in the right inguinal region, and in the upper and outer quadrant of the right breast. The inguinal swelling slowly increased in size, but caused no pain other than an occasional aching in the groin. The mammary tumour had enlarged more rapidly, and caused a shooting pain in the right shoulder and axilla.

On examination, on the right lateral aspect of the anterior abdominal wall was the horizontal scar of the previous operation, the outer end of which was stretched by an underlying tumour, nodular on the surface, and covered by thin, pink-coloured skin, in which many dilated venules were seen. The tumour formed a plaque with raised, rounded edges, and was of firm consistence. It was not adherent to the abdominal muscular planes.

The inguinal tumour was a mass of enlarged lymphatic glands, matted together, forming a swelling the size of a hen's egg. The skin over it was freely movable, and the mass was not adherent to the deep structures.

The right breast contained a firm, oval-shaped, flattened swelling, immovable in the mammary tissues, in the upper and outer quadrant of the organ. The skin over it was dimpled and adherent to it in the centre, and on attempting to raise it between the fingers showed the "peau d'orange" type. The limits of the tumour were indefinite, and it was adherent to the pectoral fascia. There were enlarged glands in the right axilla, but the glands in the cervical, supra-clavicular and infra-clavicular regions were not affected. The liver was not palpable, and no physical signs were present in the thorax.

A diagnosis of melanotic sarcoma was made, and the patient was admitted to the hospital for operation, which was performed on May 23rd, 1905. The right breast and axillary contents were removed by Halstead's operation, the costo-sternal portion of the pectoral muscles being removed, and the axillary sheath and costo-coracoid membrane dissected away. The recurrent nodule in the abdominal wall was removed at the same time, the inguinal mass being also extirpated. The immediate progress of the patient was wholly satisfactory, and she left the hospital well on July 12th. Pathologically, each tumour consisted of melanotic sarcoma, containing mixed round and spindle-shaped cells. The inguinal and axillary lymphatic glands also showed melanotic deposits.

The subsequent history of the case (kindly supplied by Dr. McConnell) showed that about the middle of August she became hemiplegic. Some time afterwards a tumour appeared in the right iliac fossa, and another to the left and below the occipital protuberance. She became subject to attacks of delirium and delusions, and died on October 12th from pulmonary oedema. No post-mortem examination was obtained.

Case II.—C.C., female, æt. 49, came to my out-patients' room in October, 1905, for tumours of the right side of the face and neck. Since a small child she had had a small pigmented mole below the right lower eyelid. This remained the same form until about fifteen months ago, when it began to increase in size, reaching that of a filbert-nut in three months, when it was removed at the London Hospital by Mr. Hurry Fenwick. She remained well for four months, when recurrence took place at the original site, and two months later she was again operated upon, not only the recurrent nodule being removed, but also the glands in the submaxillary and upper part of the anterior triangle of the right side of the neck were dissected out. Within a month after this operation she again noticed a tumour over the angle of the jaw on the right side, and five weeks later a further recurrence took place under the right eye. These have increased in size, and more recently patient

has found further tumours in the right supra-clavicular region, in the right axilla and in the back.

She was admitted into the hospital on November 2nd, 1905, and on examination at this time there was a raised, rounded tumour below the right eye, the size of a walnut, fixed to the underlying bone, blue in colour, and in its prominent portion the skin over it was very thin and shining. Over the right angle of the mandible was a large, irregularly shaped, nodular mass, fixed to the jaw, and projecting into the mouth opposite the lower molar teeth, but the mucous membrane over it was intact. The glands in the vicinity of the tumour were enlarged. Small subcutaneous nodules of growth were present in the posterior fold of the right axilla and over the back of the seventh dorsal spine. The liver was slightly enlarged but smooth. The physical signs in the thorax were normal.

No operation could be performed for this patient, and her progress in hospital has been rapidly downhill. The facial tumours increased in size and other subcutaneous nodules of growth appeared upon the abdominal and thoracic walls. The breathing has become quickened, and the patient is now apathetic.

The exact nature of the tumours in this case cannot be stated until the histological examination, but in all probability the growth is of a melanotic character. Both these cases are instances of the origin of malignant disease in the life history of an innocent tumour, and they are here brought forward to impress the fact that should an apparently innocent tumour at any time take upon itself progressive or rapid increase in size, or should its surface become ulcerated or bleed, it should be removed whenever possible by an incision carried wide from its apparent limits.

OPERATING THEATRES.

GUY'S HOSPITAL.

CASTRATION FOR TUBERCULOUS DISEASE OF THE TESTIS.—MR. CLEMENT LUCAS operated on a man, æt. 50, for tuberculous disease of both testes. There was a family history of tubercle on both sides, the man's mother and his father's sister having died of the disease. The patient was said to have had enlargement of the left testis seventeen years ago, which disappeared after wearing a suspensory bandage. He had no further trouble till, June, 1905, when the swelling again commenced, and was accompanied by dragging pain on the right side. He was treated in the country, and wore a suspensory bandage, under which the swelling at first seemed to diminish. In October he noticed a swelling upon the left testis, associated with shooting pains. The swelling gradually increased, and burst a fortnight later, discharging thick yellow matter. He was first admitted into the hospital a week afterwards. The left testis was considerably swollen and hard; in front of it was a soft fluctuating swelling, which was translucent, and due to fluid in the tunica vaginalis. On the outside the skin was indurated, and adherent round the spot where the abscess burst. The epididymis throughout was felt to be very much enlarged. The right testis was also very much increased in size, but nowhere adherent to the scrotum. The epididymis formed a large crescent on the outer and back part. Tuberculous disease of both testes, was diagnosed, but as open suppuration had occurred on the left side, it was determined to remove this testis first, together with the infiltrated skin, through which the tuberculous abscess had discharged, and to leave the right testis for a second simpler operation by drawing it up through an incision over the external abdominal ring. An incision, including skin, cellular tissue, and dartos was commenced over the left

inguinal canal, and carried downwards, and back again so as to include an ellipse of the infiltrated scrotum; the testicle was then turned out with this ellipse attached to it, the cord was clamped as high up as possible, severed below the clamp, and the testis removed. The vessels of the cord were all tied separately with fine silk, and before the clamp was removed a temporary stitch was run through the cord above the clamp, so that it should not slip up in the abdomen when the clamp was taken away this precaution being used in case any vessel should have been missed. As no bleeding took place after removal of the clamp the temporary stitch was taken away, and the cord allowed to retreat into the abdomen. This method of securing the vessels is greatly preferable in Mr. Lucas' opinion, to that of tying all the constituents of the cord together inasmuch as the latter method, by including all the nerves of the cord, gives rise to much greater pain, and as a stouter ligature is used may also contribute to suppuration and stitch sinuses. A short time ago, he said, in removing both testes at the same time, he compared the two methods, employing one on one side and the other on the opposite the patient complained of pain only on the side where all the constituents of the cord were tied together. The wound in the patient just operated on healed satisfactorily in about a fortnight, and he left the hospital, refusing to have the right testicle operated on before going home. On examining the specimen removed, two ounces of clear serous fluid were found in the tunica vaginalis. On opening the body of the testis disseminated miliary tubercle was found scattered through it, the larger and older tubercles being at the lower part. The globus minor of the epididymis showed masses of breaking down cheesy tubercle; the globus major showed even larger masses, more advanced in the direction of pus, whilst the central part of the epididymis contained an abscess through which a probe could be passed into the abscess sac beneath the skin, which had commenced to discharge a week before the operation.—The patient was re-admitted to the hospital a month later, the right testis now having gone on to suppuration, and having discharged through the scrotum by two small sinuses. This involved a similar operation to the previous one, a large part of the scrotal integument being implicated and having to be cut away. The degeneration of the epididymis and the breaking down of the tuberculous deposits to form tuberculous abscesses was observed in this specimen as in the last, but there was less evidence of miliary tubercle in the body of the organ. In neither case was there any evidence of the tubercle extending high up along the vas deferens, so that Mr. Lucas hoped that all further extension of the disease had been arrested, this man at present showing no sign of prostatic or vesical tuberculous trouble.

The second case on which Mr. Lucas operated illustrated, he said, the importance of removing a tuberculous testis to prevent extension of the mischief to the prostate, vesiculæ seminales, bladder and kidneys, after which the disease too often proves incurable. It was that of a middle-aged man who fourteen years before had had a blow on his left testis; he stated that the organ did not swell up at once, though it was painful, but some six months later it began gradually to enlarge, then went on to suppuration and discharge. After being some months under treatment the sinus healed but the testis never resumed its normal size and contour, but remained permanently enlarged. For some months before admission the

patient had begun to suffer from extreme irritability of the bladder; he also noticed some turbidity of his urine; he had no stricture or stone in his bladder. Mr. Lucas found the epididymis of the left testis greatly enlarged and the cord above thickened. Examined per rectum, the left side of the prostate was also found enlarged. The case was diagnosed as tuberculous testis, with secondary infection of the prostate, and Mr. Lucas strongly advised the man to have the organ removed. The right testis was found perfectly normal. The operation was performed through an incision over the external abdominal ring and inguinal canal, the testicle being drawn up out of the scrotum by means of the cord; as the vas deferens was also much thickened, the inguinal canal was split up so that as much as possible of the seminal tract should be removed. The vessels were tied separately as in the previous case and the wound completely closed. Primary union took place and a week later the patient began to experience some benefit from the operation as the irritability of his bladder began to subside. Examination of the testis showed the whole epididymis converted into a tuberculous mass, in part crétaceous; similar deposits in fusiform masses were found along the vas deferens. The body of the testis showed fibroid change, the seminal tubes not unravelling. The patient was afterwards treated by the injection of tuberculin at intervals to raise his opsonic index, which greatly improved after removal of the testis. Before he left the hospital, he had gained almost complete control over his bladder. The manner in which the tubercle bacillus reaches the epididymis and germinates there may, Mr. Lucas remarked, vary in certain cases, but he thought that in a good many instances the disease commences as a tuberculous urethritis and extends to the epididymis in the same way as a gonorrhoeal urethritis reaches the same organ. A remarkable instance of this, he said, came under his notice in private practice during the past year, where an insignificant and painless urethritis contracted by illicit congress ended fatally from general tuberculous disease of the urinary tract in about two years and a half. At other times it is probable, he said, that the tubercle bacillus circulating in the blood gets caught in the epididymis of a testis, that has lost its resistance either from injury or injudicious use. The second case operated on, he thought, would appear to be one of the latter, for there was a distinct history of injury, although the tuberculous enlargement did not appear till some six months later when the man was for some reason or another probably depressed in health. Again the extension of the mischief from the testis to the urinary tract did not take place till some years later, when probably some fresh cause depressed the man's general health.

Death of a Lunatic from Choking.

AN inquest was held on Saturday at Colney Hatch Asylum on the death of Alice Solomon, twenty-seven years of age, a patient, who was choked by a piece of plum pudding on Christmas Day. She suffered from mania; was in the habit of taking food from other inmates of the institution, and throwing plates at them; and had to be specially watched, as it was feared she would do violence to herself. A nurse said that she was feeding Solomon at dinner time on Christmas Day. While the woman was eating the pudding she threw back her head suddenly, and was dead before a doctor could reach her. A *post-mortem* examination revealed a piece of the pudding sticking in the throat. A verdict of death from misadventure was returned.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, DEC. 15TH, 1905.

The President, Dr. R. D. PUREFOY, in the Chair.

Dr. R. C. B. MAUNSELL showed a uterus removed by Wertheim's method for carcinoma of cervix.

Dr. JELLETT asked if he had found the separation of the uterus, as Wertheim described it, easy? Wertheim said that if the ureter were isolated it sloughed; but when were you not going to isolate it if it ran through or on top of a carcinomatous mass? If this is so, it would seem to be a necessary part of the operation to remove this isolated portion and reinsert the ureter into the bladder. He did not see any difficulty in the rest of the operation.

The PRESIDENT said that in the removal of a cancerous uterus one of the chief things was the safety of the ureters, and this was difficult to provide for. It was an interesting point that so many glands were examined and found to be free from cancer. His own feeling was that the uterus should be removed in every case in which there appeared to be even a slight chance of the patient getting over the operation, and they should try to relieve suffering.

Dr. MAUNSELL, in replying, said that he too thought that the operation should be done if possible, as he believed the suffering was less when a patient died from a secondary growth, as in the liver, than from the primary one. The ureter had to be separated if you were going to extirpate the parametrium, and he would not have the least hesitation in doing it, as he thought there was little danger of sloughing so long as you did not pinch the ureter in any way. He had found it pretty hard to carry out Wertheim's procedure—namely, to lay your finger on the ureter and pass your finger between the ureter and the uterine vessels. There was nothing very difficult in the operation, but it was rather lengthy.

Dr. HASTINGS TWEEDY showed a retro-peritoneal sarcoma.

Dr. ROWLETTE described the pathology of the tumour.

The PRESIDENT described a somewhat similar case in a girl, aged seventeen. There had been steadily-increasing distension of the abdomen for two years. Urine loaded with albumin. Operation revealed a tumour weighing 17 or 18 lbs., in the retro-peritoneal tissue in the region of the left kidney, which was free.

Dr. GOULDING asked if there was a mesentery in connection with the tumour, as it was hard to conceive that the vessels underneath would not otherwise be pressed on.

Dr. TWEEDY, in replying, said that the tumour was absolutely fixed to the spine, and he had been surprised that there was no evidence of pressure on the vessels. This class of tumour could not be diagnosed before the abdomen was opened, and once this was done the surgeon should always complete his operation.

SOME POINTS OF INTEREST IN A SERIES OF TWO HUNDRED AND ELEVEN MAJOR OPERATIONS.

Dr. HASTINGS TWEEDY read a paper dealing with some points of interest in a series of 211 major operations performed by him in the Rotunda Hospital. These comprise 44 ovariectomies, 9 panhysterectomies, 15 sub-total hysterectomies, 14 pyosalpingies, 32 ventrofixations, 2 anterior colpotomies, 11 salpingotomies, 15 tubal pregnancies, 3 ovarian resections, 9 ventral hernias, 7 radical operations for prociencia, 1 tubercular peritonitis, 2 vaginal hysterectomies for painfully retroverted uteri, 2 retroperitoneal sarcomata, 4 Cæsarean sections, 18 vaginal fixations, 7 abdominal myomectomies, 10 vaginal myomectomies, 1 enterostomy

and 5 vaginal hysterectomies for cancer. There were 8 deaths in this series—two under anæsthesia, in profoundly septic patients, 2 in abdominal, and 1 in vaginal hysterectomy for cancer, 1 vaginal myomectomy, 1 sub-total hysterectomy, and 1 abdominal removal of pus tubes. The skin wound showed some suppuration in five cases, staphylococcus albus in two, bacillus coli in one, and a diplococcus in a fourth, whilst the germ was not looked for in the fifth. Convalescence was delayed in none of these cases. Tubal disease, to a greater or lesser extent, was found in 19 of the 32 patients subjected to ventrofixation; nearly all these were sterile, and an effort was made in every instance to remove the pathological state by breaking down adhesions, resecting ovaries, and opening the lumen of the tube. He believed that neither Mackenrodt nor Wertheim had succeeded in establishing their operations for cancer on a permanent basis. Dr. Tweedy dealt with his method of closing the abdomen in layers, and by a means of a leaden plate, and pointed out that in a recent Cæsarean section, undertaken by him for the second time, no trace of silk was to be found, either in the uterine or abdominal walls, nor had any adhesions formed in the neighbourhood of the scars. He described in detail the operative technique in force in the Rotunda Hospital, and the simple and inexpensive design of the theatre. None of his failures were attributed to architectural deficiencies in his operating room, which he believed to be adequate for the requirements of aseptic surgery. In its simplicity it furnishes a crushing argument against the lavish expenditure so fashionable in the present day; an expenditure which has converted the modest workshop of the surgeon into apartments which might well serve as a dazzling advertisement for a quack electrical specialist.

Dr. JELLETT congratulated Dr. Tweedy, and said he agreed with him in his views on theatre expenditure. He also approved of having the windows open during operations. He thought that the sterilising apparatus should be removed to some distance from the theatre, as the air could, at present, be contaminated by it. He was inclined to think that face bags were not really necessary if the operator took proper care of his teeth. Discussing the technique of operating in cases of sterility, especially when caused by closure of ostia of tubes, he asked Dr. Tweedy if he had any reason to think that in a case where the tubal ostium had been glued down to the intestines there was any chance of making it patent again. He himself thought the chance small, and he thought the time might be better employed in removing the fimbriated extremities of the tubes where adhesions were most likely to form. He was much surprised to hear that Dr. Tweedy washed out the abdomen in every case, and asked what his views were on the subject of drainage.

Dr. KIDD asked what method of suturing was used in the cases of ventral hernia. He himself had used the three layer principle with good results. In the case of sloughing myoma, which was removed by morcellation, and which ended fatally, would it not have been better to treat by removal of the entire organ? He thought that many cases of sterility were due to the condition of the male. He approved of wearing a mask, as a certain amount of sputum was kept out of the field of operation by it.

Dr. HORNE agreed that the enormous expenditure incurred in making theatres was to be deprecated. He appreciated the strict asepsis of Dr. Tweedy, and suggested that the nurses also should wear masks. The fact of so many stitch abscesses having occurred showed that no matter what care was taken accidents would happen. He believed that cases of cancer frequently came for treatment when too late, owing to the fact that pain was a late symptom in the disease.

The PRESIDENT said he had not made the use of:

rubber gloves a general practice. Many operators stated that their successes were not materially increased by their use, and the difficulty of manipulation was certainly increased. He asked what Dr. Tweedy considered the indications for operation in cases of recurring displacements. Many of these cases were attended with no symptoms. He utterly disbelieved in vaginal fixation, and thought that after Alexander's operation the ligaments frequently stretched again. He thought there was likely to be trouble after these fixation operations if the woman became pregnant, and supposing the ligaments were strong enough to hold.

Dr. HASTINGS TWEEDY, in reply, said that he had enumerated all his bad cases. Those that remained recovered without causing anxiety. They neither suffered from excessive thirst nor vomiting, from flatulence distension nor obstinate constipation. This he attributed in some part to filling the abdomen with saline. The patients would probably have recovered without the saline infusion, but he felt convinced that there convalescence would have been less uneventful. His series includes 100 consecutive abdominal sections without a death, but this is not a satisfactory record so long as the majority of cancer cases seen are not submitted to operation. The submucous myoma removed by morcellation protruded through the vulva as a sloughing mass, and it was quite out of the question to suggest its removal by abdominal section.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD THURSDAY, DECEMBER 14TH, 1905.

CHARLES J. OLDHAM, F.R.C.S., Vice-President, in the Chair.

DR. D. MATHESON MACKAY read a paper on
THE LIGHT SENSE IN STRABISMUS.

After pointing out that up till now, no observations had been made and published on the conditions of the Light Sense in the Amblyopia of Strabismus, he described his examination of 1,245 strabismic or amblyopic patients, undertaken in order to discover if there were any defect in the light minimum, or the light difference, of the affected eye, which could account for the strabismus or the amblyopia. The photometer employed was a new one, described as having several advantages over those previously used. The cases were arranged in six groups, convergent strabismus with amblyopia (66 cases), convergent strabismus without amblyopia (30 cases), alternate convergent strabismus with double amblyopia (2 cases), divergent strabismus with amblyopia (9 cases), divergent strabismus without amblyopia (4 cases), and amblyopia without strabismus (14 cases).

In all these cases both the light minimum and the light difference were estimated separately, and the results in the more important groups showed that a large majority of the affected eyes had normal light sense (77 to 90 per cent., as to the light minimum, and 75 to 80 per cent. as to the light difference). The lesser groups had the same tendency, but on account of the small number of cases, their results were not insisted upon. Dr. Mackay concluded that one could only deduce from these observations that the condition of the light sense is not responsible for the squint, or for the amblyopia.

Mr. STEPHEN MAYOU read a paper on
CYCLOPS.

The specimens, four in number, were obtained at the London Hospital through the kindness of Dr. Keith. Case 1 was that of cyclops in a dog. It showed a single centrally placed eye, having only one elongated lens, and a single retina. The optic nerve consisted of two layers of cells. Case 2 was a human cyclops, having two lenses corneæ and retinae, with a single optic nerve. This specimen was peculiar in having

no proboscis or olfactory nerve. Case 3 was a human cyclops with extreme microphthalmos. It had two lenses and corneæ, and there was a partial inclusion of the proboscis between the anterior parts of the globes. The posterior halves of the ventricles were converted into a large cyst (local hydrocephalus). Case 4 was a twin cyclops, with complete union of heads, and fusion between the eyes of either foetus; the fusion was so perfect that no differentiation could be made out except a small coloboma of the nerve sheath.

Full anatomical details of the results of the mal-development of the first cerebral vesicle, together with the microscopic anatomy of the eyes were given.

RETRO-OCULAR TUMOUR.

Mr. RICHARDSON CROSS gave a description of seven cases he had operated upon for retro-ocular tumour, five of them were done by Kronlein's method. He described the various conditions in which an exploratory operation such as this would be of the greatest benefit; it assisted the diagnosis and left the patient no worse for having done it. The operation was briefly explained.

Case 1 was a fibro-adenoma of the lachrymal gland, but it left behind ptosis and partial paralysis of the ocular muscles with inversion of the eyeball, an unsatisfactory result. Case 2 was a hydatid cyst removed from the optic nerve. This was removed with good result. Case 3 was a fibro-fatty tumour of the eyeball which passed backwards into the orbit. It was removed successfully. Case 4 was a sarcoma of the upper lid, which caused proptosis. The eyeball had to be removed with the tumour, as it happened, although there seemed a reasonable probability that the eye might be saved before the operation was undertaken. The patient made a good recovery. Case 5 was a similar growth under the upper lid in which the orbit was eviscerated without any attempt having been made to save the eye. Case 6 was a large growth at the inner and lower part of the orbit, which was removed by an incision along the inner and lower walls of the orbit. Case 7 was one of severe proptosis, with retro-ocular growth treated by Kronlein's method. A sarcomatous mass had destroyed the upper wall of the orbit, and was in contact with the brain. The antrum was also involved. The wound healed up and left good vision, and good use of the eyeball, even the internal rectus was not damaged. Mr. Cross showed another case in which he considered an exploratory operation desirable. He was greatly impressed with the utility of the operation, and he urged that it should be done in any case in which there was doubt as to the nature of the condition of the orbit.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD DEC. 14TH, 1905.

SIR JAMES BARR, President, in the Chair.

DR. W. B. WARRINGTON read a note on some
UNUSUAL CASES OF SPINAL RIGIDITY,

commonly considered as forms of arthritis deformans. He related the history of a man who, after a trivial injury, rapidly developed marked rigidity of the whole of the spine, which was bent forwards, and the head flexed upon the neck. A sister of this man also suffered from a similar condition. The cases were compared with those described by Marie, as spondylose rhizomélisque, and contrasted with the form of rigidity associated with pronounced lesions of the nervous system, first described by Von Bechterew, and by him considered as primarily a nervous disease. Dr. Warrington then gave an account of the neuralgic forms, described by Forrester, and related a case of simple curable rigidity of the spine. It was suggested that in some of these cases the joints of the articular processes of the vertebrae might be the site of the disease, and that the spinal meninges became affected by direct continuity of the morbid process.

Mr. D. DOUGLAS-CRAWFORD related the case of a

girl, æt. 18, in whom, as the result of an accident, the musculo-spiral nerve had been divided. At an operation performed six weeks later there was some difficulty in finding the ends of the divided nerve, which were lying three inches apart. The operation was performed in the country, and as it was impossible to directly join the divided nerve, a young rabbit was shot, and a portion of its spinal cord used to bridge over the gap. Four months later the patient had complete return of sensation, and extension of the digits and supination of the forearm were almost perfect.

Dr. C. J. MACALISTER related a case of Mitral Disease in which a loud vibrating systolic murmur was present. This murmur varied greatly in intensity, almost disappearing during expiration and being very marked during inspiration. There were occasional attacks of tachycardia, the pulse rate at these times varying from 180 to 200 per minute. At the autopsy the mitral cusps were found partly joined by shortened cordæ tendinæ. The left vagus was adherent to the aorta, and was involved in some adhesions behind an atheromatous patch in the vessel, which was narrowed in calibre just beyond the origin of the great vessels. This constriction had probably helped to increase the blood-pressure in the heart during systole, especially during the expiratory act, and in consequence the mitral valve was then more completely closed and the murmur lessened.

Dr. JOHN HAY read a paper on

PAROXYSMAL TACHYCARDIA,

which he illustrated by numerous pulse-tracings and diagrams. Attention was particularly directed to three cases:—Case 1, a youth, æt. 19, had suffered from seventeen attacks which were typical in character, the pulse frequency being between 160 and 300. Between the attacks the action of the heart appeared to be normal in every respect. Case 2, a child, æt. 6, with no valvular disease. There had been one attack only, which varied from the usual type chiefly in its prolonged manner of termination. The pulse frequency during the attack was from 200 to 340 per minute. Case 3, a man, æt. 42, suffering from mitral stenosis, and liable to paroxysms of tachycardia, in which the heart frequency was from 160 to 180 per minute. Dr. Hay discussed the conjectures as to the pathology, and was of opinion that the evidence tended to show that the primary seat of the disorder is situated in the myocardium, that in these persons the heart is unstable in its method of contraction, the exciting factor being some cause initiating stress in the right side of the heart. As a result of this stress, there is a sudden and fundamental change in the manner of the heart's contraction, the auricle and the ventricle contracting simultaneously, each responding to stimuli originating in the fibres joining the auricles to the ventricles. Dr. Hay described the "normal venous pulse" and demonstrated its departure from the normal in cases of paroxysmal tachycardia. In Case 1 there was present that rare and significant form, the "pulsus alterans." It is an evidence of failure in the contracting power of the heart. In Cases 1 and 2 the typical pulsus paradoxus was present on several occasions. Treatment was considered and the various methods discussed. It was recognised that though much could be done for the patient, the attacks tend to follow their own course towards recovery, irrespective of medicinal treatment.

Dr R. J. H. Buchanan, Mr. Damer Harrison, the President, and Dr. P. F. Tinne took part in the discussion.

A Proposed Memorial to Harvey.

An appeal, which will secure the sympathy of medical men, from the Vicar of Hempstead, in Essex, who desires to honour the birthplace of William Harvey, the discoverer of the theory concerning the circulation of the blood. His proposal is to rebuild the church tower at a cost of £1,500. The Royal College of Physicians of London has decided to give twenty guineas. The medical profession generally may, or may not, support this somewhat impersonal memorial.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

A MEETING HELD DEC. 15TH, 1905.
Dr. LEONARD GUTHRIE in the Chair.

The discussion on the BACTERIOLOGY AND PATHOLOGY OF PLEURAL EFFUSIONS was opened by Dr. J. G. EMANUEL (Birmingham). Serous are four times as common as purulent effusions in adults, but in children they occur in practically equal numbers. In adults a purulent effusion is often secondary to a serous, but in children it is generally purulent from the first; 75 per cent. of empyemata are pneumococcal, and these may be either secondary to pneumonia or primary. Streptococcal empyema is rare in children, but common in adults. Empyemata containing staphylococci often indicate tuberculosis. An empyema complicating a case of pulmonary tuberculosis is generally pneumococcal or streptococcal. The naked-eye appearance of the pus is no reliable indication of the micro-organism. There is no essential bacteriological difference between serous and purulent effusions.

Mr. LOCKHART MUMMERY said that cases of empyema in children could be conveniently divided into two classes: (1) Those where the infection is purely pneumococcal, and (2) those where a mixed septic or tubercular infection exists. The great majority of cases are pneumococcal, and in these a free exit for the pus is all that is required, draining for any length of time is unnecessary, and it is often unnecessary to use a drainage tube at all. In the other class of cases and in those where much thickening of the pleura exists good drainage is always necessary. He advised irrigation of the pleural cavity with water of salt solution in suitable cases, and pointed out that the fatal results which have sometimes followed this practice are to be attributed to the iodine or carbolic acid solution used.

Dr. G. A. SUTHERLAND referred to the frequent absence and slight character of the symptoms in many cases of moderate pleural effusion. Breathlessness and tiredness on exertion were the commonest symptoms complained of. Coughing, pyrexia, wasting and anæmia were often present, but were not diagnostic. A lemon-coloured skin and clubbing of the fingers which had developed rapidly and without cyanosis, were strongly suggestive of purulent effusion. A diagnosis could only be made by a careful examination of the chest, noting the position and condition of the lungs, the heart, and the diaphragm as indicated by the stomach resonance and the hepatic dulness. The chief use of the exploring needle was not to determine the presence of fluid, but to distinguish between serous and purulent effusion.

Dr. HOBHOUSE (Brighton) said there can be no doubt that we can cut short the acute pleurisy and prevent effusion by active measures in the early stage, but when once effusion has fairly commenced it is very doubtful whether it can be cut short by any medical measures. Two or three different lines of treatment have been pursued by different authorities. In the first instance it was sought to reduce the quantity of fluid by increasing the fluid output and reducing the intake. With this object, diuretics, diaphoretics and purgatives were given freely, and a thirst diet adopted; most authorities are agreed that the results attained are by no means proportionate to the discomfort entailed. If a reasonable trial of medical measures is insufficient to reduce the effusion, it will be necessary to remove the fluid by puncture.

Dr. W. J. S. BYTHELL said, about three years ago he was to undertake the investigation of the bacteriology of empyema in children, and the objects at which he aimed were to determine (1) the course of infection of the pleura; (2) the species of micro-organism; (3) the influence of the bacteriology upon the clinical features of the disease. In forty cases of empyema, children whose ages varied between

ten months and eleven years, of these twenty-seven were males and thirteen females, the source of infection in over 80 per cent. was undoubtedly an acute broncho-pneumonia, 10 per cent. an acute pneumococcic infection of a pre-existing pulmonary tuberculosis; in another case it followed upon a sarcoma of the lung. In six cases the empyema appeared to be "primary." The influence of age upon the species of bacteria is well known, and his results confirm fully the great relative frequency of pneumococcus, the actual percentage in his cases was 90 alone or with streptococcus.

Dr. EWART read the notes of a case under his care at the Belgrave Hospital of a boy, *æt.* 10½, treated by paracentesis by symphonage and the admission of air into the pleural cavity, with subsequent relapse of the effusion, which was treated by intra-pleural injections of adrenalin solution without paracentesis with rapid recovery.

Dr. L. S. DUDGEON said that during the last five years he had made many examinations of the fluid taken from the chest in cases of serous and purulent effusion, and he thought that since Widal originally suggested the method it was one of the most valuable we have, because if one drew off clear effusion and found the cells, either in few or large numbers consisting entirely of lymphocytes, he thought one could definitely say it was tuberculous. If, on the other hand, one found what was described as the polynuclear phagocyte one could say it was due to one of the pathogenic organisms. After a large experience during the last four or five years he had found it practically constantly. Another point to which reference was not made was that in one case he found a very large number of cells which showed active myototic figures, and when the child died it was found to suffer from diffuse sarcoma of the chest cavity and pleura.

Mr. ARTHUR EDMUNDS said he desired to exhibit an apparatus to demonstrate the importance, in relieving empyema, of making the opening into the chest sufficiently free, not only to allow of the pus being forced out voluntarily, but for other reasons. Although everyone has realised that the chest did fill in coughing and in violent expiration, he did not think it had been sufficiently realised that that method of expiratory filling of the affected lung was one which was constantly taking place. When the lung on the other side was connected with the affected one by a bronchus, and when the passage outwards was free, as in paralysis of the larynx, the movements of the chest wall would have no effect on the movements of the other side; alterations in the tracheal pressure were not able to affect that lung. But if there were an obstruction in the outflow from that tube, which took place by the movements of the vocal cords, then, on expiration, the unsupported lung where there was an opening into the chest wall would move also. That he believed took place not only in violent coughing, because he had shown by experiments on animals that after opening the chest wall and setting up an irritative reflex from the pleural cavity, the examination of the vocal cord was sufficient to cause blockage, so that while the lung on the sound side was collapsing, the lung on the other side was expanding. That was the process which he felt sure was going on during the whole course of healing of an empyema.

THE Royal College of Surgeons has issued the regulations relating to the Begley Studentship in Surgery and Anatomy. This studentship, which is of the value of £20 and tenable for three years, has been established by funds left for that purpose by the wife of the late Dr. William Chapman Begley as a tribute to his memory.

THE annual dinner of the West London Medico-Chirurgical Society will be held at the Wharnclyffe Rooms, Hotel Great Central, London, W., on Wednesday, February 7th, 1906. Tickets 7s. 6d. each (exclusive of wine) may be obtained of the Honorary Secretaries, Dr. Walter, Windmill Road, Romford; or Mr. E. P. Paton, M.S., Queen Anne Street, London, W.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

Paris, January 1st, 1906.

SALPINGITIS.

NOTHING seems easier than to distinguish a case of acute salpingitis. Nine times out of ten, at least, it can be said that every para-uterine tumefaction filling somewhat the vaginal *culs de sac* and accompanied by pain, tenderness to pressure, and inflammatory symptoms is a case of salpingitis. Although it can be either simple or bilateral, localised or complicated with certain inflammatory phenomena of the peritoneum, yet it is none the less salpingitis, as the principal seat of the morbid manifestations is in the Fallopian tubes.

Frequently, says Dr. Faure, it is not necessary, in order to affirm the reality of the infection of the tubes, that all the classical symptoms should be present. It is often impossible, for instance, if the patient has a certain embonpoint, to distinguish with precision and tumefaction in the *culs de sac*; but a certain degree of immobility of uterus, which seems fixed at both sides when touched by the finger, is frequently sufficient to clear up the diagnosis.

According to the virulence of the infection, salpingitis can present varied forms, from the simplest lesions, where only slight tenderness is complained of, to the formidable developments of peritoneal infection.

The treatment of acute salpingitis is simple enough. Rest in bed, the ice bag to the abdomen if pain is very great, hot injections, or, better still, hot enemas.

In the majority of cases the symptoms disappear under the treatment, and resolution is complete. But this happy termination is not the absolute rule. Sometimes in spite of the above treatment the infection makes headway, the general symptoms become aggravated, the fever rises, and the pain, an important point, becomes more intense and symptoms of general peritonitis are observed, and in such cases an operation can alone save the patient. Colpotomy is frequently sufficient, but vaginal hysterectomy is sometimes necessary.

Chronic salpingitis is more amenable to surgical than to medical treatment; yet medical treatment is more or less successful when the patient is sufficiently docile and can be persuaded to take prolonged rest. However, where the pain persists and the lesions become aggravated, the physician must give way to the surgeon.

TREATMENT OF PLEURITIC EFFUSION.

Of the different agents prescribed against effusion into the pleura, salicylate of soda has obtained the most favour. It is not necessary to administer it in very large doses, but if after three weeks' trial no benefit results, it should be dropped and thoracentesis practised.

Quite recently Schedel recommended for the same malady chloride of barium, given in one grain doses three times a day, and after him Pesci made a series of experiments on forty-three patients, in whom he remarked the extraordinary curative properties of chloride of barium. Under the influence of the diuretic provoked by this drug at the above doses, the pleuritic effusions disappeared in a few days.

This effect was constant and was witnessed even in the febrile period of the malady.

NOTE.—In last letter—subject, Locomotor Ataxy—Nitrate of soda should have been printed *nitrite* of soda.

Berlin, December 31st, 1905.

At the Verein für Innere Medizin, Hr. Rothmann showed a young woman, *æt.* 22, with

DOUBLE FACIAL PARALYSIS.

The patient had at an earlier period suffered from tuberculous disease of the bones of the right ear, on account of which a radical operation had been per-

formed in February last, from which right-sided facial paralysis had resulted. Besides this, there was contraction in the region supplied by the left facial, with paralysis of the left upper branches. Careful examination revealed loss of sensation of both corneæ and hysterical analgesia of the whole side of the body. The case was one therefore of organic facial paralysis of the one side and hysterical paralysis of the other.

At the Charité Society, Mr. Bum showed a

VAGINAL CÆSAREAN SECTION

on a woman who was extremely collapsed from mitral insufficiency and stenosis. After opening the anterior vaginal arch, turning and extraction of the foetus were easily accomplished. After the operation which lasted only a few minutes and by which a living child was extracted the patient recovered rapidly.

Hr. Liepmann showed preparations from

THREE CASES OF RUPTURE OF THE UTERUS,

One at the fundus, one at the contractile ring, and one a total colpo-pontrexia caused by incautious use of the forceps. In two of the cases life was saved after laparotomy.

At the Medical Society Hr. Rosenstein showed a series of drawings that he had taken of

TUBERCULOUS KIDNEYS

that had been removed by J. Israel. Three forms were distinguished (a) the ulcerated cavernous form; (b) tuberculous ulceration of the tips of papillæ, and (c) the chronic nodular form, all three of which could naturally be differentiated only in the commencing stages. Regarding the identification of the b form not only was exploratory opening up of the kidney necessary, but under certain circumstances even free incision into the pelvis of the kidney. He hoped that in the future by functional diagnosis chronic tuberculous disease of the kidney would be recognised so early that total extirpation of the organ would be no longer necessary, but that partial resection would be enough to bring about permanent recovery.

Hr. Dith pointed out that an early stage of tuberculosis of the kidney was often enough recognised *post mortem*, where no symptoms of the disease had been noticeable during life. The first commencement of the tuberculosis was found in the medulla or in the calices at the point where the mucous membrane surrounded the papillæ tips. The early appearance of the disease in the medulla was explained by the appearance of tubercle bacilli in the straight canaliculi; in the glomeruli the bacilli must be passed out from the blood in acute miliary tuberculosis.

Of great importance for the development of tuberculosis of the kidney was tubercle of the arterial walls. From blocking up the lumen of the vessel an infarct might form, which might become tuberculous later on, or tuberculosis of the whole area supplied by the artery might be set up. Tubercle bacilli had also been demonstrated in the canaliculi without the kidney itself becoming tuberculous. (Benda.)

At the Society for Innere Medizin, Hr. Gutzmann showed a boy, æt. 12, who was sent to him on account of

DEFECTIVE ARTICULATION.

In looking at the boy's face it was seen that the whole skin of the face was affected by a sort of pasty swelling, the lips especially were very much swollen. Along with this there was complete absence of expression in consequence of immobility of the facial musculature, so that the forehead could not be wrinkled, and instead of laughing, the boy only succeeded in drawing the mouth slightly outwards. At a first glance myxœdema might be diagnosed, but a more careful examination showed complete diplegia of the abdomen. There were other malformations also—the left hand was smaller than the right, and there was a web between the second and third fingers. There was almost complete aphasia of the mammary glands and pesse quinus of both sides. The muscles of the trunk were otherwise normal. From photographs taken in early life it was seen that the disease had not progressed. The defective power of articulation was caused by the immobility of the swollen lips. The speaker was attempting to

improve the articulation by tongue exercises as a substitute for the defective lip movements.

Hr. Rothmann asked if thyroid preparations had been tried. The swelling of the face was so great that there might perhaps be myxœdema along with the diplegia of the facial.

Hr. Gutzmann replied that the thyroid was present, and the mental condition was normal, and that was against any assumption of myxœdema. The boy was very good at figures and was quite intelligent.

Hr. Goldscheider asked if the boy perspired? He asked the question because Gutzmann had said that the boy showed aphasia of the mammæ, and he himself had seen such a case in which the sweat glands were absent.

Hr. Gutzmann replied that the boy did perspire. The aphasia was not complete, the nipples were only indicated.

Vienna, December 31st, 1905.

JOSEF SKODA.

LAST week the two great medical societies, the Gesellschaft and the Doctoren Kollegium, celebrated the anniversary of Skoda's birthday. A large number of medical dignitaries and honourables were present to hear Hofrat Schrotter proclaim the greatness of Vienna's medical knowledge. In a spirited prolegomena, in which he regretfully spoke of the vacant chair of Nothnagel, he assured his audience that the medical teachings of the Austrian schools were never before in such a perfect condition as they were at the present time, for which they had to thank their ancestors for such a noble heritage. Skoda, like Rokitansky, was a foreigner, and not an Austrian, but he had, along with Rokitansky, raised the Vienna School to a very high pedestal in European medicine. Lænnec first introduced the stethoscope, but Skoda taught us how to use it, and profit by its results. His labour differentiated a number of thoracic diseases that formerly were classed as one. What Skoda commenced in auscultation and percussion Rokitansky confirmed in the *post mortem* room, with the pathological specimen. He was theoretical and practical, always ready to investigate the origin, as well as the result, and to his present knowledge of disease Vienna owes its present splendid supply of water.

He was born in Pilsner, Bohemia, 1803, the son of a locksmith in indigent circumstances. After qualifying at Vienna, he returned to his native land to practise when an epidemic of cholera swept over Europe. Subsequently he returned to Vienna, where he joined Rokitansky in all his great work. Here Schrötter related his own impressions of the "great teacher." In his farewell lecture he told them (in 1870) that he was leaving, but the microscope and chemist were coming to take his place. He died on June 13th 1881, leaving behind him a protocol to be read by every medical scientist as the real basis of our present knowledge.

SPIROCHÆTA PALLIDA.

A great fight still rages round the spirochæta in syphilis, some have it in the secretions, while others cannot find it; others affirm this is the casual germ, and by another section it is denied.

Lipschütz affirms after careful examination that he has found the spirochæta pallida in both primary and secondary syphilis, as well as in congenital syphilis. These germs are to be found in the inter cellular tissues in large quantities, as well as in the morbid products of the disease. He has injected these products into monkeys and obtained the same result—spirochæta pallida. When non-syphilitic tissues were used or secretions were used the results were negative.

IODINE AS AN ORAL POISON.

Witzel declaims against the use of iodine for painting the gums, as frequently performed in dentistry. For proof of this testimony, he relates the history of a patient who had the gums painted six times with the tincture for pain, followed by a large inflammatory abscess in the roof of the mouth which had to be incised and carefully dressed. He thinks dentists should be

warned against this savage practice of painting the gums with iodine.

Budapest, December 30th, 1905.

In the "Gyogjaszat," T. Osin publishes an article on the

STERILISATION OF SURGICAL SILK BY DIFFUSION CURRENTS.

It has been admitted that although water and alcohol have no disinfecting power alone, when one is added to an article impregnated with the other, the diffusion causes currents in and around the bacteria, which kill staphylococci in two minutes. The author has applied this principle to the sterilisation of surgeon's silk. This is first boiled in alcohol, to remove all fat, impurities, &c. It is then set aside to dry, and before an operation it is boiled in water for twenty minutes, then placed for five minutes in alcohol, then for five minutes in water, and again in alcohol for twenty minutes. He has used this silk extensively, and has not had a single case of stitch where it was employed.

Dr. Manszler writes on the DIFFICULTIES OF EARLY DIAGNOSIS OF PERITONITIS AFTER APPENDICITIS.

There is no symptom that will inform us absolutely of the advent of peritonitis after appendicitis. Fever may be altogether absent, while chills are rare. The pulse is extremely unreliable, as it may be normal with pus in the peritoneal cavity, and much increased without this. The facies constitute an important sign, but exceptions to the rule are frequent. A tendency to syncope and a change in voice have been mentioned, but are altogether too indefinite to decide so important a point. Of more importance are tympanites and inability to pass gas. The association of certain symptoms may be of some value. These are: changed facial expression, pains radiating towards navel, epigastrium or left, and persistent despite the application of ice; dyspnoea, restlessness, fall of temperature, and a tendency to syncope.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

NEW SURGICAL OUT-PATIENT DEPARTMENT, EDINBURGH ROYAL INFIRMARY.—This new department, which has for several months been under construction, was formally opened by Lady Cranston on December 22nd. In 1903 the proposal to reconstruct the surgical out-patient rooms, so as to render them adequate for the treatment of the 15,000 cases which the Infirmary has to deal with annually, was first mooted, and a committee of the managers was appointed to inquire into what was being done in other large hospitals. The immediate cause of action being taken in the matter was the occurrence of so-called "scandals"—patients being brought to the Infirmary to receive treatment for accidental injuries, and being kept waiting, unattended to, for considerable periods. Inquiry into these unfortunate occurrences fully absolved the hospital staff from blame; it was shown that the system, not the officials, was at fault, hence the resolve to tackle the matter from its foundation, and erect a new department, which will be commensurate with the work for many years to come. The new department is situated in the same part of the hospital as formerly—that is in the lower storey of the north-east pavilion, and in the adjacent ground. Facing the entrance hall is a waiting-room, from which a corridor leads to four pairs of spacious dressing-rooms. One pair of (male and female) dressing-rooms is for fractures, another for septic cases, another for "clean" cases, and the fourth is set apart for the women students. The whole is fitted up in the most approved style—tiled walls and ceilings, terrazzo floors, sterilizing appliances, etc. Beyond the dressing-rooms there is a room for the surgeon-in-charge, for the sister, and for the resident sur-

geons. From the waiting-room a glass corridor gives access to a newly erected operating theatre, accommodating about 100 students, to which four ante-rooms for anaesthesia, etc., are attached. Adjacent to the new department a casualty ward has been opened, into which patients brought into hospital unconscious may be admitted until such time as a definite diagnosis is arrived at. The arrangements for the working of the out-patient department have also been completely changed to suit the new premises. The surgical out-patients will now be under the charge of one assistant-surgeon, who is to act for four months, and during that period will be relieved of his other duties. Under him there are to be three house-surgeons, each of whom will be on duty for eight hours of the day. The nursing staff consists of a sister, with four nurses, one of whom will always be on duty. The managers of the Infirmary have also introduced another reform, which, though of minor importance, will greatly enhance the convenience of the staff, and will benefit the patients in the wards. The existing telephonic arrangements have been replaced by an exchange in the Infirmary, managed by the National Telephone Company, one of whose operators will be constantly on duty. It will now be possible for any of the staff to call up his wards directly without the delay incidental to the previous system of a private independent telephone system in the hospital.

CITY OF EDINBURGH AND THE BACTERIOLOGICAL EXAMINATION OF SPECIMENS.—Some years ago the municipality withdrew the work of reporting on sputum, etc., in cases of suspected infectious disease from the Laboratory of the Royal College of Physicians, and gave it to the then newly-opened Usher Institute. Most of the medical men in the town resented this act in some measure, because the College Laboratory, which had, on its own initiative done the work gratuitously ever since its foundation, was felt to have earned the right, now that the city had realised its duties, to some financial aid. And, as a matter of fact, for a few years prior to the opening of the Usher Institute, the town had made an arrangement with the College to pay for specimens examined—an arrangement which was later abrogated in favour of the Usher Institute, though by a very small majority, the voting being 21 to 20. Since this time the two institutions have been doing reporting work, the College Laboratory gratuitously, the Usher Institute in return for payment by the town. At the last meeting of the Town Council Dr. Cullen moved that without altering the arrangement with the Usher Institute the town should again pay the College Laboratory a fixed sum for every specimen examined. A long discussion took place, but eventually it was decided by a majority of 25 votes to 15 to maintain the *status quo*. It is said that there is a certain amount of prejudice among the practitioners of Edinburgh against the Usher Institute. That, even if this ever existed, it is being borne down now, is shown by the fact that the specimens sent have risen from 880 in 1904 to 1,300 this year. The real explanation is that medical men were perfectly satisfied with the work done by the College Laboratory, and felt it had at the time been hardly treated. But, after all, reporting work of this kind, important though it be, is largely routine, and many now think that, seeing that bacteriological work is being done by the town, the Laboratory of the College might restrict itself to the higher work of research, for which it is so well equipped. At least, it is to be hoped that Town Councillors will have no more opportunities afforded them of talking about the "trade unionism" of the College of Physicians.

LORD ROTHSCHILD has accepted the office of president, and Sir Frederick Treves that of consulting surgeon to the Royal Dental Hospital of London, Leicester Square.

SIR WILLIAM FOSTER was last week appointed to the distinguished position of Membership of the King's Privy Council.

LETTERS TO THE EDITOR.

HOSPITAL AMALGAMATION AND THE SCOTCH AND IRISH DIPLOMATES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR.—In a recent valuable leader dealing with the King Edward's Hospital Fund, you touch upon their policy of pressing forward amalgamation of the smaller hospitals. You also advert to the fact that in case of such a step the question of the unjust exclusion of Scotch and Irish qualifications by certain hospitals must be considered. The matter was forced into the field of practical politics by the proposal to amalgamate the London Orthopædic Hospitals. One of the most distinguished surgeons at the Royal Orthopædic Hospital was F.R.C.S. of Edinburgh. The Royal Orthopædic Hospital rejoices in the unjust condition of staff appointment which says that no Scotch or Irish need apply. The compact was carried out between the National and the Royal that every surgeon must have the Fellowship of the English College.

Then pressure was brought upon the City Orthopædic Hospital to join the amalgamation. There are two distinguished surgeons on the staff of that institution, and it was presumably intended to oust them also from their positions on the score of the insufficiency of the Scotch Fellowship. Now that the City Orthopædic has consented to join the scheme, it may be presumed that this abominable restriction has been removed. Anyway, the eyes of King Edward's Fund have been opened as to what injury their amalgamation policy may cause to honourable and blameless men, merely at the instigation of the worst kind of trades unionism. Thanks to your outspoken articles of a year or more ago, the risk of removing that iniquitous restriction from the staff appointments of the London hospitals has been initiated. In my opinion you deserve the gratitude of every Scotch and Irish graduate and diplomat.

Much remains to be done. You have inserted the thin end of the wedge in courageous fashion. The campaign will be carried on, I am glad to learn, by the Irish Graduates' Association, and the newly-formed and energetic Association of Medical Diplomates of Scotland. There can be no stay or compromise in the matter. What we demand is absolute equality and freedom of competition for hospital appointments all over the United Kingdom.

Individually I am glad to believe that the many London surgeons and physicians of London hospitals whom I am proud to reckon among my friends are incapable of any mean or unjust act. But, collectively, none the less, they are helping to maintain a sordid and grossly selfish system, whereby they are unfairly put in possession of a valuable monopoly.

Trusting you will find space for this somewhat long letter, I enclose my card.

I remain, sir, yours truly,
F.R.C.S.I. & F.R.C.S.Ed.

Harley Street, London, W., Dec. 30th, 1905.

THE PROPOSED APOTHECARIES' "HALL" ASSISTANTS' ASSOCIATION: AN APPEAL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—With the aid of some of my colleagues in the Public Service I am desirous of forming an association of holders of the assistants' certificate of the Society of Apothecaries of London.

I, therefore, beg to ask you to be good enough to give me your valuable assistance by allowing me to make an appeal in your columns to all who may be interested in the matter, especially to those holding appointments in the public and hospital services.

Several of us have felt for some time past that our interests are greatly imperilled through lack of organisation. We feel that the time is ripe to combine to enable us to protect the undoubted privileges and advantages which we possess.

I may say that I have had a personal interview with

Mr. A. M. Upton, clerk to the Society of Apothecaries, who assured me of the sympathy and support of that body. He also promised a very substantial aid by offering, subject to the approval of the Master and Wardens, to place a room at the Society's hall at our disposal in which to meet and discuss the several questions which are now agitating the whole dispensing body.

I therefore earnestly invite all those who may be willing to join such an association to forward to me their names and addresses at their earliest convenience. Should this appeal meet with a satisfactory response I will at once take steps to call a meeting.

I am, Sir, yours truly,

ALBERT HOWELL.

Hackney Union Dispensary, Dalston, N.E.

REVIEWS OF BOOKS.

ROSE AND CARLESS' SURGERY.*

PROFESSOR HUXLEY used to maintain that only the greatest masters of an art were competent to write an elementary text-book on it; and what an elementary text-book should be, he himself showed by his small "Physiology," which saw the light some thirty-five years ago, and (like Charley's Aunt) is still running. The writers of a text-book on surgery, then, who find their work in the sixth edition seven years after publication, may take to themselves the reflection that they have acquired a mastery of their art which has emerged triumphant from the most exacting of ordeals. The student on the whole is a conservative animal, and, not without reason, he clings to the old favourites among his text-books till he sees good reasons for acquiring new friends. But such a new friend he has found in "Rose and Carless," and it is certain that this friend has come to stay. It is not difficult to find in this treatise on Surgery the elements that have already made it an established success, for it responds readily to all the tests that a good student's text-book should be proved by. In the first place, it is scrupulously accurate. If it is didactic, that, it may be answered, is of the essence of its nature, and does not impair its accuracy. Secondly, it is lucid. This is high praise for a volume on so extensive a subject as surgery, which must be kept within the bounds appropriate to a manual. The difficulty of preserving lucidity in short essays on the complex problems of surgical diseases is one that can only be appreciated by those who have tried, and "Rose and Carless" has the high merit of never allowing the subject to master the pen, nor of leading its readers into quagmires of ambiguity when they are seeking clear, succinct, and definite teaching. Thirdly, it has interest. A text-book of abbreviated form is apt to degenerate into a catalogue of symptoms, theories, and procedures, and only enthusiasts with a touch of inspiration are capable of turning out a manual of surgery which is also a human document. Again, within their severe limits, the authors have succeeded in performing a feat of no little agility, and one which redounds to the credit of their heart no less than to that of their head. We have spoken so far of "Rose and Carless," for the book appears under the joint authorship of those surgeons, and under those names it has become as familiar in the mouth of the latter-day generation of students and young practitioners as household words. But we notice with regret that Mr. Rose has dropped out of responsibility for the present edition, and that Mr. Carless has had the whole work on his shoulders. In order to ensure the accuracy of the sections on "Bacteriology" and "The Blood in Health and Disease," he has secured the co-operation of Dr. D'Este Emery, Clinical Pathologist to King's College

* "A Manual of Surgery for Students and Practitioners." By William Rose, M.B., B.S., F.R.C.S., Emeritus Professor of Surgery in King's College, London, and Albert Carless, M.S., F.R.C.S., Professor of Surgery in King's College, London. Sixth Edition. University Series. London: Baillière, Tindall and Cox. 36 Plates and 500 Illustrations. 21s. net, cloth, and 25s. net, flexible leather, gilt.

Hospital, and this gentleman has also revised the work from the standpoint of the latest pathological teaching. Help, too, has been obtained from Mr. Reid, Radiographer to King's College Hospital, who has lent his experience in the composition of the chapters which deal with radiography and light treatment. While we find ourselves able warmly to commend the book as a whole, there are certain points naturally which lend themselves to criticism. We would draw attention to the surprising statement on page 1094—that in hernia (under certain circumstances) "taxis is objectionable, and, if employed at all, should be used in the most perfunctory fashion." We quite agree that taxis is objectionable under the conditions noted, but surely the authors do not mean that it is safe to employ it "in the most perfunctory fashion." In the chapter on prostatic enlargement, it is noticeable that the authors agree with Mr. Freyer in claiming that total prostatectomy not only is possible, but that it is the operation that is to be aimed at. It is, perhaps, still permissible for surgeons to hold differing views on this subject, but it is not quite consistent to state (page 1218) that "either procedure" (for enucleating the prostate) "is possible, and in the more exaggerated cases there is not much to choose between them," and (page 1219), "One fallacy must be avoided," namely, "Opening up a line of cleavage which runs inside the capsule between it and the adenomatous masses." Nor do we think it is adequately explained that the "capsule" in adenoma of the prostate represents the remains of the gland, thinned out, and atrophied. We note also that it is recommended that prostatic abscesses, acute and chronic, should be opened through the perinaeum, the choice of the rectal route not being given, even when pus happens to point there. These, and a few other points that might be mentioned, do not seriously impair this manual; it is a fine performance, admirably and skillfully carried out; and endows the "University Series" with a lustre equal to that of any of its companions. The publishers have been particularly happy in the selection of a type and a paper which make the book most pleasant to read, although it comprises no less than 1350 pages and is easily held in the hand.

LITERARY NOTES.

AN interesting medico-sociological study on "The Alcohol Problem in its Biological Aspect," by Dr. T. N. Kelynack, Honorary Secretary of the Society for the Study of Inebriety, is now in the press, and will be issued immediately.

READERS of that exquisite short story, "Rab and his Friends," will be glad to know that a volume of letters by its author the late Dr. John Brown, of Edinburgh, is in preparation. Few men understood child-life more perfectly, or ever gave the world a more touching study of the devotion of a shepherd's dog.

THE forthcoming number of *The British Journal of Inebriety* will contain a full report of Professor D. Crothers' "Norman Kerr Memorial Lecture," an abstract of which recently appeared in our columns.

AMONG the many changes in business methods as they affect medical men may be mentioned the enterprise of some of the leading manufacturing druggists. We have before us "The Consultant's Appointment Book," of Messrs. Burroughs, Wellcome and Co., and the handy "Note-Book" of Messrs. Scott and Bowne, both handsomely turned out, and each is, we understand, sent gratuitously to every registered practitioner in the United Kingdom. Beside the daily usefulness of these pocket remembrancers, there is an insurance coupon enclosed in "The Note Book," by which the representatives of any medical man meeting his death by accident during the year can claim £500 or £250 as the case may be, without cost of insurance policy or premium.

OBITUARY.

ROBERT TIMOTHY MATTERSON, L.R.C.S.ED., M.R.C.S.ENG.

THE death took place recently at Langenhoe Rectory, Essex, of Mr. Robert Timothy Matterson, formerly of Newark. The deceased gentleman, who was in his seventy-eighth year, was in practice at Newark for the long period of forty-two years—from 1862 to 1904. He studied at Leeds and St. Bartholomew's Hospital, and took the diploma of L.R.C.P. of Edinburgh, and that of M.R.C.S. of England in 1860. For a short period afterwards he filled the post of house physician of the Leeds Infirmary, and then proceeded to Newark. There in time he became the senior hon. house surgeon of the Newark Hospital, the public vaccination officer of the Newark district of the Newark Union, and the medical officer of the Newark School Board.

THOMAS CHARLES LANGDON, F.R.C.S., OF WINCHESTER.

By the recent death of Mr. Thomas Charles Langdon, Winchester has lost a prominent citizen, and the medical profession an honourable and accomplished member. He was born at Baampton, in 1835, and was therefore 70 years of age at the time of his death. He was educated at St. Bartholomew's Hospital, whence he took the M.R.C.S. England in 1858, and the Fellowship in 1862. His first connection with Winchester was in 1860, when he was appointed House Surgeon to the County Hospital. He held many honorary and other appointments, but was best known as Medical Officer of Health of the City, to which he was elected on July 24th, 1873. He filled that post for 32 years, truly a remarkable record of service. He leaves a widow and a large family to mourn his loss, as well as a large circle of friends.

JAMES HENRY CEELY, F.R.C.S. ENGLAND.

WE regret to announce the death of Mr. James Henry Ceely, F.R.C.S., on Christmas Day, at his residence in Tregunter Road, London, S.W., aged 96. Mr. Ceely, who had retired from practice, studied at the London Hospital, and was qualified in 1830, when he obtained the licence of the Society of Apothecaries. In 1832 he obtained the membership of the College of Surgeons of England, and 20 years later he was elected Fellow. He was formerly surgeon of Aylesbury Prison, senior surgeon of the Bucks General Infirmary, and surgeon-in-chief of the Bucks County Constabulary.

WILLIAM ARTHUR PAYNE, M.A., M.B. OXON., M.R.C.S.ENG., L.S.A.

WE regret to record the death of Dr. Arthur Payne, of Barford, Warwickshire. His medical education was conducted at St. Bartholomew's, whence he took the L.S.A. in 1886, M.R.C.S. Eng. in 1887, and M.B. Oxon. in 1893. Dr. Payne had only resided in Barford two and a half years, previous to which he practised in Ilfracombe, but the term had been long enough for him to have found a way into the hearts of the people. He was everywhere deeply honoured and esteemed as a man and fully trusted as a medical attendant. It appears that about ten days before his death Dr. Payne spent five hours one night with a delirious patient, who was suffering from septic pneumonia, in a small ill-ventilated cottage, and thereby no doubt contracted the fatal illness which carried him off.

THOMAS ALBERT CARTER, M.D. EDIN., F.R.C.P. LOND., J.P.

WE regret to announce the death of Dr. T. A. Carter, at his residence, Shottery Hill, Stratford-on-Avon, at the advanced age of 71. Dr. Carter was formerly in practice at Leamington, and came to Shottery Hall about seventeen years ago. He was medically educated at Edinburgh University, where he graduated M.D., with honours in 1856.

MEDICAL NEWS IN BRIEF.

Health of the Navy.

THE report on the health of the Navy for 1904, which was issued on Saturday last, shows generally a very satisfactory condition, there being a decrease in sickness compared with the reports of each year since 1897. Out of 110,570 men afloat, which is an increase of over 7,000, the daily rate of sick was 31.35 per 1,000. The deaths per 1,000 numbered 4.45, and invalidings totalled 2,511, the decrease being considerable in each case. The most unhealthy stations were the Pacific and East Indies. Tuberculous diseases formed by far the largest proportion of the invaliding cases, whilst diseases of the digestive tract were responsible for many thousands of others. Nervous diseases were the next highest. Mediterranean fever is specially dealt with in the report by Fleet-Surgeon P. W. Bassett-Smith, Staff-Surgeon E. A. Shaw, Fleet-Surgeon D. J. McNabb, and Fleet-Surgeon R. T. Gilmour. The report is signed by Inspector-General H. M. Ellis, Medical Director-General of the Navy.

The "Strike of Doctors" at Exeter Dispensary.

AFTER prolonged, and at times bitter, controversy the Exeter Dispensary dispute has been settled in a way most satisfactory to Englishmen—namely, by a compromise. The history of the affair is both interesting and instructive. The history is as follows—the medical staff of the Dispensary recommended the installation of an X-ray apparatus. In order to lessen the cost they advised that the apparatus should be available for persons not patients at the institution, fees thus obtained to be divided between medical attendants and Dispensary. The Committee took up the position that the staff wished to put the institution to the cost of an installation in order that they might make fees by using it for their private patients. The staff thereupon resigned in a body. The lay press has widely commented on what they choose to call the "strike of doctors," but the matter is now happily settled, and the medical staff have consented to retain their position.

Boric Acid in Sausages. Important Case—Conviction.

ON the 19th ult. at Worship Street Police-Court, London, Mr. Cluer gave judgment in the case of defendants Messrs. W. E. and C. C. Patterson, provision dealers, of Cambridge Road, London, E. The prosecutors were the Borough Council of Bethnal Green. The specific charge was the sale to the prejudice of the purchaser of a certain article of food—sausages—which contained 41 grains of boric acid per pound. The defence pleaded that boric acid was not prejudicial to health and that there was no standard for sausages. The analyst spoke of boric acid as a "foreign ingredient," but admitted that one tenth of foreign sausages imported contained boric acid, and also three fourths of the imported butter. The magistrate remarked he had to administer an Act. After an exhaustive trial, extending over two days, the defendants were convicted of the offence. In giving judgment, the magistrate said he could come to no other conclusion than that one article was asked for, and something which contained a foreign ingredient supplied. He had no doubt the case would be taken elsewhere, and he was glad to think it would be. He imposed a nominal fine of 20s., and ordered the defendants to pay also seven guineas costs.

Dispute between the Wrexham Town Council and the Local Government Board.

FOR several months the question of the appointment of a medical officer of health for Wrexham has been under the consideration of the Town Council. The Local Government Board suggested that the Council should join the Rural District Council in the appointment of a single "whole time" officer for the urban and rural districts. The rural District Council were prepared to fall in with this suggestion, but there is a division of opinion among the members of the Town

Council, and after many debates it was decided at a recent meeting by a narrow majority to appoint a medical officer for the borough alone. In response to this notification the Local Government Board wrote asking the Council to reconsider the matter, but it was replied that the Council saw no reason to alter their decision. Again the board wrote, expressing a hope that the Council would give further consideration to their suggestion, and this letter was discussed at a meeting of the Town Council on Wednesday. After some further discussion the letter was referred to the Sanitary Committee for consideration. The attention recently given to the tenure of rural medical officership and the advent of a new Government renders the situation at Wrexham particularly interesting.

Boots' Stores and Ammoniated Quinine.—Abortive Liverpool Prosecution.

ON the 20th ult., at Liverpool City Police Court, before the stipendiary magistrate, Boots', Cash Chemists, Limited, were summoned on an information laid by the health authorities, which alleged that they sold "to an inspector at 203, Scotland Road, Liverpool, to the prejudice of the purchaser, a certain drug, to wit capsules of ammoniated quinine, not of the nature, substance, and quality demanded, the same not containing any ammonia, and the average amount of quinine sulphate in each capsule being only two-thirds of a grain, contrary to the statute." Mr. Duder, for the prosecution, said the city analyst's certificate stated that the sample he received contained no ammonia, and that the average amount of quinine sulphate in each capsule was only two-thirds of a grain. The Somerset House certificate said: "The capsules contain a small quantity of ammonia; the amount, however, is only nominal, the average weight of ammonia per capsule being—Ammonia: Free, practically 1-300th part of a grain." "Ammonia combined" worked out at 1-50th part of a grain. He was instructed that "combined ammonia" in these capsules was absolutely useless for medicinal purposes; it was only the free ammonia when present in sufficiently large amounts which could be of any use at all. With regard to the quinine, the Somerset House analysis showed that one capsule contained 1.19 grains, and, according to the British Pharmacopœia, it was only necessary to have 1.09. The magistrate, alluding to the difference between some of the capsules, said this was an accidental and not wilful circumstance, which the defendants would take some means to obviate. Mr. Glynn Jones, for the defence, said it was not possible to get mathematical accuracy as between the capsules. The magistrate did not think the case for the prosecution was made out, and it would therefore be dismissed. No order was made as to general costs.

Sale of Poisons. A Chemist may Sell Veratrine to "The Man in the Street."

IN the King's Bench Division, on the 9th ult., the Lord Chief Justice and Justices Lawrence and Ridley, heard the appeal of Edward Oliver Brown, of Leeds, against a conviction by the Leeds Stipendiary Magistrate, for unlawfully selling a certain scheduled poisonous vegetable alkaloid,—to wit, veratrine, to a person unknown to him, and not being then introduced by some person known to him. The magistrate stated a special case for the opinion of the High Court. The appellant was a registered chemist and druggist, and sold a packet of ointment for destroying vermin on the head. Counsel for the respondent contended that as the ointment contained a dangerous quantity of poisonous vegetable alkaloids included in Part. I. of the schedule, the defendant was guilty of the offence charged in the information. The Lord Chief Justice said that the fact that a poison named in the first part of the schedule was mixed with another ingredient did not make it less the sale of a poison. But the general idea of the Act was that the Pharmaceutical Society should have

power to say which things should be deemed to be poisons within Part I. of the schedule or Part II. They had made an order, the effect of which he held was that the substance sold by the appellant was put in Part II. That order, he was of opinion, the Pharmaceutical Society had power to make, and therefore the sale of this article was not the sale of a poison in Part I. of Schedule (a), which required it to be sold only to a person known to him. For these reasons the appeal must be allowed. The other Judges concurred, and the appeal was allowed, with costs.

Municipal Milk for Lambeth.

THE depot recently fitted up by the Lambeth Borough Council in London, at a cost of £500, for the sale of specially prepared milk for infants will be opened shortly, under the supervision of Dr. J. Priestley, the medical officer of health, who may be congratulated on having brought his district up-to-date in this most important matter. For the supply of milk a farm has been selected in Hampshire, which will be under medical and veterinary inspection, and the milk is guaranteed to be up to Government standard with fifty per cent. of butter fat. The quantities of the milk mixture to be given vary according to the age of the infant from 1½ oz. to 42 oz. per day. It will be distributed on the familiar plan in hermetically sealed bottles in wire baskets, each bottle containing sufficient milk for one meal and each basket a day's supply. For the full supply of milk 1s. 6d. per week will be charged for infants under six months old, and 2s. per week for infants aged from six to twelve months. The cost of maintenance will be about £500 a year, and the returns are expected to average £300. Dr. Priestley says that every year 1,400 children die in Lambeth before they are a year old, and that if some of these lives can be saved the loss of £200 on the depot will be more than balanced.

The Plague.

THE following telegram from Sir C. Boyle, Governor of Mauritius, was received at the Colonial Office, on December 15th:—Eight cases of plague reported during week ended yesterday. Number of deaths seven.

PASS LISTS.

University of London.

THE following passed the M.D. Examination during December:—

Medicine.—James Alfred Butler B.S. Guy's Hospital; Harold Benjamin Day, B.S., King's College (obtained the number of marks qualifying for the University Medal); Alfred Henry Gerrard (University Medal) University College and Guy's Hospital; George Hall, University College; George Johnson Langley, B.S., St. Thomas's Hospital; Edward Lister Martin, B.S., St. Bartholomew's Hospital; Ernst George Pringle, St. Bartholomew's Hospital (obtained the number of marks qualifying for the University Medal); Gwynne E. Owen Williams, B.S., University College.

Pathology.—Charles Edward Ham, London Hospital.

Mental Diseases and Psychology.—Margaret Bernard Dobson, Lond. R.F.H. Sch. of Med. for Women; Charles Arthur Mercier (University Medal), London Hospital.

Midwifery and Diseases of Women.—Olive Claydon, Lond. (R.F.H.) Sch. of Med. for Women; Mary Gertrude Edis, B.S., Lond. (R.F.H.) Sch. of Med. for Women; David Ellis, B.S., London Hospital; Archibald Montague Henry Gray, B.S. (University Medal), University College; Anthony Richard Nelgan, St. Bartholomew's Hospital; Neville Ivens Spriggs, Guy's Hospital.

The following passed the M.S. Examination:—

Janet Mary Campbell, M.D., Lond. (R.F.H.) Sch. of Med. for Women; Robert Valentine Dolbey, London Hospital (obtained the number of marks qualifying for the University Medal); Ernest W. H. Groves M.D., Bs.Sc. (University Medal), St. Bartholomew's Hospital; Alexander Moxon Webber, Guy's Hospital.

SPECIAL ARTICLE

THE RISKS OF LUNACY CERTIFICATION.

EVERY now and then our profession receives an unpleasant reminder of its risks and responsibilities, and such an one has just been furnished by the recent action brought against Drs. Carswell and Marion Gilchrist in the Court of Session. The purely medical aspects of the case are of no special interest. The pursuer, now happily recovered, was for a time insane, was certified as a lunatic, was consigned to Gartnavel Asylum, and was there cured. Instead of showing gratitude for his restoration to health, he sued those who had put him in the way of recovery for substantial damages, and though his claim was rejected by the Court, Dr. Gilchrist and Dr. Carswell were put to all the expense and anxiety inseparable from a long proof, and were exposed to the uncertainty as to whether law and medicine would for once agree on what constitutes insanity. "When the Devil was sick, the Devil a monk would be; When the Devil was well, the devil a monk was he." Surely the writer of the old saw had such cases as this in his mind!

Every profession must take certain risks, and the prudent man does not blink these, but, foreseeing, tries to anticipate and nullify them. We must take it that when a lunacy certificate is signed and put into effect the granter is exposed (particularly if the document fulfil its prime object, and the machinery it sets in motion lead to the patient's recovery) to an action for damages for incarceration in any asylum. That such an action is very seldom successful by no means robs it of its terrors, for too often the pursuer, giving him all credit for good faith, proves a man of straw, in which case the adage of sport is reversed, and "the winner pays."

Remembering the axiom that a man cannot contract himself out of his common law liabilities, it will be seen that no form of indemnity given beforehand by the patient or his friends can be of the slightest use in barring such an action; contrariwise, to demand any undertaking of the kind would rather suggest that the granter of the certificate had his own doubts as to the propriety of giving it. The risk should be met, as so many other risks are, by insurance, and this is best effected by membership of a thoroughly well established medical defence association, which is known to have funds ample to fight any cause. Keeping in view the need for insurance, it is a further question whether the ordinary guinea fee, scarcely adequate to repay the time and skill required to fill up a lunacy certificate, should not be raised.

As we read the daily proceedings in the action which forms the text of this note—its cloud of witnesses, and legal acumen, *not* lightning darkness—we wondered whether it were all too Utopian to dream of a changed procedure. The Scotch statute provides that such actions be tried by an Outer House Judge, without a jury, thus showing that our law-makers recognize that these cases have something special about them. Could not the procedure be still further simplified? A legal assessor, a medical assessor (Home Office officials, these); an overman, locally selected by the assessors, neither lawyer nor doctor; the Board, Commission, call it what you will, to have power to call for documents, declarations on oath, and witnesses if need be; the parties to be represented by agents, who should neither be allowed to cross-examine nor to address arguments to the Court, but only to speak on matters of fact—a commission such as we have sketched could settle nine-tenths, or ninety-nine-hundredths of all cases of this kind at a tithe of the cost and in a fraction of the time which a Court of Law requires. Nor would the liberty of the subject suffer any risk of infringement; by entering a Law Court, in which blind-folded Justice holds the scales so evenly balanced that litigants cross its threshold on even terms, he is at once divested to the detriment of his opponent of the burden of disproof which he bears.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for the MEDICAL PRESS AND CIRCULAR.

PARALYSIS AGITANS.

OPPENHEIM (*Deutsch Med. Woch.*, 1905) has recently in an able paper expressed his views as to the diagnosis and prognosis of this disease. He states that cases without tremor are not uncommon, and are frequently overlooked. In some instances the tremor is latent and may be elicited by active movements or by plunging the limb into cold water. He describes a procedure which produces what he calls a false ankleclonus. The foot is strongly flexed dorsally, and held in this position for some time; on release a rhythmical tremor may result, and is quite characteristic of paralysis agitans. In typical cases without tremor the diagnosis is made on the general attitude, the stiffness, and the propulsion and retropulsion. The cases most difficult of diagnosis are those in which the disease is just beginning, and only one side or limb is involved. He states as a general proposition that a slowly developing stiffness and unwilldiness in the limbs of one side occurring in an old individual is generally paralysis agitans. The slowing of movements and stiffness in these cases usually begin first at the distal parts of the extremities. In the fingers, difficulty in flexing or extending the fingers one after another may be noted early or abduction or adduction may be difficult. Changes in the toes are less easily detected, but Frank has described a valuable diagnostic sign. This consists in the fact that any attempt to move the toes on the affected side results in movements of the toes on the non-affected side; the reverse is not the case. In some cases changes in the handwriting are of value. The patients have a tendency to write slowly and construct much smaller letters than they formerly did. Various early or premonitory signs are mentioned, which may render diagnosis easier in doubtful cases. Rheumatoid pains, gastric disturbances, salivation, and hyperidrosis are mentioned as not infrequently preceding paralysis agitans or accompanying the early stages. Bladder and rectal disturbances are rare. In some instances the patient seems totally unable for some time to start walking even when he desires to pass merely from one room to another. He stands as if rooted to the spot, and appears quite helpless. Oppenheim thinks that in these instances there is a strong psychic element at work. As to prognosis, a more optimistic view is taken than formerly. The writer has never seen complete cure result, but he states that under proper conditions he has seen the progress of the disease apparently delayed for a considerable time, and he has seen severe cases transformed into mild ones. The prognosis is most favourable in those cases in which the condition is recognized early and the recognition of the atypical forms is necessary for this. D.

KERNIG'S SIGN.

ROGLET (*These de Paris*, September, 1905) gives the following explanation of Kernig's sign occurring in cerebro-spinal meningitis: When the thigh is flexed upon the trunk and the leg at the same time extended (Kernig's position) the sciatic nerve becomes stretched. In the healthy state, the stretching of the sciatic nerve seems not to produce any pathological response since Kernig's sign has never been clearly demonstrated in healthy individuals, except when the thigh is flexed upon the trunk at a very sharp angle, *i.e.*, when the sciatic nerve is greatly stretched. In morbid conditions where the nerve itself is affected (neuritis sciatica) or when the roots are affected, which undoubtedly takes place in acute meningitis, the stretched affected roots react correspondingly; the posterior roots by producing pain, and the motor roots by producing contractions of the corresponding muscles, in the case of the sciatic nerve the flexor muscles. The pain arising from the stretching of the posterior roots makes the patient instinctively keep away from

further stretching of the posterior roots, as it happens, for instance, in dislocations when the muscles respond with strong contraction to any active or passive movements in the dislocated joint. The above explanation may be held to be at least the simplest one we have for the understanding of the mechanism of Kernig's sign. The author concludes by stating that Kernig's sign may be considered as a standard sign of inflammatory meningeal lesions, and as being due to irritation of the spinal roots produced by the stretching of the sciatic nerve. D.

THE THYMUS.

MOORHEAD (*The Practitioner*, December, 1905) summarises our knowledge of the functions of this gland and gives an account of some experimental work which he himself has done in connection with it. Following Waldeyer, the histological history of the gland, is divided into three stages. The original hypoplastic diverticula arising from the third visceral arch hollow out, lose their connection with the pharynx, and, becoming free in the neck, bud off numerous solid epithelial outgrowths. This constitutes the epithelial stage, but from the outset lymph cells appear among the epithelial cells derived either by migration from the neighbouring mesoblast or from the ingrowing connective tissue. At birth, the gland is distinctly lobulated and encapsulated, each lobule presenting a cortical and medullary zone containing more or less lymphoid cells, and in the centre of the medullary zone one or more Hassal's corpuscles. The origin of these corpuscles is still disputed, some writers considering them the remnants of the epithelial buds, while others look on them as a proliferation of the endothelial lining of the blood vessels, Eosinophilous leucocytes are numerous along the fibrous septa, and some are usually found in the cortex of the gland. Moorhead has never found nucleated red blood corpuscles except in the vessels. The weight of the gland at birth varies so much that practically no information of value can be obtained from it except in extreme cases. In man the gland continues to grow both absolutely and relatively to the body weight up to the age of two years after which time the rate of growth diminishes till puberty when a gradual degeneration begins. In this, the third stage, the gland becomes infiltrated with fat, and there is a gradual increase of interstitial tissue. Experimental study of the function of the gland has not led to much result. As Moorhead says, his experiments have had purely negative results, or "seem to conclusively prove that the function of the gland is not directly to produce any influence on the vaso-motor system." Ghika believes that the different results arrived at by different observers depend on the difference in age of the animals experimented on, and that extracts of the gland have a distinctly favourable influence on the growth and nutrition of young animals. This belief is borne out by the beneficial results obtained by the therapeutic use of such extracts in the case of rickety and debilitated children. Temporary leucopænia with diminution of weight and arrest of development in animals have been found to follow the total extirpation of the gland, but these effects passed off in about two months' time. Such experiments, however, suggest some co-relation of function between the thymus and the generative organs. Moorhead's experiments with thymotoxic sera have convinced him that in extra-uterine life the importance of the thymus gland is not great. A study of the pathology of the gland has not proved its causal connection with any of the recognised diseases. K.

TREATMENT OF ADDISON'S DISEASE.

WEIGALL (*The Australasian Med. Gazette*, October, 1905) relates the case of a boy, æt. 18, whose father had

previously died of this disease, and who himself presented well-marked symptoms of it. The boy weighed 6 st. 4 lbs., pulse 140, and compressible, heart feeble, and respirations, when at rest, 30 per minute. The skin was generally pigmented, but there were patches of pigmentation particularly well-marked on the forehead. He complained of nothing but extreme fatigue. For the first few days he was treated by saline injections into the rectum, and by hypodermic injections of strychnine. The administration of extract of suprarenal capsule in the form of tablets was then begun. The actual dose is not stated, but at first one tablet was given three times a day, and soon this was increased to two, three times a day. The improvement is stated to have been extraordinary. In two weeks he had gained six pounds in weight, and his pulse had fallen to 110, and he was able to walk about the room without difficulty. The pigmentation had considerably diminished. The treatment was continued until he had taken 500 tablets. His weight is now 10 st. 8 lbs.; he is working all day on a farm, and feels perfectly well; the pigmentation has entirely disappeared. K,

TEAK DERMATITIS.

EVANS (*The British Journ. of Dermatology*, December, 1905) relates a case of a carpenter who, while working with teak, was attacked with a severe dermatitis. The attack began on the backs of his hands and spread to the forearms, chest, and face, later involving the entire trunk and lower limbs. At first there was mere redness of the skin, but soon it became moist and vesicular, and as the eruption was attended with severe itching there were numerous excoriations. The patient stated that ten years previously, while working with teak, he had a similar attack, and on account of the severity of that attack he had refused to work in teak until two days before the onset of his present illness. Of the eight men who were working with him six were attacked similarly, but in the others the attack was not so severe. There appears to be two varieties of teak wood, the softer and more superficial wood, which is harmless, and the harder or more central wood, which produces the irritation. This central wood contains the essential oil, none of which is found in the more superficial parts of the tree. Evans considers that this aromatic oil is the essential cause of the dermatitis, just as the dermatitis caused by the Rhus toxicodendron is really caused by the oily substance toxicodendrol, which can be obtained from the plant. Teak oil is said to be used medicinally in India, but whether its local application has caused dermatitis or not is not recorded. The only satisfactory way of preventing such attacks appears to be by completely avoiding the cause. K.

INFANTILE LOCOMOTOR ATAXIA.

To the previously recorded cases (*Deutsche Zeits. f. Nerven Heilkunde*, Bd. 26 3), 42 in number, of infantile or juvenile tabes and tabetic paralysis, Hagelstum adds three from Oppenheim's Klinikue. Out of the total of 45, 16 occurred in males and 29 in females; in six cases tabetic paralysis was present, and in the remainder tabes alone. In more than 25 per cent. of these cases paralysis or cerebral lesions were present in one or both parents. The writer considers that the condition is by no means rare, and that it may occur in children who are not congenital syphilitides, although syphilis acquired or congenital is, in a majority of cases, present. The condition usually shows itself first at puberty, and both motor and sensory symptoms may be slow in developing. Spinal arthropathies and visceral crises are often met with. M.

THE TREATMENT OF HODGKIN'S DISEASES BY X-RAYS.

Among the unfavourable effects caused by Röntgen-ray therapy in cases of pseudo-leukæmia Quadrone (*Centralbl. f. Inn. Med.*, 1905, No. 31) states that he has observed the occurrence of pleural effusion in two instances. The first case was that of a girl, æt. 12,

suffering from enlarged glands at the root of the right lung. After ten exposures there was a marked improvement in the subjective symptoms, and an apparent diminution in size of the glands, but at the same time there appeared suddenly an enormous right-sided pleural exudate. This was tapped on several occasions, but was succeeded by a left-sided effusion, and by death from asystole. The second case was that of a man, æt. 28, with large lymphomata in the left cervical, supra-clavicular, and axillary regions. After thirty exposures the glands were decidedly smaller, but there appeared all the symptoms of gastro-intestinal intoxication. These symptoms subsided after a time, but on resumption of the treatment an extensive left pleural effusion appeared, which, however, completely disappeared after tapping. From the clinical characters of these cases the author is of opinion that the pleural affection was in both of these directly connected with the X-ray treatment. M.

DEATH FOLLOWING SCOPOLAMINE MORPHINE INJECTIONS.

DR. SEXTON (*Lancet Clinic*, U.S.A., November 18th, 1905) reports an important case of death following an injection of scopolamine and morphine, administered for anæsthetic purposes. The patient was a woman, æt. 47, who had suffered during the last five years from menorrhagia, due to the presence of a uterine fibroid. The excessive hæmorrhage had produced severe anæmia and general malnutrition. An operation was decided upon, and the patient was admitted into hospital and placed under tonic treatment for a time. At 7.30 a.m. on the morning of operation, an injection of scopolamine hydrobromate, 1-100th grain, and morphine sulphate 1/4th grain, was given, and caused sleep in a few minutes. At 8 a.m. the patient was completely unconscious, was cyanosed, had rapid heart action, and shallow respiration. Coffee, strychnine, and nitroglycerine were given, and later whiskey and digitaline, but without the least effect, and death occurred at 9.15 a.m. Dr. Sexton thinks that the case proves the existence of a special idiosyncrasy to the action of scopolamine, and believes that this may have been heightened in the present case by a dose of trional given over night. He believes that scopolamine is undoubtedly dangerous to elderly, and to decrepit or cachectic individuals. M.

A CASE OF POLYMYOSITIS.

PREBAJINSKY and Mayoulcis (*Revue de Medicin*, 1905, Nos. 10 and 11), report a fatal case of subacute polymyositis with autopsy record. In addition to the myositis, there was pulmonary tuberculosis. Besides the changes in the muscles, the motor cells of the spinal cord and of the medulla showed changes, while the peripheral nerves were normal. The muscle fibres varied much in thickness and were here and there degenerated and broken up; some of these appearing homogeneous, and some of them fragmented; the blood-vessels in the interstitial tissue were increased in number and showed slight thickening. Scarcely any of the muscles of the extremities escaped. The co-existence of tuberculosis and polymyositis is by no means a rare one; apparently the tuberculous poison exerts a harmful effect on muscles, in the same way as it does upon nerves. The cases always run a fatal and usually a subacute course. Myocarditis and heart weakness are common, and when degeneration of the respiratory muscles is added, the unfavourable termination is hastened. M.

NOTE.—A summary will appear each week in the following sequence:—

- 1.—"Recent Medical Literature."
- 2.—"Recent Surgical Literature."
- 3.—"Recent Gynecological and Obstetrical Literature."
- 4.—"The Recent Literature of Anatomy, Physiology, and Pathology."

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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 reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

COMMON HEPATIC STIMULANTS.

A correspondent calls attention to the comparative neglect into which that most excellent of cholagogues, podophyllin, has fallen in recent times. There can be no doubt as to the great value of that drug, but we fancy it enters into the composition of a great many hospital aperient pills, as well as those popular in many a private practice. Of other hepatics, eunoinin is worthy of much greater attention than it usually receives from practitioners. It requires to be followed by a saline aperient. Iridin, again, is of great value in "liver" cases.

CANVARDINE.—The case should be of considerable interest. The personal history is more than suggestive of tubercle, and we suggest the diagnostic injection of O.T. tuberculin by way of confirmation. We shall be very pleased to insert the case as a clinical record.

M. O. H.—The question of "return" cases of scarlet fever and other infectious diseases has been fully dealt with in a series of original papers published in THE MEDICAL PRESS AND CIRCULAR in 1904. Whatever the general tendency of notification and isolation may be in the long run with regard to the two maladies mentioned, it certainly has not so far reduced the incidence of the disease. Mortality, however, has fallen considerably in both instances.

COUNTRY PRACTITIONER (Dorset).—The only observation that occurs to us dealing with your query is that blistering formerly applied to a bald head in the treatment of insanity resulted in some cases in a growth of lanugo hair. Our scientific knowledge of the whole subject, however, is yet in its early and empirical stages.

THE MOST POPULOUS CITIES OF THE WORLD.

The official returns of the great cities from which the Registrar General receives statistics, excluding of course such as the Chinese whence no enumeration comes to hand, are as follows:—London, 4,684,794; New York, 3,948,191; Paris, 2,680,559; Berin, 2,035,815; Chicago, 1,932,315; Vienna, 1,897,630; Philadelphia, 1,438,318; St. Petersburg, 1,248,122; Moscow, 1,092,360; Rio de Janeiro, 850,000; Calcutta, 847,798; Buda-Pesth, 836,267; Glasgow, 809,936; Bombay, 778,008; Hamburg, 772,852; Liverpool, 730,143; Manchester, 631,185; Boston, 617,950; Birmingham, 542,858; Amsterdam, 554,240; Madras, 509,346; Brussels, 566,936; Rome, 514,930; Munich, 528,000; Copenhagen, 428,000.

SPMS.—The subject has been under discussion for some time, and we hope to give an answer very shortly.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JANUARY 3rd.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. F. E. Taylor, Dr. Horrocks, Dr. V. Dickinson, Dr. Griffith, Mr. H. J. Paterson, Dr. Galabin, and Mr. Dudgeon. Short Communication:—Dr. Milligan: Pylonephritis of Pregnancy. Paper: Dr. Griffith and Dr. Williamson: Fibro-myoma of Uterus undergoing Sarcomatous Change.

THURSDAY, JANUARY 4th.

RONTGEN SOCIETY (20 Hanover Square, W.).—8 p.m. Presidential Address:—Prof. F. Soddy: The Present Position of Radio-activity.
NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital N.).—4 p.m. Clinical Cases.

FRIDAY, JANUARY 5th.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY (West London Hospital, Hammersmith, W.).—8 p.m. Clinical Meeting.

THURSDAY, JANUARY 11th.

BRITISH GYNECOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Annual General Meeting. The President's Valedictory Address (Dr. William Alexander).

Vacancies.

Bristol Royal Infirmary.—Pathologist, Bacteriologist, and Director of Clinical Laboratories. Salary £250 per annum. Applications to W. E. Budgett, Secretary and House Governor.
University of Birmingham.—Demonstratorship in Anatomy. Salary £175 per annum. Applications to George H. Morley, Secretary.

Londo Fever Hospital, Liverpool Road, N.—Resident Medical Officer. Salary £250, with board and residence. Applications to the Secretary, W. Christie.
National Hospital for the Paralysed and Epileptic, Queen Square, Bloomsbury, London, W.C.—Resident Medical Officer. Salary £100 a year, with board and residence. Applications to Godfrey H. Hamilton, Secretary.
University of London.—Chair of Protozoology. Professor of Protozoology. Salary £750 per annum. Applications to the University of London, South Kensington, S.W.

Appointments.

CLARK, SYDNEY, M.R.C.S., L.R.C.P. Lond., Honorary Medical Officer in charge of medical cases at the South Leeds Branch of the Leeds Public Dispensary.
GRANT, DUNDAS, M.D. Edin., F.R.C.S. Eng., Consulting Aural Surgeon to the Royal Scottish Corporation.
JAFFREY, F., F.R.C.S. Eng., Surgeon to St. George's Hospital.
JONES, LAWRENCE, L.R.C.S. Eng., Assistant Surgeon to St. George's Hospital.
MACKENZIE, A., M.B., B.C. Cantab., Honorary Medical Officer in charge of surgical cases at the South Leeds Branch of the Leeds Public Dispensary.
NICOL, J., M.B., M.S. Aberd., Certifying Surgeon under the Factory and Workshop Act for the Alford District of the county of Aberdeen.
RALPHS, F. GERALD, M.B., Ch.B. Vict., Senior Resident Medical Officer at St. Mary's Hospital, Manchester.
SHARP, ALEXANDER D., Honorary Surgeon for Diseases of the Nose and Throat at the Leeds Public Dispensary.
SHARP, J. GORDON, M.D., C.M. Edin., Honorary Medical Officer in charge of medical cases at the South Leeds Branch of the Leeds Public Dispensary.
TRASDALE, J. O., M.B., B.S. Vict., Certifying Surgeon under the Factory and Workshop Act for the Retford District of the County of Nottingham.

Births.

FORBES.—On Dec. 27th, at 1 Oakwood Court, Kensington, London, the wife of J. Graham Forbes, M.D., M.R.C.P., of a daughter.
MACFADDEN.—On Dec. 28th, at 30 Frogmal, Hampstead, the wife of Cecil J. R. MacFadden, M.D., of a daughter.
ORMEROD.—On Dec. 23rd, at Southam, Warwickshire, the wife of Ernest William Ormerod, M.R.C.S. and L.R.C.P. Eng., of a daughter.
SOPER.—On Dec. 29th, at 307 Clapham Road, London, the wife of Bertram Soper, L.R.C.P. (née Frances Ash), of a son.
WELLS.—On Dec. 26th, at 107 Fordwych Road, West Hampstead, the wife of F. Barber Wells, M.B. Lond., of a son.

Marriages.

BEVAN—LAND.—On Dec. 27, at the Cathedral, Cape Town, Llewellyn Edgar Williams, of Salisbury, S. Rhodesia, elder son of Richard Bevan, L.R.C.P. Lond. and D.P.H., of 31, Girdlers Road, West Kensington, to Violet Isolan Marj, youngest daughter of the late William John Land, M.R.C.S., of Tonbridge, Kent.
KEALEY—BAYLEY.—On Dec. 7th, at Holy Trinity Church, Bolsum, India, Edward Herbert, I.C.S., of the Indian Political Department, fourth son of I. R. Kealey, Esq., M.D., of Alverstoke, Hants to Florence Tempe, eldest daughter of C. S. Bayley, Esq., I.C.S., C.S.I., of the Residency, Hyderabad, and Kirklanu, Reading.

Deaths.

ADAMS.—On Dec. 28th, Thomas Rutherford Adams, M.D., J.P., of 171, St. James' Road, East Croydon, aged 87, son of the late Thomas Rutherford Adams, of Kilmoganny, co. Kilkenny.
DANIEL.—On Dec. 30th, at the Silver Birch, Epsom, William Clement Daniel, M.D., M.R.C.S., L.S.A., aged 65 years.
ELTON.—On Dec. 28th, at Hunter Street, Brunswick Square, London, Henry Robert Elton, in his 45th year, third surviving son of Sur-Maj. H. N. Elton, of 12 Fordwych Road, Brondesbury.
GRAY.—On Dec. 28th, at 92 Aerley Park, London, Thomas Gray, M.R.C.S. Eng., and L.S.A., formerly of 12 Mountague Place, Poplar, E. in his 90th year.
PLATT.—On Dec. 29th, at 1 Clegg Street, Oldham, Thomas Platt, J.P., Surgeon, M.R.C.S. Eng., aged 72 years.

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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WEDNESDAY, JANUARY 10, 1906.

No. 2.

NOTES AND COMMENTS.

Amalgamation of the London Medical Societies

So far as can be seen at present there is every prospect that a more or less complete amalgamation of the London medical societies will take place, and that London will once again follow where Ireland has led the way. So long ago as 1882, the medical societies of Dublin agreed to amalgamate, and since then the Royal Academy of Medicine in Ireland has successfully taken their place. Of course, it is natural that some of the older societies should feel a difficulty in cutting themselves adrift from former associations and histories, and we understand that the Medical Society of London find themselves constantly faced with this difficulty. Still, all amalgamations necessitate a certain amount of self-sacrifice, and, if the Medical Society find themselves able to acquiesce in the scheme, it will have the satisfaction of knowing that its action is for the common good. For instance, can anyone doubt that the fraternisation of the Fellows of the Obstetrical and Gynæcological Societies would result in raising London prestige in these two subjects to the position which it ought to occupy. If we do not fall divided, we certainly should stand much stronger if united.

Wanted, a Name.

OUR contemporary the *Practitioner*, draws attention to an important *quæstio vexata*, namely, that of the future title, of the conjoined societies. The proposed title "The Royal Society of Medicine," is, as is pointed out, most objectionable, both because it is a colourable imitation of that distinguished body, The Royal Society, and also because it gives the Fellows of the latter body an excuse for resisting the claims of medical men to their Fellowship on the ground that they have a "Royal Society" of their own. Why should not the Dublin lead be followed a step further, and the title "The Royal Academy of Medicine of London" be adopted? Possibly some enthusiast may go still further, and suggest that there should be a Royal Academy of Medicine of the United Kingdom.

The Fellowship of the Royal College of Physicians of Ireland

APPROPRIATELY with the commencement of the New Year, the Royal College of Physicians of Ireland is able to make an important announcement, which we fancy will be well received by the profession in Ireland.

Up to the present, intending candidates for the Fellowship of the College were obliged to pass first an examination for the Licence of the College, and then one for its Membership. As the first of these examinations included practically all the subjects necessary for qualification save surgery, this meant

that men occupying high positions as consultants of as specialists in various departments had, if they desired to become Fellows to return to their student days. To obviate this the College applied during the past year for a new Charter, and this, which was duly granted, confers upon them the power of admitting to the membership examination graduates of all British Universities, Licentiates of the Royal Colleges or Physicians of London and Edinburgh, and, under certain conditions, medical practitioners holding foreign qualifications. Accordingly candidates for the Fellowship have in future to pass only one examination, which will embrace the principles, theory and practice of medicine and clinical medicine. This alteration should, we think, be largely instrumental in inducing many of the provincial consultants of high standing in Ireland to offer themselves as candidates for the Fellowship of the College.

Damages for "Barber's Itch."

THERE is a more effectual way of securing cleanliness and reasonable precaution in barbers' shops than by making regulations, and that is by suing barbers who propagate filth-diseases. It is a pity that sufferers are apathetic with regard to their own interests, for half-a-dozen successful actions would bring the hair-dressing fraternity to a realisation of their responsibilities considerably more quickly than all the sanitary precepts that medical officers of health try to instil into them. In the Marylebone County Court on New Year's Day a male nurse was awarded £15 damages against a barber for having inoculated him with "barbers' itch" in the course of a shave. The shop appears to have been a cleanly one, but the plaintiff when cross-examined on this point made the apt remark that "it was impossible to see a microbe on a razor." Expert evidence was called on both sides, but there was no doubt that the patient had had a skin affection of some severity, and the jury took the view that it was caused by the shave. We hope the case will be widely noticed and commented upon, for the point being established that such an occurrence is due to want of proper care, it may be hoped that barbers will be stimulated to adopt those precautions which have so long been in vogue in France and elsewhere.

SIR JOHN BATTY TUKE, the present Unionist member for the Parliamentary seat of the Universities of Edinburgh and St. Andrews, last week issued his election address. Sir John is one of the few medical men in the House who has never permitted his professional obligations to be swamped by the pressure of party politics. In season and out of season he has advocated reforms of first importance to medical men. In the present election he has a strong adversary in the person of Mr. St. Loe Strachey editor of the *Spectator*.

The absolute necessity of sending medical men into Parliament, however, has been so widely recognised by our profession in recent years that the bulk of the Edinburgh and St. Andrews doctors of medicine will probably cast their votes in favour of Sir John Tuke. In these Universities the medical vote far exceeds that of all the other faculties put together.

LEADING ARTICLE.

MEDICAL REQUIREMENTS AND THE GOVERNMENT.

WITH a New Year and a new Government the medical mind turns naturally to thoughts of legislation as applied to medicine and hygiene. Will the Liberal Party if returned to power at the General Election show themselves accessible to scientific ideas, or will they be content to plod on in the ruts left by the wheels of custom and tradition? We have read latterly in the press wholesale appeals to fashion our institutions and equipment on modern and scientific lines, the word "efficiency" has been on everybody's lips. Naturally at this time from a thousand platforms comes its echo; is it to remain nothing but an echo? That question seriously concerns all medical men who look beyond the jarring needs of the moment to the larger needs of the immediate and more distant future. At no period in modern history has advance in industrial and commercial matters been as rapid as during the last fifty years, and coincidentally with it consequent upon that advance a shoal of problems affecting the lives and health of people have sprung into being; something doubtless has been done towards meeting and tackling these problems, but when these are considered in all their aspects one must admit the fringe only has been touched. Now, truism as it may appear, it is worth re-affirming that if successful solutions are to be attained they must be attained by scientific methods. These questions have become too large to be resolved by any rule of thumb or happy inspiration. The first requisite in proceeding towards a solution is that the facts and elements should be martialled; the second, that they should be seriously studied. For medical men the problems of disease primarily arrest attention, and to their trained vision it seems that no progress which involves added disease is sound progress, and no commercial prosperity that entails suffering and early death is worth the candle. It seems to them a duty for the State to aid in the work that is now unostentatiously being performed in studies and laboratories to ascertain the causes, the means of prevention, and the mode of cure of diseases. To assert that every scientific investigation of the moment is starved for want of funds, is but to use the language of sober fact; it is, moreover, an understatement, for hundreds of such investigations which should be pursued are not undertaken for the same reason. What does the Government do for research? A few beggarly grants are made

to the Royal Society; occasional fees are paid to scientific men to undertake special investigations for individual departments, such as the Local Government Board and Home Office or for Royal Commissions; and payments are made towards the upkeep of such institutions as the Royal College of Science, which indirectly encourage private research by the professors. In an age when science is the *motif* of the whole social fabric, what can be thought of these stingy subsidies? We know from the public utterances of the late Prime Minister and of his principal lieutenant, Mr. Chamberlain, that they both realise in no small degree what research means to the happiness of the people and the prosperity of the Empire, and yet no member of the late Government had the courage to propose the grant of a substantial subsidy towards its prosecution. Will the Liberal Government, or such a Government as shall emerge from the dust and shoutings of the polls, be any wiser and any stronger? We confess we are not sanguine, but if they can be induced to propose such grants we confess we do not see how, in the light of their spoken words, the leader of the Opposition and his followers could demur. Nor, indeed, is it likely that they would. The need for the endowment of scientific research is tacitly admitted by all thoughtful men; it only remains for an advocate to bring it forward in a practical form and for a broad-minded Chancellor of the Exchequer to find the money. When the sums now available for the purpose are considered, it is tantalising to reflect what might be accomplished for the cost of a battleship or of a punitive campaign against an obstreperous savage chief—either of which would be voted without discussion in almost any House. If it be urged that such payments would not be directly utilitarian, we should reply not only that in many cases they would, but that they would at least be comparable to expenditure on education, the necessity for which no one disputes. Residents in the tropics and commercial magnates at home acknowledge with gratitude the beneficial effects on health and trade that Sir Patrick Manson and his school have conferred by their private investigations, and the incidence of tuberculosis and typhoid—to say nothing of small-pox—has been enormously reduced through proper application of the factors at work in their productions and prevention. We venture to believe that a grant of even £100,000 a year to disease-investigation and study would not only soon be recouped, but that it would bear interest a thousandfold—what proportion, too, does £100,000 bear to a national expenditure of over £140,000,000? Surely such a sum could be easily provided if it were not for inertia, want of imagination, and—should it be added?—the anti-vivisectionists.

The Chemistry of Violet Leaves.

VIOLET leaves have been so widely advocated in the public press as a remedy for cancer that it

is desirable to have some exact scientific information upon the subject. An excellent essay in that direction has been made by Mr. G. H. Whippell Gadd in a paper recently read before the Therapeutical Society. Negatively he found no volatile constituent, no alkaloid, and no salicylic acid. On the other hand, he demonstrated the presence of a glucoside, nine-tenths of which was found in a fresh infusion of the leaves. This glucoside has not been isolated, but if there be any therapeutic virtue in the leaves, it must pretty obviously lie in this constituent. The next step would be to test the glucoside therapeutically. While not denying the remote possibility of violets possessing some quality antagonistic to malignant neoplastic growths, we think it extremely unlikely; at any rate we should want convincing scientific proof of its benefits in a large number of cases before we recommended it on clinical grounds. It is cruel and inhuman to delude patients suffering from a terrible malady by crude and hasty theories formed by persons untrained in the A B C of observation and of sound reasoning.

Visiting Physicians or Resident Medical Superintendent?

We drew attention a few weeks ago to the forthcoming vacancy on the visiting staff of the Cork Street Fever Hospital, in the hope that thereby the widest publicity might be gained, and that the Governors of the Hospital might have a large field of suitable candidates from whom to select. We understood that the Governors intended to hold the election in the present month, but we have since learned that they have in consideration a step of serious nature. It is proposed, in short, to leave this and future vacancies unfilled, thereby depriving the Hospital of the attendance of a staff of visiting physicians, and leaving the care of the patients to the resident staff, aided in cases of difficulty by consultants. While much may be said on behalf of the Hospital in favour of such a scheme, something is to be said on the other side from the point of view of the profession and the public. In the first place, the present plan has always worked admirably, and the Governors have never had any difficulty in securing the services of the ablest of the younger physicians of Dublin. But the most important result of the present system is that by the necessary retirement of a physician after seven years' full service on the staff, the profession in Dublin has always had in its ranks a number of men highly educated in the diagnosis and treatment of acute zymotic diseases. This constitutes, we believe, an asset of great value to the community at large, and one that it will not be easy to replace. In the event of a serious epidemic, Dublin may have to face a disease with which its medical practitioners are almost unacquainted. We have no doubt the Governors of the Fever Hospital will exercise a wise discretion in their consideration of the question now before them, and we trust that the point

of view we have put forward will not be lightly overlooked.

Fogs and Open Air Treatment.

It is a common remark of persons who as a rule sleep with open windows, "Of course we are obliged to shut the bedroom windows when a fog comes on." Why this should be so is not clear. A stuffy bedroom is just as harmful in foggy as in fine weather. Closing the windows may shut out the mistiness of the fog, but it does not exclude its baleful products. When cabmen and other persons are said to be suffering from the effects of fog, it is just as likely that fatigue, cold, wet and other depressing conditions are at fault. In some asthmatics fog brings on an attack, but, on the other hand, quite as many sufferers are thereby cured of their asthma. Certainly London fogs do not prevent consumptives from being cured by sleeping and living in the open air. In some London hospitals patients have recovered from lung tuberculosis while passing their nights on open-air balconies freely exposed to fog and other vicissitudes of weather. That fact speaks volumes, and we must fain conclude that from a medical point of view the London fog is not half so black as it is commonly painted by the journalistic brush. Some newspaper men have adopted the curious plan of cross-examining house surgeons at hospitals as to the good or evil influence of fogs. Residents of that kind are mostly young men, full of a vast store of examiner's knowledge but lacking the ripe experience needed to tackle so intricate a problem as the effect of fogs in health and disease. Newspapers, please copy.

Health Lectures in the Army.

SEED in incalculable shoals has been sown on the stony ground which the military brain presents to the medical reformer, and at times he may well despair of seeing any fruit for his pains. But some patches of good soil have been discovered among the stones, and now in a tentative meticulous way the shoots are beginning to sprout. One gratifying piece of evidence of this fact is furnished by the orders of the General Officer Commanding-in-Chief in Scotland, for it is announced that the General has arranged for a series of lectures on barrack and camp sanitation, and on health during a campaign, to be given to the rank and file during the winter months. These lectures are to be delivered at each of the chief military centres, and it is hoped that they will be well attended. They are to embrace the questions of the purity of water, filtration and sterilisation, camp diseases, refuse disposal, disinfection, sunstroke, blistering of the feet, scurvy, alcohol drinking, venereal diseases, ventilation, consumption, and tropical diseases. We wonder what Lord Wolseley would think of occupying the spare time of soldiers with such trivialities. But when the amount of misery and loss caused by preventable diseases in the Army is taken into account surely any sensible man—medical or lay—will admit that the new departure is worthy of all praise. We congratulate Sir Charles Tucker on his bold departure from War Office tradition.

Science and the New Cabinet.

CLEARLY the endowment of scientific research and the true appreciation of the value of science to the community should be part of the programme of every progressive Government. Yet politics are for the most part permitted to swamp all claims of modern science to State recognition. The result is that scientific men are often compelled to choose the road of high thinking and penurious living, while science herself has to depend on the precarious gifts of philanthropy. Professor Clouston, the distinguished vice-President of the Edinburgh College of Physicians, has uttered a timely warning note in the present season of Parliamentary reconstitution. "Many of us think," he writes, "that questions relating to science and to health are of such enormous importance to the future of our people that they should take a first place in the consideration of His Majesty's Government and the coming Parliament. They touch every house in the land. They mean much for the efficiency of our industries, our shipping, and our sources of wealth. Many people have looked with much anxiety to see if anything is said about science and its prospects in the discussions as to the *personnel* of our new Cabinet. As yet, I have never seen a single speculation in the reams of newspaper discussions as to whether any candidate for a seat in the Cabinet has any scientific interests or knowledge, or any special enthusiasm for the health and bodily and mental welfare of the people. Every name that I have seen mentioned would be a mere amateur in matters so vital to the nation."

Registration of Plumbers.

IF the old lady who found such spiritual comfort in the word Mesopotamia were to be resuscitated from the grave in which she must have lain since time immemorial, and were she to be asked what was now the most blessed word in the language, we have no doubt she would reply—"Registration." There are few ills of the body politic for which registration has not been proposed, and equally few we fear which it has charmed out of existence. But we live in a day of small things, and must be content with such crumbs as fall from the Parliamentary table. Wherefore we heartily wish success to the promoters of those Bills which are annually introduced for the registration of plumbers. Most householders and all medical men regard the plumber as a blessing in disguise, much as we were accustomed to regard disease till we were enlightened as to its true nature by Sir Frederick Treves. The plumber is as necessary as he is often not harmless, but thanks to the efforts of the various hygienic associations and the energy of the Plumbers' Company a good deal is being done by lectures and examination to teach him his trade and to impress him with his responsibilities. Employed as he is in the bowels of the house and on work which the householder understands as little as he does Hebrew, the plumber

has admirable opportunities for displaying undiscovered both incompetence and deceit. With a State-recognised register, the useless and evil-disposed could be brought under discipline, and none could gain enrolment without examination. The machinery for administering a Registration Act has been already provided in the District Councils for the National Registration of Plumbers which exist in many parts of the country, and examinations and a voluntary register are already in being under their auspices. Moreover, the proud initials, R.P. are beginning to blossom out over plumbers' shop-fronts. This machinery deserves popular if not legal recognition.

Medical Men in Parliament.

IN the British Parliament there has never been any party that could strictly be called medical, that is to say, in the sense that there is a legal, or an army, or a brewing, or a shipowning, or a railway element. The absence of an organised professional section, however, has not excluded many distinguished medical men, but they sit in the House to represent their constituencies in the first and often also in the last instance. To this state of affairs the present election offers no exception. Among the candidates are about a score holding medical qualifications. With but three or four exceptions, these gentlemen cannot be considered in any way leaders or even representative men of their profession. In fact, the majority enter the lists purely as politicians and should they gain entrance to the House of Commons will sit as mere party supporters and exercise little or no influence in the building up of sound scientific views and the securing of sane measures relating to national hygiene. It is also to be noted that the present Cabinet, whilst representing law, literature, and commerce, has no member of any distinction as a scientific man, and yet the all-important matter of national health is left uncared for, or at all events inadequately provided for, by any responsible minister. With serious physical disabilities hampering a large section of the community and widespread deterioration prevailing amongst our working classes, as well as vast mental and bodily inefficiency among those on whom we depend for our country's protection, surely the time is ripe for the appointment in any progressive government of a Minister of Health. Both science in general and medical science in particular demand full recognition by the lawmakers of the twentieth century.

Quack Legislation.

WHEN the immense amount of harm done and suffering caused by illegitimate practice is considered, the desire of the reformer naturally is to seek legislation to make such practice impossible. The same reflection occurs, too, with regard to quack medicine. Unfortunately, it is quite impossible to expect, with a reasonable degree of confidence, that any House of Commons within the

next few years is likely to pass any provisions of the kind, and it is a question for practical statesmanship how to devise any measure that will be acceptable in itself and that will lead to more extended control in the future. A hint on this subject may, we think, be gathered from the action about to be taken in New Jersey and several other Eastern States of the American Union. A courageous and vigorous warfare has been carried on by one of the lay newspapers in America against quackery and patent medicines, and the public conscience has been considerably stirred by the consequent exposures, so that practical means are now being sought wherewith to fight the continuance of this form of fraud and greed. A neat plan is proposed. By bills which are being introduced into the legislatures of the various States concerned in the movement, it is enacted that the vendors of all proprietary medicines must disclose on a label affixed to each bottle the ingredients that the bottle contains and the proportions in which these ingredients are mixed. Moreover, the actual monetary value of the ingredients is to be stated and the price of the preparation fixed accordingly. Nothing could be simpler and nothing could be less open to objection if the business were a genuine one. On the other hand, the Bills, if passed, are likely to knock the bottom out of the whole patent medicine trade, and they are to be strenuously opposed by the newspaper and quack drug interests. We need hardly say that we wish them a safe and easy passage, if only as an example to our own country.

Wounds of the Heart.

TILL within the last few years the only wounds of the heart that were known to be recovered from were those purposely inflicted by wanton novelists on their susceptible heroes, and even these underwent a course of cicatrisation that lasted through three volumes before the final apotheosis of love and reconciliation was reached. But it is now known for certain that some wounds of the heart are amenable to surgical treatment, and recoveries have been met with in Great Britain and on the Continent. One case in this country, indeed, was so successful that the patient when restored to his old surroundings was able to renew his old relations with the police, and was recently before the magistrate for an assault committed while he was under the influence of his favourite drug. Still, such recoveries are rare, and we notice that two interesting cases were lately shown to the Surgical Society in Paris. In one the patient, a man, had been stabbed in the breast by a knife, and when seen half an hour later showed all the signs of internal hæmorrhage combined with largely increased præcordial dulness. A flap consisting of the third, fourth, and fifth rib-cartilages and their integuments was laid back, and the pericardium, which was bulging, opened. Three hundred grammes of blood flowed out, and a wound in the left ventricle was discovered and stitched up. In spite of a subsequent operation for hæmothorax,

the patient left the hospital cured in three weeks. The second case was that of a woman who had been wounded by a revolver-bullet, which produced hæmorrhage into the left pleura. In the course of an operation for the relief of this condition, a wound was found in the left ventricle, but as it did not bleed no suturing was carried out. She, too, recovered completely.

PERSONAL.

H.R.H. THE PRINCE OF WALES on laying the foundation stone of the Victoria Memorial Hall, in Calcutta on Thursday last, presented the magnificent sum of £6,000 to the Calcutta Medical College.

ON Christmas Day Dr. J. C. Martin was presented by his numerous friends in Portrush with a silver casket suitably inscribed and containing 250 sovereigns. The occasion was Dr. Martin's return after a prolonged absence due to illness.

At the last ordinary meeting of the Royal College of Physicians of Edinburgh, Dr. John Playfair was re-elected President of the College.

DR. JAMES MORRIS, who has recently tendered his resignation of the medical officership of health in the burgh of Dunfermline, has held that post for no less than forty-five years.

ON the 3rd instant a handsome testimonial was presented to Dr. Spooner, the senior medical inspector under the Emigration Department in Liverpool, on the occasion of his retirement after thirty-two years' service.

THE news was published in the daily papers on Friday last that Dr. J. F. Stewart, son of Dr. Stewart of Belfast, had been murdered and his body partially eaten by Nigerian cannibals. A notice of this shocking occurrence appeared in our columns six weeks ago.

THE opening lecture of the Spring session of the North-East London Post-graduate College will be delivered by Mr. John Langton, F.R.C.S., consulting surgeon to St. Bartholomew's Hospital, on January 12th, at the Tottenham Hospital, N. The afternoon clinical lectures throughout the session are free to all qualified medical practitioners.

MR. HENRY LABOUCHERE, now elevated to the honour of a Privy Councillorship, has proved himself a true friend to the medical profession by his fearless exposures, in the pages of *Truth*, of quackery, and deserves our best congratulations.

PROFESSOR W. R. SMITH, M.D., of Aberdeen, and D.Sc. of Edinburgh, now Mayor of Holborn, and a member of the Metropolitan Asylums Board, is fighting Sir Henry Craik, K.C.B., M.A.Oxon., LL.D. Glasgow and St. Andrews, for representation of the Universities of Glasgow and Aberdeen.

MAJÖR T. H. F. CLARKSON, Senior Medical Officer in Jersey, has been appointed to succeed Lieut-Col. J. Meek at the Tower of London on February 1st.

THE German Empress has placed herself at the head of a committee with the object of erecting a model institution for the care of infants, to be built in a West-end suburb of Berlin, at an estimated cost of 4,000,000 marks. Gifts of money to the Imperial pair on the occasion of their approaching silver wedding will be devoted to the erection and endowment of this institution, which it is stated will be the most complete of its kind in the world.

A CLINICAL LECTURE

ON THE

DIAGNOSTIC VALUE OF ALTERATIONS

OF THE

PULMONARY SECOND SOUND IN CARDIAC DISEASE.

BY
Sir CHRISTOPHER NIXON,
 Senior Physician to the Mater Misericordiarum Hospital.

GENTLEMEN,—The case which is at present under observation in St. Gabriel's Ward affords me an opportunity of directing your attention to the diagnostic value of certain signs observable in connection with the pulmonic sound of the heart. The case referred to is one of pulmonary regurgitation due to relative inadequacy of the pulmonic signoid valves, an extremely rare form of cardiac disease. The patient, a young woman, *æt.* 27, presents many of the typical signs of mitral stenosis, but on examining over the pulmonary area instead of hearing the sound of Skoda, a loud and somewhat lengthened diastolic murmur is to be heard. This murmur takes the place of the second sound, and is transmissible downwards in the direction of the right ventricle. The sounds heard over the aortic area are normal in character, the two cardiac sounds are distinctly pronounced in the carotids, there is no visible pulsation in the arteries of the neck or upper extremities, and the radial pulse presents none of the features that distinguish it in aortic inadequacy. I have no doubt of the condition being one of pulmonary regurgitation, it being the second instance of this lesion which has come under my notice within the past six months. Very frequently, as you are aware, both in mitral stenosis and regurgitation, the increased tension in the pulmonary artery results in an accentuation of the pulmonic sound, a condition pointed out by Skoda over fifty years ago. It is well, however, to lay stress upon the factors producing this accentuation. Obstruction to the circulation through the pulmonary capillaries, whether due to affections of the lungs, such as emphysema or cirrhosis, or to lesions of the left auriculo-ventricular valves, does not necessarily lead to the production of Skoda's sound. It is only when the increased tension in the pulmonary artery is reinforced by the contraction of a hypertrophied right ventricle that the sound becomes accented. A large number of cases of both mitral regurgitation and obstruction do not present this sign, in those, for instance, where compensation is defective. This may be due to a variety of conditions, the age of the patient, his condition of general nutrition, the extent of the lesion in the valve, and the absence of those favouring circumstances which determine generally compensation. In the latest stages of mitral disease two conditions may be set up which lead to diminished rather than accented quality of sound over the pulmonary artery, the occurrence of relative incompetency of the tricuspid valve, and a condition of right ventricular fatigue, such as we observe in cases of aortic patency in connection with the left ventricle. This condition of fatigue or weakness of the right ventricle is one not sufficiently impressed upon our attention, although I believe it exercises a potent influence on the progress of heart lesions generally. In this and in relative tricuspid regurgitation, the result is alike, diminished pulmonary tension, and a weakened pulmonic sound. In the case under observation, the tension in the pulmonary has been so considerable that there is reasonable ground for the assumption that the arterial ostium has been so stretched as to render the valves relatively inadequate, hence the murmur of regurgitation replaces the usually accented second sound. This condition of pulmonary regurgitation was made the object of special study by Barié, who collected some 58 cases of the lesion, most of which occurred between the ages of 18 and 34, and were traceable to endocarditis, the result of rheumatism, various infective fevers, and an atheromatous

condition of the pulmonary artery caused by chronic alcoholism. There can be no doubt, too, that a large proportion of cases is due to congenital malformation of the artery itself, and of its valves. But apart from conditions of altered structure in connection with the pulmonary valves producing leakage, there are good grounds for the acceptance of the view that relative or functional incompetency of these cusps exists. Hunter held that a natural provision exists by which the valves of the right side of the heart, pulmonary as well as tricuspid, did not exercise as perfect a function as those of the left, that what was necessary for the systemic circulation would be harmful, if incapable of modification, as regards the pulmonic circulation. Stokes early recognised this condition, and so subsequently did Gouraud, who contributed a valuable monograph on the influence of pulmonary affections on the right side of the heart, and the condition of relative incompetency of the pulmonary artery which they produce. Not many years ago some interesting experiments were performed by Dr. Gibson, of Edinburgh, in connection with pulmonary inadequacy. He showed that under the pressure of columns of fluid of various heights in the pulmonary artery of the ox, sheep, and of the human heart, a condition of relative incompetency could be readily produced from distension of the artery. It was, however, at a much later period that Dr. Gibson satisfied himself of the absolute evidence of this condition as a result of disease. More recently Jawinsky, Barr, and Graham Steele have drawn attention to the soft blowing diastolic murmur heard over the pulmonary artery in mitral stenosis, a murmur appropriately named by Dr. Graham Steele "the murmur of high pressure in the pulmonary artery." So quite apart from the legitimate acceptance of pulmonary regurgitation from the signs present in the case under observation, we have high authority for recognising the existence and mechanism of this phenomenon. In dismissing the question of the conditions under which the sound of Skoda is produced, I should like to emphasise the point that within very broad limits the sounds of the heart vary markedly in intensity in different individuals. Many circumstances quite consistent with health render the sounds more or less audible, a condition largely influenced by temperament. Thus nervous persons under conditions of excitement have the sounds sharply intensified; this is what ordinarily takes place during palpitation. On the other hand, phlegmatic persons, often of obese conformation, have their heart sounds obscure and ill-pronounced. Again in emaciated persons, where the chest walls are thin, and where the osseous structures and the skin have not their conducting properties interfered with by the existence of a non-conducting material like fat, both heart sounds at apex and base are sharply marked. In emphysema all the sounds of the heart may be obscured by the voluminous cushion of lung which intervenes between the heart and the chest wall, a point which accounts for the absence of the sounds of Skoda in this condition. All these varieties as to the character of the sounds of the heart in health and disease can only be learned by the constant practice of auscultation, and here let me quote for you the words of a great English classic, not read nowadays with the attention which its originality, its truthfulness to nature, as well as its terse and accurate form of expression deserve. I refer to Latham's work on "Diseases of the Heart." In the lecture dealing with the sounds of the heart he says:

"The sounds which naturally accompany the movements of the healthy heart can only be learned by the practice of listening to them. It is useless to describe them. They are simple perceptions of sense, which no words can make plainer than they are, when the ear has once become familiar with them. It is the same with all common sounds. By describing them you seek to make them known in a different form from that in which they are naturally known. Who ever thought of describing the sound of the wind or the rain except for poetical purposes? I must leave you, then, to be your own self-instructors in the healthy sounds of the heart, and recommend you to be constantly practising auscultation for the purpose on healthy subjects." Gentlemen, I could not in any way qualify this lesson.

Quite different in character, and in diagnostic significance from the diastolic murmur of pulmonary inadequacy is a murmur, diastolic in rhythm, which is to be heard occasionally over the pulmonary area, and on a plane lower down. It is usually grating in character, giving one the impression of an attrition murmur, but single in quality. It is generally met with in cases of acute rheumatism. The site of the murmur and its place in the cardiac cycle no doubt suggest pulmonary regurgitation due to pulmonic valvulitis. But you must bear in mind that this lesion is the rarest of all pathological conditions affecting the heart, whilst pericarditis is one of the most common. Furthermore the site of the diastolic murmur, which obscures the cardiac second sound, is in the situation corresponding to the earliest development of pericarditis, over the conus arteriosus and origin of the pulmonary artery. In those cases pain is frequently complained of over the region of the heart, and a symptom rarely absent even at commencement of pericarditis is present, viz., tenderness on pressure over the epigastrium. The progress of cases shows in the course of a few hours that the diastolic murmur is really an exocardial one, and it is in a short space of time replaced by the ordinary to-and-fro murmur of attrition. The murmur referred to may be regarded as an early sign of pericarditis.

The next point in connection with the pulmonary second sound is its re-duplication and division. If the breath be held after a deep inspiration under normal conditions, in most instances, a triple sound is heard at the base of the heart, the second sound being doubled. In some cases the two tones are not separated by a distinct interval, being more or less merged into each other so as to produce a roughish or murmurish sound. This constitutes what is known as division of the sounds, whilst in the case of the two elements being separated by a distinct interval, the condition is known as reduplication. It arises physiologically from the delay which inspiration causes to the filling of the left ventricle, thus producing a slight degree of alteration of pressure in the aortic and pulmonary systems. In a more marked degree reduplication is produced in mitral stenosis and in mitral regurgitation, but whilst in mitral stenosis, as after forcible inspiration, the aortic element of the two tones is produced before the pulmonic element, the opposite holds good in mitral regurgitation.

The explanation which I think satisfies those conditions is as follows:—The closure of the semilunar valves is effected the instant the blood ceases to flow from the ventricles, and is quite independent of the degree of pressure in either artery. The second sound is not caused by the closure of the valves, but by their sudden tension produced at the moment ventricular diastole begins. The closure is caused by the diastolic drop of pressure in the ventricle. Any factor which tends to prevent this lowering of pressure, as it delays the closure of the valves, must delay the occurrence of the second sound, whilst any factor favouring the lowering of pressure will hasten its production. Inspiration detains the blood in the pulmonary capillaries and in this way prevents the filling of the left ventricle, so that the difference in pressure in the interior of the ventricle and the aorta is greatly in-

creased, hence the aortic diastolic sound is hastened and produced before that of the pulmonary artery. The same thing holds good in mitral stenosis where the ventricle is slowly filled through the narrowed mitral orifice. But in mitral regurgitation the ventricle is rapidly filled under conditions of increased pressure, owing to the contraction of a dilated and hypertrophied auricle, so that here the tension of the aortic valve is delayed, hence the aortic sound follows that of the pulmonic. Careful examination of the sounds over the base of the heart will show which second sound is the later. Whilst the aortic sound is best heard over the aortic area, the pulmonic sound, markedly louder in character, is heard over the pulmonary area, preceding or following the weaker sound according to the conditions existent.

In discussing the mechanism of reduplicated second sound at the base of the heart a distinction must be carefully drawn between this phenomenon and the triple sound which is frequently heard over the apex beat in cases of mitral stenosis, sometimes described as apparent doubling of the second sound. This triple sound is present in one-third of all cases of mitral stenosis at certain stages of the lesion, though it may exceptionally be met with in other cardiac conditions. The mode of its production is in no way connected with asynchronism in the closure of the aortic and pulmonic valves. The triple rhythm represents three approximately equal tones heard best over the mitral area, the heart beating in $\frac{4}{4}$ instead of $\frac{3}{4}$ time. In some cases the first of the tones is replaced by a presystolic murmur, so this tone may be said to represent the auricular-systolic murmur of Gairdner. Where there is no murmur the anterior thickened segment of the mitral valve held in a condition of tension during the diastole of the ventricle, being taut from basic attachment to free margin, receives during the systole of the auricle a considerable accession of tension, with the result that a very distinct sound of presystolic tension is produced. This accounts for the first of the triple tones, a tone which can often be replaced by a presystolic murmur upon some active exertion made by the patient. The second and third tones are the altered first sound so characteristic of mitral stenosis, and the second sound of the heart.

Closely allied to the triple rhythm just described is the condition known as the gallop-rhythm, a phenomenon in which the interpolation of a third tone, simulating doubling of the first or second sound, produces sounds so closely resembling the hoof beats of a galloping horse, that it has been designated the canter-rhythm or Bruit de Galop. This peculiar triple sound is met with in many diseases altogether dissimilar in their nature such as many of the infectious fevers, diphtheria, croupous pneumonia, and in acute rheumatism with hyperpyrexia. We had quite recently in the fever wards a typical instance of it in a case of scarlatina in which signs of myocardial implication manifested themselves. There were present a small thready pulse—the *pulsus formicans*—cold extremities, congestion of the liver, and partial suppression of urine, and with these the bruit de galop. It has, too, been noted in pernicious anæmia, in leukæmia, exophthalmic goitre, and in various cachectic conditions in which there was pronounced cardiac asthenia. It is in connection with failing heart that it has been so frequently observed in the advanced stages of Bright's disease, especially that form known as interstitial nephritis, in which general arterio-sclerosis and hypertrophied left ventricle are usually associated. Galop rhythm in this condition is often a sign almost as pathognomonic of renal mischief as is the particular form of neuritis connected with albumenuria, whilst its presence is of great prognostic value as it indicates a form of cardiac insufficiency which is invariably progressive. There is considerable difficulty, where the conditions under which galop rhythm is developed are so diverse, in referring its causation to any disturbance in the valvular mechanism or to the state of the ventricle. The triple sound is heard over the entire heart, at the apex and at the base, sometimes louder over the neutral

area than the tricuspid, and *vice versa*, whilst the interpolated sound may be heard at three points of the cardiac cycle, immediately after the diastolic sound when it simulates a double second sound, in the middle of the long pause and at the presystole, when it simulates a double first sound. The weight of authority is definite as to the view that the interpolated sound is a diastolic phenomenon, and that it is produced quite independently of any alteration in the valvular mechanism. It is probable that the condition which is common to the various morbid states under which it is met with is an over stimulated cardiac activity, which leads to an abnormally quick diastolic relaxation with a consecutive sudden passive tension of the ventricular wall. This is due firstly to the *vis a tergo* of the entering blood, and secondly to the auricular contraction. Besides the pressure of the entering blood it should be borne in mind that, under normal conditions, the diastole of the left ventricle is not a mere passive act. It dilates under a negative pressure of 23.5 millimetres of Mercury (the *vacuile postsystolic* of Marey). If under conditions of disturbed innervation, associated with alterations of arterial tension, the abnormal degree of passive tension in the ventricular wall is produced at the commencement of diastole the third sound follows immediately the second sound, whilst in other instances the requisite of sudden passive tension is only reached during the auricular contraction, when the abnormal tone will immediately precede the first sound.

To summarise briefly, the points of diagnostic importance in connection with the pulmonic second sound in cardiac disease are as follow:—

1.—The rare condition of pulmonary incompetence from extreme dilatation of the pulmonary artery, a condition appropriately described under the name of "the murmur of high pressure in the pulmonary artery."

2.—The conditions necessary to produce the sound of Skoda in mitral disease, those under which it is not developed, and in which it undergoes resolution.

3.—The conditions relating to reduplication and division of the pulmonic sound.

4.—The condition of triple rhythm, simulating reduplication of the second sound, which is met with in mitral stenosis and that form of triple rhythm described under the name of the galop rhythm or bruit de galop.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The lecture in next week's number will be by Professor Schüler, of Vienna, entitled "Essential Nephritic Hæmorrhage."

ORIGINAL PAPERS.

TUBERCULAR DISEASE OF THE SEMINAL TRACT. (a)

By LEVESON-GOWER GUNN, M.A., F.R.C.S.,
Assistant Surgeon to the Adelaide Hospital.

THERE are two classes of disease that must always be of interest to us, those that are very rare, and for this reason interesting, and those that are very common, for on our power of curing common ailments depends largely our measure of professional success. It is to a very common disease, namely tuberculosis, that I wish to draw your attention for a short while to-night. The genito-urinary tract is often attacked by tubercular disease; in some parts of this system the diagnosis may be beset with considerable difficulty. In that portion of the system, the testicle, the cord, the seminal vesicles, and the prostate, to which I wish to call your attention to-night, the diagnosis leaves as a rule no room for doubt.

When the question of treatment arises there seems to

be, on the other hand, considerable difficulty in selecting the best course to pursue; for this reason I hope that this paper, since it deals more particularly with the treatment of tuberculosis of the seminal tract, may prove of interest to you.

Tubercular disease may occur primarily in the kidney, the bladder, the prostate, the seminal vesicles or the testicle, or it may occur as a secondary deposit in any of these organs. The testicle is most commonly affected of all these, by testicle I mean both testis and epididymis, for the latter is more often attacked than the former. There is an interesting difference between the primary and secondary infection of the epididymis by tubercle. In the primary, the disease is deposited in the tubules, and from its commencement is in connection with the lumen of the vas; in the secondary, the infection more commonly occurs in the connective tissue outside the tubules, and it may be months before the bacilli gain entrance to the vas: this has an important bearing on the extension of the disease from a tubercular epididymis.

In what direction does this disease spread from the epididymis? Into the body of the testicle itself, where inflammatory changes or the actions of toxins, or perhaps both causes, early in the disease render the testicle functionless. The flow of seminal fluid along the vas is very slow, except during ejaculation, when the powerful muscular walls of the vas contract strongly, the tubercle bacilli are carried along in this sluggish stream and have many opportunities of infecting the walls of the vas before they reach the seminal vesicles, where they are stored for a time until finally discharged into the urethra.

The vas may be infected the whole way along, in early cases of its infection this commonly takes place at either end, that is within an inch or two of the epididymis or near its termination in the seminal vesicle; the cord between these two points may be quite normal, and so lead one to suppose that as the cord is healthy above a tubercular testicle therefore the disease has not extended up along the vas deferens.

In February, 1905, I saw a young gentleman, who had had one testicle removed for tubercular mischief about two years before, the second testicle now had a similar deposit, the cord felt quite normal, and we hoped to be able to curette away the disease and save the testicle if there were no sign of infection spreading up to the seminal vesicles; even after the cord was exposed with its veins the vas felt normal, but the testicle was found to be too far involved to save it, and it was in consequence removed, the vas being separated from the rest of the cord at the same time. It then became apparent that the vas was not healthy, two minute nodules were situated in its wall about an inch above the testicle, as much as possible of the cord was removed, and inside the abdomen two more small nodes were found on the vas; rectal examination showed no sign of infection of the prostate or seminal vesicles, but I fear that this may occur later on.

The disease often attacks the second testicle, and from here it may extend backwards along the cord to the seminal vesicle on the same side; or the reverse may occur, the second vesicle being infected from the first vesicle or the prostate and from this the tubercle spreading to the testicle against the direction of the seminal flow. That infection can go in this direction we all know from cases, that are not uncommon, of sepsis spreading from the posterior urethra to the epididymis.

The age at which tubercle shows itself in the epididymis is from about 16 to 24, seldom after this, though deposits sometimes occur in infants.

The cause—injury is the most commonly assigned cause, where any cause at all is given, I think that a form of what I might almost call chronic injury is not without importance—I refer to masturbation. This is an unsavoury subject to discuss, and for this reason is ignored to a greater extent by more surgeons than it deserves to be. So often in taking the histories of

(a) Being a paper read before the Surgical Section of the Royal Academy of Medicine in Ireland, December 1st, 1905.

severe cases of genito-urinary tuberculosis have I learned that the patient was a masturbator, and continued the practice after the first appearance of the disease, that I feel confident that masturbation has a direct bearing both on the causation and the spread of tuberculosis of the genital tract. Where only one testicle is affected, as a rule the surgeon will not hesitate to remove the disease; in all probability to do this completely will necessitate the removal of the testicle. This loss is not a serious one from the patient's point of view, and the operation is often attended with the most satisfactory results. Sometimes this is not so, and later on the disease appears in the second testicle, or when the patient first presents himself both the testicles may be already infected. Under these circumstances general antitubercular treatment may be used, a partial operation may be done, *i.e.*, the disease scraped away as completely as possible, or a complete operation may be done and both testicles removed. Castration is a very serious operation from the patient's point of view, and unless his surgeon can promise him almost certain success as the result of the operation he will hardly submit to it, even though the testicles themselves are functionless. I have already called your attention to the fact that early in the course of the disease, be it in testis or epididymis, the function of the testicle is lost, it is, under these circumstances, useless to a patient and a source of danger to him. If the disease has extended to the prostate, seminal vesicles or bladder, there is not much use in removing the testes and hoping that this may check the disease—for such hopes are not likely to be realized. This procedure has been often recommended, but I do not think that it ever stops the advance of the disease; indeed, I believe that it has the quite opposite effect, that in reality it lessens the resisting power of the prostate and vesicles to withstand the advances of the tubercle, for the removal of the testes leads to a gradual atrophy of these organs, and with this atrophy there will in all probability be a diminished power of resistance to disease.

Can the extent to which the disease has spread be definitely made out?—In most cases it can, if the urine be clear, if the bladder holds 12 to 14 ozs. without pain, if there is no frequency in all probability the bladder is not infected.

Still, infection of the bladder sometimes occurs as submucous tubercles which may give rise to no symptoms; they can be readily seen through a cystoscope, and it is as well in all such suspected cases to examine the bladder by this means.

Infection of the seminal vesicles and prostate may give rise to similar symptoms to those of bladder infection, and here again it is advisable to make a cystoscopic examination. On the other hand, I have seen several cases of infection of both prostate and vesicles in which there were no symptoms beyond a slight feeling of weight in the perinæum, yet on rectal examination extensive disease of these organs could be easily made out.

Nodules in the prostate can be readily felt by the examining finger in the rectum, but the vesicles are harder to reach; fully distending the bladder with from 20 to 30 ozs. of an unirritating antiseptic lotion, and then placing the patient in the knee chest position, will be found of assistance in carrying out this examination.

I next wish to draw your attention to the course which this disease takes when the entire seminal tract is involved. I can best do this by describing three typical cases which have lately passed through my hands.

In August, 1905, I saw a gentleman, æt. 25, he told me that five years before the left testicle became swollen and discharged pus through the scrotum for several months, and then was pronounced well; six months later the other testicle became enlarged, broke, discharged for six weeks, and then healed up. For a year all went well, then an abscess appeared in his right groin, and this abscess has never completely healed up. Four months ago the bladder became involved; there has been increasing distress since then. His

present condition—His urine contains a quantity of pus, blood, and tubercle bacilli, he passes water every ten minutes day and night, pain always present, often very severe. There are tubercular nodules in each epididymis, in the prostate, and both seminal vesicles; the cords feel normal. The bladder is highly inflamed, tubercular ulceration has occurred in several places, the mouths of both ureters are patulous, the disease will almost certainly extend up to the kidneys if it has not already done so.

CASE 2.—A strong-looking man, æt. 28, was admitted to the Adelaide Hospital under my care, in March, 1905. From the age of 16 he has been a confirmed masturbator, at 20 he developed a small nodule in his left testicle; this was treated for some months with applications, and finally ceased to trouble him. Three years later a similar nodule appeared in his right testis; after a time this broke, and finally had to be scraped out. For two years after this he kept well, then the testis broke out again and symptoms of irritation at the neck of the bladder began to show themselves, and pus appeared in the urine; a month before admission he was attacked by a pain in the region of his left kidney, this pain has never since left him. He has great pain passing water; this he has to do every few minutes during the day and about every half hour through the night; the urine is foul, contains a considerable amount of pus, tubercle bacilli are present. There are tubercular deposits in both epididymis, in the right vas, and in both seminal vesicles, the lower end of the left ureter can be felt much enlarged, the left kidney is swollen and tender. The walls of the bladder are inflamed and in places ulcerated, the mouth of the left ureter is wide open, from it pus is coming. The left kidney and ureter are infected in this case.

CASE 3.—A soldier, æt. 26, admitted to hospital under my care in January, 1905. Patient was a confirmed masturbator until about the age of twenty. When 21, while serving in Egypt, a small tubercular nodule developed in his right testicle, it gave him no pain or inconvenience, and was not treated. Two years later while serving in South Africa the other testicle became affected; he was sent into hospital, where the testis was removed. In six weeks he was back on duty again, his health during the whole time being excellent. Two years later bladder symptoms began to come on, pus appeared in the urine, pain became severe, and finally he was invalided from the service. When I saw him his condition was pitiable; the right testicle, vas, both seminal vesicles, and prostate were infected, there was extensive ulceration in the bladder, from the right kidney a quantity of pus was coming, the kidney itself was much enlarged and tender, the left kidney was also painful and the urine coming from it contained pus; the urine was voided every few minutes; it contained numbers of bacteria, and among them tubercle bacilli.

To try and relieve the intense pain in the right kidney I drained it from the loin—it was a mere bag of foul pus; this drainage gave temporary relief. He was moved to the Rest for the Dying, and died there some two months later.

These three cases have many points in common. I could find no sign of tubercular disease outside the genito-urinary tract. In each the deposit in the testicle was, I think, primary; this was followed by the infection of the vesicles, prostate, and remaining testicle at varying intervals. From this the disease spread to the bladder. In case 2 it had reached one kidney; in case 3 it had destroyed the kidneys and finally put an end to years of suffering. I fear that the same fate is in store for cases 1 and 2; treatment may delay, but will hardly prevent a similar termination.

The disease occurred in otherwise healthy young men, who all had surgical advice and the means to carry out the treatment ordered. In the worst case the disease developed while the patient was in Egypt and South Africa, both climates which should have helped to stay its progress. These three patients would have submitted to any operation, no matter what

mutilation it might entail, if it would relieve their pain, even if it did not cure; but beyond draining the kidney in the one case, I did not see that any operative interference was justifiable. I have given these cases in some detail, for they are, I think, typical of their class, and because they have left a vivid picture on my mind of the course and termination of this disease.

Of earlier cases occurring during the past five years, in which both testicles and prostate or seminal vesicles were infected, some I have been unable to trace; but in all those that I have been able to follow, the disease has progressed from the seminal tract to the bladder, and from there has infected some vital organ, eventually causing death. I may have been unfortunate in the cases which have come under my notice; they have compelled me to believe that the ordinary methods of treating this form of the disease, such as open air, dry climate, forced feeding, etc., combined with partial operations, such as scraping away the tubercular deposit from the testicle, are of little avail in checking its course, and offer small hope of cure to the patient.

In January, 1905, a young man, æt. 22, was admitted under my care at the Adelaide. From the age of 15 he had constantly masturbated; he attributed all his troubles to this vice. Three years before his left testicle became swollen and painful. This swelling passed off, leaving a small hard nodule in his epididymis. This nodule gave him no further trouble. Three months before admission his right testicle began to swell up, broke, and pus came away. On admission there is a hard tubercular node in his left epididymis; the vas above this feels normal. On the right side the whole testicle and epididymis is tubercular, a sinus leads to the former from which pus is coming; the vas above feels as thick as a lead pencil right up to the inguinal canal, with a finger in the rectum the vas on the same side can be felt still thickened as it passes into the prostate, the vesicles and prostate itself feel normal. Urine is normal.

Cystoscopic examination of the bladder shows it to be quite healthy. I advised the removal of the right testicle, and, if possible, the whole of the vas. This I tried to do by following up the vas into the inguinal canal, the floor of which I opened, dividing the deep epigastric artery. I could not get the entire vas away through this anterior incision, and left behind about an inch of it. I left in a small drain, but nothing came away, and the wound healed in ten days.

On his discharge from hospital the patient was given orders to report himself to me once a month in case of further infection taking place. He did not come for three months. One end of the wound had opened and was discharging tubercular pus, evidently from the remains of the diseased vas, the remaining testicle and cord showed signs of fresh infection, and tubercular nodules could be felt in the prostate and both seminal vesicles. There was, in fact, active disease of the whole seminal tract. The urine remained normal, the bladder was healthy, but I could see the swollen right vesicle bulging up into the base of the bladder. I felt that the only treatment that offered a reasonable hope of success was the removal of the whole of the disease. The remaining testicle was useless and should be removed; with it should come both cords, vesicles, and prostate, if this could be done without great risk to the patient.

There are three different routes by which the vesicles may be reached—Zuckerkindl's, by a perineal incision; Kraske's, by removing portion of the sacrum pulling the rectum to one side, and so exposing the base of the bladder; and Young's, who by a large T-shaped incision through the lower part of the abdominal wall dividing both recti muscles gets at the bladder in this way. Of these three the first is the simplest and much the least severe operation. I tried this operation several times on the cadaver, but found it exceedingly difficult to reach the vesicles by this method. I looked up some recent works on genito-urinary surgery to see what advice they gave as to the

removal of tubercular seminal vesicles, the information they contained was not altogether encouraging.

Watson Cheyne says, "Some surgeons have performed elaborate operations for the removal of tubercular seminal vesicles before suppurative has taken place. It is doubtful, however, whether an operation of this kind should ever be performed, as it must be very extensive and the affection is usually secondary and therefore does not warrant it."

Lydston says: "Many of the radical operations performed on the prostate and seminal vesicles for malignant or tubercular disease are, in the author's opinion, absolutely unjustifiable. The operator displays brilliancy of technic and boldness of surgical enterprise, but no other ends are conserved."

Taylor says: "In the vast majority of cases, operative treatment is not to be thought of, unless suppurative has occurred in the sac, when its contents must be evacuated through a perineal incision, the cavity cleaned and packed with iodoform gauze. These patients should be sent to a suitable climate and receive the regular treatment for tuberculous subjects."

In spite of these remarks, I still felt that an attempt should be made to remove the disease from my patient. I decided to follow the steps of Young's operation for perineal prostatectomy, hoping by the use of his tractor to bring the vesicles well within reach. I do not intend to describe the steps of the operation, as this was admirably done by Mr. Arthur Ball at this Academy last session, a full account of which appears in last year's *Transactions*. The two dangers I feared were that in separating the adherent seminal vesicle from the bladder I might injure the ureter, the other, that the veins surrounding the vesicles and prostate might cause dangerous hæmorrhage. As a precaution against the second, I gave the patient dram doses of chloride of calcium night and morning for three days before the operation. Whether this had any effect or not I cannot say, but the amount of blood lost during the operation was very slight. I removed the testicle and as much of the cord as I could from the front, then, closing the inguinal wound, I removed through the perinæum the ends of both vasa deferentia, vesiculæ seminales, and the prostate.

I had no great difficulty in separating the upper part of the right vesicle from the ureter, but the portion near the prostate was firmly attached to the bladder wall. Either I used too much force with the tractor or had gone too deeply, for the blade of the instrument perforated the bladder-wall where the vesicle had been attached to it. I made no attempt to close this opening, but passed into the bladder two No. 12 catheters, one through the urethra and the second through the perineal wound, and packed firmly round this perineal drain with iodoform gauze. The gauze plugs were removed on the second day, the perineal tube on the fourth day, the urethral catheter on the seventh day, on the eighth day the patient was allowed up. He had then no difficulty in passing water, perfect control over the bladder, and no leakage from the perineal wound; on two occasions later on some slight leakage occurred from this wound, but did not last for more than a day, and since then the wound kept dry and healed well.

Six months later I examined this case. His bladder was quite healthy, the wound at the side of the trigone was firmly healed, urine normal; no return of the disease can be felt by the rectum; his general health is good. He has put on over a stone weight since his operation. I hope that this case is cured.

In August, 1905, another case of the same kind came under my care, with the exception that he was younger, only æt. 19, and that the one testicle was removed about a year before the disease appeared in the second. The cases were almost the same, and I will not weary you with what would be almost a repetition of the case I have just described to you. The vesicles were not adherent to the same extent and came away without any injury to the bladder wall.

The perineal wound was slower in closing up. The boy was up on the eighth day, and had perfect control

of his bladder from this on; yet for nearly a month there was a slight leakage of urine through the perineal wound every time he passed water. By the end of September he was able to resume his work and has since kept quite well, and is putting on weight. It is much too soon to say there will be no recurrence of the disease in this case, but his condition leads me to hope that he also is cured. The entire operation did not exceed in either case forty-five minutes. This time included the removal of the testicle and cord by an inguinal incision and the prostate and vesicles by the perineal. There was no shock in either case, but each patient received a saline transfusion before he left the operating table.

In conclusion let me recall to you a few important points:—(1) That infection may readily pass along a normal vas to the vesicle or prostate, the fact that the vas above a diseased testis feels healthy is no proof that the tubercle has not extended to the vesicles. (2) That when both testicles and seminal vesicles are infected radical treatment alone is likely to be followed by success. (3) That where the disease is confined to the seminal tract it can be completely removed, and that without any great risk to the patient. (4) That in all probability the patient is functionally no worse after such an operation than he is after a partial operation on both testes.

My thanks are due to Mr. Gordon, who assisted me at the first operation, to Mr. Heuston, who helped me at the second, and also to Professor Dixon for much help and advice in the anatomy of this seminal region.

THE VITALITY OF A NATION.*

By THEO. B. HYSLOP, M.D., M.R.C.P.

(Medical Superintendent of the Bethlem Royal Hospital for the Insane. Lecturer on Mental Diseases, St. Mary's Hospital, Paddington.)

The innate conceit of man renders him apt to claim for himself exemption from the universal laws of evolution and dissolution. It is open to argument, however, that just as living cells, organisms, lower animals, species, and even worlds live and die, so mankind must be subject to the same universal laws.

As the universe is the tomb of dead and dying worlds, so our earth is the tomb of dead empires; and, there is evidence to adduce that there are restrictions to the evolution of humanity in the earth's habitable portions.

Not only do races have their periods of increased virility, vitality, greatness and subsequent dissolution, but the inoculation of a community with a virus—so to speak—which leads to its greatness is followed in due course by diffusion and attenuation, and this confers immunity against further infection or regeneration. This law is exemplified in the history of every decayed race, and, from physical, geographical, ethnological, and psychological considerations, it appears that mankind is not only approaching the summit of attainment, but is also possibly growing old.

The law of antagonism between individuation and genesis, and the law of regression towards mediocrity, hold valid for the restriction of evolution; and it is demonstrable that our acquisitions and attainments, derived as they are from the artifices of civilisation, are not only impediments to true mental evolution, but tend to submerge and render less vital the human mental faculties.

Civilisation brings with it evils which render decay inevitable. Increased wants and enjoyments interfere with the simpler modes of life and the capacity for labour. It introduces new diseases, previously unknown, which on a new soil commit frightful ravages, and, more important still, it stamps and registers the numbers of those who are physically and mentally unfit to reach the standard of efficiency imposed by it.

In view of the immunity against further evolution conferred upon many races which have lived and had their day, and in view of the present rapidity with which interbreeding, overlapping, co-operation, and

mutual help are enabling mankind on the habitable portions of the earth to rise to the higher states of development, it appears warrantable to assume the approach of a crisis in mental evolution with subsequent universal immunity against regeneration.

Our race is so far civilised, or—so to speak—levelled up, that its limitations are becoming more fully exposed to view. Thus, were we to take a census of those who are able by their inherent powers of reasoning or thought to contribute to the further evolution of mind, we would be compelled to confess to indications of retrogression.

Humanity demands survival and accumulation of the unfit, on the assumption that all forms of human life are potentially for the service of God. Civilisation demands retention and accumulation of material possessions for the ease, comfort and benefit of mankind. And individual man demands retention and accumulation of knowledge for the evolution of his mental faculties. In these three demands and their effects we have in reality the chief repelling factors to true development—as distinguished from growth—of the vitality of thought or reason, *per se*.

These considerations lead one to ask, "Do our experimental operations on Nature really aid us to evolve to something greater, or do they but favour dissolution of the greater number?" In the answer to this question lies the highest of all conceptions, viz.—the real path of evolution from brute to God.

As with an individual, so with a nation; certain symptoms may portend a decay which is inevitable. With us, as with other nations which have lived and died, we have known freedom and glory. Wealth, vice, corruption and barbarism are but the sequels.

A remedy is being sought through all classes of our race, but the tendency is to deal with symptoms rather than with the constitutional defects which give them rise. Thus, compulsory education has been devised for ignorance and vice; free education and free food for pauperism; *creches* for parental irresponsibility; innumerable methods of caring for the aged to remedy filial irresponsibility; and so on until we have come to see within measurable distance the fostering of maternal irresponsibility by municipal free milk supply for infants, &c., &c. Thus we witness an age which may be termed the "splint age," inasmuch as we apply philanthropic anodynes, splints and poultices which either make or mask symptoms which are already, or soon become, evidences of constitutional importance.

The role of alcohol in the production of decay is as potent with a nation as with an individual. At the present time, however, there exists an active wave of common sense with regard to the consumption of substances which are harmful both to the individual and to the nation, and, whilst recognising that, although much has been done already, it behoves us all to put forth increased efforts to tackle each and every individual unit, and thereby subscribe as best we may to an amelioration of one of the factors which tends to make our empire drift into premature senility and an early grave, when it is yet capable of vigorous evolution and a further amplification of its share in the boundless stores of nature.

SEXUAL PERVERTS.

By ROBT. R. RENTOUL, M.D., M.R.C.S.ENG.

In the MEDICAL PRESS of December 27th, a very instructive case is referred to where this month a man was sentenced to penal servitude for life for a sexual offence. He had been sentenced twenty-nine years ago for a similar offence with penal servitude for life. After serving fifteen years he was released. Soon after he was again sentenced for two years with hard labour.

Max Nordau says that sexual perversion has the same insatiable desire upon the erotomaniac as has alcohol upon the dipsomaniac. If this be so—and I know of no one having questioned it—surely it is time that medical practitioners looked more closely into this

*Abstract of paper introducing a discussion before the Society for the Study of Inebriety, January 9th, 1906.

sad disease. The sexual pervert is a fairly common person. It is difficult to believe that any sane man will prefer morbid sexual acts when there are so many prostitutes willing—nay anxious—to oblige him by a fee ranging from a few coppers upwards. Last December, at the Liverpool Assizes, a man was sentenced to 25 years' penal servitude. For what? For criminally assaulting a baby five weeks old! I took some interest in this case, and found out that the man had been in the army in India, that he had had a severe sunstroke, that he had been dismissed, and that his mother was in an asylum. Now, what is the use of treating this poor sexual pervert—this sad product of our civilisation—as if he were a criminal, and responsible for his actions? There is neither justice, law, nor pathology in such punishment. There are thousands of cases of this kind in our country. Why do we not study the causes as we would study the causes of plague, typhoid, or yellow fever? If they are diseased conditions, why not study them?

I have, at considerable time and expense, collected the following statistics, and I think their perusal will teach practitioners—medical and legal—to honestly study these sad derelicts. The statistics are for one year only, and relate to persons convicted at Assizes, Quarter Sessions, and Courts of Summary Jurisdiction in the United Kingdom, 1902:—

	No. Tried.	No. Convicted.
Unnatural offences	33	31
Attempt to commit unnatural offences	58	33
Indecency in males	72	42
Rape	197	97
Indecent assault on females ...	621	420
Defilement of girls under 13 yrs.	114	82
Defilement of girls under 16 yrs.	179	83
Indecent exposure	2,000	1,741
Prostitution	14,907	12,356
Incest	14	1
Lewd and libidinous practices...	65	54
Procuration	43	28
Indecent advertisements	94	83
Brothel keeping	1,349	1,173
	19,746	16,204

It is to be noted that the above are only those who have been brought to the notice of the police. Is it too much to suppose that at least four times this number of cases take place? It would be most instructive to find out the number of times each sexual pervert was punished for the same offence. At present I am engaged in trying to find out. It took many years for us to find out that "Jane Cakebread" was not accountable for her actions, and for this reason I think this poor dipsomaniac deserves a public memorial. She taught us much, and may, I think, be described as the actual founder of all our legislation relating to inebriety and inebriate asylums. Lately I have been told of the sad case of an old man who has been sent to prison for the thirtieth time for indecent assaults on children. Does any man—any honest man—suggest that this person is not a sexual degenerate?

We have a large number of such degenerates at present in our prisons, where they are kept at the expense of the already overtaxed taxpayer. Is it too much to ask that these persons shall be sterilized by the operation which I have suggested for this class of degenerates—i.e., division and ligation of their spermatic cords (spermeotomy).* If it be right to remove the ovaries for a physical disease of these organs, or to remove the healthy ovaries for a distant disease—such as mollities and ossium fibroids, or deformed pelvis—surely it is equally right to treat these poor sufferers, and relieve them of the cause of their diseased actions. I have no sympathy with those who taboo such degenerates. Medical science is, or should be, above cant and cowardice. It purifies everything, because it is seeking after truth. Both the doctor and the night soil's

man have to tackle unpleasant work; but this is no reason why the work should be left undone. If we know that these perverts are a result of disease, surely they have a right to claim our earnest attention. If we neglect them we fail—through contemptible cowardice—to do our duty to a diseased portion of humanity, a portion who are not often diseased because of their own action, but because they are frequently the products of mentally diseased parents.

CLINICAL RECORDS.

TRACHEOTOMY AND REMOVAL OF HALF OF THYROID CARTILAGE FOR SYPHILITIC LARYNGEAL STENOSIS.

By FITZGERALD POWELL, M.D. St. And.,
F.R.C.S.Ed., (a).

Surgeon, Hospital for Diseases of the Throat, Golden Square, London, W.

IN a male, æt. 34. Police Inspector (India).

Previous History.—Fourteen years ago attended Golden Square Hospital with ulceration of larynx. He states he had a chance four years ago. Was admitted to Penang Hospital March 10th, 1904, and tracheotomy was performed there on April 1st, 1904, on account of urgent dyspnoea, previous examination of the larynx having been unsuccessful. The dyspnoea was increased by pot. iodi.

On admission to Golden Square Hospital, June 13th, 1904, he was wearing a Parke's tracheotomy tube. The right vocal cord was fixed. The left freely movable. There was considerable swelling of right ventricular band. The right arytenoid was immovable. A white-looking mass was seen below the cords. There was considerable stenosis of the glottic aperture.

June 19th.—He can breathe fairly easily for about twenty minutes with the tube corked, and if a hole is bored in the cork, can breathe for hours. Taking potass. iodi. 20 grs.; liq. hyd. perchlor. 1 drachm, t.d.s., with inunctions of mercury.

July 2nd.—The tracheotomy wound was enlarged upwards, and the white mass removed, and found to be part of thyroid or cricoid cartilage, which had necrosed the sequestrum lying above the tracheotomy tube.

April 16th, 1905.—He was re-admitted to hospital. Can breathe for sixteen hours with tube corked. Has been taking iodide and mercury since he left hospital in July. Patient was very anxious to have tracheotomy tube removed, as his appointment depended on his being able to speak without the tube. He urged operation.

April 15th, 1905.—I removed the tube and inserted a Hahn's canula, through which he had chloroform administered. I split the thyroid cartilage longitudinally, and removed practically the whole right side of the larynx, right arytenoid cartilage, ventricular band, vocal cord, part of thyroid and cricoid cartilages, stitched up the wound and introduced a silver dilator above and resting on the Hahn's canula.

April 16th.—Removed Hahn's canula. Durham's T tube inserted with dilator still in. Increasing sizes of these dilators were worn for over five months to keep open and enlarge the glottic aperture.

September 15th, 1905.—The tracheotomy tube was removed altogether.

December 1905.—Is now breathing quite well, and comfortably. Not the slightest evidence of any tendency to closure or contraction of the glottic opening. Small fistula in region of old tracheotomy wound is healing up. Voice fairly good and improving.

Larynx, the mucous membrane is healthy. Left vocal cord moves quite freely, and there is good room in the larynx. Patient in excellent health.

* Proposed sterilisation of certain mental degenerates, 1933.

(a) Clinical case shown at the Association of Diplomates of Scotland Meeting, 11, Chandos Street, London, W., December 12th, 1905.

THE OUT-PATIENTS' ROOM.

KING'S COLLEGE HOSPITAL.

Case of Necrosis of Jaw.

Under the care of PEYTON BEALE, F.R.C.S.

AMONGST the surgical cases in the out-patient room, Mr. Peyton Beale drew attention to a case of Necrosis of Jaw, in a man, æt. about 25, who was employed in a brass foundry. The patient had noticed about five months previously that his incisor teeth of the lower jaw were becoming loose and painful; his gums were also tender and spongy, then the gums surrounding these teeth began to ulcerate and he had the whole of the lower incisors removed. The ulceration of the gums extended, and when he applied for treatment the whole of the front of the lower jaw was bare nearly down to the meatal process but the bone was not in any way loose. Mr. Beale believed that the condition was caused by the fumes of zinc being inhaled, while the molten brass was being run into the moulds for the purpose of making castings. This would account for the gingivitis and the loosening of the teeth; the probability was that septic organisms thus gained access to the sockets of the loosened teeth and to the periosteum of the lower jaw; the septic process then spread downwards in front of and through the bone, causing it and the tissues in front of it to necrose. In treating such a case one might at once remove the necrosed bone, but he considered this procedure to be very undesirable because (1) it was impossible to say how far the necrosis had really extended particularly as regards the thickness of the bone; (2) the parts were necessarily highly septic and in dividing the bone there was a certainty of infecting tissues which were hitherto free from infection. He considered the best line of treatment to consist in cleansing the mouth as far as possible by the use of a tooth brush and a 1 in 20 solution of Lysoform, which he had found to be the most desirable antiseptic for use in the mouth. The necrosed bone would then gradually separate and in the course of a few weeks would be found quite loose and capable of being picked out bodily. The resulting deformity was very much less than it would be if the bone were removed before a natural line of demarcation had been formed. He had come across three or four similar cases and they were very like the necrosis produced by phosphorus poisoning. As regards the gingivitis the internal administration of iron and arsenic seemed to be beneficial, but it was a noticeable fact that it was very difficult to stop the inflammation owing to the difficulty of procuring asepsis in the mouth. He believed the actual necrosis was entirely a septic process, the primary ulceration of the soft parts only being caused by the fumes from the molten metal. It was of course necessary that the man should not continue with the same work.

Chronic Abscess in the Chest Wall.

A boy, æt. 12, complained of a swelling about the size of a tangerine orange resting upon, and apparently connected with, the fifth and sixth ribs on the left side. There was very distinct fluctuation in the swelling; it was quite painless, had been forming gradually for about four months, and there was no cause to account for its presence. The swelling was at the junction of the cartilage of the ribs and Mr. Beale had no difficulty in deciding that it was a chronic abscess. He pointed out the importance of thoroughly examining a patient and said that a kind of general rule which he always made was to bear in mind the superficial lymphatic glands nearest to the tumour or spot at which the patient complained of swelling or pain; then one should examine the whole of the area which was drained by these glands; if such a rule as this were always borne in mind and acted upon it insured against the possibility of missing some neighbouring abnormality which might be or might have been the primary cause of the trouble for which the patient presented himself. In this particular case, such an abscess was either the result of local tuberculosis of a rib close to its junction

with the cartilage or it was a collection of pus which had tracked along one or more ribs originally starting from tuberculous disease of a dorsal vertebra. Some of these cases were undoubtedly broken down gummata, but as regards the chest by far the commonest situation for a gumma were the sterno clavicular joint and the sternum itself at the junctions of its various parts. He had observed that in the surgical examination of candidates cases like the one under consideration were often presented, and of course it would be necessary to turn the patient over and examine the spine; he had seen many candidates come to grief in clinical surgery through neglecting to do this, but if they would only remember the general rule above quoted regarding the extent to which the patient should be stripped and examined they would not fall into any trap laid by the examiner. When such an abscess was due to local tuberculous disease of the rib the site of disease curiously enough, he pointed out, was always on the inner or pleural aspect. Bearing this in mind the only proper treatment of such cases was to expose the rib and excise the diseased portion bodily. He said that it did not follow that the disease was at the site of the abscess, but when the abscess was opened a bent probe could be inserted and would travel to the position of the mischief, though it was often difficult to find the track as it was on the pleural aspect of the rib.

OPERATING THEATRES.

ST. PETER'S HOSPITAL.

ENUCLEATION OF THE PROSTATE. — MR. SWINFORD EDWARDS operated on an old man æt. 73, who had suffered with difficulty in micturition for the past seven years. Latterly he had been entirely dependent on the catheter. On admission ten days previously, there was some cystitis, but this had been relieved by daily washings. His urine had now a specific gravity of 1012, was acid in reaction and contained but a slight amount of albumen and a little mucus. Examination per rectum revealed a prostate which was elastic and fairly moveable, of about the size of a large tangerine orange. The prostatic urethra was evidently much elongated as a catheter had to be passed in nearly up to the hilt before the water could be drawn off. As this seemed a very favourable case for enucleation, Mr. Edwards proceeded to perform the operation as follows:—A Coude catheter was first passed and the bladder well washed out with boracic solution; it was then filled with sixteen ounces of the same solution and the abdominal wall opened in the supra pubic region through the fibres of the rectus. The soft parts were stripped off the anterior bladder wall upwards by the finger. Before incising the bladder wall, it was inspected, in order if possible to avoid the large veins which often ramify on this surface; in this case it was found possible so to do. Whilst the fluid was escaping through the incision the left forefinger was introduced and the intra-vesical portion of the prostate carefully examined. Mr. Edwards now inserted a special prostatome which he had devised and had made for the purpose, and which he was now using for the first time. By means of this instrument, he incised the mucous membrane over the projecting lateral lobes of the prostate, dividing the mucous membrane in two separate places. The prostatome having been laid aside the right index finger was inserted into the bladder whilst the index and middle finger of the left hand were introduced into the rectum, pressing the prostate well up towards the wound. With the right index the mucous membrane was stripped off the prostate, which was gradually shelled out of its bed

from behind forwards. After about four minutes spent in this process of stripping the gland became free in the bladder, and was delivered by means of lithotomy forceps; but before its complete delivery could take place a small piece of urethra was cut through close to the prostate. The prostate came out whole and apparently weighed from three to three and a half ounces. A one-inch rubber tube was now inserted into the bladder and irrigation with hot boracic solution (temp. 110) was carried out by means of a catheter passed through the urethra. The catheter was next withdrawn, and the supra-pubic drain fixed by a suture in situ. A couple of silkworm gut sutures sufficed to bring the rest of the wound together. There was about the ordinary amount of bleeding, which had nearly ceased by the time the dressings were applied. The enucleation itself only took between four and five minutes, the whole operation not having lasted more than a quarter of an hour. Mr. Edwards said that enucleation of the prostate in fit cases was one of the most satisfactory operations in surgery. This he looked upon as a favourable case, for the prostate was large, elastic and movable as ascertained before the operation by bi-manual manipulation. In this case the intra-vesical portion formed a collar-like enlargement with a small so-called third lobe posteriorly but the enlargement towards the bladder was not as marked as he had anticipated. In this case, he pointed out, he used a prostatome, or knife, which resembled a small straight and narrow periosteal elevator, having a rounded and shallow cutting edge at the extreme end, which he had devised for the purpose of dividing the mucous membrane over the projecting prostate instead of scratching through with the finger nail. On former occasions he had found that the necessary manipulations tended to tire the finger before the actual stripping process began. By this means he hoped to conserve the muscular force of the operator till it was really needed, for the actual stripping process. Mr. Edwards expressed himself as much satisfied with the facility with which the instrument enabled him to carry out this object. In several previous cases he had resorted to the Trendelenburg position in order that after having opened the bladder, he might incise the mucous membrane under the guidance of the eye, but he had found that in some cases even this position together with full retraction of the bladder walls did not always give a good view of the prostate tucked up as it is under the pubic arch; moreover, the time spent in carrying out an enucleation by the latter method is considerably longer and therefore is likely to add to the gravity of the operation.

ROYAL EAR HOSPITAL.

EPITHELIOMA OF THE PINNA.—MR. MACLEOD YEARSLEY operated on a man, æt. 52, a porter at Covent Garden market, who had been admitted suffering from epithelioma of the left auricle. The history was as follows:—Two months ago the patient noticed a small growth about the size of a large shot in the fossa of the anti-helix. This grew fairly rapidly, and commenced to ulcerate one month afterwards. On admission the growth was a little larger than a sixpence, raised, very hard, and excavated by ulceration, the ulcer being distinctly crateriform. There was no glandular enlargement. The patient's urine was loaded with sugar. The external auditory meatus having been packed with gauze, Mr. Yearsley removed the whole auricle, with the exception of the lobule. Commen-

cing in the concha, he took a small semilunar flap from that region, and carried the incision upwards, round the attachment of the helix, and backwards to the posterior aspect of the concha, where he made a second curved flap, ending at the attachment of the lobule behind. The extremities of the incision were joined by a straight cut, dividing the lobule from the rest of the pinna, and the latter was dissected away completely. About four small arteries required ligation. The wound was then sutured in its entirety, the two flaps being brought together above, and stitched to the lobule below. Fresh packing was put in the meatus and the wound dressed. Mr. Yearsley said that these growths of the auricle were not common. Such a neoplasm as that just operated upon probably arose as a primary growth, and from its appearances and history was in all probability an epithelioma. Occasionally, he said, one met with sebaceous cysts in this locality, which sometimes became epitheliomatous. This case, however, he thought was not one of these. Differential diagnosis had to be made from primary chancre and gumma, both of which were rare in this region, and would have been accompanied by definite specific signs and history. The prognosis of a case like this was, he considered, decidedly favourable; the short history, the absence of glandular enlargement, and the slow progress of epitheliomata of the pinna combined to make one hope that a complete operation would not be followed by recurrence. Glandular involvement in these cases was always slow, and when it did occur usually affected the mastoid gland and the occipital group. The fact that the patient had diabetes, he pointed out, probably influenced the prognosis, but the influence one way or the other would, he thought, be known in twenty-four hours.

Instruction in Military Surgery for Civilian Practitioners.

MANY members of the West London Medico-Chirurgical Society having expressed a wish for instruction in the special work of military surgeons so that they may be in a position to render aid in time of war, the Director-General has arranged for a short course of lectures and demonstrations to be given at the West London Hospital on alternate Saturdays at 4 p.m., commencing January 20th. An endeavour will be made to give a broad and practical view of the subject without going too much into detail. Medical men residing in West London, whether members of the Society or not, who may wish to attend the course, which is free, are requested to apply by letter to W. H. Chambers, Esq., 101, Goldhawk Road, W. The course is under the direction of Col. James, Superintendent of the Royal Army Medical College, and the size of the class will necessarily be limited.

The London School of Tropical Medicine.

THE following is a list of candidates who passed the examinations during December, 1905:—Dr. J. M. Collins, Dr. H. M. Sauzier, Dr. J. C. S. McDouall (Colonial Service), with distinction; Surgeon E. R. Whitmore (U.S. Army), with distinction; Dr. J. W. Arthur, Capt. J. Booth-Clarkson (Natal Medical Corps), Dr. H. L. Burgess (Colonial Service); Dr. H. Carlaw (Colonial Service), Dr. R. Cope (Colonial Service), Dr. R. Denman (Colonial Service), Dr. A. C. Falkiner, Dr. J. D. Finlay (Colonial Service), Lieut. C. W. Holden R.A.M.C., Miss J. Hogg, M.B., Capt. T. C. Lauder, R.A.M.C., Dr. E. C. Lindsey (Colonial Service), Dr. M. Ramsay (Colonial Service), Dr. A. R. Rendle (Colonial Service), Dr. A. C. Rendle (Colonial Service), Dr. L. Sells, Dr. R. Small (Colonial Service), Dr. A. J. T. Swann (Colonial Service), Miss F. M. Wakefield, M.B., Dr. P. Wykesmith (Colonial Service).

TRANSACTIONS OF SOCIETIES.

ASSOCIATION OF MEDICAL DIPLOMATES OF SCOTLAND.

CLINICAL EVENING, MEDICAL SOCIETY'S ROOMS, LONDON, W., DECEMBER 12TH, 1905.

The President, CLAUDE ST. AUBYN FARRER, in the Chair.

DR. ALEXANDER MORISON showed a man, who had served as a cavalry soldier in the late Boer war, who was the subject of parasitic hæmaturia. After having bathed in the Blood River (!) he and eight of his companions developed bilharzia hæmaturia. The patient had painful micturition, and the blood was at times sufficient to clot. Dr. Morison exhibited the causal ova of the parasite under the microscope.

DIAGNOSIS BY TUBERCULIN.

DR. DAVID WALSH showed a man æt. 59, a waiter, with a sharply circumscribed, spreading eruption, at margin of anus and buttock, of three years' duration. Had good health up to 1895, when he developed rectal abscess, which was operated upon and followed by fistula. In 1900 he had double pleurisy and a year later the fistula was successfully operated upon. Soon afterwards a reddish slightly elevated eruption appeared near the anus and has grown slowly ever since until it is now 5½ inches in diameter. There is no history of syphilis, and no evidence of lung disease or other trouble. It was determined to inject tuberculin (O.R.) as a test. Accordingly, .001 c.c. tuberculin (O.R.) was administered subcutaneously. There was no rise in temperature, but as the patient's temperature on admission was 98.8 a slight rise might have been masked. Next day .002 tuberculin was followed by a sharp rise to 100 deg., which was maintained for a day, when it fell to 98. A third injection on the fourth day of .003 was followed by a rise to 99. At the second injection the eruption became redder and during the next few days became scaly.

This case is interesting as showing the invasion of skin by infection through an operative wound (assuming that the fistula and the pleurisy were of tubercular origin.) It also illustrates the value of the tuberculin test where any doubt exists as to diagnosis. From its site and appearance the eruption in this case might have been syphilitic.

MR. SYDNEY STEPHENSON showed the following cases, some of them being of extreme interest:—(1) A new sign of mercurial intoxication; (2) congenital lipo-dermoid tumour of the conjunctiva; (3) a case of tubercle of the lacrymal sac.; (4) a case of exophthalmos.

DR. S. LIGHTFOOT showed a case of Raynaud's disease, in which three fingers had been removed by the Bilton-Pollard method. (This case was fully reported, with an illustration, in our issue of Jan. 3rd.)

DR. FITZGERALD POWELL showed a man with removal of half the larynx for syphilitic stenosis. (This case is reported in another part of present issue. See p. 40.) Dr. Powell also showed a typical acute rheumatic pharyngitis, and angioma of palate, fauces and tongue in a male, æt. 34. This patient came for treatment for his ear. He was found to be suffering from chronic suppurative otitis media of both ears, and mastoiditis. The radical mastoid operation was performed on him on October 4th, 1905, and much diseased bone was removed on left side. He is making a good recovery. He was seen to have a large angioma of the tongue, soft palate, and fauces, mostly on left side; he says it does not cause him any trouble. His speech is thick, but he has no bleeding from it. The case is interesting from the great extent of the angioma. Great difficulty was experienced in giving him the anæsthetic at the operation, as the angioma filled and

swelled greatly, interfering with his respiration. The patient declines any treatment for the angioma.

The PRESIDENT (Dr. Farrer) showed a patient with a flail-like and atrophied right leg, in which the knee had been excised.

DR. G. W. F. MACNAUGHTON showed a man, A.P., æt. 21, a silk mercer with light duties. Face pale and somewhat anxious-looking; veins of the upper extremities engorged, the thorax has a left-sided appearance, owing to bulging of the præcordia. The maximum cardiac impact is in the sixth left interspace, in a line with the nipple. Epigastric pulsation is present, denoting in this instance enlargement of the heart. Its sounds, on auscultation, indicate hypertrophy, while there is arhythmia. Patient came complaining of cough and pain and uneasiness in the infra-axillary and sub-scapular regions on the left side. There is a slight sulcus or shallow depression, corresponding to the attachment of the diaphragm in front. No history of rickets, rheumatism, of depraved habits, or of excessive muscular efforts, and Dr. Macnaughton believed the enlargement of the heart to be due to early disciplinary singing. The rules of voice production and their frequent practice at an early time of life, when the organs are sensitive and growing, implying as they do a physical and nervous strain, are the cause of enlargement of the heart, of which this is an example. The administration of arsenic here is the most useful means of aiding this condition, with, needless to say, the cessation of singing, although when once this hypertrophy of the heart is produced, it persists to a greater or lesser degree throughout life.

RECKLINGHAUSER'S DISEASE.

DR. P. H. PARSONS showed a case of congenital multiple neurofibromata in a man, æt. 39. (This case we hope to report fully in our next issue, together with an illustration.)

DR. H. MACCORMAC demonstrated some curved needles with handles (one piece of metal) for abdominal operations.

LIVERPOOL MEDICAL INSTITUTION.

A MEETING HELD DECEMBER 21ST, 1905.

SIR JAMES BARR, the President, in the Chair.

A NUMBER of clinical cases were exhibited, and later Dr. R. J. M. BUCHANAN and Dr. C. J. MACALISTER, opened a discussion

"IS THE SANATORIUM TREATMENT OF CONSUMPTION WORTH WHILE?"

DR. BUCHANAN said that in consumption, as in other infective processes, some internal power is working towards recovery; and much may be done by stimulating this power to action or in assisting it when inactive. In all cases of phthisis, especially in the early stages, treatment is urgently called for, and is usually followed by marked benefit. He pointed out the principles upon which the treatment of consumption should be based, and said these are indicated by our knowledge of otological factors; and the principles of hygienic and dietetic treatment, which are true, honest, sensible, and right, and demand the advocacy of all true, honest, sensible, and right-minded members of the medical profession. These principles of treatment admit of no discussion, and are best carried out in a sanatorium worthy the name, by a medical man who thoroughly believes in and enforces them in a systematic and exact manner, with the due amount of respect which their truth demands. Dr. Buchanan's personal experience of sanatorium treatment enabled him to say that he knows of no treatment so invigorating, so sensible and so trustworthy, and which holds out so much hope and encouragement, or which affords so great a prospect of success.

Dr. MACALISTER said his experience of Sanatorium treatment had been disappointing, for although many of the cases had been sent in the early stages of the disease, in nearly every instance a relapse had subsequently occurred. He commented upon the utter futility of treating the poor in sanatoria, and pointed out that those patients who subsequently die from phthisis, do so in much the same period as they would have done, had they never been in one of these institutions. The death-rate from phthisis had not diminished to any great extent since the advent of the sanatorium treatment, and judging from the figures of those who kept careful records in the pre-sanatorium days, the recovery rate and the death-rate of the disease was about the same as it is in patients treated in sanatoria. Dr. Macalister thought that many of the most successful sanatorium cases represented patients in whom a strong tendency to recovery existed; and mentioned his experience with patients presenting this tendency. He thought the personal factor had more to do with recovery than any special line of treatment. He advocated the construction of inexpensive buildings for sanatoria, so that more money might be devoted to the maintenance of a larger number of cases both early and more advanced. He thought the best way of dealing with the problem was to endeavour to prevent the disease by exercising much stringency, with reference to known elements of infection, and by adequate disinfection of dwellings inhabited by persons suffering from phthisis.

Mr. COLIN CAMPBELL thought it unfortunate that after ten or twelve years of sanatorium treatment, facts remained so few, and statistics so inconclusive or contradictory. The utmost confusion still existed as regards the classification of cases, and vagueness in the reports of the various forms of cures, so called, obtained. Favourable results lie somewhere between the 60 per cent. of "economic cures," reported from Germany, and three out of 38 reported from Heswall, in which the disease was "arrested."

Dr. G. A. GRACE-CALVERT said statistics of sanatoria results are adversely affected by the very short stay many patients make—often six weeks or less, by the kind of work to which a patient has to return, and by the surroundings, often the most unsuitable, to which patients return. He emphasised the necessity of sending early cases to the Sanatorium; for the great majority did excellently, and it was wise to send such patients to the Sanatorium first and to the country afterwards, because they then early learn how to carry out treatment and much valuable time was saved.

Dr. ERNEST NEVINS considered that as Poor-law authorities and other public bodies were being urged to erect sanatoria, the phrase "worth while" should be judged from the point of view of social economy, in which case the decision would be unfavourable. Many sanatorium enthusiasts had admitted that results were unsatisfactory, but the blame was thrown on the patients who were "unsuitable." The conditions necessary to make a case "suitable" were impossible for the vast majority of consumptives, and it was little or no use teaching a man a mode of life which his social circumstances would never allow him to carry out.

Dr. W. B. H. Wood, Dr. T. R. Glynn, Dr. A. L. Morgan, Dr. W. B. Warrington, Dr. Nathan Raw, Dr. A. G. Gullan, Dr. E. T. Davies, and the President also took part in the discussion.

NORTH-EAST LONDON CLINICAL SOCIETY.

MEETING HELD THURSDAY, JANUARY 4TH, 1906.

MR. C. E. HUTT, President, in the Chair.

THE following cases were exhibited:—

Mr. WALTER EDMUNDS showed (1) a man, *æt.* 19, with a loose body in the right knee-joint. There was a history of injury two years previously, but the

feeling of weakness and of the limb "giving way under him" had only been present for the last six months. There was some creaking on movement of the joint. (2) A man with a peculiar warty growth of the lower lip.

Dr. A. J. WHITING showed (1) a man, *æt.* 49, with an aortic aneurysm, affecting the first part of the aortic arch, who had been treated with six gelatine injections. The swelling, which was palpable externally to the right of the sternum had diminished in size from that of a tangerine orange to that of a large walnut.

Mr. EDMUNDS, while acknowledging the fact of the diminution in size of the aneurysm, considered that no aneurysmal dilatation of a vessel could be really cured unless the vessel upon which it was, was at the same time occluded. In the present case the swelling still presented expansile pulsation, showing that some of the contents, at any rate, were fluid. (2) A man, *æt.* 37, the subject of phthisis in whom subcutaneous emphysema had occurred.

Dr. G. P. CHAPPEL showed a girl of ten with empyema presenting many of the features of bronchiectasis. The child had had a cough for two years, but there had never been any acute attack of pain or fever. The whole of the left side of the thorax was dull, but the heart was drawn over to the affected side. During the last month the dullness had somewhat diminished. The general appearance of the patient was healthy.

Dr. J. HUNT recalled a case of empyema he had seen on the point of perforating externally which subsequently turned out to be a typical cirrhosis of the lung.

Dr. F. H. WALLACE pointed out that there was a definite shadow in the present case seen upon examination with the X-rays, which moved with the position of the patient.

Dr. E. HOOPER MAY remarked that competent observers had shown that little reliance could be placed upon the shifting character of the dullness in the diagnosis of empyema.

Two cases of cretinism were exhibited by Dr. J. M. LAUGHTON and one by Dr. R. BROWN.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

A CLINICAL meeting of this Society was held on Friday, January 5th, 1906. In the absence of the President, Dr. G. P. SHUTER took the chair and referred in feeling terms to the irreparable loss that the Society had sustained by the sudden death of Dr. Campbell Pope, one of its original members.

The following cases were then shown by Dr. BONTOR, a case apparently of Pernicious Anæmia, which had much improved under treatment, which consisted mainly of increasing doses of Arsenic and Salol. By Mr. KEETLEY, a case of Ruptured Quadriceps Extensor Cruris in an old man treated by suture; and also a kidney which had been removed from a young lady, for hæmorrhage due to a crushing of the organ which had been completely torn into two parts. The patient made a satisfactory recovery. By Dr. SEYMOUR TAYLOR, a case of probable Gumma of the Pons Varolii. By Dr. PHINEAS ABRAHAMS, an unusual case of Lupus Erythematosus. By Dr. LEONARD DOBSON a case of Lupus, which after being very obstinate to treatment by scraping and X-rays, had been much improved by kataphoresis. By Dr. ARTHUR SAUNDERS a case of Progressive Muscular Atrophy, and also one of Rickets with an unusual form of deformity of the arms. By Mr. ESTLETT BALDWIN, a case of congenital elevation of the Scapula. By Dr. Andrew ELLIOTT a case of Embolism of the Arteria Centralis Retinæ. By Dr. GARRY SIMPSON, a case of Congenital Ichthyosis.

An interesting discussion followed the exhibition of most of the cases, and a large number of members took part.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS
ABROAD.

Paris, January 8th, 1906.

PNEUMONIA IN CHILDREN.

As everyone knows, pneumonia is very frequent in children over two or three years of age. The cortege of accidents attending the development of infantile pneumonia is very alarming for the parents and sometimes puzzling for the attending physician, as frequently the diagnosis is obscure and difficult where the temperature oscillates between 98 deg. and 104 deg.; where after five or six days it falls to the normal, leading to the belief of definite defervescence, yet the same evening the fever runs up again to 104 and so on throughout the malady.

Generally speaking, the diagnosis of pneumonia is as easy in the adult as it is difficult in children. In the adult the debut is sudden, rigor, pain in the side, vomiting, cough with characteristic expectoration, dyspnoea, fever, physical signs easy to detect, and finally the information the patient furnishes himself. There is hardly one of these symptoms, says Prof. Variot which may not be wanting in a child, especially if he be under four years of age. Has he had a rigor? Who can tell? The pain in the side is habitually absent, as the dyspnoea and acceleration of the breathing are far from being as frequent as in the adult. Generally, the children of five or six localise the pain in the abdomen, and above all in the right iliac fossa. When this abdominal pain coincides with vomiting and high fever it may suggest to the physician troubles of the appendix.

Dyspnoea is generally constant in the adult; the respiratory movements are precipitated, laborious and painful. In children it is frequently absent as a pathognomic symptom, for the number of the respirations which may amount to 30 or 40 in the minute can be observed in other febrile affections. In bronchopneumonia, on the other hand, the dyspnoea is constant, constituting a good differential sign between it and pneumonia proper. The cough during the first three or four days is slight and attracts little attention; it is rather towards the end of the malady that it becomes frequent.

As to expectoration, it is one of the most characteristic signs of pneumonia in the adult; by it alone, when it consists of rusty coloured sputa, the diagnosis can be established. In children expectoration reveals nothing, and generally they swallow it, but when it can be obtained, it is white like ordinary sputa. The fever is the most troubling symptom in infantile pneumonia on account of its embarrassing oscillations. However, they are not absolutely the rule, for as in the adult, the temperature rises suddenly to 103 deg. or 104 deg. and maintains that level with slight oscillations between morning and evening, for five or six days. The defervescence takes place towards the seventh day, but the high temperature continues sometimes longer with more or less marked remissions.

When the fever lasts several days in this manner the chest should be frequently examined, as frequently a post-pneumonic empyema will be observed. In any case, the fever is often the principal symptom by which infantile pneumonia is revealed with its usual cortege: saburral condition of the digestive tract, prostration; if the seat of the affection is very limited not exceeding the size of an orange; if it remains central without extending towards the surface of the lung. The physical signs can be so attenuated and so uncertain that the diagnosis remains obscure for five or six days; it becomes affirmative only at the moment of defervescence, when the temperature falls suddenly from 104 to 98 deg.

In presence of a febrile condition with digestive and nervous troubles, and in the absence of physical signs of the respiratory organs, dyspnoea, etc., one is tempted to diagnose typhoid fever; if at the same

time as the fever there exist vomiting and a certain delirium meningitis presents itself to the mind. It is under these circumstances that the difficulties of diagnosis reach their highest point, especially if the physical examination of the thorax is incomplete by reason of the agitation and cries of the little patients, and their general indocility. Every precaution should be taken to ensure a moment of calm on the part of the child, for many grave errors may be avoided by a patient examination.

Percussion signs can be observed two or three days before those afforded by auscultation and can be found beneath the clavicle when the apex of the lung is the seat of pneumonia, a common form in children. The dulness is frequently well marked. On the other hand, thoracic vibrations are frequently absent but bronchophony crepitant rales are always present and easy to detect.

Berlin, January 7th, 1906.

At the Society for Psychiatry and Nervous Diseases. Hr. Borchard spoke on
OPERATIONS FOR TUMOURS ON THE POSTERIOR FOSSA,
MORE PARTICULARLY OF TUMOURS OF THE
CEREBELLUM.

He describes the modern technique for opening up the cerebellum. For opening out a hemisphere a flap of the soft parts was formed with a lower base, which extended upwards 4 to 5 c.m. over the occipital protuberance. The bleeding from the bone incision was arrested by plugs of ivory and bits of wood, and then posterior hemi-craniotomy was performed.

If both hemispheres had to be exposed a larger flap over the whole occipital region was formed and the bone exposed; one after the other the bone of both sides was removed, the bridge between them was then sawn through with Gigli's wire saw. Then followed opening of the dura mater in flaps, and incision of the exposed hemispheres. No, or at the most only partial, suture of the dura mater was required. The cases calling for such operation were: (1) infectious tumours (tubercle conglomerate and gummata); (2) solid tumours, dermoids, cholesteatomata, gliomata, sarcomata, etc.; (3) cysts. The tubercle conglomerates have yielded the worst prognosis up to the present. In spite of this, however, early operation was called for, but serious tuberculous trouble elsewhere was a contra-indication. Gummata afforded a better prognosis. If a six weeks' course of anti-syphilitic treatment was without result an operation should be performed; at any rate, before atrophy of the optic nerve set in. In cases of glioma and gliosarcoma he calculated on 9 per cent. of recoveries. Dermoids and cholesteatomata had not yet been operated on.

Cysts afforded the best prognosis: of 14 cases, 13 had recovered.

Hr. Seiffer showed a patient who had been operated on by Hr. Krause. She walked without any noticeable staggering. She had a tumour of the lateral tract of the cerebellum and exhibited papillary stasis, nystagmus, trigeminal paresis, loss of corneal reflex. Limbourg's sign, cerebellar gait, headache, vomiting, and giddiness—all the general symptoms were improved, the neuralgic pains, the vomiting, staggering, and usual paresis to the right, the disturbance of sensation and papillary stasis. There still remained the nystagmus, loss of corneal reflex, diminution of sensation and deafness.

Hr. Krause observed that he could not take off the bandage. The healing of the wound was normal, but from disturbance of the circulation, the cicatrix projected and fluctuated. On puncture 50 grm. of cerebro-spinal fluid escaped. If the bandage were taken off, there would be danger of infective meningitis. The auditory nerve did not regenerate. The tumour, which was the size of a finger-tip, shelled out easily, and without any hæmorrhage.

At the Laryngologische Gesellschaft, Hr. G. Lennhoff showed a case of

TUBERCULOUS ULCER OF THE GUMS.

The patient was a woman, æt. 35, whose father had

died of pulmonary phthisis. She had had exudative pleurisy eight years ago, and had lost 35 pounds in weight during the last five years. The lungs were practically sound, as shown by percussion and auscultation, but on the alveolar process of the upper jaw was a flattened ulcer, with a greyish white base, pale secretion and excavated border. Small nodules were recognisable in the margin. There was also a flat ulcer, also with nodules, on the right upper gums. The disease had begun two years ago, with a slight feeling of soreness and bleeding on the slightest touch. There was no question of syphilis. The absence of any tendency to cicatrization was against any theory of lupus. No microscopic examination had been made yet.

Hr. Edmund Meyer showed a preparation from a case of

CICATRICAL STENOSIS OF THE PHARYNX AND LARYNX.

The patient, a man, *æt.* 70, had died from pulmonary embolism. For the last 35 years he had worn a tracheotomy canula. On the preparation three cicatricial stenoses one above the other were visible, between the base of the tongue and the posterior wall of the pharynx, between the epiglottis and the posterior wall of the pharynx, and lastly complete stenosis of the larynx.

The *Deutsche Med. Zeitung*, Jan. 1, 1906, reports a case of

BASEDOW'S DISEASE

treated with milk and blood from a goat whose thyroid had been removed. The patient, a married woman, *æt.* 41, commenced her illness after her first confinement. The usual symptoms were present, exophthalmus, palpitation, sweating. In the course of twelve years she was delivered four times and the condition got worse and worse. No treatment availed except that the struma was reduced in size after being injected with Tr. Iodi.

The first attempt was made with blood from a thyroidectomized sheep and was not very successful—but the pulse fell to 88 in the mornings and about 100 in the evenings.

Then the milk from a thyroidectomized goat was begun, after which improvement was steady, the strength increased, the nervous symptom disappeared until the patient could do her housework, a thing she had not done for sixteen years. The eyes receded, the sweatings ceased, and the weight increased by several pounds. When the goat's milk was no longer available, the condition got worse again. Then two goats were procured, and the patient again improved, and when their milk failed their blood was given to the extent of 20 gm. a day. With this the patient's improvement continued, but if she went several days without the milk or the blood she felt at once that the heart became irritable, and the old symptoms threatened to come on again.

Vienna, Jan. 7th, 1906.

SYMMETRICAL LIPOMA.

At the "Gesellschaft," Paschki showed a patient *æt.* 34, with symmetrical lipomas combined with the neuro-fibromatosis of Recklinghausen. Both of these diseases are happily rare, but when they come together in the same patient they become interesting if not instructive in showing a close affinity in their origin. Paschki affirmed that we had very few records of either in literature, and not one hitherto where both diseases have been met with in combination.

INTESTINAL CALCULUS.

Wimmer showed an intestinal calculus taken from a patient in the Maria Theresa hospital measuring 8 centimetres in length, 6 broad; and 19 centimetres in circumference, weighing 320 grammes. The section showed concentric rings around a nucleus with the episperm of grain as a centre from which it originally commenced. It was chemically composed, carbon, carbonic acid phosphate of lime, with the acid phosphates of ammonia and magnesia. The stone was

found by laparotomy immediately above the ileo-cæcal valve, where a tubercular ulcer had existed primarily, with a subsequent arrest of food or the debris of the food that led to the origin of the calculus. The cæcum and a neighbouring portion of the small intestine was resected, the parts brought together and closed, and after 18 days she was dismissed from hospital perfectly cured.

JEKORIN.

Offer next interested the members with his results of the analysis of Jekorin, which has been issued to the medical public as a palladium of sovereign merit by Drechsel, who extracted the substance from the liver of a horse. Drechsel gave the following properties of Jekorin: an alcoholic extract of the liver when evaporated to dryness can be easily dissolved in ether and again precipitated by adding alcohol to this ether solution. This precipitate is not crystalline, and when dried in vacuo with sulphuric acid assumes the appearance of a porcelain mass which again becomes fluid when exposed to the air. This ethereal solution reduces Fehling's solution, and according to Drechsel is a chemical combination of lecithin and grape sugar.

Meinertz has recently made an analysis of Jekorin, and concludes that it is not a chemical body but rather a mixture of lecithin, dextrose and inorganic salts, but the principal ingredient is lecithin.

Offer performed his analysis with the greatest care to avoid hydrolysis during the operation, and with this object in view made a cold extract at a low temperature in vacuo, and obtained the same result as Meinertz. He next reversed the operation by preparing an ætheral of lecithin into which he added a solution of grape sugar, shook them well together and allowed them to stand for some time till the ætheral solution separated from the water solution. The ætheral solution was again washed with pure water and finally with a concentrated solution of magnesium sulphate. After drying off the æther by evaporation a substance similar to Jekorin was left behind, which acted in the same manner as Drechsel's preparation, which, carefully examined, was found to contain lecithin and sugar, but the sugar is feebly bound up with the lecithin. In his further research Offer found two other bodies with distinct chemical and physiological properties—viz., dispentosamin and biose, which are somewhat analogous to Fränkel's albam, although differing from it in not having a nitrogenous combination in the pentose. In this sense it has no hydrolytic influence, although it may combine with five atoms of hydrocarbonous matter.

Budapest, Jan 7th, 1906.

At the recent meeting of the Interhospital Association, Dr. Kadosa read a paper on

GASTROPTOSIS.

He had several cases which had been kept under observation for more than a year, and his conclusions thereon were formulated in answer to the questions:—(1) To what extent is gastroptosis responsible for symptoms? and (2) of what value is prolonged external mechanical support as a means of treatment? As regards the first, he found that these cases naturally fall into two divisions: first, those in which gastroptosis is a primary condition; and those in which gastroptosis is not the main factor in the morbid state. He found that certain cases are relieved so promptly by external mechanical support alone, without any other treatment beyond regulation of the diet, that the downward displacement of the pylorus must be regarded as the primary, or, at least, the principal factor in the causation of the symptom complex. Cases of this character exhibited a moderate diminution of hydrochloric acid secretion, were free from organic disease, and showed no signs of dilatation or impaired mobility. The symptoms were those of malnutrition, gastric fermentation, attacks of frontal headache, and sensations of dragging and lack of support in the abdomen. Gastroptosis may exist absolutely without symptoms. This is shown by the demonstration of down-

ward displacement of the pylorus in the routine examination of other morbid states. Such patients were not benefited by external support, and recovered completely, although re-examinations showed that the stomach was still displaced. Gastropotosis may form a part of the symptom complex of other morbid states, such as neuroses, gastric motor insufficiency and dilatation, and passive congestion of the stomach from weakness of the cardiac muscle. Here the downward displacement of the pylorus is also relieved by a mechanical support. The value of the mechanical support was not exerted in restoring the organ to its normal position, as shown by repeated examination after the belt had been worn for considerable periods of time. It apparently produced some change in the organ which enabled it successfully to perform its functions, although displacement still existed. These changes were probably compensatory in character.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

THE ADMINISTRATION OF ANÆSTHETICS BY DENTISTS.

—The Crown Office has issued a circular to the two medical corporations in Scotland which grant dental diplomas, drawing attention to the dangers associated with the administration by dentists of such anæsthetics as ethyl chloride, without its having been previously ascertained that the patient was a suitable subject for anæsthesia. That some such warning is not wholly without justification is evident from the fact that notwithstanding the comparatively short time that ethyl chloride has been in use more than thirty fatalities have occurred. The Lord Advocate does not, it will be noticed, in any way prohibit dentists from using what anæsthetics they please; the Crown Circular is rather to be taken as a warning of the responsibility incurred in the administration of such drugs. In a former memorandum the Crown Office advised that a qualified medical man should be present during the induction of anæsthesia; but this, of course, has the disadvantage so far as poorer patients are concerned that it increases considerably the cost of dental manipulations. It seems to us that what both the public and the authorities have a right to demand is that in dentistry, as in surgery, where more prolonged anæsthesia than can be induced by nitrous oxide is required, the administration of the anæsthetic shall be placed in the hands of a skilled person who shall give his whole attention to it. Many dentists, we doubt not, have from large experience of ethyl chloride and similar anæsthetics acquired ample skill in their administration; but this is not to say that it is right for any man to attempt to divide his attention between the administration of an anæsthetic and the carrying out of a dental operation.

TEACHING OF GYNÆCOLOGY IN EDINBURGH.—Since the election of Sir Halliday Croom to the chair of midwifery the University authorities have been engaged on a scheme for the erection of a separate lectureship on gynæcology. The details of the plan have not been made public, and the negotiations which it has involved between the University and the managers of the Infirmary, who are dictators so far as the allotment of clinical material is concerned, are still proceeding. At present the clinical teaching of gynæcology is combined with that of clinical medicine—an association which is as antiquated as, and less reasonable than, its systematic teaching being part of the duty of the Professor of midwifery. It is to be hoped that some way may be found for making the gynæcological department of the Infirmary independent, so far as teaching is concerned, of its neighbours, and utilising the material in a way which has been impossible in the past.

ROYAL INFIRMARY, EDINBURGH.—The manager's annual review of the year's work has just been made public, and was submitted for the approval of the Court of contributors on January 1st. The total number of

patients treated in the wards during 1905 was 11,016—4,178 medical, 6,052 surgical cases. This shows a slight decrease from the previous year, but at the same time, owing to the more extensive employment of newer methods of treating tuberculous and nervous diseases the average stay in hospital of each patient has increased from 24.5 days to 28.3 days. The average daily number of patients in the Infirmary has been 828, as against 810. The out-patients for the year numbered 34,564. The mortality rate was 7.18 per cent, or, excluding deaths within 48 hours of admission, 5.71 per cent. The entire expenditure per occupied bed was £60 11s. 2½d., a decrease of 16s. 7½d. on the previous year, there having been a reduction of 5s. 7½d. on maintenance and 1s. 5½d. on medical expenditure for each occupied bed. The average number of nurses and probationers was 233. The applications for admission to the nursing staff were 794—a steady rise. The chief improvements and additions during the year have been the new surgical out-patient and electrical departments, which have already been mentioned in this column. Among minor changes the surgical theatre belonging to Professor Chiené's wards has been reconstructed, a disinfecting station has been completed, and a new telephone arrangement has been come to by which the installation in the building will be worked by operators of the National Telephone Company. The financial position at the end of the year was quite satisfactory.

LETTERS TO THE EDITOR.

THE LOGIC OF THOUGHT READING.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—“A Psychological Student,” in your issue of December 27th, has, I think, rendered public service in calling attention to the erratic speculations with which the eminent scientist, Sir Oliver Lodge, is wont to indulge, and in which his name has become a household word. Quite recently a certain prelate is reported in one of the dailies bewailing materialism, thus:—“We cannot forecast the issues of the future and the forces of materialism and selfishness gather into shapes of tremendous and increasing bulk.” It cannot, I think, be wondered at that so many of the more enlightened portion of the community turn with disgust from psychological speculations which exceed the range of human intellect and which defy scientific demonstration, speculations, moreover, which create confusion of thought, foster superstition, and in many instances culminate in insanity. No better instance of this can I think be afforded than what is known as “spiritualism,” concerning which Sir Oliver Lodge seriously and publicly courts investigation, as though we had not enough spiritualism in Buddhism for one world, and enough for all time, especially when we consider its modern development in “Christian Science,” the founder of which maintains we are all spirit and no matter or body. It is surely readily recognisable that any given individual endowed with a hyper-sensitive and moony type of mind could under certain conditions excite what I may be allowed to call artificially produced hallucinations, so that its possessor might vividly imagine him or herself in communication with some deceased ancestor. Granting this condition attainable, what benefit could the spread of such ideas confer upon mankind, or at what scientific value could they be estimated, or what balance could such form of belief render to an unstable mind?

The progress of science has been contemporaneous with increased sanity, hence we find that witchcraft and other forms of superstition have yielded to coherent thought. It is from considerations like these that we expect scientists of Sir Oliver Lodge's calibre to steer the public mind towards a clear and unclouded sky, not to enshroud the student in fog, nor to cause us to revert to the dark ages. It may, I think, be conceded beyond cavil that the sum total of human happiness, prosperity, and peace for the present or for any future

race ultimately depends on the sanity not of the few, but of the many, the only condition which enables an individual to safeguard himself, and one that is certain to prevent him from neglecting his neighbour.

I am, Sir, yours truly,

CLEMENT H. SERS.

Brighton, Jan. 5th, 1906.

A ROYAL COLLEGE OF NURSING.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—May I correct what appears to be a misunderstanding of my article in the *Westminster Review*?

My suggestion is not that every nurse should be examined once a quarter, but that the examinations for the Primary, Intermediate, and Final Examinations for the degree of B.N. (Bachelor of Nursing) should be held at sufficiently frequent intervals to prevent that waste of time which takes place when examinations are only held once or twice a year!

Your criticism that nursing cannot "be tested by 'a Royal College of Nursing' apart from the Hospitals" is surely contrary to all experience.

Does not every University test for its degrees in Medicine, Law, Arts, Science, etc., apart from the Colleges, and do not the Royal Colleges of Physicians and Surgeons test the knowledge of candidates for their diplomas apart from the Hospitals in which they have been trained?

The nursing profession is now evolving in the same way that the profession of surgery evolved, and surely it is wise to think out ahead the best lines on which its future should be evolved, so as to avoid those anomalies which characterise inco-ordinated and unguided developments.

I am, sir, yours truly,

JOSIAH OLDFIELD.

5, Harley Street, W. January 1st.

SPECIAL ARTICLE.

THE REPORT OF THE INSPECTORS OF LUNATICS IN IRELAND.

THE long-delayed publication of the fifty-fourth report of the Irish Inspectors of Lunatics may have caused hopeful anticipations of some fresh light on the lunacy problem, but these will rapidly vanish on a perusal of the blue book just issued, which, though its period of gestation has been much prolonged, is not in any respect a remarkable production. We learn that the statistics of the increase—or otherwise—of lunacy in 1904 have not been issued till late in December, 1905, owing to the difficulty of getting the financial accounts of asylums for the year ending March 31st ult., furnished in reasonable time, and it is intended to publish the report for 1905 without the financial statements, and the subsequent reports will contain the statistics of the calendar year and the financial statements for the year ending March 31st of the year referred to, thus following the practice of the English and Scotch Commissioners.

Dealing generally with the number of insane under treatment in registered houses it is shown to have increased from 18,094 on January 1st, 1904, to 18,615 on January 1st, 1905. On the latter date 791 were in private asylums and 3,320 in workhouses. From a table in the report, showing the numbers of lunatics under care for the past 25 years, we find that in 1880 the number in District asylums was 8,667, and in private asylums 622, so that in the interval, while the District asylum population increased by 115 per cent., that of Private Asylums and institutions increased by less than 28 per cent.; this discrepancy is still more remarkable when taken into account with the fact that the increase of admission rate into district asylums and private asylums is practically equal for the 25 years, and neither the recovery rate nor death rate accounts for the enormous difference in number of those remaining, which is most probably accounted for by the transfer-

ence of a large proportion of cases to asylums in England and Scotland. The number of insane in workhouses is only 193 less than in 1880, which shows the spirit of reform and progress has no great influence in the matter, as the workhouse treatment of lunatics is universally condemned.

A table showing the percentage distribution of the insane is not without interest:—

Proportion per cent. of total number under care.			
Year.	In District Asylums.	In Work-houses.	In Private Asylums.
1880	67	27	6
1904	81	14	5

The report on the increase in the number of registered insane will be awaited with some hope that light may be thrown on the enormous increase in the number of lunatics in face of a rapidly dwindling population. This overwhelming increase excites only a languid interest in Ireland, but its significance becomes very striking if a comparison is made between the brief table published by the Irish Inspectors and the much more elaborate one furnished by the English Commissioners in their fifty-ninth report:—

Year.	Country.	Number of Insane.	Ratio of Insane to 100,000 Population.
1879	England	69,885	275.40
1880	Ireland	12,982	250.
1889	England	84,340	296.50
1890	Ireland	16,251	344.
1904	England	117,199	347.10
1904	Ireland	22,996	522.

It should be remembered in considering these figures that general paralysis causes 6.5 per cent. of all admissions in England, whereas the total admissions attributed to it in Ireland last year were only 52 or 1.3 per cent. of total. For the second time an abstract from the report of the Census Commissioners of 1901 is republished in the report, from which it appears that in 1851 the ratio of lunatics to population was 1 in every 1,291, and in 1901 1 in every 225, the distribution by Provinces in the latter year, being in Leinster 1 in 242; Munster 1 in 191; Ulster 1 in 286; and Connaught 1 in 238; the highest ratio being 1 in 127 in Waterford, and the lowest 1 in 404 in Antrim County, and Belfast City. The figures of all lunatics and idiots bear much the same relation as regards provincial distribution.

The inspectors note with satisfaction that the admissions, 3,910 in number, have been 40 less than in the previous year and first admissions 22 less, but before taking comfort from this fact the drain of population by emigration should be remembered, and also the average annual number admitted for the ten years 1891-1900, which was 3,302, or 510 above the average annual number of the previous decade. If first admissions are to be regarded as a measure of the incidence of insanity, the opinion is expressed that the fact that they have decreased during the past two years goes to refute the generally held opinion that insanity is increasing in Ireland; over 25 per cent. of the total admissions were from workhouses.

(To be continued.)

Gresham Lectures.

A COURSE of lectures on the "Nervous System," will be delivered on January 23rd, 24th, 25th, and 26th, 1906, at six o'clock each evening, by Dr. E. Symes Thompson, Gresham Professor of Medicine, at Gresham College, Basinghall Street, E.C. These lectures are free, and are illustrated by diagrams, the syllabus embracing healthy nerves, nerves in disorder, the drug habit, and sanity and insanity.

REVIEWS OF BOOKS.

LONDON ON NODAL FEVER (a).

THE object of this work, as the author states in his introduction, is to prove that the disease commonly known as erythema nodosum is really an acute specific infectious fever, and not, as it is usually regarded, merely a skin disease. In support of his premise, he sets himself to prove by reference to clinical cases that the disease is preceded and attended by pyrexia and malaise; that its course is marked by a prodromal period, by a stage of eruption, and by a period of convalescence; and that it occurs under conditions which strongly suggest infection from one case to another.

The author was first led to believe in the specificity of the disease by the observation of a case in 1879, and since then he has carefully observed many similar cases, the records of which, with added comments, form the major part of the book. Of all his premises the weakest appears to us to be the proof of the infectious nature of the malady, as most of the cited instances of transmission could readily be explained on other grounds. On the other hand, a fairly good case for the existence of prodromal symptoms is made out, and the charts leave no doubt of the occasional existence of fever. We cannot, however, feel that the author has proved his case, for it would not be difficult to show that other skin diseases, such as eczema and pimphigus, are attended by similar phenomena. The existence of fever is, we contend, merely a proof that bacterial toxins are being absorbed, in much the same way as they are absorbed from septic wounds, *i.e.*, from a local skin infection. Of more interest is the observation that the affection is not so closely connected with rheumatism as is generally believed. This is, we believe, substantially true, and is borne out by recent statistics.

While not agreeing with Dr. Lendon's conclusions, we have nothing but praise for his work. Clinical observations like his help to keep alive an interest in ordinary work, and prevent us from becoming stereotyped in error through accepting without criticism the unsubstantiated conclusions that have been handed down to us. The book contains some excellent coloured plates, and is nicely got up. We recommend it to all practitioners who take an interest in skin cases.

ROBERTS' THEORY AND PRACTICE OF MEDICINE (b).

THERE was a time when Roberts' Medicine was the guide, philosopher and friend of a host of students, and we have little doubt that had the editions been kept up-to-date it would have held its own against the younger competitors that of late years have been crowding into the field. After a long interval a tenth edition has just been issued, and after careful reading we have come to the conclusion that this famous work is destined to take a fresh lease of life. It retains all the old qualities that made it popular—freshness, vivacity, and sustained interest—and in addition it has been brought scrupulously abreast of modern knowledge. We cannot but admire the courage of the author in taking on his shoulders the task of writing a system of medicine, complete except for mental and skin diseases, without the aid of any collaborateur, but the fact of his having done so, and done so successfully, shows that it is still possible in these days of specialists and sub-specialists for a large, catholic-minded, and full physician to take the whole of medicine for his province, and to expound

(a) "Nodal Fever (Febris Nodosa)." By Alfred Austin Lendon, M.D.Lond., Lecturer on Obstetrics and Clinical Lecturer on Diseases of Children, University of Adelaide, &c. London: Bailliere, Tindall and Cox, 1905.

(b) "The Theory and Practice of Medicine." By Frederick T. Roberts, M.D., B.Sc., F.R.C.P., Emeritus Professor of Medicine at University College, Consulting Physician to University College Hospital, and to Brompton Hospital for Consumption. Tenth Edition. Two Vols. London: H. K. Lewis. Price 26s. net.

it in its every phase. There is, it is to be feared, a danger that in the not-far-distant future text-books in medicine will become the joint works of many writers, and that the impress of a personal mind governing the whole will be looked for in vain. It is of the utmost importance, especially in the case of students, that medicine should not come to be regarded as an aggregation of facts, but should remain ever bearing the appearance, as at the bottom it has the substance, of a consistent whole. A system of medicine should, in the ideal, be the criticism of a master-mind on the facts brought before it in the course of long experience and study, and should go out to the world as an expression of opinion, self-contained, complete, and interpretive. For these reasons we cordially welcome this ripe product of the life-work of an accomplished physician, and congratulate him on having brought it to a conclusion without co-operation or delegation. But we confess to some disappointment that Dr. Roberts has not given us more of himself and his own views, and less of the undigested opinions and statements of others. We recognise that for students preparing for examination it is necessary to give alternatives to suit different kinds of examiners, but the book loses in critical value in proportion as statements, uncorroborated by the author's opinion, are given for what they are worth. This disappointment is the keener by reason of the ability of Dr. Roberts to speak as one having authority, for when he takes a clear and strong line it is always characterised by a robust common-sense that does credit alike to his judgment and perspicacity. These qualities enable the author to maintain throughout a high sense of value, and it will be remarked with especial pleasure that there are no fads introduced, and no fancies given play to; the work sails throughout on an even keel. Bias, if bias there be, is the pardonable one in favour of University College experience and the work of University College men; but there is a distinct usefulness in tinting a text-book with the colours of a particular school, especially if these be laid on, as in this case they are, with due artistic feeling. Those who are acquainted with the former editions of this work will recognise with pleasure the familiar terse, epigrammatic style, which Dr. Roberts wields with such ease. Here and there we come across rugged sentences, but the general effect is the effect of Cæsar, vivid from the absence of adornment or qualification; essentially virile. The book shows evidence of careful revision and its value is decidedly enhanced by the possession of a capital index. It is well bound, clearly printed, and nicely got up. The pleasure we have derived from reading it will, we are confident, be shared by several generations of students, for it is a sound, accurate, balanced, and brilliant résumé of modern medicine.

GRAY'S ANATOMY.*

ONCE more a new edition of the ever-profitable "Gray" comes before us for review, although it is a book whose popularity and good qualities need no bush. The present edition has been carefully revised and in part re-written. A considerable number of additional drawings have been added, especially in connection with the chapters on Embryology, the Nervous System, and the Organs of Sense. All half-tone illustrations have been re-drawn and replaced by woodcuts and line drawings, thus bringing them more fully into keeping with Carter's original illustrations. Gray's "Anatomy" will soon celebrate its jubilee, as for forty-seven years it has lightened the labour of generations of medical students. Its motto truly may be "Canus, sed semper viridis," for though decades roll over its head it is always in the forefront of anatomical knowledge.

* "Anatomy, Descriptive and Surgical." By Henry Gray, F.R.S., F.R.C.S. With drawings by H. V. Carter, M.D. Sixteenth Edition. Edited by T. Pickering Pick, F.R.C.S., Consulting Surgeon to St. George's Hospital, and the Victoria Hospital for Children, and by Robert Howden, M.A., M.B., C.M., Professor of Anatomy in the University of Durham. London: Longmans, Green and Co. 1905. Pp. 43 and 1,248.

MARSHALL ON MATERIA MEDICA. (a)

DR. MARSHALL, of University College, Dundee, and Professor of Materia Medica in the University of St. Andrews, is a well-known authority on pharmacology, whose studies of the organic nitrates, the action of digitalis and other members of the nitrite group, are familiar to our readers. He is one of the small number of experimental workers on the physiological effects of remedial agents which, unfortunately for the progress of medicine, is gradually growing smaller in Great Britain. That he should have written a book on materia medica is a subject for congratulation. Needless to say, a work from the hands of so experienced an observer is marked by a degree of accuracy and attention to minute details which is rare in such compilations. It is not only a much-needed guide to the British Pharmacopœia, but an introduction to the study of pharmacology and therapeutics. Although not dealing primarily with experimental investigation, the results obtained by it when capable of practical application are mentioned, and in some cases experiments on animals are described.

Many of the definitions given in this work, reflecting as they do the outcome of recent researches in chemical pharmacology, will come as a surprise to the average English medical student nurtured in the school of Garrod and his successors. For example, whilst Dr. Marshall frankly admitted that no satisfactory definition of an alkaloid has yet been given, it is provisionally stated that alkaloids are "nitrogenous vegetable products which have the nitrogen combined in the form of a closed ring." Atropine is defined as "an alkaloid $C_{17}H_{23}NO_5$, the solution of which does not rotate a ray of polarised light, obtained from belladonna leaves or root." It is doubtful if atropine exists as such in the plant, for hyoscyamine is readily converted by the action of heat or alkalis into atropine. Dr. Marshall deals with the somewhat complicated subject in a masterly manner, and his article on the pyrrolidine group is one of the best in the book. In almost every instance the inter-relationship existing between the natural alkaloids of various groups is illustrated by diagrams, a mode of instruction which greatly facilitates the work of the student. It must be understood that the volume, although nominally a text-book, contains a considerable amount of original matter, and that although described in the Preface as being elementary in character, it comprises a description in brief of much advanced teaching. It is a credit not only to the author, but to the Scotch Universities, of which he is so distinguished a member. Incidentally it may be remarked that the book is admirably illustrated.

SHAW-MACKENZIE ON THE NATURE AND TREATMENT OF CANCER. (b)

In the preface to this new edition the author states that he has amplified, extended, and revised his former work published under the title of "Some Methods of Hypodermic Medication in the Treatment of Inoperable Cancer." We think he has done wisely in placing before the profession, in so convenient and handy a form, the results of his latest investigations and conclusions in respect to the nature and treatment of cancer. In the ninety-eight pages of which the small volume consists is contained the most possible explanation of the cause of cancer, based upon incontrovertible scientific data, of which we have knowledge at the present time. Cancer, after all, may be but a simple disease—simple in the sense of being merely dependent upon some nutritional defect or disturbance. Now that the parasitic theory of its origin has been

generally discounted, the chemo-biological theory, to say the least, is replete with interest and possibilities. A careful perusal of this work shows that the author is able to attribute the nutritional defect present in malignant disease to the loss of functional power of the pancreas. That is to say, that the unrestrained cell-growth characteristic of cancer is probably dependent upon the absence in the body of the proteolytic pancreatic ferment, known as trypsin.

This, in a few words, forms the main line of investigation which the author follows and portrays in the work before us. The details by which he arrives at his conclusions and the scientific data, largely based upon the valuable original work on embryology published by Dr. J. Beard, of Edinburgh, demand thoughtful and careful perusal, for the purposes of which we must refer the reader to the book itself. Furthermore, it must be conceded that the author's observations upon the possible connection between cancer and diabetes are most suggestive and interesting. Here again he adduces scientific data tending to confirm his conclusions. It may be, therefore, that we are upon the eve of one of the most epoch-making discoveries in pathological science. The volume before us is, indeed, very suggestive of the possibilities of this. Let us reflect for a moment how pathology as a science has been evolved in the past, and how within comparatively recent times the study of bacteriology threw a flood of light upon the etiology and progress of disease. The startling fact in this new work on cancer is that the disease has been traced to an embryological origin, and so closely do all the latest experimental and clinical, accord and dovetail with each other in this connection, that it is almost impossible to avoid the conviction that the author has succeeded in placing before us a perfect sequence of the nature and treatment of cancer, which may hereafter prove to be the stepping-stone to the arrest and cure of this terrible and fearful malady. So greatly have we been impressed by the perusal of this work that we can only recommend every practitioner to study it carefully, and with an open mind—inasmuch as we regard it as one of the most important contributions to the literature of the subject with which it deals which, so far, has been issued from the press.

ENCYCLOPEDIA OF MEDICINE. (a)

This volume of Nothnagel's series is divided into two portions, the former on Diseases of the Kidneys occupies 450 out of a total of 800 pages, and is written by Senator, while the latter part on Diseases of the Spleen and Hæmorrhagic Diseases is from the pen of Professor Litten. Both authors have long since made their mark both as systematic writers and as investigators on the subject of which they treat, and consequently what they say, with but little exception, may be taken as expressing authoritatively current German ideas, which, however, do not in all cases coincide with English opinions. As might have been expected, most of the references given are to German authors and papers, but justice is also done, more especially in the historical accounts of diseases, to the work of Anglo-Saxon clinicians and pathologists, any defects in this respect being partly compensated for by editorial addenda.

The treatise on kidney diseases commences in the traditional manner, with an account of various morbid conditions of the urine, albuminuria and albumosuria being first dealt with. In describing the tests for albumin one is glad to note that attention is drawn to the fallacy inherent to the nitric acid test owing to the occasional precipitation of nitrates. This is a most important fallacy, owing to its very infrequency, and

(a) "A Text-book of Materia Medica", By C. R. Marshall, M.D. Professor of Materia Medica and Therapeutics in the University of St. Andrews. London: J. and A. Churchill. 1905.

(b) "The Nature and Treatment of Cancer: Some Methods of Hypodermic Medication in the Treatment of Inoperable Cancer." By John A. Shaw-Mackenzie, M.D. Lond. Second Edition, Revised and Enlarged. London: Baillière, Tindall and Cox. 1905. Price 2s. 6d.

(a) "Nothnagel's Encyclopædia of Practical Medicine, Diseases of the Kidneys, and of the Spleen: Hæmorrhagic Diseases." By Dr. H. Senator, Professor of Medicine, University of Berlin, and Dr. M. Litten, Professor of Medicine, University of Berlin. Edited with additions by Dr. James B. Herrick, Chicago. Authorised translation under the editorial supervision of Dr. Alfred Stengel, Pennsylvania Philadelphia: W. B. Saunders and Co. 1905.

yet it is often entirely passed over even in books on urine analysis. One cannot, however, help feeling surprised that the heat test with the addition of acetic acid is slightly spoken of, for our own opinion and that we believe of many competent clinicians is that it is both more reliable and also more easy to carry out than any other of the innumerable albumin tests. Senator's opinions on cyclic albuminuria coincide with those expressed by authors who have specially studied the subject. He does not however, attempt to lay down any rules whereby one may distinguish the organic from the purely functional affection, nor does he make any overt reference to the "vascular asthenia" hypothesis of Gull. The author's criticism of the various theories of urinary intoxication is necessarily destructive, but when he attempts himself to formulate a theory his ideas are so obscure either by faulty expression or mistranslation that it is impossible to understand his meaning. We refer more especially to the third and subsequent paragraphs on page 108. A very good account of the steps in the development of our knowledge of the non-suppurative inflammation of the kidney from the time of Bright to the present day is given, and an elaborate attempt is made at a complete classification of the various morbid states included under that name. We are, however, in entire agreement with the editor's remark that neither clinically nor from the standpoint of morbid anatomy can the cases be grouped in a manner entirely satisfactory, and that it is useless to worry over the proper use of the term Bright's disease. On the whole, however, the subject is treated with clearness and completeness, but its complexity will prevent any but the most advanced students of pathology and medicine from appreciating it at its full value.

Turning to the second part of the work, one is surprised to notice some serious omissions. No reference at all is made to Von Jacksh's splenic anemia of infants, and the condition of the spleen in rickets is almost as completely passed over. One cannot help also expressing regret at the American slang that here and there disfigures the pages. To quote an example, we find on page 603 some advice given to the surgeon who contemplates "going in" to the abdomen, and numerous other instances could be given. Expressions of this sort certainly have the merit of lacking artificiality, and may be expressive and to the point in a class room, but in a work of this sort a little more literary style should be aimed at. The above remarks of course, apply to the translator, and not to the author, whose work is admirably done.

The volume is bound in the manner that we are all now familiar with and has a good index. Its place will be rather on the shelves of the scientific worker, than in the hands of the general practitioner. It is, in fact, what it is called, a true encyclopædia, and forms a milestone to mark the high-water level of our knowledge at the commencement of the twentieth century.

LITERARY NOTES.

DR. ARTHUR SHADWELL, the author of "Drink Temperance, and Legislation," is about to issue through Messrs. Longmans, a two volume work under the title, "Industrial Efficiency."

DR. JOHN D. COMRIE has prepared a new "Medical Dictionary," which is to be issued by Messrs. A. and C. Black, uniform with "Who's Who."

THE "Medical Annual" for 1906, we are glad to see, in spite of the disastrous fire at Messrs. John Wright and Co.'s works at Bristol, will not suffer delay in its appearance.

"IN determining the relative values of disinfectants there can be no acceptable standardisation which, having regard to one quality only, ignores all others which are equally important." This is the basis on

which a small and instructive pamphlet now before us is founded, entitled "A Straight Talk about Disinfectants, and their Relative Values." The standardisation of disinfectants can hardly be placed in the same category as that of drugs, because the disinfectant that is considered best in surgery would scarcely be suitable for drains, nor should we be inclined to use the same for purifying the air of a sick chamber as for the destruction of decomposed refuse. There is room, we think, for all disinfectants properly so-called, and we think the writer has made out his case.

THE current number of the *Cyclists' Touring Club Gazette* contains an illustration of the beautifully simple and artistically useful roadside granite seat erected on the spot where death came to the late and much lamented Dr. Gilbert Smith, long to be remembered by staff and students of the London Hospital and a wide circle of friends.

MR. SWINFORD EDWARD'S monograph on "The Diagnosis and Treatment of Carcinoma of the Rectum" (Bailliere, Tindall and Cox) throws light on a comparatively common disease, one in which early diagnosis is all-important. The chapters on diagnosis will interest the practitioner, and those on the various operative procedure the surgeon—and possibly also the patient. While the perineal operation gives by far the smallest mortality, the choice of procedure must necessarily in great measure depend upon the site and extent of the growth. The results of early operative treatment are certainly very encouraging, especially when one reflect on the dreadful fate reserved to sufferers from rectal cancer when colotomy was held to constitute the only admissible intervention.

DR. G. A. H. BARTON has written a useful brochure, entitled "A Guide to the Administration of Ethyl Chloride," which gives the result of his own experience of this anaesthetic during 1,500 administrations. On the whole, Dr. Barton is highly pleased with the drug, but he candidly points out its drawbacks and limitations. He describes and figures an apparatus of his own invention for giving ethyl-chloride for operations on the nose and throat which last several minutes, and certainly it seems to have worked very satisfactorily in his hands. Dr. Barton is an advocate of the ethyl-chloride-ether sequence which is becoming so popular now, but we confess to being somewhat taken aback at the combined chloroform and ethyl-chloride method he uses. The pamphlet is well worthy of careful reading.

THOSE who are acquainted with Sir William Collins's writings must always feel regret that his onerous public duties prevent his contributing to medical literature more fully than he has done. Sir William Collins's occasional essays on medical subjects have a charm and distinction of their own; their originality of thought, philosophical breadth, and decisive expression strike cords that are left untouched by many of the present-day wares on the booksellers' stall. We have before us a pamphlet, "The Crystalline Lens in Health and in Cataract," which contains a reprint of the address given by the author at the Oxford University course on Ophthalmology last summer, and we venture to predict for those who read it—be they ophthalmic surgeons or general practitioners—half an hour's enjoyment in the region of pleasing ideas and stimulating thoughts.

"TIME and Tide" is the heading of a peculiarly attractive series of paragraphs which appear weekly in *The London Argus*, written by that versatile poet, novelist, and physician, Dr. G. R. H. Dabbs, whose most recent work is entitled "The Ladder of Pain."

THE first two sections of Dr. Turban's "Beiträge Zur Kenntnis der Lungen-Tuberculose" have been translated by Dr. E. C. Morland, and published under the title of "The Diagnosis of Tuberculosis of the Lung, with Special Reference to the early Stages."

MEDICAL NEWS IN BRIEF.

Liverpool Institute of Commercial Research in the Tropics.

SIR ALFRED JONES has secured the services of Mr. Malett, late Minister of Agriculture in the Congo Free State, to deliver lectures and addresses to the natives along the West Coast of Africa, in conjunction with Viscount Mountmorres and the other expert connected with the expedition who are going out from the Liverpool Institute of Commercial Research in the Tropics. It is considered that Mr. Malett's experience in the Congo, extending for a period of seven years, will prove valuable. He sails from Liverpool to-morrow.

The Cost of Small-pox.

If more than a hundred cases of small-pox occur in any district in a year they are treated as an epidemic. No fewer than nineteen such outbreaks occurred in the year ending March last. The worst case was that of Dewsbury, where 548 cases were reported, and the amount of expenditure in the twelve months came to about £12,397. It began in November, 1902, and ceased in March of last year, and involved an expense of nearly £14,000. Gateshead, Newcastle, Oldham, and Ravensthorpe each had more than three hundred cases of small-pox, and Leicester over two hundred. These outbreaks, of course, are very expensive, and teach the necessity of strict sanitary precautions and of vaccination.—*Western Morning News.*

Durham County Asylum—Dismissal of Two Officers.

An extraordinary occurrence has been reported at Durham County Asylum in the dismissal of two officers. If the details of the affair be authenticated strong action is demanded in the interests of the public no less than of the medical profession. It is stated that the only cause of offence alleged against the officers in question was that they had complained of the negligence of the stores department of the Asylum in not supplying articles of clothing requisitioned for the use of the patients. This neglect extended over a period of several months, and its existence appears not to have been disputed. The Committee of Visitors, nevertheless, called upon the medical officer and the matron to resign. It is to be hoped that the Local Government Board will order an immediate investigation into the matter. If the medical officer belongs to the Medical Defence Union or one of the kindred protection societies he will be able to enlist their powerful sympathy and help in frustrating what appears to be a gross injustice.

A Medical Man Censured for Neglect at Barnsley.

At an inquest held at Barnsley last week upon a colliery shunter, aged 27, who died from being crushed between a light engine and a wagon, it was stated that Dr. Ritchie, of Hoyland, failed to attend when called for immediately after the accident. A second messenger was despatched, and the doctor advised the removal of the wounded man to the hospital. It was stated that the man had by that time lost much blood, which prompt medical attendance would have avoided. Dr. Ritchie explained that he was suffering from an acute attack of lumbago when called. He requested that Dr. Wiggins, his partner, should be summoned, but when he found that Dr. Wiggins had another appointment he (Dr. Ritchie) started off. Meeting the second messenger on the way, he learnt that the injured man had been properly bandaged, and ordered his removal to the hospital. The jury, in returning a verdict of "Accidental Death," expressed their opinion "that Dr. Ritchie ought to be censured for his gross neglect in not attending to the deceased before his removal to Barnsley." The Coroner, addressing Dr. Ritchie, said it was his painful duty to censure him for the neglect he had shown, especially in view of the fact that he was paid to attend to these cases. Considering the man would be two hours before receiving medical attention, he (the coroner) confessed that he, to a great extent, agreed with the jury.

The Working of the Aliens Act.

THE Aliens Act is now in full swing. During the past week a number of aliens were excluded, including a sick Chinaman from a liner. On Thursday the sanitary authorities declined, on medical grounds, to allow three out of the eleven foreigners carried by the "Batavier IV.," from Rotterdam, to land. All the immigrants were Russians with the exception of a Portuguese sailor—one of the three detained—the party including two women and three children. The Portuguese sailor, who had been engaged on British ships for some time, in the course of his travels acquired a highly contagious disease, and with the object of curing it, he decided to book his passage to London, and get the best attention possible in hospital. The doctors at Gravesend, however, in the exercise of their duty, expressed a different opinion, and unless an appeal is speedily lodged, the sailor will be promptly sent back to Rotterdam. The other cases rejected were those of a woman suffering from dropsy and a man afflicted with cataract. So, whereas the fortunate eight were allowed to land at Gravesend, the remainder were detained on the "Batavier IV." in St. Katherine's Dock. A Syrian alien, suffering from cancer, who was detained at Dover on Wednesday, was eventually allowed to land, as he was proceeding to America. The Act, at this rate, will be speedily ridiculed and unworkable. Apart from medical grounds, the following case shows the inherent feebleness of the principles of this retrograde legislation. Twelve onion-sellers may be permitted to invade Devon, but not an army of seventeen. On the arrival at Plymouth on Thursday of seventeen Frenchmen from Roseoff, for onion-selling in South Devon, the Customs authorities prevented them from landing. Telegraphic instructions, however, were received from the Home Secretary to permit all of them to land after being duly warned that, in future, the Act would be strictly interpreted, and the number limited to twelve aliens, as the Act provides.

Important Pharmacy Prosecution in Liverpool.

At the Liverpool County Court on the 3rd inst., Judge Shand had before him a prosecution on behalf of the Pharmaceutical Society of Great Britain against John Thompson, unqualified assistant to Stephen Stephenson, chemist and druggist, for selling poison contrary to section 15 of the Pharmacy Act, 1868. Evidence was given by an official of the society that on October 23rd last he purchased from the defendant at Mr. Stephenson's shop, a penny package of white precipitate powder and a bottle of Mrs. Winslow's Soothing Syrup, both of which contained poison. Mr. Thomas Tickle, analytical chemist, deposed that the package of white precipitate powder contained enough poison to kill two or three people at least. It was a powder in common use by the public as a vermin killer applied to the human skin. The Judge.—Do you mean to say that anyone who goes into a chemist's shop and asks for it can get it, merely on stating that it is to kill vermin? The Witness.—I understand that the person who makes the sale is required to be a registered chemist or druggist. The Judge.—I know that, but can anyone get it on that representation? Mr. Nield.—Yes; they get it as a matter of course. The Judge.—Is that all the safeguard the public have, that if it is supplied by a registered chemist and druggist anyone can get it, and for a penny enough to poison at least two or three people? Mr. Nield.—That is so. There are two schedules of poison—one containing the more dangerous poisons, which can only be sold to a person known to the seller. The Judge.—Is white precipitate one of them? Mr. Nield.—No, it is not. The Judge.—Good gracious! What about the others; how many people would the more dangerous poisons kill? Mr. Nield.—I don't know, but they are mostly ten times as strong, or more.—The Judge.—Then the same quantity would

kill thirty people, but a poison that will only kill two or three does not matter apparently. (Laughter.) Mr. Niell.—There you must trust to the seller, and that shows the necessity for their being qualified. The Judge.—The real offender goes scot-free. Mr. Niell.—Yes; the real offender employs these persons because he gets them cheaper than qualified men. The Judge.—Is Thompson a boy or a man? Mr. Niell.—He is about 22 years of age. The Judge.—Of course, under section 15 he is liable, but I don't believe for a moment that he is the principal offender. Apparently, the Act is silent as to the more serious offender, but if there is any procedure possible against the principal offender the society should get at him, because this defendant is really only his tool. The defendant was then fined the full penalty of £5 and costs, to be paid forthwith.

Antwerp International Exhibition.

We are asked to announce that Medicine and Public Hygiene will form an important Section at this exhibition, which will be opened in April, and continued during May, 1906. Pharmacy, dietetics, wines, &c., will also be included, the enterprise being under official patronage.

Westminster Hospital Medical School.

A course of lectures on "Applied Physiology," will be delivered at the School, on Thursdays, commencing Jan. 18th, at 5 o'clock, 1906, by Bertram Abrahams, M.B., B.Sc., F.R.C.P., Assistant Physician, Westminster Hospital, and Examiner in Physiology to the Conjoint Board. They will be open, without fee, to graduates and students of the University of London, and to qualified practitioners.

Society for the Study of Disease in Children.

The Wightman Lecture of this Society will be delivered on Friday, May 18th, by M. le Docteur August Broca, *Professeur Agrégé* Surgeon to the Hôpital des Enfants-Malades and President of the Société de Pédiatrie of Paris upon "The Diagnosis and Treatment of Appendicitis in Children."

Royal Academy of Medicine in Ireland.

The Council of the Pathological Section of the Academy have decided to hold on Friday, February 16th, a general discussion on every aspect of "Abdominal and Pelvic Tuberculosis." Sir Thornley Stoker, President of the Academy, has kindly promised to preside. Papers and speeches will be limited to ten minutes each. The following Fellows of the Academy have kindly consented to open the discussion: Dr. James Little, Sir Arthur Chance, Sir William Smyly, Professor McWeeney. The Hon. Secretary of the Section (Professor White, Royal College of Surgeons) will be glad to receive the names of Fellows or Members anxious to join in the discussion.

London Post-Graduate Lectures.

DR. E. F. TREVELYAN, of the University of Leeds, has kindly consented to open the spring course of Post Graduate Lectures of the Mount Vernon Hospital held in the Central Out-Patients' Department, 7, Fitzroy Square, with an introductory address on Thursday, January 18th, at 5 p.m., his subject being "Modern Methods of Diagnosis and Treatment of Pulmonary Tuberculosis." Medical practitioners and senior students are invited to attend.

The Election of Direct Representative for Ireland.

SIR WILLIAM THOMSON has issued a second address to the medical profession in Ireland, at the end of which he publishes a list of supporters. The address refers at some length to his work on the Council, especially with regard to the Royal Army Medical Corps. It also refers to the circumstances under which he brought the grievances of the Irish Poor Law Medical Officers to the notice of the Council. We understand that the eleventh hour has produced a further candidate, and that in addition to Sir William Thomson and Dr. Kidd, Dr. Laffan of Cashel, pro-

poses to again stand. If the members of the medical profession throughout the provinces are really desirous of returning one of their own number instead of a Dublin representative, it seems unwise for more than one candidate to come forward.

Royal College of Surgeons, Ireland, School of Surgery.

We have received from the Registrar of the College a very complete syllabus of the Schools of Surgery connected with the College. These schools are attached by Charter to the Royal College of Surgeons, and have existed as a department of the College for over a century. They are carried on within the College Buildings, and are specially subject to the supervision and control of the Council. The buildings have been re-constructed, 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. All the lectures and courses of practical instruction may be attended by medical students who are otherwise unconnected with the College. In addition to full information regarding the various courses, a number of the questions set at recent preliminary examinations of the Conjoint Colleges are given as specimens of what the intending candidate may have to answer. To all students desiring information regarding their medical studies the pamphlet will be of much value.

Pencils as a Cause of Diphtheria

THE correspondent of the *Daily Telegraph* reports from New York that in Detroit school-pencils have caused an epidemic of diphtheria. The School Board buys pencils for the pupils, and these are gathered up each night and distributed in the morning. One child contracted diphtheria, and in a few days the disease was communicated to fifty pupils. The State Board of Health has now ordered the pencils to be destroyed and the system abolished. In the United Kingdom, the danger of slates as an agency for infection has long been recognised, but pencils seem to have hitherto escaped attention.

Society for Study of Inebriety.

THE last meeting of the above Society was held on Tuesday, January 9th, 1906, in the Rooms of the Medical Society of London, 11, Chandos Street, Cavendish Square, W, when Dr. THEO. H. HYSLOP (Resident Physician and Medical Superintendent Bethlem Royal Hospital) opened a discussion on "The Vitality of a Nation," an abstract of which will be found in another column under the heading of "Original Papers."

OBITUARY.

MR. M. H. GREENER, M.B., C.M. GLAS.

WE regret to announce the death of Dr. Michael Hindmarsh Greener, on December 26th, 1905, at Cardiff. He succumbed to an acute attack of pneumonia after a short illness. Born in Alnwick in 1858, he graduated as M.B. and C.M. at the University of Glasgow in 1884 and shortly afterwards began to practise in Cardiff, where he held several honorary appointments. He leaves a widow, a son, and a daughter to mourn their loss.

DR. JOHN CAMPBELL, F.R.C.S. Eng., is to be nominated for the seat on the Royal University Senate, rendered vacant by the resignation of his Honour Judge Shaw. Dr. Campbell is President of the Graduates' Association, and takes a deep interest in educational matters.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for the MEDICAL PRESS AND CIRCULAR.

SURGICAL SUMMARY.

Remarks on Shock.—Malcolm (*Brit. Med. Journ.*, 1905, December 9th) points out that in shock, sleep, extreme lowering of the surrounding temperature associated with bodily exhaustion, death from old age, and death from certain complicated febrile conditions have many features in common. The functions of the central nervous system are partially in abeyance, owing to exhaustion, so that the patient loses consciousness and the power of sensation and motion, while the temperature tends to fall. Cardiac, respiratory, and nutritive changes necessary to life are, however, carried on with a lowered degree of activity. In shock in the case of an injury the exhaustion of energy seems to be due to an over-stimulation of the sensory nerves whether the stimulus is applied gradually during an operation, or suddenly as in the case of severe accident. Some years ago it was usually taught that the cause of shock was a paralytic dilatation of the vessels in the area supplied by the splanchnic nerves, followed by anæmia of the brain. In operating on the abdomen, however, there is no evidence of this condition, although a severe state of shock may exist. Malcolm considers that in shock, and in all cases where there is a loss of consciousness, without any discoverable brain lesion, unconsciousness is due to nerve exhaustion and brain anæmia, dependent, except in sleep, to an intense contraction of the arteries. When an artery contracts the change begins in the arterioles and gradually extends to the larger vessels, and relaxation takes place in the reverse order. Clinical symptoms agree with this statement. The alterations in the circulation can be more easily followed in the slowly progressing changes in the vessels, accompanying the febrile process. Thus in the commencement of a fever when the capillaries contract the pulse is full and bounding, then as the radial artery contracts the pulse becomes small, hard, later thready, and finally imperceptible. Again, in shock, the blanching of the skin, the complete or partial anuria, the beneficial effects following the administration of vaso-dilators, such as nitro-glycerine and alcohol, and the application of heat, are best explained by contraction not dilatation of the blood-vessels. In conclusion the author maintains that his views as regards the causation of brain anæmia in shock are founded on the well-known physiological fact, that stimulation of a sensory nerve causes vaso-constriction, whereas the view that a general paralysis of the arteries is caused by an injury has no such basis. S.

Quinine Treatment of Corneal Ulcers.—Lawson ("Transactions" of the Ophthalmological Society of the United Kingdom, Vol. XXV.) after several years experience of this treatment reports strongly in its favour. Although not wishing to recommend it as a panacea for all forms of ulcers he attaches the greatest value to it. Tweedy first introduced the treatment for membranous conjunctivitis and neuropathic ulceration of the cornea with good results. The ulcers Lawson found to be the most suitable for quinine treatment are: (1) large ulcers involving the true cornea and not very infective; (2) marginal, scalloped and ring ulcers; (3) all infiltrating and infective ulcerations which are not undermining the edges and which are not accompanied by rapid hypopyon formation; (4) neuropathic ulcers. The treatment has proved uncertain in acutely infective ulcers, the edges of which are undermined and in which rapidly forming hypopyon occurs, as also in those forms of ulcers known by the name of Mooren and dendritic. The author does not advise this treatment in small superficial ulcers which usually heal readily under simple and less irritating lotions and a bandage. As to the form of the quinine solution he recommends

4 grains of the sulphate of quinine in 1 ounce of water, the least possible amount of dilute sulphuric acid being used to dissolve the salt. The eye is thoroughly douched with this solution for five minutes by means of an ordinary eye bath. This is repeated four or five times a day. Atropin is instilled twice a day and a bandage applied. Many ulcers treated ineffectively by other popular lotions have healed rapidly, and with less subsequent opacity under the quinine lotion. M.

The Significance of Eye Symptoms in Sclerosis of the Brain.—Prof. Uthhoff of Breslau ("Ophthalmoscope," Vol. III. No. 9) gives a summary of his own experience of eye symptoms in disseminated sclerosis. In nearly half of his cases the ophthalmoscopic appearances were pathological and consisted of simple atrophic alteration in the colour of the papilla. Atrophic discolouration of the whole papilla was comparatively rare, forming only 3 to 4 per cent. of the total. Cases of incomplete atrophic pallor of the whole papilla, so that the inner parts still retained some slight pinkish tint, and cases in which there was partial limited atrophic pallor of the temporal part of the papilla formed 20 per cent. of all cases. Uthhoff has not observed typical congested papillæ, but he considers that the atrophic pallor of the disc is more often of an inflammatory neuritic nature than appears at first glance. In about another 5 per cent. of cases disturbances of vision occurred without any ophthalmological changes being visible. The clinical manifestations of visual trouble were very various, but for the most part the amblyopia of disseminated sclerosis resembled the visual disturbances one observes in retrobulbar neuritis. The defects in the visual fields were also very various—viz., (1) Central scotoma with full periphery, the scotoma being generally binocular and relative; (2) central scotoma with peripheral contraction in rare cases; (3) fairly frequently were found irregular contractions of the periphery; (4) in isolated cases regular concentric functional contractions of the fields can be found in multiple sclerosis, as well as when the disease is complicated by hysteria; (5) ring scotoma were rare as were also another form; (6) in which there was at the outset a certain anomaly—e.g., central scotoma—was present and it cleared up to be followed by another anomaly—e.g., concentric contraction. Uthhoff has comparatively often found sclerotic changes in the chiasma and optic tracts, yet he has very seldom found anomalies of a hemianopic form. In about half the cases the visual troubles set in rapidly and were followed by improvement in about half of these, a fact not suggesting simple degeneration of the optic nerve fibres. In the other half of the cases visual failure came on slowly. One or both eyes were affected and permanent bilateral blindness was a rarity. Recurrences were common. Transitory, complete blindness in one eye was fairly common. Defects in the colour vision are relatively insignificant and are liable to be overlooked. Paralysis of eye muscles occurred in 20 per cent. of Uthhoff's cases. The percentage would have been considerably increased had pareses of slighter shades been included. The paralyses are generally incomplete and transitory. A complete lasting paralysis was seldom seen. The sixth nerve was the one most commonly affected. In only two cases out of 150 did Uthhoff find complete paralysis of all extrinsic muscles of both eyes, and in one of these the autopsy showed extensive sclerotic changes in floor of the fourth ventricle and aqueduct of Sylvius. The author urges the importance of distinguishing between nystagmus and nystagmus-like twitchings. Both may be seen in the same patient at the same time. Nystagmus occurred in 12 per cent. of the cases and nystagmus-like twitchings in 46 per cent. The former owes its importance

to its relative rarity in the other cerebro-spinal diseases whereas the latter is fairly common, and moreover may be found in health. . . Papillary signs, including hippus, Uhthoff passes as infrequent and insignificant. M.

The Surgery of the Prostate Gland.—MR. M. R. BARKER (*New York Med. Journal*, Dec., 1905), in a communication on this subject, says that much time intervenes from the commencement of a prostatic hypertrophy, until without complications the prostate becomes so large as to occlude the urethra. During this slow enlargement the gland is very susceptible to cold and wet, which often produce acute congestive attacks; these recur again and again with increasing frequency until at last a physician has to be called in to pass a catheter. Having done so, he should recommend the immediate removal of the enlarged prostate. The operation of perineal prostaticectomy which Mr. Barker recommends has under these favourable circumstances almost no mortality. Whatever operation is done there are three important points to remember—minimise the loss of blood, let the operation be as short as possible, and avoid traumatism to the utmost extent. In Mr. Barker's operation a large curved perineal incision is made; the sphincter ani muscle is separated from the central tendon; and the latter is drawn forwards. In this way the membranous urethra is exposed, opened, and a tractor passed into the bladder. By drawing on and raising the handle of this instrument the capsule of the prostate is brought well into view, and is opened by two lateral incisions, and the gland separated by blunt dissection. Any bands are divided by a special combined cutting and crushing clamp devised by the author. Two drainage tubes with gauze packing are left in either side of the wound, and a catheter is tied into the bladder, the cut sphincter carefully re-united to the central tendon, and the wound closed. The catheter is changed daily, the drainage tubes are removed at the end of 48 hours, the patient is allowed to sit up on the second day, and to be out of bed for a short time on the fourth. The author has treated thirty cases with one death, an old man of 73, who had led a catheter life for over six years. The tractor is Mr. Barker's own design, he claims that it is less likely to tear the bladder wall than the instruments usually used in perineal prostaticectomy. G.

The Clinical and Pathological Importance of Chronic Pancreatitis.—MAYO ROBSON (*Edin. Med. Journ.*, Dec. 1905), in an address on this subject, lays stress on the importance of an early diagnosis, before glycosuria supervenes, in order by suitable treatment to prevent much suffering and a fatal termination. Histologically, chronic inflammation of the pancreas may be divided into three varieties:—(1) Chronic interstitial interlobular pancreatitis, in which the normally obscure lobules become distinctly defined; (2) chronic interstitial interacinar pancreatitis, in which the gland becomes tough rather than hard, and is not nodular; (3) cirrhosis of the pancreas the final stage of (1) and (2.) In (1) glycosuria is rare and not till the glandular tissue is destroyed. In (2), diabetes occurs early, and may be fatal before cirrhosis is well marked. The frequency with which an inflammatory enlargement of the head of the pancreas is found, when operating for gall-stones in the common duct, has led Mayo Robson to the conclusion that far the commonest cause of disease is obstruction of the pancreatic duct, with damming back and infection of the secretion. The reason why gall-stones in the common bile duct do not always produce pancreatic inflammation are:—(a) Large gall-stones may never reach the pancreatic portion of the duct. (b) The bile ducts and pancreatic ducts may have separate openings into the duodenum. (c) The duct of Santorini occasionally is the principal outlet for the pancreatic fluid.

In 62 per cent. of all cases the bile duct is completely embraced by the pancreas. A gall-stone passing through such a duct sets up chronic pancreatitis, which in its turn from obstruction to the bile flow will lead to the persistence of jaundice after the stone

has passed. This explains the so-called chronic catarrh of the bile ducts. Chronic pancreatitis may also be caused by (a) obstruction to the pancreatic duct by a growth in the ampulla of Vater, impacted pancreatic calculus, or stenosis after ulceration; (b) direct extension of duodenal catarrh; (c) the toxins of enteric, influenza, tubercle, syphilis, &c.; (d) direct extensions, as from chronic gastric ulcer, or malignant disease of the pylorus; (e) following the acute variety; (f) cystic disease of the pancreas. All the above causes produce interlobular changes in the fibrous tissue and are benefited by operative interference. The etiology of the interacinar variety of pancreatitis is obscure; it is probably due to an abnormal state of the blood. The onset of chronic pancreatitis varies with the cause. No single symptom can, however, be relied on as being diagnostic of the disease, but the author thinks that special stress can be laid upon the progressive wasting, the usual presence of jaundice, the dyspeptic disturbances, the pancreatic reaction of the urine, and the result of chemical examination of the fæces. Physical examination, especially under an anæsthetic, may reveal tumefaction of the head of the gland. The temperature is usually not raised. Glucose in the urine is not a common symptom except in advanced cases. In the differential diagnosis of chronic pancreatitis, the most important conditions to consider are cancer of the head of the pancreas, cancer of the common bile duct, cancer of the liver, gall-stones in the common duct, and chronic catarrh of the bile ducts. Chronic pancreatitis has also been mistaken for malaria, and pernicious anæmia. Preventive treatment aims at removing the usual causes of chronic pancreatitis. If the symptoms persist, the cause should be dealt with by operation. A thorough exploration of the whole length of the common bile duct and head of the pancreas is necessary. If no obvious removable cause can be found, drainage of the infected bile and pancreatic ducts should be secured by cholecystostomy, or cholecystenterostomy. When duodenal catarrh with ulceration is the cause, gastro-enterostomy is advisable. Results: Of 102 operations performed by the author on patients whose pancreatic trouble was the chief disease, 96·1 per cent. were followed by recovery. S.

On the Treatment of Venereal Ulcers and other Skin Affections by the Continuous Application of Heat.—DA ULLMAN (*Blatter f. Klin. Hydrotherapie*, November, 1905, No. 11) contributes a lengthy article on this subject. After review of the ordinary methods in vogue for the treatment of venereal sores and gummata, by means of powers, ointments, and strong antiseptics, he remarks that in many cases these fail owing to the necessity of the patient continuing active, and the consequent neglect of and disturbance in the treatment. Even under most favourable circumstances the cure of these affections may require a considerable time. He then deals with the treatment by means of the continuous application of heat. This method has been before the profession for many years, but has not met with general adoption owing to the complicated apparatus required. Ullman, however, states that comparatively simple forms of hydrothermic regulations can now be employed, and claims that by their use very favourable results will be obtained, many chronic ulcers that had resisted all former treatment healing up within a few days. He attributes the good result to the hyperæmia induced, and particularly recommends the treatment for deep-seated skin lesions. M.

NOTE.—A summary will appear each week in the following sequence:—

- 1.—"Recent Medical Literature."
- 2.—"Recent Surgical Literature."
- 3.—"Recent Gynecological and Obstetrical Literature."
- 4.—"The Recent Literature of Anatomy, Physiology, and Pathology."

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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 INTERNATIONAL CONGRESS OF MEDICAL ELECTROLOGY AND RADIOLOGY.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

DEAR SIR,—I am requested by Prof. Doucer, the General Secretary, to ask you to kindly insert the following notice, if possible, in the next issue of your journal:—

"The Third International Congress of Medical Electrology and Radiology, which for certain reasons was not held at Amsterdam in 1905, will be held this year at Milan from the 5th to the 9th of September. Further particulars will be shortly announced. Information as to membership can be obtained from Dr. Herschell, 36 Harley Street (Correspondant du comité directeur pour la grande Bretagne)." 36 Harley Street, W. I am, Sir, yours truly,
GEORGE HERSCHELL.
January 6th, 1906.

LINCOLN'S INN.—There is as yet no established remedy for leprosy. The serum so confidently advanced some time back has failed to answer its purpose. Isolation is the only practical way known to us of dealing with this terrible malady. The definiteness of the causative bacillus, however, makes it more than probable that not many years will elapse before leprosy is brought within the control of scientific medicine.

A. B. REYNOLDS (Burton).—Sanatorium treatment will undoubtedly save a proportion of sufferers from tuberculosis, and restore them to the community as useful workers. It is practically useless, however, if broken-down and advanced cases. Then, it must be remembered, many of those who have benefited go back to an environment of poverty and other conditions unfavourable to a continuance of a high standard of health.

MEDICAL ATTENDANCE AT THE LAW COURTS.

M.D., M.R.C.P.—The dislocation of medical practice caused by the attendance of medical men at the Law Courts is well known to the judges and barristers; and the latter, in agreement with the solicitors of the case, generally do their best to minimise the inconvenience which may arise. Our correspondent, therefore, should place his position before the latter, and request the favour of being only summoned to attend at the last moment necessary for his evidence.

GENERAL PRACTITIONER.—Adenoids are very rare in late life. A case, however, has been recorded in an old man of 70 years. **JOHN B. TOPPS (Manchester).**—If your friend has the L.S.A. Lond., he is perfectly entitled to put "Physician" on his brass-plate, although he may not call himself Doctor. All this illustrates the absurdity of our many-ported system of qualification.

DR. CALDWELL is thanked for his communication, which we hope to utilise in an early number.

FIFTH YEAR'S STUDENT.—The small handbook, by Dr. Herbert French, of Guy's Hospital, entitled, "Medical Laboratory Methods and Tests," would, we think, answer your requirements.

MR. L. B. M.—You will find your enquiries answered on referring to our editorial columns, present number.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JANUARY 10th.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.).—8.30 p.m. Pathological Meeting.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chelms Street, W.C.).—4 p.m. Mr. J. Cantile: Clinique. Surgical. 5.15 p.m. Lecture: Dr. G. H. Savage: Climacteric Insanities.

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

THURSDAY, JANUARY 11th.

BRITISH GYNÆCOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Annual General Meeting. The President (Dr. W. Alexander): Valedictory Address.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chelms Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Lecture: Mr. L. Mummery: Some Problems in Morbid Physiology.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.).—6 p.m. Chesterfield Lecture. Bullous and Vesicular Eruptions; I, Urticaria; II, Pemphigus; III, Pompholyx; IV, Varicella.

FRIDAY, JANUARY 12th.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m. Papers:—Mr. L. McGavin: Transverse c. Inguinal Colotomy. Mr. A. I. Pinches and Mr. E. M. Corner: Further Cases of Torsion of the Omentum. Dr. A. E. Garrod and Dr. Langmead: A Case of Associated Malformations including Transposition of Viscera.

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

Vacancies.

Middlesex County Asylum, Napsbury, near St. Albans, Herts.—Assistant Medical Officer. Salary £160 per annum, with board, lodging, washing, and attendance. Applications to the Medical Superintendent.

York Dispensary.—Resident Medical Officer. Salary £120 a year, with board, lodging, and attendance. Applications to W. Draper, Esq., De Grey House, York.

County Borough of West Ham.—Plaistow and Dagenham Hospitals for Infectious Diseases.—Resident Assistant Medical Officer. Salary £200 per annum, with rooms and board at Plaistow Hospital. Applications to the Medical Superintendent, Plaistow Hospital.

Bristol Royal Infirmary.—Pathologist, Bacteriologist, and Director of Clinical Laboratories. Salary £250 per annum. Applications to W. E. Budgett, Secretary and House Governor.

National Hospital for the Paralysed and Epileptic, Queen Square, Bloomsbury, London, W.C.—Resident Medical Officer. Salary £100 a year, with board and residence. Applications to Godfrey H. Hamilton, Secretary.

County Borough of Burnley.—Medical Officer of Health. Salary £500 per annum. Applications to Peregrine Thomas, Town Clerk, Town Hall, Burnley.

University of Birmingham.—Demonstratorship in Anatomy. Salary £175 per annum. Applications to Geo. H. Morley, Secretary.

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

Appointments.

BOYLE, H. EDMUND G., M.R.C.S., L.R.C.P. Lond., Honorary Anaesthetist to the Paddington Green Children's Hospital.

DICKSON, FRANCIS HENRY, M.B., Ch.B. Edin., Junior Assistant House Surgeon at the Stockport Infirmary.

GAUNT, J. P., L.R.C.P. Edin., M.R.C.S., District Medical Officer to the King's Norton Union.

JAMES, WALTER TIMOTHY, M.B., Ch.B. Edin., District Medical Officer for the Aberayron (Cardiganshire) Union.

SMITH, H. WATSON, M.B., Ch.B. Aberd., Second Assistant Medical Officer to the Durham County Asylum, Winterton, Ferryhill.

THOMPSON, GEORGE WILLIAM, M.B. Edin., F.R.C.S. Eng., appointed Ophthalmic Surgeon in charge of Out-patients at the French Hospital, Shaftesbury Avenue.

WAUGH, GEORGE ERNEST, B.A. Cantab. M.D., B.S. Lond., F.R.C.S. Eng., Assistant Surgeon to the Hospital for Sick Children, Great Ormond Street.

Births.

MENNELL.—On Jan. 5th, at 57 Holland Park Avenue, London, the wife of Zebulon Mennell, M.B., of a daughter.

Marriages.

CHATTERTON-AITKEN.—On Jan. 4th, at St. Margaret's, Westminster, William Chatterton, M.D., of Penshurst, to Ethel Mary Aitken, daughter of the late Robert Aitken and of Mrs. Aitken, of Bromley, Kent.

POLLOCK-JAY.—On Jan. 5th, at Felixstowe. Major C. E. Pollock, R.A.M.C., son of the late A. R. Pollock, of Paisley, J.P. for the county of Renfrew, to Winifred Mabel, youngest daughter of C. E. H. Jay, late of the War Office, of Glenesk, Felixstowe.

Deaths.

CONDELL.—On Jan. 1st, at Guildford, Julia, widow of the late William Condeall, M.D. and F.R.C.S., formerly of Baslow, Derbyshire.

KINGDON.—On Jan. 5th, at 31 The Broadway, Westminster, during sleep, John Abernethy Kingdon, F.R.C.S., late 2 Bank Buildings, Lothbury, in his 78th year.

LUND.—On Jan. 8th, at Fern Hill, Pendleton, Manchester, Mary Crockett, aged 45, the dear wife of Herbert Lund, F.R.C.S.

PAINE.—On Jan. 6th, at Bournemouth, George Reuben Robins Paine, M.R.C.S., L.R.C.P., late of Lympstone Devon.

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, JANUARY 17, 1906.

No. 3.

NOTES AND COMMENTS.

The Election of 1906. As we go to press the nation is still in the throes of a great political struggle. The General Election of 1906 is likely to prove one of the most memorable in our modern history. Although the returns are not yet complete, it is abundantly clear that the balance of power will incline heavily in the direction of the democratic, as opposed to the conservative section of the community. One of the direct consequences of this change of governmental aim and principle will inevitably be a greater attention during the next few years to social legislation. It is with that aspect of the election that the medical profession is concerned. With politics pure and simple we are naturally not concerned. With the legislative handling of scientific medical knowledge, on the other hand, we are deeply and universally interested. For that affects the moral, the physical and to a great extent the economic well-being of the community.

Parliamentary Candidates and Temperance Legislation. WHAT, for instance, could go down deeper into our inner lives than the question of temperance legislation? But who would venture to say that Parliament during the past generation has been guided by the authority of medical science with regard to that vital matter? Apart from economic considerations, there is the purity of the alcoholic beverages sold to the public. Broadly speaking, good, pure and well-matured ale, wine and spirits do little harm to the consumer, whereas raw, adulterated and new drink spell organic disease, misery, crime and death in the largest of capital letters. If it be found impossible to make men temperate by Act of Parliament, it is nevertheless comparatively simple and easy to reduce the evils to a minimum by insisting upon the liability of the publican to supply a sound article to his customers. Meanwhile, a good start has been made by the legal decision that if a man asks for brandy he is entitled to receive grape brandy and not a distiller's substitute.

Candidates and Physical Deterioration. THE official Parliamentary report upon physical degeneration has furnished the basis of much future industrial and general hygienic legislation. In a sense, it covers the whole ground of the relation between

medical science and Parliament, inasmuch as it deals with the social product of pre-existing faulty conditions. The educated medical man studies symptoms in relation to their causes. When faced with a picture of national deterioration, of lessened stature, of shortened lives, of increasing lunacy, in a word, of a dwindling national standard, both moral and physical, he sets himself to consider the causes of so vast a malady. Will the Parliaments of our generation be wise enough to call in the medical profession to their Privy Council, or will they leave so obvious a step to our children or our grandchildren?

Parliamentary Candidates and Vaccination. YET it is well to recall the other side of the picture. We, the citizens of 1906, have at least one great heritage from our grandfathers. We no longer see every second or third person in the street seamed and pitted with small-pox; we no longer pay a vast annual toll of suffering, disease and death at the demand of that dread malady. Small-pox is preventable, and has been practically prevented—thanks to the immortal genius of Jenner and the common sense of the British Government. Yet there is probably hardly a parliamentary candidate at the present election who has not been heckled by the anti-vaccinationists, who would fain have their countrymen at the mercy of uncontrolled small-pox, rather than have the sacred liberty of the subject invaded. In this case the reasoned and deliberate verdict of medical science has been adopted by the legislature with magnificent results. Yet even here their views have been seriously flouted by the creation in recent years of that hybrid crank, the "conscientious objector." Clearly we want more representatives in Parliament to express current medical opinion whenever it may be necessary or desirable.

Acute Alcoholic Poisoning. FROM the *South African Medical Record* we learn of an interesting and tragic case of acute alcoholic poisoning. It appears that in a drinking saloon on the Rand a number of men were discussing the capabilities of a man with regard to the quantity of alcohol he could drink at a sitting, and one of the disputants wagered an opponent five shillings that he could not drink a bottle of gin straight off. Thus challenged, the

man took up the bottle and drank the contents in two draughts. Almost immediately he became unconscious, and within a few hours he died, in spite of all that could be done for him. It is hardly needful here to animadvert on the folly of these proceedings, both on the part of the challenger and the challenged, but such sudden unconsciousness and rapid death from imbibing a large quantity of spirit are rare, and, as the man seems to have been in good health, they appear to show the intensity with which alcohol can act as a poison on some constitutions.

LEADING ARTICLE.

CORONERS AND SPECIAL PATHOLOGISTS.

ON the 11th instant the long-expected decision of the Metropolitan District Auditor of the Local Government Board was published with regard to the legality of certain charges made upon rate-payers by Mr. Troutbeck, the Westminster Coroner. The question is one of great importance to the general practitioner, as that official's innovations not only deprive him of a legitimate source of professional income, but in addition brand him in the eyes of his neighbours as a man of inferior standing and unfitted to give trustworthy medical evidence in a court of law. Mr. F. B. Cockerton's decision affects the interests of a vast number of medical men in England, Wales and Ireland. As such, it will become a topic of universal discussion amongst practitioners in the countries mentioned, whose hopes were not unnaturally fixed upon the Auditor's appeal. Mr. Cockerton, however, seems compelled by some antic of fate to have the making of momentous decisions thrust into his hands. If we remember aright, it was his famous surcharge that ushered in the education struggles which for years past have vexed the legislature and convulsed the country. When compared with national education the question of the duties of coroners and the rights of medical men may seem somewhat small and parochial, but the fact of any such disproportion by no means does away with the necessity of close examination of the less as well as the greater decision. In a sense it is to be hoped that medical men will all become "passive resisters" if any serious attempt be made to enforce the letter of Mr. Cockerton's reading of the various Coroners Acts. But there is a long interval between the decision of a public official in chambers and the reversal of relations established by long usage between coroners' courts and the medical profession. The Government must indeed be strong that will deliberately rouse the hostility of a powerful profession by imposing upon it disabilities which are incapable of moral justification, even though they may be, as Mr. Cockerton thinks, strictly in accordance with the letter of the law. That the last word has been said in this matter we should be loth to believe. The right of appeal against the decision remains, and there is every reason to anticipate that it will be exercised to its utmost

capacity by the British Medical Association, the body that has been instrumental in bringing the whole matter within the range of practical politics. It was shown at the inquiry that some hundreds of medical men in South London were affected by Mr. Troutbeck's policy. Further, it was stated that during a period of twenty-two months, Dr. Freyberger, his favoured henchman, made *post mortem* examinations and gave evidence in no fewer than 862 cases, for which services he received fees amounting to £1,767. The main legal contention of the objectors was based on the Coroners Act of 1887, which said that if deceased had not been seen during life or immediately after death by a qualified practitioner "the Coroner may call in a medical man in actual practice in or near the place where the death occurred to make a *post mortem* examination, and to give evidence at the inquest." Dr. Freyberger lives near Regent's Park; that is to say, miles away from Battersea, Putney and Wandsworth, so he can hardly be said to practise "in or near" the Westminster Coroner's district, which includes those districts. Yet the opposite view was advanced by the counsel for the London County Council, which seems to have taken up the cudgels for Mr. Troutbeck, if not, indeed, to have initiated and supported consistently his obnoxious policy throughout. Fortunately Mr. Cockerton is obliged, under the provisions of the Public Health Act, 1875, if required to do so by any party interested in the inquiry, to make a written statement of the reasons for his decision. This fact he mentions in his published decision, which we give in another column, and for which we ask the earnest and careful consideration of every medical man in the kingdom, no matter what his professional position. The whole affair presents in miniature a faithful picture of the encroachments that have hitherto been allowed on all sides to sap the legitimate income of the medical man. Here the attack appears to have been instituted by certain medical members of the London County Council, that is to say, by public men to whom we should naturally look for protection and good guidance. Whether that surmise be firmly founded or otherwise, we have no hesitation in calling upon the Local Government Board to deal with this matter fairly and squarely, both in the interest of the public and of a not unimportant profession. The new President of the Local Government Board, Mr. John Burns, if called upon to decide this dispute will have an excellent opportunity of adjudicating upon a subject which must have become more or less familiar to him in his former experience as a member of the London County Council.

SIR GEORGE SCOTT-ROBERTSON, who has won a Conservative seat for Free Trade in Central Bradford, is famous for his heroic defence of Chitral, when he was besieged by Sher Afghal and Umra Khan's troops in 1895. Born in London in 1852, he was educated at Westminster Hospital Medical School, and entered the Indian Medical Service in 1878. He served throughout the Afghan campaign of 1879-80, including the siege of Sharpur, and afterwards became British Agent at Gilgit.

NOTES ON CURRENT TOPICS.

Puerperal Fever in Manchester.

MANCHESTER is one of the few—if not, indeed, the only—large city that provides accommodation at its isolation hospital for cases of puerperal fever. Although a fever hospital may not be an ideal place for the treatment of women soon after confinement, it is very much better that they should be received where proper nursing and medical facilities are to be had than left in their own homes without either, and it seems almost a corollary to the notification which the law demands and the increased employment of midwives which the law encourages that some such arrangement should be made. One good result likely to follow is that puerperal fever can now be studied under conditions that lend themselves to scientific accuracy, and from a paper by Dr. Gordon, of Manchester, published in *Public Health* this month we already learn a remarkable fact. Thirty-seven cases of puerperal fever admitted to the Isolation Hospital were examined with a view to causation and it was found that twenty-three had been under the care of midwives and fourteen under medical practitioners. In all the former there had been no operative interference, the first symptoms of the disease did not show themselves till four to eight days after delivery, and in practically all the cases the organism found was bacillus coli. On the other hand, in all the fourteen cases attended by doctors there had been operative interference, the incubation period was rarely over forty-eight hours, and the organism was a streptococcus, occasionally mixed with bacillus coli. If these observations can be taken as approximately typical of what occurs generally it would seem that puerperal fever without operative interference is very rare in medical practice, but very common in that of midwives, and also that the application of forceps and such obstetrical manipulations should be avoided as much as possible, and when performed should be accompanied by scrupulous antiseptic precautions.

Copper Sulphate and Water Supplies.

WE have had occasion in these columns to refer from time to time to the reputed value of copper sulphate in the purification of town water-supplies, and we are interested to notice that Dr. Howard Jones, medical officer of health for Newport (Mon.), has described in *Water* the first application of the treatment in this country. Three reservoirs supplying his town were treated with copper sulphate on the lines suggested by American experience, and the results are said to have been entirely satisfactory. There can be little doubt that the effect of this disinfectant varies largely according to place and circumstance. In Manilla, which is now, of course, under American administration, there was a scare of cholera in October owing to the occurrence of some cases in the area from which the town derives its water-

supply. The authorities experimented with copper sulphate solution in their reservoirs to see how far it would be possible to keep their water free from germs. It was found, however, that they could not kill the comma-bacillus with any strength under 1 in 150,000, and then it took four hours to do so. This being so, it was not deemed wise to employ the treatment as it certainly could not be pronounced safe to allow people habitually to drink the metal in so concentrated a solution. Another reason assigned was that copper sulphate might act as a disinfectant in the alimentary tract, and that by its means the evacuations might be passed in sterile condition, which, considering that the septic tank system of sewage disposal was used for the town, would hardly conduce to efficiency in working. We confess ourselves that we should need to be strongly persuaded of its necessity before we should consent to supplying the inhabitants of a town with a solution of a metal instead of pure water. At present we know little about chronic copper poisoning, but there is a good chance of our learning a great deal if the plan were widely adopted.

Women's Brains.

THE advocates of women's suffrage, who seem to be rendering themselves rather unpopular at political meetings just now, will find a scientific basis for the faith that is in them if they read a lecture given by Dr. Bernard Hollander last week. Discussing the relative sizes and shapes of the male and female brain, the lecturer showed that though a woman's brains was slightly lighter and smaller in circumference than man's, yet this did not show that her intellectual capacity was less, but merely that her capacity for all the energies was not equal to man's. The portions of male brain most markedly different from those of the female were the ones representing force, energy and animal passion, while woman's brain was better developed as regards the parts concerned in the feelings and emotions. Woman, in fact, was not mentally inferior to man; she was only dissimilar. Comforting, however, as this view may be to the fair sex who seek to battle in the same field as man, it is sad to reflect that those persons who exhibit most force and energy, and, perhaps, sad to relate, even animal passion, are the ones who are most likely to win in the long run.

Telephones and Medical Practice.

THE relation of the telephone to medical practice is forcing itself upon the attention of practitioners of all ranks. This modern system of communication places the medical man at the mercy—so to speak—of mankind at large, in addition to the vagaries and semi-official appeals of his patients. A consultation in the daytime is followed up by a question through the telephone at night, as to how to meet this, that, or the other symptom, and the time imperatively necessary to the medical man for rest, refreshment and

recreation is remorselessly taken up by the chatter of gratuitous business. The patient receiving advice through the medium of the telephone exchange as a rule does not expect to pay any fee in return. The only way out of the wood will be for the medical man to draw up strict rules to meet the situation. He will not undertake, for instance, to answer telephonic communications personally. Any professional advice given by telephone will be charged for as an ordinary consultation. Unless a strong stand be taken at the outset of what will undoubtedly become an almost universal means of social communication, the medical profession will find themselves one day placed in a false and invidious position in the matter.

Formalin Sole.

THE bad French which usually figures on the menus of public dinners and restaurant suppers is likely to be seriously threatened as the orthodox terminology of those invisible artists—the chefs. If this were the only danger apprehension would not run high, for the French menu is perhaps the most exotic form of snobbery that was ever planted on British soil. It is certainly a reproach to the insularity and good sense of John Bull that he has given way to the Parisian innovator so far as to consent to eat kickshaws for his steaks, and *bœuf à la mode* for his native roast. The solid resistance which the bullock's rump presents to the jaws and digestive juices not only gives a sensation of elation to the hearty diner of Anglo-Saxon stock, but—together with the playing-fields of Eton—may be classed with the factors that overthrew the Corsican at Waterloo. But *nous avons change tout cela*, and, unfortunately the late Committee on Physical Degeneration missed an important link in their chain of evidence by not regarding this *voilà face*. This time the change in dietetic parlance is to come from the scientific quarter, and chemistry is to take its rightful place in the ordering of gastronomy. It appears from the report of a trial for adulteration held at Worship Street Police Court recently, in which a firm was fined the exorbitant sum of 20s. for adding 41 grains of boric acid to each pound of its sausages, that when the pot is called black it considers it a defence to refer to the sable character of the kettle. Not only are 41 grains of boric acid added to a pound of sausages by one firm, but meat is by another washed with formalin, and the same chemical is used to preserve the dainty flavour of the sole. A medical witness referred to the last as a matter of common experience, but admitted that the sole should be so classified that the purchaser might be made aware of the fact. He suggested "Formalin Sole," as an appropriate designation. Are we in future to find ourselves set down to eat Borated Beef, Cupric Peas, and Condied Chops? Or will the enterprising dairy-

man advertise "Are you rheumatic? Try our Salicylic Milk?" These matters are in the lap of the gods.

Horse-Flesh Sausages: a Humour of the Election.

NOT long ago a London sanitary inspector seized some sausages and obtained a conviction on the ground that they were made of horse-flesh. The sequel now comes in the proposal that the Public Health Committee of the Paddington Borough Council shall consider and report on the action of the local sanitary inspector who seized certain German sausages, exhibited at a committee-room for political purposes, after being told they were not for sale, which sausages were ultimately rescued, with the consent of Mr. Plowden, magistrate, by their owner, Mr. Chiozza Money, the Liberal candidate for North Paddington. This novel kind of election ammunition, it appears, was intended to appeal to the reason of electors, by furnishing an object-lesson in the food of protected countries. It was not of the same category with electoral eggs.

"Optology" and the General Election.

MR. ARTHUR GREENE, of Norwich, has done a service to the profession in drawing attention in a letter to a contemporary, to the necessity of medical men impressing on candidates for Parliament their views with regard to the Bill which the British Optical Association is endeavouring to pass into law. We understand that there are two Bills being promoted of almost identical import, one by the British Optical Association, and the other by the Society of Chemist-Opticians, with the support of the Spectacle-Makers' Company. The latter Bill is to be introduced into the House of Lords next session by no less a person than Lord Goschen. The object of both Bills is to give a legal status to sight-testing by opticians. There is no need to tell medical men of the dangers of allowing even the most expert "sight-tester," ignorant of everything relating to the anatomy, physiology, and pathology of the eye, to prescribe lenses. It is necessary, however, to impress a sense of these dangers on all possible members of Parliament, and to explain to them, as Mr. Greene puts it, that the seller of spectacles has just the same claim to be protected in his practice of ophthalmology as the dealer in trusses to be established as a specialist in the treatment of hernia.

The International Medical Congress, 1906.

THE Congress is to be held in Lisbon in April next, and already medical men in these countries are beginning to discuss the question of attending it. It is said that the Organising Committee is sparing no pains to render the Congress free from those faults which gave rise to complaints on previous occasions, and that the Portuguese Govern-

ment is giving all the aid in its power. There is no doubt that the inherent difficulties in the way of an international congress are very great, and the question arises whether they are such as can be surmounted. In the first place there is the difficulty due to difference of language, which necessarily interferes with the interest of the discussions. There are few, if any, medical men who can intelligently follow the spoken word in more than two or three languages, but in an international congress the languages are as many as there are nationalities represented. It would hardly make matters easier to insist on all communications being couched in one of a limited number of "official" tongues, since such a regulation would shut out from all participation many of the most competent contributors. A lesser difficulty, but one which has caused much annoyance in the past, is that of arranging the specialties of study which shall be represented by independent sections. We learn from a contemporary, for instance, that "the most prominent representatives of laryngology in Great Britain and Germany have declared their intention of taking no part in the Congress," since laryngology is not to be dignified by a separate section! This is an example of the difficulties which lie in wait for an organising committee, difficulties which, moreover, are much more formidable in the absence of any permanent executive.

Indian Native Women and British Troops.

It is curious to note the want of perspective shown by sentimentalists who seek to reform our morals in so many directions. The practice which they condemn in one profession they condone under other guises in various sections of society. Vivisection, for instance, is a crime in the scientific laboratory, but is right and proper when practised for purposes of sport, personal adornment or mere food and clothing. The Contagious Diseases Acts were crushed out of existence in the United Kingdom by a knot of noisy faddists who preferred the hidden cancer of syphilis to the express and official control of prostitution. What have these worthy persons to say to the treatment of female natives by our Army authorities in India? Is it or is it not a fact that the British military authorities connive at a system which keeps native women practically enslaved to the vices of our soldiers? The British troops in Asia are riddled with venereal disease, the tax for which falls upon the taxpayer at home. If official control be necessary for native women in or near barracks or camps in India, let it be, at any rate, of a nature that will bear the full light of inquiry and afford public information.

School-Children of Tender Age.

THE question as to what age school is desirable for children lies at the very foundation of a rational system of education on hygienic principles. It is with pleasure, therefore, we learn that the Board of Education have had under consideration the

attendance at public elementary schools of children under five years of age. It has been, wisely, as we think, decided to reconsider the advisability of laying before Parliament the Minute which has been proposed for modifying the system of grants in respect both of children under five and of the other scholars in public elementary schools. It is of importance to note that this decision involves a reconsideration by the Board of the way in which a certain amount of relief can best be afforded to those areas where the burden of the education rate is especially heavy. Our views upon this matter have been clearly and emphatically stated. Briefly, we regard the attempt to instil book knowledge into infants as fallacious in theory and dangerous in practice. The brain of the infant has quite enough to do in acquiring the concrete facts of its environment without wandering into a topsyturvy region of abstractions.

PERSONAL.

MR. A. W. MAYO ROBSON, F.R.C.S., has been appointed to represent the Royal College of Surgeons of England at the International Medical Congress, to be held at Lisbon in April next.

MR. JOSEPH MANSENGH PALMER, F.R.C.S.I., has been sworn in as High Sheriff for Armagh.

DR. EDWARD THOMPSON, late member for North Monaghan, informed his former constituents that he would not be a candidate for the representation of the county at the present Parliamentary election.

DR. C. F. HUTCHINSON, who was elected representative of the Rye division at the by-election in 1903, is standing again in the Liberal interest. As a member of the House of Commons, he steadily supported the interests of the medical profession. He rendered special service by introducing the Public Health Bill to provide security of tenure for medical officers of health.

THE first lecture of the course of military instruction for civilian medical practitioners (with a view to the formation of a reserve force) will be delivered at the West London Hospital on January 20th by Surgeon-General Keogh, Director-General of the Army Medical Department.

DR. V. H. RUTHERFORD, who is a Liberal candidate for the Brentford Division of Middlesex, was formerly Medical Officer of the Newcastle School Board. He stood for a Yorkshire constituency recently.

ST. GEORGE'S HOSPITAL, London, will suffer a great loss in the forthcoming resignation of Sir William Bennett, K.C.V.O., who in one capacity or the other has been connected with that Institution for more than thirty years.

SIR WM. JOB COLLINS, M.D., Lond., F.R.C.S., formerly chairman of the London County Council, has been elected by the constituency of St. Pancras, West, London, as a Liberal member of Parliament for that Borough.

MR. F. BOWERMAN JESSETT F.R.C.S., was elected President of the British Gynæcological Society at the annual General Meeting on Thursday last. He occupied the Presidential Chair of the Society during the year 1893.

A CLINICAL LECTURE

ON THE

ESSENTIAL NEPHRITIC HÆMORRHAGE.

BY
Professor SCHÜLLER,
Vienna.

[SPECIALLY REPORTED FOR "THE MEDICAL PRESS."]

THE following cases may be selected to illustrate the difficulty of diagnosing essential hæmorrhage. Whilst there are many among us who are greatly concerned about this difficulty, another section maintains that the disease is only a modification of nephritis, which may be unilateral as well as bilateral. Whichever of these opinions may finally prove to be correct, the evidence at the present time is in favour of an inflammatory change of some kind in the kidneys, with the resulting "essential hæmaturia." The more closely these complex symptoms are watched the conviction grows that the morbid changes are, *sui generis*, of a badly differentiated disease from nephritis.

Each individual observer has a similar complaint that so few accurate descriptions are given that no true judgment can be formed as to whether operative or expectant treatment should be adopted. Suffering from this painful conviction of our lack of knowledge, Schüller expressed his belief that the following cases would be of interest to the profession in forming an opinion on the subject.

CASE I.—M. T., æt. 21, shoemaker, with a good family history, enjoyed perfect health up till August in 1903, when a cough commenced with an exhausted state of the body; no appetite, but sometimes pain and smarting on micturition. The urine was sometimes cloudy and tinged with blood at this time. Three days after this invasion he was received into hospital where he remained for three months. In spite of every care in the analysis of the urine nothing but erythrocytes and a corresponding number of leucocytes could be found—never casts or cylinders—only the proportion of albumin corresponding to the amount of blood present; neither could the tuberculous bacilli be detected though carefully explored.

With perfectly clear and healthy urine and the patient expressing himself as perfectly well, he was discharged on November 5th, 1903, as cured. For five weeks he performed his duties as shoemaker, when suddenly without any cause the hæmaturia recommenced without any other phenomenon than general weakness.

He was again received into hospital on January 1st, 1904, with the following report of his condition at the time:—Medium height, small boned, muscles fairly well developed, with moderate panniculus adiposus; face pale, but no œdema. Arteria radialis soft, pulse 84, rhythmical tension and fulness rather below normal, but cardiac area and sounds normal. Thorax flat; no pathological change to note, and no undue tenderness anywhere about the lower part of the thorax and commencement of abdomen. The right kidney is distinctly enlarged to the size of a man's fist, smooth surface, movable on respiration and easily palpated. The quantity of urine 1400 cubic cm., reddish colour, and reaction, sp. grav. 1018, albumin 0.4 per cent., but no sugar. The sediment contained numerous red blood corpuscles, epithelial cells, granular and hyaline cylinders, comprising 6 to 8 in the microscopic field. In all the preparations no tuberculous bacilli could be discovered. Sterile urine contained no bacterial germs, though many crystals of oxalate of lime were present.

The cystoscope was applied five days after admission with great difficulty, as the patient was irritable and very restless. With this instrument the bladder was found to be healthy and no abnormal condition could be observed at the entrance of the ureters into the organ. An effort was subsequently made to examine

the ureters, but this was found to be impracticable from the sensitive condition of the patient. On January 5th, at 11.58 a.m. 4 grains of indigo carmin were injected into the region of the gluteal muscle under aseptic conditions. At 12.6 the urine drawn off by catheter was slightly blue, a minute later it was darker blue; at this period the cystoscope was inserted to observe the colour of the urine entering the bladder from both ureters, which had a dark blue stream entering from each alike, about 12.17. From this date till January 14th, the urine was periodically examined without discovering anything abnormal; but the hæmorrhage still persisted, notwithstanding careful dieting and confinement to bed.

On January 15th, the temperature rose to 37.8. Over the site of one of the subcutaneous injections he complained of severe pain, where an intra-muscular infiltration had been induced by the fluid. On the 16th this was freely laid open with the discharge of pus. After this the temperature fell to 36.7, but the hæmaturia still persisted. Bed and diet with the administration of styptics were still persevered with, though disappointing in effect. The urine still contained cylindrical and was examined every day for tuberculous bacilli, but none could be found.

The radiograph gave no assistance—no stone or altered condition could be discovered in either of the kidneys.

On the 18th the patient was sponged over with ether, and the cystoscope again applied under this form of semi-narcosis. The mucous membrane of the bladder was observed to be abraded in parts, but not bleeding. The right ureter on this occasion was discharging blood into the bladder, but the left was emitting clear urine. The blood when compared with freezing point of blood taken from the vena mediana of the arm was 0.55. The excessive anæmia demanded some operative interference although no exact diagnosis could be arrived at, as no calculi were present, as proved from X-ray examination. Nothing now remained in the diagnosis for elimination but tumour, tuberculosis, or inflammation of the right kidney.

On January 30th, Zucker-Kandl determined to operate. Ether narcosis was performed, and an inclined incision made over the region of the right kidney, which was easily reached by the small amount of fat present in the capsula propria and the absence of any other thickening. The kidney was then carefully dislocated and found to be increased in all its dimensions, both poles greatly thickened, but no really active morbid condition could be observed. The surface was somewhat irregular, of a livid colour, and intensely injected. Tubercle or abscess was not present. On incising the capsule at the convex edge it could be easily separated from the cortical structure, which was granular on the surface and livid at the poles where the tissue was soft and friable. After resecting the entire capsule, the kidney was returned to the abdomen and the wound closed with three series of stitches, supplied with proper drainage, and finally suitably bandaged.

Next day, January 31st, no fever, though dull and heavy; neither was there any vomiting.

February 1st, no abnormal temperature, pulse 94, urine 450 grammes, cloudy, containing blood, but neutral in character. The albumin was slight with a few cylinders present and a large quantity of epithelium.

On the 2nd, still afebrile, takes milk freely, and drainage tube removed; urine passed 1,100 grammes

of a hæmorrhagic colour, cloudy, acid and sp. gr. 1012; the albumin was small in quantity with a sediment of cylinders and epithelium, and the freezing Δ , when compared with the median artery = -0.90° Centigrade.

February 3rd.—Afebrile, pulse 96, wound healing by first intention, milk diet, "Preblaner" water, quantity of urine, 1,200 grammes, and slightly hæmorrhagic.

February 5th.—Urine 1,400 grammes, of a golden colour, slight sediment, very little blood with here and there granular and hyaline cylinders.

February 6th.—Stitches removed, milk and farinaceous diet, egg and "Preblaner" water. Urine 1,400 grammes, with a small quantity of blood and cylinders as seen by the microscope. Albumin is almost negligible, urea in 1000 parts equal to 14.560 grammes, and $\Delta = -0.92^{\circ}$ C.

February 7th.—Urine 1,600 grammes, still clear, and patient convalescent.

February 8th.—Urine 1,000 grammes, and wound almost healed.

February 9th.—Urine 1,300 cubic centimetres.

February 10th.—Urine 1,000 c.c.m.

February 11th.—Urine 1,700 c.c.m.

February 12th.—Urine, 1,700 c.c.m.

February 13th.—Urine 1,950 c.c.m.

During the latter dates no blood could be detected by the microscope although cylinders still existed with a quantity of amorphous uric acid. By the 15th the patient was able to take his ordinary food, walk about, and felt well.

March 6th.—Urine clear, sp. gr. 1014, no albumin or sugar present, acid reaction, slight sediment, no erythrocytes or cylinders, but a few squamous epithelial cells with amorphous uric acid were present. No tuberculous bacilli could be found at any time. He was dismissed from hospital on the 9th.

Living far from town, the patient sent urine for analysis, which invariably gave the same result.

On July 5th he returned for examination.—Urine straw colour, slightly cloudy, neutral reaction, sp. gr. 1016, no albumin, no sugar, slight sediment, with a few squamous cells, amorphous urates, but a large number of bacteria for the first time made their appearance. This is an interesting case of unilateral hæmaturia, which had existed for a long time without any symptom beyond the periodic attacks of hæmorrhage, and a few cylindrical cells without albumin to guide the clinician in his diagnosis of the disease. The operation, however, demonstrates that a severe chronic condition of the parenchyma of the organ was present. In the literature on essential renal hæmorrhage recurring, protracted bleeding has been described by many writers on the subject. Wagner, who had a wide experience, affirms that the cause is due to chronic nephritis, which Naunyn and Israel confirm by obtaining a shrinking of the kidneys after long continued bleeding. We may, therefore, take it as proved beyond doubt that the so-called essential hæmaturia is nothing more than chronic nephritis. It was of the utmost importance to discover whether the preceding case suffered from unilateral or bilateral inflammation of the kidneys. On this point we have not the operation on the second kidney for ocular demonstration, but we may assume from the rapid convalescence and non-recurrence of hæmorrhage that the other kidney was unaffected.

Israel, in his clinical work on the subject, confirms the unilateral opinion advanced in this case, as the speedy recovery after the operation was proof to him that the second kidney was not affected. The principal question still remains to be answered: Was this a case of Bright's disease? If only one side were affected it could not be according to earlier diagnosis, but Edebohls tells us that he met with unilateral morbus Brightii nine times out of 29 cases. On the other hand, Kimmel found, after sounding the ureters of 100 cases, and examining the secretion from each, that Bright's disease was always bilateral.

From these contradictory opinions it would be

unwise to dogmatise. The correct diagnosis is not an easy matter, as may be seen from the following.

CASE 2.—A. K., was examined on October 6th, 1903. According to his own history he was *æt.* 35, engaged in the Customs and was always healthy till one and a half years ago, when he noticed his urine dark and bloody-looking, but this soon cleared up. He noticed pain occasionally in the right side that radiated up to the right shoulder. He consulted several medical men, who examined him with the cystoscope, and concluded that nothing less than an operation would cure him.

On his reception at hospital his kidneys could not be palpated, the right being very tender. The cystoscope was applied and the bladder found in a normal condition, but a plug of blood closed the orifice of the right ureter. The ureters were catheterised; the left had clear urine with traces of albumin, but no nephritic elements. Floridizin reaction was negative, although 0.005 grm. was injected. The right emitted no urine as it was stopped by a coagulum that could not be removed. The albumin in the left ureter and the clot in the right demanded another examination, but the patient left town and was not seen again for seven months.

On his return he was feeble, weak and bloodless from the constant loss; also complained of loss of sight. The muscles were weak, but had a large quantity of panniculus adiposus, temp. 36.7° pulse 68, respirations 24. The radial artery was well filled and tension high. The face and mucous membrane of the mouth were pale; lungs normal and heart tones clear, with second sound distinctly accentuated. Spleen and liver were not enlarged. Kidneys could not be palpated, the right being still very tender. The urine had a flesh colour, sp. gr. 1024; albumin $1\frac{1}{2}$ per cent., sediment, red blood corpuscles, some resembling leucocytes with hyaline casts.

Notwithstanding careful dieting the bleeding still continued. Quantity of urine 1,200 cubic centimetres. Seven days after admission the cystoscope was inserted and bladder found normal. The Segregator revealed bloody urine from both kidneys, both sides gave $1\frac{1}{2}$ per cent. of albumin, and both sides had casts in the fluid. Besides these morbid changes, retinitis albuminuria was present.

He was confined to bed, put on strict diet, with suitable drugs, but left hospital after a few weeks' residence and died a few weeks later of uræmia.

Here we had at first unilateral hæmaturia and colic without albuminuria or casts, which appears to have existed for $1\frac{1}{2}$ years according to history. After this period the disease becomes progressive and both kidneys become involved with a chronic nephritis, albuminuria, casts, and finally uræmia, two years after the first appearance.

CASE 3.—The next case teaches how careful we must be in determining which side the blood is coming from, as it was first found on the one side and then on the other. Another peculiarity is that the bleeding commenced in the twenty-second week of the last five pregnancies, but persisted in the last.

The patient was *æt.* 31, had had four children without any bad symptoms; but with the next five hæmorrhagic urine was observed about the 22nd week of pregnancy. During the intervals the urine appears to have been normal, and no pain or discomfort about kidneys. After the ninth pregnancy the hæmorrhage and the urine persisted. The cystoscope was applied and located the hæmorrhage to the right kidney. Before this Prof. Israel diagnosed the blood to be coming from the left kidney during pregnancy, with hypertrophy of the left ventricle and lung affection, for which he recommended baths, &c. The hæmorrhagic urine persisted for a year and three-fourths after the ninth pregnancy, as post-partum hæmorrhage with varying intensity. The private attendant discovered wandering kidney on left side, but radiology was negative. She went to Carlsbad for a few months, but without benefit to herself.

On her return two eminent surgeons examined her

with the Luy's instrument, and the segregator gave the following results:—

RIGHT URETER.
Urine clear or slightly yellow; reaction acid.

$\Delta = -1.49$
Albumin, 2 per cent.
Quantity per hour 15 c.c.
Sediment after centrifuging Nil.

LEFT URETER.
Urine cloudy, flesh colour. Reaction acid.

$\Delta = -1.57$
Albumin 1 per cent.
Quantity per hour 45 c.c.
Sediment after centrifuging. A large number of red corpuscles, epithelium from the canaliculi, pelvis of kidney, but no tubercle bacilli.

The orifice of the right ureter was normal, but there was a red area around the left orifice.

Two months later she consulted Zucker-Kandl, who describes her as anæmic, moderately nourished, both lungs moist rales, cardiac area increased, second pulmonary sound accentuated, radial artery, full tension normal, pulse 94, no glandular swellings, abdomen fuller than thorax, but flabby, fatty and having many old striæ. Right kidney greatly enlarged, soft and tender with irregular surface. Left kidney not palpable. A litre of water drawn from the bladder was flesh coloured, cloudy, sp. gr. 1009, reaction acid, $\Delta = -0.74$, small quantity of albumin, no sugar, and total urea 1,131 grms.

With the cystoscope the bladder and orifices of ureters were normal; Luy's segregator gave the following:—

LEFT URETER.

Quantity in 35 minutes—
35 cubic centimetres,
flesh-coloured, cloudy,
and highly acid.

Albumin, small quantity,
but not exactly measured.

$\Delta = -0.54$
Sediment, a large quantity
of blood, no casts, no
tubercle bacilli.

Urea, 0.738 per cent.

RIGHT URETER.

Quantity in 25 minutes—
35 cubic centimetres,
clear or slightly yellow,
feebly acid.

Albumin only a trace,
could be detected.

$\Delta = -0.48$
Sediment, no blood except
a few erythrocytes;
much epithelium, but
no bacilli.

Urea, 0.891 per cent.

Here is a case that controverts the theory of a unilateral inflammation. It commences with the left side after a period of bleeding, but the right kidney soon enlarges and becomes hæmorrhagic, while the left appears to recover or a sort of alternating state is established with every variety of modification.

CASE 4.—Here is another case that recently came under notice. A male, æt. 33, always healthy till 14 months before reception into hospital. Early in the hæmorrhagic attack he was examined carefully, and the blood found to be coming from the left kidney. After a course of treatment he went to Carlsbad to undertake the "Kur" where he improved. About ten months after he returned to hospital with hæmorrhagic urine. He looked well, of a strong build, no excessive panniculus adiposus, although the mucous membrane was pale; but otherwise no outward signs of any internal disease. Neither of the kidneys could be palpated, nor were they tender on pressure.

The urine was flesh-coloured, daily quantity 1,500 cubic centimetres, sp. gr., 1014, reaction acid, centrifuged, traces of albumin, many red corpuscles as well as white ones, epithelium from the bladder, but no casts or tuberculous bacilli, though often examined.

The cystoscope revealed no morbid changes in canal, prostate, or bladder. Hæmorrhagic, urine was slowly running out of the left ureter, flesh-coloured and $\Delta = -0.68$, by segregation polyuric albumin in sediment, and red blood corpuscles. He was again advised to go to Carlsbad, where he improved, but the cure was only temporary, as the hæmorrhage recurred shortly after his return home.

In all these cases we have no evidence of inflammations to adduce as the cause of the hæmorrhage; neither albumin nor casts. Yet we assume in the absence of tubercle that some inflammatory process is present as the exciting cause. The hypothesis is borne out in

some of the cases where albumin and casts have both appeared before the exitus. The intervals or pauses that occur stand in the way of a dogma in this direction, although this difficulty is relieved by assuming that there is a variation in the condition of the nephritic tissue itself. Israel assumes that congestion is the governing cause of the hæmorrhage, or possibly a diffuse nephritis without albumin or casts in the secretion due to the altered condition of the tissue. We may therefore conclude that essential hæmaturia, in the absence of all pathological demonstration, is a symptomatic form of nephritis occurring in one or other of the kidneys alternately, although it may sometimes be bilateral without albumin or casts. If essential hæmaturia be inflammatory as suggested, should operative means cure it? Zucker-Kandl has put a few cases on record disproving this theory. For example, a young man, æt. 17, consulted him for hæmaturia. He had enjoyed good health, had had scarlet fever when ten years of age, and had nothing to account for the hæmaturia. He was confined to bed for two months and was prescribed suitable medicines, but still the hæmaturia persisted. Cystoscope and separation by segregation proved the blood to be coming from the left kidney, although there was a slight trace of albumin coming from the right ureter.

He resolved to decapsule the left kidney, and, strange to say, two days after the operation the urine was quite clear! the bleeding ceased and has not returned again, but albumin has taken its place and constantly appears in the urine. Here the operation cured the bleeding, but has aggravated the albumin. Is the albumin interchangeable? We cannot say the operation has cured the patient, but it has changed the secretion. It is therefore doubtful if the nephritis still exists or is merely modified.

There is another important point in this case that should not be passed over without notice.

While Zucker-Kandl was decapsulating the kidney he excised a portion of the cortex for microscopical examination. Störk, who examined the section, found glomerulitis, proliferous and nephritic hæmorrhagic. This only confirms the assumption that the morbid phenomena are the result of inflammation, but how this inflammatory change is brought about no reasonable cause is forthcoming, as its progress is strange and unusual.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The lecture in next week's number will be by Charles B. Maunsell, M.B., B.Ch., F.R.C.S., entitled "Indications for Operation in Appendicitis."

ORIGINAL PAPERS.

RESPONSIBILITY OF CRIMINAL INEBRIATES: MEDICO-LEGAL PROBLEMS OF INEBRIETY.

By T. D. CROTHERS, M.D.,
Editor, *Journal of Inebriety*, &c., &c.

THE startling revelations in the scientific world are repeated in some degree in the sudden opening up of a new territory of medico-legal science, the jurisprudence of Inebriety. Within five years the question of the mental soundness of the inebriate and his capacity to act or reason normally has been raised with increasing frequency in a great variety of criminal and civil cases.

To-day there are hundreds of persons awaiting trial or sentence for crime committed when poisoned by alcohol. There are hundreds of business contracts disputed and contested by law made when the parties were intoxicated. There are hundreds of wills whose validity is questioned for the same reason. There are hundreds of divorce suits where the inebriety of

the parties is the vital question on which the issue of the case turns. Grave questions of social science concerning pauperism, idiocy, and criminality turn on an exact knowledge of inebriety.

Although these topics have so recently come into medico-legal notice, and are so complicated with theories and superstitions, yet they are already divided into three distinct theories or points of view.

1st.—The *ethical* and *moral* view, which seeks an explanation of inebriety from the teaching of Scripture and the opinions of theologians and metaphysicians. This view asserts that inebriety is only a phase of moral depravity innate in every life, and one that is susceptible of great growth and development by wilful neglect and gratification of all the animal instincts. Medico-legally, the remedy is severe punishment, increased responsibility, prayer, conversion, and the application of moral suasion. A man holding these views on the witness-stand believes the inebriate, in all cases, fully conscious and doubly responsible for all his acts.

The *second* is the *legal* view, which is practically an outcome or result of the moral theory. It assumes that inebriety is a phase of savagery or the inborn tendency to lawlessness, and giving up of all control and restraint; or the indulgence of the lower passions regardless of society, law, and order. The legal remedy is severe punishment, increased penalties, and suffering. The theory is to develop the higher nature of man by causing pain and suffering in the lower nature. In this way to rouse up the brain and will power to regain control of the animal part. Three hundred years ago Lord Coke held that inebriety always aggravated the offence, and the punishment should rather be increased. This has been the cornerstone of the legal view of inebriety up to very recent times.

The *third theory* is the *scientific and medical* view. This affirms inebriety to be a physical condition, the tendency of which is often inherited and also acquired. That this physical condition is always a disease, a modified or pronounced form of insanity. In other cases it is a positive symptom of insanity, and also that insanity is often a symptom of inebriety. It is a form of brain degeneration that, like other diseases, has distinct causes, development, progress, and decline. It is also urged that the continuous use of alcohol always causes disturbances of brain circulation, and is followed by brain congestion, brain paralysis, and impaired senses. The result of which is incapacity to realise the nature and character of acts, the judgment is defective, and the control is lessened and is not normal. Medico-legally this theory regards the inebriate as diseased and incapacitated to act sanely, to be treated as a sick man and placed under medical and legal care and control until recovery, or for life.

The two first theories assume perfect sanity in all cases of inebriety, and assert that the remedy is to be more severe punishment and accountability to law and society.

The third theory recognises a physical condition, and demands a scientific study of each case before the remedy or treatment can be determined.

Another theory has been asserted, that in some cases inebriety was a vice at first, then later a disease. That in some cases punishment is the remedy, and in others medical care and treatment.

Practically and medico-legally this view assumes a degree of psychological knowledge and power of discernment as to where vice and disease join that is absurd and impossible from any present knowledge. Such a theory defended on the witness-stand is a sad reflection on the intelligence of the witness. Such are some of the theories and standpoints from which the subject of inebriety is approached medico-legally. The urgency and pressing character of these cases bring these different views into greater prominence daily.

While the confusion and doubt of the exact nature of inebriety is evident to every new advance of thought, it is obvious that it is due in a large part to the failure

of physicians to study these cases independently. The dictum of judges, the teachings of theologians, newspaper views, and public opinions are too often the sources from which medical men derive their views. This was very apparent in a contested will case at Trenton, New Jersey, where five medical men testified to the mental capacity of a chronic inebriate who willed his property to a mistress. The judge declared he should act on his own judgment and decide the man unsound and incapable. In a recent case at Scranton, Pa., a man set fire to a church without apparent motive. Three physicians swore to his sanity, although he had delirium tremens repeatedly and was a chronic inebriate. The jury decided otherwise.

The general problems which are presented in these medico-legal cases are, first: Was the person an inebriate, or one who drank spirits to excess at all times or at intervals? If this fact is established beyond question, his sanity and mental capacity may be most reasonably and naturally doubted.

Second.—What was the mental condition and the circumstances of the person at the time of the commission of the act in question? Was he sane? Was the act reasonable and just in its effects and consequences? If not, the first suspicion is strengthened and the insanity of the person must be assumed, and the legal theory must be reversed; the sanity must be proven, not the insanity.

Third.—The medical man has only to gather the facts, and have the reasonable assurance of their accuracy. The limits of scientific study will not sustain any theories of the exact degree of health and disease, and will not support assumptions of boundary lines of responsibility and irresponsibility.

Recently a notable case has illustrated this mediæval spirit of public opinion which insists on judging every inebriate as fully sane and competent to determine the nature of his thoughts and acts. The following is an outline of the case. :—

John H. Swift shot his wife, July 7th, 1887, at Hartford, Conn. In December of the same year he was tried and sentenced to be hung. A year later, April 5th, 1889, the judiciary committee made an exhaustive examination of all evidence and new testimony offered, and reported in favour of commutation. Both houses of the legislature voted to sustain the report, and commute the sentence to life imprisonment. An adverse wave of public sentiment caused the Governor to veto the action of the legislature, which so influenced the members of one body that they failed to sustain their former vote. Hence Swift was hung April 18th, 1889. Swift was a chronic inebriate and had been drinking to great excess for weeks before the murder. The defence claimed that Swift was incapable of deliberation and premeditation at the time of the crime, from the effects of continuous intoxication. No medical testimony was called. The prosecution claimed premeditation, malice, and full comprehension of what he was doing. The judge reiterated the legal fiction that an unsound or insane mind is always one that cannot determine between right and wrong. Popular opinion voiced by the press insisted on sharp accountability, irrespective of every fact and circumstance, and clamoured for Swift's death in the same unreasonable spirit that urged the execution of witches less than two centuries ago.

A review of the facts in this case will show the judicial blunder and injustice in the execution of Swift.

The hereditary history showed that Swift's grandfather was an inebriate, his father was mentally defective, and his mother suffered from nervous shock for months before he was born.

John H., the prisoner, was a weakly child, and when one year of age fell out of a chair, striking his head, and became unconscious. He was under a doctor's care for brain fever for some time, then recovered. When about three years of age he began to suffer from nasal hæmorrhages, which came on at irregular periods. At six years of age he had an attack

of scarlatina, and these hæmorrhages greatly increased from this period. At times they were so severe as to require the aid of a physician, the attacks lasting from an hour or more to half a day. When eight years of age they grew less frequent and of shorter duration, and finally disappeared. After puberty, they returned and came on at intervals until death. While in gaol two severe attacks occurred. Somewhere about five years of age he suffered from severe night sweats, which continued up to puberty; frequently they followed the nasal hæmorrhages, and generally they appeared after any excitement or special exhaustion. At puberty they disappeared, and severe headaches came on. He complained of the latter all his life, but the excessive use of spirits for the last two years seems to have covered up this symptom. These headaches often preceded the nasal hæmorrhages, and in many instances followed them.

For a period of three years, ending in the murder of his wife, Swift led a life of great irregularity; working from time to time and being discharged for intoxication and incompetence; then spending his time at low saloons, playing the piano for spirits. He grew more and more incompetent and was unable to keep any place long. For four months before the murder he drank to great excess, and was discharged as crazy and on the borders of delirium tremens. He spent several nights in the woods drinking with boon companions. During the year before the murder, the drink paroxysms were followed by three distinct suicidal attempts; one a few days before the murder, in which he swallowed laudanum. After these drink paroxysms he suffered from acute headache, for the relief of which medical aid was called. When stupid from intoxication he would strike his head violently against the floor and show signs of brain pain and distress. Sometimes he came home at night, but always intoxicated. Then he would not be seen for weeks. During the three weeks immediately preceding the crime he was stupidly intoxicated, going from one concert saloon to another, and occasionally coming home at night and going away early in the morning. On the night before and day of the murder he was wildly excited from drink, and seemed suicidal and on the borders of delirium tremens. The evening of the murder he watched for his wife to pass a certain point in the street where he could see her. From her ante-mortem statement Swift met her and inquired if she would forgive and live with him, to this she replied, "No." He then said, "You must die," and shot her fatally. He then ran up an alley and tried to shoot himself, without success, the lock of the revolver failing to work. He was arrested, and later denied all recollection of the event. He reiterated this statement up to death, and claimed he could not realise why he had killed the woman of all others he loved so dearly. Exactly what he did or said before the crime is disputed. The prosecution claimed that Swift bought a pistol and affirmed that he was going to kill his wife if she did not live with him. The defence showed that he was wild and suicidal, also intensely excited for days before, and acted and talked like an insane man. When arrested he was suffering from well-marked syphilitic eruptions, and for a long time his mind was like one recovering from alcoholic excess. From this time to the execution he was cool and indifferent, expressed no fear of death and showed no special interest in the efforts made to save him. In gaol and at the gallows he manifested a strange unconsciousness of his situation and surroundings, and although his health greatly improved he remained stolidly indifferent to the last.

A summary of the facts would indicate the following:—

1.—Swift inherited a degree of mental degeneration and tendency to neurotic disease that would naturally develop from the slightest exciting causes. An alcoholic diathesis was present, and nerve and brain enfeeblement that would find in alcohol a most seductive relief. His ancestral history showed the impos-

sibility of Swift's having a sound mind in a sound body.

I conclude with a summary of the facts which seem supported by the strongest evidence presented up to this time.

1.—In all cases of inebriate criminals there is literally mental defect and more or less incapacity to reason sanely or control their acts. An inebriate who does criminal acts cannot be of sound mind. No criminal who is an inebriate is sane, and no inebriate is fully sane, and no criminal can be of sound mind long.

2.—The question for the medical witness to decide is, How far was the prisoner conscious of the nature of his acts; and how far did he have control over his acts in a certain condition when crime was committed?

3.—In a case where crime was committed under the influence of alcohol, the law asks what was the prisoner's mental condition at this time and insists on fixing the boundaries of responsibility and accountability. The law demands that science should go into this penumbra region of sanity and insanity and point out where vice and disease join, and where human justice should punish and where it should excuse as irresponsible.

4.—The scientific man demands that this question of mental condition at the time of the crime should be studied independent of all theories or legal rulings, seeking the facts and their meaning with no hesitation as to effects of such conclusions on the court or public. The scientific man refuses to draw boundary lines of disease and accountability, but insists on minute study and general conclusions based on the probable facts.

5.—Finally, in all these cases the medical witness is called to determine the physiological, pathological, and psychological facts and their meaning. The application of these facts must be made by the court, jury and law.

The medical expert and student of to-day must go beyond the theories of yesterday for the acts on which yesterday's views were based. A newer, larger field opens up to-day, and the facts are more numerous and indicate a clearer, wider view to-morrow.

DIETARY IN DIABETES AND GOUT.

By S. A. ARANY, M.D.,
of Carlsbad.

THE literature of diabetes and gout has, in the last two decades, been enriched by many a valuable treatise dealing with the etiology and symptoms of these two morbi-assimilations. Although symptoms, complications, and the course of both diseases are only too well known to the [profession, and many invaluable investigations and studies have been made to find a cure for these ailments, therapy has not, or at least very little, advanced in the last twenty years. These investigations resulted in the invention of many invaluable medical agents (antipyryn, aspirin, heroin, glycogen), which, however important they may be in other maladies, only mitigate the course of diabetes and gout, so that the only recourse left to the practitioner is to treat these ailments by means of dietary. It is, therefore, of utmost importance to the general practitioner to know what diet will best suit each individual case, and I beg to be permitted briefly to discuss the usual regimen adopted by myself in both kinds of ailments. True, it is a subject on which much has been written and to different effect, so that my way lies of necessity to a great extent over a well-beaten track; yet a man in my line of practice has ample opportunity to observe to what extent these well-known dietary principles are ignored, and the serious consequences the ignorance of them sometimes produces.

The Diet of Diabetic Patients.—I have in this paper no intention to discuss the etiology of diabetes, and I may be permitted to state that I do not make a distinction between chronic glycosuria and real diabetes,

considering them to be different stages of one and the same disease. What is generally called glycosuria is, in my opinion, the early stage of the disease which may and may not develop into the secondary stage, or what is usually called grave or real diabetes. The fact that some cases which come under the practitioner's observation are of a distinctly mild nature, whereas other cases of greater severity show almost different symptoms to the former is no proof to the contrary, as there is just as little, or even less, similarity between the different stages of syphilis, and I do not think anyone will deny that they are stages of one and the same disease. The fact that certain cases coming under observation have a very short course and soon prove fatal cannot be regarded as a proof against this view, it only proves that the primary stage of the disease has been unobserved and thus not attended to, which circumstance has accelerated the development of the disease into the secondary stage. I considered it necessary to make these introductory remarks, as the diet I am advocating varies according to the stage of the disease.

When prescribing a diet to a diabetic patient we must take two facts into consideration, viz., that the diet must be neither too greeneous nor too severe, as the former may prove just as detrimental as the latter. This aim can only be attained if the diet is controlled by frequent urinary analyses and by comparing the patient's bodily weight. The principle of the diet is to prevent the patient from eliminating sugar, and therefore, at the beginning of the treatment, it will be necessary to put the patient on a diet which is entirely free from carbohydrates. In cases belonging to the primary stage such regimen is usually followed by a most striking result: as the tormenting symptoms become alleviated in the first or second day of the treatment the amount of glucose rapidly diminishes, and in the course of two or three weeks the urine becomes free from sugar. This is usually followed by increase of the bodily weight, and patients do extremely well for a certain time to come. However, after a more or less protracted period has elapsed the patient again calls on us complaining of loss of flesh and strength, and general nervousness. On analysing the urine we find it to be free from sugar, which speaks in favour of the fact that the foregoing symptoms are not due to elimination of sugar but to the too great severity of diet. For the diet which has freed the patient from sugar has been also instrumental in restoring his assimilative power of carbohydrates to a certain extent, and in possession of this regained power the patient's system requires a certain amount of carbohydrates. In such cases it will, therefore, be advisable to enrich the patient's diet in this direction. This, however, must be done by gradually increasing the amount of carbohydrates so long as the limit of the patient's assimilative power is reached. Up to this point he will increase in weight and strength, and the urine will be free from sugar; if, however, the limit of the assimilative powers is being exceeded, diabetic symptoms set in.

In cases belonging to the secondary stage the diet is not always followed by so favourable result as in the former cases, as at this stage of the disease sugar is also drawn from the bodily tissue. It will therefore be our duty to keep the patient on a perfectly restricted diet as long as the urine does not contain acetone and diacetic acid. However, as soon as these products appear in the urine a further withdrawal of carbohydrates may easily give rise to diabetic coma, and it becomes eminently advisable to make some dietary allowances in the shape of a small amount of carbohydrates. This should be continued until the urine becomes free from acetone and diacetic acid. When this stage is reached reduce the carbohydrates, and I have found that some patients can better stand 1 or 2 per cent. sugar than traces of diacetic acid.

Having dealt with the diabetic diet in general, I shall now proceed to discuss the principal food stuffs in general. At the beginning of treatment we must

exclude carbohydrates from the patient's diet. To do this entirely is, of course, beyond possibility, as even animal food contains a certain amount; this is, however, of trifling percentage in comparison with vegetables. The patient's diet therefore must chiefly consist of animal food, viz., meat, fish, eggs, milk, butter and cheese.

(a) Meat of any kind with the exception of liver may be indulged in. Preference may be given to fat kinds of meat, *i.e.*, beef, pork, lamb, goose, whereas veal, fowl, and venison are supposed to be less nutritious in diabetic cases.

(b) Fish of any kind, fresh or tinned, may form part of the diet; moreover salmon and eel as well as sardines are generally looked upon as very valuable food stuffs for diabetics.

(c) Eggs play a prominent part in the diabetic diet, first on account of their great nutritive value, and secondly, there are so many ways of preparing eggs that patients do not get so easily tired of this kind of food. Eggs mix most readily with different fat stuffs—as butter, bacon and oil, which in their turn seem to be very well assimilated by most patients and are supposed to be a nutritious food in diabetes.

(d) Milk in smaller quantities as an addition to the tea and coffee may be indulged in even in the severest cases, whereas greater quantities of milk may only in the primary stage of the disease be prescribed. In cases belonging to the secondary stage sour milk, butter milk, as well as milks which have been freed from sugar, may be well recommended.

(e) Butter and fat stuffs in general are as a rule well tolerated, even in excessive amounts, and are apt to increase the patient's bodily weight. The same applies to cheese, and especially to the fat kinds, as cream cheese, Gorgonzola, Rochfort.

A purely animal diet, however advantageous it may be otherwise, is apt to give rise to digestive troubles of various kinds, and it is therefore advisable to add some vegetables to the former. In spite of the advice of the practitioners in olden days that greens in general may be prescribed to diabetics, modern investigations have shown that even green vegetables contain varying amounts of carbohydrates. It will therefore be advisable to prescribe in mild cases greens in general, whereas in cases of greater severity only greens containing the least amount of carbohydrates are to be recommended. Such are: Spinach, cucumber, sorrel, cauliflower, asparagus, salad, cabbage, tomatoes, and mushrooms. Peas, beans, celery and radish, should not be recommended in the secondary stage, whereas fresh or stewed raspberries, morello-cherries, currants, sour apples, and sour oranges may be indulged in.

The article the patient lacks most is bread, which, in a successful diet must, unfortunately, be withdrawn. Latterly many substitutes for bread have been manufactured by British and Continental firms, the reliability of which, however, is more than doubtful, as most of these preparations, in spite of the re-assuring advertisements of their manufacturers, and also in spite of some medical testimonials, contain a varying amount of starch. In my search for a thoroughly reliable substitute for bread I have been kindly assisted by Dr. Pavy, who called my attention to Messrs. Callard and Co.'s preparations, among which their gluten biscuits may be recommended in the severest cases, as they are perfectly free from starch and are not unpleasant to the palate either. These biscuits, which may be taken with or without butter, I usually prescribe to the patient as long as his urine contains sugar. When free from sugar for some time I replace the biscuits by small quantities of toast, which I increase as long as the urine continues to be free, but as soon as the limit has been reached no further increase must take place. A trial of similar kind may be ventured with other kinds of carbohydrates, *i.e.*, potatoes or rice, rather favourites with diabetics (stolen waters are sweet), but it is very important to start with very small quantities

and stop increasing them as soon as glucose re-appears.

As far as drinks are concerned mineral waters rank highest, and among them the aerated alkaline waters seemed to be liked most by patients, as the carbonic acid contained therein alleviates the excessive thirst and drying of the mouth. These waters may be well taken with lemon juice and sweetened with Saxein, which preparation is by far the most harmless and most palatable substitute for sugar. Among alcoholic drinks wine seems to have a beneficial and stimulating effect in most cases, but special care should be taken to ascertain that the wine be free from sugar. Light Moselle or a mature claret taken with meals and in moderation improve both digestion and strength of the patient. Brandy and whisky are, as a rule, not so well tolerated as wine; in cases of habitual drinkers, however, one is bound to permit a small quantity of these liquors, and my experience has taught me that Martel's or Hennessy's liqueur brandy and one or two whiskies of known reputation are the least detrimental of their kinds. As to the general treatment of diabetes, I would refer your readers to my article of March 29th, 1905, in the MEDICAL PRESS AND CIRCULAR.

The Diet of Gouty Patients.—Ere entering into the discussion of the diet proper, I beg to remark that the diet in question does not refer to typical cases of gout only but is also intended for the various complaints comprised in the collective name of "Uric Acid Diathesis." It is not my intention to discuss the etiology of these complaints, as it is my aim to strictly confine myself to the title of this paper. The comprehension of the dietary principles, however, requires a few explanatory remarks, which I will now briefly give:—The general view held by the majority of the profession is that gouty ailments are due to accumulation of uric acid in the system, the only difference of opinion being, whether there is a faulty elimination or an excessive formation of uric acid in gout? Which ever of the two may be the case, the practitioner's duty will be to prescribe his patient a diet containing as little uric acid as possible. The xanthins are regarded to be the chief producers of uric acid, and therefore it will be necessary to avoid all the food stuffs which contain those substances; such are, first of all, meats of any kind and description containing varying amounts of xanthin bodies, which food stuffs, however, cannot possibly be avoided altogether if we are anxious to maintain the patient's strength. To advise the patient to abstain from meat altogether would be just as great a mistake as not to restrict this article of food at all. Our teeth and digestive organs in general are an unmistakable proof of our being omnivorous creatures, or, in other words, our digestion and assimilation could not possibly manage the additional labour imposed upon them by a purely vegetarian diet, which it goes without saying must be a good deal more voluminous if it is expected to replace the calories of a meat diet. The only thing we can do is to restrict the patient's consumption of meat and to give the preference to those kinds of meat which contain the least amount of xanthins. The meat of the larger animals is as a rule richer in those substances than that of the smaller ones, viz., beef contains more xanthins than veal, mutton more than lamb's meat, and the meat of a hen more than that of a spring chicken. Boiled meat is, according to German authors, less detrimental than roast meat, as the xanthins are supposed to be soluble in hot water, which thus deprives the meat of its noxious ingredients. My own experience has taught me that it is quite sufficient to advise the patient to abstain from butcher's meat and to take fowl and fish in moderation. Besides these, eggs, milk, butter, cheese, vegetables and fruits may be indulged in, whereas broths, sweets and pastry are to be avoided. Weak coffee and tea sweetened with Saxein may be allowed in moderation and the free use of mineral waters ought to be strongly recommended. Alcoholic drinks are best avoided. In cases in which total abstinence cannot be insisted upon, a

very light Moselle or Voelau Rauhenek may be allowed in very small quantities. Under no circumstances should whisky, brandy, port or liqueurs be allowed.

The usual *regimé* I prescribe in gouty cases runs as follows:—

Breakfast.—Porridge, 2 eggs, biscuits or toast and butter, weak tea, coffee or milk.

Luncheon.—Fish, green vegetables, pudding. Bilin or Neudorfer water ($\frac{1}{4}$ bottle of light Moselle or Rauhenek).

Five o'clock.—Milk and toast.

Dinner.—Vegetable soup, fish, fowl, once or twice a week, veal or mutton, greens, stewed fruits without sugar, or sweetened with Saxein, puddings, cheese, fruit, the above-named mineral waters (same quantity of wine).

On this diet the majority of patients do fairly well, although I must admit that a good few of my patients who were total abstainers from meat on their own account were also subject to slight attacks of gout at certain intervals.

From what source the uric acid producing these attacks came, I am at loss to account. This, however, does not prevent me believing that a restricted meat diet is instrumental in producing a great deal of good in gout.

During an acute attack of gout I put the patient upon a purely milk diet, and usually obtain very satisfactory results.

CLINICAL RECORDS.

A CASE OF

RECKLINGHAUSEN'S DISEASE.*

By P. H. PARSONS, L.R.C.S., L.R.C.P.ED.

THE case is one of Recklinghausen's disease—a congenital and multiple fibro-neuromata. J. H., a male, æt. 39, working as a licensed messenger; he is small, thin, poorly developed, with scanty coarse hair. You notice that his voice is rough and hoarse, and that his hearing is defective; that his sight is also failing; he also suffers from what he terms "piles," but what is probably another manifestation of the disease with which he is afflicted. This disease began before birth, that his mother apparently suffered from it and died at the age of 59 from "chest trouble," probably similar to his own; also that his brother, æt. 38, has the same kind of skin affection. He can give no further family history. When he is stripped it will be seen that he is covered with outgrowths of various sizes, some right on the skin surface, some only to be felt under the surface; some large, some small, some painful—exceedingly so—others quite painless to touch, over some of these the skin is red and tender, some are freely movable, others not. There are also patches of colour on the skin, some light, others, chiefly the smaller ones, dark, a large patch may be noticed in the right hypochondriac region. These tumours are fibro-neuromata, and are benign, except for their mechanical action in causing paralyses, &c. There is no treatment of any avail except where possible to remove a growth causing discomfort.

The illustration on page 69 shows very well the site and the varying shapes and sizes of these multiple tumours. There are many more to be seen on the front aspect of the body.

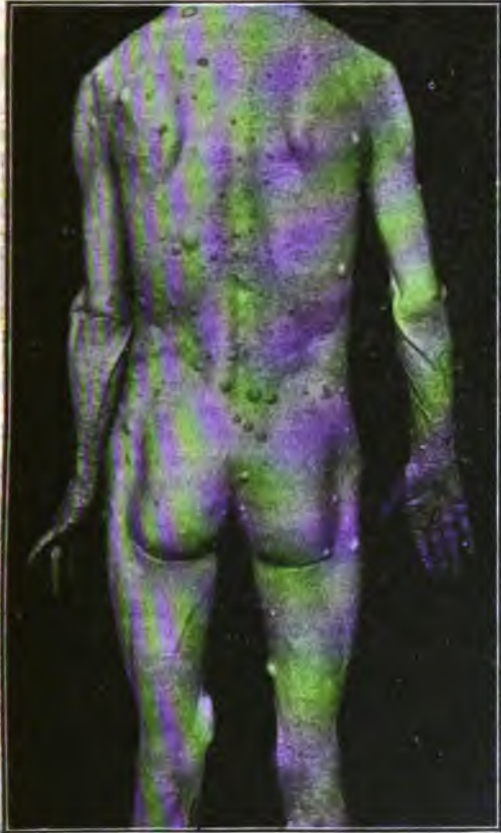
Some Notes on v. Recklinghausen's Disease.

In 1882, v. Recklinghausen described and drew attention to a condition of generalised neuro-fibromatosis or multiple fibroma, which has since been called after him. The disease is congenital, or, at any rate, shows a hereditary predisposition, it having even been found in the fœtus. As the name implies, it consists of a variable and indefinite number of fibromata arising

(* Clinical case shown at the Association of Diplomates of Scotland Meeting, 11, Chandos Street, London, W., December 12th, 1905.

in the sheathes of the nerves in any part of their course, either deep or superficial. Clifford Allbutt mentions a case where he found the visceral nerves affected. The tumours which arise on the nerve trunks may give rise to paralyses, pains, cramps, contractures, or weakness of muscles with all their varied symptoms. The tumours sometimes grow very quickly, and so may vary greatly in size. Amongst them we usually find some of the nature of plexiform neuromata. Coincident with the tumours may be found pigmentation, most frequently as spots chiefly on the trunk and upper parts of the limbs not on the face, hands, or feet, and as patches of a brownish white colour and of very variable size. The spots are not permanent, while the patches usually are. V. Recklinghausen, in his description outlined the following four essential points:

1. Soft fibrous nodules, some sessile, some pedunculated, varying greatly in size and number, scattered over the surface of the body. They may be diffuse and reach enormous size, producing a condition called "elephantiasis neuromatosa."



2. Tumours resembling those of plexiform neuromata may be present on any part of the nerve trunks from their central origin to the periphery. Their variable situation may lead to a variety of symptoms, more especially as they may arise from the nerve roots within the spinal cord or cranium. Superficial painful nodules may be present.

3. Patches of brownish pigmentation of the skin either as small spots or large areas are always present; congenital naevi are frequently present also.

4. There are many variable sensory and motor phenomena resulting from the presence of the nerve tumours, but peculiar mental changes, with loss of intellectual power and sometimes difficulty in speaking are especially characteristic of the disease. The prognosis depends on the possibility of successful removal.

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THE OUT-PATIENTS' ROOM.

WESTMINSTER HOSPITAL.

Case of Hysterical Ptosis.

DR. PURVES STEWART demonstrated a case of a young woman, a domestic servant, æt. 25, who had been sent to the hospital with the following history: Two years ago she had anæmia, her eyes then became inflamed, and for several weeks she could not open either of them. The right eye recovered, but she had been unable to open the left eye since. In addition she had occasional paroxysms of difficulty in swallowing. She screamed in her sleep, and had occasional so-called fainting attacks. On examination, the girl had a somewhat preoccupied expression. On elevation of the left eyelid passively, it was found that both visual fields were contracted, more so on the left side, and that the pupils and external ocular movements were normal. The optic discs were healthy. The question arises, Dr. Stewart said, as to the genuineness of the apparent ptosis. On careful examination, it was observed that the orbicularis was habitually contracted on that side, and more particularly that there was no compensatory over action of the frontalis muscle, such as is always present in organic ptosis. In further support of the functional nature of the case, it was found that smell and taste were completely lost, and also that hearing was markedly impaired on the left side. This combination of loss of the special senses—smell, vision, taste, and hearing—Dr. Stewart pointed out, was pathognomonic of hysteria. In addition, the girl showed a characteristic area of cutaneous anæsthesia, implicating the left side of the face, head and neck, trunk, and shoulder, sharply marked off by diagrammatic lines from the remaining normal area. The motor and reflex functions were normal. The chief interest of the case, Dr. Stewart pointed out, lay in the diagnosis between functional and organic disease. It was proposed to treat the woman by a course of isolation, massage, and electricity, according to Weir Mitchell's well-known regime. The prognosis as to ultimate recovery, Dr. Stewart thought, was good, but it was impossible to foretell the exact time necessary for such recovery. An important point to bear in mind, he considered, was that hysteria, contrary to popular opinion among laymen, is not synonymous with shamming; it is a disease as real as cancer or small-pox.

Another Case of Hysteria.

A girl, æt. 17, complained of trembling of the legs and arms of six weeks' duration, and of inability to walk in the normal fashion. On examination, she was a healthy-looking girl, who, when unaware of being observed, showed no obvious abnormality; on the approach of the physician, however, an irregular jerking movement at once started affecting the right arm and both the legs. At the commencement, it consisted of a series of short jerks at the wrist, elbow, knee, and hip, culminating in a violent antero-posterior jerk of the pelvis. These jerkings were paroxysmal with intermissions of complete freedom. On most careful physical examination no abnormality was detected in any of the functions of the body. The application of a Paquelin's cautery to the spine produced immediate cessation of the spasms of the limbs, but the pelvic jerking still persisted when the girl walked, but this, too, was ultimately overcome by holding the point of the cautery half-an-inch from the patient's umbilicus; the inhibitory effect of this prospective new stimulus succeeded in checking the pelvic jerks, inasmuch as had the latter persisted the patient would, as it were, have impaled herself on the cautery. Further treatment, Dr. Stewart said, would consist in segregation

from her old surroundings, preferably by admission to the hospital, in repetition of the local treatment by means of the cautery, and in general mental supervision of the girl. The prognosis, he thought, was excellent, more especially as there was absence of other hysterical stigmata such as the previous case showed.

OPERATING THEATRES.

NORTH-WEST LONDON HOSPITAL.

FRACTURE OF THE FEMUR WITH MUCH DISPLACEMENT.—Mr. MAYO COLLIER operated on a woman, *æt.* 56, who had been admitted with a fracture of the left femur. The patient had been mounted on a chair engaged in hanging clothes out to dry in a back garden, when, losing her balance, she fell and was found to be unable to rise. She was brought to the hospital and the house-surgeon made a diagnosis of fracture of the left femur. A long outside extension splint was applied. On Mr. Collier's visit to the hospital the case was thoroughly examined and found to be somewhat unusual. A fracture apparently existed below the small trochanter, obliquely upwards and outwards; the upper end of the lower fragment was drawn upwards and backwards below the tuberosity of the ischium, whereas the lower end of the upper fragment was tilted upwards and forwards, and pointed immediately beneath the skin in Scarpa's triangle, threatening to protrude at any moment. Mr. Collier said this was a very unusual condition of things, and demanded immediate operation so as to adjust the fragments with wire. The space between the two fragments was between three or four inches, and no hope of union could be entertained unless the parts were properly adjusted. A large incision was made, commencing immediately below the anterior superior spine, downwards for about eight inches. The tensor *vaginæ femoris* and the *vastus externus* were incised, and the site of the fracture reached. By means of considerable extension and counter-extension the fractured surfaces were adjusted. The bones were drilled so as to carry a thick silver wire, and after this had been securely fixed so as to maintain the bones in firm apposition, the wound was closed, dressed, and the patient returned to bed after the application of a long outside splint with extension. Mr. Collier said that this was a case of extreme gravity, and quite unusual in his experience of fractured thigh. The separation of the parts was much greater than was found in the great majority of cases, and demanded immediate surgical interference; but at the same time, there was some doubt as to recovery. An extensive wound such as had been necessitated, together with a fracture of the thigh in a patient, *æt.* 56, naturally was associated with grave anxiety as to the result.

Happily, in this case the patient bore the operation extremely well, and convalesced uninterruptedly. She is now, within six weeks of the operation, walking about the wards with the aid of a crutch. The limb is little short of its fellow, and promises to be as useful as ever.

PARA-SACRAL EXCISION OF THE RECTUM.—Mr. TEMPLETON operated on a man, *æt.* 66, who had been sent to him by Dr. John Brunton. The history was the following: For several months the patient had complained of pain and feeling of weight in the rectum, especially after the prolonged standing which was necessitated by his occupation—that of a tram driver. Occasional hæmorrhage took place and frequent attacks of diarrhœa, alternating with constipation. The man himself was rather broken down in health,

partly on account of his habits and partly on account of the malady. The circulation was, however, in a satisfactory condition. On examination of the rectum an extensive growth was readily made out extending from an inch and a half above the anus to a strictured point through which the finger could not be passed, this being about three inches from the lower end of the growth. There was considerable ulceration. The sigmoid flexure was pretty well loaded with fæces. No nodules were detected in the liver, though the organ was somewhat enlarged. There was no albumin in the urine. During the week preceding the operation means were taken to completely empty the sigmoid, and for the last two days 10 grains of salol had been administered morning and evening, the diet being restricted so as to produce as little residue as possible. The lower part of the rectum was thoroughly washed out immediately before operation. The patient having been anæsthetised with chloride of ethyl (the anæsthetic being continued during the operation with ether and afterwards with chloroform) was placed on the right side with the buttocks turned over and resting on a pillow. The usual antiseptic preparation of the skin having been performed, an incision was carried from the left posterior inferior spine downwards and inwards, till it reached the middle line an inch and a half behind the anus, this incision was deepened and a few small vessels caught up; the coccyx was then defined and removed. Next the various muscular structures attached to the coccyx and sacrum were freely divided till the space in the hollow of the sacrum was entered. Several enlarged glands were felt here. The rectum was now carefully defined, beginning from above downwards, and the growth was found to extend some four inches in vertical measurement, the posterior wall of the gut being more involved than the anterior. The peritoneal cavity was opened in separating the upper portion of the rectum, and, in order to facilitate the separation from the prostate, the finger of an assistant was retained in the rectum; in this way the rectum from its first portion to the anus was isolated. The upper part of the gut was now drawn down, and brought right outside the wound, and being then completely encircled with a double ligature in two places, was cut across. The remaining portion of the rectum was now completely pulled out of the wound, detached right down to the external sphincter, where it was divided. The hollow of the sacrum was next cleared of all glands. The rent in the peritoneum was closed with fine silk sutures. The ligatured proximal end was next brought out and fixed with fine silk in the upper angle of the wound; the skin being brought together below it. A large drain tube was left at the lower angle of the wound and another passed through the anal aperture. The ligature on the portion of bowel which had been stitched to the upper part of the wound was next removed and a large rubber tube passed well into the gut, so as to permit of the escape of flatus and bowel contents. Iodoform was dusted on pretty freely, and the usual aseptic dressings applied and fixed with strapping. The operation occupied a period of one hour. The patient lost very little blood and his pulse was in a very good condition at the end of the procedure.

Mr. Templeton said that the operation he had performed was justifiable when the general condition of the patient and the extent of the growth rendered it possible. Colotomy, he remarked, was a more or less unsatisfactory proceeding, as the growth is not removed and a very unpleasant condition of the patient is established by the presence of the artificial anus;

this, he thought, applied with great aptness to this particular case as the symptoms were not a source of great annoyance to the patient, and he would have suffered more from a colotomy than from an untouched malignant rectum, though, of course, the latter would have ultimately destroyed his life. Mr. Templeton laid stress on the importance of free removal of the glands and adipose tissues in the hollow of the sacrum. Great attention, he said, was also given to avoid any soiling of the wound by any bowel contents. It would also be noticed that care was taken in closing the rent in the peritoneum, this opening having been an essential accompaniment of the free necessary removal of the bowel. It should be noticed, he said, that before fixing the bowel he had given the gut part of a turn so as to obviate as far as possible subsequent incontinence (Gersuny's principle). He pointed out that sometimes in this operation it was possible to bring the bowel down to the anus, but this was not practicable in the present case, owing to the amount of the gut that had to be removed, and further, the growth was so low down that it was impossible to conserve any of the lower end of the bowel. The object in having the large drain tube in the bowel, he remarked, was to avoid as far as possible the immediate contamination of the wound.

The subsequent progress of the case was satisfactory, and four weeks after operation the patient was convalescent. The bowels now cause him very slight inconvenience, as they act spontaneously each morning

SPECIAL ARTICLE.

THE REPORT OF THE INSPECTORS OF LUNATICS IN IRELAND.—II.

(Concluded from our last Issue.)

THE number of patients discharged from the Irish Asylums during the year 1904 numbered 1,940, of whom only 1,402 are classed as recoveries; 35.9 of the male admissions, and 36.8 of the female; the lowest ratio of recoveries, 12.0, occurring in an asylum, which we learn from Appendix E, is in the opinion of the inspectors "disgracefully overcrowded," and the highest recovery rate, 50.7, was in Killarney, where the inspectors report that the recently provided "accommodation should meet the requirements of the district for some time to come." The moral seems perfectly obvious that recoveries cannot be hoped for under unhygienic conditions, and, to put it on the lowest grounds, it would pay much better to treat the patients under circumstances which would give them a chance of recovery rather than keep them to slide into terminal dementia, from which death only opens a gate of escape from the asylum—and from a charge on the rates. The recovery rate for the two quinquennial periods, 1898 to 1902 and 1893 to 1897 was for the former, 36.4, and for the latter, 38.4, and this drop in the recovery-rate is co-incidental with a gradually increasing condition of ochlesis. The recovery-rate in England in 1904 was 36.6 per 100 admissions, of whom over 6 were general paralytics, who never recover; and the average for the ten years ending 1904 was 37.7.

The deaths during the year were 1,449, an increase of 60—50 more males and 10 more females—on the previous year; the rate being 7.5 on the males and 8.2 on the females, calculated on the daily average number resident. Four of these were by suicide, four by misadventure, and two were killed by fellow patients. The highest death-rate occurred in Sligo, and the lowest in Kilkenny. With this mass of pathological material by which so much might be done to elucidate the condition of morbid brains, it is to be regretted that only 286 *Post-mortem* examinations were held; but the medical staff in most asylums is kept so low it is difficult for men to find time for these examinations, and the want of any laboratory, available for all asylums as in Scotland, where histological research could be carried on, robs us in Ireland of the chief incentive in this

matter. The number of deaths from consumption is returned as 418, or over 28 per cent. of the total; 56 persons died of general paralysis, and 30 from dysentery, colitis, or diarrhoea. Since the year 1890, 16,885 have died in Irish asylums; of these 4,671 were due to consumption, 569 to general paralysis, and 846 to epilepsy. In view of this appalling mortality from consumption, it is really time that some efforts were made to cope with the disease in Irish asylums. The inspectors draw attention to the fact that "the question of the treatment of cases of this disease in isolation hospitals has of late occupied much attention. In dealing with the insane in asylums it is not possible to follow the course adopted with ordinary patients in a hospital."

We heartily re-echo this pious opinion, and wish we had some more tangible evidence of its realization than the mildly expressed view of its desirability. With whom does the initiative lie, and how long are we to be sickened with the record of a holocaust of victims of this preventable and curable disease? It may be as well to draw attention to the fact that of the 9,334 deaths recorded by the English Lunacy Commissioners in 1904, only 1,442 are returned as due to "phthisis." Making every allowance for the higher national death-rate from consumption in Ireland, some explanation is called for as to why the death-rate in Irish asylums should be nearly twice that in English ones. The deaths by violence include one from alcoholic poisoning, and one in which a patient in Cork Asylum, one of six in a room only intended for four, was found dead on the floor from head injuries and a chamber vessel smeared with blood beside him. The coroner's jury quaintly recommended that indiarubber utensils only should be used. The inspectors quite seriously combat the suggestion on the obvious grounds, but fail to clinch it with what would probably have been, to the Committee of Management, the absolutely convincing argument of increased expense.

The record of zymotic diseases is bad during the year, the most serious being a severe epidemic of enteric in Cork Asylum, which attacked over 100 people, of whom 18 died. Dysentery is still unfortunately prevalent in the comparatively modern asylum at Downpatrick, and 50 cases occurred, of whom 11 died. In Richmond, 99 cases of phthisis occurred, and 67 deaths. There were 23 cases of pneumonia with 17 deaths.

The total expenditure during the year amounted to £52,128, odd shillings, and the net expenditure on maintenance to £459,542. Of this the Government paid £181,691 as capitation grant, and £5,110 for maintenance of criminal lunatics in district asylums. This is exclusive of the Youghal Auxiliary Asylum, the accounts of which are published "subject to revision hereafter, as an authoritative copy thereof could not be obtained up to the date of this report." The maintenance in this latter would seem to be somewhat lower than in the District asylums, which seem to be effected by a reduction of the wages bill and the cost of provisions and groceries. The attendants in Irish asylums are, as a rule, poorly paid, and the diet is not over generous as a rule. It does not seem to us that the cost under either heading can be reduced with advantage to the patients, and we search in vain in the Appendix for the minute and elaborate criticism of the administration which the inspectors are wont to furnish local Committees of Management with, and the gently insinuating recommendations for improvement. Have the inspectors, as well as the Resident Medical Superintendent of Cork, been refused access to the Youghal Auxiliary Asylum?

The average cost of maintenance, including repayment of loans, calculated on gross expenditure, was £29 17s. 4d. per head, while the cost, less loan repayments, receipts from miscellaneous sources, and receipts from paying patients, was £23 12s. 10d. The average cost of the Dundrum (Criminal) Asylum patients was £45 9s. 9d. per head.

On the whole the most we can say for the management of Irish asylums during the year is that they have been content to mark time—without any definite progress in any direction.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD JANUARY 12TH, 1906.

The President, Mr. CLUTTON, in the Chair.

MR. LAWRIE MCGAVIN read a paper on
TRANSVERSE *versus* INGUINAL COLOTOMY.

Attention was drawn on the one hand, to the danger of assuming too early that the time had arrived for the performance of colotomy, and on the other to that of its performance too late. Much more might be done than was generally supposed in non-ulcerative stenoses of the rectum by the palliative means, even in cases of severe obstruction, which fact was supported by the report of a case recently under the care of the writer. After discussing the disadvantages of the lumbar and iliac operations, Mr. McGavin gave his reasons for advocating the adoption of transverse colotomy as the routine method; the most important of these being: the firmer support for the belt and plug afforded by the subcostal space, the immunity of the transverse colon to prolapse, the greater simplicity of the operation owing to the mobility of this portion of the bowel, the greater ease with which a sphincter can be obtained, the adaptability of the position of the new anus to the easy and comfortable evacuation of the bowel and the greater facility with which the transverse colon can be reconstituted should occasion arise. Out of four cases of colotomy done by the iliac route, some difficulty of control of the motions and considerable prolapse had been complained of in three, in spite of the belt and pad. Notes of three cases done by the transverse method were read. Two of these cases had been done for fæcal fistulae, and one for dysenteric ulceration of the rectum. In all the colotomy had answered admirably, control being good, prolapse absent, and the general comfort much in excess of that usually gained by the iliac method. The writer considered that an improvement in the operation might be effected by dividing the bowel, closing the distal and drawing the proximal stroma through a broad band of fibres derived from the rectus muscle and permanently suturing it there.

The PRESIDENT said that nowadays he never saw prolapse after inguinal colotomy; he did not even find it necessary to employ any apparatus. As regards the utilisation of the rectus that of course was now the rule in iliac operations.

Mr. HARRISON CRIPPS said that he had performed over 600 inguinal colotomies, but only about a dozen transverse ones. He agreed that lumbar colotomy was now obsolete. There were three difficulties to be contended with after a colotomy. First was the question of prolapse. This was a very rare occurrence at the present day, as it could be prevented by not making the wound too low, by ensuring that no slack bowel was left above the wound, and by taking care to make the opening the right size. Secondly, there was the difficulty of retaining the fæcal matter. An important point here was to obtain a due degree of solidity of the intestinal contents, and in this connection was to be remembered the difference between the contents of the transverse colon and of the sigmoid. Thirdly, 20 to 30 per cent. of the cases were troubled by decomposing mucoid secretion in the distal part of the gut. This secretion could be treated in inguinal colotomies by syringing through, but with a transverse colotomy the distance between the opening and the anus made this treatment impracticable. In conclusion he thought that inguinal colotomy was the operation of choice, and that transverse colotomy should only be done when the obstruction is too high to permit the former operation.

Mr. T. OPENSHAW endorsed Mr. Cripps' remarks.

He would only perform transverse colotomy when the obstruction was in the splenic flexure.

Dr. BROOKS, of Lincoln, asked whether in the latter case short circuiting would not be the better treatment?

Mr. MCGAVIN, in reply, pointed out that anastomosis was out of the question in his cases as the sigmoid was no longer patent.

Messrs. H. IRVING PINCHES AND EDRED M. CORNER read a paper on

FURTHER CASES OF TORSION OF THE OMENTUM.

Case I. was a male, æt. 48. He had a right inguinal hernia for thirty-seven years; a truss had been worn for thirty-three years. The hernia came down whenever the truss was removed; it was easily reduced and never caused any pain. Onset of symptoms with slight pain in the inguinal region, the hernia could not be reduced. The pain increased in severity and the tumour became larger. There was no vomiting, the bowels were opened two days after onset. On the third day the temperature was 99, pulse 102. The tumour was extremely tender, soft and doughy to the touch, irreducible, no impulse on coughing. The lower part of the abdomen and the inguinal region were extremely tender, and the skin was reddened over this area. The tissues felt thickened over the tumour, as if there was some inflammatory lesion present. The diagnosis was torsion of the omentum in a hernia sac. Over the inguinal canal the tissues were found at the operation to be in a subacute inflammatory condition; the hernial sac was thickened. In the sac was a small mass of dark friable omentum twisted upon itself three times. The omentum was not nipped at the internal ring. The tumour was removed. Recovery took place.

Case II. was a male, æt. 45. A left inguinal hernia was present which had only been noticed a few days. A small, tender, hard, irreducible rounded lump of omentum was felt just outside the external ring. The diagnosis was left, direct inguinal epiplocele. A direct hernia was found at operation, but owing to the large amount of subperitoneal fat, the sac was difficult to identify; the omentum was adherent to the sac. The contained omentum was about the size of a walnut and had a stalk. There was a hæmorrhagic cyst within it. It was not strangulated. Although a twist of the pedicle was not seen, there was every physical and symptomatic reason to suggest its presence. This is the only example of possible torsion of the omentum in a direct inguinal hernia.

Two more published cases were quoted, which brings the number of known cases of torsion of the omentum to 57. Clinically the omentum may be in the abdomen above, a hernia alone, or more commonly in both. Two-thirds of the cases were in males, usually of middle age. The hernia was usually an inguinal one, there being no instance on record of the condition occurring in a femoral one.

The PRESIDENT discussed the significance of the words strangulation and torsion and also commented on torsion in its occurrence elsewhere in the abdomen.

Mr. FORBES ROSS asked wherein lay the interest of distinguishing clinically the condition from appendicitis, seeing that the diagnosis could in both instances be decided by operation.

Mr. W. C. SPENCER asked how the diagnosis had been arrived at in the case reported. As to the non-occurrence of the condition in femoral hernias there was no *a priori* reason why this should be so, and in fact he had seen very similar conditions in such hernias.

Mr. PINCHES, in reply, distinguished between torsion and strangulation in that the latter involved constriction by the neck of the hernia. The diagnosis in his case was arrived at by finding an inflamed hernia with extensive tenderness of the abdominal wall in a patient previously suffering from a freely moving hernia.

BRITISH GYNÆCOLOGICAL SOCIETY.

THE Annual General Meeting of this Society was held on Thursday last, January 11th, Dr. Wm. Alexander, President, in the chair.

Dr. SLIMON, Hon. Treasurer, submitted his report and balance sheet for the past year, which showed the Society to be in its usual flourishing condition. A cordial vote of thanks was accorded to Dr. Slimon for the immense amount of labour and care expended during his year of office.

Dr. MACAN, editor of the *Journal and Transactions* of the Society, then read his annual report.

In proposing that a hearty vote of thanks be accorded to the Editor, Mr. JESSETT remarked that under Dr. Macan's charge the *Transactions* had become quite a classical work, not only by virtue of the original papers and record of the doings of the Society, but also because of the abstracts and reviews of Gynæcological work on the Continent and America, and the contributions from foreign gynæcologists he had secured.

Dr. CARTER having seconded the resolution, a vote of thanks for his services was unanimously passed to Dr. Macan.

Hearty votes of thanks were also accorded to the honorary Auditors and to the honorary Secretaries, and the meeting was asked to vote on the election of officers for the year ensuing. The following is the result of the ballot:—

Hon. President: R. Barnes, M.D., F.R.C.P., F.R.C.S. *President*: F. Bowreman Jessett, F.R.C.S. (London). *Vice-Presidents*: T. Gelston Atkins, B.A., M.D., M.Ch. (Cork); William Duncan, M.D., F.R.C.P., F.R.C.S. (London); Bedford Fenwick, M.D., M.R.C.P. (London); H. Jellett, M.D., F.R.C.P.I. (Dublin); R. P. Ranken Lyle, B.A., M.D., B.Ch. (Newcastle-on-Tyne); Sir A. V. Macan, M.A., M.B., M.Ch., M.A.O., F.R.C.P.I. (Dublin); J. Jameson Macan, M.A., M.D., (London); W. H. C. Newnham, M.A., M.B., M.R.C.S. (Clifton); Thomas Oliver, M.A., LL.D., M.D., F.R.C.P. (Newcastle-on-Tyne); Heywood Smith, M.A., M.D., M.R.C.P. (London); R. T. Smith, M.D., M.R.C.P. (London); W. Dunnett Spanton, F.R.C.S. (Hanley). *Hon. Treasurer*: W. H. Slimon, M.D., F.F.P.S. (London). *Council*: S. Jervois Aarons, M.D., M.R.C.P. (London); W. Alexander, M.D., M.Ch., F.R.C.S. (Liverpool); N. T. Brewis, M.B., C.M., F.R.C.P., F.R.C.S.E. (Edinburgh); A. Donald, M.A., M.D., M.R.C.P. (Manchester); T. J. English, M.D. (London); J. H. Ferguson, M.D., F.R.C.P.E., F.R.C.S.E. (Edinburgh); Clement Godson, M.D., M.R.C.P. (London); R. J. Kinkead, A.B., M.D. (Galway); J. Macpherson Lawrie, M.D. (Weymouth); Samuel Lloyd, M.D. (London); J. A. Mansell-Moullin, M.A., M.B., M.R.C.P. (London); F. R. Mutch, M.D., C.M. (Nottingham); John Padman, M.R.C.S. (London); Ernesto Pestalozza, M.D. (Florence); J. J. Redfern, M.A., M.D., M.Ch., M.A.O. (Croydon); Mary Anne Dacomb Scharlieb, M.D., M.S. (London); H. J. F. Simson, M.B., C.M., M.R.C.P., F.R.C.S.E.; J. H. Swanton, M.A., M.D., M.Ch., M.R.C.P. (London); J. W. Taylor, M.Sc., M.D., F.R.C.S. (Birmingham); W. Travers, M.D., F.R.C.S. (London); E. H. Tweedy, F.R.C.P.I. (Dublin); H. F. Vaughan-Jackson, M.R.C.S., L.R.C.P. (Potter's Bar); Hugh Woods, B.A., M.D., B.Ch., M.A.O. (London). *Editor of the Journal*: J. J. Macan, M.A., M.D. (London). *Assistant Editor*: J. H. Swanton, M.D., M.R.C.P. (London). *Hon. Secretaries*: Smallwood Savage, M.A., M.B., B.Ch., F.R.C.S. (Birmingham); Harry Overy, M.B., F.R.C.S. (London). *Auditors*: C. H. Bennett, M.D. (London); F. A. Purcell, M.D. (London). *Trustees of the Property of the Society*: G. Granville Bantock, M.D., F.R.C.S.; R. S. Fancourt Barnes, M.D., F.R.S.E.; Clement Godson, M.D., M.R.C.P.

The retiring President then delivered his valedictory address, an abstract of which we hope to publish in our next.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, January 14th, 1906.

ASCITES IN WOMEN.

ASCITES in women does not always present very distinctive features. In cases of cirrhosis of the liver, ascites is the same in woman as in man. However, the frequency of the malady is not the same in the two sexes, cirrhosis being observed much more frequently in men. In cardiac affections the difference is slight, but the characters which are special to women, says Dr. Chauffard, are those connected with the Fallopian tubes and the ovaries, and the two great causes of ascites thus derived are:—Tuberculosis and neoplasms. Essential ascites of young girls is an affection which develops without pain in subjects whose general condition is ordinarily satisfactory. There exists also a kind of free and indolent ascites, accompanied by a slight pleural effusion. This ascites is of tuberculous origin, due to tuberculous lesions of the tubes or the ovaries.

It is of importance to recognise the real cause of ascites, as it sometimes indicates the existence of a local lesion which might be removed and the patient cured.

Where the cause is not discovered at the beginning the malady progresses, and when a correct diagnosis is made it is generally too late.

A woman, æt. 40, entered the hospital for ascites. Some time before, the apex of the right lung showed signs of tuberculous softening, and at the same time she suffered from mitral disease. On account of the existence of the pulmonary lesion the medical attendant considered the case to be one of tuberculous peritonitis, and tapped the patient several times. When she went into the hospital Dr. Chauffard, in order to clear up all doubt as to the nature of the liquid, injected a few drms. into a guinea pig. The animal exhibited no signs of tuberculosis. When the uterus and the accessories were examined, a polykystic tumour of the ovary was discovered. The diseased organ was removed, but the woman, already weakened by the malady, succumbed a few weeks afterwards. A fatal issue might have been avoided if a correct diagnosis had been made at the beginning.

In cases of ascites in women, the ovaries and Fallopian tubes should always be carefully examined. However, sometimes by reason of its volume and progressive development a serious error might result. Considered to be a case of pregnancy, the malady is allowed to take its course.

A woman, æt. 22, without any personal antecedents, commenced to feel unwell in the early part of 1904. She lost her appetite, got thin and was constipated, the menses became less abundant, and finally ceased altogether. A doctor called in by the young woman declared that she was pregnant. The patient, continuing to suffer, asked the advice of a second doctor, who gave the same opinion. She entered the maternity hospital in consequence, but there it was discovered that it was a case of ascites and she was handed over to Dr. Chauffard. At this point not only was the liquid found to be very abundant, but also a considerable effusion into the right pleura, which necessitated thoracentesis. The abdomen was also tapped and eight quarts of dark yellow liquid removed. Examination of the uterus showed the os closed, but on each side of the womb two hard and uneven tumours could be felt. Gradually the condition of the patient became aggravated, and phlebitis set in in the left leg, and she succumbed ten months after the first symptoms of her malady. At the autopsy two large tumours of the total weight of three pounds were found connected with each ovary. Microscopic examination revealed the nature of the tumour, which was that of a mixed form of sarcoma and epithelioma.

Malignant tumours of the ovaries, says Dr. Chauffard, offer in general the following characters:—Transverse position, hardness and absence of adhesions; ascites is always present.

The patient should have been operated on at the commencement when she was thought to be in the first months of pregnancy. However, it is not certain that the operation would have been successful, as cancer of the ovaries is a very grave affection, especially so in a young woman, as the malignity of epithelioma in young subjects is well known.

GERMANY.

Berlin, January 14th, 1906.

INJURIES AND DISEASES OF THE HEART FROM BLOWS, ETC.

A PAPER on this subject appears in the *Vierteljahrsch f. gerichtl. Med.*, 4, 1905, from the pen of Dr. Bernstein. The work covers a very large field, the literature of the subject has been gone into thoroughly, and the author has made a collection of ninety-eight cases from which the following conclusions have been drawn:—

1. The heart may be injured by blows on the thorax, with subsequent disease of the heart as a consequence.
2. Why and when this will happen cannot be predicted in any given case, as the accompanying circumstances cannot be predicted.
3. Diseases of the heart may be traced back to preceding blows or other forms of injuries over the thorax.
4. These can rarely be decided on with certainty, mostly with more or less probability. The decision depends mostly on the answer to the question whether a certain form of disease could develop within a certain time.
5. On the whole such occurrences were rare.

THYROID AND THYMUS IN BASEDOW'S DISEASE.

Dr. v. Hausemann has a paper on this subject in the *Berliner Kl. Wochens.* 44, 1905. Although recovery had followed operation on the thyroid in cases of Basedow's disease as early as 1882 (Bénard), it was Möbius who claimed that the disease in question was one of the thyroid gland. This view was arrived at mainly by microscopic examination of the gland. By this it was seen that the stroma of the body differed from that in health, that it was characterised by growth of the parenchyma and increase of the secretory surfaces. The growth of the parenchyma was so excessive that papillary elevation took place in the follicles, and completely filled them. Cystic struma might combine with the parenchymatous struma. The colloid substance in the follicles disappeared completely or was barely visible. In its place a fluid, readily resorbable and occasionally containing mucine, appeared. From this property of the thyroid it was undoubtedly capable of increased activity.

It was incorrect, however, to speak of hypertroidism, as the secretion from such glandular tissue was a changed and abnormal one. Feeding with thyroid had always given bad results in Basedow's disease. Toxic symptoms set up in healthy people by overfeeding with thyroid substance resembled in many particulars those of Basedow's disease. Ehrlich, on the other hand, believed Basedow's disease to be a neurosis, and the change in the thyroid to be secondary.

In all hypertrophic conditions of organs, and so with the thyroid, there was always the possibility that the change was a degeneration. This explained how Basedow's disease could be associated with myxœdema, i.e., hyperthyroidism, with athyroidism. A case of Basedow's disease was treated by mistake with thymus substance instead of thyroid, and with a good result. Similar observations had been made by others, Cunningham, Mickulicz, &c. This led to a more careful study of the thymus in Basedow's disease, and a series of cases was observed in which, along with the struma, the thymus was also enlarged, although during development the thymus gland was near to the thyroid, or later on completely changed its character. The few remaining, the Harsal bodies, showed such degenera-

tive form that there could be no question of functional activity. All known diseases of the thymus of later life were those of the lymphatic system. In the majority of cases the thymus was unchanged in Basedow's disease, i.e., it was met with in its normal atrophic condition. In eight cases that had been examined since 1897 there was enlargement of the thymus in four. The characteristic of these cases was that the thymus was always found in reginary proximity with thyroid. Either the thymus touched the thyroid, or a group of enlarged lymphatic glands lay between the two. All this indicates that a connection can well exist between an enlarged thyroid and the lymphatic system, and especially the thymus gland. The writer is of opinion that the enlargement of the thymus in Basedow's disease is not accidental, but that it is caused by the increased functional activity of the thyroid.

THE HEART IN FRIEDREICH'S DISEASE.

The *Deutsche Med. Zeitung*, 2, 1906, has a reference to the subject. In a girl who died at fifteen, the first disturbance in walking took place when she was nine, and at the same time she had convulsions with loss of consciousness. She was seen when ten years of age; there was then distinct ataxy of the lower extremities, less marked in the upper; Romberg's sign very pronounced, loss of patella reflexes, &c. A year later the epileptiform attacks had become very frequent. Gait and carriage showed the tabeto-cerebellar type. No disturbance of the sphincters. At the heart there was a prolonged first sound, but no murmur. The patient showed sudden signs of pulmonary congestion, and died.

The autopsy confirmed the diagnosis of Friedreich's disease. The most striking feature was the size of the dilated and hypertrophied heart (weight, 480 grammes). The myocardium was pale, the walls of the ventricles were 28 to 30mm. thick. No valvular disease. The microscope showed extensive and advanced myocarditis. The case led to certain conclusions, the first of which was that cases of Friedreich's disease often died of cardiac mischief, chiefly over the myocardium, which developed insidiously. In many cases the heart affection was caused by the same infective mischief that set up the nerve disease, that they were two simultaneous expressions of an infectious or toxic-infection process.

AUSTRIA.

Vienna, Jan. 14th, 1906.

PSEUDO-HYPERTROPHIA MUSCULARIS.

At the Gesellschaft für Innere Medizin, Schlesinger showed a case of pseudo-hypertrophia muscularis complicated with myxœdema which yielded to the thyroid treatment, but the hypertrophia remained much about the same. He related the history of another similar case which was acted on in the same way; it was therefore concluded that two separate causes were fundamentally the origin of the diseases, although a singular coincidence of their concurrence. The body temperature of the children was perfectly normal after two months' close observation. The myxœdema seems to have been the secondary invasion and not of so long a standing as the hypertrophy, there were no changes in the bones and the thyroid treatment acted in a few days after application.

DYSENTERY AND SERUM.

Jehle showed two cases that had suffered from dysentery, whom he had treated successfully with the "Krusse Serum." In both cases one subcutaneous injection of 25 c.cm. obtained from the Vienna state Institute was sufficient to neutralise the dysenteric virus. In describing his method of demonstration on cultures he preferred to use a mixture of serum and the physiological salt solution with a one per cent. of mannit and litmus. The latter should be used till the coloration has assumed a decided blue and the whole sterilised. To determine the flora in a suspected substance about 1 ctm. is poured into the sterilised culture and streak tests taken on agar plates. Within a few

hours the reaction can be decided when bacteria coli are present, as the red transformation, by their acid-forming product as well as the gas bubbles, can be easily determined. "Shiga-Krusa" bodies fail to produce this reaction which allows the culture to retain the blue colour. The great advantage of this method is its rapidity and easily ocular proof by reason of the number of colonies where the morphology stand in striking contrast.

RHEUMATISM Nodosium.

Horn showed a case of nodular rheumatism associated with chorea following endocarditis. Nodular rheumatism is acknowledged as a symptom following rheumatic attacks but never admitted as a primary cause. In many cases of rheumatism we have no fever, no prodroma, and only a vague feeling of pain in the limbs, particularly around joints or sinews, where it is known as periarticular and ligamentus, which are usually symmetrical on both sides of the body. In a similar manner those nodules occur as hard peas, which at first are tender and sensitive but ultimately lose that property and become normal, while they are easily movable under the skin. These nodules are evidently the product of the rheumatic poison deposited in the tendons and ligaments. It seems to be a non-inflammatory product containing fibrillary tissue when examined by the microscope, which subsequently becomes hard and boney in appearance. Therapy has no effect on these nodules, which after four or five weeks undergo a degenerative change in which the boney substance becomes fatty and finally is absorbed.

HUNGARY.

Budapest, Jan 14th, 1906.

At the recent meeting of the Budapest Interhospital Association, Dr. Heller exhibited an unusually interesting case of

AORTIC ANEURISM OF TRAUMATIC ORIGIN.

Though by far the greater majority of aortic aneurisms have their origin in a syphilitic process within the walls of the artery there is little room for doubt that trauma was the sole etiological factor in this case. A labourer was suddenly obliged to carry a very heavy weight, resulting in an acute dilatation of the beginning of the aorta with the tearing off of a portion of the wall. At the same time two aortic valves were torn, leading to an acute insufficiency with dilatation of the left ventricle. The resulting fall in pressure permitted the tear in the aorta to cover itself with intima, but the rest of the wall slowly developed into an aneurism. Microscopically, the picture can be clearly differentiated from a specific process; in the one the elastic fibres of the media are everywhere pushed apart and torn, while in the other, a small-celled infiltration with giant-cells accompanied the nutrient vessels through the media and adventitia, while later portions of the media become necrotic.

Dr. Szajfers discussed the question of

LUMBAR PUNCTURE IN URÆMIA.

The astonishing statement is made by Szajfers, that most cases of uræmia complicating scarlet fever can be cured if treated by lumbar puncture. The technique is very simple. The patient is simply placed in the lateral position and punctured between the twelfth dorsal and the first lumbar vertebra; as soon as the fluid disappears, 5 to 30 grains are aspirated by means of a syringe. The initial and oft-time fatal convulsions of scarlet fever and measles also yield readily to lumbar puncture and a trial in purely renal conditions and in eclampsia is certainly indicated.

Dr. Györi related his experience on the subject of

SUBCUTANEOUS INTRODUCTION OF FOOD.

Hitherto sterilised oil only had he said, proved suitable in the cases under his care. Kalodal, a proteid obtained from meat, had been extensively tried by Györi, and it appeared to be suitable before and after operations in weakened individuals, as it can be readily sterilised and is not followed by pain or albuminuria. Instead of giving a simple infusion of saline solution,

Dr. Györi said he now invariably adds five grains of kalodal in 500 grains of fluid, which he introduces under the skin at two different sites. This can be repeated every six hours, so that the patient receives twenty grains of albumin or 82 calories subcutaneously every day. Since a cachetic individual requires only about 22 grains, the advantages are evident. If an attempt is made to concentrate the solution, small amounts of albumin will appear in the urine, but the amount can be considerably increased by adding kalodal to nutritive enemas, as it is very rapidly absorbed from the rectum. The drug is on the market in sterile solution in glass tubes.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

UNIVERSITY OF EDINBURGH.—ANNUAL REPORT FOR 1905.—During the year the total number of matriculated students (including 385 women) was 3,165, being the highest number reached for twelve years. Of these, 1,500 belonged to the faculty of medicine, 45 per cent. being Scottish, 22 per cent. English, 18 per cent. Colonial, and about 12 per cent. and 5 per cent. from Ireland and India respectively. The number of non-Scottish students of medicine is somewhat higher than in recent years. Among the degrees conferred during 1905 were M.B., C.M., 5; M.B., Ch.B., 192; (including 9 women); M.D., 76 (including 2 women); and Ch.M., 1; while the special certificates in Diseases in Tropical Climates was granted to 77 candidates (including 6 women). Substantial progress has been made during the year with the scheme for the "Improvement and Expansion of the University," in the conversion of the old High School buildings (lately the Fever Hospital) into an engineering and physical laboratory, in doing which it has been found possible to preserve to a large extent the external fabric of the structure. Building operations will be begun early this year on an adjacent site for the erection of the Natural Philosophy department. Although the Carnegie Foundation has so far had little appreciable effect in increasing the number of students, it continues to be noticeable that many who avail themselves of its benefit take out a larger number of classes than they would probably otherwise have done. Among new Lectureships founded may be mentioned those on Disease-Carrying Insects and Venomous Animals, and on Tropical Hygiene, by which instruction is to be given in connection with the newly-instituted Diploma in Tropical Medicine. Extended provision has also been made for the teaching of clinical surgery by the assignment to Professor Chiene of definite duties in that department. Among the changes in the Professorate are the replacement of Professor A. R. Simpson by Sir J. Halliday Croom; the office of Dean of the Faculty of Medicine held by the former is now filled by Professor D. J. Cunningham. The death of Professor Copeland causes the Chair of Astronomy to become vacant; the post is now filled by Mr. Frank Watson Dyson, F.R.S., lately assistant astronomer at Greenwich Observatory. The re-cataloguing of the Library is now practically complete; in the general library 210,000 volumes have been dealt with, and, in addition, several departmental libraries, including that in the reading-room of the Medical Buildings, have also been catalogued. The printing of the whole catalogue will have to be considered as soon as the alphabetical arrangement and cross-entries are completed; meanwhile the printing of an abridged catalogue of some 25,000 volumes, for the use of students, is being proceeded with. Great progress has been made with the extension of the University Union, and it is expected that October, 1906, will see the whole building fit for occupation. A large library, reading and writing rooms, new committee-rooms, new kitchen, and two five courts have been provided. Funds to the amount of £15,000 are still needed to meet current expenditure, and to clear off existing debt.

BELFAST.

PARLIAMENTARY AND MUNICIPAL ELECTIONS.—Medical men, like other mortals, are much taken up at present with electioneering in both higher and lower spheres. Considerable disappointment is felt that we are not to have the promised entertainment of seeing Dr. Henry O'Neill contest the Parliamentary constituency of South Belfast. He had planned to do so, and those who knew his vigorous and outspoken style of debate were assured of a lively campaign, but, unfortunately, the General Election has come too soon for him. He is High Sheriff for the City, and is debarred from standing for Parliament during his year of office. He is, however, standing again for the representation of St. George's Ward in the city corporation, and at a meeting of his supporters last week he gave an account of his stewardship in the past, specially as regarded the health of the city. The death-rate has been reduced 3 in 1,000 in the past five years, he said, thanks chiefly to the efforts of the Public Health Committee. The meat and milk supply had been greatly improved, and the terrible epidemics which had swept over the city in past years were not, he thought, likely to be seen again.

Dr. J. D. Williamson has been returned unopposed to the corporation, and has refused the request of a number of his friends and neighbours to contest East Belfast with the late member, Mr. Wolff.

In South Belfast the two candidates, Mr. Sloan and Lord Arthur Hill, are both Orangemen and Protectionists, and, broadly viewed, there is little to choose between them, so some of the medical men in the division are taking the opportunity of pressing the importance of satisfactory answers to the questions put to all candidates by the local division of the British Medical Association, dealing with such matters as the reform of the General Medical Council, the Poor-law Service, Vaccination Laws, &c.

LETTERS TO THE EDITOR.

THE PROSPECTS OF MEDICAL LAW REFORM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—When the immense amount of harm done by illegitimate practice is considered, the desire of the reformer naturally is to seek legislation to make such practice impossible. The same reflection occurs, too, with regard to quack medicines. Unfortunately, it is quite impossible to expect, with a reasonable degree of confidence that any House of Commons within the next few years is likely to pass any provisions of the kind."

It seems to me impossible that anyone with adequate knowledge of the history of medical legislation during the past fifty years can dispute the above statement, which I quote from your editorial "Notes" of January 10th. If this is the case, how can we account for the fact that the British Medical Association and the British Dental Association are apparently proceeding under the assumption that their Bill will be taken up and presented to Parliament without much delay? Do they expect the Bill will be adopted by the Government; do they believe that any Member of Parliament has the power to introduce and carry such a measure unsupported by the Cabinet? Not five per cent. of the members of either House ever know anything about medical affairs, or appreciate the truth about quackery. Introduction of the Bill by a medical member would aggravate existing prejudice, and would confirm the opinion of those who look upon such legislation as always devised solely for the advantage of the profession. The case against quackery needs to be stated fully and publicly. It is an enormously strong case. The medical quack, and the concoctor and the vendor of fraudulent quack medicines rank with the worst class of malefactors parasitic upon modern society. Their cruelty, their cowardice, their cynicism,

exceed by far that of the City shark, who merely robs his victims of their money. Many of them are fully aware that their trade is really murderous; that suffering wretches, who might be cured, or have their lives prolonged by medical science, are doomed to death through reliance upon worthless panaceas. Quackery and the trade in quack medicines inflict an enormous amount of injury upon the public, and especially upon the weak and suffering, who have more claim upon the guardianship of the State. Quackery manufactures disease, and converts simple maladies into chronic or incurable diseases. These facts are capable of demonstration, whilst it is doubtful whether, from the sordid point of view, the abolition of quackery would not cause loss rather than gain to legitimate practitioners, owing to the diminution in the number of invalids which the change would in time surely bring about. To bring the whole story fully and effectively into public view seems to me the essential step preliminary to legislation; and the only practical way to accomplish this lies through the medium of a Royal Commission. Such a Commission, as I have already pointed out in the *British Medical Journal* and in your columns, would have power to call witnesses, to examine them on oath, and to guard them against penalties for statements alleged to be libellous. Commissions on questions of much less importance have been appointed within late years, and the profession acting together ought to be able in time to gain this comparatively simple point. That efforts beyond this at the present time will represent an almost complete waste of force I am, for one, convinced; that my conviction is based upon sufficient experience to warrant me at least in having a strong opinion of my own I have, I trust, made plain to your readers in various letters.

I am, Sir, yours truly,

HENRY SEWILL.

January 10th, 1906.

DISCIPLINARY SINGING AND HEART DISEASE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your last issue, Dr. G. W. F. MacNaughton refers to a case in which he believes the enlargement of the heart to be due to "early disciplinary singing," on the grounds that "the rules of voice production and their frequent practice at an early age of life, when the organs are sensitive and growing, imply great nervous and physical strain."

It is in no spirit of contradiction that I venture to point out that Dr. MacNaughton probably refers to *brainless disciplined teaching*, as voice production from the earliest age with proper control of the respiratory mechanism is one of the best possible things, and any one trained to use correctly *the true motive power* in voice production, could not injure the heart and would be in the same position as children reared in the Colonies, where, from early age, they live mostly in the open air and shout and sing from morn till night. It is undoubtedly for this reason that Australia can supply so many fine singers and still retains many superior to those on this side of the world.

The description Dr. MacNaughton gives proves conclusively that the chest poise was and had been wrong for years. If at the beginning of the vocal studies the *true motive power* had been employed it would have been impossible for the vocal use to have entailed "the veins of the upper extremity being engorged; a left-sided appearance of the thorax, and a slight sulcus or shallow depression corresponding to the attachment of the diaphragm in front." The heart could hardly be affected if proper use had been made of the respiratory process, as has been proved practically by the result of my treatment in children, not only patients sent by medical men, but the sons and daughters of these latter.

I am, Sir, yours truly,

F. MATTHIAS ALEXANDER.

109, Victoria Street, S.W., January 12th, 1906.

OBITUARY.

SURGEON-GENERAL SIR J. EDWARD, M.D., J.P.

WE regret to announce the death at Brighton of Sir Joseph Edward, retired Deputy-Surgeon-General of the Indian Army, at the age of 75. Born in Cumberland in 1831, he went to school at Carlisle, and after a year spent in the Medical School at Glasgow, entered Guy's Hospital. He graduated M.D. of St. Andrews, and took the qualifications M.R.C.S.Eng. and M.R.C.P. London. In 1853 he gained a commission in the East India Company's Medical Service, and joined the Bengal Army a year later. He served through the mutiny, and during the rest of his career in India, was promoted to many important posts, including those of Professor of Anatomy, Physiology, and Medicine, Principal of the Medical College, and Surgeon of the European Hospital. Among many administrative achievements he found time to help Miss May Carpenter in advancing the education of native women. In 1876, Sir Joseph left India in broken health, which did not improve sufficiently to permit him to return to that country. He retired in 1879 with the rank of Deputy-Surgeon-General, and settled at Brighton, where he took an active interest in local affairs, and was thrice elected Mayor of the Borough. He unsuccessfully contested Brighton in the Liberal interest in 1895, and in that year, on the recommendation of Mr. Gladstone, Queen Victoria conferred on him the dignity of knighthood. He was formerly proprietor of *Indian Annals of Medical Science*, and the author of many treatises and books relating to Indian and to general pathological subjects. His many-sided interests present an ideal picture of a strenuous and distinguished life devoted to the service of humanity.

HARRY CAMPBELL POPE, M.D., B.S.LOND., F.R.C.S.ENG.

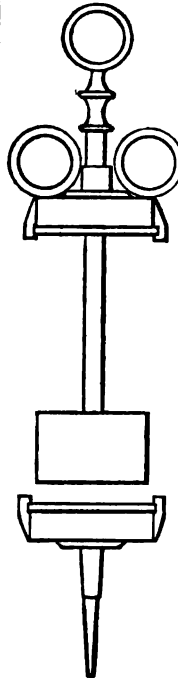
WE regret to record the sudden death of Dr. H. Campbell Pope, on January 2nd, at his residence in the West of London. He was the only son of the late Edward Pope, M.R.C.S., of Tring, and was born there in 1849. He was educated at Haileybury College, and at the Liverpool School of Medicine, and later at University College, London, where he obtained the diplomas of M.R.C.S. and L.S.A. in 1871. He graduated M.B.Lond. (with honours) in 1873, B.S. in 1874, and M.D. in 1878. He also became F.R.C.S. in 1876. In 1876 he settled in practice at Shepherd's Bush, where he took an active part in the foundation of the West London Medico-Chirurgical Society, of which he was President, and also Editor of its *Proceedings* in the year 1885-6. His contribution "The Beginnings of Disease" formed his inaugural Presidential address to the Society in 1889. In 1894, he read an important memoir on diphtheria, its causes, diagnosis, symptoms, complications and treatment, and the precautions to be followed for its prevention, especially in times of epidemic prevalence. He also read papers on inguinal colotomy, diseases of the pancreas, and the feeding of infants in health and sickness. Death was due to heart failure at the early age of 56. He has left a widow and several children.

WILLIAM GRAHAM, M.D., R.U.I., J.P., MIDDLETON, CHESHIRE.

WE regret to announce the death, on January 4th, of Dr. Graham, of Middleton, at the age of 51. Dr. Graham was born in the North of Ireland, and in 1874 obtained the degree of M.D. of the R.U.I. at Dublin, and the M.Ch. in 1883. He also studied in Edinburgh and at Owens College, Manchester, obtaining the D.P.H. of Victoria University in 1890. Dr. Graham settled in Middleton, where he built up a successful practice. He published papers on "Smoke Abatement," "Pauperism in Relation to Public Health," and on "Small-pox," and was medical officer of health to the borough for nearly twenty-five years. Dr. Graham took a great interest in education, and was a keen Liberal. He leaves a widow and two children to mourn his loss.

NEW SURGICAL APPLIANCES.

AN IMPROVED ASEPTIC SYRINGE.



By WYATT WINGRAVE, M.D., Physician to the Central London Throat and Ear Hospital.

THE defect of most piston and other syringes which are filled through the nozzle is the great difficulty of keeping them "surgically" clean. This instrument, however, since its parts are made entirely of metal and readily separated, can be easily sterilised. Further, its makers have, at my suggestion, added a nozzle which; being detachable, not only enables the syringe to be filled without risk of contaminating its interior through an infected aperture, but also facilitates the cleaning of the nozzle itself, precautions of the utmost importance in aural treatment. This syringe is made by the Medical Supply Association, of 228, Gray's Inn Road, London, with nozzles of various sizes.

LABORATORY NOTES.

ANDOUARD'S BEEF POWDER.

ANDOUARD'S BEEF POWDER (E. J. Reid and Co., Dunedin House, Basinghall Avenue, London) is well known in France and has recently been introduced into this country. It is prepared from the finest selected beef by depriving it of its water and indigestible parts, and then reducing it to powder by Andouard's process. The appended analysis shows what an extremely valuable food we have in this preparation, particularly in respect of its nitrogenous constituents, from a food point of view. It is a grey powder with an agreeable taste and can be taken in hot water, milk, tea, &c., according to taste. Not only in the sick room will it be a welcome addition to preparations already existing, but also in tropical climates where it is necessary to carry food in as small a bulk as possible, for which purpose it is supplied in hermetically sealed 60 gramme boxes. The following are the analytical data obtained by us from a sample of the Beef Powder:—

- Moisture, 6.18 per cent.
- Mineral matter, 4.14 per cent.
- Nitrogenous matter, 81.53 per cent.
- Fat, 8.15 per cent.

London Hospital Saturday Fund.

THAT most excellent institution, the Hospital Saturday Fund of London, has this year beat all previous records in the amount of its collections. In their report they note the growing interdependence of the three great Metropolitan Funds. The proposed amalgamation of throat and of orthopædic hospitals is given as an instance. Another point touched upon is the ever-green subject of hospital abuse, which the Fund considered over-rated, and we look in vain for any practical policy towards investigation or remedy. The proposal of the Hospital Central Board is mentioned with approval, and it is suggested that the Funds might form the basis of such a body. Lastly, the Saturday Fund justly congratulate themselves on their step in the establishment of sanatoria for workers suffering from tuberculosis.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons of England.

A QUARTERLY Meeting of the Council was held at the College on Thursday last, the 11th inst. Mr. John Tweedy, President, in the Chair. Mr. Bruce Clarke, F.R.C.S., was admitted a Member of the Court of Examiners. A Diploma of Membership was issued to William Arthur Bruce Young, of Bolton Infirmary, and a Diploma of the Licence in Dental Surgery was issued to Charles Magee Craig, of Belfast. Upon the recommendation of the Court of Examiners it was resolved that the list of Universities, whose Graduates in Medicine and Surgery may present themselves for examination for the Fellowship, without first becoming Members of the College, under the conditions of paragraph II., Section IV., of the Regulations for the Fellowship, be amended by the substitution of "Victoria University of Manchester" for "Victoria University," and by the addition of the Universities of Liverpool, Leeds, and Sheffield. Mr. G. H. Makins, C.B. was elected a member of the Board of Examiners in Dental Surgery (Surgical Section). Mr. Henry T. Butlin, Vice-President, was appointed Hunterian Orator for the year 1907. Mr. A. W. Mayo Robson, F.R.C.S., was appointed to represent the College at the Fifteenth International Medical Congress to be held at Lisbon next April. The following are the arrangements for the Annual Course of Lectures to be delivered at the College.

Hunterian Lectures.—Professor C. G. Seligmann, F.Z.S., "The Physical Anthropology and Ethnology of British New Guinea," February 12th, 14th, and 16th. Professor H. J. Paterson, "Gastric Surgery," February 19th, 21st, and 23rd. Professor Arthur H. Cheate, "Some Points in the Surgical Anatomy of the Temporal Bone from Birth to Adult Life," February 26, 28th, and March 2nd. Professor Warrington Haward, "Phlebitis and Thrombosis," March 5th, 7th, and 9th.

Erasmus Wilson Lectures.—Mr. James Sherren, F.R.C.S., "The Distribution and Recovery of Peripheral Nerves Studied from Instances of Division in Man," March 12th, 14th, and 16th.

Arvis and Gale Lectures.—Professor J. H. Watson, F.R.C.S., "The Viscosity of the Blood," March 19th and 21st, and Mr. Sydney W. Curl, M.R.C.S., "The Arterial Pulse; its Physiology and Pathology," March 23rd.

Richmond Asylum, Dublin, and the Local Government Board.

IN the King's Bench Division last week, counsel applied on behalf of the Local Government Board for Ireland for an order of mandamus compelling the Joint Committee of Management and the Resident Medical Superintendent (Dr. Conolly Norman) of the Richmond District Lunatic Asylum to keep their abstracts of accounts and prepare their half-yearly statements in accordance with the provisions of Article 110 of the Public Bodies Order, 1904, for a similar order directed to the County Councils of the County of Dublin, the County of Wicklow, and the County of Louth, and the Council of the Borough of Dublin, representatives of which together form the Joint Committee of Management of the Asylum, requesting them to cause to be prepared the abstracts of the accounts of the Joint Committee and the medical superintendent's half-yearly statement in the manner prescribed by the Order mentioned; and also for a similar order directed to Dr. Conolly Norman, requesting him to prepare the half-yearly statements of the Committee in accordance with the form prescribed by the Board. It appears that recently the Board came to the conclusion that it would be better to codify and harmonise all various orders, and accordingly they passed the Public Bodies Order, 1904. Several of the public bodies throughout the country were strongly opposed to this new Order, but he was glad to say they had all practically come

into line now. Some, of them, however, still held out, and would not comply with this Order, and amongst them were some of the asylums in Ireland, including the Richmond Asylum, which had point blank refused to comply with it. The Court granted the applications, directing conditional orders to issue against the Committee of Management and Dr. Conolly Norman.

Society for Relief of Widows and Orphans of Medical Men.

AT a Quarterly Court of Directors of the above Society held on Wednesday last, Sir Thos. Smith, Bart, Vice-President in the Chair, sixteen members were present. One new member was elected and one resignation was accepted. The Secretary reported that he had paid the sum of £603 to the annuitants of the charity as a Christmas present. The sum of £1,376, was voted to be distributed as half-yearly grants among the 54 widows and 19 orphans in receipt of grants. Seven letters had been received during the past quarter, from widows asking for relief, but this had to be refused owing to the fact that their late husbands had not been members of the Society. Full particulars of the Society and Proposal forms for membership may be obtained from the Secretary at the offices of the Society. Membership is restricted to registered medical practitioners, who at the time of their election are living within a radius of twenty miles from Charing Cross.

Coroners and the Local Government Board.—Report of the Auditor, Mr. Cockerton.

Local Government Board, Whitehall,

January 11th, 1906.

SIR,—I have to inform you that I have carefully considered the objections of the British Medical Association and other ratepayers, to certain payments made by the London County Council to Mr. John Troutbeck, one of the coroners of the county of London.

These payments were made to the coroner to reimburse him for fees paid to Dr. Ludwig Freyberger in respect of *post-mortem* examinations performed by direction of the coroner.

The charges to which objection has been made have been classed under the following heads:—

(a) Cases in which the medical man in attendance on the deceased before his death gave evidence before the coroner, but was not directed to make any *post-mortem* examination.

(b) Cases in which the medical man in attendance on the deceased during lifetime was neither summoned as a witness, nor gave any evidence at all.

(c) Cases in which no medical man was engaged in attendance on the deceased either before, or at, or immediately after his death, and in which the coroner did not summon a medical practitioner in actual practice in or near the place where the death happened.

(d) Cases in which a medical man was requested to make a *post-mortem* examination, and to give evidence, but although the jury made no application under Sec. 21 of the Coroners' Act, 1887, Dr. Freyberger was engaged to assist at the *post-mortem* examination.

The arguments on behalf of the objectors, together with those in support of the payments by the London County Council, were heard by me on two separate occasions, and after reviewing the whole of the facts of the case, and carefully considering the contentions on each side, I have come to the conclusion that I am bound to allow the whole of the payments in question in the accounts of the London County Council, and I hereby decide and determine accordingly.

Whilst arriving at this decision, I desire to express my sympathy with those members of the medical profession who are affected by Mr. Troutbeck's general mode of procedure, and I propose to refer to the matter in the report which I shall make to the Council at the close of the audit.

If requested to do so by any party interested in the matter, I shall be, of course, quite ready to enter a statement in writing of the reasons for my decision in the proper book of account, in conformity with the requirements of the Public Health Act, 1875, which is made applicable by the Local Government Act, 1888.

I am, Sir, yours faithfully,
(Signed) T. BARCLAY-COCKERTON,
District Auditor.

Metropolitan Asylums Board.

AN ordinary meeting of the managers of the Metropolitan Asylum District was held on Saturday at the offices on the Embankment, Mr. A. C. Scovell, the chairman, presiding. Mr. T. Duncombe Mann, the clerk, reported that during the fortnight ended Thursday last, 813 patients had been admitted to the Board's fever hospitals, 55 had died in those institutions, and 863 had been discharged recovered, the total number remaining under treatment being 4,150, as compared with 4,255 a fortnight previously—a decrease of 105. Of that number, 3,335 were sufferers from scarlet fever, 734 from diphtheria, and 81 from enteric. There were no small-pox patients under treatment. The Ambulance Committee reported that their experience of motor-omnibuses had confirmed them in the opinion expressed in their report to the Board last February, as to the suitability of motor traction for the purposes of the Board's ambulance service. The patients were in the vehicles much shorter times, and, consequently, suffered far less fatigue than in horse-drawn vehicles, and as much more work could be performed in a day by motors than by horses, the committee believed that the general adoption of motor traction would result in considerable economy. They recommended the provision of a motor workshop at the south-western ambulance station, and the employment, as a tentative arrangement, of a foreman and storekeeper, who should be a thoroughly qualified motor mechanic and driver. The recommendations were adopted. The Children's Committee reported that the Local Government Board had assented to the continuance of the use for a further period of twelve months of part of High Wood School for the accommodation of feeble-minded persons, but stated that they were advised that the temporary accommodation thus afforded should as far as possible be restricted to females. With regard to the setting up of a working colony for the feeble-minded, the Board stated that they sympathized with the object which the managers had in view, but that as the whole question is under the consideration of a Royal Commission, it appeared to them that any extended scheme should be deferred until that Commission has reported. In the meantime, the Board suggested that the managers should make arrangements as far as possible for the accommodation of the class in question by the utilization of one or more of their existing establishments. On the recommendation of the committee it was resolved to apply to the Local Government Board for their sanction to the use of Bridge School as a working colony for male feeble-minded cases when it is no longer required for ringworm cases.

Dustbins and the Daily Collection of Refuse.

In the King's Bench Division on January 11th, the case of the "Mayor, &c., of Wandsworth, v. Baines," relating to a contest between an occupier in Putney and the borough council as to the removal of refuse, was heard. The respondent, Mr. Baines, who resides in a house about 40 ft. from the highway, refused to comply with the requirement of the appellants to have his removable sanitary dustbin placed on the kerbstone in order to facilitate a daily, instead of a weekly, removal, under a bye-law of the London County Council, of refuse. Thereupon the Council declined to remove the refuse, although Mr. Baines had served them with a notice to do so, and was willing to place the dustbin outside his house in a position which was conveniently accessible to the appellants' servants. The respondent, therefore, laid an information against

the borough council for refusing to comply with his notice, and the magistrate fined them 20s. and 25 guineas costs. Against this conviction the appellants appealed. The appeal was dismissed with costs.

Dividing Hungarian Twins by Operation.

It is announced that Professor Kukula, of Prague University, has performed the operation of separating the sisters Rosa and Josefa Blazek, who have grown up united like the celebrated Siamese twins. A minor operation was first submitted to by Rosa, with the result that, while her temperature increased by six degrees, that of her sister remained stationary. This led to the conclusion that the twins enjoyed independent constitutions, and—so the correspondents state—it was found on inquiry that a few years ago Rosa had had scarlet fever and typhoid without her sister suffering in health (!) The operation, which has thus made two individuals out of one, appears so far to have succeeded perfectly, as no vital organs were involved.

The Apothecaries Hall of Ireland.

At the Gresham Hotel on Saturday evening the Governor of the Apothecaries Hall—Col. Adye Curran, F.R.C.S.I.—presided at a dinner of the members of that body and their friends. After dinner, and the toast of "The King," the chairman proposed the "Royal Universities and Royal Colleges." The Provost of Trinity, responding, thanked the Governor for his references to the good feeling which had existed among Irish educational institutions. For some years there had been a decline in the number of Trinity's students until less than 1,000 names were on the roll, but this had now been increased to more than 1,100. Sir W. J. Smyly responded on behalf of the College of Physicians. Sir Arthur Chance, in responding for the College of Surgeons referred to the question of medical reform, and said he had been opposed to the "one portal" examining system, because he thought it would be destructive to the Irish examining bodies. Sir Christopher Nixon, in replying on behalf of the Royal University, said he reciprocated what had fallen from the Provost of Trinity College, and that the two great Universities were animated by one feeling in common—to work for the good of the country. He should protest against the observation of the President of the College of Surgeons, who said that the introduction of the "one portal" system would be destructive to the Universities and Royal Colleges of Ireland. Sir Charles Cameron, C.B., in proposing "The Apothecaries Hall," said it was the oldest medical incorporation in the British Empire. The Governor responded, and, after other toasts, the dinner came to an end.

The Forthcoming Lisbon Congress.

CONSIDERABLE progress has been made with the arrangements for the holding of the fifteenth International Congress of Medicine at Lisbon in Easter week. It is announced that the national committee of Great Britain and Ireland has taken every possible precaution to secure the comfort of British visitors. The well-known steamship *Ophir* is to leave Tilbury on April 12th, and to return by April 20th. Whilst the *Ophir* lies in the Tagus the authorities will allot it the berth given to the Royal yacht when the Queen and Princess Victoria visited Lisbon recently, and passengers will be able to make the vessel their home during the Congress, their cabins being reserved, and meals served at regular hours. In this way it is intended to avoid the discomfort and confusion that were conspicuous some years ago at Madrid.

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 29th ult. The chair was taken by Dr J. Brindley James, and there were also present Dr Walter Smith, Dr. F. J. Allan, Mr. Edward Bartlett, Dr. Fredk. S. Palmer, Dr. W. Knowsley Sibley, and Dr. J. B. Ball. The accounts presented showed that

the business of the Society was in a very sound condition. The claims during the summer and autumn have been so light that the heavy expenditure incurred in the spring of the year has been more than balanced, and the whole year's working will once more show a margin in favour of the Society in the sickness account. As, in addition, a large saving is effected in the management fund and the investments earned considerably more than the rate of interest assumed in the valuation, a large sum will be found added to the financial reserves of the Society at the end of the year. Prospects and all particulars on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London.

Instruction in Military Surgery for Civilians.

The first lecture of the course on Army Medical Duties, to which we referred in our last issue, will be given by the Director-General on Saturday next, Jan. 20th, at 4 p.m., at the West London Hospital, Hammersmith. It will be on the Constitution of the Army, its Organisation, Government, and Staff; on the Constitution and General Scope of Duties of the Army Medical Service, and on its relation to other branches, its status, and powers of command. This course has no connection with any particular Hospital or College. Other of the lectures will also be given at the West London Hospital for the convenience of, and at the request of, the gentlemen (about 30 in number) who initiated the movement.

Society of Apothecaries.

A MEETING of the assistants of the Society of Apothecaries will be held on January 23rd, at 8 p.m., in the Court Room of the society's hall, Water Lane, Blackfriars, to discuss the advisability of forming an Association. Ladies and gentlemen holding the assistant's certificate are cordially invited. Those unable to attend, but in agreement with the suggested Association, should communicate their views to Mr. Albert Howell, Hackney Union Dispensary, Rosebery Place, Dalston, London.

Prize for Essay on Epilepsy.

AN important prize has been offered by the National Association for the Study of Epilepsy for the best essay dealing with the etiology of that disease. The value of the prize is \$300, and all competitive. All essays must be sent in to the examining committee by September 1st, 1906, and the award will be made in the following November. Physicians from any part of the world may compete for the prize. Full information may be obtained from the president of the association, Dr. W. P. Spratling, Superintendent of the Craig Colony for Epileptics, Sonyea, Livingston County, New York.

Fire at a London Hospital.

IN the midst of a heavy gale on the 3rd inst., and during the bustle of the dinner hour, a fire broke out at Adenbrooke's Hospital, South London. Shortly after 12 o'clock, flames were observed to be issuing from the roof of the main block adjoining the women's wing at about the spot where the progress of the disastrous fire of two years ago was arrested. The patients were promptly removed from the wards to the men's side of the building, and the firemen, who were quickly on the spot, attacked the flames with such energy that in two hours the fire was completely extinguished. Happily, no loss of life resulted from this alarming occurrence.

Medicine v. Religion.

At a meeting of the Glasgow College Conservatives the other evening, Dr. R. Cowan Lees related a pithy anecdote. A doctor in a remote part of Ireland had a large parish practice. Tickets for medical attendance were distributed by the parish priest. One class of ticket demanded the doctor's attendance on the patient, while the other provided for the patient visiting the doctor. For some reason the priest took umbrage at

the doctor and issued tickets to remote parts calling for attendance. When the medical man saw through the little game, he took to declaring the patients to be so ill as to necessitate a visit from the clergyman. The doctor by this means made things so lively for the priest that a compromise was speedily brought about.

A Case for Public Warning.

OUR contemporary, *Truth*, calls attention to a new firm of American quacks, under the title of the "Theo. Noel Co., Ltd." It announces that a "master remedy," called "Vita-Ore," at four-and-sixpence a package, sufficient for a month's treatment or more, will be sent to every reader of the advertisement, on the condition that he sends the 4s. 6d. at the end of the month if he finds himself better; otherwise he is to pay nothing. An individual who applied for a bottle of the stuff the other day was naturally surprised when he received the following answer:—

"DEAR SIR,—We do not care to send trial packets to men suffering from the class of complaints to which you refer. We have abundant evidence that Vita-Ore is remarkably well adapted to the cure of such cases, but we also know that men suffering thus are very often utterly lacking in the spirit of fair play and honesty. We have therefore decided not to risk the loss of more money over such like. You may be an exception to the rule, and perfectly honourable, but we do not intend to take any risks in the matter." This refusal to fulfil a proffered contract surely deserves the notice of the Public Prosecutor. Under the new regime at the Home Office, the medical profession and the public may possibly hope for some protection from brazen and fraudulent quackery.

Conjoint Examinations in Ireland.

CANDIDATES have passed the third professional examination as undernoted:—C. J. B. Dunlop, G. A. Francis, M. J. Glancy, D. J. Hanafin, A. Hipwell, W. E. Hitchins, J. Holmes, P. Holmes, W. S. Moorhead, A. A. Murphy, J. McGreal, H. V. McKeogh, M. H. O'Sullivan, E. P. Punch, D. P. Walsh.

WE learn that the Cork branch of the Irish Medical Association has decided to support the candidature of Dr. Leonard Kidd for the post of Direct Representative for Ireland on the General Medical Council.

MR. HV. HUTCHINSON, F.R.C.S., surgeon to the London and India Docks Company, has been appointed surgeon to the Millwall Docks.

MR. CHARLES J. SYMONDS, F.R.C.S., President of the Laryngological Society of London, was, at the annual general meeting on Friday last, unanimously re-elected to the chair for the year ensuing.

REVIEWS OF BOOKS.

DONALD ON MIDWIFERY (a).

THE present edition of Dr. Donald's work has been revised, "in the light of the Midwives Act," and every care has been taken to make clear the conditions under which the midwife must call in a medical man. How far such directions are compatible with the value of the book to medical students the author does not explain. To our mind, they are incompatible. The fact that the work has reached a sixth edition shows that it is of value, but for ourselves we confess we are not favourably impressed by it. How much this is the fault of the style and general appearance of the book is, however, another matter. The illustrations are of the poorest quality, the type and paper is unpleasing, the system of leaded headings is bad, since the same type is used to commence sections and sub-sections, and the pages are

(a) "An Introduction to Midwifery: A Handbook for Medical Students and Midwives." By Archibald Donald, M.D., C.M., M.B.O.P., Gynaecological Surgeon to the Manchester Royal Infirmary, Surgeon to St. Mary's Hospital for Women and Children, Manchester. With numerous illustrations. Sixth Edition. London: Charles Griffin and Co., 1905. Pp. xii. and 192.

uncut. Why the author or his publishers should inflict uncut pages on a busy nurse or student is a mystery best known to whoever is responsible. We have, however, little doubt that it affects prejudicially the sale of the book.

THE PREVENTION OF SENILITY (a).

SIR JAMES CRICHTON-BROWNE'S writings remind us not a little of those of another medical knight of the same cognomen—Sir Thomas, to wit. Both love to stray a little off the beaten path of orthodox medical literature; both show a penchant for the curious and fanciful; and both have a weakness for rather pedantic terms of classical derivation. It is the fashion at the moment to raise Sir Thomas Browne to almost celestial heights, and there is therefore reason to hope that some reflected glory may fall on his namesake. Certainly Sir James's article on "Education and the Nervous System," published over twenty years ago in Cassell's Book of Health, deserves to rank as a classic in medical literature; it is more than a pity—especially at the present moment—that it should not be more easily accessible to school doctors and medical officers to Education authorities. The volume before us, containing two inaugural addresses delivered before Congresses last summer, cannot compare with that masterly performance either in substance or form, but nothing that the author writes is without a distinct interest of its own, and a critical mind can find much matter to sift when dealing with such subjects as the Prevention of Senility and the present Sanitary Outlook. Perhaps the most valuable part of the essay on the former subject is where it throws cold water on the wild hypotheses of Metchnikoff and Allchin, and the least valuable where it sets forth the author's equally unsubstantiated view that man's natural span of life is a hundred years. We can hardly admit that the author carries us much further forward in the quest of a golden old age, but the subject holds itself to fanciful treatment and gives many an occasion for *obiter dicta* such as he delights in. These we can cordially recommend to our readers. We are not sure that he is quite fair to Cicero, the Roman orator drew many types of old men in the *De Senectute*, but self-sacrifice was certainly a virtue he lauded highly. Nor are we at all prepared to admit that Shakespeare was suffering from bodily infirmity in 1611, and Sir James Crichton-Browne is certainly wrong about the poet's age at death. It gave us quite a "turn"—as the vernacular has it—to read that the *Lives of the Poets* was Johnson's greatest work; we almost heard the great lexicographer turn in his grave at the suggestion. Readers will find other thoughts of an equally suggestive and stimulating character in the rest of the little essay.

HYGIENE AND PUBLIC HEALTH. (b)

IN no department of medical knowledge, perhaps, does "the process of the suns" supersede current views and render them quasi-obsolete than in the branch of prevention. Discoveries in physical science and added familiarity with the natural history of pathogenic micro-organisms modify our conceptions of disease production and prevention, and oblige us every now and then to shift our points of view. We are therefore entitled to expect every succeeding edition of text-books and manuals of public health to be "revised, enlarged, and in a great part re-written," as in the present instance.

This is certainly an admirable compendium of public health data, principles and practice, and in the 600 pages, or thereabouts, the authors have managed to compress a working *precis* of the practical and legal aspects of the subject. The task of making

(a) "The Prevention of Senility, and a Sanitary Outlook." By Sir James Crichton-Browne, M.D., LL.D., F.R.S. London: Macmillan and Co., Ltd. 1905. 2s. 6d. net.

(b) "Hygiene and Public Health." By B. Arthur Whitelegg, C.B., M.D., B.Sc., F.R.C.P., D.P.H., Medical Officer of Health for Nottingham, and George Newman, M.D., D.P.H., F.R.S.E., Medical Officer of Health for Finsbury. London: Cassell and Co., Ltd. Price 7s. 6d.

such a synopsis is one of no small difficulty, but we have satisfied ourselves that brevity has not been purchased at the cost of accuracy or comprehensiveness.

It is worthy of note that the authors are very guarded in affirming the value of hospital isolation in such diseases as scarlet fever. While logically it may be assumed that the removal of patients from crowded dwellings "cannot have failed to limit infection," the fact remains that scarlet fever has not only not been stamped out, but, on the contrary, its prevalence has not been tangibly reduced. The conditions under which alone hospital isolation is desirable and likely to prove of benefit are numerous and onerous, and, it is to be feared, not generally fulfilled.

The volume will be found useful by students and medical officers of health for ready reference.

LITERARY NOTES.

IN "Medicine and the Public," Dr. Squire Sprigge's suggestive and informing new work, a gallant attempt has been made to explain to the intelligent layman the relationship of the medical man to public life and national well-being. The average man seems to consider that what he calls "medical etiquette" is an unknowable and entirely secret means for maintaining a kind of trade unionism, and he neither knows nor cares to know the means and measures taken for the education, safeguarding and advancement of those on whom at any moment he may depend for the protection and retention of life itself.

WE are of opinion that this unfortunate lack of sympathy between the profession and the public, while due in great measure to the apathy, ignorance and neglect of the latter, has been maintained and possibly aggravated by prejudice, superciliousness, and perhaps distrust on the part of the former. We should be glad to see the companion volume to that to which we have referred, which might be well entitled "The Public and Medicine."

"MEDICAL Electricity and Light Treatment," by Kate Neale, is a little handbook written by the sister-in-charge of the Actino-therapeutic department of Guy's Hospital for Nurses, who wish to gain some knowledge of the therapeutical applications of light and electricity by means of modern instruments and apparatus. It is pleasantly written, and is free from that pomposity and dogmatism which disfigure so many books written by nurses for nurses. The different forms of electrical apparatus are described, and their appropriate applications indicated. X-rays are dealt with in rather cavalier fashion, but Finsen Light gets two chapters to itself. We can recommend the book without hesitation for the purposes and for the readers it aims at.

THE Apsley Cookery Book is a tribute to the ingenuity of Mrs. John J. Webster and Mrs. F. W. Jessop, who inscribe themselves "two grateful patients" to the Originator (with a big O) of the uric-acid-free diet. The book is simply a cookery book for the diet formulated by Dr. Haig, and when one considers that meat, fish, peas, beans, and many other popular articles of food are rigorously excluded, one is agreeably surprised to find that it is possible to devise some two hundred recipes for *plats* made with substances reported to be incapable of importing the evil acid. We can certify that such of them as we have tried are palatable enough, and if the worst comes to the worst we begin to think life might still be worth living though restricted to a *regimen* drawn exclusively from this volume. Of course, all the alimentary substances described herein are old friends, but the merit of the book is to enable the cook to "go ahead" without reference to standard treatises or to what may and what may not be eaten by the elect. It is published by Messrs. J. and A. Churchill, price 3s. 6d.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for the MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

The Complications of Vesico-Vaginal Fistula.—An interesting case of vesico-vaginal fistula followed by hæmatometra and pyonephrosis is recorded by John Phillips (*Lancet*, Nov. 18th, 1905). The patient, æt. 29, was delivered of a still-born child after labour had been established four days, by means of "forceps or cephalotripsy," the date of the operation being Feb. 1896. Subsequently she suffered from a continual dribbling away of urine for which she was operated on in the May following. The condition of affairs met with on bimanual examination were remarkable, but a diagnosis was made of "vesico-vaginal fistula with complete atresia in the upper part of the vagina from union of the upper vesico-vaginal wall with the recto-vaginal wall, cutting off the cervix. The method of closing the fistula was that of flap-splitting or dedoublement, as the amount of tissue was very limited, and the result was satisfactory save for a small pinhole opening. Fourteen months later she was admitted suffering from severe pelvic pain and a soft phosphatic calculus was removed from the bladder. It was noted that the patient menstruated regularly through her bladder, without marked discomfort. In January, 1904, she returned to hospital and exploratory laparotomy was performed, which ended in the removal of the uterus, which proved to be filled with fluid of the same composition as that found in hæmatocolpos. The convalescence was easy. Six months later patient was again admitted to hospital and operated on by Mr. Carless for a tumour on right side, which was accounted for by renal calculi with a collection of pus. The result was very satisfactory. Dr. Phillips states that at the operation of hysterectomy the lower opening of cervix could not be found even by searching carefully with a probe, and suggests that a phosphatic secretion might have formed over the surface presenting into the bladder.

H.

Icterus Neonatorum.—BUSFIELD reports (*B.M.J.*, Jan. 6th, 1906) a series of cases of Icterus Neonatorum which he considers unique as regards both the number of deaths and the rapidity with which death ensued. The case recorded by Ashby and Wright in "Diseases of Infancy and Childhood," is, he considers, the only one which nearly corresponds. The mother had borne ten children, the first did not suffer from jaundice but died of bronchitis. The second child was jaundiced but recovered. The third, fourth, and fifth all became jaundiced and died. The sixth child on the second day became icteric and the colour deepened into almost a copper colour, and death occurred on the eighth day. The next two children also were affected severely, but recovered. The ninth child died from jaundice on the fourth day, likewise the tenth, which was markedly jaundiced six hours after birth. The children have all been born at full term between the mother's eighteenth and thirty-fourth year. No constitutional disease is manifested by either parent. A *post-mortem* examination was made in one instance and negatived any suspicion of syphilis, no morbid condition being found. The treatment consisted in a small dose of calomel followed by repeated doses of castor oil, together with soda and rhubarb mixture. As the woman has not reached the end of child-bearing years any suggestions for treatment are solicited.

H.

Fibroid Tumours of Uterus in Patients, æt. 40 years and over.—Bedford Fenwick (*British Gynecol. Journ.* Nov., 1905), when reviewing Four Years' Hospital Abdominal Surgery before the British Gynecological Society, enunciates the following principles in the treatment of fibroids of the uterus in women over 40 years of age. First, that a fibroid tumour of the uterus in a patient, æt. 40 and over, which fills the pelvis, in the great majority of cases exercises dangerous pressure on the rectum, bladder,

or ureter and should therefore be removed. Secondly, that in such a patient a fibroid tumour which extends centrally half way to the umbilicus and is nodular on the surface and hard should also be removed as soon as possible, because in the great majority of cases it will sooner or later undergo degenerative changes dangerous to the life of the patient. Thirdly, that where the patient suffers from frequent and prolonged losses, unchecked by rest or medicine, where the uterus is enlarged and nodular to level of pelvic brim, hysterectomy should be performed as the safest and most certain cure of the condition. By adopting the above rules, the patient escapes the dangers of (a) fatty degeneration of the muscle of the heart wall; (a cause of sudden death) from long-continued pressure of large abdominal tumour; (b) the increasing tendency after fifty years of age to the occurrence of degenerative changes in fibroid tumours of the uterus; (c) general septic infection of tumours fixed in the pelvis. Having lost the full blood supply they received during active menstrual life, these tumours almost invariably degenerate and often become infected from the rectum. Lastly, he maintains that an ordinary healthy fibroid is never painful, and where pain in such a growth occurs and persists in ninety-nine cases out of a hundred degeneration of the growth has commenced, and the sooner the patient is operated upon the safer it will be for her.

F.

Floating Kidney.—Longyear (*American Journal of Obstetrics*, Nov., 1905) submits as results of observations on the living subject and dissections on the cadaver, new views as to the causation of floating kidney. He describes a tendinous band formed by the gathering together of fine longitudinal fibres from the fibrous network forming the framework of the fatty capsule of the kidney, and extending down, attached to the posterior surface of the ascending colon till close to the junction of the ileum, and to a less extent on the posterior surface of descending colon on left side. This ligamentous union of kidney and bowel he claims as the most important factor in the etiology of nephroptosis. The full cæcum in its efforts to push its contents upwards is making traction downwards, which pulls the kidney with it by reason of this attachment, while on the other hand the descending colon makes its counter extension upward with its fixed point below. This will explain the greater relative frequency of the displacement of the right kidney over the left (15 to 1). The pulling down of the right kidney would also account for the symptoms of a "digestive" and "nervous" character, which so frequently accompany the displacement, because the fibrous band is adherent to the descending portion of the duodenum and pulling on it by a loaded cæcum causes sinking of the bowel. He advocates as an accompaniment of this contention that an operation, to be successful, must have for its aim the attachment of both kidney and bowel, and the one which meets these indications is the fixation of this "nephrocolic" ligament into the upper angle of an incision in the loin and the fastening of the redundant mesentery, if present, into the lower angle.

F.

Gastric Disorders of the Stomach.—Reder (*Amer. Journ. of Obstet.*, Nov. 1905.) cites cases of gastric disturbances—nausea, vomiting, epigastric pain, and symptoms of hysteria and neurasthenia, without any appreciable organic disorder of the stomach or any of the abdominal organs above the umbilical line, and wholly unrelieved by gastric medication, &c. A large number of these cases on pelvic examination revealed retro displacements of the uterus, lacerations of the cervix, or adnexal disease, and 75 per cent. recovered after complete removal of the disorder by operation. He traces the reflex symptoms through

the sympathetic nerves supplying the posterior wall of the uterus to the solar plexus, and through it to the plexus gastricus anterior of the stomach. The plexus gastricus anterior is formed by the left vagus, and in its cervical portion gives origin to the various meninges—irritation of this nerve causes vomiting. F.

Insanity Precipitated by Pelvic Disease in the Female.—Higgins (*Annals of Gynecology*) does not think that psychoses are caused by any local lesion, but that they may be precipitated by one, especially among women with a neurotic predisposition or "border-line cases." He thinks it is folly to hope for a cure from any operative measures upon those in whom the degenerative stigma are so well marked, as found in the large majority of insane patients. However, if they are not too greatly exhausted, humanity demands that they have every advantage given to all sick people regardless of their mental condition. The fact that there is greater percentage of pelvic disease amongst the insane than amongst women sound mentally should at least attract our attention. Hobbs, of London, Ontario, in 1,000 insane women found pelvic disease in 25 per cent., and these were treated in the same manner as if they had been sane. Forty-one cases had ovarian disease, in all of whom the ovary was removed. Of these, 20 recovered within a year after operation, and their average duration of insanity had been eighteen months. Ten improved mentally, whose average duration of insanity had been three years. In 68 cases of uterine displacement, mental recovery occurred in 48 per cent., and improvement in 20 per cent. In 60 cases of endometritis, 19 cases recovered averaging fifteen months' insanity. Hall reports examination of 126 insane women with well-marked pelvic disease in 92 per cent., and recovery of 25 per cent., and improvement in as many more. The cases most suitable for operation are the acute psychoses, next chronic melancholics, especially those whose histories show little predisposing taint. F.

Vesical Calculus in the Female.—Cumstan (*Journ. of Obstetrics and Gynecology*, Nov., 1905), in summing up the treatment of vesical calculus in the female, says as far as the medical part is concerned it consists in careful hygiene and alkaline medication, and can only be applied in cases of uric acid or oxalic acid calculi. The surgical treatment consists in urethral dilatation, vesico-vaginal or supra-pubic cystotomy, and lithotripsy. Each of these operations has its advantages and its indications. Dilatation is not possible in girls under 15 years, will not allow of extraction of calculi exceeding three centimetres in diameter, it cannot be employed in very elderly women without rupturing urethra, or in adults with incontinence of urine due to a weak sphincter, with these exceptions dilatation is an excellent operation. If, after dilatation, the stone is found too large to be removed intact, a few strokes of the lithotrite will be sufficient to break it up into fragments, which can be removed by the urethra with forceps. Colpocystotomy is to be resorted to in cases where the stone is large or extremely hard, or is developed round foreign bodies, also in cases of vesical infection, where it is necessary to drain the bladder. There exist, however, certain contraindications, the first of which is a narrow vagina, which will prevent necessary manœuvres, and then supra-pubic route should be adopted. Regarding the supra-pubic incision in women, it must be borne in mind that it is a more difficult operation than in the male; and that it is also difficult to distend female bladder with liquid or with air. On the other hand it allows one to make a much larger opening into the bladder than any other operation, and is specially suited to removal of large calculi in young girls, and the removal with the fingers of foreign bodies or large calculi which have become wedged into a diverticulum without injuring the mucosa; it also gives a perfect view of the interior of the bladder. Lithotripsy also presents more difficulty in the female than in the male owing to impossibility of filling the female bladder under the influence of narcosis, and being large and low there is no retro-prostatic fundus into which the fragments might drop

after crushing. But in the female it is not necessary to reduce the calculus into such small fragments as in the male, on account of the shortness of the urethra and its easy dilatation. Lithotripsy would seem to be the method of choice when the stone is friable and of medium size. It is followed by the spontaneous expulsion of fragments should any be left behind, and allows the patient to resume his ordinary life within a few days if preceding inflammatory complications of the bladder do not require drainage of the organ. F.

The Growth and Changes in Submucous Myomata.—While Gusserow only recognises myomata as submucous which have freed themselves from the substance of the uterus, and are pedunculated, Schröder also adds those myomata which have a broad connection with the uterine wall, and bulge the mucous membrane into a more or less large segment of a circle. Amann (*Monats. f. Geburtsh und Gynäkol.*, Jan., 1906) agrees with the latter, since the majority of the characteristic peculiarities of the submucous myomata, especially of the covering mucous membrane, are already to be found, while the greater part of the tumour itself is in close connection with the uterine wall. He reports a number of cases which illustrate the different and also the rare peculiarities of the submucous myomata. As regards the size of the tumours, authors in general agree that they very rarely reach a large size. Gebhard says, submucous myomata never reach a very large size, as, on account of their position, septic degeneration so easily occurs. Amann then describes a pedunculated submucous myoma which, lying in the vagina, raised the uterus higher than the umbilicus. "Adhesive implantations" of submucous myomata on the mucous membrane of the body or cervix of the uterus have already been reported, and Amann adds particulars of a case of vaginal implantations, a condition which seems to be very rare. There was no œdema to be found in many of the submucous myomata removed, but he has very frequently discovered it and considers that it, along with the growth of the tumour, conduces to the dilatation of the cervical canal. Just before and during menstruation, especially, they descend deeper—that is, they are plainly felt in the dilated internal os: later they recede ("polypes à apparition intermittente"). When septic degeneration of the myoma had occurred Amann very often found purulent tumours of the adnexæ, while generally with uterine infection one finds the pelvic connective tissue involved. This is to be explained by the path of the lymphatics. Even though the tumour has a long pedicle and thus is far from its original bed, still it sends its lymphatics to the fundus and adnexæ, and the parametrium frequently remains quite free. The prognosis is not so favourable when infection of the adnexæ has occurred. In such cases a rectal examination of the adnexæ is imperative, and after the removal of the septic polypi, observation during the following days will show whether the removal of the adnexæ with the uterus is also necessary. After the extirpation of myomatous uteri he has found severe inflammatory and purulent conditions of the adnexæ, even when the submucous parts of the tumours showed no distinct signs of destruction. The relations of the uterine ligaments and the neighbouring organs can be much altered by submucous myomata. In conclusion, he reports two cases in which submucous polypi were associated with carcinoma of the cervix. It is questionable whether it can be assumed that through the long-continued mechanical irritation of a myoma protruding from the cervix, through the contact of its usually much-ulcerated surface with the cervical canal, through the increased congestion of the uterus, &c., an opportunity may be given for the origin of carcinoma in a patient perhaps predisposed to it. G.

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

NOTICES TO CORRESPONDENTS, &c.

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

SURGERY FOR ELECTION TIMES.

Conservative of course. With Liberal feeding for patient, Union by first intention, and a Radical cure!—A. D.

MR. G. C. CLARK.—We can trace no reference to the subject in our columns during the past three years, nor can we recall anything of the nature referred to in your letter that has appeared in our contemporaries.

DR. F. J. S.—We fear there is no valid hope for a change in the direction named, but will make enquiry.

A MEDICAL VICTIM TO A THEORY.

A telegram has reached this country from New York that a medical man, Dr. Sellwyn Russell by name, has just died of starvation; he believed that people ate too much, and that disease was avoidable by right living. He had entered upon a fasting experiment, to test, as he said, the influence of mind over matter, but carried his theory too far. He was in the habit of prescribing meagre diet as a cure for most ailments.

OMEGA.—The gonococcus is occasionally found in the blood. Gonorrhoeal arthritis often affects wrists and ankles as well as temporomaxillary and sterno-clavicular joints, and sometimes even the fingers. Recurrence is common, treatment often most unsatisfactory, and results to joints may be severe and permanent.

M. S. BRIERLY.—Write to the Registrar of the General Medical Council, Oxford Street, London, W. The *Medical Register* costs 5s., the *Medical Directory* 14s., or 11s. 6d. if ordered beforehand.

CONSULTANT OR GENERAL PRACTITIONER.

L. M. R. writes to ask our opinion in the following case:—He practises as a London specialist and some time ago sent a patient to a well-known Court physician for an opinion upon some medical point. Two years later he is surprised to find that the consultant in question has been attending that patient and his family on and off ever since for various maladies, some of them of a trivial nature. He asks if that is not "glorified" general practice, and if it is in accordance with accepted rules of etiquette.

[In our opinion the procedure is open to grave question. It certainly appears to violate the golden rule of "live and let live." Perhaps some of our readers may express an opinion.—ED.]

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JANUARY 17th.

ROYAL MICROSCOPICAL SOCIETY (20 Hanover Square, W.)—8 p.m. Annual Address:—The President: The Life and Work of Bernard Renault.

SOCIETY OF ARTS (John Street, Adelphi, W.C.)—8 p.m. Dr. W. A. Alkin: The Scientific Aspects of Voice Development.

THURSDAY, JANUARY 18th.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.)—8 p.m. Dr. M. Dockrell: Bullous and Vesicular Eruptions (continued): V. Herpes; VI. Zoster; VII. Dermatitis Herpetiformis. (Chesterfield Lecture.)

FRIDAY, JANUARY 19th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, Cavendish Square, W.)—5.30 p.m. Cases and Specimens will be shown by Dr. C. W. Chapman, Dr. L. Guthrie, Dr. J. G. Emanuel, Dr. C. O. Hawthorne, Dr. R. Hutchison, Dr. E. Cantley, and Mr. N. B. Harman. Short Papers:—Dr. F. J. Poynnton: Jaundice.—Dr. P. Lewis: Erythema Multiforme.

EPIDEMIOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.)—8.30 p.m. Paper:—Mr. W. Hunting: Glanders in the Horse and in Man.

MONDAY, JANUARY 22nd.

ODONTOLOGICAL SOCIETY OF GREAT BRITAIN (20 Hanover Square)—8 p.m. Annual Report. Papers: By Dr. A. G. Levy and Captain A. F. A. Howe. Illustrated with lantern slides.

THURSDAY, JANUARY 25th.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.—8 p.m. Card Specimens: Messrs. A. Stanford Morton and G. Coats, 8.30 p.m. Papers:—Dr. A. Maitland Ramsay: The Treatment of Detachment of the Retina. Mr. Simeon Snell: (a) A Case of Thrombosis of the Cavernous Sinus; (b) A Case of Acute Edema of the Eyelids. Dr. D. J. Wood: Case of Bilateral Hemianopsia.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.)—8.30 p.m. Clinical Meeting. The President (Dr. F. W. Cock) in the Chair.

Vacancies.

Seamen's Hospital Society.—Assistant Physician in charge of the Electrical Department at the Dreadnought Hospital, Greenwich. Applications to F. Michelli, Secretary, Seamen's Hospital Society. (See advt.)

Seamen's Hospital Society.—One Medical and one Surgical Registrar at the Dreadnought Hospital, Greenwich. Applications to F. Michelli, Secretary, Seamen's Hospital Society. (See advt.)

Seamen's Hospital Society.—Honorary Anaesthetists at the Dreadnought Hospital, Greenwich. Applications to F. Michelli, Secretary, Seamen's Hospital Society. (See advt.)

Seamen's Hospital Society.—Pathologist, with duties at the Dreadnought Hospital, Greenwich. Salary, £100 per annum. Applications to F. Michelli, Secretary, Greenwich. (See advt.)

City and County of Bristol.—Public Analyst. Salary, £450 per annum. Applications to Edmund J. Taylor, Town Clerk, Council House, Bristol.

Middlesex County Asylum, Napebury, near St. Albans, Herts.—Assistant Medical Officer. Salary, £160 per annum, with board, lodging, washing, and attendance. Applications immediately to the Medical Superintendent.

York Dispensary.—Resident Medical Officer. Salary, £120 a year, with board, lodging, and attendance. Applications immediately to W. Draper, Esq., De Grey House, York.

County Borough of West Ham.—Plastow and Dagenham Hospitals for Infectious Diseases.—Resident Assistant Medical Officer. Salary, £200 per annum, with rooms and board at Plastow Hospital. Applications to the Medical Superintendent, Plastow Hospital, London, E.

County Borough of Burnley.—Medical Officer of Health. Salary, £500 per annum. Applications to Peregrine Thomas, Town Clerk, Town Hall, Burnley.

Appointments.

BALL, WALTER, M.B., B.S.Lond., L.S.A., Resident Medical Officer and Registrar of the Cancer Wing of the Middlesex Hospital.

BUCKLEY, GEORGE GRANVILLE, M.B., Ch.B., D.P.H.Vict., Assistant Medical Officer of Health of the County Borough of Oldham.

FARNCOMBE, EDGAR LEONARD, M.B., B.Ch.Oxon., Certifying Surgeon under the Factory and Workshop Act for the District of Chudleigh (Devon).

HASTINGS, SOMERVILLE, M.B., B.S.Lond., F.R.C.S.Eng., Surgical Registrar to the Middlesex Hospital.

HOWELL, C. M. HINDS, M.B.Oxon., M.R.C.P., Medical Registrar and Lecturer to the Nurses at the National Hospital for the Paralyzed and Epileptic, Bloomsbury, W.C.

KEELING, G. S., M.B., B.C.Cantab., Clinical Assistant to the Chelsea Hospital for Women.

LEITCH, ARCHIBALD, M.B., Ch.B.Glasg., Assistant to the Director of the Cancer Research Laboratories of the Middlesex Hospital.

MILSOM, E. G. D., L.R.C.P.Lond., M.R.C.S.Eng., Assistant House Surgeon to the East Suffolk and Ipswich Hospital, Ipswich.

PRYCE, ETHEL J. M., M.B., Ch.B.Glasg., Clinical Assistant at the Evelina Hospital for Sick Children, S.E.

SNELL, E. H., M.D., B.Sc.Lond., Medical Officer to the Education Committee, Coventry.

STAMFORD, R. B., F.R.C.S.Edin., L.R.C.P.Lond., M.R.C.S.Eng., Certifying Surgeon under the Factory and Workshop Act for the Loughborough District of the County of Leicestershire.

Births.

ABERCROMBIE.—On Jan. 12th at 23, Upper Wimpole Street, London, the wife of John Abercrombie, M.D., of a daughter.

HOWARD.—On Jan. 12th, at Hamilton, Buckingham, the wife of Vincent Howard, M.R.C.S.Eng., L.R.C.P.Lond., of a son.

MANSELL.—On Jan. 11th, at "Crofton" West Hill, Hastings, the wife of H. R. Mansell, M.R.C.S., of a daughter.

TANNER.—On Jan. 12th, at Farnham, Surrey, the wife of Charles Edward Tanner, M.D., F.R.C.S., of a daughter.

DARGAN.—On Jan. 4th, at 45, Stephen's Green, East, the wife of William Dargan, M.D., of a daughter.

LYLE.—On Jan. 10th, at Eversley, Elmfield Road, Bromley, Kent, to Dr. and Mrs. H. Willoughby Lyle, a son.

RANSOME-WALLIS.—On Jan. 10th, at Carlton Road, Worksop, the wife of A. Ransome-Wallis, M.B., Ch.B., of a son.

Marriages.

FARNAN-MACKEN.—On Jan. 4th, at the Pro-Cathedral, Marlborough Street, by the Rev. Father Cullen, S.J., assisted by the Rev. Father Flavin, Adm., Robert Farnan, M.B., 5, Merrion Square, son of P. F. Farnan, Bolton Castle, Moore, Co. Kildare, to Laura, daughter of the late H. M. Macken and Mrs. Macken, 3, North Great George's Street, Dublin. No cards.

SMART-ORMROD.—On Jan. 6th, at East Coker, Somerset, by the Rev. C. Powell, Walter, youngest son of F. W. Smart, J.P., M.D., of Dublin, and grandson of the late Rev. Edward Nangle, of Achill, to Gladys Millicent, youngest daughter of the late James Cross Ormrod, of Wyresdale Park, Garstang, Lancashire.

Deaths.

BIDWELL.—On Jan. 10th, at 45, Church Road, Richmond, Surrey, Laura Jones Bidwell, second daughter of the late William Bidwell, Esq., M.D.

WELCH.—On Jan. 12th, at 61, Oxford Street, Southampton, Robert Welch, M.R.C.S., L.R.C.P., in his 78th year.

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To the Editor of the MEDICAL PRESS AND CIRCULAR.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, JANUARY 24, 1906.

No. 4.

NOTES AND COMMENTS.

The New Medical Members of Parliament

AMONG distinguished medical members of the new Parliament the names of Sir W. J. Collins and Sir George Robertson stand out prominently. Both are men of affairs, and both are well versed in scientific as well as in social and political matters. It is to be hoped, therefore, that their accession to the House of Commons will mark a new era in the representation of medical views and in the protection of medical interests. The Medical Acts stand in urgent need of reform, as everyone of our readers know, for the safeguarding of the public as much as of the profession.

Unqualified Practice. WHAT an incalculable amount of good, for instance, would be effected by a clause securing the effectual punishment of unqualified medical

practice! By a wave of the Parliamentary wand, the ill-gotten incomes of a host of quacks and charlatans would be diverted into their legitimate channels. It is easy to cry out against the "six-penny doctor," but he is nevertheless the direct product of our defective medical acts, and to some extent of uncontrolled hospital competition. Quack practice, however, has invaded all classes of society, and there are "specialists" of all sorts and descriptions in London and elsewhere thriving on guinea fees. Well may we cry aloud for the elementary justice of a new Medical Act!

Personation Case.

DURING the week an example was furnished in the Law Courts of the ease with which a clever knave may personate a medical man. A certain notorious rogue was prosecuted for fraud in connection with motor-cars. He had masqueraded under a number of titles and aliases, amongst them he had assumed the name of a "Dr. Forbes," and had taken charge of practices in various parts of the country in the guise of a qualified practitioner. Beyond a brief attendance at a London hospital, he had no medical standing. His fraudulent assumption of a medical title and of a medical man's personality, therefore, was divulged only as an accidental side issue in the course of a criminal prosecution.

The General Medical Council.

THE fact is, that the General Medical Council is practically powerless to prevent personation. In other words, the *Register* which is the chief end and aim of their exist-

ence is deprived of its main value by its loose and unbusinesslike conception. The lawyers who are alive to everything concerning their own material interests, insist upon yearly registration. Why should not the General Medical Council adopt so simple a safeguard? Not only would it enable them to identify names and addresses every year, but it would also bring them ample funds for administrative purposes. Although medicine is not a rich profession, yet its members would gladly pay a yearly registration fee as an insurance against personation. Here is a chance for one of our new medical M.P.'s to render himself immortal.

Hospitals that Refuse Acute Cases.

CLEARLY, our medical charities were founded with the view of affording succour to any poor person requiring medical or surgical aid. That view, however, is by no means always recognised by resident medical officers and hospital authorities. Last week an old woman was brought to our largest London hospital suffering from a broken hip. She was sent away to a local Poor-law Infirmary, where she died shortly after admission. Such cases, as a rule, run a chronic course, but in this instance the patient was probably suffering from shock when brought in the first place to the public hospital. We are at a loss to comprehend the basis of a charity of this kind if it be not meant to shelter old folks after so serious an injury as a fractured hip.

The Direct Representative for Ireland on the General Medical Council.

DR. LEONARD KIDD, one of the candidates for the post of Direct Representative for Ireland on the General Medical Council, has issued during the past week a further address to the medical profession of Ireland. In its course he promises to publish some correspondence which has taken place between him and Dr. Laffan, another provincial candidate, with regard to a preliminary poll with the object of selecting a single provincial candidate. This correspondence we publish in to-day's issue. Although with regard to the coming election, we as a journal, have assumed a completely impartial attitude towards the different candidates, we confess that Dr. Laffan's own letters have not disposed us to regard his candidature favourably. Under the circumstances, therefore, we cannot regret to learn that January 18th was the last day for receiving the names of candidates, and that Dr. Laffan's has not been found among them.

LEADING ARTICLE.

PUBLIC INSTRUCTION IN MEDICINE.

WHEN the amalgamation of the various medical societies becomes, as there is a fair prospect of its becoming, *un fait accompli*, all who are interested in the science and practice of medicine will hope that a strong, cohesive, and dignified body will come into being. Whether the title taken to designate it be the Royal Academy of Medicine or the Royal Society of Medicine or some other alternative, it is desirable that a style shall be adopted which will convey to the public that the body is one of authority and prestige, and it is no less desirable that its constitution shall be framed on as democratic a basis as possible. In this way will it be possible for the best thought in the profession to give itself expression alike in the choice of its officers, in the arrangement of its work, and in its influence with the public. If it is intended that the vested interests of the various individual societies which enter into its composition shall be maintained and perpetuated, then far better would it be that things should remain as they are; but if the societies are prepared totally to sink their identity for the sake of the common good and to work loyally together for the construction of a homogeneous influential central body, then there is every reason to anticipate that the standing of the profession in the eyes of the public may be appreciably and distinctly raised. If the amalgamating societies wish for an awful example of what they ought *not* to aim at, we can only point to the Royal College of Physicians and Surgeons. These fine old bodies, which were designed to forward the interests of medicine and to purify its practice, have deliberately refused to march in the van of progress. Resting upon their original charters and ancient privileges, they have continued to convert themselves into mutual admiration societies which exist for the purpose of perpetuating their own interests—as against those of the body of the profession. They have in consequence lost control of the profession to the General Medical Council, organisation of the profession to the British Medical Association, and now, if the cards be played judiciously, the scientific leading of the profession to the forthcoming Society. It will remain with them to justify their continued existence in the face of these public demonstrations of want of confidence. It is not, however, of the shortcomings of the Royal Colleges that we wish so much to speak as of the opportunities of the new Society. We repeat that we hope that Society will be founded on a basis of membership with common rights and privileges, and that its policy and construction will be determined by the suffrages of members, and not by an irresponsible official hierarchy. If this be so, the Society will rapidly assert itself as the mouthpiece to the public of professional opinion on scientific subjects, and it may thus serve a purpose of the highest utility. People too long have been left to form their own ideas from the penny-a-liners of the journalistic

offices armed with old editions of Quain's Dictionary of Medicine, or other reference works which they are equally incapable of understanding. Now the day has long gone by for the public to be kept in ignorance of the medical questions of the day; the cheap press and the sensational writers have seen to that. Authentic information from respectable sources not being forthcoming, garbage of a contemptible description has been served up to satisfy the craving created, with the result that the most erroneous ideas are current on medicine, pathology, and professional ideals. That this should be so is as embarrassing to the doctor in his work as it is detrimental to the progress of medical science, and a system of public instruction more in accordance with the best medical opinion of the day would confer far-reaching benefits on both the givers and receivers. The importance of this duty has at last been recognised by the New York Academy of Medicine, and it has inaugurated a series of public lectures by specially-qualified men to enlighten people on the problems that medicine is grappling with and the ways in which the solutions are being sought. These lectures are highly popular, and cultured persons are listening with pleasure and interest to views totally at variance with the stuff they used to get from the newspapers. But though such a series of lectures would be important channels of information, it is possible for the principle of keeping the public in touch with medicine to be developed along other lines of promise and utility. Thus, for instance, the Academy, or Society, might have a standing committee to whom could be referred all questions of reported cures or promised remedies on which responsible people wished an expression of opinion, and such a Committee could further give voluntarily such pronouncements on burning topics as seemed to them called for by the circumstances of the time. Many and various other means might be taken to accomplish the same end, namely, to place the public in sympathy and not in antagonism with the profession, but if once the principle we are contending for were recognised the particular means might be suggested by opportunity. But it is important that some such work should be undertaken, and we commend it to the notice of the new body, only making this reservation—namely, that in putting itself in sympathy with the public it should not put itself out of sympathy with the profession.

The Pay of Austrian Doctors.

A GENERAL strike is said to be contemplated by the communal doctors of Vienna as a protest against being compelled to perform vaccination, attend the poor, and notify infectious diseases for their present inadequate remuneration. It appears they are paid about twopence for each vaccination case and a week's subsequent treatment, whilst they get nothing for the notification of infectious cases. The highest salary paid to this class of practitioner is less than £30 a year, yet the communes profess to be unable to increase the remuneration.

NOTES ON CURRENT TOPICS.

Speculative Actions and Medical Witnesses —An Important Legal Decision.

ON the 5th of the present month Judge Russell delivered in the Wandsworth County Court a judgment of the utmost significance and importance to the medical profession. It must have happened to every medical man who has been engaged for any length of time in general practice that he has been subpoenaed to give evidence in an action taken up by solicitors on behalf of men of straw. The result of a "speculative" action under such circumstances, even when successful, means, as a rule, that the medical men receive no payment whatever for the attendance at Court, with all its inevitable expense and inconvenience. Henceforth Judge Russell has put a weapon of the strongest and most deadly calibre in the hands of the medical witness. In the case decided by him, Dr. E. A. Miller of Putney, brought a public spirited action against a Mr. Appleton, solicitor of Lincoln's Inn Fields, who had taken up the speculative case of Wright v. The Metropolitan Asylums Board. The defendant Appleton maintained that Wright was answerable for Dr. Miller's fees, and that the latter should have claimed his expenses before giving evidence. Judge Russell decided on both points against the solicitor, and refused leave to appeal. The judgment reverses hitherto accepted rules. We trust it will be duly considered and widely applied by the Medical Defence Union, whose views upon the point involved would be of great interest to our readers.

The Income Tax and Professional Men.

Now that the Liberal Party has assumed the reins of power, it would be well for medical men to bring prominently before their Parliamentary representatives certain grievances with which it may be more easy for a Liberal Government to deal than it would have been for their predecessors. Among these is one from which not only medical men but all professional men, and, indeed, all the higher wage-earning classes, suffer. It is manifestly unfair that in the incidence of income-tax an income entirely due to personal labour should be taxed at the same rate as an income resulting from invested capital. The former represents the result of personal toil and of long years of equipment, while the latter demands on the part of the owner no personal exertion whatever. From the former it is necessary to make provision for a non-earning old age, and for wife and children in case the earning period be cut short by sickness or death. Again, much of a professional man's income is to be regarded, not as the reward of labour, but as the repayment of the capital sum paid for a prolonged and expensive education. It is a distinct injustice that such recoupment should be regarded as taxable; as well might the return of any other invested capital be regarded

as taxable income. It is, we understand, not unlikely that some revision of the income tax system will soon be taken in hand, and it rests with professional men as a class to make sure that their interests are not overlooked.

"Journeyman" or "Assistant."

A WORDY war has been waged during the past month or two between representatives of the Pharmaceutical Society and of the Apothecaries' Hall of Ireland as to the legal status of the certificate of "assistant," granted by the latter body. It appears that in the eyes of the pharmacists the "assistant" has no legal standing whatever, whereas the Apothecaries' Hall holds that as "assistant" is a modern term for "journeyman," all privileges and rights formerly pertaining to the "journeyman" now belong, as a matter of course, to the "assistant." Into the merits of the question we do not enter, as it is obviously one to be decided by lawyers, but some interesting points of history have emerged during the controversy. It is stated that it was not till towards the end of the eighteenth century that apothecaries in Ireland entered on medical practice. About that time there was complaint in Dublin of physicians charging too high fees, in consequence of which, and for the first time, apothecaries were allowed to practise physic where it was not convenient to pay a physician. It would seem, too, that in recent times the Pharmaceutical Society was called into existence by the refusal of the Hall to grant any certificate entitling the holder to dispense and sell medicines without also practising physic. It is interesting, that whereas in the eighteenth century an apprentice was bound for seven years before becoming a journeyman, the Pharmaceutical Society can now qualify an assistant in four years, and the Apothecaries' Hall can do so in three months.

Vaccination Expenses.

Now that the elections are practically over and the composition of the new House of Commons is determined, we may expect to see the faddist, who has been silent for the last few weeks for fear of imperilling the chances of his party, unmuzzled once more. Of the faddists with whom the House will be troubled, the anti-vaccinationists are not likely to be the least turbulent and talkative. What lines is it probable that the anti-vaccinationists will take? They are two. First, they will attempt to bring about the repeal of those parts of the '98 Act which bear any semblance to compulsion, and, secondly, they will try to reduce vaccination expenses, or, in other words, the fees paid to public vaccinators. With regard to the first, to attempt a repeal of the Act, or, rather, part of the Act, will, we are sure, be strongly resented on both sides of the house, and could not reasonably be suggested without further inquiry. As to vaccination expenses, a member of the Wandsworth Board of

Guardians has just carried a motion calling the attention of the Local Government Board to the present expenses of administering the Act, and urging that the Guardians should have "freedom of contract" to engage doctors who were prepared to vaccinate for smaller fees. As a matter of fact, after a long inquiry by a Departmental Committee the present scale of fees has lately been arrived at, and any attempt to depart from this will be ardently resisted by medical men.

Osteosculpture.

A CORRECT and intimate knowledge of the bones is the foundation of anatomy, and anything which helps to give the student that knowledge and to fix it in his memory may be accounted a great gain. In the *Medical Record* for December 30th, a paper by Dr. Gifford describes a method he has been working at for some years for teaching osteology by modelling. After various experiments he has come to the conclusion that plaster of Paris is the best medium with which to work, and this he uses in the following way. A block, roughly of the required size is taken, and on its various surfaces the outline of the different faces of the bone are drawn according to scale, diagrams for the purpose having been constructed previously. The superfluous portions of the plaster are cut off and the outline carefully trimmed to the proper shape. With but little trouble, if the proper scales are used, a model of the bone can be produced which varies within narrower limits than do the bones of various human subjects. The sculptured piece is then hardened in glue and subsequently dried. In this condition it can be drilled and mounted as though it were an actual bone, and, of course, the insertion of the muscles marked in colour. Dr. Gifford is evidently an enthusiast, and he has induced Professor Price to try teaching his class in anatomy on this principle. The idea seems a good one but the method is rather elaborate, and we should have thought plaster of Paris too hard a material to work with easily. But the principle of teaching osteology by a constructive method is on sound lines, and we fancy that if modelling clay were used a personal acquaintance with the bones, as well as a valuable training for the hands, might be acquired in a more permanent way than any yet in use.

The Falling Birth Rate.

THE decline in the birth-rate seems to possess an almost irresistible attraction for the medical statistician and philosopher, and Circe-like it makes its suitors fall enslaved by its charm. The latest wooers of this captivating maid are Dr. Newsholme of Brighton and Dr. Stevenson of the London Education Committee, who presented a study on the question to the Royal Statistical Society last month. The value of their paper lay chiefly in establishing by authoritative

figures those conclusions which other reasoners have arrived at chiefly by conjecture and deduction. The authors find that fertility is reduced as social comfort increases, and that while the reproductive activity in the higher grades of society is certainly less than in the lower, the same principle applies to the proletariat as it rises in well-being and prosperity. In England and Germany this influence had been much marked of late, but Ireland, though its lower classes are probably somewhat better off than formerly, forms an exception to the general rule in that its birth-rate had actually increased. Denial was given to the assertion that decrease in the birth-rate is caused by the stress of modern life, the authors holding that it showed a determination on the part of a people to secure greater comfort. They arrived at the usual pessimistic conclusions—namely, that the "gospel of comfort" was becoming the ethical ideal of the people and that this connoted a lower standard of moral outlook, a lower regard for the married state, and a lower moral, and perhaps also physical, level among those who adopted it. The counter-arguments to these gloomy vaticinations are well-known to our readers, and we have generally felt ourselves that a slight loss in population, if obligatory—of which we are by no means sure—is a small price to pay for the greater comfort and well-being of the population generally.

Distilled Water a "Drug."

THE responsibilities of qualified chemists are being brought home to them by various legal decisions as regards the purity of drugs supplied to customers. Last week an important addition to the recent series was made in a West-end London Police Court, where a chemist was fined ten shillings, with three guineas costs, for having sold dirty distilled water to the prejudice of the purchaser. The Home Office analyst proved that the water was swarming with micro-organisms. The vendor, in defence, said the water was in the same condition as supplied to him by a wholesale firm. Clearly, distilled water should be collected in sterilised vessels and hermetically sealed, or it must soon become infected. If a purchaser ask for distilled water it is clear that purity is requisite for some special purpose, or he would be content to use the ordinary public supply. Suppose distilled water had been obtained from the Marylebone chemist by a surgeon in order to make an eye lotion. Had the polluted water described in Court been instilled into an eye the results might have been disastrous to everyone concerned. The decision that distilled water is a drug appears to be sound from the point of common-sense no less than of law. If chemists are going to deal

with distilled water in the unscientific manner indicated in this case it will be safer for customers in future to boil and filter plain tap water.

Company Promoters and the Medical Profession.

DURING the past week members of the medical profession have been assailed with a profusion of pamphlets relating to the Leon Syndicate for taking up a gold-field concession in Nicaragua. The capital of the syndicate is £75,000, and the circulars and prospectus are couched in the glowing and enticing language usual to such documents. There is nothing to distinguish the Leon Syndicate from the long procession of gold mines that have been paraded for the benefit of the British public in general. However, as in this instance a particular appeal has been made to the medical profession to support this South American venture, we feel it our duty to utter a word of caution upon the subject. Should any of our readers think of investing money in the Leon or any other syndicate, let him first take the obvious precaution of asking his stockbroker and his banker what they know of the Syndicate, and whether they think the reputation of the promoters is such as to warrant a reasonable chance of ultimate success. Medical men, as a rule, are not given to Stock Exchange schemes, especially in gold mines, and we fancy they will not be swept in numbers into any financial net, however well baited.

Febris Electiona Generalisata.

Etiology.—Social worry, exposure to wet and cold, over-indulgence in alcohol, have all been mentioned as predisposing causes, but the principal exciting one seems to be a too liberal or too conservative habit of life.

Pathology.—No gross lesions have been found after death, but pre-existing arterial degeneration may contribute to a fatal result. The primary disease would seem to lie in some disturbance of the cerebral circulation, caused by reflex inhibition of the normal vaso-motor nervous control. This gives rise to various psychic phenomena, and the muscles of the larynx, tongue, lips, and face are thrown strongly into action.

Symptoms.—The first symptoms that manifest themselves are to be found in alterations of the patient's habits, especially in the direction of disinclination for his normal work. Sleep is apt to be broken, and as the disease gains hold insomnia may become complete. Later acute delirious mania or profound melancholia may set in. The eyes are usually widely opened, the lips move incessantly, and the patient babbles incoherently. He easily becomes irritable and quarrelsome, and special attendants may be needed to restrain him. One of the most troublesome developments of the malady is when it proceeds towards hilarity, the subject then often losing self-control entirely and giving way to loud, piercing, inarticulate cries.

Treatment.—Isolation is essential. A good nurse may do much to calm the patient, but the strait-

jacket should always be at hand. Newspapers and lime-light pictures often act like a charm. The diet should be light but nutritious, and forced feeding may be necessary. Alcohol should not be resorted to, but a generous allowance of wine after the crisis may do much to restore the patient's spirits if he be unduly dejected.

Prognosis.—The outlook is good if the patient be carefully nursed, but death occasionally takes place. The malady is apt to run in cycles, intervals of about five years being the rule. A voyage abroad may advantageously be recommended when it threatens to recur.

PERSONAL.

By the will of the late Mr. James Henry Ceely, F.R.C.S., of Fulham, late surgeon at H.M. Prison Aylesbury, senior surgeon of the Bucks General Infirmary, and Surgeon-in-Chief to the Bucks County Constabulary, £500 has been bequeathed to that worthy institution, the Royal Medical Benevolent College. The deceased left his son £39,218.

H.R.H THE PRINCE OF WALES has expressed his satisfaction with the work of the Indian Branch of St. John's Ambulance Association.

THE Lord Mayor early last week attended St. Thomas's Hospital and unveiled a portrait by Bacon, of Mr. J. Gadesden Wainwright, who has been a governor of the Institution for forty years and treasurer since 1890.

MR. JAMES WILCOCK, J.P., of Blackburn, chairman of the Refuge Assurance Company, has celebrated his sixtieth birthday by giving £3,500 to local charities, £1,000 being to endow a bed at the Blackburn and East Lancashire Infirmary respectively.

MR. JONATHAN HUTCHINSON will deliver an address to the Hunterian Society to-day, January 24th, dealing with reminiscences of that body. The Society invites the presence of all medical men.

SIR WILLIAM H. BENNETT, in recognition of his long services to St. George's Hospital, London, has been appointed consulting surgeon to that Institution.

APART from any question of politics, it must be a matter of general regret that the medical profession has lost the services of so distinguished a representative in the Commons as Sir Michael Foster, who has been ousted from the parliamentary representation of the University of London by Sir Philip Magnus, the Conservative candidate, by the narrow majority of twenty-four.

A MAN, when arrested at the house of Mr. P. D., Sasun, L.R.C.P.Ed., at Walthamstow, on Friday night, calmly remarked: "I meant to have taken his life; he has ruined mine." Meanwhile the medical man is in the hospital in a dangerous condition, and the accused is in prison pending trial.

DR. T. B. NAPIER has been elected M.P. for the Faversham Division of Kent.

DR. RUTHERFORD has been elected as the Parliamentary representative of Harrow.

THE keen interest taken in the science and art of photography by members of the profession is shown by the fact that Dr. J. Alford Scott, F.R.C.S.I. of Dublin, is this year president of the Photographic Society of Ireland, and Dr. S. W. Allworthy, M.A. F.C.S., of Belfast, president of the Ulster Photographic Society.

A CLINICAL LECTURE

ON

THE INDICATIONS FOR OPERATION IN APPENDICITIS.*

BY

R. CHARLES B. MAUNSELL, M.B., F.R.C.S.I.

Surgeon to Mercer's Hospital, Dublin.

GENTLEMEN,—If one were to lecture daily on some aspect of disease of the appendix, it is doubtful whether at the end of a week more than half would have been outlined, let alone adequately discussed. I have to-day chosen a topic which has been the subject of debate in all civilised countries during the past fifteen years. The literature is so extensive and so scattered through journals, reports and monographs that it would be hopeless to expect the present day overburdened student to form his opinions directly from it. On the other hand, if the opinions and experience of others are neglected it would take more years of careful clinical observation and pathological investigation than form the natural span of human life before any one of us could solve the problem.

Therefore it is incumbent upon a teacher to absorb the work of others, to assimilate that which appears good, put it to the test, and, when it has been adopted or become inextricably blended with and modified by his own methods, to bring it before you in simple language, never fearing the accusation of being dogmatic.

One of the commonest remarks we hear or read in discussions upon appendicitis, and indeed of many other diseases, is that no rules for treatment can be made but that each case must be considered on its merits. This is most excellent advice provided those who are likely to act upon it conform to the following description:—(1) They must have a fairly extensive knowledge of the medical and surgical literature of the abdomen; (2) they must be careful and constant clinical observers; (3) they must have had some years' experience of the conditions disclosed by operation or autopsy, when certain clinical symptoms or signs had been observed. My advice is to start practice with an easily remembered set of rules and let future reading or personal experience point out the exceptions to these rules or add some new one to the list.

My belief is that the things which we can definitely state are as yet few, but these few may save many lives. Recently I was discussing this subject with some surgical friends and their opinion was that the subject had been fully thrashed out and that the man who could bring forward anything original upon the treatment of appendicitis would indeed be clever. I do not deny that the subject has been thrashed, but it has never been winnowed. With regard to originality, it is well to remember that striving after it will be to the detriment of our patients, and that it will only come unexpectedly to those who are working honestly and steadfastly without undue thought of self-glorification. It is a simple matter for you to test the truth of some of these statements for yourselves. When you leave this hospital to-day, ask the first three physicians whom you meet the following questions: (1) Would you give an aperient and an enema in a case of appendicitis? (2) Would you give opium or morphine? (3) Would you associate yourself with a surgeon early in the case? Then spend an hour in the library glancing through the chapters on treatment in the latest monographs, where you will see advocated various views, from prophylactic appendicectomy in every infant to the old treatment of Graves and Stokes by repeated doses of opium. To-morrow you come to me and say whether what

you have discovered would dispel the natural uncertainty with which you are likely to approach your earlier cases in practice.

In this hospital our practice is that purgatives and enemata should be given to patients who have been constipated, provided they are seen within the first twelve hours from the onset of the illness, and provided they show no signs of so-called "fulminating appendicitis." The best purgative is calomel and the enema should not exceed two pints.

Our practice is never to give opium or morphine unless operation has been decided upon, as even in small quantities they modify the symptoms. *Patients who have sufficient pain to need morphine had better be subjected to operation.*

With regard to the more obviously surgical questions, we may dismiss prophylactic appendicectomy in the healthy individual as fantastic. If in any patient we have opened the lower abdomen for some other condition requiring operation, the consideration of the prophylactic measure cannot be so easily disposed of. It appears to me to be only fair to our patient under such circumstances to remove an appendix which is known to have caused previous trouble, or which is kinked, adherent, cystic, or which contains one or more concretions, provided that there is nothing in the original operation which would negative this extension of our work. In otherwise trivial and absolutely aseptic operations such as suspension of the uterus, &c., more especially if the operator intends to use silk for his buried sutures, the appendix had better be avoided unless very markedly abnormal, and in this event it will be wiser to put aside the silk and use catgut for any buried suture in connection with the extraperitoneal portion of the operation.

Why not remove a normal appendix? It is not that I believe in any important physiological function which this little organ discharges, but because I am opposed to meddling surgery, and also the appendix has recently proved of great surgical use in the treatment of certain intestinal diseases such as mucous colitis, dysentery, &c., by enabling surgeons to perform the simple operation of appendicostomy. You have all seen the old woman who is at present a patient in the female surgical wards, in whose case I thus utilised the appendix to fix and drain the cæcum, which had become twisted upon an abnormal mesentery giving rise to acute intestinal obstruction from volvulus of the cæcum and lower ileum. Some surgeons, chiefly of American nationality, have solved all problems by operating in every case as soon as a diagnosis has been made, or even a strong suspicion of appendicitis entertained. Others operate if they have seen the patient within twelve or perhaps twenty-four hours of the onset of symptoms, but consider it safer to wait and be guided by subsequent events if this time has been exceeded, as they consider that once the inflammation has become well established around the appendix it would be safer to wait for the walling off of the diseased area by adhesions, when they could more safely operate, or perhaps allow the inflammation to run its course without further interference.

Operation during an uncomplicated attack has been strenuously opposed by the majority of European surgeons. To this opposition I have hitherto given what little help I could, but of late the more I reason with myself or others the more I think that quite enough opposition, very naturally, comes from the

* This lecture was delivered in Mercer's Hospital on January 20th 1906. It was illustrated by numerous specimens and charts, reference to which has been deleted from this report by the lecturer.

patients without our standing in the way of a line of treatment which is undoubtedly logical. I do not follow the reasoning of those who would impose a time limit, as there can be no danger from a carefully performed operation except pus or gangrene be present, and few would care to deny that the presence of either of these would prove without doubt that the operation not only was imperative, but that it should have been undertaken at an earlier period.

Granted that there are reasonable grounds for a diagnosis of appendicitis, and that the patient and the patient's friends are sensible level-headed people, should we advise operation at any period during the acute stage? Before an answer could be given we must be granted proper environment, proper assistance and the various other requirements of a modern operation. Without these I unhesitatingly state that operation should only be thought of when dangerous complications have declared themselves. All the requirements being granted, the patient or the patient's friends, should be given the option of an operation, but on no account would I undertake to urge operative treatment in a simple case, as any individual patient has a good four to one chance of recovery without any complications and a further even chance that should even the worst complications arise they could be safely treated if recognised at a fairly early stage.

You can see that whilst I consider immediate removal the most perfect method of treatment, yet, although I might suggest it or perform it by request, I would never feel justified in urging it as a necessary procedure.

We must next consider the antithesis of this immediate or a chad operation, namely, the interval or a froid, so ably advocated by Treves. The principle of this procedure is to remove the appendix at some safe and convenient time, subsequent to one or more attacks of inflammation, so that the patient may be rid of a constant source of dread or danger.

Opinions differ both as to the interval which should elapse after the acute attack and as to the number of recurrences and the residual signs or symptoms which would warrant either advising or urging this procedure.

My practice is not to wait too long after acute symptoms have subsided, from one to three weeks is generally sufficient. By operating early, adhesions will be more readily separated, the patient will be saved two distinct periods of enforced idleness, and will, moreover, be far more likely to entertain the idea of operation while the anxieties of his late illness are still fresh in his memory.

In discussing the proposed operation, the patient will wish to know the probabilities of recurrence, if he trusts to Nature. It is practically impossible to give an answer in percentages or chances, as various compilers of statistics have estimated the probability at every percentage from five to a hundred per cent.

Until more definite information can be procured we must assume the responsibility of *advising* operation after a first attack, of *more strongly advising* it after two attacks, of *urging* it when the attacks have been frequent, *being even more insistent* when they have been of a short colicky nature, as such pains generally indicate some obstruction or concretions with ever pending danger of acute perforation. All appendices which remain as a source of chronic discomfort, or which can be palpated or located by complaint of pain on pressure should be removed. If a patient has passed a year or more without a recurrence before he consults you, it is better to advise against operation, unless he contemplates going abroad, where operation might be impossible, or unless it would obviously relieve his mind to get rid of a useless and, to him, a terrifying appendage. There can be no doubt that this interval operation has been of inestimable value in restoring health and saving life; but we must never forget that it is only a prophylactic measure against future trouble and that when we are in attendance upon an acute case we should not obstinately strive to postpone operation for a hypothetical safe interval, but that we must act promptly should even a suspicion

of danger arise. I have lost patients through looking too far ahead, thinking of the nice a froid little operation which I would do, whilst meanwhile some barely suspicious sign or symptom had suddenly grown to alarming proportions, and the subject of my thoughts was removed to a place where intervals are unknown.

Now let us briefly discuss the danger signs and symptoms which may help us when treating acute appendicitis by the expectant method. The most important questions and the most difficult to answer arise at our first visit. Is it an instance of acute gangrene or perforation of the appendix, or are the symptoms, although exaggerated, merely such as frequently usher in a severe though uncomplicated inflammation?

It is well known that an onset characterised by high temperature, frequent pulse, severe abdominal pain, vomiting, rigor, or even marked collapse, may mean nothing serious. We must make up our minds what the onset does mean in time to open the abdomen within the first six hours, or at the furthest within twelve hours, if our patient is to have a reasonable chance of life. If the illness is going to take a favourable course the collapse will soon pass off, and the aspect of the patient will conform to his acute, febrile condition. The pulse and temperature may both remain up, may both increase or may both decrease in a *fixed ratio*. The pain in the abdomen, which at first may have been situated at the umbilicus, or more diffusely with this point for a centre, will most likely decrease and become more defined over the right iliac fossa. Rigidity of the abdominal muscles, if it had been present will decrease, except over the affected area, and abdominal respiration will be present although very probably in a modified form. *The rigidity will at no time have been so complete as that which marks some abdominal catastrophe.* Vomiting may or may not continue. The chief unfavourable signs and symptoms are (1) A flat or slightly distended abdomen, which is absolutely rigid. (2) A rising pulse rate with a stationary or falling temperature, or a continuously frequent pulse, with a falling temperature. (3) A history that pain was at first located over the iliac region, and then suddenly became more diffuse. (4) Pain referred to any portion of the genito-urinary organs. Retention of urine is not of much importance, but pain on micturition is of immense importance. (5) Fulness and marked tenderness found in the pelvis on rectal or vaginal examination. Whilst examining the rectum or vagina it is well to test with the other hand the rigidity of the abdominal muscles, to learn whether they relax when the attention of the patient is withdrawn. Of course we must not hurt the patient meanwhile with the pelvic hand, or the abdominal muscles will reflexly contract. (6) A peculiar pallid, drawn and anxious appearance of the patient, or of even more importance a dull leaden appearance when viewed from some distance. I have mentioned this sign last as it depends altogether on the keenness of observation of the surgeon or physician in charge, not because I attach slight importance to it.

Later signs will be (1) Steady increase of the pulse rate with only moderate temperature. (2) The tongue becomes dry and brown, whilst the vomited material smells like fæces or assumes the characters of the so-called "black vomit." (3) Distension of the abdomen becomes more marked, sometimes with great diminution or disappearance of the rigidity. (4) Free fluid may possibly be demonstrated in the peritoneal cavity.

In fact the diagnosis is no longer in doubt and any treatment is simply undertaken as a forlorn hope.

In my opinion any one of the foregoing ten symptoms or signs would indicate operation to a prudent surgeon, any combination of two or more of them should absolutely demand it from him.

I have known patients at the onset of their illness to present a grouping of some of these signs and symptoms, including that of board-like rigidity, but without elevation of temperature. My experience is that all such patients should be operated

upon immediately, for although we may not always find that the appendix is at fault, yet we will undoubtedly find perforation or strangulation of some other abdominal organ, with consequent peritonitis.

Having tidied over the first twelve or twenty-four hours safely, we must next inquire what constitute later danger signals. I will again tabulate them so that we may be concise. (1) Increase of symptoms after the first forty-eight hours. (2) A steady although gradual or a sudden increase of the pulse rate. (3) Difficulty or pain on micturition. (4) Remittent or intermittent temperature. (5) Rapid diminution of pain and tenderness whilst the general aspect of the patient seems worse rather than improved. (6) Occurrence of rigor at any period subsequent to the onset. (7) Marked tenderness or swelling found on rectal examination. (8) Absence of distinct improvement by the fifth day. (9) Incomplete subsidence of symptoms, except perhaps slight tenderness and infiltration, during the second week. (10) Recrudescence of acute symptoms at any period. It would be impossible in this lecture to discuss the various conditions which arise in peculiar or neglected cases such as subhepatic, hepatic, or subphrenic abscess, &c., neither would it be possible or expedient at this period to even outline the principles of the various operations which most of you have seen performed in this hospital, from time to time, for the various complications which I have mentioned.

NOTE.—A *Clinical Lecture* by a well-known teacher appears in each number of the journal. The lecture in next week's will be by Professor Louis Renon, Physician to the *Hopital de la Pitie, Paris*, on "*Right-Sided Pleurisy in the Subjects of Heart Disease.*"

ORIGINAL PAPERS.

THE TREATMENT OF SPRAINS.

By PROFESSOR H. MORESTIN,

Chirurgien des Hopitaux de Paris.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

I desire to make a few remarks on that common accident called sprain and its appropriate treatment.

Sometimes we have the chance of examining the patient almost immediately after the accident, a particularly favourable circumstance to prevent any troublesome results. More frequently, however, the treatment cannot be commenced before the following day, or even two or three days later. The blood effused has had time to accumulate in the synovia or to filter into the cellular tissue, and already inflammatory reaction has commenced at the seat of the accident and in its neighbourhood.

The first thing to be done is to relieve the pain and prevent or arrest the progress of the sanguineous infiltration. Later on it will be necessary to ensure the evacuation of the effusion, render to the region its form and suppleness, and prevent all complication.

When the lesions have already existed for some time, complications, as stiffness, atrophy, and persistent pain, may be expected and will have to be treated. Consequently the prognosis will be benign or grave, according to the treatment having been begun early, or several days, or perhaps weeks after the accident.

Theoretically, all sprains may be treated alike, but in reality different regions require certain modifications. Formerly, a large place was given to certain applications in the treatment of sprains. Some procured relief by the cold they produced, but the effect did not last long and that treatment was abandoned.

Physical agents can, on the contrary, render great service. Cold and heat have been employed in turn, and in many cases should be still recommended. Immersion in hot or cold water is one of the easiest things for certain regions, such as the hands and feet. For an ordinary sprain of the ankle, Baudens advised that the foot should be left in cold water as long as the patient felt comfortable in it. It was thus that he kept the part in cold water for two or three days, and then applied a compressive bandage. Without, however, going to such extremes, the cold bath, if it could be kept up for several hours, would be beneficial.

A better treatment is *warm* water, which produces very marked relief and is more efficacious. It is by this treatment that I would recommend you to begin. In regions other than the hands and feet—to the knees or hips, for instance—the heat should be applied by hot-water bottles or poultices. This treatment, in any case, is only preliminary to the essential and curative treatment comprising *mechanical means*, which, by pressing on the tissues, removes the blood and lymph exudations and consecutive infiltrations from the region. These means are powerful, rapid, and so efficacious that they take the first place in the treatment of sprains. Of all the mechanical means, *compression* is the most ancient. Before the use of cotton-wool it was a rough method, painful, and even dangerous. With the well-lined apparatus compression becomes easy to support and gives very good results; it drives the blood out of the cellular tissue and prevents œdema. The only reproach that can be made to it is that it condemns the affected part to complete immobility. Now, prolonged immobility in traumatisms of the articulation is one of the greatest errors of surgery.

Employed exclusively, this apparatus is considered to-day insufficient; wherever massage and the elastic bandage can be used, they are certainly the best resources at our disposal. Applied in the interval of baths and séances of massage, the compression apparatus finds its utility. It effectually maintains the result of the massage and contributes its part to the absorption of the exudation. The *elastic bandage* is, however, in my opinion, the best means to obtain this absorption and does not absolutely confine the limb; the movements it allows, however limited, are sufficient to preserve the function of the articulation. In any case, the band is not continually applied; it has to be removed about twice a day for washing, otherwise the moisture under the band becomes foetid and irritates the skin. Care should be taken in applying the elastic band not to draw it too tightly so as to cause pain.

It is obvious that the above treatment cannot be employed for sprains of the hip or shoulder; but we have another treatment, however, which is applicable to every kind of sprain, and that is massage. Massage was for a long time ignored by the surgical profession, and it was only towards the middle of the last century that, thanks to the

efforts of Bonnet, Girard, Estradere, and others, its merits were recognised. To-day nobody wants to contest its good effects, and there is even some tendency to exaggerate them.

The manual treatment of sprain is very simple. Massage comprises a series of movements with a view to render supple the engorged tissues, expel the stagnant liquids, and particularly the blood, and also to stimulate the muscles, tendons, and ligaments as well as the functions of the skin.

The method consists in pressure, more or less localised and more or less prolonged, by the hand, the thumb, or the four fingers. The pressure should be gradual, and centripetal, and never painful. At the beginning it should be very light and superficial, and when the affected region is accustomed to the contact a little more strength may be applied. Let us take, for example, a sprain of the ankle. The accident is recent, the pain intense, but the swelling still moderate. Massage practised at this period gives almost marvellous results; the infiltration being limited, the extravasated blood is still liquid and its absorption easy.

After the foot has been bathed, the surgeon will p lacesome vaseline on his hand and on the region of the ankle and begin by superficial rubbing of the limb from below upwards, in front, on the sides and behind. The pressure is increased very gently, especially over the seat of the lesion. The thumb, the fingers, the palm of the hand are all brought into requisition during the séance, and in a short time the patient begins to feel the good effects of the treatment. The excruciating pain disappears and even limited movements can be made by the patient. At the end of fifteen or twenty minutes the foot has assumed its normal aspect, only a slight sensitiveness being felt at the immediate seat of the accident. Motion becomes possible in the articulation, and the patient is surprised that he can stand up and even walk with but very little inconvenience. In slight sprains the cure may, from this moment, be complete and definite.

The same method, always very efficacious, is less so, and, above all, less prompt in its action when it is only applied the next day or the following, as will be seen. I have not once mentioned immobility as treatment of sprain, for it has been, and rightly so, discarded as hurtful by modern surgeons.

Up to the present, I have only spoken of the commonest of all sprains, that of the foot; but the same treatment can be applied to the wrist and the elbow. The knee, on the other hand, requires a more complicated treatment, for here massage is almost counter-indicated.

A sprain of the knee presents this peculiarity—that effusion into the joint is frequently considerable, whilst that around the articulation is almost insignificant. If the lesion is recent, the hæmarthrosis should be evacuated without delay by an ordinary trocar, and compression made over the joint with cotton wool for forty-eight hours; after which an elastic band is applied. The patient keeps his bed for a week, but is allowed to move the joint freely. If the lesion is not recent, compression of the part with an elastic bandage is combined with faradisation or galvanisation of the triceps and massage of the thigh. Massage of the knee itself is of little use. In sprain of the hip and shoulder, massage is the only good treatment when the lesion is recent, later the results are much less satisfactory.

THE SLEEPING SICKNESS IN UGANDA.*

BY CAPT. E. D. W. GREIG, B.Sc., M.B.Ed.
Indian Medical Service.

SLEEPING sickness broke out in Uganda in 1900, the country having previously been immune from the disease, and since its first appearance there 100,000 persons had died from it. A Commission was appointed by the Colonial Office, and he had been sent from India to take part in the investigation. The two main results achieved by the Commission were the discovery that sleeping sickness was due to the trypanosoma gambiense, and that the disease was conveyed by the Tsetse fly. Sleeping sickness had been introduced into Uganda from the Congo State; up till recently there was little intercourse between the two regions, but in 1900 some of Emin Pasha's soldiers crossed from the Congo basin and settled on the shores of Victoria Nyanza, and there the disease arose, since when it had spread all around the shores of the lake, but had not extended far into the surrounding country. Taking up first the clinical features of the disease, infection with trypanosomes was followed by a long period during which few or no symptoms were manifest. The temperature curve was normal, and the only sign of infection was enlargement of the superficial lymphatic glands, particularly those of the posterior cervical region. This was known empirically to slave dealers, who were accustomed to reject any slaves showing glandular swellings in this region, as they were aware that the malady would develop in them. Sooner or later, however, the temperature begins to rise, and the characteristic symptoms of the sleeping sickness develop, and progress steadily to the invariably fatal termination. A characteristic feature of the temperature is that during the last three or four weeks it falls to sub-normal, the body tending to assume the temperature of the surrounding air. The discovery that enlargement of the posterior cervical glands is an early evidence of trypanosome infection was of great importance in checking the spread of the disease, because the patients, being then in comparatively good health, moved about from place to place, and gave rise to fresh centres. When the nervous system became involved, with the onset of the febrile stage, the pathognomic symptoms developed. There were the typical facies, the somnolence, slow speech, tremor of the tongue and limbs, ataxia, and eventually loss of the power of walking. Not infrequently a certain degree of mental excitement, even amounting in some cases to mania, might occur. In the terminal stage, to which alone the name of "sleeping sickness" should properly be applied, the patient became semi-comatose, and lay huddled up with his limbs flexed, a mere mass of skin and bone. During this period the temperature fell steadily, the evacuations were passed unnoticed, food was not taken, and sores due to jigger-bites developed. At this stage the patient, if left to the natives, was put outside to die. The trypanosomes were at first present in the blood only, and in comparatively small numbers. As signs of implication of the nervous system appeared, the parasite could be detected in the cerebro spinal fluid. The blood showed no anæmia; indeed the red corpuscles and hæmoglobin might be above the normal in amount. The small lymphocytes were increased; this lymphocytosis corresponding with the action of the lymphatic glands. In the cerebro-spinal fluid of the period before the parasite was present in it there were only a few mono-nuclear elements; after the trypanosome had appeared, the mono-nuclear cells became very abundant. The pathology of the disease, according to Mott's observations, was that there was an aggregation of mono-nuclear cells in the perivascular spaces of the brain. Microscopically the exudate consisted of small lymphocytes with a few larger mono-nuclears and plasma cells. Mott believed that the symptoms resulted from the anæmia of the brain which these exudations into the peri-

* Abstract of paper read before the Edinburgh Medico-Chirurgical Society, January 17th, 1906.

vascular spaces produced. Another characteristic *post mortem* change was the occurrence of very numerous petechial hæmorrhages into the mucous membrane of the stomach; these areas were digested by the gastric juice and black erosions or ulcers resulted. Passing to their experimental work, Dr. Greig gave an account of the method in which the operations were begun, and described the appearance of the trypanosome. It had previously been known to be pathogenic to animals, but Dutton was the first to show that it produced disease in man. It reproduced itself by longitudinal fission; the question of whether there was also a sexual phase was still under investigation. They had detected the trypanosome in every case of sleeping sickness, and it next became a question as to whether the parasite was found in other persons from the infected area. It was found that about 50 per cent. of these natives harboured trypanosomes; a number of these cases were followed up and a considerable proportion subsequently developed sleeping sickness. Control observations made on a great number of natives in non-infected areas failed in any single instance to demonstrate the presence of the parasite. Coming next to inoculation experiments, they had chiefly employed monkeys. After excluding the presence of trypanosomes, these animals were inoculated with blood or cerebro-spinal fluid from patients, and in the sequel developed the disease. In monkeys, as in men, the course was chronic, and the temperature curve as well as the nervous symptoms were approximately the same. On examination of the blood and cerebro-spinal fluid, the parasite was found. The next step of the commission was to ascertain exactly the distribution of the disease by making extensive inquiries in all districts of Uganda. They found that it was endemic only around the lakes Victoria and Albert Nyanza, and that while fatal imported cases had occurred in the intervening country, none of these had caused epidemics. There was, therefore, some peculiar factor around the lakes favouring the spread of the disease. The suggestion occurred that it might be carried by the Tsetse fly, and a series of observations in the distribution of this insect were made. It was found that Tsetse districts were those where dense underwood surrounded the lakes; when the character of the country changed the insect disappeared. Several varieties of Tsetse were known; one of these (*glossina palpalis*) was the host of the trypanosome. Where blood containing the parasite was sucked by the fly the trypanosomes multiplied in its stomach, with great rapidity. Several forms appeared, probably representing a sexual phase. The Tsetse did not reproduce itself by laying eggs, but deposited one larva which in about three weeks hatched out into a mature insect. The next step was to infect Tsetse flies from sleeping sickness patients, and with them to infect monkeys. Tsetse flies free from trypanosomes were collected; these were fed on the blood of sleeping sickness cases and then were allowed to bite monkeys at periods of 8, 24, and 48 hours after they had sucked blood containing the parasite. The monkeys so inoculated took the disease, but the observers had never succeeded in conveying it by this means when the Tsetse flies had been kept longer than 48 hours after getting blood containing the parasite. Treatment had not so far been very satisfactory. Arsenic given subcutaneously had certainly the effect of checking the increase of the trypanosomes, but the effect only lasted while the arsenic was being administered. Arsenic along with trypan-oth, as advised by Koch, gave better results. Dr. Greig concluded his paper by describing his journey northwards to determine the limits of the distribution of the Tsetse fly. Wild animals in many parts of this district harboured the parasite, but were immune to its effects. Wherever both wild animals and the Tsetse fly co-existed, there domestic animals did not live. The wild animals acted as reservoirs for the trypanosome; they were "salted" and it was not impossible that some of the natives of the district, though harbouring the parasites, had a similar immunity.

THE MATERNAL FUNCTION AND THE NATIONAL LIFE.*

By WILLIAM ALEXANDER, M.D.R.U.I.,

F.R.C.S.ENG.,

Lecturer on Clinical Medicine in the University of Liverpool.

THE importance of the mother's influence in the formation of the race has been recognised by historians, statesmen, society, and by scientists. The Spartan mother has become a by-word, the Roman matron conjures up in the mind a woman stately and noble both in mind and body, inclined rather to the sterner qualities of nobility and producing sons and daughters of the same firm, unbending strain. The British matron, a good Christian, loving, sensible woman, full of kindness and of good nature, stately withal and thoroughly healthy, a woman who for centuries has reared her young bull dogs and sea dogs in such a way that with a footing in these small islands in the western main they have colonised a large part of the broad earth and dominated the sea. The mothers are the makers and the sustainers of the nation, and motherhood is the grand career for women. Some cynic has said that the function of women is "to suckle fools and chronicle small beer." This is obviously parody in both particulars. Women re-create the race for each generation, and purify and sustain society. To woman alone is entrusted by Nature the entire welfare of the child during its prenatal conditions, and to her especially is entrusted the nourishment of the child during the first nine months of its postnatal existence. After the child is weaned, it is not so dependent on the mother. Husbands, sisters, nurses, corporations, can nurse the nine months' baby up to childhood with success and even with a solicitude and self-sacrifice that may emulate a mother's tender care. Before weaning no one and nothing can efficiently take a mother's place, and in the prenatal period the mother is absolutely indispensable, the human ovum not yet lending itself to the artificial influence of incubators, and so enabling women to evade altogether the pleasures and penalties attached to their sex. It is satisfactory that we may contemplate our decease before incubated men and women occupy these chairs. It follows therefore that a woman who would be a suitable mother requires a thoroughly normal, healthy condition of the body, so that she can afford suitable nourishment during the formation of the child. She requires an equable quiescent and stable condition of mind as well as of body during pregnancy, so that, neither nervous influence nor physical shock may partially or entirely dislocate the growing foetus from its somewhat precarious attachment to the maternal structures and bring about a deformity, an abortion or a miscarriage. We have still many mothers in this country who are filled with a sacred joy when they feel the indications of another life within their own, and who instinctively and lovingly take every care that the promised fruit of their womb may come forth in due time, a full fledged, perfectly healthy baby. But it seems to me, and this is the burden of my story, that a gradually increasing number of mothers are careless, not only of the prospects but even of the existence of the unborn child. Does a condition of pregnancy interfere with a proposed trip by sea, a series of social engagements, or the pleasures of a festive season? I have known instances where the production of abortion has been contemplated and proposed and even "accidentally" carried out as a solution of the difficulty, and the possible destruction of the foetus was entertained so lightly, that the mere suggestion of the word criminal in connection with the means employed—viz., a gallop on horseback, or a game at tennis was laughed at by the unnatural though refined mother. In such cases, premature labours and still-births may result long after the indiscretion

* Abstract of Presidential Valedictory Address delivered before the British Gynaecological Society, January 11th, 1906.

has been forgotten, or if remembered is not recognised as a cause.

I have tried to obtain statistics of the annual number of still-born children and of abortions, but neither are recognised by the Registrar-General and consequently not tabulated in the death registers. The premature births are, however, registered, and in 1902, 18,909 children died from the effects of premature birth, that is, from some defect in the antenatal development or nourishment of the child. The causes of death in still-born and premature children is exactly the same and due to some fault in their environment during the antenatal period. We can only guess at the number of still-born children. In the Liverpool Workhouse Lying-In wards amongst 2,829 children born, 225 were still-born, many of these having died some time before birth. If we take these numbers as a basis, knowing that 948,271 children are born annually in England and Wales we find that 88,752 of these are still-born. This is probably too high an estimate, as the mothers in a workhouse hospital are more frequently diseased and dissipated than those of the nation generally. On the other hand, some of them are strong, vigorous women who are better mothers physically than many in the higher classes of society. As to the numbers of miscarriages and abortions, we can only proceed as before from known figures to the unknown. For instance, in the year 1903, 152 women are reported by the Registrar-General to have died from abortions or miscarriages. The mortality of abortions is very small, certainly not more than half per cent., probably much less. A half per cent. mortality of abortions would give 30,400 abortions and miscarriages annually. We have, therefore, by adding together 88,752 still-born 18,909 premature births, and 30,400 miscarriages, a grand total of 138,061 children who are conceived but who die every year from causes affecting them in the antenatal period. We know that Nature is most lavish in her provision for the continuance of the race, and squanders material in her laboratories in an apparently reckless manner. The mother aborts often in spite of the greatest care to prevent it, nay, in consequence sometimes of too much care and anxiety to prevent such an event, and medical men of the greatest experience often fail to help the mother in such cases. We admit this, and while we may doubt the absolute reliability of the figures given above, which I ask you to remember are put forward only as rough estimates, it will be admitted from everyday experience that at the present time many children are conceived and develop to a certain extent, but perish through maternal carelessness or ignorance, or both; and that multitudes of half-made infants, if we may use the expression, are born to be a weakness to the nation owing to the same ignorance and carelessness.

It should be the business of self-governing communities like ours to see that every member is effective and performs his or her part in maintaining the life of the nation. The industrious and respectable members who support themselves and bring up their children to be strong, healthy, and useful members of the community ought to be protected. They will be overborne if they have also to support an increasing and indefinite number of illegitimate or homeless and unmothered children. It is true that mothers of illegitimate children are tabooed in society and are outcasts, but they continue to have illegitimate children year after year without check or restraint. Our industrial schools are full of them, and the rest are the results of improvident marriages. In a minority of cases, death and sickness or unpreventable misfortune leave the children of decent parents stranded in such a way that only such places will take them in. It would seem to be advisable, and will soon be absolutely necessary, to have what we ought to call a Marriage Board composed of the wisest and best and most honourable in each locality, before whom pairs desiring to enter into the state of matrimony would, as a necessary preliminary, appear and satisfy its members that provision had been made for contingencies during the first

few years of married life; that the man was healthy, of good character, in steady employment for a sufficient number of years, and likely to be a good husband, and that the woman was healthy and vigorous with no hereditary disease, who recognised the responsibilities she was taking upon her in entering into the married state, and that she possessed some knowledge of the nature of her responsibilities and of how to deal with them. A certificate from such a Marriage Board should be given, and a contract, signed and witnessed, should be handed to the clergyman before he performs the sacred rite.

The Marriage Board should, through lady visitors, inspectors, or nurses, keep in touch with the newly-married so as to help them by advice and sympathy where they seem to require it, and with substantial help should misfortune assail the pair during the time of the mother's pregnancy. A pregnant woman should be helped without questions by the purveyors of public charity. Should she be undeserving, the unborn child is always innocent and deserving. A single woman should only be allowed to have one illegitimate child without interference. She may have been deceived, being innocent and inexperienced in the ways of men, but the same excuse will not avail twice. After the second time she might be sent to an institution to be kept out of harm's way, and be required to work for her living and that of her children under supervision. The father, if known, should be taxed to the same extent as legitimate fathers are for the keep of his illegitimate child.

During the antenatal nine months the onus of supplying nourishment to the mother and child rests upon the husband. The mother has only to nourish herself generously, and Nature passes on its due share to the child. When the child is born Nature has provided an inexhaustible source of suitable diet for it well preserved and well protected from contamination in the mother's breast. This is the birthright of every child, a birthright that places it above risks resulting from the ignorance or selfishness of the mother.

The nursing of a child necessitates the giving up by the mother of many things that she has loved. Her diet must be taken with an eye to the child's welfare. She cannot leave the child for long, and her duties to society must be subordinated to her nursing duties. To fashionable people the nursing of children becomes an intolerable nuisance. The child is delegated to the nurse and the bottle, and many mothers bring up their children in this way with apparent success by the aid of science, more or less specious, and much expenditure of money on advertised infant foods.

However much doubt there may be about the number of children that die in a prenatal condition, there is no doubt about the numbers that die in the first year after birth, that is, during the nursing period, when the child should be still dependent on the mother. The mortality of the new-born during the first year is 133 per thousand for the most recent year an approximate total of 126,117. This includes the 18,909 deaths from premature labour, but does not include the 119,152 still-born and abortions that might be imagined to have died during the prenatal period. The total number of children who die while in the mother's care is 245,269 annually, or in round numbers a quarter of a million. Now, the loss of prenatal children does not call for any pity for the sufferings of the deceased. They were not conscious and could not realise what they failed to become. The number (18,909) of children prematurely born, however, died early with the usual pangs, modified no doubt by the imperfection of their constitutions. Indeed, I believe that the Creator has so arranged matters that helpless babies die off more easily and painlessly than older people, otherwise the thought of upwards of one hundred thousand who die annually before their first birthday would be more appalling than it is. Many, no doubt, die from disease, in spite of every effort on the part of their parents. But ignorance and imperfect diet, drink, neglect and thriftlessness carry off numbers that may be counted by

thousands. Let us hope the new Royal Poor-law Commission will take up the cause of these helpless children and thriftless vicious mothers, and see that the Poor-law hospitals are not used, as they are at present by depraved women, for their own convenience, but will so arrange that women who bring children into the world and fail to look after them, and who kill them by neglect, carelessness, or intemperance, will be liable to punishment, and that the child may be rescued from the mother and protected from its earliest infancy. The mother should be deprived in some effective way of the opportunity of having more children, as surely the nation does not wish the continuation and the gradual increase of such a race. Let us look for a moment at the extent of the mischief. Taking the statistics of the Liverpool Workhouse Hospital for a recent year, 1904: Out of 389 births in that year, 158 were single women who were delivered there of illegitimate children. Of these 106 were confined of their first child, 31 of their second child, 16 of their third, 13 of their fourth, 9 of their fifth, and we have known some cases of the half dozen. Let us think for a moment of the extent of illegitimate births in one of the workhouses of Liverpool only, and there are two others. In one year 158 mothers brought forth as many illegitimate children into the nation, both mothers and children being fostered and cared for during their confinement with all the grand results of science in a way that the mothers of even middle-class independent and hard-working people cannot command.

Here we have the source of the deterioration of the race, of the decadence of the nation, of the ever increasing floating population who prey on the effective citizens and weigh down the prosperity of the community. It may be said that the majority of these 158 babies die within the year, and that such deaths are a merciful dispensation of Providence. It would be well were it so. But I have followed up 304 such babies born in 1903, until a year after their birth, and find that only 88 died of various diseases. That is 216 every year live to pollute the population out of one city parish, and there are several hundreds of such parishes. Their death-rate is at present 280 per thousand, rather more than twice the average. Not a word can the authorities say to these women. The foremost aseptic conditions are prepared for their confinement in the wards of most of the workhouses, and hard working men and women in the country have to pay to support them and their children not only during the infancy of the latter, but as tramps and criminals into which they degenerate for the whole of their lives.

My conclusions are:—

1. That the prosperity of the nation depends on the "annual output" of healthy vigorous children, whose parents are independent and perform their legal duties to their offspring, nourishing them and bringing them up to be sturdy fellow citizens like themselves.

2. Members of the community who do not possess the brains, the vigour or the health to make a place for themselves in the land, who cannot in other words build a nest for their young, should not be allowed to marry. They themselves are so much dead weight in the country, swelling the ranks of the unemployed and the criminals, they propagate their kind readily and rapidly, and, owing to a sympathetic and generous Poor-law, safely, assisted by the many overlapping agencies that make it easy to evade the old Scriptural law, which saith: "He that will not work, neither shall he eat."

3. That the nation should insist on mothers nursing their children. It is, as was said before, the birthright of the child, and as soon as the child is born it is under the protection of the community who should insist upon its having its birthright where it is possible.

The Fellows of the British Gynæcological Society can, by their great influence and knowledge promote these objects, help to increase the vigour and force of the nation, and proportionately to diminish the human rubbish which is now being propagated at such a rate as to threaten to retard the onward march of humanity.

THE OUT-PATIENTS' ROOM.

WESTERN OPHTHALMIC HOSPITAL.

Lachrymal Gland Abscess.

UNDER the care of Mr. G. W. THOMPSON, M.B., F.R.C.S. The patient, a child *æt.* 6, was brought to the out-patient department with marked swelling of the eyelids, slight chemosis of the conjunctiva, and moderate proptosis, the eye being directed forwards, downwards, and slightly inwards; there was practically no movement outwards of the globe. On examination under an anæsthetic a slight fulness and hardness was detected in the outer angle of the upper cul-de-sac. After dividing the outer canthus a Græfe knife was pushed up and out into the region of the lachrymal gland, and a few drops of pus were evacuated. Hot fomentations were applied. The child was seen every day, and in two days the proptosis had entirely disappeared, and by the end of the week all swelling of the lids had gone and outward mobility of the globe was completely restored. Mr. Thompson said the interest of the case lay in the fact of proptosis. He thought that perhaps this could be explained by the inflammatory condition spreading backwards into the orbit; as a rule in cases of lachrymal abscess the swelling is quite obvious either on external palpation of the lid or when the patient is made to look downwards, and at the same time especially inwards, because the inflammatory condition spreads forwards. A characteristic symptom of lachrymal abscess is œdema of the ocular conjunctiva limited to a small area between the outer canthus and the outer border of the cornea.

Rounded swelling below the lachrymal sac, lying on nasal bone and superior maxillary.

The patient, a young man *æt.* about 20, was supposed to have symptoms of a lachrymal sac abscess. He had a swelling about the size of a small marble just below the sac region. This was opened and some yellowish red pus escaped, this being suggestive of a broken-down gumma. The wound was sewn up and a small drain was left. On the next visit of the patient, five days afterwards, the wound was re-opened, and a probe, after a sinuous course, found its way into a bad tooth; the latter was removed, and the abscess then promptly healed. Mr. Thompson remarked on the peculiarity of the case; it might have been a gumma or a suppurating sebaceous cyst. The disease in the tooth had evidently been the primary cause, but this had not been suspected by him when he first opened the abscess, as he had never previously seen such a condition.

OPERATING THEATRES.

NORTH WEST LONDON HOSPITAL.

FRONTAL SINUS DISEASE.—MR. MAYO COLLIER operated on a man, *æt.* 27, who was suffering from pain and swelling in the right frontal region. The history of the case is as follows:—Six months ago the patient was affected with a severe nasal catarrh which was complicated after a few days with pain in the right frontal region. The pain was not sufficient to incapacitate him from work, nor was the temperature apparently increased, as he took his food and slept as usual. Between a fortnight and three weeks after this seizure he complained of tenderness over the right frontal region about an inch and a half above the inner angle of the right orbit. He sought local advice and was very properly treated for an abscess of the frontal sinus. Expert advice was subsequently desired, and the case was sent to the North-West London Hospital, under Mr. Mayo Collier. The specialist who had seen the case had made an incision over the swelling, and had come upon dead bone and a considerable quantity of pus. The case was admitted into the hospital about a month ago, and was seen within forty-eight

hours by Mr. Mayo Collier. On examination there was a wound in the right frontal region leading into the right frontal sinus in which there was a carious sequestrum. On examination of the nasal cavities the left was apparently normal, although the breathing space was somewhat contracted; the right nasal cavity was a little contracted, but otherwise there was not evidence of frontal sinus disease. An attempt to pass a frontal sinus catheter was unsuccessful owing to the limited space in the middle meatus, and an endeavour to remove the anterior end of the middle turbinal body met with so much difficulty that it was postponed till the frontal sinus had been investigated. An incision was made in the mid-frontal line outwards and transversely to the right to an extent of about two inches. On raising the tissues over the frontal bone a sequestrum as large as a sixpenny-piece was found covering, and opening into, the right frontal sinus. On the under aspect of this sequestrum the ridge separating the two frontal sinuses was apparent. It was now seen that the opening, which seemingly belonged to the left frontal sinus, communicated with the right frontal sinus, and that the right frontal sinus was intact. On attempting to investigate the opening corresponding to the sequestrum, which was situated over the left frontal sinus, the probe passed into the right frontal sinus. On further examination, the right frontal sinus was found to be also full of pus, and on the application of a small trephine, it was discovered that this sinus extended as far as the outer angle of the right orbit and for a considerable distance over the roof of the orbit. Mr. Collier said that here was a condition of things extremely unusual; the left frontal sinus was very small and undeveloped; the small cavity which existed communicated independently with the right nasal chamber, but the right frontal sinus was very extensive and communicated also independently with the right nasal chamber. It should be noted that the bone forming the anterior layer of right frontal sinus was extremely thin, not thicker than a sixpence. The whole interior of the right frontal sinus was full of polypoid granulations and showed considerable thickening of the lining membrane. He pointed out that in cases of this description the only hope of a radical cure rested on the removal of the anterior wall of both frontal sinuses so as to obliterate these cavities; when once the lining membrane had become so disorganised as to produce polypoid granulations little hope existed of resolution into a healthy condition. The whole of the interior was curetted and the lining membrane removed to the full extent of the sinus. The cavity was plugged with cyanide gauze and the skin adjusted, leaving a large opening over the original sinus. The opening into the nose was enlarged, and a large drainage tube inserted so as to allow free drainage into the nasal cavity.

The subsequent history of the case was very instructive. The external wound healed perfectly by first intention, leaving little or no scar. The wound drained freely into the nose, and the case proceeded satisfactorily; on the fourth day the wound was dressed, the plug removed, and drainage dispensed with, the patient's condition being all that could be wished. On the sixth day the man was sick, and the pulse below normal; there was some distaste for food, but otherwise the wound and general condition were excellent. On the seventh day the patient was examined in consultation with two physicians; the pulse now was forty-six, there was constant sickness, and the man's state was not satisfactory. The wound had healed, was free from tenderness or redness,

and there was very little discharge. The joint opinion expressed at the consultation was adverse to any further operative procedure. Mr. Collier gave instructions that if things did not change for the better the wound should be opened up and examined. This was done on the same evening. On re-opening the wound the greater part of the right frontal sinus was obliterated throughout, there was some secretion between the outer and posterior layers in the immediate vicinity of the wound. On examining carefully the posterior bony layer of the frontal sinus a small sequestrum was found. On removing this and enlarging the opening, dura mater bulged and was free from pulsation. When a needle was introduced offensive pus issued. On further opening the dura mater about two ounces of stinking pus were discharged. A drainage tube was inserted and the wound closed. It was noted that subsequent to this operation the pulse improved and rose to 120. During the next forty-eight hours the condition of the patient was satisfactory, but on the third day there was pain in the right arm complained of, with some rise of temperature; general meningitis supervened, and the patient died in the following forty-eight hours. Mr. Collier said this was a case full of instruction as far as the frontal sinus disease was concerned. A moderate sinusitis in this patient had resulted in a sequestrum in the anterior and posterior bony layers of the frontal sinus; the anterior sequestrum, as being larger and more evident, was removed, the posterior sequestrum, being quite microscopic, had been overlooked. The extreme and abnormal thinness of the bony walls was quite unusual, and had evidently predisposed the destruction of portions of the anterior and posterior walls; the peculiar arrangement of the sinuses was also, he thought, an abnormality of extreme interest; it was very rare that both sinuses should discharge into the right nasal chamber, and this, together with the association of the extremely thin bony walls, was a point in the surgery of the frontal sinuses which was well worth noting.

Royal Commission on the Feeble-minded.

ON Friday last Dr. Lionel Weatherley, Medical Superintendent of Bailbrook House Asylum, Bath, gave evidence with reference to feeble-minded criminals. He said that neither the prison nor the county asylum, as at present constituted, was a suitable place for their reception. The prison had neither a deterrent nor reformatory effect upon them. He strongly advocated a special penal colony for those who had been convicted of crime or misdemeanour, where they should be given a chance of being educated to some suitable and congenial occupation.

Presentation to Dr. Henry FitzGibbon, Ireland.

ON Thursday last Dr. Henry FitzGibbon was the recipient of a presentation from all grades of the postal service. The testimonial served to commemorate the twenty-five years' service which he has spent as medical adviser to the department, and the occasion was availed of by the various employees to give expression to their appreciation of the efficient manner in which he discharged his duties during his long and honourable association with them. The form of the presentation consisted of a massive loving cup, a silver salver, and an illuminated address. The cup was a replica of the Ardagh chalice, and was a beautiful sample of the silversmith's art. Mr. G. M. Hurley, Chairman of the Irish Post-office Clerks' Association, presided, and he and others spoke in flattering terms of Dr. FitzGibbon's work amongst members of the postal service for the last quarter of a century. Dr. FitzGibbon, who appeared deeply touched, expressed his thanks for the tokens of their affection.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, JANUARY 5TH, 1906.

The President, DR. JOSEPH O'CARROLL, in the Chair.

FRACTURES OF OS CALCIS AND ASTRAGALUS.

PROFESSOR BENNETT said—One reads in the present day the old assertions about fractures repeated as if they had not been put aside by the accumulated knowledge of the last century. I take this example from a book bearing the date 1900:—"Fractures of the tarsal bones are always caused by direct violence (passing of a carriage wheel), falling of a heavy weight upon the tarsus." To put any addition to our knowledge of the fractures of the tarsus is a matter of interest in helping to wipe out the "always" from the passage I have quoted. Bad anatomy does not help us in this difficulty. "The astragalus is a peculiar bone, inasmuch as it articulates with four different bones and shows no point of insertion of any tendon." May not the horizontal division of the external lateral ligament be regarded as tendon? I regret that I am not able to state anything of the life history of the examples I record to-night, but I present them as I have them. The first of these is a left os calcis, which Professor Dixon kindly gave to me this session, because the portion of bone forming the articular surface in front of the sustentaculum tali is wanting. The specimen agrees in many particulars with the case of Legouest, figured in the thesis of A. Ballenghein (Thèse par A. Ballenghein. July 20th, 1890. Page 126), and is wanting in the fact that the little piece of bone has not been preserved. My next two specimens concern the astragalus. Some five and twenty years ago I published a discussion on the supposed fracture of the tubercle of the astragalus whether it be a fracture or not or a vestige of the ostrigonum tarsi (*Journal of Anatomy*, Vol. XXI.). I have multiplied specimens of this kind until now my series number eleven. To-night I show a united fracture of the same region of the bone, without doubt a fracture well and truly knit but how caused I cannot say. The anterior part of the tubercle with the groove for the tendon of the long flexor of the great toe has been broken and united with the minimum degree of deformity. The question which is most difficult of solution is—How did it get broken? By what force, direct or indirect? Lastly, I show a specimen which I am again very hard set to read to-night. I put this by in spirit last summer, puzzling over it to find some solution of its mysteries. While the summer passed the spirit sped away, and when I came back to my work almost all my mysterious signs of fracture had gone. See how I got the specimen. A student in his first year had dissected the lower extremity to the last shred, and he had got the astragalus isolated neatly from the bones of the leg and from the tarsus, and, seeing me pass, asked me to look at "the fracture." I agreed in his diagnosis. I said I could see no damage or trace of it in the bones of the leg or of the tarsus, and, for some reason being pressed for time, I was content to walk off with the bone. No one here would give me credence for my diagnosis of fracture had I not put the specimen in water a few days ago, and so repaired the damage of the evaporated spirit. Read the lesion as you like. A fracture it was, taking effect on that part of the head of the bone that rests on the calcaneo scaphoid ligament, and it has not passed to any deeper extent than the cartilage.

CANCER OF THE OESOPHAGUS WITH SECONDARY GROWTH IN THE HEART.

DR. TRAVERS SMITH exhibited some of the thoracic viscera of a man, *æt.* 70, who had died under his

care in the Whitworth Hospital of flat-celled cancer of the oesophagus. The growth had caused a very narrow stricture, and had grown by direct extension into the outer coat of the descending aorta. Numerous small secondary deposits were also found in the outer coat of the aorta, and the bronchial lymph glands were cancerous. Embedded in the wall of the left ventricle near the auriculo-ventricular groove was a secondary deposit the size of a large hazel-nut, which on microscopical examination, made by Dr. Earl, showed typical flat-celled arrangement. There were no metastases of the disease below the diaphragm with the exception of a cancerous deposition in a single lymph gland situated under the peritoneum on the anterior aspect of the stomach near the oesophagus, and nearer the lesser curvature than the great. Dr. Travers Smith laid stress upon the frequency with which this gland was affected in internal, especially abdominal, cancer. He also spoke of the difficulty in fully explaining how the secondary deposit in this case had reached the heart.

The PRESIDENT said that an interesting point had been raised—namely, the dissemination backwards against the lymph stream. This must often happen also in various forms of tubercle. The particle must be supposed either to have gone against the stream or else had been carried by the subclavian, returned by the vena cava and going through the pulmonary system was deposited by the coronary artery in the heart.

PROFESSOR BENNETT said the same thing must occur in cancer *en cuirasse*, as the cancer certainly did not follow the lymphatic stream.

DR. LITTLE said that in cases of tubercular meningitis the original lesion was often found in the bronchial glands so that in such cases the infection must also travel against the stream.

DR. TRAVERS SMITH briefly replied.

HYDROCEPHALUS.

DR. O'CARROLL showed a hydrocephalic brain of a boy, *æt.* 17, who had suffered for about six years from headaches and frequent sub-comatose attacks lasting a few days. The cranium was not much larger than normal, and was fully ossified. The ventricular cavities were considerably dilated, but not to the degree of thinning the brain substance excessively. The greatest thinning was at the lower anterior part of the lateral ventricle, where the cortex was adherent to the underlying bone. During the last couple of months of the boy's life a colourless watery fluid, recognised to be cerebro-spinal fluid, used to drip freely from time to time from the left nostril. No thickening or occlusion of the pial curtain descending from the cerebellum to the medulla was found. It was evident that the serous discharge from the nostril came from the left ventricle by way of the adhesion of the temporo-sphenoidal lobe to the body of the sphenoid. It is to be noted that during life the boy had been sub-normal in intelligence, but by no means an imbecile; he had learned to read and write, and could perform simple mental calculations. He was of average height and weight, and the head was not abnormally large, but the sexual organs were poorly developed. The skin, of normal texture, seemed somewhat tightly drawn over the limbs as it ordinarily is on the outside of the thigh; but there was no scleroderma. There had been no ataxy. In walking his toes caught the ground now and again, and Babinski's toe-extension sign was present, while increased knee-jerk and ankle clonus were absent. There was no proof of hereditary syphilis; his birth had been instrumental. Dr. O'Carroll suggested that, as in other cases, hydrocephalus seems to depend on obstruction of the posterior outlet of the ventricles; this may have started in obstruction of anterior fissural outlets by an early basal meningitis of adhesive character, the outlet re-asserting itself recently in the nasal drip.

Dr. EARL described the appearance of the brain on making a *post-mortem* examination. There were a number of points on the anterior surface of the temporo-sphenoidal lobes where the brain was adherent to the bone. Also at one point on the lower surface of the left temporo-sphenoidal lobe there was a thin piece of brain left adherent, a small hole resulting. The membrane over the roof of the fourth ventricle did not appear to be thickened. The ventricles of the brain were generally distended, and the foramen of Munro was much enlarged. The sella turcica was very large as a result of the ventricular distension, not of any change in the pituitary body, which was simply flattened out.

Dr. TRAVERS SMITH said that Dr. O'Carroll deserved great credit for his diagnosis, as the diagnosis of chronic hydrocephalus was often very difficult in its early stages. He described a case which he believed to be chronic hydrocephalus in a girl, *æt.* 11. She had a distressed, anxious expression, and was completely paraplegic. Knee-jerks were lost. Legs and practically the whole trunk were anæsthetic. Pupils were widely dilated. Pulse 60. He did a lumbar puncture and the cerebro-spinal fluid came away in a strong stream. It was clear, and contained no micro-organisms and practically no cells. He presumed that Dr. O'Carroll's case was one of hyper-secretion of the ependyma, and he wondered if it had anything to do with the immature sexual organs, the condition of the skin and subcutaneous tissues.

Dr. MOORHEAD described a case of his own in which hydrocephalus had occurred after pyrexia lasting for sixty days in a man, *æt.* 65. There was no obstruction to outflow, and there was increase of the subarachnoid fluid. The cerebro-spinal fluid was distinctly turbid and he cultivated the *Bacillus coli communis* from it. He regarded the hydrocephalus as due to inflammation of the ependyma.

Dr. NEIL also described a case in an infant, *æt.* 3 weeks, from which he had removed twenty ounces of cerebro-spinal fluid through the occiput.

Dr. O'CARROLL, in replying, said that although he had got no proof of syphilis in the case, he had perhaps suspected it as being the cause. He did not know whether the condition of the skin could be associated with pituitary mischief or not.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY

MEETING HELD JANUARY 17TH, 1906.

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

Dr. JAMES CAMERON showed a strangulated testicle from a case of strangulated hernia in an infant, aged 6 weeks, successfully operated on.

Dr. DOUGLAS WILSON (Harrrogate) showed radiograms of the hands of a case of tophaceous gout.

Captain E. D. W. GREIG, I.M.S., gave a communication in the form of a lantern demonstration embodying the results arrived at by the Commission appointed to investigate

SLEEPING SICKNESS IN UGANDA.

This paper will be found in another column under the heading of "Original Papers."

Mr. GEORGE CHIENE read a paper on

STORAINES AS A SPINAL AND LOCAL ANÆSTHETIC.

After referring to the advantages which any safe local anæsthetic would present as compared with a general anæsthetic, the introduction of spinal anæsthesia with cocaine by Bier was mentioned. On account of the disadvantages attending this, Bier discontinued its use, but at a later period the method was again taken up, cocaine being supplemented by adrenalin. Later still, a new anæsthetic, storaine, had been introduced. Storaine, or hydrochlorate of amylene, was discovered by Furneau in 1904. It was prepared from tertiary amylic alcohol; its action was that of a vasodilator, local anæsthetic, and antipyretic. It could be sterilised by heat without alteration of its properties. In doses large enough to be

lethal to animals, tonic and clonic spasms, then paralysis of the legs preceded the fatal termination. Compared with cocaine it stimulated the pulse, caused flushing, contracted the pupil, and produced no tendency to syncope; it was, on the whole, much less toxic. It had comparatively few after effects; nausea, vomiting, and headache were the chief of these. Before referring to his own experience, the speaker reviewed the literature of its use as a special anæsthetic. When failure occurred probably the technique, not the drug, was at fault. For spinal anæsthesia, from 2 to 10 centigrammes of the substance, which occurred as a fine crystalline powder, were required. This should be dissolved in ten times its bulk of sodium chloride solution. An all-glass syringe was employed for the injection. The technique was very much that of lumbar puncture. After the needle was introduced into the spinal canal, a little of the cerebro-spinal fluid was aspirated into the syringe and mixed with the solution of storaine. The whole was then injected into the spinal canal. In a few minutes the patient experienced a feeling of pins-and-needles in the feet; this was followed by rapid loss of sensibility to pain, touches being still perceptible. The order in which analgesia appeared was (1) perineum; (2) toes; (3) legs, passing up over the body. In none of the speaker's cases had the loss of sensibility reached above the umbilicus. The analgesia passed off in the reverse order. In all Mr. Chiene had used storaine spinal anæsthesia in fourteen cases, with three failures. Twice he had not succeeded in reaching the spinal canal, and once he had not been able to get the storaine injected. In three of the remaining cases a limited amount of chloroform had also been required on account of an insufficient dose of storaine. He thought that the doses stated erred through being on the small side. In none of his cases had there been any unpleasant after-effects. As a local anæsthetic storaine was less powerful than cocaine, and did not seem to present any great advantage.

Dr. LUKE spoke of the risks attending spinal as compared with general anæsthesia. He had heard of three cases of gangrene of the skin from the use of storaine.

Mr. CAIRD said that spinal anæsthesia had undoubtedly come to stay. Recalling Bier's early work with cocaine spinal anæsthesia, he said that one could not fail to be struck with the fact that the patients, though they felt nothing, got into a dangerous state of collapse. Storaine anæsthesia had as one advantage that it was possible to have the patient lying horizontal, while with cocaine it was important to have the head and shoulders raised lest the drug ascend the spinal canal. He described several cases in which he had employed storaine, notably in operations about the rectum, in elderly people with heart disease and emphysema, in whom a general anæsthetic would have been risky. He had also used it for disarticulation at the hip for malignant disease. In one of his patients two hours after the injection was given, and after the operation was over, the anæsthesia extended to the neck. For local anæsthesia he preferred cocaine.

Mr. J. W. STRUTHERS spoke of the risks attending spinal cocaine-gation.

Dr. THEODORE SHENNAN read a paper on the THE RELATION OF SPIROCHÆTA (SPIRONEMA) PALLIDA TO SYPHILIS,

which we hope to publish in our next issue.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

ANNUAL MEETING AT MANCHESTER, ON JAN. 19TH, 1906.

DR. D. LLOYD ROBERTS, President in the Chair.

DR. D. LLOYD ROBERTS, delivered his valedictory address on the

EVOLUTION OF OPERATIVE GYNÆCOLOGY.

remarking that in the early days of operative gynæco-

logy the operation aimed directly at the object to be gained. He roughly estimated the difficulties and dangers to be overcome and did not elaborate improvements, the need for which was as yet unknown. Hence the early methods were crude and devoid of niceties of execution. Then improvements were added until simplicity was overlaid with complexity. The attention of later operators was given to details, to the surmounting of isolated obstacles frequently at the expense of the unities of the operation. Finally a reaction set in, complicated methods were abandoned and a return was made to primitive simplicity shorn of its crudities. Crude directness of purpose gave place to elaboration of method, which in turn yielded to that effective simplicity which represented the high water mark of applied knowledge. This central thought was illustrated by the speaker from the history of abdominal surgery in general with special reference to Casarean section. The operations for cancer of the uterus were reviewed, also those for vesico-vaginal fistula. The mode of dealing with the pedicle of ovarian tumours afforded another example of the main thought. The speaker added that the same cycle which has been observed in the evolution of gynæcological operations, is being passed through by the operators themselves. The modern gynæcologist was evolved through the obstetric physician from the man-midwife, and there was a tendency for him to give up his original function, that of attending labours. But as there must always be those who are exceptionally qualified to act as obstetricians, the primitive usage would be reverted to, and place would still be found for the obstetric physician—a specially skilled man-midwife. The value of investigations in pre-natal pathology was emphasised and this was suggested as a rich field for study for the obstetric physicians of the future.

Dr. J. B. HELLIER (Leeds) showed a pelvis deformed as a result of

INFANTILE PARALYSIS.

There was deficient development of the os innominatum of the paralysed side and the normal flattening which takes place between birth and maturity was exaggerated on the sound side on which extra weight was thrown. The left limb was four inches short and much atrophied, the left sacral plexus was atrophic, while the obturator internus and pyriformis were scarcely to be found. The patient was *æt.* 39, and had walked with a crutch. There was a difference of $\frac{1}{2}$ -inch between the oblique diameters of the pelvis at the brim. There was great contraction at the outlet; the ischial spines being $3\frac{1}{4}$ inches apart while the tip of the coccyx was within $1\frac{1}{4}$ inches of the symphysis, and deviated $\frac{1}{4}$ in. to the right.

Dr. Richard Favell, of Sheffield, was elected President of the society for the year 1906.

The following office bearers were also elected:—
Vice-Presidents: Sir William Sinclair, M.D., D. Lloyd-Roberts, M.D., Manchester; Owen Bowen, M.R.C.S., Arthur J. Wallace, M.D., Liverpool; J. Braithwaite, M.D., C. J. Wright, M.D., Leeds; John W. Martin, M.D., Percival E. Barber, M.R.C.S., Sheffield. Hon. Treasurer: E. Octavius Croft, M.D., Leeds. Hon. General Secretary: W. E. Fothergill, M.D., Manchester.

The usual dinner was held at the Queen's Hotel after the meeting. Dr. Favell in the Chair.

LARYNGOLOGICAL SOCIETY OF LONDON.

At the Annual Meeting held on January 12th, the President, Mr. Charters J. Symonds in the Chair, the following were elected as officers and members of Council for 1906:—*President*: Mr. Charters J. Symonds, *Vice-Presidents*: Dr. F. Willcox, Dr. J. D. Ball, Dr. William Hill, Dr. Watson Williams. *Honorary Treasurer*: Mr. H. B. Robinson. *Honorary Librarian*: Dr. St. Clair Thomson. *Honorary Secretaries*: Dr. H. J. Davis, Dr. W. Jobson Home. *Members of Council*: Sir Felix Semon, Mr. Philip de Santi, Dr. J. Middlemass Hunt, Mr. S. Paget, Dr. Atwood Thorne.

At the ordinary meeting, held subsequently, the following communications were made:—

Dr. W. H. KELSON exhibited a case of Sinus of the Chin, and also one of Ulceration of the Left Vocal Cord of an obscure nature occurring in a man, *æt.* 28.

Sir FELIX SEMON exhibited a patient, *æt.* 74, in whom a tracheal canula had been permanently worn for twenty-seven years for incomplete bilateral paralysis of the post-crico-arytenoid muscles which had remained unchanged all that time.

Dr. DUNDAS GRANT exhibited a case of Extensive Ulceration of the Pharynx of a Syphilitic Nature, and also skiagrams illustrating the treatment of frontal sinus suppuration by irrigation.

Dr. J. B. BALL exhibited a case of Ulceration of the Pharynx and Larynx of an Epitheliomatous Nature, the point of interest being the very early involvement of the glands and the appearance of an ulcerating mass behind the tonsil, the disease having originated in the larynx.

Dr. E. A. PETERS showed a specimen of a Tumour attached to the Base of the Sphenoid, which presented under the microscope the structure of a fibro-angioma.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, January 21st, 1906.

OXYGEN WATER AS A THERAPEUTIC AGENT.

PEROXIDE of hydrogen or oxygenated water is a powerful microbicide although it has no action on soluble ferments. According to Chamberland and Fernbach it acts very rapidly on the bacilli of typhus; also it destroys the bacilla of Koch. As far back as 1898, M. Redard announced at the Congress for the Study of Tuberculosis, several cases of cold abscesses, opened or fistulous, rapidly cured by applications of oxygen water. Since then he has applied this treatment to osteitis, osteo-arthritis and tuberculous lesions of other tissues.

Cold abscesses. The cure of cold abscesses by oxygen recommended by Luton of Reims has incontestable advantages over the other classical methods. Without causing any accident, it cures rapidly and permanently.

In cold abscesses—deep or ossifluent—after rigorous asepsy of the skin, the pus is evacuated by a large trocar and the following liquid, as used by M. Redard, injected.

Sol. of phosphate of soda (1-10), 3 oz.;

Oxygen water (12 vol), 1 oz.

The solution is injected slowly and removed after two or three minutes, when more is injected, and so on for three or four times until the cavity is thoroughly washed out. After the last injection a little of the liquid is left in and the opening sealed up. The operation is renewed at the end of ten or fifteen days.

Frequently one operation is sufficient; the quantity of liquid injected varies with the size of the cavity, but in general from one to two drachms are sufficient. Where the abscess is on the point of opening or has opened, the trochar is inserted outside the zone and through the healthy skin.

For closed cold abscesses, a cure is the rule, and much more quickly than with other modifying agents such as iodoform and oil, while in open and fistulous abscesses and so rebellious by reason of secondary infection, oxygen water acts better than any other substance; it modifies rapidly the infractious tracts and facilitates cicatrisation in a relatively short time. In such cases, also, Professor Thiriart, of Brussels, recommends injection of oxygen gas by means of an instrument he has invented for the purpose.

In superficial cold abscesses, tuberculous gummæ, tuberculous infiltration of the skin, injections of oxygen gas or water, act remarkably well. The same may be said of cases of osteitis, and tuberculous synovitis, especially where fistulæ exist.

The treatment by oxygen has the immense advantage

of being able to be employed without danger even in large quantities and without fear of unpleasant consequences.

CHRONIC IMPETIGO.

It is in scrofulous children that impetigo becomes chronic and the treatment should be both general and local and the latter is very important.

The crusts should be removed by compresses of boiled water and then the parts washed with the following solution:—

Sulphate of zinc, $\frac{1}{2}$ drachm
Sulphate of copper, $\frac{1}{2}$ drachm;
Camphor, 5 grs.;
Water, 20 oz.

After which, an ointment of

Starch, 2 drachms;
Oxide of zinc, 2 drachms;
Vaseline, 1 oz.

Cauterisations with a solution of nitrate of silver (1-10) give also very good results.

GERMANY.

Berlin, January 21st, 1906.

RICKETS AS A FOLK DISEASE.

THIS subject formed that for discussion at the Hufeland Society on the 8th inst. It was introduced by Hr. v. Hansemann, who first of all went over the symptomatology of the disease. Then, passing on to etiology, he observed that a view once held as to it being an infectious disease was given up, and also that the view that it was due to an absence of lime salts or sodium chloride was, on the basis of animal experiment, no longer tenable. He referred to the fact that all animals kept in captivity were rickety, so that rachitis was a "cross" of all our zoological gardens. On examining the skulls of 9,000 animals that were shot whilst in a state of freedom, rickets was not once met with. An ape living in Japan and then captured and held in captivity, showed distinct signs of rickets within six months. There was no rickets amongst Japanese children, and certain signs of rickets were never met with amongst uncultivated peoples. Inquiring after the cause, we found that Japanese children were brought up differently from our own. A further observation showed that children born in autumn and winter became rachitic, but those born in spring or summer were not at all or only very slightly so, and the disease made its first appearance even in them in the winter. The decisive factor was want of fresh air. There lay the difference, our children were tied up and kept in rooms. Japanese children get fresh air and are without bandages and clothes. Moreover, most of the houses had no glass windows, but were provided with paper air openings. Too much had been attributed to food; it did indeed influence rickets, but it did not cause it. Domestication was the cause of the wide spread of rickets. Cats that were not domesticated had no rickets; pigs that were required to become fat suffered much from it.

Heredity certainly played a certain *role*. Every individual had a tendency to become rickety.

Hr. Cassel would attribute more influence to food in the production of rickets than the previous speaker would, even if the air played the part attributed to it by him.

All injurious hygienic factors acting for lengthened periods might produce rickets. It was a well ascertained fact that a large number of children suffering from severe forms of rickets were such as were artificially nourished. The over-crowded rooms of workpeople were the breeding places of rickets, and more especially in the winter. Remedies acted better when the unfavourable time of the year was over. It was of interest that children with atrophy did not get rickets. The doing away with rickets was only a question of money.

Hr. Westenhöffer had seen no rickets worth mentioning in Silesia. The children there lived all the year in the open air. Others had made the same observation.

In spite of the bad food amongst workpeople in all Upper Silesia there was no rickets.

Hr. Neumann agreed in general with the previous speaker.

Children born two or three months before the cold time of the year were rachitic. Certainly catarrh of the bowels and air passages had an influence on the origination of rickets. Tuberculosis was also influenced by rickets. If we found a specially severe form of rickets we could assume that the child had masked tubercle. We found distinct traces of rickets amongst most of the older children of the poorer classes. Rachitic erosion of the teeth was an undoubted sign of the disease. Heredity played an extraordinarily important part. As regarded the influence of fresh air we should turn to Northern Italy, where conditions similar to those of Silesia existed. Here also children were in the open air day and night. Only in winter they shut them up in badly-built houses, and they had such severe cases of the disease that large institutions had to be built for it.

Hr. Bernhardt said hereditary rickets was rare. He has only seen one case that could be looked upon as congenital. In a Hungarian village, in which he had inspected all the children as to rickets, there were only two cases, and they were the children of the local doctor.

Hr. Cassel said it was the exception for a child not to be suckled in Japan, and in Upper Silesia, also, the children were thoroughly breast children.

ANASTOMOSIS BETWEEN PERIPHERAL END OF FACIAL AND ACCESSORY NERVES.

A case in which such anastomosis was made is reported in the *D. Med. Wochensch.* by Dr. Silk, of Hamburg.

A radical operation was performed on a man, æt. 23, for middle ear suppuration; in consequence of which complete paralysis of the facial nerve took place. This was in July, 1902. In the middle of December, the nerve was exposed below the stylomastoid foramen; it was grey coloured and very thin. It was severed, and the peripheral end united by suture to the accessory nerve. At first there was paralysis of the trapezius, and secondary stiffening of the shoulder-joint. The muscles of neck and shoulder wasted and the scapula moved with all movements of the right arm. In March, 1903, the patient was first able to raise the arm above the horizontal, and in six months there were traces of returning function of the facial nerve. In January, 1905, when at rest, there were no signs of facial loss of power, but slight weakness in both upper and lower branches. The eyes could be closed firmly, and the patient could whistle, and on laughing the right cheek contracted well. The function of both arm and shoulder was quite restored.

AUSTRIA.

Vienna, Jan. 21st, 1906.

MICROGRAPHIA.

At the "Gesellschaft" Bleier presented a nervous patient who had no hereditary taint, neither had he suffered from syphilis, but according to report he had been a heavy drinker. He was always very passionate and bad tempered, till last year when he became morose and bellicose. About this time his speech became impeded and his gait unsteady, but the most remarkable change was the character of his hand-writing which was microscopically small. When he attempts to walk now he reels or staggers and begins to run to maintain his equilibrium, which he does with short quick steps. He tells you he must run as he has the tendency of falling forward and by this means endeavours to regain his equipoise. When he rises from a sitting posture or stands this uncomfortable feeling afflicts him, but the strange part of the phenomenon is he falls backwards if not supported or supporting himself by something near him at the time. Two years ago he fell and broke the neck of the femur, which appears to have healed without any bad effect. The speech is very low, monotonous and quick, and is the same when reading

always repeating the last word of a phrase or sentence, sometimes frequently. He is quite unfit for duty as a cashier.

Bleier now produced the patient's handwriting before his present illness and that of the present time, which stood out in striking contrast. At the beginning of a word or sentence the letters though extremely small are yet decipherable, but as he proceeds the letters degenerate into an irregular line over which he has no control. His visage is notably stiff and stern, no grimaces or mimicry to relieve the sad immobile countenance.

Arterio-sclerosis and Graafe's symptom of difference in pupillary dilatation as well as tremor of the outstretched finger, with slight atrophy of the muscles of the right thigh were all present. There was also a limitation or diminution of upward vision.

ANEURYSM OF THE RIGHT RADIAL ARTERY.

Weinberger showed a patient, æt. 45, who was received into Schrötter's clinic on November 23rd, suffering from aneurysm of radial artery, presumably from a mycotic embolism. According to history no hereditary tendency was present, neither had he suffered from any disease in childhood, but he had had a fracture of the left fore-arm and another fracture of the right fore-arm in 1896. Since the last fracture he had enjoyed good health up to April last year, when an attack of rheumatism confined him to bed, going over every joint before relief was obtained. About the end of August he had a severe attack of pleurisy, confining him to bed for another four weeks. Shortly after this his right hand began to swell, accompanied with great pain, for which a bandage was prescribed. After twelve hours' application the back of the hand was seen to swell and pulsate, which soon extended over the wrist-joint. At the same time it was observed that he had pain in the left foot above the toes and was in a fevered condition; on his reception to clinic he had irregular fever, commencing with rigors and temperature rising to 40°1', falling on the same day to 39°8 and 36°. There were also small swellings over other joints of the body as well as hand and wrist. The urine was found to contain albumin, epithelial and granular cylinders. There was present a blowing sound at the apex of the cordia with slight increase in real dulness, but no accentuation of the second pulmonary sound, although the second aortic sound was increased. Over the wrists was a round swollen pulsating area, which had evidently been produced by an embolus from the endocardia forming an aneurysm in the radial artery.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

EDINBURGH AND ST. ANDREWS UNIVERSITY PARLIAMETARY ELECTION.—By this time the electors of this constituency will have received their voting papers, and we may be allowed to urge the only form of canvass which is proper for a scientific journal—namely, that the real opinion of the university graduates be shown through a heavy poll. The issues between the two candidates are clear. Sir John Tuke, the sitting member, is a Unionist, a Tariff Reformer in Mr. Balfour's sense, and a supporter of the late Government. Mr. St. Loe Strachey, of the *Spectator*, is a Unionist (*plus royaliste que le roi*, he claims to be) and a Free Trader. Sir John Tuke has a long record of useful work in Parliament, particularly as regards education and matters medical; Mr. Strachey's views are known through his connection with the *Spectator*; he is in favour of the Scottish Education Bill. On matters of purely medical politics it seems from their answers to a

series of questions drafted by the chairman of the medico political committee of the British Medical Association, that the two candidates are practically at one. Here, of course, Sir John's first hand knowledge must stand him in better stead, though Mr. Strachey undertakes to be guided by expert opinion in purely technical matters, and is evidently in thorough sympathy with medical reform. The political issue between the candidates thus narrows itself down to Tariff Reform *versus* Free Trade; to this must be added the not unnatural desire of the medical men who form so large a proportion of the electorate to see one of their own body represent them in Parliament. Voting papers must be returned duly signed and witnessed, by February 8th, we trust that all those on the voters roll will exercise the franchise.

GLASGOW ASYLUM NURSES.—The strike of the nurses in Woodilee Asylum, to which reference has already been made in this column, was recently before the Parish Council, who resolved to support the superintendent of the Asylum in his action in dismissing the nurses, but, at the same time, not to exclude the nurses who had thus lost their posts from offices in other institutions under the Parish Council.

LETTERS TO THE EDITOR.

CONSULTANT OR GENERAL PRACTITIONER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your heading, "Consultant or General Practitioner," is to the G. P. like the pack to the hunter. Of course, the Court physician is in the wrong. Yet is the specialist always in the right? It appears to me that the G. P. wants saving from some specialists, the specialists from the Court physician, and the latter from himself. How can we obtain this salvation? By remembering as members of a learned profession that we are gentlemen, and, this being so, we must act like gentlemen. We must do to others as we wish them to do to us. Until we have learned this lesson, we should have an ethical code drawn up binding upon G.P.'s, specialists and Court physicians. How few true specialists there are we all know. Is not £2 2s. as sweet to some specialists whether earned for diagnosing a wart on the head of the pancreas, or a slight thickening of the tympanic membrane! Money still rules the world, and we are of the world worldly.

I am, Sir, yours truly,

INTERESTED.

ICELAND MOSS IN THROAT AFFECTIONS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—May I draw the attention of your readers to Iceland moss, which at one time enjoyed considerable reputation among "throat remedies" in the form of either decoction, jelly, or lozenge, and was to be found in the British Pharmacopœia as late as 1885; but it has gradually become neglected and is now rarely heard of? Recollection of its associations awakened a desire to test the clinical evidence of its traditional value, and through the co-operation of Mr. W. H. Martindale, I am able to substantiate those traditions, and have no hesitation in suggesting its restoration to a place in our Throat Pharmacopœias.

Percentage Composition of *Cetraria Islandica*.—Cetrarin, 3; lichenin, 45; amyloseous fibrin, 36; gum, 4; non-crystallisable sugar, 4; water and salts (inorganic), 8.

It will be seen that the chief component is *lichenin* (C H₂₀O₁₀), a starch-like body which consists of two elements soluble in hot water—one of which is also soluble in cold water; there is a small quantity

of soluble gum and 36 per cent. of a substance partially extracted by boiling water, called amylaceous fibrin. Cetrarin is the bitter principle readily extracted by hot water, and gives the characteristic taste to the decoction, and was probably valued as a bitter tonic.

Thus Iceland moss affords the necessary material for lubricating and soothing the mucous membrane with which it comes in contact. This quality is amply realised in the discs called "lichenoids," perfected by Mr. Martindale, who has excluded the cetrarin. They are of a size and consistence suitable for slow and passive solution in the mouth, a process by which the demulcent and lubricating properties are better obtained than by the ordinary soft jujube, which encourages rapid mastication and active deglutition. They will be found satisfactory in inflammatory and excitable states of fauces and oropharynx, especially to speakers who suffer with dry mouth and throat. As a sialagogue Iceland moss is an excellent corrective in pyrosis.

I am, Sir, yours truly,

WYATT WINGRAVE, M.D.

Stratford Place, W.

THE GENERAL MEDICAL COUNCIL AND THE ELECTION OF A REPRESENTATIVE FOR IRELAND.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In compliance with the undertaking stated in enclosed Circular (Dr. Kidd's address to the medical profession in Ireland of January 16th, 1906), may I ask you, if possible, to publish the correspondence referred to?

Yours faithfully,

L. KIDD.

Enniskillen, December 17th, 1905.

(1)

DEAR DR. LAFFAN,—Will you kindly inform me if you intend to be a Candidate for the G.M.C. in February 1906?

If you are a Candidate are you willing to accept the verdict of a preliminary poll (in which every practitioner resident in Ireland shall have the opportunity of voting) as between you, myself, and any other provincial candidate there may be, the defeated candidate or candidates to unconditionally promote the candidature of the one at the head of the poll?

Apparently you are not aware of the efforts I made in March of this year to have the question of the D.R. for Ireland discussed by the provincial men.

The Circular, of which I enclose a copy, was sent to the Hon. Sec. of every branch I.M.A., and Div. B.M.A. in Ireland.

Yours faithfully,

L. KIDD.

I incline to the suggestion that the expenses of the preliminary poll, if held, should be borne by the defeated candidate or candidates.

(2)

Cashel, December 21st, 1905.

DEAR DR. KIDD,—I have been urged to go on, but as I am less interested in myself than in the cause, I would gladly submit to a preliminary poll, but from that poll our enemies the classes should be excluded. I mean by the classes those connected with any school of medicine, clinical hospital or examining board. Another way of coming at it would be to require each preliminary voter to publicly pledge himself to vote against the Metropolitan Candidate.

I agree with you that it is only by union that we can win and though you don't see eye to eye with me in the programme outlined by me in the *B.M.J.*, yet as our interests and our hates must need be the same I should hope either to convert you or to find you coming forward with equally good proposals. You can make any use you like of this.

Yours truly,

T. LAFFAN.

(3)

Enniskillen, December 25th, 1905.

DEAR DR. LAFFAN,—I regret you do not see your way to accept a preliminary poll in which every registered practitioner resident in Ireland would have the opportunity of voting. We must therefore proceed on independent lines, but I hope one or other of us will break the spell of the Dublin monopoly. I can honestly say I have done my best for the cause of Provincial Representation and repeatedly expressed my willingness to stand down in favour of a more eligible candidate.

You may not have seen the enclosed which appeared in the *Freeman*. Nor did I see any attempt on your part to justify the statement that you were opposed by "the entire Protestant element because you were a Papist."

You may remember that in 1886 you scored 195 votes and in 1901, 245. Whereas two other Roman Catholic gentlemen received a much heavier poll—namely, Dr. Corby of Cork, 528 in 1891, and Dr. Cuming, of Belfast, 787 in 1896.

Yours faithfully,

L. KIDD.

In explanation of this letter, I may add Dr. Laffan, wrote to the *Freeman's Journal*, Nov. 15th, 1905, stating "The whole Protestant element opposed me more than once for no other earthly reason than that I was a Papist."

I replied challenging Dr. Laffan to justify this statement, quoting the figures given above and saying it would seem the entire Roman Catholic element was opposed to him for some reason other than his religion.

I sent Dr. Laffan a copy of this letter as published by the *Freeman*.

(4)

Cashel, Dec. 27th, 1905.

DEAR DR. KIDD,—I regret that you should have thought proper to withdraw from your own offer. My letter was a letter of acceptance and nothing else, for nobody can call the limitation involved in shutting out from the poll supporters of the Metropolitan candidate a refusal. Evidently you are less interested in obtaining the support of the masses and in advocating their grievances than in obtaining the empty position of a seat in a hostile body. I now call on you to publish the whole correspondence, and of course I will not trouble you with any future letters. I am now as free as if none had ever been exchanged.

Yours faithfully,

THOS. LAFFAN.

(5)

December 28th, 1905.

DEAR DR. LAFFAN,—I beg to acknowledge receipt of your letter of December 27th, 1905. At present I have not the least intention of publishing the correspondence that has passed between you and myself, but if you do so I insist that you shall include the full text of my letters December 17th, 25th, and 28th, together with that of your letters to me.

I have not withdrawn from my original offer; on the contrary I still adhere to it. I asked you to agree to a preliminary poll, in which every registered practitioner in Ireland was to have the opportunity of voting. In reply you made an entirely new proposition limiting the poll to a certain class and disfranchising another class and you call this an acceptance of my offer. To this fresh proposal I cannot and will not assent, and repeat that in thus rejecting your suggestion I do not withdraw from the pledge I made at the very commencement of my canvass.

I also asked you to agree that the Candidate defeated in the preliminary poll should unconditionally support the man at the top of the trial poll—to this you did not favour me with any reply! Am I to take your silence, ignoring your published declaration against my candidature, as an "acceptance" of this condition of the preliminary poll?

Before plunging into further controversy it is due to

your reputation to justify, or failing to do so, to withdraw the statements to which I have publicly and privately drawn your attention.

Yours faithfully,

L. KIDD.

January 12th, 1906, I wired to Dr. Laffan:—

“Are you a Candidate?”

And I received the following reply:—“I am not too late. LAFFAN.”

SPECIAL ARTICLE.

SANITARY ADMINISTRATION.

WITHIN the past few weeks *The Times* newspaper has discussed editorially the question of sanitary administration on several occasions. First, there appeared an elaborate critical examination of the recently issued Annual Report of the Local Government Board; a leader upon this followed, and another leader on the same subject was published on January 8th. It is satisfactory to find the leading organ of public opinion directing its great influence towards promoting improvement in public sanitation. The exposure which it makes of the defects and weaknesses in the laws, and in the methods of putting them into action cannot fail to have some effect in bringing about reform.

The Times reiterates the statement—it indeed employs precisely the same terms on two occasions—that “not only may something like one-half of the actual annual mortality of the Kingdom be regarded as preventable, but that it would actually be prevented if the provisions of the existing laws were adequately carried out by the various authorities upon whom the duty of enforcing them has been imposed by the legislature.” When it comes to suggesting remedies for this truly murderous disregard of duty, *The Times* seems to fail curiously in recognising facts. It expresses pity for the unfortunate citizens and ratepayers who suffer from the existence of preventable disease, and puts the blame entirely upon the local authorities. It seems to forget that the authorities are what citizens and ratepayers choose to make them. *The Times* suggests that the ratepayers at present have no remedy, and suggests an alteration in the law, compelling authorities to co-opt into their body persons possessing special knowledge of the subjects with which they would be officially called upon to deal. The remedy and the only complete remedy is to turn out inferior members of local authorities and replace them by men imbued with public spirit, and not capable of sacrificing the welfare of their fellow citizens through ignorance, if not in pursuit of selfish and sordid ends. This remedy is in the hands of ratepayers. It is their fault and their shame that it is not applied; and were it not that disease falls upon the innocent and guilty alike one might be inclined to look with cynical eye upon some communities affected with epidemics due entirely to their own failure in the duty of citizenship. The fundamental fact to be faced is, that throughout the Kingdom the educated and cultivated classes, the men of light and leading, or at least of sufficient intelligence to appreciate the importance of modern sanitary science decline as a mass to serve on local governing bodies, or to take any sufficiently active part in electing members of those bodies. Councils throughout the country, urban and rural, are all very largely composed of, and very often dominated by, mean, ignorant and vulgar men. If they attend to the letter they disregard the spirit of all the Acts of Parliament they are morally bound to administer. It would be easy to fill some columns of your space with illustrations of this state of things. Look, for example, at the position of the Medical Officer of Health and the Sanitary Inspector. They are often engaged and paid to give only a small part of their time to their duties, and are unable to exercise supervision to any adequate extent, much less to keep themselves acquainted with the minute sanitary conditions of their districts. These officers are often really the servants of a body of men, many of

whom obtain seats upon the authority with the set 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 with his committee when flagrant neglect of duty is displayed; but it is as much as his place is worth to make any public protest or put himself in open antagonism to his employers. He knows very well that when the authority is dominated by a certain class of men it is because there exists no public opinion to which an appeal can be effectually made, and that such an appeal would sooner or later lead to loss of his position, or at least to the docking of his miserable stipend. Democratic institutions such as ours cannot be administered properly unless the bulk of intelligent citizens take due interest in their working. There exists in these islands very little of the municipal corruption such as disgraces the United States, but the prevailing apathy, the lack of local patriotism, the disinclination to make any personal sacrifice for the good of the community, constitute a danger to the State. They form one of the larger signs of the times that go to justify the pessimistic estimate of latter-day society which many thoughtful observers now so frequently adopt.

NEW SURGICAL APPLIANCES.

PLEATED AND COMPRESSED DRESSINGS.

MESSRS. BURROUGHS WELLCOME have brought out a series of compressed dressings that should be of value to surgeons and general practitioners. They comprise lint, bandages, gauze of various kinds, Esmarch's triangular bandage, and other surgical requisites. The idea is excellent. Suppose the surgeon requires, say, some sublimate gauze for a dressing, he takes out an oblong packet a few inches in length, and removes its outer covers of tin foil and parchment paper. A good supply of sterilised gauze compressed into a small compass is there ready to his hand. One advantage is that supplies of all kinds can be stored in this way without deterioration. The latest addition to the series is a pleated compressed “S.T.” or sanitary towel for the use of women. They possess the characteristics of the ordinary towel, but have the great additional advantage of economy in the amount of space needed for packing or storage. This article should become popular, as it is extremely apt and ingenious.

The Richmond Asylum and the Public Bodies Order.

At the meeting of the Committee of Management of this hospital last week, the application of the Local Government Board for a mandamus to compel the Committee to comply with the public bodies order was under discussion, and the Chairman mentioned that he had communicated with the new Chief Secretary. The latter has replied that the matter was receiving his attention; and in the meantime the Committee has not been served with any further notice regarding the mandamus. It appears that the Committee has some reason to complain of discourtesy on the part of the Local Government Board, as the first intimation that a conditional mandamus was to be applied for was the notice in the daily papers that it had been granted. The Committee approved the action of the Chairman, and now awaits a further move on the part of the Board.

The Council of the University of Sheffield have appointed Dr. Louis Cobbett Professor of Pathology. Dr. Cobbett received his medical education at Trinity College, Cambridge, and afterwards at St. Thomas's Hospital, London. He is a graduate in Arts and Medicine of Cambridge University, and a Fellow of the Royal College of Surgeons of England.

REVIEWS OF BOOKS.

JOHN BULL AND JONATHAN. (a)

THE author of these interesting and amusing reminiscences is well known in what we may call the medical commercial world, and they will be read with pleasure by professional and non-medical friends on both sides of the herring-pond. Mr. Richards, although a born American and presenting almost all the best characteristics of the Yankee, is, by nearly forty years' residence and business associations in this country, a thorough admirer and loyal supporter of British men and methods. He writes, as he himself declares, from a British-American standpoint. Much of the volume is concerned with attractive and frequently humorous personal experiences in both countries, and he sketches in clean-cut, incisive language, the difficulties and pleasures which have met him in his social and business relations. He describes contrasts and criticises manners and methods of life in the two countries in such a way as to afford material interesting to the dwellers in both. Mr. Richards has played an active part in the introduction and sale of proprietary medicines in this country, and we could have wished that he had discussed the ethics of "quack" preparations as the physician is wont to regard many of the so-called American nostrums. We fear, however, that the author would find difficulty in viewing the matter from the old-fashioned medico-ethical standpoint, for he says, "after an experience of over 50 years, I consider that advertising as a profession is the most fascinating form of speculation in existence." Mr. Richards, however, has an affection for the English physician, for he says, "of products of 'Advanced Pharmacy,' mention must be made of the ready recognition on the part of the medical profession of Great Britain of the improved method of preparing drugs for accurate dispensing which has been introduced by American manufacturing chemists and pharmacists." Public praise is here accorded also to the author's family physician "for his professional skill and services and warm, friendly interest in our welfare at all times and in all ways." This gentleman, whose name is given, has, we are informed, "retired from active practice, and has removed from London to Brighton, but still attends upon old patients and friends when possible." The author, like most business men, has failed to understand the intricacies and perplexities of medical "qualifications," and his description is not unlikely to mislead our American cousins, as will be seen by such a quotation as the following:—"In reference to the practice of medicine in England, no man may style himself a 'doctor' unless he has passed the examinations by the Royal College of Physicians and Surgeons." But in spite of a degree of liberty and license, which will take away the breath of the old-time practitioner, this is a book which, with its quaint stories, laughable anecdotes, amusing experiences, and striking records of men and things, fascinates the modern reader. We have no hesitation in recommending the work to all who relish crisp and critical portrayal of modern life.

HYGIENE. (b)

THE fact that since 1894, the date of the first edition, this work has passed through six editions places it beyond the reach of reviewers and gives it a position in public esteem which can only come from proved service and experienced usefulness. The first issue of this book was in answer to a call for a concise and yet fully expressed manual of the facts and principles of hygiene set forth in simple language suited for both non-professional and professional readers. The work speedily became an accepted favourite, both with students and teachers, and quickly occupied a place among the most

popular handbooks for those preparing for the examinations in Advanced Hygiene of the Science and Art Department, the duties of which are now undertaken by the Board of Education. The present edition has been completely revised, in many parts re-written, and such new matter has been added as to make it thoroughly up-to-date, and in every way suited to the requirements of the present-day student. The general plan of the book has been somewhat broadened, and thus the needs of a wider circle of students will be met. The most marked improvements are in the sections dealing with water examination, foods, and the infective diseases. The essential facts regarding the bacteriological examination of water supplies and the still but ill-understood subject of immunity to disease are well summarised. Without being in any way exhaustive, the work forms a comprehensive and thoroughly reliable introduction to a subject, which, perhaps, beyond any other, forms the basis of individual efficiency and national well-being.

Dr. Lane Notter and Professor Firth are not only experts in their subject but experienced teachers, and the former now holds the post of Examiner in Public Health to the Universities of Cambridge, Manchester, and Liverpool. And thus the authors of this admirable manual, knowing the needs of examiner and examinee, have provided a guide which will serve the average medical student as well as give an excellent volume of instruction for the general reader.

THE SIMPLER LIFE. (a).

THE mission which Dr. Saleeby has chosen for himself is surely one which should—if only and effectively taught—prove of special importance to the rising generation. The lay literature of the British Press has been recently so fertile in discussion of the lowering incubus of physical deterioration that attention to one of the most probably rational means of its prevention must be regarded as a duty of every philanthropic citizen of our vast Empire. The text of the booklet is divided into two parts:—(1) The Poor as seen by the Physician; (2) The Well-to-do as seen by the Physician. The first part discusses in six chapters the multitudinous terrors of the life-pilgrimage of the poverty-stricken denizens of our overcrowded slums; the second deals in thirteen chapters with the torture of the existence of the over-fed and over-dressed; who probably succeed in making their lives quite as miserable as those of their ill-fed, ill-clad, and ill-ventilated brethren and sisters. There is an immense amount of sound advice and concentrated information contained in the pages of this little volume; so much, indeed, that it would be idle to attempt to criticise the contents in detail. In presence of the facts "that 77 per cent. of our population now live in cities, as against about 50 per cent. half a century ago, and the city is the maker of poverty"—the conditions so well described by Dr. Saleeby should surely command the most active attention of the leaders of a democratic community. With regard to the still more hopelessly incurable ills which are so prone to attend luxuriant prosperity, our author places his best expectations on the psychological attainments of the medical adviser. We are delighted to observe that this last chapter of all bears the inspiring title of "How to Use a Doctor." And he informs his readers, we think, very truly, that "The proper way to use the doctor—the ideal doctor, who probably is nowhere yet to be found—is to seek his advice—it need not be followed—in relation to such important matters as habits, work and play, marriage, parenthood." We close this notice of what we regard as a very important contribution to the popular medical literature of the period by recommending its contents to the best consideration of all readers.

(a) "With John Bull and Jonathan. Reminiscences of Sixty Years of an American's Life in England and in the United States." By John Morgan Richards. Pp. xiv., 302, with illustrations. London: T. Werner Laurie. 1905. Price 16s. net.

(b) "Hygiene." By J. Lane Notter, M.A., M.D., and R. H. Firth. Sixth Edition. Pp. xiv., 491. London: Longmans, Green and Co. 1905. Price 4s. 6d.

(a) "The Doctor and the Simpler Life." A Series of Medical Criticisms on the Every-Day Habits of Various Classes of the Community." By C. W. Saleeby, M.D. London: The Pall Mall Press, 1905. Pp. 95. Price 1s.

BRUCE ON MATERIA MEDICA (a).

THE present edition of Dr. Bruce's well-known work completes the forty-seventh thousand of the book—a record of which any author may well be proud. In it, the text has been subjected to the most thorough revision, and as a result is brought up to the level of the most recent medical knowledge. In addition to this revision an entirely new part has been added containing an account of the drugs of the Indian and Colonial Addendum of the British Pharmacopœia. Further, a very considerable improvement has been made by introducing greater detail respecting the chemical and pharmaceutical relations of the individual drugs. We are confident that in its improved form Dr. Bruce's work will more than retain its old popularity, and we have great pleasure in cordially recommending it as a comprehensive and reliable guide both to students and medical practitioners.

LITERARY NOTES.

In *Who's Who Year Book for 1906*, pp. 132, published by Messrs. A. and C. Black, London, we have the tables formerly included in the well-known "Who's Who." In spite of the large number of year books now available, there is undoubtedly a place for these ready reference tables. The Editor is evidently shy in approaching matters medical, and he has reason, for as he tells us, "at the request of the British Medical Association, the table of leading London specialists which appeared in the last issue, and was found very useful by the public, has been deleted." A list, however, is given of the hospital staffs of the twelve large general hospitals, but there is no reference to the many important special hospitals, and no notice of any medical schools. In the list of medical publications, the MEDICAL PRESS AND CIRCULAR is omitted, although the oldest medical weekly but one in existence, whilst the names of several but little known medical periodicals appear. In the list of learned societies also, the Medical Society of London, although the oldest and perhaps the most important, is omitted altogether, whilst such composite societies as the Medico-Legal, and the Society for the Study of Inebriety find a place. There is a useful list of "Chairs of Professors of the Universities in the United Kingdom," which, as far as medicine is concerned, seems remarkably accurate and complete, and the whole work, in spite of the omissions to which we have referred is excellent, both in its matter and arrangement.

Medical Homes for Private Patients, a classified directory, with lists of medical consultants and specialists, by R. Pritchard Binnie (London: Scientific Press, Ltd., 1906) is clearly a speculative advertisement, although said to be "the outcome of a suggestion by a leading member of the medical profession." It is claimed that this little directory has been arranged for the use of both medical men and their patients. It contains lists of medical, surgical, and invalid homes, sanatoria, hotels, hydropathic establishments, health resorts, and names and addresses of English practitioners in fashionable places abroad. A considerable section of the work is, however, a list of consultants which its authoress Mrs. Pritchard Binnie expresses the hope may be found useful to "Country Practitioners and others," although it is not explained who these "others" may be. The sins of omissions and commission are sufficiently conspicuous to discount any claims its compiler may make for it as a reliable guide, and as the profession already has available in the official *Medical Register* and the authoritative *Medical Directory* an adequate list of "consultants," "specialists," and

(a) "Materia Medica and Therapeutics: An Introduction to the Rational Treatment of Disease." By J. Mitchell Bruce, M.A., LL.D., M.D., F.R.C.P., Consulting Physician to Charing Cross Hospital. New and enlarged edition, revised throughout, and containing the Indian and Colonial Addendum to the British Pharmacopœia. London: Cassell and Co. Pp. 632.

"every other variety" of medical practitioner, the necessity for this incomplete and selected list is not apparent.

"ELECTROLYSIS in the Treatment of Facial and other Blemishes" is the title of a *brochure* by Mr. J. D. P. McLatchie, M.B., which may be found of service by those unaccustomed to dealing with the conditions of which it treats. It is short and practical, the author having a thinly-veiled aversion to discussing pathological questions connected with his subject, and evidently preferring action to thought. Within the limits to which Mr. McLatchie confines himself—he is accurate

OBITUARY.

FLEET-SURGEON JOHN P. J. COOLICAN.

WE regret to announce the death of Fleet-Surgeon J. P. F. Coolican, of Clarinda Park, Kingstown, on January 15th. He had served on H.M.S. *Thetis* during the South African War, and had been awarded the South African Medal. Owing to failing health he retired some time after. He was well-known in Dublin and was married to the daughter of Sir George Moyers, D.L., a prominent resident in Kingstown.

H. J. P. SPRENGEL, PH.D., F.R.S.

THE death occurred suddenly on Sunday at 54, Denbigh Street, S.W., of Dr. Herman Johann Philipp Sprengel, the inventor of the mercury air-pump. He was born in 1834 near Hanover, and was educated at the Universities of Göttingen and Heidelberg, where he took his degree of Ph.D. in 1858. In the following year he came to England, which henceforth he made his home. For three years he was an assistant in the chemical laboratory of Oxford University; then, coming to London, he worked in the laboratories of Guy's and St. Bartholomew's Hospitals. In 1865 he became partner in a firm of manufacturing chemists in London but retired in 1870. He was elected a Fellow of the Royal Society in 1878. He is best known scientifically for his air-pump, which he described to the Chemical Society in 1865. It was destined to have a far-reaching importance, inasmuch as it permitted Crookes to carry out his researches of the phenomena of electrical currents in high vacua, and Swan to introduce his electrical incandescent film lamp.

DR. WM. A. WEST, OF SYDNEY.

News has just reached this country of the death of Dr. William Augustus West, at Sydney, New South Wales, at the early age of forty-six, from pneumonia followed by pleurisy and heart affection, to which he succumbed on Dec. 11th, after six weeks' illness. Dr. W. A. West was the youngest son of the late George White West, barrister at law, of Ardenode, Co. Kildare and qualified for the medical profession in Dublin. He then left for Sydney, where he became assistant to, and afterwards partner with, his brother, Dr. Arthur Annesley West, who was practising at the Glebe, a suburb of Sydney. When Dr. Arthur West died in 1885, he continued the practice alone, and was highly esteemed for his kindly disposition, during the twenty-two years he spent in the district. He leaves a widow and two children to mourn his loss.

ROBERT LAIDLAW, M.A., M.B.

MUCH regret was felt throughout Fifeshire by the death of Dr. Robert Laidlaw, Ladybank, after a week's illness. The deceased was the son of Mr. Laidlaw, of Yarrow, where he was born in the late fifties. Dr. Laidlaw went to Ladybank about twenty-one years ago, and was well-known throughout the kingdom for his sympathetic and genial disposition. During that period he had built up a considerable connection and practice, and was, so to speak, in the prime of his life, though never robust. He was educated medically at Edinburgh University, where he graduated in December 1875. He was medical officer for the Parish Council of Ladybank and Collesie.

MEDICAL NEWS IN BRIEF.

The British Gynaecological Society.

THE Annual Dinner was held at the Café Monico on Wednesday, January 17th, Dr. Alexander, president, in the chair. The gathering numbered about fifty, including guests and a fair sprinkling of ladies. After the usual loyal toasts had been proposed by the President, and heartily responded to, Dr. J. W. Eden gave what might be regarded as the toast of the evening, namely, that of the Gynaecological Society; following on with a few words devoted to his own "anticipatory nervousness" and consequent loss of "gustatory sensibility" occasioned by the task before him, he spoke of the good work done by the Society. Gynaecology, he said, had now passed into a branch of general surgery, but as obstetrics were a branch of gynaecology, he was glad to see signs of reconciliation between the obstetrical and the gynaecological societies. The president responded in a few well-chosen words, in which he referred to the twenty-one years work done by the Society and to the eminence of his predecessors in the chair. He mentioned that the Gynaecological Society had given consent at a general meeting to its amalgamation with the Obstetrical Society, to form a branch of the proposed Royal Medical Society or Academy, and ended with a few graceful words of thanks to the secretaries who had worked with him. Dr. MacNaughton Jones then proposed the "Services"; this toast was answered in an excellent speech by the Director-General Army Medical Department. The last toast was that of "The Visitors" proposed by Mr. Bowreman Jessett (the incoming president), and responded to by the President of the Hunterian Society and by Mr. Reginald Harrison. Between the toasts a very enjoyable musical entertainment was given, Mr. Astley Weaver being especially noticeable in his amusing sketch.

Is Distilled Water a Drug?

MR. PLOWDEN, at Marylebone, on the 12th inst., heard an interesting case in which Edward Dunn, a chemist, of 218, Kentish Town Road, was summoned for selling a drug (distilled water) to the prejudice of the purchaser, the water being impure. Sir Thomas Stevenson, Home Office Analyst, said he found it to be very dirty and full of mouldy growths—low vegetable living organisms. In his opinion distilled water was a drug used in the preparation of medicine. People sometimes drank it medicinally. Defendant said he had been in business twenty years, and sold the distilled water in the same condition as it had been supplied to him by a wholesale house. He did not ask the purchaser what it was to be used for, but assumed it was for photography. He should have used the water if he had had to dispense a prescription, because he was under the impression that it was pure. On the point being raised, Mr. Plowden held that the article was a drug. The defendant's character had not been affected, but fraud, or no fraud, a purchaser was entitled to receive the article in a pure state. He fined defendant 10s., and ordered him to pay three guineas costs.

Workhouse Equipment.

AT the Middlesex County Asylum, Tooting, Mr. Troutbeck held an inquiry concerning the death of Louisa Sarah Withers, fifty-two, wife of a coachman, of the Quadrant, Kensal Green. It appeared that the deceased was taken ill on Boxing Day with bronchopneumonia, and a day or two later she was removed to the Willesden Infirmary in Acton-Lane. On Tuesday, when, according to the evidence of a nurse, the patient was in a dying condition, she was removed on a horsed ambulance to the asylum, a distance of ten miles, the journey occupying an hour and a half. Death took place on Thursday morning. Dr. Alfred Webster, medical officer at the Willesden Workhouse

Infirmary, said the removal of the patient was absolutely necessary owing to the fact that they had no resident medical officer. He thought her transference to the Asylum was her only chance. At the workhouse her chance was *nil*, for the reason that he had mentioned. The Coroner: That is a serious criticism of your Institution, is it not?—I think not. It is unfortunate that we have not the accommodation. He added that he had no nurse with whom they could properly entrust a patient like the deceased, although their nurses were thoroughly trained. The jury returned a verdict of death from natural causes, and said that no blame attached to Dr. Webster or the nurse, but they were of opinion that there should be a resident medical officer at the workhouse.

Threatened Revolt of Nurses.

IN the rooms of the Medical Society of London, a special general meeting was recently held for the purpose of giving consideration to the re-drafted Bill of the Association for the State registration of trained nurses. There was a large attendance, presided over by Dr. Bezly Thorne. The Bill provides for the registration of nurses, and contains clauses making provisions for existing nurses, deals with nurses trained in the Colonies, provides for the constitution of a central board, together with penalties for obtaining registration by false representation and for the wilful falsification of the registers. The meeting dealt with the various clauses *seriatim*, and a number of amendments were considered. In connection with the clause which deals with the constitution of the Central Board, and which provides for the appointment of a number of medical practitioners. Mrs. Bedford Fenwick raised strong objection. She contended that nurses ought to be represented only by nurses, and said it was an injustice to put such a small proportion of nurses on the board to manage their affairs. An amendment to this clause was defeated, and eventually the Bill, with some slight modifications, was adopted.

Instruction in Military Surgery for Civilians.

THE first lecture of the series of Army medical duties to which we have previously referred, was given at the West London Hospital on Saturday last by the Director-General, Surgeon-General Keogh, C.B., before a large audience of medical practitioners, and proved exceedingly interesting. At its conclusion a vote of thanks was proposed by Mr. McAdam Eccles, F.R.C.S., seconded by Dr. Seymour Taylor, and voted enthusiastically.

Help for the Seamen's and Poplar Hospitals

H.M.S. "BLACK PRINCE," the latest and most powerful type of armoured cruiser, will be on view in the Victoria Docks, London, at a small charge, on Saturday afternoons, January 27th and February 3rd; also on Sunday, February 4th. The proceeds will be given in aid of the Seamen's Hospital Society (Greenwich and Albert Dock), Poplar Hospital and West Ham Hospital. It is hoped that the public will largely avail themselves of this unique opportunity of inspecting an up-to-date war vessel ready to be commissioned, thereby helping these exceptionally useful and deserving hospitals.

Society of Apothecaries of London.

THE following candidates have passed in surgery:—J. A. Kilpatrick (Section II.), S. Zweiback (Section II.). In Forensic Medicine:—L. C. W. Brigstocke. In Midwifery:—J. P. E. Henery, C. Mulholland, H. F. Wight. The L.S.A. diploma of the Society has been granted to the following candidates, entitling them to practice medicine, surgery, and midwifery:—J. A. Kilpatrick and S. Zweiback.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for the MEDICAL PRESS AND CIRCULAR.

THE RECENT LITERATURE OF ANATOMY, PHYSIOLOGY AND PATHOLOGY.

Experimental Production of Aneurysms.—Erb (*Arch. f. Exper. Path. u. Pharm.* Bd. 53) has worked with rabbits to determine the effect of repeated intravenous injections of adrenalin solution. From .1 to 1 c.c.m. of a 1-1000 solution was injected daily, some of the animals exhibiting a daily reaction, while others soon acquired tolerance. The autopsies showed in most cases the signs of acute adrenalin poisoning, namely œdema and hæmorrhagic infarction of the lung, hæmorrhagic exudates in the pleura and peritoneum, and cardiac hypertrophy. The most interesting organ, however, was the aorta, which throughout its whole length but especially in its thoracic portion, showed numerous saccular dilatations, the walls of which presented atrophy of the middle coat, with here and there calcareous deposits. Further investigations seemed to show that the aneurysms were partly produced by the general rise in blood pressure, and partly by a direct toxic effect of the adrenalin on the arterial walls. M.

Pathological Effects of Radium.—Now that radium is being used in the treatment of malignant disease, the pathological influences that it can exert are of much interest. London (Berlin. *Klin. Woch.* 1905. No. 42) has investigated them in rabbits, which were confined in a small cage in the centre of which was suspended 25 m.g. of radium bromide. Nothing was observed until the sixteenth day, and then some reddening and hyperæmia of the ears appeared. This was soon followed by desquamation of hair, and by the development of ulcers and local hypertrophy of the surrounding tissue. General apathy and slowness of movement was observed after some months' exposure, and also loss of weight and retinal changes. The animals were killed after 16 months, and at the autopsy the spleen was found to be shrunken to $\frac{1}{4}$ th of its normal size, and to contain very few white cells; the lymph glands were also small and contained few cells; the liver was fatty; the kidneys showed cellular atrophy, the testes did not contain any spermatozoa, and the epithelial elements were degenerated; in the central nervous system also atrophied ganglionic nerve cells were found. M.

Worm Toxines.—Boycott (*Journ. of Path. and Bacteriology*, Aug., 1905) has conducted some experiments bearing on the question of the toxicity of worms. There is much doubt and disagreement of opinion on the subject which the present report does little to allay. We are compelled to assume, at least on the part of some worms such as bothriocephalus and ankylostoma, the production of a poisonous secretion, since in no other way can we account for the severe constitutional effects of their presence in the body. Haldane, too, has shown us that the anæmia of ankylostomiasis is almost entirely an hydræmic plethora, and in no way resembles an anæmia due to repeated small hæmorrhages. Calmette and others have described a hæmolytic action on the part of extracts of bothriocephalus, and ankylostoma. The eosinophilia so commonly observed in the presence of most intestinal parasites seems to point also to the entrance of a toxin into the blood of the host though in the case of certain worms no eosinophilia occurs. There has also been some experimental evidence on the point. Calamida produced an extract of *tænia* possessing toxic results of extreme severity; Cattanis by keeping live *ascaris* in alkaline broth produced a sterile fluid toxic to guinea-pigs. Other observers, however, were unable to confirm these results. Cao, Jammes and Mandou were unable to satisfy themselves that the sterile juices or extracts of either *ascaris* or *tænia* had any toxic effect whatever. Boycott's results, as detailed in the present paper, are practically entirely

negative. He experimented with *ascaris lumbricoides*, *tænia solium*, *tænia mediocanellata*, *tænia* from a cat, *tænia* from a lamb, round-worms from a cow, and nematodes from a dog-fish. Extracts were made by grinding with sterile sand, having washed well in running water. As far as possible undiluted juices were used, but where necessary a small quantity of sterile saline fluid was added. Inoculations were made on fifty-six animals, consisting of ten mice, eleven guinea-pigs, and thirty-five rabbits. Of these animals there died six mice, no guinea-pig, and eight rabbits; the rest presented no symptom of weakness beyond the temporary dyspnoea and weakness which is commonly associated with any but the smallest intravenous injections in the rabbit. None of these fatalities followed the use of filtered sterile extracts. The deaths of the six mice, and of three of the rabbits were proved to be due to infection. The other rabbits, except one, are excluded on other grounds, so that in only one case is there a suspicion of the action of a worm toxin. These experiments seem to discredit the results of Calamida and Cattanis, so that for the present our belief in worm toxins must rest on a *priori* grounds. R.

Paroxysmal Hæmoglobinuria.—Eason (*Edinburgh Medical Journal*, January, 1906) has made a valuable contribution to our knowledge of the pathology of a condition but little understood. This has been rendered possible by the fact that our views of the biology of the blood are now—owing to the researches of Ehrlich and Bordet—much wider than when Chvostek wrote his monograph in 1894. Eason began with the working theory that we had to do with a hæmolytic and that, therefore, the action of the serum of a patient suffering from paroxysmal hæmoglobinuria should be tested for hæmolytic with normal blood. Having such a patient at his disposal, he adopted the simple technique of procuring serum from a blister produced by cantharides, and adding to the serum thus obtained a few drops (1) of normal blood, (2) of blood from the same patient. After sixty minutes' action of the serum on normal blood, many changes were evident. The red cells had altered in colour, size, and shape, and in many of them globules of hæmoglobin had formed. In many cases active phagocytosis of the red cells was in process, the red cells being apparently "nibbled away" by the white. This phenomenon corresponded exactly to what has been observed by Ruziczka and Gruber, in the case of red cells which are loaded with intermediary body. Eason concludes (1) That a pathological substance is present in the serum of subjects affected with paroxysmal hæmoglobinuria; (2) that this substance can dissolve corpuscles, either of the affected individual or of normal subjects, in suitable conditions of temperature; (3) that low temperatures aid the hæmolytic action; (4) that the phagocytic activity observed resembled that seen by Ruziczka, Gruber, and others, in their work on immunity, an action which they considered was due to the antecedent union of intermediary body with red corpuscles; (5) that the intermediary body of paroxysmal hæmoglobinuria requires the presence of a thermolabile complement for hæmolytic to occur; (6) that the serum of normal subjects does not cause hæmolytic. R.

Malignant Disease of the Testicle.—Foulerton (*Lancet*, December 23rd, 1905) discusses the pathology of malignant disease of the testicle; and is in favour of the view that in most cases the disease is a columnar carcinoma. He criticises (1) the common diagnosis of sarcoma, (2) Schlagenhafer's view that many cases of malignant disease of the testicle are in reality "malignant teratomata" analogous to chorion-epi-

thelioma in the female. The first view he believes to be based on the fact that the disease often occurs at an early age, and on certain histological peculiarities which are frequently met with in mesoblastic connective-tissue stroma of columnar-celled carcinoma of the testicle. It may be claimed, however, that as the epithelium of the seminal tubes is, in the opinion of most embryologists, derived from the germinal epithelium which is at one time part of the mesoblastic lining of the pleuro-peritoneal cleft, that therefore growths springing thence should, on account of their mesoblastic origin, be classed as sarcomata. In reply to this doctrine, Foulerton urges that this mesoblastic origin has never been demonstrated, and that the conception of the formation of a gland by the coalescence of tubules of mesoblastic and a tube of epithelial origin involves an anomaly in development. He therefore thinks that, in spite of embryological difficulties, these growths should be classed as carcinomata, inasmuch as they resemble in all essential particulars carcinomata arising elsewhere, and they arise in what both anatomists and physiologists regard as epithelium in spite of its reputed mesoblastic origin. (2) In distinction to chorion-carcinoma, Foulerton points out marked differences in the appearance of the cell in the two kinds of tumour. The polyhedral cells of tumours of the testicle have a sharply defined outline, a protoplasm which stains lightly, relatively small nuclei, whereas in chorion-carcinoma the cells are badly defined, the cell-body stains deeply, and the nuclei are large and irregular in shape. In explanation of the occasional occurrence of cartilage in tumours of the testicle, which some think is suggestive of a teratological origin, Foulerton points out that chondrification is in no way peculiar to malignant tumours of the testicle, since it occurs in carcinomata in other situations, as well as in simple adenomata in the testicle. Moreover, it is possible that its relative frequency in the testicle is due to an assumed bio-chemical stimulus dependent on the secretory activity of seminiferous epithelium acting on the neighbouring connective tissue.

R.

Recent Cancer Research.—Bashford (*Brit. Med. Journ.*, December 9th, 1905) gives an interesting and valuable summary of recent progress in cancer research, based for the most part on the work done under his direction in the Laboratory of the Imperial Research Fund. When the work of the Research Fund was started three years ago, our knowledge of cancer was in such a chaotic state that it was necessary before all else to attempt to arrive at certainty on preliminary matters. For this purpose five questions became objects of inquiry:—(1) to define the extent to which cancer occurred among the civilised and uncivilised races of man; (2) to determine the extent of its distribution among animals; (3) to ascertain if it were transferable; (4) to demonstrate that experiments made with cancer in animals would give conclusions applicable to cancer in man; (5) to ascertain the uses of statistics, and to define the data on which they should be based. On most, if not all, of these points, some amount of fixed knowledge is now available as a foundation, whereon to build. (1) The ethnological distribution of cancer is as wide as possible. There is probably no race, however untouched by Western civilisation, exempt. (2) Among vertebrate animals, wild and domesticated, the disease is widely distributed. Malignant new growths have been investigated from birds, tame and wild; from mice, from trout in hatcheries, from carp, from marine fish in a state of nature, from frogs, from a lioness, from a tigress, and from a marsupial. Up to the present a true malignant growth has not been described in a reptile, but evidence was bound to be late in the case of certain groups, and there is no reason to suspect that cancer in reptiles will not be eventually discovered. (3) Cancer is transmissible, but only under very favourable circumstances, and only from one animal to another of the same species. In fact, it is only in the case of mice that transmission has been successfully practised. Moreover, the cancer of a tame mouse will only grow well in other tame

mice of the same race, that of a wild mouse in other wild mice of the same race. The cancer of a tame or wild Danish, German, or French mouse, grows with difficulty or not at all in an English mouse of corresponding race. Its transmission naturally is very improbable, and in no case was cancer accidentally transmitted from diseased to healthy animals, although housed together. In this point of transmissibility, therefore, cancer differs markedly from the diseases known to be infective. It has been established, too, that whereas cancer cells when transplanted continue to live as individuals, the stroma cells speedily die; nevertheless, the cancer continues of the original type. Moreover, whereas cancer is much more common among the aged, it can be implanted in the young with greater ease than in the old. (4) The histological structure of cancer as found in man and in animals is identical. Moreover, it has the same marked association with old age throughout the vertebrates. Bashford states some general conclusions mostly of a negative nature, which he thinks may now be agreed on. Judging from the difficulty of transmitting cancer from mice of one race to mice of another, it is unlikely that the prevalence of cancer among such races as the negroes of America has been brought about by contact with white men. Still less can it be held that the white man is the focus whence cancer has spread to the lower animals. The wide distribution of cancer among men and animals show that the old theories based on geological, climatological, and dietetic considerations must be abandoned. There is evidence, too, against all the explanations yet advanced as to the cause and nature of cancer; there is proof that cancer cells have not reverted to an embryonic undifferentiated state, and that the ceaseless growth of cancer cells does not resemble the intermittent growth of reproductive tissue. He closes with a serious appeal for co-ordinated investigation.

In contrast with Bashford's iconoclastic criticism, Butlin's Bradshaw lecture (*British Medical Journal*, December 16th, 1905) appears singularly fanciful. He sets himself to argue that carcinoma is a parasitic disease, the cancer-cell being itself the parasite; or more fully that the carcinoma cell is an independent organism, like many a protozoon; that it lives a life which is wholly independent and proper to itself; and that it lives as a parasite in the body of a host. To support this doctrine it is necessary in the first place to combat the generally received opinion of the epithelial origin of the cancer cells, and Butlin remarks that this origin has never been actually demonstrated. This he "illustrates" by certain figures which are either meaningless or have a misleading suggestion. The question next arises, whether on this hypothesis the parasite is introduced from without, or is formed within the body of the host. In opposition to Hauser, who has maintained the latter hypothesis, Butlin inclines to the former.

R.

Typhoid Bacilli in Sputum.—Rau (*Zeits. f. Hukl.* Bd. 25. S. 385) reports a case of pneumo-typhoid, in which the diagnosis was made by the finding of typhoid bacilli in the expectoration. No other bacterial excitant of the pneumonia could be detected. No intestinal symptoms were present, but the general course of the case was identical with that of ordinary typhoid.

M.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "Recent Medical Literature."
- (2) "Recent Surgical Literature."
- (3) "Recent Gynæcological and Obstetrical Literature."
- (4) "The Recent Literature of Anatomy, Physiology, and Pathology."

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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 reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

THE PURE BRANDY CONTROVERSY.

Two correspondents, who were recently called on to give evidence in an adulteration case, have asked us to define what is pure brandy. Unfortunately the "British Pharmacopoeia" omits all mention of tests, which is probably due to the fact that when published (1893) the analysis of brandy had not received so much attention. The following, however, may be taken as the standard:—"An alcoholic liquid obtained by the distillation of the fermented unmodified juice of fresh grapes, and at least four years old." It must contain between 36 and 47 per cent of alcohol by weight, and the total solids are to be under 15 grammes per c.c.; and a limit of acidity is laid down, i.e. 100 c.c. shall not require more than 1 c.c. of normal KHO to make it distinctly alkaline to litmus.

DEUS INCUBAT ANGI.

Probably few of our readers know the meaning of the words which form the St. George's Hospital motto, "Deus incubat angul." Among the most original interpretations were, "The God incubates snakes," "The God is laying it into the snake," and last, but not least, "God hammers it in with angulak!" The words come from Statius' "Sylvarum," book III., story iv., p. 369 of vol. I. in the Delphin edition, published by Valpy in 1824. The passage is as follows:—

"Dicitur, Idalios Erycis de vertice luco
Dum petit, et molles agit Venu aurea cygnos,
Nergameas intrasse domos ubi maximus aegris
Auxilliarum adest, et festinantia sistens
Fata, salutifero mitis deus incubat angul."

Literally, the "God leans upon the serpent"—an allusion to the snake on the staff of *Asclepius*.—*St. George's Hospital Gazette.*

MARTIN, C.—A somewhat similar point was mentioned by a witness in a recent lawsuit. A lady wished to be reacquainted on her back. Although not in itself evidence of insanity, so unusual a desire had a corroborative value when taken with other evidence of eccentricities.

LIFE SPRINGS FROM DEATH.

None can deny the fact that die we must,
Our bodies sink into the grave and turn to dust;
Nature digests the morbid-mass, and in exchange
Gives fruit, and flowers, and grass, to arrange the balance just!
—A.D.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JANUARY 24th.

SOCIETY OF ARTS (John Street, Adelphi, W.C.).—8 p.m. Paper:—Dr. J. Nisbet: The Planting of Waste Lands for Profit.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.).—8.30 p.m. Mr. J. Hutchinson: Reminiscences of the Hunterian Society. (Hunterian Lecture.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (23 Chancery Street, W.C.).—4 p.m. Mr. A. H. Tubby: Clinique. (Surgical.) 5.15 p.m. Lecture:—Dr. B. Abraham: The Treatment of Rheumatism.

THURSDAY, JANUARY 25th.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.—(11 Chandos Street, W.).—8 p.m. Card Specimens will be shown by Mr. A. S. Morton and Mr. G. Coats. 8.30 p.m. Papers:—Dr. A. M. Ramsay: The Treatment of Detachment of the Retina. Mr. S. Snell: (1) A Case of Thrombosis of the Cavernous Sinus; (2) A Case of Acute Oedema of the Eyelids. Dr. D. J. Wood: Case of Bilateral Hemianopsia.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m. Clinical Meeting.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Lecture:—Mrs. M. Scharlieb: The Differential Diagnosis of Abdominal Tumours.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m. Dr. M. Dockrell: Paratuberculides (due to Tuberculous Toxins); I., Macular; II., Papular; III., Pustular; IV., Pigmentary. (Chesterfield Lecture.)

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7 Fitzroy Square, W.).—5 p.m. Lecture:—Dr. J. E. Squire: Phthisis in Old Age. (Post-Graduate Course.)

FRIDAY, JANUARY 25th.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m. Exhibition of Clinical Cases followed by discussion. Patients will be in attendance from 8 to 9 p.m.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Dr. St. Clair Thomson: Clinique. (Throat.)

Vacancies.

- Bristol, City and County of.—Public Analyst. Salary £450 per annum. Applications to Edmund J. Taylor, Town Clerk, Council House, Bristol.
- Burton-on-Trent Infirmary.—House Surgeon. Salary £120 per annum, together with furnished rooms, board, coal, and light, free. Applications to the Hon. Secretary, Mr. John Wood, the Infirmary, Burton-on-Trent.
- Parish of Bermondsey.—District Medical Officer. Salary £125 per annum. Applications to the Clerk to the Guardians, 283, Tooley Street, S.E.
- West Ham Union.—Four District Medical Officers. Salaries £130 per annum. Applications to Fred. E. Hilleary, Clerk, Clerk's Office, Union Workhouse, Leytonstone, N.E.
- West Riding Asylum, Wakefield.—Assistant Medical Officer. Salary £140 per annum, with furnished apartments, board, washing, and attendance. Applications to the Medical Director.
- Willenden Urban District Council.—Male Assistant Medical Officer. Salary £125 per annum, with board, lodging, and washing. Applications to Stanley W. Ball, Clerk to the Council, Public Offices, Dyne Road, Kilburn, N.W.

Appointments.

- BOWEN, J. ARNOLD, L.D.S.R.C.S.E., Dental House Surgeon at Guy's Hospital.
- BURGESS, ARTHUR H., F.R.C.S. Eng., M.B., M.Sc. Viet. Honorary Assistant Surgeon to the Manchester Christie Hospital for Cancer.
- BURROWS, HAROLD, M.B., B.S. Lond., F.R.C.S. Eng., Assistant Surgeon to the Seaman's Hospital, Greenwich.
- DODD, STANLEY, M.A., M.B., B.C. Cantab., M.R.C.S., L.R.C.P., Resident Medical Officer at the Chelsea Hospital for Women.
- GRAY, A. G., M.B., B.S. Aberd., Bacteriologist to the Hospital of St. John and St. Elizabeth, St. John's Wood, N.W.
- HAMILTON, ROBERT, J., F.R.C.S. Eng., Honorary Ophthalmic Surgeon to the Stanley Hospital, Liverpool.
- JUBA, ARCHIBALD, M.D. Glasg., Assistant Medical Electrician to the Glasgow Royal Infirmary.
- KERRAWALLA, M. P., M.D. Brux., Clinical Assistant at the Samaritan Hospital for Women.
- MCBRIDE, JOHN, L.D.S.R.C.S.E., Dental House Surgeon at Guy's Hospital.
- MERCINE, C. A., M.B. Lond., F.R.C.S. Eng., F.R.C.P. Lond., Physician for Mental Diseases at Charing Cross Hospital.
- SCOTT, CHARLES WALTER, M.B., C.M. Edin., M.E. C.S., L.R.C.P. Lond., Clinical Assistant to St. John's Hospital for Diseases of the Skin, Leicester Square.
- TRELLING, W. H., MAXWELL, M.D., B.S. Lond., M.R.C.P., Honorary Physician to the Meanwood Convalescent Home for Children.

Births.

- CHAPPEL.—On Jan. 20th, at Lansdowne House, Tottenham, the wife of George P. Chappel, M.D., of a son.
- MORGAN.—On Jan. 19th, at Westcliff-on-Sea, the wife of W. Harmon Morgan, M.R.C.S., L.R.C.P. Lond., of a daughter.
- WATSON.—On Jan. 16th, at 5, Mount Ephraim Road, Tunbridge Wells, the wife of Charles R. Watson, M.D. Brux., M.R.C.S., L.R.C.P., of a son.

Marriages.

- EMERSON-TAIT.—On Jan. 16th, at St. Mary's, Castlegate, York, Lieutenant-Colonel I. Bomford Emerson, R.A.M.C., eldest son of the late John Emerson, of Deer Park, King's County, to Alice Emily, youngest daughter of the late Sir Peter Tait, D. L., J.P.
- FAIRBROTHER-HUGHES.—On Jan. 19th, at the Parish Church, Conway, Percy T. Fairbrother, third son of the late Henry Fairbrother, of "Holmea," Altrincham, to K. Winifred Hughes, widow of the late Captain M. L. Hughes, R.A.M.C., and daughter of Henry Simpson, M.D., of Glas Morfa, Conway.

Deaths.

- DE FARECK.—On Jan. 19th, at his residence, in London, William Frederick de Fareck, M.D., M.R.C.S. Eng., retired Surgeon-General Indian Medical Service.
- HILL.—On Jan. 19th, at 8 Churchfield Road, Ealing, David, third son of the late Andrew Hill, M.D., Cupar, Fife, aged 48.
- MALLAM.—On Jan. 19th, at 91, High Street, Oxford, suddenly, after a short illness, Henry Parr Mallam, M.R.C.S.
- SARELL.—On Jan. 15th, at 5 Sunderland Terrace, London, Fanny, daughter of the late Richard Sarell, M.D., M.R.C.P., of Constantinople.

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, JANUARY 31, 1906.

No. 5.

NOTES AND COMMENTS.

A Medical Man as Will Maker.

THE unbusinesslike ways of medical men are proverbial. The systematic tabulation and orderly conduct of documents and accounts are simply abhorrent to the average man of medicine. Indeed, nothing could be more remarkable than the contrast between his laxity in such matters and the accurate tenacity with which he usually controls his professional pursuits. An amusing instance of an Irish graduate's will came before the law courts last week. Genial, popular and the friend of everybody, this unbusinesslike gentleman was one day brought home in an injured condition after a carriage accident. Some mention was made as to his not having made a will, and he scrawled a few testamentary lines across an envelope, his signature to which was witnessed by a servant. That curious document has been upheld in the probate court, and the widow has inherited upon the strength of this truly Milesian will.

Not so Shallow After All.

A THOUSAND anecdotes might be recalled showing the want of business aptitude on the part of members of the medical profession. For all that, the defect is due to lack of special training rather than to any intellectual narrowing. In matters of organisation medical men, as a rule, display great prudence and fixity of purpose. Hardly any of the enterprises for self-protection and self-advancement have failed to become prosperous. We are still waiting, however, the crowning effort of professional combination which will give to us a really representative general medical council, control of our corporations, compulsory registration, a one-portal system of qualification, reformed Medical Acts, and other advances towards the medical millenium.

Mr. Troutbeck on the Coroner's Court.

THE Westminster Coroner, Mr. John Troutbeck, has been unburdening his mind to an interviewer of the *Daily Mirror*. From the published report of his utterances on that occasion we gather that he is in favour of sweeping reforms in the procedure of the Coroner's Court. So important are his remarks that we purpose dealing with them at length in our next issue. Meanwhile, it will be sufficient to state that they hinge more or less upon the assumption that every coroner should be a lawyer with the services of a skilled pathologist at his command. It is to be

regretted that the holder of a prominent public office should resort to so undignified a method of defence—for that is what the above-mentioned interview amounts to—in answer to attacks that have been weighty, well-sustained, multitudinous, and delivered in the full light of day.

Mr. Troutbeck's Trembling Hands.

THE Westminster Coroner has an unhappy gift for stirring up the waters of strife. He has done more towards the ultimate abolition of the ancient office of coroner than can be undone in a generation. He has embittered the medical profession, and embroiled them in a needless fashion with the London County Council. He has roused the British Medical Association, the defence societies, and the medical journals, while the whole medical profession, with the exception of Dr. Freyberger and one or two medical faddists on the County Council, are up in arms against his arbitrary and injurious methods. The fact seems to be that Mr. Troutbeck is so imbued with a profound distrust of his own ability to weigh ordinary medical evidence, that his heart yearns for the support of a so-called "expert." Why not adopt the simpler expedient of putting a well-trained medical man into the position now administered so unhappily by his trembling hands?

The Central Midwives' Board Again.

ONCE more the Central Midwives' Board has rescinded its previous resolutions in order to permit facilities to certain nurses, facilities which are contrary to the regulations of the Board. As will be seen elsewhere in our columns, on November 23rd the Board refused to grant an extension of time for signing schedules in the case of nurses belonging to the Cheltenham Nursing District Association, yet on January 25th, this resolution was rescinded and the extension granted. We think that the motion to rescind was proposed by the same lady who strenuously resisted all attempts to treat the Belfast Maternity Hospital with justice, and who also opposed the claims of the Rotunda Hospital. In spite of the protestations of the President and Dr. Dakin, the motion was carried. Dr. Dakin is a newly elected member of the Board and though this procedure must have opened his eyes to its manner of doing business, it will be some time before he can accustom himself to the entire absence of method and, indeed, in many cases, of legality in its procedure.

Rumoured Awakening of Army Medical Service. THE example of Japan in excluding enteric fever from its recent war operations appears to have stimulated—more or less—our own military authorities. It is rumoured at Aldershot that a school of hygiene is to be established there for the instruction not only of the R.A.M.C., but also of regimental officers. Well may officers of the old school rub their eyes and wonder what next is going to happen in the Service. The South African war, with its terrible mortality from enteric fever, shows the lamentable backward state of British camp and hospital hygiene. The Japanese have since proved that by ordinary scientific precautions preventable disease can be practically excluded from an army in the field. If British troops were sent out on a campaign tomorrow they would probably be not a whit better guarded against camp infection than they were in the South African campaign. After all, the re-organisation of the R.A.M.C. is only one of many military reforms that are urgently needed. Lastly, it is well to bear in mind that the War Office moves slowly in such matters, and that the school of hygiene is at present founded simply on rumour.

LEADING ARTICLE.

THE ORGANISM OF GENERAL PARALYSIS.

It is hardly possible for the man of moderate imagination to forecast the future progress of bacteriology. Even now, in its comparative youth, that ancillary science has simply revolutionised the practice of surgery, physic, public health, and other associated branches of medical work. Within the past nine months the elusive organism of syphilis has been almost certainly identified, although the chain of logical demonstration has not been yet absolutely linked together. The next step, supposing that the pathogenic nature of the *Spirochete pallida* to be established, will possibly be to show its relation to nerve syphilis, which is now known to us as an inveterate and progressive result in some cases of infection. The conclusion that locomotor ataxy is almost invariably the outcome of preceding syphilis has been established by methods of inference less direct than the detection of a constantly present specific organism in the affected areas of the spinal cord. Another disease of the nervous system, general paralysis of the insane, has also been ascribed to syphilis. It must be confessed, however, that hitherto the etiology of that mysterious and fatal malady has been among the obscurest problems of medicine. The possibility of microbial invasion is certainly suggested by many characteristics of the complaint. Some investigations by Dr. Ford Robertson, recently communicated to the Royal College of Surgeons of Edinburgh, cannot fail to draw universal atten-

tion to this peculiar form of associated progressive dementia and palsy. It appears that during the last six years a special investigation into the subject has been carried on in the laboratory of the Scottish Asylum, and at the Royal Edinburgh Asylum. Without being in possession of the full statement it may be briefly said that the results of these researches tend to show that general paralysis is dependent upon a bacterial toxæmia, and that the point of entry of the pathogenic organism into the system is usually through the alimentary canal. Dr. Robertson has found a micro-organism closely resembling that of diphtheria constantly present in the alimentary or respiratory tracts in cases of general paralysis. This organism has been detected in the fresh blood, in the cerebro-spinal fluid, and in the walls of the cerebral vessels. The bacilli were rarely capable of staining in the ordinary way, but cultures had been obtained from the brain in nine out of twenty-three cases of the disease in question. Dr. Robertson also made the statement that he and Dr. M'Rae were now able to bring forward evidence to show that general paralysis and the allied pathological condition, *tabes dorsalis*, were as specific in their causation as tuberculosis, enteric fever, diphtheria, and other well-known definite pathogenic infections. Other investigators have been at work on the same lines as regards the relation of diphtheroid organisms to general paralysis. The central fact of Dr. Robertson's announcement is the identification of the bacillus in the blood, the cerebro-spinal fluid, and the cerebral arteries. The confirmation or otherwise of his observations will be awaited with profound interest by medical men throughout the world, not to mention the large and increasing section of the outside community that takes an intelligent interest in the progress of medical science. The general consideration of this reported discovery leads inevitably to the regret that we have no great State-supported laboratories where these things might be investigated. As a mere commercial investment the cost of a great national organisation of the kind would soon be more than amply repaid, for there can be no greater economic saving to a community than that which follows the prevention of disease. Indeed, it says much for the unselfishness and the patient persistence of our great pioneers in scientific medical work that their achievements have been as a rule brought about with scanty means and by self-sacrificing toil. Their reward has been for the most part the consciousness of having left a rich heritage of knowledge to their own and to coming generations. Whether the news of the discovery of the specific organism of general paralysis be well founded or otherwise, it deserves authoritative examination by the State, backed with all the expert knowledge and special resources that can be supplied by the national exchequer. Failing that, we have no doubt the question—like many other great scientific problems—will be settled in the laboratories of private workers.

NOTES ON CURRENT TOPICS.

"Safe" Watercress.

THE repeated exposure of polluted watercress beds as a cause of enteric fever has naturally damaged the market for that particular greenstuff. The fact is that watercress farms ought to be registered and kept under strict sanitary supervision. It must be remembered, however, that they are often fed from streams and rivers that, hopelessly contaminated with sewage as they are, nevertheless supply drinking water to whole districts. Apart from that general consideration, there is often serious and open sewage pollution of the watercress beds themselves. We note with some trepidation an attempt on the part of certain public newspapers to restore confidence to the mind of the watercress consumer. The plan is specious, but woe to the luckless citizen who listens to the voice of the siren! The statement is to the effect that watercress is safe during the winter months, and that the only time when any danger of infection exists is during the summer and autumn. As a matter of fact, typhoid fever is always with us, and may spread by way of cesspools and drains in the winter as well as in the summer. Besides, there are many other disease organisms injurious to man contained in sewage. Our first and last words are that nothing can render watercress safe except the absolute purity of the beds from harmful germs. This latter can be secured only by official sanitary supervision and control. The sooner the man in the street recognises this, and demands a short Act of Parliament to keep his watercress sweet, the better for all concerned, whether growers, sellers, consumers, or sanitary authorities.

A Lawyer as Aural Specialist.

UNDER the heading, "A Lawyer Among the Quacks," our contemporary, *Truth*, relates a remarkable story. It appears that during the past few months, a new "cure" for deafness has been extensively advertised under the title of "Aug. Royel, Ltd." The originator and the chief, if not the only director, according to the journalistic authority above mentioned, is a Mr. H. W. Clarkson, a partner in a firm of London solicitors. The idea of starting an independent trade venture in deafness appears to have arisen from the fact that the firm in question acted as legal advisers to the notorious Drouet Institute. The stock in trade appears to have been an electric battery and a supply of pseudo-scientific pamphlets and other literature. The directorate apparently consisted of Clarkson and a commercial traveller, the latter of whom was eventually ejected after various legal actions commencing with a charge of embezzlement. The case is worthy of the attention of the Incorporated Law Society, for it may be pretty safely predicted of any advertised cure of deafness that it is a sheer, unadulterated fraud upon the public. The medical profession should be much indebted to *Truth* for discharging defence functions

on its behalf that would more appropriately appertain to our own General Medical Council.

Medical Man sued for Mistaken Diagnosis.

THE diagnosis of enteric fever, as every medical practitioner realises, is at times surrounded with insurmountable doubt and difficulty. Indeed, there is little reason to doubt that a certain percentage of cases of the "ambulant" variety run their course unrecognised. The sympathy of reasonable persons, therefore, must be with any medical man who pronounces an attack to be typhoid fever, whereas it is in reality some other serious illness. Last week a Brixton practitioner was called upon to defend an action for damages brought on behalf of a patient who had been certified as suffering from enteric fever and taken to an infectious hospital. The grounds for alleged damages appear to have been detention for seventeen days and injury to some goods in the process of "disinfection." For the latter, however, the local sanitary authorities were surely responsible. The judge very properly remarked that the action should never have been brought, and dismissed the suit with costs against plaintiff. Were any other result possible under such circumstances the conditions of medical practice would become intolerable. In any case the medical man who suspects enteric fever will do well to err on the safe side and treat the patient for that malady. To make the opposite error is to court speedy and irretrievable disaster.

A Medical Executioner.

AMERICA is recognised as the world's great birthplace of sensations. It must be confessed, however, that the public confession of a medical man that he has deliberately taken a patient's life in order to put her out of suffering—to us what is usually regarded by Britishers as pure Yankee vernacular—"caps creation." Yet the news comes with all the smoothness and circumstance of a concise report of a thing that has happened, although at the same time our readers will do well to keep at hand the grain of salt needed for most of the dishes of yellow journalism. Dr. Kempster, so runs the story, "one of America's most famous specialists in mental diseases," gave an overdose of morphia to a patient, the wife of a colonel. The unhappy lady was suffering terrible pain from severe burns, and had attempted suicide. There was no prospect of her recovery, so he ordered a local practitioner to fill a syringe with morphia, which he injected. An analysis of this case suggests that the fact of a medical man committing such an act wilfully is equalled only by his subsequently proclaiming it to the world. From a philosophical point of view, there is much to be said as to the justifiability, or at any rate the expediency, of destroying the lives of imbeciles, insane persons and persons smitten with mortal disease. There have always been two primary difficulties in the way: First, who is to decree the death, and, secondly, who is to carry out the sentence? Society would certainly not

permit the word of a single medical man to settle the fate of a fellow creature, nor is it likely that he would be an ideal executioner. However, the world travels fast nowadays, and it is well to bear in mind that Dr. Kempster's confession was called forth by a Bill now before the Ohio legislature to empower medical men to take the lives of incurables.

Abortionists' Methods.

THE way of the abortionist in this country is happily surrounded with so many difficulties that individual profits in this line of business are hardly sufficient to attract many competitors for favour, and the newspapers which stick at little in the way of advertisement do not lend their columns to further this crime. In America things seem to be different, or were so till an association was formed for the purpose of prosecuting people who lived by practising the procreation of abortion. To what length these anti-social pests had gone in seeking for business before the crusade was entered upon is shown by a circumstance that was brought to light at the trial of a certain Dr. Roberts, *alias* Hunt, of Boston. It appears that this scoundrel, who claimed to be a medical graduate of Edinburgh, had the impertinence to circularise the members of the profession at Philadelphia last summer by letter, pointing out that whereas many patients doubtless consulted doctors for the purpose of having an abortion procured, yet from the "specially delicate" nature of the case many men preferred not to "handle" them themselves, and that "family patronage" was thereby lost. Moreover, this tender-hearted philanthropist continued, the patients were thus driven "into the hands of quacks and irresponsible charlatans by which the city is pestered. You are well aware that this line of practice is too delicate in nature and too often involves risk of human life to be undertaken by any but one of undoubted qualifications and equipment." To the English mind it is amazing that any man—lay or medical—could have had the consummate impudence to write thus openly to the profession in a large civilised city, seeking their patronage for his trade; indeed, it is barely credible. The crusade against these criminals has begun none too soon. It is satisfactory to be able to record that Dr. Roberts, *alias* Hunt, is now undergoing six years imprisonment, along with several others of his peculiar kidney.

Football.

WE recently took occasion to call attention to the dangerous character the game of football was assuming in America, and at the same time expressed a wish that our players would not follow their lead in the development of the game. We have now before us the report of Drs. Nichols and Homer Smith, surgeon and assistant surgeon respectively to the Howard University football "squad" for 1905. It appears that it is necessary to have one of these gentlemen on duty not only

during the time when matches are played, but also during practice. In fact, they state themselves that the proportion of injuries sustained in matches and in practice is much the same. The report is enough to startle any English footballer. From it we learn that about 150 men passed through the "squad," but most of these did not remain in it long, and that seventy would constitute the real playing strength. Among these no less than 145 injuries of a character to prevent a player continuing to play were received during 1905. There were twenty-seven fractures of one kind and another, and eighteen dislocations, even if we do not reckon ten dislocations of the semilunar cartilages of the knee-joint that took place. One case of middle meningeal hæmorrhage occurred, and one of fracture-dislocation of the second cervical vertebræ are recorded, but though it is not specifically stated whether the patients recovered, the fair inference is that they did not. All the injuries detailed are severe, some being extensive contusions and bad sprains, others ruptured muscles and wounds. The medical corps includes a trained masseur, who seems to have been kept pretty busy, and surgical apparatus of all sorts was ready to hand during all games. We are not ourselves inclined to criticise the authors' contention that "the percentage of injury is too great for any mere sport," beyond saying that if they had said that the game had degenerated into a cross between a bull-fight and a gladiator-show we should have found even less reason to quarrel with their assertion.

The Universal Pill.

IN the course of recent electoral amenities, Mr. John Burns made fun of Mr. Chamberlain's policy by describing it as a "Morrison Pill." Since the days of Morrison and Carlyle many a universal pill has arisen and brought affluence to its proprietor, but it is interesting to notice that the ingredients of them are substantially the same. The basis of all—or practically all—the liver pills, head-ache pills, back-ache pills, and fancy pills for foolish folk is aloes; probably on account of its cheapness and convenience. Morrison's pill, we learn, was a compound of aloes, jalap, extract of colocynth, gamboge, rhubarb, and myrrh, surely as catholic and impartial a combination of laxatives as ever a "blunderbuss" prescriber conceived. We do not know if it enabled its enterprising proprietor to amass sufficient wealth to endow colleges for ladies and to found lunatic asylums, but it certainly permitted him to gain a handsome profit at the hands of his credulous customers, and to perpetuate the name of Morrison to generations unborn through the medium of "Past and Present." This mention by Mr. Burns of the famous quack and his claims only serves to remind one that fifty years more of experience and education have done nothing to awaken people to the fallacies of "Universal Pills," or to the lies of their proprietors.

The Profession and Alcohol.

THE *Medical Temperance Review*, in the first number of its ninth volume is very jubilant at the progress that has been made by the British Medical Temperance Association during the thirty years of its existence. The Association and its journal have every reason to congratulate themselves, for it is indisputable that the general opinion of the profession on the question of alcohol has undergone a striking change during that period, and it is probable that the Association itself has had some share in aiding the transformation. The establishment of the London Temperance Hospital in 1873 was a bold experiment in then-existing conditions, but though the Institution has gone through various vicissitudes, it has now established itself firmly as a well-equipped modern hospital, with a death-rate and cure-rate good enough to please its founders' hearts. As medical opinion with regard to the use of alcohol has become more moderate, so, too, if we mistake not, have the opinions of the bulk of scientific teetotallers, and it is possible that in the near future a *via media* may be established where all may meet on common ground. At present the *Temperance Review* holds out strongly for total abstinence as the only way by which the admitted curse of alcoholism may be banished from the community. That, we fear, is impracticable so far as the masses of men are concerned, at any rate, till education and culture are far wider spread than they are to-day. And at present the well-educated classes consider themselves able to judge how far they may take alcohol without exceeding the bounds of strict moderation, so that total abstinence becomes a matter for individual choice. But that any man is materially the worse for being a teetotaler, we fancy there would be but few medical men at the present day prepared to maintain.

Beri-beri in the Japanese Navy.

A SOMEWHAT remarkable observation has recently been made known with regard to beri-beri. Speaking before a New York Medical Society, Baron Takaki, Surgeon-General of the reserve of the Japanese Navy, stated that the introduction of a meat diet had practically stamped out beri-beri in the Navy. The significance of that fact becomes apparent when it is added that previously no less than 40 per cent. of the crews suffered from the disease. The average weight of the sailors, according to the same authority, had increased by eight pounds. The etiology of this peculiar form of peripheral neuritis has always been in doubt. Although it has often been ascribed to a diet deficient in nitrogenous food; the point has never been established. The possibility of so well-marked a nervous disease being amenable to diet opens up a great field in kindred affections. From many points of view the Japanese Navy experience in beri-beri appears to possess a potential value of a kind difficult adequately to estimate.

PERSONAL.

DR. W. OSLER will deliver the Harveian Oration of the London Royal College of Physicians on St. Luke's Day, October 18th, 1906.

THE Milroy Lectures of the same College will be delivered by Dr. W. H. Hamer in March; the subject being "Epidemic Disease in England; the evidence of variability and of persistency of type."

SEVERAL representatives of the Liverpool School of Tropical Medicine recently attended Bunbury Church at a memorial service and the unveiling of a stained glass window to the memory of Dr. J. Everett Dutton, who, it will be remembered, died whilst out in the Congo investigating sleeping sickness.

THE Metropolitan Branch of the Society of Medical Officers of Health held its jubilee dinner at the Holborn Restaurant last evening, under the presidency of Dr. John Priestley, medical officer of health for Lambeth.

AT the ordinary quarterly *comitia* of the Royal College of Physicians of London, held on Thursday, the following Fellows of the college were elected to fill vacancies in the council:—Dr. William Osler, Dr. H. R. Crocker, Dr. H. H. Tooth, and Dr. T. D. Acland.

H.I.H. the German Emperor has conferred the Crown Order of the Third Class on Mr. Charles A. Ballance, F.R.C.S.

DR. BEEBE, of the Cornell Medical School, claims to have manufactured from diseased human thyroid glands a serum that will cure exophthalmic goitre.

PRINCE LOUIS OF BAVARIA, a skilled surgeon, has performed during the last fortnight several operations in Madrid, where he has been staying for the marriage of his son.

MISS ANNA HALL has drafted a Bill recently introduced into the Ohio Legislature authorising physicians in certain circumstances to put invalids to death.

DR. ERNEST OTT, who was his Majesty's medical attendant during his stay at Marienbad last year, had the honour of being invited to dinner at Windsor Castle on Saturday last by the King and Queen.

WE have to record two important Continental appointments which were made last week—the chair of the late Prof. Nothnagel, in Vienna University, has been filled by Prof. van Noorden of Frankfort, and Prof. von Bergmann, who, it will be remembered, was called in with the late Sir Morell Mackenzie in the Emperor Frederick's fatal illness, has been given a seat in the German House of Lords by the Kaiser.

THE GENERAL ELECTION.—The following members of the medical profession have been returned to Parliament since our last issue: The Rt. Hon. John Morley, Dr. Cooper, Bermondsey; Sir W. J. Collins Paddington; Mr. R. Ambrose, West Mayo; Mr. R. J. Price, re-elected for East Norfolk; Dr. A. R. Rainy, for the Kilmarnock Burghs; Sir G. S. Robertson, K.C.S.I., Bradford (Central), and Dr. V. H. Rutherford, the Brentford Division of Middlesex. Amongst those who have lost their seats are Sir Michael Foster K.C.B., for London University, and Dr. C. F. Hutchinson for Rye.

THE Committee of the Bristol Royal Infirmary have unanimously elected Mr. Walker Hall, M.D., C.H.B., to the newly-formed post of pathologist, bacteriologists, and director of clinical laboratories.

A CLINICAL LECTURE

ON

RIGHT-SIDED PLEURISY IN THE SUBJECTS OF HEART DISEASE.

By Prof. LOUIS RENON, M.D., Physician to the Pitié Hospital, Paris.

(SPECIALLY REPORTED FOR THIS JOURNAL.)

THREE patients at present in my wards suggest to me as a subject for to-day's lecture the occurrence of right-sided pleurisy in persons suffering from heart disease, an affection which runs a peculiar course, and the diagnosis whereof is often a matter of some difficulty. This right-sided pleurisy is met with in the subjects of valvular disease as well as in the victims of cardio-vascular lesions.

Allow me to point out to you first of all the differences that present themselves between valvular and cardio-vascular affections, and I hope to make it clear that the two states are very unlike each other. In valvular disease the lesion starts in the valve and ends in the myocardium; after the initial rheumatic endocarditis comes valvular deformation, with its murmurs; more or less prolonged period of compensation, then we come to the periods of hyposystole and asystole, with œdema of the limbs, passive congestion of the lungs and the cardiac liver. In cardio-vascular affections the picture is quite different. The patients have never had rheumatism, instead of which we discover that they have suffered from gout, alcoholism, over-indulgence in tobacco—this great excitant of cardiac spasm, lead poisoning, excessive indulgence in meat or chlorides, depressing emotions, excessive intellectual work, and senile degeneration. The cardiac muscle is involved in its arterial system, and the patient begins with myocarditis, to finish by valvular lesions. You may meet with transitory or permanent murmurs; these are not the murmurs of valvular deformation, but are most frequently due to functional inadequacy, consequent upon dilatation of the heart cavities and orifices. Asystole in these cases is not, as in the other cases, a terminal condition, the natural end, so to speak, of the malady; it is, on the contrary, an acute state, a hypertensive complication arising, it may be, from a slight cause—digestive disturbance, overwork, a passing emotion, an infection, dietetic errors or an excessively salted alimentation or an intercurrent intoxication.

Pleurisy occurs more frequently in connection with arterial cardiopathies than with valvular disease. The pleurisy is usually on the right, indeed, it may be laid down as a general rule that pleurisy in a cardiac subject is almost always on the right. The three following cases afford an additional proof of this right-sided tendency. When I have briefly described them we will discuss the clinical aspects of these effusions.

My first case is that of a woman, æt. 40, who came into the service last December, a prey to violent dyspnoea and presenting marked œdema of the lower limbs and of the abdominal parietes. The symptoms had started three years before by dyspnoea following an effort and had been steadily getting worse for two months past. The only point of interest in her personal history was a slight tendency to ethylism. On examination the heart-beat was heard to be irregular and rapid, and the sounds were muffled and, so to speak, lacked precision. Percussion caused too much pain for us to be able to establish the outline of the organ. The pulse was small, rapid—120 per minute. The lungs were the seat of coarse, sibilant, sonorous râles, and there were unmistakable signs of pleural effusion at the right base; absolute dulness, entire absence of vibrations, absence of breath sounds, without ægophony and without aphonic pectoriloquy. The urine was scanty, very dark and loaded with albumin. The liver was big and painful on pressure, its lower margin extending three fingers' breadth below the false ribs.

In presence of all these symptoms I diagnosed asystole with right pleural effusion, reserving a decision as to the exact nature of the heart lesion for the present, since it could not be determined. I applied wet cups over the cardiac area and ordered a mild saline purgative, a milk diet and fifteen drops of a 1-000 solution of crystallised digitaline. On the following day the dyspnoea had greatly diminished, the pulse was slower and on auscultation I was able to make out two murmurs over the aortic area, one systolic and the other diastolic. I substituted theobromine (25 grains in the twenty-four hours) for the digitaline. Cytological examination of the fluid showed it to contain numerous epithelial bunches, some red corpuscles and lymphocytes. During the next few days the patient's breathing was easier, diuresis was copious, the œdema diminished, and she was improving rapidly, when, on December 26th, in consequence of an imprudence, she became suddenly worse. The temperature rose, the left lung was congested, and the lower limbs again became œdematous. At the right base local fremitus was diminished and the vesicular murmur was abolished, but the supervention of fine friction râles justified the supposition that the pleural surfaces were in contact, and that there was no effusion. On January 2nd, 1905, the patient died suddenly in the act of sitting up in bed.

Post-mortem.—When the thorax was opened, a yellow liquid escaped in large quantities from the right pleural cavity. The right lung, pressed upwards and backwards, was flattened against the posterior wall of the thorax and all the liquid was contained between the base of the right lung and the greatly depressed diaphragm. The liver which had appeared to be greatly enlarged only weighed a little over two pounds. It was small and hard, and was evidently merely pressed down by the fluid and in no wise hypertrophied. The lungs were markedly congested. The enlarged heart weighed eighteen ounces. The edges of the aortic valves were indurated and thickened. The aorta was dilated at the arch and incrustated with atheromatous patches. The kidneys were cyanosed and the spleen was small and hard, and its consistency increased.

In this description I would call your attention to the existence of an aortitis, to the right pleurisy and to the sudden death of the patient, due apparently to the copious effusion which we thought had dried up. Remember also the small size of the liver which we took to be greatly enlarged when, as a matter of fact, it was merely pushed down by the liquid that had accumulated between the base of the lung and the upper surface of the diaphragm.

The second case is that of a man who is now in our wards for the third time. He is sixty-five years of age, and in the course of three years has been tapped thirteen times for right pleural effusion—the first in 1902, the last in March, 1904. Twelve punctures were performed in seven months, eight of which were done in four months. On eleven occasions the fluid was sero-fibrinous, and twice it was hæmorrhagic. It was cytologically examined on three occasions, a first time in December, 1903, when epithelial patches and a few lymphocytes were found, and on two other occasions when lymphocytes were also discovered in the hæmorrhagic liquid.

There are several points to be noted in the evolution of this recurring right-sided pleurisy. To begin with the effusion was not very abundant though the dyspnoea was intense, and on each occasion more fluid

was withdrawn than had been anticipated. With regard to the cause of the effusion the presence in the fluid of epithelial plaques and lymphocytes suggested pleurisy of mechanical or tuberculous origin. As no tubercle bacilli were found in the expectoration, though repeatedly examined, and as the patient was suffering from arterio-sclerosis we were fain to assume the cause of the pleurisy to be cardiac.

The arrhythmia, the tachycardia, the heightened arterial tension, the presence of a systolic murmur, essentially temporary and variable, as it always is in this affection, all pleaded in favour of this view. Moreover, there was no history of rheumatism and when the patient again applied to us it was on account of intense dyspnoea accompanied by frothy expectoration similar to that of the cardio-renal patients who, in the course of hypertension, develop the main symptoms of acute pulmonary oedema.

The third case is that of a woman, also suffering from cardio-sclerosis, who was punctured a few days since in a very unusual spot, *viz.*—in the third right intercostal space in front on the nipple line. The liver dulness appeared to be enormous, and seemed to reach above to the second rib. Taught by the experience of the previous cases, I declined to adopt the view of the liver being so large, and I mentioned to you that we probably had to do with a right-sided pleurisy of which there was no outward manifestation. Several of you appeared sceptical as to this, but you had to give way when an exploratory puncture into the dull area gave issue to sero-fibrinous liquid. I will not dwell longer on this case, there being several other points to which I must call your attention.

These right-sided pleurisies in cardiac patients are really pleurisies and not hydrothorax. The pleural inflammation is unilateral, it is accompanied by fibrinous exudation and false membranes, and, lastly, it presents a special cytological formula. The fluid is purulent, hæmorrhagic or sero-fibrinous. These cardiac pleurisies vary as to their seat and the symptoms are modified accordingly. The pleurisy may involve the general pleural cavity or it may be diaphragmatic, mediastinal or encysted. In spite of the differences of symptomatology due to the difference in position, these pleurisies have certain features in common—*viz.*, a slow insidious onset, a certain latency of the symptoms, always masked by the concomitant cardiac dyspnoea, and the quantity of fluid is always superior to that estimated prior to making the puncture. These cases present the signs of ordinary pleural effusions, which I need not describe. But, as in my first two cases, we must note the possibility of recurrence of the effusion and considerable displacement of the liver which may lead us to diagnose hypertrophy.

Right diaphragmatic pleurisy is much more interesting. My third patient gives a very good idea of the curiously special aspect of these pleurisies. The history of this patient is in all points similar to the three cases which I discussed here in 1903.* I summarised the clinical features of this type of pleurisy in the "Archives generales de Medicine" (1903, p. 1508), where I laid it down as follows:—Always before we look out for pulmonary infarct in patients with heart disease, whatever its nature, whether valvular or arterial; these cases are capable of taking you off your guard, as you will see. We will suppose that you are treating a patient suffering, say, from mitral stenosis. In addition to the ordinary signs of this particular heart lesion, you find passive congestion at both bases. Under the influence of the usual treatment, the dyspnoea diminishes, the general state improves, and the end of the attack seems within measurable distance, when one day you are summoned on account of a sudden violent pain in one or other part of the right lung. On examination, you find the signs of pulmonary infarct: dulness, fine sub-crepitant rales and a souffle; a day or two later the appearance of characteristic bloody sputum confirms the diagnosis.

So far so good; you dry or wet cup, you do your best to calm the distressing oppression and you hope that in a short time the small infarct will be completely absorbed. But if it happens to be situated just beneath the pleura, and if, owing to the special septic condition of the embolised territory, it determines a sero-fibrinous effusion your forecast will not be realised. The effusion will take place, and the liquid will, as a rule, collect in the general pleural cavity, but sometimes it becomes encysted, loculated, or forms in the mediastinum. Lastly, it may hide itself between the base of the right lung and the diaphragm—an odd, unfortunate situation which is pretty sure to escape your vigilance, unless you happen to be acquainted with it. We are now far from the original pulmonary infarct that seemed so simple a matter.

This diaphragmatic, right-sided pleurisy runs a latent course. The only sign is the dyspnoic pain of the infarct. None of the ordinary signs of pleurisy are present, no dulness or only the partial dulness of the congested bases, vocal fremitus is preserved, and on auscultation we hear merely some fine sub-crepitant rales. Sometimes the signs leave us in doubt and to clear up the diagnosis we puncture in the two last costal interspaces in the axillary line, and we find nothing.

In the axilla, in front, we may, however, discover something unusual. The liver seems suddenly to become enlarged, the liver dulness may reach almost from the clavicle down into the abdomen, and the margin can be felt below the false ribs for two or three fingers' breadth. The only explanation that suggests itself is a large cardiac liver, and we turn our attention to the heart lesion, enjoining perfect repose, milk diet, purgations and cardiac drugs in order to reduce the size of the liver, and all at once the patient dies, an unhappy experience which was mine in the first of the three cases I have related to you.

Post-mortem you find three pints of fluid in the right pleura, hidden away underneath the base of the lung, between it and the diaphragm. A tolerably thick layer of lung tissue reaches backwards, covering the costal wall right to the very bottom of the costo-diaphragmatic sinus. This explains why we could not detect the pleurisy, although we searched for it daily and even resorted to an exploratory puncture. The fluid was only in contact with the diaphragm, and the base of the lung. Another surprise is sprung on us, the liver that we had taken to be immensely enlarged turns out to be of normal dimensions; it has merely been pushed down by the layer of fluid on the upper surface of the diaphragm, and the dulness that we found in front during life was dependent upon two different conditions: above there was the liquid dulness, and below the liver dulness. Our error has been threefold; we were wrong as to diagnosis, as to prognosis and as to treatment.

If you are acquainted with this clinical type, the diagnosis is fairly easy, and in the two last cases I was able to make out the actual condition of things, warned as I had been by my previous mistakes. Following an infarct of the right lung, I found a few days later, extensive dulness in the axilla in front with displacement downwards of the liver. There was an absence of thoracic vibrations and of vesicular murmur, and that placed me on my guard. I made an exploratory puncture in the fourth right intercostal space in the nipple line, and I withdrew some sero-fibrinous fluid. A puncture behind, in the ordinary spot, gave no result, in consequence of the thickness of the layer of lung tissue lying against the thoracic wall, it was only with a very long needle that I should have had a chance of coming upon the fluid after piercing first the thoracic wall and then the layer of lung in contact therewith.

I have nothing to add to this description; the various observations that I have since made only confirm what I have said.

The mediastinal pleurisy of cardiac patients presents the usual symptoms of mediastinal effusion.

* *Mémoire. 'La Pleurisie intestines-diaphragmatique des Cardiaques.'* Journ. des Praticiens, June 6th, 1903.

The mediastinal syndrome dominates the scene with its pressure phenomena. This form of pleurisy often ends in the formation of a serous or purulent collection.

Encysted pleurisy is rare in cardiac patients. The signs are extremely variable according to the particular part of the serous membrane where it happens to become encysted.

The pathogenesis of right pleurisy in cardiac patients is wholly dependent on sub-pleural pulmonary infarct, septic or not. In many cases the pulmonary apoplexy is obvious, a sharp pain followed by the appearance of bloody sputum precedes the effusion by a day or two. Sometimes the signs are less characteristic, the pain may be trifling, but the dyspnoea is well marked and the unexpected presence of some muco-purulent expectoration attracts the attention.

It follows that the diagnosis of this form of pleurisy is both easy and difficult, easy when it is situated in the general pleural cavity, although even then one is apt to be greatly deceived as to the quantity of the effusion. In all other cases it is difficult, especially in the mediastinal form, and in latent right supra-diaphragmatic pleurisy. I warn you to be on your guard in such cases when you find dulness in the axillary hollow or in the right sub-clavicular region. Hesitate to accept the hypothesis of a very large cardiac liver of which the upper limits are quite abnormal. I have explained to you that in such cases the liver is, as a rule, simply displaced and not hypertrophied. Make an exploratory puncture in the dull area and often, greatly to your surprise, you will strike fluid. If you puncture behind, in the ordinary spot, use a long needle for, you will have to pierce a layer of pulmonary tissue lying against the posterior thoracic wall. The cytological examination of the fluid, demonstrating the presence of endothelial plates with a few lymphocytes will confirm the nature of the effusion.

The prognosis in right-sided pleurisy in cardiac patients must be guarded. To begin with, these effusions, essentially latent, may easily be overlooked. Then, too, they are very apt to reform, and, lastly, they add another factor of oppression to a disease itself dyspnoic in character, and they may aggravate a condition already sufficiently precarious.

The treatment comprises two principal indications. The first is to evacuate the fluid as often as may be necessary; the second is to treat the original cardiac lesion in order to avert the further formation of infarcts, the commonest cause of these pleural complications.

NOTE.—A *Clinical Lecture* by a well-known teacher appears in each number of the journal. The lecture in next week's will be on "*Syphilitic Pseudo-General Paralysis*," by Hy. T. Bewlay, M.D., Dub., F.R.C.P., Physician to the Ad-*laide* Hospital, Dublin.

ORIGINAL PAPERS.

THE RELATION OF SPIROCHÆTA (SPIRONEMA) PALLIDA TO SYPHILIS.*

By THEODORE SHENNAN, M.D., F.R.C.S.

Senior Pathologist to the Edinburgh Royal Infirmary, Lecturer on Pathology and Bacteriology, School of Medicine, Royal College of Surgeons, Edinburgh.

That syphilis is due to a *contagium vivum* has long been believed. Even in the seventeenth century this was the view held by Kirscherius and David Abercromby, while in 1723 Deidier urged a similar hypothesis. In 1839, Donné described as the exciting agent a "*vibrio lineola*," while since his day a great number of micro-organisms had been isolated

and put forward as the causal agents of syphilis. None of these, however, had been proven to the satisfaction of other than the discoverers; among those which had had the greatest vogue were Lustgarten's bacillus (probably a *smegma* bacillus), and the organisms of Lostörfer, Winckler, Niessen, Schüller, and Siegel. The last-named had discovered an amoeba-like organism, to which he gave the name of *cytorrhyses luis*, and it was on the publication of this discovery that Schaudinn and Hoffmann were appointed by the Prussian Government to investigate the relation of the *cytorrhyses* to syphilis. In the investigation they discovered the *spirochæta pallida*, and their observations had been abundantly confirmed and amplified during the year which had elapsed since their first communication appeared. In and about venereal and other sores on the genitals one or more varieties of *spirochæta* are commonly found. One of these is merely saprophytic, and is also present in the mouth or other parts of the body. To it the name of *spirochæta refringens* is given. The *spirochæta pallida*, on the other hand, has so far only been detected in syphilitic lesions of the primary and secondary stage; it has been detected in hard sores, syphilitic bubos, mucous patches, and, though with greater difficulty, in the roseola and in the circulating blood. It has also been found fairly constantly in the viscera and the fluid from the bullæ of pemphigus of still-born syphilitic foetuses. An important point in connection with the organism is that it is most readily detected in the deeper parts of the lesion. The description of the *S. pallida*, as given by Schaudinn and modified by subsequent observers, is as follows: It is an extremely delicate organism from 7 to 14 μ in length, and consists of a series of deep, regular spirals from six to twenty in number, the average being eight to ten. Flagellæ have also been described, and so has a granule placed about one-third way along the organism. There is some doubt as to the existence of a vibratile membrane. The *spirochæta* can be seen in unstained and stained preparations; when alive it is motile, the movements being spiral, lashing, and backwards and forwards. The *spirochæta pallida* is believed to be related to the *trypanosomes*. The *spirochæta refringens* is saprophytic; its spirals are larger and less regular, and it is in every way a less delicate organism. The best stain for the two *spirochætae* is Giemsa's, by which *S. pallida* is tinted a delicate pink and *S. refringens* a deeper purple colour. This is the only differential stain known. In preparing films the important point is to get tissue juices and cells from the deeper parts of the lesions after scraping or thoroughly cleansing the surface. The juice of the bubos may be removed by a syringe, the glands being massaged the while. A few blood cells are not disadvantageous, as they assist focussing, and the *spirochætae* are often attached to them. Only fresh tissues should be used to obtain the organism. After six or eight hours none can be found in excised glands or sores—a point of some interest in connection with the short persistence of the syphilitic contagion about bodies. Films should be very thin, and fixed as soon as possible by alcohol or osmic acid. At least six should be examined before the organism was pronounced to be absent. *Spirochætae* intermediate in form and appearance were very commonly met with; for this reason it was necessary to be very careful in coming to a conclusion where *spirochætae* were present in great number, especially in preparations made from ulcerated lesions. As a rule only a few *spirochætae* were found in films made from deep parts. A further proof of the etiological character of the organism was found in the fact that Metchnikoff and Roux have detected it in the experimental lesions produced by inoculating chimpanzees, orang-outangs, macacus, and cynocephalus monkeys with syphilis. Dr. Shennan then enumerated the cases in which he had demonstrated the organism, and gave a statistical *resume* of the frequency with which it had been found by other observers. From this it appeared that it could be got in the great majority of primary and secondary syphilitic lesions, but not in the tertiary

* Abstract of paper read before the Edinburgh Medico-Chirurgical Society, January 17th, 1906.

stage. The only two instances of spirochætae in tertiary syphilis were really cases of late secondary. In one of his cases he had detected a peculiar flagellated body, of the nature of which it was impossible to be certain. Castellani and Wellmann had also found the *S. pallida* in yaws. Very many control observations made on ulcers of non-syphilitic nature, skin diseases, tumours of all kinds, &c., had failed to show the occurrence of *S. pallida* in lesions other than those of syphilis. The etiological relationship, however, could not as yet be regarded as settled, though there seemed a fair probability that it was the true cause of the disease. One of the difficulties was that there were so many forms intermediate between *S. pallida* and *S. refringens*. On the other hand, the fact that *S. pallida* was found chiefly in the deeper tissues, and particularly in the viscera of congenital syphilitic fetuses, was strongly in favour of its specific character and against its being a mere saprophyte.

A NEW METHOD OF SERUM THERAPY.

By D. M. PATON, L.R.C.P., L.R.C.S.ED., L.F.P.S. Glasgow.

FOR eight years the writer has been studying, clinically and experimentally, the use of serums exhibited by the mouth. During that time he has used over twenty million units of anti-diphtheritic serum (ADS.) and forty gallons of simple plasma of the horse, sheep, and ox. This article is a short statement of some of the results obtained, but the writer hopes shortly to put the whole work more fully before the profession in book form.

Among the clinical examples are some from the writer's own experience, as well as from others who have tested the treatment. The trouble has not been so much about the actual results as about a rational explanation of the phenomena observed. The theory which at present seems to most fully explain the results is indicated in the course of the article.

The anti-diphtheritic serums used have been supplied by Messrs. Parke, Davis and Co., who stock a low potency serum in 1 oz. bottles containing 6,000 units, enough for eight doses—1 oz. serum in aq. 4 oz.— $\frac{1}{2}$ oz. dose. They have supplied it to my order for years, and have called it "Paton's" serum. For chronic suppuration there is another serum with greater anti-proteolytic power. It has been called "Special," and the dose is the same as the other serum.

For acute conditions, 1 dr. of serum at once and every half-hour or hour for three or four doses, then every two or four hours as required. For less acute cases, 1 dr., four times a day, is generally sufficient.

I.—(a) *The Use of Simple Plasma by the Mouth in Function Deficient through Innutrition.*—The plasma is the food elaborated and fitted for direct tissue feeding and energising. In the animal its mission is to maintain nutrition and repair of tissue and enable function to be carried on in a state of normal efficiency. When given to a suitable patient by the mouth in doses of 1 dr., four times a day, it does the same work in the patient for which it was elaborated in the animal. The writer has seen scores of cases during the last two years, and has used about 40 gallons of the material in his work. A typical case on which to test the value of the plasma is that of a *post-partum* patient who is making a poor recovery, whose tissues are flabby and soft, who has little appetite or digestion, little energy or capacity for walking, probably some sub-involution and a deficiency in either quantity or quality of milk or possibly both. The use of plasma in 1 dr. doses four times a day has proved a sovereign remedy, leading to restoration of tissue tone, and renewing the lactation, so that it becomes what is normal for the patient in quantity and quality. The reaction which produces this effect is all the more marked if there is present the tuberculous diathesis, a fact which indicates the unique character of its action.

Not only is the milk restored, but preceding and accompanying it there is a restored appetite, digestion, and assimilation of food, a feeling of *bien-être*, and capacity to get about and do household duties and a freedom from the continuous feeling of weariness and exhaustion. When that is accomplished reduced doses will maintain what has been gained.

In anæmias alone, or in conjunction with ordinary treatment, in convalescence from disease or operation, in the very old and debilitated, and the very young, the oral use of plasma has the same effects as in the typical cases mentioned.

Now the albumin in $\frac{1}{2}$ oz. of plasma is quite incapable of any such result; even if it were all absorbed unchanged it never would produce a return of digestive function and all the other tissue vigour, and there must be something else in it to account for the results. There are evidently in the serum the elements which the animal has elaborated for the energising of the nerve centres which control the various tissues, and these, addressing themselves to the centres controlling the tissues requiring increased vigour, are able to produce results which are otherwise quite incapable of reasonable explanation. It is simply an increased tissue tone producing normal function and ceasing when normal conditions have been attained.

II. *Simple Plasma in Infection.*—The horse and sheep are resistant to tubercle, but, the initial resistance overcome, they deteriorate as fast as any other animal. Thus it is their initial defence which is their resistance to the infection. The ox has less initial resistance to tubercle, but, on the other hand, is extremely resistant to influenza.

In the treatment of over fifty cases of tubercle of all kinds, the oral use of the simple plasma of the horse and sheep has proved itself capable of transferring to the patient the resistance of the animal to the disease. That is, that the reaction which is seen in non-microbial cases, and which leads to restoration of tissue tone and normal function, is also obtained in the presence of the tuberculous infection where it is not mixed with other infections or is not of such an intensity as would inhibit the reaction in the animal itself. The horse and sheep are susceptible to catarrh and influenza, and the advent of these in a case which is doing well on plasma is seen at once by the inhibition of the reaction, exactly as it would happen in the horse or sheep. Thus we obtain the reaction in the presence of those infections to which the animal is more than usually refractory but in no others.

This action cannot be antitoxic for antitoxin is not absorbed by the stomach. The action on the tissue tone is such as can only be explained on the same grounds as the reaction in non-microbial cases, with the addition that the tissue tone which is produced is of such a character that it maintains the functions unimpaired in the presence of the infection and is by so much a resistance to the disease.

Cases have been treated privately in my own and other practices, in Echuca Sanatorium in Victoria, Stobhill Hospital, Glasgow, and in the Bridge of Weir Sanatorium Dispensary in Glasgow. The net results have been that more than 75 per cent. of the patients have shown the reaction. Their resistance to the disease has been materially increased, and their symptoms, appetite, cough, expectoration, general strength and frequently physical signs have all shown a marked improvement. A week's treatment is generally sufficient to tell whether the patient is going to obtain benefit or not.

If for nothing else, the use of plasma in this disease would justify itself by its action on those troublesome dyspeptic symptoms which are so frequently seen in tubercle. No case so far has failed to yield to the plasma, three tuberculous throats have all had their pain removed, bladder, surgical, and phthisis cases have all done well. It is not cure but it is an essential in the cure of the disease, for its action is the restoration of the tone of the tissues, the lowering of which was the

cause of the infection and subsequent deterioration of the patient.

Children do remarkably well, one who has had eight weeks' treatment being so much better in a colleague's practice that he examined her afresh to see if he had not made a mistake in diagnosis. Abdominal tubercle, unless in the last stages has shown itself amenable by the removal of pain, diarrhoea, &c., and the return of appetite, digestion, and increased vigour. The keynote for the use of plasma is lowered "tone" in the tissues, that intangible something which is nevertheless our defence against infection. Practically it means a lessened reaction which in turn prevents the tissue from procuring sufficient nutrition and its capacity for resistance is correspondingly lowered.

An interesting result was seen in some cases which had been treated with plasma with benefit and to which Jacob's sero-tuberculin was added hypodermically. As the dose of the tuberculin was increased the effect of the plasma gradually lessened and then ceased. It was clear that the one treatment was antagonising the other. The plasma was then withdrawn with the result that, although the tuberculin was given in doses of a half and a third of what was due, there followed in all the cases a marked reaction after the next dose of tuberculin. Some of the temperatures reached 104° and 105° , but all subsided, and with the reduced dose after that there was no undue reaction. The lessened tissue resistance was very evident in all the cases after the plasma was withdrawn, and with the reaction there was also a decided loss of weight.

III.—*Antidiphtheritic Serum in the Treatment of Septic Inflammation and Suppurations.*—The theory of the action of serum in the preceding paragraphs, as well as in the remainder of this article, may be summarised as follows:—

1. Every tissue has a capacity for nutrition and repair and maintenance of function.
2. This capacity becomes resistance to infection when it is capable of carrying on the function unimpaired in the presence of the infection.
3. The oral use of the plasma (normal) of an animal conveys to the patient the elements elaborated by the animal to produce in its tissues the reactions necessary for nutrition, repair and maintenance of normal function. And its oral exhibition produces in the patient the same reaction as in the animal.
4. When these normal reactions raise the tissue tone so that a natural refractoriness to any particular infection is produced in the animal the same result is produced in the patient by the oral use of the plasma of the animal. Such as the horse and sheep in tubercle and the ox in influenza.
5. Where an animal is artificially immunised to an infection, the elements in the serum producing the reaction for the nutrition, repair, and maintenance of function in the tissue pathologically affected by the toxic products of the organism used are all abnormally developed.
6. In antidiphtheritic serum the elements developed to maintain function unimpaired in the presence of the paralytic and muscle depressing and the proteolytic and albumose-forming elements in the toxic culture used in the production of immunity are available to meet the action of the streptococcus and staphylococcus on the same tissues.
7. The same tissue-restoring elements are available in traumatism or tissue damage from any non-microbial cause. Hence they are tissue restoring and maintaining elements and are not specific antitoxins.
8. The developed elements in antidiphtheritic serum are a muscle recuperative power to antagonise the muscle depressant and an antiproteolytic to meet the proteolytic action of the organism; also a hæmopoietic power leading to increased leucocyte production where required.

Antistreptococcal serum contains at least the first of these qualities.

That is, that immunity consists not only of antitoxins and antibacterial agents, but also of a resist-

ance which in a drug-habit patient we call "drug tolerance"—that is, that the tissue cell has so adapted itself to its environment that it is capable of carrying on its functions unimpaired in the presence of the poison. To do this it has to develop certain qualities, and these qualities are in the serum and can be transferred to the patient by oral exhibition, to produce in him exactly the same conditions as they were intended to produce in the animal originating them.

IV.—*The Treatment of Inflammation by the Oral Use of Antidiphtheritic Serum.*—In antidiphtheritic serum there are present along with antitoxin the properties in the serum which the animal has elaborated for its defence against the proteolytic and albumose-producing and the paralytic and muscle depressing elements in the toxic culture.

The writer has defined these properties as being an increased capacity for resisting proteolysis and an increased recuperative power in the muscle affected by the organism—the involuntary muscular systems. These properties are in the serum, and their specific effects can be obtained by their oral exhibition, not only in diphtheria, when given in time, but also in inflammation due to the staphylococcus, streptococcus, and bacillus coli communis as well as that arising from simple traumatism. Along with the antitoxin they, with other properties as yet unrecognised form the expression of the whole resistance of the animal to the injections of the diphtheritic culture. Unlike the antitoxin, they are absorbed and made available by the mouth and are operative in the presence of other infections as well as where no infection is present. These two properties are all that have been defined, as yet, but there are probably others in the serum, as both in experimental and clinical work a decided leucocytosis has been clearly manifest where required. Whatever, in fact, has been necessary for the animal to produce for its own effective defence against the organism will be included in the serum. The fact that these properties, while available against the infection for which they were elaborated, are also potent in other infections and where no infection exists, proves that they are entirely distinct from antitoxin, and the conclusion arrived at is that they are the elements in the serum intended for the maintenance of function and integrity of tissue unimpaired in the presence of the infection for which they were originally produced, and hence being tissue resistances they are available against all attacks on the integrity of these tissues by agents similar in their character and requiring the same defence as the original organism or toxic culture injected.

For inflammation, we thus possess in the antidiphtheritic serum three properties—(1) a muscular recuperative power which is the agent mainly effective against the streptococcus; (2) an anti-proteolytic power which is effective against the staphylococcus (proteolytic in its action) along with the muscular recuperative; (3) a hæmopoietic reaction leading to increased leucocytosis where required.

The essential vascular lesion in inflammation is the blood vessel wall, and in it the main element is the unstriated muscle. In this there is loss of tone varying according to the conditions producing it. Recovery is produced when this tone is restored, and this is Nature's own method. Anything, then, which will restore the normal tone or directly assist in doing so will be acting on parallel lines with normal recovery, and by so much increase the certainty, thoroughness and rapidity of the results desired. Here the recuperative power of antidiphtheritic serum fulfils all the conditions required, and its use so strongly reinforces the normal effort that further extension is prevented and recovery follows rapidly, ensured by an increased tissue resistance of which the patient alone, unaided by serum, was totally incapable. The soil having been rendered unsuitable for the pathogenic action of the organism, it is readily overcome and eliminated if the tissue tone in the meantime is maintained. Should the serum be discontinued prematurely the tissue tone

at once falls below what is required to prevent the pathogenic action of the organism and the inflammatory process very soon reappears, the organisms not being affected directly by the action of the serum and sufficient time not having been given for the opsonic, agglutinative, antibacterial, or whatever agent is present to aid in their elimination, to completely remove the infection present.

In the same way, the proteolytic action of the staphylococcus is inhibited by the action of the serum, making the soil an unsuitable field for the digestive action of that organism, and the anti-proteolytic action of the serum being maintained by the regular administration of the proper serum in sufficient dosage leads to exactly the same result as has already been described in the process as applied to the involuntary muscle. Hence where there is an invasion involving both the muscular tissue and the digestion of tissues there is present in the serum the necessary elements to enable the tissues involved to make an effective resistance.

Increased leucocytosis is not seen where the use of the serum rapidly overcomes the pathological conditions present exactly as in normal conditions, when serum is not being used. Where, however, the resistance is greater or where there is loculated pus, then there is a greatly increased leucocyte count. This is seen both in animals experimentally and in man clinically under the use of serum orally. In the treated animal there is an increased reaction with a greater leucocytosis, a larger amount of pus, and a more rapid maturation is observed than in the control animal. In man, where the pus is contained in firm tissue, the patient will discontinue the serum, as it gives more pain with every dose from increased tension in the abscess. It is probable that this local condition is due to the increased vaso-motor tone, local and general. Locally the renewed tone of the vessel wall leads to a contraction of the congested area around the focus, and this, with the increased general vaso-motor tone, causes a concentration of effort on the focus itself more than would be possible in normal conditions, and thus leads to the more intense reaction seen in the lesion.

From the nature of the action of serum on the tissues it must be clear that the earlier in the pathological process its action is obtained the less repair will be required and the more rapid and satisfactory the result obtained. While its action offers hope to the practitioner who has come to the end of his resources in a case and is ready to grasp any straw, that is not its legitimate field any more than it would be legitimate to leave our cases untreated till they became desperate. To obtain all that it is capable of doing for the pathological conditions within its range of action, it must be used in the earliest possible stage of the disease and depended upon to treat the case instead of being something to fall back upon as a last resource when everything else has failed. Used thus, it has in the writer's hands, and in those of his friends who have tested it, proved itself even more reliable in the treatment of inflammation by its oral exhibition than it has done hypodermically for the infection for which it was originally produced. The capacity for tissue restoration is seen in the rapid healing of wounds, whether septic or non-septic.

In the septic condition, where drainage is good, the pus is rapidly lessened, the wounds take on a healthier look, and the healing processes are strongly reinforced. Where drainage is not good or where a slough is present in a lesion such as a carbuncle, the rise in tissue tone shows itself by an increased reaction, and the greater amount of pus discharge. This leads to separation of the slough rapidly, and below it is found a healthy, granulating surface which under serum administration very quickly heals, while the patient's whole involuntary muscular system is raised in tone and the usual debility is materially decreased.

(To be concluded in our next.)

SIR WILLIAM BROADBENT recently celebrated his seventy-first birthday.

CLINICAL RECORDS.

A CASE OF COINCIDENT INFECTION WITH DIPHTHERIA AND TYPHOID FEVER.

By J. T. C. NASH, M.D. EDIN., D.P.H. CAMB.,
Medical Officer of Health for Southend.

THE comparatively rare combination of the coincident infection of a person with both diphtheria and typhoid fever induces me to briefly relate the history of the following case:—

A female child (Jewess), æt. 10, arrived in Southend indisposed, and was admitted to hospital as suffering from diphtheria on August 16th, 1905. The history data were: Sore throat on August 12th, headache and vomiting on the 13th. Diphtheria antitoxin (? units) administered before admission.

On admission the temperature was subnormal (97° F.). A clinical examination showed membranous deposit on both tonsils, but no adenitis nor nasal discharge. The tongue was dirty and there was an absolute loss of appetite. A characteristic diphtheritic odour was noticeable, and typical Klebs-Löffler bacilli found on bacteriological examination.

Treatment.—Diphtheria antitoxin (P. D. and Co.), 2,000 units on admission. Milk diet. A mixture of euclorine and liq. strych. (P.B.) 24 minims per diem. On the 22nd, it was noted that although the throat was cleaning there was no improvement in the appetite or in the state of the tongue. A mixture of rhubarb and soda was prescribed. On the 24th, I considered it advisable to resume strychnine (giving 20 minims per diem in combination with iron).

On the 30th, the patient complained of cramping pains which apparently were felt in the fasciæ of the muscles of the right thigh and the left foot.

On the 31st, the pains had extended to the left thigh and calf and to the right foot.

Sodium salicylate, gr. 15, every four hours, was prescribed. On September 1st, an antitoxin rash was seen on the face and legs, and the patient vomited.

On September 2nd, the temperature was found to be raised (100·6° F.), and the pulse 110. The tongue had remained coated and the appetite poor since admission on August 16th. A mixture of rhubarb and soda was again tried alternating with liq. strych., minims v., ter in die.

The morning (8 a.m.) and evening (8 p.m.) temperatures for the next few days were registered as follow:—

Sept. 3rd, 1905.—Morn., 99° F.; even., 100·4° F.

4th.—Morn., 100° F.; even., 101° F.

5th.—Morn., 98·6° F.; even., 100·6° F. Vomited

and complained of headache. A suspicion of typhoid fever entertained.

6th.—Morn., 101·8° F.; even., 102·6° F. Three macular spots seen on abdomen, fading on pressure. Mist. euclorine. Diet: Milk, beef-tea, 1 egg. (Widal reaction 40 per cent. positive in a 1 in 30 dilution.)

7th.—Morn., 100·2° F.; even., 101·4° F. P.120. Quin. sulph. gr. v. bis die.

8th.—Morn., 99·4° F.; even., 99·2° F. P.115. Calomel gr. ½.

9th.—Morn., 100° F.; even., 103° F. P.120. Mistura. acid. Nitro-hydrochlor. dil.

10th.—Morn., 101·6° F.; even., 100° F. A suspicious loose pea-soup-like stool with specks of undigested milk. Milk—freely diluted.

11th.—Morn., 102° F.; even., 102° F. Dark liquid stools; a few more spots on abdomen; spleen not palpable. Diet: *Whey*, beef-tea, and 1 egg.

12th.—Morn., 101° F.; even., 99° F.

13th.—Morn., 102° F.; even., 102·4° F.—A few more spots; slight deafness.

14th.—Morn., 100·4° F.; even., 102° F. Small sloughs in motions with small curds of undigested milk.

A four-hourly temperature charted since September 9th, showed a more characteristic typhoid fever

temperature than the 8 a.m. and 8 p.m. records. On September 15th, a positive Widal reaction was obtained in fifteen minutes. Two half-drachm doses of castor oil were prescribed to clear out the undigested curds present in the intestines.

On September 16th, the patient was placed on grey-powder gr. $\frac{1}{4}$, ter in die Lemon jelly given. On the 18th, typhoidal deafness was marked. The motions were pale and semi-formed. Liq. strychninæ 3 min. ter in die.

On the 19th, acetozone (xx. grs. to 2 pints of water) administered *ad. lib.* Amount of urine, 20 ozs. The patient very wasted. On September 20th, diluted milk (1 in 4) given. On the 22nd, the temperature touched the normal again. Urine, 14 ozs. Oil enemata prescribed (patient constipated). On the 23rd, better in every way. *Appetite better than since admission* on August 16th. Boiled custard, boiled bread and milk, and a lightly boiled egg permitted.

On September 26th, the temperature was still irregular, varying between a degree above and a degree below the normal line. *This is generally an indication of insufficient nourishment after an exhausting illness.* The dietary was improved to the extent of permitting thin slices of bread and butter and some boiled strained apple.

On September 28th, the temperature was more settled and fish was added to the dietary.

On October 1st, a mixture of iron and perchloride of mercury was prescribed, the temperature now keeping sub-normal.

On October 4th, the patient was allowed minced meat and thereafter rapidly improved. On October 13, on examining her mucous membranes, in anticipation of her early discharge, I found a few crusts in the nose under which the nasal membrane was slightly congested; a swab showed the presence of diphtheria bacilli. The crusts were cleaned away, and pure Izal applied to the diseased mucous membrane. No diphtheria bacilli could be found on October 17th.

The patient was discharged on October 20th, daily increasing in weight, able to walk, and with a good appetite.

Remarks.—As to dietary, I treated this child on the principle of treating the patient, not the disease (as is my usual custom in typhoid fever cases). Had this child been kept too long on a limited diet she would in my opinion have succumbed.

Realising the physiological and psychological moments for increasing the dietary saved the patient's life.

THE OUT-PATIENTS' ROOM.

ROYAL FREE HOSPITAL.

Multiple Gummata of the Leg.

Under the care of T. P. LEGG, M.B., B.S.(Lond.), F.R.C.S.

THE patient was a man, æt. 35, who came complaining of multiple ulcers and swelling of one leg; this had been going on for four or five months; there was not much pain and he had had no previous treatment except a local application of some ointment which he had procured from a chemist. There was a history of primary syphilis dating from the time he was in South Africa, that is to say, four or five years ago. On examination numerous ulcers were found on both the back and front of the left leg below the knee; some of the ulcers had a characteristic horseshoe shape, others were circular and arranged in groups, and some had run into one another, so as to produce an irregular outline; all of them had steep edges, smooth bases, and some were covered by a yellow slough. The tibia was very much thickened by the deposition of new bone; the lower end of the femur was uniformly increased in circumference by a smooth deposit of bone; the knee joint was enlarged by somewhat irregular thickening of the synovial membrane, the skin over the

knee and the lower end of the femur being natural, whilst that on the lower part of the leg was very much thickened and hardened from infiltration by inflammatory changes. The general condition of the patient was good and there were no other lesions of a similar nature. The case, Mr. Legg said, was a typical one of multiple cutaneous gummata together with an osteomyelitis of the lower end of the femur, and of a considerable length of the tibia as was shown by the uniform thickening of these bones. The synovial membrane of the knee joint was also involved in the gummatous change. As regards the treatment, Mr. Legg remarked there were several points to be considered—first, the local treatment, which he considered almost as important as the general treatment; in these cases there was very often a septic element present which had to be combated; this was best accomplished by dressings containing mercury which can be frequently changed. One of the best methods of applying the drug locally is, he thought, in the form of a powder containing calomel, say 20 grs. to the ounce made up with boracic acid; the addition of iodoform, 15 grs. to each ounce, is often beneficial but on account of its odour, one does not often use it. Hot fomentations should be applied and changed at not longer intervals than four hours; the limb should be washed every night and morning. Some patients, he pointed out, complain of the smarting and pain caused by the application of the powder, and in these cases, a mercurial lotion should be substituted. Internally, iodide of potassium and mercury should be administered, the latter being given in the form of a pill, of hydrargc. C. creta 2½ grs., night and morning; this was, he considered, a better way of giving the drug than in a mixture of the two which, often, the patient cannot take. The iodide should be given in doses of 10 grs. to begin with, and, if necessary, increased to 20 grs. or sometimes 30 grs. three times a day, and the patient is instructed to take a tumbler full of water with the medicine, the reason for this being that symptoms of iodism are not so readily set up when the iodide is well diluted. In addition to the constitutional treatment, the general treatment, he thought, is of great importance and therefore instructions as to diet of the patient should be given; this should be wholesome and readily digestible, alcohol being forbidden. If the general health of the patient is good the results of these lines of treatment, he remarked, are excellent, but when the patient is feeble, half starved, and especially alcoholic, the improvement is often not observed. This point had, been, he said, well illustrated in the case of a woman who had come to his out-patient room a few months ago, and a second time a few weeks ago; she was half starved, very hard worked, and given to alcohol; she had symmetrical gummata on the anterior aspects of both knee joints, the pre-patella bursa on both sides being the seat of a gumma; very little improvement followed treatment carried out for several weeks. The effects of treatment in the man were at once evident, the ulcers being practically healed in three or four weeks and the thickening of the synovial membrane being perceptibly less; the enlargement of the femur and the tibia had also diminished.

OPERATING THEATRES.

CANCER HOSPITAL.

CARCINOMA OF THE UTERUS—WERTHEIM'S OPERATION.—Mr. BOWREMAN JESSETT operated on a woman, æt. 43, for advanced cancer of the uterus. The os uteri was extensively affected as well as the cervix, the surrounding areolar tissue being also invaded by the growth. The vaginal walls were not affected, and the uterus was slightly mobile. The case was clearly one not suitable for vaginal hysterectomy, but it was thought to be a fair subject for Wertheim's operation. A week before the present operation the patient was anaesthetised, placed in the lithotomy position, the

diseased portions of the uterus scraped away, and the surface thoroughly burnt with a Paquelin's cautery; the woman was then returned to bed. The patient was now again put under an anæsthetic and placed in the Trendelenburg position; the abdomen was opened by a median incision between the umbilicus and the pubes. Doyen's retractor was then placed in the wound, and thus a good view was obtained of all the pelvic organs. The uterus was withdrawn through the incision with vulsellum forceps, the utero-sacral ligament divided on each side and the ureters found and traced downwards to the cervix uteri. After the bladder and the anterior fold of peritoneum had been reflected from the uterus, the Fallopian tubes and round ligaments were ligatured on each side and divided. The index finger was next passed in front of the ureter on the right side beneath the uterine artery, which last was then ligatured and divided; the same process was attempted on the left side, but it was found that the ureter had become embedded in the cancerous growth and parametrium, and in endeavouring to separate this the ureter was torn across. Mr. Jessett then ligatured the uterine artery on that side and carefully removed the diseased structures from the vesical end of the ureter, and with some difficulty opened up the vault of the vagina. A flap of peritoneum was removed from the posterior part of the uterus, the vagina opened up in Douglas's pouch, and the uterus removed. Mr. Jessett then proceeded to unite the upper and lower ends of the torn ureter on the left side. The peritoneum was stitched over the floor of the pelvis and a large gauze drainage passed down through the vagina. The abdominal parietes were closed in three layers, and the patient returned to bed. Mr. Jessett said that this was only the third case of Wertheim's operation he had performed, and he did not agree with Wertheim that such cases as the one just operated on were suitable for it; for, should the disease extend so as to implicate the ureters and extend round about the cervix and parametrium, he had come to the conclusion that operations for the removal of the uterus by Wertheim's or any other method were better left severely alone, as he was quite sure that the disease would recur under any circumstances within a very short time.

The patient made a tardy recovery, and left the hospital about five weeks after the operation. The left ureter for five days after operation appeared to be firmly united, and to act normally; after that the urine escaped from the sloughed ureter by the vagina, and the patient was left with a urinary fistula.

ST. PETER'S HOSPITAL.

PAPILLOMA OF THE BLADDER.—MR. THOMSON WALKER operated on a female, æt. 38, who had been admitted suffering from pyuria. She gave the following history: Three years ago she first noticed that her water was thick; this came on suddenly and disappeared as suddenly. From that time onwards she had repeated attacks of pyuria, which lasted two or three days and came on at intervals of from three to six months. During the attacks of pyuria she suffered from frequent micturition, but in the intervals she passed urine three or four times during 24 hours. She had once passed a clot, but there had been no other sign of hæmaturia. When seen by Mr. Walker in August, 1905, the urine showed a heavy deposit of pus, but no blood was present. She had never passed a stone or gravel. She was unable to come into hospital for cystoscopy at that time, and this attack, like the others, passed off. In January, 1906, there was some pain and tenderness in the right kidney. On

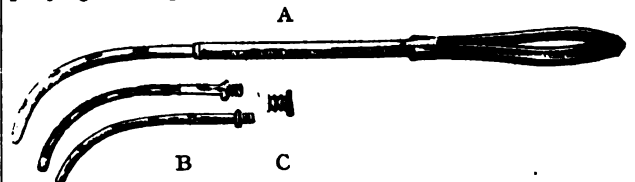
cystoscopy, a small papilloma about the size of a thumb nail was seen lying outside and to the right of the right ureteral opening. The bladder was opened above the pubes, and the growth demonstrated. The pedicle was clamped with rectangular forceps, and the growth cut away with scissors. The base was then seared with the electro-cautery and the forceps removed. The bladder wound was stitched with interrupted catgut sutures which did not penetrate the mucous membrane, and a large catheter was tied in the urethra. Mr. Walker said that the peculiarity in this case lay in the symptoms; pyuria was rarely a symptom of papilloma of the bladder, and in this case might have led to a mistaken diagnosis and possibly to an operation upon a healthy kidney. The presence of papilloma was demonstrated by means of the cystoscope where its presence could not have been suspected from the symptoms. It was not always advisable, he pointed out, to suture the bladder even after removal of an aseptic growth in cases where the bleeding had not been completely controlled; it was much safer to drain the bladder supra-pubically for a day or two than to run the risk of a bladder full of clot blocking the outlet and leading to rupture of the vesical wound. When the bladder wall was sutured it was well, he thought, to insert a small drain into the pre-vesical space for 48 hours in case of leakage. The tube should not, however, be left in too long for he had seen in another case a copious discharge of pus, that at once ceased on removal of the tube, which had been retained for eight days.

A week after operation the patient was doing well, no leakage having taken place through the supra-pubic wound.

NEW INSTRUMENTS AND APPLIANCES.

A MODIFICATION OF BANDL'S INTRA-UTERINE SOUND.

USERS of Bandl's hollow intra-uterine sound know that this valuable means of applying caustics or other medicaments to the interior of the uterus possesses the great drawback that in its usual form it is most difficult to clean. Blood from the cervix collects in its lumen, and when then acted upon by an astringent, such as pyroligneous acid, forms a firm clot, which it is most difficult to remove. Recently I pointed out this difficulty to Messrs. Arnold and Son's traveller, and suggested to him that a sound should be made composed of lateral halves, held together at the handle by a screw and above by a collar or small cap. The accompanying drawing shows the manner in which the firm



A. Sound ready for use. B. Lateral halves. C. Screw for extra top.

in question have turned out the sound, and in this form I consider that it offers a great advantage over the older form. The detachment of a single screw allows the halves to separate, there are no projections or holes in which dirt can collect, and several different-sized sounds can be attached to the same handle. When not in use, the parts of the spare sounds are held together by a small screw cap.

HENRY JELLET, M.D., F.R.C.P.I.,
Gynecologist and Obstetrical Physician to Dr. Steevens' Hospital,
Dublin &c.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD JANUARY 26TH, 1906,
The President, Mr. CLUTTON, in the Chair.

DR. H. D. ROLLESTON showed a case of Multiple Lipomas (Adeno-lipomatosis). The patient, a man, *æt.* 43, had noticed fatty tumours in the neck for about four years, but until his attention was drawn to them was not aware of the others. The multiple lipomas were almost everywhere symmetrical. There were lipomas on both submaxillary and parotid regions, in front of the temporo-maxillary articulations, in both supra-clavicular fossæ, in the axillæ, on the posterior aspects of the arms over the triceps muscle, in the pectoral regions, over the recti abdominis muscles, where they were not symmetrical, in the right groin, and outer side of right thigh. There were none on the legs or forearms. The lipomas in the neck, by fusion, would probably lead to a diffuse lipoma before long. There had recently been some pain in the lipomas on the right side of the abdomen and in the right groin, but the other lipomas were neither painful nor tender, and pain had not preceded the appearance of the lipomas, as is the case in *adipose dolorosa*. No enlarged glands could be felt in connection with these lipomas, which, in their distribution, resemble that in so-called "adeno-lipomatosis." The knee-jerks were present; there was no loss of muscular power. The thyroid could not be felt. There was no epistaxis.

The PRESIDENT pointed out the surgical importance of distinguishing between the diffuse and the encapsulated lipomata.

Mr. W. G. SPENCER discussed the pathology of the condition and speculated as to whether the vascularity or the fatty growth was the initial change.

Dr. ROLLESTON, in reply, said that he thought that as a rule the diffuse cases began as localised tumours. As regards the pathology of the condition, he could only suggest that the hæmorrhages and the fatty growths were both due to a common factor, disease of vessels due to alcohol.

Mr. JOHN R. LUNN showed a case of (?) General Paralysis of the Insane in a boy, *æt.* 16. The mother stated he had always been untrustworthy with money, and she thought he was a kleptomaniac. He had had three unconscious fits, April 15th, September 9th, and September 15th, 1905. Since having the fits he had become duller, and had had occasional twitchings of the left arm and leg. He walked with his left arm flexed, abducted, and hand flexed on the forearm, and dragged his left leg. There were no tremors, but there appeared to be some weakness of the elevating muscles of his mouth, but neither facial muscles were affected. Some weakness of the left arm and hand. Sensation over the body normal. Speech not affected. Sphincters normal. Reflexes: left elbow and wrist present, but not present on the right side; patella reflex brisk on both sides; no clonus. Left pupil larger than right (contracts under guttæ eserina). No ocular paralysis. No changes in the fundus. There was no history or evidence of syphilis.

Mr. JOHN R. LUNN showed a case of Myasthenia Gravis (?) in a man, *æt.* 39. The last seven years there had been weakness of his hand and neck muscles. The patient stumbled when he walked. *Nervous System*.—Motor weakness of arms, forearms, hands and legs; the fine movements of the fingers were lost. Flexion and extension at the elbows were weak. The anterior tibial muscles of both legs were weak, and there was foot-drop. Some loss of power in the face muscles, and ptosis. His eyes could not be raised above the horizontal: paresis of both orbiculares oris and palpebrarum and some weakness of both occipito-frontales muscles. Right supinator longus muscle and right interossei were wasted. Some contraction

of the sterno-mastoid muscles, but not sufficient to raise his head from the pillow when in bed. *Sensory*.—Tactile sensation to heat and cold normal. Both knee-jerks and plantar reflexes absent; hypogastric and epigastric reflexes present. The tongue did not appear wasted; taste normal. The pupils react to light and accommodation; no changes in the fundus. Speech blurred, the blurring increased by talking; some slight difficulty in swallowing. All the wasted muscles reacted to faradism, but not well, and a strong current was necessary; they did not react to galvanism.

Dr. FARQUHAR BUZZARD said that apart from the muscle atrophy, this case would be called an undoubted one of myasthenia gravis and he could think of no other category into which to place it. Recently muscular atrophy had been described in several undoubted cases.

Mr. JOHN R. LUNN showed a case of Molloscum Fibrosum in a man, *æt.* 22. Present condition was first noticed eighteen months ago. Six months ago he had been obliged to give up his work as some lumps appeared on his face. Two lumps on his toes had disappeared, leaving only slight scars. He had experienced no pain in the swellings, only slight itching at night-time when he got warm in bed. There was no family history of any kind of tumour. *Present condition*.—Healthy-looking man. The patient's trunk was covered all over with tumours, varying from the size of a millet seed to that of a cherry; most of them were sessile, but a few were becoming pedunculated; they were movable on the deeper structures, and adherent to the skin, which was rather thinned over their centres. The distribution did not appear to correspond to any nerves. He had had arsenic and thyroid tablets by the mouth, but no changes in the tumours had taken place. Two of the tumours were excised for examination and sent to the Clinical Research Association. "The larger of these two tumours is a localised, but not encapsuled growth of fibrous tissue, plentifully nucleated and containing blood-vessels and nerves. The presence of the latter, with their concentrically-arranged sheaths, is of some importance, pointing to the probability that this fibroma has arisen from the nerve sheath, and is therefore a neuro-fibroma. The fact that the growths are multiple is also in favour of this, but it does not necessarily follow. The smaller tumour is more diffuse in appearance, and there are no nerve fibres to be recognised in it. Neither of these tumours shows any sign of malignancy."

Mr. LAWRIE MCGAVIN had seen a similar case, which however, had developed a tumour on the sciatic nerve. On excision this tumour proved to be a spindle-celled sarcoma.

Mr. LAWRIE MCGAVIN showed a case of Laminectomy for Traumatic Paraplegia. The patient was a man, *æt.* 36. A steel plate twenty feet long and four feet wide had fallen across his back. On admission there had been complete loss of sensation and motion in both lower extremities; the scrotum and penis were partially anæsthetic; there was complete absence of knee-jerks and of plantar reflexes, and the bladder and rectum were paralysed, as was also the sphincter ani. A depression was found over the spine of the first lumbar vertebra deep enough to meet the tip of the finger. The patient was submitted to operation three hours after the injury. The spinous processes and posterior halves of the first and second lumbar vertebra were found to be completely detached, and forced down upon the cord; the left lamina of the second lumbar vertebra was comminuted, and a portion of this bone was found to have been pushed forward between the cord and the transverse process. The whole of the detached bone was removed, and the wound was closed except for the presence of a horse-hair drain at the lower angle. Twenty-four hours later sensation had returned in the right leg and thigh, and the foot and ankle could be moved. On the following day sensa-

tion returned in left leg and thigh, with the exception of the area supplied by the genito-crural nerve and the lesser sciatic. In three weeks the paralysis of the rectum and bladder improved; and under massage and faradisation the motor and sensory functions have gradually returned, although the left leg and thigh still remain feeble. The patient was now able to walk without the help of either crutches or sticks; the right knee-jerk was still delayed and feeble, and the plantar reflexes were absent.

The PRESIDENT commented on the absent reflexes as being usually regarded as a contra-indication to operation.

Dr. C. E. BEEVOR explained that the significance of the absent reflexes was different according as the lesion was in or above the lumbar enlargement. In the former instance, as in this case, operation was indicated, not so in the second instance.

Mr. JAMES BERRY showed a case with Congenital Aperture in the Centre of the Palate. The patient was a woman, *æt.* 16. The aperture is symmetrical and oval, 7 mm. long and 5 mm. wide. Two-thirds of the opening were in the hard palate, one-third in the soft. The edges were thin. On either side of and behind the opening the tissues were thinner than is natural. The uvula and posterior edge of the soft palate were congenitally cleft. There was no harelip nor any other defect of development except those mentioned. The mother stated that the opening in the palate was noticed soon after birth, and that it was then "nearly covered with a thin membrane."

The PRESIDENT suggested congenital syphilis as a possible diagnosis.

Dr. ESSEX WYNTER remarked that the presence of the bifid uvula supported the diagnosis of a congenital defect.

Mr. BERRY, in reply, said that he could find no evidence at all of syphilis.

Dr. C. H. THOMPSON showed a case of Shaking Head or Spasmus Nutans in a girl *æt.* 8 months. In the first week in December, when the child was six months old, her mother had noticed movements of her head and eyes, which had continued up to the present time. She lives with her parents and two elder children in a dark back room in a basement in Soho. There was no history of injury or fits, and there were no signs of rickets, although sweating about the head at night and throwing off of the bedclothes had been noticed. *Present condition.*—There were almost continuous movements of the head, both lateral and to and fro, while the child was awake. The movements ceased during sleep and when the eyes were bandaged. They also ceased if the child grasped any article and became intent on obtaining it. There was marked nystagmus, lateral, rotatory, and vertical. These movements of the eyes became more marked when the head was grasped and steadied.

Dr. J. WALTER CARR showed a case of Amyotrophic Lateral Sclerosis in a man, *æt.* 33. His present illness had begun about four years ago with weakness and wasting of the right hand; two and a half years ago the right leg had begun to get weak and stiff. A year ago weakness had been first noticed in the left arm, and during the last few months in the left leg. At the present time the legs presented well-marked spastic paraplegia, with extensor plantar reflex, exaggerated knee-jerks, and, on the right side, ankle clonus. There is some *pes cavus* on both sides. The arms showed distinct flaccid paralysis, affecting mainly the small muscles of the hands, and, to a much less degree, some of the shoulder muscles. Fibrillary twitchings were very marked in nearly all the affected muscles. The intrinsic muscles of the hands showed a partial R.D., nowhere complete, except that the right first dorsal interosseous gave no reaction to either current. There was no affection of sensation, of co-ordination, nor of the sphincters, and no indication of any bulbar paralysis, except slight weakness of the right facial muscles. There was well-marked nystagmus of the

right eye, but this is perhaps connected with the blindness of the left eye due to ophthalmia neonatorum.

Dr. W. P. HERRINGHAM showed a case of Transverse Myelitis, with Recovery, in a man, *æt.* 29. Nine days before admission he had had pains in legs and back, which had got worse. His arms had become weak, and he had lost control of his sphincters. Loss of power and anæsthesia had rapidly developed in his legs. On admission there was paralysis of the intercostals, diaphragm, and legs. The arms were weak. There was anæsthesia of the legs, which soon spread upwards as far as the level of the nipples. His condition gradually improved until now, nine months later, he was able to walk about unaided. He still had some weakness of the sphincters, but this was improving. His knee-jerks, which could not be obtained during the early part of his illness, were now present on one side.

Dr. C. E. BEEVOR suggested that the case was one of peripheral neuritis, in spite of the affection of the sphincters. The recovery of the knee-jerks showed that they could not have been lost from a transverse myelitis above the lumbar enlargement.

Dr. HERRINGHAM, in reply, said that the retention incontinence did not suggest a lumbar region. The upper paralysis of the arms and diaphragm had very rapidly recovered. The severe bed sores were strongly in favour of myelitis.

Mr. P. MAYNARD HEATH showed a case of Charcot's Disease in the Thumb, of a man, *æt.* 45. The patient had cut his left thumb with a saw three months ago. There had been some inflammation about the part, but the wound had healed. Soon after the thumb had begun to swell. A month later the skin had become red, and lately the swelling had become much greater. There had been very little pain. At the present time the thumb was very much swollen, and the skin was red and in parts scaly. The swelling was most marked over the interphalangeal articulation, and this joint was disorganised. The metacarpo-phalangeal articulation was normal. There were well-marked signs of tabs. The knee-jerks were unobtainable. The pupils showed the Argyll-Robertson phenomenon, and Romberg's symptom was present.

Dr. C. E. BEEVOR commented on the extreme rarity of this localisation of the joint affection, but the diagnosis was beyond doubt.

Mr. HEATH quoted a series of interesting statistics taken from, amongst other sources, Henderson's paper in the *Journal of Pathology* of 1905.

Dr. BERTRAM ABRAHAM showed a case of Sudden Paralysis of the Third Cranial Nerve in a woman, *æt.* 43. For the last month there had been twitching of the left eyelid. On January 18th and 19th she had been drowsy and sleepy, and had had frontal headache. On the morning of January 20th she found that she saw objects double; the left eye was partially closed, and during the morning the closure became complete. There was no history of syphilis. *Present Condition of eyes.*—*Left*: slight elevation of eyebrow; complete ptosis; slight proptosis. Pupil three-quarters dilated; not quite circular; did not react to light or accommodation. Eye deviated outwards at an angle of about 25°. Movement *outwards* unimpaired, *inwards* not beyond centre of orbit, *upwards* lost, *downwards* lost except a slight downward movement with inward rotation (sub. oblique). *Right*: normal, transverse axis greater than vertical. No iritis; disc and fundi natural. There was crossed diplopia, both horizontal and vertical. In horizontal meridian, the false image was below and to right of line. In vertical false image was below line with downward movement, and above it with upward. When the image was on the level of the centre of the eye it was single.

The other cranial nerves and the rest of the nervous system were natural. There was a systolic bruit at the cardiac apex, and a to-and-fro murmur at the aortic base. The liver was enlarged, the dulness extending to two fingers-breadth below the costal margin in the left mammary line. There was no other abnormal physical sign. The palsy was in an early stage, over-

action of the external rectus and radial dilator of the iris not having developed.

The PRESIDENT commented on the possibility of moving the limb in the adducted position, which is unusual with coxa vara.

Mr. BUCKNALL, in reply, agreed with the President that the case could not be one of the usual varieties of coxa vara. He thought the affection was possibly congenital.

Mr. RUPERT BUCKNALL showed a case of Bilateral Deformity of the Neck of the Femur. The patient, a boy, æt. 9, who always had had difficulty in walking, which had increased as he had grown older. No history of injury; not thought to have had rickets; had been kept in bed during the past twelve months. The lower limbs were of equal size and length. The trochanter on either side lay higher than normal, its tip being three-quarters of an inch above Nelaton's line. Otherwise, when lying at rest the limbs did not appear abnormal. The head of the femur could easily be felt in Scarpa's triangle, much below the level of the great trochanter. Extension was perfect; flexion was good; adduction was slightly increased in range; abduction was remarkably diminished, both in the extended and flexed positions of the limb. When extended, the angle of abduction between the two thighs did not exceed twenty degrees. Internal rotation was slightly diminished. External rotation only could be carried out through half the normal range. The marked adduction of the thighs interfered with walking, and almost led to a cross-legged gait, and running was impossible. Skiagrams showed marked bending of the neck of the femur downwards.

The PRESIDENT suggested the diagnosis of leontiasis ossea.

Mr. KELLOCK, in reply, said that the asymmetry of the condition, together with the microscopic examination, negated this view.

Mr. THOMAS H. KELLOCK showed a case of Osteo-Sarcoma of Frontal Bone, in a man of 23. Between six and seven years ago the patient had first noticed a small hard swelling on the left side of the forehead just above the eyebrow; this had gradually increased in size; it had never been tender nor given rise to any pain or symptoms. A large tumour now involved the left half of the frontal bone and extended a little beyond the mid-line above the nose; it was 18½ inches in circumference, and rose about 4 inches above the level of the rest of the skull; it was densely hard, except in a few spots, which felt soft and elastic; the veins in the scalp over it were somewhat distended. The left eyeball was displaced downwards and forwards, but there was no diplopia. There were signs of optic neuritis in both eyes. A skiagram showed the tumour to be chiefly composed of bone, but the periphery was irregular. The patient's general health was bad but had been excellent, and he had followed his occupation up to the present time. On January 2nd an exploratory incision had been made into the tumour by turning backwards a flap of the scalp, and the periosteum which overlay the growth had been separated. The surface of the growth was found to be soft, and microscopic examination of a piece that was removed showed it to be sarcomatous; the central portion of the tumour was very hard, and was with difficulty cut with a gouge. There was rather free hæmorrhage, which was arrested by the application of adrenalin solution. The wound was closed, and had healed by first intention.

Dr. A. E. GARROD referred to a similar case he had had under his care which was reported to this Society recently by Dr. Langmead. In this case the sigmoid was dilated and the attacks of tetany could be aborted by lavage of that organ.

Dr. BATTY SHAW, in reply, commented on the absent reflexes, and drew the analogy between the condition and the cord changes in another intestinal poisoning, pernicious anæmia.

Mr. H. T. MANT and Dr. H. BATTY SHAW showed a case of Tetany of seven months' duration associated with Gastro-Umbilical Disorder in a girl, æt. 9, appar-

ently cured by the use of thyroid substance. The patient had suffered from gastro-intestinal disorder for the last four years. For the last eighteen months she had been unable to walk because of weakness of the lower extremities, and during this period the abdomen had become much distended. There was marked peristalsis present. She had suffered from repeated attacks of tetany during the last seven months, and had become very pale, the blood examination showing severe anæmia. She was somewhat puffy in the face, and a firm œdema had been present in the feet and hands. The knee-jerks had been lost on a previous occasion, but returned, and the tetany disappeared under treatment in hospital with salol, etc. The same treatment had now failed and the knee-jerks were still absent. The attacks of tetany disappeared immediately after the use of thyroid substance, and though this remedy had been given for a week only, attacks had not recurred. The points of interest in the case were—

1. The long period (seven months) during which the attacks of tetany had been frequently reported.
2. The association with marked gastro intestinal disorder and distension of the alimentary tract.
3. The failure of the antiseptic treatment of the bowel, though on a former occasion it appeared to be successful.
4. The apparent prompt response to thyroid treatment.

Mr. HUGH M. RIGBY showed an infant, æt. 15 months with Plexiform Angioma of the Hand and Arm. The left brachial and radial arteries were dilated and tortuous, and communicated a well-marked thrill. The palm of the hand was occupied by a pulsating vascular tumour. The third part of the left subclavian artery was ligatured in February, 1905. Skiagrams showed gigantism of the bones.

Mr. HUGH M. RIGBY showed a case of Cavernous Nævus of the Tongue. The patient, a girl, æt. 11, was in the London Hospital eighteen months ago for cavernous nævus of the right border and dorsum of the tongue. In July, 1904, the right lingual artery and veins were ligatured, and the tumour apparently completely dissected out. The present condition showed a gradually increasing recurrence.

Dr. C. E. BEEVOR showed a case having Perforating Ulcers and Joint Changes with only slight sensory changes. The patient five years ago had had two fits, with paræsthesia all over right side, and loss of speech. He was in bed six months. He had been unable to move legs, which were stiff, for six weeks; power had returned gradually and steadily. Resumed business in nine months. Sphincters and sensation unaffected. Three years ago toes became stiff; blisters appeared on dorsal and plantar surfaces, which ulcerated. Three pieces of dead bone separated on various occasions; one was evidently distal end of terminal phalanx of great toe. Had pains in right ankle, but could walk with a stick until nine months ago, when pain in ankles worse; feet tender, painful if he trod on a stone. Gave up walking ten weeks ago.

Present Condition.—Some ptosis; slight overaction of frontalis. Pupils equal; react to light and convergence. Talkative, and apt to get confused; lisps. *Sensation.*—Slight difficulty in distinguishing between touch and prick, and also heat and cold on soles of feet and dorsal aspect of toes. Otherwise sensation was normal throughout. No lightning pains. Ankle-joints were stiff on admission, but now appear normal. *Muscular system* normal, except some difficulty in moving the toes; knee-jerks increased; plantar reflex gives flexion of toes. Right foot flat, bones of tarsus and proximal ends of metatarsal bones were large, but joints were movable actively and passively without grating. On admission to hospital there was much swelling of ankle, tarsus, and metatarsus and toes in both feet. This has diminished with rest in bed. Right toes: four external toes were now about normal size; formerly enlarged and stiff. Great toe much enlarged in the soft tissues, which were still larger on admission. Bones of metatarso phalangeal joint were large, but joint

moved well actively and passively without grating. Phalangeal joint quite disintegrated; formerly large perforating ulcer on under aspect, through which three pieces of bone have sloughed, one of which was distal extremity of terminal phalanx, which was absent in skiagram. Toe-nail had been lost many times. Left foot. Arch was not flattened as in right. Outer three toes normal. Great toe misshapen. Great enlargement of metatarso-phalangeal joint, especially in dorso-plantar diameter; considerable bony deformity all round joint; passive movement only possible, and grating was obtained. Fair movement, active and passive, in phalangeal joint; no grating, but joint was abnormally loose. Perforating ulcer less severe under this joint. Second toe abnormally thick and straight, seen from above, but had a large bulbous, soft swelling under the distal phalanx. Metatarsal joint much increased in dorso-plantar diameter; abnormal exostosis at the end of the metatarsal bone; movement of joint very limited; dorsiflexion impossible; no actual grating; movements of phalangeal joints almost absent. Nail was at the extreme end of the toe. The case was probably one of syringomyelia with slight sensory changes. Extraordinary bone changes were sometimes seen in syringomyelia, he had seen a case that had been operated on for leontosis ossæ.

Dr. W. P. HERRINGHAM showed a case of Addison's Disease. The patient, a man *æt.* 25, had had frequent attacks of diarrhoea and vomiting. He had been under observation for over two years, and still did hard work. The bronzing was diminishing. There was no reaction to tuberculin. A hysterical paralysis of the right leg with hemianæsthesia was present.

Dr. WALTER CARR had seen a similar association of Addison's disease with hysterical hemianæsthesia.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF SURGERY.

MEETING HELD FRIDAY, JANUARY 12TH, 1906.

The President, Sir ARTHUR CHANCE, P.R.C.S.I., in the Chair.

REMARKS ON GASTRO-ENTEROSTOMY.

Mr. R. CHARLES B. MAUNSELL read a paper entitled "Remarks on Gastro-enterostomy, with Description of a New Clamp." He advocated operation in gastroptosis and atonic gastritis in addition to the more commonly recognised indications. He considered that there should be no fixed rule for the site or form of incision in the abdominal wall, or for the site of junction of the viscera, as the first would depend upon the amount of ptosis present, often lying partly below the level of the umbilicus on the left side, the junction of the viscera being made near the pyloric antrum, or at the most dependent portion of the stomach, according to the amount of muscular power present in the stomach walls. A new form of clamp was described and shown, it was made somewhat on the principles of Carwardine's intestinal clamp and held the parts neatly in position during the operation. A short *resumé* was then given of the various post-operative troubles and their treatment.

The PRESIDENT expressed himself in favour of clamps, and recognised the advantages of those designed by Mr. Maunsell. In some of his cases vomiting did not occur at all after the operation. He referred to the advisability of suturing the proximal loop of the jejunum to the meso-colon with a view to prevent subsequent internal strangulation.

Mr. BLAYNEY was not in favour of clamps, as he considered their use endangered risk of post-operative hæmorrhage. He had not known of any case in which dispensing with clamps had led to any untoward result through escape of stomach contents or prolongation of the operation.

Mr. JAMESON JOHNSTON was in favour of clamps, and had not noted hæmorrhage in any of his cases. He considered it essential that the anastomotic opening should be free, and that the direction of the peristaltic wave in the stomach and jejunum should correspond. He admired the principles of Mr. Maunsell's clamps.

Mr. WILLIAM TAYLOR had used clamps like those of Moynihan, but of a lighter build; he thought those of Mr. Maunsell were an improvement. He also thought hæmorrhage after gastro-enterostomy could be prevented if the sutures were properly introduced. He had seen one fatal case of vomiting due to the vicious circle.

Mr. EDWARD H. TAYLOR had been rather startled by hæmorrhage in one case after gastro-enterostomy, although he had used every precaution in the suturing process. At present his practice was, in making the gastric incision, to divide the muscular coats carefully and expose the principal vessels in the submucous coat and suture them separately before incising the mucous membrane. In some of his cases vomiting had not occurred once after the effects of the anæsthetic had passed away, and he had observed that those who did best in this respect were those in whom there was decided pyloric obstruction. Where the pylorus was fairly patent one was more likely to encounter post-operative vomiting.

Mr. W. S. HAUGHTON said he had sometimes experienced difficulty in making a sufficiently large aperture in the meso-colon, and he would like to know if Mr. Maunsell considered it likely that the vitality of the colon would be dangerously affected by dividing some of the colic vessels. Instead of clamps on the stomach and intestine he used strong fixation sutures, which held the parts steadily in apposition and facilitated accurate suturing.

Mr. KENNEDY said he had discontinued the use of the Murphy button in gastro-enterostomy. He had met with two cases of hæmorrhage where gastro-enterostomy had been performed some months previously; both recovered, however, under ordinary treatment.

Mr. MAUNSELL, in reply, said he had only meant to touch on a few points respecting the operation of gastro-enterostomy. His habit now was to suture the margin of the divided meso-colon along the line of gastro-jejunal junction. He always ligatured the larger vessels met with when incising the stomach. He did not think there was much likelihood of the peristaltic currents in the stomach and jejunum being reversed if ordinary care were taken. If he could not make the aperture in the transverse meso-colon large enough without tying vessels he tied them. The proximal jejunal loop should be long enough to enable it to be connected with the most dependent part of the stomach without tension. He considered that the vomiting was due chiefly to the anæsthetic.

PARTIAL GASTRECTOMY FOR PYLORIC TUMOUR.

Mr. WILLIAM TAYLOR read a paper on the above subject. The patient, a woman, *æt.* 60, was exhibited in perfect health, free from stomach trouble of any description, able to eat anything and everything without the slightest discomfort. The history dated back for three years, during two and three-quarter years of which she complained of ill-defined stomach trouble, to which she applied the term "weakness." During the three months prior to admission pain after eating became a very prominent feature of the case, but the pain continued after vomiting; in fact, she was never free from pain during this period, but food greatly aggravated it. At times it was so severe as to compel her to press her stomach across the back of a chair or edge of the table; at other times she rolled upon the floor in agony. About two months before admission she noticed a tumour forming, which increased very rapidly in size, and it was on account of this tumour and the severe pain and vomiting that she sought admission to hospital. On examination the tumour was found to be situated a little above and to the right of the umbilicus; it was hard, nodular, and

firmly fixed to the anterior abdominal wall. There was no tenderness. The stomach was moderately dilated. The patient herself was greatly emaciated. Examination of the gastric juice showed a complete absence of free hydrochloric acid. The diagnosis of malignant disease was made on account of the age of the patient, her cachectic appearance, the rapid growth, the hard, irregular nature of the tumour and the absence of free HCl. from the gastric juice. Exploratory laparotomy was performed, when it was discovered that by excising portion of the abdominal wall to which the tumour was adherent the growth could easily be brought outside. This was accordingly done, and as the tumour presented all the naked-eye appearances of malignancy, a partial gastrectomy was performed. The cut ends of the stomach were sewn up with two rows of silk sutures. The duodenum was freed by dividing the peritoneum over the right kidney and fixed by two rows of sutures into the opening made in the posterior wall of the stomach, about one inch beyond the line of section. What was taken to be oesophagus during this procedure was subsequently found to be a constriction, due to the healing of an old-standing ulcer, which had contracted and produced an hour-glass condition of the stomach. This condition was immediately remedied by the performance of gastroplasty. Two enlarged glands were removed from the lesser omentum, and the abdominal wall repaired. The entire operation occupied exactly seventy minutes, and the shock was very slight. Recovery was rapid and uninterrupted, and she left for the convalescent home on the twenty-third day after operation. Examination of gastric juice that day (Jan. 12th, 1906), seven months after the operation, showed that there was not a trace of free HCl, or, indeed, any other free acid to be found. The pathological report of the tumour demonstrated that it was apparently a mass of inflammatory material around an old-standing ulcer. Mr. Taylor then discussed the question of the diagnosis of inflammatory tumours from carcinomata, after which he went into the question of the operative treatment of gastric carcinoma involving the body or pylorus, and contrasted gastro-enterostomy with gastrectomy, both as regards the immediate mortality of these procedures and the average length of life after the performance of these respective operations. The comparatively small number of cures after gastrectomy was attributed to the inability to make a diagnosis sufficiently early, and Mr. Taylor advocated strongly more frequent recourse to Mr. Moynihan's advice, viz., "that one should operate not to confirm but to make a diagnosis."

Mr. MAUNSELL stated that the symptoms upon which he laid stress in the diagnosis of gastric cancer were absence of free hydrochloric acid, short duration of gastric symptoms and, in many cases, irregular pyrexia. In one case he had performed almost complete gastrectomy, but with fatal result. Quite recently he had operated on another case, and took away about half of the stomach, and the patient was making good progress. He thought that, short of cancer in the liver, every effort should be made to remove cancer of the stomach.

Mr. JAMESON JOHNSTON considered that the growth should be removed if possible, as much more benefit was likely to ensue than after gastro-jejunostomy.

Mr. HOUGHTON having also made some remarks, Mr. WILLIAM TAYLOR replied, and the Section adjourned.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD THURSDAY, JANUARY 25TH, 1906.

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

Mr. SIMEON SNELL (Sheffield) related a case of SEPTIC THROMBOSIS OF THE CAVERNOUS SINUS. On May 1st, 1895, a medical man pricked a small

vesicle on the upper lip with a gold scarf pin which had been used previously to open an abscess, and which was thought to be clean. The next day there were redness and swelling, and later on that day he was obliged to go to bed. On the 5th the condition of the lip was worse and the blush extended to the left cheek and orbit. This was followed by proptosis and swelling of the conjunctiva and eyelids. Later the right side followed the same course, the proptosis being even more marked on this side. The movements of the eyeballs were interfered with, and there was paralysis of the right facial nerve and deafness on the right side, also dulness and evident effusion of the right side of the chest. The patient died fourteen days after the commencement of the illness, his mind having been unaffected throughout. Mr. Snell remarked that the initial lesion was that on the lip, which the medical attendants had considered to be malignant facial carbuncle. No *post mortem* was allowed.

Mr. SNELL also related the case of a pork butcher, æt. 48, who came to him with Acute Œdema of the Eyelids on both sides. The day before he had been dressing a pig, when the gut, which contained a large number of worms, burst, and the contents splashed into his face. The Œdema was present three or four hours later. When first seen by Mr. Snell, twenty-two hours later, the eyelids on both sides were intensely œdematous, projecting as large semi-transparent swellings, leaving only a chink between them. There was considerable chemosis of the conjunctiva. The next day the swelling had much subsided, and the day after the condition of the eyelids had almost passed away, though the conjunctiva remained red. The worms in the pig were the same class as *Ascaris Lumbricoides*, and in seeking an explanation for the condition, Mr. Snell mentioned that it had been recorded that these worms, when alive, give off an irritating vapour. From another pig in which worms had collected together, the contents of the gut were taken, and also nutrient broth into which some of the worms had been placed, after having been cut to pieces, and this created no irritation when instilled into the conjunctiva of a guinea pig.

Prof. A. MAITLAND RAMSAY, of Glasgow, read a paper on the

TREATMENT OF DETACHMENT OF THE RETINA. based on a record of fifty consecutive cases of detachment of the retina, treated in the Glasgow Ophthalmic Institution, during the four years ended October 31st, 1905. The active treatment consisted in sub-conjunctival injections of 5 to 20 minims of 1 in 2,000 bichloride of mercury with 8 per cent, chloride of sodium solution, the severe pain that always followed being mitigated by the addition of a few drops of 1 per cent. cocaine solution. The injection was repeated as often as might be necessary, at intervals of from four to six days; and if no decided improvement showed itself within a fortnight, free diaphoresis was induced by the sub-cutaneous injection of from $\frac{1}{4}$ to $\frac{1}{2}$ of a grain of pilocarpine, this alternating with the sub-conjunctival injections. If the site and character of the detachment were deemed favourable, the sub-retinal fluid was always evacuated by scleral puncture. The patient was kept prone in bed with his eyes bandaged, and every effort was made to improve his general well-being by careful attention to diet and to the action of the bowels, kidneys, and skin. Marked chemosis of the conjunctiva was essential, and when the reaction to the sub-conjunctival injections was absent or ill-marked, 1 to 2 per cent, of dionine was added to the bichloride and chloride of sodium solution. Of the fifty cases treated, ten showed a decided improvement, and thirteen a moderate improvement, though of the former group five, and of the latter group two, relapsed at intervals varying from two weeks to four years. The more recent the detachment the more favourable the prognosis, but the pathological antecedents of the affected eye were more important than the duration of the condition. Failure was the rule in all cases marked by a seriously degenerated choroid, a pupil sluggish to mydriatics, a much diminished tension,

and a red-coloured separation. The method of treatment outlined was simple, applicable to all cases, and, as far as the author's experience went, never did any harm.

Dr. D. J. WOOD related a case of

BITEMPORAL HEMIANOPSIA.

The patient was a man, *æt.* 33, who had suffered for over a year with frontal headache, failing vision and loss of memory. The vision of the right eye was 1-60 and the left 6-60, and there was bitemporal hemianopsia with contraction of the field and loss of fixation in the right. He was mentally dull and forgetful, and there was marked delay in answering questions. The pupils were sluggish, and the knee jerks were almost absent. During the 52 days he was in hospital he grew worse mentally, and on account of his foul language and filthy habits it was impossible to keep him in. After 62 days, during which there was little change, he suddenly sat up and began to ask sensible questions, and when seen some months later he was mentally quite well. His right eye showed optic atrophy, was blind and divergent. The left improved to 6-18, his patellar reflexes were normal, and his memory for events after his sudden recovery was good. He had no recollection of anything during the previous 3½ months. His history was given by his wife, brother-in-law, and mother, who all agreed as to the details. The case was thought to be one of cystic growth of the pituitary body, which during a fit of coughing had ruptured through the eroding bone and had escaped into the pharynx or nasal cavities, but nothing of this sort was noticed by the friends, and the patient was more or less unconscious until the actual relief of pressure had occurred.

ULSTER MEDICAL SOCIETY.

MEETING HELD IN THE MEDICAL INSTITUTE, BELFAST, ON JANUARY 25TH.

Dr. CALWELL, President, in the Chair.

Dr. R. W. LESLIE read notes of a case of

PERNICIOUS ANÆMIA

treated by cacodylate of soda. The patient was a lady over 60 years of age when she came under treatment last summer. She was extremely weak, vomiting continuously, and oedematous in the legs and under the eyes, and appeared practically moribund. She was given rectal injections of the drug, and rapidly improved. The blood count, which had been 703,000 red corpuscles, when she came under treatment, increased in three weeks to 1,900,000. Improvement was steady; she was able to be out in a month, and subsequently returned to her home in England. Dr. Leslie had lately heard from her medical attendant there that she continued to do well.

In his remarks on the case Dr. Leslie said that the point of interest was that while Professor Fraser said that the drug was inert, he had observed in this, as in several other cases he had previously reported in which marked improvement took place, there was a strong smell of garlic in the breath. Another reason against the supposed inertness of the drug was the fact that several cases of peripheral neuritis had occurred apparently from its use. To avoid the risk of this he used it for ten days, then remitted for ten days. He preferred to give it by the rectum to avoid sickness.

Dr. MITCHELL said that he had used cacodylate in keratin coated pills in one case with improvement, but the case relapsed after a year.

Dr. GARDNER ROBB read notes of two unusual cases of

PERFORATION IN TYPHOID FEVER.

The first case was a boy in whom all the symptoms of typhoid were latent till perforation took place, and the actual cause was only demonstrated *post mortem*. The second case was that of a man, in whom perforation occurred on the 123rd day, when he had been

partially convalescent for seven weeks or so. He could find no similar case on record.

Dr. A. B. MITCHELL showed several cases of surgical interest.

Mr. ROBERT CAMPBELL showed a boy of 9, in whom he had done decapsulation of the kidneys for chronic nephritis. Previous to operation the urine was scanty, with a large amount of albumin and casts, and the boy was dropsical. Since the operation he had steadily improved, and now the urine was nearly 40 oz., and contained only a trace of albumin. The dropsy had also disappeared.

THE CENTRAL MIDWIVES BOARD.

MEETING HELD JANUARY 25TH, 1906.

The President, Dr. CHAMPNEYS, in the Chair.

AFTER the Standing Committee had adjourned, Mr. WARD COUSINS moved: "That the Form of Suggestions accompanying the Agenda of December 14 for the guidance of the medical advisers of the Local Supervising Authorities, respecting the duties of Inspectors appointed to exercise general superintendence, be approved and issued to the Local Supervising Authorities."

Dr. PARKER YOUNG inquired if the local authorities would not deem such suggestions an impertinence?

Mr. WARD COUSINS said he was sure any suggestions from the Board would be welcomed.

The PRESIDENT suggested that a Committee be formed to consider and make suggestions and communicate the same to Mr. Fordham for his opinion.

Dr. PARKER YOUNG thought it would be advisable to say that the Board, after consideration of replies from examiners, see no reason to make any alterations, also that a member of the Board was present when the papers were set. This was seconded by Miss PAGER and agreed upon.

A letter was read from the Clerk of the Privy Council with copy of a resolution from the Lutterworth Union complaining of unfairness and asking for the number of cases for a qualification to be reduced from twenty to seven.

Dr. PARKER YOUNG said the question was absurd, and would lead to retrogression if granted. A higher standard was needed, not a lower one. It was then agreed to send a refusal to the Lutterworth Guardians.

Further correspondence read showed that Dr. W. Rivers Pollock and Dr. W. Tate wished to resign as Examiners, which resignations were accepted, the President suggesting Dr. Hicks, of Guy's, London, as one substitute.

Dr. PARKER YOUNG objected, saying there were many men who would like the post and the requirement should be made known in the medical journals that each man might have a chance.

The PRESIDENT pointed out that it was wise to have some examiners in reserve or ready, that was his reason for suggesting Dr. Hicks.

This suggestion was adopted, and a letter from Dr. A. J. Wallace, saying a lady who had attended his lectures to his satisfaction six years ago, now wanted her certificate signed for such satisfactory attendance, but he was unwilling to do so as he had no knowledge of her present acquirements.

The PRESIDENT said this was a case of common law not to be adjudicated on by the Board, and the writer must go by written rules and his own conscience.

Dr. Eustace Hill, County Medical Officer for Durham, inquired by letter as to the extent of the exemption from supervision conferred by Rule E., Sec. 11, on midwives working in hospitals, workhouses, and poor-law institutions under a medical officer, as the Act included *all* midwives.

The PRESIDENT answered it was taken for granted that all medical officers at such institutions were resident and capable. It was highly desirable, but not practicable, that the position be more clearly defined.

Miss WILSON then moved: "That a Committee be appointed to consider the Board's penal proceedings generally and report thereon, as many trivial cases came up which could have been settled otherwise than at the meeting, and much time wasted."

Drs. Boxall, Roberts and Parker Young were therefore appointed as a Committee to inquire further and make suggestions.

The important question of rescinding a motion came up again, when Miss WILSON moved: "(1) That the resolution of the Board of November 23rd, refusing the application of the Secretary of the Cheltenham District Nursing Association for an extension of time for signing the schedules for the February examination in the case of four nurses now being trained by the Association be rescinded," saying that Cheltenham had fixed their dates before the alteration of dates by the Board. That the women would have fulfilled the required time all but two days and would lose appointments ready for them after the Examination, as the Cheltenham nurses were in high repute for their excellent training and rarely failed to pass.

Dr. PARKER YOUNG had much pleasure in seconding the motion. It would be a gross act of injustice to refuse.

Dr. DAKIN inquired if, legally, it could be done.

The PRESIDENT answered it could not, and they would land themselves in a difficulty by acceding.

Dr. PARKER YOUNG remarked it was not a question of formula but an act of justice.

Dr. DAKIN objected, saying that hundreds of other women might take this as a precedent and apply.

Dr. PARKER YOUNG replied that two wrongs did not make a right, whereupon

Dr. DAKIN asked if he found any more cases could he promise them the same "justice"?

The PRESIDENT concluded the discussion by saying that as they were going to drive a coach and six through an Act of Parliament, Dr. Dakin had better get any more through before the gap closed. The Cheltenham authorities had been told once it could not be done; now they were going to grant the request. He, himself, though sympathising with the applicants, must vote against the Resolution.

Dr. Dakin also voted against it, but the same was passed, and intimation to that effect sent to Cheltenham.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, January 28th, 1906.

TREATMENT OF JAUNDICE.

THE treatment of the different forms of icterus depends naturally on the cause, but at the beginning the treatment should be in every case symptomatic.

Milk regime increases diuresis and diminishes the toxins of the intestinal tract. About three quarts, says Prof. Huchard in an article on the subject, should be given daily mixed with alkaline water. Patients should not be forced to take too much milk, as frequently it is not well digested. A slight laxative is better than a drastic purgative, which weakens the patient. Numerous authors prescribe calomel, but neither Dr. Huchard nor M. Chauffard recommend it. According to these authorities adult persons support it badly; it could give rise to phenomena of mercurial intoxication. As to intestinal antiseptics, naphthol, betol, salol, they irritated the organism. Moreover, they take from the tissues the mineral salts which, constitute them, sulphur, potash, &c., and thus demineralise the tissues.

Internal antiseptics by naphthols is one of the greatest errors of the present time. Cold enemata (one quart

morning and evening) may be given and retained five or ten minutes; they produce diuresis, increase arterial tension, and empty the portal vein. In case of colic the enema should be given warm instead of cold.

The morning laxative might be continued eight days and suspended eight days, and so on. During the period of rest benzoate of soda at the dose of 15 grains at mid-day and the same amount at six o'clock in the evening in Vittel water should be prescribed; it acts as a stimulant to the hepatic secretion.

When the icterus is prolonged without much improvement other symptoms set in, and notably pruritus, which causes considerable inconvenience. In such cases, the treatment must be frequently changed to content the patient, for a sovereign remedy is not to be found in the arsenal of therapeutics. Alkaline baths of ten minutes' duration, warm shower baths, lotions with spirits of camphor (1-4), sublimate (1-2000), ichthyol (1-100), chloral (20-1000), give some relief. After the lotion the parts should be powdered with:—

Menthol	10 grains.
Talc	3 ounces.
If the itching persists, paint the region with		
Glycerine	2 ounces.
Chloroform	4 drachms.

If the jaundice shows no sign of abating a calculus is the probable cause, and Vichy treatment may be ordered, or perhaps surgical intervention may be necessary.

In cases of tumour an operation is useless. Where signs of grave icterus are present, two quarts of milk should be given daily, and each morning a purgative enema, followed by an hour later an enema of salt water (1-100).

Agitation is relieved by enveloping the patient morning and evening in sheets steeped in warm water (100° F.) and wrung out. Opothropic treatment might be tried with a chance of success. Dr. Malescopulo, of Alexandria, obtained several cures of infectious icterus by means of hepatic extract.

HYDROCELE.

The classical treatment of hydrocele with injections of tincture of iodine is very painful, and in certain debilitated subjects have produced very grave results. Prof. Teissier recommends the following, which he affirms is painless and free from accidents:—

Orthoform	30 grains.
Proof spirit	6 drachms.
Distilled boiled water	1½ ounces.
Caustic potash	1-32 grain.

The addition of the caustic potash is to obtain a perfectly limpid solution.

After evacuation of the serosity of the hydrocele, and leaving the needle in place, the above liquid is injected, and the parts malaxed for a few moments. The liquid is then withdrawn and the usual tincture of iodine is injected. At the end of ten minutes this solution is again removed and the needle withdrawn. A plug of cotton wet with collodion seals up the wound. The anæsthesia produced by the orthoform lasting a long time by reason of the slow absorption of the drug, the patient experiences no pain during nor after the injection, although the inflammatory reaction is produced as usual.

The solution of iodine which M. Teissier employs is as follows:—

Tincture of iodine	1 ounce.
Distilled water	1½ ounces.

CHAPPED HANDS.

The following will be found very effective in this uncomfortable condition of the hands:—

Glycerine (pure)	1½ ounces.
Peruvian balsam	4 drachms.
Salicylate of soda	1 drachm.
Rose water	6 ounces.

used as a lotion morning and evening.

GERMANY.

Berlin, January 28th, 1906.

At the meeting of the Berlin Society for Psychiatry and Nerve Diseases, Hr. Oppenheim showed preparations from a case of

CEREBELLAR TUMOUR.

He spoke of the difficulties of operation in such cases, and of the great changes set up in the brain by them.

The case was that of a man *æt.* 38, who was attacked in August, 1904, with noises in the right ear and deafness, and later on giddiness. It was not until July last that more grave symptoms appeared—paræsthesia of the right half of the face, spasms and loss of visual power, nystagmus on looking to the right, slight optic neuritis, also slight cerebellar ataxy, and paresis of the right facial nerve.

Diagnosis.—Tumour in the region of the right side of the pons.

An operation was performed by Hr. Borchardt at two sittings. The last in December last when large masses of the tumour were removed. Some portions of cerebellum were also taken away. The patient died in a state of coma the next day. The growth was very extensive, the medulla oblongata, being forced a good deal to one side.

Hr. Mosse showed a case of

PARALYSIS AGITANS.

remarkable for its rapid advance. The hands were blue, and there were jerky movements of the vocal cords from rigidity of the laryngeal muscles.

Hr. Henneberg spoke on

CYSTICERCUS,

as affecting the brain. After going over the symptomatology and pathological anatomy, he went on to say that cysticercus was still comparatively frequent in Berlin. One death took place generally every year in the Nerve Klinik of the Charitee. Cases in which it was doubtful as to whether the disease existed were not so rare.

He reported the following case:—A woman, *æt.* 22, during pregnancy had pains in the stomach, constipation, vomiting, a feeling of constriction in the neck, headache and giddiness, distress and delirium. On admission there was some delirium, optic neuritis, paresis of the abductens of the left facial, the hypoglossus, pain in the neck, static ataxy, loss of patellar reflex, no lymphocytosis of the cerebro-spinal fluid, no increase of pressure, no fever. The autopsy showed cysticercus in the right thalamus. The *foetus* was macerated, there was no hydrocephalus.

He characterised the case as a pseudo tumour cerebri and assumed an auto-intoxication, but he could not exclude an action on the part of the cysticercus with certainty. The frequency of epilepsy and psychosis in cysticercus had been over-estimated. These were often due to accompanying conditions. Epilepsy of childhood from cysticercus was sometimes very pernicious. At the base of the brain the cysticercus often took a racemose form and led to chronic fibrous leptomeningitis. He brought forward five cases of vasa cysticercus. Ventricular cysticerci arose from the choroid plexus. In consequence of the stream of fluid they were most frequent in the fourth ventricle. Brun's symptoms were not always present in these cases and it could not be attributed to change of position in the cysticercus. A man *æt.* 38 had headache, vomiting, giddiness, noises in the ears, hyperæsthesia, hysteriform leptoform attacks. Suddenly paralysis of respiration, and death. Autopsy: A moderate degree of hydrocephalus, a perfectly free cysticercus, the size of a cherry stone in the fourth ventricle. The treatment could be only operative—division of the worm, and this had not yet been carried out.

SPIROCHÆTA PALLIDA.

Volk and Landsteiner exhibited preparation of *spirochæta pallida* in tissue prepared after Levaditi's method.

AUSTRIA.

Vienna, Jan. 28th, 1906.

EXTIRPATION OF LARYNX.

ALBRECHT exhibited a patient on whom Hochenegg operated for carcinoma of the larynx by extirpating the entire larynx. The patient is now well and with the aid of an artificial larynx can make himself perfectly understood. He is able to converse with others in a neighbouring room with closed doors. He is a surveyor and measurer, and can call out on the field with intelligence and energy. In cold weather, to prevent rapid change in the trachea he can breathe from the pharynx by means of an india-rubber tube.

Exner suggested a modification of the instrument, which would enable the patient to whisper or alter the tone at will, and which could be managed by the lips.

TUBERCULOSIS OF SKIN IN APES.

Kraus again informed the meeting that he had conducted other experiments on the *Macacus rhesus* with the same results as in his previous reports. He believes with Kren that it is quite possible to inoculate the monkey with cutaneous tubercle. He has now performed this operation many times, with direct inoculation from the human skin as well as by pure cultures of the tubercle bacilli. He has also obtained similar results with different species of "Provenienz Tuberculosis" as well as with *perl sucht bacilli* on the site of inoculation within 8 or 10 days after inoculating which, can be distinguished from genuine tuberculosis as the latter does not appear within 16 days after the operation.

Paltauf wished it to be distinctly understood that the identity of these two bacilli, the rinder and human, did not destroy the proof that they were different species of bacilli, neither did it disprove the opposite.

LYMPHANGITIS AND LYMPHADENITIS.

Khautz next demonstrated a girl, *æt.* 12, with tuberculous lymphangitis and lymphadenitis cubitalis in the left arm, which suddenly appeared half a year ago after cutting her thumb with the bread knife. No signs or trace of tubercle can be discovered in any of her ancestors, leaving the source of infection a mystery. All the other organs are perfectly healthy. The primary wound has left a morbid growth about the size of a two shilling piece over the extensor surface of the thumb, which dermatologists have diagnosed as tuberculosis verrucosa cutis. In one of these softened glands taken from above the elbow fourteen days ago the tubercular bacilli were found, but in small quantity. The infected lymph vessels are knotty, lying like strings of beads along the sulcus of the bicipitalis internus as well as the flexors of the fore-arm, down to the infected thumb over which the skin is movable, and in no way reddened.

THORACIC DEFECTS.

Ranzi showed the members a boy, *æt.* 9, with defective ribs from the second to the sixth; there was absence of the sterno-costal portion of right pectoralis major; partial defect of the pectoralis minor, serrati, hypoplasia of the right scapula brachydactylia, syndactylia and convex scoliosis. In the second case, 6½ years, there was an absence of ribs on the left side from the seventh to the eleventh, with an elevation of the right scapula and right convex scoliosis.

Berlin Doctors' Incomes.

THE Medical Chamber of Berlin has recently issued some statistics regarding the incomes of local medical practitioners. It would seem that no fewer than 1,322 physicians in Berlin in regular practice do not reach £250 per annum. The average income for a Berlin medical man is £450. In the upper regions of the profession fifteen have an income of £2,500 to £3,000, thirteen from £3,000 to £3,500, three from £3,500 to £4,000, six from £4,500 to £5,000, four from £5,000 to £6,000, five from £8,000 to £9,000, and one each with incomes £13,000 and £16,500.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

WOMEN GRADUATES AND PARLIAMENTARY FRANCHISE.—In view of the fact that voting papers for the coming contest for the Parliamentary representation of Edinburgh and St. Andrews Universities have been sent out only to male graduates, a meeting of the women graduates of these universities was held in Edinburgh on January 27th. A large number of graduates from all parts of the country were present. The proceedings were private, but we understand that it was unanimously decided that immediate steps should be taken to test the legality of the action of the authorities in declining to supply ballot papers to women. It seems that the construction of the statute bearing upon university representation is in this respect by no means clear; indeed, when the Act was passed many of the universities did not confer degrees upon women, and in any case the present is the first contest in which any considerable number of women have been on the roll of members of the General Council. The matter is of very considerable general interest and importance, as should it be decided that female graduates have the same right as males to vote for a University representative in Parliament it would mean the introduction among a limited section of the community, of female suffrage.

BELFAST.

BELFAST HOSPITAL FOR SICK CHILDREN.—The annual meeting of this charity was held last week, and a good year's work was put on record. In the intern department, 841 cases were treated; the annual cost per bed was £50 6s. 8d., and the average cost per day 2s. 3d. The cost of the keep of the household and children per day is less than 7½d. per individual. There were 39 deaths in the wards. The operations numbered 366 in the intern and 341 in the extern department. In the out-patient department, 5,196 new cases were seen with a total attendance of 16,545. The secretary of the Board stated that the question of patients being paid for was very thoroughly investigated by a large committee of the Board and lady representatives. A large number of parents and others were interviewed, and after mature consideration it seemed to be conclusively proved that there was no abuse of the charity, and that only an infinitesimal minority of the parents could contribute anything to the funds. The Dean of Belfast, in speaking at this meeting, made some excellent observations on the necessity of having a united collection for all the hospitals of the city on a given Saturday and Sunday, and not, as at present, each hospital taking care of itself. This matter has often been mentioned, but no step has yet been taken to bring the end in view any nearer.

LONDONDERRY DISTRICT NURSING ASSOCIATION.—The Duchess of Abercorn presided at the annual meeting of this charity last week. The report showed that during the year 1,356 cases had been attended, and 24,136 visits paid.

LETTERS TO THE EDITOR.

SPECULATIVE ACTIONS AND MEDICAL WITNESSES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Whilst agreeing with you that Dr. Miller, of Putney, is to be congratulated upon the success of his action against a solicitor for recovery of fees for attendance in Court as a medical witness, I am afraid that the success is not so far-reaching as is imagined by those who have merely read the newspaper report of the case. In the case it was amply proved that there was an arrangement between the solicitor and his client that the former was to pay all expenses

in the original action against the Metropolitan Asylums Board, and that the client was not to be liable for any costs. It was this important point which enabled Dr. Miller to recover his fees from the solicitor who had thus practically made himself liable for the costs in the action. It must therefore not be taken for granted that in any action brought by a "man of straw" so to speak, that the solicitor would be liable and could be successfully sued. It is only when legal proof is available to convince the Court that the solicitor has accepted the liability in this respect that a successful issue for the recovery of the fees from him can be gained. I am afraid that in the majority of instances such evidence would not be available, and that therefore Dr. Miller's case, although decided upon sound law, cannot be taken as extending the liability of a solicitor except under the very special circumstances of the individual action concerned.

I am, Sir, yours faithfully,

A. GEORGE BATEMAN, M.B.,

Gen. Sec. Medical Defence Union.

Medical Defence Union, 4 Trafalgar Square, W.C.,
January 24th, 1906.

THE APOTHECARIES' HALL AND THE PHAR- MACEUTICAL SOCIETY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am more than amazed to find that the MEDICAL PRESS, which usually advocates the rights of the Irish Medical Corporation, has allowed itself to be led into such a serious error as to state that whereas formerly apothecaries' assistants were required to serve a seven years' apprenticeship, now they get their certificates after three months' training. The fact is, that the regulations require at least two years apprenticeship at present. In the middle of the last century (1852) it was reduced to three years, and previous to that time the seven years was insisted on for the apothecary keeping open shop, whilst his assistant, foreman or shopman, was required to serve five years. I venture to think that the medical profession does not realise how it will be hit if the Pharmaceutical Society of Ireland succeed in their pretensions. Already the British Society has made a mere tool of the Medical Council, and hypnotised it into declaring that if a medical practitioner should keep a pharmacy, and allow his assistant to sell a drachm of precipitate powder, the practitioner will be adjudged to be guilty of infamous conduct and will be struck off the Medical Register unless the assistant happens to be a fully qualified chemist.

Now the law in Ireland is different and still more drastic. It is an offence in this country not only to sell a poison, but to compound a medical prescription; and hence it follows that if the Pharmaceutical Society succeed in upsetting the validity of the certificate of the assistant, which has been issued by the Apothecaries Hall for over one hundred years, every medical practitioner in Ireland who allows anyone but a pharmaceutical chemist to compound his prescriptions will be at the mercy of any common informer who may choose to report him to the General Medical Council, and that body will be bound, according to their own ruling, to strike him off the Register.

To realise the colossal cheek of the effort of the Pharmaceutical Society to discredit the apothecary assistant we must remember that the number of qualified assistants on the Society's own books (excluding pharmaceutical chemists) is only 37, and their argument is that these must be considered the only qualified men to supply the 1,600 pharmacies, drug stores, and private surgeries in Ireland. The pharmacists say that the Act of 1791 compelled the Apothecaries' Hall to examine every assistant in every medical hall in Ireland from 1791 to 1875, but they insist that every certificate given during all that time was invalid unless it was such a one as would have enabled the holder to get on the Medical Register.

So monstrous are the claims of the Pharmaceutical

Society, or rather of Mr. Wells, the ex-president, that one would think they need but be brought into court to be quashed. But the Society has plenty of money and seems inclined to spend it in law, whilst the Apothecaries have not the same lust for the Law Courts. Happily, however, they have in evidence what they lack in litigiousness. They have the charter granted to the Dublin Society of Apothecaries in 1746, in which assistants are given very ample powers. They have registers entitled "Register of Assistants or Journey-men, 1796 to 1828." They have record after record in their minutes from 1793 showing that persons who were refused the certificate to keep open shop as apothecary were given a certificate enabling them to act as assistant to an apothecary. They have proof that so long ago as August 9th, 1859, they moved that when a candidate appealed against their decision to the College of Physicians and the appellant was successful he was granted a certificate to enable him to act as an assistant, but not to use the title "apothecary," and they have the most ample proof of the gradual differentiation and development of the examination required according as the candidate desired to act as a mere journeyman assistant—or as a journeyman further certified to keep open shop—which, in course of time developed into the triple qualification of the present day.

I am, Sir, yours truly,
J. C. McWALTER.

Dublin, Jan. 22nd, 1906.

[The statement to which Dr. McWalter objects was made in the discussion to which we referred, and had passed without contradiction. We quoted it merely as an illustration of the changes that have taken place in education during the past century, and not as a reflection on the Apothecaries' Hall. The main point is, as we said, one to be settled by lawyers.—ED.]

SANITARY ADMINISTRATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—As one of the public taking part in sanitary administration I thank you for the article in your issue of January 24th. My mild astonishment at some of the remedies for existing evils put forth from time to time by the very able member of the *Times* editorial staff, who discusses these subjects, has not been diminished by the fact that he is mostly so well informed and that his writings seem to show that he is a member of the medical profession. Is it not quite evident that if authorities were compelled to co-opt a few sanitary experts these would be outvoted whenever a majority of reactionaries were present on the Council and on the other hand that such experts would not be necessary in any place where a sufficiently strong public opinion prevailed? Without public opinion to appeal to the experts would become as powerless as the medical officers now remain. Then again, the proposal to give these last named officers fixity of tenure in their appointments would form a far from complete remedy for their present virtual impotence. The authorities would continue to select candidates and fix the amount of their remuneration. By cutting down the stipend of the medical officer to the lowest possible figure they could make tolerably certain that none save such as recognised themselves to be failures in their profession would apply. Such men would not be as a rule, difficult to intimidate; and the knowledge that any increase in pay and the prospect of a pension for long faithful service would still depend upon the authority would probably suffice to make them as subservient as the authority could desire. The only cure for existing evils is that to which you point—namely, improvement in the personnel of governing bodies; and this can be brought about only by the development of local patriotism. The remedies proposed by the *Times* would form a step towards bureaucracy, and there can be no doubt bureaucratic administration if only tolerably honest, would in most places be of far greater advantage to the public than the present pseudo-democratic method. Gambetta once said, "You cannot

have a republic without republicans," and in the same way you cannot have true "government for the people by the people," when the majority of the public refuse to do their duty as citizens—that our citizens nowadays decline to do their duty, is as you suggest, one of the many ugly signs of the times.

I am, Sir, yours truly,
SANITARIAN.

January 26th, 1906.

OBITUARY.

DR. H. S. PURDON.

THE death of Dr. Henry Purdon removes a figure well known for many years in Belfast, where he practised as a dermatologist, and also acted as medical inspector under the Factory Acts. Dr. Purdon was a little over sixty, and was the eldest of the second generation of medical men of the name in the town. His father, Dr. Charles Purdon, and his uncle, Dr. Henry Purdon, were leading practitioners forty or fifty years ago; two of his brothers are in practice—one in the city and one in England, and two of his sons have entered their father's profession, one of them following him at the Belfast Skin Hospital.

Dr. Purdon studied in Belfast, then in Dublin, Glasgow, and London. For many years he was on the staff of the old Royal Hospital, but later confined his attention to the Skin Hospital and his Factories work. He was a singularly quiet and retiring man, with few intimate friends except those of his boyhood who remained here. He was known to be in bad health for some time past; the cause of death was organic obstruction of the bowel.

DR. JOHNSON, OF BRADFORD.

DR. JOHNSON was an Ulsterman, educated at Queen's College, and a graduate of the Queen's University. Though settled in Bradford for more than thirty years he kept up an intimate connection with his native land, and many a successful practitioner in Belfast and elsewhere has begun life by passing from Queen's College, Belfast, to act as assistant to Dr. Johnson. He was a bachelor, and two of his great interests in life were the Bradford Medico-Chirurgical Society, and the Bradford Rifles, of which for twenty-two years he was surgeon, retiring with the rank of Surgeon-Lieutenant-Colonel about three years ago. He was an excellent shot, and wore the Volunteer medal for long service. He was a great personal favourite with a large circle of friends.

DR. E. J. HAWKES, J.P., OF RAMSGATE.

WE regret to record the sudden death, on the 22nd inst., of Dr. Edward John Hawkes, J.P., of Ramsgate. He had recently recovered from a somewhat severe indisposition, and had for some days been actively pursuing his professional duties. As late as the morning of his death he occupied a seat on the Bench at Ramsgate in his capacity as a borough justice. Later on in the day, he passed away as the result of the breaking of a blood vessel. Dr. Hawkes, who was sixty-four years of age, came of an old Cornish family. He studied medicine at the Bristol Medical School and at Edinburgh. For some years he practised at Hastings, and later took charge of the South Devon Hydropathic Establishment for three years. He came to Ramsgate in 1886.

DUNCAN MACGILVRAY, M.B., C.M.GLASG.,
L.F.P.S.

WE regret to announce the death of a well-known Glasgow practitioner, at the early age of forty-seven. Infection caught in the course of his ordinary work developed into blood poisoning, and a vigorous career was speedily brought to a painful termination. He was undoubtedly a victim to the faithful performance of a duty wherein danger lay. He was M.B. and C.M. of the University, and also a licentiate of the local

Faculty. He was president of the Glasgow Southern Medical Society, and chairman of the Glasgow Medical Club. He was unmarried, and is survived by his mother and sisters.

**WILLIAM WINGATE SAUL, M.D., HEIDEL.,
M.R.C.S. ENG., OF LANCASTER.**

SURGEON-COLONEL WINGATE SAUL, who for over a quarter of a century was one of Lancaster's leading physicians and public men, died on the 22nd inst., aged sixty-four. Deceased was connected with the Duke of Lancaster's Yeomanry for twenty-two years, and served under six commanding officers. He was the founder of the Lancaster St. John Ambulance Association. For nearly twenty-five years Colonel Wingate Saul was surgeon to the civil and military prisons. For some years the deceased was a member of the Central Committee of the Royal Albert Asylum at Lancaster.

**SURGEON-MAJOR-GENERAL WILLIAM
FREDERICK DE FABECK, M.D., M.R.C.S., Eng.**

THE death is announced of Major-General de Fabeck, late of the Indian Medical Service, who died at his residence in London on January 18th. He entered the Army Medical Department in 1855, and served both in the Crimean campaign and in the operations for the pacification of Northern India following on the Mutiny. After holding many military medical appointments and also district civil surgeoncies in India, he was selected in 1886 for the post of deputy-surgeon-general for the Nagpur force and the Central India regiments. Four years later he became surgeon-general with the Government of Madras, and continued to hold executive charge of the medical service in the presidency until his retirement in May, 1894.

SPECIAL ARTICLE.

POPULATION RETURNS (IRELAND).

THE Report of the Registrar-General for Ireland for the year 1904 has recently come to hand, nearly twelve months from the termination of the period to which it relates. It is difficult to see any reason for this long delay, as the Report does not contain any novel features, and the entire compilation might be performed in fewer weeks than it has taken months.

The estimated population of the country is still decreasing—the decrease shown in the present Report being some twelve thousand, as compared with over eighteen thousand in 1903. As usual, this decrease is entirely due to emigration, the births showing a healthy preponderance over the deaths. The actual numbers are—births, 103,811; deaths 79,513; emigrations, 36,902. That is to say, the natural increase of population of 24,298, was overbalanced by the number of emigrants, resulting in a decrease of 12,604. To this, there should be a slight set-off from immigration of which no official record is taken. In the face of these dismal facts it is some little consolation to learn that the emigration rate per 1,000 of the population is at present, and has been since 1900, on the decline, though the actual fall is very slight. It is to be feared that the present marked depression in trade will show itself in the next emigration tables by a distinct rise. It is perhaps a sign of increasing prosperity that the marriage-rate has, during the past twenty years, shown a consistent upward trend, and now stands at its highest point, 15.22 per 1,000 of the population. The number of persons married under age is very small, being only 1.42 per cent. of the men married, and 6.32 per cent. of the women. Of those married under age the highest proportion of both men and women was in the province of Ulster, and the percentage in Ireland as a whole was much less than in either England or Scotland.

Of the children whose births were registered during the year, only 2.5 per cent. were illegitimate. The percentage in Ulster was 3.4, in Leinster 2.6, in Mun-

ster, 2.2, and in Connaught 0.7. These returns compare favourably with the returns of most other countries.

In the table of the causes of death, tuberculous diseases still stand easily first, with a total of 12,694 deaths, yielding an annual rate of 2.9 per 1,000 persons living. This is the maximum rate yet reached, and it is deplorable that whereas the death-rates from tubercle in England and Scotland have declined almost by half in the last forty years, the rate in Ireland has gradually increased.

The rate, too, which represents the total deaths from malignant disease, was the highest yet recorded for Ireland, 0.69 per 1,000.

The Report has been carefully prepared, and contains a mine of information for the statistician and the medical man. We notice that the Registrar-General gratefully acknowledges his indebtedness to Dr. Ninian Falkiner, Medical Superintendent of Statistics.

NEW BOOKS AND NEW EDITIONS.

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

- J. B. BAILLIÈRE ET FILS (Paris).
Mouches et Choléra. By A. Chantemesse and Frédéric Borel, Pp. 96.
- JOHN BALE, SONS AND DANIELSSON, LTD. (London).
Indigestion: Its Causes and Treatment. By Fernandez Clarke, L.S.O., L.R.C.P., &c. Pp. 85. Price 2s.
- Patent Foods and Patent Medicines: Two Lectures by Robert Hutchison, M.D., F.R.C.P. Second Edition Pp. 47. Price 1s. net.
- A. AND C. BLACK. (London).
The Englishwoman's Year-Book and Directory, 1906. Edited by Emily James. Pp. 402. Price 2s. 6d.
- CHAPMAN AND HALL, LTD. (London).
An Introduction to Volumetric Analysis. By A. Jamieson Walker, Ph.D. (Heidelberg), B.A., and Owen E. Mott, Ph.D. (Heidelberg). Pp. 64. Price 2s. 6d. net.
- ARCHIBALD CONSTABLE AND Co., LTD. (London).
Lectures on Tropical Diseases, being The Lane Lectures for 1905. By Sir Patrick Manson, K.C.M.G., M.D., &c., &c. Pp. 230. Price 7s. 6d. net.
- HENRY J. GLAISHER. (London).
Oliver Wendell Holmes and The Contagiousness of Puerperal Fever, by C. J. Cullingworth, M.D., F.R.C.P. With Portrait. Pp. 35. Price 1s. 6d. net.
- T. C. AND E. C. JACK. (Edinburgh).
The Edinburgh Stereoscopic Atlas of Anatomy. Section 3. Edited by David Waterston, M.A., M.D., &c., &c., Price 25s. net.
- MACMILLAN AND Co., LTD. (London).
A Handbook of Climatic Treatment, including Balneology. By William R. Huggard, M.A., M.D., &c. Pp. 536. Price 12s. 6d. net.
- A Text-Book of the Diseases of the Ear, Nose and Pharynx. By D. B. St. John Roosa, M.D., LL.D., and Beaman Douglass, M.D. Illustrated. Pp. 621. Price 12s. 6d. net.
- YOUNG J. PENTLAND. (Edinburgh).
The Edinburgh Medical Journal. Edited by Alexis Thomson, M.D., L.R.C.S. Ed. and Harvey Littlejohn, M.B., F.R.C.S., Ed. New Series, Vol. XVIII. Pp. 576.
- W. B. SAUNDERS AND Co. (London).
A Text-Book of Physiology for Medical Students and Physicians. By William H. Howell, Ph.D., M.D., LL.D. Illustrated. Pp. 905. Price 18s. net.
- A Manual of the Diseases of Infants and Children. By John Rubrah, M.D. Illustrated. Pp. 404. Price 10s. net.
- THE SCIENTIFIC PRESS, LTD. (London).
Surgical Instruments and Appliances used in Operations. By Harold Burrows, M.B. Lond., B.Sc., &c. Pp. 96. Price 1s. 6d. net.
- SMITH, ELDER AND Co. (London).
Bodily Deformities. Vol. I. By the late E. J. Chance, F.R.C.S. Eng. Edited by John Poland, F.R.C.S. Eng. Second Edition. (in 2 vols.) Pp. 315. Price 6s. net.

WALKER'S ARBORETA DIARY forms a most convenient diary with detachable sheets. The cover is of solid leather, and may be had of various qualities and prices. There is provision for cash accounts and other medical and general memoranda. Altogether it is an excellent diary. As to the medical case-book, constructed on the same plan, it is one of the best we have hitherto seen. It has a temperature chart and diagram of chest with spaces for name, age, family, and personal history, notes of case, and so on, all on detachable sheets, which can be filed separately. It is the very thing for an honorary medical man attending hospital to take notes of rare or interesting cases, or for the general practitioner or consultant to keep a systematic record of bedside memoranda. Published by J. Walker and Co., Warwick Lane, London.

MEDICAL NEWS IN BRIEF.

A Herbalist fined under the Pharmacy Act.

AN action was brought by the Council of the Pharmaceutical Society of Great Britain, for whom Mr. J. B. Marsh appeared to recover £5, under the Pharmacy Act of 1868, from Thomas B. Fahy, herbalist, of 139, Golden Hillock Road, Small Heath.—Mr. Marsh explained that the action was brought to recover the penalty imposed upon the defendant for having described himself as a chemist, whereas his name did not appear on the register which was kept by the Pharmaceutical Society. He believed there was a letter before the judge in which defendant admitted the offence, and undertook to pay the full penalty by £1 per month. He asked for judgment on those terms.—This was entered accordingly.

Patient Sues Medical Man for mistaken Diagnosis of Enteric Fever.

IT is alleged by Mrs. Hall, wife of a Brixton billiard marker, that Dr. Louis Stamm wrongly diagnosed her to be suffering from typhoid instead of influenza, that she was taken to Stockwell Fever Hospital for seventeen days, and that some of her goods were destroyed in a process of "disinfection." The sequel was a claim for £40 damages made in the Wandsworth County Court on January 24th, by Mrs. Hall, and her husband against Messrs. Burgess, Brock and Stamm, physicians and surgeons, for alleged negligence. Just before her illness, it appeared, Mrs. Hall had eaten a quantity of oysters. Two of the hospital doctors gave evidence that the symptoms were very suggestive of typhoid, and that Dr. Stamm's action was justified. Judge Russell said it was a case which ought never to have been brought. Dr. Stamm sent the woman to the hospital for proper treatment, and in return the plaintiffs had shown their appreciation by bringing an action against him. He gave judgment for the defendants, with costs on the "C" scale.

A New Prophylactic against Plague.

THE Local Government Board's medical department has issued a preliminary report, made by Dr. Klein, F.R.S., on a new prophylactic against plague, and it is hoped that his experiments will point the way to some more certain and uniform method than those at present in use.

The Gresham Lectures.

DR. E. SYMES-THOMPSON, as Gresham Professor, continued his course of lectures on the nervous system at the Gresham College on Friday last, and, in dealing with the question as to which kind of food was best for the maintenance of the nerves, said the whole matter rested upon the health of the individual. If a man was healthy he could get adequate nourishment from almost any kind of food. The particular foods best suited for the building up of the nervous system were those of a fatty nature, such as milk, cream, butter, eggs, and white meats. Where the digestion needs assistance, the nervous system benefited by one or other of the artificial nerve foods containing glycerophosphates, which was a particularly valuable, in fact, one of the most valuable, foods. He strongly deprecated the indiscriminate use of drugs, such as antipyrine, though it might be beneficial in certain cases when taken under the instructions of a medical man.

Colonies for the Feeble-minded.]

THE Royal Commission on the Care and Control of the Feeble-minded is continuing its sittings at Westminster, the evidence on Friday last being of an interesting and suggestive character. Dr. Nathan Raw, visiting medical superintendent at the West Derby

Union Infirmary, Liverpool, said that he thought defective children should be separated into two divisions—those capable and those incapable of education. The first should be under the control of the education authority, and the second taken charge of by the county councils, and either classed in special institutions or in the present county asylums. There was no difficulty in the case of adults obviously certifiable as insane, but for those on the border line the case was not so easy. Many cases had come under his notice of persons repeatedly convicted of offences who were not really responsible for their actions. Such people should be drafted off to proper colonies, where they could be under permanent detention, and made to lead a useful life. On a large scale these colonies might be made practically self-supporting. Dr. Thomas Jackson, late assistant medical officer of the Glamorgan and Notts Counties Asylums, urged the necessity for establishing a system of notification of cases of feeble-mindedness. It would, he said, be useless to insist that the parents of those afflicted should notify, as relatives rarely admitted that a kinsman was mentally unsound. For statistical purposes, it was necessary that proper notification should be instituted as well as on the score of economy. Idiots, imbeciles, epileptics, and others were repeatedly thrown on to the rates at a late period of their lives, when they were practically useless and incapable of any training.

Medical Society of London—The Lettsomian Lectures.

THE first of the Lettsomian Lectures (1906) on "Some Points in the Surgery of the Brain and its Membranes" will be delivered by Mr. Charles A. Ballance, M.S., F.R.C.S., Surgeon to St. Thomas's Hospital, and to the Hospital for Paralysis, on Monday next, Feb. 5th, at 9 p.m., the subject being "The Surgery of Meningitis."

Apothecaries' Hall of Ireland.

AT the January Medical Examination, W. Shaw-Stewart, passed in Chemistry and Junior Anatomy, and completed 1st Professional. J. E. McDonogh passed in Chemistry and Physics, M. Moody passed in Senior Anatomy, and completed the 2nd Professional. J. Gillespie passed in all subjects and completed the 3rd Professional. D. J. Boyle and J. Hartigan passed in Pharmacy and completed the 3rd Professional. M. J. Murphy passed in Hygiene and completed the 3rd Professional. M. Moody passed in Hygiene, J. Gillespie and J. Hartigan passed in Medicine, Surgery, Midwifery, and Ophthalmology, and completed the 4th (final) Professional. D. J. Boyle passed in Medicine, Surgery, and Midwifery.

The Diploma entitling the holder to practice Medicine, Surgery, Midwifery and Pharmacy, will be granted to the following candidates—J. Gillespie and J. Hartigan.

Conjoint Examinations in Ireland.

CANDIDATES have passed the Second Professional (January) examination as undernoted:—W. M. Woods (with Honours), J. J. Barry, G. Collins, A. Cullen, C. T. Cullimore, J. Farrell, J. A. J. Flannery, G. W. M. Gleeson, C. Greer (Victoria, Australia), C. Macauley, H. E. M. Miles, D. McCormack, F. J. McManus, T. J. O'Donoghue, G. Patton, H. B. Sherlock, C. Stringer.

Candidates have passed the Final Professional (January) Examination as undernoted:—Leopold ApArthur Andrews, Charles Joseph Rea Clarke, Frederick O'Dowda Fawcett, Thomas A. Flynn, Cormac Gordon, Michael Joseph Christopher Kennedy, Ernest Henry Marcus Milligan, Richard Vincent Murphy, John McQuillan, Benjamin Alexander Odium, Cornelius William O'Keeffe, Caroline Elizabeth O'Mear, and William Roche.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for the MEDICAL PRESS AND CIRCULAR.
RECENT MEDICAL LITERATURE.

The Elimination of Chlorides in Nephritis.—Miller (*Journal of the American Association*, Dec., 1905) gives the results of his experiments in investigating the action of chlorides on the kidney functions in cases of nephritis. Working on the lines of previous observers, he made observations on the urine in cases of acute and chronic parenchymatous nephritis. The patients at first were kept on a dietary almost free from salt, and then, the effect was noted of the administration of large quantities of sodium chloride. The first three days the patient had merely the chlorides contained in his food; the following three days he received daily an additional 10 grammes of NaCl; then the three following merely the chlorides contained in his food. The total urine for each of the three day periods was noted; the total chlorides in each period; the grammes of chloride retained in the body when extra salt was given, and the percentage of it in the urine during each period. Two cases of acute nephritis were examined and six of chronic parenchymatous nephritis. In all there was a visible increase in the œdema during the saline administration, one patient gaining 3 lbs. during the taking of the chloride, and losing it when the salt was discontinued. In all there was a chloride retention, the urine was diminished, and the amount of albumin markedly increased. Two patients developed uræmic symptoms. In two patients suffering from uræmia, following administration of the salt the urine was lessened—one case from 500 to 240 c.c.—and scarcely any of the extra chloride appeared in the urine. The œdema was decidedly increased, and the patient's condition worse. Four patients without apparent heart or kidney trouble were tested as controls. All of these showed a chloride retention about equal to that of the milder cases of nephritis. In these the quantity of urine was not diminished. No œdema resulted. Assuming that the salt was absorbed from the intestinal tract, it must have remained in the tissues, associated with sufficient water to maintain the proper dilution—i.e., the patient had an undemonstrable œdema. The tissues of the nephritics were already water-logged so that any increase in œdema was readily observed. In support of this view one of the patients was weighed daily and showed an increase of 2½ lbs. during the administration of the chlorides. From his observations Miller deduces that both in normal subjects and in cases of moderate nephritis there is a chloride retention when large quantities of NaCl is given—i.e., only a small quantity of the extra salt appears in the urine, but in advanced cases of nephritis, there is a very marked impermeability of the kidney to sodium chloride; that during administration, the patient gains in weight, the œdema becomes more marked, the albumin increases and symptoms may develop resembling uræmia. From a therapeutic standpoint in cases of nephritis he suggests that common salt should be avoided as it causes not only water retention, but, by increasing the osmotic pressure of the blood, lessens perspiration, and the amount of water lost by respiration. Two grammes of sodium chloride are sufficient for the animal economy. Disappearance of œdema and general improvement in cases of nephritis have been noted on the following dietary; meat 400 grammes; potatoes, 1,000 grammes; sugar, 100 grammes; butter (unsalted), 80 grammes; fluids, 2,500 c.c. This diet contains only 1.5 grammes of chloride. The use of subcutaneous injections of salt is contra indicated as it may favour the development of uræmia. D.

Treatment of Attack in Spasmodic Asthma.—Morrison (*Lancet*, Dec. 1905) describes his treatment of the attack in spasmodic asthma as carried out frequently and always with success. The principle of the treatment is to aid the patient to empty the chest of

air. With one hand on the back and the other on the front of the chest, Morrison empties it at the end of each inspiration. After several manœuvres of this kind relief is given. Even in old people with stiffened chests he has found compression by one hand over the thorax and the other over the epigastrium, the lower ribs, or preferably over the right hypo-chondro-epigastric region, give relief from the thoracic anxiety attending the fixation of the chest, which is chiefly inspiratory. It is unnecessary to give any drugs. D.

Therapeutic Value of Lecithin.—Fritz Levy writes (*Berlin Klin. Woch.*, Sept., 25th, 1905, No. 39), on the medicinal uses of lecithin and of lecithin containing food stuffs. He points out that previous observers had noted an increase in red cells and in hæmoglobin when pure lecithin was administered, and then details the result of his own experience with lecithoyen, a lecithin-containing cocoa. Three or four teaspoonfuls of the powder were given daily, mixed with milk, to five patients, and the clinical results were accurately noted day by day. All of these patients were suffering from anæmia, and in all of them he observed a rapid increase in the number of red cells and in their hæmoglobin contents, and a corresponding increase in body weight. At the same time there was an increase in the output of urinary phosphates. From this he concludes that lecithin containing substances are absorbed as readily as pure lecithin, and are of equal therapeutic value. M.

Miliary Aneurysms of Stomach.—Hæmorrhage resulting from small miliary aneurysms in the gastric mucous membrane are very rare. Up to this only six cases have been recorded in the literature. Hirschfeld (*Berlin Klin. Woch.*, 1905, No. 22) now describes a seventh in a man, æt. 38. The patient first suffered from bleeding in 1883, and the hæmorrhage recurred thirteen times in the course of twenty years, the last proving fatal. At the autopsy all the organs, including the liver, appeared to be perfectly healthy, but close observation revealed the presence of multiple miliary aneurysms in the gastric mucous membrane, many of which were only to be detected by the aid of the microscope. It appears probable that many cases of obscure hæmatemesis may be due to this condition, especially in individuals of a hæmophilic tendency. M.

Carcinoma of the Thoracic Duct.—Schwedenberg (*Virchow's Archiv*, Bd., 181, H2) reviews the literature dealing with this subject and comes to the conclusion that carcinoma of the thoracic duct is not so rare as is generally believed. He himself met with twelve cases in the course of two years. In eleven of these the primary tumour was infradiaphragmatic and in the twelfth was mammary. In some of the cases the cross section of the duct was in part as thick as the little finger. Its lumen was sometimes obstructed, sometimes free, and frequently tumour cells were found in the midst of lymph [or blood coagula, in addition to forming part of the thickenings in the wall of the duct. The author believes that involvement of the duct arises from cells which become caught in coagula, and after organisation of these latter develop and invade the interior of the duct. Once the duct is attacked retrograde metastases can occur in the lungs and elsewhere. M.

Raw Meat Feeding in Tuberculosis.—Philip (*Lancet*, December 23rd, 1905), reports his experience in the treatment of tuberculosis by raw meat. The meat, he says, may be ordered in one of three ways—namely (1) as pounded raw meat; (2) as meat juice; (3) as raw meat soup prepared with milk. The clinical results that he claims are (1) Improvement in general

appearance and in muscular tones; (2) slowing of pulse with rise in blood tension; (3) rapid increase in hæmoglobin; (4) increase in weight; (5) lowering of a hitherto raised temperature; (6) general improvement in gastro-intestinal functions, and improvement in local lesions. These observations are the result of many years' experience, and they are confirmed by experimental investigations.

M.

Convulsions in Typhoid Fever.—Osler (*Practitioner*, Jan. 1906) discusses the occurrence of convulsions in typhoid fever. Murchison has pointed out the rarity of the phenomena, even in serious cases of the disease having met only with six cases out of a total of 2,960 typhoid patients. At the Johns Hopkins Hospital convulsions occurred in eight out of a total of between 1,500 and 1,600 cases. Osler groups these eight cases into three classes, according to the period of the disease at which the convulsions appeared. In the first class where the convulsions appeared at the onset of the disease there were two cases both of which ended favourably. In the second class the convulsion is a manifestation of the toxæmia and occurs during the course of the disease. Half of the cases belonged to this class and two of them eventually ended fatally. One of these patients admitted on the twenty-eighth day of the disease with an attack of great severity had on the next day five separate convulsive attacks after which, though there was no paralysis, there was marked rigidity and increased knee jerks. Eventually the rigidity almost completely disappeared and the patient was able to leave hospital but died at home about a week later. In the third class where the convulsion is the result of severe cerebral complications there were two cases both of which ended fatally. In one case the convulsions occurred at noon and the patient died some six hours later. *Post-mortem* examination showed thrombosis of the branches of the middle cerebral artery due to extensive arteritis. The other case was one of combined typhoid and tubercular infection, and at the *post-mortem* there were evidences of fresh tuberculous meningitis. Osler states that in the six cases of meningitis in his typhoid series only one had convulsions. In a few rare instances convulsions occur from unknown causes during convalescence. On the whole, considering the alarming nature of the complication the prognosis is not very grave.

K.

Xanthelasma and Chronic Jaundice.—Futcher (*Amer. Jour. Med. Sci.*, December, 1905) contributes a paper on this subject founded on the only three cases which occurred in the wards of the Johns Hopkins Hospital, during the first sixteen years of its existence, ending May, 1905, among 18,400 medical admissions, including a large number with chronic jaundice. The history of the three cases is briefly as follows:—1. Female, aged 30, gives a history of enteric fever about three and a half years before admission, during which she had cholecystitis. About thirteen months before admission she became jaundiced and the jaundice has persisted ever since. There had been severe pruritus. About eight months after the onset of the jaundice she noticed flat yellow patches appearing on the palms of the hands, elbows, axillæ, and sides of the neck. On admission there were numerous patches of various sizes, some of which were raised but the majority of which were flat. Later some small patches appeared over the upper and lower incisor teeth. The blood coagulation time was eight minutes and fifteen seconds, but after treatment with calcium chloride it became reduced to three minutes and fifty-five seconds. The patient was operated on and several gall-stones removed. Four years later the xanthomata had completely disappeared. Case II.—A female, aged 39 years, had persistent jaundice for eight years before admission, and two years ago had developed yellow patches on the palms of the hands and subsequently on other parts of the body. The liver was enlarged and the gall-bladder could be felt below the edge of the

ribs. In this case the blood coagulation time was fourteen minutes and under treatment was reduced to four minutes and fifty-three seconds. Patient refused operation and died a few days after leaving hospital. *Post-mortem* gall-stones and biliary hypertrophic cirrhosis of the liver were found. In this case there were numerous nodular xanthomata. Case III. Female, aged 42, had persistent jaundice for two and a half years before admission, during one and a half of which she had noticed yellowish patches developing below the eyes. Exploratory laparotomy was performed, but no gall-stones were found and a diagnosis of hypertrophic cirrhosis of the liver was made. In this case the xanthomata were confined to the eyelids. Dr. Williams made a careful histological examination of xanthomata excised from Cases I. and II., and came to the conclusion that they are of endothelial origin, thus differing from Crocker, who held that the primary factor was an inflammation and that the whole process was of toxæmic origin.

K.

Stokes-Adams Disease.—Stengel (*Amer. Jour. Med. Sci.*, Dec. 1905), reports a case which practically establishes the fact that experimental heart block and the phenomena of this disease are identical. He first reviews the experimental work which has been done to demonstrate the phenomena of heart block, and especially that of Erlanger. Erlanger, by a carefully devised experiment on the intact heart of dogs was able to compress the auriculoventricular bundle of His and thus produce heart block, and he had suggested that the phenomena of the Stokes-Adams disease might probably be due to the involvement of His' bundle by a patch of sclerotic endocarditis beginning on the anterior mitral leaflet at its base and aortic border and extending to the interventricular septum where the bundle of His passes upward toward the ventricle. Stengel's patient was a man aged fifty-seven years, who two and a half years ago, while at work suddenly fell backwards and became unconscious for a few moments. Three months later he had a similar attack and then others in more rapid succession. He gave up working about five months before admission to hospital when the attacks had become very frequent. On admission the pulse rate was 36 and there was a loud systolic murmur in the mitral area in which region a systolic thrill could also be felt. The attacks now became much more frequent and during one the pulse stopped for two minutes and ten seconds. During the last few days of life a condition of complete heart block appeared to be present, the auricular and ventricular pulsations being entirely independent. On *post-mortem* examination a general arteriosclerosis was found. The heart was hypertrophied but the muscle normal in appearance except where an endocardial lesion affected a small area at the upper part of the interventricular septum. The chief lesion of importance was one on the anterior mitral leaflet, toward its base and aortic edge. This patch was of atheromatous character, sclerotic and white and it extended to the endocardium exactly over the bundle of His where this band passes from the ventricle to the auricle.

K.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "Recent Medical Literature."
- (2) "Recent Surgical Literature."
- (3) "Recent Gynæcological and Obstetrical Literature."
- (4) "The Recent Literature of Anatomy, Physiology, and Pathology."

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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. HY. M.—Unfortunately for you the early admission you made to the patient gives him a suggestive hold of you; if he is determined to prosecute his claim we advise you to compromise the matter, as the law costs would be heavy, even were you to gain your case.

DR. S. E. T.—There are already so many duties the profession is called on to perform gratuitously, or for next to nothing, that we can hardly agree with your suggestion to make another ailment notifiable.

EDINBURGH STUDENT.—The work referred to is the most reliable, and at the same time the pleasantest to read on the subject with which we are acquainted.

DR. A. W.—Next week if possible.

L. L. ALEXANDER.—The volume of medical journalistic literature upon the subject is enormous, but the pith of it would not be hard to compress within a short paper, say, of 1,000 words. Although the discovery was first announced only within a year it has been the object of almost universal investigation. There is plenty of room, however, for independent work, if original and skilled.

WISE AND OTHERWISE.

At a recent meeting of physicians, an American contemporary informs us, one speaker remarked that "the rage for parcelling out the human frame into special territories is passing all bounds. We have specialists for the nose, the throat, the ear, the lungs, the heart, the genito-urinary organs, the rectum, the mouth, the brain, &c. It seems to me, gentlemen, that it will not be long ere the specialists, like Alexander, will have to sigh for new regions to overcome. So far as I can see, the umbilicus is about the only portion of the human body not allotted to a specialist."

Whereupon a veteran practitioner exclaimed: "Doctor, you're forgetting the naval surgeons."

KARL STROMMEYER.—It would be simpler to enter one of the London medical schools, unless you care for one of the provincial universities. In some of these an arts degree is compulsory, and means a longer period of residence.

C. F. (Earl's Court).—If you want to find out the present position of the hospital you mention you had better write to the Secretary of the Hospital Saturday Fund, which we understand is now engaged in making a special inquiry. It will be well carefully to disassociate past scandals from present conditions, which the committee claim to have set straight absolutely from one end to the other.

DR. R. J. L.—Your letter is unavoidably crowded out of our present issue.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JANUARY 31st.

SOCIETY OF ARTS (John Street, Adelphi, W.C.).—8 p.m. Paper:—Mr. T. Adams: The Garden City and the Cheap Cottage.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20 Hanover Square, W.).—5 p.m. Papers:—Dr. A. Morrison: The Present Position of the Treatment of Cardiac Disease by Baths and Exercise. (If time permits) Dr. Braithwaite (Buxton): Cases treated at the Devonshire Hospital by the Buxton Waters.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. F. L. Daniel: Clinical (Surgical). 5.15 p.m. Lecture:—Dr. P. Stewart: Disorders of Articulation.

THURSDAY, FEBRUARY 1st.

NEUROLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8.15 p.m. Annual General Meeting. Election of Officers. 8.30 p.m. Paper:—Mr. W. Bateson: Mendelian Heredity and Its Application to Man.

NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital, N.).—4 p.m. Dr. A. J. Whiting and Dr. G. Basil Price: Clinical and Pathological Demonstration (illustrated by lantern slides).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinicque. (Surgical.) 5.15 p.m. Lecture:—Mr. A. H. Tubby: Surgical Diseases of Children.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—8 p.m. Dr. M. Dockrell: Syphilis: I, History and Primary Invasion (Constitutional and Local). (Chesterfield Lecture).

FRIDAY, FEBRUARY 2nd.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. A. Lawson: Clinicque. (Eye.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Dr. G. N. Meachen: Acne and Its Treatment.

THURSDAY, FEBRUARY 8th.

BRITISH GYNÆCOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Dr. Jellet: I, Advanced Carcinoma of both Ovaries; II, Double Pyosalpinx associated with the presence of a Four Months' Extra Uterine Fœtus. Dr. Bedford Fenwick: Two Cases of Fibroid Complicated by Pregnancy. Dr. H. Macnaughton Jones: A Note on Cryst. of the Vagina. Paper by Dr. Jellet: Notes on two rare conditions met with in the Pelvis during Operation. The President's Inaugural Address.

Vacancies.

Beckett Hospital, Barnsley.—House Surgeon. Salary £100 per annum and all found. Applications to R. Pawser, Hon. Sec., 8 Regent Street, Barnsley.

Bradford Poor Law Union.—Resident Assistant Medical Officer. Salary £100 per annum with rations, apartments, and washing. Applications to George M. Crowther, Clerk to the Guardians, Union Offices, 22 Manor Row, Bradford.

Burton-on-Trent Infirmary.—House Surgeon. Salary £120 per annum, together with furnished rooms, board, coal, and light, free. Applications to the Hon. Secretary, Mr. John Wood, the Infirmary, Burton-on-Trent.

Cheltenham General Hospital.—Surgeon-in-Charge of the Branch Dispensary. Salary £90 per annum, with board and lodging at the General Hospital. Applications to W. H. Head, Secretary.

Kent and Canterbury Hospital.—House Physician. Salary £90 a year, with board and lodging. Applications to the Secretary.

Kent and Canterbury Hospital.—House Surgeon. Salary £90 a year, with board and lodging. Applications to the Secretary.

Leeds General Infirmary.—Resident Medical Officer. Salary £100 per annum, with board, residence, and washing. Applications to the Secretary to the Faculty at the Infirmary.

Royal Sea Bathing Hospital, Margate. Resident Surgeon. Salary £120 per annum, with board and residence. Applications to the Secretary, R.S.B.H. Offices, 13, Charing Cross, London.

Sierra Leone.—Princess Christian Hospital, Freetown, West Africa.—Medical Officer. Salary £250 a year and rooms. Applications to Rev. Arthur Sinker, 136 Southwark Park Road, S.E.

St Mary's Hospital Medical School, Paddington, W.—Lecturer on Physica. Salary £100 per annum. Applications to H. A. Caley, M.D., F.R.C.P., Dean.

Appointments.

BALL, J. BRAMLEY, L.D.S.R.C.S.Eng., Dental Surgeon to the Royal Hospital School, Greenwich, S.E.

COX, FRANKLIN, M.R.C.S., L.R.C.P.Lond., District Medical Officer for the Clutton Union.

DOBSON, MARGARET B., M.D.Lond., Pathologist to the West Riding Asylum, Wakefield.

FITZWILLIAMS, DUNCAN C. L., M.D., Ch.B., F.R.C.S.Edin, Casualty Officer to the Hospital for Sick Children, Great Ormond Street.

GARRATT, G. C., M.D.Cantab., Certifying Surgeon under the Factory and Workshop Act for the Singleton District of the county of Sussex.

HARRIS, HERBERT, M.D.Edin., Honorary Medical Officer to the Rochdale Infirmary.

LAVAL, EVARISTE, M.B.Edin. Assistant Medical Officer to the Warneford Mental Asylum, Oxford.

LYSTER, ROBERT ARTHUR, M.B., Ch.B.Lond., D.P.H., B.Sc. in Public Health, Assistant County Medical Officer of Health to the West Riding County Council.

MILLER, JAMES WEBSTER, M.B., Ch.B.Aberd., Assistant Medical Officer at the Dorset County Asylum.

MONTGOMERIE, HUGH MAYER, M.D., O.M.Edin., Physician to the West Cornwall Infirmary, Penzance.

MONTGOMERY, JAMES BARCLAY, M.D.Glasg., F.R.C.P.Lond., M.R.C.S., Honorary Physician to the West Cornwall Infirmary, Penzance.

POLLOCK, W. B. INGLIS, M.D.Glasg., Pathologist and Bacteriologist to the Glasgow Eye Infirmary.

SUTCLIFFE, AMELIA, M.B., Ch.B.Edin., Clinical Assistant to the Southern Branch of the Leeds Public Dispensary.

Births.

FITZGERALD.—On Jan. 24th, at Chatham Down, near Canterbury, the wife of G. C. FitzGerald, Esq., M.D., of a daughter.

GAITSKELL.—On Jan. 23rd, at Burgess Hill, Sussex, the wife of H. Ashley Gaitskell, Esq., M.D., of a son.

HARVEY.—On Jan. 24th, at Clarence Villa, Hartfield Road, Wimbledon, the wife of Joseph Harvey, M.B., of a daughter.

Marriages.

FINCH-SMITH.—On Dec. 13th, at Boree Cabonne, Sidney, youngest son of the late Dr. Robert Finch, of Blackheath, London, to Mary Maud, second daughter of Lancelot Noel Smith, of Boree Cabonne, New South Wales.

LINTON-ROBBS.—On Jan. 27th, at St. Stephen's Church, Dalwick Denys Linton, eldest son of the late Right Revd. Sydney Linton D.D., Bishop of Riverina, N.S.W., to Annie Louise (Nancy) youngest daughter of the late Charles Henry Denny Robbs, M.B., of Grantham.

Deaths.

CAHILL.—On Jan. 24th, at 9 Edith Villas, West Kensington, London Elizabeth (Beasle), second daughter of the late Thomas Cahill, M.D.

HAWKES.—On Jan. 22nd, at 4 West Cliff Road, Ramsgate, suddenly, of aneurism, Edward John Hawkes, L.R.C.S., L.R.C.P.Edin., in his 63rd year.

LEDGARD.—On Jan. 23rd, at Kirkby Lonsdale, William Edward Ledgard, L.R.C.P.Edin., M.R.C.S.Eng., elder son of the late J. A. Ledgard, Surgeon, Wetherby, aged 59 years.

WAUGH.—On Jan. 25th, at Conger House, Teddington, Bedfordshire, Lily Lavinia, wife of J. Waugh, M.D., J.P., aged 45 years.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, FEBRUARY 7, 1906.

No. 6.

NOTES AND COMMENTS.

The Doctor's Boy.

TIME was when "the doctor's boy" was a familiar figure in social life. Clad in a neat page's uniform, and resplendent with many buttons, he went his rounds, leaving at the houses of his master's patients physic which he unearthed from the depths of a double-flapped wicker basket. Even now, in the year 1906, it appears he has not finally retired from the scene. At a London police court last week a medical man was fined for keeping a male servant without a licence. In vain he pleaded that a doctor's boy who carried medicine and ran errands was no less necessary than the untaxed oilman's boy who delivered bundles of wood. Notwithstanding this defence, which, by the way, presents in tabloid form the commercial side of the practitioner's life the magistrate upheld the view of the opposite side, namely, that a boy who cleaned boots and windows, polished the big handle of the front door and so on, was a page in the eye of the law. This decision means, therefore, that medical men may be in future called upon to pay duty upon a boy employed by them mainly in a domestic capacity, and incidentally only in the delivery of medicines.

A Liverpool Skin Specialist—so-called.

SOME day the public will wake up to the farce that is being played at their expense by the legislature in the matter of the Medical Acts. The depths of infamy have surely been sounded by a Liverpool quack, whose proceedings were recently brought under the notice of a coroner's jury. It appears that the deceased woman was suffering from a "highly septic" inflammatory skin affection, for which she was attended by a medical man. Upon her improvement, however, he was told his services were no longer needed, and that a "skin specialist" was going to look after her. The person thus imported was an unqualified man, named Wolfender. His remedies seemed to have consisted of lard, olive oil, beeswax, and so on, but lacking the necessary antiseptics. Under these circumstances the septic condition returned in full force, and the unfortunate woman died. The Coroner censured Wolfender, and told him that he had brought himself "very near" a criminal prosecution. It is not easy to see how such notorious quackery could escape criminal prosecution, even with the machinery of our feeble and antiquated Medical Acts. The attention of the Liverpool police and of the Public Prosecutor may well be called to this case. The crucial point is whether

the death would have occurred under proper—i.e., duly qualified and recognised—medical treatment. A negative answer spells manslaughter.

Medicine as a Great Electoral Power.

THE analytical faculty of the Conservative party has been sorely taxed in the effort to lay bare the ultimate causes of their recent defeat at the polls. A hundred reasons, plausible and otherwise, have been advanced, laying the blame upon this, that or the other person or circumstance. It was left for a daring writer in the *Morning Post*, however, to draw up a formal indictment of the medical profession. One cause of his own defeat, he asserts, was the refusal to answer hundreds of questions "cunningly arranged to commit the answerer." "Though I saw a deputation on the subject of the British Medical Association," he writes, "and we agreed on all important points, one doctor refused to vote for me, though he sympathised in general party politics, because I still refused to sign a promise to vote as the string of questions demanded." According to this authority, then, the medical profession had a considerable finger in the recent election pie, whereas the professional journals have been singing jeremiads a generation over our wasted political opportunities. The two other reasons given by this defeated candidate were Chinese labour and the Post Office Vote. Medicine ran third.

The Union of the London Medical Societies.

THE Committee of Representatives responsible for the Society amalgamation propose to admit two grades of members. "Fellows" are to be admitted at a subscription of three guineas annually, and "Members" of a particular section at one guinea. We cannot say that we altogether approve of such an arrangement. The, to us, fundamental principle of an "Academy," or whatever the new Society is to be termed, is that every one joining it joins the entire organisation, and not one or other section. If two scales of fees are necessary by all means adopt them, but let each scale ensure full membership so far as the right to attend all sections is concerned. The one scale can carry with it the "Fellowship," the other "Membership," and distinctions can be made as to the use of libraries and reading-rooms, and to the receipt of the Society's Transactions. The scale of fees also appears to us to be wrong. Two guineas should carry with it the Fellowship and all rights, and by so fixing it the funds would not suffer since many men who under the present arrangement can join one Section for a guinea would gladly become Fellows if the privilege simply cost an extra guinea. Further, the Society cannot expect a great influx of country Fellows at three guineas, since that is too high a scale for

privileges that perhaps would be exercised only once or twice in the year. The Committee of Representatives would be well advised to add to their present proposals one for the admission to the Fellowship of men residing, say, one hundred miles from London at an annual subscription of one guinea.

LEADING ARTICLE.

THE STATE AND INEBRIETY.

It is claimed in all the Liberal newspapers and magazines that an era of social reform, the like of which has never been known, is about to dawn on the country. We hope with all sincerity that this is so. Both political parties in the past, partly through limitation of opportunity, partly—and principally—through lack of a sufficiently strong force of public opinion behind them, have touched social reforms only with tongs. But little party capital, it was felt, was to be made out of "parish pump politics," and most people had widely different ideas both as to what to do and how to do it. Every country gets the Government it deserves, and, if the great and pressing social reforms that are needed have been held in abeyance too long, the delay must be put at the door of the payer who called the tune rather than of the piper who did not play. But if the new Government is really agog with eagerness to be up and doing in the cause of the welfare of the people, we can point to a dozen hygienic and social problems that they may take in hand with the full and complete approval of the profession. At the moment there is one to which we would especially like to call attention. We mean the reform of inebriate legislation. The Acts relating to the restraints that should be placed on chronic drunkards are lamentably defective both as to scope and powers, and though there is little or nothing to repeal there is a vast deal to be done in the way of extension and consolidation. The modest little Act which the late Lord Ritchie guided so skilfully through Parliament is simply an instalment of a wider and more far-reaching measure designed to abolish, or at any rate materially to lessen, the scandal of inveterate drunkenness with all its tales of misery and degradation. It is thoroughly recognised by the medical profession that the chronic drinker is far more than a ne'er-do-weel; he is as great an enemy to himself as to his fellows, and he is incapable, after a certain stage, of reforming his habits. In fact, his complaint is one of the mind, and should be dealt with as such. In speaking of the drunkard as "he" we do not lose sight of the fact that in the even sadder and more hopeless cases the victim is a woman. If a vote were taken among practitioners as to which class of patient they found themselves most powerless to help, we fancy it would be pretty generally given for the female inebriate. Degrading and demoralising as is a drunken husband, it is impossible to compute a tithe of the evil wrought by a drunken wife and mother, and, as the law stands, while either the one or the other fails

to make frequent public exhibitions of their vice in the streets, no relative or official can do more than use moral suasion to induce them to put themselves under medical treatment or restraint. If legislators would clearly understand that the disease is of the mind, they would not hesitate to consent to treat such patients as the other classes of mentally diseased persons are treated at the present day, namely, by compulsory detention in properly organised establishments under public control and Government inspection. As it is, they fear to trench on the sacred principle of individual liberty. It is, then, much to be desired that a Royal Commission should be appointed at an early date to gather evidence and recommend legislation. The feeling in Scotland on the subject is already running high, and the municipalities of the leading towns have now before them the draft of a Bill which it is proposed to promote in Parliament with a view to giving extended public control over inebriates. In this Bill, among other things, it is provided that a near relative of the drunkard may, with the consent of two magistrates, call upon a Sheriff to institute a public trial before a jury of the party complained of, and if the jury find the accused to be an habitual drunkard, and by reason of his habits and conduct a fit and proper person for treatment in an inebriate reformatory, the Sheriff may sentence him to a term of detention not exceeding three years in duration. It is surely obvious that a Bill making such a decided inroad into personal freedom has not the slightest chance of passing into law except as a Government measure, and the procedure recommended is open to the gravest criticism. The publicity of the process as proposed would act as such a deterrent with relatives, especially of the well-to-do classes, as would make the Act a dead letter. Moreover, there would be opened up channels for persecution and blackmail which should not be possible. A Royal Commission could take all circumstances and factors into account and produce a report on which official action would be based, and based authoritatively. Such a Commission would probably find the method least open to objection would be one fashioned on the analogy of the lunacy proceedings, namely, either by medical certificate and magistrates' order, or by inquisition as in the case of Chancery lunatics. The latter, if the expense could be rigidly cut down, would present many advantages, especially in the case of drunkards with important responsibilities or property. Legislation on temperance questions is generally strongly opposed by "the trade," but the licensed victuallers recognise the inebriate as their own enemy as well as that of society, and more than one leading member of the trade has spoken approvingly of the principle of the Scotch Bill already mentioned. We believe that the House of Commons would present no difficulties to the passage of a well-thought-out and authoritative scheme, and such a measure would be one by which the Government of the day would gain credit and gratitude on every hand.

NOTES ON CURRENT TOPICS.

The Election of Direct Representative for Ireland on the General Medical Council.

THE result of the election of the Direct Representative for Ireland will probably come as a surprise to many members of the Profession, although perhaps those who knew most were inclined to think that the voting would be very close. That their opinion was correct, the result has shown, for never in the history of these elections has the majority of the successful candidate been so small. To the victor go the spoils, and therefore we desire first to offer our sympathy to the defeated candidate. Sir William Thomson during his period of office has discharged his duty in a thoroughly capable manner, and with the knowledge that he has done so, and that his defeat is due to the not unnatural desire for a provincial representative, will, we trust, remove from his own mind any sense of the bitterness of defeat, just as it tells his medical brethren that his defeat was due to no other cause than the revolution of the hands of the clock of time. The tendency of the time showed that sooner or later a provincial candidate was bound to come forward who would receive the confidence of the majority of his medical brethren. To the victor we offer our congratulations. Dr. Leonard Kidd has had a hard and uphill fight, and has fought it in an honourable and straightforward manner. Should he in future be as *suaviter et sagaciter in modo* as he has proved himself *fortiter in re*, his success as a direct representative of the medical profession is assured. On one point we desire to congratulate the entire profession in Ireland. Despite many efforts by lay organs and individuals, no trace of sectarian or political venom has been allowed to mingle with the desire that the most suitable man should be found to represent the profession. We are confident that Dr. Leonard Kidd will not in his official capacity be influenced a hair's breadth by such prejudices, and we also believe that should a medical man of different creed or political faith come forward on a subsequent occasion, who is as suitable a candidate as were those at the present election, he will receive the same whole-hearted support from all sections of the medical profession, provided that his appeal to them is based on his professional attainments and reputation and on those alone.

Instruction in Temperance.

THERE is no doubt that some good may be done in the direction of temperance reform by proper instruction given to the young. It is, however, a matter of considerable difficulty to choose the best form in which to administer such instruction. On the one hand, a child pays but little attention to mere statement of facts unless it can be made interesting, and on the other if any extravagance be used he is likely, on reaching what has been wittily called "years of indiscretion," to discard too much of his early training. While

medical men are, perhaps, not the best fitted to give sensational lectures on such subjects as temperance, they are above all others fitted to give sound and sane advice on the physical aspects of the question. The plan has, therefore, been adopted in some places of inviting medical men to give short lectures on temperance in primary schools, and we believe that teachers generally have regarded the results as successful. Some two years ago, a number of lectures of this sort were delivered in Dublin schools with great success, and we understand that this spring it has been arranged that lectures on temperance shall be delivered by medical men in practically all the parish schools of Dublin and the suburbs. The organizer of the scheme, the Rev. Principal Moore, has had no difficulty in obtaining the co-operation of many well-known physicians, most of them members of hospital staffs, and we have no doubt their efforts will have a good effect.

Sleep at Schools.

WHEN Canon Lyttelton was appointed headmaster of Eton various stories were set about of his peculiar notions about boys' dress and habits and of the changes he intended to introduce into Eton, the home of authority and tradition in all that pertains to high-class education. The fact was that Canon Lyttelton, among prominent classical schoolmasters, was the one who perhaps best realised what modern hygiene had to teach with regard to the development of the young, and we welcomed his appointment particularly on the ground that if he could introduce his ideas into Eton their influence might spread through the public school system. So far we have not heard of any startling revelations, but one change has just been made which will probably be resented as a curtailment of Eton privileges but which may also be regarded as a bold and wise step. Impressed by the force of the contentions lately raised as to the length of sleep given to boys at public schools, Canon Lyttelton has fixed the bed-time of the lower school at half-past nine instead of ten, and of the upper school at ten instead of half-past, so that all boys will get an extra half-hour in bed. Whatever the lads themselves think, their parents should be very grateful to a headmaster who puts himself on the side of common sense and sound hygiene.

Work for Consumptives.

ONE of the many difficult problems in connection with tuberculosis is the provision of suitable work for consumptive patients. Too often it happens that a patient, improved and educated by sanatorium treatment, has to return to surroundings the worst possible of the kind for his condition of health. It is obvious that country life, or, at any rate, open air work is the best suited to improve his health, but we can hardly hope to find country or open air employment for the thousands of town tradesmen, to speak of no other class, who suffer from tubercle.

A city-bred subject, whether in good or bad health, is not likely to content himself with country life, even were it possible to find work of which he would be capable. An additional difficulty is that employers nowadays have a very marked dread of receiving into their houses, offices, or places of business a person infected with tubercle. The public has, indeed, become firmly convinced of the infectivity of tubercle, and it rushes to the extreme of regarding every unfortunate consumptive as plague-stricken. It is the duty of medical men to make clear that a consumptive patient, instructed in hygienic measures and careful to carry them out, is in no way a danger to the community. In papers on the whole subject in the January number of *Tuberculosis*, by Drs. Jane Walker and W. J. Fanning, the suggestion is made that in every large town there should be a central bureau charged with the duty of finding employment for consumptives, particularly those recently discharged from sanatoria. An organisation of this sort would attract to it offers from well-disposed private individuals, and would doubtless be a great boon to a very unfortunate class.

'A Ladies' Health Society.

THE ladies of Manchester have set, in the formation and working of their Ladies' Health Society, an example which might well be followed in other towns. The Society is entirely voluntary, and it maintains, aided by the Corporations of Manchester and Salford, a large number of health visitors who, under the direction of the medical officers of health of the two cities, spend their time in visiting the dwellings in their districts. They endeavour, by persuasion and advice, to bring home to the women of the working classes the value of cleanliness, fresh air, and wholesome food. Particular attention is given to young mothers and their babies, and, when artificial feeding is absolutely necessary, advice is given as to the most suitable forms of food. Though the intention of the Society is not eleemosynary, yet in some cases it has been found advisable to give aid in money or in kind. For instance, it has sometimes happened that a mother, herself on very inadequate diet, is found nursing a child. Instead of giving artificial food to the child the visitor has provided the mother with some addition to her own diet, such as a given quantity of milk, the result to mother and child being excellent. In cases of deficient sanitation or other grave fault, the visitor, in case suasion fails, has power to invoke the aid of the public health department.

Lincoln Epidemic Compensation.

WE commented in these columns some time ago on the fact that a large number of actions for damages were being prepared against the Lincoln City Council in relation to the late typhoid epidemic. That epidemic, our readers will

remember, was due to the systematic neglect of medical warning and advice which had been given year after year. The outbreak was extensive and the provision of hospitals, medical relief, and a pure water service involved the town in large expenditure. On top of all this came the threat of actions for damages to be brought by the actual sufferers. Had these actions been persisted in, and proved successful, the rates of the city would have risen to such a crushing figure that the prosperity of the town would have been gravely compromised. At the same time, it would have been well from a public standpoint had it been possible to demonstrate conclusively that a negligent sanitary authority was liable for the results of their negligence, as it would have brought home a sense of civic responsibility to those councillors who regard their seats on municipal bodies as positions of privilege, or as opportunities for advancement, rather than as trusts committed to their keeping by their fellow citizens. We learn, however, that the Lincoln Council have decided not to face the music, and have decided to award compensation on a scale which involves them in a nett cost of £4,000. This may be well for the ratepayers, and may be considered by them a lucky let-off, but a fight to the finish would have had a larger public value. The citizens themselves could not have been altogether cleared of responsibility for contributory negligence in that they continued to elect representatives who were determined not to alter the old water-supply arrangements, and the terrible results of this wilful stupidity could not have been made known too widely among the inhabitants of other towns.

Medical Men in the New Parliament.

IT is interesting to note the occupations represented in the newly-elected House of Commons. Heading the list we find 105 barristers, as against the next numerous class, that of journalists, who number 36. If to the barristers we add 34 solicitors, we have the proportionate figure of 139 representatives of the legal profession. Hitherto the great influence of the legal element in the Commons has not made itself felt either in the clearness of legislative Acts or in the urgently needed codification and simplifying of law. Possibly under the influence of the new democracy, the lawyers will exercise their powers more freely in the interests of the nation. There are 54 Labour M.P.'s, who should have something to say on the question of law reform. There are four brewers and four distillers, a much smaller number than that usually present in the House, and one that may possibly augur well for temperance legislation in the near future. Of medical men there are ten, a number totally out of proportion to the enormous influence wielded by their profession upon the social, the moral, and the scientific enlightenment and advance of the community. It is difficult to see how our professional representation can be increased, seeing that most of its members lead busy lives and are not, as a rule, possessed of

independent incomes. The scheme whereby the British Medical Association hopes to return professional representatives to Parliament appears to be futile, if only on the ground of the impossibility of reconciling party differences. A Conservative practitioner, for instance, could hardly be expected to vote for an advanced Liberal, or *vice versa*, simply in order to increase the weight of the medical profession in the legislature. That sacrifice of individual principles, however, is asked for by the Association.

A British Dumping Ground for American Quacks.

FOR years past the United Kingdom has been exploited by American quacks. By availing themselves of the simple commercial method known as "dumping" they compete boldly with our own extensive knot of producers, vendors, and proprietors of sham remedies. The American quack simply places on foreign markets the overplus of the particular fraud he is engaged in manufacturing. Unfortunately, on this side of the Atlantic we Britishers have no effective law against the sale of secret or quack nostrums, no matter how flagrant their pretences or how heartless their fraudulent practices. Judging from the signs of the times, the evil of this unwholesome alien competition is likely to increase rather than to lessen in the near future, for in America the more enlightened portion of the community appears to be getting somewhat out of patience with the methods of quackery. Not long ago, President Roosevelt directed the prosecution of some quack proprietors for obtaining money under false pretences. Now we hear of a medical society prosecuting a man named Hilgut for practising as a doctor without a licence. His plan was simple. He sold to credulous customers "magic boots," which he guaranteed to cure paralysis, locomotor ataxy, neurasthenia, heart disease, sciatica, tic douloureux, St. Vitus dance, and many other maladies. It is said that Mr. C. W. Schwab paid £1,000 for a pair of these precious appliances, and Bishop Potter £300. The "magic" is held to be a pinch of white pepper in the soles of the boots. Fantastic and foolish as this story may seem, it is not a whit less ridiculous than the claims of the "rheumatic ring," which has an enormous sale in the United Kingdom for the cure of rheumatism. American law, however, can punish quacks effectively, whereas British law cannot.

Sanitation in the Isle of Wight.

ONE is accustomed to look on certain South Coast spots specially favoured by nature as ideal resorts for regaining health and passing happy holidays. From time to time the ruthless inspectors of the Local Government Board shatter these ideals by publishing reports in which the sanitary circumstances and administration of these enticing resorts are shown to be far from conducive to either health or enjoyment. Several instances will occur to each reader in which this iconoclastic process has been brought to bear. As a result of complaints,

the Local Government Board, which has repeatedly drawn the attention of the Rural Council of the Isle of Wight to the want of proper sanitary inspection, sent Dr. Timbrell Bulstrode to report in detail. The island was thoroughly explored by this gentleman from a sanitary point of view, and after full inquiry and investigation he has furnished the Board with a report, saying that in his opinion the present system is bad and that no improvement can be looked for till the machinery is completely overhauled. One of the complaints he makes is that the duties of Inspectors of Nuisances and of Highway Surveyors are discharged by the same person in many instances, with the result that both functions are not performed as they should be. He urges that disinfecting apparatus, proper arrangements with regard to infectious diseases, and other reforms should be instituted, and that the Board should not sanction financial aid to the Rural Council till modern requirements are satisfied. It remains with the Isle of Wight to clear its character as a health resort by seeing that these changes are made at an early date.

PERSONAL.

ON February 1st, news was cabled from the Cape that Dr. Anson Donaldson, of Brockville, Canada, had been shot down by German soldiers at Swakopmund. As a matter of fact, Dr. Donaldson sailed from Liverpool last week as Surgeon on the Elder-Dempster steamer *Papele* for West Africa.

MR. A. T. COOKE has tendered his resignation of the post of Surgeon to the Stroud General Hospital after more than forty years' service. He was the first house surgeon to the Institution.

A HANDSOME presentation has been recently made to the Hon. William Thomas Prout, C.M.B., M.B. Edin., Principal Medical Officer in Sierra Leone, by fellow officials on the occasion of his recent decoration with the companionship of the order of St. Michael and St. George.

THE first of an important series of lectures upon food and nutrition was delivered by Dr. William Stirling, Fullerian Professor of Physiology, at the Royal Institution, London, on the 5th instant.

THE sum of £100 has been left to the Medical Society of London, by the will of the late Mrs. Gant, the widow of a former president.

THE Basingstoke Cottage Hospital receives £1,000 under the will of the late Sir Wyndham Spencer Portal.

VACANCIES on the Council of the Royal College of Physicians of London have been filled up by the appointment of Dr. William Osler, Dr. H. R. Crocker, Dr. H. H. Tooth, and Dr. T. D. Acland.

THE late Mr. Capper Pass, of Bristol, bequeathed £1,000 to the Bristol General Hospital, and £2,000 more conditional upon his son attaining his majority.

UNDER the presidency of Mr. L. A. Bidwell, the annual dinner of the West London Medico-Chirurgical Society takes place at the Grand Central Hotel, on the 7th instant (date of present issue).

PROFESSOR EBSTEIN, of Göttingen, who is seventy years of age, is resigning the directorship of the University Clinic and Polyclinic.

MR. A. H. TUBBY will deliver the Hunterian Oration at Pagani's Restaurant, London, W., on February 14th, at 6.30 p.m., on "The Treatment of Certain Forms of Paralysis."

MR. J. C. HUDSON will read a paper on "American Schools and their Relation to the Child and Society," before the British Child Study Association, at the Parkes Museum, London, on the 8th instant, at 8 p.m.

PROFESSOR W. KEERTE, of Berlin, will preside at the Thirty-fifth German Surgical Congress to be held at Berlin, April 4th to 7th.

A CLINICAL LECTURE

ON

SYPHILITIC PSEUDO-GENERAL PARALYSIS.

Delivered at the Adelaide Hospital, Dublin.

By HENRY T. BEWLEY, M.D. Dub., F.R.C.P.I.,

Physician to the Hospital; Lecturer on Forensic Medicine and Hygiene, Trinity College, Dublin.

SYPHILIS affects the central nervous system in a variety of ways. The connection between the syphilitic poison and the nervous lesion may be direct, as when gummata form, or when syphilitic end-arteritis occurs; or the connection may be indirect, as when the syphilitic poison lowers the vitality of the nervous structures so that they become liable to certain forms of degeneration, such as occur in tabes, and in general paralysis. You must, however, always remember that in some cases of tabes and of general paralysis no antecedent syphilis is demonstrable; so that we are not in a position to say in all cases of these diseases that even an indirect connection with syphilis exists.

The cases which I wish to bring under your notice belong to the first group; the lesions are part of the tertiary stage of syphilis; and they are directly amenable to specific treatment—a feature which markedly distinguishes them from the diseases belonging to the second group—the so-called parasymphilitic diseases.

But if the effects of treatment sometimes help us to distinguish between diseases belonging to one or other of these groups, yet there is not the same degree of difference between their symptoms; we may be for a while in doubt as to the category a certain case belongs.

The direct effects of syphilis on the central nervous system may be divided into four groups: (1) symptoms (hemiplegia, aphasia); (2) focal lesions (gummata) arising from vascular occlusion due to end-arteritis of the cortex and cortical membranes; (3) gummatous meningitis of the base of the brain; (4) diffuse and wide-spread arterial and meningeal lesions. The cases which I am showing you belong to this last group. They present both mental and motor symptoms, and they belong to a group of cases which often present symptoms which closely simulate those of general paralysis of the insane. But there is a very real difference between general paralysis and the disease which I am about to describe, to which the names of pseudo-general paralysis or syphilitic dementia have been given.

The history of the first case is as follows: Some years ago this young man, who now is *æt.* 30, contracted syphilis. He was treated and appeared perfectly well till June, 1904, when he one day fell unaccountably while playing at a school fête; he said he felt as if his foot suddenly refused to obey his will. In July, 1904, he awoke one morning seeing double, and this trouble continued for four days. In October, 1904, he became sleepless and began to suffer from neuralgic pains in his head.

In January, 1905, he consulted Dr. James Little, complaining of general weakness and want of energy. On February 14th, he awoke feeling as if his face, arm, and leg on the left side were asleep; when he got up he found he could not walk properly, on account of weakness of the left leg; and soon afterwards he fell while walking across his room. The weakness increased, and extended to his right arm and leg. His speech became affected, and his utterance slow and hesitating. He became unable to stand, and was admitted into hospital on March 13th, 1905, under the care of Dr. Little, and subsequently I took charge of the case.

When admitted to hospital he was unable to stand alone; his legs were both weak and the deep reflexes greatly exaggerated. His mind had become enfeebled, and his memory exceedingly defective, so that if he tried to read he was unable to grasp the meaning of the

passage. His articulation was indistinct and confused. When asked a question he would pause a considerable time before answering and then the words were slurred and indistinct, and he had much difficulty in forming even simple sentences. He occasionally complained of headache. There was a certain expressionless appearance in his face. His tongue protruded to the right. His pupils and retinae were normal, but there was a defect in the conjugate lateral movements of the eyeballs. His grasp was very feeble with both hands. His urine was passed involuntarily every three or four hours, and he had very defective control over his rectum. His thoracic and abdominal organs were normal, except that his heart's action was feeble.

Here, then, we had a case of disease of the central nervous system so wide-spread in extent that almost all parts were affected from the intellectual centres in the brain down to the centres which preside over the bladder and rectum, which are situated in the lumbar enlargement of the cord. When I first saw the case I was inclined to think the disease might be general paralysis, but the progress of the case showed that Dr. Little's diagnosis of diffuse syphilitic vascular disease of the central nervous system was correct. The patient was subjected to a course of mercurial inunctions, and subsequently was treated with iodide of potassium in doses increasing from 15 grains three times a day to 45 grains three times a day.

He, under this treatment, steadily improved. By July his mental powers had greatly improved, so that he was able to read a book and to remember quite well what he read. His speech was slow; there was slight slurring, and he spoke with great deliberation. His power of grasping was approximately normal. He could walk with the aid of two sticks; ankle-clonus and exaggerated knee jerks were present. Still he had trouble with his urine; every three or four hours the bladder would suddenly empty itself with a force which he could not restrain. The control of his rectum was also defective. In this state he left hospital and has since lived either in a suburb of Dublin or in the country.

As you now see him (December, 1905) he is vastly improved. His memory is quite good. His speech is fairly rapid but from time to time there is some hesitation. He talks in little rushes of words—a few words uttered quickly; then a pause; then some more words, something after the manner of a drunken man. His facial and ocular muscles are normal; his tongue protrudes a little to the right. His arms are normal; his legs are in a state of spastic paralysis; he can walk pretty well but tends to drag his toes, and his reflexes are much increased. He has not regained full control over his rectum, and the bladder still empties itself automatically every three or four hours, so that he must constantly wear a rubber urinal.

The second case is that of a gentleman, aged now about 50 years, who, about 2½ years ago contracted syphilis in a very severe form; about nine months later he had some kind of hemiplegic seizure from which he recovered to a very great extent. During the summer of 1904 he began to use wrong words—*e.g.*, when he wished for a drink of water he said "I want a book." This symptom continued at intervals from that time on. During the summer of 1905 his mental faculties were noticed suddenly to become duller than formerly. This dullness increased until in September he was quite stupid; he could not in the least understand a book when it was read aloud to him. In

October his speech became very imperfect ; he could only enunciate the simplest sentences, and that with difficulty and hesitation ; he forgot many words and also frequently called things by wrong names ; he became entirely unable to write ; when asked to write a very simple sentence he would slowly trace the first two or three letters correctly and then make a mistake in a letter, and finally write down an utterly wrong series of letters ; he had enough mental ability to know that he made mistakes but not enough to be much troubled about them. There was no obvious paralysis, but his muscles generally were weak.

I was asked to see him as the doctor who was treating him had a suspicion that the case was one of general paralysis. I came to the conclusion that the case was one of syphilitic dementia ; and as treatment could not be efficiently carried out at home, he was brought into a pay-ward in the hospital.

GENERAL PARALYSIS.	SYPHILITIC DEMENTIA.
Indirect, or may appear to be non-existent. Often later—after many years	Direct. Often occurs earlier—a few years after infection.
Delusions of expansive nature common. Dementia becoming more marked as the case progresses.	Enfeeblement (dementia).
A marked symptom.	Absent, or slightly marked.
Rare. When they occur, they may be temporary.	Common—(e.g., hemiplegia, monoplegia, aphasia).
Progressive tendency toward death.	Ill-defined ; may improve up to a certain point.
Antisyphilitic treatment unavailing.	Hg and KI often produce great improvement.
	Connection with Syphilis. Time of onset. Nature of mental symptoms. Tremor. Paralyses. Duration and course. Effects of treatment.

When admitted his chief symptoms were mental ; his brain formed ideas with slowness and difficulty ; he could understand only the simplest questions ; he could hardly speak as he had forgotten most words. He did not complain of headache ; there were no sensory symptoms ; his limbs were weak but there was no actual paralysis and no tremor, except for some old iritis his eyes were normal ; he had control over his sphincters ; his reflexes were all normal.

He was treated by mercurial inunction for a month, and is now taking iodide of potassium, 30 grains thrice daily.

As you now see him (December, 1905), his speech is quicker and more correct, but he still slurs some of his words. He has a much greater command of words than formerly, and his mental powers are greater than they were. He cannot, however, carry on any conversation and cannot understand a book when it is read to him. He is able to sign his name correctly,

though with difficulty. He will soon leave hospital and I shall advise that he should continue the iodide for some months. He has improved under the vigorous treatment, but I do not expect he will ever regain much mental energy.

In both of these cases there have been widespread lesions of the brain and spinal cord ; both cases were for a time supposed to be examples of general paralysis ; and yet not only were the symptoms somewhat different from those commonly found in this disease, but the course of the cases was entirely unlike what occurs in general paralysis. Both patients are suffering from syphilitic pseudo-general paralysis or syphilitic dementia ; they are the subjects of diffuse arterial and (probably) meningeal lesions of syphilitic nature.

I have embodied in tabular form (taken mainly from Fournier's work) the main features which distinguish this condition from ordinary general paralysis.

Optic neuritis, severe headaches and vomiting are more likely to occur in cerebral syphilis than in general paralysis. I need not dilate on these diagnostic points, for the cases you have seen illustrate most of them.

As regards prognosis and treatment, these cases are directly syphilitic ; they are a part of the tertiary stage of syphilis ; hence they are far more successfully treated than are such parasymphilitic diseases as general paralysis and tabes. In syphilitic dementia energetic treatment will probably check the course of the disease, and may cause great improvement. I am, however, doubtful if complete recovery ever occurs, especially if there is vascular disease. With regard to the mode of administering antisyphilitic remedies in these cases, I am in favour of a course of mercurial inunction followed by a prolonged course of iodide of potassium, the dose of the iodide being increased from 30 grains up to 120 grains a day, divided into three doses. I have never seen large doses disagree where small doses were well borne, and I am satisfied that large doses of iodide often succeed where small doses fail to relieve the symptoms.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The lecture in next week's will be by William Murrell, M.D., F.R.C.P., Physician and Lecturer on Medicine at Westminster Hospital, &c., on "Gonorrhæal Rheumatism and Gonococcic Infection."

ORIGINAL PAPERS.

A NEW METHOD OF SERUM THERAPY.

By D. M. PATON, L.R.C.P., L.R.C.S.Ed., L.F.P.S Glasgow.

(Concluded from page 121.)

V.—Inflammation, Suppuration, Abscess.—Serum treatment falls into line with present day pathology in that it ignores the distinction which used to prevail between what was then called simple and septic inflammation.

The various phenomena of inflammation need not be enumerated here, but for the purposes of treatment the whole course of inflammation may be divided into three stages.

1. The initial stage, including all that precedes the death of tissue.
2. The death of tissue and formation of pus.
3. The rupture or incision of abscess and elimination of the products of the previous processes.

1. In the stage which precedes the death of tissue ADS. when used properly is specific. The acute pain is the first symptom to be affected, and the patient can

soon be rid of that pain which will not give him rest. The following is a fair example:—

Miss M'C—, æt. 42, had been suffering from an acute bursitis of the left knee and had been continuously fomenting and poulticing it for thirty hours during which she had no rest, and when the prospect of another such night was before her she sought advice. She was at once given ADS., one dose every hour for the first three doses. At the time I said to her that she would probably be asleep before she had the third dose. The forecast was correct, as she fell asleep after the second dose and had to be wakened for the third. She took eight doses, and felt so well that she stopped the treatment against advice, and in twenty-four hours the trouble had begun to return. Another eight doses cleared up all inflammation, and she had no further recurrence. The fluid was not touched, and it gradually became absorbed while she was about her work as a trained nurse. The case had just been seen in time to prevent the formation of pus.

So certain is its action in aborting inflammation which has not reached the second stage, that when it fails within forty-eight hours to materially reduce the symptoms I commit myself to the diagnosis of the presence of pus and have no hesitation in saying so to the patient.

The following case of septic infection, seen in time to prevent pus formation, although the process had considerably extended, is interesting:—

Mrs. M—, æt. 47, had received a wound in her third finger of the right hand three weeks before being seen. The wound refused to heal, and the inflammation began to extend. When seen, the inflammation was well-marked on the dorsum of the hand, there was a considerable area of it on the ulnar side of the arm just below the elbow, above the elbow on the same side an abscess threatened, the axillary glands were inflamed, and pain was complained of on movement all down the right costal area. Cultures from the finger wound showed the presence of the staphylococcus pyogenes aureus and albus.

The finger wound was dressed with an antiseptic and ADS. was administered, 1,500 units every two hours for the first four doses, then 750 units 4tis hori. No other local treatment whatever was used, full dependence being placed on the serum. From the first there were decided signs of improvement which became more and more marked day by day. In four days she was practically well, and the treatment was continued in a modified form for two days more so as to confirm the result obtained. Seven days from the first dose she was dismissed absolutely well, all signs of inflammation having disappeared, and the finger wound having completely dried up. It need scarcely be added that the patient was something more than satisfied with the result.

The following teaches the lesson that it is false economy to discontinue the treatment too soon.

Mr. B—, æt. 37, is subject to severe attacks of quinsy, one of which was aborted by serum treatment. When the next attack came on it was twenty-four hours before serum was begun. In three days, however, the attack was aborted by 12,000 units, and the patient was dismissed. Three days later, the attack recurred, and went to pus formation in spite of vigorous administration of ADS. The serum being continued, pain was much relieved, the abscess was rapidly matured, and it was incised on the third day. Another 6,000 units at the first attendance would have saved the second attack.

Summary of Dr. Maclean's (Pollokshields, Glasgow) Case.

Mrs. T—, æt. 35, multipara, normal labour, placenta adherent and separated by hand; uterus flushed out; lochia scanty and sanious on third day, and ceased entirely on fifth day. Temperature was rising and respiration accelerated, and when lochia ceased there was abdominal distension without pain, but pain in left hypochondrium, and temperature was 102°. Four days later, there being dulness and friction

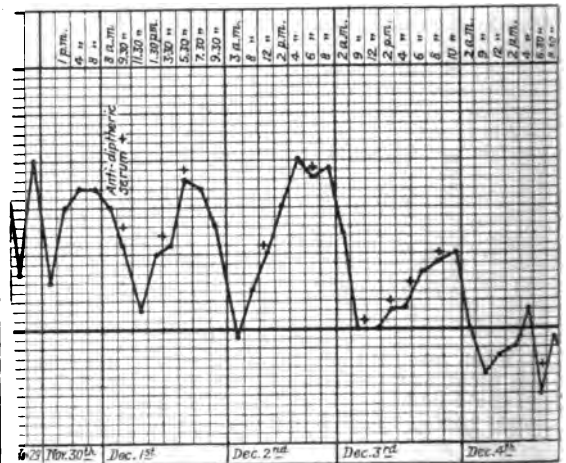
at the left base, she had a collapse, and in reaction temperature reached 103°. Next day dulness at right base. Treatment, antiseptic douching, poultices, and 20 c.c. antistreptococcal serum. Two days later condition was: Dorsal decubitus, acute pleuritis in both sides, crepitation and broncho-vesicular breathing at left base, dusky complexion, respirations rapid and shallow, profound intoxication with grave interference with vital functions. At this stage, twelve days' *post-partum* oral use of antidiphtheritic serum (special) was begun—1 dr. 4tis hori, also 10 min. doses of strychnine. From that time patient steadily improved in her general condition, and all her symptoms declined.

Six days later she began to menstruate normally both as to quantity and quality, and two days from its inception she complained of pain in left groin. This gradually extended down the leg, and was accompanied by swelling. It gave very little trouble and was completely cured in a fortnight. With it she had several slight attacks of vomiting. The temperature fell to normal eighteen days after serum was begun, and the pleural effusion, which consisted of a turbid serum, began to diminish three days later, and in a week had quite gone.

Dr. Maclean adds: "The serum . . . apparently did what was expected of it, namely, it supplied the patient directly with a means of resistance to the proteolytic action of the staphylococci and the toxic effects of the albumoses produced by the organisms, rendering her system a less suitable host for the bacilli and at the same time freeing, as it were, her tissues and organs to carry on their proper functions."

Dr. Wm. McLennan's Report.

Mrs. K., æt. 37, had abdominal section many years ago for recurrent attacks of localised peritonitis. The operation revealed extensive adhesions, which were separated as far as possible. Probably the seat of trouble was the appendix, which was so adherent that it was not removed. In October she complained of the onset of pain in the right side almost 2 ins. below the ribs (in nipple line). Pain increased and fever followed. For the first three weeks it was morning 99°, evening 100°. Then an acute rise took



place, with great increase of pain and temperature—morning 100°-101°, evening 101°-102° and over. There were rigors and sweats, and it was clear that great septic absorption was going on and probably pus formation. Operation was contemplated. "Paton's" serum was given at this stage, but the patient disliked the chloretone taste and could only be induced to take two doses a day for two days one or more of which she immediately rejected. On the third day serum was given regularly and in thirty-six hours temperature was normal and the patient on the high road to recovery. She has done well.

A few weeks later this patient showed symptoms of

a recrudescence of her trouble, and was at once given serum 1 drm. four times a day. In twenty-four hours all symptoms had disappeared, and Dr. McLennan reports the result as "very satisfactory."

When inflammation has reached the second stage and we have broken down tissue with pus formation, the conditions for serum treatment are entirely altered. ADS. will only act on living tissue, and hence it can only influence the collection of pus and *débris* by its action on the living tissues which are adjacent and affected by the extension of the inflammatory process. This process is limited in every case by the serum, and the usual foul condition is materially benefited and generally removed. According to the size of the abscess, the virulence of the infection, and the amount of tension in the cavity will depend how much can be done for the case. Depending then upon the proportion of each of these elements, ADS. will do good work in removing the surrounding inflammation and lessening the pain and other constitutional symptoms and by such work conserve the strength and comfort of the patient.

Pain, here, arises from two causes, one cause being tension outside and the other tension inside the abscess cavity. The first cause is removed by the serum, and where the tissues affected are loose in texture there is a very marked amelioration in this symptom. Mastitis is a very good example of this, for under ADS. this painful disease is robbed of most of its terrors, even when it has been seen too late and pus has formed.

The pain of tension in an abscess cavity is one that is not benefited by ADS. treatment, and it is probably increased by its use. The reason for this lies in the fact that where treatment has been begun too late to abort the attack the serum increases the reaction and raises the vaso-motor tension, causing increased exudation into the cavity, greater tension, and more pain. Where the structure of the tissues involved is of a firm and unyielding character, such as in periosteum and even a synovial membrane, the pain is increased by every dose shortly after it has been taken, and patients have of their own accord stopped taking it on account of this action.

There seems to be an exception to this rule, and that is in cellulitis of streptococcal origin. This was the character of the first case treated and its success started me out on this investigation.

Mr. B—, æt. 61, had been bitten on the hand by a cat and had a superficial erysipelas which easily yielded to treatment (bathing with spt. vini meth.). A week later he returned with a most acute cellulitis of hand and arm. The hand was swollen immensely, and the dorsum was tense, bright, and shining, while the arm was in a similar condition up to half-way between the elbow and the shoulder. He had all the symptoms of toxic resorption—headache, malaise, temperature over 100°, anorexia, &c. The first impulse was to incise the dorsum and give him an injection of anti-streptococcal serum, but to test the oral use of ADS. he was given 1,000 units in four doses, one dose every hour. Next day he had lost all his constitutional symptoms, temperature was 97°, head clear, a visible improvement in his hand, less pain, and able to move his fingers, which he could not do the previous day. After this, he would not allow me to use the knife on it, but demanded more of the same treatment. He had no other treatment except bathing it with spt. vini meth. He had the same dosage every day, the arm and hand steadily mended and he was discharged on the thirteenth day perfectly well. For some time he had stiffened fingers from tendons being fixed in remains of inflammatory processes. He still carries an exostosis on one of his metacarpals as a memento of the occasion. This was in March, 1898, and now he would get three times the quantity of the serum and be cured so much the more quickly.

As an example of the benefits to be derived from ADS. treatment where pus is present and before in-

cision, the following case of empyema is interesting. It is also a good example of the next stage.

Mr. C—, æt. 37, had pleurisy with effusion, which became empyematous. ADS. had been given too late to prevent the formation of pus, but in this case it so modified the constitutional symptoms that temperature was reduced to 100.4° and pulse to 84, while the patient ate and slept well. So well was he that a colleague, called in to chloroform for me while the tube was being put in, would not believe that pus of such recent origin was present in the case until convinced by aspiration. With the tube in, the treatment was continued, and he progressed steadily until it was thought that he was sufficiently well to do without it, and it was then stopped. In a day or two he began to show signs of relapse, and soon he had hectic night sweats, and increased discharge, which also gained an odour which became more pronounced day by day. His appetite and general health failed steadily, and he was rapidly going down hill. The treatment was resumed and the patient at once began to improve and continued to do so until in a short time the discharge had become so small that the tube could be removed and he made an uninterrupted recovery.

In this case even before the operation the symptoms were so ameliorated that it was difficult to believe that such a condition existed, and after it the recovery was due to the serum without any doubt whatever. In all, he used 46,000 units of ADS.

VI.—*The Elimination of the Products of Previous Processes.*—Generally, when free drainage is established, the recovery proceeds normally, but there are cases as in the examples given, in which the patient's resistance has become so enfeebled that his tissues are unable to resist the action of the organism even under the most favourable conditions, and the process is continued indefinitely. The addition to such cases of the tissue resistance supplied by the appropriate serum enables normal condition to be attained and normal results being seen. In this condition the following case illustrates the difference between simple plasma and the antidiphtheritic serum.

A. T., æt. 53, had been suffering from acute cellulitis above and below the elbow for several weeks. There were six incisions all discharging pus freely, while from his temperature and appearance there was considerable absorption. Under ADS. the whole condition rapidly improved, temperature fell, pus discharge rapidly lessened, sleep and appetite with clean tongue returned, and he was doing well. Before the case was quite right, simple plasma was substituted for the antidiphtheritic with the result that the case promptly relapsed, pus discharge increased, temperature rose, absorption again showed itself, all within a week. On resuming ADS., the whole of the symptoms rapidly disappeared, and in three days all but one sinus had ceased discharging. Further treatment on the same lines led to recovery. It was clear that in ADS. there were elements and capacities not found in normal serum.

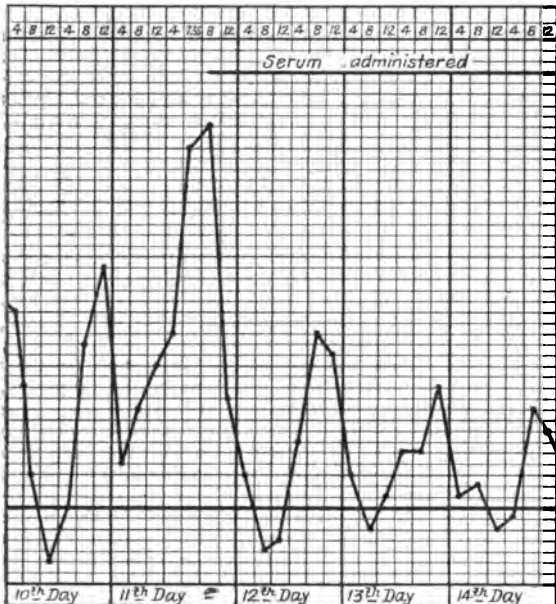
Dr. Alex. McLennan's (Glasgow) Cases.

VII.—*Stage of Continued Suppuration after Pus has been drained (two cases).*—M. M., was operated upon for an empyema on October 23rd, 1905. The previous condition had been pneumonia (?) without a crisis. From October 3rd, the operation temperature had varied from 99° F. to 104.4° F. For three and a half days it had been between 99.2° F. and 100° F. After operation it ranged daily between 99.2° F., 103° F., and 103.8°. Serum was begun on November 2nd. Previous evening temperature was 103° F.; on November 2nd, 101.4° F. November 2nd to November 6th, temperature ranged from normal to 99° F. November 6th, serum stopped; November 6th, 8 p.m., temperature 100.4° F. November 7th, temperature 101.4° F. Serum begun after this on November 7th. Since then temperature has ranged from normal to 100.4° F. The pulse which has been rapid has varied

with the temperature. There are obscure abdominal symptoms. A coverglass preparation of the pus from the empyema showed numerous cocci, in groups and few in short chains; no culture was taken.

The general condition has improved with the decline in temperature and pulse rate. This patient went on to perfect recovery under reduced dosage.

Dr. McLennan also reports a case of pyelitis with temperature ranging to 105° F. the night before serum was begun, fell as per chart, while serum was being administered. This gave an opportunity for nephrectomy, which was successfully performed, and the patient did well. The operation was necessary for causes extraneous to the kidney.



MERCURIAL INJECTIONS IN THE TREATMENT OF SYPHILIS.

Synopsis of the Discussion at the Medical Congress held at Paris, 1905.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

The preference to be given to the administration of mercury by hypodermic injection rather than by the mouth or by inunction is a big question, and in order to enable our readers to grasp the situation we cannot do better than place before them a *resume* of the arguments advanced at the last Medical Congress in Paris, in which Drs. Julien, Hallopeau, Abadie, Leredde, Fournier, and others took part.

The hypodermic method of administering mercury is of comparatively recent introduction, that is to say, it only dates back some forty years. It was in 1863 that Hebra and Hunter called attention to the possibility of treating syphilitics by injections of corrosive sublimate. In 1864 Scarenzio, to whom the credit of introducing it was really due, began to make use of calomel in suspension. At present mercurial injections have come into general use, but like all active medications they may be productive of mischief unless carefully handled, so that it behoves the practitioner to make himself conversant with the indications and with the technique.

In some instances attempts have been made to obtain the purely local effects of the drug by injecting it in the immediate vicinity of the damaged tissue, as, for instance, in Professor Bouchard's method of injecting small doses locally, the advantage whereof is best seen in ophthalmological practice by subconjunctival injections, and in Mr. Sicard's sub-arachnoid injections in neuropathology.

It is, however, especially as a means of obtaining the constitutional effects that mercurial injections are usually employed. There are two principal methods of administering the drug, one by the method of daily injection of the same, or a progressively increasing dose of the drug calculated to satisfy the requirements of the syphilitic organism; and the method of periodical injections of insoluble salts which are deposited in the tissues at regular intervals, thus supplying a certain quantity to be utilised by the organism at its leisure.

MERCURIAL PREPARATIONS FOR INJECTION.

Soluble Preparations.—These comprise principally the biniodide, the benzoate and the perchloride of mercury.

1. *Perchloride of Mercury.*—Drs. Barthelemy and Levy-Bing recommend the following formula:—

Hydrarg. perchloridi, 0 grms., 10;
Pulv. sodii chlor. pur., 0 grms., 075;
Aqua dest., 10 grms.

The chloride of sodium has the advantage of rendering the injections less painful, and there is no reason why the proportion of this salt should not be increased. In Germany they employ the following:—

Hydrarg. perchloridi, 1 grm.;
Sodii chloridi, 10 grms.;
Aqua dest., 100 grms.

One cubic centimetre of either of these solutions represents one centigramme of the sublimate, an average daily dose. In some cases, however, this dose is not sufficient, and the injection may be increased advantageously to two centigrammes daily for twenty days, carefully watching the state of the mouth, intestines, &c.

2. *Benzoate of Mercury.*—Stoukowenkoff's formula is:

Oxybenzoate of mercury, 0 grm., 30;
Pure chloride of sodium, 0 grm., 10;
Muriate of cocaine, 0 grm., 15;
Distilled water, 40 grms.

This solution requires to be freshly prepared, as the cocaine precipitates the mercury in a few days.

Another solution, recommended by Bretonneau and Desesquelle:—

Benzoate of mercury, 0.60 to 3 grms.;
Cocaine, 0 grm., 12;
Benzoic acid, 0 grm., 60;
Distilled water, q. s. to make 60 cc.

A simpler formula is the following:—

Benzoate of mercury, 1 grm.;
Pure chloride of sodium, 0 grm., 75;
Sterilised distilled water, 100 grms.

One centigramme (about a sixth of a grain) of benzoate of mercury is a small daily dose, and we may safely give two centigrammes daily for three weeks. Gaucher, however, considers this a large dose, though other authorities advise the drug being pushed to three and even four centigrammes daily.

3. *Biniodide of Mercury.*—This can be injected in an oily solution by Panas' formula:—

Biniodide of mercury, 0 grm., 40;
Purified sterilised olive oil, 100 grms.

This solution contains four milligrammes in each cubic centimetre—rather a small proportion, necessitating, therefore, the injection of at least two cubic centimetres.

By dissolving the biniodide in walnut oil, washed with alcohol and sterilised, it is possible to obtain a solution containing ten milligrammes per cubic centimetre, and by mixing equal quantities of this oil and castor oil, the proportion can be raised to fifteen milligrammes per cubic centimetre.

Biniodide of mercury, 1 to 1.50 grms.;
Oil of walnut treated as above, 50 cc.;
Sterilised castor oil, 50 cc.;

to be dissolved at a temperature of 70° C.

This biniodised oil must be kept in coloured phials and not exposed to light, and on the whole it is preferable to make use of freshly-prepared solutions. The injection is not absorbed as rapidly as, and is more painful than, aqueous solutions, consequently the latter are generally preferred when intended for daily pro-

longed use, although their action is less pronounced.

The following is a watery solution of the biniodide:—

Biniodide of mercury, 0 grm., 20 ;

Iodide of sodium, 0 grm., 20 ;

Distilled water, 10 cc.

The daily dose for three weeks' treatment is one cubic centimetre—two centigrammes. The dose may gradually be increased to three or four, or even five centigrammes.

The addition of iodide of sodium increases the solubility of the biniodide. Instead of distilled water we may employ a 75 solution of chloride of sodium.

Biniodide of mercury, 0 grm., 20 ;

Iodide of sodium, 0 grm., 20 ;

Chloride of sodium, 0 grm., 0.75 ;

Distilled water, 10 cc.

4. *Cyanide of Mercury*.—This is very active in a 1 per cent. solution, and it does not occasion much pain. We shall show later that the cyanide and the oxycyanide are specially indicated, when we propose to make intravenous injections.

INSOLUBLE PREPARATIONS.

These preparations are composed of calomel or metallic mercury in the form of grey oil (*huile grise*). The usual formula is the following:—

Sublimed calomel, 1 grm.;

Pure liquid vaseline, 10 cc.

Vaseline oil is an excellent vehicle, being perfectly stable; it has, however, the drawback of causing irritation in certain subjects. Pure olive or sweet almond oil would no doubt be better, but they do not keep well. Dr. Balzer suggests a mixture of equal parts of liquid vaseline and olive oil. In making the injection the bottle must be well shaken in order to secure the proper proportion of calomel.

For metallic mercury we may select one of the three following:—

Mercury ;

Lanoline, aa 3 parts ;

Rectified olive oil, 4 parts (Lang) ;

Metallic mercury, 20 grms.;

Lanoline, 5 grms.;

Vaseline, 35 grms. (Brousse and Gay).

Purified mercury, 40 grms.;

Anhydrous sterilised lanoline, 12 grms.;

White sterilised vaseline, 13 grms.;

Sterilised liquid vaseline, 35 grms. (Lafay).

One cc. contains half a gramme of mercury.

The average weekly dose of calomel is 10 centigrammes, and of mercury 7 or 8 centigrammes, and from 40 to 50 centigrammes for the complete treatment.

As the injections of insoluble salts are made once a week, the usual dose will be 1 cubic centimetre of the above calomel solution, equal to 10 centigrammes of the salt, and a seventh of a cubic centimetre of grey oil, equal to 7 centigrammes of mercury.

THE MODUS OPERANDI.

Mercurial injections must never be made subcutaneously, on account of the pain and the inflammatory nodules they provoke. The injections should be made deeply into the muscle substance either in the spinal furrow or into the gluteal region, taking care to avoid the sciatic nerve. Every antiseptic precaution must be observed, the injection should be made deeply, and before emptying the syringe it is well to ascertain that no blood is escaping through the needle, in order to avoid the possibility of an embolism. The patient should be lying down. After the injection the part should not be massaged, but simply dressed with collodion. Under these circumstances it is hardly necessary to insist upon the fact that these injections must of necessity be left in the hands of the surgeon.

It is absolutely necessary when making use of mercurial injections to keep an attentive eye on the patient's mouth and on the intestinal functions. Mercury is known to cause stomatitis and enterocolitis, consequently the treatment must be suspended whenever there is pyalism, salivation or diarrhoea. Stomatitis, however, may be caused even with small doses

if the patient's mouth be in a bad state, consequently before commencing the treatment the teeth should be attended to, if required, and the patient must be enjoined to pay great attention to keeping the mouth in a hygienic condition.

With the soluble preparations it is customary to inject for some twenty days following; for the insoluble preparations one injection a week for five weeks.

The intravenous method has recently been recommended. For that purpose we make use of solutions of the cyanide or oxycyanide, because they do not coagulate the blood. The following solution may be used:—

Cyanide of mercury, 1 grm.;

Distilled water, 100 grms.

One cubic centimetre is injected daily, equal to 1 centigramme of the cyanide.

Intravenous Injections appear to act very promptly; they are easy enough in spare subjects whose veins are readily accessible, but are more difficult in women. It is necessary to insist on the extreme importance of absolute asepsis.

Drawbacks and mishaps with mercurial injections.—

Reference has already been made to the sometimes very sharp pain that follows the injection, especially of the insoluble salts. In spite of every precaution, aseptic abscesses sometimes follow the injection of insoluble salts; indeed, they have been accused of causing the death of the patient, but such fatal cases as have been recorded were probably due to too large doses, to the debility of the subject or to mere idiosyncrasy. If the treatment be unduly prolonged the patient loses weight, and his general nutrition suffers. It is therefore a good plan before commencing the treatment to weigh the patient, and to repeat the process from time to time. So long as the weight remains stationary or increases the treatment may be continued, but should the patient lose flesh, the treatment should be suspended, or, at any rate, modified.

INDICATIONS FOR INJECTIONS.

Some authorities, among them Dr. Hallopeau, hold that mercurial injections are not to be recommended in general, and that they should only be had recourse to in severe cases. He says: "These injections may give rise to intolerable pain, to aseptic abscesses, to fever and to pulmonary embolism. On several occasions they have caused death, even when carried out with every possible precaution. On the other hand, it has been shown that the method does not invariably present the superiority of action claimed for it." Dr. Hallopeau substantiates his view by the case of a patient who had an acute generalised papulo-tubercular eruption within a few days of a prolonged treatment by the benzoate of mercury, and that of a man who developed gummata in the very arm where the injections had been made. He suggests that inunctions might very well yield equally good results, especially if made on the hairy parts. The injections, moreover, are very costly for the patient, and this is a reason for abstaining from recommending them unless clearly indicated. His present practice is to order injections of the insoluble salts in threatening cases, especially at the onset of tabetic symptoms, and he gives the preference to grey oil, the action whereof is slower on account of the fact that it takes time for the lymphocytes to absorb the molecules of calomel. Apart from these cases, injections should only be employed if the patient for any reason cannot or will not consent to inunctions, and even in such cases it is well to try what can be done by administering mercury by the mouth.

Most authorities, however, consider the method of mercurial injections to be by far the most active and trustworthy plan, and they devote their attention to pointing out the indications and the reasons for preferring the soluble or the insoluble salts. It is generally admitted that the intramuscular injection of insoluble salts is much more active than that of the soluble salts, but on account of the greater number of drawbacks

which the latter present they should only be employed in special cases.

Professor Fournier, at the Medical Congress at Paris in 1904, formulated the following indications for the use of the insoluble salts: The daily injection of the biniode or the perchloride is, he says, good treatment, the action whereof may be compared with that of pills and inunctions. But it is not an extremely active treatment. That remark, however, does not apply to the weekly injection of grey oil in large doses. This treatment by the injection of insoluble salts is not an exceptional treatment; it is a treatment to be adopted in presence of certain indications, and these indications may be grouped as follows:—

- (1) Phagedenic chancres; (2) tertiary phagedænis; (3) dry tubercular syphilides or tuberculo-crustacea; (4) gummatous laryngitis; (5) palmar and plantar psoriasis; (6) syphilitic lesions of the tongue.

In threatening cases, as in gummatous laryngitis, and in case refractory to other methods of treatment, such as palmar and plantar psoriasis, the injection of the insoluble salts often gives quasi-miraculous results. Calomel acts specially well in lesions of the tongue.

So much with regard to the indications for the use of the insoluble preparations. We will now proceed to the discussion of the employment of mercurial injections in special cases.

Infantile Syphilis.—Insoluble preparations are dangerous in the young, who, however, readily tolerate the benzoate and the sublimate. But, employed in 1 per cent. solutions, of which from $\frac{1}{4}$ to 1 cubic centimetre is injected daily, or every other day, they entail an assiduity of treatment that cannot always be obtained. To obviate these inconveniences Dr. Imewol, of Jassy, recommends Lukaszewicz' method, which consists in making one injection weekly of a 5 per cent. solution of the sublimate. He employs the following solution:—

Chloride of sodium;
Perchloride of mercury, aa 0 grm. 50;
Sterilised distilled water, 10 grms.

This contains 0 grms., 05 centigramme of the salt in each cubic centimetre, and therefore 5 milligrammes to each division of a Pravaz syringe. In the very young the strength of the solution is reduced to 2 per cent., so that each division of the syringe contains only 2 milligrammes of the active substance.

Perchloride of mercury;
Chloride of sodium, aa 0 grm. 02;
Sterilised distilled water, 10 grms.

These are the doses according to the age of the subject:—

Between one and three months, from 0.002 to 0 grm. 004; from three to twelve months, from 0 grm. 005 to 0 grm. 010; between one and two years, from 0 grm. 010 to 0 grm. 020; at three years, from 0 grm. 020 to 0 grm. 025; between four and six years, from 0 grm. 020 to 0 grm. 030; between six and twelve years, from 0 grm. 025 to 0 grm. 040.

One always begins with the smallest indicated dose, gradually increasing it, according to the tolerance of the child and the refractoriness of the manifestations, until the maximum dose is reached. The injection is made once a week, or every five days, in serious cases, and the treatment is continued until the subsidence of the manifestations.

The sublimate solution must be clear, and should it become turbid it must be discarded. After the injection, the interior of the needle must be cleansed in order to remove the black deposit left by the sublimate. Needles of irido-platinum are preferable to steel needles, since this metal is not attacked by the salt. Dr. Imewol usually obtains a cure after from three to five injections, but rarely has he found it necessary to go as far as six, and the latter number he has never exceeded.

Ocular Syphilis.—According to Dr. Abadie, intravenous injections (of the cyanide or oxycyanide) are specially recommendable in ocular syphilis. In slowly developing irido-retino-choroiditis, and in cer-

tain varieties of late optic atrophy, inunctions, pills and intra-muscular injections often fail and intravenous injections alone can save the patient. In senile syphilis contracted after sixty years of age the eyes always suffer early, and intravenous injections alone can save the patient's sight. When for any reason we cannot have recourse to intra-venous injections, Abadie advises recourse to intra-muscular injections of large doses of the biniode or cyanide of mercury (from 2 to 2½ centigrammes).

Syphilis of the Nervous System.—In these cases, especially where there are cerebral lesions, such as syphilitic cerebro-spinal meningitis, cerebral tumours, &c., injections are to be preferred, but in acute syphilitic meningitis all mercurial preparations seem to act well, however employed. In cerebral gummata we must have recourse to the mixed treatment. Fournier recommends iodide of potassium internally in average daily doses of 5 grammes, with the inunction of from 5 to 10 grammes of mercury daily. Mercurial injections seem to be more active, and the soluble preparations are usually employed. Syphilitic cerebral arteritis is one of the manifestations of syphilis on the nervous system that most readily responds to the injection of soluble salts of mercury. In syphilis of the medulla the action of mercurial injections is by no means uniformly favourable.

Nevertheless, in view of the good effects of mercury in some few cases we are justified in cautiously trying the effect of mercury, and for this purpose pills for inunctions, or the injections of soluble preparations should be resorted to.

CLINICAL RECORDS.

CASE OF CEREBRAL TUMOUR.*

*Under the care of LEONARD GUTHRIE, M.D.,
Physician to Paddington Green Children's Hospital, etc., etc.*

W. K. (M.), clerk, æt. 29, admitted to hospital October 24th, 1905, with right-sided hemi-paresis and double optic neuritis. Seven years ago he contracted syphilis, for which he was under treatment 3 months. No obvious secondary symptoms, but health never good since. Complained of "general deterioration, mental and physical." Fifteen months ago the patient noticed gradual weakness of right arm and leg, which increased until he had to give up employment owing to inability to write or hold his pen properly. Slight headaches at times, but no vomiting.

On admission, optic discs showed double neuritis most marked in left. Condition resembling "choked disc," without much swelling. V. fields contracted especially left. V.—L.—6-9 R. 6-6. Pupils reaction normal. Ocular movements normal. No paralysis of facial nor other cranial nerves. Speech rather hesitant and slurring. Slight tremor of lips. Right hand grip weaker than left. Clumsy in executing precise movements—e.g., buttoning clothes. Condition more ataxic than paretic. Right leg spastic, slight talipes equinovarus. All movements against resistance in R. leg weaker than in left. Nutrition and sensation normal. All tendon reflexes active and greater on right than on left side. Ankle clonus absent. Plantar response extensor on R., flexor on L.

Progress.—After admission, optic neuritis and contraction of fields increased. On November 3rd, slight epileptiform seizure occurred with general convulsions, but no focal commencement. Loss of consciousness, tongue not bitten, urine not passed. Duration about ten minutes. On November 8th, two more attacks in which he became dazed and stupid but without loss of consciousness. No fits before nor since. Treatment by iodides pushed until by mid-December he was taking 50 grains of mixed iodides t.d.s. Swelling of the left disc then began to subside, that on the right remaining

*Notes of a case shown at the Harvelian Society, January 25th, 1906.

in statu quo. Slight iodism, soreness of eyelids and a few spots. Iodides then gradually reduced to 24 grains of mixed salts t.d.s.

Patient has improved in general health and has gained weight. Hand movements have become less ataxic under treatment by exercises. He now writes fairly well, though slowly. The gait is less spastic.

Diagnosis.—Gumma probably supra-cortical in mid area of left cerebral hemisphere.

THE OUT-PATIENTS' ROOM.

KING'S COLLEGE HOSPITAL.

Rodent Ulcer.

By G. LENTHAL CHEATLE, C.B., F.R.C.S.

AMONGST the out-patients was a female at 32 years, a case of rodent ulcer on the back, sent to Mr. Cheatle by Dr. Arthur Whitfield, not for diagnosis or treatment, but for him to see and record among his cases of rodent ulcer on the body. Mr. Cheatle said that Dr. Whitfield knew that was a case of rodent ulcer because he had removed a piece of the tumour's edge for purposes of diagnosis. Rodent ulcers on the body were rare compared to the frequency of their appearance on the face. He (Mr. Cheatle) had so far been able to collect pictures of 19 cases, that case making the 20th. However, there were a few more recorded cases, of which he could not get pictorial records.

Squamous epithelioma on the body was rarer still. He had only seen two cases, one of which had two separate growths, one on the shoulder and the other over the posterior superior iliac spine.

The case before them, Mr. Cheatle said, was the 12th case among rodent ulcers which had begun on the back, compared to 8 which had appeared on the front of the body, and it was the third which had appeared in this region, namely on the skin covering the posterior aspect of the upper border of the trapezius muscle. Those three cases were females. He could not find any mechanical cause why rodent ulcers should appear at this point in females. Females did not wear braces. Had these three cases been men the cause for this common point of incidence could have been explained as one due to the mechanical irritation of the brace. That woman could not give them any reason to suppose that so gross a mechanical irritant was etiologically connected with the incidence and genesis of that tumour.

In the *British Medical Journal*, April 29th, 1905, he had pointed out that that was a point of incidence common to leucoderma and scleroderma, and it was known that those two diseases were pretty generally believed to be neurotrophic in origin and spread. He ventured to suggest that the incidence and spread of cancer was also closely connected with the same influence. The peripheral nerves, upon whose distribution those three rodent ulcers appeared were the acromial branches from the cervical plexus. The skin on either side of the spinal column from the vertebra prominens to the tip of the coccyx was another favourite area of incidence for rodent ulcers, leucoderma and scleroderma.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

ENUCLEATION OF A TUMOUR FROM THE NECK OF THE HUMERUS.—Mr. A. CARLESS operated on a man, at 30, who had been brought to the hospital ten days previously complaining of pain and swelling in the right shoulder. His story was that when he was riding in a covered van in the erect posture, the van gave a lurch and he laid hold of a strap above his head to steady himself, and to prevent himself from falling he had to make a sudden jerk with his arm in the "strap-hanger" position. Sudden and severe

pain was felt and all subsequent movements of the arm were painful. On careful examination a few days later, the shoulder was swollen, but no evidence of a dislocation could be detected, although a definite lump could be felt in the axilla, which somewhat suggested a sub-glenoid dislocation. On manipulation slight crepitus was obtainable in some movements. The existence of a fracture of either the anatomical or surgical neck of the humerus could be negatived, as also fractures of the clavicle or of the body of the scapula. It was thought that possibly there was a fracture of the lesser tuberosity or of the coracoid process. On radiographic examination, it was found that the head of the bone was *in situ* and that no ordinary fracture was present. An oval shadow was seen encroaching on the inner half of the neck and the adjacent portion of the humerus and projecting inwards and downwards to a somewhat greater extent. It seemed possible that this might be the lesser tuberosity pulled off and drawn inwards; but this supposition was negatived by observing that the supposed fragment would have been displaced downwards as well as inwards, a direction in opposition to that of the axis of movement of the sub-scapularis muscle; moreover, the compact tissue of the humerus was continuous with that on the outer aspect of the lump, and there was no solution of continuity observable, whilst the inner margin of the lump was constituted by a definite line of thickened bone. Under these circumstances, it was obvious that the lump which could be felt in the axilla was the lower end of a tumour involving the upper end of the humerus from and into which it grew. Its invasion of the neck of the humerus showed that it could not be an exostosis, and Mr. Carless considered that the diagnosis probably lay between a chondroma and a sarcoma, and that the growth was probably cartilaginous in type as it is unusual for a sarcoma to be limited by a layer of sclerosed bone. After thorough purification of the arm and shoulder, an incision was made parallel to the lower border of the pectoralis major, opening up the axillary connective tissue and extending down to the biceps tendon. A little dissection demonstrated that the lump was connected with the humerus, and that the crepitus was in the substance of the tumour, which projected forwards between the subscapularis above and the tendon of the teres major below. To remove the growth it was found necessary to make more room by dividing the pectoralis major muscle; this was done by an incision at right angles to the former. It was then possible to define the limits of the growth, which was freely gouged away. It was found to extend into the bone and in order to ensure its complete removal the shoulder joint had to be opened and part of the cartilage covering the articular surface removed. The bone exposed by the removal of the growth was firm; it was thoroughly scraped and well swabbed over with liquefied carbolic acid, the excess of which was subsequently washed away by alcohol. A drainage tube was introduced, the pectoralis major muscle firmly sutured and the wound closed. Mr. Carless commented on the interesting nature of this case, emphasising particularly the fact that the crepitus which had been detected was due to a fracture of the bony tissue contained within the tumour. As to the nature of the tumour, it was of a soft, somewhat friable consistency, reminding him, he said, more of a parotid tumour than anything else, and he thought it quite possible that on microscopical examination the growth might turn out to be an endothelioma.

It is satisfactory to record that the wound healed perfectly, and that the patient is already, ten days after operation, able to move his arm inwards and outwards.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

MEETING HELD FRIDAY, JANUARY 19TH, 1906.
The President, Sir WILLIAM SMYLY, M.D., P.R.C.P.I.,
in the Chair.

THE DIAGNOSIS, TREATMENT, AND PATHOLOGY OF EMPYEMA.

A DISCUSSION on the diagnosis, treatment, and pathology of Empyema was introduced by Dr. W. G. Smith, Sir Thornley Stoker, and Dr. Earl.

Dr. WALTER SMITH opened the discussion. His remarks referred chiefly to etiology and diagnosis. As to nature of effused fluids, it is sufficient to group them into (a) sero-fibrinous; (b) purulent. The main advance in etiology is the firm establishment of the doctrine that most pleuritis are due to, and are caused by, infective agencies. Three points may be noted:— (1) The serious significance of the tubercle bacillus; (2) the comparatively favourable outlook of even purulent effusions when due to the pneumococcus; (3) the serious and frequently fatal character of cases due to acute streptococcus invasion. In regard to physical diagnosis, half-a-pint is about the smallest quantity that can be recognised. Percussion is more valuable, diagnostically, than auscultation. Damoiseau's parabolic curve of dullness can often be made out. Bronchophony may be heard through a considerable mass of pleural fluid. Vocal fremitus may be normal, or, even *weakened*, in acute pneumonia, and is often increased just above upper limit of an effusion. Exploratory puncture is the most valuable and certain mode of detecting fluid. Special attention was drawn to the problem of intra-pleural pressure, and a brief summary was given of our present state of knowledge. Stress was laid upon the prime importance of the elasticity of the lung as the chief and essential factor to be considered. Even with the most powerful expiration, the pleural pressure remains negative. In presence of effusion, we have no right to consider positive pressure until and after the elasticity of the lung has been exhausted. Then, and then only, does true compression of the lung begin. Measurements of pleural pressure in cases of effusion give discrepant results, which are not yet susceptible of complete explanation.

Sir THORNLEY STOKER introduced the discussion on the Surgical Treatment of Empyema, and gave the results of his own experience as to various methods. He laid great stress on the early drainage of the pleural sac, and set aside as quite out of date the use of aspiration. He strongly advocated that when thoracotomy is called for, it should not be practised by intercostal incision, but by removal of a portion of a rib. He claimed that this should be the routine method, as it gives room for digital exploration, avoids the pinching of drain-tubes between the ribs, can be conducted more cleanly, is free from risk of bleeding, permits the discharge of the large masses of lymph usually found, and can be practised with great rapidity. He advocated the performance of thoracoplasty at a period anterior to that at which it is often resorted to, and claimed that when done in time, without delaying to the last moment, and when performed in a certain way, it is not a very serious proceeding and is usually a very successful one. The U-shaped flap should be avoided, and the portions of ribs operated on removed through straight incisions parallel to their axes. One incision sufficing for the resection of portions of as many as three ribs. He stated that in his practice he had not found removal of the periosteum necessary; it increases the length and danger of the operation, and the membrane causes no ill effects if left behind. Irrigation of the pleural sac is to be avoided in most

cases, and only resorted to if foetor is present, or discharge unduly persistent. It is often dangerous to life by causing collapse or convulsions. Of methods ancillary to operation, and intended to assist the closure of the pleural cavity by helping the expansion of the lung, he advised positive pressure, by respiratory gymnastics, such as forced inspiration and expiration, or the blowing of water from one large bottle to another by James's plan. The introduction of condensed air into the lung has often been found dangerous. Of negative pressure, he could only say that he did not see how it could be made practically available in a vital and restless machine like the human body. Finally, he forecasted in the near future an assistance to our present means, or even a supersession of them to some extent, by the studies of the uses and actions of bacterial vaccines, and of the opsonic powers of the blood, at present being pursued.

Dr. EARL read a short paper on the Bacteriology of Empyema. He pointed out the importance for prognosis that bacteriological examinations have particularly in cases of pneumococcal and streptococcal origin. He also discussed the difficulty of diagnosis of the nature of tubercular cases, and the value to be attached to the sterility of an effusion.

Sir JOHN MOORE read notes of two cases illustrative of the difficulties which attended the differential diagnosis of empyema, or pyothorax and hypophrenic abscess. In the first case, that of a woman, *et. 30*, the physical signs led to a diagnosis of right empyema. Paracentesis was performed, and 170 ounces of most offensive pus were drawn off. The patient sank, and at the autopsy the seat of suppuration proved to be altogether below the diaphragm, constituting a hypophrenic abscess, and involving the liver also. The starting point of all the mischief was probably a perforating gastric ulcer, in connection with which adhesive inflammation had occurred. In the second, a man, *et. 52*, suffered from cancer of the oesophagus. He complained of difficulty of swallowing, sharp pain in his chest, and spasmodic cough. Exploration of the right pleura showed a serous effusion. He subsequently grew worse. The right side of the chest became immobile, the lower interspaces were effaced and there was local oedema. A syringe of stinking pus was drawn off from the right side in the seventh intercostal space. Mr. Taylor afterwards excised a portion of the right tenth rib, in a line with the inferior angle of the scapula, and evacuated an enormous collection of very foul-smelling pus. The man died three days later, and the *post-mortem* showed that a perforating cancer of the oesophagus had opened into the posterior mediastinum, thence reaching the right pleura and setting up a septic empyema. The examination of the abdomen revealed nothing abnormal.

Sir ARTHUR CHANCE said that the policy of surgery towards empyema was very simple. Early efficient drainage, expansion of the lung, and, if necessary, a contraction of the chest wall by surgical means, with possibly removal of diseased pleura, were the simple surgical indications; but to carry them to a successful issue was very difficult, and one was confronted by the difficulty of the different varieties of empyemata. He preferred to open the chest wall lower down and further back than Sir Thornley Stoker had advocated, and he believed in a particularly short skin incision. He agreed as to the wisdom of always removing a portion of the rib, and he always used a very large drainage tube. The records of thoracoplasties was not very good, but perhaps this was due to delaying too long, &c. He thought Estlander's operation open to the objection that it left behind a very large thickened pleura, and he was inclined to remove not only rib, but the intercostal structures and parietal pleura. The operation to be done in stages. Empyemata might be divided into three varieties: The class

following pneumonia, which got well with moderate care, efficient drainage, &c. The neglected class, in which the prognosis was fairly good. The tubercular class, in which the prognosis was very bad indeed.

Dr. A. C. O'SULLIVAN gave particulars of the opsonic power of the blood and pus from two cases of empyema.

Dr. HAYES showed four cases illustrating the good effect after operation done up to ten years previously. He pointed out that formerly irrigation was always carried out, but this was never done now. He relied on puncture with a long needle as the best aid to diagnosis, and thought the severe operation recommended by Sir Arthur Chance unnecessary, as his cases showed that the thickened pleura had resolved.

Dr. NINIAN FALKNER submitted, from the Registrar-General's statistics, a tabular statement of the ages of those whose deaths had been attributed to empyema in 1904, and of the associated conditions.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD JANUARY 19TH, 1906.
Dr. PORTER PARKINSON in the Chair.

Mr. ARTHUR EDMUNDS showed a case of "Cutaneous Pigmentation," showing on the buttocks and back a curious bluish mottling similar to the pigmentation in a large number of Asiatic races of mixed descent. The pigmentation resembles that shown in a Japanese baby recently exhibited at the Society by Dr. Sutherland. Much discussion has been caused by this pigmentation, some holding that it is an evidence of a negroid ancestor, while others, especially the Japanese authors, hold that it is merely a racial characteristic. In the present case there is no history of any negroid ancestry.

Dr. GEORGE CARPENTER showed a case of "Sclerema neonatorum" in a girl of 8 weeks. The child was well nourished and healthy-looking, weighed 20½ lbs.; there was no cyanosis. There was a brawny induration of a pinkish purple hue over the whole of the back and back of the neck, also over the buttocks and upper part of the thighs posteriorly; also two small patches over the occipital region of the scalp.

Dr. PORTER PARKINSON showed microscopic specimens from a case of "sclerema neonatorum" taken from an eight-months infant, who died when 10 days old. The sections of the skin showed chiefly thinning of the epidermis with considerable thickening of the cutis vera, apparently due to increase of fibrous tissue, but this seemed insufficient to account for the sclerema which, the exhibitor suggested, was due to a chemical rather than a structural change.

Dr. LEONARD GUTHRIE showed a case of "Lipomatosis" in a very fat child, but neither weight nor height was abnormal, the discrepancy between weight and appearance being probably due to lightness of skeleton. The obesity appeared to be a morbid condition, not a mere "normal abnormality." Possibly there is a connection between deficient thyroid development and lipomatosis, whilst in the latter lessened oxidation owing to the cardiac condition may play a part. Dr. Guthrie suggested that the case might be one of arrested development with obesity.

Dr. C. O. HAWTHORNE showed (1) two children with Mental Defect and Optic Nerve Atrophy, and (2) a boy, æt. 7, who had almost completely recovered from an Infantile Hemiplegia which followed a convulsive seizure at two years of age.

Dr. GEORGE CARPENTER and Mr. LOCKHART MUMFORD showed a case of Hemihypertrophy in a child of 2½ years, the left side being larger than the right. The face and tongue on the affected side were appreciably larger, and the head was half an inch broader. The left side of the trunk was one inch larger than the right, the left arm half an inch longer, and the left leg one inch longer and correspondingly enlarged. The bones on the hypertrophied side were also larger.

Dr. GEORGE CARPENTER showed a boy, æt. 18 months, who had a soft, freely movable, elastic swelling the diameter of a 2s. piece in the breast, which had been noticed since birth. Latterly it had decreased a little in size. The contents on exploratory puncture resembled milk and were micro-chemically of that nature.

Dr. GEORGE CARPENTER showed a specimen of congenital hypertrophic stenosis of the pylorus, which had been removed from an infant of four weeks. It was born healthy, but persistently vomited immediately after nursing, ever since birth. A tumour the size of the terminal phalanx was felt during life in the neighbourhood of the pylorus. An attempt was made to feed the infant by simple milk dilution, next by a mixture of whey and cream, and then by whey with a fat substitute for the cream, but unsuccessfully. The child vomited and lost weight in spite of the dietary and despite stomach washings, rectal injections of normal saline and minute doses of opium. Albumin water caused the least gastric disturbance. Gastrojejunostomy was performed by Mr. Ewen Stabb, but the infant could not withstand the shock of the operation, and died six hours afterwards.

Dr. GEORGE CARPENTER and Dr. THEODORE FISHER read notes of a case of fatal dilatation of the heart occurring in a boy, æt. 8, in which after death there was no adhesion of the pericardium and no valvular disease. Apparently he had suffered from symptoms indicating cardiac failure from about 1 year, but the only history of rheumatism was of an attack four months before admission. After death the heart was found to be not only dilated but hypertrophied. It weighed 10½ ozs. Microscopically there was considerable fatty degeneration of the cardiac muscle, but this probably was a comparatively recent pathological change.

Mr. ARTHUR EDMUNDS showed a case of successful removal of a congenital sacral tumour.

The tumour had been present from birth, but the mother thought that it was slowly, but steadily increasing in size. It consisted of two distinct parts; one of which was distinctly solid, while the other was definitely cystic. The former was situated slightly to the right of the middle line, overlapping the right sacro-iliac synchondrosis. The skin over it was slightly more hairy than the rest of the body, but otherwise it was quite normal. The tumour itself was about the size of an orange, firmly fixed to the skin, while a fair amount of mobility could be obtained on the deeper tissues. The specimen exhibited shows a section of the whole tumour and the terminal part of the coccyx. The solid portion is seen to consist of fat pervaded by coarse strands of fibrous tissue. In one place a small bone was found with cartilage covered ends. The section shows a small nodule of cartilage. Running through the centre of the tumour there is a branched tube containing the small fatty epithelial balls, which are characteristic of dermoid tumours.

Dr. J. G. EMANUEL (Birmingham) showed an infant with Congenital Absence of the Skin affecting the hands, legs, and feet. In addition, over the temples, the bridge of the nose, and the middle of the lumbar region there were irregular shaped areas in which a similar congenital deficiency in the formation of the epidermis existed. The parts affected were smooth, free from hair, sharply defined from the neighbouring healthy skin, and transparent, so that the delicate underlying blood vessels were clearly visible. The infant was born dead at full term. Microscopic examination of sections showed that the defect consisted of a complete arrest of development of all layers of the epidermis, including its associated glands and hairs. The cutis vera was unaffected except, of course, in so far as it lacked hair follicles, sweat and sebaceous glands.

Dr. PERCY LEWIS (Folkestone) showed photographs of a case of Erythema Multiforme in a boy, æt. 8. He considered it produced by a toxæmic condition induced by injudicious feeding.]

HARVEIAN SOCIETY OF LONDON.

A "Clinical Meeting" held January 25th, 1906, at the Stafford Rooms.

Dr. ALEXANDER MORISON showed a case of Endocarditis in a child, associated with chorea.

Dr. GUTHRIE showed a case of probable "gummy Tumour" in the left cerebral hemisphere. The case will be found in another column under the heading of "Clinical Records."

Mr. CAMPBELL WILLIAMS suggested intra-muscular injections of some form of mercury, preferably calomel, as the most suitable treatment.

Dr. SQUIRE showed a case of "Leontiasis Ossea" (?) in a woman, æt. 29. There had been proptosis and deformity of the forehead from birth. The blindness of the right eye was first noticed at the age of nine. Has been gradually losing sight of left eye; can just count fingers. Forehead is large and there is a marked bony protuberance at the site of the anterior fontanelle. The nasal bones are thickened and the septum is deflected.

Dr. LEONARD GUTHRIE suggested that the malformation was a congenital deformity due to premature synostosis of certain cranial sutures, rather than one caused by Leontiasis Ossea. In such cases, the cranial bones, if prevented from growing in one direction by premature ossification of sutures, expanded in another in order to make room for the growing brain. Characteristic malformations to which various names had been given, resulted. Thus, "Scapho-cephalus," or "boat-shaped" skull, narrow and long with projection of frontal and occipital bones and keel-shaped ridge on the vertex, was due to premature synostosis of the sagittal suture.

The name "Spheno-cephalus" (wedge-shaped skull) had been given to such cases as the present in which synostosis of the parieto-occipital and parieto-frontal sutures led to shortened antero-posterior diameter. The frontal bone here was small and retreating, whilst at the site of the anterior fontanelle, a large wedge or dome-shaped promontory had been formed in order to accommodate the brain. The "frog-face" with bulging eyes, ill-shaped nose, narrow, high arched palate, depended upon defective development of the sphenoid from a similar defect in ossification. The optic atrophy might be due to pressure on the optic nerve, but more probably was a primary and early decay in keeping with general mal-development.

Dr. CAUTLEY agreed with Dr. Guthrie that the case was one of "tower-shaped" skull due to congenital malformation.

Mr. CRISP ENGLISH showed a case of abnormal growth of hair on the chest and shoulder in a man. He also showed a case of carcinoma of both breasts in a woman, æt. 54. A depressed scar on right breast had been noticed twelve months, a swelling of left breast for six months. There were some enlarged glands in both axillæ. He raised the question of treatment.

Mr. EDMUND OWEN advised removal of both breasts, but pointed out that the swelling of the arm was of serious prognostic significance as it implied obstruction to lymphatics or pressure on veins by the growth.

Mr. RAYMOND JOHNSON considered that the swelling of the arm probably indicated actual invasion of the veins by the growth.

Mr. LAMING EVANS showed a case of a skin eruption in a boy, which he considered to be an unusual form of Lichen planus.

Mr. CAMPBELL WILLIAMS discussed the case.

Dr. JOHN BROADBENT showed a case of pulmonary stenosis, probably of congenital origin, in a man, æt. 26. There was a loud systolic murmur over the pulmonary cartilage, but no thrill, and no cyanosis or dyspnoea except on exertion.

Dr. ROBERT MAGUIRE held that the defect in such cases was uncertain except in the case of defect of the inter-ventricular septum. The case under discussion was exceptional. The absence of enlargement or undue

pulsation of the right ventricle seemed to negative pulmonary stenosis. He suggested a persistent ductus arteriosus. It was remarkable that an extreme degree of malformation might exist without cyanosis. In one case he had under observation for eight years there was frequently no cyanosis, but at the autopsy there was only one ventricle, the septum being practically absent.

Dr. ALEXANDER MORISON considered that the lesion might be a defect of the inter-ventricular septum.

Dr. CAUTLEY agreed with Dr. Broadbent that the case was probably one of pulmonary stenosis.

THE LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, JANUARY 18TH, 1906.
MR. FRANK T. PAUL, F.R.C.S., President, in the Chair.

A NEW REMEDY FOR DIABETES.

Dr. J. HILL ABRAM read a note on the exhibition of Secretin, the acid extract of duodenal mucous membrane, in cases of diabetes mellitus. Among other cases Dr. Abram related one of well-developed diabetes in a young patient who made an excellent recovery whilst taking secretin.

Prof. WM. CARTER considered Dr. Abram's communication as most hopeful and full of encouraging possibilities in the treatment of a disease, which, when occurring in patients as young as one of his, had always been regarded as fatal. He for one thanked him heartily for having unreservedly placed in our hands his methods.

Dr. F. A. POND related a case occurring in a young girl of nineteen. The patient was in extremis on the eighteenth day, but recovered completely under the exhibition of tr. digitalis and tr. nucis vomicæ, and the administration of sugar.

Prof. Moore, Dr. R. J. M. Buchanan, Dr. Stooka, Dr. E. T. Davies, Dr. Graham-Martin, and Dr. J. T. Williams also spoke.

THE HÆMATOLOGY OF PREGNANCY AND THE PUERPERAL STATE.

Dr. J. C. M. GIVEN read a paper on "The Composition of the Blood in Pregnancy and the Puerperal State." It was based on the investigation of twelve cases of labour in which the blood was examined before and after labour and at stated intervals during the lying-in periods. A marked leucocytosis of the polymorphonuclear type occurs immediately after labour, and rapidly sinks to normal by the end of the first week. A progressive increase in the number of the lymphocytes then occurs, until at the end of the second or third week they are more numerous than the polymorphonuclear cells. The influence of premature labour, stillbirth, albuminuria, &c. on the blood count was noted.

The PRESIDENT expressed his regret that time would not permit of any discussion on Dr. Given's valuable and interesting paper.

THE COMPLICATIONS OF PNEUMONIA AND THEIR TREATMENT.

Dr. NATHAN RAW read a paper on "The Complications of Pneumonia" which he had met with in an observation of 1,832 cases. He referred more especially to empyema, pericarditis, endocarditis, and the acute general infections produced by the pneumococcus, such as septicæmia, meningitis, arthritis, and peritonitis.

Prof. WM. CARTER referred to two conditions in pneumonia not alluded to by Dr. Raw, one at the onset of the disease, where the engorgement was sometimes so general as to threaten life; the patient sat up, the right heart was over-distended, the pulse small, the face pale or livid, and the respiration laboured; in this condition bleeding was followed by speedy relief. The other was the violent delirium which sometimes suddenly followed the crisis. Opium, which would possibly have killed the patient at an earlier stage, would now save his life. Thirdly, Dr. Carter thought that considering the intense coagulability of the exudate

and the fact that it contained a large amount of calcium salts, preparations of this metal should not be administered at any stage of the disease.

Dr. J. HILL ABRAM said that in a healthy subject complications were less often seen than in almost any other infective disease. They were mainly due to previous damage, e.g., pneumococcal endocarditis, implanted upon old valvular trouble. Many complications, too, are due to secondary infections, as in a congenital heart case under his own care, where the infective trouble was proved to be streptococcal in nature. He could not agree that jaundice was often seen in right-sided cases; in the early stages jaundice was the result of toxæmia, and not serious.

Dr. W. B. WARRINGTON remarked that among the complications seen by him were: apical abscess of the lungs, the diagnosis being made by the persistent presence of elastic fibres in the sputum with diplococci and no tubercle bacilli; extensive and confluent hæmorrhages under the skin, the autopsy revealing pneumonia only; gangrene of the lungs and apparently primary pneumococcal meningitis.

Dr. A. G. GULLAN related two cases of pneumonia, in which typical relapses occurred after 24 hours of normal temperature. These relapses both lasted about eight days, terminated by crises and were accompanied by the physical signs of lobar pneumonia in another part of the lungs.

The following gentlemen also took part in the discussion:—Drs R. J. M. Buchanan, Dr. E. E. Glynn, Mr. Stockdale, Dr. E. T. Davies, Dr. J. Lloyd Roberts.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD. FRANCE.

Paris, F.bruary 4th, 1906.
ABDOMINAL NEURALGIA.

THE commonest forms of neuralgia are those of the face, the sciatic and intercostal nerves. Neuralgia can exist in every place where there is a nerve, but certain forms, as those three just mentioned, are observed most frequently. As regards affections of women, says Dr. Leon Archambault, in his work just out, we are often called to treat abdominal neuralgia, closely connected with the complex genital organs of woman. One form may be due to metritis, another to salpingitis, still another to erosion of the os, etc.; they are of reflex origin.

Women are more predisposed than men to neuralgia; there exists also a question of heredity, and certain maladies, as anæmia, intermittent fever, gout, syphilis, predispose to it. And, a remarkable fact, there is frequently disproportion between the effect and the cause; a very insignificant cause may give rise to intolerable neuralgia, while a very grave affection is attended with but little pain.

Neuralgia of the uterus, for instance, is frequently caused by a small lesion, but is so intense that a grave affection is feared by the patient; happily, there is nothing of the sort. Hystericalgia is generally observed in patients of a nervous disposition and especially in those who present signs of hysteria, and even attacks of hysteria have preceded the neuralgic pains. Sometimes the suffering is very intense; at others moderate, and yet, again, the phenomenon consists only in simple pruritis. Walking, dancing, equitation increases the pain, but curious to say the menses have no influence on this form of neuralgia.

Neuralgia of the ovary, like hystericalgia, is observed in nervous and neurasthenic persons, but it is not so painful, it exists only at one side, that of an ovary that had been formerly diseased and in which there still exists a painful cicatrix. Rarely both sides are affected.

Any effort, abdominal palpation, can provoke the pain, and sometimes an attack of hysteria. Neuralgia

of the vulva is often observed, but, strictly speaking, it consists simply in an excessive sensibility of the external genital organs. The slightest contact produces intense suffering, and that in the absence of any lesion. Naturally marriage is impossible to these patients.

Other kinds of neuralgia are the indirect consequence of abdominal affections in women, as intercostal neuralgia, seen so often in cases of metritis and especially in lesions of the os; sciatica, observed in every affection of the pelvis, but more especially in salpingitis, cardialgia or pain at the apex of the heart, accompanies frequently genital affections, as well as neuralgia of the breast, which is frequently very painful.

Gastralgia is very frequent in all women's diseases. All these forms of neuralgia are fortunately easy to relieve, but in some patients they are very tenacious, and of a duration impossible to define, as they belong more to a nervous state of the constitution than to a lesion of an organ.

The treatment of neuralgia in women is that of neuralgia in general, but it requires frequently tact and tenacity. The anti-neuralgic agents are very numerous, but antipyrin might be tried the first.

Antipyrin	2½ drachms.
Tincture of digitalis	1 drachm.
Water	2 ounces.

A teaspoonful every three hours.

Exalgin gives good relief as well as phenacetin, but they should be prescribed with prudence. Five grains of the former, two or three times a day, and from 10 to 30 of the latter, in fractions of 5 grains.

Methylene blue is very active and without danger, but the patient must be told of its effect on the urine.

Methylene blue	1½ grains.
Medicinal soap	q. s.

For one pill. 2 to 10 daily.

Oxycamphor is also a sedative, but acts especially on dyspnoea; it is given in from 15 to 30 grains daily.

Atropine and morphia in subcutaneous injections act well, but there is danger of the patient falling into the morphia habit.

Revulsion over the affected part is of great utility.

Menthol	15 grains.
Sulphide of carbon	1 ounce.

To be painted over the seat of pain.

A blister gives frequently good results, or pulverisations with chloride of methyl. Tincture of iodine or poultices are anodyne methods, but might sometimes be employed.

Certain medicinal agents are unreliable in their action, but have sometimes succeeded where others failed; iodide of potassium, 5 grains twice a day; sulphate of quinine in small doses (5 to 10) grains daily.

For the treatment of sciatica the following injections are recommended:—

Glycerophosphate of lime ..	¾ gr.
" of magnesia ..	"
" of potash ..	"
Water	15 m.m.

For one injection.

The following pills succeed also very well.

Ext. of belladonna	4 grains.
Ext. of stramonium	8 grains.
Lactophenine	1½ drachms.

Divide into 20 pills; 2 to 3 a day.

HÆMORRHOIDS AND FISSURES.

Storain	5 grains.
Sal. of adrenaline (1-1,000) ..	30 m.m.
Lanoline	½ ounce.
Vaseline	½ ounce.

PSORIASIS.

Pyrogallic acid	1 drachm.
Salicylic acid	1 drachm.
Ether and spirit to liquefy ..	"
Elastic collodion	2½ ounces.

Apply with a brush to the patches.

GERMANY.

Berlin, February 4th, 1906.

THE TREATMENT OF DIABETES INSIPIDUS.

DR. C. POSNER has an article in the *Klin. Wochensch.* in which the treatment of this distressing and fatal malady is discussed. He says the treatment can only be etiological when the disease is caused by syphilis, and that even then it not unfrequently fails. The recently recommended strychnine also fails in individual cases. The restricted water cure sometimes gives results that are lasting. This form—the "dry treatment"—is recommended in all cases of primary polydipsia, whilst in cases of primary polyuria it not only does no good, but may do harm.

We are therefore thrown back upon a symptomatic treatment, that of the tormenting thirst and dryness of the mouth. The writer makes use of the chewing tablets (Bergmann's) 5 or 6 a day, which stimulate the secretions of the salivary glands and help to lessen the distressing thirst. This was successful in the case of a woman, æt. 56. On the first and second days of treatment, she secreted 250 to 300 grammes of saliva, the quantity becoming reduced later on. The thirst was better even when the urine still continued above the normal. The specific gravity corresponded to the diminished excretion of urine (from 6,800 to 3,000 cc.m.), and rose from 1004 to 1012. The writer thinks the tablets will prove useful in other forms of polyuria and polydipsia.

THE PRIMARY RESULTS OF ANTICIPATED CLIMAX

In the *Monatsch. für Geburtsh. und Gynäkol.*, an article appears on this subject by Dr. Emil Pollok, and is a discussion of the subject from an experimental side. After castrating a number of female rabbits the animals were killed and the parts subjected to examination eleven months afterwards. He found the mucous membrane of the tubes partly swollen and corresponding to a commencing carvolyolysis; fatty cells were present in the protoplasm. Ciliated epithelium, which is normally present in the tubal epithelium of German rabbits was no longer so. The degenerative changes also affected the muscular coats of the tubes. Castration set up distinct changes in the uterus itself, which consisted in swelling, deposition of fatty granules, and disappearance of the utricular glands. The further action of castration consists in a fatty inundation of the parenchymatous organs in which, in an especial manner the musculature of the heart suffered. The fatty infiltration of the muscles of the heart perhaps had some connection with the climacteric symptoms that women suffer from in anticipated climax.

Paul Rosenstein discusses the

TRACT OF INFECTION IN THE FEMALE GENITAL ORGANS.

Isolated tubercle of the ovary was not proved, it was associated with tubercle of the peritoneum and Fallopiian tubes. In the latter the descending form was the most frequent—the next frequent form was through the blood vessels, whilst the ascending form was only rarely observed with certainty. Tuberculosis of the tubes appeared to be always bilateral and to be located in the first instance in the mucosa. Tubercle of the tubes as well as of the ovary led quickly to regressive changes—to cariation. The adenoma-like growth on the isthmus of the tubes was not necessarily tuberculous. The characteristic histological changes were sufficient proof of their tuberculous character without any staining of tubercle bacilli.

AUSTRIA.

Vienna, Feb. 4th, 1906.

LEPROSY.

Neumann gave the history and showed a patient he presented to the "Gesellschaft" in 1900, suffering from leprosy. The patient is an officer from Bulgaria, æt. 45, who had suffered from *Leprosy-maculo-tuberosa* five years before he presented himself to Neumann. The forehead was dark brown, the eyebrows, lids and cheeks, greatly swollen, and the body covered with numerous brown patches. On the abdomen and legs hard swellings varying from the size of peas to that of large beans, sharply defined, and dark-coloured. In the sputum, nasal secretions, and parts excised from

the skin, the lepra bacilli were found in large quantities.

The treatment comprised injections of Chaulmoogra oil, *solutio Fowleri* combined with the iodide of potassium.

The patient now seems perfectly free from every symptom of the disease, and is in excellent health!

SPINA BIFIDA OCCULTA.

Frisch showed a patient with accentuated lordosis, slight sclerosis, elevated scapula, and waving gait, as if he suffered from congenital luxation of the hip joint, while the head of the femur was found to roll naturally in the acetabulum.

Over the site of the second lumbar vertebra a deep hole could be found, hard and bony at the bottom, from which a serous fluid exuded on both sides. The Röntgen rays revealed a separation of the cord into two portions.

PERINEXITIS OF BLADDER.

Exner showed a patient he had operated on for perivascular inflammation of the bladder.

The patient was fifty-four years of age, and took ill about a year and a half ago, with severe pain on micturition and cloudiness of urine.

The attendant discovered a small swelling in vesicle region at the time, which as suddenly disappeared. The patient remained thereafter two months perfectly free from pain, but was again visited with all the symptoms of cystitis. The cystoscope was applied, and a small tumour about the size of a marble was found projecting from the inside wall of the organ.

The operation of *sectio-alta* was performed, and the top of the bladder found to be firmly embedded in peritoneum, in which was entangled the omentum and part of the small intestine.

After the adhesions were removed the peritoneum was found penetrating the wall of the bladder, which formed the tumour on the inside. The morbid part of the bladder was resected, the organ closed with sutures, and the patient recovered without any untoward symptoms.

The subsequent examination of the tumour disappointed the presumption first formed of the growth being a malignant neoplasm.

It proved to be a splinter of wood embedded in a mass of granulation tissue, but how the foreign body reached this inaccessible region no evidence is forthcoming. The presumption is that the wood was swallowed in the food and subsequently passed through the wall of the small intestine, carrying the inflammatory peritoneum with it into the wall of the bladder.

Kapsamer recorded a similar case in a female, æt. 40, who came to him with all the symptoms of cystitis. On examining with the cystoscope an inflammatory tumour was discovered on the right side of the bladder as an incrustation. The *sectio-alta* revealed a long phosphatic stone 3 centimetres in length, embedded in the shaggy papilla of the mucous membrane and covered with the product of cystitis proliferans. This supposed stone turned out to be an incrustated bone of a fowl. The patient was dismissed from hospital perfectly cured.

A year later she returned with severe pain in the bladder and pyuria. The cystoscope revealed a tumour on the same place as before, but on this occasion it had a more necrotic appearance. *Sectio-alta* was again performed and an incrustated tumour of fæces about the size of a pigeon's egg removed. After removing the stone the index finger could be passed into a channel running along the wall of the bladder, to an opening in the bowel, where an abscess had been created. The wound was finally closed, but the inflamed mucous membrane of the bladder never seemed to heal, but took a sort of œdema bullosum from which she died some time after.

The *post-mortem* added no more to our knowledge in the case. No history of a trouble with the bowel or alimentary canal was complained of during life, nor anything in the abdomen that would lead one to suspect injury or alteration in the alimentary canal. All the symptoms pointed to the bladder from beginning to end.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

GLASGOW ROYAL INFIRMARY AND ST. MUNGO'S COLLEGE.—At the annual meeting of contributors, held on January 29th, Dr. D. C. McVail moved an amendment to the report of the Infirmary in the following terms: "That as the annual report contains no information regarding St. Mungo's College, the medical school of the Infirmary, which was founded by the Infirmary, and as important questions have arisen vitally affecting the status and future of the College and in particular the question of affiliation to the University, and, further, as an important representation by the Governors of the College has been made to the managers of the Infirmary to which no answer has yet been sent, this meeting, so far as regards the approval of this report, do stand adjourned to this day month, in order that full information on these matters may be laid before the qualified contributors, and such action taken thereupon as may by them be deemed proper." In speaking to his amendment Dr. McVail said that he was the mouthpiece of St. Mungo's College, and that if the reply of the managers to the memorial of the College Governors was unfavourable, the Governors would not continue the College, which had no longer any reason for its existence except to get affiliated to the University in terms of the Act of 1889. The clauses in the Act regulating affiliation had been inserted at the desire of the Infirmary managers who had been the originators of the College. It was the opinion of the Governors that unless their dispute with the Infirmary was settled, affiliation could not be obtained. The amendment was opposed by Mr. J. D. Hedderwick, Chairman of the Managers of the Infirmary, who said that while it was hopeless to discuss the whole of the subjects which interested the managers and the Governors of the College, it was easy to state in a word the fundamental point of disagreement between them. Up till 1883 the term of office of the staff of the Infirmary was 15 years; it was then decided, for various reasons, to reduce this to 10 years, with a possible extension of 5 years in special cases. Then St. Mungo's College came into existence, and the Professors held appointments as members of the staff of the Infirmary; in every case where the 10 years' period terminated in the case of a Professor the 5 years extension was granted, while in the case of other members of the visiting staff who were not Professors, at the end of 10 years they were allowed to go. This discrimination among members of one staff led to dissatisfaction, and in 1898 the managers passed a resolution that staff appointments should be retained until the holders reached the age of 60. In 1905 it happened that three of the members of the staff had been compelled to retire through the operation of this rule, and it was this that had brought about the difference between the College and the Infirmary. He did not believe that the life of St. Mungo's College was threatened because three of its Professors were compelled to resign. To agree to the memorial of the College would be to perpetuate what had been found in other hospitals a misfortune—namely, the indefinite retention of office by certain members of the staff. After some further remarks, it was agreed that the amendment should be withdrawn on the understanding that failing a private arrangement between the parties the matter should again be brought up in public. The question of an age limit is always a vexed one in hospitals, and it is a matter in which it is very difficult to introduce reform without trampling on some vested interest or supposed vested interest. Desirable as a retiring limit is, it is undoubtedly unfortunate for St. Mungo's College, on the eve of affiliation, to be compelled to "swap horses," and possibly some *modus vivendi* will be arranged which will permit of the retention of office of the old teachers until the period of transition is safely over.

SMALL-POX IN SCOTLAND.—On the morning of the 29th, on the arrival at Dundee of the ss. *Pindari*, a

somewhat serious outbreak of small-pox was discovered on board the vessel. She left Calcutta in December, and while in the Red Sea small-pox broke out among the Lascar crew, which subsequently also attacked eight of the British officers. Dr. Templeman at once boarded the vessel, and had the patients conveyed by a special tug to hospital.

ELECTION OF DIRECT REPRESENTATIVES FOR SCOTLAND.—Dr. Bruce, Dingwall, contradicts the rumour that he is not going to seek election as direct representative at the Election next October.

BELFAST.

FORSTER GREEN HOSPITAL FOR CONSUMPTION.—The tenth annual meeting of this hospital was held in Belfast last week, when an interesting medical report was read by Dr. Howard Sinclair, the honorary secretary of the medical staff. The extern department, which is carried on in the city, is practically a selecting ground for cases to be treated in the hospital, the latter being conducted as an open-air sanatorium. During the past year 525 new cases were seen in the extern department, and 180 patients were treated in the hospital, the average number of beds occupied being 33. Dr. Sinclair referred to the recent researches of Professor Behring, and to the discoveries of our old fellow-townsmen Dr. Almroth Wright concerning the resisting powers of the blood. An interesting point about Dr. Wright's investigations is the way in which they confirm from the scientific side what we so firmly believe on clinical grounds, the great value of open-air treatment.

NEWTOWNARDS NURSING SOCIETY.—At the annual meeting of this society, which was held last week, the chair was taken by the Marchioness of Londonderry, who gave a long address on the work in which she is so deeply interested. There were some nine or ten speakers at the meeting, but no medical man is mentioned among them, or even among those present. It is a matter of great regret that the medical men of towns and districts where such nursing societies exist do not keep more closely in touch with the management of them. No doubt cases occur where the nurse seems to interfere with the proper work of the medical attendant, but such cases often occur through ignorance, and the influence of medical men on the committees of management is the best preventive of trouble.

ELECTION OF DIRECT REPRESENTATIVE.—As far as can be judged from conversation Dr. Kidd obtained in the recent election a large measure of support in Belfast and its neighbourhood. So far back as last spring the members of the Ulster Medical Society agreed by a large majority to support his candidature, not from any special objection to Sir William Thompson, but on the ground that it was unfair that all the Irish members of the General Medical Council should be Dublin men. Sir William Thompson had, however, a number of personal friends in the north, who remain faithful to him. On the whole the election has attracted exceedingly little interest, probably because we are surfeited with elections and election literature at present.

PUBLIC HEALTH.—In the five weeks ending January 20th, the cases reported under the Notification Act in Belfast were as follows:—131 scarlatina, 99 typhoid, 55 simple continued fever, 46 erysipelas, 21 diphtheria, 6 typhus, 2 membranous croup, and 1 puerperal fever. Of the six cases of typhus five occurred in one house. The deaths from zymotic diseases were 39, from phthisis and diseases of the respiratory system, 192, as against 103 and 271 in the corresponding period last year. The death rate from all causes was 19.9. The question of the contamination of the Belfast water supply by the discharge of sewage into the Stoneyford Reservoir, was discussed at the last meeting of the Corporation, but the only satisfaction which could be got from the chairman of the Public Health Committee was that the matter was being inquired into, an answer which has been given in various forms for several years. Meantime typhoid shows distinct signs of increasing.

MEDICAL NEWS IN BRIEF.

An Alleged Bogus Doctor.—Serious Charge at Southam.

At Southam, John Dale Tucker, alias William Edward Tucker, alias Dr. William Eldon Tucker, was charged by the Director of Public Prosecutions "for that he did feloniously give a false certificate, and that he did utter the said certificate knowing it to be forged." The evidence was to the effect that the executors of the late Dr. Roper advertised the practice at Napton for sale, and prisoner, writing in the name of W. E. Tucker, replied. By arrangement with one of the executors, prisoner went to Napton and represented himself as Dr. William Eldon Tucker, of Bermuda, which place he said he had to leave because he was consuming two bottles of brandy a day. He was engaged temporarily as *locum tenens*, at four guineas a week, and agreed to purchase the practice for £150, in monthly instalments of £5. Only two instalments had been paid, and before the second sum was received it was ascertained that prisoner was negotiating for the sale of the practice to Dr. Croby for £170, a thing he had no right to do. Witnesses spoke to prisoner giving certificates of death, signed W. E. Tucker.—Dr. Henry Robinson, of London, said he was well acquainted with Dr. William Eldon Tucker, who was in a settled practice in Bermuda. Prisoner was not the man. Police-Constable Isaac Hetherington said in 1904 prisoner lived at 101, Everton Road, Liverpool, and was practising as an unqualified practitioner under the name of Dr. Henry Gould. Subsequently witness came to know him as John Dale Tucker.—Dr. Henry Croby, M.D., said he agreed to purchase the practice for £170. He drew a cheque, payable to William Eldon Tucker, M.B. The prisoner was committed for trial at the next Warwick Assizes, and was offered bail: himself, in £200 and two sureties in £200 each.

Lead Poisoning.—Dangerous Manufactory in East End of London.

THE manufacture of electric accumulators has been scheduled by the Home Office as a dangerous trade, and at the Thames Court, the London Electrical Syndicate, Ltd., of Abbott's Road, Poplar, were summoned for having their works in such a condition that the manufacture of the accumulators could not be carried on without danger to health. Dr. T. Morrison Legge, Medical Inspector of Factories, visited the workshop on Jan. 23rd, and found that the regulations had not been complied with. The mixing of red lead and litharge paste had been carried on without an exhaust fan to carry away the dust. Witness found a workman who had suffered from lead poisoning. In addition to the fan, the bench at which the mixing was done should be covered with sheet lead and the floor concreted, so as to be capable of being washed down every day. The Magistrate made an order that the manufacture should not be carried on until the improvements had been effected, and allowed 25s. costs.

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 26th ult. There were present Dr. A. Havilland Hall in the chair; Mr. H. P. Symonds (Oxford), Dr. J. Brindley James, Dr. Frederick S. Palmer, Dr. M. Greenwood, Mr. Edward Bartlett, Mr. F. S. Edwards, Dr. F. J. Allan, Mr. J. F. Colyer, Dr. W. Knowsley Sibley, and Dr. J. B. Ball. The records of the business for the month of December were very satisfactory and enabled the committee to form an estimate of the result of the working of the society for the year 1905. It was found that the heavy sickness pay disbursement experienced in the spring had been more than balanced by the small

claim account of the summer and autumn and the net result of the years' working is a substantial addition to the financial reserves of the Society. The working expenses have been, as usual, less than half the amount allowed by the rules, and the number of new entrants greater than in any previous year. 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.—Presentation to the Registrar.

AN interesting ceremony took place at the usual monthly meeting of the College on Friday last, when the President, Sir William Smyly made a presentation in the name of the Fellows to Dr. James Craig, Registrar to the College, on the occasion of his approaching marriage. The presentation took the form of a handsome cabinet of table silver and cutlery, to which was added an album containing the signatures of the Fellows. Dr. Craig has acted as Registrar now for nearly twelve years, and has endeared himself to the Fellows by the manner in which he has discharged his many duties. In addition to his official connection with the College he possesses many other interests in the medical world in Dublin, and as General Secretary is responsible to a large degree for the management of the Royal Academy of Medicine in Ireland. His many friends in the medical profession will welcome the very fitting compliment which has been paid him by his College.

Medical Appointments in Viceregal Household.

HIS Excellency the Lord Lieutenant has been pleased to make the following appointments to the Viceregal Household:—Physicians in Ordinary—Sir Christopher Nixon, M.D., William John Thompson, Esquire, M.D. Surgeons in Ordinary—R. F. Tobin, Esq., F.R.C.S.I., Sir Arthur Chance, President R.C.S.I. Surgeon to Household—John Lentaing, Esq., F.R.C.S.I. Surgeon Oculist in Ordinary—Frank C. Crawley, Esq., M.D., F.R.C.S.I. Surgeon Dentist in Ordinary—Kevin E. O'Duffy, Esq., L.D.S.

Indian Medical Service.

DURING the competitive examinations for Commissions in the Indian Medical Service, held in January, forty-four candidates presented themselves for twenty-three vacancies. The following is a list of the successful candidates arranged according to merit:—

Harry Pierpoint, Liverpool Univ., F.R.C.S.Eng., L.R.C.P.; William David Henderson Stevenson, Glasgow Univ., M.B., Ch.B.Glasg.; Henry Puttullo Cook, Edinburgh Univ., M.B., Ch.B.Edin.; Percy Strickland Mills, Guy's Hosp., M.B., B.S.Lond., M.R.C.S., L.R.C.P.; Khandu Gaupatrao Gharpurey, Edin. Univ., L.R.C.P. and S.Edin., L.F.P. and S.Glasg.; William James Fraser, Edinburgh Univ., M.B., Ch.B. Edin.; Desmond Charles Villiers FitzGerald, Dublin, L.R.C.P. and S.Ireland.; Charles Richard O'Brien, Edinburgh Univ., M.B., Ch.B.Edin.; Robert Siggins Kennedy, Queen's College, Cork, M.B., B.Ch. Royal Univ., Ireland.; Charles Aubrey Godson, St. George's Hosp., M.R.C.S., L.R.C.P.; Bernard Higham, St. Thomas's Hosp., M.R.C.S., L.R.C.P.; Norman Haliburton Hume, Durham Univ. and London Hosp., M.B., B.S.Durh., M.R.C.S., L.R.C.P.; Reginald Henry Lee, Trinity College, Dublin, M.B., B.Ch.Dub.; Greer Edmund Malcomson, Guy's Hosp., M.D.Lond.; Frank Phillips Wernicke, Edinburgh Univ., M.B., Ch.B.Edin.; Patrick Heffernan, Trinity College, Dublin, M.B., B.Ch., B.A.Royal Univ., Ireland; William Anderson Mearns, Aberdeen Univ., M.A., M.B., Ch.B.Aberd.; Duncan Macdonald C. Church, Edinburgh Univ.; M.D., Ch.B.Edin.; Stanley Trefusis Crump, Leeds Univ., M.R.C.S., L.R.C.P.; Harry Stewart Hutchison, Glasgow Univ., M.B., Ch.B., B.Sc.Glasg.; Robert George Gibbon Croly, Queen's

College, Cork, M.B., B.Ch. Royal Univ., Ireland; William Barbour Alexander K. Cullen, Edinburgh Univ., M.B., Ch.B. Edin.; James MacGregor Skinner, Owens College, Manchester, M.B., Ch.V. Vict.

Army Medical Service.

List of successful candidates at the recent Competitive Examination for the Royal Army Medical Corps, arranged in order of merit:—

Charles M. Drew, M.A., M.B., Ch.B. Glasg.; Archibald A. Sutcliff, M.B., B.S. Lond., M.R.C.S. Eng., L.R.C.P. Lond.; Arthur G. Cummins, M.B., B.Ch., R.U.I.; Alfred S. Millard, M.B., B.Ch., B.Sc. Edin.; Hugh E. Gotelee, M.R.C.S. Eng., L.R.C.P. Lond.; Archibald S. Littlejohns, M.R.C.S. Eng., B.A. Cantab.; Frank A. McCammon, M.B., B.Ch., R.U.I.; William R. Galwey, M.B., B.Ch., B.A. Dub.; Robert G. Archibald, M.B., B.Ch. Edin.; George de la Cour, M.R.C.S. Eng., L.R.C.P. Lond.; William Egan, M.B., B.Ch., R.U.I.; Frank Forrest, M.R.C.S. Eng., L.R.C.P. Lond.; Timothy W. O. Sexton, M.R.C.S. Eng., L.R.C.P. Lond.; Robert G. H. Tate, M.D., B.Ch., D.P.H., B.A. Dub.; Augustus S. Williams, M.R.C.S. Eng., L.R.C.P. Lond.; Alexander Dawson, M.B., B.Ch. Aberd.; Clive T. Edmunds, M.R.C.S. Eng., L.R.C.P. Lond.; Valentine G. Johnson, M.R.C.S. Eng., L.R.C.P. Lond.; Ernest W. M. Paine, M.R.C.S. Eng., L.R.C.P. Lond.; Edward J. Porteous, M.B., B.Ch. Edin.; Edward M. O'Neill, M.B., B.Ch., R.U.I.; Victor C. Honeybourne, M.R.C.S. Eng., B.A. Cantab.; James C. L. Hingston, M.R.C.S. Eng., L.R.C.P. Lond.; George B. Edwards, M.R.C.S. Eng., L.R.C.P. Lond.; Frederick D. G. Howell, M.R.C.S. Eng., L.R.C.P. Lond.; Charles R. M. Morris, M.B., B.Ch. Dub. Patrick Sampson, L.R.C.P. & S.I.; William H. Gillatt, M.B., B.Ch. Glasg.; John W. L. Scott, M.R.C.S. Eng., L.R.C.P. Lond.; William C. Smales, M.R.C.S. Eng., L.R.C.P. Lond.; John B. G. Mulligan, L.R.C.P. & S. Edin., L.F.P. & S. Glasg.; Arthur H. Bond, M.R.C.S. Eng., L.R.C.P. Lond.; Marcus G. Hill, M.B., B.Ch. Ed.; Richard E. U. Newman, M.B., B.Ch. Edin.; Harold Jacques, L.S.A. Lond.; Donald de Courcy O'Grady, L.R.C.P. & S.I.; Thomas T. H. Robinson, M.B., B.Ch. Dub.; Thomas C. C. Leslie, L.R.C.P. & S.I.; Lawrence G. Gibson, M.R.C.S. Eng., L.R.C.P. Lond.; Philip S. Stewart, M.B., B.Ch. Dub.

Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, and Faculty of Physicians and Surgeons of Glasgow.

The quarterly examinations of the above Board, held in Edinburgh, were concluded on January 29th, with the following results:—

Second Examination (five years' course).—Of twenty-seven candidates entered the following seventeen passed the examination: John McKelvey, Belfast; Peter Morrison Tolmie, Inverness; Hubert Wybrant Powell, Cork; Ormonde Rashleigh Belcher, Cork; Augustus Yourdain Kelsey, Mauritius; Alfred Benjamin Bateman, Cork; James Morham, Edinburgh; Secossene Piarroux Mauritius; Andrew Downie Macfie, Greenock; Thomas Mohan, Louth; Khorshed Sorabji Kanga, Bombay; Edward John Lumsden, Co. Wexford; Charles Austin Paterson, Brazil; Charles James Fail, Edinburgh; George Walter Rundle, Sydney; Llewellyn Etter Davies, Southport; and Hugh Sharpe Williams Roberts, Wales; and one passed in Anatomy.

Third Examination (five years' course).—Of twenty-nine candidates entered the following nineteen passed the examination: Effie Jemima Cassels, Glasgow; Louis Joseph Patterson-Clavier, West Indies; Timothy John Vaughan, Co. Cork; Charles Nyhan, Co. Cork; Richard Baring Davidson, Congleton; Thomas Richard McKenna, Brisbane; James Scott Jackson Stenhouse, New Zealand; Robert Mathia Jones, Holywell (with distinction); William James Valentine Curtain, Melbourne (with distinction); Vincent Sylvester Delany, Longford; John Alfred Steele Phillips, Bengal; Hugh Ferguson Watson, Lochwinnoch; Harry Stokes, India; Lawrence Albuquerque, India; Lakshmiapati, India; Maneckji Burjorji Patel, Bombay; David Williamson, Anderson, South Queensferry; Kaikhusru

Sorabshah Commissariatwalla, Bombay; and Fred Yates, Burnley; and one passed in Pathology and one in Materia Medica.

Final Examination.—Of sixty-two candidates entered the following twenty-five passed the examination and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P. & S.G.: John Galloway, Co. Durham; William Fleming, Durham; Joseph Foreman Berry, Wigan; William Cooke Renshaw, Altrincham; Bernard William Dakers, Hawick; Robert James Manion, Ontario; Syed Imtiaz Hasan, India; John Theodore Anderson, Victoria; Ivan William MacKinnon, Charlottetown; William George Hugh Brooks, Karachi; Oscar Nargolese, Heidelberg; William John Barber, Ontario; Krishnaji Waman Dani, Poona; Clarence William Field, Ontario; George Waller Meade, Cork; Nena Beatrice Ievers, Ceylon; Isaac Harris, Sunderland; William Wilton Johns, Carmarthen; Walter Emory Davies, Wisconsin; Charles Francis, Ceylon; Gilbert Heathcote, Derbyshire; Malcolm Claud Russell Grahame, South India; Robert Carswell, Dalbeattie; John Arthur Cullum, Canada, and George Hart, Glasgow; and eight passed in Medicine and Therapeutics, seven in Midwifery, and ten in Medical Jurisprudence.

NEW PREPARATIONS.

FORMAWN.

THE object of this somewhat novel departure is to treat catarrhs and other abnormal conditions of the nasal mucous membranes with medicated vapour. The special features of the Formawn apparatus may thus be summarised. There is a convenient little inhaler with a double nose-piece and the inhalant is available in the form of a tablet. Nothing could be simpler and handier than the apparatus, which can be carried about from place to place by persons subject to nasal catarrhs. Perhaps one of the most valuable points about the whole thing is the fact that the remedy may be used not only as a curative but also as a preventive for coryza. Medical men wishing to try Formawn can be supplied with samples and literature on application to the Chemical Works, 26, Southwark Bridge Road, London, S.E.

OBITUARY.

SMART ATKINSON FOTHERGILL, L.R.C.P. Ed., M.R.C.S. Eng.

THE death is announced at Haswell of Dr. Smart Atkinson Fothergill. The deceased, who was sixty-eight years of age, had been ill for only about a fortnight. Dr. Fothergill was L.R.C.P. (Edinburgh), and L.M., 1871; and M.R.C.S. (England), 1861. He was public vaccinator in the Haswell and Shotton districts of the Easington Union, surgeon to various local bodies, and a member of the Northumberland and Durham Medical Society. He leaves a widow and grown up family.

GEORGE WELLER, M.R.C.S., L.S.A.

MR. GEORGE WELLER, who practised for many years as a surgeon at Wanstead, died on Thursday at his residence, Russell Lodge, South Croydon, at the age of sixty-five. Mr. Weller received his professional education at the medical school of the London Hospital, where he filled the offices of assistant medical officer, resident obstetric officer, and house surgeon and thence he qualified as M.R.C.S. of the English College, in 1863. While practising at Wanstead he was medical officer to the Royal Merchant Seamen's Orphan Asylum, Snaresbrook, surgeon to the J Division of Police, and surgeon accoucheur to the Wanstead Maternity Society. He had contributed various papers to the professional journals.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

Clinical Remarks on Pelvic Appendicitis. — Armstrong, of Montreal (*Brit. Med. Journ.*, Jan. 13th, 1906) reports six cases of pelvic appendicitis, which bear such a close resemblance to each other clinically that he considers they form a fairly distinctive group. There is usually in these cases a sudden onset of pain, which is often more generalised than in the typical form of the disease. Temperature and pulse rate are only moderately increased. Tenderness on pressure is not marked, except on deep pressure over the pelvic region. The diagnosis at the outset is probably appendicitis, but the attendant does not feel certain about it. In twenty-four to forty-eight hours the symptoms improve, and the diagnosis becomes still more uncertain. Then quite suddenly, after two days of apparently normal convalescence, a sharp recrudescence occurs, peritonitis develops, and the condition of the patient soon becomes alarming. In operating on three cases in which the pelvic peritoneum is primarily involved, the Trendelenburg position is of great value, as it renders manipulation more easy, and ensures greater efficiency in cleansing the infected area. Drainage is always necessary—very occasionally in a dependent position, as through the vagina. Convalescence is usually slow. The author's special plea is that a routine rectal and bimanual examination, by fully establishing an uncertain diagnosis, would suggest earlier operative treatment, and lower the death rate in this variety of appendicitis. S.

Carcinoma of the Breast and its Spread into the Lymphatics. — Lockwood (*Brit. Med. Journ.*, Jan. 27th, 1906) considers that when cancer attacks a structure like the mammary gland, which has no capsule, there is hardly any interval of time between the onset of the growth and its spread into the lymphatics. As it is the author's habit to make an immediate microscopic examination of suspicious tumours of the breast, he has often operated on the disease in an unusually early stage. For instance, a female had a small indurated ulcer of the nipple resembling a Hunterian sore. Before operation no glands were felt. When the whole mammary gland, and both pectorals were removed, several enlarged lymphatic glands were found, the largest one highest up and adherent to the upper part of the axillary artery. In some early cases the lymphatics were larger than the growths from which they sprang. Frequently under the microscope the largest glands do not show cancerous structure, while those that are smaller may do so. Enlarged glands may also prove to be tubercular. In Lockwood's experience it is a dangerous delusion to consider duct cancer as less malignant than the other varieties found in the breast. As to the order in which the lymphatic glands will be affected, it is undesirable to have too definite preconceived ideas as to the direction the disease will take. Cancerous growths occasionally extend from one breast to the other, which is contrary to our earliest notions of the scanty anastomosis of vessels across the middle line. The lymphatic on the inner side of the breast may carry carcinoma into the mediastinal glands, and through the epigastric angle into the abdomen. It is always advisable to remove the lymphatic bearing fascia which lies over the junction of the great pectoral muscle and the aponeurosis of the rectus. As regards the axillary invasion, cancer usually spreads to the glands as follows:—Firstly, the glands along the lower border of the pectoralis major are affected, then those about the uppermost part of the axillary vein, and onward to the subclavian. Subsequently the glands about the subscapular, the lower end of the axillary and upper end of the brachial vessels become involved. But the

upper axillary glands may be enlarged though those under the pectorals may have escaped. Deceptive intervals may also intervene between groups of cancerous glands. Disease spreading to the glands in the cervical region is a late complication, but the condition is not a contra-indication to operative procedure. After a flap of skin is turned off the triangles of the neck, a very searching dissection can be made. Moreover, the process of repair in the neck is rapid, and attended with little pain and constitutional complications. S.

Spindle-Shaped Enlargement of the Blind Spot Associated with Congestion of Optic Disc. — Drs. Ramsay and Sutherland (*Oph. Review*, Jan. 1906) in the course of some perimetric observations in cases of sympathetic irritation were enabled to demonstrate by using Bjerrum's screen that Mariotte's blind spot underwent a change in form and size. They describe the normal blind spot as an oblong space with rounded corners lying to the right or left of the fixation point and having a proportion of 6 to 4 in the vertical length and horizontal breadth and as having one third of the space above horizontal level of the fixation point. They then record five cases of sympathetic irritation in which the blind spot of the sympathising eye was lengthened out into a vertical spindle with a proportion between the length and breadth varying from 10 to 4 to 18 to 4. In all five cases there was congestion of the optic disc with more or less lowering of vision. After enucleation of the exciting eye the congestion of the papilla disappeared and vision improved and the blind spot assumed a normal size and shape. Drs. Ramsay and Sutherland consider that this change in the blind spot affords a useful danger signal. In four of the cases reported part of the visual failure was due to transitory myopia of -0.75 to 0.5 D. M.

Amaurosis following the Injection of Paraffin. — Rohmer (*Annales d'oculistique*, Sept., 1905) records the case of a woman who had suffered from syphilitic necrosis of the nasal bones which produced the usual deformity. A medical man made five or six injections of paraffin with intervals of five to six weeks. The last injection was accompanied by pain in the left eye and immediate loss of sight. The pain which lasted some days, caused the woman to lose consciousness. It was not until a year after the accident that Rohmer met the case and then found in the left fundus very large flame-shaped hæmorrhages and areas of choroiditis disseminata. Vision=0. The author considers that the blindness of her eye was due to thrombosis of the retinal veins. As to the technique of the injections, Rohmer thinks that no more than 3 grammes of paraffin (41° to 42° C.) should be injected slowly with a Lürer's syringe, and the area affected should be controlled by pressure of the fingers. Rohmer refers to such another case which occurred in Nancy. Four or five cases of a similar accident have been recorded within the past few years. M.

Hæmorrhages in the Eye present at Birth. — Dr. Coburn (*Arch. of Ophthalmology*, May, 1904) examined the eyes of 37 infants who were still born, or who had lived for varying periods up to 22 days. He found hæmorrhages in various parts of the eye in 17 cases (21.5 per cent.). The results of other investigators gave a frequency of 10 to 41 per cent., some relying on the ophthalmoscope and others on the microscope for their information as to the presence of hæmorrhages. Coburn found the hæmorrhages in all the tissues behind the ciliary body except the choroid. Retinal hæmorrhages were present in all of the 17 cases. Although in the vast majority of cases in

which this form of accident has occurred there are no after effects to be recognised in adult life, yet, it may be supposed that some of the cases of amblyopia and strabismus, chorioidal atrophy, retinal changes or even glioma have had their origin in hæmorrhages at the time of birth. The author considers the hæmorrhages to be due to the disturbance of the retinal circulation, resulting from compression of the optic nerve and its central blood vessels, due to a distention of the optic nerve sheath with cerebro-spinal fluid from compression of the head occurring during labour. M.

A Note on the Condition of Patients after the Removal of the Appendix.—Lawrence Jones (*Lancet*, Dec., 1905) inquired into the present condition of patients who had been operated on in St. George's Hospital during the three previous years. Of these he was able to trace 87; information was specially asked for on the following points:—(1) the existence of pain, constipation, flatulence, &c., as being possibly caused by adhesions; (2) tenderness of the scar; (3) ventral hernia. Of the 87 patients, 54 had been in perfect health since their discharge from hospital, 27 have enjoyed good health, but have symptoms which from time to time call their attention to the scar; six have definite grounds for complaint of bad health since the operation, three having ventral hernias, three having pain. The author again divides these 87 cases into 44 in which there was drainage employed, and 43 in which the wounds were closed, of the former 19 have had after troubles, of the latter only 14. 13 patients in all have had bulging of the scar or actual hernia. Of these 9 belong to the group whose wounds were drained, only 4 to those whose wounds were closed. In 17 cases where an abscess had formed the appendix was not removed, two of these cases had subsequent acute attacks of appendicitis. Mr. Jones believes that bad after results are far less common among patients whose appendices are removed early in an acute attack, especially if it is the first attack, than where the case is allowed to go on to suppuration or to the formation of adhesions consequent to the recurrence of the disease. G.

The Vicious Circle after Gastro-enterostomy.—In a paper on this subject John Deaver (*New York Med. Journ.*, Dec., 1905) applies the term "vicious circle" to all those cases in which patients suffer from persistent vomiting after the operation of gastro-enterostomy. He points out the fact that while we do not know the real cause of the vicious circle yet we have learned empirically that the posterior anastomosis, with a portion of the jejunum as short as it can conveniently be made, is the form of operation of all others least likely to be followed by pernicious vomiting. By performing this operation, which Mr. Deaver believes to be the correct one, troublesome vomiting will in the large majority of cases be prevented, but should it occur, then no time must be lost in re-opening the abdomen, when in all probability an entero-anastomosis will be the best treatment. Should this fail, then the pylorus should be ligatured with strong silk, and in this way the contents of the stomach prevented from entering the over-distended duodenum. If this second attempt fails, then ligation of the proximal loop should be tried as a last resort. G.

Post-Operative Vomiting and Nausea.—L. Holmes (*Amer. Med.*, Dec., 1905) draws the following conclusions from a careful study of 100 cases:—(1) As a rule, post-operative nausea and vomiting are less dependent on the anæsthetic used than on other causes. Of the pre-disposing causes, sex seems to be the most important, women suffering more than men. (2) The amount of post operative disturbance bears a more or less definite relation to the nature of the operation, those performed on the female genital organs being the worst; abdominal operations coming second, and least upsetting of all, operations in which neither the female genital organs nor the abdomen are interfered with. (3) Vomiting after chloroform is as bad or worse than that which follows the administration of ether. (4) The proper preparation of the patient before operation and the correct treatment after operation

are most important, everything should be kept out of the stomach for at least 12 hours and if possible for 24 hours after an anæsthetic. (5) The degree of gastric disturbance following etherisation has no relation whatever to the amount of ether used. G.

Axillary and Pectoral Cicatrices following Removal of the Breast.—John B. Murphy (*New York Med. Journ.*, Dec., 1905) classifies undesirable sequelæ following mammary amputations and axillary dissections into the five following classes:—(1) fixation of the arm to the chest with more or less limitation of movement. (2) Venous stasis in the arm and forearm with œdema. (3) Lymph œdema of the arm and forearm. (4) Neuralgia in the arm and forearm. (5) Sensitive retracting scars. He gives the causes of these sequelæ as (a) line and position of the incision; (b) excision of skin; (c) leaving arteries, veins, and nerves in the excavated axilla without a muscular or aponeurotic covering; (d) malposition of the arm immediately after operation; (e) allowing too great a dead space to exist between the apex and the base of the axillary triangle during the process of repair; (f) an absence of accurate contact of all the wound surfaces in the axilla immediately after operation; (g) recurrence of carcinoma in the axilla or the sub-clavicular space. The worst results follow when the incision is made along the margin of the pectoralis muscle, as the contracting scar draws the arm closer and closer to the side. The best results are obtained by making the incision high up on the chest and rectangular, the apex just beneath the acromion, the inner limit parallel to the fibres of the pectoral, the outer parallel to the long axis of the humerus. The exposed axillary vessels and nerves must be covered by taking a flap of muscle from the outer edge of the pectoralis major or from the latissimus dorsi, and fixing this in to the apex of the axilla, in this way forming a good covering for the vessels and nerves. The arm is held at right angles to the body by means of a plaster of Paris casing, which is removed on tenth day, leaving the arm free. G.

Operation for Urethral Stricture.—Goldman of Freiburg (*Lancet*, Dec., 1905) discusses the treatment of urethral stricture and strongly recommends the excision of the stricture with end to end anastomosis of the cut ends of the urethra. He shows that it is possible to remove from 4 to 8 c.cm. of strictured urethra and still be able to bring the cut ends of the canal together again, and what is more important still, to obtain quick and firm union, the dorsal vessels of the penis supply the cavernous tissue of the urethra with blood, there is practically no communication between the cavernous bodies and the urethra, hence we may dissect the whole of the bulbous urethra from the penis without running the risk of producing gangrene. Before the urethra is divided the whole of the strictured area should be dissected away from the surrounding tissues, the cut ends are then united with fine catgut over a soft catheter which is tied into the bladder. G.

The Diagnosis of Mediastinal Tumours.—Goldman of Freiburg (*Lancet*, Dec., 1905) describes the great difficulty of obtaining information by tracheoscopy in cases of tumours of the root of the neck or thorax. Its technique is so troublesome that tracheoscopy can be of little use to the general surgeon. He finds that X-ray photographs of the trachea afford valuable information as to its position. The trachea being filled with air appears as a faint white line on the negative; it can often be distinctly traced right down to its bifurcation, and shows on the negative if it is displaced by, or enveloped in, a new growth. G.

NOTE.—A summary will appear each week in the following sequence:—(1) "Recent Medical Literature"; (2) "Recent Surgical Literature"; (3) "Recent Gynaecological and Obstetrical Literature"; (4) "The Recent Literature of Anatomy, Physiology, and Pathology."

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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 reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

DIRECT REPRESENTATIVE FOR IRELAND.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—Will you allow me through your columns to thank most cordially all those who voted for me at the recent election of a direct representative for Ireland, and all those who worked for me so energetically. The result has been my defeat by four votes in a poll of 1,835, but the gratification remains to me that I have retained the confidence of so many of my professional brethren in Ireland.

Dublin.

I am Sir, yours truly,

WILLIAM THOMPSON.

BOOKWORM.—Our correspondent is advised to subscribe to Mr. Lewis' Medical and Scientific Library; herein he would be able to obtain the reading of all the books he is likely to require for a nominal subscription. We do not think *The Times* Subscription Library, to which he refers, stocks medical books to any extent, the fee also is, we understand, heavier in the latter.

THE REPORT OF THE REGISTRAR-GENERAL FOR IRELAND FOR THE YEAR 1904.

In view of our comments on the delay which has characterized the appearance of this report, the Registrar-General for Ireland has drawn our attention to the fact that for four months of this delay his office is not accountable. It appears that the report was in print and signed "for the Press" on August 12th last, and in spite of this some official red tape caused its appearance to be delayed for another four months. No one appears to be able to account for this delay, but it is evident that it was not the fault of the Registrar-General, with whom and with whose staff we sympathise in being deprived of the credit which should attach to them for the manner in which they have carried out their laborious task.

R. L.—Your letter is unavoidably held over.

THE GRESHAM LECTURES.

A correspondent writes mentioning the fact that Professor Symes Thompson, in drawing attention to the value of foods containing glycerophosphates, spoke of Sanatogen as a valuable remedy. This observation appears to have been amply borne out by the experience of many medical men, both in our own country and on the Continent.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, FEBRUARY 7th.

SOCIETY OF ARTS (John Street, Adelphi, W.C.).—8 p.m. Paper:—Mr. L. Gaister: Progress in Electric Lighting.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. Horrocks, Mr. Targett, and Dr. Handfield-Jones. Short Communication: Dr. H. R. Spencer: A Second Case of Ovariotomy during Labour. The President (Dr. Dakin): Annual Address.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chelsea Street, W.C.).—4 p.m. Mr. J. Clarke: Clinique. (Surgical.) 5.15 p.m. Lecture: Dr. J. Cantile: The Tropical Affections commonly met with in Britain.

THURSDAY, FEBRUARY 8th.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8 p.m. Cases will be shown by Mr. A. Lawson, Mr. G. Coats, Mr. S. Morton, and others. 9 p.m. Clinical Evening.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.).—Papers:—Mr. O. Williams: The Ethics of the Profession in Relation to Syphilis and Gonorrhoea. Dr. J. J. Perkins: Tubercular Pleurisy—its Treatment and Diagnosis by New Methods.

BRITISH GYNECOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Dr. Jellett: I. Advanced Carcinoma of both Ovaries; II. Double Prolapsus associated with the presence of a Four Months' Extra Uterine Foetus. Dr. B. Fenwick: Two Cases of Fibroid Uterus Complicated by Pregnancy. Dr. H. Macnaughton Jones: A Note on Crusts of the Vagina. Paper:—Dr. Jellett: Notes on two rare conditions met with in the Pelvis during Operation. The President: Inaugural Address.

CHILDHOOD SOCIETY AND THE BRITISH CHILD STUDY ASSOCIATION (Parkes Museum, Margaret Street, W.).—8 p.m. Lecture:—Mr. J. C. Hudson: American Schools and their Relation to the Child and to Society. (Arranged by the British Child Study Association.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chelsea Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique (Surgical.) 5.15 p.m. Lecture:—Dr. F. J. Mc Ann: Abortion and Premature Labour. **ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN** (Leicester Square, W.C.).—6 p.m. Dr. M. Dockrell: Syphilis: Eruptions—Erythematous (I. Macular; II. Maculo papular); Papular (I. Miliary; II. Lenticular; III. Squamous; IV. Moist). (Chesterfield Lecture.)

FRIDAY, FEBRUARY 9th.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m. Papers:—Mr. B. G. A. Moynihan: A Review of 50 Cases of Cancer of the Stomach treated by Operation. Mr. J. Sherre: Three Cases of Intestinal Obstruction. Dr. Garrod and Dr. Langmead: Associated Malformations, including Transposition of Viscera. **MEDICAL GRADUATES' COLLEGE AND POLYCLINIC** (22 Chelsea Street, W.C.).—4 p.m. Mr. J. Horne: Clinique. (Throat.)

TUESDAY, FEBRUARY 13th.

MEDICO-LEGAL SOCIETY.—8.15 p.m. Paper:—F. S. Toogood, M.D. Alcoholism and Irresponsibility. Paper:—Albert Wilson, M.D.: The Medico-legal Aspect of Dual and Disjointed Personality.

Vacancies.

Bradford Poor Law Union.—Resident Assistant Medical Officer. Salary £100 per annum with rations, apartments, and washing. Applications to George M. Crowther, Clerk to the Guardians, Union Offices, 22 Manor Row, Bradford.

Kent and Canterbury Hospital.—House Physician. Salary £90 a year, with board and lodging. Applications to the Secretary.

Kent and Canterbury Hospital.—House Surgeon. Salary £90 a year, with board and lodging. Applications to the Secretary.

Leeds General Infirmary.—Clinical Pathologist. Salary £200 per annum. Applications to Thomas Blair, General Manager.

Lincoln County Hospital.—Senior Male House Surgeon. Salary £100 per annum, with board, lodging, and washing. Applications to the Secretary, 2 Bank Street, Liverpool.

Manchester Ancoats Hospital.—Resident House Surgeon. Salary £100 per annum, with board, residence, &c. Applications to Saml. Baron, Secretary.

Manchester Ancoats Hospital.—Resident House Physician. Salary £80, with board, &c. Applications to Saml. Baron, Secretary.

Milton and Sittingbourne.—Medical Officer of Health. Salary £450 per annum. Applications to W. J. Harris, Clerk, 76 High Street, Sittingbourne, Kent.

Newcastle-on-Tyne Dispensary.—Two Visiting Medical Assistants. Salary £160 per annum. Applications to the Honorary Secretary, Joseph Carr, Chartered Accountant, 26 Mosley Street, Newcastle-on-Tyne.

Richmond District Asylum, Dublin.—Two Clinical Assistants. Salary £60 per annum, with furnished apartments and full rations. Immediate applications to Conolly Norman, Medical Superintendent. (See advt.)

Stirling District Asylum, Larbert.—Assistant Medical Officer. Salary £150 per annum with board. Applications to Medical Superintendent.

Appointments.

BARWELL, HAROLD, M.B. Lond., F.R.C.S. Eng., Surgeon for Diseases of the Throat, to St. George's Hospital.

BROWN, W. LANGDON, M.D. Cantab., M.R.C.P., Physician to the Metropolitan Hospital.

DICKMAN, H. G., M.B., M.S. Edin., Certifying Surgeon under the Factory and Workshop Act for the Holbeach District of the county of Lincoln.

FAIRFAX, N. P., L.R.C.P. and S. Edin., L.F.P.S. Glasg., Certifying Surgeon under the Factory and Workshop Act for the Innerleithen District of the county of Peebles.

FULTON, JOSEPH, L.R.C.P. and S. Edin., Visiting Surgeon, Belfast Union Infirmary.

GRAHAM, J., L.R.C.P. and S. Edin., L.F.P.S. Glasg., Certifying Surgeon under the Factory and Workshop Act for the Cokerthorpe District of the county of Cumberland.

GRANT, J. DUNDAS, M.D. Edin., F.R.C.S. Eng., Honorary Aural Surgeon to the Royal Otolaryngical Asylum, Busby, Heils.

IVENS, FRANCIS, M.B., M.S. Lond., Surgical Registrar to the Royal Free Hospital, Gray's Inn Road.

LEMIEUX, OSCAR E., L.S.A. Lond., Clinical Assistant to the Chelsea Hospital for Women.

NESBITT G., Resident Physician, Richmond, Whitworth, and Hardwicke Hospitals.

MACFARLANE, W. D., M.B., M.S. Glasg., Clinical Assistant to the Chelsea Hospital for Women.

REID, J., M.B., M.S. Aberd., Certifying Surgeon under the Factory and Workshop Act for the Doune District of the county of Perth.

RUTHERFORD, H. R. C., House Surgeon, Richmond, Whitworth, and Hardwicke Hospitals.

TURNER, A. S., M.R.C.S., L.R.C.P. Lond., Certifying Surgeon under the Factory and Workshop Act for the Beckenham District of the county of Kent.

WAUGH, ALEXANDER, L.R.C.P. Lond., M.R.C.S., Deputy Medical Officer for the Midsomer Norton District of the Clutton Union.

Births.

DOVE.—On Feb. 3rd, at Gothic Lodge, Leatherhead, the wife of W. B. Dove, L.M.A., M.B., of a son.

HODGSON.—On Feb. 3rd, at The Crescent, Salford, Lancs., the wife of Stanley Hodgson, M.D., B. Lond., M.R.C.S., of a son.

THYNE.—On Feb. 1st, at Tudor House, Barnet, Herts., the wife of William Thyne, M.A., M.D., of a son.

WALKER.—On Feb. 4th, at 35, Westgate, Peterborough, the wife of R. Alec. Walker, M.B., F.R.C.S., of a daughter.

WILLIAMS.—On Jan. 25th, at 37 Hope Street, Dunedin, New Zealand, the wife of Ernest Williams, M.B., of a daughter.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, FEBRUARY 14, 1906.

No. 7.

NOTES AND COMMENTS.

The Gramophone as Medicine. It is the wont of Medicine as a progressive science to press into her service the latest scientific discoveries. One of the most recent captives is the gramophone. The surgeons at a London hospital wishing to secure a record of the actual defects of articulation before operating on a boy with a defective palate, translated the voice into terms engraved on the wax cylinder of a gramophone. Then came the operation, and the subsequent improvement in speech could be accurately determined by comparing it with the reproduction. This ingenious test is clearly capable of extension. Not only improvement but changes for the worse in progressive nerve lesions and other maladies could be estimated in a similar manner.

A Royal Crèche. A SIGNIFICANT sign of the times is the interest shown by Royalty in all that concerns the health of the people. Last week one of those gracious acts that warm the hearts of the people towards the reigning family was performed by H.R.H. Princess Christian at Hammersmith, a suburb of London that possesses a large poor population. The appalling infantile mortality of that place has caused considerable heart-searching in the Town Council. Hence the visit of the Princess to a public meeting of that body.

A Home without Parents. THE crèche is to look after the infants whose parents are away at work. The daily absence of the father is the rule in working-class families, and where poverty is extreme or where women can readily obtain employment the mother frequently leaves home also. The risks to the children thus left to their own devices or to the haphazard supervision of a neighbour may be readily imagined. In Hammersmith alone, 1,800 women are employed in factories, 600 in incandescent mantle making, 1,000 in laundries, and 200 in sweetmaking. The municipal crèche is a move in the right direction, and British royalty could find no nobler and simpler means at hand of directly reducing the infantile mortality which is a blot upon our modern civilisation.

Nurs.'s Military Funeral. It is a pleasing indication of the more cordial *entente* that is springing up between the military and medical officers in the Army that appreciation for services rendered during times of sickness is being shown by military officers to the members of Queen Alexandra's Nursing Service.

We had occasion to chronicle some months ago the fact that a nurse in an Army hospital who died of typhoid was accorded the honour of a military funeral—the first time that such a tribute had been paid to a nurse. We expressed a hope at the time that the precedent would be followed, and we are glad, therefore, to note that a Miss Fitzgerald, a nursing sister at Aldershot, who died last week of pneumonia, was buried with full military honours. The pomp of bands, gun-carriages and uniformed men is never more impressive than at the grave-side, and the feeling of comradeship which these touching displays evoke can do nothing but good to both soldiers and nurses.

Arsenic in Beer. A CASE of arsenical beer poisoning has been reported by the Medical Officer of Health for the City of London. Dr. Collingridge was notified of the fact by a medical man, and it was found that the victim had been drinking large quantities of "four ale." On analysis, the particular brew was found to contain a trace of arsenic less than 1'100 grains per gallon. In proof of the diagnosis arsenic was found in the man's hair, but surely traces of arsenic are commonly found in hair, apart from any question of poisoning. Now that the purity of glucose is a matter of rigid scrutiny, the chief sources of arsenic in beer are malt and hops. That conclusion must be somewhat disquieting to the pure beer enthusiasts. It is a matter of interest to know what must be the fate of patients who are often dosed with arsenic for long periods. If minute traces cause such disastrous effects, what must result from the far larger doses administered under the direction of the medical man?

A Strike amongst Medical Men. THE parish doctors of Austria are still on strike, and it is reported that there has been an alarming consequent increase of the death-rate. The reason of their discontent is not hard to gather when we learn that the Governmental fee is twopence for each case of infectious disease, which entails a detailed diagnosis. Let us hope that the Austrian movement will result in better pay for medical men all round. It has become too much of a fashion for governments and private citizens to do good vicariously at the expense of the medical man. Possibly the revolt will travel westward to the United Kingdom, where much beggarly exploitation awaits the besom of reform. It would indeed be a spectacle for gods and men were the medical profession of our own country to organise for the raising of ill-paid club, union, and other contract practice.

LEADING ARTICLE.

WHAT IS WHISKEY?

THE problem of food adulteration, set on foot a generation ago by the indefatigable genius of the late Dr. John Hassall, is still with us. Notwithstanding the crucial importance of maintaining the highest possible standard of purity in food and drink, there can be little serious doubt that the community is at the present moment being defrauded in pocket and injured in health by the extensive adulteration of the articles in question. The fact of the matter appears to be that the progress of public health involves one long battle against the vested interests that batten on the misery, the vice, the poverty, and the helplessness of the masses. Hitherto the tendency has been to focus attention upon articles of food, and to a great extent to ignore the vitally important question of the purity of alcoholic liquors. Years ago a series of spasmodic prosecutions of publicans in London revealed wholesale adulteration of a most serious nature. It is more than probable that the abuse still exists, but Excise prosecutions are just as rare as police proceedings against licensed victuallers. And so "the trade" is allowed to pursue its own sweet will, and to strengthen its position from time to time by the enormously powerful brewers' and distillers' influence at work in both Houses of Parliament. With all this social tangle the medical profession is deeply concerned, inasmuch as the evils of intemperance profoundly affect the moral and the physical health of the community. It would be impossible to imagine any great public health gospel that did not put the control of the liquor trade in a foremost place. Of late, medical men have turned their attention to some of the practical aspects of the question. One of the most important steps achieved within recent years was in the legal decision that said brandy must be made from the juice of the grape. A similar approach to a standard is still wanting as regards whiskey, but litigation is pending that it is to be hoped will settle the point once and for all in a satisfactory fashion. The solution of the problem is of importance to those who find it necessary to prescribe this particular form of stimulant. We will endeavour to state concisely the antagonistic and conflicting views which are held on the subject. There are two different substances advertised and offered for sale under the designation. First there is the old-fashioned all malt whiskey made in a pot still, and there is the more modern silent spirit made in a patent still and flavoured to taste. The ingredients used vary in the two cases, and there are also certain minor but not essential differences between the Scotch and Irish varieties of pot-still whiskey. Scotch whiskey is a spirit distilled in a pot-still from malted barley mixed, in some cases, with a little unmalted barley and wheat. In the case of Irish whiskey, in addition to the malt, certain other indigenous grains are used, the term "indigenous" being employed in

the definition to exclude rice and Indian corn, which are not admissible. In Ireland, in the process of distillation, anthracite coal is employed as a source of heat, whilst in Scotland they use peat, the fumes of which, passing up through the perforated floor on which the malt rests in the kiln, gives it that peculiar flavour which is its great characteristic. The patent-still spirit is made from Indian corn, rice, or potatoes—in fact, almost any substance containing starch will suffice. The product is known as "silent" spirit from the fact that it gives no clue to its origin, so that if properly flavoured it may be made for brandy, whiskey, or anything else of a spirituous nature. The pot-still product, however, is redolent of its origin, and is whiskey and nothing else. There is also a difference in chemical composition, for whilst silent spirit is simply ethylic alcohol, pot-still whiskey contains a number of bye-products of which ethers, the higher alcohols, and certain acids and aldehydes are the most important. Amongst chemists these bye-products are sometimes spoken of technically as "impurities," but this term is not employed in the ordinary and popular sense of the word; in fact, so far from their being injurious, it is on their presence in adequate proportions that the virtues of whiskey as an alcoholic stimulant depend. Silent spirit can be produced at a considerably less cost than pot-still whiskey, and little by little the custom has grown up in this country of selling the substance with a certain admixture of real whiskey under the name of whiskey, with, perhaps, the addition of some fancy title suggestive of a Scotch or Irish origin. This, it is contended, is a fraud on the public, seeing that it is sold to the prejudice of the purchaser, and is not of the nature, substance, and quality demanded. This is practically the question which has been under the consideration of Mr. Fordham at the North London Police Court since November 6th last, and still remains undecided. With the commercial aspect of the subject we are not concerned, but medically it is to us a matter of considerable moment. Dr. Murrell, of the Westminster Hospital, the only member of our profession who has yet given evidence, pointed out that during the last twenty years there had been a considerable change in the form of alcoholic stimulant employed and that whilst formerly brandy was universally prescribed, it is now very largely superseded by whiskey, the explanation offered being that good old well-matured brandy is difficult to obtain. Whiskey is used to stimulate the heart, to dilate the blood vessels, and ward off collapse in many of the acute specific diseases, such as enteric fever and pneumonia. It is also used in various forms of dyspepsia, especially the atonic dyspepsia of the aged and the gouty, when wines and other saccharine beverages would prove harmful. We attach much importance to the presence of the bye-products in whiskey, and silent spirit, which differs but little from the rectified spirit of the Pharmacopœia, has not the same

therapeutical effects. Whiskey ought to be pot-still and made from malted barley, with possibly, in the case of Irish barley, the addition of some unmalted whiskey and other indigenous grain. A point to which sufficient attention has not been paid is that all whiskey used for medicinal purposes should be of some age and well matured. It is difficult to lay down hard and fast rules, but whiskeys fifteen to twenty years old are readily procurable and at a moderate cost. There is no doubt that whiskey improves by keeping, but there is no evidence that a similar change occurs in patent silent spirit. In Scotland, both doctors and patients are reputed to be good judges of their national beverage, but in England many people who are supposed to be life-long whiskey drinkers have in all probability never tasted the real article. The farther north the "fatter" the whiskey; in other words, in Scotland "all malt" is drunk, whilst in the South the consumer has to be content with a mixture containing a large percentage of the artificial substitute.

NOTES ON CURRENT TOPICS.

Professor Behring's "Tuberculase."

THE recent address of Professor Von Behring to the German Agricultural Council, on his researches into the prevention and cure of consumption, appear to have roused a good deal of criticism amongst his fellow scientists. There seems to be a somewhat prevalent view that his claims to curative treatment have been premature and founded on theory. Nor are his latest announcements likely to escape serious criticism. He claims to have made a serum which will protect calves from tuberculosis. He further states that by means of a curative agent called "tuberculase," he can cure cows, a fact shown by the disappearance of tuberculosis germs from their milk. His third claim is that by means of a serum he can cure tuberculosis in the human subject. While it would be unwise to form any opinion as to the ultimate value of Professor Behring's work, it is nevertheless much to be regretted in the interests of mankind at large that he was tempted to announce his beliefs before they were capable of definite scientific demonstration. Experience has repeatedly shown, however, that even our greatest minds may walk open-eyed into the pitfall of anticipation.

Pre-Arranged Appointments.

COMPLAINTS frequently are brought to our notice by candidates for medical appointments that though such posts are advertised with circumstantial detail and every appearance of *bona fides* they are in reality not vacant at all, because the body in whose gift they lie have already made up their minds as to whom they will elect. This is a genuine grievance, and one that should be removed. There are often good reasons, such as personal knowledge and previous services, that entitle a committee to regard a certain man as

thoroughly suitable for a position; in that case no advertisement should be issued, or, if issued, a clause should be put in to indicate that the notice is only formal. Occasionally there are less worthy reasons, but even then it is not fair to invite competition for what is practically a close appointment. Many candidates for house-surgeoncies and similar posts are put to much inconvenience in obtaining testimonials and recommendations, and even waste weeks of valuable time waiting for a possible summons to appear, when all the time there has been no demand for their services, and the advertisement has only been issued to comply with a by-law of an institution or a resolution of a committee. To say that an appointment is vacant when it is practically filled is substantially to say what is not true, and the practice of so-doing reflects no credit on those who do so in order to give an appearance of fairness to an unfair proceeding.

Medical Black List.

It would be interesting to find out which class of the community is most generally and regularly swindled, but in the absence of demonstrable evidence we strongly incline to the idea that medical men are. Excluding "God's poor" and the "poor devil" whom the doctor is always willing to do his best for, irrespective of payment, there are a vast number of people who systematically neglect the payment of their doctor, or, rather, their doctors, for they successively patronise the whole faculty in the neighbourhood. It should be possible, by means of combination and organisation, for medical men to guard themselves against swindlers of this kind, and we recommend to their notice the action of the doctors of St. Louis who have recently decided to issue, for mutual protection, a black list containing the names of people who owe them money. There are supposed to be no less than fifteen thousand names ready for the first number which is to appear shortly, and to these there will be added monthly those of other *chevaliers d'industrie* who prey on the profession. Were such a list arranged in every town for private circulation among practitioners, it would pretty effectually put a stop to the major portion of the bare-faced robbery that deprives an honourable body of men of the reward for their labours.

The "Tribune" and Advertisements.

OUR new contemporary, the *Tribune*, has been well received in all quarters, a fact which is not without encouragement for those who feared that the days of responsible and sober journalism had passed away. We note with particular satisfaction that the proprietors announce that they intend to exercise a strict supervision over their advertisement columns, and will refuse insertion to anything of a fraudulent or offensive character. Moreover, they will, on proof, stop the insertion of any advertisement which does not accurately describe the article sold. It is a bitter, but by no means supererogatory, comment on the com-

mercial morality of a large section of the newspaper world that a notice of this kind should be deemed necessary, and, without wishing unduly to praise a person for doing what is plainly his duty, we may remark that this determination of the proprietary of the *Tribune* does them great credit. But, alas for the frailty of man, we have only to turn over the pages to find the usual proportion of quack medicine advertisements, garnished with the usual high falutin' suggestions and suppressions. On page 4 of the issue of February 8th, there is an advertisement of "Anturic Salts, Ltd.," headed "Rheumatism's Danger Signals," which describes in purple language the dangers of rheumatism and gout, the prodromal symptoms of these affections, and their method of cure by using "Anturic Salts" in the bath. We select the following statements:—"Anturic Bath Salts is (*sic*) the real remedy. . . It positively cures in the bath. . . Drugs are unnecessary, and there is no need to diet. . . Anturic Bath Salts cures (*sic*) by penetrating the skin, dissolving the poisonous uric acid salts, and discharging them from the system. . . . Whether the complaint is in its early or advanced stage, the result is always the same, because Anturic Bath Salts completely eradicate the cause." We would ask the proprietors of the *Tribune* whether they are of opinion that such phrases, "accurately describe the article sold," or, indeed, any article in the compendium of human philosophy.

Children and Sexual Questions.

THE right and the wrong way of letting children understand the relation of the sexes is one of the highest importance to society, both from the point of view of general morality and from that of the prevention of venereal disease. The general *laissez-faire* policy adopted by parents cannot be too strongly condemned, for it makes for guilty knowledge and practice among boys, and is accountable for a certain amount of seduction and much married misery among girls. The evils of this course are being strongly shown up by medical men in America, and the case for responsible explanation and information on the part of the parent is forcibly insisted upon. A book by Dr. Wilson, of Philadelphia, has lately been published with a view to guiding parents as to how the question may best be approached, and the cognate subjects of venereal disease and illegitimacy dealt with sensibly—and without prudery. The wisest plan appears to be to approach the subject from the biological aspect, tracing the methods of reproduction of plants and the lower animals, and thence to pass through the higher animals till man is reached. The drawback to this method is that it pre-supposes a certain acquaintance with biology on the part of the average parent, which in fact he is not possessed of. A very little study, however, will enable him to acquire it, and to medical men in relation with their own children and those of their patients who seek advice on the point the subject presents no difficulty. Incidentally

it may be noted as one of the advantages of teaching science in schools that the sexual relationship naturally arises and is as naturally disposed of.

Nursing on its Dignity.

A MEETING of the Royal British Nurses' Association was held on February 7th to discuss the Bill for the State Registration of Nurses, which the Association propose to introduce into Parliament this session, and a very lively meeting it was. Trouble began by the chairman, Sir James Crichton-Browne, announcing that it had been discovered that through technical flaws, the last meeting of the Association was irregular, and it was therefore proposed that its proceedings should be rescinded. Several ladies espied in this an attempt to stop discussion, and loud clamour arose. Eventually the proposal was passed on a promise being given that the Bill should be debated clause by clause, and the meeting settled down to business. However, when the composition of the proposed Board came to be discussed, the excitement rose high again, as a section of the audience felt that too many doctors were to be on the Board, and that this arrangement would tend to the undue subjection of the nursing element. The excitement, which was gradually working up, culminated in the statement made by one of the nursing representatives that many doctors knowingly sent out women of bad character as nurses, and that under the proposed constitution they would be able to put such women on the "Register." Nor did the protests of the audience succeed in inducing the lady to retract her words. The next speaker, also a lady, said that she would rather be governed by medical men than by the turbulent women who were present, and Sir James Crichton-Browne, aptly remarked that the Association need not fear any extreme avidity on the part of doctors to snap up seats on the Board.

State Children.

ALL good economics start from the individual as surely as they end with him; that is to say, that the individual welfare is, or should be, the aim of all State organisation. The political problem is how best to accomplish this end, but it is certain that no system which does not regard the well-being and good upbringing of children can be sound. Into our old State this truth is beginning to make headway, but it is difficult to find the best medium for its expression among old prejudices and long-standing ideas. The Colony of New South Wales, which, like all the Australian colonies, wants population first and foremost, has risen to a high sense of the value of children and to its responsibility for their welfare. A State Children's Relief Board was recently created to take charge of all children who either had no parents or bad parents, or were bad in themselves. Under the guidance of the Hon. Dr. Mackellar, an enthusiastic administrator, this Board has succeeded in doing great things for

such children. It has now some seven thousand children under its care, about half of whom are placed in respectable homes under good guardianship or in State institutions, whilst the other half are with their mothers or relatives under a strict system of instruction. Many of the latter are illegitimate, and the Board does not hesitate to aid indigent mothers with pecuniary help when they are unable properly to tend their children. The aim of the Board is to promote the physical and moral well-being of children generally, and it guards children in all departments of life with a jealous eye. When parents are considered unfit to rear children in a decent manner they are taken from them and placed under proper guardianship, the parents being compelled to aid in their maintenance. Special Children's Courts are in existence for the trial of juvenile offenders, and parents are punished for contributing by wilful default to the delinquency of their offspring. The Board is receiving warm support from the medical profession in the Colony.

Yellow Fever via the Panama Canal.

HITHERTO the Pacific Islands have been free from the scourge of yellow fever. This fact is curious when we consider that they possess, in common with the West Indies, the tropical temperature necessary for the incubation of the *Stegomyia fasciata*, which harbours and transmits the parasite of yellow fever. The only absent link is the specific micro-organism which, according to Mr. V. L. Kellogg, of the United States Fisheries Bureau, has not been able to survive the conditions of the voyage round Cape Horn, hitherto necessary to transit from the West Indies to the Pacific Islands. All that will probably be changed by the completion of the Panama Canal, and the yellow fever organism may be transmitted from West to East in a state of fell activity. In that case the result would be like putting a light to dry heather. If trade be established by the new route, it is, moreover, difficult to imagine how the risk could be averted by any known sanitary precautions.

Force of Life Company.

QUACKERY, for some curious psychological reason, finds a peculiarly congenial soil in the American temperament, and the number and variety of patent medicines, osteopathic cures, nerve treatments, and illegitimate medical enterprises of one kind and another is positively astonishing. It would be difficult to say which has the most dupes, but the "Force of Life Company," which is said to have treated something like a million patients, must, we imagine, very nearly have attained that distinction. The vast ramification of its operations is only equalled by the appalling simplicity of its methods of "cure"—most of these being of the lowest order of imposture on credulity. American citizens of high position and presumably intelligence are amongst its *clienteles*, and the profits have been

enormous. President Roosevelt has turned his personal attention to this huge swindle, and has lately ordered the arrest of some of the directors for using the Post Office to defraud. Fortunately in America the Post Office has regulations of its own against the transmission of fraudulent advertisements—an example which our own department might well copy—and now that the prosecution has been initiated it may be hoped that the "Force of Life Company" will be dealt with according to its deserts.

PERSONAL.

H.R.H. PRINCESS CHRISTIAN attended a meeting held in the Hammersmith Town Hall on the 7th instant to consider the possibility of founding a crèche in the neighbourhood.

SIR JOHN BATTY TUKE has been re-elected by a large majority as Parliamentary Representative of the Universities of Edinburgh and St. Andrews. His record of work in favour of the medical profession in the last Parliament more than warrants the confidence of the electors.

THE Chair of Forensic Medicine in Edinburgh University, rendered vacant a month or two ago by the resignation of Sir Henry Littlejohn, has been filled by the appointment of his eldest son Dr. Harvey Littlejohn, lecturer on Forensic Medicine, Surgeons' Hall, Edinburgh.

WE learn that Dr. Stocker, medical inspector at Glasgow under the Emigration Department, has been appointed to succeed Dr. Spooner as chief medical emigration officer at the Port of Liverpool.

PROFESSOR VON BERGMANN, the well-known Berlin surgeon, has been recently elevated to the peerage.

SIR E. P. WILLS has generously given £1,500 for the endowment of a bed at the Bristol General Hospital.

THREE lectures on the physical anthropology and ethnology of British New Guinea will be delivered at the Royal College of Surgeons, by Professor Charles G. Seligmann, on February 12th, 14th, and 16th. The lectures will be illustrated by the lantern and will begin at 5 p.m.

MR. JAMES CRAWFORD MAXWELL, District Commissioner, who is returning to Sierra Leone, is a graduate of Edinburgh University. He was formerly in the Army Medical Service, and holds the West African medal with clasp, 1898-1899. During that campaign he was severely wounded in the neck in one of the brushes with the natives. On another occasion a native at short range deliberately fired at him with an old flintlock musket. Fortunately the aim was not true, and a miscellaneous assortment of broken metal lodged in the body of a carrier, who died within twelve hours.

PROF. ROBERT BOYCE, F.R.S., has kindly consented to give an address at the fifteenth International Medical Congress on "The Prophylaxis of Yellow Fever as the result of the 1905 Epidemic in Central America and New Orleans." This address will take the place of the communication promised by Sir Patrick Manson, K.C.M.G., who is unavoidably prevented from attending the meeting at Lisbon.

THE second annual dinner of the Association of Medical Diplomates of Scotland will take place on the 23rd instant at the Trocadero, London, when Dr. McGillivray, President of the Edinburgh College of Surgeons, will be the principal guest, together with Mr. Tweedy, President of the London College. Tickets, 10s. 6d. each, may be obtained of the Dinner Secretary, Dr. Féré, Northampton Square, London, W.C.

A CLINICAL LECTURE

ON

GONORRHOEAL RHEUMATISM AND GONOCOCCIC INFECTION.

Delivered at the Westminster Hospital.

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

Physician and Lecturer on Medicine at the Hospital, and Examiner to the University of Aberdeen.

GENTLEMEN,—I beg to present to you to-day for your consideration certain cases of gonorrhœal rheumatism, and the first point I wish to impress on you is that there is no such disease, but that it is simply a manifestation, or symptom if you like, of a general gonococcic infection. In previous lectures I have demonstrated to you, and I hope to your satisfaction, that both in tuberculosis and in pneumococcic infection almost every organ and tissue of the body may be involved. It is pretty much the same with the gonococcus; it is a disease of the septicæmic type and the gonococci are being constantly conveyed to different parts of the body through the agency of the blood and the lymph channels, exciting secondary local manifestations not only in the joints, but elsewhere. The site of inoculation is usually the urethra in men, the vagina or os uteri in women and the vulva in little girls. The conjunctiva is often the starting point in children; less commonly in adults. Rectal and buccal cases have been recorded on the Continent, but with these we need not deal. Some enthusiastic observers have injected themselves subcutaneously and experimentally with cultures, and have been duly rewarded with elevation of temperature, malaise, pains in the muscles and inflammation of the joints. It seems a useless and unjustifiable experiment, for so much more can be learnt by simple clinical observation. The gonococcus under favourable circumstances produces its specific effects by whatever channel it effects its entrance into the body, and gonococcic infection does not of necessity involve a preceding urethritis, although it is one of the commonest forms of origin. Incidentally it may be noted that the gonococcus is most readily absorbed from the urethra when there is a stricture.

Returning to our gonorrhœal rheumatism it is incorrect to speak of it as a rheumatism or even as an arthritis, for it is more commonly a synovitis with effusion into the sheaths of the tendons. It differs from rheumatism in every essential particular and is not amenable to the same methods of treatment. The first attack may or may not be preceded by a specific gonorrhœal discharge, but when such is the case subsequent attacks may follow a urethritis in which gonococci are absent or are not readily detected, and still later there may be attacks without any urethral discharge. The interval which elapses between a gonorrhœal infection and the onset of the arthritic manifestations varies much in different cases, it may be only a few days after the first appearance of the discharge, or it may be delayed for some weeks. The onset is not sudden, and is rarely ushered in by a rigor. There is little elevation of temperature, and when it is hectic in character it may be taken as an indication that there is a mixed infection. In uncomplicated cases there are the usual indications of constitutional disturbance such as headache, furred tongue, loss of appetite, constipation and pains in the limbs, but they are transitory and never severe. There is a common opinion that gonorrhœal rheumatism is essentially a man's disease, but it is met with quite as commonly in women, and then is usually ascribed to some other condition, such as gout or rheumatoid arthritis. Another prevalent opinion is that it is a monoarticular affection and that the favourite site is the knee. It is true that the knee frequently suffers, but the joint from its exposed situation and from the fact of its being imperfectly covered by other tissues is liable to arthritides of all kinds. This proclivity is not

characteristic of gonococcic infection, and is not more pronounced than in other diseases in which the joints are affected. The hip, wrist, elbow, shoulders, and hand are frequently involved. Certain joints not usually attacked by rheumatism may be implicated, notably the temporo-maxillary, the sacro-iliac and the sternoclavicular. The onset is usually marked by swelling and pain, the swelling being due to the effusion of serum into the joint cavity and its surrounding tissues. There is little redness or blush on the surface, and the pain, although severe is not comparable to that of gout or acute rheumatism. Exceptionally, however, arthralgia is the prominent symptom, and there may be little swelling or other evidences of inflammation. Metastasis is not common, and there is no tendency for the inflammation to shift from one joint to another, a point of diagnostic importance. Effusion into the tendon sheaths is of frequent occurrence, especially when the wrist and ankle are involved. The dome-shaped swelling of the dorsum of the hands is common and characteristic. Affections of the fasciæ are frequent, and the plantar fasciæ are especially liable to suffer, giving rise to flat-foot. Cases of pain in the heel, which cannot be referred to a short os calcis or to gout, are due to this cause. Another symptom is pain in the muscles, which may be mistaken for chronic myositis or rheumatism. When it attacks the lumbar fasciæ it is readily confounded with lumbago. The effusion into the joints rarely runs on to suppuration, although the complication may occur in tuberculous subjects, and is not uncommon in pyæmic gonorrhœa. The inflammation as a rule soon subsides, but after repeated attacks the joints may be irremediably damaged, and may be rendered useless by fibrous adhesions. The determination of the particular joint affected often depends on some accidental cause. A man plays football a few weeks after contracting a gonorrhœa and the disease attacks his ankles; his friend, under similar circumstances, carries a parcel to oblige a lady and gets it in the hand. I have known it occur in a medical man in the right wrist after a heavy "placental" case. The determination of site is not peculiar to gonococcic infection, but is seen in gout and in other arthritic affections.

The articular manifestation is but one evidence of gonococcic infection, and there may be accompanying conjunctivitis, iritis, and sclerotitis; of less common occurrence but well recognised sequelæ are endocarditis, pleurisy, meningitis, neuritis, especially of the sciatic variety, and general arteritis. Many cases of arterial degeneration are due to this infection; in fact there is no tissue of the body which can claim immunity from its attacks. Even subcutaneous abscesses are sometimes formed, gonococci being found in the pus. This, it must be admitted, is a rare complication, for the gonococcus alone rarely leads to purulent formation. On the other hand the chances of a mixed infection are great, considering the facilities which are offered for the invasion of pyogenic organisms from a gonococcic lesion.

I should like to say a few words about gonococcic iritis because it is a subject on which there seems to be some difference of opinion. Some people have even gone so far as to say that this form of iritis does not exist, but that is an entire mistake. The two forms of iritis which rest on a sure and firm basis are the syphilitic and the gonococcic. The rheumatic is nebulous, and when a man comes to you with a diagnosis of gouty iritis you had better inquire into his past history and

that will probably solve the mystery. Gonococcal iritis is concurrent with the arthritic affection, or at all events comes on about the same time. I have, however, known it appear some months after the subsidence of the joint trouble and quite apart from any fresh infection.

In women, in addition to these symptoms we get the effects of direct continuity of infection, such as salpingitis, metritis or ovaritis. A large proportion of cases of sterility are due to gonorrhœa. The husband contracts gonorrhœa in his bachelor days and although free from all acute symptoms, still retains a hardly perceptible gleet, which is quite sufficient to account for the mischief. These women are usually œmic, destitute of energy, and incapable of much physical exertion. They are treated for womb trouble, and undergo curetting and other modes of treatment favoured by gynecologists. They suffer from many of the general symptoms met with in the victims of "larval syphilis." The co-existence of a vaginal discharge, whether acute or chronic uterine or ovarian mischief, and an inflammatory condition of one or more joints should always excite suspicion.

The connection of gonococcal infection with the invasion of tubercle is well-known. In some cases of gonorrhœa the tubercle bacilli as well as gonococci have been detected in the discharge. This is probably the explanation of some cases of genito-urinary tuberculosis of the "ascending" variety. In man the testicle, epididymis, prostate, bladder, or kidney may all suffer. In much the same way joints which have undergone gonococcal inflammation may at a later stage become tuberculous.

Gonococcal arthritis of conjunctival origin is common in young children. Clement Lucas has recorded a series of cases which show that ophthalmic rheumatism may attack infants either as an acute arthritis accompanied by much pain, swelling and redness, or as a subacute synovitis, with effusion. The original ophthalmia may be due to an inoculation from the vaginal discharge of the mother at the time of birth, or as in the epidemic form which occurs in children, from infected towels or linen. In these cases the joint affection develops about the end of the second week from the infection. The arthritis speedily clears up, and rarely leaves permanent mischief. This form of infection is rare in adults, but the following is a case in point:—

A man, æt. 25, was brought to Westminster Hospital in an ambulance on Sept. 21st, 1904, suffering from what was supposed to be rheumatic fever. The history was that on the previous day, being then in perfect health, he had an attack of acute double conjunctivitis followed in a few hours by inflammation of the right wrist and the left knee. The patient on admission had a temperature of 101.8° F., and was sweating profusely. On examination it was found that the wrist itself was not involved, but that there was considerable effusion into the cellular tissue of the dorsum of the hand, which was dome-shaped and boggy, a condition which might readily have been mistaken for chiragra. The knee was swollen, red, hot and tender, but contained no fluid. On the following day the inflammation in the left knee subsided and the left elbow and the right knee were attacked. The temporo-maxillary, sacro-iliac, and sterno-clavicular articulations were not implicated. The patient was placed on full doses of salicylate of sodium, first of the synthetic and then of the natural salt, but without amelioration of the symptoms, the temperature ranging from 100° to 102° daily for many weeks. There was no cardiac complication and no pericardial rub or effusion could be detected. There was no tonsillitis and there was no history of syphilis, gout or alcoholism. A gonorrhœal history was suspected, but the patient denied any attack past or present, and squeezing the urethra gave a negative result. The urine was of specific gravity 1020, acid, and contained no albumen. No flocculi were at any time observed in it. There was a history, at the age of 22 years, of an attack of acute rheumatism

of some weeks' duration. The œdema of the hand continuing, the fingers were carefully examined but no abrasion or wound could be detected, and the temperature was not of a hectic type. The eyes were treated with boracic acid lotion, but without improvement in their condition, and on October 7th, in addition to the conjunctivitis, there was much ciliary congestion. The patient having derived no benefit from the salicylates was given first aspirin and then iodide of potassium in full doses, but again without benefit. On the 10th, there being effusion into the right knee-joint, it was aspirated and the fluid examined, but no micro-organisms were found in the films, and there was no growth in any of the media after four days. On the 18th there was a renewed attack of acute purulent conjunctivitis of the left eye, for which a 5 per cent solution of argyrol was prescribed, the application of which promptly relieved the inflammation. The conjunctival secretion was examined, but no gonococci were found. The patient had several subsequent attacks both of conjunctivitis and arthritis of gradually decreasing severity, and he was discharged on November 15th, relieved of all his symptoms.

This case of multiple arthritis presented many points of interest and much difficulty was experienced in arriving at a definite diagnosis. In favour of its being acute rheumatism was the history of a previous attack, presumably rheumatic in origin, although on that point there was no positive evidence. Against this theory was the absence of an initial tonsillitis, the rebelliousness to the salicylates, the cellulitis of the dorsum of the hand, and the freedom from cardiac complications. The diagnosis of gout was not seriously entertained and, apart from other considerations, the duration of the attack negated that theory. From the first a suspicion was entertained that it was a gonococcal infection and the effusion into the tendon sheaths supported that view. The absence of a urethral discharge could not be held to outweigh the general evidence in favour of that theory. The fact of gonococci not being detected in the fluid from the knee-joint could not be regarded as conclusive, and probably the conjunctival secretion was examined too late in the progress of the case to carry much weight. It is practically certain that this was a true case of conjunctival arthritis, the conjunctivæ being inoculated with an attenuation of gonococcus. How the infection took place it is needless to discuss.

Gonococci in the ophthalmic secretion were discovered by Darier in 1889, and demonstrated by Deutschmann in the fluid from the inflamed joints in 1890. The synovial membranes should always be carefully examined. The remote effects of the infection are probably due to gonotoxin. The purulent form may be associated with streptococci or staphylococci. The diagnosis of gonorrhœal rheumatism rests on (1) The history of gonococcal infection or on the presence of obvious gonococcal lesions; (2) the implication of certain joints not usually affected in other forms of articular disease; (3) the absence of metastasis; (4) the involvement of the fasciæ and tendon sheaths. In many chronic cases the diagnosis is difficult and must remain uncertain. The patient cannot be made to remember whether or not he had a urethritis, and if there is a history of an attack it was so many years before and so long an interval has elapsed that it is doubtful if it can be regarded as an antecedent cause. In the case of married women the difficulty is enormously increased, and it is often inadvisable to inquire too curiously into the antenatal history of either husband or wife. Bacteriological investigation in these cases, unless the infection is recent, throws but little light on the subject. It is difficult to find the gonococci in late cases, probably because they are ousted by more robust pathogenic organisms. Gonotoxin inhibits phagocytic action and so predisposes to mixed infection. It is well to recognise the fact that gonorrhœa is very easily overlooked in women. It is usually regarded as an acute vaginitis, but it much more frequently involves the ducts of the vulvo-vaginal glands and the parts imme-

diately surrounding their orifices. Unless the urethra is implicated it gives rise to little scalding or inconvenience. The great danger arises from the fact that the cervix becomes early infected and the inflammation spreads upwards beyond the range of local applications. The result of gonococcal salpingitis is the sealing up of the fimbriated extremities of the Fallopian tubes by adhesive inflammation. These people bear no children, or are at the best "one-child women." The child, too, is rarely robust or of good quality.

The prognosis in cases of gonorrhœal rheumatism is on the whole favourable, although from time to time cases are seen in which there is a recrudescence of the arthritic manifestations when the patient takes up his abode in a damp climate and especially on a clay soil. The outlook is distinctly less favourable in those who have already suffered from one or more attacks of acute rheumatism, especially when there is cardiac mischief. Several cases of fatal gonococcal ulcerative endocarditis and gonococcal pyæmia have been recorded, a condition which has been mistaken for enteric fever, malignant disease of the prostate or purulent cystitis. There is one other point to remember with regard to prognosis, and that is that gonorrhœa is a much more serious disease than syphilis, that is when the latter is of home manufacture. The Egyptian and other foreign varieties are apt to be virulent and cannot be recommended. There is one important difference between syphilis and gonorrhœa; the syphilitic organism affords protection, although admittedly incomplete, whilst the gonococcus not being of a robust nature fails to maintain its influence and leaves the unfortunate patient liable to future invasions. What is required is a protective gonococcus, but as yet it has not been cultivated.

With regard to treatment it is easier to enumerate drugs which are inefficacious than to find those which are valuable. When the disease follows a urethritis that must be cured, and when there is a stricture that must be dilated. When the eye is the point of entrance of the poison the instillation of nitrate of silver or of argyrol is necessary. The affected joints should be kept absolutely at rest and hot fomentations and poultices should be employed. A good poultice is made with equal parts of linseed meal and precipitated sulphur. Counter-irritation with iodine or capsicum or rubbing in a liniment of aconite, belladonna and chloroform will be found useful. In chronic cases the iodides internally in large doses may do good, especially when the pain is worse at night. The ammoniated tincture of guaiacum is sometimes useful, and sometimes general tonic treatment with arsenic and iron is indicated. Should the fluid show no signs of absorption the joint may be aspirated and injected with from a drachm to a drachm and a half of a 1 in 4,000 solution of corrosive sublimate, or with the same quantity of a 5 per cent. solution of carbolic acid. In chronic cases affecting the wrist, wearing a tightly-fitting strap does good, probably by keeping the parts at rest. Hot air baths and electricity may be recommended, and when all else has failed surgical treatment should be resorted to, followed by the careful selection of a suitable climatic station.

The choice of an alcoholic stimulant in these cases is a matter of some moment. To deny the patient alcohol in any form is a considerable deprivation, and is not attended with good results. Wines and other saccharated beverages are clearly inadmissible. The best drink is an antique pure Highland whiskey distilled from the finest malted barley and freely diluted with water. The quantity to be prescribed and the frequency of administration is a matter for individual consideration. It need hardly be said that the ordinary public-house whiskey of the silent spirit description is a powerful toxic agent. To get good whiskey you must go to Scotland, and even then a certain discrimination is necessary.

The points to remember about gonorrhœal rheumatism are:—

1. That it is not rheumatism and has nothing to do with rheumatism.

2. That it is not essentially an arthritic affection, and that the brunt of the disease falls on the fasciæ and on the tendon sheaths.

3. That it is not a monarticular affection and that many joints and their surrounding tissues may be involved.

4. That the temporo-maxillary, the sacro-iliac and sterno-clavicular articulations are frequently implicated.

5. That it need not be preceded by a urethritis, specific or otherwise.

6. That it is not solely a man's disease, but that it is common in women and children.

7. That iritis and other eye affections are common results of gonococcal infection.

8. That in women it is frequently associated with salpingitis, metritis, ovaritis, and other manifestations of gonococcal infection.

9. That the infection is one of the most frequent causes of sterility.

10. That marriage frequently revives an old and latent gonococcal infection.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The Lecture in next week's will be by Arthur J. Whiting, M.D., M.R.C.P. Lond., Dean of the North-East London Post-Graduate College, Assistant Physician to the Tottenham Hospital, and to the Mount Vernon Hospital for Consumption, on "Hemiplegia."

ORIGINAL PAPERS.

OBSERVATIONS ON PERCHLORIDE OF MERCURY AS A DISINFECTANT.

By DAVID SOMMERVILLE, B.A., M.D., D.P.H.
M.R.C.P.,

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AND

J. T. AINSLIE-WALKER, F.C.S.

THAT there is wide scope for investigation in the field of disinfection, especially in relation to the comparative values of different disinfectants, is daily becoming more manifest. Very erroneous views of the germicidal powers of many disinfectants are still abroad, and whilst we remain without an officially accredited method of testing the efficiency of disinfectants these must of necessity continue.

It is universally admitted that mercuric chloride is an efficient disinfectant, but loose statements have been made regarding the value of this efficiency. It has been asserted, e.g., that solutions of 1 in 50,000 and 1 in 100,000 are reliable germicides, whilst nothing whatever is said of the nature of the changes effected, which result in the death of the bacteria concerned.

Tons of HgCl₂ have been used, and are still being used in India for the disinfection of *B. pestis*, with results, alas! only too well known. Apart from exact knowledge of the strengths and methods of use of the solutions employed, it is impossible to arrive at an opinion, other than the broad one, that up to the present, at least, it seems to have been of little practical value.

In common with other salts of heavy metals, HgCl₂ is an active coagulant of albumen, but its energetic powers of coagulation militate at times against its germicidal efficiency. It would seem that, in accordance with the chemical fact that a weak alkaline solution is the best solvent for proteids, the alkaline emulsions must hold a premier place as disinfectants of proteid masses whose interiors contain bacteria, by reason of their larger powers of penetration.

Here it may be pointed out that in using the Rideal-Walker or other test, it is quite possible to obtain an inaccurate impression of the germicidal value of a

disinfectant which is a strong coagulant of albumen, when applied to such infected material as intestinal sloughs in typhoid stools. It is obvious that more thorough disinfection will be obtained when wholly liquid stools are dealt with, than when stools containing solid masses are used. In the former case there is greater opportunity for the disinfectant to come into contact with all the bacilli. Moreover, the loopful removed from a medicated mixture of a fluid stool containing solid masses, for implantation in a culture medium, will contain no such solid mass, and therefore any bacteria that may be found in the centre of such mass are left behind uninjured, whilst the disinfectant receives credit for having killed them all. This is but one of the many features of the complex problem of practical disinfection which require careful study.

The following experiments in the disinfection of spores of anthrax and B. typhosus with HgCl₂, bring to light an inhibitory action exerted by this disinfectant which would appear to account for the many wild statements to be found in the text-books in connection with this body.

Working with the Rideal-Walker method of standardisation, we are unable to assign a carbolic-acid co-efficient to HgCl₂, as phenol (the control disinfectant) does not kill these spores in the time limits of the test.

Tables I. and II. demonstrate the difference in the germicidal powers of HgCl₂ upon anthrax spores, and Tables III. and IV. the difference in these powers upon B. typhosus, according as the inhibitory action is, or is not, eliminated.

Through the conveyance of the medicated spores or organisms to culture broth by a platinum loop, a small quantity of HgCl₂ is introduced into the broth, which exerts the above-mentioned inhibitory action on the organisms, and that this action is merely inhibitory and not disinfectant is seen by the fact that precipitation of Hg as HgS by a drop of H₂S water (saturated solution) previously added to the broth tube (whereby the organisms are rapidly liberated from the influence of HgCl₂) permits the growth of organisms that otherwise would not take place, within the time limits of the experiments. This change has its expression in the lowering of the germicidal powers of HgCl₂, recorded in Tables II. and IV.

TABLE I.
ANTHRAX SPORES EX AGAR.
Room Temperature 15°-18° C.

Sample.	Dilution.	Time culture exposed to action of disinfectant—minutes.						Sub-Cultures in broth.	
		2½	5	7½	10	12½	15	Incub.	Temp.
HgCl ₂	1 in 3000	X						7 days	37°C
	1 ,, 4000	X							
	1 ,, 5000	X	X						
	1 ,, 6000	X	X	X					
	1 ,, 7000	X	X	X	X				

TABLE II.
ANTHRAX SPORES EX AGAR.
Room Temperature 15°-18° C.

Sample.	Dilution.	Time culture exposed to action of disinfectant—minutes.						Sub-Cultures in broth X H ₂ S	
		2½	5	7½	10	12½	15	Incub.	Temp.
HgCl ₂	1 in 40	X						7 days	37°C
	1 ,, 60	X	X						
	1 ,, 80	X	X	X					
	1 ,, 100	X	X	X	X	X			
	1 ,, 120	X	X	X	X	X	X		

1. A growth of anthrax spores on agar was emulsified in 3 cc. of sterile distilled water, and filtered. Five drops of this emulsion mixed with 5 cc. of a 1 in 3,000 mercuric chloride solution for 2½ minutes, showed no life when sub-cultured in broth for seven days. Life appeared, however, in the case of 1 in 4,000 solution applied for 2½ minutes, and in 1 in 5,000 solution applied for 5 minutes, as seen in Table I.

2. The addition of a drop of H₂S water to the broth tubes, prior to their receiving a loopful of medicated spores, requires a stronger solution than 1 in 40 applied

for 2½ minutes, and a stronger solution than 1 in 60 applied for 5 minutes, to completely kill, as seen in Table II.

TABLE III.
B. TYPHOSUS, 24 HOURS' AGAR CULTURE
AT 37° C.

Room Temperature 15°-18° C.

Sample.	Dilution.	Time culture exposed to action of disinfectant—minutes.						Sub-Cultures in broth.	
		2½	5	7½	10	12½	15	Incub.	Temp.
HgCl ₂	1 in 20,000	X	X					7 days	37°C
	1 ,, 40,000	X	X						
	1 ,, 60,000	X	X	X	X				
	1 ,, 80,000	X	X	X	X	X	X		
Phenol	1 ,, 100	X							

Carbolic Acid Co-efficient between 200 and 400.

TABLE IV.
B. TYPHOSUS, 24 HOURS' AGAR CULTURE
AT 37° C.

Room Temperature 15°-18° C.

Sample.	Dilution.	Time culture exposed to action of disinfectant—minutes.						Sub-Cultures in broth—H ₂ S.	
		2½	5	7½	10	12½	15	Incub.	Temp.
HgCl ₂	1 in 2000	X	X					7 days	37°C
	1 ,, 2300	X	X	X					
	1 ,, 2600	X	X	X	X				
	1 ,, 2900	X	X	X	X	X	X		
Phenol	1 ,, 100	X	X						

Carbolic Acid Co-efficient 20.

3. Working under the same conditions with agar cultures of B. typhosus, HgCl₂ was put in competition with pure carbolic acid. Table III. shows that under these conditions it possesses a co-efficient of 200-400.

4. When, however, the medicated mixture is sub-cultured in broth to which a drop of H₂S has been added, the coefficient drops to 20.

The necessity for recognising this factor of inhibition in deriving the carbolic-acid coefficient of HgCl₂ is thus plain

THE MORISON LECTURES ON THE PATHOLOGY OF GENERAL PARALYSIS.

DELIVERED IN THE ROYAL COLLEGE OF PHYSICIANS,
EDINBURGH, ON JANUARY 24TH, 26TH, AND 29TH,
By W. FORD ROBERTSON, M.D., F.R.C.P.ED.

ABSTRACT OF LECTURE I.

DR. FORD ROBERTSON referred at the outset to the prevalence and recent increase of general paralysis in this and other countries. Every year nearly two thousand persons died from this disease in the asylums of England. It was one of the most terrible maladies that could afflict a human being. It was fatal, with rare exceptions, within a few years. Its causation and exact nature, notwithstanding many positive assertions that had been made regarding them, had hitherto been a profound mystery. In the recent literature of the subject there could be traced a growing feeling of scepticism regarding the widespread view that the disease is essentially syphilitic in its origin. After briefly sketching the main facts already known as to the morbid changes that occur in the brain, Dr. Robertson proceeded to give an account of the investigations into the pathology of the disease carried out by his colleagues and himself during the last six years at the laboratory of the Scottish asylums, and at the Royal Edinburgh Asylum, and also independently by Dr. L. C. Bruce at Murthly Asylum. The earlier researches, conducted on the clinical side by Dr. Bruce and on the pathological side by the lecturer, had tended to show that general paralysis is dependent on an active bacterial toxæmia, and that the point of attack is commonly the alimentary tract. In 1902, along with Dr. M'Rae and Dr. Jeffrey, he commenced a bacteriological investigation. A

micro-organism closely resembling the bacillus of diphtheria was found to be specially prominent. It was constantly present in the alimentary or respiratory tracts in cases of general paralysis, and in several instances cultures were obtained from the brain. The lecturer and Dr. M'Rae had since been endeavouring by various methods of research to determine whether this bacillus had any special relationship to general paralysis, and every step forward had been attended with the elucidation of some fresh fact which rendered the hypothesis more probable. They were now able to bring forward evidence to show that general paralysis and the allied disease—*tabes dorsalis*—are as specific in their causation as tuberculosis, typhoid fever, and diphtheria. Histological and experimental evidence had contributed in a considerable measure to the support of this view. They had now succeeded in obtaining the diphtheroid bacillus from the brain in nine cases out of twenty-three, in which cultures were made from this organ; they had also succeeded in detecting the bacilli in microscopic preparations in the fresh blood and cerebro-spinal fluid, as well as in the walls of the cerebral vessels. In these instances the bacilli were rarely capable of staining in the usual way, and this fact has raised the question whether these bacilli were not from time to time gaining access to the circulation, and being rapidly destroyed by phagocytic and lysogenic action. This hypothesis had been experimentally put to the test by investigating the action of the living blood upon pure cultures of diphtheroid bacilli isolated from cases of general paralysis. The results of this inquiry had served to throw light upon the problem of the pathogenesis of the disease.

ABSTRACT OF LECTURE II.

Dr. Robertson said that he wished to deal chiefly with the results of an experimental inquiry that Dr. M'Rae and he had made into the action of the living blood and blood serum upon pure cultures of diphtheroid bacilli isolated from cases of general paralysis. The bacillus with which they had worked was one which in respect of the morphological characters, staining reactions and power to form acid in glucose broth, closely resembled the Klebs Löffler bacillus. It had been laid down by high authorities that an organism differing from the diphtheria bacillus solely in want of virulence must be regarded as merely a diphtheria bacillus in an attenuated condition, and should be spoken of as such. In previous papers the organism had therefore been provisionally regarded as an attenuated form of Klebs-Löffler bacillus. Whether it was really of this nature or not was an open question. Their more recent observation strongly inclined them to the view that it was a special organism. Having referred to the remarkable polymorphism of this bacillus the lecturer considered especially its thread form. The organism had been observed to invade the tissues in this form in several general paralytics; it had also been observed invading in four rats fed or injected with cultures of the bacillus. The bacillus when first isolated often showed a strong tendency to form threads. They had endeavoured to ascertain how the organism could be made to assume this special character, and they had succeeded in obtaining a filamentous growth by cultivating it for several days at 41° C. upon blood films. It was therefore probable that invasion by the thread form occurred in cases in which there had been a sustained high temperature on several days before death. One of the points they had specially studied was the phagocytic action of the leucocytes upon the bacillus. They had used a technique of their own. Two actions required to be studied, namely, the power of the leucocytes (in the natural serum) to take up the bacilli, and the power of the leucocytes to dissolve the bacilli when engulfed. No constant alteration could be detected in the power of taking up in the general paralytic's blood. On the other hand, the power of dissolving the bacilli when taken up had in most cases been distinctly greater on the part of the leucocytes of the general paralytic

than on that of the leucocytes of the control. Within the first three hours of incubation, at least, the lysogenic section was entirely intra-corpuseular. Having studied the appearances presented by the dissolving organisms in the experimental films, they endeavoured to ascertain if bodies having a similar appearance could be found in the fluid and tissues of the general paralytic. Every case studied with this object had given the same affirmative answer. Diphtheroid bacilli, more or less altered by lysogenic action, were present in great numbers in the catarrhal pneumonia foci that occurred in most general paralytics dying in congestive attacks. They could also be detected in the adventitial spaces of the inflamed cerebral vessels and in the meshes of the pia arachnoid. Further, they could be observed in films made from the blood of the living paralytic, especially if the patient was suffering from a congestive attack. They could also be detected in the centrifuge deposit from the cerebro-spinal fluid, obtained by lumbar puncture. Lastly, they were often present in large numbers in the centrifuge deposit from the urine, especially during a congestive attack. This experimental study had suggested to them that failure to obtain cultures from the blood and cerebro-spinal fluid depended upon the fact that most of the bacilli were dead, and that the few living ones that were occasionally present were killed in consequence of the continued action of the phagocytic cells. They had therefore tried various measures with a view to preventing the continuation of this bactericidal action, the simplest of which was to allow the tubes to stand in the cold for twenty-four hours before incubating them. By adopting this plan, or slight modifications of it, they had succeeded in getting pure growths from the blood in four cases (three of the patients being in congestive attacks) and from the cerebro-spinal fluid in two. The growths were first generally extremely feeble, but the organisms could be invigorated by being sub-cultured upon blood films. A search had been made for a specific action of the blood of the general paralytic upon these bacilli. The most distinctive reaction they had obtained was that which concerned the power of the leucocytes to dissolve the bacilli. They had estimated the percentage of altered bacilli in the leucocytes after three hours' incubation. This gave what they called the intra-corpuseular bacteriolytic index. As far as their observations went it was as a rule higher in the general paralytic's blood than in control bloods. It seemed, however, probable that more direct methods of bacteriological diagnosis would become available.

THE OUT-PATIENTS' ROOM.

METROPOLITAN HOSPITAL, KINGSLAND ROAD, N.E.

Occasional Hæmaturia.

By LEONARD WILLIAMS, M.D., M.R.C.P.

In demonstrating the case, Dr. Williams said: This man, whose age is 70 (he looks little more than 60), complains of occasional hæmaturia. The amount of blood, when it comes, is considerable; the urine is thoroughly red, it is not merely smoky or tinged; it is characteristically and unmistakably sanguineous. The patient has a sort of premonition of its coming. He does not know why, but he knows he is going to pass blood. When the blood comes it is not intimately mixed with the urine from the outset. Clear urine comes first, and the appearance of the blood is delayed until the *coup de piston*, as the French term it. This has been going on at intervals, sometimes very considerable intervals, for three years. He has been to other hospitals, but unlike many patients he is not able to give us even a garbled version of the judgments which have been there passed upon him. He nevertheless comes with a diagnosis with which he has been favoured by his club doctor. This diagnosis is that of granular kidney, and although I believe that this is not a correct view of his condition it is a view which

is far from being discreditable to the person who held it, inasmuch as it shows that he remembered a fact which we are all of us much too liable to forget, namely, that granular kidney is one of the most powerful producers of hæmorrhage in all parts, even in most unlikely parts, of the body. That the doctor, in remembering this fact, failed to see it in its proper perspective with relation to some others only proves that, in common with the rest of us, he is liable to make mistakes. The only people who are never guilty of diagnostic errors are the newly-qualified. Let us remember, then, in connection with this man that granular kidneys may give rise to hæmorrhages anywhere, so that when we meet with epistaxis, with bleeding from the rectum, with hæmoptysis, with hæmatemesis, we may recall the fact that renal cirrhosis is not an impossible, nor, indeed, an improbable cause. Hæmorrhage into the brain, causing apoplexy, to be followed by a hemiplegia, is the classical instance of one of the dangers of interstitial nephritis, but we must be careful not to let our imagination stop short of this picture; we must include in our survey any bleeding, however slight and unimportant it may for the moment appear to be. I have said that I do not believe this man to be the subject of renal cirrhosis, and my opinion is based upon the fact that apart from the hæmorrhage (the *coup de piston* character of which is suggestive rather of bladder trouble), I can find no evidence of kidney disease. The absence of albumin in the urine is no criterion. If it is present it constitutes valuable confirmatory evidence; but the man who cannot determine the presence of interstitial nephritis without this aid is, diagnostically, naked indeed. Interstitial nephritis, as you know, is associated with high blood pressure; that is why it is apt to give rise to hæmorrhages. I say "associated" with high blood pressure, because I want to guard you if I can from the too common error of believing that granular kidney *causes* the high blood pressure. Frequently it is the high blood pressure which causes the fibrosis in the kidney. More frequently still, perhaps, they are both due to a common cause. Nevertheless, it is a fact that where there is renal cirrhosis there also will high blood pressure be found. We have not yet an instrument for measuring blood pressure here, which is a misfortune, because even highly-educated fingers are liable to err in estimating slight degrees. But if this man had had an interstitial nephritis for over three years, there would have been no question of slight degrees. The hypertension of his pulse would have been obvious to the least educated of naked fingers; he would have had an enlarged left ventricle, displacing his apex beat to the left of the nipple line, and he would have had a loud ringing second sound at the aortic cartilage, telling of the strain to which the semi-lunar valves were subjected at each diastole. He has none of these, and in their very definite absence I feel justified in asserting that whatever else is the matter with him he is not the subject of chronic interstitial nephritis. To say what is the matter with him is, however, not an easy task. I have urged him to come into the hospital, and allow the surgeons to explore his bladder, which I assume to be the source of his hæmorrhage, but he remains obdurate to all my representations. He says that at the age of 70 he prefers to bear the ills he has rather than fly to others that he knows not of. And, having regard to all the circumstances, I cannot help thinking he is right.

OPERATING THEATRES.

FRENCH HOSPITAL.

INTESTINAL OBSTRUCTION FOLLOWING GONORRHOËAL PYO-SALPINX.—MR. EDMUND OWEN operated on a female, æt. 20, who had been admitted suffering from acute gonorrhœa of a fortnight's duration. The girl complained of severe abdominal pain chiefly in the hypogastric and left inguinal regions. A tumour could be felt on deep palpation in these regions rising out of the

pelvis. Examination by the vagina showed that the uterus was fixed by a mass of exudation above the left fornix and in Douglas's pouch. The left tube was evidently involved in this mass and formed a tumour about the size of an orange which could be felt bimanually. No fluctuation could be detected. The patient had a temperature and an aspect of a septic character. The tumour in the left inguinal region increased in size and tenderness; fluctuation could soon be elicited. On performing abdominal section, a large quantity of ill-smelling pus escaped from the abscess, which had extended into the abdominal cavity, but was limited by adhesions. The patient did very well for a fortnight, the abscess cavity having practically healed, but she then developed signs of acute intestinal obstruction. A second operation having been decided upon, an incision was made in the middle line. The intestines were found to be closely matted together and they were covered with masses of lymph. A coil of small intestine, greatly distended, was found firmly glued to the bottom of Douglas's pouch; this was freed and various adhesions were broken down, the obstruction being thus released. An ounce of a strong solution of magnesium sulphate was injected into the bowel by an exploring syringe. The right Fallopian tube was examined and found to be healthy.

Mr. Owen said that, considering the small size of the French Hospital, it was quite remarkable for the number of cases of pyo-salpinx which came under the care of his colleagues, Dr. Sunderland and Mr. Clayton-Greene, and himself for operation, and that few operations afforded greater interest or more interesting complications. Acute intestinal obstruction, he pointed out, was by no means an uncommon sequel of such operations, and, considering the extent of the area of inflammation which must inevitably be left after such operations, it was almost a matter of surprise that this complication did not more often occur. When vomiting and abdominal distension, together with a quickening of the pulse and a distressed appearance set in after an apparently successful operation for pyo-salpinx, he was of opinion that abdominal exploration should not be unduly delayed.

The woman made an uninterrupted recovery from the operation, and left the hospital, cured, six weeks after the second operation.

TOTTENHAM HOSPITAL.

HYSTERECTOMY FOR FIBROSIS, COMBINED WITH OVARICTOMY.—DR. ARTHUR GILES operated on a married woman, æt. 47, who had been admitted on account of persistent hæmorrhage, and an abdominal tumour. She had been seen in the out-patient department where she was regarded as suffering from uterine fibro-myoma. On examination, a mass was felt which could not be distinguished from the uterus; the outline was irregular, and the diagnosis of uterine myoma was confirmed. At the operation, when the abdomen was opened the tumour was found to consist of uterus alone, but of uterus and ovarian cyst, the latter originating on the right side. A complete extirpation of uterus and tumour was effected, the hysterectomy being of the type known as supra-vaginal. The operation presented no special complications, and the abdomen was closed in the usual way. Dr. Giles said that the question of diagnosis was a very interesting one in this case. A history of long continued hæmorrhage, associated with a large tumour apparently uterine, and of firm consistence would lead one to a diagnosis of uterine myoma every time, although such a diagnosis would turn out incorrect in a small

percentage of cases. He did not think there was any method by which one could avoid the possibility of error in such cases, the symptoms were identical, and the physical signs hardly distinguishable. In a case in which the tumour was ovarian the uterus would be of only normal length, but this might be true also of a case in which uterine myomata were sub-peritoneal and pedunculated. An ovarian cyst would usually give the sensation of a fluid tumour in contra-distinction of the hardness of a fibro-myoma, but a myoma might be partly softened suggesting, an ovarian cyst, or, on the contrary, an ovarian tumour might present a firm

consistence as in the case just operated on. As a rule, an ovarian cyst was not associated with hæmorrhage; when this symptom was present one of several rare conditions might be found, namely, ovarian carcinoma, a simple ovarian cyst combined with uterine polypus or ovarian cyst complicated by fibrosis. He anticipated that the uterus in the present case would prove to be the seat of fibrosis; in any case, with such a history as this patient presented a simple ovariectomy would practically be of no use, and for this reason he did the hysterectomy at the same time. The patient made an uninterrupted recovery.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, FEBRUARY 9th, 1906.
The President, Mr. CLUTTON, in the Chair.

Mr. B. G. A. MOYNIHAN read a paper on
THE SURGICAL TREATMENT OF CARCINOMA OF THE
STOMACH,

based on the records of 59 operations for this condition during the last eight years. The operations performed were gastro-enterostomy, 35 cases with 5 deaths; gastrectomy, 10 cases with 3 deaths; gastrostomy, 5 cases with no deaths; jejunostomy, 3 cases with no deaths; and exploratory laparotomy, 6 cases with 1 death. Dealing first with gastro-enterostomy, he considered that this operation was indicated in cases with an irremovable growth causing pyloric obstruction; where there was no obstruction to the outlet of the stomach the operation did not give relief commensurate with its risks. Mr. Moynihan had found that, in suitable cases, gastro-enterostomy prolonged the patients' lives and allowed them to spend their last weeks or months in tolerable comfort. With regard to gastrectomy he was convinced that modern improvements in technique had rendered the radical operation applicable to a wider range of cases than formerly, not only as a means of complete cure, but as an operation to be undertaken deliberately in preference to gastro-enterostomy as a palliative measure. In 5 cases where the growth caused obstruction at the cardiac end of the stomach Mr. Moynihan performed gastrostomy; adopting Senn's method in 4 cases, Frank's method in 1. Jejunostomy is adapted to those cases in which gastro-enterostomy is impossible by reason of the extensive involvement of the stomach, and where gastrectomy is contra-indicated by the presence of secondary deposits. It is chiefly of importance when the prolongation of life, for even a brief time, is of great moment. He deprecated the prevalent opinion that an exploratory laparotomy "to confirm the diagnosis" is devoid of risk. Cases where the diagnosis is in need of operative confirmation are those where close scrutiny and handling of the parts is necessary; where the condition can be recognised by merely inserting a finger within the abdomen the clinical diagnosis as a rule requires no corroboration. Mr. Moynihan drew attention to the frequent incidence of cancer at the pyloric end of the stomach, and to the regular invasion of the curvatures, both these facts being well brought out in his series. Between the pyloric and pre-pyloric forms of growth he believed that a diagnosis was often possible by careful attention to the onward march of symptoms. As bearing on the frequency of malignant transformation of simple ulcer, he has found that out of 39 cases of carcinoma of the stomach where attention was directed to this point 24 gave a previous history indicative of gastric ulcer. He noted the fact that both ulcer and cancer affect the same portion of the stomach wall, and was inclined to assume that a chronic inflammatory condition was the cancerous precursor as frequently here as elsewhere in the body. He believed that the

discouraging results of the surgical treatment of gastric carcinoma were due to the fact that the insidious onset of the disease rendered early diagnosis far from easy, but he hoped that in the future by a careful application of clinical methods and a wider recognition of early symptoms, the surgeon would be more often called upon to explore in order to *make* a diagnosis rather than to *confirm* one arrived at by waiting until too late.

Mr. CLUTTON commented on the large number of these cases seen by the Leeds surgeons.

Mr. MAYO ROBSON pleaded for earlier consultations between physicians and surgeons in stomach complaints. He had operated on 120 cases of cancer of the stomach, over 80 having been during the past ten years, and was now preparing an analysis of them. He was impressed with the importance of earlier diagnosis in these cases, and was in favour of exploratory laparotomy even when the diagnosis was obscure, if medical treatment was of no avail in a few weeks. There was very little risk in this operation provided it was done early enough. He referred to cases of chronic inflammatory thickening, which, even at the operation, were diagnosed as cancer, but which got quite well after gastro-enterostomy. He considered that ulcer was a most important factor in the causation of gastric cancer.

Mr. LEONARD BIDWELL recommended not performing a radical operation, when possible, at the first operation, but rather to do gastro-enterostomy as a routine and then a partial gastrectomy a fortnight later. He had only lost one case out of five treated thus. As to gastrostomy, he always found that the use of Symonds' tubes gave greater benefit.

Dr. DE HAVILLAND HALL supported Mr. Robson in his claim for early surgical consultation.

Dr. FAWCETT was doubtful about the alleged importance of gastric ulcer as a precursor to cancer. It was not supported by the analysis of the Guy's records. What did Mr. Moynihan consider sufficient evidence of ulcer?

Mr. JAMES BERRY asked Mr. Moynihan whether he did a gastro-enterostomy prior to gastrectomy, whether he performed entero-anastomosis at the same time as the former operation, and whether he found clamps essential.

Surgeon-General LONGHURST was glad to hear that cancer was a local disease and not a general one. He emphasised the importance of calling surgeons in to stomach cases early.

Mr. F. C. EVE asked Mr. Moynihan what his practice was when glands were found in the pancreas, for such glands were frequently inflammatory not malignant and so might exercise undue deterrence as regards the performance of radical operation. He assented in the observation that pre-pyloric cancer sometimes produces the same clinical picture as pyloric cancer, and also in the possibility of chronic inflammatory masses being mistaken for cancer.

Mr. MAKINS queried the value claimed for gastro-enterostomy. His patients rarely lived for over a year

and were not always in perfect comfort. The advantages of the operation were difficult to estimate.

Mr. MOYNIHAM, in reply, said that it would be a good thing if the practice that held in the North of sending stomach cases to physicians only if a surgeon considered operation inadvisable were introduced into London. He always removed the growth straight away whenever possible, without a preliminary gastro-enterostomy. As to the question of ulcer in the ætiology of cancer, in over 50 per cent. of his cases ulcer had been diagnosed by the medical attendant years before the cancerous condition developed. In his opinion chronic dyspepsia was usually due to ulcer, and vomiting was quite rare in this condition, hæmatemesis being rarer still. He regarded hospital records as quite worthless unless the point under discussion had been specially looked for. He never did entero-anastomosis, as in his operation this was quite impossible, the upper end of the opening being over an inch below the duodenal jejunal flexure. He always used clamps and was convinced of the saving in time effected by them. He removed all glands whether they were obviously cancerous or not.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD FEBRUARY 7TH, 1906.

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

Mr. J. M. COTTERILL showed (1) a fibro-sarcoma of the eighth nerve, removed from the cerebello-pontine angle along with a large part of the cerebellum, excised for the purpose of exposing the growth. (2) Specimens of enlarged prostate removed by suprapubic prostatictomy.

Dr. W. ALLAN JAMIESON exhibited a patient with an extra-genital chancre.

Dr. NORMAN WALKER showed a case of melanoma, probably an early instance of scroderma pigmentosum.

Dr. F. B. BOYD read a paper on

RECTAL FEEDING,

of which the following is an abstract:—

Our present knowledge of the exact value of rectal feeding is indefinite and conflicting. The following observations have been undertaken, with the assistance of Miss Robertson, in order to elucidate certain points as to the absorption of food substances by the bowel. The severe cases, in which sufficiently prolonged investigations could be carried out to warrant these deductions being drawn, representing only the most favourable cases, *i.e.*, those which tolerated rectal feeding well. They form only a few of the many observations which were attempted but broke down either on account of the gastric disturbance which the rectal feeding caused, or because menstruation set in soon after the injections were begun, and thus rendered impossible accurate estimations of the nitrogen balance, &c. Before rectal feeding was begun an aperient, mixed with charcoal was administered, and after the bowels had been freely moved and charcoal was being passed in the fæces, the observations were commenced. After a cleansing enema had been given, nutrient injections were administered, and the total nitrogen excretion, the fat, and the carbohydrates, contained in the fæces were estimated daily. The calorific value of the food was known, as well as its nitrogen, fat, and carbohydrate content. The patient's weight was ascertained daily. The food was predigested; it consisted of milk, eggs, and dextrose, and was prepared in bulk, so as to be of uniform composition, being preserved by the addition of a little chloroform. It is agreed that at rest a person requires to be supplied with food representing about 2,000 calories per 24 hours; the quantity of proteid required is usually stated at from 80 to 100 grams, but recently Chettenden has maintained that this is excessive, and that 40 grams is sufficient. The first point to be considered is the *absorption and metabolism of proteid* given by the bowel. The best results attained in these observations were the absorption of 10 and 13 grams of proteid;

in the majority of Dr. Boyd's cases the figures were much lower. The amount of proteid taken up from the injected food seems to bear no sort of relationship to the total quantity of proteid contained in it. The calorific value of the proteid in these two test cases was 43 and 56 respectively. Taking an average of all the cases, the absorption of nitrogen was only 0.297 grams per kilo of body weight, a figure which is very considerably less than that given by German investigators, who have found that the amount is as high as 1 per kilo. In all his cases there was a negative nitrogenous balance of about 4 grams on the average, this showing that the patients were excreting nitrogen at the expense of their tissues. *Absorption of Fats*: It is advisable to use an animal fat, and that selected was yolk of egg. Some investigators have stated that not more than about 10 grams of fat can be absorbed from the bowel daily in rectal feeding, but these observations show that as much as 45 grams, or nearly 43 per cent. of the total fat in the injections may be taken up. The amount absorbed is directly proportionate to the quantity contained in the injections. *Absorption of Sugars*: It is difficult to determine this, and the objection has been raised that when the method adopted is that of estimating the amount introduced, and the amount excreted in the fæces, and taking the difference between these as representing the quantity absorbed by the bowel, no account is taken of the fact that much of the sugar may be broken down to lactic acid, &c., by putrefactors and other fermentations in the bowel, and hence the diminished amount which is credited to absorption is really partly due to decomposition. This point had been attended to, and check experiments made, which showed that fermentation did not diminish the amount of sugar by more than 1 per cent. It was found that practically all the sugar introduced in a nutrient enema is absorbed. Sugar is very often said to be irritating to the rectum, but this is due probably to impure sugar containing traces of sulphuric acid, &c., being employed. To obviate this difficulty he had always employed pure dextrose. As the result of his observations the question arises, How far is rectal alimentation of real value? In the cases of which tables were shown, the maximum calorific value of the food absorbed was about 500 calories, never more than 600, about one-fourth of what was actually needed—and this in persons who tolerated enemata remarkably well. He had tried Leube's pancreatic extract in nutrient enemata, and had found it of use. It causes irritation, and is extremely objectionable from the amount of intestinal putrefaction which results. Auto-intoxication is produced, and the evacuations become extremely offensive. The practical deductions from his observations are that nutrient enemata cannot be trusted to supply sufficient nutriment for the needs of the body; moreover, in many acute gastric cases it is better to trust to saline injections alone, because nutrients, as has been proved, reflexly excite gastric secretion and may cause vomiting. In giving nutrient enemata it is commonly stated that the quantity should not exceed 4 to 6 ounces. Probably it is better to give larger amounts, up to 10 ounces. Nutrients should be pre-digested, and should consist of milk, eggs, dextrose, and a pinch of salt. They should be introduced gradually through a funnel and catheter, rather than by a syringe.

Dr. NOEL PATON congratulated Dr. Boyd on his very laborious investigations. He asked whether account had been taken of the output of nitrogen in the fæces, which was due to intestinal secretion, epithelium, &c.?

Dr. RITCHIE thought that Dr. Boyd was unduly pessimistic as to the value of nutrient enemata; even if only a fourth of the necessary calories could be introduced, it was better than nothing.

Dr. RUSSELL also agreed that what Dr. Boyd had said was not of such a nature as to discourage them in using rectal alimentation. He hoped Dr. Boyd would continue his investigations with the view of discovering what particular form of nourishment was best absorbed.

He had for some time had the impression that pancreaticised foods were apt to intensify intestinal putrefaction.

Dr. AFFLECK spoke of the great comfort which patients derived from nutrient enemata, which he considered a valuable aid to treating acute gastric disorders.

Dr. Church and Mr. Cathcart, and Dr. Gulland also spoke.

In his reply Dr. BOYD said that he had not meant to decry nutrient enemata altogether, but merely to point out their limitations. For instance, he regarded it as impossible to restore the nutrition of a patient, say with pyloric stenosis, prior to operation, in this way. All the most nutrient enemata could do was to delay loss of weight. In acute gastric cases a great deal of the comfort derived from enemata was due to the absorption of water. After a hæmorrhage, for example, the tissues cried for fluid, and saline injections alone might increase the patient's weight. Other carbohydrates than dextrose might be used; the object in choosing this particular substance was because it could readily be accurately estimated.

Mr. C. W. CATHCART read a paper on
BIER'S METHOD OF TREATING ACUTE INFLAMMATION
BY PASSIVE CONGESTION.

Surgery, he said, could tell them how to destroy organisms outside the body, and how to prevent their entrance into wounds, but when once a patient came to the surgeon already infected, antiseptic methods were of comparatively little value in curing suppuration. When pus is forming, the best agents in limiting its spread are the tissue cells and fluids, and surgery can do nothing more than assist these in their conflict with the organisms. For such conditions as whitlows, osteomyelitis, suppuration in joints, tendon sheaths, or cellular tissues, and infected wounds, which the surgeon is powerless to prevent, a curative method is much needed, and it seems as though Bier's treatment by passive congestion, though its *modus operandi* is unknown, may supply the want. It is not claimed that the method is infallible, but only that in many cases it will prevent or limit suppuration. Bier looks on inflammation as a curative process, and the practical outcome of the theory is to favour the condition of the parts which inflammation produces—redness, congestion, and œdema with serous effusion—by the application of an elastic Martin's bandage to the proximal part of the limb. Bier has employed this since 1893, but it has only recently been introduced into this country. A considerable amount of experience is required as to the degree of pressure which may be applied; the limb should become red and angry-looking, there should be œdema, and a good deal of serous effusion. The bandage is allowed to remain in position for as much as 20 hours daily in these acute cases. One of the first results is relief of pain, which is often very marked and comes on within a few minutes of the application of the bandage; this is a practical test as to whether or not the bandage is correctly applied. With this the patient's general condition improves, and his pulse and temperature fall, unless there is already systemic infection. The more acute the local inflammation, the easier is it to produce œdema and congestion by the ligature. No dressing save a light porous one should be applied to the part. After progress has once begun, it usually continues, and then the periods of congestion may be shortened. When a definite abscess is present after the treatment has been continued for a day or so, the pus should be evacuated, but it is only necessary to make a small incision, and no drain is required. Before detailing his own results, Mr. Cathcart quoted a number of cases from Bier's writings to illustrate the scope of the treatment. Bier had successfully employed passive congestion to control abscess formation in pyæmia secondary to scirrhus of the breast; by it, though somewhat rarely, an acute abscess could be converted into a cold abscess, and in some cases could be made to disappear altogether. The method of treatment seemed peculiarly beneficial in acutely

inflamed joints, particularly in gonorrhœal infections, and also in suppurative arthritis. After the elastic ligature was applied the joint was not immobilised, but early passive movement was begun as soon as the anæsthetic effect of the congestion was manifest. Thus a cure was obtained even in the most severe cases. If sinuses had already formed they were squeezed so as to empty them, but were not drained. In that most trying form of suppuration, namely, infection of the tendon sheaths, the method also found a useful field of work. Cases of whitlow did very well under it if it was begun early; and if the tendon sheaths were already invaded, passive congestion was only palliative. In acute osteomyelitis nearly half of the cases recovered without necrosis, in the rest there was only a small sequestrum. Bier's method could be applied to all forms of acute inflammation, even such as were not due to micro-organisms, e.g., bites of poisonous insects. It could also be applied to almost every part of the body. Bier did not hesitate to apply an elastic ligature round the neck, if necessary; while for sites where proximal ligatures were impossible, suction cups of various shapes and sizes had been devised. Mr. Cathcart's personal experience of Bier's method had been surprisingly satisfactory, and he described as illustrative cases (1) acute suppuration in the tendon sheath of the little finger, causing gangrene of the finger, and extending into the forearm; (2) cellulitis of the hand; (3) gonorrhœal synovitis; (4) gummata of the tibia in congenital syphilis; (5) cellulitis of leg; (6) septic wound of the foot, which was so inflamed as to make moist gangrene appear imminent. In all these the results had been good; the relief of pain is great, and is induced so rapidly that the action resembles that of a general anæsthetic. The temperature is lowered, from diminished absorption of toxins. The rationale of the treatment is not clear; it seems that the increase in the serum in the part has something to do with the results; at least, Bier always likes to see a large serous effusion. It was possible that the serum antagonised the organisms directly, or that it simply diluted the ptomaines, or that it actually neutralised the ptomaines. In this connection it was of interest to note that other measures directed against inflammation, and which were undoubtedly beneficial, must act in almost the opposite way to Bier's method—for instance, free incision and the application of cold; again, the ligature of a main vessel undoubtedly sometimes checked an inflammatory process. On the other hand, poulticing acted to some extent like Bier's method, and that surgeon thought it was less objectionable than was usually taught.

Mr. GEORGE BERRY said that even in ophthalmology a method analogous to the passive congestion treatment had been introduced—the use of dionin in inflammatory conditions of the eye to produce œdema locally.

Mr. CARMICHAEL said that Bier laid considerable stress on the proper selection of cases, and that he emphasised two points in carrying out the passive congestion treatment: (1) *The bandage must cause no discomfort*, and (2) *it must never make the limb cold*, particularly in tubercular cases.

Mr. STRUTHERS also described some of the results he had witnessed at Bier's clinic, and gave an account of his own experience, which was in the main favourable in out-patient work.

Mr. Thomson and Mr. Stiles also discussed the paper.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF ANATOMY AND PHYSIOLOGY.

MEETING HELD FRIDAY, JAN. 26TH, 1906.

The President, Mr. E. H. TAYLOR, in the Chair.

Mr. H. M. JOHNSTON gave a communication on "Abnormalities of the Carpus in Man and their Morphological Significance." He gave a short account of the structure of the carpus in some of the lower forms of

vertebrates and described two cases of supernumerary carpal bones, and exhibited them to the Section. The specimens showed instances of accessory bones attached to the lunar, and corresponding to the epilunar and hypolunar of Pfitzner. In addition, the specimens also showed a divided scaphoid bone and a marked prominence on the dorsal aspect of the hand, formed by a process of the os magnum articulated with the styloid process of the third metacarpal. The subject was illustrated by diagrams and lantern slides.

Dr. T. G. MOORHEAD asked what stress Mr. Johnston laid on the fact that the tables he exhibited indicated that these abnormalities were found more frequently at a later age than at an earlier? He suggested the possibility of the outgrowths being of rheumatic origin and thought the ossicles should be cut across to see if they were of this nature, or were really cancellous bones. He thought also the condition of the scaphoid might be due to an old ununited fracture. He asked if the X-rays had been used in the investigation.

Prof. DIXON remarked that unless specimens, such as those exhibited, had been prepared by the investigator himself, one could not be certain regarding the position or even of the presence of the minute ossicles described by Pfitzner. He believed that many such ossicles were congenital.

Professor FRASER was inclined to agree with Dr. Moorhead and found it difficult to imagine the specimens were of congenital origin.

Mr. JOHNSTON, in replying, said he would be glad to try the transmissibility of the specimens to X-rays.

The PRESIDENT made some observations on Types of Stomach in Man, illustrated by specimens. He pointed out the surgical importance of recognising the existence of such types as those described by His.

Professor FRASER mentioned a case in which half the stomach was in the thoracic cavity and could be pushed in and out of it with the greatest ease. Also another case in which there was a large pocket, larger than the ordinary duodeno-jejunal pouch, which was completely isolated and into which the stomach could be easily pushed.

Professor DIXON referred to the advances in our knowledge of the form of the human stomach, which were due to the work of the late Professor Birmingham, and he also drew attention to the fact that the occasional tubular form of the organ had been recognised by the older writers.

Professor FRASER doubted if there were any practical value in describing the particular form of any hollow organ where the extremes of contraction and dilatation were so great, and the forms and positions varied so much.

Dr. MOORHEAD agreed that there was little practical importance attached to the shape of the hollow viscera.

The PRESIDENT, replying, agreed that the shape of the stomach was extremely variable.

Professor A. F. DIXON exhibited a series of skulls which gave indications of the presence of an occipital vertebra. The significance of the various markings around the foramen magnum was mentioned, and it was suggested that the body of the occipital vertebra was perhaps to be sought for in the little ossicle normally developed at the apex of the odontoid process of the axis vertebra. The relatively early appearance of this ossicle, and its ossification, sometimes, at all events from two centres, seems to favour this idea, and to distinguish the little bone from the vertebral epiphyseal plates with which it is usually included. Further, the fact that the anterior end of the notochord at first lies dorsal to, and is not included in, the cartilaginous basi-occipital perhaps justifies one in not seeking for the body of the occipital vertebra in the occipital bone.

Professor FRASER made the following communication on "the relations of the pneumogastric and other nerve fibres to the persistent arterial arches", which he illustrated on the board, basing his remarks mainly on what could be easily dissected on the left side of the human subject. The superior laryngeal represents the nerve which passes to the larynx between the

internal carotid and the early dorsal aorta, the latter disappears between the carotid and aortic or fourth arterial arch and so lets the nerve free. Should the early connection persist as a cord, the nerve would be found at the junction formed between it and the internal carotid artery, just as the recurrent or inferior laryngeal nerve is always found looping round the junction of the ligamentum arteriosum with the dorsal aorta. Between the internal carotid and the ligamentum arteriosum, which latter represents the sixth arterial arch, there are two arterial arches one of which, the aortic, has always a complete loop of nerve fibres around it formed mainly by the upper cardiac branches of the vagus, that of the left side passing in front of the arch to join its neighbour of the right side behind the arch. The primitive fifth arterial arch disappears, but there is clear evidence of a second loop of nerve fibres round the aortic arch coming chiefly from the last cervical and first dorsal ganglia of the sympathetic, those from the left side being mainly in front and joining those from the right side behind. As I am only dealing with the persistent arches I may leave this loop out of consideration for the present. In addition to those enumerated—viz., superior laryngeal round the internal carotid arch, the cardiac branch loop round the aortic arch, the evidence of a second loop round the aorta, which may represent that of the lost fifth arterial arch, the recurrent laryngeal round the sixth arterial arch, I invariably find another loop formed from the vagus, passing round the front aspect of the functional pulmonary artery (on the left side) to join the nerves behind, this loop is quite clear of the branches running to the lung root, and points suggestively to the Gill cleft origin of the lung.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

CLINICAL EVENING, THURSDAY, FEBRUARY 8TH, 1906.
CHARLES OLDHAM, F.R.C.S., Vice-President, in the Chair.

MESSRS. ARNOLD LAWSON and GEORGE COATS showed preparations from a case of

CONGENITAL ANTERIOR STAPHYLOMA previously brought before the Society by Mr. Lawson. The eye had spontaneously ruptured six weeks later. The central portion of the cornea was thinned and had a cicatricial appearance. The cornea was perforated with a knuckle of iris caught in it. The lens capsule and iris were adherent to the back of the cornea. Owing to stretching the ciliary processes, pars plana, ora serrata, and anterior part of the choroid were carried forwards with the cornea. Owing to the firmer attachment of the ciliary body to the sclera, this had been left in its normal position. Thus the ciliary processes were further forwards than the termination of Descemet's membrane, and the ora serrata was actually in front of the ciliary muscle. Only one other case of the kind had been described, also in a similar case to this one. The reason of this displacement was due to the fact that in fetal life the inner layers of the uvea were less intimately connected with the outer than is the case after birth and the same occurs in many of the lower animals especially in birds. The staphyloma in this case was believed to be due for certain to intrauterine inflammation and perforation of the cornea.

Mr. HOLMES SPICER showed a patient, *æt.* 48, who had always been short-sighted. The left eye had been blind ever since an injury he had received 30 years ago, and the right eye failed in 1901, and now had total posterior synechia and no P.L. The left eye had a corneal opacity and tremulous iris, the lens was tilted and lightly dislocated backwards, it was quite opaque and there was no fundus reflex. The vision was P.L., and the projection was good. On March 3rd, 1903, a needle was introduced behind the ciliary body, and the lens was pushed backwards. Sight was at once obtained, and it had since improved

so that he was now able to see 6-60. There was a large area of myopic atrophy of the choroid about the disc, and the shrunken lens was visible at the bottom of the vitreous.

Mr. SPICER also showed a case of SUPERFICIAL PUNCTATE DEPOSIT ON THE CORNEA. The patient was a girl, *æt.* 16, whose right eye was attacked with interstitial keratitis in 1897. She became deaf in 1902, and she had an attack of interstitial keratitis in the left eye in 1905. The latter was severe and led to much opacity, and to the development of salmon patches in two places, and a deposit of keratitis punctata at the back of the cornea. The left cornea had cleared considerably; there was some deep opacity near the centre, and numerous small brown or dirty white dots exactly like keratitis punctata, but they were evidently close to the surface, and in front of the old interstitial opacity.

Mr. LUDFORD COOPER showed a girl, *æt.* 11, suffering from

ELEPHANTIASIS NEUROMATOSIS.

There was much deformity of the right upper eyelid and temporal region. The lid was pendulous, and all its structures were greatly hypertrophied. The lid was also considerably everted. The patient was unable to lift it, and it could with difficulty be raised so that the small shrunken globe beneath it could be seen. The lens was opaque and the tension was normal. The outer and lower portions of the frontal bone, and of the squamous portion of the temporal bone were much more prominent on the affected side. The condition was congenital, and was slowly increasing.

Mr. E. E. HENDERSON showed a woman *æt.* 29, who had a growth on the upper palpebral conjunctiva. For several weeks she had noticed something movable beneath her upper lid, and for three days it had protruded. An oval mass was found about 2.5 cm. long and 1 cm. broad. Its surface was smooth and vascular, and was attached to the fornix by a strip of conjunctiva containing vessels. It was thought to be tubercular.

Mr. SYDNEY STEPHENSON showed a boy, *æt.* 9, who had two detachments of the retina in one eye, one above and the other below. The tension was increased, and the vision was bare P.L. Transillumination showed that light passed readily through both detachments. The other eye was myopic, with some vitreous opacities. There was an obscure history of injury, and a doubtful history of tubercle in the family. The question was one of diagnosis, though it was considered to be of a tubercular nature by Mr. Stephenson.

Mr. H. S. MORTON and Mr. LAWSON showed interesting cases.

Mr. TREACHER COLLINS showed two cases of CONGENITAL COLOBOMA OF THE IRIS WITH A BRIDGE. In the first case there was a bridge of pigmented iris tissue about 1 m.m. in breadth, stretching across the space formed by the pupil and the coloboma. It was situated a little below the level of the margin of the pupil, which was pear-shaped, with the small end downwards.

In the second case the two eyes presented two lesser degrees of the same condition. In one eye the stroma of the iris was alone deficient below the bridge, the pigment epithelium being left exposed. In the other eye, the space below the bridge formed in part a complete gap in the iris, and was in part filled with pigment epithelium. The developing iris receives its blood supply from two sources—(1) loops of vessels budding off from the anterior ciliary arteries, and (2) branches continued forwards round the sides of the lens from the central hyaloid artery; these form a circle of anastomosis anteriorly. The gap in the iris peripherally in these eyes might be explained by the failure in formation of one of the loops from the anterior ciliary arteries and the bridge, by the normal formation of the anterior circle of anastomosis from the central hyaloid artery.

An outbreak of diphtheria has occurred amongst the nurses and maidservants at the General Hospital, Nottingham, and nine of them have been removed to the Isolation Hospital at Bagthorpe.

THERAPEUTICAL SOCIETY.

At a meeting on Tuesday, January 23rd, at the Apothecaries' Hall, Sir LAUDER BRUNTON in the chair.

Dr. J. NEWTON PITT described the treatment of exophthalmic goitre by antithyroid serum. Graves' disease required long treatment, and though many remedies are beneficial, none are panaceas but antithyroid serum is often of much service. Formerly digitalis, belladonna, potassium iodide, and arsenic were used or an operation was necessary. It is still doubtful whether the disease depends on toxic or nervous conditions. In 1899 the use of the serum from the blood of dogs whose thyroids had been removed, or the dried blood, or in some cases the milk of goats similarly operated on was employed. Five cc. of serum was at first injected subcutaneously, but recently it has been given by the mouth, with equally good results; still each dose costs two shillings and often more than 100 doses are needed, the treatment lasting 5 to 10 weeks. Under this treatment the thyroid and exophthalmos are diminished, the pulse becomes lower, the general health and weight improve, the tremors and the nervous symptoms diminish and the patient is apparently well, but sometimes relapses occur and require the treatment to be resumed. Dr. Pitt has treated six cases by this method, all in women, using also rest in the open air. In one case in five weeks the pulse fell from 160 to 100, and in two months there were no tremors, nor insomnia, and she felt well. In another case of two years' duration, with the antithyroid treatment only, she became quite well in two months, and able to walk four miles. A third case in one week's treatment gained 1 lb. in weight, and the pulse was lowered 10 beats. In another case with a very large thyroid causing dysphagia, the gland was greatly reduced in 14 days and the patient's condition was much improved; in two other cases the pulse and nervous symptoms were ameliorated though the thyroid was not much diminished. The treatment by antithyroid serum is almost always successful, the tremors and the nervous symptoms are relieved, and it is only as a result of nervous affections that death occurs in Graves' disease. No ill results have occurred from this treatment except in one case, in which a patient took 240 doses without consulting the doctor, and symptoms of myxedema occurred, but these were relieved by leaving off the treatment. The flesh of goats deprived of thyroids has been tried without any beneficial result.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

A PATHOLOGICAL meeting (the first meeting of the kind in the history of the Society) was held on Friday, February 2nd, the President, Mr. L. A. BIDWELL, presiding.

On taking the chair, Mr. BIDWELL presented to the Society a very tasteful badge to be worn by future presidents at the meetings of the Society. The badge was accepted by Dr. F. Lawrence, in the name of the Society in suitable terms. Dr. Lawrence then invested Mr. Bidwell with the new badge of office.

The following members showed specimens, &c.:—The President: A stone formed round a clinical thermometer removed from the bladder of a woman by supra-pubic lithotomy and sections of an unusual tumour of the omentum removed by operation. Dr. J. A. Coult's: Two stomachs of children, showing pyloric and duodenal obstruction. Dr. George Pernet: Microscopic sections of various forms of unusual skin disease. Dr. J. R. Lunn: Drawings and paintings of various morbid conditions and also specimens of adventitious stones introduced into the bladder by an hysterical female patient, and microscopic sections. Dr. W. L. Harnett: An instructive series of specimens of morbid anatomy including a large cyst of the spleen and many microscopic sections. Dr. Hamilton Wright:

A collection of microscopic sections and specimens of morbid anatomy. Mr. McAdam Eccles: A stomach removed by operation for colloid carcinoma, with recovery of the patient. Dr. J. A. Mansell Moullin: A large uterine fibroid and other specimens removed by operation. Mr. Richard Lake: A most instructive collection of specimens, models, and paintings illustrating various forms of ear disease. Dr. Leonard Mark: The broken umbrella and seared clothes of a woman who was struck by lightning in Hyde Park, but who ultimately recovered. Dr. A. E. Russell: A series of kidneys showing various forms of common pathological change. Dr. Otto Grunbaum: A heart with a gumma of the inter-ventricular septum in which the band of His was involved. The patient during life showed symptoms of Stokes-Adams disease. Mr. J. G. Pardoe: A series of prostates removed by suprapubic prostatectomy. Mr. Woodford: Microscopic specimens of the various forms of spirochæta, including the *Spirochæta pallida*.

Lantern slides of great interest were shown by Mr. C. F. Keetley, of various forms of deformity of the hip, by Dr. A. Morison, of changes in the coronary arteries in a case of angina pectoris, which had apparently affected the ganglion cells, and by Dr. Chisholm Williams, showing the effects of X-rays treatment on certain cases of malignant disease.

THE LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, FEBRUARY 1ST, 1906.
FRANK T. PAUL, F.R.C.S., President, in the Chair.

ACUTE HÆMORRHAGIC PANCREATITIS.

DR. F. W. BAKER YOUNG said that his patient was a man, æt. 30, and addicted to alcohol. He was taken ill while at work, walked home, a distance of fifty yards, and died within forty-five minutes of the onset of symptoms. At the autopsy the body and tail of the pancreas were found enlarged and infiltrated with fluid blood; the head of the organ was also involved but not to the same extent. There was blood-stained fluid in the lesser sac of the peritoneum and an ecchymosis on the left kidney over the site of its relation with the body of the pancreas. No other lesion was found that could account for death. The following points were of special interest:—(1) Rapid onset and rapid termination; (2) the patient's age; (3) absence of vomiting; (4) absence of pain; (5) the fluid state of the blood no clots having been found even forty-eight hours after death; (6) the engorgement of the abdominal veins with fluid blood; finally, the medico-legal aspect of the case—had the pancreas not been examined the cause of death could not have been stated.

Dr. WM. CARTER drew attention to the similarity of the symptoms in death from irritant poisoning and from hæmorrhagic pancreatitis respectively, quoting the following from Dr. A. J. Chalmers' monograph on "Pancreatitis in Ceylon":—"Especially I desire to draw attention to the legal *post-mortem* form where no mention of the pancreas is to be found, I think that this should be rectified and that in all legal *post-mortem* careful note should be made of the condition of the pancreas."

POSTERIOR VERTEBRAL TUBERCULOSIS.

MR. K. W. MONSARRAT read a short paper on Posterior Vertebral Tuberculosis. After mentioning the primary seats of the disease as it has been found in the vertebral arches, he related two cases. In the one, the disease involved the transverse process, pedicle and lamina in the dorsal region; in the other, it was confined to the lamina of the fourth cervical vertebra on the left side. Both cases were complicated by abscesses and the cervical case also exhibited paralytic phenomena, beginning on the left side and subsequently extending to the right and involving the bladder function. The paralysis in the second case rapidly disappeared after laminectomy and the clearing out of a mass of granulation tissue from the spinal canal.

Dr. T. R. GLYNN related a case of caries of the atlas and axis with displacement of the atlas backwards, in which recovery took place—the patient ultimately dying from internal hydrocephalus. The caries was associated with post-pharyngeal abscess and the condition being recognised, the patient, a girl, was placed on a bed raised at its upper end, her head fixed by a bandage to a rail, the body extended by a weight attached to the feet. All her limbs and the bladder became paralysed and respiration embarrassed. Atropine proved valuable in relieving respiratory trouble. After many weeks she recovered, the last symptoms, those pointing to descending lateral sclerosis, nearly passing away. She entered service and remained well for several weeks, but was re-admitted—comatose. After death, great distension of the lateral ventricles was found. The odontoid process had slipped backwards and upwards; the cord was compressed to the size of a goose quill; the axis and atlas were partly destroyed and ankylosed together. The hydrocephalus was probably caused by the displaced odontoid process thrusting the medulla upwards against the cerebellum and closing Majendie's foramen.

CARDIAC HYPERTROPHY IN GRAVES' DISEASE.

Dr. T. R. BRADSHAW showed a girl, æt. 16, with Graves' disease incompletely developed. There had been palpitation and suffocative sensations for a year. The most prominent sign was hypertrophy of the right ventricle, for which none of the common causes were present. Latterly, slight enlargement of the thyroid had become apparent. Dr. Bradshaw commented on the rarity of demonstrable cardiac hypertrophy in Graves' disease, a fact pointed out long ago by Trouseau.

THE X-RAY DIAGNOSIS OF KIDNEY STONES.

MR. C. THURSTAN HOLLAND read a paper on the X-ray diagnosis of kidney stones. The paper was divided into three portions, the positive, doubtful, and negative evidence of calculi. Illustrative cases were cited and lantern slides shown to prove the value of the positive and the difficulties of the doubtful diagnoses. The paper was based on a series of 76 cases, in 22 of which calculi were shown by X-rays. The value of the negative evidence was discussed, and it was shown that too frequently reliance was placed on plates which were not good enough to warrant a negative opinion; if plates of the proper quality were obtained, then, and then only, was negative evidence reliable. The value of a pressure tube apparatus in taking these radiographs was also dwelt upon.

The PRESIDENT referred to the valuable aid in diagnosing kidney lesions afforded by the urine separator and radiography. Liverpool was fortunate in possessing an exceptionally skilled specialist in each department and he had had many opportunities of testing, and though at first he had not been prepared to give an unqualified acceptance to the results obtained by these methods, experience had assured him that in proper hands they were thoroughly reliable, and of the utmost assistance.

Dr. J. HILL ABRAM said that one of Mr. Holland's cases was a man, æt. 43, who had been sent to him for pain in the right hypochondrium and loin. There had never been any renal colic, or hæmaturia, and nothing could be detected by physical examination. On one occasion Dr. Abram found a few pus cells in the urine. Dr. Holland's report was decisive and Mr. Rushton Parker successfully removed two stones from the kidney. It was an enormous gain to have had such an advance in our methods, and it would enable physicians to recommend surgical interference with much lighter hearts than in the past.

Mr. W. THELWALL THOMAS alluded to the great service X-rays in Mr. Holland's hands had been to him in many cases of kidney stone—even in a case of a large kidney filled with pus and in a very stout patient, in confirming the diagnosis. He would in every case of suspected calculus call in an expert radiographer for confirmation.

The following gentlemen also took part in the

discussion of the paper Mr. Rushton Parker, Dr. Nathan Raw, Sir James Barr, and Dr. T. Welby.

CORK MEDICAL AND SURGICAL SOCIETY.

GENERAL MEETING HELD WEDNESDAY, JANUARY 24TH, 1906.

Professor PEARSON, M.D., in the Chair.

PROFESSOR CUMMINS showed a Cystic Tumour removed by him from a two-parous married woman, two months after birth of second child. She noticed it first in the right iliac region when *æt.* 14, and on her admission to the hospital it extended up to the lower surface of the liver and well across the median line of abdomen, and was so large as to excite wonder that there had been room for it and the pregnant uterus together. There were no untoward subjective symptoms, and the urine was free from abnormal constituents. A cystoma of the broad ligament was diagnosed and an operation undertaken. A median incision was made, and transversely running vessels were found entering the tumour; these were ligatured and the growth removed without difficulty. There was no connection with ovary tube, or ovarian vessels. He was reluctant to remove the kidney with the tumour, but the cyst was so intimately fused with that organ as to render this step imperative. The huge cavity left was packed with gauze, for which a drainage tube was in due course substituted, and patient's recovery was uneventful.

Dr. MOORE reported on the cyst, whose origin he attributed to an error of development—a persistence of part of the Wolfian body. In this case, the capsule of the cyst had split to receive the kidney with whose capsule it was inseparably fused. He demonstrated the normal ureter, thus excluding hydronephrosis.

The CHAIRMAN characterised the cyst as a unique specimen, and agreed with Dr. Moore's opinion as to its genesis. He was a bit dubious about removal of kidney, but thought he most likely would have done the same himself.

The CHAIRMAN showed a tuberculous kidney and ureter that he had removed from an unmarried woman, *æt.* 28. She had been a domestic servant in England, where the symptoms—pyuria, &c.—showed themselves. Coming back, she put herself under his care. Having examined the bladder with cystoscope, which revealed no cystitis, he used Luys' Segregator, and found, on estimating urea in healthy urine coming from the right ureter, that the daily excretion was 300 grains. Thinking this satisfactory, he operated, making the usual Howard Kelly incision—an incision he had always used before Kelly's book came out—and found evidence of considerable peri-nephritis and great thickening of the ureter. Having secured the renal vessels by clamping them, he clamped the ureter as far down as possible, and then ligatured it. He left the forceps on the renal vessels for forty-eight hours. Post-operative vomiting was very troublesome, as is common in these cases. He thought the usual explanation of this symptom, *viz.*, increased strain on healthy kidney, incorrect, inasmuch as the diseased organ had been functionless for some time. A more probable explanation was excessive humidation of coeliac plexus following section of the sympathetic fibres going to the kidney. He pointed out the advisability in these cases of dealing with the vessels first, and then with the ureter, and raised the question of the order of infection. On the latter point there was some discussion, and the general opinion favoured the idea that the disease was primary in the case under review.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD. FRANCE.

Paris, February 10th, 1906.

RHINITIS.

COMMON cold in the head should no longer be considered a simple affection which gets well a little sooner when left alone than when treated. Coryza is frequently the first stage of an infection which may be followed by very grave consequences. By its means microbes take possession of a natural inlet of the organism.

The functions of the nasal cavities, says Professor Lermoyez, are not only to acquaint us with the different odours, but also to warm the inspired air, to charge it with vapour, to purify it in arresting particles of dust, and to destroy or neutralise on the spot infectious germs by the bactericide effect of the mucus which they secrete.

When by inflammation these actions cease, a series of affections may result which Lermoyez classes as follows:—Nasal obstruction, infection of nasal origin, reflexes of nasal origin.

Nasal obstruction is rapidly produced in infants by reason of the narrowness of the canal that a slight inflammation and swelling of the mucous membrane obturates almost completely. The child cannot draw the breast, it experiences a sense of choking and throws itself back with vivacity. When the impermeability is very pronounced, the child may succumb from inanition or asphyxia.

In infants, rhinitis is frequently the cause of infection of all the respiratory tract, and also of the middle ear; the secretion from the ear is purulent, and contains numerous streptococci and pneumococci, the virulence of which can provoke septicæmia.

There are certain differences in the frequency & complications of coryza in infants, children, and adults. Purulent sinusitis is rarely observed in infants because these cavities are not well developed. On the other hand, inflammation of the middle ear with certain reaction of the tonsils are the rule. All the adenoid tissue of the pharynx is engaged, and these inflammations are frequently accompanied by irritation of the lymphatics, which sometimes end in suppuration. But in a large number of cases the lymphoid tissue becomes hypertrophied and is converted into adenoid vegetations so frequently observed in children.

Broncho-pulmonary complications of coryza are well known, and it is to-day proved that careful antiseptics of the nose and the pharynx constitutes, with the removal of vegetations, the best prophylactic means against recurrent bronchitis in the young.

Nasal inflammation can be propagated to the eyes producing phlyctenular keratitis, conjunctivitis, blepharitis, &c., impetigo of the face, and thickness of the upper lip.

If the lesions of the nasal cavities become chronic hypertrophy of all the adenoid tissues of the nose, pharynx, and tonsils will result, and frequently the repulsive infirmity called *ozena* supervenes.

Coryza is not of itself a grave affection; it becomes so by complications. It should be treated with care.

To arrest coryza a host of remedies have been recommended, but that of Brand seems the best.

Pure phenic acid,	1 drachm.
Liq. ammonia,	1 drachm.
Proof spirit $\frac{1}{2}$ oz.	
Water, $\frac{1}{2}$ oz.	

Pour 10 drops on a piece of blotting paper and let it be inhaled through the nose for a few seconds.

It may be repeated every hour.

If the child has already suffered from complications from a previous coryza, great precautions are necessary; he should be put to bed with the legs wrapped in cotton wadding, warm drinks to provoke perspira-

tion, and a few drops of belladonna given in a little water.

Locally, pulverisations of cocain (1 per cent.) are very useful to facilitate respiration, but they should not be ordered for children under æt. 12. Solutions of menthol and oil (1—50) or resorcine (1—50) are frequently instilled into the cavities with benefit.

The general condition of the patient should not be neglected; quinine, in case of fever, and a gentle purgative. Later, the state of the nose and of the posterior nasal cavities should be examined for possible vegetations.

Coryza in the infant is a really grave affection. It does not know how to breath through the mouth, and the nasal cavities being very narrow, they are completely obstructed by the inflamed membrane and the secretion.

Respiration is very difficult at all times, but much more so when lying down than when sitting up, for when sleep comes on the tongue falls back against the velum obstructing any air that may come through the mouth.

As soon as the little patient commences to doze, a snuffing sound is heard, and the child wakes up choking, makes several large respirations in its thirst for air and cries. Sometimes this attack of dyspnoea assumes the intensity of an attack of spasm of the glottis; the child is frightened, the cartilages of the nose dilate, the cry is almost inaudible, the respiratory movements are rapid, and agitated, and cyanosis is imminent.

All these troubles end by affecting profoundly nutrition, the broken sleep, the difficulty in taking the breast contribute to the weakening of the frail organism. The infant gets thin, loses its strength, and succumbs either to convulsions or to broncho-pneumonia.

However, this fatal termination is not frequent, and the malady if treated in time gets well with little trouble.

The first thing to be done is to free the nasal fossæ from all mucosities. This can be effected by the use of the Politzer douche (dry douche), which removes the secretions very rapidly. The insufflation of air should be repeated each time before putting the child to the breast. The nose should not be irrigated. Local antiseptics may be obtained by a solution of olive oil and menthol (1—100), injected into the nostrils every three hours.

When the coryza diminishes, the following powder may be blown into cavities.

S.N. of bismuth,
Boric acid 2 drachms;
Resorcine, 30 grs. ;
Menthol, 4 grs.

GERMANY.

Berlin, February 10th, 1906.

At the meeting of the Society for Folk's-Hygiene Professor Orth discussed some aspects of the

ORIGIN AND PREVENTION OF TUBERCULOSIS.

In answering the question whether in any way bacilli that entered the system by kissing, by food, by breathing bacilli-containing dust, the individual receiving them must necessarily sicken of the disease, he said, "God be thanked, No!" We should then all die. As regarded the consumption of milk or flesh from animals suffering from bovine tuberculosis, the danger was not great, especially if these foods were not consumed raw. Moreover, in the parts of the animal that were sold for food there were but few bacilli. If the food containing tubercle bacilli was cooked, it did no harm. The same applied to milk. Whoever never drank unboiled milk would never infect himself with tubercle through the milk. Mothers whose children could not bear boiled milk should suckle their children themselves, and if they were not able to do that, they should have recourse to a wet nurse. In order to retain the system in good condition to resist the influence

of bacilli, he recommended strict inspection of meat, also of dairies, notification of disease, instruction in schools, disinfection, and hygiene of dwelling-houses. As the existing institutions for the treatment of consumption were for the milder stages of the disease, others must be erected for the bad cases. The luxurious fitting up of present institutions were superfluous, and not practical. Light, air, and strengthening of the system were the principal weapons against tuberculosis, and generally a hygienic mode of life both of sick and well, general cleanliness, and good food that strengthened the body. Every measure that raised the price of bread and meat furthered tuberculosis, and, on the other hand, every measure that cheapened the people's food was a remedy against tuberculosis. Special means of strengthening the system artificially so that the individual should become more resistant against tuberculosis, did not yet exist. Whoever should discover a means of rendering the human subject immune against tuberculosis would be the greatest benefactor of his race.

At the Society fur Innere Medezin, Hr. Manasse showed a patient who first came under treatment in 1902 with a swelling on the chin, the result of a scratch, as was supposed. The swelling appeared to be of a fundiculous nature, and was incised; it was then seen that the swelling reached to the bone. The incision brought no relief, and in the course of the next few months metastatic abscesses formed in the middle of the neck, in the sheath of the great vessels, in the right buttock, and the right half of the pelvis, and on the other side also, in the thigh, which on incision showed the same character as the original one. Four months later matters came to a standstill, the patient had recovered somewhat, and at his wish was sent home. Only a short time afterwards, however, he returned in a decrepit condition and with great pain in the right lower part of the thorax. Examination showed dulness below on the right lessened vesicular breathing at the spot, but normal above, the lower margin of the lung normally movable on respiration. The liver was not enlarged, but a further examination was practicable on account of tension. A subphrenic abscess was diagnosed, and this on operation was found to be correct. There was a large cavity about the size of the adult head between the convexity of the liver and the diaphragm. Recovery gradually ensued; but in the beginning of last year suppuration again took place in the right lower part of the chin, which, however, healed after a longish time. The patient has since then had no further attack and was now fit for work.

AUSTRIA.

Vienna, Feb. 10th, 1906.

ASCITES AND TALMA OPERATION.

At the Gesellschaft, Frank showed two patients, a man and a woman, on whom he had operated for ascites, the result of cirrhosis. The female case seems to have been of a congestive nature, and was therefore easily removed, but the male required more heroic treatment for his relief, as the spleen had to be brought to the surface and fixed after Talma's method of relieving ascites, which he affirmed was successful with all the intraperitoneal organs, such as spleen, liver and gall bladder.

His theory was to establish a collateral circulation between the parietes and the internal organ by fixing the later, after wounding or rawing its surface, in the parietal incision, where adhesion subsequently took place and a new vascular circulation produced. The easiest of these operations is with the omentum and peritoneum, which are accessible, while the liver, spleen, and gall duct require more expert knowledge. In cirrhosis of the liver, where the organ is greatly shrunk and the vessels compressed into narrow compass, the dragging forward of the organ into the parietal wound becomes a difficult and dangerous undertaking. The fixation of the spleen is not such a difficult operation, although when the organ is small and shrunken

considerable difficulty is experienced in retaining the organ in the wound, but where it is enlarged little or no difficulty exists.

Care should be taken to secure the peritoneum carefully to the margin of the laparotomy wound before attempting to fix the organ. This difficulty may often be troublesome to the surgeon as in the present case, where the muscular portion could not be easily caught.

When the spleen lies above the ribs firmly fixed in a shrunken condition as it was in the present case, it is almost impossible to perform the operation with any hope of success.

Notwithstanding the hopeless aspect of this case the operation was commenced on December 4th, 1905, by a long incision, 10 centimetres in length, along the margin of the tenth rib, while a part of the eleventh was resected whereby the diaphragm and pleura could be raised to admit of access to the organ, where it was found hard and shining through the peritoneum like a mass of porcelain.

With great difficulty its lower pole was dragged forward and fixed to the thoracic wall with the hilus remaining in the peritoneal opening. In this position it was firmly fixed by means of sutures and the whole finally covered with skin. The spleen thus lay subcutaneously embedded firmly between the ribs above and the muscles below, and allowed to heal. In the course of four days pneumonia marred the healing process and increased the ascites to an enormous extent for a considerable time after the operation, but it has now quite disappeared, leaving the patient free and comfortable without any sign of dropsy.

Teley said he had operated on a man, *æ*t. 26, who suffered from syphilitic cirrhosis and ascites. He tapped three times without success, and as an ultima ratio resolved on Talma's operation to fix the omentum in the abdominal wound for collateral circulation. The veins were very large, forming a *caput medusæ* after every tapping. When the incision was made the veins stood open like large quills. The omentum majus was fixed in the wound, but the peritoneum could not be, as it was firmly adherent to bowel and liver and could not be removed. The wound was closed and all firmly secured with sutures, but with no better success than the tapping. After ten days the stitches were removed, while the ascites went on, and eight litres of water were again drawn off. Some time after the patient died from inanition. Teley thinks that the operation is successful in a few cases, but not in cases like this, where the vessels are so widely distended.

Eiselberg said he had often fixed the spleen in the wound without the previous fixing of the peritoneum, and had obtained good results.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

PROFESSORSHIP OF MEDICAL JURISPRUDENCE, EDINBURGH UNIVERSITY.—This vacant post has been filled by the appointment to it of Dr. Harvey Littlejohn, the son of the late occupant of the chair. The appointment was announced on the 5th instant, and it may safely be said that none which has been made in recent years has been received with such unanimous approval. When Sir Henry Littlejohn's retirement was intimated, it was universally felt in medical circles in Edinburgh that the Secretary of State had no difficult task before him in finding a successor, and that no one could more fittingly occupy the chair than the candidate who has now been selected. Professor Harvey Littlejohn is 44 years of age, and took his degree in medicine in 1886; after some time spent in resident hospital appointments he studied abroad in Vienna, Berlin and Paris, returning to Edinburgh in 1888 to assist his father in teaching medical jurisprudence. In 1891 he received the important appointment of medical officer of health for Sheffield, where he remained for five years, returning to Edinburgh again in 1897 to

lecture on Medical Jurisprudence in the College of Surgeons. Professor Harvey Littlejohn is a Fellow of the Royal Society of Edinburgh, and was a Senior President of the Royal Medical Society. His contributions to the subjects of Medical Jurisprudence and Public Health are numerous and widely known; he is a member of the Sanitary Institute, the Epidemiological Society, the Society of Medical Officers of Health, and the Society for the Study of Inebriety. He is also one of the editors of the *Edinburgh Medical Journal*.

SCOTTISH UNIVERSITY PARLIAMENTARY ELECTION. Polling for Glasgow and Aberdeen Universities closed on February 6th, and the results were officially announced next day, as follows:—Sir Henry Craik, 3,543; Professor Murison, 2,450; Professor W. R. Smith, 1,240. Two days later the figures of the Edinburgh and St. Andrews election were published:—Sir John Batty Tuke, 4,893; Mr. St. Loe Strachey, 2,310. In a short address at the declaration of the poll, Sir John Tuke said that he had received support from electors of every shade of political opinion, and that he regarded his victory as a great academic gain.

ROYAL MEDICAL SOCIETY.—The annual dinner took place in the Society's hall on February 7th, and was attended by a large company of medical men. Professor Clifford Allbutt was the guest of the evening.

QUEEN'S NURSES IN EDINBURGH.—An important extension of the premises of the Queen Victoria Jubilee Institute for Nurses was opened on February 9th, by the Countess of Eglinton, in the unavoidable absence of the Duchess of Buccleuch. In opening the new flat the Countess of Eglinton spoke of the great services rendered to the community by the nurses, who made it possible to perform operations in the homes of the poor, and thus spared the over-crowded hospitals. In addition, the nurses spread a knowledge of sanitary laws, and the care of health among the community in which they worked. She pleaded for an extension of the work of Queen's nurses, in remote and outlying parts of the country, for a home of rest and convalescence for the nurses, for a pension fund, and for a sick fund. For all these greater generosity on the part of the public was required; at present they needed income rather than capital to carry on and extend their work.

BELFAST.

DONATION TO THE ROYAL VICTORIA HOSPITAL.—At a meeting of the Board of this hospital, held last week, it was announced that a letter had been received from Dr. H. L. McKisack, one of the honorary physicians to the hospital, intimating that the trustees of the late Mr. Henry Matier, of Belfast, purposed handing over to the hospital a sum of £5,000. Dr. McKisack is a son-in-law of the late Mr. Matier, who was a well-known merchant in the city. This handsome addition to the funds of the hospital will be most welcome, in view of the increasing work of the institution.

THE MEDICAL CURRICULUM.—Considerable interest is being taken at present in the subject of the medical curriculum in the Royal University, as it is known that some of the northern members of the Senate are pressing for certain changes. Two such changes have been widely discussed, and would be generally viewed with favour. One is the simplification of the course in physiology, so that it would interfere less than it now does with clinical work in the later years of the curriculum, and another proposed change is the reintroduction of compulsory attendance at a children's hospital. The two changes are of course connected, for it is obviously impossible to lengthen the course, and if there is to be more hospital, there must be less college work. It certainly does seem rather absurd, considering the vast importance of diseases of children in practice, that a young man may receive his diploma and licence to practise from the Royal University without ever having spent ten minutes in the examination of a sick child, though he has spent scores of hours in making tracings of muscle curves with complicated electric apparatus, which he is not likely to see again in all his future life. It is no doubt right that the

Royal University should maintain a high standard for its degrees, but some common-sense must be exercised that the standard may not be too high for a poor country. If it is found that the five years' curriculum is not nearly sufficient for the great majority of students to obtain a degree, it is clear that the standard is too high, for the majority of Irish students come from families who often enough have difficulty in keeping the student for even the minimum of five years. The whole subject certainly merits careful attention.

HEALTH OF NEWTOWNARDS.—It is not many months since this little town was visited by a severe outbreak of fever, and now it is the seat of an outbreak of measles and whooping-cough. A meeting was held in the Town Hall last week, convened by the Urban Council, to which all managers of day and Sunday schools and the principal teachers were invited. The position of affairs was explained by Dr. Jamison. Since the 1st of January there had been ten deaths from measles and seven from whooping-cough. It was arranged to close the schools for a week for thorough cleansing and disinfecting, and to let the parents of scholars know the risks run by sending children to school from infected houses.

LETTERS TO THE EDITOR.

"MEDICINE AS A GREAT ELECTORAL POWER."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The question dealt with under the above heading in your editorial "Note" on February 7th, deserves serious consideration. The letter to which you allude was written by Sir G. C. T. Bartley, whose heckler, no doubt, acted upon the suggestion that candidates for Parliament should be questioned on behalf of medical reform. That this advice received little response I am able to vouch, a fact which speaks well for the common-sense of the profession. The instance you refer to exemplified the mischief which might have been caused by wide adoption of the plan. Sir G. Bartley's heckler placed himself, if not his profession, on a level with those egoists, faddists, and fanatics who loudly proclaim their indifference to every great national and imperial interest, and devote themselves to the cult of the insignificant cause to which they are devoted. Perish India, away with the Colonies, down with the Empire, but let us before all prohibit vivisection, abolish vaccination, or promote legislation for the advantage of our own particular trade or profession. In the current papers there appeared a letter from the secretary of a notorious anti-vivisection society, urging all voters in a county division near London to vote for a certain candidate regardless of any other consideration, because he had pledged himself to support the Dogs Protection Bill. The committee of the society appealed "to all humane voters to concentrate their efforts for the return of Mr. —, and vindicate the claims of man's best friend for exemption from the tortures of the laboratories." A heckler on behalf of a profession, in taking up a position such as Sir G. Bartley rightly denounced, creates the belief that he is not actuated by public spirit, but by the narrow spirit of Trades Unionism which seeks its own advantage regardless of the interest of the community and the State.

How is it possible for a Parliamentary candidate to pledge himself to support amendment of laws with the scope and character of which he is entirely unacquainted, and which require considerable study before they can be understood. If the candidate be honest he must say this; if he be of the disingenuous variety, he may promise to give sympathetic attention to the question or even to help promote a change in the laws.

Lawyers in Parliament are not cognisant of the vast injury to the public which the present state of the law allows and encourages; they do not understand that whatever benefit medical reform might bring to the

profession, it would confer far greater advantages upon the people, and until the facts are brought home to them it is hopeless to expect that the drastic changes in the laws so urgently called for can be brought within the scope of practical politics. Not only ignorance but powerful and active prejudices have to be overcome. How enlightenment of public opinion throughout can alone be accomplished I have in previous letters explained. Growing knowledge of all the circumstances confirms me in the belief that it can be done only through the medium of a Royal Commission.

I am, Sir, yours truly,

HENRY SEWILL.

February 8th, 1906.

TREATMENT OF RESERVOIRS WITH CUPRIC SULPHATE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I read the remarks in THE MEDICAL PRESS of Jan. 17th, on the Newport experiments in the treatment of reservoirs with cupric sulphate together with those made at Manilla with the view of killing the comma bacillus, with interest. The comments in reference to the danger of supplying copper sulphate solution to the public as the result of its use is, I fear, likely to prejudice water authorities and the public against the method of treatment. In my paper on the subject, which appeared in *Water*, Dec. 15th, 1905, it was clearly shown that the copper sulphate was precipitated very rapidly. This precipitation of the copper salt can be completed, if the water does not contain sufficient carbonate, by the addition of lime which will further help to clarify the reservoir water. The public need have, therefore, no fears in respect to the possibility of being poisoned as a result of the copper treatment, if the process is carried out under the supervision of a competent chemist.

I trust, therefore, that you will correct this impression in your next issue in order that no misunderstanding may arise as to any possible injurious effects upon the potability of the waters so treated.

I am, Sir, yours truly.

J. HOWARD-JONES.

Newport, Mon., Feb. 5th, 1906.

THE SCIENCE OF THE TEMPERANCE QUESTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Do you not think that it would be interesting and of practical value if we had the general opinion of the medical profession on the temperance question? Not very many years ago, Dr. Todd and his disciples were strong advocates for alcohol in the treatment of disease.

If a man were brought into a London hospital with a broken leg he would be ordered 8 oz. of brandy, before anything was done. That was the rule of the day. Things have changed, or rather, theory has been made to give place to practice, and the two sometimes do not work together.

We are now beginning to ask what is alcohol, and we see cases coming into court on the question of what is, and what is not "whiskey."

The whole question seems to reduce itself to the pure chemistry of fermentation; a process of singular character and difficult to deal with. Do you not think that it would be well to draw a line between fermented liquids, and alcohol? We might allow simple fermented liquids to be sold under very different conditions to alcohol. To estimate any fermented liquid by the amount of alcohol it contains is questionable, at the least.

I am, Sir, yours truly,

INQUIRER.

P.S.—It is well to bear in mind that we can stop fermentation by adding some spirit to the fluid, as is done often in Spain and other countries, to obtain and sweeten wine.

MEDICAL NEWS IN BRIEF.

The Royal College of Physicians of Ireland.—Address to the Lord-Lieutenant.

AN address of welcome was presented to Lord Aberdeen, the new Lord Lieutenant of Ireland, by the President and Fellows of the College on the 7th inst. His Excellency received the address personally in the Throne Room of the Castle, and after hearing it and replying, had each of the deputation presented to him individually. The following is the text of the address :

May it Please Your Excellency,—We, the President and Fellows of the Royal College of Physicians of Ireland, desire to approach Your Excellency upon your arrival in this country as the representative of His Gracious Majesty the King with a cordial welcome and an expression of our devoted attachment to the Throne. The Royal College of Physicians of Ireland, founded in 1667, received in 1878 and 1890 additional powers from the late Queen Victoria, and during last year a supplemental Charter was granted by His Majesty the King which has placed the College on an equal footing with the sister Colleges in London and Edinburgh in regard to its membership. The President and Fellows of the College have ever been mindful of the great and important functions entrusted to them, both by His Majesty and by His Majesty's Royal predecessors. The President and Fellows have at all times sought to further the advancement of medical science, and to secure a succession of highly-trained physicians for the service of the State. A considerable number of the medical officers in the Navy and the Army hold the Diplomas of this College, while most of those holding the position of medical officer under the Poor Law System in Ireland are also Licentiates of the College. The President and Fellows from time to time have placed their services at the disposal of the Government, more particularly in devising and giving effect to measures bearing on the public health, and upon the present occasion they desire to assure Your Excellency of their readiness, now as in the past, to afford His Majesty's Government their hearty assistance in all matters relating to medicine and the health and welfare of the people.—W. J. SMYLY, President; JAMES CRAIG, Registrar.

His Excellency replied as follows:—

Mr. President and Gentlemen,—I appreciate very heartily the visit of this large and influential deputation to present the address of loyalty and good wishes to which we have just listened. I need hardly assure you that I recognise and appreciate the far-reaching importance and value of the work of the great and beneficent professional calling which has, so to speak, its headquarters, so far as Ireland is concerned, in your ancient and honourable College. I note also with pleasure and interest what is stated in your address regarding the practical share offered and exercised by your institution in the promotion of those measures for the maintenance of the public health, which it is the duty of the Government to maintain or encourage. It is, of course, impossible to over-estimate the national importance of the effective carrying-out and improvement of such measures in relation to sanitation and public health. It is, no doubt, also most desirable to foster that without which even the most skilful and scientific systems cannot have their full scope and effect—namely, a public opinion which will recognise and support the value and the application of such measures. Assuring you of my hearty good wishes for the success of all your efforts in these and other directions, I again thank you for your attendance here to-day.

On Friday last an address of welcome was presented by the Royal College of Surgeons in Ireland, which was graciously received by His Excellency, who in his reply alluded to the pleasure with which he looked forward to being present to the annual dinner of the college.

The Otolological Society of the United Kingdom.

AN ordinary meeting of this Society was held at 11, Chandos Street, on Monday, Feb. 5th, 1906, the President, Mr. Cumberbatch, in the chair. Messrs. Fitzgerald Powell, J. S. Barr, E. S. Steward, A. K. Gordon, and H. J. Davis were elected members. After a short address by the President, Mr. Macleod Yearsley showed a specimen of epithelioma of the pinna removed from a man, aged fifty-two, and a patient in whom the left tympanic membrane was of a dark slate-blue colour. The latter case attracted much attention, but no adequate cause could be assigned for the phenomenon. Dr. Albert A. Gray gave a photographic and lantern demonstration of some pathological conditions found in the human labyrinth, and on some points in the comparative anatomy of that organ. Other cases were shown by Mr. Lawrence, Mr. Whitehead, Dr. Milligan, and Dr. Dundas Grant.

Royal College of Surgeons of England.

At an ordinary meeting of the council, held at the college on the 8th inst., the following candidates were admitted members of the college:—L. E. Acomb, Cardiff and Middlesex; E. L. Atkinson, St. Thomas's; C. K. Attlee, Camb. and St. Thomas's; J. S. Avery, Bristol; A. Barber and B. H. Barton, St. Bartholomew's; A. Beeley, Leeds; C. Bennett, St. Thomas's; L. C. Blackstone, Univ. Coll.; R. O. Bodman, Bristol; C. W. Bowle, St. Thomas's; D. W. A. Bull, Camb. and St. George's; R. Burgess, Camb. and London; W. B. Burr, Middlesex; G. Chaikin, Sheffield and London; A. de C. C. Charles, Camb. and St. Thomas's; H. D. Clement-Smith, St. Bartholomew's; A. F. Clough, Guy's; O. C. P. Cooke, London; G. L. Coe, Camb. and Liverpool; N. R. Cunningham, Camb. and St. Thomas's; H. F. Curl, Camb. and London; F. B. Dalglish, St. Thomas's; A. P. Day, Camb. and London; H. L. Deck, Sydney and St. Bartholomew's; C. C. A. de Villiers, Guy's; A. N. Dickson, Camb. and St. Thomas's; A. Dinnis, Charing Cross; W. A. E. Dobbin, Cardiff and St. Mary's; G. S. Earl, St. George's; G. B. Edwards, London; J. Evans, Camb. and St. George's; T. Ll. Evans, Cardiff and Univ. Coll.; A. H. Fardon, Camb. and St. Thomas's; A. R. Fisher, Leeds and King's Coll.; J. E. Foreman, London; A. T. W. Forrester, St. Bartholomew's; C. W. Gibson, Guy's; J. N. Glaister, Univ. Coll.; J. M. P. Grell, Camb. and King's Coll.; J. Grogono and R. M. Grogono, London; G. W. Hardy, Leeds; R. F. Hebbert, St. Thomas's; G. H. Heron, St. Mary's and Liverpool; V. C. Honeybourne, Camb. and St. Thomas's; N. G. Horner, Camb. and St. Bartholomew's; F. R. Hotop, New Zealand; J. I. Jaffe, Dublin and King's Coll.; R. R. James, St. George's; E. C. Jones, St. Thomas's; H. T. Jones, Univ. Coll.; W. H. Jones, Manchester and St. Bartholomew's; E. G. Kelgren, Camb. and St. George's; T. W. Kirby, Toronto and Guy's; H. E. Kitchen, Camb., Manchester, and St. Mary's; T. B. Layton, Guy's; A. L. Loughborough, St. Thomas's; A. H. McCandlish, London; W. St. C. McClure, Sheffield, Univ. Coll., and London; J. E. R. McDonagh, St. Bartholomew's; S. G. MacDonald, Camb. and St. Thomas's; W. J. O. Malloch, Toronto and London; L. Myer, Guy's; J. C. A. Norman, London; N. H. Oliver, Guy's; W. H. Orton, Camb. and St. Bartholomew's; W. S. Orton, Guy's; C. M. Page, St. Thomas's; E. W. M. Paine, St. Bartholomew's; J. W. Parker, Cardiff and Univ. Coll.; M. C. M. Pitkin, Camb. and St. Thomas's; H. R. Prentice, St. Bartholomew's; W. P. Purdom, Guy's; H. E. Quick, St. Bartholomew's; A. Randle, Univ. Coll.; S. Reader, Guy's; M. J. J. R. Rigoulet, Paris; W. O. Sankey, St. Thomas's; E. Schenck, Freiburg; F. Shingleton-Smith, Camb. and Bristol; C. A. Stidston, St. Bartholomew's; J. Tate, Univ. Coll.; G. M. Taylor, and F. Thompson, London; E. M. Thomson, St. George's; A. C. Watkin and J. A. Watt, Univ. Coll.;

L. White, Westminster; H. B. Whitehouse, St. Thomas's; E. D. Whittle, Univ. Coll.; W. D. Wilkins, Manchester; E. Wilkinson, Birm.; A. H. Williams, London and Durham; W. T. Williamson, St. Bartholomew's; C. J. Wilson, Camb. and London; M. R. O. Wilson, Bristol; J. H. Wolfe, London; H. D. Wyatt, Guy's.

The following received diplomas in public health (granted jointly with the Royal College of Physicians): A. C. Birt, H. Caird, H. Chesson, J. M. Collnys, G. Corcoran, J. Gillies, F. Harvey (captain R.A.M.C.), G. H. Lock, G. E. Malcomson, P. K. Muspratt, J. F. Northcott, O. H. Peters, J. W. S. Seccombe (lieutenant, R.A.M.C.), F. B. Skerrett, L. P. Stephen (captain, I.M.S.), P. G. Stock, T. B. Winter (lieutenant-colonel, R.A.M.C.), C. H. Wright.

The Election of Direct Representative for Ireland.

In view of the slight majority obtained by the successful candidate, Dr. Leonard Kidd, at the recent election, Sir William Thomson has asked for a recount, and a scrutiny of the votes. This re-count commenced at 10 a.m. yesterday morning, but at the time of going to press we are unable to say whether it has been possible or not to finish it in one day. If a close scrutiny is to be made of each vote, we fancy that several days must elapse before the result is known.

West London Medico-Chirurgical Society.

THE annual dinner was held at the Hotel Great Central, on Wednesday, February 7th, the President (Mr. Bidwell) being in the chair. There was a large attendance, including the Presidents of the Medical and other societies, and the Director-General of the Army Medical Service. The latter pointed out the pressing need for the formation of a Civilian Army Medical Reserve, to take on the duties, at any rate in part, of the R.A.M.C., which would, in the event of a great war, of necessity be to a large extent withdrawn from this country. He referred sympathetically to the scheme initiated by the West London Society for the formation of such a Civilian Reserve.

The Case of the Feeble-Minded.

THE Royal Commission on the care and control of the feeble-minded sat again last week at the Royal Commissions House, Westminster. Lord Radnor presided, and there were also present Mr. Byrne, Mr. C. Hobhouse, M.P., Mr. H. D. Greene, K.C., Mr. W. H. Dickinson, M.P., Mrs. Pinsent, Dr. Needham, Mr. Chadwyck-Heale, K.C., Dr. Dunlop, the Rev. H. Burden, and Mr. Mothersole, secretary. Mr. J. W. Willis Bund, chairman of the Worcestershire County Council, quarter sessions, and Education Committee said he thought that in respect of uncertified persons, local authorities should be bound to take steps to supplement the contributions made by the State and the locality by payments from the earnings of these persons as far as possible or by obtaining contributions from his property or his friends. At present there was a decided objection to spend anything beyond the poor-rate, or to adopt the Elementary Education (Defective and Epileptic Children) Act, 1899, with the result that no effective means were taken for dealing with uncertified persons, and therefore things went from bad to worse. Uncertified children required their education to be continued long beyond the age of 16 if any good was to come. It was therefore necessary to detain the children longer. The second step was a colony or home for uncertified persons, where they would be kept and properly looked after. Persons who could neither work nor be improved should be drafted off either to asylums, to workhouses, or to a special colony. Evidence was also given by Dr. P. W. Macdonald, on behalf of the Dorset County Council; Dr. C. E. Liesching, chairman of the Lunacy Committee of the Tiverton Town Council, the Rev. W. F. Norris, rector of Barnsley; Mr. Alderman G. Pearson, Bristol; and Mr. D. T. Cowan, director of education, county of Southampton, and Mr. F. G. Barnes, hon. secretary of the National Association of Teachers of the Deaf. The Commission adjourned.

LITERARY NOTES.

Who's Who becomes every year a more substantial and more indispensable book of reference. As a comprehensive and accurate dictionary of current biography it is simply unique, and is now found on the study table of the medical man as a stock volume of reference. Its yearly compilation must involve an immense amount of painstaking labour, but on the other hand there is a solid recompense in the production of a standard annual reference book. Its well-known and popular editor, Mr. Douglas Sladen, may be congratulated upon the great and increasing prosperity of Messrs. Black's useful publication.

THE bones of the illustrious Dean Swift might well move in tremors of cynicism and anger at "*Laputa*," revisited by Gulliver Redivivus in 1905 (London: Hirschfeld Bros., Ltd.), a superficial but amusing plagiarism of his motive, if hardly of his style. The unseemly revivification of Gulliver, still in his adventurous frame of mind, would seem to show that after nearly two hundred years of silence, his enterprise and ingenuity had undergone deplorable degeneration. If we remember rightly, the illustrious traveller set out for Laputa in 1706, and in the records of that adventure, succeeded in admirably expressing in skilfully moulded language, the eccentricities and extravagancies of thought and action of the philosophers and would-be scientists of the Queen Anne period. The main object of the record of this "*Second Voyage to Laputa*" is to caricature present-day methods and manners, science and politics. The work is certainly amusing, and the view of ourselves through Gulliverian spectacles might well teach us most necessary lessons.

"*Operations Vade Mecum*," by Prof. E. Leser, of Halle (published by S. Karger, Berlin), is a work intended specially for country practitioners, who may be compelled to operate on emergency cases; in the small space of 180 pages an attempt is made to describe the technique of all operations likely to come under this heading. Prof. Leser has carried out well an exceedingly difficult task, his descriptions are clear, but of necessity concise, such operations as hernia and tracheotomy are given, as they deserve, extra space; the treatment of perforative peritonitis is very briefly dealt with, while the treatment of the frontal sinus and rhinoplastic operations might well be omitted from such a work without diminishing its value. The book is profusely illustrated, but the pictures, most of which are from photographs, are somewhat lacking in clearness.

OBITUARY.

ALLAN CUTHBERTSON SYM, M.D. EDIN.

We regret to record the death of Dr. Allan Cuthbertson Sym, which occurred last week, at Edinburgh. Dr. Sym was the fourth son of the late Mr. William Sym, and a brother of Dr. W. G. Sym, ophthalmic surgeon, Edinburgh, and Sheriff-Substitute Sym, Perth, who was formerly attached to the Edinburgh Courts. Deceased was educated at Craigmount and Edinburgh University, and was an M.B., C.M., and M.D. of the latter. He was in practice for about twenty years in Morningside. His comparatively early death will be a matter of deep regret amongst an unusually large circle of patients and friends.

It is reported that President Roosevelt has ordered a strict investigation into the facts behind a statement by Professor Wiley, the head of the Chemical Bureau of the Agricultural Department, to the effect that more than 3,000,000 children die annually in infancy because of being dosed with nostrums and soothing syrups and fed on bad milk.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

The Position of the Struggle against Carcinoma Uteri.—E. Opitz (*Monatssch. f. Gebursh. und Gynakol.*, January, 1906) says the time has come when the late results of the radical abdominal operations can be recorded, and an opportunity given for comparison with the vaginal methods. The effort to be as radical as possible, and at the same time to prevent the immediate dangers of the operation has been an incentive to the correction of the technique. The results must become better when the patients are seen as early as possible. Winter has done much for this by his instruction of women in general, as well as midwives and physicians. He has found many followers, and it can be hoped that everywhere the success of his work will make itself felt. By this means the greatest advance will be made. Regarding the method of operation, the abdominal route is now most favoured on account of the greater, far greater, number of permanent cures. We are now able to satisfy Winter's claim for five years' observation. Still in some hands the abdominal method did not give good late results, and therefore so much the more valuable for criticism are the microscopical reports on the tissues removed at operation, and *post-mortem*. Pankow found in only one-fifth of the cases an agreement between the clinical diagnosis and the microscopical report regarding the condition of the parametrium. A parametrium which seems quite free can be completely infected, and one much infiltrated may not contain any cancer cells. The parametrium was infected in over half the cases operated on (Pankow 46 in 67 cases. Mackenrodt 41 in 48). The glands were affected in about one-third of the cases (Barsch 11 times in 38 cases). The glands are more often carcinomatous when the parametrium is affected. Therefore even though one should feel doubtful about the removal of the glands, the parametrium alone drives us to the abdominal route. It is urged against the removal of the glands that it adds to the danger of the operation, and that it is not possible to recognise and remove all those affected; and that two-thirds of them are not involved; but the success of Döderlein and others, from whose patients carcinomatous glands were removed, the patients remaining healthy to-day, must prevent haste in declaring the removal unnecessary and dangerous. We cannot accept as certain that metastases in the glands perish, though this in the experience of some has become probable (Schauta, Mackenrodt, Petersen, &c.). The fact that the worst cases are treated abdominally, and that the abdominal operation is only in its infancy may explain the primary mortality of 18–20 per cent. The results are becoming better (Kröni 2 deaths in 47 cases; Döderlein's last 25 cases without a death, &c.). The vaginal primary mortality is about 6–8 per cent. Regarding technique. Bumm does not drain, holding that it encourages pus formation, and may kink the ureters. Author advocates the use of rubber drains instead of gauze. Injuries to neighbouring organs are not so liable by the abdominal method, but against this is the danger of necrosis of the ureters, cystitis, pyelonephritis, &c. Nothing is more difficult than to decide which cases are suited for operation. Clinically it is scarcely possible (Krönig). Author advises that perhaps in cases which clinically seem inoperable one should not operate in order not to raise the mortality too high, even at the risk of leaving a woman to her fate who might otherwise be saved. The late results can also be improved by removing the recurrent cancer if it should appear. The operation may be difficult, but has been successfully performed. A means may possibly be found

to destroy the cancer remaining after operation, or better, to help the body in bringing about its destruction. One may hope that when very few cancer cells are left a favourable opportunity may be given to remedies to act, which under other circumstances are powerless. G.

On Foreign Bodies in the Uterus.—Dr. Hellier (*Practitioner*, February, 1906) enumerates, among others, pessaries, tents, hairpins, a tin box. They are usually introduced to procure abortion, but a pessary may migrate from the vagina to the uterus, especially when introduced shortly after labour. The symptoms are those common to endometritis, subinvolution, and other pelvic ailments. The leucorrhœa is likely to be offensive. If the presence of the foreign body be unsuspected, one may become suspicious of malignant disease of the body. G.

On Ventrifixation, with Details of a Complicated Case.—Sir William J. Sinclair (*Brit. Med. Journ.*, Jan. 27th, 1905) in referring to the discussion on ventral fixation recorded in the *British Medical Journal* of December 16th, 1905, says he cannot agree with the remarks made by one speaker who held that the chief indication for the operation in addition to complicated retroflexion was the condition found in "cases of prolapse of the uterus in women at or past the menopause." In his opinion the operation was unjustifiable in these cases. Again he finds himself in disagreement with Drs. Herman and Horrocks as regards the danger of operating in cases complicated by adhesions. He holds the opinion founded upon the experience of 100 cases that the operation gives rise to little post-operative trouble and further, that a pelvis affected by peritonitis is less likely to be infected than the virgin structure. He quotes a case in which the operation was performed where numerous adhesions complicated matters, but where after history was excellent. H.

Does Diachylon Affect the Infant when it Fails to Procure Abortion?—Heelis, Jacob, and Trotman (*Brit. Med. Journ.*, February 3rd, 1906) record an interesting case under this heading. A young woman in her third pregnancy had symptoms of abortion at the third month—severe uterine and intestinal pains with vomiting and constipation. The os was patulous, but there was no bleeding. A blue line was noticed on the gums, but she denied taking anything that would have accounted for this. She remained in bed for two weeks, and after that went to full term without sickness, and was delivered of a live hydrocephalic child. The blue line by this time had disappeared. The patient then confessed to having taken pills of lead plaster—three or four daily for a week—when she found herself to be pregnant, but had desisted finding no result followed. Symptoms of poisoning did not appear till a month after. The child's head measured 16½ inches round its largest circumference. A *post-mortem* examination marked thinning of the brain, which contained a pint of fluid. A chemical examination of the liver showed the presence of lead in the proportion of 0.0002 per cent., an evidence that lead taken by the mother does reach the foetal tissues, and is eliminated very slowly. The question arises, did the lead produce the hydrocephaly? H.

Ventral Fixation of the Uterus and its Alternatives. Remarks introductory to Discussion by Ernest Herman, M.B. (*Journ. of Obstetrics and Gynecology*, January, 1905).—Having addressed a few remarks on the safety and simplicity of uncom-

plicated cases of ventral fixation, Herman said the first question for discussion was—In what cases should we advise patients not to wear a pessary but to submit to surgical treatment instead, and his views may be summarised as follows:—First, cases in which with retroflexion there is great tenderness of the body of the uterus, sacral and hypogastric pain, with intermittent dysmenorrhœa and dyspareunia; and, secondly, cases in which the uterus is fixed by adhesions in a retroverted position, and is very tender. On the other hand, in the majority of cases of retroversion, in which the uterus is not congested and the displacement only causes symptoms, because it is associated with slight descent, a pessary will give nearly complete relief, and such cases should be advised to be content with that treatment. The few of this class which fail to get relief from mechanical support should resort to surgery. Supposing, now, that relief is to be given by an operation; what operation? He discusses Alexander's operation, vaginal fixation and ventral fixation, and concludes that ventral fixation is the best mode of relieving symptoms caused by retroversion or retroflexion of the uterus, when the result of mechanical support is not satisfactory. That combined with dystrochophy, but not without it, ventral fixation is an efficient treatment of prolapse. That if the operation is properly performed, subsequent difficulty in labour need not be feared. By "properly performed" he meant that the anterior half of the *fundus uteri* is stitched to the muscle about half way between the *symphysis pubis* and the umbilicus.

F.

Embolism following Operation.—Dearborn (*Annals of Gynecology and Pediatrics*, November, 1904). The author describes thrombosis as resulting from three conditions:—First, after a prolonged or severe operation, secondly, as a result of sepsis in the wound, and, thirdly, where neither of the above conditions obtain. The thrombosis differs considerably both as to its type and liability to produce infection, according to its cause. If due to stagnation of blood, it most commonly occurs seven to ten days after operation. It is more common after operations in the pelvis. Too forcible use of retractors causing injury to large venous trunks, ligation of a vein near its entry to the main trunk, and loss of blood, the remaining blood being more easily coagulated, are given as likely causes. The most frequent cause of pulmonary embolism is thrombosis of the veins of the leg; next pelvic and abdominal operations, and parturition. The branches of the pulmonary artery supplying the lower lobe of the right lung are the most often occluded. Death may be caused absolutely suddenly by syncope, a little less suddenly by asphyxia; or in an hour or two on the first attack of asphyxia having passed off, another and another supervene, and death does not take place for a day or two. A pulmonary embolism which does not cause death too rapidly gives rise to a hæmorrhagic infarction accompanied by pleurisy. It usually commences with a rise of temperature to 102 deg., falling a little in twenty-four hours, so that it is possible that many cases of pneumonia, pleurisy, and pulmonary abscess following operation are due to emboli, and therefore when after operation the patient has an attack of pneumonia or pleurisy great care should be taken to keep her very quiet. The prospects of recovery depend on the size and nature of the embolisms and the state of the lungs. Very small non-infected emboli usually run a favourable course. In non-septic cases most of the danger of infarction is over in a fortnight; in septic cases not for six weeks or so. The essential treatment is rest, helped in some cases by morphia, strychnine and oxygen.

F.

Metrorrhagia Myopathica.—Brooke M. Anspach (*American Journal of Obstetrics*, Jan. 1906). Metrorrhagia myopathica is a form of uterine hæmorrhage independent of the usual causes of metrorrhagia, and

produced by a pathological condition of the uterine muscle. It manifests itself towards the close of the child-bearing period and does not occur in nulliparous women. If in a given case there is no new growth of any kind; if pregnancy can be excluded; if there is no adenexal visceral or general complication; if, in short, none of the usual causes of metrorrhagia obtain, the condition is, as a rule, regarded as obscure, and variously relegated to the domain of apoplexia uteri, endometritis senilis, preclimacteric bleeding, &c., &c. Apoplexia uteri presupposes arterio-sclerotic changes in the uterine arteries with an actual rupture of one of these unhealthy vessels; the author has failed to find such a condition in upwards of 300 uteri examined, and agrees with Reinecke in concluding that it alone cannot account for persistent metrorrhagia. The term senile endometritis merely means atrophy and is normal, and the symptoms referred to it arise from cystic glanular endometritis or disease of the muscularis. Preclimacteric bleeding is a specious name given to cases of metrorrhagia myopathica, which conveys no meaning, but the period of life at which the hæmorrhage occurs. It is plain, from the existence of these terms, that there is a class of cases which are not very well understood, and this class the author has designated by their chief symptom as cases of metrorrhagia myopathica, believing that the cause lies in the uterine muscle, whether it be a primary disease or a secondary lesion, the result of a general condition. What is the nature of the pathologic process in the wall of the uterus? Arterio-sclerosis of the uterine vessels was considered to be a sufficient cause. Therlhabes and Meir believe that a fibrosis of the uterine musculature leads to metrorrhagia. Pick found the elastic tissue varies in its amount and form at different periods of life and in different diseases. After the menopause the uterine vessels become diminished in calibre from a thickening of their walls, the vessels show more or less arterio-sclerotic changes, have a tendency to grouping, and there is a great increase of elastic tissue about these groups and in the external layers of the uterus. This change in the proportion of the elastic tissue is believed by Melnikow to take the place of atrophied parenchyma, be it epithelial or muscular, and furthers the mechanical internal equilibrium of the organ. In normal menstruation the endometrium plays a passive part—there is no actual rupture of vessels, but a diapedesis of the menstrual fluid through the thin-walled capillaries—the quantity of the flow being in direct relation to the pressure within the endometrial capillaries, this press in turn depending on the force of the arterial supply and the calibre of the venous channels of return. At the menstrual periods the slight contractions of the uterus narrow the venous but have little influence on the arterial channels, and in this way congestion and a resulting diapedesis are developed. It is natural then at the close of menstrual life that the muscular elements atrophy; that the intravascular area should be diminished by sclerotic changes in the vessel walls and by an increase of elastic tissue which helps to contract the vessels and takes the place of lost parenchyma. Hence a failure in the normal increase of elastic tissue or the obliterative changes of the vascular channels, or an excessive atrophy of the muscular elements, or an excessive hypertrophy of the connective tissue, might result in disturbances of the endometrial circulation and produce profuse menorrhagia or metrorrhagia.

F.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "Recent Medical Literature."
- (2) "Recent Surgical Literature."
- (3) "Recent Gynecological and Obstetrical Literature."
- (4) "The Recent Literature of Anatomy, Physiology, and Pathology."

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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 reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

A QUACK SKIN SPECIALIST.

A correspondent writes us from Bedford as follows:—"DEAR MR. EDITOR,—I fancy you will find a geographical error on the first page of your valuable journal, 'A Liverpod Skin Specialist So-called,' should, I think, read 'A Lancaster Skin Specialist So-called.' I fancy the case is one to which my attention was called, reported in last Friday's *Lancaster Observer*. The specialist is a farmer, Wolfenden, who acknowledged having treated 400 cases.—Yours truly, S. J."

CAMBRINUS.—Nutrition is the key—or at any rate the necessary foundation—of a rational therapeutic system, both in alcoholism and in drug crav. g. The overwhelming desire for further stimulant is often merely the physiological expression of tissue exhaustion and starvation. Hence the value in such cases of forced feeding and of the selection of nutritive and easily digestible foodstuffs. This line of treatment is unfortunately not of the kind taught in our medical schools.

ETONIENSIS (Folkestone).—In answer to your question we should advise you to be extremely guarded in speaking of Behring's serum to your patient. The curative powers of that remedy, it must be remembered, depend solely upon his *ipso dixit*. To announce a great medical discovery, and at the same time to defer full publication of its details is contrary to all the best traditions of Medicine. The reputation of the great German professor, nevertheless, is so illustrious and untarnished that the scientific world awaits final results with an extraordinary amount of interest and curiosity.

CHILD LIFE IN OUR MODERN CITIES.

"It is a question," writes a medical man from Huddersfield, "how far the liberty of the subject should be permitted to interfere with legislation to prevent the terrible destruction of child life by parental neglect, ignorance, and vice. There can be no reasonable doubts that the greater part of the infantile death-toll is absolutely preventable. To shrink from dealing with the problem is to shirk the plain and bounden duty imposed upon us as a nation. Moral responsibility cannot be indefinitely shirked, either by the community or by the individual."

K. B. MORTON (London).—Aneurism of the hepatic artery is of extreme rarity, and there are only a few cases recorded. In one instance the swelling ruptured into the hepatic duct. If you care to send any question in the form of a short note we shall be pleased to publish the same in this column. An answer is pretty sure to be forthcoming from some of our readers, however obscure the point thus raised may be.

W. A. S.—Cigarette smoking, especially when the smoke is inhaled or passed through the nostrils, is most baneful in excess.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, FEBRUARY 14th.

SOCIETY OF ARTS (John Street, Adelphi, W.C.).—8 p.m. Paper:—Mr. C. Johnson: The Horseless Carriage, 1885-1905.

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

HUNTERIAN SOCIETY (Pagan's Restaurant, Great Portland Street, W.).—5.30 p.m. Hunterian Oration:—Mr. A. H. Tubby: Recent Surgical Methods for the Treatment of Certain Forms of Paralysis. 7.45 p.m. Anniversary Dinner.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. L. Cheate: Clinic (Surgical.) 5.15 p.m. Lecture: Dr. H. Campbell: Observations on Treatment.

THURSDAY, FEBRUARY 15th.

CHILDHOOD SOCIETY AND THE BRITISH CHILD STUDY ASSOCIATION (Parkes Museum, Margaret Street, W.).—8 p.m. Lecture:—Dr. R. Milne: Conditions of Children, Physical and Mental, in Resident Schools. (Arranged by the Childhood Society.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinic (Surgical.) 5.15 p.m. Lecture:—Dr. P. Horrocks: The Use of Pessaries.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—8 p.m. Dr. M. Dockrell: Syphilis: Pustular and Tubercular (Nodular and Gummatous). (Chesterfield Lecture.)

FRIDAY, FEBRUARY 16th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, Cavendish Square, W.).—5.30 p.m. Mr. J. H. Evans: Meningocele (cases and lantern demonstration). Short Papers:—Dr.

F. J. Poynton: Jaundice in Infancy. Dr. E. C. Williams (Bristol): Splenicmegalic Biliary Obstruction. Mr. W. G. Nash Bedford: I. Alopecia Areata Neurotica; II. Renal Calculus. Dr. F. Langmead: Tuberculous Ulceration of Stomach.

EPIDEMIOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.).—8.30 p.m. Paper:—Dr. C. Childs: A Study of the Typhoid Fever Epidemics in the United States Volunteer Camps in 1898.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. L. Lake: Clinic. (Ear.)

TUESDAY, FEBRUARY 20th.

THERAPEUTICAL SOCIETY (Apothecaries' Hall).—4.30 p.m. Conversation. Ladies admitted. Thomas Maben, Esq., will illustrate the Preparation of Anti-diphtheritic Serum by illuminant view. Dr. Stuart Tubby will describe Clouds and Climate. Mr. Fernandez Carr: Some Uses of High Frequency Currents.

Vacancies.

Bury Infirmary.—Senior House Surgeon. Salary £110 per annum, with board, residence, and attendance. Applications at once to Honorary Secretary, Dispensary, Knowley Street, Bury, Lancashire.

City of Winchester.—Medical Officer of Health. Salary £300 per annum. Applications to Thomas Holt, Town Clerk, Guildhall, Winchester.

Denbighshire Infirmary, Denbigh.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to J. Parry Jones, Secretary.

London County Asylums, Banstead, Surrey, and Colney Hatch, New Southgate, N.—Junior Assistant Medical Officer. Salary £150 per annum, with board, furnished apartments, and washing. Applications to H. F. Keene, Clerk of the Asylums Committee, Asylums Committee Office, 8 Waterloo Place, R.W.

Leicester Infirmary.—House Surgeon. Salary £100 per annum, with board, apartments, and washing. Applications to Harry Johnson, House Governor and Secretary.

Lincoln County Hospital.—Senior Male House Surgeon. Salary £100 per annum, with board, lodging, and washing. Applications to the Secretary, 2 Bank Street, Lincoln.

Newcastle-on-Tyne Dispensary.—Visiting Medical Assistant. Salary £100 per annum. Applications to the Honorary Secretary, Joseph Carr, Chartered Accountant, 26 Mosley Street, Newcastle-on-Tyne.

Newcastle-on-Tyne Dispensary.—Visiting Medical Assistant. Salary £100 per annum. Applications to the Honorary Secretary, Joseph Carr, Chartered Accountant, 26 Mosley Street, Newcastle-on-Tyne.

Appointments.

BARWELL, HAROLD, M.B. Lond., F.R.C.S. Eng., Surgeon for Diseases of the Throat at St. George's Hospital.

BRODIE, DEBOROUGH, M.B., B.S. Lond., L.R.C.P. Lond., M.R.C.S. Lond. District Medical Officer of the Tetbury (Gloucestershire) Union.

COOKE, ALFRED B., M.R.C.S. Eng., L.S.A., Consulting Surgeon to the Stroud General Hospital.

DODDS, H. B., M.D. Edin., Assistant Resident Medical Officer at the Royal National Hospital, Ventnor, Isle of Wight.

FREEMAN, W. T., M.D. Durh., F.R.C.S. Eng., Medical Officer to the Reading Prison.

GRIFFITHS, E. R., M.R.C.S., L.R.C.P. Lond., Senior Assistant Medical Officer at the Lewisham Infirmary.

HAFWORTH, F. ARTHUR, M.B., B.O. Cantab., House Surgeon at the Derbyshire Royal Infirmary.

MCNEILL, JOSEPH JAMES, L.R.C.S. and P. Irell., Medical Officer of Rosguill Dispensary District, Carrigart, co. Donegal.

NEWMAN, ERNEST L., M.B. Syd., House Surgeon at the North-Eastern Hospital for Children, Haekey Road, Bethnal Green, E.

PETERKIN, G., M.D. Edin., D.P.H., Certifying Surgeon under the Factory and Workshop Act for the Forfar District of the county of Forfar.

ROBERTS, ADELINA MARY, M.D., B.S. Lond., Medical Registrar at the Royal Free Hospital, London.

ROBERTS, E. J., M.R.C.S., L.R.C.P. Lond., House Physician at the Derbyshire Royal Infirmary.

WILMOT, T. J. T., M.B., Ch B., B.A.O. Dub., House Surgeon at the Derbyshire Royal Infirmary.

Births.

MARJORIBANKS.—On Feb. 3rd, at 562 Green Lanes, Haringey, London, to Dr. and Mrs. Robert Bruce Marjoribanks a daughter.

MORROW.—On Feb. 8th, at Bush Hill Park, Enfield, the wife of Ringland Morrow, M.B., of a son.

Marriages.

ARMSTRONG—CRUISE.—On Feb. 10th, at St. James' Church, Spanish Place, London, Edmund C. R. Armstrong, eldest son of the late Captain Andrew Armstrong, 2nd Queen's Royal, to Mary Frances, second daughter of Sir Francis Cruise, M.D., B.L.S.G.S., Honorary Physician-in-Ordinary to His Majesty in Ireland.

CREE—KENT.—On Feb. 8th, at the Parish Church, Godalming, Surrey, John William CREE, of the Inner Temple, eldest son of John Cave CREE, of Godalming, late of Calcutta, to Ada Mary, widow of Herbert Arthur Kent, M.R.C.S. Eng., L.R.C.P. Lond., of Ringwood, Hants.

Deaths.

WOOD.—On Feb. 8th, at 12 Lewes Crescent, Brighton, Frederick Wood, F.R.C.S. Eng., in his 87th year.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, FEBRUARY 21, 1906.

No. 8.

NOTES AND COMMENTS.

The London School of Clinical Medicine.

ALTHOUGH a somewhat late arrival, the London School of Clinical Medicine shows signs of lustiness that augur well for its future career.

Of all places in the Kingdom, the Metropolis is the one *par excellence* for post-graduate teaching. It is, from the very nature of things, the home of great teachers and great masters of medicine and surgery. Where the provinces reckon their stars by the half dozen, London numbers them by the score. That result is clearly the outcome of the unrivalled field for practise afforded in the huge city which forms the centre not only of the United Kingdom, but also of the Colonies, and of a great part of the civilised globe. So it is fitting that a strong effort should be made to provide a post-graduate school worthy of the name and fame of London medical workers and teachers. We venture to think that object has been more than achieved by the London School of Clinical Medicine, to which we cordially wish a long and prosperous career.

Waiting for the Verdict.

FROM New York we hear of another of those tragedies which the medical world is only too painfully familiar. While inoculating a rabbit with anthrax in his laboratory a sudden movement of the animal caused Professor Meyer, of Tulane University, to plunge the point of the syringe into his own fingers. With prompt and thorough surgical treatment there should be a good prospect of averting any serious consequences. However, journalists on both sides of the Atlantic have seized upon the sensational side of the incident. In a London newspaper, for instance, the Professor is pictured as waiting for ten terrible days to know whether the accident will or will not cost him his life. How the ten days limit is arrived at we hardly know. If the inoculation be not aborted the characteristic pustule, well termed "malignant," will appear in two or three days, and if it is going to be fatal, will probably do so within five or eight days. Not that the gravity of the accident should be under-rated. The risks are indeed terrible, and anthrax has already claimed various victims amongst medical investigators.

THE curse of water-borne typhoid fever probably becomes in most cases sooner or later a blessing in disguise. The havoc wrought by a sudden outburst of that terribly fatal malady enforces a never-

fading lesson upon the most careless and ignorant community. Last year Lincoln paid the penalty of its neglect in an enormous loss of lives and of commercial prosperity. This year its citizens are paying huge sums in compensation to the victims and friends of the victims of the typhoid-laden water supplied to them by the civic authorities, in spite of twenty years of official warning and condemnation. This costly popular education, however, is not likely to end in the present generation. The medical officer of the Gainsborough Rural District Council, for instance, recently reporting on an outbreak of typhoid in Trentside villages, said the people had disregarded his warnings against drinking water taken direct from the Trent. The people replied that they had drunk the water all their lives. The impression amongst them was that the Almighty sent typhoid and such things, and that any precaution on their part was useless. Well may Fleet Street head this item of news "Kismet."

Bogus Death Certificates.

TRUTH to say, a wholesome spirit of activity appears to have invaded the country, and news of quack prosecutions are pouring in upon every hand. An unqualified man who has been posing as a qualified practitioner in Liverpool for some years past was charged last week on six several informations for forging certificates of death. His real name was Jolly, but for the purposes of practice he called himself Dr. Joseph Fitzgerald, L.K.Q.C.P.I. The prosecution which was instituted by the Registrar-General resulted in a fine of £40 and £10 costs. If the Registrar-General would take wider cognisance of cases of this kind, the career of a large number of fraudulent adventurers would speedily be brought to an end. Why should not the General Medical Council bring pressure upon the Registrar-General and upon other agencies likely to curtail irregular practice? But the Council does not profess to be the champion of the medical profession.

A Herbalist caught by the Excise.

THERE are more ways than one of cooking a goose. It has been often pointed out in our columns that the defects of the Medical Acts can be compensated by calling in the aid of other existing laws. The Registrars of deaths and births, for example, could hamper the trade of irregular practitioners to an almost incalculable extent, especially if they were in touch with the

coroners. The police, needless to remark, could soon put an end to quack practice simply by prosecuting offenders for obtaining money under false pretences. In Liverpool last week the Excise showed their power in the same direction by prosecuting a herbalist for selling without a license "anti-stomachic drops" and other remedies containing methylated spirits. The defendant was fined £2 for each of several specified offences, and £5 5s. costs. The result of the prosecution should encourage our Defence Societies, as it adds another to the various indirect methods by which these pests of society may be brought to book.

**Bristol Bogus
"Doctor"
Fined.**

IN Bristol a notorious electrical quack has been laid by the heels, thanks to that champion of our profession, the Medical Defence Union. From the evidence, it appears that he held an unrecognised American diploma, and managed an Institute where X-ray, sinusoidal, high frequency, and many other forms of electrical treatment were obtainable. All this he might have done quite safely in the present ridiculous state of British law as regards quackery, had he not called himself "Doctor." Upon that score he was convicted by the magistrates and fined £10, together with £5 costs. Obviously the loss of £15 now and then will not put a stop to so lucrative a business as that of an unqualified medical electrician. Moreover, the offender in question is likely in future to be content with calling himself plain Frank Lee, and thereby avoid expensive and ornamental titles. One significant point brought out in the course of the trial was that the precious institute belonged to a clergyman and a Justice of the Peace. In this case the Bishop of the Diocese would, in our opinion, be justified in depriving the owner of a bogus medical concern of his cure, and the Lord Chancellor in removing the other from his magistracy. Will the Medical Defence Union kindly inquire into the possibility of thus following up the victory?

**The Election
of Direct
Representative
for Ireland.**

IN accordance with the request of Sir William Thomson, a recount and a scrutiny of the votes cast at the recent election took place during the past week. During the scrutiny a number of votes were objected to on the ground that the papers were improperly filled, and these were submitted at the close of the court to a meeting of the Irish branch of the Medical Council. The result of the proceedings was that Dr. Leonard Kidd was declared to have obtained 909 votes and Sir William Thomson 901. Dr. Kidd's majority was thus increased to eight, instead of four as declared after the first count. The recount will do good, if it serves to direct the attention of medical men to the necessity for adhering to the letter of the rules given for filling up the voting forms. If these rules had been followed in every case, it is unlikely that a recount would have been required, and thus a consider-

able amount of expense would have been saved—expense which can be none too well borne by the exchequer of the Irish branch.

LEADING ARTICLE.

MR. TROUTBECK'S SENSE OF "DUTY."

MR. CORONER TROUTBECK'S general distrust of the medical profession appears to be equalled only by his pathetic faith in the findings of his pathologist, Dr. Freyberger. The latter, in a recent inquest case, with rare skill and scientific insight detected perforation of a stomach as the result of a chronic tubercular ulcer. To that difficult technical observation he added the further brilliant inference that death was due to "sudden failure of the heart, accelerated by hæmorrhage of the lungs, while suffering from general blood-poisoning, the result of rupture of a chronic ulcer." Why an "expert" pathologist is needed at high fees to tell us this tangled tale is known possibly to Mr. Troutbeck, but to average plain medical men it is a thing past understanding. The unfortunate subject of the inquest was an inmate of Wandsworth Workhouse, who died within two days of the receipt of an injury. The master of the institution in question stated that deceased had met with an accident and was struck in the groin one Sunday evening while carrying a bag. He telephoned to the medical officer, who, in answer, ordered hot fomentations and an opium pill, and the patient at twelve next day. Monday the man vomited blood and died. The medical officer's story is that he telephoned at nine o'clock on Sunday morning, and was told the patient was better. He saw him at noon, and formed a tentative diagnosis of peritonitis, but at the patient's request did not remove him to the infirmary, especially as he thought it best to avoid rough movements. In his opinion, the blood had little to do with the death. Dr. Freyberger, on the other hand, was of opinion that an early diagnosis would have permitted an operation whereby life might have been saved. Where is this sort of thing to stop? The "expert" pathologist—if we are to accept the newspaper reports found that the vomited blood came from the lungs. Not content with the remarkable coincidence of hæmoptysis with ruptured gastric ulcer, he has next plunged into the difficult field of operative surgery. A pathologist is about the last person in the world one would turn to for advice on the vexed question of when it is justifiable to operate upon perforations of the stomach and intestine. He would be a bold surgeon who would perform a gastric section if called in to a man of 38 suffering from chronic tubercular ulcer of the stomach. It is to be presumed, moreover, that, as Dr. Freyberger reported hæmorrhage from the lungs, those organs were also more or less seriously involved in the tubercular process. Yet Dr. Freyberger has no hesitation in advancing a general

proposition that an operation might have saved the patient's life, regardless of the grave injury he is thereby doing to the medical man in attendance before death. Dr. Freyberger, be it noted, founded his views, which from internal evidence appear rash and untrustworthy in the extreme, upon an examination of the body after death. Any stick is good enough, however, for Mr. Coroner Troutbeck when he wishes to attack the medical profession either generally or individually. In the present case we regret to say that the stick has been placed in his hand by Dr. Freyberger, as we firmly believe, on grounds that reflect considerably on the soundness of his professional skill and judgment. There can be no hesitation in saying this, because Dr. Freyberger by an *ex cathedra* declaration in the Coroner's Court, where there is no chance of discussing or of controverting his utterances of opinion, is dealing a most injurious blow at the reputation of a Poor Law Medical Officer. If the authorities of the Local Government Board are jealous of the credit of its officers they will insist upon a full inquiry into this unhappy case. It seems possible that the opportunity of investigation will possibly be afforded them by Mr. Troutbeck, who gravely informed the jury that the telephonic messages opened up an entirely new situation, which he would deem it his duty to send for inquiry either to the Guardians or the Local Government Board. *Quem deus vult perdere, prius dementat.* Mr. Troutbeck always has the courage of his opinions, but we can hardly think him unwise enough to refer this case to the Whitehall authorities. If he does we most heartily express a wish that we might be there to see. There must be bounds settled somewhere to such arrogant indifference to the rights and traditions of a great profession as that displayed by Mr. Troutbeck and his henchman pathologist.

NOTES ON CURRENT TOPICS.

Secret Commission and the Veedee Vibrator.

We have received during the past week a copy of a circular which is being sent round to the medical profession by an individual of the name of H. E. Garratt, who proposes to send on free trial an instrument which he terms the "Veedee Vibrator." With the implement itself we have no concern, save to say that it is stated by its proprietor to cure rheumatism, gout, sciatica, constipation, liver, kidney, and stomach trouble, nervous debility, etc., etc., and that "Dr. J. Mortimer Granville, the great specialist and consultant, who studied the subject deeper and more practically, probably, than any other man," is, by an ingenious twist of the King's English, made to recommend its use. *En passant*, we may say that this gentleman's name does not appear on the *Medical Register*, in spite of the fact that he is "a great specialist and consultant." The matter with which we are concerned is the "special note" which appears on a slip marked "private

and confidential" appended to the circular letter. This note runs as follows:—"Any medical man desiring to prescribe the Veedee Vibrator and Attachments may instruct me to send to the patient direct and charge to the patient at list prices. In all such cases I would, immediately I receive the patient's remittance, send 25 per cent. to the medical man as his profit." This announcement, for sheer impudence, has had little to beat it since a maker of canvas Turkish baths addressed a somewhat similar circular to medical men. We confidently believe that there are but very few in our profession at the present day, who would so lower their professional status as to accept secret commissions in so gross a form. We regret that the Bill which was brought forward by the late Lord Chancellor with the object of preventing the giving of such commissions was not passed, and that this man cannot be brought within reach of the law, and we trust that our lay contemporaries will bring this paragraph to the notice of the general public.

A Delayed Autopsy.

In but few cases has it been possible to make an autopsy on a body a century dead, and to be able to discover therein pathological conditions sufficient to account for death. This has been done, however, in the case of Paul Jones, the famous American seaman, who died in Paris in 1792, and whose body was examined only last year. A full account of the recovery and examination of the body is given in the *Revue d'Ecole d'Anthropologie* (tome VIII.) and reproduced in the current number of the *Edinburgh Medical Journal*. The body had been packed in straw, soaked in some alcoholic preservative fluid, and enclosed in a leaden coffin. It was found, on opening the coffin, to be in an excellent state of preservation, in appearance like a mummy, but with the soft parts still soft. The resemblance to known portraits and descriptions, the colour of the face, the accurate agreement of measurements, and the initials "P" and "J" on the linen shirt were sufficient to afford identification of the body. But further evidence was forthcoming. Paul Jones was known to have suffered for some time before death from disease of the left lung, and in his last illness general dropsy was superadded. There was no doubt, on examining the lungs last year, of the presence of pleurisy, particularly on the left side, and patches suggestive of broncho-pneumonia were also discovered. The kidneys were small and suggested the presence of interstitial nephritis. The organs were submitted to Professor Corniel for histological examination, and to his astonishment, the results obtained were practically identical with those which might have been afforded by the organs at an ordinary *post-mortem* examination. In the lungs were typical patches of broncho-pneumonia, and the kidneys showed the changes of advanced interstitial nephritis. The liver was healthy, and afforded beautiful sections. A curious fact is that on the skin,

viscera, and other parts, were found small white firm masses consisting of crystals of tyrosin. The whole story is one of the strangest records in the history of pathological work.

"Sei-i-Kwai Medical Journal."

OUR contemporary, the *Sei-i-Kwai Medical Journal*, the official organ of Sei-i-Kwai, or Society for the Advancement of Medical Science in Japan, is always a welcome addition to the medical monthlies that come under our notice. Valuable as it is from the point of view of professional merit, it is perhaps more so as showing the intimate connection between Anglo-Saxon and Japanese medicine, a connection which was organic in its origin and which we hope will remain vital in its development. From the December number which lies before us we learn many interesting facts. To those who claim the Japanese as fellow-vegetarians it may be of interest to know that the daily ration of the sailor contains, besides biscuit (or bread), rice, barley, vegetables, sugar, and tea, five ounces of preserved or seven ounces of fresh meat, and five ounces of preserved or fresh fish. The advantage obtained by including proteid foods in the dietary of the Navy was long ago demonstrated by Takaki, and although his reasoning is denied by some authorities of the present day, the fact remains that after the introduction of his scale beri-beri disappeared from the Navy, which up to that time had been annually decimated by it.

Sleeping on the Roof.

As our city populations grow more dense so the value of land rises. Of recent years a great deal has been done to multiply the housing room of every given site by building skywards. But the people multiply at racing pace and the limit of added house-room is speedily exhausted. The only alternative is to migrate to green fields and open country, but even there the price of land is for the most part prohibitive. Under these circumstances it is no wonder that social economists have turned their attention to the roofs. One London hotel, at any rate, boasts of a garden on the roof-top. A generation or two hence it may be that all city dwellings will have a roof space laid out for recreation, for gardening, games, exercise or what not. In South London there are some working-men's blocks of tenements with large flat roof-tops that are used by the children for a playground, by their elders for recreation and vicariously as a drying-ground for laundry purposes. In America a society craze has sprung up for simple life on the house-top. The medical men of New York are said to be denouncing the fashion as highly dangerous, although a few cures have been reported therefrom in the case of consumptive patients. The cult of the house-top is clearly capable of much development. It would be easy enough to provide shelters thereon against the rigours and eccentricities of our own insular climate.

Anthrax and its Prevention.

THE recent case of anthrax at Bradford has called attention once more to this deadly but absolutely preventable disease. Many regulations have been enforced by legislation, but they miss the vital point as to the nature of the disinfectants to be used. Clearly the destruction of the anthrax bacillus and its spores must depend on the efficiency of the methods of sterilisation. It is interesting, therefore, to learn that Professor Klein has completed an important series of experiments in the sterilisation of anthrax spores, the result of which proves that Cyllin when diluted in the proportion of 1 in 50 is capable of destroying the most virulent strains when exposed for a period of 45 minutes. The experiments were first conducted with 60 minutes exposures, and were later repeated with equal success, as stated, with exposures of 45 minutes. The spores employed by Professor Klein in carrying out these experiments were isolated from a recently fatal case of "Wool-Sorters' Disease." Of course, it is not for a moment suggested that good results could not be obtained with other antiseptics. Dr. Klein's experiments, however, seem to us so direct and conclusive as to deserve special notice.

Instruction in Medical Ethics.

THE medical curriculum through which the unfortunate student of to-day has to wade to the practice of his profession is already not so much over-burdened as crushed by the weight of its ponderosity. The plan of teaching students to be medical factotums is likely soon to perish through obvious futility, and then it may be hoped that a capable practitioner rather than an inverted encyclopædia will be the aim of the efforts of the examining boards. One may well hesitate, in awaiting that day, to recommend any further subject for instruction; but in so far as a practitioner rather than a pedagogue is sought, so should certain matters of immediate practical moment replace some of the theoretical absurdities of the present. In any re-modelling that may be done now or hereafter a place should be found for the teaching of medical ethics, and, what is even more important, the implantation of a true professional spirit in the physician and surgeon of to-morrow. Now that the days of apprenticeship have gone, never, probably, to be recalled, it is the more incumbent on teachers to make students feel that when they leave the hospital they become units of a great profession having high obligations to its individual members, as well as to the public. Such an idea is foreign to much of the teaching and even the practice of many medical schools, and the result in want of loyalty or want of good taste is plainly visible in not a few young practitioners. The weight of these obligations is only borne in on them by time and experience, and in the meanwhile their own careers may be blighted and much professional misunderstanding and bad feeling have been caused. *An esprit de*

corps such as exists in the public services should be early instilled into those seeking to enter the profession and maintained, once they are in it, as a priceless possession.

Copper Sulphate and Drinking Water.

IN our last number we published a letter from Dr. Howard-Jones, Medical Officer of Health for Newport, Mon., in which he took exception to some remarks of ours which appeared in THE MEDICAL PRESS AND CIRCULAR of January 17th, with regard to the sterilisation of drinking-water by means of copper sulphate. We had said that we should have to be strongly persuaded of the necessity of employing this disinfectant before recommending its adoption for the sterilisation of reservoirs, because of the danger, which we admitted was an unknown quantity, of giving rise to chronic copper poisoning among those who drank the water habitually. Dr. Howard-Jones thinks that our remarks are likely to prejudice water authorities and the public against the method, and he maintains that the copper in solution can all be precipitated in the reservoir by the addition of lime to the water containing it. Therefore, he writes, the public need have no fear "if the process is carried out under the supervision of a competent chemist." If, instead of using the word "prejudice," Dr. Howard-Jones had said of our remarks that they were calculated to make water authorities and the public take great heed before committing themselves in the matter, we should have had no reason to find fault with his criticism. In our note we adduced a specific case, that at Manila, where the process had failed to fulfil expectations, through the operation of some local cause or causes unknown. We do say that it is a serious thing to embark on the impregnation of the public water supplies with a metallic poison until long and extended experience has revealed all the factors, probable and possible, which enter into the process of sterilisation or precipitation, and which may upset the most exact and scientific calculations. The use of copper sulphate on emergency may be justifiable and even valuable, but we should rue the day when, instead of collecting water from unimpeachable sources and conveying it by unimpeachable means, it was deemed necessary to use copper sulphate as a routine measure in the purification of the normal water supply of towns.

A Health Conscience

A GOOD deal has been heard during the last few years about the cultivation of that psychological abstraction—a health conscience. To call a thing an abstraction is not to deny it a being, and even a function, but only to draw attention to its intangibility. Dr. Clouston, we notice, has been urging its evocation in the columns of our contemporary, the *Spectator*, and he thinks that the conviction of sin against health is growing. We believe this is so, to a certain extent at all events, but we doubt if the conscience is growing either

at the proper rate or in the proper direction. We take it that conscience is an educated sense of the fitness of things, moral, religious, or hygienic, as the case may be, and that given a nature capable of response and given a training of an appropriate character, a conscience, or consciousness of right and wrong, may be created where it only potentially existed before. Can it be maintained, first that all men are capable of producing this conscience, and, secondly, that the training that is going on is of an appropriate character? Probably most, if not all, civilised beings have the constituents of a health conscience in their composition, but we can hardly believe that it is being properly evolved. The necessary training in the health, as in the moral sphere, is largely one of example, and the example of healthiness is one hardly set by the bulk of the nation. Moreover, in so far as precept is concerned, our health teachers are far too often, like the men who lose most money at Monte Carlo, men with systems with this one diet, with that one drink, and with the other exercise. If a health-conscience is to become a general possession, our health-teachers must be men who are of the world as well as in it and follow the ways of righteousness while living the ordinary lives of ordinary men, yet without sin. Food-worshippers, teetotallers, and Sandow-exercisers may attract schools, but they will not convert the world.

PERSONAL.

A GOOD many Colonial *conféres* are in England just now; among the arrivals last week were Dr. Adam Jameson of the Transvaal, brother to the Premier, and Dr. H. Lorans, Chief Sanitary Officer of Mauritius.

Two important Colonial appointments have just been filled. Dr. W. A. B. Hutton has obtained the post of Government Medical Officer to the East Coast of Vancouver, and Dr. L. B. Barbeau becomes Director of the Health Department of Mauritius.

SURGEON-GENERAL J. P. WALKER, M.D., who died last week at the age of eighty-six, was the oldest living member of the Indian Medical Service. He was through the whole of the Mutiny, and retired from the service thirty years ago.

WE congratulate Dr. Reginald Eager of Northwoods Asylum, Winterbourne, on the courage displayed in entrapping a would-be blackmailer and prosecuting him last Friday at the Bristol Assizes. Dr. Eager had the satisfaction of hearing his conduct publicly approved by the Judge, and the scoundrel sentenced to five years penal servitude.

PROFESSOR ROBERT KOCH has been commissioned by the Imperial Government to proceed again to East Africa, in order to resume his investigations into the causes of the sleeping sickness.

ON the 16th inst., the Lady Mayoress of Sheffield unveiled a portrait of Dr. H. C. Sorby at the local University in commemoration of fifty years distinguished scientific work connected with that town.

THE venue of the appeal in the Cardiff trial for damages against Dr. Skryme and Mr. Lynn Thomas has been removed to London.

A CLINICAL LECTURE ON HEMIPLEGIA.

Delivered at the North-East London Post-Graduate College on January 25th, 1906.

By ARTHUR WHITING, M.D., F.R.C.P.,

Assistant Physician to the Tottenham Hospital, N., and the Mount Vernon Hospital for Consumption and Diseases of the Chest, and Dean of the College.

PARALYSIS of one side of the body, face, arm, and leg, described in medical terms as hemiplegia, and popularly as a "stroke," is not, as you know, a disease, but a sign of disease. It is proposed here rather to consider hemiplegia in relation to the nature of its cause than to discuss the well-known characteristics of this form of paralysis.

CAUSES OF HEMIPLEGIA.

Although there is only one anatomical explanation of hemiplegia, namely, a lesion of the motor tract in one side of the cerebrum above the face centre in the pons, there are several common pathological causes, and the importance of recognising the nature of these causes is evidenced by the difference in the treatment of the patient, according to the difference in the cause. The main proximate pathological causes of hemiplegia are thrombosis, embolism, hæmorrhage and tumour in the brain, and with the unrecognised changes underlying the condition known as functional or hysterical paralysis.

Clinically, the influence of one or other of these proximate pathological causes is fairly definitely indicated by the character of the onset of the paralysis. Speaking generally, it may be said that the hemiplegia which is due to cerebral tumour is slow in its development, and by that I mean a space of weeks or months as a rule elapses between the first indication of the paralysis and its full development. The hemiplegia of cerebral hæmorrhage is usually sudden in its onset, a matter of minutes or even seconds; that of embolism is also sudden, but probably less sudden than in the hæmorrhagic cases; and that of thrombosis is neither sudden nor slow, but might be said to be deliberate, taking, it may be, hours for its full development.

CLINICAL ACCOMPANIMENTS OF HEMIPLEGIA.

In the case of hemiplegia due to cerebral tumour, there are usually the general signs of increased intracranial pressure, headache, purposeless vomiting, double optic neuritis, and often fits limited to one side or beginning on one side and extending to the other, and with or without loss of consciousness. In the earlier stages the hemiplegia is usually more profound for a while after the fits. Although as a rule the onset of the hemiplegia from this cause is slow, yet sometimes it is sudden, possibly from the occurrence of hæmorrhage into a slowly growing tumour.

Before a hemiplegia due to thrombosis there are sometimes premonitory subjective phenomena, e.g., attacks of tingling limited to the face, arm, trunk, and leg of one side. The attack comes on as a rule during rest and especially when the heart is slackened during sleep. As a rule there is no loss of consciousness. In addition to the weak circulation, there is usually evidence of arterial disease leading to roughening of their inner wall. In young men the usual form of arterial change is syphilitic end-arteritis; in older people it is usually atheroma associated or not with chronic nephritis. In young women the predisposing constitutional state is usually anæmia.

The embolic hemiplegia may or may not be associated with loss of consciousness, according to my own experience it more commonly is. There is evidence in the majority of cases of cardiac valvular disease, more especially mitral stenosis, but often aortic valvular disease. There may be other evidence of embolism elsewhere, of which the most picturesque is that of embolism of the central artery of the retina. There is often some history of precedent and unaccustomed exertion.

The hemiplegia due to hæmorrhage practically always comes on during exertion or excitement. The specimen from a case of cerebral hæmorrhage I now show you was from a woman who fell down unconscious as she was walking from church last Sunday morning. It is the almost invariable rule for consciousness to be lost in this group of cases. On examination there will, as a rule, be found a hypertrophied and violently acting heart, an accentuated aortic second sound, rigid arteries, and other evidence of renal cirrhosis.

CLINICAL VARIETIES OF HEMIPLEGIA.

The division of cases of hemiplegia according as they are left or right sided, or alternate or double sided, is a mechanical subdivision, and one needing but little attention. As regards the left-sided cases, I would merely remind you that the functional cases are more often of this kind, and that it is with right-sided hemiplegia in right-handed persons that a true aphasia occurs. The importance of a crossed or alternate hemiplegia is solely derived from the indication afforded of the position of the lesion; for example, when the third nerve is paralysed on one side and the face, arm, and leg on the other side, it is at once clear that the lesion is in the neighbourhood of the crus cerebri, the third nerve being injured after it has decussated and the other motor fibres before. Similarly, if the face is paralysed on one side and the arm and leg on the other, our knowledge that the decussation of the seventh nerve fibres is about the middle of the pons allows us to decide at once that the lesion is in the pons below that level. Double hemiplegia, which is chiefly seen in thrombotic cases, gives a strongly marked clinical picture from the circumstance that the difference between the escape of the automatic and the extreme interference with the highly specialised movements, as seen in the one-sided cases, no longer holds. The leg does not escape now as compared with the arm, and walking becomes impossible. The muscles of deglutition and of articulation are now greatly involved, and, what is practically never seen in a really one-sided hemiplegia, the sphincters participate in the paralysis. So pronounced are the bulbar symptoms that the condition is often called pseudo-bulbar paralysis, but it may readily be distinguished from the labio-glossolaryngeal paralysis of nuclear origin by there being no atrophy, e.g., of the tongue and no degree of the reaction of degeneration.

CLINICAL CHARACTERS OF HEMIPLEGIA.

By way of illustration of the clinical features of the hemiplegic state, I hope to show you a few typical cases. There are, however, a few clinical points I would shortly refer to. As regards the face, the paralysis, as you know, generally leaves untouched the upper facial muscles for the reason that they are more automatic and more bilaterally supplied than the lower. The tongue, in a majority of cases, but not a large majority, deviates to the paralysed side, because the genio-hyoglossus muscle of the sound side pushes out that side of the tip of the tongue more vigorously than the other. A true aphasia is not infrequently seen in right hemiplegia in right-handed persons, but in left hemiplegia the conversation of the patient may be unintelligible. This is due not to defect in the mechanism of speech processes, but to clumsy articulation.

In regard to the limbs, the extremities with their more specialised movements are more paralysed than their proximal parts, shoulder and particularly hip. As regards the trunk, it will be remembered that while most of the pyramidal fibres decussate in the medulla

to form the direct pyramidal tract, a few pass down the cord on the same side, and these are believed to supply the deep muscles of the back. At any rate, with weakness, e.g., of the right arm, there is also weakness of these muscles on the left side. The physiological correlation of the muscles of the limb and back is well illustrated by the muscular contraction required for, say, carrying a pail of water.

In regard to the *anæsthesia*, it is a hemianæsthesia, but not so complete or absolute as in functional hemiplegia (and I may here say that I have refrained from taking into account the cases of functional hemiplegia to-day because I so recently had an opportunity of discussing that subject with you). The stress of the organic hemianæsthesia falls mainly on the hand and foot. It fades away towards the trunk, and the limit in the middle line is not sharply bound by that line as in the functional cases, but overlaps it both in front and behind.

In regard to the *reflexes*, the general rule is that the deep reflexes are increased, accompanied by ankle clonus and the extensor plantar reflex, and the superficial reflexes are diminished.

In hemiplegia of one side the *sphincters* and other automatically acting muscles, as those of deglutition are not affected.

In regard to the *special sense*, the characteristic change which is itself usually associated with hemianæsthesia is hemianopsia.

TREATMENT OF HEMIPLEGIA.

The treatment of hemiplegia resolves itself into two sets of measures, the one to meet the attack, the other to prevent its recurrence. When it is due to a new growth in the brain, there is no treatment of the paralysis except perhaps in syphilitic cases, where vigorous antisiphilitic measures should be tried. The treatment of the case is essentially surgical: opening the skull, it may be, to relieve or stop the headache and vomiting, to save the vision from destruction by a consecutive atrophy, and to obviate the tendency to sudden death, or, a step further, attempting to excise the tumour, but in this case there will obviously be no amelioration of the paralysis itself; it is, indeed, certain to be made worse if that be possible.

The treatment of an apoplexy due to *hæmorrhage* is almost directly the opposite of that due to thrombosis. In the hæmorrhagic case the indication is by all means to lower the blood pressure and to promote clotting in the ruptured vessel. Hence the use of free purgation, and possibly of venesection, and the avoidance of all stimulation of the heart. The after-treatment, apart from the effort to minimise the effects of the paralysis, is largely one of quieting the circulation and combating the constitutional state manifested by, and partly due to, the cirrhosis of the kidneys often present. There is little, if any hope of influencing directly arterial degeneration, the aim is to control the blood pressure.

The treatment in the *thrombotic* cases is directed to an improvement of the circulation and the prevention as far as may be of clotting. To this end stimulants may be cautiously given, ammonia, which is believed to have an influence in both these directions, being probably the best; but alcohol in moderate quantities may be given; nitrites, say doses of 1-100th mm. of nitro-glycerine, are probably of value in dilating the arterioles and thus promoting circulation; to act on the heart small doses of digitalis, strophanthus, sparteine, or caffeine are of value. Purgation, if at all, must be gentle, and venesection is inadmissible.

In treating the constitutional state with the object of preventing, if possible, another attack, everything that would favour arterial degeneration, and therefore roughening of the interior of the vessels must be avoided; much nitrogenous food, the free use of alcohol, and anything that favours what is known as the gouty state should be interdicted. The heart's action should be kept as far as may be quiet, regular, and fairly strong.

In the syphilitic cases, I am firmly convinced of the protracted and intermittent use of iodides and mercury

not with the hope of materially influencing the already softened area, but with the object of improving the arterial disease and thus preventing a succession of attacks.

In the treatment of *embolic* cases the chief aim is to promote a regular cardiac action, for it is probable that a heart contracting first weakly and then strongly, is more likely to encourage the detachment of vegetation from its valves. In all cases some weeks' rest in bed is strongly indicated.

As to the *treatment of the attack* of paralysis, the tendency is to spontaneous improvement. Nearly always it may be promised that recovery of the leg will occur sufficient to allow of walking. What cannot be promised is that the delicate movements of the fingers will be regained. The exceptional cases in which walking is not regained, or only very imperfectly, are usually those with hemianæsthesia, the reason being that the leg fibres are the most posterior of the motor fibres adjacent to the sensory fibres in the internal capsule and are, therefore, more profoundly injured by a posterior lesion. If the lesion be anterior or in the middle of the motor fibres in the internal capsule, the leg recovers first, although its fibres may be as much damaged as the arm fibres, because the leg movements are more automatic and are probably more richly supplied from the healthy side of the brain.

Perhaps the chief aim, although the hope is not great, is to diminish the rigidity; but very gentle Faradism may be applied to the paralysed muscles, especially to those normally weaker, as the extensors of the wrist and fingers. Passive movements, the breaking down of adhesions, and gentle massage to the especially weak muscles may be tried with circumspection.

It is probable that a second attack in a majority of the cases will follow the first, and the treatment of "hemiplegia" is, therefore, essentially prevention of its proximate causes by keeping in abeyance its ultimate causes.

NOTE.—A *Clinical Lecture* by a well-known teacher appears in each number of the journal. The *Lecture* in next week's will be by William J. Dargan, M.D., Physician to St. Vincent's Hospital, Dublin, on a case of "Secretary Neurosis of the Stomach."

ORIGINAL PAPERS.

INAUGURAL ADDRESS ON

CARCINOMA OF THE UTERUS.*

By F. BOWREMAN JESSETT, F.R.C.S.,

President of the British Gynaecological Society.

IN my address this evening I do not think I can choose a better subject than that to which I have for a considerable number of years paid especial attention—I refer to Cancer of the Uterus. It is more than twenty years since I first attempted to deal with this terrible disease by the removal of the entire organ, which up to that time had not been attended with any amount of success. To Dr. Purcell is due the credit of having been the first surgeon in this country to carry the operation to a successful issue, at which operation I was present and was much struck by its feasibility. My first few cases, however, were attended with such disastrous results that I determined, excepting in very suitable cases, not to attempt it again, and it was not until the year 1892 that I again met with a case which I considered favourable; the patient on whom I operated made an excellent recovery, and since then I have operated on over 200 cases.

Diagnosis.—We are beset with difficulties in the selection of suitable cases for operation, as we rarely meet with a case in its early stage. At the Cancer Hospital a very small percentage of cases present themselves in which any operation would be

* Read before the Society, February 8th, 1906.

justifiable. Now one would think that cancer of the uterus should be as readily diagnosed as cancer of any other portion of the body, and no doubt it would be if patients presented themselves for examination early enough, and if the family medical man would insist upon a vaginal examination when any of his patients consulted him for vaginal discharge or any irregularity connected with menstruation. Unfortunately, however, women through delicacy rarely do consult their medical attendant for these troubles until the discharges become offensive or blood-stained, or they suffer inconvenience or pain from the presence of the disease; even then, I regret to say, they are too often treated by some astringent vaginal douche. Had patients suffering from advanced uterine cancer presented themselves early for examination, I venture to say in many cases they could have been freed from their disease and spared for many years to come.

Sir Halliday Croom has drawn attention to the frequency with which malignant disease begins, or, at all events, progresses after labour. It is not at all uncommon to meet with women who have recently been confined or aborted who have complained of hæmorrhage for weeks afterwards, and on examination malignant disease is discovered. American physicians insist upon the importance of periodical examinations after confinements so as to note the condition and appearances of the parts. Kelly goes so far as to say that all women aged over 40, with a laceration, should be yearly examined with this view.

CANCER OF THE VAGINAL PORTION OF THE UTERUS.

If examination were methodically carried out there would be little difficulty in recognising carcinoma of the vaginal portion of the uterus and os; although not uncommonly erosion and a lacerated os uteri, accompanied by chronic inflammatory mischief, often closely resemble malignant disease. If, however, the eroded or ulcerated surfaces readily bleeds and the os uteri is nodular and uneven, suspicion should be aroused and a small wedge-shaped piece should be excised and submitted to the pathologist. If it is pronounced to be malignant, operation, by high amputation of the os and cervix, as recommended by Sir John Williams and others, or vaginal hysterectomy, should be at once practised, and in these cases I am sure a large proportion of women could be cured.

CANCER OF THE BODY OF THE UTERUS.

What is true as regards the diagnosis of the vaginal form of the disease is also true to a lesser extent of the fundus. If the disease be recognised in its early stages, there is every chance of the patient being restored to health; the disease, however, is not readily recognised.

Women often have this form of disease existing without any symptoms whatever—no pain, no discharge, no inconvenience, as the disease progresses, perhaps the menstrual flow is noticed to be a little excessive, or between the periods there is a slight bleeding, but this does not attract much attention, but how ominous!

Matters thus are allowed to proceed; then the patient experiences a sense of weight and perhaps some pain in the sacral region; the menstrual flow increases in volume, and continues somewhat intermittently for some days after the regular flow has ceased. Then perhaps she consults a friend or possibly her medical attendant, who probably at first, owing to the age of patients suffering in such a manner being usually between the forties and fifties, assures her she is suffering from that *bête noir*, "change of life," and treats her accordingly. Matters, however, steadily go from bad to worse, then an examination is deemed advisable. Probably very little is to be felt; the os is healthy, the uterus perhaps somewhat large and heavy, in other respects there is little to denote any existing disease. By the speculum a muco-gelatinous discharge will be seen exuding from the os, possibly blood-stained, otherwise denoting nothing more than some endometritis. If a sound is passed, however, it will usually cause some bleeding, the uterine cavity

will be found in many cases elongated and enlarged.

Under such circumstances suspicion should always be aroused, and curetting the uterine cavity advised, with a view of having the *débris* examined by a competent pathologist; but often this report is disappointing and fallacious.

Even here we are beset by difficulties, for, as Sir Halliday Croom, in a most interesting paper has pointed out, we apparently cannot always be guided by the pathologist's report. In this paper he quotes two among several cases in which he had curetted the uterus and as a matter of routine sent the *débris* to the microscopist for examination, and received the reply in one case, "Malignant." A second examination from the same authority gave the same report. Sir Halliday Croom was still sceptical, and did not feel justified in operating. The patient went to London and her uterus was again scraped, and the *débris* microscopically examined, the report being "there is nothing at all."

Another case in which a small scraping was pronounced to be malignant by the pathologist, the uterus was removed, but no trace of cancer whatever discovered, but only a fungating polypus.

I quite agree with Sir Halliday Croom that when submitting scrapings, &c., for microscopic examination we should send with them a report of the condition of the patient from whom they have been taken.

CANCER OF THE CERVICAL CANAL.

The most frequent part of the uterus to be affected is undoubtedly the cervical canal. The importance of early diagnosis here is very much more to be insisted on than when the disease attacks either the os or fundus, for here the disease commencing in the glandular tissues quickly invades the whole thickness of the cervix eating its way downwards to the os, forming a large fungating growth, and also infiltrating the cellular and areolar tissues around the cervix extending often to the bladder. These cases are by far the most unfavourable for any form of treatment. They usually are not recognised until the disease becomes firmly established. From the fact that the disease has commenced in the cervical canal patients have often been examined in fairly good time, and the os being found smooth and apparently healthy the more deeply seated disease has been overlooked, and although by digital examination the cervix feels harder than normal, there is little to indicate the nature of the existing disease. If a sound is passed usually bleeding will be caused, and this should excite suspicion; and if any doubt exist a small curette can be introduced and a portion of the mucosa and deeper tissue removed for pathological examination, when the true nature of the disorder will be recognised.

The importance of early diagnosis in this form of the disease cannot be over-estimated as the parametrium rapidly becomes invaded and the uterus fixed quite early; later, the ureters are implicated and the sacral glands affected. The peritoneum, bladder, and rectum are later invaded through the lymph channels. When the ureters become involved and constricted, the kidneys speedily become disorganised and the patient dies of uræmic poisoning.

In many cases of cancer of the cervix uteri, on removal of the organ and careful examination of the muscular tissues, isolated patches of carcinomatous disease will be discovered, which Professor Jacob ascribes to the extension of the disease through the blood vessels anastomosing between the cervix and the body of the uterus. This point is very important to remember in connection with the treatment to be recommended, as it is clear from such a condition existing nothing short of total removal of the uterus could be of any avail in freeing the patient from the disease.

AFFECTION OF THE GLANDS.

A question of very great importance arises as to the affection of the glands in cancer of the uterus. My own experience, based in the first instance by

examination of a large number of cases in the *post-mortem* room, led me to the conclusion that glandular infection did not exist nearly so frequently as was imagined; even in patients who had died from advanced cancer of the uterus I frequently found but little infiltration of the glands of the pelvis or iliac glands, and in some cases which had died after operation the glands were not apparently affected at all. My experience corresponds to that of other observers who have paid attention to this subject, and as this must necessarily influence our advice as regards operation it is most important. Krömer, Giessen (*Archives f. Gyn.*, Bd. lxxiii., S. 57), who has investigated the course of the lymphatics in the cadaver in thirty cases, nine of which were carcinomatous, points out that experimental injection gave results agreeing with those of Brihus and others. His results necessarily point to the necessity of strictly separating the malignant tumours of the uterus according to their seat and histological structure. From his observations there can be no doubt that while the lymphatics become somewhat early invaded when adeno-carcinoma exists in the cervix extending into the parametria, yet in those cases when the disease is limited to the fundus the lymphatic system is rarely, or, at any rate, very tardily infected. The same applies to early carcinoma of the os of the squamous-celled variety.

Schauta, Vienna (*Monats. f. Geb. u. Gyn.*, Bd. xix., S. 475), records much laborious anatomical research into the condition of the glands in uterine cancer. These results would indicate that the complete radical removal of carcinoma of the uterus, with all carcinomatous glands in relation with it, is possible only in the most exceptional cases in which the glands are not affected at all.

Doederlein removed enlarged glands from the pelvis in 65 instances, and these were cancerous in 22.8 per cent. of the cases; but in only 9 per cent. of cancers of the corpus uteri, and in those the disease had broken through the uterine wall. Pankow quotes that he removed the glands in 40 per cent. of all cases operated on by him, and only 50 per cent. of these proved to be cancerous.

Mackenrodt, Berlin (*Monats. f. Geb. u. Gyn.*, Bd. xix., Hft. 4), finds that in 95 per cent. of all cases in which the glands are infected only those of the first line are so. The rare infections of the glands of the second line are far less dangerous in regard to local recurrence than the glands of the first line close to the cicatrix.

OPERATION.

In discussing the question of treatment of carcinoma of the uterus by operation it must be borne in mind what I have already said respecting the extent and position of the disease, as by studying this one is more able to decide as to the wisdom of recommending an operation or not. Now, as I have shown, the iliac and sacral and lumbar glands are not found to be affected in nearly so many cases as one would suppose—indeed, I am convinced that the glands escape infection in the majority of these cases in which the disease is limited either to the os uteri or the body of the uterus, whereas in those in which the disease commences in the cervical canal and extends into the areolar tissue between the vault of the vagina and peritoneal cavity, the lymphatics become somewhat early infected, and metastasis will be found to exist in the gland. In these latter cases the chances of a radical cure of the disease is very small, yet if seen early enough doubtless much relief can be obtained by free excision of the uterus and the areolar tissue and parametrium, the patient's life being prolonged, and her latter days made more bearable.

The question which must exercise our minds most is to decide when we shall recommend operation; in what cases can we hold out a fair hope to the patient and her friends that benefit and possible cure may accrue from operation. Here, I think, English gynaecologists are much more conservative than our *compatriotes* on the Continent or America. Kroenig, Jena, in advanced cancer, which is immovable even under

narcosis, and in which it may be expected that the bladder and ureters are involved, operates by making a transverse incision and keeps the operative field extraperitoneal by Mackenrodt's method; in spite of the drawbacks of the increased danger of infection owing to the cavity left and the extensive wound in the connective tissue, and of increased anxiety in regard to the functions of the bladder. In six cases he records the extension of the disease rendered partial resection of the bladder and ureter necessary, but the danger from shock and escape of urine after resection of the bladder and ureters, he says, is less than by other methods. Such heroic surgery as this, I scarcely think, will commend itself to gynaecologists in this country. Surely the last state of that woman, even if the operation were successful so far as the removal of the disease is concerned would be worse than the first. I am convinced that in no case where the uterus is fixed and the ureters and bladder implicated can we expect to perform any operation which will benefit the unfortunate patient in any way. But there are cases on the border line in which we may hope to be able to get beyond the disease. I refer to those in which the os was primarily affected and the disease has extended along the roof of the vagina extending just into the areolar tissue beneath. In such a case the body of the uterus will be found to be quite mobile, while by deep pressure bimanually it will be felt that there is a narrow, somewhat hard band between the hands in the roof of the vagina, in either one or both fornices, which fixes the cervical portion of the uterus. In such a case I think we are justified in advising an operation.

In the discussion which followed upon Dr. Wertheim's paper ("Treatment of Cancer of the Uterus," *Brit. Med. Journ.*, No. 2334, pp. 689, Sept. 23rd, 1905) on the diagnosis and treatment of cancer of the uterus, read at the meeting of the British Medical Association at Lincoln, one could not but be struck by the diversity of opinion as to the best method of operation. Primarily it resolved itself into the abdominal and vaginal route, although one or two speakers recorded good results, which they had obtained by high amputation of the cervix, with the actual cautery in cases of cancer of the os.

Dr. Wertheim's paper was a very valuable addition to our knowledge, and his results are truly surprising. Since 1898, he has performed the operation as described by him in 270 cases, with a mortality of 15 to 18 per cent., but out of the last thirty cases he has lost only two.

One has only to study the description of the operation to appreciate its magnitude. The importance of the operation is all the more significant as Dr. Wertheim does not suggest any change in the present mode of dealing with cancer of the body of the uterus or of early cancer of the cervix. His paper deals with cases in which the disease has extended beyond the cervix into the surrounding cellular tissues. These are cases in which English gynaecologists have hitherto agreed that it was quite inadvisable to interfere with, by means of any operation, contenting themselves with palliative treatment. So that the results of Dr. Wertheim's operations are all the more surprising, as he tells us that from 60 to 70 per cent. of his cases have remained free from recurrence after four or five years.

Now just let us for a moment, without describing the operation to you, as most of you are already familiar with the technique of it, consider some of its special features. Dr. Wertheim tells us his early operations lasted from two to two hours and a half, with more practice he has reduced this to half that time, and anyone who has performed this operation, when the cellular tissue has been invaded by the disease, in which the ureters have been surrounded, and when the bladder has been implicated, can readily understand the operation occupying the time named. Dr. Wertheim's object as laid down in his paper is by no means undertaken with the exclusive, nor even the principal object of removing the lymphatic glands; on the contrary, from the beginning he attaches the

chief importance to the thorough removal of the cellular tissue network round the uterus. He says, in his opinion, the treatment of the ureters and the possibility offered in the way of removing the parametrium, together with the uterus, is the principal object, and that the resolve to extirpate the lymph glands was an addition.

He finds that the proportion of cases suitable for his operation has risen from 15 to 30 per cent., then to 50 per cent., and will probably rise higher in the future.

An important histological result of his operation has been in the examination of the glands. Many thousands of these have been removed by him and carefully examined histologically; in 28 per cent. of the cases the regional lymphatic glands were affected with cancer. The cancerous glands were always enlarged, very considerably so. In the elongated spindle-like glands which so to speak only represent a thickening of the lymphatic ducts, carcinoma was never found.

In a further 30 per cent. of the cases the glands were more or less enlarged, but no carcinoma was found within, only hyperplasia and infiltration. The experience of Dr. Wertheim is fully in accord with that of Schauta, Kröenen, and my own as already mentioned on this point.

Notwithstanding the brilliant results of Wertheim's operations, I think it will be some time before British gynaecologists will feel disposed to adopt it in cases in which the uterus is fixed, the parametrium infiltrated, and the ureters and bladder perhaps involved, yet these are cases in which Wertheim operates with a light heart, and occasionally in cases of necessity carries out a resection of the ureter and bladder.

I have performed the operation as described by Wertheim on three occasions. In one case I had removed the os and cervix with Paquelin's cautery, and the following week performed the abdominal operation.

From 1890-1897, Professor Jacob practised systematic vaginal hysterectomy in 81 cases with 1 death; 10 cases were lost sight of; of the 70 cases left—of these there was recurrence in 49 during the first year, 9 during the second, 11 during the third, and only 1 was alive after the fourth year.

Professor Jacob subsequently adopted the abdominal operation with slightly better results; of 95 operations, he had 6 deaths, 6 have been lost sight of, 48 had recurrence within a year, 26 within two years, 4 within three years, 2 within four years, 2 within five years, and 1 within six years. Of the 87 cases only 2 were alive when he read his paper.

How can we account for this enormous difference in the mortality between Germany and Belgium? Does cancer assume a more malignant type in Belgium? It can scarcely be from inexperience, as Professor Jacob is well known as a bold and expert operator. It is true, as Wertheim has pointed out, he did not expose the ureters, but can this account for the enormous difference? I can scarcely think so.

In this country, gynaecologists have not yet adopted the abdominal operation to such an extent as one would have thought after the results reported by German and American gynaecologists. Yet I find numbers who were quite wedded to the vaginal operation are beginning to veer round and practise the abdominal.

Drs. Lewers, Purcell, and I have all operated on a large number of cases by the vaginal route, with, I consider, good results. Dr. Lewers published in 1902 the after results of forty consecutive cases of vaginal hysterectomy for cancer of the uterus; of these 40 cases, 14 were alive and free from recurrence at periods varying from 2 to over 7 years.

Dr. Purcell has operated on 265 cases by the vaginal route; of these 41 died within a year from recurrence; 43 in two years; 46 in three years; 48 in five years; and 47 in six years.

I have operated on over 200 cases, with a mortality from operation of 10 deaths, but in the last 73 cases only one patient died. Of 180 of these, which were

performed over two years ago, very many have been lost sight of. Of the remainder, 17 are still alive and well at periods varying from twelve years to three years, while 20 per cent. lived and kept free from recurrence for periods varying from two to five years.

Professor Doederlein (Hegar's *Beitrag*, Bd. ix., Heft. 27) endeavours to show, by comparing the results from vaginal and abdominal hysterectomy in his klinik, that of all the cases seen 48.3 per cent. were operated on by the vagina with a mortality of 16.4 per cent.; and permanent cure in 40.6 per cent.

In comparing the relative merits of the abdominal operation with the vaginal there is still a great discrepancy of opinion, as Besson (*Sci. Med., Lille*, June 11th-18th, 1904) has pointed out, after going very carefully into the question, the mortality at present in cases operated upon is two or three times greater after total abdominal hysterectomy than after vaginal hysterectomy. The proportion of 38 per cent. of survivals in operated cases after two years appears encouraging. The greater proportion of survivals in cases operated on by vaginal hysterectomy indicates the corresponding superiority of this operation in cancers sufficiently localised.

It is difficult, then, to lay down any hard and fast rule as to which operation shall be adopted.

I think when the fundus or body is attacked it has been pretty well established that no glandular infection takes place unless the disease ulcerates through the wall of the uterus; therefore, in such cases, vaginal hysterectomy is the better operation, for the reason that shock to the system is not nearly so severe and patients make a much readier convalescence.

Vaginal hysterectomy is also, in my opinion, the better operation for those cases in which the disease is limited to the os and vaginal portion of the uterus. But when the disease has extended up the cervical canal, infiltrating the cervix and possibly infecting the cellular tissue, then the abdominal route or perhaps the combined abdominal-vaginal operation would be the wiser if not the only operation which would hold out any hope of success.

Lastly, those cases in which the uterus is fixed and the ureters and bladder possibly implicated, I am convinced they are better left rigidly alone, notwithstanding Professor Wertheim's brilliant record.

THE MORISON LECTURES ON THE PATHOLOGY OF GENERAL PARALYSIS.

DELIVERED IN THE ROYAL COLLEGE OF PHYSICIANS,
EDINBURGH, ON JANUARY 24TH, 26TH, AND 29TH.

By W. FORD ROBERTSON, M.D., F.R.C.P. EDIN.

ABSTRACT OF LECTURE III.

In discussing the problem of etiology and pathogenesis of general paralysis and tabes dorsalis in the light of the investigations detailed in the two preceding lectures, Dr. Robertson wished as far as possible to avoid a controversial attitude. His purpose was simply to endeavour to show that a new and solid edifice could be constructed out of the facts elicited by his colleagues and himself. A passing critical reference to the syphilitic hypothesis was, however, inevitable. He contended that the part played by syphilis was only that of weakening the general and local defences. There were many strong reasons for believing that these diseases could not be essentially syphilitic in their causation, and moreover there was the clearest evidence that the general paralytic suffered from an active bacterial toxæmia. Having summarised the evidence in support of the view that general paralysis and tabes dorsalis are dependent upon infection by a diphtheroid bacillus, he described what appeared to him to be the essential pathogenesis of these two diseases. In general paralysis, the specific bacillus appeared to be conveyed from individual to individual by contagion. There was ample warrant

for the conclusion that it could neither multiply to any extent upon a healthy mucosa nor invade the tissues. A preliminary weakening of the local and general defences was evidently necessary. There were numerous inimical forces that could produce this condition of impaired local and general defence, but there were three that seemed of special importance in relation to general paralysis and tabes dorsalis. They were the pathogenic agent of syphilis, alcohol, and nitrogenous foods used in excess. There was evidence that a mere saprophytic infection might continue for a long time without leading to any important toxic effects. It was probably only when the state of the local and general defensive forces was such as to permit of the bacillus invading the tissues that the paralytic toxæmia became of any great intensity. Of the occurrence of such invasion there was ample evidence. The more recent observations of Dr. McRae and himself had led them to attach special importance to the bronchi as a seat of chronic infection, although there were many cases in which bacillary invasion could be shown to have taken place from the alimentary tract. It was virtually a life and death struggle between the bacilli and the polymorphonuclear leucocytes. It was a conflict in which the leucocytes after a long succession of victories were ultimately defeated, for their power of renewal was limited, whilst that of the bacilli was virtually unlimited. Under certain conditions the defensive forces were placed at a disadvantage. One of these conditions had been ascertained experimentally. It had been found that lowering of the temperature four or five degrees (C.) below the normal greatly diminished the power of the leucocytes to take up these bacilli. It was therefore reasonable to believe that lowering of the body temperature was an important cause of aggravation of the bacillary attack. Local invasion manifested itself clinically in a congestive attack. Large numbers of the bacilli reached the circulation either by way of the lymphatics or through the capillary walls. They could be seen in the blood stream in the neighbourhood of the infective foci and also in films made from the patient's blood during life. Most of the bacilli that reached the blood were quickly seized by leucocytes and digested, but many escaped from the circulation in one or other of two ways, namely, through the capillaries of the kidney into the urine and through the walls of the cerebral vessels into the adventitial lymph-channels. The further disintegration of the bacilli that took place in these lymph channels gave rise to a local toxic action. There was thus a general toxæmia due to the disintegration of the bacilli at the seat of invasion and in the blood and an added local cerebral toxic action dependent upon the disintegration of the bacilli that had passed through the endothelium of the cerebral vessels. In some instances a successful repulsion of the invasion was followed by a prolonged period in which the bacillus was kept at bay. Clinically, this corresponded to a remission. More commonly there was a continuous comparatively slight absorption of toxins from the infective focus and a succession of more or less severe invasions, which time after time were repelled. In the end, however, the defensive forces were overcome. There was then a fatal congestive attack. Coming next to the subject of the pathogenesis of tabes dorsalis, he referred to the recent observations of Orr and Rowe upon the production of tabetic lesions of cord by the absorption of toxins from peripheral septic foci. The toxins passed up the perineural sheaths without injuring the nerve fibres and affected the fibres of the posterior root as they entered the cord at the spot where they lost their neurilemma sheath. In order to account for the similar lesions that occurred in tabes it was necessary to find some peripheral toxic focus. So far as their evidence went, it pointed to this focus being in the bladder. In ten consecutive cases of tabes they had found that there were abundant living diphtheroid bacilli in the urine, and therefore the patients were

suffering from a diphtheroid cystitis. In these cases the bacilli were present in too great numbers to have come merely from the urethra, which in other cases very frequently contained some diphtheroid bacilli. If further observations confirmed the testimony of these ten cases, then they would be bound to conclude that in tabes dorsalis there was in the urinary tract an infective focus comparable to that which occurred in the respiratory or alimentary tract in general paralysis. The bacilli were invading and therefore produced toxic effects far greater than those that resulted from the simple passage of disintegrating bacilli through the urinary tract. After referring briefly to some objections that might be raised to the views advanced, he considered the question of treatment. There was evidence that the general paralytic defended himself, and often with prolonged success, by manufacturing specific bacteriolytic anti-bodies. It seemed therefore worth while to produce such anti-bodies in suitable lower animals, and to use them as therapeutic agents. They were at least going to give this method of treatment a trial. In conclusion, he said he desired to acknowledge his indebtedness to the General Board of the Laboratory of the Scottish Asylums, to the representatives of the Edinburgh, Glasgow, Dumfries, Aberdeen, and other asylums, for the facilities they had afforded his colleagues and himself for carrying out their researches.

CLINICAL RECORDS.

A CASE OF VAGINAL CYST.*

By H. MACNAUGHTON-JONES, M.D.

The patient, æt. 35, was curetted for glandular endometritis in September, 1905. During the operation a cystic tumour was found in the vaginal vault about the size of a large pigeon's egg. While dissecting out the cyst it ruptured, when some glairy fluid escaped, so that it could not be removed completely. The pathological report on the portion of cyst wall sent for examination was that it might be a retention cyst and was lined by spheroidal epithelium.

In December, 1905, the patient returned complaining of vaginal distress and pain, and on examination I found a fair-sized cyst low down on the posterior wall, inclined rather to the right side. This was about the same size as the one previously removed, and contained thin clear fluid.

There was some difficulty in dissecting out this cyst, as the wall was thin and incorporated with the subjacent tissue in the recto-vaginal septum, closely approaching the rectum. Through a small cut some of the fluid contents escaped. The accompanying drawing shows the cyst considerably reduced in size owing to shrinkage in the preservative fluid. The pathological report states the cyst is circular, one inch in diameter and is surrounded by fibro-muscular tissue. It has a convoluted waxy lining, and in the depth between the folds the microscope shows a lining of cubical epithelium.

I am not aware of any published cases in which there have been two cysts of the size I have mentioned, and obviously of different portions of the vagina. It seems to me the cyst in the vaginal vault was glandular in origin, while that in the lower portion was of a Gartnerian or Wolffian nature.

THE OUT-PATIENTS' ROOM.

FRENCH HOSPITAL.

A CASE OF "SUCCESSIVE" SYPHILITIC CHANCRES ONE GENITAL AND THE OTHER EXTRA-GENITAL.

By HENRI DARDENNE, M.D. EDIN., M.R.C.P. LOND.

AMONG the out-patients on October 20th, 1905, was a man, by occupation a clerk, with a painful sore on

* Read before the British Gynecological Society, Feb. 8th, 1906.

the index finger of his right hand, and also with another one on the corona glandis. On examination they were found to be syphilitic.

The history was briefly: On September 18th the patient had connection, and three weeks later he noticed a slight red pimple on the corona. Five days later he noticed a slightly painful sore on the dorsal aspect of the first phalanx of the right index finger. This became rapidly worse, and for the last three nights he said that the pain prevented him from sleeping. The inguinal glands were enlarged, and three or four could be felt in each groin. They were hard and slightly painful. On the glands the chancre was characteristic.

The chancre on the index finger was about the size of a sixpence. It was covered with thick black crusts and looked most unhealthy and malignant. It was exquisitely painful, and distinct red lines could be seen arising from it up to the lower third of the dorsal aspect of the forearm. The olecranon gland was enlarged to the size of an average chestnut. The chancre in shape was circular. The induration was characteristic of chancres in such a situation—*i.e.*, not one that could be distinctly felt, and exactly the size of the chancre, but it was massive. The skin, subcutaneous tissue, and tendon were fixed, and formed one mass with the bone below.

Dr. Dardenne made the following remarks:—Extra-genital chancres may affect any part of the body, this depending on the mode of contagion. In children they are chiefly to be seen on the face. The lips, the cheeks and the eyelids are the parts most frequently affected. Persons affected with mucous patches and kissing these children are the source of contagion in such cases. In adults extra-genital chancres, when affecting the chin present one peculiarity, and that is, their multiplicity. Five, six and seven chancres have been seen in that region. He had had a case which showed four distinct hard chancres. The man suffered from chronic sycosis and was in the habit of being shaved by barbers.

Extra-genital chancres have long been thought to be the precursors of a syphilis more malignant in nature than that acquired in the usual way. No doubt that at times the syphilis of which they are the primary symptom is most virulent. This is a mere coincidence, and is due to the nature of the soil. Patients with early sclerotic changes in their blood vessels are more apt to suffer later on from cerebral syphilis than those with a good constitution and healthy vessels. The treatment is generally much delayed, the lesion not being recognised from the first; in many not until tertiary symptoms have made their appearance and all the patient's arteries are already affected with the syphilitic arterio-sclerosis. Coincidence consisting in the nature of the soil and late and bad treatment have been the two reasons in affecting the prognosis of extra-genital syphilis, and hence has arisen this popular belief.

The case under consideration, Dr. Dardenne pointed out, presented another interesting and most rare feature. The chancre on the index finger being "successive," *i.e.*, appearing five days after the one on the genital. It was most characteristic. According to Diday, Kopp, Fournier, the interval is usually from one to twelve days. It has been noticed up to twenty-five days after the first chancre. This, however, is open to caution. Balanoposthitis causing ulceration; herpes and secondary lymphangitis, with interrupted nodular indurations, have been mistaken for real indurated successive chancres. The "successive" chancre is also considered to be smaller, more indolent and benign than the primary, the constitution having already been immunised to a certain extent. In the present case it was the reverse, and the "successive" chancre was by far the more virulent one of the two. With regard to treatment, the genital chancre was treated with black wash and calomel ointment, and extreme cleanliness was enforced as most necessary for its cure.

Nothing, he said, was more grateful for the relief of

the exquisite pain of the finger than constant immersion in a warm boracic lotion, and this for two and three hours at a time. The inflammation and the pain soon disappeared, and the sore assumed a healthy and granulating aspect. During the night and in the intervals of the bath the finger was fixed by a light cardboard splint, and dressed with calomel ointment. The patient was also rapidly put under the effects of mercury and the salt which Dr. Dardenne generally uses is prot. iodide. In this case half a grain three times daily was increased in a few days to three grains in the twenty-four hours. Within a month the sores had completely healed. Dr. Dardenne said he could not too strongly emphasise the most excellent effect of the prolonged immersion. Chancres of the most virulent and malignant aspect which would soon become phagedenic and gangrenous improve rapidly and are soon cured by this mode of treatment. Phagedænis, which is caused chiefly by dirt and meddling treatment with irritants and caustics in a weak constitution, was thus, he considered, in the majority of cases even of the worst description avoided when such treatment was carried out thoroughly and at once.

OPERATING THEATRES.

TOTTENHAM HOSPITAL.

OPERATION FOR RECTAL CARCINOMA.—Mr. H. W. CARSON operated on a married woman, æt. 35, who had been admitted suffering from severe pain and continued diarrhoea. The patient gave a history that she had been losing strength for some months; she could give no definite statement as to the beginning of the trouble, but she complained that for the last few weeks sacral pain had been almost constant, and diarrhoea had been very troublesome. She had not sought advice until one week before admission, when she was seen by a medical man, who advised her to go into hospital. Examination of the rectum showed a growth implicating the anterior wall of the bowel at a point that could just be reached by the tip of the finger. Under an anæsthetic the growth could be freely palpated bimanually, and it was found to extend towards the left pelvic wall, and a hard tumour could be felt in the situation of each ovary. Abdominal examination was negative. In the hope of being able to remove the growth by the abdominal or the abdomino-perineal route, the patient was put in the Trendelenburg position, and the abdomen opened in the middle line. The sigmoid loop was found adherent to the fundus of the uterus; when this was freed a large growth was found in the anterior wall of the upper part of the rectum extending outwards into the broad ligament on the left side. Both ovaries were the seat of stony hard growth; a cancerous nodule was found in the sigmoid at the point where it had been adherent to the fundus of the uterus; a small nodule was present in the omentum, and secondary deposits were found in the lumbar glands. Radical operation being obviously impossible, the wound was closed and inguinal colotomy done. Mr. Carson remarked that the case was instructive in many ways. The insidious onset was very characteristic, it being quite unusual for malignant disease of the rectum to give definite signs in its early stages; it resulted from this that nearly 50 per cent. of cases when first seen were too advanced for successful radical operation; in a few cases hæmorrhage was the first sign, and these cases generally sought advice early. Mr. Carson referred to the case of a man upon whom he had operated two and a half years ago, who had suffered, whilst apparently in excellent health, from a severe rectal hæmorrhage.

Examination proved that he had a small malignant ulceration; this was readily removed, with the result that the patient is now in excellent health. Another point of interest in the present case, Mr. Carson remarked, was the patient's age; 35 was decidedly young for malignant disease of the rectum. It was doubtless due to this cause that the growth had been so rapid. A point of great importance, he thought, was that in this case, as in so many cases of malignant disease of the rectum, the principal sign was diarrhoea, and Mr. Carson urged the imperative necessity of a rectal examination in all cases of prolonged diarrhoea. Strauss's proctoscope, he said, was a valuable instrument in the diagnosis of growths situated high up, as it admitted of a thorough examination of the lower ten inches of the bowel; an anæsthetic was not necessary, and the passage of the instrument was free from danger if ordinary care were taken. With regard to the colotomy, he advised that the method of choice should be one which admitted of great rapidity, especially if immediate opening was unnecessary, as patients requiring colotomy were usually in a condition which rendered any prolonged operation inadvisable. He recommended that as small an opening in the peritoneum as possible should be made, the colon well pulled down, and a loop fixed in position by means of a glass rod passed through the mesentery; a single suture at the top and bottom corners passed through the longitudinal band and the abdominal wall, being all that was required to complete the operation.

GREAT NORTHERN HOSPITAL.

THYROIDECTOMY—MR. PEYTON BEALE operated on a man, æt. 25, who had been transferred from Dr. Morison for extensive enlargement of the isthmus and both lateral lobes of the thyroid. The patient's history was as follows: He was deaf and dumb and there was evidence that when a small boy he had suffered from one or more "fits," the thyroid enlargement was of some months duration and on admission the thyroid was exerting so much pressure on the trachea that the patient even when at rest had great difficulty in breathing. The man was anæmic and had slight albuminuria. Operation was, however, absolutely essential although Mr. Beale said he would not have performed it had it not been necessary to save life. It might be mentioned he said, that the isthmus was so large and extended downwards to such an extent that tracheotomy was impossible. An incision was made vertically over the right lobe, this last was freed with considerable difficulty and brought out of the wound. It was then found that it, together with the isthmus, was very firmly adherent to the larynx and trachea. The right lobe was removed, numerous ligatures being applied between it and the isthmus. It was now seen that the patient's respiration was not in any way improved; it was not possible to take away the isthmus, as it was so adherent that it could neither be dissected or peeled off without the certainty of wounding both larynx and trachea. It was therefore decided to remove the very large left lobe, and this was found to be more difficult than the right, owing to the adhesions between it and the important structures to the left of the trachea, thus the isthmus alone was left (a mass about the size of a tangerine orange) and the lower part of this was separated from the trachea so that tracheotomy might be done if it should be found necessary. The wounds were dressed in the ordinary way. The patient did perfectly well for six days: on the sixth day he developed some difficulty in breathing and very marked symptoms of tetany, spasmodic contraction of all or

nearly all the voluntary muscles being readily evoked by touching the skin over them, this was most marked in the face. It was then observed that he was breathing with his diaphragm only, his ribs did not move at all, and his sternum was drawn inwards at each inspiration; this was clearly due to the contraction of the sternal fibres of the diaphragm. The patient was seen by Dr. Beevor and Dr. Morison, who advised full doses of thyroid extract, it being clear that the man was suffering from loss of thyroid tissue. Under this treatment he gradually improved and in a fortnight was quite well. Mr. Beale said that this was the first case in which he had removed both lobes of the thyroid and he would not have done it here had he seen any other way of relieving the pressure on the trachea. The interval of six days seemed rather a long one; he would have supposed that symptoms of tetany would have come on much sooner; tetany had been observed after removal of too much of the thyroid in previous cases, but he had not himself come across any. The paralysis of the muscles which elevated the ribs in inspiration was, he supposed, an example of paralysis or paresis of a group of muscles such as had also been observed in previous cases, but he did not know that paralysis of this particular group had been described. Had there been any paralysis of the diaphragm he would not have been surprised, the adhesions in the neighbourhood of the phrenic nerves, between them and the lateral lobes of the thyroid were so dense that injury to the nerves was to be expected.

Collier and Barber.

At Tredegar on Tuesday (before his Honour Judge Owen) Job Lugg, collier, Beaufort, claimed £30 damage from Walter Bishop, hairdresser, Brynmawr, in respect of barber's rash, alleged to have been contracted by shaving at defendant's shop. Plaintiff said he was shaved at defendant's shop on October 7, and defendant's assistant, while performing the operation, was talking about football, and cut him on the chin; then wiped his face with a towel hanging up, and on which there were spots of blood. A few days afterwards eruptions broke out on his face, and on November 10 he gave up working and consulted a doctor. About the end of October defendant was informed and told that the eruptions were caused by the negligence of his assistant, and he replied that he warned him several times. Defendant said he would report the matter to the Hairdressers' Association. In cross-examination plaintiff denied that there were eruptions on his face previous to this, and he denied stating that he had been shaved at several shops. He had seen a report of a case in London on January 2 in which damage had been awarded, and he went to see the defendant on January 8. Dr. Dwyer, Beaufort, stated that he examined plaintiff and found him suffering from barber's rash. In reply to Mr. Parsons, witness said that barber's rash was identical with ringworm, and could be contracted from dirty cats and dogs. His Honour, in giving judgment for the defendant, said there were circumstances of a serious nature in the case which were not for him to deal with, but which might be dealt with hereafter.

The Danger of Soothing Syrups.

An inquest was held at Todmorden on the 12th inst. on the body of Leonard Wild, aged four weeks, son of Francis Wild, cotton piecer, Millwood. It was stated that the child had been in poor health since birth. A dose of soothing syrup was given to it on Saturday, and the child slept for so long a time that the parents became alarmed, and called in a doctor. Death took place next day. The soothing syrup had been found to contain opium. The jury returned a verdict of "death from intestinal atrophy." The Coroner spoke strongly against the practice of giving these soothing syrups to children.

TRANSACTIONS OF SOCIETIES.

BRITISH GYNÆCOLOGICAL SOCIETY.

SPECIAL MEETING HELD FEBRUARY 8TH, 1905.
Mr. F. B. JESSETT, President, in the Chair.

THE PRESIDENT thought this was an important meeting, and required some explanation as to why it was called. Those who were at their last annual meeting when the election of the Council took place would remember that there had been a good deal of discussion as to the validity of the notice of that meeting. The President had then ruled that the form was in order, but after the Officers and Council were elected they found that only twenty-three Fellows were elected on the Council. The Articles of Association stated that there must be twenty-four members. He then called a council meeting and suggested that twenty-four Fellows should be elected, but it was pointed out to him that that would be against the Articles of Association. They therefore adjourned that meeting. Since then he had been advised that the only way to get out of the difficulty was to have paragraph 8 (i.) of the Articles of Association altered by adding the following resolution:—"That in the event of any vacancy occurring amongst the officers of the Society or in the Council, by death, resignation, or in any other manner, the Council shall have power to fill such vacancy from amongst the Fellows of the Society. And any Fellow so appointed by the Council shall hold office until the next annual meeting." Eighteen Fellows of the Society had asked him to call a meeting for that purpose so as to put that in order, because it was clear that if it were not put in order whatever the Council did during the remainder of the year would be out of order. That meeting was called for that purpose and he could not think that there was a single Fellow in the Society who would question the wisdom of their action. In the present Articles of Association there was no provision made for filling up any vacancy during the year were such to occur.

Dr. BENNETT moved, and Dr. ROUTH seconded the proposed resolution, and the PRESIDENT then put it to the meeting, when it was carried *nem. con.*

Dr. SIMON proposed—

"That in view of the proposed amalgamation of London Societies recently brought before this Society and approved of, 'The examination of nurses be discontinued.'"

Dr. TRAVERS seconded.

Dr. HEYWOOD SMITH said in case that amalgamation did not take place the question of the examination of nurses might be continued. Would it not be better to leave the matter as it was until the question of amalgamation came up?

Dr. FENWICK, as one of those who were interested in carrying out the scheme with regard to the examination of nurses, said he thought it was only fair to mention that for the first two years it was a great success, until the Council prevented the nurses from going in for examination at all. It was a matter of perfect indifference to the Board of Examiners whether the scheme went on or not.

The resolution was carried with only one dissentient.

Dr. PURCELL then proposed, Dr. BENNETT seconded, and Dr. FENWICK supported a resolution that Dr. Macnaughton-Jones be made a Member of the Council. The resolution was unanimously adopted.

The ordinary general meeting then commenced. After the minutes had been read and confirmed,

Dr. FENWICK read notes on a specimen of
UTERINE FIBROID WITH PREGNANCY.

The patient from whom this specimen was taken was sent to me by Dr. Hosford, of Holloway. She was æt. 36, and had only been married 4½ months. Her periods commenced at 12, and had always been

quite regular, the loss being normal in quantity and lasting four days. For the last year or two she had complained of increasing constipation and frequency of pain with micturition. The last period finished on September 6th, and was normal in every respect. Ever since she had complained of increasing pain in the left side and swelling of the abdomen. When I saw her there were two distinct nodular masses above the pubes, the pelvis being filled by a densely hard nodular growth which could not be moved. The cervix was drawn up behind the pubes and felt soft, but could only just be reached by the finger. The swelling on the left side was softer than that on the right of the abdomen. The vagina was a little discoloured and there was a little secretion in the breasts. The diagnosis was 4 months pregnancy with an impacted fibroid. It would have been difficult to induce labour, and the increasing pain and rising pulse showed that pregnancy could not continue to full time. If labour had been induced the fibroid, filling the pelvis, might have prevented the extraction of the fœtus, and the fibroid to the right side might have prevented complete clearance and contraction of the uterus. On January 16th I therefore performed supra-vaginal hysterectomy, and with some difficulty lifted the lower mass from the pelvis into which it was firmly moulded, and it will be noticed the pelvic out-growth which arises from the cervix has so twisted and compressed the cervical orifice that it is doubtful if the canal could have been opened sufficiently to allow the fœtus to pass. The patient recovered quickly.

Dr. ROUTH asked how long the patient had been pregnant when the operation took place, and said he was inclined to object to that hysterectomy. He had met similar cases himself where a tumour grew to a considerable size and he had generally found one of two things occur. As the child grew it was pushed generally on one side, or especially above, and then by bringing on labour about the eighth month or so they got a live child. Unless the tumour were very large he thought that was the proper thing to do. In these days of diminishing population in their great Kingdom, he did not think they had a right to destroy children when it could possibly be avoided. He remembered one case of a very large tumour, where he allowed the woman to go on to about the full period. After using the forceps, he succeeded in getting the child out alive, and it was living now as far as he knew. He knew of another case in which similar circumstances occurred, but in a different manner. When the patient was first examined there was a tumour, and it seemed to him that the tumour would prevent the child being born. As the case progressed the tumour quietly made its way up to the top of the uterus, and the woman was delivered safely. He considered that people were too fond of hysterectomy. He therefore thought it was important before removing the child or the tumour, to wait a little while until nearer the full period, and then if necessary open the belly from the front and save the child.

Dr. PURCELL said it seemed that the uterine wall contained three other fibroids in addition to the specimen shown, so that if the woman had been allowed to go on to full term, or a Cæsarean section had been done, the child might have been saved, but the uterus would have had to be eventually removed.

The PRESIDENT asked if the patient had any urgent symptoms?

Dr. FENWICK replied that she had great pain and a rapidly rising pulse, it was 120 when the operation took place. It was very difficult for him to say anything after the reasoned judgment which they had had from one of the veterans of the profession. But he was forced to retain his own opinion that with a fixed

calcified mass like that in the pelvis, he could not understand how any child of any size could be brought out. The canal would barely admit his finger. He did not think the patient would have lived another five months had she not been operated upon.

Dr. MACNAUGHTON-JONES showed a specimen of vaginal cyst, which will be found fully reported on page 159 of the present issue.

Dr. ROUTH said the cases were interesting particularly as their anatomical and physiological characters were well explained. He wished to allude to some kinds of cysts in the vagina which were puzzling. A patient, of his æt. 18, evidently had a cyst in the side of the vagina extending from about an inch above the external opening right up the vagina. It was undoubtedly a cyst because when the one finger was placed in the rectum and the other in the vagina fluctuation could be felt. The cyst was about the size, he supposed, of a small sausage. He did not at the time think it was a cyst. He removed a quantity of pus. The case went on and the discharge continued for some time, but gradually ceased. One day when examining her with a sound he found that it led into a second uterus. As a matter of fact, the contents of this second uterus had been poured into the so-called cyst, which turned out to be a second vagina, which he opened up and no further discharge took place. There was another case, not his own, but which he had the opportunity of examining. It was a case of Dr. Greenhalgh's at St. Bartholomew's. On examining the patient the vagina and uterus were found to be natural, but a little closer examination revealed something like a cavity in the side of the vagina at the opposite side. This was found to be another vagina extending upwards, and led to another uterus. When the sound was passed in it went right up into a uterus. Those two cases proved that what they sometimes took to be a sort of abscess or cyst in the vagina was in reality another vagina, or part of it.

Dr. SAVAGE said he happened to have an opportunity of seeing a case of Professor Taylor's about a fortnight ago, and it was very similar to the case which Dr. Routh mentioned in which there was a kind of sausage-shaped swelling on the right side of the vagina and extending upwards and backwards. When opened it led into a cavity which seemed to occupy the right broad ligament. The lining of that cyst was thick and the contents were composed of clot and fluid, and seemed like serum. Professor Taylor thought it was a case of second uterus and second vagina. He happened recently to see in the *British Gynaecological Journal* of some two or three years ago an account of vaginal cysts, and it was mentioned that hæmatoma of the vagina following pregnancy might occur and simulate those cysts.

Dr. MACNAUGHTON-JONES said in reply that one source of vaginal cysts he had mentioned was closure of the vaginal folds, which just met what Dr. Routh had said. It was mainly on the character of the epithelium that the diagnosis depended.

Dr. MANSELL MOULLIN showed three specimens of uterine myomata. The first case was a portion of a large multi-nodular tumour removed from an old lady of 53. This was a class of tumour which was supposed not to occur after the menopause. But the tumour became degenerated, and therefore caused symptoms. The specimen was an example of calcareous degeneration. Part of the omentum had become adherent to the calcareous portion and the bowel itself was adherent. He had succeeded in removing the tumour, and the old lady was delighted to be rid of what had caused her so much discomfort for about two years. The second specimen was a calcareous tumour. It was quite hard and an opening had been made in one soft portion of the wall. It proved to be a calcareous shell, the contents were mucoid, and it was found entirely detached from a large tumour which was

removed at the same time. It was intimately adherent to the bowel and the omentum, as in the previous case. The third specimen was an example of soft myoma of the submucous variety. It had been entirely contained in the uterus, but now the greater portion of the tumour was exposed. The tumour suggested that it could have been very easily enucleated, but the patient was an unmarried elderly lady, and the hymen only admitted just the tip of the finger. The tumour extended up to the umbilicus, and he did not think any operator would have suggested removing it otherwise than from above.

The PRESIDENT asked what was the result of the operation and Mr. Mansell Moullin replied that it was very satisfactory.

Dr. MACNAUGHTON-JONES remarked that the first specimen was very interesting from the fact of the multiple myomata which were contained in the mass. The practical point was that these multiple myomata were found more frequently after the menopause, and often gave rise not only to discomfort, but also to most dangerous and fatal hæmorrhage. Dr. Mansell Moullin's specimen of calcareous degeneration was really a beautiful and very rare one. As a rule they did not get an isolated calcareous mass such as occurred in that case. There was another point to be noted in connection with the first specimen, namely that the hyaline degeneration which was got in myoma frequently preceded calcareous degeneration. Calcareous degeneration was not frequently found in young people. It was found in women who were rather advanced in life more frequently than in young women. The practical points connected with the first two cases were these: That they both afforded irrevocable proof of the value of early interference with myomata. They showed that if an operation were postponed until there was a whole mass of small myomata growing and increasing, then, if these did not succeed in killing the woman before the operation, they led to pain and discomfort and possibly to secondary degeneration independent of the multiplicity of the myomata. Therefore, the two specimens were not only from the operative point of view valuable, but they additionally proved the necessity for early operation in myoma.

Dr. SWANTON proposed that the third specimen be referred to the Pathological Committee for report.

Dr. MACNAUGHTON-JONES seconded the proposal, which was unanimously agreed to, that the specimen be sent to the Pathological Committee.

The PRESIDENT then delivered his address, which will be found on page 195.

Dr. MACNAUGHTON-JONES said in his opinion they should deal with cancer of the uterus just as they dealt with cancer in any other part of the body.

Dr. ROUTH, in seconding the vote of thanks, remarked that Mr. Jessett had done good work in harmonising many difficult points in connection with cancer. The paper which they had just listened to was one which every man in that Society who had a love of investigating scientific and difficult points in their profession would read very carefully. He said that while on the one hand it was perfectly true that cases of cancer were very difficult to cure, he did not agree that some cases were not cured. He believed a cure depended in some cases on the nature of the cancer. He had known old women operated upon for what was considered definitely to be cancer of the uterus, and yet they had lived to be as old as himself. Therefore he did not believe the disease was incurable.

Dr. MACNAUGHTON-JONES put the vote of thanks to the meeting, and it was carried by acclamation.

The PRESIDENT suitably responded, and afterwards announced that the next meeting of the Society would be held on March 8th. Previous to that meeting, at half-past seven, a special meeting would take place in order to confirm the resolutions they had passed at the special meeting held that evening.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, FEBRUARY 2ND, 1906.
The President, Dr. R. D. PUREFOY, in the Chair.

SIR A. MACAN exhibited a specimen of degenerated uterine fibroid. He said that after opening the abdomen of the patient he found the tumour pedunculated, and with adhesions. On section the tumour gave evidence of being an ordinary fibroma. Pain had previously been complained of. This form of red degenerative change is said usually to begin in the centre of these tumours. They are liable to be coloured, and to slough.

Dr. ALFRED SMITH exhibited a specimen of a myomatous uterus undergoing sarcomatous degeneration. The patient was about forty-five years old, married, but had no family. Her menses had ceased. Operating he found a mass of brown matter, which he took to be a polypus. He removed the entire uterus. Professor McWeeney's report on the specimen showed, apparently, a polypoid formation projecting from the mucous membrane, of undoubted sarcomatous structure. The sarcoma tissue itself was undergoing mucoid degeneration in some places, otherwise the uterus was in an advanced stage of fibro-myomatous overgrowth. Slides demonstrating the sarcomatous changes were also shown under the microscope.

Dr. HASTINGS TWEEDY considered that Dr. Smith's case showed the necessity for the early removal of all myomata.

Dr. JELLETT suggested that in Sir A. Macan's case the red degeneration might have been the result of bacillary infection.

Dr. PUREFOY instanced a case in which he removed a tumour from an unmarried woman, which underwent a dark, mahogany-brown discolouration, almost identical with that seen in Sir A. Macan's specimen, and in which the change was due to telangiectasis.

Dr. JELLETT showed two carcinomatous ovaries and a uterus removed from a patient, aged forty-seven. The tumours were so fixed in the pelvis that at first sight their removal appeared impossible, but, on making a transverse incision from the centre of the usual mesial incision outwards towards the left anterior superior spine, it became possible to pass the fingers below the left ovary, and so to work across the pelvis to the right. The broad ligaments were so infiltrated that it was impossible to tie them, and the uterus was in consequence removed, hæmorrhage being controlled by two clamps passed upwards from the vagina. There was a large collection of very foul pus in Douglas' pouch, and from this an infection of the abdominal wound resulted. The patient, whose pulse at the end of the operation was 160, made an uneventful recovery, save for the wound infection. At the present time, six months after the operation, she states that her health has been good, and that she has gained in weight. On examination, however, it is probable that a return is taking place in the tissues round the rectum.

Dr. JELLETT also showed a double pyosalpinx, and the remains of an extra-uterine foetus removed from a patient who had been pregnant eighteen months before the operation, and who had believed that she had miscarried. No ovum, however, was seen at the time, and the condition, of the removed foetus made it probable that it had been retained since the supposed miscarriage. The foetus was aged about 4½ months.

Dr. KIDD said the first case reminded him of one of sarcoma of the ovaries, in which the hæmorrhage was so profuse after removing one ovary that he decided to let the other alone.

The PRESIDENT doubted the value of operation in such cases.

Dr. J. SPENCER SHEILL then read a paper entitled "Sequel to an Attack of Eclampsia." The patient,

a young primipara, had had her left kidney removed three years previously for tuberculosis. She contracted eclampsia in March, 1905, when about 5½ months pregnant. She had seven seizures, which caused the death of the foetus. Her uterus was emptied by induction of labour, and her recovery was rapid and complete. She again conceived; and on examination early in July, 1905, was found to have been two and a half months pregnant. She was cautioned about her condition, and placed on milk diet. A little later, in spite of diet and care, she developed albuminuria, which, however, was successfully combated by appropriate treatment. Again, in December last, albumin made its appearance in the urine, this time permanently. (Edema now began to complicate this case. Although the most vigorous measures were adopted, on the 8th of last month (Jan., 1906), when she was within about a month of term, owing to the onset of symptoms which indicated the near approach of eclampsia, induction of labour was performed, and she was delivered in eighteen hours of a living child. A few hours later she had a typical eclamptic seizure, and was successfully treated. The points of particular interest are:—(a) Are there no methods by which we can with certainty abort threatened eclampsia? (b) Would it not be for the good of everyone concerned that this woman should be rendered sterile by the operation of tube tying?

Dr. PUREFOY said he believed that when our efforts to relieve the patient's condition were only partially successful, we should take measures to empty the uterus, though eclampsia may come on before we have succeeded. He thought that in the second pregnancy of this patient he would have waited considerably longer before inducing labour.

Dr. HORNE preferred to have the ovaries removed, and mentioned two similar cases of his own experience. When a patient had eclampsia once, the question was, Was she not likely to have recurrent eclampsia? The second pregnancy of this patient should have been prevented for this reason. He believed the kidneys were the primary cause of the disease.

Dr. SHEILL said that a dead foetus was a foreign body at best; and, therefore, to empty the uterus was the most natural thing to do. Noting eclampsia was imminent in the second pregnancy of this patient, he thought it was safer to induce labour. Two lives in this case were in danger; but that of the mother was paramount. Both were saved. He would like to hear their opinion.—Should sterility be effected in a patient who is liable to attacks of eclampsia?

Dr. PUREFOY said he would not render her sterile.

The following *Card Specimens* were shown:—

Dr. R. A. FLYNN—(a) Ovarian tumour with twisted pedicle and hæmorrhage into cyst; (b) parovarian cyst.

The meeting then terminated.

ULSTER MEDICAL SOCIETY.

MEETING in the Medical Institute, Belfast, on Thursday afternoon, February 15th, the President, Dr. Wm. CALWELL, in the chair.

This was a Clinical meeting, and a large number of patients were present, including many rare and interesting cases.

Dr. CALWELL showed (1) a case of Onychiauxis, a peculiar talon-like development of all the nails with a hyperkeratosis of the palms and soles. (2) A case of Bilharziosis with urine. The bladder was affected in this patient, a young lad from South Africa. He showed slight scars on the feet, and had been accustomed to run about barefooted, thus supporting the theory that the parasite enters through the skin. (3) A case of Actinomyces in the neck, now under treatment by X-rays for three weeks with steady improvement.

Professor LINDSAY showed (1) a case of thoracic aneurism. (2) A case of muscular atrophy, well-marked and progressive, in a girl æt. 19, but limited

to the right hand and fore arm. It was of three years' duration. (3) A case of tubercular Peritonitis, which had been severe, and now, after seven weeks treatment by mercurial dressings to the abdomen, and general tonics, was convalescent. Tuberculin was not given.

Dr. H. L. MCKISACK showed a pathological specimen of an aneurism of the basilar artery.

Dr. JOHN McCAW showed several cases of diseases of children, including (1) a case of Hydrocephalus in a child *æt.* 4 months, the point of interest being that the child was in apparently perfect health a fortnight ago, when it was seen by a medical man attending the family and even now seemed healthy and well nourished, with no symptom beyond the enlargement of the head from its normal circumference at that age—14 in. to 21 inches. (2) A case of Hypertrophic Stenosis of the Pylorus. The child, *æt.* 3 months, was admitted to hospital on December 1st, emaciated, with obstinate constipation, vomiting, dilatation of the stomach, and only weighing 6 lbs. The pylorus could not be felt. It was given frequent very small meals of milk and lime water, and enemata, and now weighed 12 lbs.

Dr. H. M. KILLEN showed a case in which a wound of the sclero-corneal region was treated by the flap method.

Mr. A. B. MITCHELL showed (1) a case of epithelioma of the tongue, in which the trypsin treatment had just been started. He proposed to show the same case in a month, so that members may judge of the progress, if any. (2) Four cases of gastro-enterostomy which were operated on during the last six weeks, all doing well.

Drs. W. B. McQUITTY, ROBERT BOYD, and BLAKELEY showed two cases of General Paralysis.

Dr. J. S. MORROW showed a case of exophthalmic goitre.

Dr. CECIL SHAW showed (1) a case in which he had done laryngotomy for papilloma in a child, *æt.* 4. The operation was done nearly a year ago, and there was no sign of return. The voice was strong but rough and hoarse. (2) A case of periostitis of the orbit.

Dr. THOMAS HOUSTON showed (1) a case of Psoriasis treated with thyroid extract. The case was one of general psoriasis of the trunk, arms, and legs, in a child. It cleared up in a few weeks under treatment, but relapsed in a day or two, when treatment was stopped, and cleared again when it was resumed. (2) A case of severe Anæmia in a boy, *æt.* 12, whose sister, *æt.* 10, is at present being treated in hospital for an exactly similar condition. In appearance the case closely resembles one of pernicious anæmia, though a blood count does not bear out the likeness.

Mr. T. S. KIRK showed (1) a case of spindle celled sarcoma of the jaw, incompletely removed by operation and subsequently treated by X-rays with complete disappearance of the growth. (2) A case of severe injury to the fore-arm—compound fracture of the ulna, compound dislocation of the elbow, and extensive ablation of the skin of the fore-arm, treated successfully by extensive skin grafting.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD. GERMANY.

Berlin, February 17th, 1906.

At the Verein f. Innere Medizin, Hr. J. Orth spoke on EXUDATION CELLS IN GENERAL AND THOSE OF VARIOUS FORMS OF MENINGITIS IN PARTICULAR.

After a historical retrospect, he went on to say that by pus corpuscles was understood the cells of acute inflammatory exudation, and therefore exudation cells. It was certain that in the majority of these cells exudations, neutrophile leucocytes were present. Many were of opinion that there was no difference between pus cells and leucocytes. The teaching of Rindfleisch and Cohnheim formed the basis of that view from the transmigration of leucocytes from the

blood vessels. Two observations led to the history as to this view. (1) Experimental observation: Dead corneal membrane provided with excitors of inflammation was introduced into the body of the living animal, and showed after a time the same appearance as the living cornea. Here it was objected that the cornea was not quite dead, and the tissue cells had perhaps recovered in the animal's body. In order to show the fallacy of this objection, the speaker had allowed the membrane to steep in a 10 per cent. solution of formal, then softening it so that fluid could permeate the tissues; it was then boiled in vinegar and cauterised with croton oil, and then introduced into the abdominal cavity of a rabbit. On removal, the membrane was certainly partially softened, but the lattice-work of the inflamed cornea could be seen in places beautifully marked. This inflammation in the dead membrane must have been caused by immigrating cells. By means of the new granula staining the granula of the leucocytes could be demonstrated in the pus corpuscles.

Besides the leucocytes, still other cells were found in the exudation. (1) such as covered the surface, epithelium cells, cover cells; (2) lymphocytes; (3) connective tissue cells, *i.e.*, not fibro-blasts but only such as appeared in the connective tissue, but not the connective tissue cells themselves; they were when freed very strongly phagocytic; the form of the macrophages were also found. Such cells were very numerous in the later stages of inflammation.

There were exceptions, however, in which leucocytes did not play the chief part. Here caseous or tuberculous pneumonia belonged, in which the exudative cells were not leucocytes, but large cells with round nuclei, and thus different from those of croupous pneumonia. These cells were first cast off epithelial cells. But not infrequently alveoli were found, the epithelium of which was completely retained, but a plug of such cells was found in the lumen of these alveoli. If the nuclei of the exudation cells were compared with those of the epithelial cells, they were found to be smaller. Finally, such cells were to be found in the lung framework, in the connective tissue. These cells were partly desquamated epithelial cells, but in part they were of other origin; they were wandering cells, not leucocytes, but lymphocytes. There were, therefore, then still other inflammatory exudations in which the leucocytes were not the essential part, as in tuberculous pleuritis and in purulent meningitis. Here clinical inquiry was in advance of pathological anatomy. It had recognised that the cell contents of spinal fluid varied in the different forms of meningitis, and it had drawn diagnostic conclusions from the fact (Quincke). This was naturally the same for exudation between the cerebral membranes. Here nothing could be determined macroscopically, but it could be microscopically. At any rate the most recent text-books of pathological anatomy left one in the lurch as regarded these specific differences. Here, then, was a hiatus for the filling up of which the speaker had already commenced an investigation, and had recently instituted an inquiry through Hr. Esparoni for determining the typical variations in the exudation cells. Twenty-five cases had been investigated, 10 of tuberculous meningitis, 15 of non-tuberculous meningitis; of the latter, 11 were cases of cerebro-spinal meningitis, 2 from pneumococci, 2 from streptococci. The two latter pairs showed themselves identical microscopically—much fibrine, leucocytes with ragged nuclei. In the cases of cerebro-spinal meningitis, fibrine played a much lesser part; it might be absent altogether; there were here further leucocytes with ragged nuclei with numerous degenerative changes; finally large phagocytes. In the tuberculous meningitis cases, these leucocytes played no part; on the other hand, there were numerous lymphocytes, larger and smaller. Where did these come from? In a photogram in which, therefore, all colour is excluded, we see in a vein large lymphocytes, and in another photogram we see a lymphocyte partly, and, even with a part of its nucleus, passing through the wall of the

vein; in fact, the same extravasation that lymphocytes made. It was, therefore, clear that there were tuberculous inflammations in which not leucocytes but lymphocytes were the exudation cells.

At the *Otologische Gesellschaft*, in a discussion regarding operation for empyema of the frontal sinuses, it was worthy of note that at last a protest was made against the *operirwahnsinn* (operative mania.)

When Ritter, in 22 cases, as well as the *Königliche Ohren klinik* had to record two deaths from post-operative meningitis, it was an earnest warning for restraint, considering the slight troubles arising from chronic suppurative disease of the frontal sinuses. Heine gave a note of warning against injuring the lamina cribrosa of the cribriform bone, and rejected immediate suture of the cutaneous wound. Herzfeld had also had good results from Kuhnt's operation, combined with a confessedly long after-treatment. Hartmann claimed that removal of the anterior wall of the sinus was unnecessary, and that the use of the sound and inflation with air was frequently sufficient to remove headaches for months. Schötz declared that mere suppuration was not an indication for operation. Herzfeld thought foetidity, in spite of washing out, was an indication. Ritter, in order to protect the lamina cribrosa now left the upper part of the median wall of the capsule of the cribriform bone standing.

AUSTRIA.

Vienna, Feb. 19th, 1906.

OSSEOUS CYST IN FEMUR.

Haberer showed a youth, *æt.* 17, with a thickened femur, presumably of cystic origin. Some ten years ago the patient was brought to hospital in ambulance with a fractured femur, where he was treated, and four weeks lay with it in extension apparatus, and finally three weeks in a gypsum bandage, after which he was dismissed perfectly cured.

At the fracture, on dismissal, there was a slight bend, but nothing unusual, as the patient affirmed his leg was stronger than ever it was before, which continued so till a year ago after very heavy exercise, when pain commenced in the upper third of the bone accompanied by slight arching with the convexity outwards.

In the region of the curve the bone had a spindle shape, hard, but not painful on pressure. This change had produced a shortening of the leg by a centimetre which caused him to limp when walking. The patient affirms that the limp has continued since he had pain in the leg, but the morbid process seems to be still progressing. The Röntgen rays show the right or sound leg to be normal, but the left in a state of *coxa vara*; in the region of the spindle great thickening of the bone was present with a spongy condition of the cortical substance, in many places perforations. The general appearance was that of an osseous cyst, but no other bone was affected, although a systematic search was made with the hope of discovering another centre, but in vain. Whether this isolated centre is malignant or benign or whether the neoplasm is of an inflammatory character there is no reliable testimony to confirm our opinion, unless an excision be made for histological purposes. Waiting, with repeated examinations by the Röntgen rays, may in time give some assurance, but the former method is to be preferred, as the cyst can be cleaned out and tamponned and the part given a chance to heal.

It is well to remember, however, that cysts occurring after fractures often heal spontaneously or become greatly reduced and remain quiescent and subsequently disappear altogether. If this view of the case were correct all interference should be avoided. Haberer at this point recorded several cases in support of this hypothesis, one of which was a female, *æt.* 19, who broke her left humerus, which was treated in the usual manner. About a year after she returned

with an osseous abscess near the seat of fracture, which was diagnosed with the Röntgen rays.

The arm was kept at rest, and in a short time the swelling began to recede. When examined last with the rays the cyst was still there, but greatly reduced in size.

ICHTHYOSIS AND PEMPHIGUS.

A young man, *æt.* 22, the son of a doctor, who since birth had suffered from *ichthyosis simplex fere universalis*, according to his father's observation, which remained stationary till he was six years of age, when a new crop of vesicles appeared on the skin but soon disappeared again, leaving the *ichthyosis* as before. He continues healthy. Six weeks ago the patient took ill with high fever and a repetition of the *pemphigus vulgaris* on the upper part of the body with intolerable itch. Resorcin, borax, etc., were applied with happy results. Since then other vesicles had appeared on the extremities, as if the skin had been macerated along the extensor surfaces. After a time they desquamated, leaving a red inflamed base. There were also epithelial erosions on the upper lips with typical mucous changes as in *pemphigus* and *ichthyosis*.

Newmann said the case was one of *pemphigus vulgaris* and not combined with *ichthyosis* at all. The locality was against the latter, being confined to the internal side of the joints, nates, and extensors of the three joints from which the epithelium was shed, leaving a flat smooth surface not to be found in a case of *ichthyosis*.

HUNGARY.

Budapest, Feb. 19th, 1906.

At the last meeting of the Interhospital Association, Dr. Vamosy delivered a lecture on the

PREVENTION OF OPERATIVE INFECTION.

He made a series of experiments on guinea-pigs for the purpose of determining the possibility of increasing the resistance to peritoneal infection with the colon bacillus. For this purpose, like Borchard, he used injections of nucleic acid, horse serum and physiological salt solution. Subcutaneous injections with the two latter were sufficient to protect the animals against subsequent infections of fatal doses of the colon bacillus. The nucleic acid was not only inefficient, but gave rise to a severe local reaction. The solutions were also injected into the peritoneal cavity and all three substances applied in this way were efficacious in increasing the resistance of the subject, so that two or three times the ordinarily fatal dose of bacteria could be survived. It was found that the highest point in the resistance occurred about forty-eight hours after the injection, which is much later than the highest leucocytosis. The protection was found to last about four days. The lecturer believes that the possibility of infection from laparotomy may in this wise be considerably diminished.

Dr. Palotai related his experiences with spinal anaesthesia in obstetrical cases.

The good results which were described by Professor Martin, induced Dr. Palotai to experiment with the injection of cocaine, preceded by adrenalin into the subarachnoid space in women about to give birth. The anaesthesia frequently lasted up to three hours, and not rarely extended as far as the clavicles. After-effects, with the exception of vomiting, he did not notice. Hypodermic injections of caffeine have recently been recommended to prevent vomiting, but in the speaker's hands, they were without effect. It seems that patients, weak and advanced in years, possess a special tolerance for cocaine, so that this may often be substituted with advantage for chloroform. Application of forceps, version, and perineal suture can be done without inducing pain, but it is undeniable that the contraction of the womb and of the abdominal muscles is somewhat retarded. Involution of the uterus and the formation of milk are not interfered with.

AID FOR CONSUMPTIVES.

A Bill has been prepared by Dr. Kuthy Dessz

which is shortly to be introduced into the legislature by a medical man. The Bill provides for an appropriation of about £40,000 for the establishment of camps, hospitals, and dispensaries in a section of not less than 700 acres in the healthiest part of Hungary. They are to be established under a tuberculosis commission of six, and are to accommodate at least 200 patients at all times. The minimum period of treatment of each patient is to be three months.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

QUEEN'S COLLEGE.—Dr. Wm. Mair has resigned the post of Riddel demonstrator in Pathology, and has gone to act as assistant to Professor Lorrain Smith, at Manchester University. The post, which is worth £150 per annum, is now open. A complete list of subscriptions to the Better Equipment Fund is now published, the total amount being over £70,000. The Council has resolved to spend about £300 on procuring new microscopes of the most recent type for the various scientific departments of the College.

PUBLIC HEALTH.—The report of the medical officer of health last week showed a rather serious state of things in the city. The cases of typhoid reported the previous week were 24, as against 12 in the week before, and seven in the corresponding week last year. There were 35 cases of scarlatina as against 12 the corresponding week last year. It was said at the public health committee that the regulations concerning the notification of infectious disease are not being strictly observed, and it was arranged to call the attention of the medical men of the city to the necessity for observing them.

HOME OFFICE APPOINTMENTS.—The inspectorship of factories held by the late Dr. Henry Purdon has not been given to a single medical man, but has been divided between three. Dr. Charles Milligan, who held the inspectorship at Ligoniel, a manufacturing village on the outskirts of Belfast, has had his district extended so as to include part of the city, and two new men have been appointed, Dr. E. B. Purdon, son of the late inspector, and Dr. J. E. MacIlwaine. Among the comparatively small number of medical men in the city who had not applied for the post these appointments are very well received. Like his father and grandfather before him, Dr. Purdon may be relied upon to do his work quietly and conscientiously, without appearing much before the public eye. Dr. MacIlwaine, who was one of the most brilliant students of his time, and who after graduating with high honour and a gold medal in the Royal University studied in Vienna, Paris, and Berlin, will be fully competent to carry out any of the scientific inquiries into matters affecting the health of factory workers which are now in vogue at the Home Office.

LETTERS TO THE EDITOR.

THE DECAY OF FRANCE.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—The report on the health of Paris commented upon recently in your columns, forms only one of a great cloud of straws which indicates beyond doubt the direction of the wind in France. Paris does not stand alone as an example of neglect of sanitation. The same conditions prevail throughout, from small villages to great towns. All the latter are below the level of German or English cities, whilst some of them, such as Marseilles and Toulon, display a truly oriental disregard of the fundamental necessities of sanitation. Paris has a huge debt incurred in rendering the city beautiful, in providing the outside show which dazzles the foreigner, gratifies the vanity, and satisfies the æsthetic sentiments of the people.

All beneath this outward show is rotten; and in spite of the superb climate which enables the inhabitants to spend much more time in the open air throughout the year than is possible in London or Berlin, the mortality shows, as you point out, an appalling total. The preventable sickness in the French army, mainly tuberculosis and typhoid, diminishes its strength to the amount of a corps—at least twenty thousand men. The same diseases in the German army are comparatively trivial; and seeing that the Germans have nearly twice as many men to draw upon, the loss of strength is more than merely serious. It helps to complete the humiliation of the nation, to make more plain the fact that without allies she would be at the mercy of her hereditary foe. Knowledge of their powerlessness drove the French to make their cowardly, immoral, and hypocritical alliance with the Russian Government—a government that represents the absolute negation of every one of the fine ideas of which the French constantly and loudly proclaim themselves the champions. The bottom cause of the whole situation is to be found in a fact which has been fully discussed in your columns—the practice of limiting the number of children in families to one or two has, besides keeping the population stationary for two generations, led to the growth throughout the whole people of a spirit of narrow egotism essentially anti-social and anti-national.

I am, Sir, yours truly,
H. S.

"CRAMMING" IN EDUCATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Some of your readers will probably have read the report in our leading dailies of the address by Sir William Anson to the Association of Technical Institutions. "He believed they had blundered over the common stumbling-block, and had forgotten the primary importance of asking what it was they wanted to produce," and Sir William's address was really a review of the errors which have been made of late years over the question of education. Sir William ought to reflect upon the part that he and his contemporaries played thirty years ago in the errors he was criticising. We seem to be engaged now in sad retrospection and in tracing the troubles of the present to the sources from which they have come. Now, Sir William's remark may be applied to the very serious and interesting question of the education of those who are preparing to practise medicine. A system of cramming for examinations has grown up, book work replaces practical teaching, and there is no doubt but that most of our younger men are not prepared, as they ought to be, for ordinary "doctors' work when they get their legal qualifications to practise. It is well to recognise the fact that our Universities are not the best schools for ordinary practitioners. Those three or four years are spent on work that is only fitted for men who are going to take up the highest line of practice. There is a tendency to over-value the right to affix such titles as are given by the letters after a name, as M.B., M.S., &c., &c., and too much importance may be attached to these by young students, and parents anxious to start them well. Many live to find out that time and money may be spent to no purpose, and this subject might well receive attention in your journal.

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

AN IDEAL MEDICAL JOURNAL.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—As a constant reader for fully thirty years, I congratulate you on the improved form which your paper has gradually assumed. The hypercritical can always find fault, but I am sure the impartial reader must admit that the MEDICAL PRESS approaches more closely than any of its contemporaries to the ideal of what a weekly medical journal ought to be

It is in every department clear, concise, and sufficient. It gives everything that any practitioner can possibly need to know, and he has not the trouble of fishing it out from an encyclopædic mass of matter mostly superfluous, if not altogether useless. To suppose that bulk is synonymous with value is a mistake, and when one knows how slow is and must always be the progress of medical science and art, it seems evident that for the man engaged in the active work of his profession, the essence of things as you supply it will, rather than the raw mass, always be that which he can take in and assimilate with satisfaction.—I am, Sir, yours truly,
Feb. 15th, 1906. [AN OBSCURE PRACTITIONER.]

THE TRIBUNE AND QUACK ADVERTISEMENTS. To the Editor of THE MEDICAL PRESS AND CIRCULAR.

Sir, As a medical practitioner of many years' standing I am delighted to note the stand you make against the encouragement given by the lay press to quacks and quackery. Without the aid of the press the whole brood of parasites would perish miserably in a short while. It is past my poor comprehension how the editor of a paper professing high moral principles can admit the advertisement of patent remedies and nostrums, and quackeries of all kinds. Coming down to the root of the matter it is a conspiracy to defraud the public got up between the quack and his aider and abettor, the newspaper proprietor. The latter shares the plunder in the shape of well-paid advertisements.

How is this evil thing to be scotched? First let us have a Royal Commission to lay bare the facts of this wicked business. Then let us amend the Medical Act so as to control irregular practices of the kind. Lastly, let us prosecute—as Roosevelt is doing—newspapers that insert the lying advertisements of quacks.

I am, Sir, yours truly,
A FULHAM G. P.
Feb. 17th, 1906.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—May I be allowed space in your next issue for a few remarks relative to your criticism of the advertisements appearing in *The Tribune* of February 8th. I desire at the outset to point out, notwithstanding your suggestion of incredulity, that a strict supervision is really being exercised over the advertisement columns. Every advertisement is examined with the result that I am able to refute absolutely your statement that "you find the usual proportion of quack medicine advertisements" in our columns. As a matter of fact, insertion has been refused to many proprietary articles, quack medicines, as you prefer to term them, and although *The Tribune* is a new paper, this refusal, besides being productive of personal animosity towards the paper, already represents a loss to the proprietor of many hundreds of pounds. We are told over and over again that the other daily papers without exception accept this or that particular advertisement we refuse, but our guiding principle is that if we find internal evidence that the article is *bona-fide*, we are prepared to insert it.

Naturally the medical press would wish to prohibit the sale of all proprietary articles without distinction as to merit, but after all is said, and human nature being what it is, if sufficient evidence is adduced that the cure of any particular disease has been effected by means of a proprietary article, one is apt to give the proprietary article a chance in other similar cases.

The aim of the proprietor of *The Tribune* is to produce a daily paper which shall at once be wholesome, accurate and above suspicion—the moral tone of the paper being gauged by the character of the advertisements as much as by the character of the news it carries. If, therefore, as we state in the notice to our readers, any article is shown to be inaccurately described in our columns, and consequently a fraud on the purchaser, we undertake to stop the insertion of the advertisement. This applies to all

advertisements, so that if you are able to furnish us with satisfactory evidence that the Anturic Bath Salts advertisement comes within this category further insertions will be cancelled.

I have been tempted to write at greater length than I intended but the subject is a very important one, and I am prompted to hope that in fairness to *The Tribune* this reply will be inserted.

I am, sir, yours truly,
23-29, Bouverie St., E.C. J. G. SPARKHALL.
Feb. 19th, 1906. Advt. Manager, *The Tribune*.

[The above letter arrived shortly before going to press, and we hope to refer to it fully next week. Meanwhile, we should like to ask the writer who is to decide what is "satisfactory" evidence as to the merits of any particular preparation? Is the vendor, for instance, competent or any of the *Tribune* staff?—ED. MEDICAL PRESS AND CIRCULAR.]

SPECIAL ARTICLE.

THE HEALTH OF THE NAVY.

THE Blue Book containing the Statistical Report of the Health of the Navy for the year 1904 has recently reached us. It is unfortunate that, as in the case of most Government publications, interest in the contents is greatly lessened by the long interval which has elapsed between the period to which the Report refers, and the time at which it sees the light. That the Director-General and his subordinates are not directly responsible for the delay in this case is shown by the fact that the Report was presented to the House of Commons as long ago as last August.

The returns for the total force serving afloat may be considered satisfactory. Compared with the average of previous years, there are decreases in the ratios of cases of sickness, of invalidings, and of deaths.

The total force serving afloat, corrected for time, in the year 1904, was 110,570. The total number of cases of disease and injury entered on the sick list was 83,447, which is in the ratio of 754.69 per 1,000, being a decrease of 118.07 per 1,000 as compared with the average ratio of the last seven years. The average number of men sick daily was 3,467.25, giving a ratio of 31.35 per 1,000, and showing a decrease of 5.22 in comparison with the last seven years' average. The total days' sickness on board ship and in hospital was 1,269,015, which represents an average loss of service from disease and injury of 11.47 days for each person, which is a decrease of 1.84 in comparison with the average of the last seven years. The total number of persons invalided was 2,511, which is in the ratio of 22.7 per 1,000, and shows a decrease of 7.28 in comparison with the average of the last seven years. Deaths number 493, a ratio of 4.45 per 1,000, a decrease of 1.01 per 1,000 as compared with the ratio for the last seven years.

Of the general diseases appearing in the sick list the following are the most important: Influenza, 1,586 cases; malarial fevers, 693; tubercular diseases, 456; Mediterranean fever, 430; enteric fever, 226; dysentery, 133; parasitic diseases, 4,289; rheumatism, 2,361; syphilis, 6,219; and gonorrhœa, 6,039. In addition there are 1,035 cases classed as "other continued fevers." The rate for venereal disease shows a slight decline from the average, but a rate of 110 per 1,000 is still unpleasantly high.

An interesting feature of the Report is the valuable scientific matter in the Appendix, in the form of papers by various naval surgeons on subjects of pathological and practical importance, at which they had worked during the year. Malta fever has attracted much attention of late, and there are four papers dealing with it from different points of view. Fleet-Surgeon Bassett-Smith gives an account of some useful experiments bearing on the growth of the specific organism outside the body, and he also discusses the distribution of the disease in the Fleet. Staff-Surgeon Shaw gives a clear and excellent account of the agglutination

reaction in Mediterranean fever, while Fleet-Surgeon McNabb discusses symptoms and treatment. Caisson disease is the subject of careful papers by Fleet-Surgeon Mourilyan and Fleet-Surgeon Barrington. The curious condition of eczema produced by exposure to "Ningpo varnish," is described by Staff-Surgeon Boyden. These scientific papers deserve a better fate than interment in a Blue Book.

REVIEWS OF BOOKS.

THE RELATIONS OF MEDICINE TO OTHER ARTS AND SCIENCES. (a)

THE volume before us consists of a series of twelve lectures, some of which were delivered by the author at the University of Berlin, on the subject of medical "Kulturgeschichte," which, as is pointed out in the introductory chapter, was defined by Stricker in 1865 as the "boundary zone between practical medicine and many other arts and sciences," and which the author largely interprets as "the relations and connections between medicine and other branches of knowledge." The subject is, of course, an enormous one and full of interest, and no more than the mere fringe of it can be adequately discussed in the book before us, which contains only a little over 100 pages. The writer is, however, apparently a master in the matters of which he deals and is deeply learned in the traditions of medicine and in the philosophical bearings of its folklore. He is, in consequence, able to present a narrative which is no mere chronological statement of the phases of medical thought, but which summarises the wider sociological influences which it has exerted, and shows how medicine itself has been affected by current ideas and by succeeding waves of thought.

The first relationship dealt with is that which exists between Theology and Medicine. To this, four chapters in all are devoted, one of which deals with "Homœopathy and the Mystic Tendencies of the Nineteenth Century." The origin of medicine as an art, a mere accumulation of empirical remedies in the hands of the priests, is discussed, and also the origin of medical charms and amulets. These last are derived, according to the author, from the Persian "Emanation System," and their influence finds expression in the words of the Evangelist who speaks of "The Word" as the reflection or image, the Son, of God. Astrology and alchemy are considered, with their hidden meanings, and in connection with the former, says the author "This science is not dead but slumbers, to awake again in our time of radium and radio-therapy, but with a modern aspect." The medicine of the Old Testament, and that embodied in various codes of ritual, is not neglected, nor is the conflict between rational medical ideas and some of the present Christian dogmatics passed over without remark.

In the next three chapters the connection between philosophy, the science of sciences, and medicine; between law and medicine; and between general sociology and medicine is reviewed, and considerable stress is laid upon the *rolé* which physicians in general have played as educators of their own and of other countries. In these and in the succeeding chapters, which deal with physicians as statesmen, poets and artists, the writer, to our mind, lays a little too much stress upon the material part which has been played by members of the profession, and too little upon the general influence on ideas exerted by the science as a whole. Finally the importance of mathematics and kindred subjects as an aid to the advance of medicine is insisted upon, and some specific instances of its value in statistical inquiries are given.

We have perused this work with real pleasure and can heartily recommend it to those who desire to take a wider view of the position and responsibilities of the medical profession in relation to the complicated

mechanism and motives of civilised life. Perhaps some enterprising publisher will bring it more within reach of the many by affording an English translation.

OBITUARY.

A. L. PEACOCK, M.R.C.S.ENG.

THE death of Dr. A. L. Peacock, of Lincoln, which occurred on the 9th, is regretted by a large circle of friends. The deceased gentleman came to Lincoln between twenty and thirty years ago as doctor to the Manchester Unity of Oddfellows' Friendly Society. In 1882 he was appointed medical officer to the workhouse, and was also appointed medical officer for the home district, which comprised several of the city parishes in the Union. Though able to attend to his private practice, he has not enjoyed good health for some years, and his death was not unexpected. Dr. Peacock was in his sixty-sixth year, and he is survived by a widow and two daughters.

FALCONER CLARK, M.R.C.S.ENG.

WE regret to announce the death at Dorking of Mr. W. Falconer Clark, who had practised in that town as surgeon for many years. Mr. Clark joined the old East India Company and served on the North-West Frontier and during the Mutiny. He was present at the Siege of Delhi and the Relief of Lucknow, and possessed two medals with four clasps.

CANON OAKLEY COLES, B.D., L.D.S.

THE death is announced of the Rev. Canon Oakley Coles, whose name was at one time well known in the dental and medical professions. Whilst a student he married the sister of the late Sir Morell Mackenzie. While practising in Wimpole Street, London, he produced his work on "Oral Deformities," and afterwards became lecturer, dean to the National Dental Hospital, and editor of the *Monthly Review of Dental Surgery*, as well as the *Medical Examiner*. In 1886, being called to the ministry of the Church of England, he was presented at the house of Sir Edwin Saunders (the dentist to the Queen), with a testimonial and £100 from students and members of the dental profession. In 1899 he was appointed honorary canon of Canterbury, and in the following year received from the Archbishop the honorary degree of B.D.

F. J. C. PARSONS, M.R.C.S., L.R.C.P.LOND.

THE death occurred on the 9th inst. of Dr. F. J. C. Parsons, a well-known medical practitioner of Bridgewater. The deceased had been ailing for some considerable time, but his end was somewhat sudden. In addition to having lucrative private practice, Dr. Parsons had been for a number of years medical officer of health for the borough, and also the rural district. He was also an honorary visiting surgeon at the Bridgewater Hospital, in the making free of which he was a constant and earnest advocate. Until a few years ago Dr. Parsons was a keen cricketer, playing with regularity for the Bridgewater team. He leaves a widow, but no children.

GEORGE LOWSON, M.B.GLAS.

WE regret to record the death of Dr. George Lowson, Dundee, at Duncraig, on the 9th inst. The news will be received with deep regret by his many friends in Dundee and elsewhere. Dr. Lowson was a comparatively young man, and a native of Dundee. An unfortunate accident he met with two years ago, and which necessitated the loss of his leg, seemed so much to undermine his health that he never quite recovered his former cheerfulness and vigour. He studied in Glasgow University, and graduated in 1890 with the degree of M.B. and C.M. He was honorary surgeon to the Convalescent Home in William Street, and surgeon to the Hilton Lodge of Ancient Shepherds. He was laid aside from active duty only a week ago owing to a severe attack of heart trouble. Deceased is survived by a widow and three young children, for whom the deepest sympathy is felt.

(a) "Grundriss eines Systems des Medizinischen Kulturgeschichte." By Dr. Julius Feyer, Professor of the History of Medicine, Berlin University. Berlin: S. Karger. 1905.

MEDICAL NEWS IN BRIEF.

The Royal Academy of Medicine in Ireland. Address to the Lord Lieutenant.

On Friday last, the President and Council of the Academy presented an address of welcome to the Lord Lieutenant in person. The address, after congratulating His Excellency on his appointment, referred briefly to the past history and associations of the Academy, which was incorporated in 1882, being formed by the amalgamation of all the Dublin societies of standing which were cognate to the various branches of Medicine and Surgery, and which are now represented by its various sections. In 1887, on the occasion of her Jubilee, her late Most Gracious Majesty conferred upon it the title of "Royal." Its history has been prosperous and successful, as may be seen from the quality of the work in our annual volumes of transactions. That its foundation principles are good is shown by the fact that the Medical Societies of London are at present negotiating a movement of the same character that resulted in our foundation 24 years ago. His Excellency in reply, referred to the statement that the Academy was formed of the societies which formerly existed, and said that it was also very interesting, and very gratifying, to observe the token of the success of amalgamation—namely, that the medical societies in London are preparing for a movement of the same character as that of the Academy. It is obvious also that the two branches of the great professions to which, I understand, you furnish elements of help and sources of assistance in the most practical way, combining as they do science and the application of science in a most important and practical way, cannot fail to derive much advantage from such a body as yours, ready at all times to facilitate in promoting their ministrations. I thank you heartily for the kind expressions of goodwill towards Lady Aberdeen and myself, for our health and success while in Ireland. His Excellency hoped that with the healthy air of Ireland, and with a tolerably tough constitution, he might not have occasion to resort either to the scientific or the administrative side of the medical profession. But the more he met the members of the profession on another footing the better he should be pleased. The deputation shortly afterwards withdrew.

The Dental Hospital for Ireland.

The annual report of this hospital shows that the work it has done during the past year has been very considerable, the number of cases treated exceeding the large total of the previous year, being 41,620, against 40,725. Of these 33,881 were dispensary cases, 4,474 fillings, 495 cases of irregularity, 148 patients supplied with dentures, and 2,558 operations under anæsthetics. It may be noted that the fees received from nearly 34,000 dispensary cases amount to less than 3,000 shillings, showing in this department alone some 31,000 cases treated gratuitously. The Board of the Hospital have decided to allow medical students who have passed their half to take a short course of instruction at this hospital similar to that given to Naval and Military Surgeons. This privilege will, we fancy, be largely availed of.

The Irish Local Government Board and Asylum Control.

We published a few weeks ago an account of proceedings in the King's Bench at the instance of the Local Government Board with the object of obtaining a mandamus against the Committee of Management of the Richmond District Asylum, Dublin, and its Resident Medical Officer Dr. Connolly Norman, to compel them to comply with the terms of the Public Bodies Order. On that occasion, the Board obtained a conditional mandamus on which they have not as yet acted. We now learn that the new Chief Secretary for Ireland has stated that if the Asylums will not contest the right of the Local Government Board to make certain

regulations, it should be possible to arrange the matters in dispute after a conference. With this object he has consented to postpone further action, and thus afford the Asylums interested an opportunity of resuming the negotiations which were broken off by that Board. As to the abstract of accounts, the Chief Secretary was much impressed by the importance of having these abstracts uniform. He suggested that they ought not to have any difficulty in furnishing the abstract desired, while at the same time keeping the accounts of the Asylum in the form found most suitable by the committee. We further understand that representatives of the various Asylums which have resisted the Order have now decided to meet in conference in Dublin to discuss the matter, after which their views are to be submitted to the Chief Secretary. The Public Bodies Order appears to have pleased nobody, and if the question of its adoption or rejection can be arranged in a friendly manner it will be a matter for congratulation.

Medical College in China.

A REUTER telegram from Pekin states that the Lockhart Medical College, named after the British pioneer missionary, and organised by the London Mission and the American Methodist, Presbyterian, and Congregational Missions, was opened last week. The ceremony was attended by members of the Diplomatic Body, while the gathering of high Chinese officials was unprecedented at an event of this nature. Na Tung, President of the Foreign Office, congratulated the committee on behalf of the Dowager Empress. Sir Ernest Satow, British Minister, Mr. Rockhill, American Minister, and Sir Robert Hart delivered speeches. The college has accommodation for 350 students.

Norwood Sanatorium.

THE Norwood Sanatorium, we learn, was acquired some eight months ago by Mr. Joseph Rowntree, whose enthusiasm for temperance reform caused him to acquire it in order to enable the medical treatment of inebriety to be placed on a scientific basis. Mr. Rowntree has already handed over to an advisory medical committee the control of all medical and medico-ethical matters. Among those who have already consented to serve on the advisory committee are Professor Sims Woodhead (Cambridge), Dr. Harry Campbell, Dr. Rushbrooke, Dr. Cope, Dr. Claye Shaw, Miss Mary Sturge, M.D., and Sir Victor Horsley. Each patient is assigned a separate room, and is treated, as Mr. Stark says, "like a guest." It is claimed that the special form of medical treatment enables the patient to conquer the drug-taking and drinking without being subjected to the physical tortures which accompany so many "cures."

Aliens in the Port of London.

DR. HERBERT WILLIAMS, Medical Officer of Health for the Port of London, who is the medical inspector under the Aliens Act, has reported to the Corporation that the inspection works very smoothly. Since January 1, 33 immigrant vessels have arrived in the Port of London, bringing 1,184 alien steerage passengers. These have all been medically inspected; 17 have been certified as "undesirable" on medical grounds. The Immigration Board allowed ten out of these to land and ordered the deportation of the seven others. As was expected, the number of "undesirable" aliens rejected on medical grounds has diminished, the various steamship companies having found it to their advantage to have all passengers medically inspected before allowing them to embark at the port of departure. Dr. Williams gives extracts of reports made by the sanitary inspectors as to the way in which some of the people are brought to this country and the accommodation provided for them. In one vessel from St. Petersburg,

carrying 305 alien steerage passengers, the vessel was in a filthy and offensive condition. The available air-space per head was only 60 cubic feet, and floor space eight square feet. There was no provision made for the separation of the sexes. The ventilation and lighting were unsatisfactory, the sanitary provisions insufficient, and in the event of bad weather the passengers had to be confined to their quarters, as the after main deck was entirely occupied by horses. In another vessel from Libau with 234 steerage passengers the state of things was even worse. The whole of the after deck was occupied by 147 Russian ponies. As these vessels were Russian, the Medical Officer of Health recommended that the facts should be reported to the Board of Trade and the Russian Consul-General in London.

The Honorary Fellowship of the Royal College of Surgeons in Ireland.

ON Saturday last the Royal College of Surgeons in Ireland conferred its Honorary Fellowship upon Surgeon-General Keogh, Director-General of the Army Medical Service; Professor Henri Hartmann, Surgeon-in-Chief to the Lariboisiere Hospital, Paris (*in absentia*); and Dr. A. E. Wright, Pathologist to St. Mary's Hospital, London. The ceremony of presentation was an interesting one, although perhaps it followed more closely the procedure adopted in a university than is usual in collegiate functions, and consisted in the introduction to the President of each candidate successively by the vice-president, who recalled, in an interesting speech, the special deeds of each new Fellow. The Lord Lieutenant honoured the ceremony by his presence. Subsequently the annual dinner of the College was held, and was very largely attended. Sir Arthur Chance, the President, presided. Numerous toasts and speeches followed after dinner, amongst the chief of the former being "The King," "The Lord Lieutenant," "The New Honorary Fellows," "The Guests," and "The President."

Important Medical Prosecution.

ON February 14th, at Bristol Police Court, Frank Lee, of the Bristol Electropathic Institute, Cumberland Street, was summoned that he, not being a registered medical practitioner within the meaning of the Medical Act of 1858, and the Medical Act of 1886, and the Acts amending the same, and not then being a person recognised by law as a physician, surgeon, licentiate of medicine and surgery, practitioner in medicine or an apothecary, did unlawfully pretend to be and take and use the name and title of "Dr.," thereby implying that he was registered under the Medical Act, and that he was recognised by the law as a Doctor of Medicine, or a practitioner of medicine, contrary to the Statute 21 and 22 Victoria, cap. 90. There were three summonses for the same offences, relating to January 5th, 23rd, and 26th. The magistrates were of opinion that the defendant intended the public to believe that he practised as a doctor to heal disease, that he wrongly called himself a doctor, and that he did this for personal benefit, thereby gaining his living. A fine of £10 and £5 costs were then imposed.

Bogus Death Certificate.

BEFORE Mr. W. J. Stewart, at Liverpool City Police Court, on the 15th inst., Hamilton Jolly, alias Joseph Fitzgerald, an elderly man, who had been practising as a medical man in various parts of Liverpool for several years, was charged on six informations with forging certificates of the cause of death for the purpose of the Births and Deaths Registration Act, 1874. The defendant, who was not legally represented, pleaded guilty. Mr. R. P. Cleaver prosecuted on behalf of the Registrar-General, and said he would submit certificates signed by the defendant whereby it would be seen that the signature was "J. Fitzgerald, L.K.Q.C.P.I." The cases of which complaint was made were only part of a large number of death certificates which had been received by the various registrars in the West

Derby Union. These, together with a number of vaccination certificates which had been handed in signed by the defendant, made it clear that a somewhat extensive practice had been carried on by the defendant. Jolly at present occupied premises at 59, Redrock Street, West Derby Road. According to the Medical Directory, 1906, the tenant was Dr. Joseph Fitzgerald, L.K.Q.C.P.I., but the defendant was the only person who attended any of the persons in regard to whom the certificates were issued. Dr. Joseph Fitzgerald resided in Erskine Street, and had been seen by vaccination officers in reference to certificates signed by defendant in his name. Jolly was not a duly qualified medical practitioner, and it was an extremely serious matter not only as against the law of registration, but the poor people who paid the defendant fees he was not entitled to receive. He might say that he believed that Jolly was a relation of Dr. Fitzgerald. Defendant, who had nothing to say, was fined £10 in each of two cases, £5 in each of the other four cases, and ordered further to pay £10 in cost.

Queen Alexandra Sanatorium.

LORD CHELSEA and Sir Joseph Leese, M.P., spoke at a meeting over which Dr. Huggard, the British Consul, presided, held at Davos-Platz recently in aid of the Queen Alexandra Sanatorium, Davos. The sum of £12,374 has already been subscribed, and £21,000 is still required for building and furnishing. The sanatorium is intended to enable consumptive persons of limited means to take advantage of the high mountain climate.

Methylated Spirit in Medicine.

A HERBALIST named William Edward Evans, carrying on business at Lowhill and West Derby Road, Liverpool, was summoned by the Excise authorities on two informations for having in his possession on November 28th an article capable of being used internally as medicine called "Stomach and Liver Mixture," in the preparation of which methylated spirit had been used, contrary to the statute; and for having in his possession bottles containing a mixture labelled "Anti-stomachic drops," which also contained methylated spirit. Mr. Cecil Simpson (solicitor to the Inland Revenue Department) explained that an officer visited defendant's premises and purchased bottles of two mixtures, which on analysis were found to contain methylated spirit. Mr. Quilliam appeared for the defendant, who admitted the offence, but pleaded that he acted in ignorance. A fine of £2 was imposed in each case, and £5 5s. costs.

Conjoint Examinations in Ireland.

THE following candidates have passed the Diploma in Public Health Examination as undernoted:—Mary Annie Griffin Iles, M.D., Univ. Lond.; Richard John Bertram Buchanan, L.R.C.P. and S.I., R.A.M.C.; Patrick Dwyer, M.B., R.U.I., R.A.M.C., and Charles Walter Holden, L.R.C.P. and S.I., R.A.M.C.; with honours. Roland Thomas Groves Aickin, M.D., Univ. Edin.; William Lucknow Bradshaw, L.R.C.P. and S. Edin.; Henry Lawrence Esmonde-White, M.R.C.P.I., R.A.M.C.; Hubert Rodney Ross Fowler, L.R.C.P. and S. Edin.; James Albert Gibson, M.D., Univ. Edin.; Ernest Sydney Hawthorne, F.R.C.S.I.; Robert Arthur O'Donovan, L.R.C.P. and S.I.; and Jacob Philip Zierooel, F.R.C.S.I.

A MEETING of the Assistants of the Society of Apothecaries will be held on Wednesday, February 21st, at 8 p.m., in the Court Room of the Society's Hall, Water Lane, Blackfriars, E.C., for the purpose of founding an Association, confirming constitution, and rules and enrolling members. Ladies and gentlemen desirous of becoming members, but unable to attend, will please communicate (if they have not already done so) with the hon. sec., Mr. Albert Howell, Hackney Dispensary, Rosebery Place, Dalston, N.E. The subscription is fixed at 2s. 6d per annum.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT LITERATURE OF PHYSIOLOGY AND PATHOLOGY.

Bacteriology of Acute Rheumatism.—Beattie (*Journal of Med. Research*, January, 1906) gives the results of experiments intended to support the view that the "micrococcus rheumaticus" is the infective organism of acute rheumatism. In particular, he directs himself to distinguish the organism from ordinary streptococci as regards pathological effects. With a culture of micrococcus rheumaticus obtained from the synovial membrane in a typical case of acute rheumatism, and with a culture of streptococcus from the vegetations of a heart valve in malignant endocarditis, series of parallel experiments were conducted. The results show that whereas the streptococcus tended to give rise to general septicæmia, the micrococcus caused endocarditis, polyarthritis, or chorea. There was no similarity between the pathological effects of the two organisms. Moreover, though closely resembling each other morphologically and culturally, the two organisms present certain differences, of which the most important is the greater vitality in culture of the micrococcus. R.

Typhoid Bacilluria.—Dods Brown (*Edin. Med Journ.*, February, 1906), sums up our knowledge of this important clinical condition, and adds the results of his own observations. Discarding results obtained prior to the differentiation of *b. typhosus* and *b. coli* in 1895, Brown shows that, taking the average from the returns of many investigators, of whom Horton Smith, Herbert, Vincent, Richardson, Petruschky, and Lewis are the chief, bacilluria obtains in 21.24 per cent. of all cases of typhoid fever. The percentages obtained by individual investigators, however, vary greatly, and this suggests that there cannot have been any uniformity of method; thus, Lewis places the incidence of bacilluria as low as 2.22 per cent., while Lesieur and Mahaud place it as high as 46.66 per cent. Dods Brown's return—based, however, on only 15 cases—is even higher, 53.3 per cent. There are, moreover, other discrepancies between the results of the older observers. There is, for instance, much difference of opinion as to the period of the disease when the phenomenon appears. Vincent gives the usual period as from the eleventh to the seventeenth day, and Lesieur and Mahaud found bacilli in the urine on the tenth day. Brown's earliest day is the 28th. The period of persistence is just as variable as the date of appearance. Petruschky found bacilluria seven weeks after the subsidence of fever, and Busing six months after cure. Gwyn reports one case in which bacilluria was observed four years after an attack of typhoid fever, and Houston a similar case in which the organism persisted three years. Debate has waged, too, on the question of the association of bacilluria with albuminuria, with pyuria, with roseola, and with the severity of the disease. Various theories have been held as to the pathology of the condition—(1) that the bacilluria causes nephritis, followed by bacilluria; (2) that the bacilluria is consequent on typhoid abscess in the kidney; (3) that the organisms pass by the shortest route from the rectum to the bladder; (4) that a few organisms pass through the kidney and thereafter multiply in the urine. This last theory is by far the best founded, and is adopted by Dods Brown. His conclusions are—(1) *B. typhosus* appears in the urine of typhoid patients in from 30 to 35 per cent. of cases; (2) in most cases it causes no symptoms; (3) bacilluria is frequently, but not invariably, accompanied by albuminuria and oliguria; (4) the bacilli appear in the third or fourth week, and persist for a varying time—weeks or months; (5) bacilluria occurs more frequently in severe cases of typhoid fever, but is of no prognostic

importance; (6) bacilluria gives no aid to diagnosis. The importance of the phenomenon from the point of view of public health is great. In all cases the urine should be destroyed as carefully as the fæces, and care should be taken to avoid pollution of clothes with urine. Before discharging typhoid patients from treatment, the urine should be examined for bacilli. R.

Enteric and Mesenteric Cysts.—Ayer (*American Journ. of the Med. Sciences*, January, 1905), in reporting one case, describes this rare condition. His case was that of a cyst in the posterior wall of the cæcum, as large as a duck's egg, and containing three or four ounces of clear, viscid fluid; a funnel-shaped process extended a couple of inches under the mesentery of the ileum. In a discussion of the general subject Ayer adopts the following classification (based on that of Dowd):—(1) Cysts arising from the glandular structure of the intestine:—These are usually multiple, and of small size (1-4 cm. in diameter); they contain mucin. Though they may occur anywhere in the intestine, small or great, they are most common near the ileo-cæcal valve; (2) Parasitic cysts:—These have apparently only been found in the mesentery, and not at all in the intestine. They are due to the tænia echinococcus, and resemble cysts of similar causation occurring elsewhere; (3) Embryonic cysts. These—the most common abdominal cysts—are of many kinds. (a) Remains of foetal organs Wolffian and Mullerian bodies, omphalomesenteric duct. There are many instances on record which can have no other explanation. (b) Snared-off pieces of intestine, Remak's and other diverticula. These are usually recognised by the wall being of similar structure to that of the intestine. In some cases the connection with the intestine can be traced. (c) Cysts arising from sequestrations of intraperitoneal organs. Of this condition there are many records. Misplaced pieces of liver and pancreas, accessory spleens, suprarenals, and prostates have been described. (d) Dermoids, common enough in the female, but apparently unknown in the male. (4) Cysts of the normally placed retroperitoneal organs:—These are common, the pancreas being most frequently the site. (5) Cystic malignant disease, rare in this site. The article is a concise summary of much scattered literature, to which full references are given. R.

Light as a Cause of Cancer.—Hyde (*American Journal of the Medical Sciences*, January, 1906) discusses the possible activity of light in the causation of some forms of cancer. He devotes himself altogether to the acknowledged relation between xeroderma pigmentosum and epithelioma. This rare disease, occurring in young children, is characterised by a hyperæmia of the exposed parts of the body, followed by pigmentation, growth of angiomas, and finally of malignant warts. Linna and others regard the chain of morbid phenomena as due to the weakened resistance of the skin of the child, to the more refrangible rays of the solar spectrum, the hyperæmia and pigmentation being endeavours to inhibit the passage of the ultra-violet and blue rays. Hyde thinks it possible that in other cases also actinic influences may be at work in the causation of cancer. Thus it is said that negroes are immune to superficial cancers, as are also miners working underground. Superficial cancer is said to be more common in country dwellers than in city folk, and as is well known, it is more common in men than in women. These facts point, in his opinion, to a higher incidence of the disease in those exposed to light. He finds parallel results in the case of X-rays, of Becquerel rays, and of the radiations of radium. It is quite possible that irritation by light, like other irri-

tations, may be an exciting cause of cancer, but we are hardly justified in carrying Hyde's suggestion any further.

R.

The Causation of Syphilis.—MacLennan (*British Medical Journal*, February, 3, 1906) publishes a preliminary note suggesting a possible developmental relation between the *Spirocheta pallida* of Schaudinn, and the *Cylorrhycle luis* of Siegel. In several films prepared from syphilitic sores, he has seen the bodies described by Siegel under this name. They appeared, however, in various stages of development, of which, apparently, Siegel has only observed one. Between some of these bodies and the spirocheta there was a close resemblance, and MacLennan thinks it possible that the spirocheta is merely another stage of the same organism. In some of his preparations he saw some of the bodies he describes invading the red corpuscles. A full report, accompanied by microphotographs, is promised.

R.

Cerebro-Spinal Meningitis.—Elser (*Journal of Medical Research*, November, 1905) gives a bacteriological report of 130 cases of epidemic cerebro-spinal meningitis studied by him in New York. In 109 cases the diplococcus intra-cellularis of Weichselbaum was found either in cultures, or in smear examinations of the spinal fluid. In 16, no organisms were discovered by any means. In the remaining 5, the organism was not found during life, but was isolated in pure culture from the spinal fluid after death. Cultures were made from the spinal fluid during life in 105 cases, with positive results in 86. In many cases, cultures had to be repeated frequently before positive results were obtained, and in many cases several examinations had to be made before the organism was found in cover-slip preparations of the spinal fluid. Of the 16 negative cases, 12 were only examined once; it is probable that repeated examination would have detected the organisms in most, if not all, of these cases. Mixed infections were uncommon. In two cases the diplococcus of pneumonia was found associated with the diplococcus intracellularis; in one the streptococcus was found in the kidney and spleen, and in another in the blood. Staphylococci were sometimes met with, but were supposed to be due to contamination. Blood cultures were made during life in 41 cases in which a positive bacterioscopic diagnosis had been made from the spinal fluid, with positive results in ten cases. Elser believes that with improved technique, the percentage of positive results would have been much higher. He regards the presence of the meningococcus in the blood as a sign of grave prognosis. In 6 out of 22 cases, the meningococcus was separated from the nose or throat. Cultures from the urine in 5 cases were negative. In the pathological anatomy as seen in the autopsies, the principal point of interest was a characteristic hyperplasia of the thymus and lymphoid structures in most of the fulminating cases, which was absent in the cases which ran a more protracted course. Elser regards the status lymphaticus as having a causal relation to the rapidly fatal issue.

R.

Mycotic Aneurism.—McCrae (*Journal of Pathology and Bacteriology*, August, 1905) reports a case of this rare condition, and discusses the etiology. In addition to chronic aortic and mitral endocarditis, and acute fibrinous pericarditis, there were five small aneurisms of the ascending aorta, with acute vegetative endarteritis of the surrounding intima. Perforation of one of these into the pericardium had taken place, with resulting sudden death. Two of the aneurisms had continuous with them sharp slits in the intima, as clean and definite as if cut with a knife. In the infiltrated tissues at the bottom of the aneurismal sacs were numerous diplococci, both in the cells and between them. As the autopsy did not take place till seventy-two hours after death, cultural experiments were of no use. Two possible modes of development of such lesions are considered: (1) a primary local infection of the intima with ulceration, the ulceration spreading

into the media and causing an infiltration of aortic blood between its layers, and ultimately through the adventitia; (2) an infection reaching the media by the path of the vasa vasorum, and there setting up an inflammation, the ulceration of the intima being secondary. As regards his own case McCrae thinks the first hypothesis untenable, since if the disease began in the intima we should expect evidence of ulcerative conditions confined to the intima; but direct infection of the intima is very rare, although the presence of bacteria in the blood-stream is common. To explain the sharp-cut lines, McCrae suggests that the tissues had undergone hyaline change, rendering them brittle, and that a sudden increase of pressure from any cause is sufficient to cause a sharp cleft. The sequence of events in such a case as his he supposes to be (1) infective thrombosis of some of the vessels supplying the wall of the ascending aorta; (2) splitting of the wall of the aorta with subsequent rounding of the edges, or else simple ulceration; (3) contemporaneous formation of aneurism; (4) growth of fresh vegetations on edges of openings; (5) further splitting of aortic coat from peripheries of aneurismal openings; (6) rupture of an aneurism with death.

R.

Bacteriology of Empyema.—Emanuel (*Lancet*, January 13th, 1906) discusses various reports on the bacterial findings in empyema in children. There is a marked difference in the infective organisms as found in children, and in adults. Netter gives the following figures:—In adults, streptococci, 53 per cent., streptococci and pneumococci 2'5, pneumococci 17'3, staphylococci 1'2, tubercle and putrid 26; in children, streptococci 17'6 per cent., streptococci and pneumococci 3'6, pneumococci 53'6, tubercle and putrid 25'2. It will be seen therefore that whereas the incidence of tubercle is practically the same in children and in adults, the former are much more liable to pneumococcal infection than the latter. The figure (57'2) given by Vetter as the pneumococcal percentage, is much lower than that given by other observers. Koplik reports his experience as 60 per cent., Bythell as 65, Blaker as 88, and Still as 93. The average is probably about 75 per cent. Cases of pneumococcal empyema are either primary or secondary. The secondary empyema, i.e., associated with or following on pneumonia, is the more common, and there is even a question whether primary empyema ever occurs. Emanuel defends both on theoretical and empirical grounds, the view that true primary empyema is sometimes encountered. Speaking generally, pneumococcal infections are less virulent than streptococcal, but, nevertheless, they vary greatly. He classes them according to three types, varying in severity: (1) The infection is localised to the pleural cavity; (2) infection spreads by the lymphatics, and by direct extension, giving rise to pericarditis, peritonitis, or empyema of the other side; (3) pneumococcal septicæmia, giving rise to multiple abscesses, and distant infections. Although the tubercle bacillus is regarded as the infective agent in some 20 or 25 per cent. of the cases, it is notoriously difficult to detect it in the pus of empyema. According to some observers, the absence of any organism as the result of search suggests a tuberculous origin. Some help is given by examination of the cells in the exudate—"cytodiagnosis," as it is called. In tuberculous effusions, there is a preponderance of lymphocytes, and in acute infections of polynuclear leucocytes. In rare cases, other organisms—typhoid bacillus, colon bacillus, Friedländer's bacillus, diphtheria bacillus—have given rise to empyema. Staphylococci are often present, but probably not in a causal capacity.

R.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "Recent Medical Literature."
- (2) "Recent Surgical Literature."
- (3) "Recent Gynaecological and Obstetrical Literature."
- (4) "The Recent Literature of Physiology, and Pathology."

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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 reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

MARK TWAIN ON COD LIVER OIL.

This humorist recently attained his seventeenth birthday, and at a complimentary dinner given in his honour he said, in characteristic fashion, when replying to his health:—"Since I was seven years old I have seldom taken a dose of medicine, and have still seldom needed one. But up to seven I lived exclusively on allopathic medicines. Not that I needed them, for I don't think I did; it was for economy. My father took a drug store for a debt, and it made cod liver oil cheaper than the other breakfast foods. We had nine barrels of it, and it lasted me seven years. Then I was weaned. The rest of the family had to get along with rhubarb and ipecac and such things, because I was the pet. I was the first Standard Oil Trust. I had it all. By the time the drug store was exhausted my health was established, and there has never been much the matter with me since."

DE SENECHUTE (Swansea).—The compulsory retirement of members of honorary medical staffs of hospitals at the age of sixty is a somewhat moot point. As a matter of fact many men are capable of good work for a considerable time beyond that period. The general advisability of the rule appears to be based on good grounds. At the same time there is a great deal to be said on the other side.

AN INSANITARY RRECONSHIRE VILLAGE.

Vaynor and Penderyn District Council propose to spend £7,758 on sewerage works at Cefn, just outside Merthyr incorporation area, and a Local Government Board inquiry was held lately upon the subject. The clerk to the council explained that it was proposed to acquire land compulsorily for the bacterial tank system. Dr. Webster, J.P., medical officer, said that last year was the first for thirty years that Cefn village was free from typhoid; some of the houses wanted gunpowder under them. Cefn is within the area of Merthyr Parliamentary boroughs.

A WANDSWORTH PRACTITIONER.—Chronic nephritis is rare in childhood. When it occurs it generally follows some acute specific fever, but it may also result from gout, syphilis, and heart disease. Treatment is unsatisfactory. Hot-air baths are worthy a careful and prolonged trial.

DEFENCE (L. A. T.).—When Parliament has its hands less full—if that ever arrives—the question of the control of fraudulent patent medicines may possibly be considered. The remedy is clearly to prosecute for conspiracy to obtain money by false pretences. If a man sells a cough-cure warranted to cure—say, asthma, chronic bronchitis, and consumption, he is publishing a lie, and should be held answerable by the law for the consequences.

The Phagocyte! The Leucocyte!
(We seem to know them well by sight).
No wonder then we got a fright,
When told the story of their fight;
How it went on both day and night.
We argued were the savants right?
'Tis time the doctors should unite,
And make the microbes take to flight;
And seas that with infectious bite
Disturb our peace both day and night.

—A. D.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, FEBRUARY 21st.

ROYAL METEOROLOGICAL SOCIETY (70 Victoria Street, Westminster, S.W.).—7.30 p.m. Paper:—Mr. W. B. Newton: The Dispersal or Prevention of Fog.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m. Prof. H. J. Paterson: Some of the results of Gastric Surgery. (Lecture II.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. E. Owen: Clinique. (Surgical.) 5.15 p.m. Lecture:—Dr. R. Hutchison: Dilatation of the Stomach.

THURSDAY, FEBRUARY 22nd.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchison: Clinique. (Surgical.) 5.15 p.m. Lecture: Dr. R. Hutchison: Chronic Gastritis.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—8 p.m. Dr. M. Dockrell: Treatment (Constitutional and Local in all its forms). (Chesterfield Lecture.)

FRIDAY, FEBRUARY 23rd.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m. Papers:—Mr. J. Sherrin: Three Cases of Intestinal Obstruction. Mr. H. W. Cannon: Three Cases of Appendicitis due to Transposition of Viscera. Mr. J. D. Malcolm: A Case of Appendix Abscess with Fevere Hemorrhage.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m. Prof. H. J. Paterson: Some of the Results of Gastric Surgery. (Lecture III.)

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

Vacancies.

Bristol Royal Infirmary.—House Physician. Salary £100 a year, with apartments, board, and laundry. Applications to W. E. Budgett, Secretary and House Governor.

City of Winchester.—Medical Officer of Health. Salary £300 per annum. Applications to Thomas Holt, Town Clerk, Guildhall, Winchester.

Devon County Asylum.—Third Assistant Medical Officer. Salary £125 per annum, with board, residence, and laundry. Applications to Medical Superintendent, Exminster, Devon.

Leeds Public Dispensary.—Junior Resident Medical Officer. Salary £100 per annum, with board and lodging. Applications to the Secretary of the Faculty, Public Dispensary, North Street, Leeds.

Leicester Infirmary.—House Surgeon. Salary £100 per annum, with board, apartments, and washing. Applications to Harry Johnson, House Governor and Secretary.

Manchester Port Sanitary Authority.—Medical Officer of Health. Salary £350 per annum. Applications to Arthur Holmes, Clerk, Bexley Square, Salford.

Royal Cornwall Infirmary, Truro.—House Surgeon. Salary £100 a year, with board and apartments. Applications at J. C. R. Crewes, 4 Parkvedras Terrace, Truro.

Torbay Hospital, Torquay.—House Surgeon. Salary £100 per annum, with residence, board, and washing. Applications to H. J. Paake, Secretary.

Trick County Lunatic Asylum.—Assistant Medical Officer. Salary £130 per annum, with board, apartments, and laundry. Applications to Dr. Miller, Hatton, Warwick.

Appointments.

BRODIE, DESBOROUGH, M.B., B.S. Lond., L.R.C.P. Lond., M.R.C.S.—Surgeon to the Tebury (Gloucestershire) Cottage Hospital.

BROWN, W. LANGDON, M.D. Cantab., M.R.C.P., Medical Registrar and Demonstrator of Morbid Anatomy to St. Bartholomew's Hospital.

CARWARDINE, T., M.S., M.B. Lond., F.R.C.S., Honorary Surgeon to the Bristol Royal Infirmary.

GEDGE, ARTHUR BYDNEY, M.R.C.S., L.R.C.P. Lond., Medical Officer for the Fifth District by the Devises Board of Guardians.

LITTLEJOHN, H. H., M.B., F.R.C.S. Edin., Professor of Forensic Medicine in the University of Edinburgh.

MAGGILLVRAJ, W. J. HOOKER, L.R.C.P., L.R.C.S., L.M. Edin., L.F.P.S. Glasg., Medical Referee to the General Life Assurance Co. for Districts of Rushmore and Fallowfield, Manchester.

MELLISH, JOHN STAFFORD, L.R.O.P. Lond., M.R.C.S., Surgeon to the Tebury (Gloucestershire) Cottage Hospital.

SCOTT, T. GRAHAM, M.R.C.S., L.R.C.P. Lond., Anaesthetist to the Dreadnought Hospital on Mondays.

Births.

CHAMBERS.—On Feb. 14th, at 27 Cheriton Gardens, Folkestone, the wife of W. F. Chambers, M.R.C.S., L.R.C.P. Lond., of a daughter

Marriages.

JESSETT—DOUGALL.—On Feb. 15th, at St. James's Church, Paddington, F. B. Jessett, son of Fred. Bowreman Jessett, F.R.C.S., President of the British Gynaecological Society, to Alice, daughter of the late Andrew Dougall, of 6 Queen's Gardens, London, W.

SMITH—ROSS.—At Lucknow, India, on Feb. 14th, Major A. G. Baird Smith, Royal Scots Fusiliers, to Mary Hamilton, eldest daughter of the late Surg.-Major J. Halyburton Ross, 39th Regiment, and Mrs. H. Ross, Southsea.

Deaths.

CLARK.—On Feb. 13th, at Dorking, Wm. Falconer Clark, M.R.C.S. L.S.A., late Medical Staff Indian Army, aged 75 years.

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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No. 9.

NOTES AND COMMENTS.

The Need for a Medical Assessor in Legal Cases.

WE have for many years advocated, as our readers know, the urgent necessity for the establishment of a medical assessor who will sit with the judge in cases in which medical questions are involved, as a naval assessor does in Admiralty cases. In April, 1901, the Royal College of Surgeons in Ireland passed a resolution calling attention to the need for this reform. The resolution was sent to the judges of the High Court in Ireland, and by them politely read and forgotten. In June, 1904, the Belfast Division of the British Medical Association discussed the matter, and expressed a unanimous opinion that the present system was a scandal, but no definite action was taken. We recall these facts because within the past week an Irish judge, Mr. Justice Ross, sitting in the Land Court, has, on his own account, called attention to the view which he has for some time held, that there should be a medical assessor in cases involving a difference in the opinions of medical witnesses. As matters stand at present, medical men are examined, cross examined, and paid as *ex parte* witnesses, and are then reproached for being so by the very men who have forced them into this invidious position. Should the Royal Colleges decide to take up again the reform of medical evidence, they would obtain valuable support from Mr. Justice Ross' statements in Court, and would we believe, be supported by the large body of medical opinion.

Infantile Mortality.

OF all the war-cries raised by public health enthusiasts, that of the infantile mortality is the most pathetic, as it is one of the most important. From various more or less philosophical standpoints the declining birth-rate dwindles into insignificance by the side of the swelling tide of the infantile death-rate. There are many curious facts connected with this absolutely unnecessary drain upon the life-blood of the nation. One would imagine, for instance, that more children would survive the first twelve months of existence if born in the highlands of Scotland rather than in the slums of Edinburgh and Glasgow. As a matter of fact, the chances are about equal. Dr. Baily, the Medical Officer of Health for Oban, pointed out in a recent lecture that whereas the child mortality of a town of that size should be about 45 per 1,000, the actual rate was 117—higher than Edinburgh and Perth and almost as high as Dundee. The lowest rate

he had to record was 37 in 1893, and the highest 119 in 1903. The rate for Argyllshire was 41 when that of Oban reached 112. Nearly all the babies were born healthy.

What Kills Them?

HERE, then, is a part of the country famous for native purity and wholesomeness, yet it is the precise spot to be distinguished by an appalling infantile death-rate. What kills these babes and sucklings? Dr. Baily is careful to inform us that the parents are healthy, and the children healthily born. The causes must be sought, therefore, in defects of environment. According to the medical officer of Oban, these unfortunates are simply not allowed to live owing mainly to carelessness, improper feeding and dirt—while underlying all is the terrible curse of alcohol. The picture thus presented may well give pause to the twentieth-century philanthropist. There is no need for him to send out missionaries to convert far-off nations while here at hand human beings are being sacrificed in hecatombs at the shrine of ignorance. The housing conditions of the poor Highlander are a disgrace to our modern civilisation. Government can, at any rate, put an end to that source of danger. Meanwhile happy the infant who is born away from the Scotch Highlands!

Oysters and Municipal Responsibility.

THE easy assumption of local authorities that they are free to poison the public at their own sweet will has of late years received sundry rude awakenings. The Lincoln sanitary authorities, for instance, have been forced to pay heavy damages to sufferers from enteric fever due to their polluted water supply. Now the proprietor of an oyster-bed has obtained an injunction and £1,500 damages against the Southend Corporation. The finding of the Court was, in point of fact, that the body in question had no common or statutory right to pollute the Thames estuary with sewage. This decision, if upheld on appeal, will materially strengthen the hands of sanitary reformers. It may be remarked, by the way, that if the Southend Corporation be answerable to the owner of the oyster-bed they must be logically responsible to any person infected by enteric fever from Southend oysters. Lastly, if it be wrong to pollute the estuary of the Thames, it must be far more culpable to contaminate the main stream, especially in its upper reaches

whence it is taken to supply Londoners with their drinking-water.

First Steps of the Toddler.

COMPLICATED as the problem of excessive infantile mortality may be, there are, nevertheless, obvious remedies that could be applied forthwith by any well-governed community. For instance there is the municipal *creche*, or day nursery for the tending of infants whose mothers are working away from home through the day. The good effected by this simple means is incalculable, and the organisation may be made partially self-supporting. Another great weapon at hand is the provision of pure milk by a municipal milk supply. The feasibility of such a system has been proved in many towns both at home and abroad. It means the substitution, at a cheap rate, of pure good milk in place of an adulterated and often contaminated unwholesome article. To secure a plentiful supply of pure milk for municipal babes is to strike at the root of things, and to lay the foundation of sound bone, brain and muscle for the next generation. Yet there is only one municipal milk supply in London!

Medical Inspection of School Children.

At a later age children are exposed to a thousand and one additional perils when they go to school. It needs less than Socratic wisdom to foretell that the aggregation of large numbers of children from the homes of the poorer classes will tend to foster and spread communicable diseases. That it has done so, notably in the case of diphtheria, is well known. That it maintains to a great extent the abnormally high rate of whooping-cough, measles and scarlet fever also seems more than likely. Yet it is only within the past few years that an attempt here and there has been made to secure the systematic inspection of board-school children. In London a specially-skilled and qualified inspector has been appointed in the person of Dr. Kerr. His field of work is wide and complicated. London school children, for instance, are riddled with ringworm. How many years will it take to rid our elementary schools of that gross infection?

LEADING ARTICLE.

THE TRIBUNE AND ITS ADVERTISEMENTS.

LAST week, shortly before going to press, we received a letter from Mr. Sparkhall, advertisement manager of *The Tribune*, disputing certain contentions contained in an article published in the MEDICAL PRESS AND CIRCULAR of February 14th. Mr. Sparkhall expressed the hope that in fairness we would publish his letter, and we may say at once that we were very glad to do so, both as affording our readers an opportunity of judging the question at issue after hearing both sides, and also as giving us the opportunity of illustrating certain great principles from a particular incident. We would like to preface our remarks by asserting that we have nothing but admiration for *The Tribune* as a newspaper; it seems to

us, as indeed we said in our original article, that *The Tribune*, by its general tone of responsibility and its absence of sensationalism, marks a healthy reaction from the "Americanisation" of journalism that has made such rapid strides of late years as to infect the whole, or nearly the whole, of the daily press. Politics apart, all thinking people will be prepared to admit that *The Tribune* is a welcome addition to breakfast-table literature. But by whom much is claimed, from him will be much required; and *The Tribune* makes a particular and special claim to the support of right-minded people, namely, that it exercises a strict supervision over its advertisement columns, and endeavours to prevent the insertion of any advertisement which is fraudulent, or offensive, or which does not accurately describe the article sold. As Mr. Sparkhall puts it in his letter, "The aim of the proprietor of *The Tribune* is to produce a daily paper which shall be at once wholesome, accurate, and above suspicion—the moral tone of the paper being gauged by the character of the advertisements as much as by the character of the news it carries." This is a high and noble aim, and we hope we have not so far lost faith in our fellow-creatures as to doubt the possibility of such a journal being carried on as a successful enterprise; but, undoubtedly, the signs of the times are not wholly comforting in this respect. If *The Tribune* is able to live up to this ideal, and to flourish in maintaining it, a valuable example will be established for its rivals and contemporaries. But is this ideal compatible with the insertion of high-flown advertisements of those goods which Mr. Sparkhall calls "proprietary articles," or which we should designate "quack medicines"? The particular article which we referred to in our original remarks we know nothing of scientifically or practically; and, indeed, it is better from the point of view of arguing the general question that we should not. We had never heard of it before, nor have we come across any reference to it since, but we would simply take the claims made by that article as an example of those put forward by its class. The question is really bipartite, Is it good (or moral) to advertise quack medicines? and, Are statements of the class quoted accurate descriptions of the article sold? Now, in answering the first, we want no better coadjutor than Mr. Sparkhall, for he says in his letter, "human nature being what it is . . . one is apt to give the proprietary article a chance in other similar cases." It is a quite a fair paraphrase of these words to say, "human nature being weak and credulous, and its possessors not being able to distinguish between the malady of A and the malady of B, men are apt to give to B the article that seemed to do A good, when he seemed to be suffering from similar symptoms, if that article be sufficiently held up to their admiration." That position we traverse. We say that the function of a moral journal should be not to take advantage of the weakness of human nature to obfuscate or confuse, but to lay itself out to show the better way and the true reasoning. Let us now come to the

definite statement quoted. We will only take one. "Whether the complaint (*i.e.*, rheumatism and gout) is in its early or advanced stage, the result is always the same, because XY completely eradicates the cause." Is it possible to predicate this absolutely of any known disease, from chilblains to cancer, or of any known remedy, from bicarbonate of soda to the Röntgen rays? It is flattering to speak of it even as an hyperbole. One remark made by Mr. Sparkhall shows an attitude of mind which is a common, and, we think, a mistaken, one. He says: "Naturally, the medical press would wish to prohibit the sale of all proprietary articles without distinction as to merit." Now, in writing that sentence, we should say "unnaturally." The medical profession, which is served by the medical press, are frequently gainers financially by the habit people fall into of having recourse to quack medicines, for disease is dallied with and allowed to run on while "proprietary articles" are given a "chance," and in the result chronic ill-health with prolonged medical attendance is incurred. But seeing the misery and incapacity thus caused so frequently, the medical profession and medical papers feel it their duty, against the gain to the pocket, loudly and frequently to protest against quackery in all its forms. We trust that this view of the case will appeal also to the proprietor and manager of *The Tribune*, and that they will succeed where most of their contemporaries have failed in meeting the high responsibility that rests on those who cater for the public's instruction.

A REVOLUTION IN THERAPEUTICS.

THERE was a delicate element of humour, not, we think, altogether lost on the chief person concerned, in the compliment recently paid to Professor Almroth Wright by the Royal College of Surgeons in Ireland. The function of a college of surgeons is, we suppose, the improvement of the art of surgery, and the upholding of the interests of the practisers of the art. If, however, Dr. Wright's recent discoveries are as far-reaching as he and others believe, then much of the necessity for the very existence of the art of surgery will disappear. If the advance party be on the right track, then the operating theatre is to give place to the laboratory, and the surgeon's knife to the vaccinator's syringe. The course of advance in serum therapeutics has, indeed, been so remarkable since the first crude attempts in organotherapy, that all that was necessary to increase their scope to the widest seems to have been supplied when Dr. Wright introduced his method for the estimation of opsonins. This term, which is a puzzle to many, is the name by which he designates those protective bodies produced in the serum of an animal inoculated with an infective organism which have the power of preparing the invading organism for phagocytosis. Where the protective reaction of the animal is good the opsonic index is high, and where it is poor the opsonic index is low. The determination of the opsonic index, though

resting on principles of the utmost simplicity, is a matter of somewhat fine technique. It is, in fact, the performance of an artificial phagocytosis under conditions open to observation. The practical utility of the possibility of determining the opsonic index of any serum is the power that we thereby gain of controlling the dosage of vaccines. According to Dr. Wright, one relative failure in the past in the use of such vaccines as tuberculin has been due not to any fault in the principle of the method, but to our inability to graduate our dose to the condition of the patient. As an overdose is likely not merely to fail to produce protective bodies, but actually to lessen their production, this is a matter of great importance. By the estimation of the opsonic index, we are able to time our injections so as to maintain a constant production of protective bodies. Dr. Wright and many of his disciples have applied this method of vaccination, guided by opsonic observations, with the greatest success in the treatment of local infections due to a great variety of infective organisms. The most notable instances are localised tubercle and staphylococcal infections, such as boils and acne. Detailed instances of the treatment of many such conditions were given by Dr. Wright in his lecture before the Royal College of Surgeons in Ireland. There seems little doubt that the method not merely has a great future before it, but that it actually opens up a new era in therapeutics. Though not likely just at once to interfere with the usual surgical measures for the treatment of local infections it should in all cases be used along with them, and in time it may come to displace them. While it is perhaps idle to speculate on the lengths to which Dr. Wright's discoveries may ultimately lead, it would be folly to overlook their importance or to allow any criticism of points of detail—and many points are open to criticism—to interfere with the granting of a thorough trial to his methods.

NOTES ON CURRENT TOPICS.

Doctors' Fees in Compensation Cases.

ONE item in the sumptuous bill of fare which the Government have prepared for the delectation of Parliament this Session is an Act to amend the Workmen's Compensation Acts. Notice of the introduction of this Bill has already been given. The subject of the right of workmen to compensation for accidents and the duty of employers to provide such compensation is a large one, but the principle being now admitted in all civilised countries the real difficulty comes in in drawing the exact line of demarcation. We may say that from our point of view it should be very rigidly drawn in a certain direction, namely, that which inclines towards doctors' fees. It goes without saying that when an accident occurs a medical practitioner is summoned, and as the case is always one of emergency he does not trouble to inquire as to who is incurring the liability for

his services. More often than not the summons comes from some casual witness of the accident who happens to have the longest legs or the stoutest "wind." At any rate, the doctor's time and skill are laid under requisition, often at great inconvenience to himself, and frequently he is unable to recover any payment for his services. A Government that recognises the liability of employers to provide compensation to their workmen cannot consistently neglect the accompanying liability for medical attendance. In France this liability falls on the employer, and in the new Act for this country it should be recognised as a definite charge on the employer or as a deduction from the sum payable to the workman. We trust the medical members of Parliament will strongly press this point when the Bill is under discussion.

Chemists' Shops and Limited Liability Companies.

ON the day of our present issue the famous Bill to restrict the poly-pharmacies of large firms will be presented to Parliament. Its aim is to restrict that form of trading so that each shop shall have a single responsible owner. It is promoted by the Pharmaceutical Society, and amongst its clauses are those that seek to impose registration upon chemists' shops and the limitation of dispensing to qualified persons. In all these points the Society will gain the hearty approval of the medical profession. The somewhat similarly-based proposal to restrict the practice of dentistry by companies, which is being advanced by the British Dental Association, may possibly form part of the forthcoming Medical Acts Amendment Bill. Obviously it is little use protecting the public against unqualified practitioners if the law can be evaded by organised trading ventures.

A Sanitary Authority.

IN view of the facts that came to light during the hearing of the case *Hobart v. the Mayor and Corporation of Southend*, in the Chancery Division of the High Court last week, we shall have to revise our ideas of what constitutes a sanitary authority. The plaintiff was a fish salesman in London, and he sought an injunction against the defendants restraining them from discharging crude sewage so as to cause a nuisance to him, and from permitting the discharge of sewage so as to cause water to flow over his land and to contaminate his oyster-beds. He also claimed damages for loss in his business resulting from the defendants' acts. After a protracted hearing, the judge found for the plaintiff and granted him an injunction and £1,500 damages. In the course of the case it came out that the plaintiff leased certain oyster-beds at Hadleigh Bay, near Southend, and the defendants discharged crude sewage into the estuary of the Thames, so that from the outfalls to Hadleigh Bay there was solid sewage and sewage scum, which, in the judge's opinion,

polluted the plaintiff's oyster-beds. The judge held that the defendants had no legal right to commit this nuisance and were, moreover, forbidden by a specific by-law under the Act for the protection of the fishery in the Thames from acting as they were doing. The plaintiff had suffered loss in his business, and the judge hinted that he would have given larger damages had it not been that the oyster-trade had suffered generally in consequence of the Winchester "scare." The danger of eating oysters contaminated by sewage has been clearly established, and none have taken a more active part in directing attention to this danger than the medical profession; it is, then, but bare justice to the oyster dealer to record how he is handicapped by those charged with the local administration of the public health Acts.

Christian Scientists' Privileges.

A GENERALLY-CONCEDED right, perhaps the only "right" which the State accords to a doctor, is that exempting medical men from jury-service. The same holds in New York, and it is amusing to note that a Christian Science healer in that State lately regarded himself so seriously as to neglect a summons to serve as a juror. The judge did not recognise the self-arrogated privilege, and the gentleman in question had to pay out a hundred-dollar fine. It is from facts like these that we gather hope that the righteous men in that Sodom of quackery—the United States—will eventually prove sufficient to save their country from the wholesale bamboozlement which at times seems to threaten to engulf the intellect of all its classes. Moreover, the *New York Times*, in commenting on the incident, goes so far as to say that it is inconsistent with common-sense to allow such a person as a Christian Scientist to serve on a jury at all, for a man who denies the value of all evidence is hardly likely to form an efficient adjudicator in a case resting entirely on evidence. We should not care to be parties to a law-suit tried before a jury containing even one Christian Scientist, and probably most of our fellow creatures would agree. If then, it be proposed that the followers of what our contemporary, the *Medical Record*, calls the "Eddyotic" creed claim exemption from serving on a jury, it would seem only in accordance with common humanity not to press them to take part in the proceedings.

French Brandy.

THE quantity of fraud that surrounds the sale of brandy has led to the formation of an association of the great brandy firms of the Cognac district, and from the report presented at the annual meeting last month, it appears to be in a flourishing condition. Forty firms have joined the Association, and a balance of over 50,000 francs to the good was shown as the result of last year's work. The fund is to be employed in the protection of the mark "Cognac" as a guarantee in all countries that the article so described is genuine brandy from that favoured district. From the medical point of view we welcome this

activity in their own interests on the part of the Cognac firms, as it coincides not only with the interests of the public, but in a special degree with the interests of patients for whom brandy is prescribed medicinally. With the commercial object of pushing the sale and popularity of brandy we have no concern, except as part of the general temperance question, which is one that appeals with great force to all modern hygienists. It is admitted that the English demand for brandy has fallen off of late years, but this is probably due to the increased popularity of whisky and not to any particular wave of temperance passing over these islands. It is, however, important to recognise that good and pure spirit is a *desideratum* from the point of view of the moral welfare of a people, and though medical men might wish to see brandy and whisky drunk far less than they are at present they would, certainly prefer to see sound articles consumed than the fiery and ardent poisons that are often foisted on to the unskilled and impecunious buyer.

The North Pole for Consumptives.

ONE would not be wrong in saying that surely no other disease has had so many different treatments recommended for it as consumption. From the vault of the heavens to the bowels of the earth every corner seems to have been ransacked to furnish some therapeutical contribution to lay on its insatiable shrine, and still the ingenuity of man manages to devise some surprise or novelty each week. There really seems a good deal to be said, however, for the advantages presented by the Arctic climate—in summer—for the treatment of early consumptives. To the *Journal of the American Medical Association* for February 3rd, Dr. F. Sohon has contributed a paper, accompanied by charts and photographs, advocating the northern regions for tuberculosis and some other chronic affections. The points that tell most in its favour are the complete absence of dust and other irritating particles, the sterility of the atmosphere, the prolonged sunshine, with its high actinic quality, and the stimulating effect on nutrition of the cool, dry climate. The proposal is one that does credit to the imagination of its originator, and, granted its practical feasibility under favourable conditions of travel and housing, early consumptives might certainly do worse than spend a few months in the higher latitudes. So far as we know, too, there are no Esquimaux Quarantine Boards with restrictive regulations.

PERSONAL.

THE proposed shooting expedition of the Prince of Wales in Nepal has been abandoned owing to the outbreak of cholera in a camp there.

THE first of the Dr. James Watson lectures under the auspices of the Glasgow Faculty of Physicians and Surgeons was delivered in the Faculty Hall on the afternoon of February 19th, by Sir Hector Clare Cameron, M.D. The subject of the lecture was "The Evolution of Wound Treatment during the last Forty Years," and Dr. W. L. Reid presided.

THE 149th annual general meeting of the Royal Maternity Charity of London, which was founded in 1757, was held at the Mansion House on the 20th inst., under the presidency of the Lord Mayor, who was accompanied by the Lady Mayoress.

Mr. J. TWEEDY, President of the Royal College of Surgeons of London, together with Dr. MacGillivray, President of the Edinburgh Royal College of Surgeons, were the principal guests at the annual dinner of the Association of Scotch Diplomates, held on the 23rd instant at the Trocadero, London.

WE regret to hear the report that Mr. Martin F. Ellis, M.A. Cantab., L.R.C.S. and P. Edin., has been severely wounded in the recent disastrous native attack upon a British force in Sokoto.

THE Duke of Abercorn, Chairman of the West London Hospital, will hold a reception at the *Conversazione* to be held in connection with the Post-Graduate School on March 14th next.

DEPUTY-INSPECTOR-GENERAL OF HOSPITALS AND FLEETS HENRY THOMPSON has been appointed Inspector-General of Hospitals and Fleets.

THE Honorary Fellowship of the Royal College of Surgeons of Ireland has been conferred upon Surgeon-General Keogh, C.B., Director-General of the Army Medical Service, and upon Professor A. E. Wright.

MR. OSKAR GRUNER, M.B. Lond., has been elected to the post of Clinical Pathologist in the Leeds University.

AT the annual dinner of the past and present students of the University of Durham College of Medicine, Dr. G. H. Hume was presented with a handsome testimonial on the occasion of his retiring on an age limit from the Royal Infirmary, with which he has been officially connected for a period of thirty-seven years.

SIR THORNLEY STOKER, President of the Royal Academy of Medicine in Ireland, recently presented an address on behalf of that body to the Lord Lieutenant of Ireland.

ON the 20th inst., Mr. Henry Morris was entertained at dinner at the Imperial Restaurant, London, by former house surgeons and dressers, on the occasion of his retiring from the active staff of Middlesex Hospital.

THE Gibson Scholarship in Pathology of the Society of Apothecaries, London, has been awarded to E. W. Ainley Walker, M.A., M.D., B.Ch. Oxon.

SIR WM. J. COLLINS, M.D., M.P., has been placed by the Treasury on the new permanent Advisory Committee on Education.

MR. K. S. WISE, M.R.C.S., of the London School of Tropical Medicine has proceeded to British Guiana to fill the new Government appointment of Bacteriologist to the Public Hospital, Georgetown. Mr. La Frenais, L.R.C.P. Edin., has been appointed a Government medical officer of the same Colony.

THE jubilee of the discovery by Dr. William Henry Perkin of the dye-stuff "mauve" by which the foundation was laid of the coal-tar colour industry, occurs this year. A public meeting was held at the Mansion House on Monday last, when the Lord Mayor proposed to open a subscription list for (1) presenting to Dr. Perkin for his lifetime an oil portrait of himself, to become the property of the nation at his death; (2) placing a marble bust of him in the rooms of the Chemical Society; (3) establishing a "Perkin Research Fund," for the promotion of chemical research, to be administered through the Chemical Society.

A CLINICAL LECTURE

ON

A CASE OF SECRETORY NEUROSIS OF THE STOMACH.

By WILLIAM J. DARGAN, M.D.,

Physician to St. Vincent's Hospital, Dublin.

THE condition we are to consider this morning is, I think, an unusual one, still, the patient's history as detailed by himself, and verified by the doctor who attended him before his admission, together with the observations made during his stay in hospital, should enable us to arrive at, at least, a probable conclusion. The patient, J. P., was admitted to St. Vincent's Hospital, October, 1905. He is a postman from co. Waterford, æt. 37, married, with two children. Up to the time of his present illness he seems to have been singularly healthy. He was exposed to severe wettings in the course of his occupation, but never was incapacitated from his duties even for a day. He has been a man of temperate habits both in eating and drinking, and never was addicted to alcohol. His dietary has always consisted of plain food, the only indiscretion being some indulgence in tea, but even this beverage never was taken in great excess. He never suffered from constipation or dyspeptic trouble. In July, 1904, he first complained of feeling unwell. He suffered then from diarrhoea, for which he could assign no dietetic error. The attack, after lasting for four weeks in a varying degree, passed away without seeming to materially affect his general health. From July on to Christmas, 1904, he continued pretty well, but complained at times of the bowels being somewhat constipated, and suffered from flatulency. On Christmas morning, without having eaten or drunk anything unusual, a very severe attack of vomiting set in. The vomiting was almost continuous, and very large quantities of fluid were ejected. The first day he states upwards of three quarts were brought up, and on subsequent days fully a quart was vomited, in fact, he says he "could not tell where it was all coming from." This condition lasted for ten days. At first the vomit consisted of food contents, later it was greenish, and towards the end of the attack was quite a clear fluid. Great nausea preceded and accompanied the vomiting. He experienced a sense of extreme exhaustion, being unable to stir from the recumbent position, and suffered from severe pains in the abdomen. He also complained of severe headache during the attack and great thirst. The ejection of stomach contents did not seem to give him relief to any extent, and any attempt to take fluids aggravated his condition. The retching would not cease for more than three or four hours at a time, and he would wake from sleep to suffer a renewed paroxysm. He attempted to take nothing but milk and water, but this was returned in thick curds. Throughout the attack he was constipated. At the end of the ten days he appeared to recover quite rapidly—could take food, and was able to resume his occupation. After three weeks of what he states was quite his normal state of health, he suffered from a recurrence of the symptoms, which again came on suddenly, lasted for about the same time, and as abruptly ceased. From that time up to the date of his admission to hospital, every month, with almost clock-work regularity, he suffered from like seizures, which lasted for about ten days, appearing and disappearing with the same abruptness. Since he first suffered from the attacks he has lost over two stone in weight, but in the intervals would pick up as much as three pounds. Between the attacks he felt quite well, was able to carry on his occupation, and could take all kinds of food. The onset of the attacks was quite independent of the kind of food taken. Before the spells of vomiting he sometimes experienced a splashing in the abdomen. During his

later attacks the fluid brought up was clearer than it used to be at first, in fact, as he says, often "like water." The vomited matter was never frothy. In the intervals he never suffered from headache.

Such is the history as given by the patient, and, as I said, verified by the local doctor. I will now tell you what observations were made since his admission to hospital. When he first came under my care he had just recovered from an attack, so that for some time we were unable to observe the phenomena of the seizure. His general condition did not present anything unusual, and did not differ from that in which you see him this morning. He is, as you see, a man of somewhat spare physique, but quite wiry, with well-developed muscles, and shows no appearance of cachexia. The heart and lungs are quite healthy. The urine is normal. The tongue is not furred, and the teeth in pretty good preservation. The liver dulness does not differ from the normal, and there is no distension of the abdomen. Palpation of the abdomen elicited a slight splash in the region of the stomach, and inflation through the stomach tube showed that the stomach extended slightly below the umbilicus. The splash is still sometimes present, but not so marked as before, and, as you see, inflation shows increase in the dimensions of the stomach. There is no tenderness or tumour to be made out in the abdomen. The knee-jerks are normal, and the eyes reveal no abnormality. Physical examination then shows us only that there is moderate dilatation of the stomach. Information was next sought from examination of the gastric contents. Since his admission he has had several test meals. The meal used was Ewald's, that is, a couple of slices of stale bread with a large cup of weak tea, without milk or sugar. This was given at 8 a.m. and removed by the stomach tube in about three-quarters of an hour. The contents were invariably found to be hyperacid. The indicator used for the total acidity was phenolphthalein, and for the free HCl, dimethyl amido-azobenzole, and Gunzburg's reagent, the titration being made with decinormal sodium hydrate solution. The acidity was almost entirely due to the hydrochloric acid both in the free and combined state. The organic acids were never present. The average percentage of total acidity was about '24 per cent. HCl., and the percentage of free HCl about '14 per cent. These figures, of course, only refer to the examinations made when the patient was in a comparatively healthy state between the attacks, but still the percentage of HCl is greater than we usually meet with in health. The patient was then put on a dietary containing a relatively large amount of proteid, such as lightly done meat, eggs, &c., given in small quantities at a time. He was given medicinally gr. $\frac{1}{4}$ nitrate of silver in water thrice daily. For over a month he continued well and put on weight; in fact, so well did he feel that he believed he was over all his troubles, and was anxious to return home, when suddenly he developed one of his old attacks. This began with uneasy sensations in the stomach, nausea, and some splashing was felt on movement. Then severe vomiting set in with pains throughout the abdomen, not localised to any distinct area, headache, and intense prostration. The temperature was not raised, and the pulse was about 100. A large quantity of fluid was brought up—fully a couple of quarts in a short time. This contained food contents, which on subsiding, left a clear supernatant fluid. The vomited matter gave a

strong HCl reaction, and was reserved for analysis, but unfortunately was removed accidentally before a titration was made. Milk was returned in thick curds. The stomach was washed out with plain water, but only slight relief was experienced. He was then washed out with a bicarbonate of soda solution which gave him instant relief. The nausea and vomiting began to subside, and after three or four washings with the alkaline solution the stomach was settled. The attack, instead of persisting for ten days, was ended in less than two, though for another two or three days he did not feel quite himself. He has remained free from the attacks since, under the following treatment:—He takes the ordinary hospital dietary, with rather more proteid than usual. Every third day the stomach is washed out and sprayed with a dilute solution of silver nitrate. He experiences no uncomfortable distension, the appetite is good, he is not constipated, and never feels any splashing. Examination of the gastric contents still, however, shows a hyperacidity—the HCl percentage averaging about the amount stated in the previous investigations.

Let us now consider the nature of his affection. The presumptive evidence goes to show that this man suffered from an affection of his stomach, for we can exclude such reflex causes of vomiting as disease or irritation of the other abdominal organs. His kidneys are apparently healthy; there is nothing to suggest renal calculus. The symptoms or physical signs do not point to gall-bladder, intestinal, or pancreatic trouble. He had no temperature or symptoms suggesting a toxæmia. Further, we may eliminate cerebral causes, such as brain tumour, as shown by the absence of headaches and the normal condition of his discs. He has no sensory or motor symptoms pointing to a cord affection, and his knee-jerks and pupil reflexes are normal, so we can rule out such conditions as the gastric crises of locomotor ataxy. His heart, lungs and liver are unaffected, consequently circulatory disturbance cannot explain his condition. Next, we may ask ourselves, could his condition be accounted for by a pathologico-anatomical lesion of the stomach? Here we have a difficulty in making his symptoms fit in with those attributable to a distinct lesion. Gastric catarrh could not explain the marked periodicity of the attack with the intervals of complete well-being. The question of ulcer or cancer can hardly be entertained in the absence of local tenderness and tumour, and the complete absence of pain and distress in the intervals. You saw that there was some dilatation of the stomach. Now we recognise that the causes of dilatation of the stomach are divided into the obstructive and non-obstructive. By the obstructive causes we mean those conditions where a mechanical obstruction is interposed to the passage of the stomach contents through the pylorus. This might be a constriction of the pylorus due to hypertrophic stenosis, a tumour at the pylorus usually cancer cicatrix of a former ulcer, constriction by bands or adhesions, the dragging of a displaced right kidney. Such causes would, however, be in constant action, and could not explain the periodicity of the attacks, and also, having regard to the fact that palpable physical signs are absent, may be disregarded. The non-obstructive causes of dilatation are those that interfere with the propulsive power of the stomach by producing weakness of its muscular coat, or such conditions as would cause over-distension of the viscus. Weakness of the muscular coat might result in the later stages of gastric catarrh and follow fevers or general debilitating conditions, such as anæmia or neurasthenia. Over-distension leading to permanent dilatation might occur from excessive fermentation in dyspeptic states, the taking into the stomach of unduly large quantities of food or drink, or, possibly, by the pouring out of an excessive amount of gastric secretion. Now, in the present instance there is no history of any condition that would produce muscular atony, and the patient's symptoms are not those that we should expect in an atonic stomach; in fact, the motor power seems to be

in no way impaired. There is no weight or fullness after meals, he is not troubled with flatulence or headache, and, moreover, the gastric functions seem to be quite normal in the intervals between the attacks. Again, we have no history of large quantities of food or drink at any time being taken, so that it is difficult to assign dietetic excesses as the cause of the dilatation.

We know that the stomach is supplied by three sets of nerve fibres—the motor, the sensory, and the secretory, and we know also that affections of either of these sets of fibres give rise to well-defined stomach symptoms. Now, either of these sets of fibres may be involved so as to affect their corresponding functions, whilst the nature of the irritation, though sometimes due to lesions of the brain or cord, may often be quite a mystery to us. We speak of such affections of the nerves producing deviations from the normal process of gastric digestion not based on pathologico-anatomical changes, as neuroses of the stomach. Thus we speak of the motor, sensory and secretory neuroses. The motor neuroses result from involvement of the motor nerves of the stomach, in which condition irregular impulses stimulate the muscular fibres. In this group we may have sudden spasms of the pylorus or cardia, the condition known as rumination, nervous vomiting, or the affection known as peristaltic unrest, when the contractions of the stomach are very constant and the food contents are often hurried through the pylorus with undue rapidity. Affections of the sensory nerves may give rise to neuralgic pain, which we call gastralgia, abnormal sensations of appetite, or an irritable hyperæsthetic condition of the mucosa. When the secretory nerves are involved the total secretion of the gastric juice may be greatly increased or lessened, and we speak of hypersecretion and achylia gastrica. Again, the constituents of the gastric juice may be secreted in relatively abnormal amounts. When the free HCl is in excess the condition is called hyperchlorhydria; when greatly reduced or absent, hypochlorhydria, or anachlorhydria. Let us now suppose that the secretion of gastric juice in the case before us through the action of the secretory nerves varied from time to time, that before the attacks and during, a very large quantity of a hyperacid juice was poured out, and I think we should be in a position to explain the patient's symptoms. The very acid secretion would act as an irritant to the stomach, producing the distress and vomiting, and at the same time the large quantity of fluid poured out would cause over-distension of the stomach cavity. If we regard the case as being one of a secretory neurosis of the stomach, we must suppose that the excessive secretion comes on at periodic intervals, and that between these intervals the stomach secretes in a comparatively normal manner. Now in a functional nervous disturbance it is fair to assume that this periodicity can occur. We have analogous conditions in migraine, and in many cases of neuralgia where the attacks often occur with a marked periodicity and subside in a definite time. Furthermore, in connection with the stomach itself we know that patients often suffer periodic gastric pain or gastralgia, so that there is no reason why the secretory fibres should not be similarly involved. When we refer to the literature of the stomach, moreover, we are borne out in our assumption for we find that such periodic cases of hypersecretion, though rare, do occur, and also that the hyposecretion is accompanied by a marked hyperchlorhydria. Reichman was the first to call attention to the periodic continuous flow of gastric juice, and named the condition gastro-succorrhœa continua periodica. His description corresponds very closely in symptomatology with the case we have under consideration, and the following account of the attack as given by Einhorn is worth quoting.

"In the midst of perfect health a sensation of discomfort is experienced in the gastric region, which is associated with restlessness. Soon afterwards the discomfort changes into a rather painful sensation and nausea appears. The patient is compelled to

occupy a recumbent position. The symptoms increase in severity, and in about an hour or two the nausea ends in vomiting of a large quantity of gastric contents. The patient may now feel a little relieved for a short time, but soon the same symptoms return. The appetite is entirely lost, and instead there is extreme thirst. The more the patient drinks the more, as a rule, he has to vomit. If he abstains from drinking the vomiting is less frequent, but persists nevertheless. Thus, as a rule, in the middle of the night or early in the morning, the patient has to vomit a large quantity of a watery liquid which is very acid in character, and either quite clear or greenish from admixture of bile. If this liquid be examined it will be found that free HCl is present in large quantities, as are the ferments (rennet and pepsin). After such an attack, frequently a constant desire to vomit persists, and the patient suffers from very violent and painful retching. Often a quarter of an hour after the last paroxysms, the patient's efforts to vomit cause a small quantity of clear yellow bile to be ejected. Even if the patient absolutely abstains from all kinds of food and drink, a few hours later a large quantity of gastric juice may again be vomited. The patient in this condition is hardly able to sleep for any length of time, as the pain awakens him soon after he has fallen asleep. The abdomen, as a rule, is sunken. The patient looks extremely pale and his extremities are cold. Severe headaches often accompany this train of symptoms, and constipation is almost a constant concomitant. After this condition has lasted for three or four days or longer, the nauseous feeling disappears, the pains subside and the patient experiences for the first time a desire for food. He is now able to eat without vomiting, and in a day or two feels like himself again. It is characteristic of this affection that the symptoms disappear almost suddenly, and the patient who seemed in a wretched state a few hours before may now appear nearly well. After a period of perfect euphoria varying from weeks to months or a year, or even longer, a similar attack may occur. The attacks may then either recur after the same period of time, or the intermissions of health may become gradually shorter, so that ultimately the patient has hardly recuperated from his last attack before a new one supervenes. The latter condition forms the intermediary stage between periodic and chronic gastric-succorrrhoea. During the free intervals the gastric secretion takes place either in a perfectly normal manner or hyperchlorhydria may exist. In either case, however, the stomach remains free from secretion in its empty state."

I think we are justified in placing our case amongst those described by Reichman as gastro-succorrrhoea periodica.

This case, however, seems to have been one of unusual severity, for not only have the attacks been very frequent, but they have lasted an unusually long time. The duration of the attacks in most cases is about three or four days, and only rarely—as in the present instance—do they persist as long as ten days.

As to the cause that initiated the attacks in the above case, I am quite unable to hazard a suggestion, as also whether they are due to discharges of central origin, or brought about reflexly. In the reported cases mental worry or excitement, or excessive brain-work are suggested as causes, but in the present instance there is no such history.

The prognosis in the condition is on the whole not bad. Cases of complete cure are reported, and, at any rate, the severity of the attacks may be markedly influenced by treatment, and their occurrence rendered less frequent. If neglected the condition would lapse into one of continuous hypersecretion, with permanent dilatation of the stomach and increasing exhaustion. In the present instance, having regard to the unusually severe nature of the attacks, it seems almost too much to hope that permanent cure can have been effected, and probably we may hear of subsequent attacks occurring in this patient.

The treatment of the attack may be carried out on the lines suggested above. Before it comes on, when the patient is beginning to suffer the preliminary nausea, a large dose of bromide is recommended. When vomiting has set in, lavage of the stomach with bicarbonate of soda solution gives relief. Copious draughts of suspensions of calcined magnesias, or sodium bicarb. may also be taken during the attack. In the intervals the patient should avoid irritating articles of dietary, especially alcohol, strong tea, coffee, &c., and should take plain food with some preponderance of proteid when hyperchlorhydria is present. Hemmeter states 30 gr. doses of strontium or ammon. bromide daily has an effect on the frequency of the attacks. He also recommends spraying the stomach with silver nitrate solution (1-1,000) from time to time.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The lecture in next week's will be by Professor Hans Kühn, M.D., of the Allgemeinen Poliklinik, Vienna, on the "Cause and Therapy of Elephantiasis."

ORIGINAL PAPERS.

REMARKS ON GASTRO-ENTEROSTOMY, WITH DESCRIPTION OF A NEW CLAMP.*

By R. CHARLES B. MAUNSELL, M.B. (UNIV. DUB.),
F.R.C.S.I., Member of Council, R.C.S.I.,
Surgeon to Mercer's Hospital, Dublin.

THE operation of gastro-enterostomy has been prominently before the profession during the past ten years. Much has been written, and much spoken on the subject, so much, indeed, that some surgeons think that the last word has been said, at least for the benefit of our patients, and that further words will be more for the benefit of the surgeons. I do not acquiesce in this opinion, but think that there is much yet to be debated upon before this most useful procedure has definitely found a place with well-defined limits.

The literature of the subject being so voluminous, I will not discuss various methods of operation but merely the technique which I use in performing Von Hacher's posterior gastro-enterostomy. Neither will I labour the indications but will state that, in addition to the generally accepted indications, I have found most remarkable benefit follow where I have performed the operation for gastroptosis and gastreectasis, where, although there were no obvious signs of narrowing of the pylorus or of ulceration, yet examination of the gastric contents at various periods after test meals demonstrated the fact that there was distinct motor insufficiency. There can be no two opinions that by far the most immediate and most striking advantage follows in patients operated upon for definite pyloric stenosis; indeed, this fact has been so much impressed upon our American colleagues that many of them advocate closing or narrowing of the pylorus when examination during operation discloses that it is patent.

We must not always look for sensational results, and intelligent treatment after operation will ensure just as lasting benefit in the other conditions which I have named. Before describing the operation, I wish to draw attention to the great help in diagnosis and in determining our method of operative procedure which is gained by auscultation and auscultatory percussion over the abdomen and lower portion of the thorax, both before and after distension of the stomach by gas or air.

In operations upon the stomach the site and form of abdominal incision are of importance. The length of the primary incision must depend upon the size of the operator's hand.

* Read before the Surgical Section of the Royal Academy of Medicine in Ireland, January 12th, 1906.

I am totally opposed to the so-called exploration of the abdomen through an incision which will not admit more than one or two fingers, as I believe that this imperfect examination must lead to many a carcinoma being left *in situ*, as inoperable, when a more thorough search might have stimulated the surgeon to attempt its removal. A patient who will consent to an exploration will not give up his last hope because it is proposed to make a three-inch incision instead of the little hole advocated by some writers upon this subject.

It is fairly generally recognised that the site of the incision for gastro-enterostomy should be to one side of the middle line, the rectus muscle being split or drawn aside. Most operators make the incision through the sheath of the right rectus above the umbilicus, but I think there should be no fixed rule as when gastropexy and gastrectomy are present an incision on the left side, the lower end of which lies below the umbilicus, will give much more direct access to the viscera we wish to expose.

In operations undertaken more for exploratory purposes, or in which there is a doubt as to what operation may be necessary, the ordinary median incision is much simpler and much more easily adapted to the varying requirements of a difficult case.

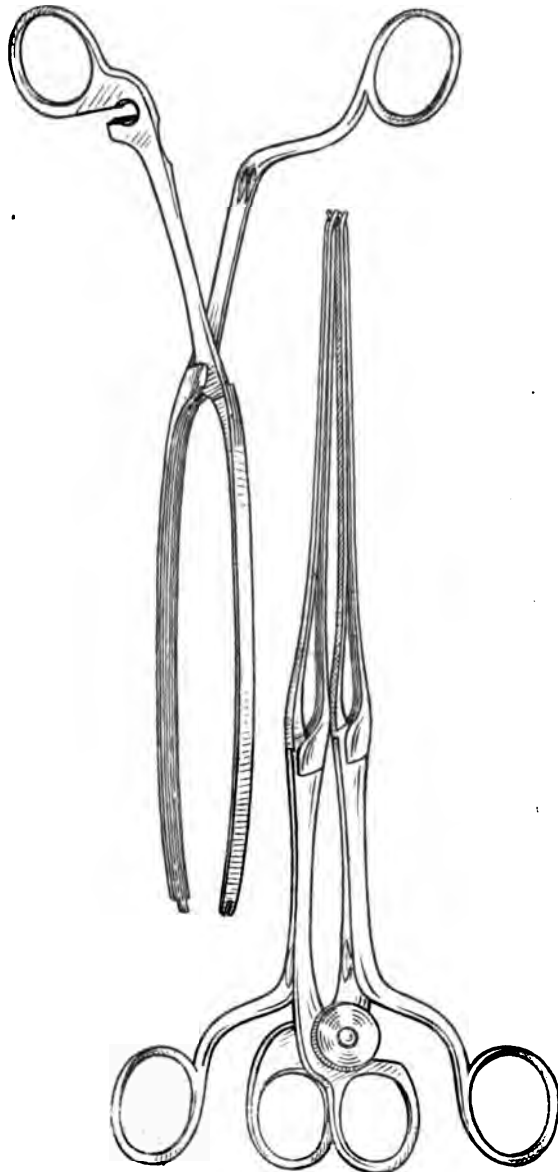
The points of importance in making the junction between the stomach and intestine are (1) The form and position of the incision in the stomach; (2) the form and position of the incision in the jejunum; (3) the method of union; (4) the use of clamps.

The incision in the stomach should be two and a half inches in length, its direction oblique from above downwards and to the right, its position in the pyloric end of the moderately dilated stomach or at the most dependent portion of a flaccid and much dilated viscus. In the jejunum the incision should be of equal length to that in the stomach, longitudinal and opposite the mesenteric attachment; its position will vary in each operation, as it should be at a place which will lie easily in apposition with the stomach without either leaving a loop below the flexure or being dragged upon when the dilated stomach resumes its dependent position. I have frequently heard and read directions given in terms of inches measured from the duodenojejunal flexure and I am convinced that these definite directions account for many a "vicious circle."

The method of union which I adopt is by three separate rows of continuous No. 1 silk suture, the main blood-vessels having been separately ligatured as soon as the peritoneal coat had been incised.

During the past few years I have always used clamps as an aid in the performance of this operation, and I have found them of inestimable value, as by their aid the work is extra-abdominal, only very small portions of stomach and intestine are exposed, there is no chance of soiling by intestinal contents and the need for manual assistance is almost abolished. The clamps which I have used until lately are those designed by Moynihan, but I consider that, useful as they are, yet they might be improved upon. The faults which I have to find with them are that they are too clumsy, and they must be held in position by an assistant. I have designed a clamp which has been made for me by Messrs. Weiss and Sons, and which I have used in my last few operations, and I think it will prove useful to others as well as to myself. It is what might be called a twin clamp, and at first sight appears to be an enlarged Carwardine's intestinal clamp. On examination, however, you will see the peculiar interlocking points which keep the blades true when grasping a mass of tissue, the single slot which joins the two clamps together thus enabling the surgeon to separate them during the operation without unduly stretching the posterior rows of suture, and the fact that the forceps designed to grasp the stomach is almost twice as powerful as that designed to grasp the more delicate jejunum. The length of the blades is five inches, and that of the entire forceps nine inches. When these forceps are applied and locked together the parts are firmly held in the most exact position during the process

of suture of the viscera. I find it better either to separate the two forceps, or, indeed, to remove them altogether, as soon as the three posterior layers and the first anterior layer of sutures have been introduced, as this allows of infolding of the parts without tension, and also because a clamp at this period of the operation has ceased to be of any assistance. These forceps may be used either with or without thin rubber tubing drawn over the blades. Personally, I have not found rubber necessary.



With regard to post-operative troubles and mortality, we hear various statements.

The experience which I have gained from my own patients is that practically every patient vomits during the first few hours after the anæsthetic (ether). Most of these patients vomit a small amount of altered blood, more especially if a portion of the stomach had been rendered anæmic by the use of clamps. I have once seen a patient vomit sufficient fresh blood to cause anxiety—in this patient's case, however, clamps had not been used, or separate ligature of the vessels performed. Many patients vomit bile during the first twenty-four hours; some show this tendency for a few days. I have had one experience of "vicious circle"

in which I found the cause to be hernia of the jejunum through the opening in the meso-colon, and I was able to remove all symptoms by performing a lateral anastomosis between the two loops of jejunum. I am sorry to say that I have also seen one death in a patient who, but for a lack of judgment on my part, should have made an uneventful recovery. The particulars were as follows:—Male, æt. 55, had periodical vomiting for many years; had been washing out his stomach every few days for two years. At the operation, a dense fibrous stricture of the pylorus was found and a very much dilated stomach. Progress after the operation was good, except for complaint of a feeling of distension, until later in the evening of the second day, when repeated vomiting of small quantities of very much diluted bile and altered blood occurred. When I saw him next morning he was still vomiting, and rapidly passing into a collapsed condition with very frequent pulse. Upon passing a stomach tube, several quarts of fluid similar to that which had been vomited were drawn off, but the patient never rallied, although copious injections of saline solution were given subcutaneously. *Post-mortem*, it was found that the junction had been made at the pyloric end of the stomach, and that the greatly dilated cardiac end had sagged down full of fluid and completely kinked the new outlet, thus causing an acute intestinal obstruction. My mistake was that I had not rightly judged the position for the opening. It was unfortunate that in my absence some one did not wash out the stomach as soon as the vomiting assumed a continuous character, and distension of the stomach became obvious. I believe that if this had been done the obstruction might have been relieved, at least for a sufficient time, to allow of operative rectification of the faulty junction.

I will crystallise my remarks on the treatment of these troubles as follows: (1) If simple vomiting occurs, wash out the colon and give nourishment by the rectum. If weakness ensue give subcutaneous saline injections. (2) For hæmatemesis of such amount as to need treatment, give drachm doses of adrenalin chloride (1 in a 1,000 solution), if bile or other fluid is also present in the stomach wash it out with plain water before giving the adrenalin. (3) For bilious vomiting, wash out the stomach with plain water. (4) For "vicious circle" perform a lateral anastomosis.

In conclusion, I would say that the operation of gastro-enterostomy is one of the greatest blessings which has come to patients who suffer from chronic gastric disorders, but that it is not such a trivial operation that it should be advised until other methods of treatment have been fully considered and tried. I feel convinced, however, that where there are obvious signs of pyloric obstruction non-operative treatment is practically useless, and certainly no discussion as to possible medicinal treatment should be entertained if the symptoms suggest cancer, but all such patients should be immediately subjected to an exploratory operation.

A CASE OF

DISJOINTED PERSONALITY AFTER INFLUENZA.*

By ALBERT WILSON, M.D.

PSYCHOLOGY is often regarded by the legal profession as a medical myth. There is a condition of mental instability in which the *ego* becomes disjointed and separate units appear as distinct personalities. The *ego* is the focus or resultant of the combined mental units evenly balanced and correctly adjusted. The law distinguishes between crime and sin, and does not aim at the cure of crime. One disjointed unit may overshadow the whole *ego*.

M. B., the case to be described, was an example of multiple personality, in which all mental self-con-

sciousness was lost except to the one mental unit or personality which, for the time being, was manifest.

This unique case had nothing to do with hypnotism, crystal gazing, nor anything occult; nor was it a lapse of memory. It followed an attack of influenza.

What is its medico-legal value to us?

1. We must consider every mental variation.

2. It suggests a closer examination of the criminal classes on the subject of alternating personalities.

There is a specialism in crime which suggests multiple personality.

Case.—M. B., æt. 13. Easter, 1895. I call the normal, A; the abnormal personalities, B₁ to B₁₀. Each personality was a distinct life in itself, with no consciousness of any other. Each personality was continuous in its associations and memories. The handwriting varied in different personalities.

B₁. Mania, coma and trance.

B₂. Like a child, æt. 3. Quite ignorant, requiring re-education in all details.

B₃. A romping mischievous girl, æt. about 8, called "Nick."

B₄. Deaf mute.

B₅. Only remembers quite recent events.

B₆. Like a girl, æt. 12; well behaved and helping in house duties, but ignorant and too childish.

B₇. Remembers events of early infancy, even when two years old.

B₈. Mental confusion.

B₉. An imbecile and blind, but could draw perfectly by touch; no other personality could draw.

B₁₀. A degenerate.

These personalities appeared and disappeared without apparent cause for three years from March, 1895. The normal appeared in and out, but disappeared entirely. Since April, 1898, M. B. has been B₆, and is making her own living. She knows nothing of her normal life, or of her friends previous to Easter, 1895. The varying personalities are also so many blanks in the memory of her personal history. The true *ego*, M. B., seems gone for ever, yet no ordinary person could detect any abnormality in B₆.

The Cause.—Theosophy says a case of possession. I suggest a material explanation, based on the stratification of the brain cells and the circulating arteries. That there are planes of development, education, and intelligence, as years roll on, the earlier years relating to the deeper layers. Spasm of the arteries shutting off blood supply in different planes may cause arrest of function or memory. Thus a portion only of the brain will be active at such times, a unit of the whole, or as we may call it a personality.

At birth we are equipped with extra layers of undeveloped brain cells (embryonic) waiting their time of activity and education. These being unstable, are likely to undergo degeneration under the adverse social conditions of poverty, vice, and alcoholism. It results in personalities altered for the worse. The true *ego*, which Nature or Providence gave them, has been destroyed by "civilisation" and "Society." Does not the whole question merit more consideration? Why cannot we make a clinical picture of the criminal and learn to understand him?

THE OUT-PATIENTS' ROOM.

WESTMINSTER HOSPITAL.

Peculiar case of Perineal Neuralgia.

By PURVES STEWART, M.D., M.R.C.P.

AMONGST the out-patients was a well-known professional cricketer, æt. 30, who complained of intolerable perineal pain. He was a man of temperate habits and of powerful athletic physique. Two and a half months previously he began to have slight intermittent pain in the perineum, which was aggravated by walking. No apparent cause was assigned for this pain, and there were no symptoms either referring to the bladder or to the rectum. Two months ago when bowling at a cricket match he was seized with a

* Resume of Paper read before the Medico-Legal Society, Feb. 13th, 1906.

paroxysm of intense pain in the perineum spreading half-way along the penis, he had to stop bowling and walked home with difficulty; he went to bed and on the next morning he found himself unable to walk alone, but capable of walking if he rested one finger of each hand on some neighbouring object; this lasted for about three days, since when he had been able to walk quite normally, but if he walked or ran forwards or if he assumed the attitude of bowling pain at once recurred with great severity; on the other hand he could skip, jump, or run up or down stairs without pain. On examination the patient showed no physical abnormality; his gait was normal, the rectum and bladder were healthy, there was no varicocele or any other abnormality of the genito-urinary system, all his reflexes including the bulbo-cavernosus reflex were brisk. Dr. Purves Stewart said that there were several possibilities in the diagnosis. In every local pain it is the first duty of the physician to search for a local cause, in this case, however, there was no evidence of disease in the bladder, urethra, rectum, or genitals. He should therefore look elsewhere for the cause of the pain; some cases of tabes are associated with lightning pains which may affect any part of the body, but the normal condition of this patient's sensory, motor, and reflex functions, together with the fact that he had not had syphilis, excluded such a possibility. The history of the case was much more suggestive, he thought of hysteria; hysteria, he said, must not, however, be confounded with malingering; this man was not malingering, he had already consulted numerous physicians, and at last had taken a journey of many hours to London in the hope of obtaining relief from a pain which was preventing him from earning his living as a professional bowler. Hysteria, Dr. Stewart pointed out, was a real disease; the intermittency of the patient's symptoms and the fact that the pain was produced by running and bowling, whilst skipping and jumping were painless, strongly supported the hysterical theory. On this supposition Dr. Stewart proposed to make the attempt to get rid of the pain by producing a stronger local sensory stimulus, an example as it were of "the expulsive power of a new affection": a white hot Paquelin's cautery was therefore applied to the painful spot in the perineum; the original pain instantly disappeared. The patient retired to St. James's Park to verify his cure by going through the movements of fast bowling; he now found himself able to execute these without producing the old pain, and returned to the hospital to announce the fact. It was proposed to give the man a mixture containing bromide and valerian for a few weeks.

OPERATING THEATRES.

WEST LONDON HOSPITAL.

TRANSVERSE COLOTOMY.—MR. SWINFORD EDWARDS operated on a woman, *æt.* 53, who had been admitted four days previously with symptoms of obstruction. On examination a large mass was found in the rectum, which was evidently a fungating carcinoma. It was fixed and the finger could not reach above it. The patient was seen by Mr. Bidwell, who considered that an inguinal colotomy was the best course to pursue. The patient was, accordingly, taken into the theatre, and the usual incision was made for left iliac colotomy. The abdomen having been opened, whilst searching for the sigmoid colon a large escape of pus occurred with a distinctly faecal odour. This looked as though the bowel had given way in the neighbourhood of the growth. Under the circumstances the operator thought it best to postpone opening the bowel, merely contenting himself with a free drainage of this offensive abscess cavity. As the symptoms of obstruction still persisted forty-eight hours afterwards, Mr. Edwards

considered that the time had arrived for relief; he therefore proceeded to do a transverse colotomy; a longitudinal incision two and half inches long was made over the usual position of the inner border of the right rectus muscle just above and to the right of the umbilicus; on deepening the incision no muscular tissue was discovered, although the incision was fully one inch to the right of the linea alba. The peritoneum was opened and an examination of the abdominal contents made. The cæcum and transverse colon were found to be full of faecal masses and a line of induration in the lower part of the abdomen marked the upper limit of the abscess cavity before referred to. The omentum having been turned on one side, a loop of transverse colon was brought into the wound and fixed there by a couple of deep sutures made with thick silk, which were passed through its mesentery and each lip of the wound and tied tightly through a piece of rubber tubing; the bowel was also fixed by three or four fine silk sutures to the edges of the wound. The gut was not opened as Mr. Edwards thought the symptoms were not too urgent to admit of its being left for twenty-four hours. Mr. Edwards observed that transverse colotomy was a rare operation in his hands; undoubtedly, he said, the site of election was that in the left iliac fossa; if this, whether from extension upwards of the growth or otherwise, was not available he would open the descending colon through an incision at a slightly higher level than that employed in inguinal colotomy, employing the same method here—namely, by separating the various layers of muscular fibres in their respective axes; the descending colon would be opened about the same level by this operation, as when the old lumbar colotomy was performed, which was the operation in the seventies no doubt, he said, but few of the gentlemen present were old enough to have either seen it or performed it. He did not consider that the present case was a fitting one in which to open the descending colon on account of the contaminated condition of this part of the abdomen; by opening the colon where he had he got as far away from the infected area as was possible. He strongly objected to the formation of an artificial anus in the cæcum on account of the liquid state of the faeces, which in many cases produced much excoriation, and emaciation was also likely to follow. In the present case if symptoms of obstruction had been more urgent Mr. Edwards would have opened the bowel and inserted a Paul's glass tube. He also remarked on the fact that, although he had planned his incision to expose the muscular fibres of the right rectus, no muscular tissue was present owing to the wide interval between the recti, which were much attenuated. It was a lucky thing, he thought, that in his first incision he did not go into the bowel, as the abdominal wall in this situation was abnormally thin. The bowel was opened at the end of twenty-four hours, and the patient is doing well, the abscess cavity gradually closing up.

The Apothecaries' Hall of Ireland.—Address to the Lord Lieutenant.

ON Monday, February 19th, in the Throne Room, Dublin Castle, an address was presented to the Earl of Aberdeen from the Governor, Deputy-Governor, and Court of the Apothecaries' Hall of Ireland. The deputation consisted of Lieutenant-Colonel Adye-Curran (Governor), Dr. Seymour Stritch (Deputy Governor), Dr. Hanrahan, Sir Charles A. Cameron, Dr. A. Atock, Dr. J. M. Day, Dr. O'C. J. Delahoyde, Dr. J. D. Crinion, Dr. W. V. Furlong, Dr. W. Fottrell, Dr. R. Montgomery, Dr. S. M. Thompson, and Captain Adye-Curran, R.A.M.C.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON

MEETING HELD FEBRUARY 23RD, 1906.
The President, Mr. CLUTTON, in the chair.

MR. JAMES SHERREN read an account of
THREE UNUSUAL CASES OF ACUTE INTESTINAL
OBSTRUCTION.

Case I. was that of a male patient, *æt.* 31, who had a stricture, possibly congenital, at the junction of the jejunum and ileum. Enterostomy, with enterectomy three weeks later, was followed by recovery.

Case II. was a strangulated left duodenal hernia in a girl, *æt.* 13. There had been no previous obstruction. The hernia was reduced seven hours after the onset of symptoms, and the patient recovered. There were ten cases in the literature, four of whom had survived.

Case III. was a volvulus of the cæcum. The patient, a man, *æt.* 31, was operated on in seventeen hours after the onset of acute abdominal symptoms. The cæcum had to be resected for gangrene and the ileum joined to the ascending colon by means of lateral anastomoses. Corner and Sargent had collected fifty-seven cases of this accident, and had recorded five of their own.

The PRESIDENT remarked on the rareness of the cases and their interest. He commented on the very high mortality in cases of volvulus.

MR. J. HUTCHINSON, jun., had recently seen a case of volvulus of the cæcum with great laxity of the mesentery. The cæcum had passed under the mesentery and was found near the spleen. The patient, a young man, had made a good recovery. In the literature were nine similar cases of twisted small intestine and cæcum; four had been operated on, but only one had recovered.

MR. RAYMOND JOHNSON referred to a case that he had seen in Mr. Beck's ward at University College Hospital some years ago. The twisted cæcum was undone and then aspirated. The patient, a man of 49, died within twelve hours. The cæcum was enormously distended, and had passed beneath the small intestine.

MR. W. G. SPENCER related the case of an old man in whom a twisted cæcum was found near the spleen. Death occurred. He remembered seeing Mr. Walsham operating on a case of volvulus of the cæcum; the cæcum was stitched to the anterior abdominal wall without being reduced, and Nélaton's operation performed.

MR. A. E. J. BARKER had recently published a case in which the whole of the small intestines had twisted round a gastro-enterostomy point. He had had two cases of stricture of the small intestine, one being secondary to a strangulated hernia. It was possible that duodenal herniæ were more frequent than was usually supposed.

MR. SHERREN, in reply, said that he had had a case in which perforation had occurred above a stricture, the result of an old strangulated hernia. As regards the mortality in volvulus operations, two out of the five cases he had operated on in the past couple of years had recovered.

MR. H. W. CARSON communicated details of
TWO CASES OF APPENDICITIS ASSOCIATED WITH THE
PRESENCE OF OXYURIS VERMICULARIS.

The first case was that of a woman, *æt.* 10, who, on the day before admission to hospital, had been seized with violent abdominal pain and vomiting. The temperature was raised to 103° and a rigor had occurred. On admission, the temperature was 103·8°, pulse 110, respiration 32. Superficial tenderness was marked over the right side of the abdomen and right loin. There were no other physical signs. The appendix

was removed and a single oxyuris vermicularis was found, the mucous membrane of the distal half-inch being much congested, but not ulcerated. The second case was that of a woman, *æt.* 24, who was admitted to hospital on the second day of an attack characterised by severe abdominal pains and vomiting. Temperature 100·6°, pulse rate 118, respiration 28. Severe pain was complained of in both iliac fossæ, and there was much tenderness on examination, especially in the pelvis. There was no muscular rigidity, no sign of tumour, and the abdomen moved well in respiration. Three thread-worms were found in the appendix. There was no injection or ulceration of the mucous membrane. In neither case was there any history of thread-worms, nor have thread-worms been seen in the motions since operation. Mr. Carson contrasted the course and symptoms of these two cases with ordinary cases of appendicitis and discussed the question of the relation of the appendicitis to the presence of the parasites. He referred to Dr. G. F. Still's paper on 200 necropsies of children under twelve, in which the oxyuris had been found twenty-five times in the appendix without symptoms, and reported thirteen cases in which the appendix had been found to contain thread-worms after removal for appendicitis. He expressed the opinion that it was more reasonable to believe that the appendicitis in these cases were due to the presence of the thread-worms than to believe that their presence was merely a coincidence.

The PRESIDENT thought that the worms were merely coincident phenomena in these cases. He referred to the importance of operating early in cases of appendicitis, as Mr. Carson had done, but deplored the fact that surgeons rarely had the opportunity.

MR. J. HUTCHINSON, jun., was in doubt as to the relation of worms to appendicitis, though he had published a similar case some years ago. Their rarity was noteworthy in view of the frequency of the disease.

DR. BROOK, of Lincoln, agreed with the President as to the desirability of early operation in appendicitis.

MR. CARSON, in reply, pointed out the high mortality in the first attack of appendicitis, which was a strong argument for operation in such cases.

MR. J. D. MALCOLM related the case of
AN APPENDIX ABSCESS, WITH SEVERE HÆMORRHAGES.
The patient was a woman, *æt.* 36. A foul appendix abscess was evacuated and drained on the ninth day of the illness. On the third and sixth days after the operation there were severe hæmorrhages from the abscess cavity, the second producing unconsciousness from collapse. The wound was opened up and much clot was removed, but no fresh bleeding occurred, and the appendix was not found. The cavity was packed with gauze and healed soundly by granulation. Instances of hæmorrhage from the bowel, associated with appendicitis, and three cases resembling the one related were referred to. The complication was attributed to a sloughing action induced by micro-organisms developed in the bowel, and was compared to the secondary hæmorrhage of the days before antiseptics were introduced.

The PRESIDENT related a case in which continuous oozing occurred for fourteen days, starting on the fifth day after operation; it was not an abscess case. It was curious how rare the secondary hæmorrhage was in appendicitis.

MR. W. G. SPENCER said that possibly this rareness might be explained by the process being due to a special organism, the streptococcus hæmorrhagicus of Klein, in the existence of which he still believed. He referred to two cases of hæmorrhagic cellulitis he had seen.

MR. RAYMOND JOHNSON had seen an alarming hæmorrhage in a similar case in a boy, *æt.* 17. The

external iliac artery had been ulcerated, and had to be tied. Recovery ensued.

Mr. CHARTER SYMONDS had seen deaths from this accident many years ago. He asked whether packing or a tube had been used in Mr. Malcolm's case.

Mr. J. HUTCHINSON, jun., referred to a series of cases, published in the *Bull. de la Soc. Anat.*, in which the accident had occurred before operation. Many of the cases proved fatal. He had seen only one case after operation, it was on the ninth day. Some of the cases might be due to the slipping of the ligature on the meso-appendix. He disagreed with Mr. Symonds as to the desirability of using gauze to drain appendix abscesses.

Mr. F. C. WALLIS was strongly in favour of the use of gauze, especially a strongly antiseptic one, as iodoform.

Mr. MALCOLM said that in his case he had inserted two tubes, a large one and a small one, with no gauze.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF STATE MEDICINE.

MEETING HELD FRIDAY, FEBRUARY 9TH, 1906.

The President, F. C. MARTLEY, M.D., in the Chair.

DEATH-RATES OF THE UNITED KINGDOM.

THE PRESIDENT delivered an address on the death-rates of the United Kingdom, explaining how the crude death-rate had to be corrected for age and sex distribution. For every 100 deaths that occurred in the United Kingdom as a whole, in Ireland amongst males, only 92.6 took place, and in England and Scotland, 100.9 and 101.7 respectively; while in the case of females the corresponding figures were 107.1, 98.7, and 102.5, thus showing how the male and female death-rate of Ireland differed so widely not only from the rates of the other kingdoms, but also from each other. In the same way the male death-rates for the different counties of Leinster were compared with those of the divisions of England, and it was found that the South Midland division had a better index of morbidity than the lowest of the Leinster counties; but what was still more noticeable was that the figure for Dublin reached the enormous height of 172.8, while in London it was only 110.7.

COMPULSORY RE-VACCINATION.

Sir JOHN W. MOORE read a paper entitled "Compulsory Re-vaccination: the Solution of Vexed Questions Relating to Small-pox," in which he drew attention to the difficulties which beset sanitary authorities who wished to make provision for the treatment of small-pox arising in their districts, and referred to legal cases—one in England and one in Ireland—where application had been made before a judge to grant an injunction restraining the sanitary authority from erecting such hospitals on the ground that they were likely to spread small-pox by aerial convection. In the English case the judge had refused—owing to contradictory expert evidence—to give a judgment, while in the Irish case the injunction had been granted as regards small-pox, but this judgment was afterwards reversed by the High Court on appeal. The author then discussed the question as to whether the infection of small-pox was carried through the air, and expressed his belief that it was. He then went on to show that efficient vaccination and re-vaccination were the real solution of this question, and pointed out that in the experience of Germany, where they had compulsory vaccination and re-vaccination, the number of persons susceptible to the poison of small-pox was so small that there were practically no special hospitals for the treatment of that disease, and he therefore held that if vaccination and re-vaccination were made compulsory in the United Kingdom we should have no need for special small-pox hospitals.

The PRESIDENT did not think anybody who studied the question from a scientific standpoint could possibly

have any doubt as to the efficacy of vaccination in the prevention of small-pox, and further expressed himself as agreeing entirely with the opinions held by Sir John Moore.

Dr. DELAHOYDE held that it would be very difficult to enforce compulsory vaccination and re-vaccination in these countries, though he thought it would be easier to have such laws carried out in Ireland than in England and Scotland, as the people of Ireland were more inclined to take the advice of medical men on such subjects, and he further said that previous to attempting to obtain legislation we ought to endeavour to educate the public.

Dr. T. P. KIRKPATRICK said that it was, in his opinion, a matter of complete indifference how small-pox was disseminated, because if the community were protected by vaccination and re-vaccination the disease could not spread.

Dr. H. U. BYRNE spoke as a public vaccinator, and, while completely agreeing with the paper, he instanced the difficulty he had experienced in getting the working-men to consent to be re-vaccinated, though they were quite willing that their families should be done. This difficulty was caused by their natural objection to be unable to go to work. He further held that there was no real objection on the part of the public in Ireland to vaccination, but went on to express his doubts as to whether the number and depth of the scars of primary vaccination were any guide as to the amount of protection enjoyed by the person.

Sir JOHN MOORE then shortly replied, and expressed the opinion that it would not be wise at present to advocate the bringing in of a Bill in favour of compulsory re-vaccination, although no opportunity should be lost of impressing on the public the value of re-vaccination as a preventive of small-pox, and the necessity for it at or about the age of twelve years.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, FEBRUARY 15TH, 1906.

The President, FRANK T. PAUL, F.R.C.S., in the Chair.

GANGRENE OF THE TOES FOLLOWING LIGATION OF THE POPLITEAL ARTERY FOR WOUND OF THE ANTERIOR AND POSTERIOR TIBIAL ARTERIES.

Mr. G. P. NEWBOLT read notes of a case of stab wound of the anterior and posterior tibial arteries and posterior tibial veins at the lower end of the popliteal space. It was necessary to ligature the lower end of the popliteal artery, and also the ends of the wounded arteries and veins. Gangrene of the toes ensued, the line of demarcation forming at the metatarso-phalangeal joints. The patient was likely to have a useful foot.

Mr. R. W. MURRAY said that a case had been recorded, in which end-to-end anastomosis of a divided popliteal artery had been successfully performed, and thought that in the case Mr. Newbolt had related anastomosis of the divided tibial vessels might with advantage have been tried.

The PRESIDENT referred to two cases bearing on Mr. Newbolt's remarks. One, a case of popliteal aneurismal varix due to gunshot wound, in which he had ligatured the artery above and below the orifice; the other, a diffuse popliteal aneurism in which he had turned out the clots and tied the artery above and below the sac. In the former case the patient just escaped gangrene; in the latter gangrene occurred, and he had to amputate the limb.

PULMONARY TUBERCULOSIS—KOCH'S NEW TUBERCULIN AND THE OPSONIC INDEX.

Dr. R. J. M. BUCHANAN read a note on a case of pulmonary tuberculosis which had been treated for some months with excellent results in a sanatorium. During a relapse, at a later period, inoculations with Koch's new tuberculin were commenced by Dr. R. Walters, and had been continued by Dr. Buchanan

since, the opsonic index being used as a guide. It was interesting to note that under relatively large doses, above 1-500 mg. the index rose, but on reverting to the smaller doses of 1-1000 mg. it had gradually fallen to below 0.8. No pyrexial reaction followed the inoculations, but with the larger doses the patient for two or three days had slight dyspnoea and lassitude. The local and general result had proved most encouraging, cough and expectoration having disappeared, as had also enlarged glands from both axillæ.

Dr. T. R. BRADSHAW said the report of the case was of especial interest because most of the successful cases hitherto published were those of external tuberculosis, probably because in them the evidence of recovery was more easily demonstrated. He had seen the cases successfully treated by Professor A. E. Wright, and they were most striking and convincing. In cases where auto-infection was taking place there was generally a variable opsonic index, due to the fact that the patient was receiving irregular doses of toxin, with the production of a negative phase, followed by more or less temporary immunity.

Dr. Wm. Carter, Dr. Grace Calvert, and Dr. J. Hill Abram also joined in the discussion.

A CASE OF PELLAGRA OCCURRING IN ENGLAND.

Dr. A. CASSELS BROWN read notes of a case of pellagra occurring in England. The symptoms having raised a suspicion as to the true nature of the disease, it was found that the patient, a young girl, had been in the habit of eating some of the maize with which she fed the fowls, and also that some of the fowls had died from the poor quality of the maize provided.

ACUTE NEPHRITIS AND ITS TREATMENT.

Dr. A. GORDON GULLAN read a paper on "Acute Nephritis (Morbus Brightii) and its Treatment," based on observations made on 42 cases of that disease. Among the predisposing causes Dr. Gullan placed a "previous attack," of which there was a distinct history in four of his cases; acute rheumatism was one of the rare exciting causes, and was illustrated by a typical example, but cold and wet, and scarlatina, were the common causes. He considered that polyuria and a moist skin were favourable signs, and noted that in some instances a fall of blood pressure, as shown by the sphygmometer occurred when the albuminuria was disappearing. Œdema was present in all the cases, but in one with very marked evidence of the disease there was no albumin in the very scanty urine for four days. The modes of termination, recurrences and relapses were described, and also a sub-acute nephritis which occurred in persons who had already suffered from the acute affection. Dr. Gullan advocated a strict milk diet, and strongly deprecated the use of solid or nitrogenous foods, and gave several examples to show that they were the frequent cause of aggravation and prolongation of the complaint. Free purgation by means of hydrogogues, free diaphoresis and counter-irritation over the loins were recommended. He considered digitalis and stimulating diuretics should never be used except in cases with complications such as cardiac failure. The treatment of uræmia should be most vigorous; bleeding followed by the intravenous injection of a saline solution, together with the judicious administration of pilocarpine was advocated. Dr. Gullan had also found chloroform inhalations useful in certain cases of uræmic asthma and convulsions.

Dr. Wm. CARTER, while agreeing generally with Dr. Gullan, differed from him on the following points:—He thought that pilocarpine should never be injected in uræmic coma, owing to the abundant bronchial secretion it produced; secondly, he objected to the total exclusion of morphine—where the complex of retained urinary poisons produced dilatation of the pupils instead of contraction, as well as other symptoms similar to those caused by atropine. A hypodermic injection of $\frac{1}{4}$ gr. brought natural sleep, followed by cessation of convulsions; thirdly, oxygen might often be freely administered with great advantage—the dissolved oxygen of the blood serum might be increased five-fold by this method, and he was sure that he had

seen lives saved by it, owing probably to the oxidation of toxic products to the condition of harmless urea, as the urea was certainly increased after giving it; lastly, in cases of total suppression, a hypodermic injection of 2 or 3 grs. of caffeine dissolved in a solution of salicylate of sodium would be followed by the passage of a little bloody urine and then copious diuresis. One drachm of salicylate solution will dissolve 20 grs. of caffeine.

Dr. T. R. BRADSHAW said that a moderate rise of blood pressure in the course of acute Bright's disease was of good augury, the worst cases being those in which the pressure remained permanently low.

Dr. A. STOOKES regretted that Dr. Gullan had not discussed the question of treatment of severe uræmia associated with pregnancy. No mention had been made of certain methods of treatment which were at present interesting to obstetricians, e.g., large doses of morphia, thyroid extract, lavage of the stomach, or injection of normal saline solution into the cellular tissue or veins. Dr. Stookes wished to draw attention to a remarkable series of cases lately published by the Rotunda Hospital, where 71 cases of eclampsia were treated with a mortality of 1.69 per cent.

Dr. J. LLOYD ROBERTS called attention to the fact that nephritis occasionally occurred in children, as a complication of mumps—a fact which made the routine examination of the urine in this complaint desirable. He also referred to the usefulness of morphia in certain cases of uræmic dyspnoea.

Sir James Barr, Dr. E. T. Davies, and Dr. Buchanan also spoke.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT SHEFFIELD, FEB. 16TH, 1906
Mr. R. FAVELL, the President, in the Chair.

PUERPERAL SEPSIS WITH THROMBOSIS OF THE OVARIAN VEINS—DOUBLE LIGATURE—RECOVERY.

Mr. A. CUFF (Sheffield) read a communication on the treatment of septic thrombosis of the pelvic veins by means of ligature as advised by Bumm in 1894, and showed the charts of some of the few cases in which this measure has been employed. He recorded a case of sub-acute puerperal pyæmia in a woman, æt. 30, who began to have rigors two days after she had been delivered by a midwife. Serum was first injected for several days, but the rigors continued, and the case ultimately came under Mr. Cuff's care. He found a doughy swelling in the right iliac region, and after observing the case for a week, during which the patient lost ground, he opened the abdomen and found the mass to be composed of thrombosed veins and œdematous connective tissue. The tube and ovary were not affected. The mass was ligatured within and without, and the left ovarian vein, which contained clot throughout its length, was ligatured just below the kidney. The rigors ceased at once, and the patient made a rapid and complete recovery.

FIBRO-MYOMATA WITH VARIOUS COMPLICATIONS.

Drs. BRIGGS and WILLETT (Liverpool) showed two fibroid uteri removed, one by vaginal, and one by abdominal hysterectomy. The cavity of the uterus in each case contained a polypus more or less tongue-shaped, and of considerable size. On microscopic examination one of these polypi proved to be a large round-celled sarcoma of the endometrium, while the other was an adeno-carcinoma of the endometrium. In the latter case the ovary contained secondary carcinomatous masses.

Dr. DONALD (Manchester) described a patient with multiple fibroids, one of which necrosed and consequently became firmly adherent to the abdominal wall and to bowel. This caused intestinal obstruction, which was with difficulty overcome after lasting for a week. The uterus and myomata were subsequently removed with success. He also showed a uterus with multiple fibroids—one of which occupied the uterine

cavity. This had caused bleeding only at the advanced age of sixty-four years, which suggested the existence of malignant disease of the body.

Dr. LEA (Manchester) showed a fibro-myomatous uterus, the size of a football, which caused no symptoms whatever until pregnancy began. It then caused intense pain and difficulty in micturition and defecation, and was therefore removed at the sixth week of gestation. In a second case the fibroid uterus was removed near the seventh month of pregnancy because it was causing constant pain, for the relief of which morphia was required, together with intense bladder trouble and pressure on the bowel. He had been forced to operate to relieve the symptoms, and not in anticipation of difficulty during parturition.

Dr. BLAIR BELL (Liverpool) showed a growth occupying the uterine wall and consisting largely of small arteries whose walls had undergone hyaline degeneration. When fresh it appeared as a grey gelatinous mass interspersed with hard white nodules, and seemed to occupy a cavity within the uterine wall. It was best named an angiomatous fibro-myoma.

Dr. BLAIR BELL also showed a tumour of the kidney which had occupied the right iliac fossa. It was the size of a foetal head, and was an example of the rare growths known as hypernephromata and developed from suprarenal "rests" within the kidney.

ECTOPIC GESTATION.

Dr. W. WALLER (Manchester) showed two specimens of ruptured tubal pregnancy removed by abdominal section at the sixth and eleventh weeks. In each case sudden abdominal pain preceded severe fainting. In the first case, marked pulsation of the uterine artery aided the diagnosis.

THERAPEUTICAL SOCIETY.

A GENERAL meeting and conversazione was held in the Apothecaries' Hall, on Tuesday, February 20th, Sir LAUDER BRUNTON, President, in the chair. Thomas Maben, F.C.S., read a paper on the

PREPARATION OF ANTI-DIPHTHERIA SERUM.

illustrated by very good limelight views, showing that the toxin of diphtheria is formed by cultivating the bacillus in alkaline beef bouillon for about seven days, and then filtered and stored in the cold. It is then tested on guinea-pigs, and afterwards injected into perfectly healthy horses, in minute doses at first, gradually increased every week, till 1,000 c.c. can be injected without injuring the animal; this dose would kill 100 unprotected horses. By this a powerful anti-toxin is developed in the blood, which protects the animals from the diphtheria toxin. This usually requires nine months' treatment, after which about a gallon of blood is taken from the jugular vein every week into glass cylinders, kept cold for four days till the serum separates, which is drawn off and filtered, and used after three weeks if the horse keeps well. If properly kept it may retain its power for two or three years, and it is most important to inject the serum into a case of diphtheria without any delay, as if it was used on the first day of the disease only one in 238 died, while if delayed to the fourth day one in nine died. As there is no danger from the serum, large doses should be used; in severe cases from 12,000 to 24,000 units are often required. In America and Germany the Government guarantees this efficiency of the serum, but in England private experts test it. Dr. Montgomery Paton states that the serum is also useful for other microbes, as the streptococcus, staphylococcus, and bacillus coli communis.

A paper on

CLOUDS AND CLIMATE.

by Dr. STUART TIDEY, of Montreux, Switzerland, showed that there a cloudless day is rarely met with after sunrise, as very shortly afterwards mists arise from evaporation, on the snowfields and glaciers, and gradually extend over the neighbouring valleys, and may form rain, but after sunset evaporation ceases, and the clouds disappear. The clouds increase more

rapidly when the air is moist than when dry, and are higher in summer and lower in winter, even down to the level of the lakes, so that in winter the summits of the mountains are often free from mists and in full sunshine, while the lower altitudes are covered with dense clouds, but in warmer weather the lower levels are free from mists while the peaks are enshrouded by them. Hence it is advisable in the autumn to reside at a low level with easy communication with higher regions, and Montreux is very favourably situated, as in warm weather it is free from clouds and damp, but in winter when it is wrapped in clouds several railways lead to higher regions, such as Sierre 1,765 feet, Seysin 4,500 feet, Caux 4,000 feet, LesAvants 3,200 feet, which are easily reached by rail from Montreux, and have good hotels and winter sports. Also Corbryer, 3,500 feet, is one of the best winter stations with good hotel accommodation, but it can only be reached by to carriages as there is no railway.

THE CENTRAL MIDWIVES BOARD.

MEETING HELD, FEB. 22ND, 1906.

The President, Dr. CHAMPNEYS, in the Chair.

At the beginning of the meeting a letter was read from Dr. Stookes, of Liverpool, as to the scope of the teaching prescribed by the Board on the subjects of (1) sanitation; (2) emergencies. The writer said grave risks were run by the varied teaching given, and by (comparatively) ignorant women using in emergencies instruments for serious operations, such as curetting the vagina, etc.

Letters were also read from Dr. Fairbairn and Dr. Hicks with regard to the defective training of a candidate at the recent examination. She had the vaguest ideas as to aseptic conditions.

The PRESIDENT said that these letters would meet with consideration when the rules were revised, and the secretary read a letter from Dr. Fothergill, on behalf of the Manchester examiners, suggesting the board should publish an official handbook for midwives to secure more uniformity of teaching.

Sir WM. SINCLAIR remarked that the Board was two years behind the times. In Germany there had already been six such manuals.

Mr. WARD COUSINS added that one of the chief difficulties of examination lay in the elementary educational condition of some of the candidates. These did not seem to have language at command to formulate their answers. Moreover, they ought, besides the midwifery course, to have lessons as trained nurses have. Very often one of the latter would be more useful than a midwife.

Sir WM. SINCLAIR answered it was clear that deficiencies existed in clinical teachers and their methods. Many on the list were not qualified to give such instruction. Such women should have had training as a fully certified nurse.

As Dr. Swayne (Bristol Centre) had also to complain of defective training, it was resolved to hold a committee of examiners and receive their suggestions.

The matter of institutions claiming exemption from Government inspection with regard to lying-in wards was again discussed, as the Clerk of the L.C.C. had written for a full definition of Rule E. 21 which deals with this, and the Stockwell Private Hospital had claimed exemption.

The PRESIDENT said the rule had been framed to avoid interference with the staff of large institutions, but the Local Government Boards were always trying for exemption, and he was glad for the L.C.C. to support the Central Board of Midwives.

Sir WM. SIMPSON remarked that it would never do to exempt small institutions and private hospitals, for these were the very places where grave moral abuses might be in vogue.

It was then agreed to send an answer confirming the L.C.C. in their action.

The Secretary's report of the February examination was presented to the Board.

Sir WM. SINCLAIR protested against the way in which it was drawn up. A mere list of successes told nothing. The prime question just now was the efficiency of teachers. A list of those who had failed and who had taught them ought also to be given. It was his impression that the failures had been under illiterate midwives. He had carefully studied returns from institutions and found women had signed certificates of more cases attended than could possibly have come under their attention.

Mr. WARD COUSINS then moved a resolution, which was passed:—"That the form of suggestions accompanying the Agenda of December 14 for the guidance of the medical advisers of the local supervising authorities, respecting the duties of inspectors appointed to exercise general superintendence, be approved and issued to the local supervising authorities." Adding that such clearer guidance as to their duties would be welcomed by all such authorities.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, February 28th, 1906.

RHINITIS IN CHILDREN.

ACUTE purulent rhinitis coincides frequently with impetigo of the face, but it can exist alone. It is subject to intermissions and has a tendency to become chronic.

The maximum of frequency of this affection is between seven to twelve years of age; it is particularly observed in lymphatic children. The inflammation may be localised to the vestibule of the nares, or it may invade the pituitary membrane. In the former, the edges of the cavities are inflamed and fissured. The interior of the nose is filled with hardened secretions. When these become detached, the mucus membrane is red, glistening, and sometimes ulcerated. The secretion continually renewed obstructs the passage of air, and the patient shows the symptoms of adenoid vegetations—mouth open, snoring at night, &c.

In the deeper form of rhinitis, the disorders are still greater; the inflammation can extend to the pharynx, and all the organs which communicate with the nose; ocular complications, keratitis, kerato-conjunctivitis, ulcer of the cornea; of the ear, otitis acute and chronic; of the skin, erysipelas, impetigo; of the pharynx, inflammation of the tonsils, adenitis, ending in vegetations; of the respiratory tract, laryngitis, bronchitis, and broncho-pneumonia.

The diagnosis of purulent rhinitis is easy, but two causes of error should be borne in mind—the presence of a foreign body in the nares and adenoid vegetations. A careful examination will eliminate those possibilities.

The treatment consists in irrigation of the nose by means of an enema syringe. Each naris should be washed out two or three times a day; a pint of solution should be used each time. The child should hold its head over a basin, and avoid speaking or swallowing, so that the liquid should not penetrate into the Eustachian tubes.

The solutions should be warm, and composed of, says Lannoyez, chlorate of potash, bi-carbonate of soda, or bichlorate of soda at 5 per cent., and afterwards antiseptic solutions might be used as phenosalyl (1—1,000), resorcin, $\frac{1}{2}$ per cent., boric acid, 3 per cent. In slight forms an ointment of boric acid (2 per cent.), resorcin (5 per cent.) or salicylic acid (1 per cent.) inserted into the nares may be sufficient. Sometimes a powder might be substituted for the ointment, either euphene or aristol mixed with equal quantities of sugar, of milk and used as snuff.

If the desired result is not obtained, a preparation of nitrate of silver may be ordered.

Nitrate of silver, 5—10 grs.

Talc powder, 6 drachms.

The general treatment consists in cod liver oil tonics and a season at Challes or Luchon.

PURULENT RHINITIS OF INFANTS.

The child can come into the world with purulent rhinitis; in such cases it is injected by the amnion which had prematurely escaped. More frequently twenty-four or forty-eight hours after birth the malady is declared, and almost always it is due to hæmorrhagic contagion during the passage of the head in the vagina. The nature of this coryza, for so long denied, is to-day proved. The fact of the co-existence sometimes observed with purulent ophthalmia and rhinitis is a sufficient demonstration.

The symptoms are here more pronounced than in the preceding form. The pus is thick, creamy, and irritating. The nares are inflamed and painful, while the nasal obstruction is considerable. The affection is very tedious and ends frequently in ozena.

Ænorrhagic coryza differs from the syphilitic form by its early appearance and by the aspect of the secretions; in syphilitic patients, the liquid secreted is sero-sanguinolent and, moreover, other manifestations of the specific disease can be observed.

The nose should be irrigated by the same solutions as in the ordinary purulent type and the following powder blown into the nose:—

Iodoform, xv;

Berzoin powder, $\frac{1}{2}$ drachm;

Boric acid, 3 drachms.

Irrigation of the nose with resorcin (1 per cent.) is very efficacious in such cases.

CEREBRO-SPINAL MENINGITIS.

Numerous are the agents tried for this dreaded affection, and amongst the most recent may be mentioned the injection of collargol into the rachis. M. Papillon reports such a case. A child, $\text{æ. } 3\frac{1}{2}$, suffered from cerebro-spinal meningitis. A first injection of one-third of a grain of collargol produced improvement, but temperature having risen to 104° a second injection of one grain of collargol was injected and the patient rapidly recovered. Another practitioner reports four cases of meningitis cured by the creation of artificial abscesses. Twenty drops of essence of turpentine were injected into the external part of the thigh. At the end of a week the abscess was ready to be incised. In one case the injection produced no inflammation, and the patient succumbed.

Intra-rachidian injections require a certain amount of practice, and consequently are not within reach, perhaps, of the ordinary practitioner; but the creation of abscesses can be done by any one, and are worth a trial.

GERMANY.

Berlin, February 24th, 1906.

At the Verein für Innere Medizin, Hr. Senator discussed

THE DIETETIC TREATMENT OF GASTRIC ULCER.

In his remarks he would restrict himself to the question: How is the recent bleeding ulcer of the stomach to be treated? It was known that in such cases it had been recommended to exclude food by the mouth absolutely for a time, to feed by the rectum and then cautiously return to stomach feeding again, and this method of treatment had found many adherents. More recently Lenhartz had opposed this on the ground that it tended to exhaust the patient's strength, and thereby retard the healing of the ulcer. He ordered from the first a very concentrated albuminous diet, beaten-up eggs, and from the sixth day scraped meat. In this way he was said to have obtained quicker results. Since then experiences recorded from various quarters had seemed to confirm this. Kleinberger, however (against his own will), from experiments had confirmed the views of Zienissen-Leube as to the

advisability of abstention from stomach feeding, or under feeding. He found that this method ensured a lowered blood pressure, concentration of blood, increase in hæmoglobin, in fact exactly the condition met with during the fasting state.

The speaker had proposed a middle way and had tried it in many cases. He had given small quantities of albumen, gelatine, fat and sugar. He had used gelatine for thirty years in his fever diet on account of its great nutritive value, and its easy digestibility. But gelatine had also great power of coagulating blood and of arresting hæmorrhage, its local effect being very marked, and its remoter action after injection into vessels being far less. Fat and sugar, independent of their great nutrient value, were, the latter, a relief for acids, and, the former, a soother of irritation and calmative. He gave the gelatine in the form of a decoct. gelatine alb. pures 15 to 20 grm., with 50 gm. Eleosæch, citr., the dose to be taken in the 24 hours. With this as albumen he gave a small quantity of cream with a little fat and sugar, the fat in the form of butter, which was best taken in the form of small frozen pellets (30 grm. pro die). This food gave the patient twice as many calories in the day as Lenhartz's—900 to 1,000. It contained far less albumen than Lenhartz's, being almost replaced by gelatine. Later on milk, beaten up eggs, scraped meat, etc. Occasionally he had seen hæmorrhage take place immediately after taking the gelatine decoction. This diet could be modified according to the patient's taste. Chicken jelly, calves' foot jelly could be given with variations. Fat was best given as butter, but also in the form of almond oil emulsion. This diet was rational, healing, and nourishing.

At the meeting of the 5th inst., Hr. Löwenstein communicated a note on

IMMUNITY.

He said that whilst in most cases of acute infectious disease a condition of immunity follows the cessation of the disease this was not so in the case of chronic infectious diseases. In this respect they resembled the two acute diseases that gave rise to no immunity, viz., gonorrhœa and erysipelas. These two were also alike in that the disease in both remained local and did not attack the organism as a whole. The speaker expressed his belief that this property of merely local action was the cause of the absence of immunity when the disease subsided. To produce the immunity, therefore, it was necessary that there should be a general saturation of the organism with the disease, and in the case of the chronic infectious diseases this should be brought about by introducing the disease product into other organs. For example, in carcinoma, carcinoma mass should be given internally.

At the Society of Charité Physicians, Hr. Orth spoke on

BONE CALLUS.

In a man æt. 84 who had had an impacted fracture between the neck and the strap of the femur, and who died fourteen days after, it was found that the greater part of the callus was formed of osteoid tissue, and with this a large amount of bone substance. The causes of callus luxurians were of an individual nature, they were neither great dislocation nor much movement of the fractured parts. With regard to the origin of "parosteal" callus, a connection with the periosteum was possible. On the other hand, the assumption of a heterogenous bony formation was allowable. Such heterogenous bony growth, when it did not spring from the periosteum, was the result of metaplasia. Connective tissue, cartilage and bone could pass into one another. One had to distinguish between cell and tissue metaplasia. In the first the connective tissue cells showed an osteoblastic function, in the latter the connective tissue fibres became bony basic substances and the connective tissue cells bone cells. There were no typical osteoblasts in the case under notice; there was no periosteal origin, but a development from connective and fatty tissues. Besides this the preparation showed calcification, but not of the

newest bony masses. Wherever there was lime there was also a positive iron reaction, as was also shown in normal osteous formations. As regarded the occurrence of cartilage tissue in callus, this was found in aseptic fractures, as was shown by animal experiments, in the adult as well as in the child.

Hr. Beitzre communicated a note on

DIFFERENTIATION OF STREPTOCOCCI BY CULTIVATION ON A BLOOD NUTRIENT SOIL.

Several of the streptococci of the streptococcus longus and the streptococcus meteor changed the character after lengthened cultivation, partly after passage through animals, one after inadvertent passage through the speaker himself, when cultivated on blood, the streptococcus longus becoming converted into the s-meteor and vice versa. E. Fraenkel's criterion also failed (characteristic growth on litmus, milk, sugar agar). S. mucosus was only distinguishable from the pneumococcus on a solid soil by its mucoid growth, but even this distinction was lost by prolonged cultivation. The speaker therefore classed the streptococcus mucosus as a pneumococcus.

AUSTRIA.

Vienna, Feb. 24th, 1906.

At the Gesellschaft Kirchmayr presented a young woman, æt. 26, on whom he had operated for abscess of the liver. The patient took ill with typhoid in September, but in November commenced to show signs of irregular temperature with increase of the spleen.

This organ was probed twice and pus obtained both times. The spleen was next resected by carrying an incision across between the tenth and eleventh ribs. On reaching the spleen an abscess about the size of a hen's egg was met with, which when opened was found to be mucoid pus full of typhoid bacilli.

CATGUT STERILISATION.

"Frank recorded his success in sterilising catgut by keeping it two days in a concentrated solution of Formalin and then boiling for twenty-five minutes in water; finally placing it in alcohol for immediate use.

Shnitzler said he had tried that method for some time, but now prefers iodine catgut as being better sterilised and also a disinfectant when left in the tissues.

SUBLINGUAL GROWTHS.

Goldreich showed a child with a swelling about the size of a marble in the frenulum linguæ, hard and of a fungoid appearance; not painful on pressure, but ulcerated on the surface. The history is most peculiar; for seven weeks past it has suffered from pertussis, but according to the mother's convictions it suffered from a spasmodic cough shortly after birth. The real cough commenced about seven weeks ago, occurring every quarter or half-hour. The mother affirms that no swelling was present when the whooping commenced. The question arises, What is the cause? Is it due to the incisor teeth causing first ulceration with subsequent infiltration? He was of opinion that the pathological origin was a mechanical irritation resulting in a papilloma or granuloma.

He had tried the usual absorbing and assuaging methods without success and now proposed to extract the incisors.

Swoboda recorded several such cases coming under his notice which went away of their own accord. He thought extracting the incisors too heroic at the present time. Kassowitz also thought such treatment unnecessary.

PURPURA AFTER SCARLATINA.

Schick showed a specimen taken from a girl, æt. 5½, who commenced with fever and vomiting on December 16th. A few days later the throat became affected, while a typical scarlet rash appeared on the skin and which disappeared after three more days.

On the sixteenth day of the illness points like pin heads began to bleed on the cutaneous surface of the right arm, hand, mucous membrane of the lips and throat. The deposit on the membrane of the throat and fauces was black with intense fætor exore from the

resulting gangrene. The lymphatics were about the size of hazel nuts and hard. On the seventeenth the urine became hæmorrhagic, but no albumin beyond that calculated in the blood.

The patient died on the twenty-first day of the illness from exhaustion. In the *post mortem* the entire surface of the fauces, tongue, tonsils, and larynx were covered with a reddish stinking fluid. Below the epiglottis the same conditions existed. The origin seemed to be due to a hæmorrhagic diathesis.

CONGENITAL STENOSIS OF INTESTINE.

Preteitner related an umbilical hernia in a new-born child, where laparotomy was performed, and the ileum found connected with the amniotic sac. The cord leading into the bowel was two fingers thick and contained meconium. At the attachment to the small bowel the lumen of the latter was obliterated. The stenosis was removed but the child died.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

THE FACTORS WHICH MAKE FOR SUCCESS IN LIFE.—Sir Frederick Treves gave his Rectorial Address to the Aberdeen Students in the Mitchell Hall, on the 22nd inst. The speech was listened to with close attention and interest throughout and the whole proceedings were orderly in the extreme. After thanking the undergraduates for choosing him as their Lord Rector, Sir Frederick took as the subject of his remarks, the factors which make for success in life—particularly in the medical career. The fascination of medicine was the heroic character of the calling, and the true spirit of the profession was not illustrated by the brilliant surgeon who holds the operating theatre spellbound, not by the learned teacher who can grasp the attention of a crowded audience, but by the solitary man in a gig pushing over a bleak moor in wind and rain to help another poorer than himself. Modern medicine finds its romance in discovery; the shadowy Argo or the weather-beaten brig the "Golden Hind" seeking a new world are no more romantic than the figure of Laennec glancing with rapture at the almost invisible speck on the needle's point—the miliary tubercle discovered after months of monotonous toil. Few detective stories surpass the tale of the tracking down of the miscreant malaria after many years of astute watchfulness. In enumerating the factors which make for success, money, influence and social position, and above all, genius, are supposed to be of importance. In Sir Frederick's estimation, ample or moderate means at the outset of a career was a positive drawback; no influence would make a worthless man worthy, nor the incompetent capable. As for luck, the man who is content to wait for a stroke of good fortune will probably wait until he has a stroke of paralysis. Most specious of all is the contention that success in a profession needs genius. Genius in its crude or natural state is not wanted in medicine, nor has it been a marked attribute of those who have attained the highest position in that calling. Genius in a physician would be apt to give us flippancy, instantaneous diagnosis, the instinctive detection of disease, and other astounding phenomena which one attributes to the charlatan. In like manner brilliancy in a surgeon is a quality from which he may well pray to be saved. The synthetically composed genius is safer and more reliable than the congenital genius—into the making of the synthetic genius enter the capacity for hard work, for patient observation and experiment, for persistent reasoning; these have no supernatural origin, but are within the reach of any mortal. The important factors in success are health, serviceable knowledge, sympathy, and honesty; industry is pre-supposed. Sound health means more than capacity for work; it means an equable mind, a prompt judgment, and a disregard for worry. Highly cultivated special knowledge must be supplemented by

an intimate knowledge of the anatomy and physiology of man as a social being—a subject slow and hard to learn. In the mathematics of life no factor is more important than the personal equation. The successful physician is a finished student of men. From the doctor the public demand unwavering dogmatism, and will have no talk of uncertainties. Now that medicine approaches an exact science there is no need for invention to gratify the demands of a sick man—it is not even necessary to babble about his "constitution" or his "tone," any more than to tell him now that a malady is due to a "humour" as the mediæval physician must have said to his patient in the days when truth was as scarce as the supply of radium. Sympathy counts for much—not a mere profession of kindly platitudes, but such a frame of mind as is attained by anyone who can project himself into another's place. The physician who is able to conceive of a disease not only as his art would show it to him, but as it appears to the view of his patient, has grasped the foundation of therapeutics. The blunt, outspoken truth may, from want of tact and insight, be far from commendable. Finally, honesty, of which there is one degree—it either is, or it is not—is not only the best, but the only policy. That "Nothing succeeds like success" is no article of faith in a true *religio medici*. Riches is the least of its gains, but by the earning of gratitude the humblest practitioner lays hold of wealth beyond the dreams of avarice.

BELFAST.

OVERCROWDING AT THE DISTRICT ASYLUM.—A special meeting of the Asylum Committee was held last week to consider the question of overcrowding at the old asylum at Grosvenor Street, Belfast, and the feasibility of transferring all patients there and at the Ballymena Workhouse (where a number are at present housed) to the new asylum at Purdysburn. Year after year the Government inspectors have made strong remarks on the very inadequate accommodation at the old asylum, and the Committee have now to face a scheme for the removal of all patients to Purdysburn, whither the excess were removed some years ago, and housed in four new villas. The Purdysburn estate comprises 372 acres in a splendid situation within easy reach of the city, and there would be many advantages in having all the insane together under one central administration, instead of scattered as at present. But a complete set of villas, with the necessary water supply and administrative block would cost about £100,000, a sum not to be lightly disposed of. The committee practically agreed that some such step was unavoidable, and appointed a sub-committee to inquire into the matter and formulate a scheme.

DOWN DISTRICT ASYLUM: INCREASE OF SALARY.—The Committee of Management of the Down Asylum last week decided to increase the salary attached to the office of junior assistant medical officer from its present figure of £100 to £130, rising by annual increments of £10 to £150 a year.

BELFAST MATERNITY HOSPITAL.—The one hundred and twelfth annual meeting of this charity was held last week, when the medical report was read by Dr. Osborne. It stated that 326 patients were treated in hospital last year, 306 children were born alive, and 21 still-born. There were four maternal deaths, one from tuberculosis, one from pleurisy, one from pneumonia, and one from eclampsia, the last having been admitted in a moribund state. 312 patients were attended in their own homes.

THE late Mr. Thomas Moreton, M.R.C.S., of Hartford, Northwich, Cheshire, surgeon, left estate valued at £54,097. The testator left £100 each to the R.S.P.C.A. and N.S.P.C.C., £200 to his coachman, £50 to his servant Albert Dutton, £10 to his servant Ann Bowyer, and a life annuity of £20 16s. to Mary Cotterill, late caretaker of his surgery at Northwich.

LETTERS TO THE EDITOR.

MERCURIAL INJECTIONS IN THE TREATMENT OF SYPHILIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—With reference to the synopsis of the discussion at the Medical Congress held in Paris, 1905, published in your issue of the 7th inst., would you allow me to state that I most cordially agree with Dr. Hallopeau when he says: "Mercurial injections are not to be recommended in general, and should only be had recourse to in severe cases." I suppose by severe cases he means cases presenting severe symptoms, especially tabetic symptoms, and in these the intra-muscular injections would undoubtedly be of use in helping to remove the symptoms, but here, Sir, to my mind comes the great point: there seems to be too much inclination amongst medical men in treating syphilis only to consider the symptoms present at the time, and to lose sight of the constitutional disease which it is their duty to eradicate from the patient's system. We all know how strictly, as a rule, the patients themselves adhere to treatment as long as any symptoms persist, and how consistently they neglect to continue a remedy which necessitates the slightest trouble when all visible signs of the disease have disappeared. In my opinion, therefore, intra-muscular injections should be reserved for the treatment of any particularly obstinate symptoms such as those enumerated in 1904 by my old teacher, Professor Alfred Fournier, but I do not think they will ever come into vogue for the eradication of syphilis from the system; to do this requires the administration of mercury for at least two, some say three years. Now, where is the patient who will consent to undergo a bi-weekly injection into the muscle substance of his gluteal region or of his spinal furrow during two or three years, or even during one year, which last is, I believe, the limit of time fixed in this method of treatment? To go further, let us suppose a man has submitted to the expense and delectation of a bi-weekly spearing with the syringe for one year, would a medical man feel himself justified in then giving his patient permission to marry on the assumption that the poison of the disease had been eliminated by the treatment? Personally, I should not. Apart from the unpleasantness of these injections, there is the question of expense, which to many would be a serious consideration; the intra-muscular treatment, if continued for any length of time, could only be the appanage of the rich, and if carried out for a short, and therefore a quite useless, period the appanage of the very poor, who are supposed to be the class receiving relief at our hospitals. Again, this treatment, however carefully carried out, must always present some risks, as pointed out by Dr. Hallopeau. To sum up, it is the duty of every medical man to eradicate the poison of syphilis from the patient's system and this is only accomplished by a mercurial course lasting from two to three years; therefore the internal treatment is, in my opinion, the proper one as well as the most easy, and for this reason the most likely to be rigorously continued by the patient at the time when symptoms have temporarily disappeared; intra-muscular injections, on account of their power of producing at once greater mercurial activity, may be of great use during a short period in combating any individual severe symptom. It is essential to watch the case carefully at the beginning of the internal treatment in order to find out the form or combination in which the mercury can be administered to the patient under notice without producing any results but those desired; were this invariably done, those unpleasant effects sometimes brought about by the drug when administered by the mouth, which are invariably mentioned in disparagement of the internal treatment, would cease to exist.—I am, Sir, yours truly,

H. DE MERIC.

13, Nottingham Terrace, Regent's Park, N.W.
Feb. 22nd, 1906.

SPECIAL ARTICLE.

THE CAUSATION OF INSANITY.

ONE of the features of Dr. Easterbrook's annual report of the Ayr District Asylum is the careful investigation which is made as to the causation of the insanity of the patients, and as there are on the Asylum Register about 500 patients, with 151 admissions during the year, the numbers dealt with are sufficiently large to be of statistical value. Dr. Easterbrook has been able to trace the family history of 120 direct admissions, with the result that the following hereditary diseases were found to be present:—Insanity in 26·8 per cent., neurosis in 14·1 per cent., tuberculosis in 14·1 per cent., paralysis (chiefly apoplexy) in 12·5 per cent., alcoholism in 9·1 per cent., heart disease and cancer in 6·6 per cent., chronic rheumatism in 5·8 per cent. From these facts a table has been prepared showing the degree of affinity to the patient of the relatives affected; as might be expected, the morbid heredity shows itself most frequently in affinity of the first and second degree, namely, parents, and brothers and sisters, and much less often in the third degree (grand-parents) or fourth degree (uncles and aunts). Dr. Easterbrook believes that the neuro-insane constitution was the most important factor in producing insanity among his patients, being present in nearly 58 per cent. of cases. The neurotic diathesis alone accounted for insanity in 29 patients; in the rest it was assisted by emotional strain and the physiological crises of life. The question of the relation of alcoholism to mental disease is always of interest, and we note that in the experience of Ayr Asylum it is a less potent factor than is held by some. Alcoholic excess was manifested by 33 patients, in 14 of whom it was symptomatic of insanity, and in 19 the essential causal factor. These figures show a slight increase over the preceding year, which may be co-related with the signs of revival of trade. Dr. Easterbrook divides cases of alcoholic insanity into three groups:—(1) The true *dipsomaniac*, in whom the disease consists, not in the effects produced by constant excessive indulgence in alcohol, but in a periodic intense craving for the mental state induced by alcohol, morphia, or similar drugs, which, acting on the higher functions of the brain, excite or calm the mental functions. The dipsomaniac seldom finds his way into an asylum, may occasionally be induced to go into an inebriate retreat, but usually is screened by relatives, who, knowing his weakness, if wise do all in their power to help him to fight against it. (2) The careless or ignorant *drinker* who constantly takes more than is good for him, but manages to keep more or less respectable until some day a breakdown occurs. This type forms a large proportion of the alcoholic insanity in asylums. They often, though not always, recover, and seldom return—one lesson, the *dernier ressort*, has been enough. (3) The chronic inebriate or alcoholic *deteriorate*, who as the result of prolonged habits of vicious indulgence—he may have begun as a dipsomaniac or careless drinker—has spent his money, mind and morals in drink, and is left as a derelict for the asylum, beyond redemption. To all these—the dipsomaniac, the drinker, and the deteriorate—the only safeguard is total abstinence.

As to the mental and bodily condition of the patients admitted, 10 were in the first class of mental reduction (60 in the second class, *i.e.*, showing marked depression, exaltation, or confusion, or hallucinations, delusions, stupor, etc; and 56 in the third class, *i.e.*, more marked degrees of the above, or the presence of morbid obsession, inhibition or moral sense, or dementia, etc. Grouping mental and physical characters together, 5 were bodily fair and mentally mild; 53 bodily poor, or mentally moderate; 68 bodily weak or mentally severe. The recovery rate for the year, 42·06 per cent. of the direct admission, is gratifyingly high. The death rate was 13·62, the most frequent causes of death (*p.m. exam.*) being tubercle, heart disease, general paralysis, and pneumonia. The death rate is

higher than the average, but the mean age at death was also high, and it has happened that during the year a number of debilitated old women have been carried off by intercurrent maladies.

From the administrative part of the report, we find that the New Hospital is approaching completion and will raise the available accommodation from 500 to 650 patients. Electric light has been installed, and a fire alarm system of electric bells introduced. The reports of the Commissioners in Lunacy are couched in complimentary terms.

REVIEWS OF BOOKS.

KRAEPELIN'S CLINICAL PSYCHIATRY. (a)

TEXT-books on mental diseases are apt to fall into two classes—the ponderous or recondite, fit only for the expert, and the sprightly, or unsatisfying, which the student and general practitioner have to put up with. The volume before us hits a very happy mean between the two. Let us say at once that no reader, expert or student, can fail to be influenced by the charm and sagacity of the author, and if he gain nothing more from its perusal than a lively sense of the attractiveness of clinical psychiatry, he will be refreshed on the one hand and stimulated on the other. But valuable, highly valuable, as is this attribute, we should be doing the author an injustice if we did not add that it is instructive in a rare degree. The expert will find in it the fruit of a ripe clinician which will taste fresh and luscious after some of the Dead Sea fruit which rasps his palate from time to time; let him take it to his fireside on an evening, and he will soon forget the asperities of the day. To the lay, or non-expert, it will be a very Hans Andersen for fascination; more interesting than a novel and more filling than a text-book. The author has chosen the clinical lecture form in which to express his thoughts, and in a few sure strokes he succeeds in delineating a vivid picture of the leading features of each of the various types and phases of mental disease in such a way as to convey a clear-cut and lasting impression. We have come across no book which would better serve as an introduction to the systematic study of psychiatry, and we can strongly advise students who are attending asylum demonstrations to make it their hand-book during their course. If they do so, and compare its teaching with what they see in the wards, they will carry with them into practice a personal acquaintance with the clinical manifestations of insanity and their diagnostic significance which will stand them in good stead for the rest of their lives. Although this volume is not primarily a systematic treatise, the lectures it contains practically cover the field of mental disease, and an attempt to bring them into orderly relation is made by adding a scheme of classification. Of this it may be said that it is about as satisfactory or unsatisfactory as any other scheme of the kind. As long as symptomatology and clinical history are relied upon to furnish the criteria for one part of a classification, and toxic insanities are relegated to groups in which etiology determines the relationship for the other, it is hopeless to expect anything like scientific precision or absolute consistency. That this should be so merely indicates the confusion of thought that exists everywhere with regard to the interdependence of the several departures from the normal which are termed mental diseases, and which would appear only capable of reconciliation by the adoption of Sankey's generalisation that insanity always follows a definite course and passes through the various stages of dissolution—melancholia, mania, dementia, and amentia—however much any individual stage of the

process may be abbreviated or thrust into prominence. Till this theory, or some better one, is adopted generally by alienists, we shall continue to have these classifications which at best can only be stop-gaps in the absence of fuller light. And Dr. Kraepelin's is as good as any for the purpose. The translator is heartily to be congratulated on the skill he has shown in doing the book into English. He has almost completely eliminated the heavy Teutonic rumble which grates so uncomfortably on the Anglo-Saxon ear in all German books and nearly all English translations of them. He has given us a bright, crisp, vivacious, and idiomatic rendering of the author's text, which makes the reading of it a pleasure in itself. In a word, he has "Englished" it.

KAYSER ON DISEASES OF THE LARYNX, NOSE AND EAR. (a)

THE attention of the author, as expressed in his paper, is to record for future reference his lectures—not to supplant those lectures, for, as he justly points out, nothing can actually take the place of clinical observation—and also he lays stress upon the inclusion in one volume of the three special branches of surgery, throat, nose, and ear, which have been divided up too much, and which, as he points out, have so much in common that it is hard to separate them. After some general remarks with regard to the use of reflected light, &c., he passes to the consideration of laryngeal examination, and discusses the various methods of direct and indirect laryngoscopy and also bronchoscopy.

On page 20 will be found two useful illustrations of the conditions called Pachydermia laryngis, and Singer's nodes, which show well the difference between them. Each lecture is clinical, and thus we find he compares the ulceration of tuberculosis and syphilis, &c., in one; tumours in another; and so on. In the chapter on anterior nasal examination he says that he uses Duplay's speculum, though most authorities now prefer one of those made with a handle. One is compelled here to remark that the illustrations of instruments are somewhat antiquated. The chapter on the nasal septum lacks reference to the operation now almost universal—namely, submucous resection, which enables relief to be given to many cases almost hopelessly before.

His short description of the accessory sinuses is good, as it follows Hajek throughout, also his list of the various operations on the antrum; though, as is natural, there is not space to discuss the deeper and more difficult bone cells and their treatment. The remainder of the book is devoted to the ear, and the various descriptions are good; especially worthy of note is the chapter describing the ordinary catarrh of the middle ear and the various forms of sclerosis. Fig. 106 is a little misleading, as it is usually advisable to slit the drum head from top to bottom to let out discharge; the small opening figured would close almost immediately. The work can be highly recommended for those who read the German language, and it is nicely arranged, and easy to read.

OSLER'S COUNSELS AND IDEALS. (b)

THIS volume is a collection of extracts from the writings and addresses of Prof. Wm. Osler. In all, forty-seven of his lectures and essays have been consulted. The object of this book is to bring the influence of this master mind to bear more widely upon the medical student. This "individual influence" is, of course, best gained from actual contact with the teacher, but in default of this the present work will do much to fill up the gap. The extracts are arranged

(a) "Lectures on Clinical Psychiatry." By Dr. Emil Kraepelin, Professor of Psychiatry in the University of Munich. Authorised translation from the Second German Edition. Revised and Edited by Thomas Johnstone, M.D., M.B.C.P. Second English Edition. Pp. xviii. and 852. Price 10s. 6d. net. London: Baillière, Tindall and Cox.

(a) "Anleitung zur Diagnose und Therapie der Kehlkopf, Nasen, und Ohrenkrankheiten. Vorlesungengehalten in Fortbildungscursen für practische Aerzte." Von Dr. Richard Kayser, in Breslau. Dritte vermehrte und verbesserte Auflage, Mit 132 Abbildungen. Berlin: Verlag von S. Karger, 1905.

(b) "Counsels and Ideas from the Writings of William Osler." 4s. net. Oxford and London: Henry Frowde, 1905.

under definite headings, constituting altogether twenty distinct subjects or groups. Some of the subjects dealt with are "Pioneers in Medicine," "Catholicity in Medicine," "Charity and Fraternity in Medicine," and "Religion, Death and Immortality." Some of the extracts are of the very greatest value. We quote the following as an example:—"It is the confounded tales of patients that so often set us by the ears, but if a man makes it a rule never under any circumstances to believe a story told by a patient to the detriment of a fellow practitioner . . . he will have the satisfaction of knowing that he has closed the ears of his soul to ninety-nine lies, and to have missed the hundredth truth will not hurt him." And this is but one of the many wise counsels set forth in this admirable volume. We would have every medical man make this book his guide and friend, as by so doing we feel sure that the rough places will be made smoother and the crooked paths straighter. No one can study these extracts without feeling impressed by the nobility of character which stamps each one of them. The volume is tastefully bound, and is printed in clear type on thick paper. It will be found an inspiring book to dip into at odd moments, and one that is sure to be welcomed by a wide circle of the profession.

In sending the first number of the third volume of *Our Hospitals and Charities Illustrated*, Messrs. Macmillan and Co. point out that it has taken up rather a new stand-point, being the first journal that attempts to represent the vast body of people who subscribe to charitable institutions. It contains much that is new and interesting, and attention may be specially drawn to the article on the Salvation Army and the unemployed

OBITUARY.

WILLIAM HUGH HUGHES, M.R.C.S., L.S.A., J.P.

MR. W. H. HUGHES, one of the best known men in Ashton-under-Lyne, died on the 18th instant. He was educated at the Winwick and the Warrington Grammar Schools, and was a student at the Manchester Royal School of Medicine. He took the qualifications M.R.C.S. and L.S.A., and was for a time resident surgeon at the Manchester Infirmary, and afterwards of the Chorlton Union Hospital, Withington. In 1861 he went to live at Ashton-under-Lyne, where he had held many important offices. He had been for a great number of years the medical officer of health for the borough, and was the examining doctor under the Factory and Workshops Acts, the medical officer to the police force, the union workhouse, and the Post-office. He was a magistrate for the borough, and also for the Lancashire county.

THOMAS FRANCIS ODLING, C.M.G., M.R.C.S.

DR. T. S. ODLING, C.M.G., physician to the British Legation, the Telegraph Department, and the Imperial Bank of Persia, died at Teheran on Saturday of typhoid fever. He qualified M.R.C.S. of England in 1872.

HARRY MAY, M.D. ST. AND.

MR. HARRY MAY, M.D., formerly of Ware, Herts, died on the 23rd inst., at Parkstone, at the age of seventy-four. Dr. May studied at the London Hospital and was admitted M.R.C.S. England, L.S.A. in 1852, and L.R.C.P. London, in 1861. He was formerly honorary surgeon to the Loughton Cottage Hospital. He received the M.D. degree from St. Andrew's University in 1880.

JAMES WILLIE HOLMES, M.R.C.S., L.R.C.P.

MR. JAMES WILLIE HOLMES, of Malinda Street, Sheffield, the eldest son of the Rev. T. W. Holmes, passed away at the Charing Cross Hospital, on the 18th inst. A fortnight ago he came to London to undergo an operation, after having suffered for a considerable time from a kidney trouble. The opera-

tion was successful, but the patient had not sufficient strength to rally. Deceased was only forty-three years of age, and obtained his degrees sixteen years ago. He received his training at the Charing Cross Hospital, and has since practised in Sheffield. He was married some years ago, and leaves a widow and one son. The family will have sincere sympathy from a large circle of friends.

BENJAMIN COCKS, M.R.C.S.

MR. BENJAMIN COCKS, M.R.C.S., a Hertfordshire surgeon, formerly of Buntingford, died on the 23rd inst. at Bath, at the age of seventy-three. He was professionally educated at St. Mary's Hospital, and was admitted a licentiate of the Society of Apothecaries in 1858, and later M.R.C.S. Eng., and L.R.C.P. Ed. Mr. Cocks was at one time house-surgeon to the Marylebone Infirmary.

ROBERT KEALY, M.D.

DR. ROBERT KEALY has died at his residence, Ashley House, Gosport, in his seventy-sixth year. Professionally educated at the medical school of King's College, he became a member of the Royal College of Surgeons, England, in 1855, and M.D. St. Andrews, in 1862. Dr. Kealy had been Admiralty Surgeon to Portsmouth Harbour and the Naval Ordnance Department, and physician to the out-patients at the Portsmouth, Portsea, and Gosport Hospital, besides filling many other public appointments in Portsmouth.

EDWARD PILKINGTON, M.R.C.S.

MR. EDWARD PILKINGTON, formerly a well-known medical practitioner in Sunderland, but who had retired and taken up his residence in Harrogate, has died there recently in his eighty-fifth year. He was the author of a "Report to the Registrar-General on the Mining Population of Sunderland."

ALFRED HENRY NEWTH, M.D. ABER., M.R.C.S. ENG

WE regret to announce that while attending a patient at Hayward's Heath on Feb. 22nd, Dr. A. H. Newth had a seizure. A cab promptly conveyed him home, where he became unconscious, and died shortly afterwards. Deceased was the author of many works on insanity. He received his medical education at St. Thomas's, London, and at Aberdeen. He became M.D. Aberdeen, in 1868, and took the M.R.C.S. England a year earlier.

London Inter-Collegiate Scholarships Board.

A COMBINED Examination for a large number of entrance scholarships and exhibitions tenable at University College, King's College, and the East London College will be held in London by the London Inter-Collegiate Scholarships Board on Tuesday, May 15th, 1906, and following days. The Competition is limited to those who have not previously been students at any one of the Colleges *except where the contrary is stated*. No competitor can be elected to more than one scholarship or exhibition. No candidate will be admitted to the examination for these scholarships and exhibitions unless he has passed the Matriculation examination of the London University, or any examination accepted by the University in lieu thereof, or is the holder of a School-leaving Certificate, or is able to furnish some evidence of having had a sound general education which is satisfactory to the Board. Application should be made to the Secretary of the London Inter-Collegiate Scholarships Board, University College, Gower Street, London, W.C., for forms of entry, which must be filled in and returned together with a certificate of age and one of good conduct from the Principal of the candidate's last school or other satisfactory reference not later than May 1st, 1906.

DR. J. A. CLOUGH, Medical Officer of Lagos, takes over the duties of Resident Medical Officer of the Lagos Hospital during the absence of Dr. W. L. Taylor in England on leave.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons in Ireland.—Address on Therapeutic Inoculation.

ON February 10th, Dr. A. E. Wright, Lecturer on Pathology at St. Mary's Hospital, London, delivered an interesting address in the college hall on Therapeutic Inoculation. The chair was occupied by the President, Sir Arthur Chance. Dr. Wright, who was cordially received, dealt at first with the various principles of inoculation, and by means of an excellent series of charts demonstrated the action of inoculation on the opsonic index. He cited a number of cases which had passed through his hands and which had been treated by means of inoculation. As a result it appeared to him that many of the present methods of dealing with particular diseases might be dispensed with if the theory of therapeutic inoculation were properly developed. In his experience he had inoculated cases of appendicitis, suppurative diseases of the kidney, acne, and other forms of pyogenic infection, with good results, and at the moment he was dealing in the same way with a patient who was suffering from leprosy. So far the treatment had given success, but as to the ultimate result he was yet unable to venture an opinion. Dr. Wright then dealt with cases where more than one variety of pathogenic organism was present in the body, and suggested that in such cases it would be well to discover which variety was the most injurious and then to make injections accordingly. He felt that if his system of inoculation was fully developed it would remove a good deal of the medical and surgical methods now in use. If the belief that cancer was the result of the action of a microbe was proved to be true, he felt that in the course of time it would be possible to deal with the disease by means of inoculation.—Dr. Swanzy, in proposing a vote of thanks to the lecturer, said Dr. Wright had acted in the most kindly and unselfish manner in postponing his departure from Dublin in order to give them the benefit of his experience. Even if Dr. Wright proposed to take away all medicinal and surgical practice they could not but feel grateful to him for his address.—Dr. Bennett seconded the vote of thanks, and the motion was carried unanimously.—Dr. Wright replied, and the proceedings closed.

King's College Hospital London.

THE annual court of governors of King's College Hospital was held on the 22nd inst. in the board room of the hospital. The Rev. Dr. Headlam (principal of King's College) presided. The 67th annual report of the committee of management was presented. It stated that the number of in-patients treated during the year showed a decrease of 140 as compared with 1904, and there had also been a decrease in the out-patient department, which was largely due to the construction of Aldwych and Kingsway, and the consequent displacement of the poor population formerly residing in the locality. The ordinary expenditure for the year was £21,487, being a decrease of £333 as compared with the previous year; the ordinary income for the year amounted to £16,200, as against £15,717 in 1904. Legacies were received amounting to £12,270. The committee also reported the resignation, owing to ill-health, of Miss Monk, who for 21 years had held the office of sister-matron. The chairman, in moving the adoption of the report, said that it was necessary that they should bear in mind the difficult task they had before them of keeping the hospital going, and at the same time of collecting sums of money for the removal fund. Owing to the fact that they had received an unusual sum in the way of legacies during the year they had been able to pay their way. It was necessary, he said, that the hospital should have a larger income during the ensuing year. Mr. C. M. Tatham seconded the motion. Sir E. C. K. Ollivant stated that it was hoped to hold a fete during the year for the purpose of raising money for the removal fund. The report was adopted. After some

formal business had been transacted, the chairman made a statement in regard to the removal of the hospital. He said that of the £300,000 they had appealed for they had received about half. They were now in full possession of the site and had a substantial sum in hand to enable them to begin building immediately. The architect who had been selected was Mr. W. A. Pite, F.R.I.B.A., and he had been instructed to prepare the working drawings of the out-patient department, which would be ready in about two months. They therefore hoped to begin the building of that department within the next three months. They had sufficient money to see them to the end of the year, but they required more to complete the hospital. A vote of thanks to the chairman was passed and the proceedings terminated.

The National Hospital for Consumption, Ireland.

THE fourteenth annual general meeting of the supporters of this hospital took place on Friday last at the Royal College of Physicians. The chair was occupied by Mr. O'Brien Furlong, and amongst those present were His Excellency the Lord Lieutenant and the Countess of Aberdeen. The annual report was read, and, as it is a document of considerable practical importance, we hope to deal with it in a special article in our next issue. After mentioning that the new block for women patients was completed, and ready for occupation, early in February, 1905, the report continued: With the completion of this new block the number of beds in the hospital has been raised to 100, thus realising the original scheme of a hospital to accommodate 100 patients suffering from pulmonary consumption. That the subscription list should continue to show an increase is eminently satisfactory; it is evidence of the continued sympathy on the part of the public with every effort made to combat the dread disease of consumption. At the same time the Board would point out the large and necessary increase in the cost of provisions and maintenance consequent on the additional number of beds provided in 1905. The number of daily diets was 43,166 in 1905, as against 36,987 in 1904—an increase of about 16.6 per cent. The report was adopted, and then Sir William Watson proposed, and Dr. Lumsden seconded: "That the thanks of the meeting be given to the Visiting Physicians, Dr. Coleman and Dr. Parsons, and to the staff, for the efficient manner in which they discharged their duties." The resolution was adopted, and shortly afterwards the proceedings terminated.

Diphtheria in Kent Villages.

FIFTY cases of diphtheria have been reported at Well Hall, Eltham, Kent, within a few weeks. All the Sunday schools are closed, and the London County Council day school in Grangehill Road is to be closed if the epidemic continues. Diphtheria has been prevalent in East Greenwich and Charlton since December, mainly among children attending the Lombard Wall School. The school building was disinfected during the holidays, but the disease continued to spread after the term began.

House of Commons.—Bovine Tuberculosis.

MR. BURNS informs Mr. Field that he cannot say precisely when the report of the Royal Commission on Bovine tuberculosis will be issued, but that it is being pressed forward as speedily as practicable. In reply to a further question, the right hon. gentleman states that he could not promise pending this report to introduce a Bill providing compensation to the owners of animals purchased at full market value in open market but subsequently condemned for alleged tuberculosis. Legislation would be necessary to secure a uniform system of meat inspection, but a report to the Local Government Board by Dr. Buchanan, one of their medical inspectors, has lately been issued on adminis-

tration in London with regard to pigs affected by tuberculosis, which will no doubt receive the consideration of local authorities, and will Mr. Burns hopes, lead to some improvement in the present system.

Outbreak of Diphtheria in a Greenwich School.

LAST week the Greenwich Borough Council commenced an investigation which may have important results for London. No fewer than 91 school children in that borough have recently suffered from diphtheria. The great bulk of them are scholars at the Lombard Wall School, and as the London County Council ventilates its main sewers at this particular point the object of the proposed inquiry is to find out whether this is not the cause of the infection. Dr. Annis, the medical officer, believes that the present outbreak has at last been got under. At his request the L.C.C. sent one of its medical men to the school. As a result of two examinations of the children's throats made by him several of the scholars were told to stay away. The school was thoroughly disinfected, but fresh cases appeared among the scholars. The condition of things became so serious that the school was closed for several days in the early part of the present month, and the premises again thoroughly disinfected. As the County Council ventilates its main drainage system at many other places in London, it is felt that evidence from other districts would help Greenwich to arrive at a sound decision. Such an inquiry would be important at the present time, for the several main sewers now being constructed by the L.C.C. involve the erection of sewer ventilators.

The National Physique.

MR. J. G. LEGGE, H.M. Inspector of Reformatory and Industrial Schools, and a member of the departmental committee appointed to inquire into the question of physical deterioration, lectured last week at the London Chamber of Commerce, at the first of a series of joint conferences arranged by the Federation of Working Men's Social Clubs, in conjunction with the Club and Institute Union. Further meetings will be held in March, April, and May. Mr. Legge claimed that the committee, though it had been accused of attempting too much, had performed a very useful service by its study of the question. It was interesting to note that comparison of the results of the anthropometric records secured in 1883, so far as they related to industrial school boys, with measurements taken by himself in 1901 and confirmed in 1903, suggested that their physique had slightly but distinctly improved. The beginning of the remedy was the systematic collection of data, especially relating to children which might be secured by school teachers on a day set apart for the purpose once a year, and by certifying surgeons engaged under the Factory Acts, who annually dealt with some 375,000 persons from 14 to 16 years of age. Overcrowding was one of the chief causes of physical degeneracy, but the children of the suburbs were equal in physique and mentally superior to the purely rural juvenile population; and by opening out the towns as much good would come as by taking the people back to the land. There was need for a stricter suppression of the pollution of the atmosphere; the clearance of insanitary areas; more effective control of common lodging-houses, all beneath the eyes of central medical officers of health. Small holdings and "garden cities" meant much to the future physique of the race. The health conditions of large towns had largely increased in the last half century, but much remained to be done.

The Recent Disturbances at the Royal University of Ireland.

IN Parliament on Wednesday last, Mr. Lonsdale asked the Chief Secretary of Ireland whether he was aware that, in consequence of the disorderly conduct of some graduates and undergraduates at the conferring of degrees on October 27th last, whereby the singing of the National Anthem was forcibly prevented, the Senate of the Royal University of Ireland passed a resolution declaring the urgent necessity of obtaining

powers to deal with all matters connected with the honour and discipline of the University, and whether the Government propose to take the necessary steps to give the Senate power to deal with cases of disloyal and disorderly conduct on the part of graduates and undergraduates of the Royal University. Mr. Bryce replied that he was advised that the Senate of the Royal University already possessed full power to maintain order at all meetings of the University, and to frame such statutes or rules as may be necessary for the purpose.

Annual Dinner of the Association of Medical Diplomates of Scotland.

THE second annual dinner of the Association of Medical Diplomates of Scotland at the Trocadero, London, on the 23rd inst., proved a most successful gathering. The President, Dr. Farrer, was in the chair. The toast of the evening—namely, "The Association," was proposed by Dr. C. W. MacGillivray, President of the Edinburgh Royal College of Surgeons, one of the distinguished guests. The toast of the guests, proposed by Mr. Sydney Stephenson, was responded to by Mr. John Tweedy, President of the English Royal College of Surgeons and by Mr. Bidwell. Other distinguished guests were Dr. Herschell, Dr. G. Carpenter and Mr. E. Canny Ryall. Dr. Skene-Keith proposed the Officers and Council, to which Dr. Hardyman (Bath) and Dr. David Walsh replied. The latter alluded to the exclusion of Scotch and Irish diplomates from most London and many provincial hospital posts.

Increase of Lunacy in Kent.

IN their annual report to the Kent County Council, just presented, the committee state that the condition and management of the asylums at Barming and Chartham are good, and the care of the patients therein have been generally satisfactory, but at the Barming Heath Asylum the accommodation of the number of patients now resident therein is insufficient. Good progress has been made in the erection of new blocks to that asylum for the accommodation of 100 male and 100 female patients authorised by the County Council, but it will be some time yet before the work is complete. The patients at Barming number 1,486, whilst at Chartham there are 1,061. The Commissioners in Lunacy, who had visited the asylum, stated that "on the male side the asylum is overcrowded, there being 34 patients in excess of the proper number, and on the female side there are only 23 vacancies, the accommodation, therefore, which the new additions to this institution will not provide probably under two years, is urgently needed, in view of the fact that during the year 1904 there was an increase of 150 patients over the preceding year. It is therefore clear that even with a smaller rate of annual increase further asylum accommodation for the county of Kent over and above that shortly to be provided at this institution will be necessary in the near future.

Royal College of Surgeons, Ireland. Fellowship Examination.

THE following candidates having passed the necessary examinations, have been admitted Fellows of the College:—A. Charles, L.R.C.S.I. (1902), W. C. Cremin, L.R.C.S.I. (1903), C. A. Cusack, L.R.C.S.I. (1904), T. H. Delany, B.Ch., Royal Univ. Ireland (1893), Captain, I.M.S.

The following have passed the Preliminary part of the Fellowship examination:—S. Blake, Student R.C.P. and S.I.; T. C. Boyd, Student, R.C.P. and S.I.; Miss M. Clarke, Student Bgham. Univ.; J. C. L. Day, Student R.C.P. and S.I.; F. N. Holden, Student R.C.P. and S.I.; J. R. D. Holtby, Student R.C.P. and S. Edin.; A. E. S. Martin, Student R.C.P. and S.I.; E. Montgomery, Student R.C.P. and S.I.; J. Campbell-Murray, Student, R.C.P. and S.I.; K. F. P. Rynd Murray, Student R.C.P. and S.I.; W. G. Ridgway, Student R.C.P. and S.I.; G. W. Stanley, Student R.C.P. and S.I.; and W. M. Woods, Student R.C.P. and S.I.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

Chronic Acetanilide Poisoning.—Herrick and Irons (*Journ. of the American Ass.*, February 3rd, 1906) discuss chronic acetanilide (antifebrine) poisoning, and report a case in which the absorption of the drug was from an ulcer of the leg, to which it had been applied for its analgesic effect. The drug appears to be a common constituent of many patent medicines, especially "headache powders," and has a very marked effect, as an analgesic and hypnotic, in such conditions as neuralgia, sciatica, migraine, &c. It is sometimes used by dermatologists as a dusting powder in the treatment of painful or itching skin affections. Withdrawal of the drug from one accustomed to its use is followed by exacerbations of pain, sleeplessness and restlessness, in fact much the same condition as is seen in the morphia-taker. According to Herrick, the acetanilide habit is to be suspected in a patient who presents a secondary anæmia, cyanosis, dyspnoea, nervousness or gastric intestinal disturbance without an adequate explanation for it in heart, lungs or other organs. Splenic enlargement is not uncommon. The urine is dark in colour, darkens still more on standing, and contains an increased amount of conjugate sulphates and also paramidophenol. They suggest that if some of the obscure cases of neurasthenia, anæmia, dyspepsia, &c., were more carefully examined an explanation for them would not infrequently be found in the acetanilide habit, the drug being taken either as such, or as one of the ingredients of the many headache remedies and pain-killers. D.

The "Spleen Point."—Signorelli (*Riforma Medica*, Jan., 1906) has found that the sensibility of the skin is altered in certain places whenever there is inflammation or other morbid process in the spleen. In case of acute tumefaction of the spleen or exacerbation of a chronic tumefaction a zone of cutaneous hyperalgesia, he says, will be found corresponding to the fifth interspace on the left, near the left nipple. This is what he calls the "spleen point"; it may be a little to one side or above or below the nipple. In addition to this zone in front, there is frequently a corresponding zone at the fifth, sixth, seventh, or eighth spinous process, and occasionally another in the side, corresponding to the sixth or seventh interspace on the median axillary line. The zones correspond to Head's sixth metameric segment, and throw light on the embryology and physiology of the spleen, and aid in differentiating affections of this organ. D.

Deep Injections of Alcohol in Neuralgia.—Ostwalt (*Presse Med.*, Paris, Jan., 1906) states that he has made 250 deep injections of alcohol in cases of tic douloureux, and never has had the slightest mishap or unpleasant by-effect. The pain was arrested at once. The effect is like a transient gasserectomy, as for the time being the functions of the Gasserian ganglion are suspended. In at least 90 per cent. of the cases the neuralgia was cured by the procedure. In about a third of the patients recurrence was observed after four or five months, but one or two more injections definitely banished the pain. He injects 1 or 1.5 cc.—80 per cent. alcohol, to which .01 gm. of cocaine or stovain, has been added, making the injection along the trunk of each of the branches affected at the point where they emerge from the bone. He prefers a bayonet shaped needle and has found these deep injections of alcohol effectual in cases of neuralgia elsewhere in the body, in sciatica, &c. He has also cured cases of rebellious facial hemispasm by injecting, a drop at a time, 70 per cent. alcohol along the trunk of the facial nerve. D.

Acute Anglo-Neurotic Edema.—Herter (*Deut. Med. Woch.*, Jan., 1906) describes a case of angio-neurotic œdema in which the œdema developed always after midnight, reached its maximum towards morning, and then gradually subsided during the forenoon. The patient was an otherwise healthy woman of 69. The œdema was restricted to the lower part of the face and tongue. The attacks have recurred at intervals of a few weeks or months during the last eight years. D.

Certain Appearances of X-Rayed Hairs.—Williams (*Journ. British Dermatology*, Feb., 1906) contributes an interesting note on this subject. Complete alopecia was caused by several short exposures of ten minutes each. The hairs showed marked tailing out. In these hairs there was very little pigment found in the attenuated part, and in this part there was no visible medulla. The fine end is often quite pointed, and without any cupping so that it is not easy to decide whether or not they are papillary hairs. This type differs markedly from that of the hairs which result from a single long exposure, timed by the Sabouraud method. In such hairs there is far less tailing out and the hair ends look wedge-shaped. In cases where depilation was not complete the hairs presented a curious appearance. As they grew an attenuated pale portion appeared on the surface, and as the hairs gradually became stronger the natural thickness and colour were recovered. These hairs appear drawn out like a piece of glass tubing. Williams considers that the action of the X-ray on the vegetative function of the hair root and papilla is to cause a weakening of the power to produce cornified cells. The short-tailed hair is the result of the rapid paralysis of this function by a single, long exposure. The long-tailing and pointed ends of the hairs produced by a series of short exposures leading to complete alopecia is the result of a progressive weakening culminating in complete paralysis of this function. The resemblance of the third variety to the narrow portion of a moniliform hair is very striking. Moniliform hairs also occasionally appear in alopecia areata, and this suggests an intermittent interference with the trophic function of the papilla as a cause of moniliform hairs. The keratosis of the mouth of the follicle described by F. Bering is not always present, and if it be a primary condition it may act directly on the papilla and not by mere pressure on the hairs as Bering suggests. K.

The Etiology of Gall-stones.—Lartigan (*Cal. State Journ. of Med.*, Jan., 1906) has recently reviewed the various factors in gall-stone formation, and recorded the results of a large series of personal experiments. The mere presence of an aseptic foreign body does not suffice to produce gall-stones. The introduction of pieces of cotton, fragments of human calculi, grains of wheat, and other irritating substances does not lead to calculus formation, even when the outflow of bile is partially obstructed. The introduction of bacteria, associated with mechanical irritation of the mucosa, is followed in a considerable percentage of cases by the formation of stones; however, this is still more likely to occur if in addition to the organisms there is a foreign body present and the flow of bile be retarded. Out of nine rabbits inoculated and flow of bile partially obstructed, eight developed stones. The chronic cholecystitis produced by the bacteria is associated with desquamation of epithelium and this in turn favours the formation of cholesterol and bile rubin calcium. It is suggested that the clumping of bacteria may be an important preliminary step, the clumped bacteria acting as nuclei for the stones. In

many instances infection takes place from the bowel, but not always so, as many cases of gall bladder infection are due to bacteria not usually found in the duodenum, and there is positive evidence that bacteria introduced into the general or portal circulation may be recovered from the gall bladder. In many cases of gall-stones, no history can be obtained of a general, or even a severe intestinal infection, but these cases may be explained on Adam's theory of latent infection, according to which even healthy intestines allow the passage of bacteria into the portal circulation, and thence into the gall bladder. D.

Food Factor in Paroxysmal Neurosis.—Hare (*Pract.*, Feb., 1906) discusses this subject. In the past these conditions were generally explained as the result of a tendency on the part of the nervous centres to the irregular accumulation and discharge of nerve force, but this hypothesis Hare rejects as not being sufficiently comprehensive. Instead he frames the following provisional hypothesis: "That the recurrent affections—migraine, asthma, major epilepsy, and acute articular gout—depend primarily upon an accumulation of unoxidised, or imperfectly oxidised, carbonaceous material in the blood; and that each paroxysm is a conservative measure adapted to disperse such accumulation." The fate of the hypothesis depends, in the absence of experimental demonstration, on its conformity with verified facts. Hare states that although he framed this hypothesis some seven years ago, he has hitherto failed to find in medical literature any recorded observation which is at all necessarily inconsistent with it. It is generally assumed that when carbonaceous material accumulates in the system it does so in the extravascular tissues in the form of fat, glycogen, &c., but this assumption Hare denies, and considers that such material may, in some circumstances, accumulate in the general blood stream, giving rise to a condition which he terms "hyperpyræmia." He then proceeds to show that the various conditions which favour this hyperpyræmia favour the attacks of the paroxysmal neuroses, while those which are opposed to it tend to ward off the attacks, or are curative of them. In asking for the acceptance of this generalisation, Hare lays down the two following cautions to be observed:—(1) The humoral is but one of a number of factors which together go to make up the causation of these paroxysmal neuroses, and in many cases the other factors were more dominant in causation, and so more worthy of therapeutic attack in the first instance. (2) In many cases the hyperpyræmia determining the paroxysm must be regarded as merely a relative, and not an actual one. K.

Mucous Membrane Lesions in Lupus Erythematosus.—Smith (*Brit. Journ. Dermatol.*, Feb., 1906) corrects the prevalent idea of the rareness of this condition. He made careful examination of fifty-six consecutive cases of lupus erythematosus and found that sixteen had some affection of the mucous membrane, or 28 per cent. The supposed rarity of the condition is doubtless due to the fact that very little complaint is made of it by the patient. The majority of the patients were unaware of the existence of any lesion in the mouth. Some admitted a little soreness which they attributed to the irritation of decayed teeth, but none made any special complaint of the lesions. The list of cases include affections of the inner surface of the cheeks, the palate, inner surfaces of the lips, the mucous membrane of the nose, and the conjunctiva. In no case was the tongue observed to be affected. K.

Clinical Experiences with Marmorek's Antituberculous Serum.—Stadelmann and Benfry contribute an important article to the *Berl. Klin. Woch.* (No. 4, 1906), detailing their results with Marmorek's serum. They point out that since Marmorek's original communication in 1903, numerous favourable reports have been published, but they themselves can confirm none of these. They have given the serum to five patients in the different stages of pulmonary phthisis, and have observed such unfavourable results

that they did not consider themselves justified in giving it to others: They never observed any improvement in objective lung symptoms, and they frequently found that the injections were followed by a week of hectic exhausting fever. Skin affections, such as urticaria, and hæmorrhages, or painful swellings at the site of the injection, were frequent occurrences, and there was often some enlargement of neighbouring lymph glands. The serum employed was obtained almost directly from Marmorek, and was used at first in exact accord with his directions. Later on some modifications of method were introduced with the hope of getting better results, but no good followed the change. The writers give analyses of their cases, which fully support their statements. M.

Progressive Facial Hemiatrophy.—Loebl and Wiesel (*Deuts. Zeits. f. Nervenheilk.*, Bd. 27, 1905) report a case of facial hemiatrophy in a woman, æt. 36. The condition had started at the age of 22, and had gradually progressed. The patient died of pulmonary phthisis, and histological investigation gave the following results:—The skin was atrophied down to its deepest layers; there was atrophy of the muscles supplied by the fifth nerve, and marked changes in the nerve itself on the diseased side, below the Gasserian ganglion; there was, in short, a proliferative interstitial neuritis, and both sensory and motor portions of the nerve were involved in the process. Examination failed to reveal any change in the ganglion itself, or in its cerebral connections, so that the case can locate the disease in the peripheral part of the fifth nerve. M.

Intrathoracic Dermoids.—Drs. Batty Shaw and Williams record (*Lancet*, Nov. 4, 1905) a case of intrathoracic dermoid cyst. The patient, a female, æt. 26, had suffered from pulmonary symptoms from childhood, and was admitted to hospital complaining of dyspnoea, and of the expectoration of phlegm and hairs. Examination revealed all the physical signs of a tumour situated in the upper part of the right side of the chest, while the left chest was normal. The diagnosis was made from the presence of hairs in the sputum. This symptom, the authors point out, is the only pathognomonic one of the condition, and was present in almost all recorded cases which were diagnosed during life. M.

Lobar Pneumonia with Hypoleucocytosis.—Pehoff (*Russische Med. Rundschau*, No. ii., 1905, p. 752) refers to the fact that fibrinous pneumonia as a rule only runs a favourable course when the number of leucocytes in the blood is increased. The author then refers to a case which he had observed, in which the number of leucocytes was greatly diminished, reaching only 2212 per c.m., and yet the case terminated in complete recovery. Careful examination of the case, however, revealed the symptoms of a latent malaria, and the plasmodium was found in the blood. The author found, moreover, that after the pneumonia the number of leucocytes sank still lower, apparently due to the malaria, and he concluded that during the pneumonia an actual increase above the previous number of cells had taken place. This was, moreover, borne out by a differential count during and after the disease, showing that in the former period the proportion of polynuclear cells was much greater than in the latter period. The author concludes that a bad prognosis should only be given when true leucocytosis, as determined by differential counting, is shown to be absent. M.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "Recent Medical Literature."
- (2) "Recent Surgical Literature."
- (3) "Recent Gynecological and Obstetrical Literature."
- (4) "The Recent Literature of Physiology, and Pathology."

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

EXCLUSION OF SCOTCH DIPLOMATES FROM HOSPITAL APPOINTMENTS.

Any Scotch or Irish diplomates willing to help in the forthcoming protest against their unjust exclusion from nearly all the great general hospitals staff appointments are requested to communicate with Dr. David Walsh, Hon. Sec. A.M.D.S., 18A, Hanover Street, London, W.

BOURNEMOUTH J.P.—The recent trial—Hadleigh Bay v. The Southend Corporation—is of the utmost importance in its bearing upon the responsibilities of local sanitary authorities with regard to the disposal of sewage. The discharge of drainage into the nearest stream or foreshore is becoming more and more perilous to municipal boards. Mr. Justice Buckley's summing up of the case deserves careful study. It is worth while now for almost any one who has been attacked with typhoid fever to enquire as to the possibility of recovering damages from his district sanitary authorities.

THE FORTHCOMING INTERNATIONAL MEDICAL CONGRESS, LISBON, 1906

To the Editor of THE MEDICAL PRESS AND CIRCULAR.
SIR.—The Executive Committee desire me to inform you that it has been decided to issue a limited number of cards of membership to the Medical and Political Press. These invitations will be gratuitous, and applications for them are to be made through the National Committee for each country before March 20th, 1906.

10A Chandos Street, I am, yours very truly,
Cavendish Square, D'ARCY POWER,
London, W. Hon. Sec. for Great Britain and Ireland.

PHARMACY AMENDMENT BILL IN PARLIAMENT.

The exact wording of the notice of presentation of the Bill to amend the Pharmacy Acts is as follows:—"Mr. Winfrey.—Pharmacy.—Bill to provide for the further regulation of the sale of poisons and the compounding of medical prescriptions, and to amend the Pharmacy Acts, 1832 and 1868. Wednesday, February 28th." Mr. Winfrey, M.P., the member for South-West Norfolk, is a pharmaceutical chemist.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, FEBRUARY 28th.

SOCIETY OF ARTS (John Street, Adelphi, W.C.).—8 p.m. Paper:—Captain G. S. C. Swinton, L.C.C.; London Traffic.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.). 8.30 p.m. Papers:—Dr. W. H. Kelson: Some Throat Affections. Dr. P. Stewart: What is the Earliest Stage at which we can Diagnose Tabes Dorsalis? Dr. W. A. Milligan: The Diagnosis of Early Extra-uterine Pregnancy.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m. Hunterian Lecture:—Prof. A. H. Cheate: Some Points in the Surgical Anatomy of the Temporal Bone from Birth to Adult Life.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. T. P. Legg: Clinique. (Surgical.) 5.15 p.m. Lecture:—Mr. J. Pardo: Difficult Micturition and Retention of Urine.

THURSDAY, MARCH 1st.

CHILDHOOD SOCIETY AND THE BRITISH CHILD-STUDY ASSOCIATION (Parkes Museum, Margaret Street, W.).—8 p.m. Lecture:—Miss Miyakawa: Child Life in Japan. (Arranged by the Childhood Society).

NEUROLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8.30 p.m. Papers:—Dr. L. E. Dudgeon: Acute Diphtheritic Toxemia with Special Reference to Acute Cardiac Failure. Dr. G. Holmes and J. H. Parsons: The Pathological Anatomy of Amaurotic Family Idiocy.

NORTH EAST LONDON CLINICAL SOCIETY (Tottenham Hospital, N.).—4 p.m. Clinical Cases.

ROYAL COLLEGE OF PHYSICIANS OF LONDON (Pal Mall East).—5 p.m. Milroy Lecture:—Dr. W. H. Hamer: Epidemic Disease in England—the Evidence of Variability and of Permanency of Type.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Lecture:—Prof. C. A. Morton (Bristol): Some Cases in which Collections of Stones formed in the Prostatic Urethra.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m. Dr. M. Dockrell: Syphilis as it modifies other Eruptions of the Skin, Symptoms, Diagnosis, and Treatment. (Chesterfield Lecture.)

FRIDAY, MARCH 2nd.

SOCIETY OF ANESTHETISTS (20 Hanover Square, W.).—8.30 p.m. Paper:—Mr. C. C. Braine: Experience of Anesthetics in 200 Cases of Prostatectomy.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m. Hunterian Lecture:—Prof. A. H. Cheate: Some Points in the Surgical Anatomy of the Temporal Bone from Birth to Adult Life.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Dr. H. Tilley: Clinique. (Throat.)

MONDAY, MARCH 5th.

OTOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos

Street).—4.30. General Meeting. Exhibitions, &c., by Messrs Furniss, Potter, Hugh Jones, J. S. Barr, Secker Walker, &c.

THURSDAY, MARCH 8th.

BRITISH GYNECOLOGICAL SOCIETY (20 Hanover Square, W.).—7.30 p.m. Special General Meeting. 8 p.m. Specimens. Dr. Jellett: I. Advanced Carcinoma of both Ovaries; II. Double Pyosalpinx associated with the presence of a Four Months' Extra-uterine Foetus. Mrs. Scharlieb: I. Endothelioma of the Uterus; II. "Peritelloms" of the Uterus. Papers:—Dr. Jellett: Notes on two rare conditions met with in the Pelvis during Operation. Mrs. Scharlieb: The Advantages of the Abdominal Route in Operations for Cancer of the Uterus.

Vacancies.

Clonmel District Lunatic Asylum.—Assistant Medical Officer. Salary £125 per annum, with furnished apartments, &c. Applications to the Resident Medical Superintendent. (See advt.)

Devon County Asylum.—Third Assistant Medical Officer. Salary £125 per annum, with board, residence, and laundry. Applications to Medical Superintendent, Exminster, Devon.

Leeds Public Dispensary.—Junior Resident Medical Officer. Salary £100 per annum, with board and lodging. Applications to the Secretary of the Faculty, Public Dispensary, North Street, Leeds.

Metropolitan Borough of Battersea.—Medical Officer of Health. Salary £200 per annum. Applications to W. Marcus Wilkins, Town Clerk, Town Hall, Battersea, S.W.

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

Royal Cornwall Infirmary, Truro. House Surgeon. Salary £100 a year, with board and apartments. Applications to J. C. R. Crewes, 4 Parkvedras Terrace, Truro.

Township of Manchester.—Assistant Medical Officer. Salary £100 per annum, with furnished apartments, fire, light, washing, and attendance. Applications to James Macdonald, Clerk to the Guardians, Poor Law Offices, New Bridge Street, Manchester.

The London Hospital Pathological Institute.—Director. Salary £250. Applications to Munro Scott, Warden, The London Hospital Medical College, Turner Street, Mile End, E.

Urban District Council of Handsworth, in the County of Stafford.—Medical Officer of Health. Salary £250 per annum. Applications to H. Ward, Clerk, Handsworth.

West Bromwich District Hospital.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to the Honorary Secretary, T. Foley Bache, Esq., Churchhill House, West Bromwich.

Appointments.

EDGEWORTH, FRANCIS HENRY, M.B., B.C. Cantab., D.Sc. Lond. Honorary Physician to the Bristol Royal Infirmary.

FAYRE, SIR JOSEPH, Bart., M.D. Edin., L.R.C.P. Lond., F.R.C.S. Eng., LL.D. Edin. and St. And., F.R.S., Honorary Consulting Physician to the Falmouth Hospital.

GRAHAM, G. H., M.D. Durh., Assistant Physician in charge of the Electrical Department at the Dreadnought Seamen's Hospital, Greenwich.

LATHAM, HENRY, M.B., C.M. Edin., Assistant Physician to the Peterborough Infirmary.

THOMSON, MAY, L.R.C.P., L.R.C.S. Edin., L.F.P.S. Glasg., L.M.Dub. Honorary Clinical Assistant to the Leeds Public Dispensary.

WALDO, HENRY, M.D., C.M. Aberd., M.R.C.P. Lond., M.R.C.S., Honorary Consulting Physician to the Bristol Royal Infirmary.

Births.

BELLAMY.—On Feb. 20th, at Blandford, Kew Gardens, the wife of Gerald E. Bellamy, M.R.C.S. Eng., of a son.

CROOKSHANK.—On Feb. 24th, at D'Antraques, Barnes, London, the wife of F. Graham Crookshank, M.D., of a son.

GENTLE.—On Feb. 23rd, at 28 Colville Square, London, the wife of J. Alexander Gentle, M.B., C.M., of a son.

STEELE-PERKINS.—On Feb. 20th, at 47 Southernhay W., Exeter, the wife of J. Shirley Steele-Perkins, B.A., M.B., B.C. Cantab., M.R.C.S. Eng., L.R.C.P. Lond., of a son.

WAYNE-MORGAN.—On Feb. 17th, Ty Gwyn, Whitechurch, the wife of L. Wayne-Morgan, M.R.C.S., L.R.C.P., of a daughter.

Marriages.

DUNN-FLOOD.—On Feb. 21st, at St. Stephen's Church, Bayswater, Hugh Percy Dunn, F.R.C.S., 54 Wimpole Street, Cavendish Square, London, third son of the late Rev. J. W. Dunn, M.A., Vicar of Warkworth, Northumberland, and grandson of the late Rev. Luke Yarker, M.A., of Leyburn Hall, Yorks, to Marian Sara Georgina, only daughter of John C. H. Flood, of 9 Tavistock Road, Bayswater, and of the Middle Temple, barrister-at-law.

SULLY-KING.—On Feb. 24th, at the Parish Church of St. Mary, Acton, Albert May Sully, M.R.C.S., of Claygate, Surrey, to Adeline, daughter of the late Robert King, J.P., of Durban, South Africa.

COOPER-BARBER.—On Feb. 24th, at St. Michael's, Ravenstone, Edith, second daughter of Rev. H. Barber, M.D., to Arthur Tann r Cooper, M.R.C.S., L.R.C.P., youngest son of William Temple Cooper, of Kingston-on-Thames.

Deaths.

ROUSE.—On Feb. 21st, at Wyndcroft, Worthing, Georgina, widow of the late James Rouse, F.R.C.S. Eng., Consulting Surgeon, St. George's Hospital, etc.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, MARCH 7, 1906.

No. 10.

NOTES AND COMMENTS.

Amateur X-Ray Treatment.

THE grave risks attached to X-ray treatment are universally recognised by the medical profession. The method, indeed, is permissible only in the hands of skilled and responsible qualified medical men. Yet in spite of reason and experience some short-sighted members of our profession persist in handing over radiography, and, in some instances, actual treatment by the focus tube, to chemists, electricians, and other unqualified persons. A recent trial in the South of England brought to light an incident of the kind. The plaintiff sued Bridger and Co., chemists, of Bournemouth, for burns inflicted upon his back while undergoing X-ray treatment for locomotor ataxy. There are several points in this case of vital interest to medical men. First and foremost, the patient was sent to the chemists in question by a Bournemouth practitioner. Why should not an expert medical electrician have been chosen for the purpose?

Chemists doing the Work of Medical Men.

HARDLY less extraordinary from our point of view is the fact that Bridger and Co., a well-known and respectable firm of chemists, should have undertaken treatment. It is all very well for them to plead they did so only on the understanding that they were to act under proper medical supervision. As a matter of fact they did nothing of the kind, and the practitioner who sent the patient to them stated in Court that he knew nothing about the special methods involved. Can Messrs. Bridger and Co. fail to realise that in accepting such a commission they were taking legitimate work out of the hands of medical men? However, they no doubt recognise now the folly of such a proceeding, and they would in our opinion be well advised if they gave up radiography also. They can never be safe, as non-medical workers, from claims for damages inflicted by their focus tubes.

Medical Men traitors to their Cloth.

NOR will the moral of the action be likely to fall less forcibly upon the inner consciousness of the medical man who so lightly entrusted his ataxic patient to the tender mercies of a chemist radiographer. In that particular case the tissues of the victim would obviously be extremely vulnerable to traumatism. That fact

would have been recognised and insisted upon had a medical radiographer been called in. In other words, the practitioner would in that event almost certainly have escaped the monetary loss, mental anxiety, and injury to professional reputation entailed by the publicity of his patient's litigation. It is to be hoped that his unhappy experience will act as a warning to others who may be tempted to send their patients to unqualified persons for electrical, massage, and other kinds of treatment.

The Metropolitan Sunday Fund and Hospital Abuse.

THE annual report of the Hospital Sunday Fund issued last week views things for the most part in a highly complacent manner. Everything is for the best in the best of all possible hospital worlds, as surveyed with the rose-coloured spectacles of Sir Edmund Hay Currie and his fellow councillors. Their attitude with regard to hospital abuse must seem ludicrously feeble and ineffectual to those who know the seamy side of the question. Abuse of the kind, they say, in effect, is practically non-existent, what little there may be can be readily checked by hospital authorities. The very sensible suggestion made with a view of lessening abuse, that patients after a first visit should not be permitted to attend a second time without a letter from a local medical man, is dismissed with the curt observation that they do not agree with that proposal. In their opinion it would be better to refer the patient—ye Gods!—to the nearest self-supporting dispensary.

Medical Charities first—Medical Men last.

THAT shows how the Sunday Fund worship their one god—medical charity—and are prepared to sacrifice to him the manliness of our citizens and the livelihood of the medical profession. Their cynical method is to transfer the patients who should be paying small fees to outside practitioners from a general hospital to a paying dispensary. How is the cry of the robbery of the medical profession to be met by substituting two blacks in place of one? Moreover, many general hospitals, such as the London, descend to the incredibly mean practice of charging threepence to each of their poor patients! In that case the Sunday Fund presumably would not advise London hospital patients to be handed on to paying dispensaries in the district. The

fact of the matter is that the main man of the medical profession is absolutely not represented on the hospital funds. The medical men on the Council simply represent the consultant ranks, who have little knowledge or sympathy with the struggles of the general practitioner, and who have not the faintest desire to disturb the serenity of our present hospital system.

LEADING ARTICLE.

LAY NEWSPAPERS AND QUACK ADVERTISEMENTS.

THE harm done to the health and the well-being of the community by the sale of quack medicines and quack nostrums is incalculable. By "quack" we characterise claims advanced by medically unqualified persons to treat and cure diseases by methods that are contrary to scientific experience, and are supported by assertions which are in most cases obviously false, extravagant and self-contradictory. The Medical Acts of the United Kingdom fail to protect the public against either quack practice or quack nostrums. The time has now come, in our opinion, when it is desirable in the interests of the nation that the truth of the whole matter should be stated without fear or favour. This week we propose to draw attention to an advertisement appearing in the *Daily News*. That particular newspaper is not selected because it is one of the worst offenders. On the contrary, its columns, on the whole, contain a considerably less number of objectionable advertisements than the average daily journal. The editorial tone of this publication we regard as genuinely high, and it is precisely on that account that we press this question upon its consideration. A certain Professor Heynel, unknown to the medical *Register*, advertises to cure asthma, consumption, chest and stomachic complaints. He advertises himself as a specialist of twenty-five years' standing and director of an institute at Brighton, but offers free consultations at an address in Shaftesbury Avenue, London. In all the diverse conditions mentioned he offers complete cure. Suppose a patient to have cancer of the stomach or lungs, or general tuberculosis, or advanced disease of heart, lungs, pleura, or stomach, this omnipotent professor undertakes, according to his advertisement, to cure them all. This claim is, on the face of it, absurd and misleading. As it is advanced with a view of getting money from the public it follows that it is fraudulent. Its appearance in the columns of the *Daily News* makes the Editor of that journal *particeps criminis* in the attempt to procure money under false pretences. What has the Editor of that journal to say in defence of the advertisement in question? With the ingenuity that characterises the quack advertiser, the unhappy Editor is represented as giving his direct and personal support to the claims of Professor Heynel, by means of the following passage:—"We cannot impress upon our readers who suffer themselves (or whose friends are in distress

through these terrible diseases) too much the importance of immediately putting themselves or their friends in immediate communication with the Director of the Institute." We can only sympathise with the Editor whose hospitality has been purchased and betrayed in so base a manner. As a matter of fact, we believe the Editor of the *Daily News* to be a moral and social philanthropist of the highest order. How he can reconcile his principles with the publication of such wicked and mendacious advertisements is a mystery indeed! There can be no doubt that Professor Heynel has had to pay a large sum of money to have a three-quarter column advertisement inserted in the *Daily News*. Nor can there be any doubt that the lay newspaper press generally draws an enormous revenue from quacks and quackery. In later issues we propose to extend our analysis of the situation to other journals, but for the present we are concerned with the *Daily News* alone. Let us ask the Editor if he realises the potential harm done by such advertisements as those of "Professor" Heynel. The very fact of the issue of so costly an advertisement indicates the large sums that must be secured therefrom. If the Editor of the *Daily News* accepts our view that the advertisement is inherently false, then he is not only being made the catpaw of a charlatan, but is sharing in his profits. We fail to see any other logical reading of the position. The fact that such advertisements are universally inserted in lay newspapers is no excuse for individual cases. The editors of journals drawing profits from such a source are earning money for proprietors and shareholders from base quarters. The victim of the charlatan for the most part come from the ignorant of all classes, but especially among the poor. Too often the sufferer from some serious malady is led into the use of advertised "cures"—save the mark—at a period when his condition is not, humanly speaking, past hope. To cure the incurable is the alluring lie of the quack—and to fill his pockets his one gospel. Let us implore the *Daily News* in future not to play into his hands and to lend its powerful aid to the furthering of heartless frauds upon the community. There has been one honourable exception in English journalism to the practice of receiving objectionable advertisements in our contemporary *Truth*—although what we should call quack remedies have now and then crept into its columns. One suggestion we would make to lay editors is that they should henceforth rigorously exclude from their advertisements those that have appeared in the black-list of *Truth*. Next week we purpose saying a few words about the yellow press, by the side of which the *Daily News* appears as a comparatively mild offender.

JAMES HENRY MITCHELL, a Kendal butcher, for sending to the London Meat Market the carcass of a cow which was slaughtered while suffering from milk fever, was last week sent to prison for a month. The farmer who sold him the cow was deprived of his costs of coming to the Guildhall as a witness.

NOTES ON CURRENT TOPICS.

Chronic Alcoholic Leptomeningitis.

DR. SPALDING LAURIE, writing in the *Australian Medical Gazette* for November 20th, records three cases of chronic alcoholic leptomeningitis. The patients all seem to have been pretty heavy drinkers, and, though syphilis could not be excluded absolutely, no evidence of its having occurred was obtained in any of the three. The first patient was taken suddenly ill with head-ache and giddiness; he had some retching and a tendency to fall to the left side. Four days later there was well-marked paresis of both hands and arms, but there was no other evidence of nervous disease. After slight improvement under potassium iodide and mercury, he became rapidly worse, with headache and giddiness, and died three weeks after the first seizure. *Post-mortem*, no lesion was found, but thickening of the arachnoid and pia mater over the frontal lobes. The second case was one of eight years' duration. The illness began with twitching of the right hand, which was followed five years later by similar symptoms in the left. Three years subsequently the lower limbs were affected with formication and "pins and needles," and gradually the power of walking was lost. Stupor then supervened, accompanied by coarse tremor of the hands, lips, and eye-lids. *Post-mortem*, the brain was œdematous and its veins were engorged, but the skull and dura mater were healthy. The arachnoid and pia were much thickened over the Rolandic area on both sides and slightly over the frontal lobes. The last patient, a heavy drinker, was attacked with left hemiplegia and rapidly became comatose. He died in two days. Besides recent hæmorrhages in the right lateral ventricle, the pia and arachnoid were thickened and slightly opaque over the frontal and Rolandic areas. The author points out that his cases are instances of a rare condition, and each differed from the usually-described type in that the dura, which is generally implicated in alcoholic meningitis, was free, the thickening being confined to the pia and arachnoid and no part of the brain substance involved. He then discusses the differential diagnosis from paralysis agitans, general paralysis of the insane, and tumour. He shows that the special points to look out for are head-ache, vomiting, Jacksonian epilepsy, tremors, paresis, inco-ordination, optic neuritis, delirium, loss of memory, and mental failure. Any or all of these may occur according to the extent of the pressure on the brain.

Scientific Education.

THE report of the Committee on Technological Education appointed nearly two years ago by Lord Londonderry was issued last week, and in its main features will be generally approved by scientific men. The fact, long known to everyone outside Government offices, that England is far behind Germany and America in the opportunities and

machinery she provides for scientific and technical training, is duly acknowledged by the Committee. They recognise the importance of keeping this country in a line with its competitors as "essential," and dwell on the lack of facilities for instruction, the lack of co-ordination among existing institutions, and the lack of appreciation by employers of the value of technical training. Teachers should be drawn from the highest ranks in their professions, say the Committee, and should be provided with the chance of pursuing pure scientific investigations, unhampered by routine drudgery. A large scheme of consolidation and extension of the Royal College of Science, the Royal School of Mines, and similar institutions is then recommended, and a suitable governing body indicated. We understand that the Board of Education is prepared immediately to find £20,000 a year to promote the scheme, and it may therefore be assumed that it will go forward. Although primarily concerned with the advancement of industrial technique and training, we are sanguine enough to hope that the presence of Sir William Church on the Committee is a guarantee that the ancillary medical sciences have not been overlooked in this provision. £100,000 a year to prevent disease and death would be the best investment the Government of a country ever made.

Small Hospital Schools.

THE decision of the King's Hospital Fund not to give grants to those hospitals which allocated a portion of their general funds to the maintenance of their medical schools is making things embarrassing for some of the smaller schools. Evidence of this was given last week by the annual report of the Middlesex Hospital, and by a meeting called at the Westminster Hospital to consider the question of the maintenance of its medical school. The Middlesex Governors' appeal is almost pathetic. They have come to the end of their available capital and are anxiously considering how the difficulty is to be surmounted unless some substantial aid is forthcoming soon. At the Westminster meeting it was resolved to open a separate fund for the maintenance of the school and to ask subscribers to the hospital to allow the Committee discretionary power to use part of their subscriptions for the use of the school. Whilst it is plain to everyone who thinks on the matter that hospitals are the only places where doctors can be trained, it is not equally clear to the public that a school is a positive asset to a hospital and its patients, both directly and indirectly, and we hope that these two worthy institutions will be successful in their endeavours to raise money to carry on their work. They are unluckily suffering from the bad advice originally given to the King, who, at the inauguration of his hospital fund, was made to say, through Lord Knollys, that no money given to it would go to support any medical laboratory. The want of accuracy and courage with which the anti-divisionists were met by the King's advisers on that occasion can only be sincerely lamented.

"Progress."

We have been asked to notice the arrival of a new journal, entitled "Progress," in the field of literature. This we are very glad to do, and can wish our infant contemporary nothing better than that its aims may be rapidly and effectively realised. The object of "Progress" is to secure social advancement for the poor and the raising of the standard of the industrial livelihood, and so long as the *desiderata* are approached on economically sound lines and by natural, as opposed to artificial, channels, we are heartily in accord with the editorial plan. The frequency with which our countenance is sought by journals of this and others of kindred nature shows how much the practice of medicine is becoming bound up in the practice of sociology, and how much is expected of the profession in that domain of effort. By assuming responsibilities in connection with the health of the people, medicine is being drawn more and more into civic paths, and its influence, and the influence of its knowledge, is becoming more and more warmly recognised. So long as the profession lends, as it is always willing to lend, its skill, its training, and its technical advice to the cause of social reform, and so long as it keeps clear of party politics as such, it is difficult to assess what its future influence for good may become.

Medical Care of Sailors.

At the annual meeting of the Seamens' Hospital Society, last week, Sir George Vivian, Deputy-Master of Trinity House, was in the chair, and made some pertinent remarks about the medical care of merchant seamen. He spoke of the "methods of barbarity" by which the sick sailor of old was treated by the members of the ship's company, usually the mate, who did doctor's duty, and he expressed his own desire to see ship's officers compelled to pass an examination in first aid, surgery, and pharmacy before qualifying under the Board of Trade for their strictly professional duties. Those who are read in the works of Mr. Frank Bullen and other writers of the sea as it used to be can only shiver at the thought of what the tender mercies of the mate as a doctor must have been, and one cannot wonder that the typical sailor of a hundred years ago should be represented as saying:—

"If my maxim's disease, 'tis disease I shall die on."

The prospects of recovery must indeed have been remote, and the period intervening before death a pretty ghastly one. Doubtless merchant seamen have experienced the benefit of the greater spread of humanity of late years, but even humanity without skill is of little avail in time of sickness. The efforts of the St. John's Ambulance Association to promote some knowledge of first aid among ships' officers have met with some voluntary response, but we warmly associate ourselves with Sir George Vivian's demand that

a simple medical and surgical training should be compulsory for all officers of the mercantile marine.

Consumption at the Cape.

HAPPY indeed is that country which can tackle its tuberculosis problem with some prospect of finality! A vigorous effort is being made at Cape Town to rid the town of both its consumptives and its consumption-breeding areas, and the promoters maintain that it is possible if their suggestions are carried out for the Table Mountain City to be permanently freed from the infection of the disease. It appears that, like all large cities, Cape Town has its slums and over-crowded quarters, and that in these, which are chiefly occupied by natives, tuberculosis is rife. Dr. Forsyth of that city is urging that these quarters should be purged of their unhealthy elements, and that the sufferers should be transported to the high-and-dry regions in the Karoo desert, there to form an open-air colony. Such an arrangement can only make the dwellers in the old cities of Great Britain jealous of the facilities offered by new countries for dealing so effectively and so comfortably with the curse of consumption. Land in the Karoo cannot be expensive, and a colony, we take it, could be made almost self-supporting through the work of the patients who were able to undertake light agricultural duties. The climate, too, of the desert is an ideal one for consumptives, and under good management the recovery-rate should be high. But it seems certain that if the authorities undertake this venture they will put down their foot firmly against the importation of further tuberculous cases; indeed, the Cape Colonists, like the New Zealanders, are getting very restive at the dumping of British consumptives on their shores. If they adopt restrictive legislation, with a view to putting a stop to it, one would find it hard to blame them.

Anti-Vivisection Strategy.

If the obvious difficulties or the repeated failure of frontal attacks show that a position cannot be carried by a *coup de main*, the strategist lays his plans for preparing a flank attack, or for sapping and mining up to the enemy's stronghold. The anti-vivisectionists have long fought in the open field, and some of them are now beginning to recognise that but small successes are likely to accrue from this method of warfare. A different plan of campaign has been adopted in certain quarters, and, as it is both specious in its claim to attention and insidious in its effect, it is well that it should be fairly and squarely recognised. The form it is taking is that of asking for exemption of different classes of animals from experiment, and the immediate question to be laid before Parliament this Session is whether dogs shall not be saved from the "vivisectionist." Now, as the dog is "the friend of man" in a more intimate sense even than the horse, it is certain that such an appeal will touch the hearts of a large number

of people who would not be worried by a more general and sweeping proposal; and, moreover, a Bill to this effect being short would stand a very good chance of passing in the allotted time. On the other hand, if it did find its way to the Statute Book, an important precedent would be established and it would not be difficult in succeeding Sessions to get other classes of animals protected by similar short measures. Strategically, then, the move is well planned, and it will need all the more skill on the part of opponents to defeat it. We need hardly repeat that if experiments on animals are immoral, it is immoral to experiment on a dog as on a guinea-pig, perhaps more so, as the dog is capable of presenting greater resistance to his captors, and if experiments on animals are valuable to medical science, no animal which is likely to help in the defeat of disease should be excluded from the field.

Aberdeen's Lord Rector.

SINCE Sir Frederick Treves, by his retirement from active practice, became "unmuzzled," he has been playing the part of candid medical friend to a good many audiences, and he maintains the character he has always borne as a vigorous and emphatic speaker. Unfortunately, the emphatic speaker is apt to over-emphasise the particular side of the question that he wishes to present, and consequently an erroneous impression is apt to result in certain instances. Elected Lord Rector of Aberdeen, Sir Frederick Treves gave his constituents the customary Rectorial address at his installation, and in it he dwelt in strenuous terms on the advantages and disadvantages of the doctor's life. He paid a warm and well-deserved tribute to the unostentatious heroism of the country doctor—"the man in the gig"—who drove by day and by night to distant cottages, bringing healing and comfort to the poor and the sick. Admirable, too, were his words as to the necessity for absolute honesty in the practice of medicine, a calling apt to lend itself to euphemisms and prevarications. But we can hardly follow the Lord Rector when he argued that money and social influence were not only not advantages, but positive disadvantages in following the career of medicine. To speak thus is to fly in the face of evidence that is obtainable on every hand, and to cite cases like that of Sir James Paget is only to prove the rule by pointing out the exception. Though money and social influence are not the only factors in medical success, they are powerful adjuvants against which it takes men of worth, ability, and pluck to struggle. How many even of the good men in the leading practices of their districts to-day would be there if they had found themselves after qualification without a shilling in their pockets?

We understand that the Worshipful Company of Goldsmiths have made a grant of £10,000 to the Institute of Medical Sciences Fund of the University of London, on the assumption that a site for the institute will be provided at South Kensington.

PERSONAL.

THE Council of the Royal Institute of Public Health has appointed Professor Elie Metchnikoff to the post of Harben Lecturer for the present year. The annual congress of the institute will be held at Cork from June 27th to July 3rd, under the Presidency of Professor Bertram Windle, F.R.S., President of the Queen's College, Cork.

WE regret to learn that Mr. A. H. Benson, F.R.C.S., has resigned the Secretaryship of the Royal Medical Benevolent Fund Society of Ireland, a post which he has held for the past twenty-four years. The central Council of the Association has passed a resolution accepting Mr. Benson's resignation with deep regret.

DR. COOPER, M.P., who has sat on the London County Council as senior member for Bermondsey for over seventeen years, has resigned in consequence of the pressure of his newly-acquired parliamentary duties.

SIR WALTER FOSTER was last week elected chairman of the Medical Members Committee at the House of Commons. Seven members out of the ten constituting the committee were present.

DR. BEVAN LEWES, the well-known Director of the Wakefield County Asylum, entertained the Medico-Psychological Association and delivered an important address on alcohol, crime and insanity.

A HANDSOME presentation was made at South Normanton last week, to Dr. W. J. Le Grand, who for about eleven years lived in the place, but recently left for Blackwell.

MAJOR-GENERAL Lord Cheylesmore last week presided over the quarterly court of governors of the Brompton Hospital. The medical Committee's report showed that very satisfactory results were experienced by patients treated at the Sanatorium and Convalescent Home, but there was an urgent need for funds towards its maintenance.

IN the absence of Lord Ludlow, president of the Cancer Hospital, London, Lieutenant-Colonel Thomas R. Parr took the chair at the annual general meeting of the governors last week.

IT is stated that Dr. Norman Walker, of Edinburgh, will, next autumn, again offer himself as Direct Representative for Scotland on the General Medical Council. At the last election he ran second to Dr. William Bruce, of Dingwall.

PRUDENTIAL ASSURANCE.

FEW of our readers can have any conception of the extent to which life assurance is now carried on, and it augurs well for the thrift of the community that its adaption is increasing by leaps and bounds. If we take as an example the annual report of that gigantic institution the Prudential Assurance Company now before us, we arrive at the figure of 773,051 as the number of life policies in force at December 31, 1905, assuring, with bouns, £85,944,245, and producing a premium income of £4,118,360 per annum; whilst the life annuities payable are 3,369 in number, and amount to £114,081 per annum. In the Industrial branch the number of policies in existence at December 31st last was 16,065,268, including 1,102,267 free or paid-up policies, and the amount assured £159,683,044. The weekly premiums receivable in respect of these policies amounted to £122,626 per week, or £6,376,552 per annum.

A CLINICAL LECTURE

ON THE

CAUSE AND THERAPY OF ELEPHANTIASIS.

By Professor HANS KUHN, M.D.,
Of the Allgemeinen Poliklinik, Vienna.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

It may be interesting and instructive to follow the history of a case of elephantiasis that came to the out-patient department seeking relief from her burden, that had gradually invaded the left leg.

The patient, a female, was *æt.* 45. Her father died when *æt.* 71, of apoplexy, while her mother died at 62 from some pulmonary trouble. She has three brothers alive perfectly healthy, and no trace of her present illness could be found in any of her ancestors. When *æt.* 7, she suffered from scarlet fever, complicated with nephritis, but since that time has been comparatively healthy. Her menses commenced when *æt.* 14, and have continued regularly since, with pain on suppression. She often suffered from hemicrania ophthalmica when the menses were approaching, but was relieved with their advent.

In 1891, she first observed her left leg commencing to swell, which soon became much thicker than the right around the thigh, and which had become the seat of repeating erysipelas, accompanied with high fever. During the intervals between the attacks the skin never recovered its normal colour and softness, but continued thick and hard. From the first attack this annual recurrence has added to the thickened condition which is greatest over the inguinal canal, and extends down to the knee. The skin, formerly soft and smooth, now became thick, hard, and warty, subsequently forming knobs that hung in folds from the front of the thigh till the weight and dimensions became so great that it was a burden for her to move.

In 1896, she fell on the door-step and contused the lower third of the tibia without breaking the skin of the left leg. This was followed by a black area that soon ulcerated, forming a large sore as great as the palm of the hand, which necrosed and discharged a large quantity of *debris* before it healed, leaving a deep irregular cicatrix. After four or five years' repetition of the erysipelas, the extremity became unwieldy, which was accompanied with difficulty of breathing and cardiac palpitation; her corpulence, but not fat, had become so burdensome that she sought relief in every quarter without avail, which finally brought her to the poliklinik.

Her report on admission was medium height, corpulent, bony structure good, and muscles well developed. The right leg is enormously thickened, but the left far surpasses it, especially in front, where the swelling from the inguinal region down the front of the left leg lies over on the right like a monstrous labial hernia, extending almost to the knee. The skin of the left leg at the knee is drawn into folds and greatly thickened. A side view represented two tumours, one behind reaching down to the knee-joint about the size of a child's head, and the other in front as described. The skin over the calf of the leg was enormously thickened and swollen, extending down to the irregular cicatrix. The whole cutaneous surface was rough, irregular, and warty, while the parts between the folds of thickened skin were red and swollen, exuding an evil-smelling fluid with epithelium, but nowhere were excoriations or ulcers to be found.

The internal organs were:—Lungs, normal, sound on percussion, with a few dry bronchial rales on auscultation at the base. The area of cardiac dulness was greatly enlarged, extending from a line a finger's-breadth outside the mammary line towards the right to the external margin of the sternum and upwards to the fourth rib. The apex beat was found in the fifth intercostal space about an inch outside of the

mammary line. Auscultation revealed a dull sound without a murmur over the auricular region, which was slightly accentuated on the second sound. The action of the heart was slightly energetic and irregular. The liver and spleen were not enlarged, and all the other internal organs normal. The urine was wine colour, specific gravity 1014, and of acid reaction. There was a slight sediment, containing lymph cells and squamous epithelium. The indican of the urine was increased, while albumin was found in a small quantity. The nerve system was entire, while the



lymphatic glands were enlarged over the left inguinal region, but no tenderness or pain was present, neither was there sclerosis of the arteries observed. The radial pulse was moderately tense, unequal, and slightly arrhythmic, although the vessel was soft and full. The lips and mucous membrane were cyanotic, while the patient breathed slowly and with difficulty. Nothing pathologically was observed, internally or externally, about the genitals.

On account of the presence of myo-cardiac insufficiency, which was indicated by the dull cardiac tone, irregular movement, dilatation, and cyanosis, and presence of albumin, operation was considered a dangerous undertaking. Iodide of potassium was prescribed, while the extremities were raised and liquor Burowii, or a solution of alum and acetic acid, applied to the limbs, and then swathed in bandages. This was continued for several weeks without any visible sign of reduction. It was then resolved to operate, notwithstanding the danger of anæsthesia. On October

14th, a large wedge-like part of the upper tumour was removed, and from the incisions exuded a large amount of reddish-yellow fluid. The cut vessels were wide, both venous and lymphatic, but by pressure and bandages the parts were tightly brought together and kept in position with a few stitches and sterilised gauze. The wound rapidly healed without rise of temperature, but a large amount of lymph drained from the wound. On October 21st, the first change of bandages was made, and on the 23rd the stitches were removed. Sixteen days after operation the patient was again out of bed.

This favourable result encouraged a second operation on November 22nd, when another tumour about the size of a child's head was removed from the inner side of the thigh. After careful coaptation and stitches the wound again healed. On this occasion drainage tubes with injections of the tincture of iodine were applied to the lymphorrhœa, and the patient left hospital on December 27th.



To illustrate the effects of the operation, I present two photographs. The first gives a side view before operation, while the second shows the leg from behind.

THE MEASUREMENTS TAKEN BEFORE OPERATION.

	Right Leg. cms.	Left Leg. cms.
Over the instep	27	29
Around leg above malleolus....	32	34
Around calf of leg	52	59
Around middle of patella	48	69
Around middle of femur	60	84
Around upper part of femur....	70½	90

AFTER OPERATION.

Over instep	27	29
Around leg above malleolus....	32	34
Around calf of leg	52	59
Around over patella	48	69
Around over middle of femur ..	60	74
Around over upper part of femur	70½	80

The weight of the first tumour removed was 2,900 grammes; the second, 1,300 grammes.

The patient is now able to move about freely, doing light duties which were quite impossible to be performed before the operation, and besides feels much better in health. The left leg is unchanged in dimensions, and above the normal proportion, but the right is still abnormally large, but the patient is pleased with her present condition, and refuses to undergo any further operations.

The etiology of this disease may be considered as an indigenous pathological change brought about by trophic disturbances, and may be classed along with Dr. Favarger's "Autochthoner Elephantiasis" as the following macro- and micro-scopic results show:—

The excised tumours contained a mass of œdematous fibrous tissue, the cut surface resembling the section of a ripe pear with fibrous bands running through it as we meet with in hard, chronic œdema, with gaping blood vessels whose walls are greatly thickened. The lymphatic vessels are greatly increased in number, while thickened and distended in the same manner as the blood vessels. Large quantities of small cells were found in the infiltration irregularly distributed. Lymph vessels, arteries and veins were greatly thickened in their tunica media and adventitia. The perivascular tissue was also filled with nuclear and small-celled infiltration. The general appearance was that of a subcutaneous chronic inflammation with congestion, hypertrophy, hyperplasia, and other elementary forms.

The congenital forms of elephantiasis usually commence with chronic œdema and other anomalies in the circulation, which exposes the tissues to any infecting agent like cocci or septic germs, which set up chronic inflammation, thickening, and final deformity.

We may consider two forms possible in temperate zones, viz., that arising from varicose veins, eczema, infection from strepto- and staphylo- cocci, periphlebitis with ulceration, and œdema, all leading on to disorganisation and profuse lymphorrhœa.

The second form arises after repeated attacks of erysipelas recurring without any apparent cause on a healthy surface, which after healing leaves behind a thickening of the tissues and may go on for years. The skin finally gets hard, thick, and warty, with tubercles here and there; the follicles begin to atrophy and the hair fall out, while the general increase goes on till the elephantine deformity is produced. It may be seen from the two forms described that the case recorded is a mixed one and partakes of both before the operation.

In conclusion, it may be noted that the case described yielded favourably to the operation; although somewhat risky, under the morbid conditions of the heart, it would have been hazardous to press it further. In the temperate zone these cases are not so frequent as in the torrid zone, where filaria is a potent factor in the transmission of the disease.

The treatment may be internal as well as external. The internal medicine has not met with that success frequently attributed to it, although purging, sweating, iodide and its salts, with decoctions of Zittmanni and arsenical preparations, have been said to check the progress of the disease, but never cure it. Considering the etiology of the process, it is reasonable that internal and external treatment should proceed together, as the elastic hard bands on the extremities cannot be reduced by internal applications. Compresses with lead and iodide plasters tightly applied often reduces the swelling for a short time but is not always successful, although attention is given to diet, heart, and kidneys.

Operating is not a new method of treating elephantiasis, as it has been practised freely before and since the introduction of antiseptic surgery, either by the wedge operation or extirpation of the whole morbid mass. In other cases the tying of arteries supplying the morbid areas has often sufficed to reduce the tumour, but this is very untrustworthy.

English and American surgeons who have to deal with the filarial type in tropical regions tell us how tumours varying from 20 lbs. to 100 lbs. have been

removed without any inconvenience or danger to the patient, but sporadic cases like the above appear to be more exhaustive or more difficult to manage from heart and renal complications, as the mortality is always high (75 per cent.) in the temperate zone. The first of these operations was performed by Maddox-Titley at St. Christopher in the West Indies, when a tumour, 70 lbs. in weight, was removed from the scrotum. It is more frequent in males than females in hot countries, but apparently the opposite in temperate latitudes. Considering the high mortality of 75 per cent. in temperate climates it becomes a serious matter to decide if ligaturing the artery is not the best and safest for the patient, as it seems to succeed admirably in the hands of some surgeons. Following up this idea of cutting off blood supply, Dufouin contrived an instrument with a pelotte arrangement for compressing the femoral artery. The operative treatment before antiseptics led surgeons to adopt this form of treatment more frequently than at present, or since the introduction of Listerism, still, in temperate climes it is preferable to operating when the heart or kidneys are at fault. We therefore conclude that the correct treatment of elephantiasis is first to discover the real condition of the circulation, renal organs, and, as far as possible, the probable etiology of the disease. If either the circulation be bad or the kidneys be diseased, there are very grave apprehensions of sepsis and gangrene supervening which may prove fatal. When such conditions exist it is better to diet the patient, administer internal treatment with external applications such as bandages, compresses, &c., or, if some minor or local operations can be performed under local narcosis, they may be undertaken without much risk to the patient.

NOTE.—A *Clinical Lecture* appears in each number of the journal. The lecture in next week's will be by George Herschell, M.D.Lond., Senior Physician to the Queen's Jubilee Hospital on the Routine Examination of the Fæces in General Practice and what we may learn from it.

ORIGINAL PAPERS.

ON PARTIAL GASTRECTOMY FOR PYLORIC TUMOUR. (*)

By WILLIAM TAYLOR, M.D.DUB. UNIV., F.R.C.S.I. Surgeon to the Meath Hospital and County Dublin Infirmary; Surgeon to Cork Street Hospital; Member of the Council Royal College of Surgeons, Ireland, etc.

My object in bringing forward this communication is not that of recording any personal triumph but of eliciting a discussion which may be alike interesting and instructive. The patient is a woman, æt. 60, who was sent to me in the month of July, 1905, by Dr. Wessels, Assistant Master, Coombe Hospital.

The history she gave on admission was that for about three years prior to this she had suffered on and off from pain in the abdomen and stomach trouble of an ill-defined character to which she applied the term "weakness."

For the last three months of her illness she said the pain had become so aggravated as to compel her to lie with her stomach pressed against the side of her bed, or to roll in agony upon the floor.

During this period she was quite unable to make use of anything in the form of food. Everything she ate was vomited very soon after. The vomited matter was generally frothy and consisted principally of what she had recently partaken, but, on several occasions during the few weeks immediately preceding her admission to hospital the vomited matter was dark—as she termed it "like porter." Almost three months previously she had discovered a lump in the stomach, but it was only during the few weeks immediately before coming to hospital that she noticed it increasing very rapidly in size.

On examination, we saw a thin, emaciated woman, whose face was drawn into innumerable wrinkles and furrows from suffering. The skin was simply hanging on her bones and so far as age was concerned she looked nearer eighty than sixty years. She was almost edentulous, and her general appearance would be best appreciated by saying she was a cadaverous looking old woman. On inspection of the abdomen one could easily see projecting through the attenuated walls a tumour situated a little above and to the right of the umbilicus.

On palpation the tumour felt hard and irregular, and was obviously quite adherent to the abdominal wall. There was no rigidity of the abdominal wall, and the patient did not complain of any tenderness. On percussion the stomach was thought to be dilated, but there was no splashing.

Dr. Craig saw the patient with me and we both formed the opinion that the case was one of carcinoma gastræ possibly supervening upon an old-standing ulcer. This opinion we formed from the age and appearance of the patient, from her thin, emaciated condition, from the history of three years' trouble prior to the formation of a tumour, and from the rapidity of the growth of the tumour as well as from its strong, hard, irregular nodular character. A test breakfast was given next morning and the contents of the stomach subsequently withdrawn and examined for free hydrochloric acid, but with a negative result.

From our previous opinion this was only what was anticipated. Operation did not seem to hold out much prospect of relief or cure, but on consultation with Dr. Craig I decided to place the matter fully before the patient, explaining the gravity of any operation in her then state of health, as well as the very small likelihood that her condition could either be ameliorated or cured, with the result that I was given a free hand to act as we thought best, as, she said, her life was then utterly unbearable from pain and vomiting. Three days later, the patient being meanwhile put through the usual preliminary preparations of feeding and cleaning of the mouth, we operated.

The abdomen was opened through the right rectus and on passing the hand within, the tumour was found firmly adherent to the abdominal wall. As there was no discoverable evidence of secondary involvement of the liver or other structures in the neighbourhood save a couple of enlarged glands in the lesser omentum, and as we saw that by excising the portion of the abdominal wall to which the tumour was adherent, the growth could easily be withdrawn, we determined to act accordingly and perform a partial gastrectomy.

The anterior portion of the sheath of the rectus muscle over the tumour was then dissected up, leaving apparently quite healthy muscle underneath. The rest of the abdominal wall to which the tumour was adherent was then excised by an elliptical incision and the stomach with the tumour and portion of the belly wall withdrawn. The growth presented all the naked eye appearances of cancer, which seemed to have been pyloric in origin, well limited towards the duodenum but spreading along both curvatures of the stomach.

The greater and lesser omenta corresponding to the amount of stomach I decided to remove were ligatured and cut off. The coronary artery was double ligatured and two large clamps applied across the stomach, so that section of the stomach could be made between them at a point which would leave at least two inches of apparently healthy stomach between the growth and the point of section. The stomach was divided by the knife, and the pyloric portion with the tumour being well wrapped up in sterilised sponges was pulled well over to the right and left hanging over the right side of the abdominal wall. The cut edges of the cardiac side were then rapidly sewn together with a medium sized silk suture applied continuously, the sutures passing through the entire thickness of the stomach walls and pulled sufficiently tight to be hæmostatic as well as co-optive. The clamp was removed and there being no sign of bleeding a second continuous suture of fine silk

(*) Paper read before the members of the Surgical Section of the Royal Academy of Medicine in Ireland, January, 1906.

taking up only the sinews and muscular coats was then applied so as to enfold the first row.

The duodenum being freed by incising the peritoneum to the right of its second portion was clamped and section made between $\frac{1}{2}$ in. and 1 in. below the growth. It being then determined that the cut edges of the duodenum could be easily approximated without tension to the back of the stomach beyond the sutured edges, this procedure was carried out as described by Kocher, by a double row of continuous sutures of fine silk. What was taken to be the œsophagus during this procedure was then found to be a constriction of the body of the stomach due to the cicatricial contraction of an old standing ulcer, producing an hour-glass condition of the stomach.

It was obvious that, to close the abdomen and leave such a constriction about $2\frac{1}{2}$ inches to the left of the gastro-duodenal junction we had effected, would necessitate, in case of recovery, a further operation at a date not very distant. The patient's condition being very good and as only some 40 minutes had elapsed from the time the operation started, I decided to perform gastropasty for the hour-glass constriction, which was accordingly done in the usual way. The lines of the suture were then sponged with warm saline solution, the packing removed and the edges of the abdominal wall adjusted, the defect in the rectus being remedied by transverse suturing of the posterior portion of the sheath and overlapping of the anterior part of the sheath. Repair was rendered easy by the relaxed state of the abdominal walls. The resulting cicatrix is everything that could be desired. The completed operation occupied exactly 70 minutes and the shock was not at all severe.

The subsequent course of the case I will not weary you with, suffice it to say that there never was any symptoms until the present moment which caused us the slightest apprehension. Her progress to recovery was uninterrupted and rapid. The method of feeding was that adopted after any ordinary gastro-enterostomy. On the fourth night after operation she asked for some albumen water, but the moment the nurse proceeded to get it, the patient got out of bed and, in spite of all the nurse could do or say, walked round the ward. On speaking to her next day about the risk she ran in acting in this fashion, she told me she merely acted as she did in order to see how she could get along after going through so much. The only effect of the midnight peregrination seemed to be that of producing a sound sleep of almost seven hours. Fish was given on the tenth day, and she was allowed up on the fourteenth day, and left hospital for the convalescent home, Bray, on the twenty-third day, able to eat meat without pain, discomfort, or sickness. Since then she has remained in perfect health and as she expressed it to me last week, "she has no pain, never vomits, can make use of anything she gets, and in fact feels grand."

On making a section through the tumour and portion of stomach and duodenum removed, the centre of the growth was found to be occupied by a circular ulcer with sharply cut edges, the surrounding tissue being dull and hard. A small piece was cut out of the edge of the ulcer and adjacent tissue and examined by Dr. Boxwell, who informs me he believes the tumour to be merely a mass of indurated inflammatory tissue around an old-standing ulcer.

The points on which I would be glad to elicit discussion are the question of the differential diagnosis of inflammatory growth around old-standing ulcers from carcinoma gastrici and the treatment of undoubted gastrici carcinoma. In connection with the first of these points much has been written, but so far as I know a reliable diagnosis cannot be made even with the abdomen opened. Mr. Moynihan at the discussion in connection with the surgical treatment of chronic gastric ulcer at the annual meeting of the British Medical Association, August, 1905, stated that he believed he could then reliably distinguish the inflammatory tumefaction

from the carcinomatous condition after opening the abdomen, but I think the points upon which he laid most stress are not by any means infallible. Numbers of cases have been considered absolutely hopeless by even the most experienced surgeons, any attempt at removal of the tumour being looked upon as utterly impossible. The palliative operation of gastro-enterostomy was performed as it was said, to render the last few weeks or possibly months of life more endurable, but the subsequent results upset all calculations previously formed about the nature of the growth, as the patient got perfectly well. In several such cases the abdomens were opened subsequently for other conditions and on examining the stomach all evidence of tumour formation had disappeared, the only sign of any pre-existing pathological lesion being a cicatrix or puckered condition of the stomach wall or pylorus. With regard to the second point—viz., the treatment of cases of undoubted carcinoma gastrici much difference of opinion still exists. In endeavouring to arrive at an opinion on this point one should compare the average length of life of patients suffering from carcinoma who remain unoperated upon, the average duration of life of such cases after the performance of the so-called palliative operation of gastro-enterostomy, and the average duration of life of patients after the performance of partial or even complete gastrectomy. The mortality of the two operative processes mentioned should also be contrasted.

Von Mikulicz has published the results of his experience so far as this inquiry is concerned from the observation of no less than 458 cases. (I take this very largely from his article in Von Bergmann's Surgery, Vol. 4.) The average duration of life of the unoperated cases was a little over eleven months.

The average duration of life of cases upon which simple exploratory laparotomy alone was performed was nearly fifteen months. If these groups are added together we get the average duration of life as about thirteen months from the onset of the disease, and this is the figure Mikulicz takes as his basis for determining the results of the operative treatment of gastric cancer. The average duration of life after the performance of gastro-enterostomy was in 145 cases a little over 12 months—that is a little less than the average duration of life of the unoperated cases, calculating from his basis as taken above. The average duration of life after gastrectomy (partial or complete) was performed was $24\frac{1}{2}$ months. When these statistics were published, of 20 cases of gastrectomy then living, 4 were alive, and without any sign of recurrence for over $3\frac{1}{2}$ years, while no less than 10 cases were alive over 2 years.

As regards the mortality of these two procedures, the comparison is also interesting. The mortality of the operation of gastro-enterostomy stood at no less a figure than 26.5 per cent., whereas the mortality of gastrectomy, which up to 1898 had stood at 46.5 per cent., has since that date fallen to 25 per cent. Clairmont, in a paper based on 258 operations on the stomach from Professor Eiselberg's clinic, says out of a series of 77 cases of malignant disease of the stomach excision of the growth was performed in 24 with a mortality of only 3 eq. 12.5 per cent.—a truly phenomenal result. The average duration of life after gastro-enterostomy in this series of cases was 200 days as contrasted with 400 days after partial gastrectomy.

All surgeons at the present time will readily concur that where it is possible to perform gastrectomy partial or complete, for gastric carcinoma, this is unquestionably the proper procedure to adopt, but no very good purpose can be served by endeavouring to draw a comparison between the average length of life after the performance of gastrectomy and gastro-enterostomy respectively, for the operations are performed in totally different conditions. The cases in which the palliative operation of gastro-enterostomy was performed were cases too far advanced for gastrectomy. A true comparison could only be drawn if a large number of cases had been taken in all of which gastrectomy could have been easily performed, but in

half of which gastro-entrostomy was done while gastrectomy was performed in the remainder. Then the average longevity of one might more fairly have been contrasted with that of the other. But one could scarcely conceive a surgeon deliberately performing what at best could only be a palliative operation, while it was possible to perform a radical operation, and by this means give the patient even a slender chance of complete cure. There is, therefore, no good to be gained by following the hypothesis further. The operations are performed in patients who have reached totally different stages in the progress of the disease, and the results should not be contrasted.

After the performance of gastrectomy a few cases may be said to have been permanently cured, while life in others was prolonged from one to four years in tolerably good health. A comparison of these results with the absolute futility of medication, high frequency currents and other non-operative methods of treatment, renders the great benefit of operation more apparent. Mikulicz says "the results of gastrectomy compare very favourably, as regards duration of life after operation, with the results of operations for cancer of the tongue and rectum, and are not very much worse than those of operations upon cancer elsewhere in the body, the surgical treatment of which is recognised as justifiable." He sums up his conclusions on this subject by stating that "in view of the considerable number of patients who die within a few days after operation and the still greater number who live only a few weeks, one must conclude that gastro-entrostomy for cancer of the stomach is an operation of little value and one which is likely to be performed less and less often." And from these facts "One must admit that resection of the stomach when it is technically advisable is the best palliative operation for gastric cancer."

Moynihan, in his recent book on "Abdominal Operations," gives prominence to this expression of opinion when he says "the question may arise as to whether gastrectomy should not be performed deliberately as a palliative operation in cases where an early secondary deposit can be seen in the liver, or, inaccessible or irremovable glands are found in the pancreas, or along the aorta or vena cava, if we take into account the following advantages of gastrectomy as compared with gastro-entrostomy. That a prolongation of life for 10 months longer than the period given by gastro-entrostomy is the rule. That the comfort, general health, appetite and well-being of the patient are all emphatically better, and; "finally, that the patient has always a chance, even though it is of the slenderest, of a complete recovery from this disease."

The first of these alleged advantages I have already dealt with above, with the second I fully concur, but I must say I fail to see what "slender chance of complete recovery" a patient can have after gastrectomy for cancer if "inaccessible or irremovable glands are found in the pancreas, or along the aorta or vena cava, or if a secondary deposit is seen in the liver." My own opinion is that one is not justified in performing gastrectomy for cancer if secondary deposits are seen in the liver, or if glandular involvement exists to such an extent as to be impossible of removal, though the operation of gastrectomy may be technically possible it is not under such circumstances, I think, "technically advisable."

The comparatively small number of cures that are effected must be attributed to our inability to make a diagnosis sufficiently early. In how few cases do we see a diagnosis of carcinoma *gastri* made before a tumour can be palpated, and it has been stated that when a cancerous condition of the stomach has progressed so far as to give rise to a palpable tumour the case has by that time passed beyond the sphere of radical operation with any prospect of cure. That this statement is very largely true is obvious from the fact that one frequently sees cases in which a tumour can be palpated only with the greatest difficulty, it seems small and quite freely movable, yet, when the abdomen is opened a few days later with the idea of performing a radical operation, the area of infiltration is found to be

so extensive along the lower curvature that even a completed gastrectomy cannot be performed. There seems to be little or no definite ratio between the size of the tumour palpable through the abdominal walls and the extent of the disease one finds within.

Occasionally one finds a comparatively large tumour on palpation, and on opening the abdomen there is but little infiltration of the stomach wall—at any rate so far as the fingers and naked eye can detect. Mr. Moynihan's advice on the question of diagnosis is an eminently practical one: "to better our results we must explore, not to confirm, but to make a diagnosis."

ON TORSION OF THE SPERMATIC CORD.

WITH REPORT OF A CASE.

By J. LACY FIRTH, M.S.LOND., F.R.C.S.,

Surgeon to the Bristol General Hospital.

TORSION of the spermatic cord is a rare condition, and one which has seldom been recognised before the affected parts have been laid bare by operation. I believe most surgeons would consider the possible existence of the condition if confronted with a case in which severe pain and swelling in the groin had attacked a male possessing an imperfectly descended testicle on the affected side. But I suspect that few of us, when considering the diagnosis of acute painful enlargements of the fully-descended testicle, are in the habit of recollecting that the cause of the swelling may be torsion. I confess that in the past such has not been my custom, and that, partly for this reason, when at last I met with a case of testicular swelling from that cause I failed to recognise its nature. The nearest approach I made to a correct diagnosis, if I may speak of approaching that which I left so distant, was to recognise that the case was peculiar, and one which I did not fully understand. Later, finding this mental position uncomfortable, I took the downward step of attributing the swelling to a cause entirely different from the real one. The following are the notes of the case:—

W.S., æt. 23, a labourer, came to my out-patient department at the Bristol General Hospital on Friday, August 5th, 1904, complaining of pain and swelling in the right testicle and scrotum. These troubles had begun five days previously without known cause. No strain or blow had preceded their onset. There had been an attack of vomiting at the beginning, but none later. The first symptom had been pain, chiefly in the groin, and the swelling of the testicle had been first noticed [a] few hours later. For five days the swelling had gradually increased and the pain continued.

Examination showed the right testicle swollen to the size of a large hen's egg and very tender. The organ felt heavy and firm. It was most firm posteriorly. In front, in the upper two-thirds, deep fluctuation could be elicited. The spermatic cord and vas deferens felt absolutely normal above the swelling. The scrotum on the same side was reddened and slightly œdematous.

There was no history of venereal disease, and the urine was clear and free from gonorrhœal shreds or other deposit. Rectal examination showed that the prostate was normal, and that there was no enlargement of the vesiculæ seminales.

After questioning him, the man stated that on two occasions, one two years, the other eight weeks previously, a swelling had descended from the groin of the same side (right), with uneasiness rather than pain, and had remained for a few hours. On each occasion this had been dispelled by rubbing the groin. He described the present swelling as having descended from the groin in a similar way. (I surmise that at least, in the present instance the pain in the groin had led to the patient's misconception on this point. During the whole time he was under my observation, there was no sign of any abnormality in the groin.

It seems not unlikely that the groin troubles on the other two occasions were the result of a slight degree of torsion of the spermatic cord, and that coincidentally with the friction the torsion had disappeared.)

The man was first treated as an out-patient, but at the end of ten days, no improvement being manifest, I admitted him as an in-patient. On the eighteenth day of his illness I explored the swelling, which had changed very little, though if anything it had increased a little in size and become slightly redder and more painful, with a needle and syringe, using full antiseptic precautions. The needle was passed twice into the deeply fluctuating area in front. About one drachm of blood-stained fluid was withdrawn. I considered the fluid to be inflammatory effusion in the tunica vaginalis secondary to some form of testicular inflammation. A further period of rest in bed was ordered. During the following ten days discomfort rather than pain was felt in the testicle. On the thirty-second day of the illness ether was given, and I exposed the testicle by incision. For a day or two previously there had been a return of pain, and the skin had become more reddened and adherent to the parts beneath and fluctuation more distinct. At this period I held the view that most probably the trouble was of tubercular origin, the more because there was a strong family history of phthisis.

At the operation the skin and subcutaneous coverings of the testicle were found to be œdematous and about three-quarters of an inch thick. The parietal layer of the tunica vaginalis was also thickened, and in some places directly adherent to the visceral layer, in others separated from it by blood-clot. From the uppermost part of the sac, however, about a drachm of turbid yellow fluid escaped, and this had an offensive odour. The testicle and epididymis were soft and mottled greyish-yellow and brownish in colour. Immediately above the testis, in the highest part of the tunica vaginalis, the spermatic cord was found to be twisted, the condition being recognised by the spiral course of the dilated veins and by spiral grooves. It was not difficult to untwist the cord. To completely do this the testis had to be rotated certainly through two half-turns. At the time I estimated the degree of twisting to be three half-turns. The epididymis was a little swollen, but had not a hæmorrhagic appearance. It lay obliquely along the uppermost border of the testis, the latter having its long axis almost horizontal. Though the testicle and epididymis had their long axes almost horizontal there was a slight inclination of these downwards, outwards and backwards, and the globus major was slightly lower than the tail of the epididymis. The twisted part of the spermatic cord, which was entirely within the cavity of the tunica vaginalis, had a vertical length of about half an inch. The testicle, at this stage, the adhesions to the tunica vaginalis having been separated, hung suspended from the top of the tunica vaginalis by a short length of twisted spermatic cord. The twisted cord provided, in short, a pedicle by which the testicle was suspended in the vaginal cavity of the tunic, and the organ had no other attachments. As the testicle was obviously gangrenous, it was removed with its tunic. The spermatic cord was ligatured about half an inch above the twisted portion, where it appeared quite healthy. The wound was closed, a small drainage-tube being inserted at the lower end. Primary union followed, the wound running an apparently aseptic course. Before operation the patient's temperature had fluctuated between 98° F. in the morning, and 99° in the evening. After operation the morning temperature was usually 98° and the evening 98·4° or 98·6°.

Examination of the parts removed, after preservation for some weeks in formaline solution, shows that the twist was from within out, or in the direction opposite to that of the movement of the hands of a watch. When the cord is untwisted by one half-turn, the globus major and the upper pole of the testicle to which it is attached are brought from an inferior, posterior and external position to one superior, anterior

and internal. Another half-turn in the same direction carries the globus major again to a posterior and external position, but leaves the long axes of the testicle and epididymis horizontal. It seems a little uncertain whether the testis was twisted another half-turn during life or not. If the testicle is given another half-twist, *i.e.*, a third, in the direction opposite to that of the original twist, the free border of the upper pole of the testicle will be directed forwards; in other words, the testicle will then be horizontal, with the tail of the epididymis directed backwards, that is, will be in a position of combined "anterior inversion." and "horizontal inversion." It is certain that the testicle before torsion of the cord occurred had the abnormal position of "horizontal inversion." I believe now, as a result of a careful examination of the specimen, that the degree of torsion was two half-turns, and that before torsion the testicle had the abnormal position of horizontal inversion, but not that of anterior inversion. In addition, the testicle is in shape more flattened from side to side than normal.

The organs were not cut into until they had been hardened in formaline for several weeks. The section shows that for one-third of an inch at the periphery the testicular tissue is white in colour, but the central parts, the rete testis, and the whole of the epididymis are of a homogeneous, dull brick-red colour. The red colour must be due either to the previously-congested state of the affected parts or to congestion together with extravasation of blood.*

The chief facts of interest in the case recorded above may be summarised as follows:—A young adult, with the testis (right) completely descended, but possessing the anatomical peculiarities of being suspended freely in a horizontal position from the top of the tunica vaginalis by a pedicle of mesorchium, was attacked rather suddenly with severe pain in this testicle, followed in a few hours by swelling of the organ and œdema and redness of the scrotum, and on the thirty-second day, an exploratory puncture having been made on the eighteenth day, the cause of the trouble was found by operation to be torsion of the spermatic cord and gangrene of the testicle.

The first recorded case of torsion of the spermatic cord appears to be that of Delasiauve in 1840. The next, in order of publication, were those of Scarenzio in 1859, Langlet in 1871, Langton in 1881, and Nicoladoni in 1885. Nicoladoni thought he had discovered an undescribed affection when he published his first case, and must have been unaware of the earlier publications mentioned above. To the present time between forty and fifty cases of torsion have been recorded. The best account of the affection with which I am acquainted is that of André Lapointe in a small monograph entitled, *La Torsion du Cordon spermatique et l'Infarctus hæmorrhagique au testicule*, 1904, and I must here express my indebtedness to that writer for many of the facts, considerations and references given.

Of volvulus of the testis between forty and fifty cases have been recorded. In addition a number of cases have been recorded in which the testicle had passed into a state of hæmorrhagic infarction, like that produced by torsion of the cord, but in which no such torsion was found.

Causation of Volvulus of the Testicle.—The testicle, with normal anatomical arrangements, rests upon the posterior wall of the scrotum, much in the same way as certain parts of the colon rest upon the posterior abdominal wall, and has only a partial covering of serous membrane. There is no mesorchium or mesotestis composed of two layers of serous membrane, and comparable to the mesentery of the small intestine. With these arrangements volvulus of the testicle is probably impossible. The one constant abnormality found in cases of volvulus appears to be the presence of a more or less elongated mesorchium or mesotestis and the suspension of the testis in the cavity of the tunica vaginalis by this mesorchium. It is this mesorchium, forming a suspensory pedicle for the testicle, and containing the spermatic cord, which becomes

* For a more complete pathological report see Postscript.

twisted. This relation of the testicle to its fibrous tunic is analogous to that of the heart to the pericardial sac. In one exceptional case, recorded by Lexer*, the twisted pedicle suspended the testicle, but not the epididymis. The torsion had taken place between the globus major and the superior pole of the testicle. The rest of the epididymis was unattached to the testicle, and lay outside the tunica vaginalis.

It is important to remember that the testicle with a twisted cord has been found perfectly descended and imperfectly descended about an equal number of times. The essential cause of torsion is not therefore imperfect descent of the testicle, but, as we have seen above, the formation of a mesorchial pedicle. In its abdominal position, before descent, the testicle possesses a mesotestis or mesorchium. During the normal descent of the organ this mesotestis disappears. With imperfect or delayed descent, just as with complete descent, the mesotestis may or may not persist. The persistence of a mesotestis does not necessarily cause either imperfect or delayed descent of the testicle, though no doubt it favours these occurrences by interfering with the natural action of some of the forces which normally produce descent. Hence a testicle retained in the groin is more likely to have a mesotestis than a testicle which has passed into the scrotum. Many of the victims of torsion of the cord gave no history whatever of imperfection or delay in the descent of the affected testicle. In fact, a testicle provided with a mesotestis may reach the fundus of the scrotum before birth, and therefore without recognisable delay in descent. Possibly a fully-descended testicle with a mesotestis is more liable to torsion than a testicle with a mesotestis remaining in the groin, for in the former case the mesotestis is more likely to be elongated and attenuated.

In addition to having a pedicle, the testicle, in cases of torsion, has frequently had the abnormal position in the scrotum of either "horizontal inversion," or "vertical inversion," or "anteversion." In horizontal inversion the long axis of the testicle and epididymus is horizontal. In vertical inversion the change of position is the same in kind but greater in degree, and the globus major lies below and the globus minor above. In anteversion the epididymis is in front, and the free border of the testis faces backwards.*

In these cases it would appear that during descent the testis has been more fixed at its lower than at its upper pole. The upper pole has therefore descended relatively more than the lower, and the testicle has passed into the position of horizontal inversion, and either remained in that position or passed from it to that of vertical inversion, pivoting as it were in these movements upon its lower pole. Kocher has shown that when the testicle pivots in this way on its lower pole the descending upper pole drags with it most of the vessels of the spermatic cord, and separates, to a certain degree, a vascular fasciculus from a deferential fasciculus in the cord. With these fasciculi separated in horizontal inversion, producing the so-called "bifurcation of the cord," it is easy to realise that a smaller degree of torsion will effect a greater degree of vascular obstruction, through one fasciculus compressing the other, than if the torsion takes place with the fasciculi close together, as in the normal cord. In some of the recorded cases of torsion with infarction of the testicle the degree of torsion was only one half-turn. Horizontal inversion existed in most of these cases, and affords an explanation of the great effect of the small twist. Various abnormalities of

the tunica vaginalis have been found with torsion of the testicle, such as persistence of the funicular process with or without a hernia. It is obvious that the more roomy the tunica vaginalis the more easily can the testicle within become rotated. Lastly, the shape of the testicle has been abnormal, e.g., flatter than usual, or pear-shaped in some cases.

Symptoms.—The age of patients with this affection has varied from four months (Dowden) to sixty-two years (Nicoladoni). The symptoms comprise those produced locally and those at a distance, the latter being the reflex effects of compression of the nerves in the cord. At first the pain may be lumbar or iliac, but soon passes into the testicle. The abdomen may be rigid and retracted, and the thigh flexed. Vomiting is frequent, and has been known to become stercoraceous (Whipple and Nash). Syncope, pallor and sweating, with a rapid and feeble pulse, are common symptoms. In nearly all cases the onset of severe symptoms has been sudden, an important diagnostic point. In a few cases, however, the onset symptoms have not been severe, and the patients have then been able to walk and even work for a day or two. Later, in these cases, the symptoms became more severe, and compelled the patients to take to their beds. In another group of cases the symptoms have quickly subsided, but the patients have remained liable to recurrences. In Van der Poel's case, for example, the patient, a medical man, 25 years of age, had had many such attacks, usually during the day, but occasionally coming on at night during sleep. Sometimes he had two attacks in one day, sometimes months passed without an attack. The patient, after a time, discovered that the cause of his trouble was torsion of the testicle, and that he could relieve himself by rotating his testicle in the opposite direction. Gifford Nash has recorded a case in which he successfully relieved a youth with torsion by untwisting the cord. The symptoms had lasted an hour and a quarter. A tender swelling of the cord itself above the swollen testis helped Nash in making the diagnosis. Subsequently the affected testicle became smaller than the other.

Diagnosis.—Hitherto a correct diagnosis of torsion of the cord has been rarely made. The confusion has most often been with incarcerated or strangled hernia. But in torsion intestinal obstruction is not absolute, and vomiting not as a rule persistent. It is in the cases of torsion of the imperfectly-descended testicle that confusion with hernia is most likely to occur. The mistake could hardly be made if the testicle were fully descended, unless an irreducible hernia was present at the same time, for otherwise the inguinal canal would be free. If a strangulated hernia of the partial variety (Richter's) occurred in association with an undescended testicle, the difficulties in diagnosis would be very great. Dowden* points out that in strangulated hernia the swelling and pain begin almost simultaneously, whereas in torsion the swelling follows the pain.

When the cord of an undescended testicle is twisted the condition has also to be distinguished from the other disorders which may affect such a testicle, viz. from the so-called strangulation of the undescended testis, and from inguinal orchitis. The first of these, strangulation of the undescended testicle, produced, it has been supposed, by the pressure of the pillars of the external abdominal ring upon the testicle suddenly extruded between them, or upon the cord of a testicle so extruded, cannot be distinguished clinically from torsion. Godlee and de Quervain † have reported cases of strangulation of this kind without torsion. The condition seems to be an extremely rare one, and it is highly probable that in most of the cases in which the diagnosis of strangulation has been made the real condition present, though unrecognised, was torsion of the cord. It is equally probable that many cases which have been regarded as examples of inguinal orchitis have been really examples of torsion, though

* *Arch. f. klin. Chir.*, 1894, xiv. 311. 201.

* I have adopted the English and French phraseology for these abnormal positions of the testicle. German Surgeons use similar terms in a rather different sense, and by *inversio verticalis* mean that the change of position is round the vertical axis of the testis, and by *inversio horizontalis* that it is round the horizontal axis, both being either complete or incomplete. Thus the "Inversio verticalis" of the Germans is the anteversion of the English writers, and the "vertical inversion" of the English is the complete "Inversio horizontalis" of the Germans.—*Vide Lehrbuch der Urologie*, Von Leopold Casper, 1903, p. 323.

* *Scottish M. S. & J.* 1901, ix. 329.

† Quoted by Lapointe, *Op. cit.*, p. 103.

naturally a testicle in the groin is not exempt from the forms of inflammation which attack the fully-descended organ, e.g., gonorrhoeal or traumatic orchitis.

When the cord of a fully-descended testicle has become twisted the condition has to be distinguished from epididymitis, epididymo-orchitis, or orchitis of urethral or other origin, suppurative inflammation of the tunica vaginalis, tubercular disease of the testicle, ruptured, varicocele, and acute hæmorrhagic infarction of the testicle. The difficulty in these scrotal cases in the past has been no doubt chiefly due to the fact that, torsion has been regarded as an affection of the imperfectly-descended testicle only. The local symptoms are not pathognomonic, but the sudden onset of the pain, the rapid swelling of the testicle and its coverings, and the associated abdominal symptoms and collapse should enable one to recognise the disease if its possible existence is borne in mind.

Prognosis.—No case of torsion of the spermatic cord yet recorded has ended fatally. The testicle itself has, in at least three cases, been saved by timely detorsion. Two cases of this kind have been mentioned above, and a third is recorded by Perry.* In all the other cases the testicle has either been removed by castration, or has sloughed, or has atrophied. As pointed out by Lapointe, there are eleven cases on record in which the cord was untwisted by open operation, and the testicle not removed. In one additional case the testicle was left to its fate without untwisting the cord by Langton.† In that case, and in six of those in which the cord was untwisted, the testicle was subsequently eliminated in a septic state. The records of three only of the remaining five report the ultimate fate of the testicle. The fate was atrophy. They are the cases of Von Meyer, Bryant, and Defontaine. The question arises, Why did the testicle slough in the other six cases? It is significant that in all there had been an operation. No testicle with torsion of the cord has been spontaneously eliminated by septic processes without a previous operation. The fate of a testicle which has undergone hæmorrhagic infarction from torsion would seem then to be simple atrophy, partial or complete. If gangrene ensues it is the result of superadded infection. The path of infection may be either the wound inflicted by the surgeon or possibly the blood stream, the contamination of the blood having taken place elsewhere in the body.

Treatment.—The methods of treatment available for torsion are as follow:—

- (1) Detorsion by taxis.
- (2) Detorsion through an incision.
- (3) Detorsion, with fixation of the testis in the scrotum (orchidopexy), including transplantation if the testis is imperfectly descended.
- (4) Castration, immediate or secondary.

Detorsion without fixation of the testicle is not ideal treatment, for it leaves the patient liable to a recurrence of the trouble. Detorsion with fixation of the testicle in the scrotum in such a way that recurrence will be rendered impossible is the method of choice if it can be satisfactorily carried out. Immediate castration is required, first, if the testicle has become infected and is gangrenous; and, secondly, if detorsion and orchidopexy are found impracticable or have been tried and failed. If a non-infected hæmorrhagic testicle is left after detorsion and the wound remains aseptic, a portion of the gland at least may survive to be of use in the economy. If, however, the wound becomes septic, gangrene of the testicle will almost certainly follow, and secondary castration become necessary.

POSTSCRIPT.—Since the above was written and published Dr. Newman Neild, Pathologist to the Bristol General Hospital, has kindly examined sections of the testical and epididymis microscopically, and furnished me with the following report:—

"On transferring the specimen from formaline into spirit, the dark colour disappeared, and was replaced

by a pink colour. The nuclei of the seminal tubules do not take hæmatoxylin stain, and the protoplasm is granular. The nuclei of the interstitial fibrous tissue and the septa do not take the hæmatoxylin stain except near the corpus Highmori; here there are numerous cells with irregular nuclei, which take the stain, but not so well as normally. The blood vessels are filled with degenerated blood corpuscles. There is no extravasation of blood. In the epididymis many fibrous tissue cells take the stain, and degeneration is not so well marked here as in the epithelial part of the organ. The tube in the epididymis shows deeply-stained spermatozoa.

"The condition of the organ is histologically suggestive of the condition found in an anæmic infarct of the kidney."

In nearly all the previously recorded cases of torsion of the cord in which the affected parts were exposed and inspected they were found to be in a state of hæmorrhagic infarction. In my case, the microscopical examination of the specimen shows that the testicle and epididymis were not hæmorrhagic, but rather in a state of anæmic infarction or simple necrobiosis, though the tunica vaginalis contained effused blood. The only explanation of this fact I can suggest is, that in my case, either from the beginning or from a very early period, there was arterial obstruction as well as venous obstruction, but I am unable to explain why the arteries should be obstructed in this case, and not in nearly every other recorded case.—J. L. F.

CLINICAL RECORDS.

TWO CASES OF RENAL CALCULUS IN CHILDREN UNDER TEN.*

By W. GIFFORD NASH, F.R.C.S.Eng.,
Surgeon to the Bedford County Hospital.

CASE I.—G. C., a boy, æt. 8, was admitted into the Bedford County Hospital on May 27th, 1905, with a history of abdominal pain and frequency of micturition since an early age. The left kidney could be distinctly felt. The urine was acid, and contained pus, but no crystals were found. *Operation:* The left kidney was exposed by a lumbar incision and a stone was felt in its pelvis. The cortex was incised and a stone weighing 30 grains was removed. Seven small calculi were washed out of the kidney. A tube was inserted and the wound sutured. Urine escaped from the loin for a few days. The child made a good recovery. The size of the main stone shows that it had been present in the kidney for a considerable time. The presence of the small stones suggests that others may have been present and may give rise to further trouble.

CASE II.—E. C., a boy, æt. 4, was admitted into the Bedford County Hospital on October 11th, 1905, with an indefinite history of renal calculus. For two years he had occasionally passed blood in his urine and complained of feeling cold in his belly. At times he cried at night and screwed his legs about. The urine contained a trace of albumin, but no pus or crystals. There were no other symptoms of stone in his kidney no frequency of micturition, no attacks of vomiting, no swelling, and no renal tenderness. But there was one definite piece of evidence. Three skiagraphs were taken by Mr. King, the house surgeon, and in each, in the region of the left kidney, was a very distinct shadow. Exploration of this kidney was decided on, and the kidney was first exposed, and then brought out of the lumbar incision. Some hardness in the renal pelvis was felt, and puncture with a needle showed this to be a stone. A small incision was made in the renal cortex and a grooved director passed into the pelvis; next the wound was enlarged with a blunt forceps and the tip of the index finger. The stone, which was felt lying in the renal pelvis, was seized with a pair of forceps and delivered with some difficulty owing to its peculiar flat shape. Then followed a

* Read before the Society for the Study of Disease in Children, February 16th, 1906.

* Birmingham M. Rev., 1898, xliii. 279.

† St. Barth. Hosp. Rep., 1881, xvii. 188.

continual welling up of venous blood from the kidney. Attempts were made to arrest this by ligature of some vessels, which could be seen bleeding near the hilum of the kidney, by suturing the incision in the cortex, and by gauze packing, but without materially lessening the flow of blood.

The child was rapidly becoming exhausted from the loss of blood, so he (Mr. Nash) decided to remove the kidney. The vessels and ureter were ligatured and the kidney removed as far from the ligatures as possible. Consequently most of the pelvis of the kidney was left behind. The stone removed consisted of uric acid and weighed 25 grains. It was a flat-shaped stone with a sharp edge. Recovery was retarded by some suppuration, but the ultimate result was good, the child passing about 20 ozs. of urine daily when he left the hospital.

This case illustrates the value of X-rays in the diagnosis of obscure renal calculus.

THE OUT-PATIENTS' ROOM.

FRENCH HOSPITAL AND DISPENSARY.

A Protracted Case of Localised Eczema.

By LOUIS VINTRAS, M.D., B.Sc.

AN Italian waiter, C. A., æt. 23, came to the out-patients' department on February 15th, 1905. He had a large patch of eczematous eruption on the back of his neck, extending transversely in a band about one inch and a half wide by about four inches long. The patch presented a rough surface, with squamous crusts here and there, while the rest was red and weeping. The skin was much thickened, and the band presented an abrupt and well-defined margin. There was a good deal of irritation, which was increased, of course, by the friction of the collar, of which the patient's occupation necessitated the continued wearing. Two years previously, the patient had first noticed a diffused eruption in the same place, which came and went, but increasing in area with each return. About six months later he contracted syphilis, for which he underwent treatment privately. Sometime after contracting syphilis the eruption on his neck became aggravated, no longer disappeared at intervals, and gradually assumed the appearance it presented when he first came to the hospital. He had then followed no treatment of any kind for three or four months. Arsenic internally and soothing lotions soon diminished the irritability, the crusts disappeared, the surface became dry, and the redness diminished. For some time, however, there were periods of renewed activity, more especially at the margin, but these were evidently due to the fact that as soon as there was any amelioration the patient resumed his collar and neglected the treatment. This went on for some months, during which the local conditions further improved, but only gradually. The surface was healed, but the thickening of the skin showed no signs of diminishing. Dr. Vintras then put him on iodide of potassium and bark, and ordered inunctions night and morning with the following ointment: Ung. hydrarg nit., 1 drachm; ung. ac. boric, $\frac{1}{2}$ oz.; vaseline, ad 1 oz.

This was continued for some time without producing any marked effect. Internal remedies seemed to make no impression on the local condition, for a course of mercury likewise produced no satisfactory result. About five weeks ago Dr. Vintras substituted Resinol ointment for the one the patient had been using, and since then there has been a decided improvement, the colour of the part is much more natural and the thickening of the skin much diminished. Dr. Vintras pointed out that the patient was a strong, well-built man, who otherwise enjoyed excellent health. The case was interesting, he thought, as showing the density of the fibrous thickening of the skin produced by a simple but long neglected eczematous eruption and the difficulty with which it subsequently cleared up.

MERCY HOSPITAL, CORK.

Case of Extensive Dermatitis Following a small dose of Quinine.

Under the Care of Dr. J. O'CONNOR, M.A., M.D., M.R.C.P.I.

THE patient was a young woman, æt. 24. As she suffered from anæmia she had purchased two drachms of citrate of quinine and iron (containing 20 grains of quinine) four days previously. She had dissolved this in a half-pint of water, and had taken half the amount when seen. During the previous night she felt hot and restless, and felt her skin flushed and itching. When seen her face was flushed, with a bright eruption resembling the rash of scarlatina covering the forehead, cheeks and ears. The eruption, however, was distinctly raised. The arms and hands were thickly covered with a bright red rash in large raised patches resembling urticaria, except for their colour which was of a bright pink hue. The thighs and knees were similarly covered, the legs below the knees being only slightly affected, the lesions here being more discrete and somewhat resembling the rash of measles. The neck, the chest, and the scapular region were similarly affected, but the lower part of the back and the entire surface of the abdomen were quite free from the eruption. In all situations the edge of the rash was distinctly defined, and the raised borders were quite evident. The temperature was 98.8°, though the feel of the skin was suggestive of a higher degree of pyrexia. The drug was stopped, a calamine lotion containing a little liq. carb. deterg. ordered, and a saline purgative given. Next day the temperature was normal; the patient reported that she had spent rather a good night, the rash was much less noticeable and had faded in many places. On the second day the rash was quite gone, and the patient felt all right. She had never previously had a rash of any kind, and though she had often taken tincture of iron for anæmia she had never previously taken quinine. Though quinine rashes are not very uncommon, the intensity of the dermatitis in this case was, apparently, out of all proportion to the amount of the drug absorbed, only 10 grains of quinine having been taken altogether.

OPERATING THEATRES.

NORTH-WEST LONDON HOSPITAL.

CONSERVATIVE SURGERY OF TUBERCULOUS DISEASE OF THE JOINTS.—MR. MAYO COLLIER operated on two cases of tuberculous disease, one of the hip and the other of the elbow joint, illustrating the modern method of treatment of this affection. 1. Tuberculous disease of the hip-joint. The patient was a boy, æt. 5, the subject of advanced tuberculous disease of the left hip-joint. The history of the case extended over a period of two years. When æt. 3, the child complained of pain in the region of the left hip-joint, extending down the thigh and knee. Advice was obtained, and the boy was admitted into a metropolitan hospital, and treated apparently by fixation and extension. The boy, according to the mother, left the hospital seemingly cured. On attempting to use the limb, however, and to run about in the ordinary way, he used the limb cautiously and was never as free with it as with the opposite extremity. The history of the present illness dated some nine months ago. The child was confined to bed with swelling and pain of the outer aspect of the limb. Advice was again sought in the out-patient room of a hospital. The parents refused further indoor treatment. It appeared from the statement of the mother that the case was then allowed to take its own course, and was subjected only to unskilled treatment. On admission to the North-West London Hospital, the boy was pale, emaciated, and in an extremely reduced

condition. The limb was flexed, adducted, and somewhat rotated inwards, and the parts in the region of the joint were riddled with discharging sinuses. The examination of the lungs and abdominal viscera revealed no complications. The general condition of the child was not encouraging. Mr. Collier said that here he had to deal with a case of advanced tuberculous disease of the left hip-joint, where one of two courses was only possible to pursue—amputation at the hip-joint or ex-section with free drainage. Against the proposal for amputation was, in the first place, the severity of the operation and the maimed condition of the patient if recovery took place, offering no prospect of useful employment during existence in after life; against the alternative of removing the whole of the diseased tissues in and about the joint, and leaving Nature to do the best she could to re-form a more or less useful limb, was the fact that the patient was now already much exhausted by a long-continued suppuration and bad nutrition. Considering the age of the boy, Mr. Collier elected to adopt the latter course. The sinus at the anterior border of the tensor vaginae femoris was enlarged and the finger passed into a necrosed and carious hip-joint. The joint was found to be completely disorganised. The whole of the cartilage of the acetabulum was gone and replaced by an extensive carious surface; the head of the femur was necrosed; the sinuses in the gluteal and iliac regions communicated with the main cavity, and the fibrous and muscular tissues about the joint were considerably contracted. Mr. Collier curetted with a sharp spoon the acetabulum, and removed the head of the femur, curetted the various sinuses, and divided any tense bands of fascia which prevented the limb being brought into the normal position. The tracts of the sinuses and the acetabular cavity were injected with emulsion of iodoform, and packed with strips of cyanide gauze soaked in the same solution. The incisions into the bands of fascia had been made originally well away from the seat of the original trouble. The limb was put up in a single Thomas's splint, and orders were given for the patient to be fed on albuminous diet consisting chiefly of raw eggs and milk.

It is gratifying to record that the patient, after six weeks' retention in the hospital, has now completely convalesced, the wound has entirely healed, the child has regained flesh, the limb is in a fairly good position, and there is every prospect of health with a permanently useful limb.

Case 2.—Tuberculous Disease of the Elbow Joint.—The same surgeon operated on a case much resembling the preceding one, except that the disease had here attacked the elbow-joint instead of the hip-joint. In this case, the prognosis, Mr. Collier said, was even more unfavourable than in the preceding one. The child, a boy, *æt.* 7, had already been treated for disease of the knee-joint and for tuberculous glands in the neck, and had spent most of its short existence in the wards of various hospitals. The scars about the knee-joint were an eloquent testimony to the severity of the disease that had affected this region, and the scars in the neck were unmistakable signs that the glands in this situation had been extensively affected. The affection of the elbow had existed for some twelve months, and the parents, being apparently discouraged by the previous continued illnesses, had not up to this time sought for advice at any hospital. On admission, the general condition of the child, Mr. Collier pointed out, was not so bad as might have been expected. He was fairly nourished, and of good colour, and there were no complications of the internal organs; the left

elbow, however, was enormously swollen and deformed by several large granulating surfaces that presented discharging sinuses. The skin around these sinuses was much undermined and invaded by tuberculous deposit, leaving few areas of healthy tissue about the joint. Here, again, Mr. Collier said, two courses presented themselves—amputation or ex-section. The same arguments as applied in the previous case were here to be considered. The patient was evidently riddled with tubercle, but he had got the better of two previous affections and his present general condition was fairly hopeful. Mr. Collier decided to give the limb a chance by removing the whole of the diseased tissues, as he had done in the previous case, reserving amputation in case the course of convalescence was less speedy than was to be desired or in case of complications or extension of the disease in other directions. The sinus between the head of the radius and the olecranon process was slit up and the joint opened; the olecranon was removed, and the whole of the interior of the joint exposed. Every part of diseased tissue that was found was removed with scissors and forceps and the sinuses curetted; the joint was packed with cyanide gauze and iodoform emulsion, and put up on a splint in a semi-flexed position. Here, again, orders were given for the patient to be dieted with albuminous food consisting mostly of raw eggs and milk, and the boy has made most satisfactory progress. The parts a month after operation were almost healed, the general condition had much improved, and there was every prospect of a sound and useful limb. Mr. Collier said that the procedure he had adopted in these two cases was much in advance of the surgery of tuberculous disease of these joints when he was a house-surgeon. The best that could then be hoped for, but which was seldom attained, was a stiff, useless, and deformed joint, and a shortened limb; more often, after months of the patient's confinement to bed, return of the disease took place in the excised limb, and amputation was resorted to when it was too late.

X-Rays at Cambridge.

At Gonville and Caius College the triennial Thruston prize of £54, open to a member of the college of not more than fifteen years' standing who has published in the course of the preceding three years the best original investigation in physiology, pathology, or practical medicine has been awarded to W. S. Perrin, B.A., research student of the college. At the invitation of the Regius Professor of Physic and the Professors of the New Medical Schools in Cambridge, recently, a large audience heard a lecture by Dr. Hugh Walsham on the use of the X-rays in diagnosis. The lecture was illustrated by numerous lantern slides prepared from skiagrams taken by Dr. Walsham. The latter half of the lecture was devoted to a demonstration and description of the most recent forms of X-ray apparatus. Dr. Walsham drew attention to the efficient and powerful X-ray installation he was using to demonstrate the various points. This apparatus had been presented to the committee for the study of special diseases by Dr. R. C. Brown, of Preston, Lancashire, and had been supplied by Watson and Sons, of London. Professor Allbutt, in proposing a vote of thanks, said they were deeply indebted to Dr. Brown for the extremely valuable and costly apparatus he had presented to the committee. Professor Woodhead, in seconding the vote of thanks, wished to say how grateful they felt to Dr. Walsham for coming to give the work of the Committee for the Investigation of Special Diseases, which had been organised by Mr. Strangeways, the Huddersfield Lecturer in Special Pathology, a good send off. This committee, having undertaken the study of rheumatoid arthritis, soon found that X-ray photography was essential.

TRANSACTIONS OF SOCIETIES.

SOCIETY FOR THE STUDY OF
DISEASE IN CHILDREN.

MEETING HELD FEBRUARY 16TH, 1906.

Mr. TUBBY, M.R.C.S., in the Chair.

Mr. HOWELL EVANS showed three cases: (1) Meningocele occipitalis; (2) Meningocele lumbosacralis; (3) Thyroglossal appendage; and these were illustrated by a lantern demonstration. He remarked that it is stated that the most frequent cause of spina bifida is the non-union of the laminae of a vertebra or vertebrae. This he did not consider to be a fact, but that the interposition of the membranes prevents the normal union of these osseous centres. He believed the cause of the formation of these protrusion cysts to be due to the toxicity of definite chemical bodies of primary maternal origin, these diffusible poisons transferred to the embryo stimulate certain epithelial or secreting surfaces with consequent increase of secretion.

Dr. F. J. POYNTON read a paper on two cases of "Jaundice in Children." Persistent jaundice in infancy was such a dangerous symptom, that the two cases which had come to his notice in the last two years were, he thought, of practical interest. This first case was a female infant, *æt.* 3 months. She was then distinctly jaundiced, and had been so since birth. The conjunctival mucous membranes and skin were yellow, the motions as a rule were undigested and white, the urine very dark. In fact, there was well-marked obstructive jaundice, which had lasted from birth. The liver was large, but not tender or unusually hard, the spleen was not felt, there were no hæmorrhages and the umbilicus was healthy. The second case occurred in a boy, *æt.* 4 weeks, and the first child. No cause at all was forthcoming for the jaundice, which had appeared upon the third day and was found to have persisted.

Dr. E. CECIL WILLIAMS contributed some notes on a case of "Splenomegaly Biliary Cirrhosis" in a boy, *æt.* 6½, and regretted it was impossible for him to show the Society his patient, but hoped the photographs he exhibited would convey some idea of the hepatic and splenic enlargement. He remarked that there was a doubtful history of paternal syphilis. Three years ago the child was jaundiced and said to have an enlarged liver. Abdomen, much distended; girth, 26 ins.; enlarged veins over surface, liver dullness extending from the fifth rib to the level of the umbilicus, where its free edge could be felt; left lobe could also be felt below the ensiform cartilage; spleen, much enlarged, extending from the eighth rib to within a couple of fingers' breadth of the iliac crest in the axillary line. That this was an example of the juvenile type of splenomegaly biliary cirrhosis, described by Gilbert and Fournier, seemed to him to be fairly certain. Clubbing of fingers and toes is a much more constant symptom in this form than in the adult type.

Dr. F. LANGMEAD showed three specimens of "Tuberculous Ulceration of the Stomach." *Case I.*: Mary C., *æt.* 8 months, was admitted to hospital for whooping cough; developed signs of pulmonary consolidation, and died two months after admission. At the *post-mortem*, general tuberculosis was found. The stomach was not dilated, but on its anterior wall were six shot-like submucous tubercles, each capped by a tiny ulcer, and two more were situated on the greater curvature. Their distribution was *via* the arteries, and on holding the specimen up to the light when it was first removed each tubercle could be seen perched upon an arterial twig. *Case II.*: Stephen B., *æt.* 1 year and 11 months, was admitted for whooping-cough and bronchitis, and died a few weeks later. *Post-mortem*:

At the middle of the anterior wall of the stomach about half-way between the cardia and pylorus, was a small tuberculous ulcer stellate in appearance, and surrounded by a slightly raised and rolled edge. *Case III.*: William T., *æt.* 7 months, was admitted collapsed, with a history of five months' "croupy cough" and wasting. *Post-mortem*: Near the greater curvature of the stomach, and midway between the cardia and pylorus, were two small ulcers with flat, slightly raised edges, the larger measuring only 4mm. in its greatest diameter, and being plainly situated on a vessel. The other, which was slightly smaller, was about half an inch distant. The peritoneal surface was unaffected.

Mr. W. GIFFORD NASH showed a case of "Symmetrical Alopecia Areata Neurotica," accompanied by a bulbous eruption on the face, in a girl, *æt.* 14, who was seen on November 13th, 1902, suffering from an eruption on the face and loss of hair. The history was that on November 7th, a lock of hair along the course of the right supra-orbital nerve fell out and on November 11th, blister-like spots began to appear on the face. Two years previously she had suffered from similar spots on her face and hands. These had occurred over a period of some months and had left brown stains. As already stated, the first patch of hair to fall out was along the course of the right supra-orbital nerve. Ten days later a similar bald patch suddenly appeared on the left side. The symmetrical distribution is well shown in the photographs. This affection is classed by Crocker under alopecia areata neurotica var: localis.

Mr. W. GIFFORD showed two cases of "Renal Calculus" in children under ten. These will be found on page 253.

Dr. A. ERNEST JONES showed a case of "Parenchymatous Goitre" in a girl, *æt.* 6.

Dr. GEORGE CARPENTER showed a case of "Scurvy" in an infant, *æt.* 10 months, slightly rickety, a tripe anæmic, and with hæmorrhagic gingivitis, subperiosteal hæmorrhage of the left tibia. The urine contained albumin and blood casts, but was free from other casts. Been fed on patent foods.

The following members took part in the discussion of the papers and cases:—Dr. Chapman, Mr. Tubby, Mr. Pernet, Dr. Frederick Taylor, Mr. Drew, Dr. Fisher, Dr. Milner Burgess, Dr. Porter Parkinson, and Dr. Sutherland.

ULSTER MEDICAL SOCIETY.

MEETING HELD IN THE BELFAST MEDICAL INSTITUTE
ON MARCH 1ST, 1906.

Dr. J. R. DAVISON, Vice-President, in the Chair.

Dr. J. SINGLETON DARLING showed a patient from whom he had removed the inferior maxilla for a sarcoma involving that bone. The treatment of the resulting deformity was discussed by Drs. A. B. Mitchell and Howard Stevenson.

Dr. FIELDEN read a note on the
SOLAR REFLEX

occurring in abdominal operations. In giving anaesthetics he had often noticed reflex phenomena in operations on the stomach and kidneys specially, and these might be so severe as to necessitate an entire alteration of the plan of operation. Adhesions of the viscera undoubtedly made these symptoms more likely to appear, traction on the adhesions being the immediate cause. The breathing became shallow through a complicated reflex which was not certainly known, and cardio-inhibitory symptoms appeared as a direct result of stimulation of the vagus. The depth of the anaesthesia in no way modifies these reflex symptoms, but if they appear when chloroform is being used a

change to ether or A.C.E. mixture may be beneficial. They are more often seen in operations on the right kidney than on the left, owing to the greater liability to traction. They do not commonly appear in operations on the intestines.

Dr. THOMAS HOUSTON AND Dr. J. C. RANKIN read a paper on the methods and results of giving

Therapeutic Inoculations in Staphylococcal and Tuberculous Lesions.

Dr. Houston, who read the first part of the paper, referred to Dr. A. E. Wright's methods as forming the basis for a system of rational therapeutics such as we have never had in dealing with these affections. After a brief account of the method of determining the opsonic index of the blood, he enunciated the conclusions that in many affections opsonines exist in the serum; that opsonine is thermolabile, *i.e.*, destroyed by heat, and that the serum is the active agent in promoting phagocytosis. Various experiments were then described by means of diagrams on the lantern screen. In the first it was shown that with a given quantity of serum, washed corpuscles, and emulsion of staphylococci digested for a given time, 218 cocci were found in 100 cells, whereas when the experiment was repeated exactly, only that the serum was heated first, only 28 cocci were found in 100 cells, showing the injury done to the serum by heat. Bullock's experiments proved that opsonine is a new body, and apparently specific for each micro-organism, hard though it is to accept this.

After these preliminary observations, Dr. Houston said that he proposed to deal with lesions due to the staphylococcus, leaving it to Dr. Rankin to deal with tuberculous lesions. The first question they had set themselves to determine was whether their own opsonic power remained constant at different periods of the day, and from day to day, and they found that it did remain so. Another experiment showed them that any staphylococcus might be used for inoculations, and that it was not necessary to prepare a fresh culture from each patient treated. The method of preparing the emulsion of the staphylococcus was then described; the vaccine is a growth of the organism sterilised by heating to 60 for an hour, and tested by planting out for a night to be sure that all cocci are killed. The beautiful and ingenious method of standardising the emulsion, due to Dr. Wright, was described. An equal quantity of blood and emulsion are taken, diluted with saline and stained, and the relative numbers of corpuscles and cocci counted. Then since the number of corpuscles in a cubic millimetre is known, the number of cocci is easily estimated. A number of cases of lesions with low opsonic indices were described by Dr. Houston, many being boils due to septic poisoning. The dose of vaccine given was in most cases from one to five million staphylococci. If the vaccine was good, there should be no suppuration afterwards. The general effects of the inoculations were (1) a negative phase, with lowered resistance to infection; and (2) a higher resistance, gradually growing less, but still in many cases ending higher than it began. The negative phase is a function of the dose, and varies in different patients; it may even last for several months. Of the many cases described it may be said that those of furunculosis were generally cured, while those of acne were improved, but only one was cured. Dr. Rankin dealt with inoculations for tuberculous lesions. There was much more difficulty in getting a uniform emulsion of the tubercle bacillus than of the staphylococcus. The cases described included fifteen cases of lupus, five cystitis, five adenitis, four tuberculous peritonitis, and two phthisis. On the whole, the results were very encouraging, though in these chronic cases a long time is needed to judge well of results. The tuberculous peritonitis cases were specially successful, the immediate change under treatment being very marked. All the cystitis cases also improved, and put on weight steadily.

NORTH-EAST LONDON CLINICAL SOCIETY.

MEETING HELD MARCH 1ST, 1906.

Dr. C. E. HUTT, President, in the Chair.

The following cases and specimens were exhibited:—

Dr. R. MURRAY LESLIE showed (1) a man, *æt.* 60, with a hard, infiltrated swelling in the left supra-clavicular region of many months' duration. The surface over it was oedematous. He complained of pain extending down the left arm, but there was no difficulty in breathing. There was a history of syphilis and there were some old pigmented scars on the legs.

Mr. H. W. CARSON considered that it was a gummatous condition breaking down, the trouble probably originating at the sternal end of the left clavicle.

(2) Three female patients with Myxœdema, undergoing treatment, and presenting varying degrees of improvement. It was noteworthy that the one who had reacted most quickly to the treatment had been taking the raw thyroid gland obtained freshly from the butcher's every day. One patient had a magnificent crop of hair upon the scalp, but none in the axilla. All showed the characteristic, parchment-like condition of the skin upon the backs of the hands.

Dr. G. P. CHAPPEL showed (1) a boy, *æt.* 6, with Congenital Heart Disease; (2) a boy, *æt.* 10, a congenital imbecile, affected with Fibroid Phthisis. A persistent cough had been present for a long time, and when first seen the right lung was full of crepitations. The cardiac impulse was felt in the right nipple-line. (3) A man, *æt.* 30, a bootmaker, with Malignant Disease of the Lung. The whole of the right chest was dull, and the voice-sounds and breath-sounds obliterated. He had lost four stone in weight during the last year. The X-rays showed that the right side of the diaphragm was practically fixed and also a deep shadow occupying the lower part of the right chest. These appearances were quite consistent with the presence of malignant disease.

Dr. LESLIE thought that there was very little fluid present as the cardiac impulse was hardly displaced at all. He considered that the condition was probably one of sarcoma and that the prognosis was very grave.

(4) An old lady, *æt.* 65, with ascites and displacement of the heart to the left. She had had paracentesis performed, when nine pints of fluid were withdrawn. Several nodules were then felt in the abdomen, and the exhibitor was inclined to the view that it was a case of primary carcinoma affecting some portion of the intestinal tract. The liver was also enlarged, but there had been no jaundice.

Dr. ERNEST CURTIS showed a little girl of nine who had had an injury to her foot seven weeks ago, and since then had been unable to put the foot to the ground on account of pain. An examination with the X-rays, undertaken by Dr. Higham Cooper, revealed an indistinctness at the lower end of the tibia.

Mr. CARSON and Dr. COOPER considered that the radioscopic appearance together with the clinical aspect of the case left little doubt that the condition was one of tuberculous disease affecting the os calcis, and possibly the adjacent portion of the astragalus and tibia.

Mr. CARSON exhibited (1) a child, *æt.* 2, with a peculiar swelling in the left side of the neck, resembling enlarged glands, but in places distinct collections of fluid could be made out. He was inclined to the view that the tumour was a Cystic Hygroma. (2) A specimen of an appendix containing three thread-worms which he had removed.

In reply to Dr. J. HUNT, who inquired if the presence of the parasites was merely accidental or whether the worms bore any causal relationship to appendicitis, the exhibitor referred to a paper which he had recently read before the Clinical Society of London upon the subject. He had been able to collect fifteen cases in all of appendicitis associated with the *Oxyuris*.

vermicularis. The most noticeable feature of these cases was the severity of the subjective symptoms as compared with the objective signs of disease. In one case the pain was so intense that a diagnosis of pyosalpinx was seriously entertained before the abdomen was opened! (3) A portion of the pyloric end of the stomach showing a large perforation in a case of gastric ulcer. No operation was undertaken, as the patient was moribund on admission to hospital. (4) A Cysto-Sarcoma of the Testicle which had been slowly growing for six weeks, and which, clinically, resembled a hæmatocele.

Dr. G. BASIL PRICE showed specimens of enlarged lymphatic glands weighing 18 ozs., from the axilla of a patient who had died from lympho-sarcoma, together with a portion of the stomach, ileum, and spleen, affected with secondary deposits. The latter organ weighed 3½ lbs.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD MARCH 2ND, 1906.

Mr. L. A. BIDWELL, F.R.C.S., presiding.

Dr. J. A. COUTTS read a paper on
SOME POINTS IN INFANTILE SCURVY.

The paper was based on some cases recently under the care of the author, in one of which extensive hæmorrhage occurred under the periosteum of the femur, the lower epiphysis of the same bone being separated. Although the usual treatment of such cases, namely, milk feeding and the administration of lemon juice was adopted, the case did not rapidly clear up in the usual way, and new bone was deposited under the periosteum which had been raised off the shaft of the bone, so that egg-shell cracking was clearly to be felt. An incision was then made into the swelling and some of the clot turned out, but the child did not recover. A similar case was then described in which no operation was done. It was subsequently found that the reason why the cases had not rapidly recovered under treatment was that the dairy company which supplied the institution in which the infants were under treatment had, unknown to the authorities, been supplying Pasteurised milk instead of ordinary cow's milk; when this was rectified the second child recovered. The paper was illustrated by the specimen obtained from the first case and skiagrams showing deposit of new bone under the periosteum in the second.

A discussion followed in which the President, Dr. Arthur Saunders, Dr. Fry, Dr. Joll, and Dr. Muir took part.

Dr. E. FURNISS POTTER then read a paper entitled
REFLECTIONS ON THE TREATMENT OF CHRONIC OTORRHEA.

The author pointed out that much attention had been turned to this subject recently, but although he thought that the profession generally were alive to the importance of the subject the public required a good deal more education in the matter. He then detailed the measures that were advised for the routine treatment of a chronic aural discharge by means of injections, drops, and the like, and pointed out that the time necessary, and the frequent visits which would be required to the medical adviser made it impossible, in a very large number of cases, for this form of treatment to be efficiently carried out. On reflection this had led the author to think that the much more frequent adoption of the radical mastoid, or complete post-aural operation, would be a great benefit to those who were the subjects of a running ear. This procedure was safe, and offered an almost certain prospect, in properly chosen cases, of curing the discharge in a reasonable time, and so freeing the patient from a trouble which was a constant menace to life. An interesting discussion followed in which Mr. Bidwell, Dr. J. B. Ball, Mr. Richard Lake, and Mr. Paton, took part, Mr. Lake showing by the lantern a number of

instructive pictures illustrating the complete mastoid operation. Dr. POTTER replied, and the meeting then adjourned.

CORK MEDICAL AND SURGICAL SOCIETY.

MEETING HELD ON WEDNESDAY, FEBRUARY 14TH, 1906.

The President, Dr. R. P. CROSSIE, in the Chair.

CASE OF CONCURRENT ACUTE RHEUMATISM AND ACUTE CHOREA, COMPLICATED BY CEREBRO-SPINAL MENINGITIS.

Dr. O'SULLIVAN showed a girl, æt. 10, admitted to the South Infirmary in a highly feverish condition, with well marked choreic movements. These were so severe as to render alimentation by the mouth impossible, so rectal feeding was begun and continued for the lengthened period of twenty-five days. To make matters worse, two big, unhealthy-looking bed-sores were present. Auscultation revealed the presence of murmurs at all the orifices, and, in fact, a condition of pancarditis prevailed. About a week after admission, retraction of the head was noticed, together with convergent strabismus of the right eye. Albumin appeared in the urine, and the joints were so relaxed that dislocation of the sternal end of the right clavicle occurred. The treatment consisted in counter-irritation by fly blisters over the second, third, fourth, and fifth intercostal spaces. Alkalis and aspirin to combat the rheumatic poison, and bromide of soda to relieve the meningeal hyperæmia, whilst strychnine was given hypodermically for the grave asthenia. The patient made a good recovery.

Dr. O'SULLIVAN remarked on the rare occurrence of such a case, and invited discussion as to the etiological factor in the complicating meningitis.

Dr. MOORE thought that the meningitis was due to the organism of rheumatism.

THE "FANGO" TREATMENT.

Dr. A. A. HUDSON read some notes on "Fango di Battaglia," giving an interesting account of its origin, chemical composition, the technique of its application, and the indications for its use. He said that not only was it invaluable in arthritic cases, but it was beneficial in anæmia, chlorosis, scrofula, eczema, psoriasis, &c. He read clinical notes of cases, Continental and English, and some that came under his own care, treated with brilliant results.

Dr. P. G. LEE then gave a paper on
THE PREPARATION OF ANTI-TOXINS,
illustrated by lantern slides showing the various steps and apparatus used.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD. FRANCE.

Paris, March 3rd, 1906.

OZENA.

Two principal symptoms characterize ozena—
increase in the nasal secretions, fætidity.

The secretions are increased; the patient uses several handkerchiefs daily and the flow is abundant, and of yellowish green colour. Sometimes it is dry in the form of crusts, which the patient expels at one effort, but which are reproduced continually.

The odour of the secretions is repulsive, and somewhat like the fætid smell of the sweat of certain feet. This odour becomes so intolerable that the patient is excluded from the school or the workshop.

The external aspect of the nose presents no characteristic deformity, but the examination of the cavities reveal a considerable enlargement of the nostrils, through which the posterior wall of the pharynx can be seen. The walls of the nasal cavities are covered with greenish mucus or with crusts. If they are

removed, the subjacent mucous membrane will be found smooth, brilliant, but without ulceration.

Localised at the beginning in the nares, the lesions extend rapidly to the pharynx, and even in some cases to the larynx and trachea, creating a special form known under the name of laryngo-tracheal ozena.

From a subjective point of view, the malady scarcely affects the general economy. The patient is unaware of his infirmity, but sooner or later the affection finishes by abolishing the sense of smell.

The complications observed in ozena are very few. The ear is hardly ever affected in ozena, contrary to what happens in acute rhinitis. On the other hand the eye is frequently the seat of lesions such as sacro-cystitis, conjunctivitis, ulcers of the cornea, keratitis.

Moure has described the following forms of ozena:—
Adenoid. Described by Grünwald and due to the presence of vegetations. This form is rare, but its existence is beyond doubt.

Necrosis of the ethmoid bones. It is natural to suppose that a lesion of these bones should give rise to ozena.

The purulent form is very frequent in children. At the beginning of the affection, the mucous membrane is swollen and painful, but later atrophy sets in in spite of every treatment.

The atrophic form of ozena is that generally observed. The nares are enlarged, the mucous membrane and the subjacent bones become atrophied, while the decomposition of the secretions produces the fetidity of the breath.

Ozena, insidious at the outset, constantly progresses, and once firmly established, atrophy develops with more or less rapidity and yields to no treatment.

Researches have been made for a specific microbe of ozena, and Løwenberg, and more recently Perez, described micro-organisms which they considered as the responsible agents of the malady.

On the other hand, ozena is very frequently hereditary, and appears to be transmitted more generally from mother to daughter. Syphilis, scrofula, lymphatism, constitute favourable grounds for the development of the malady, which is observed generally between the ages of eight and fifteen.

Treatment.—Ozena is an infirmity, and if the treatment cannot produce a radical cure, it can improve the symptoms. It consists in irrigations, ointments, powders, and medicated plugging.

The first thing to do is to remove the crusts by a plug of absorbent wool moistened with glycerine and phenic acid (1-15). Then abundant irrigations of the nares (one or two quarts) twice a day with some antiseptic solution: Salt water, 1 per cent.; phenosalyle, 1—1,000; resorcine, 1—400; thymol, 1—1,000; borax, chloral, &c.

After each irrigation, pulverisation of the cavities should be made with:—

Menthol, 15 grs.;
Eucalyptol, 2 grs.;
Vaseline oil, 2 oz.

Another method is as follows: Each day an irrigation of saline solution, at the end of a fortnight every two days, and, finally, twice a week, according to the need. Massage of the nasal mucous membrane by means of a plug of cotton-wool steeped in phenicated glycerine (1—15) should follow the irrigation, and the parts finally touched with a solution of iodine and glycerine (1—10) or chloride of zinc (1—60).

This treatment should be continued months and years. As general treatment, iron, arsenic, cod liver oil, &c., will be prescribed according to indications.

As local treatment, the following has also been recommended:—

Collargol, 8;
Sugar of milk, 2½ drachms.

To be blown into the nose twice a day after antiseptic irrigation. Or:—

Refined petroleum, 1 oz.;
Nitrate of strychnine, ¼ gr.;
Oil of eucalyptus, ten drops.

Paint the nares after irrigation.

GERMANY.

Berlin, March 3rd, 1906.

AMONG some interesting cases shown at the meeting of Charitée Physicians, Hr. Lesser introduced one of (a) a "self-inflicted skin wound" in a hysterical patient, æt. 16. She had numerous deep symmetrical cauterizations of the face from applying fuming nitric acid. She had disfigured herself in the same way on three previous occasions. In cases of "spontaneous" gangrene the condition was sometimes brought about in a similar manner. (b) A child, æt. 3, with a septic pemphigus-like rash that ran a febrile course, and had developed after removing the scab from a vaccination spot. In a discussion that took place, Hr. Henneberg remarked that the first patient was weak-minded and that she suffered from hereditary taint, and that she had been led to produce the disfigurement by various motives.

Hr. Roscher showed (a) "Spirochætæ," a section removed from a papule on the mamma, the preparation being stained after Levaditi's process. (b) Two cases of lues maligna with multiple genital and extragenital primary lesions. (c) A case of gangrenous herpes zoster in a case of syphilis, that affected the region of the first branch of the trigeminus, and had led to neuro-paralytic keratitis.

Hr. Brüning showed two "apes with primary syphilis of the eyelids." The course for such primary effect, were: a period of incubation from three to four weeks, transmissibility, immunity, microscopical appearances, and the discovery of spirochæta pallida.

Hr. Grumme showed (a) a case of syphilitic meningomyelitis in which the symptoms (disturbance of reflexes, anæsthesia, and serpiginous syphilides) had been improved by antisymphilitic treatment. (b) A case of tertiary syphilis with ulcers on the buttocks and legs, which had led to elephantiasis thickening.

Hr. Henck showed a case of congenital syphilis which, in addition to the usual symptoms, had developed arthritic changes on both hands.

At the meeting of the 18th ult, Herren v. Legden and Blumenthal described a case of

ACUTE YELLOW ATROPHY OF THE LIVER.

The case was that of a woman, æt. 27, in addition to the jaundice, which was very deep, there was mental disturbance, and, towards the end, coma. No trypsin was present in the urine. The autopsy confirmed the diagnosis of acute yellow atrophy of the liver. The first question was as to whether the tissue disturbances present were due to an increased production of amines acids or to a specific disturbance of the power of assimilation for those products. It was further striking why there was no disturbance of the power of assimilation for other amine acids than leucine and tyrosine. In the normal liver within the cells there was a ferment that split off these bodies. In acute yellow atrophy of the liver they were set free by the great disintegration. Along with this there was also a diminished power of assimilation. The question of autolysis was inquired into. No ferment acting upon another organ albumen was found, nor glycogen, nor sugar.

Hr. Lazarus spoke on

BIER'S LUMBAR ANÆSTHESIA IN MEDICINE.

It played a part also in internal medicine as, for instance, in the crises of locomotor ataxy, in compression myelitis, myoclonus, spastic spinal paralysis, in painful contractions in remobilising, and in the operation for stretching the sciatic nerve. In this, sensation was frequently paralysed, "dissoziert" as in syringomyelia. Other methods of anæsthesia had been sought for on account of the headache and the vomiting, often lasting for days, that accompanied it; over the peripheral nerves compression, cold, and Schleich's infiltration came under consideration. The speaker had now studied the action of change of the molecular concentration of the spinal fluid in 64 rabbits. He found that lowering of it by injection of distilled water caused pain, whilst a 0.2 per cent., a 0.75 per cent., and a 0.92 per cent. solution of sodium chloride were quite indifferent. Injection of highly concentrated

chloride of sodium solution caused the death of the animals with convulsions, a 7 to 8 per cent., on the contrary, caused anaesthesia and paralysis. Isosmotic solution of bromide of potassium and magnesium had the same effect. Whether these effects were produced by diffusion or by osmotic difference of tension was questionable. Histologically, oedema was found with this paralysis. The anaesthetic action of solution of sulphate of magnesia was shown, also on the exposed motor cerebral centres.

Hr. Bosse reported on experiments made in the Surgical Klinik of the Charité on the same subject. Alypin and stovain were employed in 55 cases. The time required for the onset of the anaesthesia varied very much, and its extent was irregular. In eight cases the results were nil, and headache, sickness, thoracic oppression, incontinence, and slowing of the pulse were observed repeatedly. In one of the cases ecchymosis of the pleura was seen. For these reasons, the speaker observed, these methods of lumbar anaesthesia were not a perfect substitute for chloroform.

Herren. Michaelis and Fleischmann spoke on

ANTI-LIVER SERUM.

They said that antibodies were readily demonstrable so long as a visible reaction was obtainable; but when this was not so their demonstration was difficult. Through experiments made by themselves they had discovered a new way of proving their presence (the method of complementary disappearance). Complementary disappearance could also be observed in the living animal, but in the human subject no such phenomenon had been demonstrable.

AUSTRIA.

Vienna, March 2nd, 1906.

CRETINISM IN DOGS.

At the "Gesellschaft," Wagner presented a dog with all the symptoms of endemic cretinism. The dog came from Weiskirchen, in Styria. The head was small, with thick bones and hypertrophy of the soft structures, more particularly those of the face. The legs were heavy, thick, and short, and moved with an awkward apathetic gait.

Wagner thought this an important subject for investigation among animals, as it may account in many cases for the endemic production of this disease in the human species. Several years ago, in conjunction with Schlagenhauser, he commenced to investigate this subject, as he suspected such an origin, but their labours ended in disappointment at that time. Since then many obscure suspicions have been confirmed, and this pathological anomaly in dogs may lead to a revelation in the origin of cretinism.

Pupovac remarked that he was rather sceptical about the cretinism of dogs producing endemic cretinism in the human race. He recollected a gentleman in Admont who had a dog that gave birth to five young, three of which were cretinic, the other two feeble. All were fed on thyroid gland, with the result that the three cretinic became strong and healthy, but the other two which were at first supposed to be only weak, and not affected, died.

Alexander gave a brief description of the anatomical defects in the hearing of the cretin animal and particularly dogs. The defective perception of high tones, while moderate and deep tones can be heard, proclaims a lesion of the internal apparatus, probably the labyrinth, or acoustic nerve, either extra- or intracerebral. After localising this lesion he confined himself to the division of the pathological changes met with in the human subject. These, he thought, might be divided into three classes or groups according to their characteristics. The first group comprehended tubal catarrh, which affected the echo or resonance of sound. This morbid change in hearing is often produced by hypertrophy of lymphoid tissue of the pharynx in the form of adenoid vegetations. This group of changes is greatly improved by a course of thyroid treatment—the catarrh disappearing and the hearing more acute.

The second group is composed of the cretinic deaf and dumb, resembling the congenital form of deafness, having no pathological centre in the anatomy marked out as the cause of deafness.

The third group includes cases not so severe as to prevent testing of the physical power of hearing, although this function is performed with difficulty. In cretins, this group recovers rapidly in hearing under the influence of the thyroid gland, just as the internal cases do. There is no doubt of the defective hearing in cretins, but the difficulty is intensified when we attempt to determine the degree, as the intelligence is low and no reliable data can be deduced from the tuning-fork test, therefore no exact diagnosis can be obtained in these cases.

Hammerschlag repeated the results of Eberth's research on calves which were also affected by cretinism. He also quoted Habermann's conclusions that all cretins were defective in the perception of sound as recorded by his apparatus.

Wagner remarked that Eberth's and Habermann's cases were those of chondro-dystrophia, which in no way could be allied with cretinism, but was more probably a sort of micromyelia in the adult.

LYMPHANGIOMA IN LEFT GROIN.

Lieschner showed a patient, æt. 40, who for six years had a swelling in the left groin about the size of a walnut. It rapidly increased in size and finally a fistula formed that discharged a clear fluid. It was of a hard consistence, lying about the middle of Poupart's ligament, and having a knobby surface with a mushroom appearance. Below Poupart's ligament another tumour of a similar character and about the size of a man's fist formed, but soft in consistence as if cystic.

By pressure it could be reduced to half, while the upper became larger. When the upper was pressed the opposite effect was produced.

By pressing or coughing the tumour was enlarged, but no sign of hernia was perceived.

An operation was contra-indicated, as subsequent inflammation might supervene from the fistula present.

Payer's method for treating lymphangioma was adopted with excellent results. This consists in arrows of magnesium being inserted with an injection of iodoform glycerine.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

EDINBURGH ROYAL ASYLUM.—The annual meeting of the Corporation was held on February 26th, when Dr. Clouston, the Physician superintendent, submitted his annual report. During the year 200 male, and 228 female patients were admitted, while there were discharged 130 males and 127 females. The average number of patients resident was 870. One of the most striking features of the admissions, from a medical point of view, was the large number—sixty-four—of cases of general paralysis, which was in excess of any previous year. Even more remarkable was the comparative increase of the disease in the female sex among the poor. When Dr. Clouston first came to the asylum as assistant physician in the early sixties it was most uncommon to have a woman admitted suffering from general paralysis; in 1872 there were no such admissions, and in 1874 only 3 cases. This year 38 women suffering from the disease were taken into the asylum. General paralysis was most frequent among the rate paid class, there being only 5 males and one female among the private patients. 18.6 per cent. of the rate-paid patients suffered from the disease, while among the private patients only 5 per cent. were so afflicted. For the first time the number of admissions of female general paralytics exceeded that of the men. This was a bad sign of the moral status and mode of life of the class from which these patients came, and was a sidelight of a very depressing character on our social life.

To show the enormous difference in the local distribution of the disease, he instanced Ireland, in which with a population of 4½ millions only 52 such cases were admitted to all the asylums. Great cities, vice, dissipation, and undue excitement, were the breeders of general paralysis. Dr. Clouston then alluded to Dr. Ford Robertson's work on

THE MICROBIC ORIGIN OF GENERAL PARALYSIS, to which the Morison lectures, of which an abstract has recently appeared in this journal, were this year devoted. He accepted as now proved this new theory of the etiology of the disease; the difficulties he had felt had been overcome by the convincing facts brought out by the investigations in the Laboratory of the Scottish asylums. The immediate cause of the disease was a microbe, acting specially on brains weakened by dissipation or poison. He did not expect the microbe theory to be at once accepted by the whole medical profession; before full confirmation was generally admitted Dr. Robertson's methods and research would have to be repeated. The cheering point in the investigations was that it pointed to the possibility of a method of cure being found.

ALCOHOL AND INSANITY.—Of the admissions 110, or 25 per cent., were due wholly or partly to excess of alcohol; in the men it was 30 per cent., in the women 22 per cent. This was an increase on the average of the past five years, and it was lamentable to note that the percentage in women had gone up from an average of 16.2 in the previous 5 years to 22 per cent. this year. The proportion of cases among private patients was only about half of that in the rate-paid class. Education and better social circumstances were accompanied by increased self-control in this respect, a fact which points to the best remedy for undue indulgence in alcohol. But our alcoholic insanity rate was still far too high among all classes. The latest researches on heredity tended to prove that the results of excess in drink did not end with our generation, but produced mental and physical degeneracy in the descendants. There was much room for the educator, the religionist and the legislator in this matter. The Medical Man and the physiologist were more and more compelled to warn people on the present and far reaching dangers of alcoholic excess. Old prejudices and custom should be counteracted by teaching the young to regard modern scientific knowledge as one of the great rules of life. The great bulk of recent cases of insanity were of the melancholic type—a reversal of the rule of twenty years ago. The great epidemic of influenza of 1889-90 and subsequent lesser epidemics, notably caused many deaths, and lowered the nerve tone of the community, and in consequence the melancholy phase of insanity throughout the country has become much more common than previously. The recovery rate for the year was 32 per cent. of the admissions, a low rate as compared with their average of 39.2. The death-rate was high—13.3 per cent. on the average number resident, and 9.2 per cent. on the total under treatment. The mortality was much higher (18.2 per cent.) among rate paid than among private patients (7 per cent.), which was accounted for by the large number of cases of general paralysis and organic brain disease among the former class. The average length of residence among rate-paid inmates was 5.8 years, and among private patients 10.3 years. Craig House still maintained its unbroken record of no consumption among its inmates, and that had been continued during the 11 years it had been open which was a unique fact in the history of mental hospitals. There was clear statistical proof that nowadays aged dotards and broken-down persons whose mental power was affected were sent to asylums in large numbers if they could be got on the rates, while the better off classes nursed such patients at home. This was the explanation of the apparent enormous increase of rate-paid insanity in recent years. Until the numbers of private patients, paid for out of their own means or by their relatives showed an increase in admissions to asylums—and since 1858 there had been no increase in the Scottish asylums—he could not believe that

there was any alarming increase of lunacy in the country. In concluding his report Dr. Clouston adverted to the question of treatment of early cases. The Royal Infirmary or Parish council should provide hospital accommodation for transient uncertifiable forms of mental disease as an important means of decreasing ultimately incurable insanity. While it was notoriously difficult to forecast the future course of health legislation, the trend of democracy was towards measures for the greatest good of the greatest number, irrespective of the feelings of the individual, and it was quite possible that mental diseases might become notifiable as one means of eliminating the unfit for marriage.

CARNEGIE TRUST AND THE PAYMENT OF CLASS FEES.—The fifth annual report of the Carnegie trustees is a more than usually interesting document. The part dealing with Clause A of the constitution, under which payments are made towards equipment and teaching, and original research, calls for no special remark, because by the system adopted some years ago of allocating definite sums to the universities for specified objects, payments being spread over a quinquennial period, all that is recorded is the gradual fulfilment of these objects, the construction of buildings, and the endowment of lectureships, etc. A number of grants have also been made for analogous purposes to various extra mural teaching bodies. The endowment of research has been carried on as in previous years, about £5,000 being spent on this object. During the year 36 investigators worked in the College of Physicians laboratory, which is now the property of the Trust. A volume of reports has been published and material for another is accumulating; besides this, many theses for the degree of M.D. have been based on the work in the laboratory, while the surgical fellowship was gained by one of the investigators. The section of the report dealing with the payment of class fees, however, contains much food for reflection. The fact is that if the present system is continued, funds will soon run short. The number of beneficiaries for the winter 1905-6 is 3,184, an increase of 109 over the previous year, while the fees paid during the year amounted to £47,853, distributed among the universities as follows:—St. Andrews, £3,483; Glasgow, £11,032; Aberdeen, £6,286; Edinburgh, £11,466. The amounts expended on class fees for the previous financial years 1902, 1903, 1904—£40,285, £44,104, £45,903—have steadily increased, not merely by the growing number of beneficiaries, but also by the rise of the average fees paid per beneficiary, this rise being due partly to the greater number of classes attended, and partly to three of the Universities having raised certain class fees. A year ago the committee formed the expectation that the limit of expenditure had been reached, but this anticipation has not been fulfilled, as the expenditure this year shows a rise of close on £2,000. An analysis of the relative increase of beneficiaries and average fees per beneficiary shows that the greater amount expended has been required from both these causes.

As the *Scotsman*, in an editorial puts it—"the fee fund may be said to be insolvent, because the universities have been too eager to use it for replenishing their purses. The cow has been cruelly milked." Making all allowance which the temptation of being able to draw on a fund vested in trustees, instead of the pockets of the students' parents, affords, it looks very like greed that Aberdeen should in five years have increased its average fee from £12 10s. to £16 15s., or nearly 33 per cent. It is quite notorious that many students avail themselves of the benefits of the Carnegie Funds whose parents are perfectly able to pay a very considerable part, at least, of the fees, and it has been no part of the plan of the trust to check this in any way. Indeed, the founder contemplated payment to any otherwise qualified student who applied, without restriction or curious inquiry. Possibly the publicity given to the state of matters may diminish the drain on the funds from this source, which is, of course, one direction in which the trustees may turn their eyes in trying to reduce their expenditure.

LETTERS TO THE EDITOR.

IS WRIGHT'S OPSONIC INDEX ESTABLISHED?

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—With regard to Wright's opsonic index I venture to ask if it is not somewhat premature to term his complicated system a new era of therapeutics. That it is an attempted move in the right direction seems certain, but that it is a practical addition to our working methods I venture to doubt. The crux of the whole thing is to test the resistance of the blood, natural and acquired, to tubercle (and other) bacilli, and thereby to secure data for correct anti-bacterial dosage. The whole method is highly technical and can be carried out only at a prohibitive cost. Ten guineas is an ordinary charge for a single examination in private practice, and that has to be repeated indefinitely. In hospital practice so much time is required that a highly-paid pathologist and a well-equipped laboratory are indispensable. After all said and done do we gain anything that might not be learnt by simple clinical observation? I say emphatically we do not, and, moreover, the method is riddled with crude fallacies. The standard opsonic of normal blood, for instance, varies between .5 and 1.3; a fine standard, forsooth, for a system that aspires to finality in accurate estimation. I trust, sir, that the world of medicine will wait awhile before accepting Professor Wright's fascinating theories—or we shall find ourselves once more grasping at a Will-o'-the-Wisp.

I am, Sir, yours truly,
CUNCTATOR.

Balham.

ECLAMPSIA.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your issue of February 28th, Dr. A. Stookes is reported as having stated at a meeting of the Liverpool Medical Institution held on February 15th last, that "He wished to draw attention to a remarkable series of cases lately published by the Rotunda Hospital, where 71 cases of eclampsia were treated with a mortality of 1.69 per cent."

I regret that we cannot lay claim to results so satisfactory as this, and 1.69 should read 16.9 per cent.

I may, however add that my own statistics are a great deal better than the above.

I have attended in all 27 cases of eclampsia with 2 deaths, which gives a percentage of 3.7.

These fatalities will be described in my annual Report of the Hospital shortly to be published, and are both far removed from the type of eclampsia usually encountered.

I am, sir, yours truly,
E. HASTINGS TWEEDY,
Master Rotunda Hospital.

Rotunda Hospital, March 4th, 1906.

HOSPITAL PHYSICIANS, SURGEONS, AND THE PUBLIC.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It would be well that those who are interested in hospitals, and the public generally, should understand clearly how the services of the physicians and surgeons for hospital work are obtained.

The public may not take much, if any, interest in the education of medical students, and there are some who object to hospital patients being utilised in any way for that purpose. The question then must arise what return are you going to make for the important services of your physicians and surgeons? For if those services are gratuitous, it is only from the medical schools that any pecuniary profit can for certain be made.

If a physician or surgeon looks for a return from the reputation his hospital may give him, he may find that a special hospital is worth far more than a general one, and he would rather use it for special work and know-

ledge than for any profit from teaching. The education of students preparing for the practice of medicine is like that of many other arts in this country, in a bad state. Engineering is beginning to stir a little as there is more money invested in such work than in the arts of music, painting, and medicine. The time has come when the profession will have to make a stand, and there is not much doubt that if our hospitals are not going to be used for teaching, they will not get good professional help for nothing. Those who know anything of the work that William and John Hunter did as teachers; and what the results of their work were, and how men like Wm. Laurence, South, Travers, and others were trained to be great surgeons, they will, let us hope, not let the education of our students lapse into the anæmia that seems to have come over teaching generally in this country. The public will suffer for it sooner or later, and I hope that the influence of your journal will be brought to bear on this subject.

I am, sir, yours truly,
INQUIRER.

IRRIGATION OF THE NOSE IN RHINITIS IN CHILDREN.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your issue of this date, it is recommended by your Paris correspondent in the treatment of this affection, that an enema syringe be used in washing out the noses of children suffering from purulent rhinitis (p. 230). Your readers should know that such syringing of the nose has been condemned by almost all the great otologists who have written during the past quarter of a century. It is a very efficient means of setting up acute otitis media.

I am, Sir, yours truly,
February 28th, 1906. JOHN B. STORY.

HOSPITALS AND THE PUBLIC.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I saw in Thursday's *Daily Telegraph* a report of the meeting held at the Westminster Hospital when the question of the relation of the Medical School to a hospital was discussed.

It seems rather doubtful whether it is of any advantage to the physicians or surgeons of a hospital to have a school attached to their hospital, and certainly a "special" hospital may be of far greater advantage in the matter of reputation and practice.

Dr. Allchin's connection with the Westminster Hospital school I thought was severed some time ago, and this makes it difficult to understand the remarks he made at the meeting.

I am, sir, yours truly,
A HOSPITAL SURGEON.

OBITUARY.

ADAM WILKINSON, M.D.St.AND., F.R.C.S.Ed., M.R.C.S.Eng., J.P.

DR. ADAM WILKINSON died last week at Sheerness, at the age of seventy-four. He was professionally educated at Charing Cross Hospital, and qualified in 1867 as M.R.C.S. and L.R.C.P., Ed. He took the M.D. degree, of Brussels in 1883, and of St. Andrews in 1884, and the following year was elected a F.R.C.S. Edin. He was consulting physician to the Westminster Memorial Cottage Hospital at Shaftesbury, of which he was formerly medical officer, and he had been a member of the General Council of the University of St. Andrews.

EDWARD JOHN LONGTON, M.D. Edin.

WE regret to announce the death of Dr. Edward John Longton, formerly a well-known medical practitioner in South-West Lancashire, at Ulverston, at the age of seventy-six. He was born in 1829, and pursued his medical studies at King's College, London, and the University of Edinburgh, being admitted a

member of the Royal College of Surgeons, England, in 1852, and a L.S.A.Lond., and M.D. of Edinburgh in 1853. He was formerly honorary surgeon to the Southport Strangers' Charity. Dr. Longton was a magistrate for Lancashire and a Fellow of the Zoological Society.

WM. ROBINSON, M.R.C.S.ENG., OF HUDDERSFIELD.

We regret to record the death of one of the best-known men in this borough in the person of Mr. William Robinson, who was the doyen of the medical profession in Huddersfield, in the eighty-eighth year of his age. He entered the medical school at University College, London, where he was admitted a member of the Royal College of Surgeons of England in 1839. Returning to Huddersfield he became a house surgeon at Huddersfield Infirmary for a period, and then joined his father in private practice, remaining with him till he died in 1865. He was greatly esteemed by his professional brethren, one proof of which was given by his election as first president of the Huddersfield Medical Society.

THE DEATH OF DR. LOUIS DE WECKER.

It is a curious fact that scarcely any notice has been taken by the medical press of the death of Dr. de Wecker, of Paris, who passed away on January 24th last. De Wecker's name is not unworthy to rank beside those of Von Graefe, Bowman, Donders, and Desmarres. The following sympathetic little notice we extract from the current number of the *Ophthalmoscope*:—"The death is announced from Paris of Louis de Wecker, aged eighty-three years. Born at Frankfort-on-the-Main in 1832, de Wecker pursued his earlier medical studies at Wurzburg. He afterwards became Desmarres' assistant in Paris, and studied with v. Graefe in Berlin. In 1861 he obtained his Paris degree, and purchased from Deval the well-known clinic in the Rue Visconti. A few years later he attended Leon Gambetta, one of the most interesting statesmen who has ever flitted across the troubled stage of French politics. De Wecker removed an eye from his distinguished patient. In 1870, de Wecker left the Rue Visconti for the Rue de Cherche-Midi, where he established one of the largest and best-appointed eye clinics in Paris. He continued his devoted services during the darkest days of the siege of Paris, and was nominated surgeon to the national guard. De Wecker's name and fame are known in every part of the world where ophthalmology is practised. He was the author of "Traité des maladies des yeux" (1863), of "Traité des maladies du fond de l'œil" (1870), of "Thérapeutique oculaire" (1878), of "Chirurgie oculaire" (1879), and finally, in conjunction with Landolt, of that monument of patient research and prolonged labour the "Traité complet d'ophtalmologie" (1882-1885). He wrote numerous articles in the periodical press, especially upon such subjects as cataract extraction, iridectomy and jequirity. De Wecker introduced sclerotomy as a cure for glaucoma, and the operation of tattooing as a means of concealing leucomata and of improving sight in cases of the kind. His name will always be associated with his *pince-ciseaux* for the division of after-cataract, and with his double strabismus hook for advancement of the recti tendons. A master of ophthalmology has gone from us. May he rest in peace!"

J. R. KEALY, V.D.

We regret to announce that Dr. Robt. Kealy, V.D., of Ashley House, Gosport, died on Saturday evening. He caught a chill about ten days ago, and took to his bed on Wednesday last. He was attended by Dr. Lamplough.

Dr. Kealy was probably the best-known medical practitioner in Gosport, where he resided since 1849, and he was born at Ipswich on September 8th, 1830, and worked on the Board of Health in London at the time of the cholera epidemic in 1849. He was also vice-chairman of the Church Schools' Council of Alver-

stoke, and was president and lecturer of the Gosport and Alverstoke Literary Association. The deceased gentleman was for many years a hon. surgeon to the out-patients' department of the Royal Portsmouth and Gosport Hospital, and was always a kind, sympathetic, and clever physician. He was greatly respected by his fellow-townsmen, who will feel his loss keenly.

LITERARY NOTES.

DR. ARTHUR E. BODINGTON, of Winchester, has edited a reprint of his famous forebear's essay on "The Treatment and Cure of Pulmonary Consumption," which appeared in 1840, and foreshadowed the modern "open air" methods now so generally approved.

DR. T. N. KELYNACK has just issued a useful little work on "The Alcohol Problem in its Biological Aspect," which deals with the so-called temperance question on sound scientific lines likely to be of service to teachers and students.

SIR FREDERICK TREVES is a Dorset man, claiming fellowship with such distinguished Dorchester men as Hardy the novelist, and Barnes, the poet; and it is therefore particularly fitting that he should have undertaken the preparation of the volume on Dorset for the justly popular "Highways and Byways" series published by Messrs. Macmillan.

MILITARY men, litterateurs, and the clergy, by some indefinable force which we cannot attempt to explain, seem irresistibly attracted to the mysteries of medical quackery. A notable example is now conspicuous in the new editor of our immortal contemporary, *Punch*, for according to *The British Weekly* Mr. Owen Seaman is "treasurer of the Society which provides the 'Normyl' treatment for the cure of alcoholism and the drug habit." Surely this incongruous association of *Punch's* chief representative with a discredited piece of quackery might offer material for the welcome cartoonist, or at least a subject for discussion at the time-honoured dinners.

"A Guide to Diabetic Cookery" is before us. It is a concise and well-arranged handbook which will meet the needs of both practitioners and patients. In the management of diabetes detailed instructions are of paramount importance and within these pages will be found one hundred and fifty-one recipes affording a varied and attractive dietary. Formerly "diabetic foods" was an expression almost synonymous with "distasteful diets," but if the instructions afforded in this little manual are followed, the grievances of these long-suffering invalids will be in a great measure removed. The little work is published at a low price, which places it within the reach of the poorest patient, by Messrs. Callard and Co., of Regent Street, London, the well-known food specialists, a sufficient guarantee that every care has been taken in its preparation. To many a perplexed physician this collection of recipes will prove most helpful.

THE current (March) number of *The Ophthalmoscope*, edited by Mr. Sydney Stephenson, is devoted to the important practical subject of "cataract." Our enterprising contemporary has secured original articles from such masters of the subject as Sir Anderson Critchett, Major H. Herbert, Lieut.-Col. E. F. Drake-Brockman, Mr. Henry Power, and Mr. C. Devereux Marshall, to say nothing of less ambitious contributions from Dr. A. L. McMillan (Glasgow), and Dr. D. S. Sager (Brantford, Canada). *The Ophthalmoscope* contains, besides, classified abstracts of British and foreign work on many questions dealing with cataract—as, for example, operations, pathogeny, pathology, and complications after extraction. It is altogether an admirable number, reflecting credit upon those responsible for the management of the journal.

MEDICAL NEWS IN BRIEF.

Death from Ethyl-Chloride in Dentist's Chair.

WHILE under an anæsthetic at the surgery of Mr. Warburton Browne, dentist, of Charles Street, Mayfair, the Rev. William Henry Eley, aged sixty-seven years, Rector of Deene, Wansford, Northamptonshire, died. The inquest when held revealed that ethyl-chloride, which was administered to the patient, possessed unexpected dangers. Mr. Browne said that the rector had consulted him for several years. Two years ago Mr. Eley was placed under the influence of gas and oxygen, which he took well. On Tuesday he attended to have four teeth extracted, and the anæsthetic on this occasion was ethyl-chloride. The patient was one minute taking the anæsthetic, and the operation lasted one minute and a half. When the fourth tooth had been drawn, Mr. Eley became very pale, and died almost immediately, remedies which were promptly applied proving useless. Witness had seen ethyl-chloride given on about 200 occasions; it had been known for about three years. Dr. Alex. Browne, of Kentish Town (brother of the dentist), who administered the anæsthetic, said his experience of ethyl-chloride had been very favourable, and he had given it in one-third out of about 150 cases. It was liable, however, to give rise to a good deal of muscular rigidity at times, so that respiration might be suspended; but he did not know that it dangerously depressed the action of the heart. Before the operation he examined Mr. Eley, and realised that the arteries were rather thick and brittle. He did not examine the heart in great detail, because the patient, who was not at all nervous, seemed unwilling. He had never known a case of heart failure through the use of this new anæsthetic. After this case he had altered his opinion as to ethyl-chloride; apparently it was not as safe as his previous experience had led him to suppose. Dr. Robert S. Trevor, of St. George's Hospital, who made a *post-mortem* examination said death was due to syncope while Mr. Eley was suffering from fatty degeneration of the heart. The jury returned a verdict in accordance with the medical evidence, and absolved Messrs. Browne from all blame.

Malta Fever—Report of Special Commission.

THE Royal Society has issued a further report of the commission appointed by the Admiralty, the War Office, and the Civil Government of Malta, for the investigation of Mediterranean fever. In a previous report it was shown that goats in Malta are susceptible, this being demonstrated by the presence in their milk of the specific microbe, *Micrococcus melitensis*. It has also been determined that certain species of mosquitoes in Malta act as carriers of the microbe, while there is a strong probability that it is transferred by the insect from man himself. It appears that Malta fever can be acquired by the absorption of infected goats' milk from the alimentary canal, and that this mode of infection is largely responsible for the disease among the Maltese, who drink raw milk drawn at the doors of their houses. Drastic preventive measures are recommended.

St. Thomas's Hospital.

THE following House Officers have been appointed from yesterday (Tuesday), March 6:—*Casualty Officers*.—(Senior) G. R. Footner, M.B., B.C.Cantab., M.R.C.S.; (Junior) F. R. E. Wright, M.B.Lond., M.R.C.S., D.P.H. *Resident House Physicians*.—F. M. Bulley, M.R.C.S., L.R.C.P., M.A.Cantab.; R. C. Jewsbury, M.A., M.B., B.Ch.Oxon., M.R.C.S.; and W. O. Meek, M.B., B.S.Lond., M.R.C.S. (extension) C. St. A. Coles, M.R.C.S., L.R.C.P. (extension). *House Physicians to Out-Patients*.—M. A. Cassidy, M.A., M.B., B.C.Cantab., M.R.C.S.; H. S. Singleton, M.R.C.S., L.R.C.P. *Resident House Surgeons*.—H. T. Gray, B.A., B.C.Cantab., M.R.C.S.; A. W. Hooker, M.B., B.S.Lond., M.R.C.S.; J. H. Drew, M.B., B.S.Lond.,

M.R.C.S.; H. Falk, B.A., M.B., B.C.Cantab., M.R.C.S. *House Surgeons to Out-Patients*.—R. J. H. Cox, M.R.C.S., L.R.C.P.; F. S. Hewett, B.A. Cantab., M.R.C.S.; A. B. Howitt, B.A.Cantab., M.R.C.S., W. G. Howarth, M.A., M.B., B.C.Cantab., M.R.C.S. *Obstetric House Physicians*.—(Senior) R. E. Whitting, M.A., M.B., B.C.Cantab.; (Junior) S. R. Gibbs, M.R.C.S., L.R.C.P. *Ophthalmic House Surgeons*.—(Senior) C. R. B. Eyre, M.R.C.S., L.R.C.P.; (Junior) H. E. Gotelee, M.R.C.S., L.R.C.P. *Special Departments*.—(Throat) S. G. MacDonald, B.A.Cantab., M.R.C.S.; H. B. Whitehouse, M.R.C.S., L.R.C.P.; (Skin) W. O. Sankey, M.R.C.S., L.R.C.P.; A. N. Dickson, M.R.C.S., L.R.C.P. (Ear) R. N. Cunningham, B.A.Cantab., M.R.C.S.; A. L. Loughborough, M.R.C.S., L.R.C.P. *Children's Surgical*.—C. M. Page, M.R.C.S., L.R.C.P.; and S. G. MacDonald, B.A.Cantab., M.R.C.S. *Electrical (X-ray Dept.)*.—N. R. Cunningham, B.A.Cantab., M.R.C.S.

Metropolitan Hospital Sunday Fund.

A MEETING of the council of the Metropolitan Hospital Sunday Fund was held on the 2nd inst., at the Mansion House, the Lord Mayor presiding. Sir Edmund Hay Currie, the secretary, read the report of the Committee of Distribution on the increase of out-patients. They stated that on July 27th last a resolution was passed by them expressing the opinion that the serious increase in the number of out-patients (many of whom had trivial complaints) was detrimental to the welfare of the hospitals and patients, inasmuch as they were a burden to the funds and prevented the staffs from giving the necessary attention to serious cases. A copy of this resolution was forwarded to 80 hospitals having out-patient departments inviting the opinions of their committees on the question, and asking if they could suggest any remedy. The replies had been received, and the suggestions tabulated. The reports seemed to show that the number of general out-patients was decreasing, but the attendances at the special departments caused an increase in the actual figures. Suggestions had been made to the committee that, after the first visit, patients should not be allowed to attend a second time without a certificate from a medical man in the neighbourhood that the case was a proper one for treatment at a hospital. They could not see their way to agree to this proposition, but they were of opinion that if such cases could be referred to a private practitioner or to a self-supporting dispensary (provided sufficient of these could be established), nothing but good would result, especially if the dispensaries were attended, not by a few medical men in the district, but by the whole of the general practitioners in the immediate neighbourhood, such dispensaries to be affiliated to the nearer general hospitals. The committee recognised that the constituents of the fund had, for the first time, decided to make grants to "district nursing associations, employing fully-trained hospital nurses" (there were about 300 of them engaged throughout the metropolitan area), and as these nurses worked only under the direction of local medical men, it was felt that some sort of affiliation should be made, and that casualty patients might be recommended to apply to the superintendents of these associations after receiving "first aid" at the hospital, thus coming under the professional care of the local medical men. The committee were of opinion that, notwithstanding the large number of attendances in the out-patient departments of the general hospitals, those institutions had hitherto increased their accommodation and qualified staffs to an extent sufficient to enable them to cope with all such cases. The committee also thought that there was not any serious abuse of the out-patient departments in the general hospitals, and that any which might exist at the present time could be

effectually met by an efficient system of investigation, conducted by a competent staff in the out-patient department, who should visit the homes of the patients, and for that purpose the addresses of all out-patients should be taken. The committee had considered it advisable to confine its investigation to the general hospitals only, and not to the special ones.—Sir William Church moved that the report should be adopted, circulated among all the hospitals, and sent to the Press. After a short discussion the report was adopted. A resolution was passed to authorise the council to take steps for the incorporation of the fund. It was stated that a meeting of secretaries of London hospitals held the previous day at the Mansion House in order to devise a uniform system of accounts had appointed a committee for the furtherance of that object.

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 February 23rd. The chair was taken by Dr. de Havilland Hall, and there were also present Dr. J. Pickett, Dr. J. Rundley James, Mr. Edward Bartlett, Dr. St. Clair B. Shadwell, Mr. William Thomas, Mr. J. F. Colyer, Dr. F. S. Palmer, and Dr. J. B. Ball. The past winter has been unusually favourable to the society. For many years past the amount of sick pay disbursed during the winter months has been considerably in excess of the average of the whole year while the light experience of the summer has balanced this leaving a margin in favour of the society. But since the beginning of December last the claims received have amounted to less than the average expectation of the whole year and thus a profit has been made at a time when a considerable loss is usually sustained. The number of new entrants is also very good, and on the whole the year 1906 has opened very favourably for the society. Prospectuses and all other information on application to Mr. F. Addiscott, Sec. Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

Meat Inspection in the United States.

CONSUMERS of American meat imported to this country will be somewhat reassured after the recent attacks by a contemporary, with the result of an inquiry by the *New York Medical Journal*, which suggested that its English contemporary had to some extent been misinformed, particularly as to the data on which it founded its statement that only hogs were inspected, and, of those animals, only such as were destined to be exported to Continental Europe, those intended for Great Britain and for home consumption going entirely without inspection. The "Twenty-first Annual Report of the Bureau of Animal Industry," has been received, from which it appears that during the year there were 64,613,383 inspections of animals previous to their slaughter—namely, 12,599,831 of cattle, 14,633,129 of sheep, 1,143,962 of calves, and 36,236,461 of hogs. The *post-mortem* inspections amounted to 39,590,370, including 6,383,080 of cattle, 8,269,133 of sheep, 767,927 of calves, and 24,170,230 of hogs. Of the living animals, there were rejected (subject to the results of *post-mortem* examination): At the abattoirs, 757 cattle, 1,230 sheep, 500 calves, and 3,807 hogs; and in the stock yards, 42,263 cattle, 12,442 sheep, 6,555 calves, and 59,519 hogs. The numbers of carcasses condemned were 16,145 of cattle, 8,414 of sheep, 2,129 of calves, and 62,487 of hogs. This effectually disposes of the contention that only hogs are examined. The United Kingdom certainly is not wholly neglected by its own inspectors, as representatives of the Bureau of Animal Industry inspected 380,365 living cattle and 270,066 living sheep from the United States and Canada, the inspections being conducted at London, Liverpool, and Glasgow. The special microscopical examination of pigs for trichina is of course unnecessary in this country as the public do not eat raw flesh as in Germany, but it is gratifying to note that meat inspection generally is so efficiently carried out on both sides of the herring pond

The "Sanitas" Company.

AT the twenty-eighth Annual General Meeting of this company, held on Thursday last, Mr. C. T. Kingzett F.I.C., F.C.S., presiding, the Chairman stated that the sales for the year 1905 slightly exceeded those of the best previous year, and the profits allowed of the usual final dividend and bonus, making a total distribution for the year of 7½ per cent. The Chairman remarked upon the steady growth of "Sanitas" in public favour and in that of the medical profession, and while it was still regarded, from an all-round point of view, as a standard disinfectant (being the only preparation which combined in itself all the properties that could be desired for sick-room and household applications), it was necessary for the Company to meet competition from all sides. Hence, as the result of long investigation in their laboratories, the Company was about to introduce a new disinfectant to be known as "Bactox," which would favourably compare with the strongest known bactericides hitherto available, having a guaranteed co-efficiency of from 13 to 40 as compared with pure carbolic acid. It was described as a neutral non-corrosive, saponaceous preparation, and having regard to its great germicidal strength and price would be found cheaper in use and as strong as, or stronger, than any competing article on the market, and devoid of all objectionable qualities. They would, therefore, in future, be able to offer to the public and sanitary authorities the choice of the best disinfectant for household and sick-room purposes on the one hand, and the strongest germicide for rough disinfecting and surgical use on the other hand.

The Forthcoming International Congress of Medicine at Lisbon.

WE are asked by the National Committee for Great Britain and Ireland to state that the executive committee have secured a considerable number of rooms, some single bedded, but for the most part with several beds in a room at a cost of six, eight and ten francs a bed per night. There are also a few boarding houses which will take in members at a cost of fifteen francs a head. Tickets for these lodgings will be obtainable at the Rocio Station, which is the terminus for passengers arriving in Lisbon by train, and visitors are required to pay for the whole eight days during which the Congress lasts. Accommodation will be reserved in strict accordance with the priority of application made to Mr. Manuel Jose da Silva, Palacio Foz, Praca dos Restauradores, Lisbon. The hotels and restaurants as well as the buffet in the Congress buildings will solve the difficulty of obtaining meals.

The Cancer Hospital, London.

THE fifty-fifth annual meeting of the Governors of this charity was held on Wednesday last; Lieut.-Col. Parr presiding. From the report of the Committee it appeared that during the year 1905 there were 713 new in-patients, and 1,693 out-patients, with a total number of visits of 18,405, and the daily average number of beds occupied was 88. Owing to the deficiency of the ordinary income, it was found necessary during the year to realise between £4,000 and £5,000 from the capital to meet the expenses. The sanitary and hygienic condition of the hospital had been thoroughly investigated, and many renovations and additions carried out, one result of the additions being that nine more beds have been placed at the disposal of the surgeons, bringing the total number available up to 114 as against 105.

MR. AND MRS. ETHELBERG HOSKING, of Turner's Hill, East Grinstead, were last week presented with a handsome testimonial on the occasion of the silver anniversary of their wedding.

£1,100 has been realised by the Exhibition of His Majesty's battleship "Black Prince," which, by the kindness of the Thames Ironworks Shipbuilding and Engineering Co., was recently on view for the benefit of the Seamen's Hospital Society, also Poplar and West Ham Hospitals. During the three afternoons the vessel was open it was visited by the very large number of over 21,000 persons.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.
RECENT SURGICAL LITERATURE.

Cervical Rib with Resulting Gangrene of the Fingers.—Babcock (*St. Louis Med. and Surg. Journ.*, Dec., 1905) describes the case of a farmer, *æt.* 22, on whom he operated and removed a right cervical rib. On careful palpation, a deep-lying bony rod was felt running from the right lateral aspect of the seventh cervical vertebra downwards and forwards, passing under the clavicle near the junction of the inner and middle thirds. Since the patient was thirteen years old, every winter his right arm became pale, cold, numb, and useless. Recently the distal phalanx of the right middle finger had become gangrenous and the bone dry and exposed. The tips of the third and fourth fingers were affected to a lesser degree. There was no evidence of active inflammatory reaction. The entire right arm was smaller than the left, and no radial or ulnar pulse could be made out. The patient constantly assumed a position with the head inclined to the right side, the shoulder elevated and carried forwards, and the arm close to and across the body. Any other position caused him great pain. Pain was sometimes so severe at night, that the patient was obliged to walk the floor. The abnormal rib was reached by a transverse incision over the centre of the clavicle, and was found to be attached to the first true rib by firm, bony union. The cervical rib was divided at its centre and each half removed separately. The day following the operation, throbbing and burning pain developed in the right hand, which became red and warm. The pain soon disappeared, and on the third night the patient slept without an anodyne for the first time for several months. On the tenth day a faint radial pulse developed. The tips of the fingers subsequently dropped off, leaving healthy tissue. The author believes that the ischæmia so often associated with cervical rib is not caused so much by compression, but results rather from retardation of the blood flow due to tortuosity of the subclavian artery. The cervical rib, which is always present at the outer side and below the artery, tends to produce three rather sharp curves in it, one round the scalenus anticus, the second round the anterior portion of the cervical rib, and the third where the artery passes under the clavicle from a higher level and nearer the middle line than in the normal position (when the thorax and clavicle are not in such close proximity).

S.

Hereditary Syphilis.—R. W. Taylor (*New York Med. Journ.*, Feb. 3rd, 1906) reports two series of cases, all patients of his own, to further substantiate the fact that syphilis occurring in the grandparent may, without further syphilitic infection, be transmitted as hereditary syphilis to the grandchild. As support to his evidence, he quotes fully the cases recorded by Jonathan Hutchinson (two), and by Casar Boeck (one), as in the author's opinion no department of heredo-syphilis presents more doubt, uncertainty, and scepticism, than in the question whether syphilis can occur in three successive generations. *Case I.*—The grandmother was affected with syphilis in 1869, and had secondary and tertiary lesions of much severity. She was careless of treatment. In 1872, this first genitor gave birth to a girl who presented classical hereditary syphilitic symptoms. This child, after many vicissitudes, grew up an apparently healthy and strong woman. She was married to a healthy man, well known to the author, and never was infected with acquired syphilis. In 1890, two years after her marriage, this woman, the second genitor, gave birth to a weakly girl (third generation), who at birth gave no distinct evidence of hereditary

syphilis. But in five years this child suffered from an unmistakable and virulent form of late syphilitic manifestations, viz., Hutchinson's teeth, keratitis, gummatous tumours, &c. *Case II.*—A healthy woman married a man who was syphilitic for two years. She contracted syphilis two years later, coincident with the development of pregnancy. A male child was born, soon showing characteristic hereditary syphilis; the symptoms continuing for several years. He, the second genitor, was never infected with acquired syphilis, and married a healthy girl. Three years after the marriage his wife gave birth to a thin, weakly girl. Four years later, many dystrophic symptoms of bones and joints developed in this child, and were promptly cured by active anti-syphilitic treatment. The author also reports a case of hereditary syphilis cured by anti-syphilitic treatment, who subsequently was infected with acquired syphilis.

S.

On the Indications and Contra-Indications for the Removal of the Gall Bladder.—Mayo Robson (*Brit. Med. Journ.*, Feb. 24, 1906) protests against the indiscriminate removal of the gall-bladder in all cases in which an operation on the bile passages is called for. As bile is constantly being formed at a rate of one ounce per hour, if the gall-bladder is removed, its reservoir function is replaced, as has been seen in some cases, by dilatation of the common duct. This must necessitate back pressure on the secreting part of the liver, and possibly biliary absorption. Mayo Robson analyses his fifty-seven cases in which cholecystectomy was necessary. The indications for this operation are: (1) Cancer or other new growth where the disease is local or limited. (2) In contracted and useless gall-bladder, the result of repeated attacks of cholecystitis. (3) In dilated and hypertrophied gall-bladder resulting from obstruction in the cystic duct; (a) always if resulting from stricture, (b) usually if resulting from impacted gall-stones with ulceration, (c) usually if resulting from kinking of cystic duct and adhesions. (4) In phlegmonous or gangrenous cholecystitis. (5) In empyema, calcareous degeneration, and mucous fistula of the gall-bladder. (6) In gunshot or other serious injuries of the gall-bladder and cystic duct. The author finds that a firm sandbag under the patient at the liver level brings the common and hepatic ducts several inches nearer the surface. The incision is over the middle of the right rectus, and when further exploration is necessary the incision is prolonged, not downwards as formerly, but upwards as high as possible between the ensiform cartilage and the right costal margin. By lifting the lower border of the liver an almost straight passage is found from the fundus of the gall-bladder to the entrance of the bile duct into the duodenum. The surgeon has under his eye the whole length of the duct with the duodenum and head of the pancreas. The gall bladder is removed by dividing the cystic duct between two forceps near the common duct. Ligation of all bleeding points is important, as in jaundice cases the compressed and unligatured vessels are apt to bleed subsequently.

S.

Perinephritic Abscess, Diagnosis, and Treatment.—In a paper on this subject, Dr. Ramon Gutieras (*New York Med. Journ.*, Jan. 27th, 1906) describes fifteen cases of this affection, which he had treated, and draws from them the following conclusions: (1) Many more cases of perinephritic abscess are due to suppurative renal disease than is generally supposed, a fact which will be proved with the rapid strides that are now being made in renal surgery. (2) Traumatism, exposure, and similar influences to which

primary perinephritis is attributed are not so important as many observers have claimed. They are often vaguely given as causes, when they are simply coincidences, or the active causes of rupture of already existing abscesses in the kidney or neighbouring structures. (3) It is important, though difficult, to determine the source and course of the pus. Therefore, before the operation, pus should be looked for in the common urine and the separate urine by the ureteral catheter. During the operation the surgeon should try and determine whether the kidney is the source, and, if not, what tissue or organ is. It is equally important to discover the road taken by the pus, as it indicates where a counter opening should be made, and the further treatment of the case for complications. (4) The elements of success in operations for perinephritic abscess may be summed up as follows: Early incision and evacuation before the pus has had time to burrow extensively; thorough exploration without timidity, opening the kidney and exploring the ureter if need be; thorough drainage down to the deepest part of the sac by means of large soft rubber drains or gauze, the drain being kept in place until a well-formed sinus exists down to the deepest part of the cavity; nephrotomy, nephrostomy, or nephrectomy should be performed if indicated at the time of the operation or later on if necessary. G.

Subcutaneous Pelvic-ureteral Lumbar Implantation.—In a paper on the treatment of the ureter after nephrectomy, Dr. Ernest Gallant (*American Medicine*, Jan. 13th, 1906) asks the question: Is the removal of ureter advisable, desirable, or necessary? He himself prefers to treat the ureter in the following way: The ureter is cut across about one inch above the junction of the ureter and the pelvis of the kidney, the renal vessels are then ligatured and that organ removed. The funnel-shaped opening into the ureter is then sutured to the lumbar fascia at the lower end of the wound, in such a way that the mouth is not exposed on the skin surface, but opens into the subcutaneous fatty tissue; when the discharge ceases the skin readily closes over the outlet and buries it. In cases of tuberculous kidney or pyonephrosis, without ureteral obstruction, it may be well in female patients to resect the vesical end of the ureter through a vaginal incision, close off the vesical end of the tube, and suture the proximal end of the ureter into the vaginal wound, and so provide free drainage. Dr. Gallant claims the following advantages for this method of lumbar implantation: (1) It avoids the additional risk of immediate ureterectomy; (2) it secures free drainage and maintains an opening through which drugs may be introduced to hasten retrograde changes in the ureter; (3) the opening being beneath the skin does not prevent primary union, should mucus or pus form they cannot accumulate or burrow in the retro-colonic space; they are easily recognised and let out through a small skin incision; (4) the presence of a drainage tube in the ureter, with or without the vaginal implantation, does not interfere with the patient getting out of bed at an early date after the operation. G.

Radical Operation for Dacryocystitis.—Fromaget, of Bordeaux (*Société Franc. d'Ophthal.* May, 1905) considers that cases of chronic dacryocystitis, which are so intractable as to call for any of the various radical methods of treatment that have been hitherto recognised as suitable, had better be treated by performing at one time the three operations of extirpation of the lacrymal sac, curetting of the nasal duct and removal of the lacrymal gland. M.

Ophthalmia Neonatorum of Lacrymal Origin.—Pechin (*Société Franc. d'Ophthal.* May, 1905) points out that there are cases of conjunctivitis in new-born infants with muco-purulent secretion in which the usual remedies prove useless. These cases are often found to be due to lacrymal obstruction, or in some cases even to eversion of the punctum in very fat babies. In such cases it is necessary to remove the obstruction by syringing or passage of a probe. M.

The Sub-Mucous Caustery Treatment of Hypertrophy of the Inferior Turbinates.—S. J. Kopetzky, New York (*The Laryngoscope*, Oct., 1905) introduces to his readers a form of sub-mucous caustery which has given good results in his hands. The instrument is made of an alloy consisting of "about 30 per cent. platinum iridium." This mixture of metals has sufficient stability to retain its shape and permit its introduction into the tissues while cold. The caustery end is one and one quarter inches long, one quarter inch broad, and as thin as is consistent with rigidity. The handle is of metal and fits any standard caustery handle. Kopetzky's object is to attack the centre of the inferior turbinal rather than the mucous surface. He claims the following advantages for his method: (1) Less cocaine required for anaesthesia, (2) after effects and reaction nearly absent, (3) danger of adhesions forming absent, (4) no scabbing or crustation, (5) no destruction of superficial epithelium or functioning structures brought about, (6) the method produces a contraction of the turbinal body, without destroying its contractile tissues, (7) results have proved uniformly good. M.

The Treatment of Atrophic Rhinitis by an Oro-nasal Canula.—S. Iglauer (*The Laryngoscope* Nov., 1905), calls atrophic rhinitis "das Schmerzskind der Rhinologie" and considers any treatment which gives any relief to be worthy of record. He briefly reviews the recent literature as to the origin and treatment of this disease. It occurred to Iglauer that the saliva, being a secretion foreign to the nose, might perhaps exert a stimulating or irritating effect on the mucosa and might thus reproduce one of our therapeutic endeavours. There is also the possibility that the bacteria of the mouth might act injuriously on those found in ozena. With a view to bringing the saliva in contact with the nasal cavities, the author devised the plan of making an oro-nasal fistula through which the patient might irrigate the nose with his own saliva. With this object in view he anaesthetises the mucous membrane and periosteum of the hard palate with cocain and adrenalin, then exposes the bone by means of knife and periosteotome, about 1 cm. from median raphé and with a bone drill (5 mm.) a hole is bored into the nose. To avoid stripping up the nasal mucosa with the drill, it should be nicked with a curved bistoury as soon as the drill has reached the membrane. To establish a permanent opening a rubber-flanged tube has to be retained until the bone and membranes have healed, when a permanent silver canula is inserted. This healing process is often tedious—four and a half months in one of the first cases. Through this canula the patient frequently squirts or sprays saliva over the mucous membrane of the nose. The oro-nasal opening does not interfere with phonation. Three cases are recorded from which we gather that symptoms, crusts and fœtor at least were alleviated. Iglauer presented the paper in the hope that some of his colleagues would give the treatment a trial. M.

Primary Lympho-Sarcoma of the Tear Gland.—Gondron (*Société Franc. d'Ophthalmologie*, May, 1905) records a case of a tumour growing under the upper orbital margin of a man, æt. 18. The tumour was removed by Kroenlein's operation and proved to be a lympho-sarcoma springing from the capsule of the lacrymal gland. Recurrence took place a few months after the removal with a fatal result. M.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "*Recent Medical Literature.*"
- (2) "*Recent Surgical Literature.*"
- (3) "*Recent Gynaecological and Obstetrical Literature.*"
- (4) "*The Recent Literature of Physiology, and Pathology.*"

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

DR. J. BEARD (Liverpool).—Your paper on "Profuse Desquamation in Typhoid Fever" is marked for early insertion.
OBSERVATION.—Physician: "Has the patient followed my prescription, nurse?"—Nurse: "No, doctor; if he had he would have broken his neck, for he threw it out of the window."

ADVICE TO YOUNG ADVERTISEMENT WRITERS.

"In preparing copy for patent medicines you will endeavour not so much to prove the disease curable as to convince the reader that he has it." This extremely suggestive and witty maxim is taken from the *Business Man's Magazine* (N. York).

A SUBURBAN PRACTITIONER.—The cases of infectious diseases within the area of the Metropolitan Asylums Board are considerably fewer than at the corresponding period of last year.

MR. J. S. SUTTON.—The diminution of the birth-rate continues without intermission, but you overlook in your comparison that the death-rate has decreased to a much larger extent.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MARCH 7th.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Mrs. Scharlieb, Dr. Lockyer, and Dr. A. Routh. Paper:—Mr. J. D. Malcolm: Peritonitis and the Staphylococcus Albus.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20 Hanover Square, W.).—5 p.m. Paper:—Dr. C. Watson (Edinburgh): Observations on Diet with Special Reference to a Meat Diet and Uric Acid (with lantern demonstrations).

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m. Hunterian Lecture:—Prof. W. Howard: Phlebitis and Thrombosis.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Cheapside Street, W.C.).—4 p.m. Mr. J. Berry: Clinique. (Surgical). 5.15 p.m. Lecture:—Dr. L. Brown: Acid Intoxications.

THURSDAY, MARCH 8th.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8 p.m. Card Specimens will be shown by Mr. S. Stephenson, Mr. A. Levy, and Mr. P. Smith. 8.30 p.m. Papers:—Mr. C. Worth: Hereditary Influence in Myopia.—Mr. J. H. Parsons and Mr. G. Coates: Further History and Pathological Examination of a Case of Microphthalmia associated with Congenital Tumours previously shown by Mr. Parsons.—Mr. P. Smith:—A Scotometer for the Rapid Diagnosis of Incipient Glaucoma and other purposes.

BRITISH GYNECOLOGICAL SOCIETY (20 Hanover Square, W.).—7.30 p.m. Special General Meeting. 8 p.m. Specimens will be shown by Dr. Jellitt and Mrs. Scharlieb. Papers:—Dr. Jellitt: Notes on two rare conditions met with in the Pelvis during Operation.—Mrs. Scharlieb: The Advantages of the Abdominal Route in Operations for Cancer of the Uterus.

ROYAL COLLEGE OF PHYSICIANS OF LONDON (Pall Mall East).—5 p.m. Milroy Lecture:—Dr. W. H. Hamer: Epidemic Disease in England—the Evidence of Variability and of Permanency of Type.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Cheapside Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Lecture:—Mr. A. E. Tubby: Surgical Diseases of Children.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—8 p.m. Dr. M. Dockrell: The Relation between Clebsitz, Keloid, Scleroderma, and the Treatment of each. (Chesterfield Lecture.)

FRIDAY, MARCH 9th.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m. Papers:—Dr. H. French and Mr. C. B. Ticehurst: A Note upon the Relation of Traumatic Diabetes Insipidus to Glycosuria.—Dr. F. Buzzard and Mr. J. Cunnling: A Case of Post-traumatic Hemorrhage from the Superior Longitudinal Sinus without Fracture of the Skull, Operation and Recovery.—Mr. J. E. Spicer (introduced by Dr. P. Kidd): An Unusual Case of Dilatation of the Stomach following Hour-glass Contraction.—Dr. A. E. Garrod and Dr. Langmead: Associated Malformations, including Transposition of Viscera.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m. Hunterian Lecture:—Prof. W. Howard: Phlebitis and Thrombosis.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Cheapside Street, W.C.).—4 p.m. Dr. L. Lack: Clinique. (Throat.)

Vacancies.

Birkenhead and Wirral Children's Hospital. Woodchurch Road, Birkenhead.—House Surgeon. Salary £100 per annum, with board, residence, and laundry. Applications to F. W. Archer, 25, Storeton Road, Birkenhead.

Bradford Children's Hospital.—House Surgeon. Salary £100 per annum. Applications to C. V. Woodcock, Secretary.

Bristolington House Private Asylum, Bristol.—Assistant Medical Officer. Salary £180 per annum. Applications to the Resident Licentiate.

British Ophthalmic Hospital, Jerusalem.—Assistant Surgeon. Salary £300 a year, with residence. Applications to R. Brudenell Carter, F.R.C.S., 76 South Side, Clapham Common, S.W.

Corporation of Sheffield Fever Hospital.—Junior Assistant Medical Officer. Salary £120 per annum, with board, lodging, and washing. Applications to H. Bayer, Town Clerk, Town Clerk's Office, Town Hall, Sheffield.

Metropolitan Hospital.—Casualty Officer. Salary £150 per annum. Applications to Charles H. Byers, Secretary.

North Staffordshire Infirmary and Eye Hospital, Hartshill, Stoke-upon-Trent.—Senior House Surgeon. Salary £100 per annum, with furnished apartments, board, and washing. Applications to Albert E. Boyce, Secretary and House Governor.

Parish of Saint Leonard, Shoreditch.—Medical Officer to Cottage Homes at Hornchurch, Essex. Salary £130 per annum. Applications to Robert Clay, Clerk to the Guardians, Clerk's Office, 213 Kingsland Road, N.E.

The Asylums Committee of the London County Council.—Assistant to the Pathologist of the London County Asylums. Salary £250 per annum. Applications to H. F. Keene, Clerk of the Asylums Committee, London Asylums Committee Office, 6 Waterloo Place, London, S.W.

The London Hospital Pathological Institute.—Director. Salary £500 per annum. Applications to Munro Scott, Warden, The London Hospital Medical College, Turner Street, Mile End, E.

Walsall and District Hospital, Walsall.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to the Chairman, Mr. E. J. Brookes, Leicester Street.

West Kent General Hospital, Maidstone.—House Surgeon. Salary £120 per annum, with board and residence. Applications to the Secretary.

Appointments.

COBENS, WILLIAM BURROUGH, L.R.C.P.Lond., M.R.C.S., Medical Referee under the Workmen's Compensation Acts, 1897 and 1906, for Weymouth County Court, in County Court Circuit, No. 55.

COXON, STEPHEN A. T., L.D.S.R.C.S.Irel., Honorary Dental Surgeon to the West Norfolk and Lynn Hospital.

FINCH, G., M.R.C.S., L.R.C.P.Lond., Junior House Surgeon at the Radcliffe Infirmary, Oxford.

HAMILTON, A., L.R.C.P., L.R.C.S.Éd., Certifying Surgeon under the Factory and Workshop Act for the Ashton-under-Lyne District of the county of Lancaster.

HORNER, N. G., B.A.Cantab., M.R.C.S., L.R.C.P.Lond., Assistant House Surgeon at the Westminster Hospital.

MACGILVRAY, W. J., HOOKER, L.R.C.P., L.R.C.S., L.M.Éd., L.F.P.A., L.M.Glasg., Medical Officer to the Royal Liver Friendly Society for Manchester, Salford, and District.

MACILWAINE, J. E., M.D.R.U.I., Certifying Surgeon under the Factory and Workshop Act for the North Belfast District of the counties of Antrim and Down.

MALLAM, ERNEST, M.B., B.S.Oxon., Certifying Surgeon under the Factory and Workshop Act for the Oxford District of the counties of Oxford and Berks.

MULLIGAN, E., L.R.C.P. and S.Irel., Certifying Surgeon under the Factory and Workshop Act for the Foxford District of the county of Mayo.

PARK, J. R. A., L.R.C.P. and S.Éd., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Dukinfield District of the county of Chester.

PURDON, E. B., L.R.C.P. and S.Éd., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the South Belfast District of the counties of Antrim and Down.

RISSEN, E. RUSSELL, L.S.A., Certifying Surgeon under the Factory and Workshop Act for the East Hlsley District of the county of Berks.

SHEPPARD, A. L., M.B., B.S.Durh., Senior House Physician at the Bristol Royal Infirmary.

Births.

CAZALET.—On March 1st, at Sutton, Surrey, the wife of Grenville Wm. Cazalet, L.R.C.P.Lond., M.R.C.S.Eng., of a son.

GAVIN.—On March 2nd, at the Medical Mission House, Anand, India, the wife of Nell M. Gavin, F.R.C.S.E., of a daughter.

GREENE.—On Feb. 25th, at 124 Crossbrook Street, Cheshunt, Herts, the wife of William A. Greene, M.R.C.S., of a daughter.

MAINGAY.—On March 3rd, at 33 Queen Street, Scarborough, the wife of H. B. Maingay, F.R.C.S., of a son.

MASTERMAN.—On Feb. 18th, at Jerusalem, the wife of E. W. G. Masterman, F.R.C.S., D.P.H.Cantab., of a daughter.

SOUTH.—On Feb. 28th, at the Manor House, Moreton, Dorset, the wife of Fleet-Surgeon Henry Erskine South, R.N. (retired), of a daughter.

Marriages.

PARRY JONES—THORN.—On March 3rd, at the Old Parish Church of St. Mary's, Ealing, Lieutenant W. D. Parry Jones, elder son of the late W. D. Jones, M.D., of Rhianfa, Ruthin, to Catherine, younger daughter of C. Spencer Thorn, solicitor, Caerwys.

Deaths.

CHARLES.—On March 2nd, at Flushing, Cornwall, Surgeon-General Thomas Edmondston Charles, late of the I.M.S., M.D., LL.D.Éd., F.R.C.P.Lond., K.H.P., aged 71, late of Calcutta.

DEAN. On March 4th, at 4 Rosary Gardens, South Kensington, the residence of her grandparents, Anne, the only child of Henry Percy Dean, M.S., F.R.C.S., 89 Harley Street, London, aged 1½ year.

HERBERT.—On March 2nd, at 6 Elliott Terrace, The Hoe, Plymouth, Deputy-Surgeon-General Henry Carden Herbert, M.D., F.R.C.S.I.

LONGTON.—On Feb. 27th, at Brown House, Ulverston, Edward John Longton, M.D., J.P., late of The Priory, Southampton, aged 76 years.

TUCKWELL.—On March 2nd, at 84 High Street, Oxford, Henry Matthews Tuckwell, M.D., F.R.C.P., in his 72nd year.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, MARCH 14, 1906.

No. II.

NOTES AND COMMENTS.

Increase of General Paralysis.

THE constant increase of insanity in the United Kingdom is alarming. Professor Clouston, of Edinburgh, has recently drawn attention to the large increase of patients suffering from general paralysis. Last year the number of female asylum patients admitted under his care for that particular malady for the first time on record exceeded that of the men. Further, the rate of general paralysis was 18.5 per cent. of asylum patients as against 5 per cent. in private practice. From these figures, Dr. Clouston augurs unfavourably as to the social life of the class from which hospital patients are drawn. Yet behind it all lies the inspiring hope that general paralysis will ere long be treated as a curable if not an absolutely preventable disease. At any rate, so careful and distinguished an authority as Dr. Clouston now endorses the theory of Dr. Ford Robertson that the terribly malady in question is the result of invasion of the body by a specific pathogenic microbe.

Alcohol and Insanity.

ALCOHOL always figures in the indictment against the causes of insanity. Dr. Clouston says in his report:—"It is incontestable that our alcoholic insanity rate is still far too high. An educated public opinion and healthy conscience are still needed in a much higher degree to avoid and resist the hurtful social evil of excess in drink. The latest researches into the subject of heredity tend to prove that its results do not end with our generation, but produce physical and mental degeneracy in the descendants of those who destroy their reason by excessive drink. There is much room for the educator, the religionist, and the legislator in this matter. The medical man and the psychological scientist are, as the question is more carefully studied, more and more compelled by the facts of their experience to warn people in regard to the present and far-reaching dangers of alcoholic excess."

The Census of the Empire.

A GREAT and historic blue-book was on Thursday last presented to Parliament by the President of the Local Gov. Bd. It gives, in a way that has never been done before, a bird's-eye view of the vast empire which—in the words of the report—"extends to every continent and climate, and includes representatives of practically every race, creed, language and caste." The present is the first comprehensive and authoritative official summary of the facts of the case. The British flag floats over a fifth of the land-surface of the globe. It dominates some four hundred million human beings, of whom only fifty-four millions are whites, and only fifty-eight

millions are Christians. Well may the imagination stagger at the vastness of this great burden! There are about 208 millions Hindu subjects, 94 millions Mahometan, 12 millions Buddhists, and 23 assorted non-Christian religions. Naturally, this vast collection of figures will furnish much valuable material to the medical statistician.

Racial Infirmities.

SOME of the facts are hardly in accordance with established beliefs. We find, for instance, that deaf-mutism is not more frequent among the Mahometans, in spite of their consanguineous marriages, than among the Hindus, who avoid intermarriage. It would be of great interest from the medical point of view to obtain figures relating to imbecility, bodily deformities, and nerve diseases among the Mahometan population. The worst of official statistics is that they are apt to stop tantalisingly short of the facts when one refers to them. To know that deaf-mutism is not relatively common among our Mahometan subjects is simply to whet the appetite for more information as to the important group of consanguineous degenerations. One important fact emphasised by this blue book is that taking together the lunatics and imbeciles and the feeble-minded, the proportion in nearly all the colonies is much below that at home. Why is the mother country going mad?

Hospital Out-Patient Abuse.

THE Metropolitan Hospital Sunday Fund whitewashes the hospital authorities, and declares there is no abuse of the out-patient departments. Henceforth let the general practitioner know once and for all that his grievance against hospital competition is a vain phantom—for lo! the Sunday Fund, through its professional philanthropists and its urbane consultants, tells him that there is practically no abuse. The Hon. Sydney Holland, most amiable of enthusiasts, denies the existence of anything of the kind. All the talk about abuse of hospitals, quotha, comes from people not connected with them. What does that sarcasm mean? As a matter of fact, the complaint comes mainly from medical men who are deprived of legitimate fees by the indiscriminate relief granted by hospitals to persons capable of paying private practitioners. That is the gist of the whole charge. So that the Hon. Sydney Holland is strictly accurate when he says that the protest comes from persons unconnected with the hospitals. The average medical man ceases his connection with hospitals when he has become qualified, and has perhaps held a resident post or two. Does Mr. Holland remember how his challenge to prove abuse of the London Hospital was taken up by an East London Medical Society and proved? The money problem is all

important to the struggling practitioner. To Mr. Holland it means raising half a million or so for the charity in which he is interested on the one hand, and on the other charging every poor patient a few pence towards cost of relief.

LEADING ARTICLE.

THE DAILY MAIL AND ADVERTISEMENTS.

LAST week we said that we proposed to draw attention to the type of quack advertisement that appears in different organs of the daily press, and this week we proceed to glance at some of those in the columns of the *Daily Mail*. Taking at hazard a recent copy of this paper, we find a crop of these delectable and informing announcements as luxuriant and as misleading as that in any of its contemporaries. The first thing that catches our eye is a two half-column puff of the virtues of Bile Beans. A large portrait adorns the advertisement, and the words, "Made helpless by Rheumatism" are printed in leaded type immediately beneath. Then comes a short dissertation on the pathology of rheumatism, and the ability of Bile Beans to "expel" acid from the blood and correct this malady by virtue of its "unique vegetable composition." A long statement of the usual grandiloquent type, asserted to be the production of Mr. Thomas Coxhill, gardener, of 78, Northfield Road, Harborne, Birmingham, follows, and, as might be guessed, the unfortunate Coxhill, after being under doctors innumerable for twelve years, finally found salvation from muscular rheumatism by means of Bile Beans, which were brought to his notice by the proverbial neighbour. According to analysis, this "world's most successful tonic-alterative" consists of cascara, rhubarb, liquorice, and oil of peppermint, coated with gelatine, and anybody who is fool enough to believe that doctors innumerable would fail to know of the specific value of these simple drugs if they were possessed of the specific value claimed by the proprietors of Bile Beans, can only be the victim of such reiterated falsehoods as quack-medicine vendors commonly tell to disparage the medical profession and prejudice their customers against medical science. To push forward this cruel work, the *Daily Mail* does not hesitate to sell space in its columns and to fill the pockets of its proprietors. If any doubt existed as to the nature of Bile Beans and the character of their owners, they were laid to rest by the recent exposure in Court, and by the words of the judge, who, having heard the evidence for and against this "world's most successful tonic alterative," refused to be any party to protecting a preparation where such was pushed forward by a tissue of falsehoods. In the same issue of the *Daily Mail* is an advertisement, garnished also with portraits of patients and copies of letters asserted to have been received from them, of a Professor Keith-Harvey's treatment for deafness. In it this "Professor" says: "If you are a sufferer from Deafness or Head Noises, and desire a complete and permanent cure, write to Professor

Keith-Harvey for Pamphlet fully describing an entirely new self-applied method which he will send you gratis and post-free on mentioning '*Daily Mail*.'" Here it will be noticed that though the individual who touts for innocents does not actually promise a complete and permanent cure, there is the same alluring *suggestio falsi* about the specious phrase used as there is about the words, "Free to the Deaf," by which the advertisement is headed. What deaf person does not wish a "complete and permanent cure," we wonder, and what is there free about the Keith-Harvey process except the precious pamphlet? On one page of the *Daily Mail* that we have before us are two advertisements of drugs for the hair—one of the so-called "Capsuloids," and the other of a certain Paul Lind, who, like his brother, Keith-Harvey, calls himself "Professor," without specifying at which University he attained the distinction. It is interesting to note that the statements contained in the "Capsuloids" and Paul Lind advertisements are mutually contradictory. The learned Professor by means of his liquid is able to stimulate the "pigmentary glands" of hair and thus cause "a true and permanent alteration in the natural shade." If he reads the "Capsuloids" advertisement he will learn what even his university apparently failed to teach, namely, "Nothing can be any good for hair which is falling out or prematurely grey except Capsuloids, because harmful germs which injure the hair can only be gotten at through the blood, and the only remedy which can reach them through the blood is Capsuloids. It is utterly useless to rub stuff on the scalp." Surely it is obvious to anyone that if both of these statements are not lies, at least one of them must be. Then there are advertisements of "Veritas" Rheumatism Rings, Sloan's Liniment, Vitalia, Coleman's Nerve Pill, Eadie's Gout Pill, a Freckle cure, a "Depression" remedy, Bravais Iron, &c., besides two systems for obtaining beauty and strength by exercises, and odd advertisements of a similar character. In fact, it may safely be said that the quack advertiser is the back-bone of the *Daily Mail*, and from what we have seen, so long as he pays the *Daily Mail* is quite careless as to whether what he says is true, half-false, or wholly a lie. If it is by money gained in this way that affluence, political influence, and power are attained, it may not be a bad thing that we have a House of Commons bent on social reform.

Medical Postal Packets.

At the Middlesex Sessions recently John Melinger, surgical and medical appliance maker, of New Southgate, was indicted for sending 341 postal packets containing improper prints. Sir Ralph Littler the chairman, addressing the grand jury, said it was the first case of its kind to come before a jury, although the Post Office Act under which the proceedings were taken had been in existence twenty-one years. The circular to which objection was taken dealt with a subject that had been written upon by scientists and divines, and the opinions of many were cited. The trade carried on by the accused, said the chairman, was absolutely legal. The grand jury threw out the bill, and the accused was discharged.

NOTES ON CURRENT TOPICS.

Medical Men and the Conveyance of Infection.

THE decision in the case of *Crier and Wife v. Hope and Currie* last week in the King's Bench is of the utmost importance to the medical profession. The defendants, two medical men practising at Hanwell and West Ealing, were sued for damages for alleged negligence on the part of Dr. Currie, which resulted in his communicating scarlet fever to the female defendant in her confinement. The only weak point in the defendants' case was that Dr. Currie appears to have denied that he was at the time of the confinement attending any scarlet fever cases. The decision that all reasonable precautions had been taken and the dismissal of the claim is fortunate for the public at large, as otherwise it would be impossible to continue ordinary medical practice. Medical men have to attend infectious cases at any time of the day or night. They have also to bring children into the world at frequent intervals. They themselves have to take the risk of infection, and so, to put it somewhat bluntly, must their patients. At the same time, with the precautions as to clothing and antiseptics taken by every responsible medical man, the risks of conveying infection are reduced to a minimum. Were it otherwise, the whole country would be continuously decimated by communicable diseases. Were responsibility for chance infection imposed on medical men, there would of necessity arise a special set of practitioner for midwifery alone and another set for infectious diseases alone. Who would pay them? The present all-round practitioner is rewarded on a starvation scale.

Condensed Milk.

A good deal of capital is being made in certain quarters out of some remarks that occurred in a recent lecture by Dr. Edward F. Willoughby at the Institute of Hygiene on "Popular Foods." In the course of that lecture it was said that coroners incurred a grave responsibility by sweepingly and indiscriminately condemning condensed milks as food for infants, for although some brands were prepared from skimmed milk, others were made from unseparated milk, and on these latter were reared thousands of the healthiest children. Dr. Willoughby admitted, however, that the excess of sugar in these condensed milks did not render them an ideal food for infants. We take it that the only advantage which can be urged in favour of preserved milks over natural milks is their cheapness, and, used as they are by the very poor only, the power of discriminating between trustworthy and untrustworthy brands not being present, the choice of a milk will be largely guided by price. Hence a great danger arises that condensed milk-fed children will be reared on skim-milk and sugar, or, rather, allowed to pine on it. No one will deny that a number of healthy, vigorous infants will thrive on foods that are far from being ideal, but it is vitally important

that medical men should concentrate their energies on obtaining, even for the poorest, a supply of animal milk—cow's, ass's, or goat's—which shall be both fresh and clean. All processes of preservation and sterilisation alter more or less profoundly the composition of or proportions of constituents in milk, and till the physiological chemistry of both child and milk are thoroughly well understood any tampering with milk is fraught with unknown dangers. We know, for instance, that fresh milk contains three important groups of ferments; we do not know how their absence prejudices a child. Condensed milk at its best is a necessary evil; at its worst it may be rank poison.

The Folly of Flogging.

THE wisdom of Solomon in these degenerate days is frequently called in question. Corporal punishment since the days of the philosopher-king has been considered a meet and right method for the inculcation of moral truths and the rectification of the sins of omission and commission which a righteous public periodically confess, but persistently adhere to. Birching in the days of our forefathers was viewed as a necessity for the discipline of the developing mind and the direction of the youthful body. But with the growth of knowledge and the coming of a measure of wisdom, corporal punishment has passed under the ban of popular opinion. The recent action of the Admiralty in forbidding at least, for a year, the brutal and degrading punishment by flogging in the Navy is a sure sign of the growth and power of an elevated tone and sound common sense which will be gladly welcomed by the medical profession. It is not long since the savage custom of flogging "round the fleet" was considered necessary for the maintenance of discipline and the protection of patriotism, but now we are in danger of passing to the other extreme and adopting effeminate and unscientific methods of correcting serious ills. Should we scratch the surface of the most highly civilised it is not difficult to lay bare the elemental savage, and we therefore cordially welcome every measure which helps to conquer the brute by evolving the man.

Pure Lymph, Violet Leaves and Insanity.

WE are frequently asked to notice the *Westminster Review*, an old-established Liberal monthly, which often contains excellent articles, but such as are more likely to be relished by the supporters of the present Government than by its opponents. It is an interesting political phenomenon that the Liberal party seeks to attract to its ranks in considerably larger proportion than the other side those extremists who war against the current opinions of doctors—a fact which is all the more curious in that of all professions it is the most liberal and catholic. In the March number of the *Westminster Review* this feature is emphasised by the appearance of three articles by different authors on such varied subjects as "Pure Lymph," the "Violet Leaf Treatment of Cancer," and the

"Progress of Insanity." The first is a survey of the origin of the various strains of lymph used for vaccinating purposes, and the various methods employed to obtain a supply free from extraneous organisms. It is written by an anti-vaccinator, and is marked by the intemperance of utterance that seems bound to cling to controversial statements on anything to do with vaccination. The second deals in so transparently simple a manner with the violet-leaves "cure" of cancer, that we could be content to pass it by without comment, if it did not contain the dangerous suggestion that early malignant disease should now be brought within its sphere of influence. With the evidence at present at our disposal of the nature of cancer and the virtue of violet leaves, it would be a terrible responsibility to postpone operation while such a method of treatment were coquetted with. Finally, the writer of the article on the "Progress of Insanity," though he seems to have a poor opinion of the Lunacy Commissioners, will be found better worth reading than the other two contributions.

Condition of Nurses' Work.

A GREAT deal of nonsense has been written during the past few weeks in Dublin, and a great deal of printers' ink wasted, in discussions regarding the conditions of nurses' work in hospitals and private houses. Public interest was roused in the matter by the unfortunate incident of a nurse's suicide in one of the city hospitals, when the coroner's jury added to their verdict an entirely irrelevant rider to the effect that the hours of duty were too long. A coroner's jury is hardly a fit body to decide as to what are suitable hours of duty for nurses, nor do we think hospital management and the nursing profession likely to gain advantage from a discussion in the halfpenny press. Mis-statements of the wildest sort have been rampant, as, for instance, that during their hours of duty nurses were forbidden on any account to sit down. On the one hand, nurses came in for fulsome adulation; on the other, for vulgar detraction. There is, of course, no doubt that nursing is a laborious occupation, and that none but strong, active women are competent to practise it. The process of weeding during the first few months of probation is, of course, hard on those who fail, and it is impossible to prevent some failing, since no matron or selection committee is infallible. We believe, however, that on the whole hospital nurses as a class are, both physically and mentally, remarkably healthy, in spite of the risks to which they are exposed. The hard work and regular hours, with wholesome diet, constitute in most cases an excellent regimen. The hours of duty by no means represent hours of labour, as anyone conversant with hospital life is aware. We wonder how many of the "Readers" "Paterfamilias," "Justitias," and so on who have recently unburdened themselves on a subject on which they know little have devoted any attention to a subject of which they ought to know

something—the conditions of domestic labour in their own homes.

Underfed Children.

It is highly creditable to the feeling of the present House of Commons that it should have passed the second reading of a Bill for the provision of meals for half-starved children not only without a division, but almost without a dissentient voice. This reform has often been championed in the MEDICAL PRESS AND CIRCULAR. No one will deny that such a measure is surrounded by difficulties, nor that its administration will be attended with dangers, but with a well-thought-out Bill these should be reduced to a minimum, and the gain to the health of the nation and to the cause of education will be of first-class importance. The Bill has now been referred to a Select Committee, and Mr. Birrell has promised to give Government facilities to allow it to pass through its first stages when it has been reported to the House, so that one may with confidence look forward to an Act being placed on the Statute Book which this session will remove one of the causes that hamper materially the development and the physique of the poor. The prime factor in the training of the mind is to arouse and fix the attention, and till that is accomplished the most highly trained teacher and the most sanitary school building will fail to achieve any educational results. It stands to reason that a child who is hungry is quite incapable of sustained mental exertion, and therefore to spend money on that child's instruction is throwing it wantonly away. A far better investment would be to translate it into food, and so do away with the education. However, as education is by law compulsory, this cannot be done, and the duty of providing food becomes a necessary corollary to enforced education. At the same time the parent who, though viciousness or extravagance, neglects to feed his own child, should be severely dealt with.

The Tramp.

THE report of the Departmental Committee on Vagrancy has just been issued as a Parliamentary paper. The Commissioners have evidently taken great pains in the collection of evidence and the preparation of their report, and in all but a few minor details they are unanimous. The tramp is such a well-recognised medium of infection, especially of small-pox infection, that he has to be seriously considered as a factor in sanitary administration, and we are glad to see that this aspect of the problem he presents has not been overlooked. Of course, the real difficulty lies in the classification of tramps, and the evidence submitted to the Committee shows that only about three per cent. consist of honest workmen in search of employment. The rest are composed of those who will never do any work for long, those that are habitually on the march and never show any desire to work, and those who through age and infirmity are too old to work.

The Committee recommend that the tramps in future shall be looked after by the police, who shall give way-tickets to all *bona fide* wayfarers in search of work, but who shall deal with the others more firmly and effectually than has been possible in the past. It is proposed that labour colonies shall be established for the benefit of the incorrigible, and that industrial and agricultural work shall be carried on in them, whilst women and children shall be received into the workhouse, the latter, when admissible, being sent to industrial schools. Special regulations are advised for the prevention of small-pox. These suggestions, if acted upon, would doubtless do much to keep a puzzling and dangerous element of the community in check.

The Professions and Pauperism.

PAUPERISM is for many a remunerative profession, but to some, unfortunately, professional life affords a path to pauperism. The hon. secretary of the Clergy Provident Union has recently published the results of an interesting research. By applying to the authorities of 700 unions and asylums he has ascertained that during the last ten years over 100 of the clergy have joined the ranks of the paupers; 42 were resident in county and borough pauper asylums, and 61 in union workhouses. Of these no less than 18 were University graduates. In the clerical and legal professions there are wide differences regarding their professional income. In the medical profession the extremes of poverty and wealth are, fortunately, seldom seen, and it is generally recognised that for every member there is what may be considered a living wage. Many, however, through infirmity, incapacity or misfortune, are brought near the poverty line, and we have no doubt that some drift into the clutches of the Poor-law. It would be well if some medical enthusiast in sociological studies would undertake a research such as the one to which we have alluded. The results would, we fear, throw strange light on certain phases of professional experience, and might perhaps indicate means whereby human wreckage might be prevented and the prestige, dignity and general well-being of the profession safeguarded.

Medical Advertising.

We must take very grave exception to the apparent action of those medical gentlemen who have allowed themselves to be drawn into contributing not alone their opinions, but even their photographs, to the pages of a monthly contemporary. In the *Strand Magazine* for March appears an article, entitled "How to be Healthy at all Ages. A Symposium of Eminent Doctors." The article commences with the statement (in which is embodied a series of questions) that "a number of medical gentlemen of high-standing were approached and asked if they would accept a commission to answer the questions." What these are our readers can ascertain elsewhere. They are too long to be reproduced, and in them-

selves are unobjectionable. Some nine gentlemen were found to consent to this arrangement, and the remainder of the article is taken up by their answers—and their photographs. Of those thus distinguished the addresses range from Harley Street, London, to Roxburghshire in Scotland. Irishmen, we are glad to say, are conspicuous by their absence. The professional attainments of these gentlemen and their contributions to medical literature are apparently as varied as their addresses. The qualifications and appointments of one occupy a third of a column of the Medical Directory, those of another occupy six lines only. One contributed to medical literature for the last time in 1876, another for the first time in 1903. Four apparently possess the same address they possessed in 1903, and four have since changed. One was qualified in 1859, another in 1901. According to the magazine referred to, they all possess a high range of experience, and, in our humble opinion, if they have acted, as our contemporary leads us to suppose, they have done so in direct contravention of the rules of medical etiquette. Should any of the contributors feel aggrieved by this statement we shall be most happy to give their explanation every publicity. If they have been unwittingly drawn by enterprising journalists into the false position they occupy, they should see to it that the latter are made to publicly apologise.

PERSONAL.

HIS MAJESTY THE KING, being present in Paris during the taking of the quinquennial census, made his return from the British Embassy. It is interesting to recall the fact that at the last census both the late Queen Victoria and the King, then Prince of Wales, were in France.

THE London Hospital will soon possess a statue of its President, Her Majesty the Queen, who has graciously consented to give sittings for the purpose to Mr. George Wade.

A GLASGOW University club has been started in Manchester under the presidency of Dr. Alexander Welsh, of Whitworth, who graduated in the year 1864.

DR. KYNASTON COUCH was last week entertained by a large circle of friends on the occasion of his departure to Western Australia. Dr. Couch has been connected with hospital work in Swansea for the last eighteen years.

DR. W. K. HUNTER has been elected to the vacant post of physician to the Glasgow Royal Infirmary, and Dr. H. Rutherford and Dr. P. Paterson to the two vacant surgeoncies.

DR. JOHN CAMPBELL, Belfast, President of the Royal University Graduates' Association has decided to offer himself as a candidate for the Senatorship of the Royal University of Ireland. In his address he states that he is in favour of extern examiners, an interesting statement in view of the fact that the Senate for some so far unexplained reason has just abolished them.

THAT most flourishing energetic body, the Irish Medical Schools' and Graduates' Association will hold their next dinner at the Hotel Cecil, Strand, on Saturday March 17th, at 7 p.m. Details may be obtained of the Hon. Sec., E. Canny Ryall, Esq., 85, Harley Street, London, W.

A CLINICAL LECTURE ON THE ROUTINE EXAMINATION OF THE FÆCES IN GENERAL PRACTICE, AND WHAT WE LEARN FROM IT.

By GEORGE HERSHELL, M.D. Lond.,
Senior Physician to the Queen's Jubilee Hospital.

ANYONE who peruses a modern text book of medicine cannot fail to be struck by the omission of almost any mention of the clinical examination of the fæces. In any case when given the methods described necessitate the use of a properly-equipped laboratory and are not applicable to the exigencies of ordinary practice. And this omission is the more inexcusable from the fact that in the last two or three years important work has been done in this field and methods elaborated, which for all practical purposes place the examination of the fæces on the same level as the examination of the stomach contents, with which we all are, or should be, familiar.

It is the object of the present lecture to give a short description of such of these methods as are easy of execution, within the compass of any medical man even although unversed in laboratory methods, and from which results can be obtained of sufficient value to repay those who will take the trouble to perform them. The tests in question are few in number, and will be discussed seriatim.

(A.)—ESTIMATION OF THE TIME OCCUPIED BY THE FOOD IN PASSING THROUGH THE ALIMENTARY CANAL.

The time taken by the food in passing through the gastro-intestinal tract is a matter of great importance, and as yet has received singularly scanty attention from practising physicians. The first and most important fact to grasp in commencing the study of the subject is, that delay in the passage of the food may occur, not only in cases of obvious constipation, but may be present in patients who are passing a daily stool, and whose functions are considered to be regular, not only by themselves, but also by their medical attendant. In such cases, what we may justly term a *latent constipation*, may be the real cause of obscure conditions of ill-health to which no obvious cause can be assigned. In these cases there is, in all probability, a slight continued auto-toxis from the intestines. With respect to intestinal peristalsis we may conveniently divide all patients into the following groups:—

(a) Those in whom the food traverses the whole of the alimentary canal in the normal time. In these cases there is a sufficient stool every day. The period occupied by the food in passing from mouth to anus will vary somewhat according to the diet on which the patient is living. Thus, with a diet consisting entirely of lean meat the time is twenty hours (Strauss), with a purely milk diet thirty-six to forty-eight hours (Maurel), and with an ordinary mixed diet as we should naturally expect, about twenty-four hours (Kozickowski).

(b) Cases in which the food traverses the small intestines and colon as far as the commencement of the sigmoid in the normal time, but afterwards delay occurs. In some few of these cases the condition must be considered a normal one. In the cases under consideration the natural capacity of the sigmoid is so great as to allow the debris from the meals of two days to accumulate before it is filled sufficiently to set up the reflexes leading to defæcation. But when this takes place the sigmoid is completely emptied and we must consider these persons as normal, but with increased sigmoid capacity. But in other cases there is a condition of atony which interferes with the complete emptying of the lower bowel, and the stools are either deficient in quantity or in severe cases retained in the bowel until extraneous help be given either by injections or laxatives.

(c) Cases in which the whole delay is in the upper part of the intestine and the sigmoid, and the rectal reflexes are normal. In these cases there is not of necessity any constipation as the patient understands it, as there may be, and usually is, movement of the bowels every day. The effect of the delay of material in the intestine is to allow a constant slight degree of auto-intoxication which inaugurates and perpetuates a chronic condition of ill-health. In these cases the fæcal retention continues until a point of tolerance is reached, when the patient will experience a "bilious attack" or will take a dose of medicine and empty the bowels. I am convinced that in the majority of patients who suffer from periodical attacks of this nature the real source of the trouble is an unsuspected condition of intestinal atony leading to chronic slight fæcal retention. It is quite possible for patients with this condition of atony to suffer from looseness of the bowels or diarrhoea. This may happen in cases of catarrh of the lower bowel.

(d) Cases in which there is atony of the whole of the intestines. This condition is frequently met with in chronic colitis and is usually accompanied by constipation.

(e) Cases in which intestinal peristalsis is increased. In these cases we usually find diarrhoea more or less marked. We are thus able to see that things are not always as they seem, and that patients, with apparently regular movements of the bowels and even with a certain amount of looseness may really be suffering from intestinal atony, with delay of the food in the intestines, and to appreciate the clinical advantage it would be to us in our work if we had some simple method of measuring the actual time taken by the food in its passage along the alimentary canal. Fortunately we have such a method at the disposal of anyone who will take the trouble to use it, which is simple in the extreme. We have merely to administer to the patient with one of his meals some coloured substance, which shall be harmless, unacted on by digestion, and unalterable in colour, and note the time when it appears in the stools.

Technique of the Test.—We give the patient at breakfast one or two Belloc's pastilles of vegetable charcoal. Normally the stool next morning should be blackened. If the charcoal does not appear in the stool until the next day or the day after that there is abnormal delay. In cases of constipation the rectum may be emptied by means of a small enema of cold water:

Clinical Indications derived from the Test.—The estimation of the time actually occupied by the food in its passage may be useful under the following conditions:—

1. In cases of neurasthenia, so-called lithæmia, indigestion, and conditions of chronic ill-health generally, in order to ascertain whether these morbid conditions may not be due to delayed passage of food and consequent auto-intoxication.

2. In cases of obvious constipation to obtain a measure of the actual degree of the delay.

3. In cases of diarrhoea to inform us as to which part of the intestinal tract is involved. Thus—(a) If the indicating colour does not appear in the fæces until nearly the proper time we are able to learn that the morbid process has its seat in all probability in the lower parts of the colon, and that the peristalsis of the small intestine is not increased. (b) If the indicator appears in five or six hours, we are definitely able to state that the seat of mischief is in the small intestines. This finding will be confirmed by the test for bilirubin

to be presently described. Of course in cases of diarrhoea we shall examine every stool.

4. As an indicator to tell us when a test meal has reached the rectum.

(B.)—THE EXAMINATION OF THE STOOLS FOR "OCCULT" BLOOD.

One can have no hesitation in saying that, from the point of view of the gastro-enterologist, the introduction of this test into practice is one of the real advances in clinical medicine which have been made during the last two years. Not only is it of definite value, but its technique is so simple as to place it among the processes which are applicable to every-day practice. By occult blood is meant blood in such small quantity as not to be visible macroscopically. Such blood in the stools cannot be demonstrated by the microscope on account of changes it has undergone during its passage along the alimentary canal, and requires a chemical test for its recognition. For this valuable test we are indebted in the first instance to Boas, subsequently to Hartmann and others.

Technique of the Test for Occult Blood.—It is obvious that the first thing to do is to put the patient on a diet from which hæmoglobin-containing substances are excluded, and, unless the time occupied by the food in passing through the alimentary canal has already been estimated, to give a dose of charcoal as an indicator. We shall in this manner be enabled to judge when the contents of the alimentary canal at the moment of commencing the hæmoglobin-free diet have left the body and our test diet commences to appear in the stools. Then, and not until then, can we apply the test with any expectation of reliable results. The test diet must be free from meat and fish, and should consist of milk, junket, eggs, custard, bread, oatmeal, rice, tapioca, macaroni, cauliflower, white beans, onions, butter, and cheese. With these a sufficiently appetising menu can be constructed for the patient to tolerate for a week or two. Such, for instance, as the following should not be any very great hardship for a short time—

Breakfast.—Porridge and cream; eggs, bread and butter; tea, coffee, or cocoa.

Lunch.—Milk, soup, white fish, mashed potatoes, macaroni with milk, or *au gratin*.

Dinner.—Soup made with vegetable stock, white fish, a savoury dish of eggs, no meat stock, or Liebig's extract being used in the gravy, but the flavour obtained with onions, celery, Maggi's essence, or curry powder. Potatoes, white fish, a vegetable course such as haricot or salad, junket or custard, apple fritters, cheese, butter, biscuits and celery, and as dessert, nuts or almonds.

Of course, it is needless to say that such a diet as the above would not be given to a patient with obvious disease of the stomach, and is quoted mainly as an example of an ordinary diet modified in such a manner as to give no reaction with the test. In the majority of cases where ulcer or cancer is suspected the patient will be already upon liquid diet, and nothing more will be required than to make sure that all beef tea, meat broths, and stock are excluded from the dietary.

The apparatus required consists of several small porcelain dishes, a glass mortar, a glass rod, and a test tube graduated at 10 cc., 13 cc., and 18 cc. We also require the following re-agents—methylated ether, acetic acid, freshly made tincture of gualacum, ozonised oil of turpentine, aloin in powder, and a small quantity of 70 per cent. spirit of wine.

A small piece of faecal matter is rubbed up in the mortar with a few cc. of water, poured into the graduated test tube and further water added to the 10 cc. mark. Place the thumb over the top of the tube and give it a good shaking. Now pour in ether to the 18 cc. mark, shake again and place in the rack to settle. Whilst you are waiting for this, occupy your time by preparing an alcoholic solution of aloin in the following manner: Take as much dry aloin as will lie on the point of a

pen-knife and place in a dry test tube with about 5 cc. of the alcohol, shake vigorously and place aside in the rack. By this time the first tube will be ready, and it will be found that the ether has risen to the top, carrying with it the fat contained in the faeces. This has to be removed and the easiest way to do this is to suck it up with one of the pipettes or medicine droppers by compressing and allowing the rubber bulb to expand. Remove carefully all the fat-containing ether from the surface of the fluid which should now stand again at the 10 cc. mark in the tube. Pour in acetic acid to the 13 cc. mark and shake for a couple of minutes. Now add ether to the 18 cc. mark and shake again. Now place in the rack for a short time. The acetic ether extract will now rise to the surface and will contain the colouring matter of any blood which may be present. With another of the pipettes suck up one or two cc. of this and place in one of the porcelain dishes. Repeat the process and place the same quantity in a second dish. To the contents of the first dish add 5 minims of the tincture of gualacum and stir up with a glass rod. Now add drop by drop 5 to 10 minims of the turpentine. If any blood be present the mixture will assume an intense blue colour. To the material in the second dish add 10 minims of the turpentine and stir up well. Then add a few minims of the alcoholic solution of aloin and stir again. A bright red, turning to a cherry red on standing, will denote the presence of blood. It is as well to make use of both the gualacum and of the aloin in every case as thereby we eliminate any source of fallacy due to the dark colour of the acetic extract or to the presence of fat or fatty acids.

This method of performing the test I venture to think removes the chief difficulty experienced by the beginner—that of removing the ether extract from the fluid underneath. This is difficult to pour off in the small quantity with which we are working, and the separator in use in laboratories is naturally not available, and, moreover, cannot be conveniently applied to the small quantities which I advocate to be used. The advantages of working with small quantities from an æsthetic point of view is of course obvious.

Clinical Indications derived from the Test.—The presence of occult blood in the stools will point to slight bleeding at some point of the gastro-intestinal tract, (hæmorrhage from gums, nose, and throat being, of course, excluded), and will have precisely the same significance as macroscopic blood under the same conditions. In medical practice the knowledge that such slight bleeding is taking place is useful to us in the following conditions:—(a) In chronic disorders of digestion from a diagnostic point of view. If occult blood be found in the stools there is, in all probability, either cancer or ulcer of the stomach or duodenum, the conditions which may also be attended with slight bleeding under certain circumstances having first been carefully excluded. These are, purpura of the gastro-intestinal tract, hæmophilia, hæmorrhoids, fissure and fistula of the rectum, and cirrhosis of the liver. Of these the last is the most important, from a diagnostic point of view, as it is the most likely to lead to errors in practice. It has been reported by some observers that occult blood has been found in spastic and non-malignant stenosis of the pylorus, but it is more than likely that ulceration was really present in these cases. The more experience I gain the stronger grows my conviction that there is some ulceration present in practically all cases of reflex spastic contraction of the pylorus. These conditions then having been excluded, if we find the occult blood on several successive days it is almost certain that we have to do with malignant disease. If, on the other hand, there are days on which it cannot be found, there is a strong probability that ulcer is present. The fact has now been definitely determined that in cancer the blood is almost always invariably present, but in ulcers only intermittently. It is, therefore, our duty to place the patient on an appropriate test diet and examine the stools for occult blood in every case of chronic dyspeptic trouble which is rebellious to treatment, in which there is emaciation

or in which the patient is losing ground—however slowly.

In such a case we would first of all make sure that the conditions which might lead to error are absent, we then put the patient to bed and commence the test diet by giving a dose of vegetable charcoal with the first meal. As soon as the stools become black we may commence our tests for occult blood. We continue the tests for a week, during which the patient remains in bed for many and weighty reasons. As the result of our tests—

1. We may find blood on each occasion. There is almost certainly cancer.
2. We may find blood on one or more occasions during the week, but not every day. The case is probably ulcer.
3. We find no blood. In this case we wait a couple of weeks and then devote another week to testing. If the result be still negative we can pronounce the patient to be free from cancer and ulcer.

The comparatively long period taken up by the test should not carry any weight either with ourselves or the patients when we take into consideration the importance of the issues involved, and the fact that upon our finding will depend whether we condemn the patient to a long treatment in bed or to a serious operation.

(b) During the treatment of a gastric ulcer we may derive invaluable information. This has been well detailed by Dr. J. Dutton Steele* in a paper read before the Section in General Medicine of the College of Physicians of Philadelphia, Nov. 13th, 1905. He states that in his opinion the test for occult blood will be of prognostic and therapeutic value in the course of gastric ulcer under the following circumstances:—First, to determine the length of the various periods of the medical treatment of ulcer. Second, to detect a tendency to bleeding during the course of gastric ulcer, and by appropriate medical and surgical measures to anticipate and prevent serious hæmorrhage. Third, to determine when the medical treatment may be considered to have failed and surgical treatment is indicated. Fourth, perhaps the test may prove useful under certain circumstances in detecting the development of a cancer upon the floor of an ulcer.

(c) As a means of anticipating the occurrence of hæmorrhage in typhoid fever. As a rule serious hæmorrhage from the bowels in this affection will be preceded by occult blood for three or four days. We should, therefore, examine the stools two or three times a week during the dangerous period as a matter of routine.

(C.)—THE SUBLIMATE TEST FOR THE CONDITION OF THE BILE PIGMENT.

In a normal stool the bilirubin of the bile has been reduced to hydrobilirubin. In cases in which from any cause there is increased peristalsis in the small intestine the semi-digested food is hurried on before there has been sufficient time for this change to take place. We are able therefore, by determining the presence of bilirubin in the reduced or unreduced form respectively, to know definitely whether the peristalsis in the upper bowel is or is not increased, and consequently in cases of diarrhoea to give a definite opinion as to which part of the intestinal tract is involved in the morbid process.

Technique of the Test.—If the stools are liquid they can be used undiluted. If solid or semi-solid, a small portion is to be rubbed up with distilled water in the glass mortar. About 5 cc. of the liquid stools or of the stool solution are to be placed in a test tube and to them are added an equal quantity of a 25 per cent, watery solution of corrosive sublimate. If the stool is normal as regards the bile acids, a pinkish colour will develop showing the presence of hydrobilirubin. A green colour will show the presence of unreduced bilirubin.

Significance of the Test.—In a case of chronic diarrhoea the normal pink reaction would point to the fact that we had a colitis to deal with, and that the small intestine was not involved. Per contra—a green colouration

would point to the fact that the small intestine was involved.

(D.)—THE FERMENTATION TEST.

This test is very easy to carry out and is of great value in cases of presumed intestinal indigestion, as it enables us to determine not only the presence of abnormal fermentation in the intestine, but also whether the starchy or the albuminous ingredients of the food are the subject of the morbid process.

Technique of the Test.—Mix a small portion of the fæces with distilled water in the mortar until it is a little thinner than cream. With the mixture fill a Doremus' or Down's ureameter. Stand this in a warm place for twenty-four hours. Any fermentation which takes place will be accompanied by the evolution of gas, which will displace downwards the contents of the upright tube. The volume of gas may then be read off on the scale exactly in the same manner as the volume of nitrogen produced in the course of the familiar urea test. In the first place we must distinctly understand that fermentation of any kind is abnormal. If the gas evolved in twenty-four hours fills one-third of the tube there is certainly some pathological condition present, as there must be considerable fermentation of the intestinal contents. To find out whether the fermentation is amylaceous or albuminous we compare the total acidity before and after fermentation has taken place. If the total acidity is increased, the fermentation is of an amylaceous nature, if, on the contrary, the acidity is diminished, the fermentation is albumin fermentation. In the latter case the solution of fæces has become alkaline and foul smelling, and the condition of matters is often sufficiently obvious. The method of estimating the total acidity is the usual one of titration with a decinormal solution of sodium hydrate with phenolphthalein as an indicator. For the benefit of those of my readers who may not be familiar with the modern laboratory methods I may be pardoned if I briefly give directions for estimating total acidity. The first thing to do is to ascertain whether the fæces are acid or alkali. This is best accomplished by dropping a little of the solution of fæces which we have made into a little weak watery solution of litmus in a porcelain dish. If we find it acid we may proceed with the test for total acidity. We measure out ten cc. of the solution of fæces and add to it a few drops of a one per cent. alcoholic solution of phenolphthalein and stir up well with a glass rod. You now allow to run into this, drop by drop, a decinormal solution of sodium hydrate and note the moment when a red colouration is produced which does not disappear on stirring. The number of cc. used to produce this reaction multiplied by ten, is conventionally taken to represent the degree of acidity. If, however, we find the solution of fæces alkaline or neutral, we titrate in the same manner with a decinormal solution of hydrochloric acid until the fæces will give a reaction with litmus. The amount of hydrochloric acid added will represent the acid deficit in terms of hydrochloric acid. If any acid is produced during the process of fermentation the acid deficit will, of course, be correspondingly lessened.

Clinical Indications derived from the Test.—This test is especially valuable in deciding upon the dietetic treatment of cases of intestinal indigestion. By knowing for certain the kind of indigestion, we are enabled to reduce, or cut off entirely for a time, the food stuff which the test shows us undergoes abnormal changes, and thus to arrest the multiplication of the offending germs by depriving them of their accustomed pabulum. We are thus enabled to gain time to adopt the measures which experience has shown us are adapted to restore functional health to the organs and tissues involved.

(E.)—THE EXAMINATION OF THE FÆCES FOR UNDIGESTED CONNECTIVE TISSUE AND MEAT FIBRES.

Technique of the Examination.—This is merely a simple microscopic examination.

Clinical Indications.—The presence of undigested connective tissue fibres in any quantity will point to a

* Abstracted in the *New York Medical Journal*, Jan. 20th, 1906.

disturbance of the gastric digestion. If undigested meat fibres are found the indigestion is situated in the small intestine. In the latter event the precise condition present is unfortunately in the present state of our knowledge not revealed, and we are unable to say whether the trouble is caused by:—(a) a pancreatic secretion deficient in quantity or defective in quality, (b) deficiency in the enterokinase, the ferment which renders the pancreatic juice functionally active; (c) the onward movement of the food before efficient digestion has had time to take place, the result probably of increased peristalsis.

The knowledge obtained by this test cannot fail to be of considerable use to us in the treatment of chronic affections of the gastro-intestinal tract, especially as regards the appropriate diet to be given. For instance, in cases of chronic diarrhoea it will not infrequently be found that there is an inability to digest meat fibre, whilst the functions of the stomach are approximately normal. In these cases a restriction of the diet to starches and fat will usually be promptly followed by the cessation of the diarrhoea and a restoration of the patient to health. Conversely, in many cases of intestinal flatulence, it will be found that whilst both the meat and connective tissue are well digested the test already described shows that there is abnormal fermentation of starch in the intestine. In these cases a largely proteid diet, together with the administration of taka-diastase, has been followed by the happiest results.

It is an important point to bear in mind that, for a couple of days before making the examination for undigested meat fibres or for connective tissue in the stools, the patient should be placed upon a diet containing approximately 100 grammes of meat in the twenty-four hours, with a proportional amount of other articles of food to constitute an ordinary mixed diet. This quantity of meat is selected because it represents the amount which should be easily dealt with by the normal digestive apparatus, whilst at the same time it is a very fair test for a slightly lowered digestive capacity. The actual test diet recommended by Dr. Dutton Steele, to whose valuable work allusion has already been made, is as follows:—

Breakfast.—Two eggs, two pieces of toast and butter, two glasses of milk, and a plateful of oatmeal porridge with milk and sugar.

Dinner.—A quarter of a pound of underdone steak, two pieces of toast and butter. One and a half tumblers of milk.

Supper.—Two glasses of milk, one or two eggs, two pieces of toast and butter.

(E.)—THE DETECTION OF ABNORMAL MUCUS IN THE STOOLS.

We will omit the consideration of the large quantities of mucus which are characteristic of mucous colitis and the mucus of little or no significance which is so often observed coating the surface of hard, faecal lumps, and direct our attention to that which is intimately mixed with the stools. This alone is of any considerable importance from our present standpoint.

Technique for the Demonstration of Mucus.—Rub up a piece of the faeces with distilled water and pour the solution obtained on to a flat glass dish. The dishes used in photography answer admirably, and only cost a few pence. Hold the dish over a piece of black velvet, paper, or card, so as to form a background, and allow a good light to fall upon the dish from the side. The mucus can be recognised as small transparent flakes, often stained yellow by bile.

Clinical Indications.—The important point to bear in mind is, that although mucus is always present in normal stools it can only be demonstrated by chemical tests. It may be enunciated as an axiom of universal application, that when one is able to find it macroscopically it is always pathological. In fact, it is a general rule that the presence of mucus in the stools in the form described indicates the presence of inflammation in some portion of the mucous membrane

lining the gastro-intestinal tract, and may be considered an infallible sign of its presence.

These, then, are the few simple tests which I feel confident may be usefully employed as diagnostic aids even in the hurry of daily practice. They are easy of performance, require practically no special apparatus, and take up no more time than the routine examination of urines to which we are all so accustomed.

In the limited space at my disposal it has been, of course, obviously impossible to deal at all exhaustively with a subject covering so considerable a field; for instance, the significance of fat in the stools has not even been touched upon. It is, however, hoped that sufficient details have been given to enable the several tests described to be performed without difficulty, and that the deductions which may be legitimately drawn from the results obtained have been set forth with sufficient explicitness to render them as serviceable to my readers as they have proved to myself.

If no more has been accomplished, I venture to hope that I have done a little towards awakening an interest in methods which must infallibly enhance our power of dealing effectively with the obscure clinical problems which continually offer themselves for solution.

NOTE.—A *Clinical Lecture by a well-known teacher appears in each number of the journal. The lecture in next week's will be by Mr. A. B. Mitchell, F.R.C.S.I., Surgeon to the Royal Victoria Hospital, Belfast, on "Acquired Flat Foot."*

ORIGINAL PAPERS.

ACUTE NEURITIS OF BRACHIAL PLEXUS.

A WELL-KNOWN hospital surgeon has sent to us the following interesting notes upon his own case:—In early October, whilst staying in an hotel in London, I felt what I considered to be a little rheumatism about the left shoulder. After three days, when about to join a shooting party, I found I was not able to hold the gun, and on that day I went to bed in the afternoon, suffering somewhat considerable pain. On the following day (Sunday) I went to take my usual morning warm bath, but on lifting the left arm experienced an excruciating pain like tearing the muscles in the upper arm, and was forced to return to bed. The pain now became little short of intolerable, and from its position and character, it was clear that the nerves forming the brachial plexus were affected almost up to the cord, for the pain extended along the intercostal nerves and the side of the chest. The pain was deep-seated and aching in character, along the inside of upper arm, extending along the ulnar into the little finger over the skin of the fore-arm; it was lancinating like thousands of punctures; at the back of the shoulder it was boring, like a bradawl being worked through the centre of the scapula. Any attempt to move the arm was accompanied by a terrible tearing pain along the inner upper arm. Some local medical friends came to see me and with their opinion, we concluded that it was neuritis, probably of a gouty character, as I had already had an attack of gout in the great toe, and my father and grandfather had been what are termed martyrs to the gout. The treatment was colchicum, bicarbonate of potash, and tr. belladonna; also daily purgation, and for the relief of pain occasional doses of phenacetin and local application of laudanum applied on lint within a sheet of cotton wool. When the pain was sickeningly severe I was advised to have a morphia injection, but I made objection as I was not aware of the state of the kidneys, and did not wish to investigate whether they were sound or not. The arm was kept perfectly still on a pillow, wrapped in the cotton wool, and any accidental movement such as turning the body brought on the tearing pain of the muscles. From time to time during the

day the pain ceased so long as no movement was made, even for some hours at a time, and after remaining in bed for a fortnight I attempted to get up and remained sitting in a chair with the arm supported in a sling for some four hours, but at the end of that time the aching was again excessively severe and I had to return to bed. It now became necessary to have a hospital nurse. The intolerable pain in all its varieties was as severe as ever. With the nurse, hot fomentations were applied, Salicin and also guaiacum were taken in addition to the other remedies, aconite liniment was applied, but it was not until the end of six weeks that any great diminution of the pain took place. Now I was able to get up for three or four hours a day and to sit in an easy chair with the arm slung.

I was brought to London with the object of taking advantage of Turkish baths, but the first bath increased all the symptoms, and the second bath very plainly showed that it was a wrong treatment; it was clear that the movements necessitated in the course of taking a bath, and more especially during the process of the massage, were injurious to the inflamed nerves, and I was quite unable to continue them. As I was now again becoming daily worse I sent for a London physician, a former colleague of my own, who ordered me aspirine and the electric light bath with warm douche, and also a local application of menthol, chloroform, &c. Under these my pains subsided rapidly. I continued the treatment for three weeks, taking a bath every other day, and at the end of that time I was able to leave England on December 15th, for South Spain, but still being compelled to retain the arm in a sling. If the arm were allowed to hang, aching commenced in a few minutes, and it was not for another fortnight that I could dispense with the sling.

The attack extended over a period of thirteen weeks. The remedies did not demonstrate any immediately successful effect. The local applications of aconite, menthol, &c., in my opinion, increased nerve irritation and induced pain, but laudanum subdued nerve irritation and relieved pain. All the synthetical remedies — phenacetin, anti-pyrine, antikamnia — certainly subdued nerve irritability, relieved pain and permitted or induced sleep. The objection to the use of subcutaneous injection of morphia resulted in the loss of a most valuable remedy which certainly would have relieved the pain at a time when its severity was scarcely to be borne, and might have shortened the disease. Hot fomentations were unmistakably beneficial. The Turkish bath treatment is clearly contraindicated, for the inflamed nerves cannot bear pressure, manipulation, or even movement more than could an acutely inflamed periosteum. The electric light bath and gentle hot douche were most grateful and soothing, and unmistakably an effective remedy, but as more than five weeks of the disease were spent in a condition in which I was unable to change the position of the body without bringing on the unbearable pain, it would have been difficult or impossible to take advantage of it before some of the severity of the disease had been subdued. The question may be asked, was the disease functional such as neuralgia may be conceived to be, or was there actual change in the nerves? I made out a distinct enlargement or infiltration in the region of the plexus, but I need scarcely add that I objected to much manual examination, for pressure on the plexus or the shoulder or the scapula or the axilla or in that region where the anterior branches of the intercostal nerves penetrate immediately gave rise to the acute pains in all the other regions as by reflexion, but a fact worth being recorded is that pressure could be applied above the clavicle where the upper nerves forming the plexus could be reached, and yet no pain was thereby produced. So far as permanent damage to the nerves is concerned I may say that at the present time, five months from the commencement of the attack, the strength of the limb is unaffected, but small or precise movements of the little finger are awkward, less strong and precise, and, so far as sensation is concerned, lying upon the limb at night or

exposure to cold, such as on damp or extra cold days, produces aching results.

Finally, I may say that as a surgeon I did not meet with idiopathic neuritis of an acute form, and scarcely believed in its existence, but the last five months have given me a very thorough insight into the disease.

TWELVE CASES OF PROFUSE DESQUAMATION IN TYPHOID FEVER.

By JOSEPH BEARD, F.R.C.S. EDIN.

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In a contemporary journal in the early part of the year 1904 there appeared amongst the annotations a reference to desquamation of the skin in typhoid fever.

The note after referring to the great French clinician, Louis, as having long ago described the condition, further said that desquamation in typhoid fever is either unnoticed or little more than mentioned by most writers. On exploring modern text-books for information I am struck with the scanty and apparently unimportant short references to the condition, and the few remarks with which the writers content themselves do not leave any one the wiser with regard to the pathology of the process. It is true, as Dreschfield in "Allbutt's System of Medicine" says, "that desquamation of fine branny scales is often observed towards the end of the fever, or during convalescence," and with those remarks dismisses the subject. Osler, "Principles and Practice of Medicine," fourth edition, says that "a branny desquamation is not rare in children, and occasionally peels off in large flakes."

Notice is further paid to an article which appeared in the *American Journal of Medical Sciences* for January, 1904, which contained an important paper by Dr. David Riesman, who reports two cases and reviews the literature upon the subject.

I will quote briefly the facts of one of the cases as recorded by him.

"A male adult admitted into hospital January 23rd, 1902, with typhoid fever eruption. The attack was severe with widespread rash. The spots appearing on the face, arms, thighs, and legs. The temperature became normal on February 12th, probably the end of the fourth week. On March 3rd the patient had a severe chill, after which the temperature rose to 106°F., with pain in right side, followed by pleuritic effusion. Aspiration was performed and early in April the patient left hospital in fair health." He says that "desquamation occurred during convalescence (date not given), it was widespread and some of the scales were a quarter of an inch long. The chest and abdomen most marked, and but little less marked on the limbs, distinct on the face and neck. Scalp, shoulders, palms, and soles not affected. Riesman concludes that three forms of desquamation in typhoid fever may be distinguished.

I. That confined to the roseolar spots; sometimes the spots have a tiny vesicle on their summit, which forms a thin scale.

II. That appearing as a sequel to sudamina. This form is confined to the area of the sudaminal eruption, though Louis states that the intervening skin may be peeled off. The desquamation is usually furfuraceous but is sometimes scaly; it occurs upon the trunk and proximal parts of the limbs, never upon the distal parts of the limbs or upon the face.

III. Desquamation as illustrated by the case briefly recorded above, where there may be almost universal desquamation, furfuraceous or lamellar, and which he says may be due to "trophic changes analogous to shedding of the hair."

It affects the trunk and proximal parts of the limbs, rarely the distal parts of the limbs and face. Usually the extent and intensity of the desquamation are related to the severity of the fever.

During the past eighteen months I have had under my care eleven cases of typhoid fever in which well-

marked desquamation has taken place, and I have also seen one other case in the practice of a friend, the notes on which I also add to those of my own cases.

This latter case was a female, *æt.* 20, whom I saw with a medical friend in North Wales. When first seen she had been in bed for four days, her temperature was 102.4°F., expression easy, tongue coated with thin white fur, with sides and tip reddened, no diarrhoea, abdominal signs nil, no spots observed, Respiration 20 per minute. Pulse 102 per minute, regular, full and soft. She remained very much in this condition for sixteen days, when general improvement set in. The temperature for a few days was remittent, but quickly fell to normal. On the second day of the normal temperature she complained of tenderness of the toes and skin of the feet over the plantar aspect of the metatarsophalangeal joints of both feet (a condition which occurs in some cases of typhoid fever), and it was also noticed that the skin of the trunk was very rough. In a few days she had profuse desquamation, the face, scalp, palms and soles escaping. The skin of the trunk desquamated in large flakes a quarter of an inch long, the shoulders, arms, and forearms, being smaller and more furfuraceous in appearance.

The notes of my own eleven cases are briefly as follows:—

Case I.—E. W., male, *æt.* 12. Admitted ninth day of disease, abdomen distended, bowels loose, averaging two motions per day during first week, after which constipated, spleen easily felt, spots, about seven observed, Widal's reaction positive, temperature on admission 104°F., afterwards regularly remittent and intermittent and until thirty-seventh day when it became normal, after first day temperature was never over 103°F. Desquamation was first noticed on the twenty-seventh day of disease and continued for thirty nine days. The desquamation was universal. The flakes from the lower part of the back and abdomen being almost half an inch in length. The general desquamation was furfuraceous.

Case II.—G. A., male, *æt.* 19, admitted tenth day of disease. Temperature on admission 102.6°F., reached as high as 104°F. on the fifth day after admission, after which irregular remissions took place, intermitting on the eighteenth, twentieth, and twenty-fourth days after admission, reached normal on the thirtieth day after admission—*i.e.*, fortieth day of disease. The attack was smart; he was drowsy on admission, rambling and somewhat incoherent in speech; spleen easily felt, spots very profuse, occurring in hundreds on the trunk, both front and back, and also upon the arms and thighs. Bowels loose first two motions, but not afterwards during the whole time in hospital. The skin on the eighteenth day of disease was observed to be very dry, and on the twenty-first day began to desquamate freely, and in large flakes from the trunk and legs, small flakes from the shoulders and arms, but scarcely any from the forearms, desquamation was completed on the thirty-third day of disease. (Widal's reaction positive.)

Case III.—E. McC., male, *æt.* 11, admitted fifth day of disease, had history of epistaxis and diarrhoea. Temperature on admission 101°F., reached 103°F. third day after admission. Fifth day after admission became irregularly remittent and on seventh day intermittent, reached normal on the twenty-fourth day after admission. Condition on admission restless but sensible, abdomen flat with tenderness in right iliac region. No spots observed. No diarrhoea, spleen easily felt. (Widal's reaction positive.) Desquamation commenced on the nineteenth day after admission, first the trunk then the face, arms, and legs, in large thick flakes, and was completed on the thirty-fifth day after admission.

Case IV.—M. H., female, *æt.* 13, admitted about fifteenth day of disease. Temperature on admission, 103.6°F., the highest point reached, from the first remittent until the twenty-second day, when it became intermittent, reaching normal on the thirty-first day of disease. Abdomen on admission somewhat full, spleen easily felt, no diarrhoea, three or four spots only

observed. Desquamation (no note of day of commencement) of a furfuraceous character from the whole of the trunk, the arms and legs. (Widal's reaction positive.)

Case V.—G. A., male, *æt.* 8. Admitted eighteenth day of disease. Temperature on admission 101.6°F., fell to normal in forty-eight hours, remained slightly below normal for three days, then by a gradual ascent rose to 101.4°F., falling to normal again in forty-eight hours. Thirtieth day of disease reached 100.6°F., fell in thirty-six hours to normal. (Widal's reaction positive.) Thirty-eighth day temperature rose to 100°F. and was irregularly remittent and intermittent, varying from 98°F. to 101.4°F., for ten days, when it became normal and remained so. (Widal's reaction positive.) On admission the child was apparently very ill. Abdomen flat, a few spots, about four in number, on the abdomen, spleen easily felt, no diarrhoea. Pulse 100 per minute, irregular and dicrotic. Desquamation (no date of commencement), of furfuraceous character small but plentiful from the whole of the trunk; shoulders, arms, &c., did not desquamate.

Case VI.—F. D., female, *æt.* 16, admitted ninth day of disease. Temperature 104°F. which was the highest point reached. Temperature became remittent on the twentieth day, and fell to normal on the twenty-fifth day. On the following day, there was slight progressive pyrexia which reached 103.6°F., on the thirty-sixth day, and until the fifty-eighth day, the temperature was irregularly remittent and intermittent, varying from 104°F. (highest) to 96.6°F. (lowest). She was markedly ill on admission, abdomen distended, diarrhoea (first day only), spleen easily felt, tongue very dirty; pulse 120, markedly dicrotic; bases of lungs congested, no spots. (Widal's reaction positive.) Desquamation commenced on the thirty-first day of disease and continued until fourteen days before her discharge. The whole of the body was involved in the desquamating process, which took the form of large thick flakes, some of them from the trunk were half an inch in length, whilst flakes from the palms and soles came away in pieces varying in size, but some being as large as a penny piece. The head, face, shoulders, arms, and legs desquamated in flakes a quarter of an inch in length or only slightly less. After this profuse condition had subsided or almost subsided, she began to desquamate again, and the whole of trunk with the exception of the shoulders was involved—some of the flakes being about an eighth of an inch long, but mostly furfuraceous. Her length of stay in hospital was 106 days.

Case VII.—M. H., female, *æt.* 10, admitted on the fifteenth day of disease. Temperature on admission 103.4°F., subsided by regular remissions, and fell to normal on the twenty-seventh day (Widal's reaction positive.) Spots plentiful on chest and abdomen. No diarrhoea, deafness, spleen easily felt. Desquamation (date not given) took place in large flakes from the lower half of back, chest, abdomen, legs and arms.

Case VIII.—A. M., female, *æt.* 8, admitted on the eighth day of disease. Temperature on admission 103°F., the highest point reached. She appeared very ill on admission, bases of lungs congested. Tongue dry, brown, and cracked. Abdomen somewhat full, no diarrhoea, spots plentiful, but localised to lower costal margins and over both scapulae. (Widal's reaction positive.) The temperature after admission which was regularly remittent, became intermittent about the eighteenth day, and fell to normal in three days. Next day desquamation commenced, and was profuse upon the abdomen and back in flakes quarter of an inch long, and upon the arms and legs in smaller flakes.

Case IX.—D. C., male, *æt.* 45., admitted on the fifteenth day of disease. Temperature on admission 103.6°F. The fever for twenty days was of a regularly remittent type, but the night and morning variations varied two to four degrees F. It became intermittent for the next two days, when it again rose to 104°F., afterwards gradually falling by irregular intermissions until it reached normal on the forty-fifth day of disease. (Widal's reaction positive.)

Patient had a smart attack, profuse crop of spots on chest and abdomen, no diarrhoea, spleen not felt, pulse markedly dicrotic. Desquamation began on the twenty-ninth day of disease, first on the flanks, from which flakes half an inch long were observed. Two days later small flakes were shed from the legs and arms, later a fine desquamation occurred on the back, especially the lower half.

Case X.—J. R., female, æt. 27, admitted about the twelfth day of disease. Temperature on admission 103.4°F ., which after regular remissions and intermissions fell to normal on the thirty-seventh day of disease. Patient had a smart attack, a plentiful crop of spots on the abdomen, no diarrhoea, spleen easily felt, abdomen tender generally, not distended. (Widal's reaction positive.) Desquamation first noticed on the thirty-first day of disease, took the form of large flakes from the abdomen and lower half of back, and smaller flakes from the arms and legs,

Case XI.—R. B., male, æt. 16, admitted about the tenth day of disease. Temperature on admission 103.4°F . Soon became irregularly remittent, the night and morning variation being 1.5° to 4.5°F . until the twenty-first day, after which it became regularly remittent and intermittent, falling to normal on the forty-first day. Patient had a smart attack, much congestion of the bases of the lungs, abdominal distension and diarrhoea, thirteen spots were observed on the abdomen, spleen easily felt. (Widal's reaction positive.) Desquamation began on the thirty-first day of the disease, from the trunk in large flakes, some half an inch in length, and from the arms and legs in smaller flakes.

The classification of these cases by Riesman into three recognisable groups I think is quite arbitrary, but possible, although not one of my cases could be said to belong to Group II. of his classification.

It is not, I think, so much a question of variety, as of extent and intensity in the desquamation process; moreover, the arrival at a correct interpretation of the pathology relating to the process presents many difficulties. Riesman is of opinion that the condition arises from a trophic change, analogous to the falling of hair. The question thus arises, as to the latitude given to the word trophic; if it embraces sequelæ of acute and chronic inflammatory and degenerative changes other than those of the nervous system, and resulting from idiopathic, specific, toxic, chemical, nutritional, and hosts of other causes, then I think the desquamation occurring in influenza, pneumonia, appendicitis, &c., should be regarded as trophic; and if we do thus include the latter desquamations my appreciation of the term is fallacious, or differs very much from conditions generally referred to by pathologists as trophic.

CLINICAL RECORDS.

A CASE OF ACUTE CHOREA—ACUTE RHEUMATISM & CEREBRO-SPINAL MENINGITIS IN A GIRL OF 10 YEARS.—RECOVERY.*

By P. T. O'SULLIVAN, M.D.,

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† L. F., æt. 10, was admitted into the hospital on November 24th, 1905, suffering from acute chorea and acute rheumatism. She was a badly nourished, fair child with large thin-walled veins showing through her transparent skin, she had a bed-sore owing to the want of nursing during the fortnight she was ill prior to her admission.

When I saw her she was very sick, and the prognosis was very grave. Her movements rapid and inco-ordinate, to this was due the difficulty in getting her to swallow. Temperature, 100.5° , pulse practically uncountable, respirations, 60–80, with choreic spasms of diaphragm well marked, causing a great deal of

distress. Her mouth was sore, and her tongue from the incessant movement against her teeth was enlarged, excoriated and painful.

Her heart was enlarged, the apex being in the sixth interspace and half an inch outside the nipple line. She had peri- and endocarditis, the latter of old standing. The amount of pericardial effusion was small, and yielded readily to treatment. Her temperature went up to 103.4° on the evening of the 26th, then remitted to 101° for two days, on the 29th it went up again to 102.8° , it then gradually dropped and in a week became normal, remaining so until the end.

On the morning of December 5th, I noticed slight retraction of her head, and by the morning of the 7th her head was almost at right angles with her body, she developed at the same time internal convergent strabismus of the right eye. She had little or no tenderness over the cervical spines. The development of the cerebro-spinal meningitis caused such a strain upon her neck as to absolutely prohibit swallowing, she had to be fed rectally until December 29th, a period of 22 days. Her vision was good, she had slight diplopia for a few days at the onset of the meningitis.

When first admitted her urine contained traces of albumin, this disappeared when her temperature dropped, her urine being normal afterwards. Owing to the bed-sore she was nursed a good deal on her right side on a waterbed, and during the sixth week of her illness she got dislocation of the sternal end of her right clavicle, due to the softening of the ligaments of the joint.

I regret exceedingly that I was unable to get a blood culture, the microscopic examination revealing no abnormality.

The treatment consisted in applying small blisters over the 3rd, 4th, and 5th intercostal spaces, half an inch outside the border of the sternum. Her vitality at this period was so low that the blistered surfaces became almost gangrenous, and took six or seven weeks to heal. Whilst able to swallow she got a mixture containing aspirin with alkalies, and, in addition to control the choreic movements, small doses of sodium bromide. She also had 1–100th of a grain of strychnine hypodermically every sixth hour; whilst unable to swallow, the medicines were introduced rectally.

The rectal feeding was carried out very carefully, and to this I attribute her recovery. She had a wash-out enema every morning with a weak antiseptic solution; her rectum was then rested for an hour, and six and often eight ounces of food were introduced slowly through a soft rubber catheter and funnel, under gentle pressure; in this way the rectum tolerated the above quantities of nutriment. For 22 days she was thus fed, showing that the nursing was of the highest character.

At this date (February, 4th) the child is comparatively well; her heart is damaged, but compensation is good and she has no inconvenience; the squint is improving; the dislocation of her clavicle cured itself when she was placed on her back again.

The clinical picture presented in this case is of extreme interest. I have seen meningitis develop in cases of rheumatic fever and end fatally. I have never seen cerebro-spinal meningitis as a complication in such cases, and the question arises as to whether the micrococcus rheumaticus was the primary source of infection in this case? The case undoubtedly points to specific infection, and I am of opinion that all three conditions arose from the one specific organism.

We understand that Mr. Jonathan Hutchinson has a book in the press, "On Leprosy and Fish Eating." It comprises statements as to the history of leprosy, its nature, its prevalence in different countries, and the conditions under which it has disappeared from many. Facts are brought forward to show that it is not ordinarily contagious, and that its real cause is the use as food of badly cured fish. The publishers will be Messrs. Constable and Co., Limited.

* Read before the Cork Medical and Surgical Society on February 14th, where patient was shown.

THE OUT-PATIENTS' ROOM.

GREAT NORTHERN HOSPITAL.

GANGRENE OF A DEFORMED THUMB.—A man, *æt.* about 20, was sent up to Mr. Peyton Beale with the following history: As a result of a fall from a bicycle a fortnight previously, he had received a severe lacerated wound of the thenar eminence. He reported that there had been very considerable hæmorrhage, which, from his description, was clearly arterial and seemed as if it had been from the superficialis volæ. The present condition was one of commencing gangrene of the whole of the terminal phalanx of the thumb extending upwards to the proximal phalanx. The wound itself was rather at the base of the thenar eminence, and, though septic when first seen, there was no reason to suppose that the sepsis was in any way the cause of the gangrene. An examination was made to elucidate the position of the vessels in the neighbourhood of the thumb; the radial artery was quite normal, but there was every reason to suppose that the Dorsalis pollicis and the Princeps pollicis were absent, the small muscular branches of the superficialis volæ being practically the only supply to the thumb. On looking at the thumb of the other hand, a very marked deformity was found in the shape of a supernumerary digit, in appearance like a little finger, having a perfect terminal phalanx and nail but only a rudimentary proximal phalanx. This did not appear to articulate by a joint with any of the bones of the thumb, but simply appeared as a bud contiguous to the proximal phalanx of the thumb. No other congenital abnormalities appeared to be present in the patient, and there seemed little doubt that the gangrene was due to the severing of the only artery which happened to be present to supply the thumb.

STRICTURE OF THE SIGMOID FLEXURE.—A woman, *æt.* about 25, presented herself suffering from very marked distension of the abdomen and chronic constipation. The latter was an old trouble of four or five years' duration, and had been getting steadily worse and for the last week the patient had passed no motion. She had never passed any blood, nor had she had any pain. When the abdomen was examined, with the patient lying on a couch, a distinct tumour about the size of a hen's egg was felt apparently in connection with the sigmoid flexure; the tumour was freely movable, and nothing in the shape of enlarged glands could be felt. On examination of the rectum it was found to be empty and considerably ballooned, but no tumour could be reached. The patient had not the aspect or the history of one suffering from malignant disease, nor did she look more ill than would be expected in a person who had suffered from complete obstruction for a week. Mr. Beale remarked that this seemed like a case of non-malignant stricture probably resulting from the slow cicatrisation of an annular ulceration of the sigmoid. He considered the best treatment in such cases was as follows: (1) To perform right inguinal colotomy, bringing out the upper part of the cæcum and opening it on the second or third day; (2) in three weeks' time to cut down on the sigmoid, excise the stricture with one and a half inches of healthy bowel on each side of it, and to perform an end to end anastomosis, by far the easiest, quickest, and most efficient method being, he thought, that of Maunsell's; during the time which elapsed between the colotomy and the excision of the stricture, the colon and the rectum should be thoroughly irrigated daily so as to keep both empty and clean. (3) In the course of a fortnight or three weeks to close up the cæcal colotomy wound and drop the cæcum into the abdomen. This process, he pointed out, might seem a somewhat long and complicated one, but by following it one could ensure—(1) a rapid relief of the obstruction; (2) that when the stricture was exposed to view the bowel on either side of it would be of the same diameter and practically empty; (3) an end to end anastomosis could be performed

much more rapidly through a fresh wound than through a wound which had been used for colotomy, and he ventured to think that although the patient would be subjected to three operations she would suffer much less from shock than if the whole procedure was carried out in two stages, at any rate, that was the result of his experience in many similar cases.

OPERATING THEATRES.

GUY'S HOSPITAL.

OPERATIONS FOR CHRONIC INTESTINAL STASIS AND ITS RESULTS.—MR. ARBUTHNOT LANE operated on a woman, *æt.* 36, who had suffered from the above condition for a very long period of time. Within the last three years she had rapidly lost flesh, which had become much more marked in the last few months. She looked a great deal older than her age, her skin had become dark and patches of a deeper taint had formed in and about the eyelids, temples, and over all areas exposed to friction, such as the neck, the folds of the axilla, the prominences of the spinous processes, the waist, &c.; she suffered greatly from headache, lassitude and total inability to perform her household duties. Her mental condition was one of considerable depression—she complained also of a great deal of tenderness in the right iliac region, in her pelvis, the right sacro-iliac synchondrosis posteriorly, and below her last rib; in this last situation her pain was of a dragging character, when in the erect position and when in the supine position of a dull aching character, also she had pain in the position of the sigmoid which was converted from a mobile loop into a rigid fixed piece of bowel which was very tender on pressure; at times this last pain became very severe and griping, which was probably due to the passage of faecal matter, through the narrowed and telescoped sigmoid. The cæcum and transverse colon were felt to be very much distended, and displaced downwards into the pelvis. Her constipation was very considerable, her bowels having never been opened except with medicines, and then only when drugs were taken in large quantities. The patient also had clinical and physical evidences of dilatation of the stomach, and of a retention of a considerable quantity of fluid in the small intestines. Most of the symptoms of which she complained became more marked as the day went on, and her day practically ended at about one or two o'clock, as after that time she felt quite unfit to do any work. She was very anxious for some operation to be done which might alleviate her misery. Consequently the abdomen was opened in the middle line, the ileum was divided within a few inches of the cæcum, its proximal end being closed; the termination of the ileum with the cæcum, ascending and transverse colons was removed, and the large bowel closed at the splenic flexure; a communication was next established by lateral anastomosis between the end of the ileum and the rectum, which was then fixed by sutures to the right side of the pelvis, in order to make the most convenient passage of the contents of the ileum into the rectum.

The patient is now progressing very satisfactorily.

The next case of chronic overloading of the intestines occurring in a woman, *æt.* 38, was of an unusual type, in that the sigmoid loop had not become telescoped, atrophied and fixed, but had instead become much elongated, hypertrophied, and dilated, forming a loop of very considerable size. It was obvious that this loop frequently experienced much difficulty in emptying its contents into the rectum, but as far as one could gather the obstruction had never been complete

for a sufficient length of time to produce symptoms of acute obstruction. The symptom which, however, caused her most discomfort was an enormously dilated stomach, for which she had been under treatment in the medical wards for some time. The abdominal cavity contained a large quantity of fluid. It appeared, as if the dilatation of the stomach was secondary to the descent of the transverse colon, and was a consequence of the chronic constipation from which she had suffered for so long. The patient was exceedingly feeble. On opening the abdomen a very large quantity of fluid escaped. The presence of fluid appeared to be due, Mr. Lane observed, in part to the distension of the stomach and in part to the dilatation of the big bowel. Situated in the concavity of the stomach was a gastric ulcer which was quite free of the pylorus. The acquired ligaments or peritoneal bands which develop in cases of dilated stomach, and which hitch up its pyloric end and the first piece of the duodenum and so obstruct the exit of the contents of the stomach, were, Mr. Lane pointed out, remarkably well developed. The patient's condition did not permit of any other operation but a gastro-jejunostomy, which immediately afforded her relief from the symptoms due to the dilatation of the stomach.

The patient, unfortunately, got some bronchitis a day or two after operation, which in her very enfeebled and emaciated condition naturally caused some anxiety.

SPECIAL ARTICLE.

THE SANATORIUM TREATMENT OF CONSUMPTION IN IRELAND.

THESE are at present under discussion schemes for the establishment of sanatoria for tuberculosis in several parts of Ireland. In Cork the scheme has been in hand for some years, and is at the moment held up on the question of a site. In Belfast and Dublin, as well as in some country districts, local authorities are discussing the advisability of establishing public sanatoria. Under these circumstances it is inevitable that the question should rise in Ireland, as it has in England, as to whether sanatorium treatment is justifiable.

There are several functions claimed to be performed by sanatoria, any one of which may be sufficient to justify the expenditure of private or public money. To sum these in a sentence, they are the curative, the educative, and the segregative influences exerted. It is the last of these which is most likely to appeal to local authorities in control of the public purse. We have not quite got to the stage when it is admitted to be a part of public policy to provide care for the sick other than the sick poor, or to spend large sums of money in spreading hygienic knowledge. The community has, however, now for many years been in the habit of controlling the spread of infective disease at the public expense, and viewed from this standpoint there can be no theoretical objection raised to the provision of sanatoria for tuberculosis. The more consumptive patients are kept in sanatoria the less the disease is spread, and it is even conceivable that by a careful supervision of every consumptive patient, if that were possible, the disease might be totally eradicated. With regard to the curative and educative functions there may be more question, and it is in this relation that the Medical Report of the Royal National Hospital for Consumption at Newcastle will be found to contain information of peculiar interest. It is notoriously difficult to furnish statistics of any value on the sanatorium treatment of consumption, since there is no uniform or conventional set of standards by which the results of different observers may be compared. The Hospital at Newcastle, however,

has had the advantage of being under the control of the same Resident Physician, Dr. Steede, since the beginning of its work ten years ago, so that, at any rate, the same system of classification has been applied to a fairly large number of cases. This system is described as follows:—

"As in previous years, we divide the patients into four classes, according to the stage of disease on admission. This classification is of course arbitrary. The objective signs on which it has been made are somewhat as follows:

"A 'comparatively early' case has signs of slight consolidation, and has, in at least two lobes, crepitation on coughing; or has somewhat more advanced disease in one lobe, and no (or very slight) signs elsewhere. A typical 'moderately advanced' case has early cavity formation in one lobe, with crepitation also in two other lobes; or with more advanced but less extensive signs (as, for example, early cavity formation in both apices, and lower lobes quite free). All who have less signs than a 'comparatively early' case are classed as 'incipient.' All in whom the signs are more developed than in the 'moderately advanced' case are classed as 'advanced.'"

Of course, as the Report goes on to point out, some cases are met which do not easily fall into any of these classes, but it is impossible to devise any system to which the same objection does not apply.

Of the 62 "incipient" cases treated during the year with an average stay in hospital of eleven weeks and five days, 19 were discharged "very much improved," 23 "much improved," 18 "improved," and 2 "unchanged." Of the 144 "comparatively early" cases, 8 were discharged "very much improved," 49 "much improved," 71 "improved," 11 "unchanged," and 5 "worse." It is to be noted that the medical staff wisely avoided designating any patient as "cured." Nevertheless, they bring abundant evidence in the history of cases treated eight or nine years ago, that the improvement which was then obtained has persisted to the present time. Many of these earlier patients write to say that they feel perfectly well, and that they have been able to work without interruption.

Nearly all these old patients keep up what they call "the Newcastle treatment," that is to say, open-air life, and some of them mention the fact that their example has been followed with good effect by other sufferers. As the Report remarks:—

"Patients who enjoy sleeping in the open, either on verandahs or under a tent, with the sides open all round, will not willingly return to stuffy rooms. On his return home a patient not infrequently improvises an 'open-air shanty' for himself; and we frequently hear that other old patients have 'taken out the windows.' Every patient on his discharge is given a leaflet containing short and clear instructions about the management of his expectoration, and the importance of fresh air, &c.

"Amongst the general public, a just appreciation of the value of 'fresh air' in the sanatorium sense is more common than formerly, and sanatoria may justly claim a very large share of the credit for this important change in the minds and, to some extent, in the habits of the community. Sanatoria have demonstrated that what was almost universally considered dangerous and harmful is, in reality, useful and beneficial; and, even in this way alone, have done, and are doing, an untold amount of good. Even without considering 'economic cures,' and direct benefits conferred on patients, we believe that this consideration alone—namely, the influence sanatoria have on public opinion, medical and lay—affords in itself a sufficient answer to the question sometimes asked: 'Is the sanatorium treatment worth while?'"

We have touched on but a few points in a Report, whose judicial sobriety and conscientious compilation render it of value to all interested in the problem of tuberculosis.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, MARCH 9TH, 1906.

The President, Mr. CLUTTON, in the Chair.

DR. HERBERT FRENCH and Mr. C. B. TICEHURST read a note upon the

RELATION OF TRAUMATIC DIABETES INSIPIDUS TO GLYCOSURIA.

The patient, a man, *æt.* 44, was himself shown to the Society. Five years ago he had been thrown off his bicycle, remaining unconscious for 14 days, with cerebro-spinal fluid dripping from his nose. On recovery bilateral temporal hemianopia and ocular pareses showed that he had fractured the base of his skull in the region of the optic chiasma. Previous to the accident he had been perfectly well; after it he suffered from extreme polyuria and thirst, passing up to 10,000 cc. of pale urine, sp. gr. 1004.6, free from albumin and sugar. The expectation that the "sugar centre" in the medulla was also injured led to an extensive metabolism research in which all food and excreta were analysed. By increasing the carbohydrates in the food it was attempted to produce glycosuria. Dextrose, starch, and cane sugar were all assimilated well, up to as much as 700 grains (dry) of carbohydrate in 24 hours. No sugar could be made to appear thus in the urine. Two years later, however, glycosuria developed spontaneously. The urine remained of comparatively low specific gravity. Careful dieting diminished the sugar passed, but did not entirely prevent glycosuria. Upon careful dieting, both acetone and diacetic acid were present as well as sugar. On ordinary diet there were no acetone and diacetic acid. The patient feels weak and is unable to carry on active work; but his weight is well maintained, and if he could see better he could carry on an occupation which was not very strenuous. Similar cases were quoted from the literature, but none exactly like this one could be found. Injury as a cause of either form of diabetes was not very common, and the association of the two forms together was very rare.

Dr. A. E. GARROD remarked on the peculiar features of the case, in its tendency towards recovery, and yet in the long duration of the glycosuria from such a cause. Traumatic glycosuria usually lasted only until the glycogen reservoirs were emptied. He referred to the general obscurity prevailing on the subject of non-diabetic glycosuria.

Dr. FARQUHAR BUZZARD asked whether there were in the literature any other cases similarly present with localising brain symptoms.

Dr. FRENCH in reply, said that there were two such cases recorded. It had been suggested that the condition might be due to an injury of a hypothetical "thirst" centre, the polydipsia and polyuria being secondary.

Dr. E. FARQUHAR BUZZARD and Mr. JOSEPH CUNNING read a paper on a case of

POST-TRAUMATIC HÆMORRHAGE FROM THE SUPERIOR LONGITUDINAL SINUS WITHOUT FRACTURE OF THE SKULL; OPERATION AND RECOVERY.

On April 1st, 1905, a man, *æt.* 25, fell on the back of his head and inflicted a small scalp wound which healed without trouble. A fortnight later he complained of continuous and increasing headache, and on examination showed no physical signs except an extensor response and a diminished abdominal reflex on the left side. In the course of the next few days he developed complete left hemiplegia and hemianæsthesia with stupor and slow pulse and vomiting, but no optic neuritis. On April 18th he was trephined over the right post-parietal region and a large accumulation of blood was found beneath the dura mater and rapid hæmorrhage taking place from the neighbourhood of the superior longitudinal sinus. Forceps were placed on the bleeding point and the patient given a

saline infusion. On April 30th, the forceps were removed, and on April 2nd improvement in the paralytic condition set in. This has progressed to a complete recovery. Reference was made to the extreme rarity of bleeding from the superior longitudinal sinus without fracture of the skull and to the slow development of symptoms as its result. The slowness of the recovery was probably due to œdema of the brain substance.

Mr. PEARCE GOULD remembered seeing Mr. Christopher Heath operate successfully on such a case; there were no paralytic symptoms.

Mr. J. E. SPICER, introduced by Dr. PERCY KIDD, exhibited a pathological specimen showing

UNUSUAL DILATATION OF THE STOMACH FOLLOWING HOUR-GLASS CONTRACTION.

The patient, a woman, *æt.* 37, had suffered from dyspepsia more or less continuously for twenty years, and had vomited blood on three occasions. On February 15th, 1906, she was admitted to the London Hospital under Dr. Percy Kidd with an increase in the severity of her symptoms, and signs pointing to dilatation of the stomach. Four days later she suddenly developed general peritonitis and died in three hours. The *post-mortem* examination showed a constriction in the stomach in the neighbourhood of the pylorus. The peritoneal cavity contained between two and three pints of a thick green fluid resembling thin spinach, which was oozing from a perforation in an old ulcer situated in the constricted portion. The proximal portion of the stomach was much the smaller, and contained about 10 ozs. of partly digested milk. The distal portion contained several pints of thick green fluid such as was found in the general peritoneal cavity and formed the large swelling that had been felt during life. Its axis lay roughly at right angles to that of the proximal portion with the perforation on the anterior wall of the connecting passage. The opening into the duodenum was found in the outer wall of the angle, close to the perforation also. The perforation had been closed over by a thin lip of the lobe of the liver, the adhesions between the two having only recently been separated.

The PRESIDENT remarked on the importance of operating in such chronic cases.

Mr. ROUGHTON asked why no operation had been considered (a) to relieve the dilatation, and (b) after the occurrence of perforation.

Dr. PERCY KIDD said that he had not seen the patient before admission, and that then her general condition was good. He referred to the curious sac formed at the pylorus, and suggested that it might have originated in a congenital *cul de sac*.

Dr. GARROD drew an analogy between the condition and œsophageal diverticula.

Mr. SPICER said that he had been called up at two a.m. and found the patient moribund; she died two hours after.

Dr. A. E. GARROD and Dr. LANGMEAD read the notes of a case of

ASSOCIATED CONGENITAL MALFORMATIONS, INCLUDING TRANSPOSITION OF THE VISCERA.

These occurred in a female infant, *æt.* 9 months, who was admitted into the Hospital for Sick Children, Great Ormond Street, under Dr. Garrod for wasting and constipation. An operation had been performed for imperforate anus when the child was 24 hours old. She was a badly nourished, ill-developed child, and was pale, but showed no cyanosis or clubbing of the fingers. Her appearance was characteristic of the Mongolian type of idiocy, from which it only differed in that the back of the head was slanting and not flat. Examination revealed the heart to be situated on the right side and the liver on the left, an observation confirmed by a skiagram (produced). A systolic murmur was heard

over the normal mitral and aortic areas and behind the sternum, and also in the back. *Post-mortem*, complete transposition of viscera was found. The heart, as well as being misplaced, was malformed. There were present a patent foramen ovale, an imperfect septum ventriculorum, and a patent ductus arteriosus. The upper lobe of the right lung was missing. They remarked that in this case were thus associated, four distinct congenital malformations—viz., imperforate anus, a congenital heart lesion, complete transposition of viscera, and idiocy of the Mongolian variety. Of these the two first were definitely malformations of arrest, none of them were malformations of excess. That in some instances the cardiac lesion met with in such associations is not an anomaly by arrest, but is one of those which have been ascribed with some show of reason to the occurrence of foetal endocarditis. They thought that it might be as Rokitansky suggested, that a primary malformation predisposes to foetal endocarditis, since there is certainly evidence to show that malformed valves have some special liability to the *post-natal* lesions of ulcerative endocarditis. They considered that transposition of viscera was not infrequently associated with other malformations, and referred to a paper written by Dr. Garrod eleven years ago, in which were quoted several cases from the literature, in which transposition was accompanied by malformations in addition to congenital heart lesions. In conclusion, they considered that this case afforded an example of an association of quite special frequency—viz., that of congenital heart lesions with Mongolian idiocy, an association pointed out by Dr. Garrod in 1899, and confirmed by a number of other observers since. They stated that it is in the outpatient department of children's hospitals that this association is seen, for such children seldom survived the first year or two of life, and so it is seldom observed in asylums among Mongolian idiots, who have passed the age of five years.

The PRESIDENT said that in his experience congenital deformities occurred in first-born children, or in children born when the mother was exhausted, by either too frequent or too many pregnancies.

Dr. GARROD pointed out that this was not in trend with modern Mendelian views as to heredity, but that it was well worthy of investigation.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF SURGERY.

MEETING HELD FRIDAY, FEBRUARY 23RD, 1906.

MR. G. S. GUNN, F.R.C.S., in the Chair.

APPENDICITIS.

MR. D. KENNEDY read a paper on the above subject. He strongly advocated operation in the course of the disease as being calculated to shorten the illness and reduce the mortality. He gave a brief history of eight cases out of a series of forty-three, upon which he had operated during the acute stage without a death. The dangers of operating during an acute attack, he believed, were greatly exaggerated. Unless complications were present, appendicectomy was as safe during the attack as in the quiescent period. The ideal operation was removal of the offending structure. If pus were present, free drainage should be provided. Mr. Kennedy condemned indiscriminate douching and rough sponging of the peritoneum. The diagnosis of the disease was frequently difficult in children, and a proper examination could only be made in these cases by the aid of an anæsthetic. In all cases he recommended a rectal examination and in females a vaginal examination, when possible, for diagnostic purposes.

Mr. GUNN referred to the importance of a leucocyte count in coming to a diagnosis, and recommended the employment of palliative measures before urging operation.

Mr. A. B. MITCHELL (Belfast) alluded to the difficulty

sometimes experienced in diagnosing appendicitis in an early stage. He had seen the condition confounded with perforation of a duodenal ulcer. He thought it advisable to remove the appendix in suppurative cases, and also at a very early period if the disease were diagnosed with certainty. Failure to remove the appendix might lead to recurrence with abscess formation.

Dr. SAVAGE mentioned some facts illustrating the connection between appendicitis and suppuration elsewhere in the body. In one case he thought an attack of appendicitis had followed upon follicular tonsillitis ending in suppuration.

Mr. A. B. MITCHELL read a paper on Excision of the Scapula for Neoplasm. He described in detail the steps of the operation, laying emphasis upon the more important points. The patient was exhibited and demonstrated the range of movement and the functional capacity of the limb. Skiagrams of the affected scapula taken before operation, were presented for inspection.

The communication was discussed by Sir Thomas Myles, Mr. Kennedy, Dr. Johnston and Dr. Goulding.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD, THURSDAY, MARCH 8TH, 1906.

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

MESSRS. J. HERBERT PARSONS and GEORGE COATS read a paper on a case of

ORBITAL ENCEPHALOCELE ASSOCIATED WITH MICRO-PHTHALMIA.

Mr. Parsons had shown the child to the Society when 13 weeks old. There were then large cyst-like masses in the right orbit pushing the globe over to the outer side. The right eye was evidently microphthalmic and showed ophthalmoscopically a coloboma of the nerve entrance, and also of the macula. Various diagnoses were made as to the orbital condition. As the tumour was increasing in size it was operated on, but the child died a few days later. The mass in the orbit consisted of brain tissue which pressed upon, and caused deformity of the globe. It was connected with a large mass of brain substance within the skull which lay beneath the frontal lobe. The intracranial mass had displaced the latter upwards, and the temporal lobe backwards, but had no connection whatever with either. It was therefore believed to be either a teratological inclusion, or a piece of brain substance snared off in early foetal life, possibly from the region of the caudate nucleus, and growing independently. The eye showed three deformities, each of which was rare. (1) An ectasia on the nasal side of the papilla, which still had a lining of stretched choroid and normal retina (2) a coloboma of the nerve entrance which was peculiar in being on the temporal side of the nerve and in being entirely within the area of the porus opticus; (3) a macular coloboma which consisted chiefly in a partial defect and depigmentation of the pigment epithelium, both the choroid and retina being almost intact. The relation between the encephalocele and the abnormalities of the globe was discussed.

Mr. PRIESTLY SMITH described a Scotometer for the diagnosis of glaucoma and for other purposes. It was intended to facilitate the examination of the central parts of the field of vision, especially in cases of suspected glaucoma. It consisted essentially of a disc of millboard covered with black cloth and figured on the back with the degrees of the circle. The test object was a small cutting of grey wool which was laid upon the cloth at any desired distance from the centre. In the case of suspected glaucoma it should be placed at 25° from the centre, as shown by a faint mark on the cloth, and the disc should then be slowly rotated. Should it nowhere disappear or grow dim in all probability glaucoma does not exist, for, as Bjerrum had shown the defect; in the glaucoma field was almost always radical or sector like, and, with a delicate test

could be traced inwards. If a defect were found its extent should be noted on the graduated circle so that it could be used for future comparison. Other circles could be explored if necessary. The authorised maker of the instrument is Mr. Bailey of Bennett's Hill, Birmingham.

Mr. C. WORTH read a paper on

HEREDITARY INFLUENCE IN MYOPIA.

Though often regarded as a simple error of refraction grave complications may arise which altogether overshadow the original condition. Myopia is frequently inherited. In a series of 687 cases examined by the author, 33 were malignant and 654 were uncomplicated. Of the latter 56 per cent. gave a family history of myopia, while of the former in only 24.25 per cent. was evidence of heredity found. In one family, whose pedigree was shown, nearly all the males were myopic and none of the females; but the myopia was transmitted through the female line. The amount was in all cases examined about the same—viz., 10 to 12 D with some astigmatism. The fundi showed crescents, but grave complications were wanting. Curiously enough in this family all the healthy eyes were blue, and all the myopic ones were brown. Night blindness was only admitted in one family. The statistics of the 687 cases were as follow:—Of 313 with no family history of myopia, 163 were males and 150 females. Of 374 with a family history of myopia, 228 were males and 146 females. This showed the usual preponderance of myopia in men was increased in those in which myopia was hereditary. Of the 374 cases in which a family history of myopia was obtained, in 159 the parents were myopic, but the myopia was present in uncle, aunt, or grand-parent. The fault was on the mother's side in 104 cases, on the father's side in 33 cases, and on both sides in 32 cases.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, MARCH 1ST, 1906.

MR. FRANK T. PAUL, F.R.C.S., President, in the Chair.

EXHIBITION OF CLINICAL CASES.

DR. T. R. BRADSHAW showed, amongst several other cases of interest, (1) a case of paralysis of both 6th nerves in a young woman from whose neck cancerous glands had been removed; (2) congenital heart disease, with cyanosis, drumstick fingers, and systolic murmur at base; (3) disseminated sclerosis in a boy 19, after pneumonia—the symptoms were ataxy of legs and arms, brisk reflexes, scanning speech, but no nystagmus.

DR. A. G. GULLAN showed a man of 27, with complete transposition of the viscera. The man enjoyed excellent health and had been through the South African War.

Dr. Gullan also showed two cases of exophthalmic goitre, which had improved under the treatment of rodagin in drachm doses.

DR. NATHAN RAW showed cases of mitral, pulmonary, and aortic stenosis respectively, two of myxœdema, and one of arsenical neuritis.

THE PRESIDENT exhibited a patient upon whom he had performed orchidopexy for crypt-orchidism.

DR. G. STOPFORD TAYLOR exhibited a case of mycosis fungoides in which all evidence of the disease, except some pigmentation, had disappeared after treatment by the X-rays. Fifteen exposures of ten minutes' duration, each equal to a Holzknicht's unit, were administered, two exposures being given each week. The diagnosis had been confirmed by a microscopic section of the growth.

DR. F. H. BARENDT exhibited a man of 22 with seborrhœa corporis caused by wearing a vest continuously night and day for a fortnight in spite of free perspiration during work. The eruption consisted of discrete macules—salmon-coloured—marginate and

slightly scaly—scattered over and limited to the anterior and posterior aspects of the trunk.

DR. LESLIE ROBERTS showed cases of lupus, keloid following syphilis and follicular epithelioma.

DR. A. C. BERNARD a case of digital primary syphilis with secondary manifestations.

DR. K. GROSSMANN showed a case of albinismus confined to the iris, the structures of which with the exception of the uveal layer were free from pigment. The pupils were both excentric, indicating congenital displacement of the lenses which caused slight horizontal astigmatism. Horizontal nystagmus was present and, in the left eye, capsular cataract. The hair and fundus oculi were pigmented throughout.

MR. R. J. HAMILTON showed (1) a case of ptosis and paresis of the external rectus in the right eye and paresis of the left inferior rectus; (2) persistent increased tension in the eye of a girl of 18 years of age after removal of traumatic cataract. Iridectomy had failed to give more than temporary relief.

APPENDICITIS.

THE PRESIDENT read a paper on this subject in which he discussed the relative success of early and "interval" operations. Everyone agreed in operating at once in cases which suppurated, or in which general peritonitis supervened; but, apart from these complications, interval operation as recommended by Sir Frederick Treves was the goal to aim at. Statistics were wanting as to the mortality from appendicitis when an early operation was uniformly undertaken, but from what he had seen of it he was sure that the death-rate was much higher than when uncomplicated appendicitis was properly treated through the attack and appendectomy done on recovery. In any statistics it was necessary to consider the mortality as a whole. Since his previous paper five years ago, he had operated on 252 cases, including 43 abscess and 17 peritonitis cases. The mortality was 6.3 per cent. During the last year there had been considerable improvement. For 72 cases, including 16 abscess and 4 peritonitis cases the mortality was 2.7 per cent. For interval operation there should be practically no loss of life and very little in abscess cases if taken early and the appendix not removed. In general peritonitis the results were improving but the mortality was still high. Early operation might save a few cases from fatal complications, but was itself a cause of greater loss of life. For those who adopted the view that early operation was the best there should be no half measures; the essence of the practice was immediate operation in every case; it was a comfortable doctrine and saved the surgeon from all anxiety as to the right time to operate, but he could not subscribe to it as he felt sure it was not the best thing for the patient.

MR. R. W. MURRAY spoke in favour of early operative interference. In an urgent case the operation should be performed at once; if the symptoms were of a less urgent nature the operation might be postponed for a few days. The dangers of the operation were known to be slight, and were for the most part avoidable, whereas the dangers of delay were unknown and unavoidable. He considered the administration of morphia inadvisable, for the drug tended to impair the movements of the intestines, and the great omentum, which had been proved to contain a host of phagocytes, depended upon the intestines for its locomotion, and might thus be prevented from arriving at the seat of the disturbance and so from localising the trouble.

MR. E. M. STOCKDALE thought that the improvement in the statistics of general peritonitis might be attributed to the fact that cases were nowadays sent earlier to the surgeon, so that more cases might be classed as "diffuse" rather than "general" peritonitis.

He related the case of a youth of 20 who died within ten hours of the bursting of an abscess in connection with the appendix, the symptoms of general septic absorption being so severe as to preclude operation.

MR. G. P. NEWBOLT considered that the Trendelenberg position with the patient lying on the left side, prevented the small intestines and omentum from

getting into the way and much facilitated the operation. He drew attention to the occurrence of bladder symptoms in the early stages of the attack, and remarked that it was often the best plan to separate the appendix from the base to the apex in troublesome cases. He favoured the interval operation and did not remove the appendix in cases of suppuration unless it lay exposed in the cavity of the abscess.

Mr. W. BLAIR BELL would remove every appendix within twenty-four hours of the onset of an attack, if the case were seen in time. There was no more danger in this proceeding than in the "interval" operation, while it was the means of saving cases which might go from bad to worse; further it did away with the possibility of abscess formation, faecal fistula, hernia, &c. Concerning the after-treatment, he thought that the use of frequent saline injections per rectum added to the patient's comfort and prevented various thromboses.

Mr. T. C. LITTLER JONES, while congratulating Mr. Paul on the gratifying results he obtained by the "interval" operation, pointed out that the whole difficulty lay in diagnosing those cases which would go on to suppuration or general peritonitis. At all times he relied on the pulse for guidance and made a point of examining the rectum in every case. He also drew attention to a discharge of mucus which preceded perforation of the bowel. Unless the peritoneal fluid was of that abundant thin, easily diffusible character which had already, probably, infected every part of the peritoneum, he did not wash out but relied on careful swabbing.

Dr. A. G. GULLAN said that the great majority of cases of acute appendicitis treated by absolute rest, starvation diet, and rectal enemata recovered; he believed small doses of morphia were of great benefit, provided the temperature and local conditions were more closely watched. He never gave purgatives. He agreed with the President that the interval was the best time for operation on recurrent cases.

Sir James Barr, Mr. Damer Harrison, Captain Douglas, Dr. J. Hill Abram, Dr. E. T. Davies, Dr. H. Harvey, Dr. A. E. Davis, Dr. G. Westby and Dr. R. J. M. Buchanan also took part in the discussion.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS.

ABROAD.

FRANCE.

Paris, March 10th, 1906.

KERNIG'S SIGN.

ALTHOUGH the description of Kernig dates from 1884, the sign which bears his name was not generally known before 1898. It was at that period that it was considered an almost pathognomic symptom of meningitis. However, a reaction soon occurred, for this sign was found, after careful research, in a host of other affections, as typhoid fever, pneumococcal infection of the lungs, pneumonia, tuberculosis, sciatica, hemiplegia, etc.

According to Sinton and Voisin, Kernig's sign should be sought for as follows: The patient lying on the back, an assistant places his hands on the thighs to prevent any flexion; if the patient is told to sit up, he is unable to do so.

By another method, the patient is placed in the sitting posture in the bed, and the hands of the attendant endeavour to press on the thighs to obtain complete extension of the lower limbs so as to adapt them exactly to the surface of the bed. Where the sign exists this extension is impossible, the leg remains flexed on the thigh no matter how strong are the efforts to overcome the contraction of the articulation of the knee.

Where the contraction of the neck and the back prevent the patient from sitting up, an endeavour will be made to bend the thigh on the pelvis by maintaining the limb in complete extension.

The same sign has been described by Chauffard as affecting the upper extremities in a case of cerebro-spinal meningitis.

As soon as the patient sits up, says this author, the arms become rigid, contracted, in a half-flexed position impossible to correct this attitude even by employing considerable effort, all these phenomena disappear as if by enchantment as soon as the patient lies down.

Kernig's sign may be met with in about three-quarter of the cases of tuberculous meningitis. It is modified according to the progress or the recession of the inflammatory process and seems to coincide with the absence of reflex of the rotula.

The value of the sign is especially interesting in the latent forms of meningitis and even in infantile paralysis. It should be completed by the lumbar puncture and the cytologic examination of the rachidian liquid.

In all general affections the sign of Kernig may be observed where symptoms of brain excitement are present and in particular in typhoid fever, pneumonia, purulent pleurisy, gastro-intestinal affections of children, uremia, medullary affections, hysteria, hemiplegia, cerebral abscess, chronic encephalitis, locomotor ataxy, lumbago, sciatica.

The nature of the symptom is evidently a contraction of the flexor muscles of the leg.

Different theories have been expressed to explain the phenomenon. Some authors believe the cause to be due to an exaggeration of the muscular tonus, while others pretend that it is produced by hypertension of the cephalo-rachidian liquid. This explanation, however plausible, does not hold good, as Kernig's sign is seldom or never observed in cases of hydrocephalus.

For Kernig himself, as well as Dieulafoy and Netter, maintains the sign is due to local irritation of the spinal medulla and the cauda equina.

ACUTE NEPHRITIS.

Prof. A. Robin recommends the following treatment for acute congestion or œdema of the kidney. Blood letting when possible no diuretics in the acute stage, neither milk nor infusions which only go to stimulate an organ that cannot work. Instead of provoking the function of the gland, the smallest amount possible of liquid should be given, and that only water; the patient will be allowed to drink only as much pure water as is necessary for his thirst. Wet cupping should be applied over the renal organ or better still seven or eight leeches and a drastic purgative given.

If the action of the purgative is not sufficient the following mixture may be ordered, of which a third part is taken every fifteen minutes.

Jaborandi leaves, 1 drachm.

Proof spirit, 2 drachms;

After one hour's maceration

Add boiling water, 6 ozs.

A half-hour after the absorption of this medicine, the patient commences to salivate, and in a few minutes profuse sweating sets in, while the salivation becomes very abundant. Unfortunately, jaborandi causes sometimes vomiting. But M. Mollière, of Lyons, has remarked that an ointment of pilocarpine applied over the whole surface of the abdomen and lumbar region, and covered with a sheet of impermeable tissue provokes abundant sudation and salivation—

Hydrochloride of pilocarpine, 2;

Vaseline, 10 oz.

To stimulate the liver, which plays an important role in the excretion of different substances, the patient will be ordered 6 to 10 capsules of ether daily. Cold enemata may be ordered to stimulate the intestines and the patient will inhale oxygen gas.

For dyspnoea, inhalations of nitrate of amyl are indicated, and very small doses of digitalin (5 drops daily of 1-1,000 solution).

At the end of a few days, diuresis will set in, which

may be facilitated by theobrimin, at the dose of ten grains twice or three times a day.

UTERINE FIBROMA.

For women suffering from fibroid tumours, ten grains of powdered sabina given every morning for months and years will relieve the pain, diminish the volume of the tumour, and regularise the menses. The patient should remain in bed during the menstrual period, and the treatment should be suspended three weeks every two months.

GERMANY.

Berlin, March 10th, 1906.

FIBROLYSINE IN GYNÆCOLOGICAL PRACTICE.

This subject is treated in a paper in the *Korr. Bl. f. Scherw.-Aerzte*, Feb. 1906, by Hr. Vogelsanger. He refers historically to the introduction of thiosinamine into practice by Hebra in 1892, for the softening of cicatricial contractions, and to the confirmation of Hebra's expectations by numerous observers; its use in Dupuytsen's contraction and also in affections of both eyes and ears. Its principal use was, however, internally for the relief of strictures of most varied kind—retractile processes on the valves of the heart, pleuritic adhesions, and those of the abdominal cavity.

It was used early in gynæcology in chronic parametritic exudates and the fixations resulting from them. Prof. Offergeld had, however, quite recently denied that it had any effect in these cases. In view of the generally favourable results spoken of a systematic investigation was undertaken in the Basel Women's Hospital, the preparation employed being a double combination thiosaminosodium salicylate, to which the name of fibrolysine was given. Thiosinamine was met with in white crystals, quite insoluble in water, but soluble to the extent of 20 per cent. in alcohol. It had to be given subcutaneously. A glycerine solution in warm water was proposed by Van Horn Juliusberg (Thiosn. 10, glycerine 20, water ad. 100). This was painless on being injected. The thiosinamine, however, re-crystallised on the solution getting cold, and necessitated a re-warming of the mixture.

Fibrolysine was readily soluble in cold water, and proved itself very suitable to subcutaneous injection. As the solution would not keep exposed to the air, it had been put on the market in closed glass ampullæ, containing 2.3 c.c. of fibrolysine equal to 0.2 gm. of thiosinamine. When used in the hospital it was always injected subcutaneously into the gluteal region, and the injection was generally painless.

It was used in 18 cases, and 130 injections were given in all. They were mostly cases of cicatricial contraction of the pelvic tissues; twice in cases of atrophic parametritis; four were cases of deep laceration of the cervix, and nine remains of old pelvic cellulitis.

As regarded results, which differed very much, two groups were to be recognised each embracing about a half of the cases. In the first group the effect was unmistakable, even after the first two or three injections it was noticed that the firm cicatricial bands became softer, and after six the diseased side could not be distinguished from the sound one by the examining finger. Subjective improvement went hand in hand with the objective, the symptoms gradually disappearing.

The favourable results were obtained mostly in case of laceration of the cervix and contraction of the principal uterine ligaments, not so much in contractions situated in Douglass' pouch.

In the second group the effects were not so well marked and injection rarely led to complete disappearance of the bands. These cases were generally associated with grave nervous disturbance and the parts affected were usually the utero-sacral ligaments. The two cases of atrophic parametritis posterior belonged to this group. Here also the subjective improvement was but little marked. In addition to

the fibrolysine treatment the bands were systematically stretched by massage or otherwise, and the author attributes Offergeld's failure to the omission of this necessary adjunct—the mechanical stretching.

In retro-uterine hæmatocele after tubal abortion, and in two cases with comparatively recent parametritic exudations, there was no special acceleration of absorption. Somewhat disagreeable accompaniments of the treatment were that in two cases there was a disagreeable taste of garlic after each injection, and this was also noticed when the injection was intravenous—a proof of the rapid decomposition of the fibrolysine in the blood into its component parts. In a third case, along with the disappearance of the bands and the accompanying pain, prolapse of the uterus took place, which required the application of a pessary.

Certain people had a peculiar idiosyncrasy as regarded thiosinamine (a very itchy rash after each injection). Others had observed giddiness, headache, and sickness after large doses. The injection should not be made in the cicatrices themselves, or abscesses might be caused.

ECHINOCOCCUS OF THE ORBIT.

Dr. E. Trew relates a case in *Arch. f. Augenheilk.*, of a woman who had suffered from slight exophthalmus for nine years, got suddenly worse, after an energetic digital examination the sight also failing somewhat. The œdematous conjunctiva of the lower lid projected as a crescentic swelling. The lower half of the ocular conjunctiva was also œdematous, whilst the upper halves of both conjunctivæ were normal. The eye projected so far as to be almost outside the orbit. A fairly resistant mass was felt in the orbit. This was cut down upon and a slightly nodular elastic tumour was reached, which on puncture gave exit to a clear fluid containing echinococcus membranes and numerous scolices. Eight cysts were opened altogether, and curetted. A large piece of the conjunctival swelling was removed. Healing *per primam*, the exophthalmus disappeared, mobility returned, and the vision also again became normal.

AUSTRIA.

Vienna, March 10th, 1906.

ENDEMIC ELEPHANTIASIS.

Eiselsberg presented a case of sporadic or endemic elephantiasis to the Gesellschaft. The patient was a young man, æt. 24, who had never been out of Vienna and suffered, when about eight, with swelling of the right leg about the thigh, which has now grown to enormous dimensions.

The father of the patient died of cardiac disease, but the mother and five sisters are alive and quite healthy. The present enlargement commenced, as stated, about the eighth year without any recognised cause and without any complaint, injury to sura, or other abrasion to the cutaneous surface. The swelling proceeded slowly till the fourteenth year was reached, when he went to his father's workshop for the manufacture of fancy jewellery. The lad had not long commenced his apprenticeship when he began to grow weak and feeble, till finally he could not stand or walk. By this time the feet assumed a plantar flexion till he went to bed, where he remained off and on till he was twenty-one years of age, by which time the disease had become quite stationary and admitted of renewed movement. Within the last few years repeated fever attacks have occurred with reddening and pain resembling erysipelas in the right leg. On his recent reception into hospital he was blanched and greatly emaciated about the thorax and face with every symptom of catarrh, though the heart and kidneys were found normal. Scoliosis was present with leucocytosis 22,000. The lower extremity was quite without shape from its swollen condition while the surface was strewn over with scars and excoriations. The skin was thick and hard with round hard subcutaneous nodules in the tissues. Any movement of the parts was impossible although there appeared symptoms of spontaneous

fracture at the neck of the femur. Closer examination, however, with the Röntgen rays proved that it was only a luxation of the hip joint with a diastase at the knee-joint, that is, that the femur and tibia were wide apart. The tibia and fibula seemed to diminish to a mere shadow as they descended while the metatarsal bones could hardly be observed and were widely set apart. Needle pricks could not be felt from the middle of the femur downwards. The interesting points in this case are the enormous size, the luxation of the hip joint, and the apparent disappearance or absorption of the bony structure of the lower part of the limb. The case reminded him very much of one described by Katholicky and presented to us two years ago, and which he diagnosed as lymphangioma cavernosum.

The treatment of this case seems to point to the enucleation of some part of the morbid mass, although the greatly impoverished condition of the patient imposes great risk on the operator.

OTOGENER FACIAL PARALYSIS.

Alexander showed a case of facial paralysis from Politzer's clinic which he had successfully improved by anastomosis with the facial accessorius. The functional results have been excellent.

LYMPH-ANGIOMA.

Leischner showed a preparation taken from an excised portion of a similar case described above by Eiselsberg. The subcutaneous tissue was filled with cysts and caverns sharply defined as lymphangioma, but there were no symptoms of chyle or chylous vessels present.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

GIRGENTI INEBRIATE REFORMATORY, GLASGOW.—During the fifth year of the working of this institution terminating on December 31st, 1905, twenty-five patients were admitted, making a total of 113 from the commencement, the average daily number of inmates being 31.3. During the year 18 patients were allowed out on licence under the care of suitable guardians; of these 6 relapsed, one absconded, 4 returned to the Reformatory having given complete satisfaction to their guardians, the sentences of 4 expired while they were on licence, while three continue on licence. During the year 14 inmates escaped or attempted to do so. One escaped five times; two, 3 times; four, twice; and seven once. One of these patients is still at large, while two have been transferred to Perth. The large number of escapes is partially accounted for by the fact that the Girgenti Reformatory is not a walled-in Institution. Seventeen out of the 29 inmates discharged during 1904 have since the expiry of their sentences been convicted of drunkenness, and a similar fate has befallen 6 out of 16 inmates discharged during 1905. Dr. John Cunningham, the medical officer, in his report on the working of the reformatory, states that it is still impossible to form any decided opinion regarding hereditary alcoholism among the inmates, but most admit having had a drunken father. Probably not the disease, but a tendency to it, is inherited which shows itself in other neuroses as well as inebriety. The largest number of the patients belong to the lowest stratum, and are practically pauper inebriates. During 1902 Dr. Cunningham made exhaustive inquiry about so-called "cures" for alcoholism by secret drug treatment without being able to recommend any of them for use in the Home. Last year, on the recommendation of a medical gentleman, who claimed most wonderful results, he tried the administration of sulphate of atropine, grs. 1.00 daily, and a mixture containing quinine, sodium, ammonium, and aloin. The treatment was tried on 22 inmates for a period of one month; they suffered more or less from gastro-intestinal symptoms for a few days, but thereafter the medicine

acted as a tonic and a more liberal diet was permitted as a consequence of the increased appetite. The patients were not specially selected in any way. The following is the result of the experiment. Three patients, who, when previously licensed out had relapsed, have remained abstainers, 11 patients have returned to their former habits, and 8 patients have still to be liberated on licence before any judgment can be formed as to the effect of the treatment. Dealing with the "failures when liberated," Dr. Cunningham's opinion is that the hopeless cases, in whom there is mental enfeeblement, should not be liberated, but should be transferred to the wards of a poor-house or kept constantly under supervision by boarding them out in the country as is done in the case of harmless female lunatics.

EDINBURGH ROYAL INFIRMARY.—The managers have appointed Drs. Carnegie Dickson and Henry Wade assistant pathologists in place of Drs. Stuart McDonald and Lyon, resigned. Dr. W. T. Ritchie has been appointed clinical pathologist to the institution. Dr. A. H. F. Barbour has been appointed gynaecologist *vice* Dr. D. Benj. Hart, resigned.

BELFAST.

SAMARITAN HOSPITAL.—At the annual meeting of the Samaritan Hospital, held last week, the resignation of Dr. J. St. Clair Boyd on the ground of ill-health was accepted, and Dr. G. A. Hicks was appointed in his place. There was no contested election, as Dr. Hicks has been for some time Dr. John Campbell's assistant, and as such has constantly helped him at his hospital work, and now by this arrangement becomes his colleague.

NURSES FOR THE SICK POOR.—The annual meeting of this most excellent society was held in Belfast last week, and the report of another year's work presented. There are now ten nurses, who nursed 1,136 cases, including 202 of consumption and 65 of cancer, and paid 33,542 visits during the year. Professor Byers, in speaking at the meeting, dwelt particularly on the educative effects of the nurses' visits in the homes of the poor, which he regarded as very important.

ULSTER EYE, EAR, AND THROAT HOSPITAL.—The annual meeting of this hospital was held last week, and the hospital re-opened after general cleansing and renovating. The medical report showed an active year's work, there having been over 2,500 extern patients and 329 intern.

BELFAST WATER SUPPLY.—In consequence of various rumours as to the contamination of the water reservoir at Stoneyford, near Belfast, a statement on the subject was made at a meeting of the Water Commissioners last week. It seems that no cases of typhoid exist in the catchment area, and the last quarterly report of Professor Frankland gave the water an excellent character. Arrangements have been made with the dispensary doctor to notify any case of typhoid or other infectious disease occurring in the neighbourhood to the Commissioners, so that prompt steps may be taken to prevent contamination of the water, and about £50,000 has been spent in the last few years to give them more complete control over the land round the reservoir.

LETTERS TO THE EDITOR.

PROPOSED UNION OF MEDICAL SOCIETIES—A DISCLAIMER.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

DEAR SIR,—I trust that you will have the goodness to allow me the courtesy of your columns to make a personal explanation.

At the recent annual meeting of the Royal Medical and Chirurgical Society, *apropos* of the question whether the premises at 20, Hanover Square would be suitable for the proposed amalgamated society, I understand that one of the Fellows present stated that I had been consulted as to the condition of the

premises, and that I had reported "that the building would require pulling down and re-building in about fifty years."

I desire to say that there is not the slightest foundation or justification for such a statement. I have not discussed the matter with any but the Officers of the Society, and had I been asked for my opinion as to the probable duration of the present building, I should have stated emphatically that it was, in my opinion, as likely to stand for another hundred years as any building of its age in London, and I have not the slightest doubt that it will remain a good and useful building for even a longer period if kept in proper repair.

I am, Sir, yours truly,

JOHN BELCHER, A.R.A.,
President R.I.B.A.

20, Hanover Square, W., March 8th, 1906.

A MEDICAL VIEW OF THE NATIVE LABOUR IN THE TRANSVAAL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is stated in recent news from London that one of the Transvaal companies has been compelled to shut down because there was no prospect of finding an adequate number of natives to work the mines.

An explanation of this and other similar news coming from the Transvaal mines for some time back, may be furnished by the corresponding medical news in the Colonial journals, namely, that the natives soon become affected by blindness, so as to unfit them for any work below, where semi-darkness prevails. After some treatment in the local hospitals for the alleviation of the malady they get temporarily better, but the blindness recurs as soon as they return to work in the mine below ground.

It may be conjectured that the air in some galleries of the mines is fouled by the fumes from the gold and other ores, so it requires to be thoroughly ventilated by adequate machinery to fit it for the respiration of the natives of the country. Presumably the Chinamen now being employed are less affected by the foul air, and therefore have, in due course, supplanted the natives of the country in this class of work below ground in consequence, as the latter are naturally habituated to crop and field work.

I am, Sir, yours truly,

A MEDICAL TRAVELLER.

THE TRIBUNE AND QUACK ADVERTISEMENTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—If Mr. Sparkhall, the manager of the *Tribune*, wishes to realise at first hand the iniquity of the quack medicine trade he can easily do so in the out-patient department of any great hospital. I well recollect the first case that attracted my attention to this subject. It was a woman who applied to the late Mr. Teevan, at the West London Hospital, with cancer of the breast. The disease was quite beyond the scope of surgery, and had progressed during two years into that state whilst the wretched patient had relied upon a "heal all" ointment, then most extensively advertised, and which brought its infamous proprietor a vast fortune. Besides cases like this, all sorts of serious diseases made chronic or incurable through reliance upon the false pretences of the quack, a vast number of victims of quackery of other sorts will be easily discoverable. Not the least sad among them are the poor infants, systematically drugged by simple, ignorant mothers with soothing syrups of one kind or another. An inquest on an infant dead from this cause is reported on page 201 of the issue of Feb. 21. Those that escape with their lives are often made rickety cripples from this cause alone. A vast proportion of cases of diseases of the rectum are due solely to the prolonged use of quack pills, nearly all of which, whatever their pretensions, are compounded solely of coarse drastic purgatives. It is only a short time ago that a minute analysis was made of a variety of extensively advertised

"cures" for fits and epilepsy. They were all found to be crude frauds, and whilst they were retailed at prices from several to many shillings a packet, it was proved that in no case did their intrinsic value exceed a few pence. All these facts are easily to be verified by any newspaper manager who cares to take the trouble.

I am, Sir, yours truly,

G. P. No. 2.

February 21st, 1906.

THE OPSONIC INDEX.

To the Editor of THE MEDICAL PRESS AND CIRCULAR

SIR,—Your correspondent "Cunctator," undoubtedly touches on a practical disadvantage in the application of opsonic estimation to the control of vaccine treatment, when he mentions that the process is highly technical. It does not, on that account, deserve the condemnation he metes out to it. Similar objections were raised, to mention only one or two instances, to Listerism, when first introduced, and to the Widal test for typhoid fever. I do not know whether ten guineas is, as "Cunctator" states, a usual fee for a single estimation, but I know that one of the clinical laboratories lists it at a guinea and a half, and there are many competent pathologists willing to make observations for slightly higher fees. When "Cunctator" states that we gain nothing by knowledge of the opsonic index beyond what we might learn by simple clinical observation, he shows, I fear, a somewhat slight study of the subject. Professor Wright has made it clear that clinical observation gives us no indication of the suitability of the dose until the damage has been done, whereas opsonic estimation allows a very accurate control of the dosage of vaccines. The success of the method both in his own hands and in those of his pupils is sufficient justification. There are doubtless many points open to criticism in Professor Wright's arguments. The criticism, however, should be intelligent and instructed. Sneers and jibes, such as those with which "Cunctator" closes his letter, do not help the settlement of any point in science.

I am, Sir, yours truly,

CRITICUS.

REVIEWS OF BOOKS.

STEWART'S PHYSIOLOGY. (a)

FIVE editions and three reprints in the course of just over nine years ought to satisfy any author that he has not written in vain. And this is the record of Professor Stewart's *Manual of Physiology*, a new edition of which lies before us. A good deal of re-writing and the addition of a considerable amount of new matter have been necessitated by recent work and more extended experience, but by the adoption of a smaller type this manual remains a manual. To those who are unacquainted with it, it may be said that a distinctive—and a very valuable—feature of Professor Stewart's *Physiology* is that theoretical disquisition and practical exercises are treated as integral parts of instruction, and the book is so arranged that laboratory work illustrating the principles dealt with in the text is described at the end of each chapter. It is thus intended that the book shall combine the functions of a treatise and a practical handbook, and the course is so mapped out that each shall proceed *pari passu* with the other. The author's experience as a teacher, examiner, and investigator on both sides of the Atlantic have given him a wide knowledge of his subject in relation to students' requirements, and we are not therefore surprised at the gratifying success which has attended his attempt to produce a systematic work. The more the book is studied the easier

(a) "A Manual of Physiology. With Practical Exercises." By G. N. Stewart, M.A., M.D., D.Sc., D.P.H., Professor of Physiology in the University of Chicago. Coloured Plates and nearly 400 other illustrations. Fifth Edition. Demy 8vo. Price 16s. net. London: Baillière, Tindall and Cox, 1906.

will it be to see why it is so much appreciated. The style is free, but dignified; the thought clear and lucidly expressed; and the teaching as definite as it is possible for physiological teaching to be. It is marvellous, indeed, how Professor Stewart has contrived in less than 900 pages of text, a good deal of which space is occupied by illustrations, to include all the essentials of a physiological course without any appearance of "cram." The author is evidently in love with his subject and he succeeds in imparting to his readers the feeling that physiology is the science of living tissues, and not a conglomeration of microscopic preparations and electrical apparatus. He has evidently taken great pains with the revision of the text, and it seems to us as accurate in letter as it is in fact. We can cordially recommend the book to the notice of teachers and demonstrators, feeling sure that they and their students could have no better guide.

THE EDINBURGH MEDICAL JOURNAL. (a)

THE half-yearly volume of this journal has just reached us in its familiar form. No lengthy review of it is necessary, as some of the individual numbers of which it is composed have already been noted in our columns, and abstracts of two or three important papers contained within it have been published in our "Weekly Summary." While not containing any very epochal papers, it is still characterised by the general high character of the original articles which have been contributed to it, many being of more than passing interest, and constituting valuable additions to the literature of the subjects with which they deal. Among these may be mentioned the report by Dawson on his investigations into "The Condition of the Blood after Operation and Fracture." The investigation was carried out in a most thorough manner, and led to the following among other, conclusions:—(1) After every operation the leucocytes increase in number, independently of the number of red blood corpuscles. This increase reaches a maximum within a few hours, and then slowly disappears in the course of the next couple of days. (2) The leucocytosis is principally of neutrophile leucocytes, but the hyaline cells also take part in it. The lymphocytes and eosinophile cells, on the other hand, show diminution in both relative and absolute numbers. (3) The leucocytosis is apparently independent of (a) the amount of hæmorrhage; (b) the severity of the operation; (c) the anæsthetic employed; (d) the preparation of the patient. (4) A failure in the normal decrease of leucocytosis after a couple of days is to be regarded as pointing to the existence of some septic complication. Another most valuable paper, or rather monograph, is that on "Hypertrophic Pulmonary Osteo-arthritis," by Dr. Donald Hall. Two new cases are reported, in one of which death occurred from sarcoma of the lung, and in which a full *post-mortem* examination was obtained; a very complete summary of the previous literature is given, and the paper is illustrated by some excellent photographs and skiagraphs, and a bibliography is added. Dr. Gibson's paper on Bradycardia is also well worth reading, containing as it does the results of the writer's matured experience, and last, but not least, must be mentioned Barry Pain's "Treatment of Facial Palsy." It is, we imagine, this writer's first communication on a medical subject, but we hope that it will not be his last.

THE TREATMENT OF SYPHILIS. (b)

THIS little book, which is evidently the outcome of the author's great experience gained in many lands and climates (as mentioned in the preface by Surgeon-General Gellway), should be of great interest and use to all naval and military surgeons; it strenuously advocates the intra-muscular treatment, and this is undoubtedly one easily carried out on patients who are under discipline and who come daily under the personal

(a) "The Edinburgh Medical Journal," Vol. xviii, 1906. Edinburgh and London: Young J. Pentland.

(b) "The Treatment of Syphilis." By F. J. Lambkin, Lt.-Col. R.A.M.C. Pp. 60. London Baillière, Tindall and Cox. Price 3s.

observation of the medical attendant. Medical men, however, will read with surprise the author's dictum that after mercury had been administered by the mouth for, say, a couple of months, it began *in most cases* (the italics are ours) to disagree with the patient, the digestive system becoming upset and impaired and the general health falling off in consequence"; also "With regard to diet, among the advantages of the external methods is that under them it is luckily not necessary to curtail diet *in the same way as it is with the internal*" (the italics are ours). On the other hand, Col. Lambkin's arguments in favour of the intramuscular treatment are sound, and his words must be received with due consideration. The treatment might certainly be carried on with advantage in the Navy and Army and amongst those of the leisured and wealthy classes who would face the discomfort and risks (however small) of a surgical operation (however trivial) twice a week during at least a year.

PUBLIC HEALTH LABORATORY WORK. (a)

THE purpose of this well-printed and handsome manual is to provide an "outline of the more important matters discussed at practical examinations in Sanitary Science." In fact, the title and the purpose described above are somewhat wider than the actual scope of the work. It is a compilation of some of the principal methods of laboratory examination of water (90 pages) sewage effluents (3 pages), soils (3 pages), air (28 pages), various foods and disinfectants; with an appendix of the preparation of some standard solutions and of the general chemical reactions of common metals and acids whether important for the public health laboratory or other requirements (54 pages). The descriptions are admirably neat and clear, though not always as detailed as would be desirable; and while necessarily having no pretensions to originality the book will leave the student who works through it with a knowledge probably sufficient to get through such an examination as the author contemplates in the special branches of the subject which come into the book. It must be confessed, however, as will be seen by the analysis of the space devoted to the subjects named above, that the author's sense of the prospective importance of the various subjects is open to question. It is difficult to imagine a student coming away from a laboratory course conducted in accordance with Dr. Sommerville's chapters with a practical grip of proportion between the various parts of the science. For the most part the methods are not only well described but well selected; we noticed, however, occasional discrepancies between the text book and practical experience which should be rectified in another edition. The copper zinc couple, for instance, cannot be used for sewage with even as much accuracy as the phenol-sulphonic acid method, which for water is much less accurate. If the reader is presumed to be so placed in chemistry as to have a use for the appendix on the reaction of metals and bases, it is scarcely reasonable for his study of sewage to be complete in three pages and meat in eight; nor would he be likely to have in advance the familiarity with bacteriological method which is postulated by the author in dealing with the biological examination of water. These criticisms notwithstanding, we can strongly recommend the work to all aspirants for the D.P.H., of which the foundation of its pages is the practical course at King's College, London.

ORGANOTHERAPY. (b)

ORGANOTHERAPY is no new means of combatting disease. The administration of animal tissue for the prevention and alleviation of human maladies is a practice the origin of which is lost in the ruts of pre-historic

(a) "Practical Sanitary Science: A Handbook for the Public Health Laboratory." By David Sommerville, B.A., M.D., D.P.H. (Camb.), M.R.C.P. (Lon.), London: Baillière, Tindall and Cox, 1906. With 92 plates and other illustrations. Price 10s. 6d.

(b) "Organotherapy or Treatment by Means of Preparations of Various Organs." By H. Batty Shaw, M.D., F.R.C.P., Lecturer on Therapeutics, University College, London, &c. London: Cassell and Co. Limited, 1905. Price 6s.

times. Modern organotherapy may be said to date from 1889, when Brown-Séquard brought the question of internal secretion into prominence by his advocacy of the use of testicular fluid as a means of staving off the oncoming of old age. Later the great benefits derived from thyroid administration, and, more recently, the remarkable service rendered by suprarenal abstract, have quickened interest and stimulated research into all matters touching organotherapy. Dr. Batty Shaw has therefore accomplished a real service in furnishing so admirable an epitome as is offered in this compact, concise and yet comprehensive manual. The author claims that his book is "an attempt to place before the reader a short account of the physiology, &c., of the glands of the body with special reference to internal secretion, and to supply a review of the practical applications in disease of the derivatives of various organs." And he has attained his end. The work is divided into five sections dealing respectively with the thyroid and para-thyroid glands, the adrenals, the alimentary tract, including pancreas and liver. Genito-urinary organs, and such other organs and tissues as the pituitary body, the thymus, the spleen, bone marrow and lymphatic glands. Much painstaking care has been taken, and extensive bibliographical research is evidenced on almost every page. The work is an excellent epitome and well suited to the needs of the busy but conscientious practitioner, eager to keep himself abreast with the best results of recent medical research. But in spite of its many excellencies the work is disappointing. It lacks the force and vigour of personality. The author never ventures to express his own views, and we have failed to discover any reference to personal researches or original observations. Nowhere in the volume can we find the personal pronoun, and such self-suppression tends to make a work lack in suggestion and powers of service. What is presented is so excellent that we could have wished that the author had allowed us the benefit of his own opinions, and the guidance of his own clinical observations. But this lack we trust may be rectified in the next edition. The general get-up of the volume is thoroughly good and quite in accordance with what we expect from the publishers.

WOOD ON THERAPEUTICS.(a)

We can quite understand how it is that Dr. Wood's large work has reached its twelfth edition in America, as it appears to us to be clearly expressed, written in a scientific spirit, and almost comprehensive. Of necessity, however, an American, or any other foreign work on "therapeutics," is at a serious disadvantage in this country, owing to the non-correspondence of the pharmacopœia of the two countries. Dr. Wood's work is divided into two main parts. Part I. deals with "Remedies, remedial measures, and remedial methods which are not drugs," and under this heading is grouped a large amount of information regarding foods, caloric, electricity, and the treatment of "systemic states." Part II., which constitutes the major part of the book, deals with drugs. The author's classification of the latter is simple. He first constitutes two main groups: "Systemic remedies" and "extraneous remedies." The systemic remedies are divided again into "general remedies" and "local remedies," and the former of these is subdivided into "nervines," "cardiants," and "nutrients." One naturally shudders at the idea of a work on therapeutics written in Americanese, since the terminology of the subject is capable of affording such evident opportunities to philological reformers, and lest the three last-mentioned terms should make the reader think that Dr. Wood's work is so written, we hasten to reassure him. Throughout the book is written in the English language, a fact on which we congratulate both author and publisher. We think we can perhaps best show the opinion we have

(a) "Therapeutics: its Principles and Practice." By Horatio C. Wood, M.D., LL.D., Professor of Materia Medica in the University of Pennsylvania. Twelfth edition, revised and adapted to the eighth edition of the United States Pharmacopœia. Philadelphia and London: Lippincott and Co. 1905.

formed of Mr. Wood's work by saying that in spite of the fact of the difference in the English and American pharmacopœia, we can recommend it to English readers with a certainty that they will derive extreme profit from a perusal of it.

HARROGATE—WATERS, BATHS, AND CLIMATE.(a)

This book follows much the same lines as others of its class. It describes the various waters and baths to be obtained at Harrogate, and gives a sketch of the climate and situation of the Spa. Some physiological and clinical material is supplied to aid in the proper comprehension of the advantages offered by residence at Harrogate, and the diseases that may and may not be expected to be assuaged are detailed. Analyses of the various waters are given, and we learn that sodium chloride appears to be the most prominent ingredient. Sulphur and iron are present in some. Luxurious baths of all kinds are installed, and the amenities of spa-life are well catered for. We cannot, then, but wonder why practitioners continue to send so many of the patients to the Jordans of Germany, when Abanas and Pharpars of such elegance and therapeutic efficiency are within a few hours' journey of the metropolis.

LITERARY NOTES.

THE "St. Thomas's Hospital Reports," for 1904 (New Series, Vol. XXXIII.), edited by Dr. Hawkins and Mr. Battle, is as carefully prepared and exhaustive as any of its predecessors. The statistical tables are, indeed, marvels of condensed information, and there are added concise notes on all medical and surgical cases of special interest. Messrs. Cuthbert Wallace and Percy Sargent contribute a useful critique on Appendicitis, based on the last 1075 cases observed in St. Thomas's Hospital. Messrs. Ered Corner and H. Pinches discuss Torsion of the Omentum with a *résumé* of all recorded cases. There is a very interesting and sympathetic obituary notice of the late Sir John Simon, which pictures a side of his character but little known—that of hospital surgeon. The volume of Reports is well worthy of the great hospital from which it emanates. ***

DR. THOS. JOHNSTONE (translator of Professor Kraepelin's classic work on "Clinical Psychiatry" voices an opinion in his paper on "Dementia Præcox" which deserves to become axiomatic, that "age is a relative term; a man is as old as his bloodvessels, and lives till his heart batters him to pieces." ***

THE fifth edition of Professor G. N. Stewart's "Manual of Physiology" is now free of the press. It is an ideal text-book for students, and we hope shortly to refer to the many alterations and additions made by the author in this new edition. ***

We are glad to note that Dr. Bianchi's great work a "Text-Book of Psychiatry" has just been brought within the compass of English-speaking physicians, by Dr. J. H. Macdonald, physician to the Govan Asylum, who has translated it at the author's request. Bianchi, whose name is held in honour by alienists in all parts of the world, is now Professor of Clinical Psychiatry in the Royal University of Naples and Minister of Public Instruction in Italy.

Society of Apothecaries of London.

THE following candidates having passed the necessary examinations, have received the L.S.A. Diploma of the Society, entitling them to practise medicine, surgery, and midwifery:—W. G. H. Cable, M. O. Dollie, C. W. Gibson, J. P. B. Snell, R. J. S. Verity, and M. C. Vivian.

(a) "The Physiology and Therapeutics of Harrogate Waters, Baths and Climate, applied to the Treatment of Chronic Disease." By William Bain, M.D., M.R.C.P., and Wilfrid Edgecombe, M.D., F.R.C.S. 7s. 6d. net. Longmans, Green and Co., London, New York and Bombay. 1905.

NEW BOOKS AND NEW EDITIONS.

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

- SIDNEY APPLETON.** (London.)
Differential Diagnosis and Treatment of Disease. By Augustus Cailla, M.D. Illustrated. Pp. 867. Price 25s. net.
- BALLERE, TINDALL AND COX.** (London.)
Gynaecological Diagnosis: A Manual for Students and Practitioners. By Arthur E. Giles, M.D., B.Sc., &c. Illustrated. Pp. 212. Price 7s. 6d. net.
- The Treatment of Gonorrhoea in the Male. By C. Leedham-Green, M.B., F.R.C.S. Pp. 152, with 36 figs. Price 5s. net.
- The King's Coroner. Being the Practice and Procedure in his Judicial and Ministerial Capacities. By R. Henslowe Wellington. Vol. 2 (complete in itself). Pp. 148. Price 7s. 6d. net.
- Laboratory Manual of Physiology. By Frederick C. Busch, B.S., M.D. Illustrated. Pp. 206. Price 6s. net.
- Examination Questions for the Diploma of Public Health. By Hugh R. Jones, M.A., M.D., D.P.H. Pp. 100. Price 2s. 6d. net.
- J. F. BERGMANN.** (Wiesbaden.)
Leitfaden Studium der Experimentellen Biologie der Wassertiere. By J. v. Uexküll.
- Die Verletzungen der Nase und deren Nebenhöhlen. By F. Kopke.
- Über Missbildungen der Menschlichen Ghedmassen (Nene Folge). By Prof. Dr. F. Klaussner.
- Über das psychische Verhalten des Arztes und Patienten vor, bei und nach der operation. By Professor Dr. F. Klaussner.
- J. & A. CHURCHILL.** (London.)
Clinical Applied Anatomy; or, The Anatomy of Medicine and Surgery. By Charles R. Box, M.D., &c., and W. McAdam Eccles, M.S. F.R.C.S. Illustrated. Pp. 471. Price 12s. 6d. net.
- Essentials of Surface Anatomy. By Chas. R. Whittaker, L.R.C.S. L.R.C.P., &c. Pp. 40. Price 2s. 6d. net.
- Chavasse's Advice to a Mother. Sixteenth Edition, revised and largely re-written. By Thomas Dewich Lister, M.D. Lond. Pp. 454. Price 2s. 6d.
- CORNISH BROS., LTD.** (Birmingham.)
Diseases of the Rectum. By F. Victor Milward, M.B., B.C., &c. Pp. 193. Price 5s. net.
- ARTHUR C. FIFIELD.** (London.)
Curdled Milk: A Natural Key to Health and Long Life. By Dr. A. Montenius. Translated by Fredk. Rottwell, B.A. Pp. 59. Price 6d. net.
- WILLIAM GREEN AND SONS.** (London.)
The Cleansing, Disinfection, and Protection of the Hands. By Dr. Carl S. Haeger. Translated by Charles Heron Watson, M.A., M.B., &c. Illustrated. Pp. 218. Price 6s. net.
- T. C. AND E. C. JACK.** (Edinburgh.)
The Edinburgh Stereoscopic Atlas of Anatomy. Edited by David Waterston, M.A., M.D., &c. Section 4, containing 50 Stereographs. Price 25s. net.
- RICHARD J. JAMES.** (London.)
The Alcohol Problem in its Biological Aspect. By T. N. Kelnack, M.D., M.R.C.P. Pp. 143. Price 2s.
- H. K. LEWIS.** (London.)
The Liverpool Medico-Chirurgical Journal. Vol. XXV. 1905. Pp. 414. Price 7s.
- LONGMANS, GREEN AND CO.** (London.)
The Health of Our Children in the Colonies. By Dr. Lilian Austin Robinson. Pp. 182. Price 2s. 6d. net.
- MACMILLAN AND CO., LTD.** (London.)
Chemistry of the Proteids. By Gustav Mann, M.D. Ed., B.Sc. Oxon. Pp. 606. Price 15s. net.
- On Professional Education with special reference to Medicine. By T. Clifford Allbutt, M.A., M.D., &c., &c. Pp. 60. Price 2s. net.
- OLIVER AND BOYD.** (Edinburgh.)
Notes on Surgery for Nurses. By Joseph Bell, M.D., F.R.C.S. Ed. Sixth Edition, thoroughly revised. Pp. 187. Price 2s. 6d.
- REBMAN, LTD.** (London.)
On the Relations of Diseases of the Skin to Internal Disorders. By L. Duncan Bulkley, A.M., M.D. Pp. 175. Price 6s. 6d. net.
- W. B. SAUNDERS CO.** (Philadelphia.)
Reference Handbook of the Diseases of Children. By Prof. Dr. Ferdinand Fruhwald. Edited by Thompson S. Westcott, M.D. Illustrated. Pp. 533. Cloth, 18s. net.
- The Operating Room and the Patient. By Russell S. Fowler, M.D. Illustrated. Pp. 172. Price 10s. net.
- JOHN WRIGHT AND CO.** (Bristol.)
Lectures to Teachers on the Prevention of Infectious Diseases. By Wm. Berry, F.R.C.S.I. Pp. 64. Price 6d. net.
- First Aid to the Injured and Sick. By F. J. Warwick, B.A., M.B. Cantab., &c., &c., and A. C. Tunstall, M.D., F.R.C.S. Ed. Fourth Edition. Pp. 242. Price 1s. net.

OBITUARY.

JOHN CHESTNUTT, B.A., L.R.C.S. & P. ED., V.D.

THE death occurred at Matlock on February 4th, of Mr. John Chestnutt, of Howden, Yorkshire, at the age of fifty-five years. Mr. Chestnutt was a native of Ireland, being son of the late Rev. Wm. Chestnutt, of Tralee. He had a distinguished college career, being senior scholar, exhibitioner and prizeman. He graduated B. A. with honours at the Queen's University obtained the licence of the Royal Colleges of Physicians and Surgeons, Edinburgh. His College course was at Cork, Leeds, and Edinburgh. He settled at some twenty-five years ago. He was

medical officer to the district workhouse to the post-office staff, and various clubs, and enjoyed an extensive practice, being extremely popular with all classes. He was a member of the St. John's Ambulance Association, and was for many years Lecturer and Examiner through his efforts also the Howden Nursing Association was formed for work among the poor. An ardent volunteer, he retired a few years ago with the rank of Major and was awarded the volunteer decoration for long and good service; he rejoined in the medical department as Surgeon-Lieut. and was gazetted surgeon Major a week before his death. He was a Fellow of the British Gynaecological Society and member of the British Medical Association, of the Royal Society of Antiquaries, Ireland, and Archæological Society of Yorkshire.

THOMAS EDMONSTONE CHARLES, M.D., LL.D. ED. F.R.C.P. LOND.

WE regret to announce the death of Surgeon-General Thomas Edmondstone Charles, M.D., late of the Indian Medical Service and an honorary physician to the King, on March 2nd, at Flushing, Falmouth, in his seventy-second year. He was born in Calcutta and educated in Edinburgh; an M.D. of Edinburgh in 1885, and also studied in Paris and Berlin. In 1856 he entered the Bengal Medical Service, and went through the Indian Mutiny. For some time he was Superintendent General of Vaccination and Professor of Midwifery in the Medical College at Calcutta. He retired from the Indian Medical Service in June, 1883, as a deputy-surgeon-general, and since that date had been an honorary physician to her late Majesty and the King. For several years afterwards he practised with great success at Cannes. In 1895 he received the degree of LL.D. from his university. He has left behind the bright example of an honourable and strenuous career.

JOHN DAVIES JAMES, M.R.C.S. ENG., J.P., D.L.

DR. JOHN DAVIES JAMES, of The Grove, Blackwood, died on Sunday at the age of seventy-two. He was the second son of Mr. Edmund James, of Tynemoyd. He was medically educated at St. Bartholomew's Hospital, and became a member of the Royal College of Surgeons in 1857. In the same year he took up his residence at The Grove, Blackwood. After achieving a reputation as a skilful practitioner, Dr. James retired in 1890 from the profession, to which for over thirty years he had devoted himself. He was placed on the commission of the peace in 1869. In 1871 he was elected a member of the first Bedwelley School Board. Dr. James was made Alderman in November 1903. In 1897 he became chairman of the Bedwelley Division of county justices, and performed the functions of the office with an ability that secured the approval of his colleagues and the esteem of the general public. The position of deputy-lieutenant for the county was one that when conferred upon Dr. James gave lively satisfaction to a host of friends and well-wishers. In politics he was a Conservative, and in religion a Churchman.

The Royal Waterloo Hospital.

THE energetic authorities of the Royal Waterloo Hospital for Children and Women have issued a preliminary prospectus of an enterprise on a very large scale, which is to take place at the Crystal Palace, Sydenham, in June next, the proceeds being devoted to the special appeal fund of the hospital referred to. The entertainment will consist of a reproduction of the Nice Carnival, with processions of decorated cars, battle of flowers, costume ball, etc. The entire fêtes are being organised by E. Douglas White, and several prominent members of the theatrical profession have kindly offered their services.

H.R.H. THE DUCHESS OF CONNAUGHT has consented to inaugurate the Elizabethan fair and fête which is to be held in London next May in aid of the King's College Hospital Removal Fund. In connection with the same Fund the directors of Messrs. Harrods (Limited) have made a donation of 2,000 guineas.

MEDICAL NEWS IN BRIEF.

Crier and Wife v. Hope and Currie.

THE hearing of this case, on the 8th inst., in the King's Bench was concluded. The plaintiffs, Mr. and Mrs. Crier, sued a firm of medical practitioners, practising at Hanwell and West Ealing, to recover damages for alleged negligence on the part of Dr. Currie, whereby he was said to have conveyed scarlet fever infection to the female plaintiff. The defendants denied liability. Mr. Justice A. T. Lawrence, in summing up to the jury, said the plaintiffs were not entitled to demand the highest skill in their medical men, but only the reasonable skill and care of the ordinary doctor. It had been said that if a doctor went from an infectious case to a case of confinement, even though he took precautions, he did it at his own risk. He thought for himself that that was putting the case too high. Dr. Currie was told that the confinement was expected on November 15th, but, as they knew, the fixing of these dates was always somewhat uncertain. On the 14th, he saw the little girl at Mrs. Miller's suffering from scarlatina, and the next day he visited the boy, who was also infected. It was said that, knowing that the confinement was expected on the 15th, he ought not to have made these visits; but it seemed to him that in the case of a general practitioner it would be rather straining things to lay down such a rule. To his mind the whole case turned on the question of the precautions he took before seeing Mrs. Crier. Then it was said he should have sent another doctor; and this raised a more difficult question. Was it negligent not to do so? That depended upon whether he thought the precautions he had taken were adequate or not. If he thought they were not he should have sent for another doctor, without doubt. That brought him to the chief question: Were the precautions those which a reasonably skilful doctor would take? On this the evidence of the doctors for the plaintiffs and defendants was divergent. [His Lordship described the precautions as detailed by Dr. Currie.] He had walked to visit a patient, and then half-a-mile to a cabstand. The plaintiffs contended that this was not sufficient, that all the clothes should have been changed. The defendants' reply was that this was a counsel of perfection not practicable in actual practice. Where an epidemic was raging it would be impossible for a medical man to take a bath and change his clothes after visiting every infectious case. As to what took place subsequently, it was alleged that Dr. Currie had made untrue statements, and he had admitted that he had not been altogether candid. If they thought that this showed that he knew he had been guilty of a want of care these statements were important, otherwise they were less important. Dr. Currie had frankly admitted that he had intended to mislead Mr. Crier in speaking of his attendance on scarlatina cases. The jury retired to consider their verdict at 12.25. They returned into court at 1.45, and the foreman said that they all agreed that Dr. Currie had taken the usual precautions, and found a verdict for the defendants. The learned judge gave judgment for the defendants on the question of negligence, with costs. Stay of execution was granted on the usual terms.

Royal University of Ireland.

At a meeting of the Senate on Wednesday, March 7th, 1906, a letter was read from the Rt. Hon. the Earl of Meath, K.P., intimating that for the reasons stated therein, he had placed his resignation as Chancellor of the University in the hands of his Excellency the Lord Lieutenant. The following resolution was unanimously adopted:—"The Senate have heard with great regret that the Earl of Meath has resigned the office of Chancellor of the University, and they take this opportunity of expressing their high sense of the

whole-hearted devotion with which he applied himself during the period for which he held office, to the work of the University, and to the promotion of its interests."

The following resolution, to consider which the meeting was specially convened, was proposed by the Most Rev. Dr. O'Dwyer, Bishop of Limerick, seconded by Rev. Dr. Hamilton, and adopted:—"That the Report of the Royal Commission in its animadversions on this University as an examining body, indicated truly the essential defect in its constitution, and we believe that its reform in this respect, so as to make it a technical university with colleges adequately constituted and brought into organic connection with it, is a matter of urgent need both for the University itself and for the interests of higher education in the country." And it was ordered that copies be sent to his Excellency the Lord Lieutenant, the Prime Minister, and the Chief Secretary.

Irish Medical Schools' and Graduates' Association.

THE Annual Festival Dinner of the Irish Medical Schools and Graduates' Association will be held on Saturday next, March 17th (St. Patrick's Day), at 7.30 p.m., in the Grand Hall, Hotel Cecil, Strand. The guest of the Association will be General Sir John French. Applications for tickets from members to be sent to E. Canny Ryall (hon. sec.), 85, Harley Street, London. W.

University of London.

THE following candidates have passed the Intermediate Examination in Medicine:—Eileen Elizabeth Allen, Malcolm Edward Ball, Frederick Michael Bishop, Herbert Orpe Brookhouse, John Philip Buckley, Arthur Laurence Candler, Bernard Arthur Cheadle, Joseph Harry Clarke, Ernest Neville Cook, Ethel Constance Cousins, Lawrence Croft, Aston Ridley Dale, Arthur Davies, Trevor Berwyn Davies, Newton Charles Davis, Canut Deunzter, Ethel Adelaide Douglas, Evan Parry Evans, Thomas Evans, William Vincent Field, Josephine E. L. Griffiths, Ethel Margaret Eades Hall, George Blenkhorn Harland, William Roberts Harris, Fredk. Whewell Hogarth, Sidney Ernest Holder, Kenneth Hill Hole, Habibmia I. Janmahomed, David Judah, Arthur Norman Leeming, Alfred Everard Lees, Herbert Cubitt Lucey, Edmund Garvin Mack, Claude Herbert Marshall, Edward Kenneth Martin, John Birch Martin, Howard Edwd. Hall Mitchell, Max H. Edwd. R. Montesole, Mark Alleyne Nicholson, Owen Brynrog Parry, Mary Elizabeth Parsons, Eustace M. Parsons-Smith, Philip Seymour Price, Thomas Edwin Pryce, Douglas Reynolds, Rowland Waters Rix, Mabel Russell, Arthur Fredk. Sanderson, Harold Willis Scawin, John Edward Scudamore, Frank Standish, Tom Stansfield, Horace Elliot R. Stephens, Kenneth Henry Stokes, Hugh Stott, Gravenor Robert Strong, Geoffrey Viner, Dora Muriel Watney, Lilian Enid Watney, Richard Tudor Williams.

THE Twenty-third Annual Congress of the Royal Sanitary Institute will be held at Bristol, July 9th to 14th, 1906, under the presidency of the Rt. Hon. Sir Edward Fry, D.C.L., F.R.S. Her Grace the Duchess of Beaufort will preside over the Ladies' Conference, and the following will act as presidents:—Section I., Sanitary Science and Preventive Medicine, Sir William J. Collins; Section II., Engineering and Architecture, Edwin T. Hall, Esq.; Section III., Physics, Chemistry and Biology, W. N. Shaw, Esq.

MESSRS. Thomas Lewis, M.B., B.S.; C. S. Parker, M.B., B.S., F.R.C.S.; W. B. L. Trotter, M.S., F.R.C.S., Graduates in the Faculty of Medicine of the University of London, have been elected to Fellowships in University College.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

A Case of Tuberculosis of the Pregnant Uterus and Placenta is recorded by Ph. Jung (*Monatsschrift f. Geb. und Gynäkol.*, February, 1906). He thinks it most probable that the placenta became infected through the circulation, owing to the numerous tuberculous deposits all over his patient's system. This agrees with the observations of Schmori and Geipel. The possibility, however, exists in the author's case that the placental infection was due to the tuberculous alterations which existed in the genital organs and peritoneum. In this case, as in two from Schmori and Runge, the placental infection occurred not at the end, but during the progress of the pregnancy, at any rate, before the eighth month. Schmori emphasises that in his two early cases the tuberculous process was localised in the decidua basalis. This was also found by author. Schmori and Geipel believe that a longer or a shorter time before the normal end of pregnancy, tuberculous alterations of the decidua basalis cause hæmorrhages which can lead to premature delivery. From the twenty cases recorded it is proved that tuberculosis already in utero can extend to the child, and a hereditary infant tuberculosis must be recognised. G.

To the Etiology of Fatal Post-Partum Atony Ed. Martin (*Monatsschrift f. Geb. und Gyn.*, February, 1906) contributes details of a case in which, after delivery of the child, such severe hæmorrhage set in that manual removal of the placenta became necessary. This was not possible. The placenta was so closely united to the uterine wall, only a small portion could be removed in little fibrous pieces. The uterus was so extremely thin and flabby that the intestines could be easily felt through it. In spite of hot douching, massage, and tying of the uterine arteries the patient was not saved. On examination of the uterus, the placenta which was inserted from fundus to the internal os seemed in several places to have almost grown through the uterine wall. The muscle clothed the placental mass as a thin layer of tissue. Microscopically, there is an irregularly thin layer of chronically inflamed muscle into which the placental tissue has more or less penetrated. Nitabuch's line is present. Only a trace of the decidua basalis is to be discovered. Author considers that it is very probable that at the time of the implantation of the ovum the uterine wall was in a more or less advanced state of inflammation. The mucous membrane being in a diseased condition, its decidual reaction had produced such a weak resistance in some places to the trophoblast that the basalis was soon overcome, and the former fastened itself directly on the muscular layer. The cause of the atony which must have begun in the first stage is the insufficiency of the muscular layer. It may be considered as certain in this case that the penetration of the cells into the uterine wall was not the result of absence of the basalis, but that the latter, springing from diseased mucous membrane had been quickly destroyed. The large placenta was probably due to an effort to get sufficient nutriment from its diseased bed. G.

A Case of Puerperal Fever Cured through Total Extirpation of the Uterus is recorded by Dr. Oscar Vértés (*Monatsschrift f. Geb. und Gyn.*, February, 1906). The patient had a fibroid uterus. The tumours obstructed the delivery of the child, and prevented the delivery of the placenta. The latter was removed manually. On the third day after delivery, the temperature rose to 39° C, pulse 120, after a rigor. The patient suffered from sapræmia. Her uterus was douched daily. The temperature did not again rise higher than 38.7° C., the pulse varying

between 100 and 120 till the evening of the eighth day, when there was another rigor and the temperature rose to 40°, pulse 140. The general condition of the patient was completely changed. She was evidently very ill, and probably septicæmia had now taken the place of the sapræmia. Owing to this, and to the fact that the myomatous uterus would possibly give trouble afterwards, the operation was decided on before the patient could become completely infected. The abdominal route was chosen. The pelvic peritoneum forwards and backwards was sewn to the wall of the vagina, and a gauze drain inserted from the vagina to the abdominal cavity. As indications for the operation, Dützmänn came to the conclusion from his blood examination in many cases of puerperal and post-operative sepsis, that we can make a prognosis with more or less certainty from the number of the leucocytes. When the latter are increased in number the prognosis is good; where there is diminution death is, as a rule, to be expected. The weakened sickly organism is not always in a position, after fighting for a certain length of time, to produce so many leucocytes as may be sufficient to resist the invading bacteria. When it is possible for us therefore to remove the source of infection before too many bacteria have got into the circulation the patient is saved. The leucocyte counts together with the bacteriological examination of the blood will act as a thermometer of the resisting power of the organism. Sometimes, of course the virulence of the infection is so great that the patients, even though operated on at the earliest stage, die. These cases of "foudroyant" sepsis are, however, rare. The majority present the usual picture of septicæmia or pyæmia. Prochowink von Leopold, Fehling, and others consider the operation contra-indicated when the infection has extended past the uterus. G.

Treatment of Retroflexion of the Uterus by the General Practitioner—Stoedel (*Berlin Klin. Woch.*, December, 1905) believes that in uncomplicated cases of retroflexion the treatment should be rather by conservative methods than by operation. Not every case diagnosed needs correction. Many cases are entirely without symptoms, especially in virgins and old women. Treatment is demanded when bladder symptoms, backache, menorrhagia, and leucorrhœa exist; and for these cases, when there are no adhesions, the author uses a pessary which very often gives relief. When pregnancy exists with retroflexion, it becomes necessary to replace the uterus by gentle bimanual manipulations before introducing the pessary, and to have the patient lie in bed on the side until the uterus has risen above the promontory. Incarceration means gangrene of the uterus from pressure, and the beginning of this is indicated by severe bladder complications. In difficult cases of replacement a catheter is placed in the bladder and the patient put to bed; after a few days an attempt is made to replace the uterus, no narcosis being necessary. The author seizes the vaginal portion of the uterus with forceps, pushes it forward, pushes the fundus up with two fingers of the other hand, and then draws back the cervix. Sterility as arising from retroflexion is doubtful, but in some cases pregnancy takes place after reduction of the deformity. Whether retroflexion is responsible for hysteria is undecided; the application of a pessary often gives relief to the nervous symptoms. The sound should seldom be called into use during manipulations, and when severe pain is produced it is time to stop. Douching is only necessary when there is excessive leucorrhœa. Treat-

ment by pessaries is inapplicable when the retroflexion is complicated by marked prolapse, diseases of the adnexa, salpingitis, tumours, &c., and the symptoms are due to the complications, not to the false position. Glycerine tamponade, rest in bed, local heat, massage, &c., must be used and operation later if relief is not obtained. For the poor working woman we must counsel operation, as she cannot spare the time or strength for long treatment.

F.

Recent Researches into the Bacteriology of Peritonitis in Relation to Pelvic Surgery. By Percy Sargent (*Journ. of Obstetrics and Gyn.*, February, 1906).

Peritonitis is no longer regarded as an independent disease, but is rightly recognised as a serious complication of many widely different pathological conditions. The means by which the peritoneum may become infected are: By accidental operation wounds, by rupture of a hollow viscus, cyst or abscess; by passage of micro-organisms from an inflamed unruptured hollow viscus, cyst, or abscess; by the indirect infection of blood extravasated into the peritoneal cavity in too great a quantity to be disposed of by the natural peritoneal absorption, and by infection by way of the blood stream as in septicæmic peritonitis. What are the micro-organisms which are responsible for the peritonitis arising from these causes, what is their relative frequency, and how may they be scientifically dealt with? The author found that by examining bacteriologically all kinds of peritoneal lesions in many different stages, and by considering the subject as a whole, he was able to differentiate certain types according to the type of infection. The most important and frequent organisms concerned in peritonitis are the staphylococcus albus and the colon bacillus. After these may be placed the streptococcus pyogenes, bacillus pyocyaneus pneumococcus, gonococcus, and rarely the staphylococcus aureus. He places the staphylococcus albus first because it is the organism most frequently found in the peritoneal cavity. It appears, however, to exercise an influence which is the reverse of harmful, for it undoubtedly provokes the appearance of an exudate containing vast numbers of phagocytic cells, on whose presence and their power of dealing with organisms, the chances of recovery depend. In cases of localised pericæcal suppuration, this staphylococcus is found beyond the limits of the abscess in 77 per cent.; when the abscess has been dealt with, and the patient returns some weeks later for the removal of the appendix, the coccus is still present upon the peritoneum in the cæcal region in 62 per cent. The colon bacillus, in one or other of its varieties, is undoubtedly the commonest causative agent of peritonitis, and may exhibit a degree of virulence second only to the streptococcus pyogenes. Apart from puerperal peritonitis, the streptococcus pyogenes is of comparatively rare occurrence as a cause of peritonitis. When present it causes a rapidly fatal form, for the leucocytes appear to be powerless against the infection. The other organisms mentioned as causes of peritonitis in general may be said to be of rare occurrence. In the consideration of the peritonitis arising from diseases of the female pelvic organs the relative frequency of these various organisms becomes altered, and as they vary greatly in their virulence, and the less virulent are most often met with, it follows the mortality from peritonitis in this region is low compared with that of peritonitis in general. The author next deals with the peritonitis met with in gynaecological work. One of the simplest forms is that which follows hæmorrhage into the peritoneal cavity as in extra-uterine gestation. It has been established that there is to be found in the peritoneal cavity and especially in the older clot a white staphylococcus of a low degree of pathogenicity. It is the organism found so frequently in cases of intestinal obstruction and strangulated hernia, and it is the organism which, when inoculated into the peritoneal cavity of guinea pigs, produces such an abundant leucocytosis as to protect the animal against an otherwise lethal dose of the colon bacillus. This white staphylococcus causes both the peritonitis

and the fever. In more than half the cases of pyosalpinx, no organisms are found, the contents of these sacs would therefore be harmless, nearly half the remainder show evidence of the gonococcus, and Dudgeon has shown with the author that the gonococcus can be an actual and probably is, a common cause of peritonitis. In three fatal cases of inflamed ovarian cysts, the lethal organism in two was the colon bacillus and in one the streptococcus pyogenes, though this latter organism is only rarely found with appendicitis. These cases are bacteriologically similar to cases of peritonitis arising from appendicitis and the resemblance is borne out by the white staphylococcus being found in pure culture at a distance from the primary focus of infection. The author concludes that: Pathology teaches that in mild infection, when there is much foreign material to be removed, copious and general irrigation should be employed, but that in the more virulent infections the cleansing treatment should be strictly localised, so as to avoid spread of infection, and removal of turbid exudate containing phagocytes. Bacteriology and practical experience teach:—that drainage is unnecessary in peritonitis, intra-peritoneal hæmorrhage and pyosalpinx, but when arising from a suppurating ovarian cyst, a drain should be employed; that localised collections require ordinary abscess treatment; that opium masks symptoms, favours intestinal paralysis, prevents omentum playing part of scavenger, and inhibits leucocytosis.

F.

Albuminuria in Pregnancy.—Sharp (*Brit. Med. Journ.*, February 24th, 1906) reports a case of "Albuminuria in Pregnancy; Epistaxis; Conjunctival Hæmorrhage," occurring in a secundipara. He was called on January 5th to see the patient, who was suffering from severe epistaxis, which was controlled only by plugging by Bellocq's method. Some hours later she was confined of a still-born seven and a half to eight months' child, and her recovery was uninterrupted. Examination of the urine three days later revealed about 1 part per 1,000 of albumin, and the ophthalmoscope showed a hazy swelling round the optic disc of one eye and a patch of greyish white degeneration. Further it was noticed that blood was slowly dripping from the conjunctival surface of the lower lid on the right side, the side from which most of the bleeding from the nose had come. No blood could be seen coming from the canaliculi or nasal duct. H.

Childbirth after Colotomy.—Under this heading, Dr. Mitchell (*Brit. Med. Journ.*, March 3rd, 1906) relates the following history: A multipara, æt. 28, suffering from complete obstruction due to malignant disease of the rectum, was operated on—left inguinal colotomy being performed, the patient having previously refused an extensive operation. This was in March, 1905. The result of the colotomy was very satisfactory, all the symptoms of obstruction being relieved and almost complete control over the evacuations was obtained. A few months subsequently the patient was found to be pregnant. On January 10th, 1906, less than ten months after the operation, the patient was delivered after podalic version by the combined method had been performed, owing to obstruction caused by the mass of malignant disease in the rectum. The child, weighing 10 to 11 lbs., was full term and living. During the period of gestation there had been no trouble save for pain in the rectum. The puerperium was normal and the patient's condition is fairly comfortable, no secondary deposits having manifested themselves.

H.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "*Recent Medical Literature.*"
- (2) "*Recent Surgical Literature.*"
- (3) "*Recent Gynaecological and Obstetrical Literature.*"
- (4) "*The Recent Literature of Physiology, and Pathology.*"

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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.

UNQUALIFIED PRESCRIBING.

WA correspondent draws our attention to the fact that certain unqualified persons in the West-End of London are issuing prescriptions to patients. The prescription is drawn up in the usual way, except that the "R" is omitted, together with the final "Misce, fiat mistura." The paper is initialed. Our correspondent asks if such a document does not lay the writer open to prosecution. If the unqualified prescriber took a fee we should imagine that he or she would be prosecuted. In any case we should be glad to receive full information of any such cases that may come under the notice of our readers. It would be essential to secure the documents incriminating, with full statements as to facts.

DR. A. D.—Your point as to the origination of the "expression plan" is of course quite right. In regard, however, to your second point, you forget that though the bed clothes are in contact (as you say) with the vulva for hours, they do not get into the vagina, and in our mind there is a wide difference between the vulva and the vagina. At the same time we, personally, do not allow bed clothes to remain in contact with the vulva, as we are accustomed to treat the latter in a manner very similar to that we adopt in treating an incision into the abdominal cavity.

LAUDANUM AND INFANTILE MORTALITY.

A mixture of laudanum and aniseed, frequently used as a soothing mixture for babies, was, said Dr. Marriott, the presiding magistrate at Stockport, responsible for the death of 15,000 babies every year.

R. M. O. (Midlands).—The outcry against understaffing of the nursing department in Poor-Law infirmaries is of old standing. The only way in which the matter is likely to be made public is when some scandal occurs more or less directly due to inadequacy or inefficiency of nursing arrangements. It is difficult to give advice. Too often scandals are hushed up. The matron, again, is tempted to sweat the nurses and to cut down the staff in order to keep in favour with cheese-paring guardians. The medical man who honestly protests probably brings a hornet's nest around his ears.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MARCH 14th.

HUNTERIAN SOCIETY (Court Room, Guy's Hospital).—3.30 p.m. Cases can be examined. 4 p.m. Clinical Afternoon Meeting.

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

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m. Erasmus Wilson Lecture:—Mr. J. Sherren: The Distribution and Recovery of Peripheral Nerves studied from Instances of Division in Man.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. M. White: Clinique. (Surgical). 5.15 p.m. Lecture:—Dr. F. Stewart: The Cerebro-Spinal Fluid and its Diagnostic Importance.

THURSDAY, MARCH 15th.

CHILDHOOD SOCIETY AND THE BRITISH CHILD-STUDY ASSOCIATION (Parkes Museum, Margaret Street, W.).—8 p.m. Lecture:—Dr. J. W. Slaughter: Imagination in Childhood. (Arranged by the Childhood Society.)

ROYAL COLLEGE OF PHYSICIANS OF LONDON (Fell Mall East).—5 p.m. Goulstonian Lecture:—Dr. E. B. Shaw: Auto-Intoxication.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m. Lecture:—Dr. Langdon Brown: Therapeutical Applications of Adrenalin and Allied Bodies.

FRIDAY, MARCH 16th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, Cavendish Square, W.).—5.30 p.m. Cases and Specimens will be shown by Dr. W. Ewart, Dr. C. O. Hawthorne, Dr. E. Pritchard, Dr. F. J. Poynton, Dr. E. Cautley, Dr. K. E. Hay, Mr. D. Drew, Mr. H. Lett, and others.

EPIDEMIOLOGICAL SOCIETY (11 Chandos Street, Cavendish Square, W.).—8.30 p.m. Paper:—Dr. J. T. C. Nash: Evolution in Relation to Disease.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m. Erasmus Wilson Lecture:—Mr. J. Sherren: The Distribution and Recovery of Peripheral Nerves studied from Instances of Division in Man.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. M. Yearsley: Clinique. (Ear.)

Vacancies.

Birkenhead and Wirral Children's Hospital, Woodchurch Road, Birkenhead.—House Surgeon. Salary £100 per annum, with board, residence, and laundry. Applications to F. W. Archer, 25, Storeton Road, Birkenhead.

Bradford Children's Hospital.—House Surgeon. Salary £100 per annum. Applications to C. V. Woodcock, Secretary.

Bristol House Private Asylum, Bristol.—Assistant Medical Officer. Salary £180 per annum. Applications to the Resident Licentiate.

British Ophthalmic Hospital, Jerusalem.—Assistant Surgeon. Salary £300 a year, with residence. Applications to R. Brudenell Carter, F.R.C.S., 76 South Side, Clapham Common, S.W.

Corporation of Sheffield.—Fever Hospitals.—Junior Assistant Medical Officer. Salary £120 per annum, with board, lodging, and washing. Applications to H. Sayer, Town Clerk, Town Clerk's Office, Town Hall, Sheffield.

Dr. Steevens' Hospital, Dublin.—Anesthetist. Applications to the Secretary at the Hospital.

King Edward VII. Sanatorium (Midhurst).—Assistant Medical Officer. Salary £150 per annum, with board and residence. Applications to the Secretaries, 35 Seymour Street, Portman Square, London, W.

Lancashire County Asylum, Winwick, Warrington.—Assistant Medical Officer. Salary £150 per annum, together with furnished apartments, board, attendance, and washing. Applications to the Medical Superintendent.

Metropolitan Hospital.—Casualty Officer. Salary £150 per annum. Applications to Charles H. Byers, Secretary.

Middlebrough.—North Ormesby Hospital.—House Surgeon. Salary £120 per annum, with apartments and board. Applications to R. T. Milner, Secretary, Royal Exchange.

Taunton Isolation Hospital.—Medical Attendant. Salary £120 per annum. Applications to W. F. B. Daws, Clerk.

The London Hospital Pathological Institute.—Director. Salary £200 per annum. Applications to Munro Scott, Warden, The London Hospital Medical College, Turner Street, Mile End, London, E.

West Kent General Hospital, Maidstone.—House Surgeon. Salary £120 per annum, with board and residence. Applications to W. C. Lewis, Secretary.

West Norfolk and Lynn Hospital, King's Lynn.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to the Chairman of the Hospital.

West Riding County Council.—Scalebar Park (Private Asylum), Burley-in-Wharfedale.—Assistant Medical Officer. Salary £150 per annum, with board, furnished apartments, attendance, &c. Applications to the Physician Superintendent.

Appointments.

HEGGS, T. BARRETT, M.D., Ch.B.Aberd., D.P.H.Camb., Medical Officer of Health to the combined Districts of Sittingbourne and Milton, and Medical Superintendent of their Isolation Hospitals.

HITCHINS, CHARLES VERNON, M.R.C.S. L.S.A., Honorary Consulting Surgeon to the Weston-super-Mare Hospital.

MATLAND, LYTTON, M.B., B.S.Lond., House Surgeon at the Great Yarmouth General Hospital.

MASEWELL, JOHN WILLIAM, M.R.C.S., L.R.C.P.Lond., an Honorary Medical Officer to the Chorley Dispensary and Rawcliffe Hospital, THOMPSON, WILBERFORCE, L.R.C.P.Lond., M.R.C.S., L.S.A., D.P.H. Lond., Medical Officer of Health for the Bridgwater (Somerset) Rural District.

TOSWILL, LEONARD ROBERT, M.R.C.S., L.R.C.P.Lond., Honorary Surgeon to the Exeter Dispensary.

TREBIDDER, WILLIAM ELLIOT, M.B., B.S.Lond., Medical Officer for the Chudleigh District by the Newton Abbot (Devon) Board of Guardians.

WOODHOUSE, ORCIL, M.D., B.C.Cantab., Clinical Assistant to the Chelsea Hospital for Women.

Births.

HARRIS.—On March 2nd, at the Manor House, Southwick, the wife of Henry Arthur Clifton Harris, M.R.C.S., L.R.C.P., of Brighton, of a son.

SIBLEY.—On March 8th, at Abercorn, Hanger Lane, Baling, the wife of Osbert Carden Sibley, L.P. and L.S.A.Lond., of a son.

WILLIAMS.—On Jan. 31st, the wife of E. Bridgman Williams, M.R.C.S., of Newcastle, Natal, S. Africa, of a daughter.

Marriages.

HORNIBROOK-THOMSON.—On March 7th, at the Chapel Royal, Dublin Castle, Murray Hornibrook, Esq., of Templemore, Co. Armagh, to Gladys, only daughter of Sir William Thomson, M.D., M.Ch., L.R.C.S.I., Hon. Surgeon to H.M. the King in Ireland.

PURSER-INGLIS.—On March 10th, at St. Andrew's Church, Upper Norwood, Captain L. M. Purser, Royal Army Medical Corps, to Hilda, youngest daughter of the late A. B. Inglis, Esq., of Calcutta, and Mrs. Inglis, of Upper Norwood.

Deaths.

BLYTH-WYNTER.—On March 11th, at Cairo, Annie Elizabeth, wife of A. Wynter-Blyth, M.R.C.S., of St. Marylebone.

MEEBREWSTER.—On March 7th, at Simon's Bay, Cape Colony, from malignant malarial fever, Staff-Surgeon Alworth L. Merewether, M.B., B.S., M.R.C.S., L.R.C.P., Royal Navy, I.I.M.S. "Crescent," aged 38 years.

MEYRICK-JONES.—On March 8th, at Rio de Janeiro, Arthur M. Meyrick-Jones, F.R.C.S.E., eldest son of the Rev. G. M. Meyrick-Jones, of Stanley House, Gloucestershire, aged 43.

PATERSON.—On March 9th, at 46 Beaumont Street, Portland Place, London, Adam Black Paterson, M.D., aged 81.

STARK.—On March 7th, at Torquay, Mark Dugald Stark, M.D., of 6 Broad Street, Oxford.

WILLIAMS.—On March 7th, at Abernig House, Talgarth, B.S.O., Breconshire, Thomas Edward, F.R.C.S.E., J.P., in his 65th year.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, MARCH 21, 1906.

No. 12

NOTES AND COMMENTS.

A False and Defamatory Libel.

MEDICAL men are specially open to attempts at blackmailing. There can be little doubt that many such charges have attained their nefarious object because of the difficulty of proving their falsity. Nowadays the services of the Medical Defence Union or of one of the junior protection Societies are available for their members. Sooner or later the attack of the blackmailer has to be faced by almost every member of the profession, no matter what his rank or standing. Early in the present month a man named Foxlee pleaded guilty at the Central Criminal Court for uttering a false and defamatory libel concerning Dr. Arthur Waddell, of Potter's Bar. The reckless bitterness of this wretched person led him into the actual publication of a circular, in which he stated that the prosecutor was intoxicated and neglected his duties while attending his wife on a certain date. Further, he charged Dr. Waddell with performing upon his child a cruel and unnecessary operation, whereby permanent injury had been inflicted.

The Bitter Bit.

READING between the lines, the apparent motive of the attack was blackmail, nothing more nor less. That was the view taken by the prosecuting counsel when detailing the annoyances and threats which Foxlee inflicted upon his victim. Letters advising settlement with a view to avoid publicity being disregarded, the matter culminated in the issue of the libellous circular. Fortunately Dr. Waddell is not the kind of man to become the prey of blackmailers. He prosecuted Foxlee for libel with the result that the defendant on promising not to repeat the libel, was bound over in two sureties of £50 to come up for sentence if called upon. At the same time the Recorder told Foxlee he was extremely fortunate in not having been indicted for attempting to extort money by threats of publishing the libel, for if he had been convicted he would have been sent to prison. The law is surely defective if it cannot imprison a man for conduct so base and criminal as that pleaded guilty to by the defendant. The absolute falsehood of the libel may be inferred from the single fact that Dr. Waddell is a total abstainer. We congratulate him on his prompt vindication of his own reputation and of the honour of his profession.

A Tooth Extractor.

A CURIOUS case has just been before the Coroner's Court at St. Helen's. The evidence showed that a boy of eight was taken by his father to the market place of that town on January 19th last, when he had two teeth extracted

by a "lightning tooth extractor," named Mitchison. Another "extractor" subsequently removed two stumps said to have been left behind by the first operator. The poor boy died on March 4th as the result of septic infection. The gentleman with the claims to lightning speed stated that he had three places of business in St. Helen's, and had been an extractor of teeth for about sixteen years, and on certain days extracted teeth in the market gratis. The jury found death was due to blood poisoning, but did not attach any blame to anyone. The illogical state of English law as regards the Dental Acts, could hardly be better illustrated. Although the science and practice of dental surgery has been placed on a definite and legitimate basis, it is, nevertheless impossible to put an end to that dangerous and reckless pest of society—the itinerant tooth extractor.

A Chemist's Error.

THE action brought by an Arbroath minister against a local chemist for the wrongful dispensing of medicine, whereby the pursuer's daughter was injured, has been settled on appeal. The fact that strychnia was dispensed instead of codeia was admitted. The Sheriff who delivered judgment appears to have confined himself mainly to the question of damages, which were laid at £100. The chief point insisted upon in the decision was that the extent and amount of the resulting injury was not definitely proved. The former decision was sustained, namely, that the defender should pay the expenses of the action, with the exception of certain fees for analyst and other expert evidence, together with three pounds damages. The result of these protracted lawsuits is not encouraging to persons who may in the future suffer from careless dispensing.

Salicylic Acid in Jam.

THE dismissal in Liverpool of another prosecution for the use of salicylic acid as a food preservative adds to the prevailing confusion upon a vital question. The prosecution has asked leave to state a case, and it is to be hoped that appeal will settle the point definitely one way or the other. Medical testimony in the case was contradictory. One set of witnesses maintained that salicylic acid in jam was harmful and the other harmless. For our own part we fail to see why properly made jam wants the addition of a chemical preservative. With proper boiling and proper packing jam should keep sound and wholesome for many years. The addition of preservatives to such perishable food as sausages stands on another footing. In the interests of the public the whole question of food preservatives should be authoritatively and definitely settled.

LEADING ARTICLE.

PUBLIC NEWSPAPERS AND QUACK ADVERTISEMENTS.

WE are happy to believe that the public newspapers of the United Kingdom may on the whole be regarded as high in principle and aim. As regards the particular detail of quack advertisements, however, with hardly a single exception, their attitude is one of reckless and venal negligence. It is hardly possible to pick up at random any daily or weekly journal published in this country that does not contain advertisements of so-called remedies and "cures" of an obviously false and therefore fraudulent nature. The purchasers of worthless medicines or apparatus are induced to spend their money on the strength of the lying assertions contained in the puffs, for which a high rate of payment is exacted by publishers. In other words, the proprietors of such a journal, the editorial staff and all who make a living, directly or indirectly, out of the publication partly draw their living wage from money wrung out of the pockets of the poor, the sick, and the afflicted, by the lying statements of quacks. Yet while this pernicious practice is swelling the profits of the journal on the one hand, the editor on the other may be posing as a representative of the highest ideals of justice, freedom, and uprightness. Following our usual practice, we take up a journal at random in order to illustrate our remarks. This week we turn to *Reynolds' Sunday Newspaper*, a journal which is particularly loud and emphatic in its appeals to a higher social and political morality. It seems to us that it is futile for the Editor to fan the flames of social unrest with unsparing zeal in the interests of the community, while he is at the same time making money by attracting a host of victims to the snares of the most monstrous villain of modern society, namely, the quack medicine vendor. Turning to the issue of *Reynolds'* for March 16th, 1906, we find one benefactor of mankind advertising to "cure" rheumatism by a new remedy, of which he offers to the public 50,000 boxes free. The term "rheumatism" is a wide one, and there is no drug or combination of remedies known to medical science that can be guaranteed to cure all cases of any single variety. A certain drug, it is true, exercises a specific control over many cases of acute rheumatism, but even in the most skilful hands it fails occasionally, and death or serious complications may arise in spite of every care. To use this drug successfully demands the utmost care and skilful supervision on the part of a medical man. Supposing, then, that an ignorant layman got hold of this drug it would be far more impossible for him to cure all cases of acute rheumatism, for less all cases of all varieties of rheumatism. In other words, the advertisement is a wicked and palpable lie, and *Reynolds'* has accepted money for its publication. How about the purchasers of this nostrum, who are possibly or probably throwing away their only chance of

escape from hopeless heart disease or chronic joint disease by deferring properly qualified medical treatment in favour of the stuff advertised by an interested proprietor in the columns of an interested newspaper. The vendor is not content with the preposterous claim that his wares can cure rheumatism, but he adds gout to the list. There is absolutely no remedy known to science that can cure both maladies. The specific that cures many cases of acute rheumatism is useless in gout. These facts we offer seriously and emphatically to the consideration of the Editor of the journal in question. We have no intention of criticising the sordid series of advertisements of a similar nature that appear in the same issue. We may just mention in passing Veno's lightning cough cure, which asserts in bold type that pleurisy and congestion of the lungs are cured by its use. That any medicine can exercise a specific influence over pleurisy, in other words, can cure that affection, is inconceivable. To say so is, in plain Saxon, to state a lie. Pleurisy is the outcome of many diverse conditions—not infrequently it is due to unsuspected tubercle. In any case, we should say as our deliberate opinion that any person suffering from pleurisy who trusted to Veno's lightning or any other particular remedy would thereby greatly lessen his chances of recovery. The death of such a person under such circumstances would under any properly conceived scheme of social order be laid at the door of the vendor of the nostrum. Moreover, the death would be indirectly due to the Editor and the publisher of *Reynolds'*, or of any other paper that had given publicity to the lying assertions of the nostrum vendor. As a simple matter of fact, the three persons mentioned are parties to a conspiracy to obtain money under false pretences. We fancy that if a death occurred under such circumstances as those above suggested that a heavy action for damages might be brought with a fair chance of success against all concerned. Finally we may say that we have no personal feeling against *Reynolds' Newspaper*, which we believe to be neither better nor worse than most of its fellows. In succeeding numbers the searchlight will be turned in various directions, and we shall hope at some future day to be able to point out newspapers whose columns are purged of this most cruel, heartless, and abominable class of advertisement.

As the result of generous contributions to the Queen Victoria Memorial Hospital at Nice, which was opened by Princess Christian on Saturday last, there will be, from the commencement of its career, 36 beds, of which no fewer than 24 will be entirely free for poor and necessitous cases, whilst another eight will be provided for persons of very limited means, but who yet desire to pay some small acknowledgment for the benefit they receive. There will also be four beds for paying patients, who, from accidental circumstances, are forced to avail themselves of the advantages of an English hospital. At least one-half the free beds are already either permanently endowed or subscriptions for their special maintenance promised. The late Sir John Blundell Maple gave £3,700 to the fund, and Sir George White has given £3,000. Over £12,000 has already been collected.

NOTES ON CURRENT TOPICS.

A Medical Banquet.

THE account which is given by a contemporary of what, for want of a better name, we must be content to designate as the dining-room of a medical gentleman in London, will, we fear, be apt to make the mouths of the more socialistic and less successful of his confrères water, and their hearts formulate more or less trite sentiments on the unequal distribution of wealth. To mark a special occasion, a "banquet" was given to the members of the local medical society. It "took place in the Court of White Marble built by the host at his residence. The guests were welcomed in the study, which is remarkable for its Egyptian decorations, and from this room admission was obtained to the court by a flight of marble steps flanked on each side with a bas-relief of a lion attacking a bull, copied from the ruins of a well-known palace at Persepolis. The court, which is a replica of the Paris model of the marble hall of the great King Artaxerxes, the son of King Darius, contains thirty-two columns each sixteen feet high. On the top of these the heads of Assyrian bulls support the roof. The columns are gleaming white and stand out against the walls, which are faced with enamelled bricks of a pale greenish-blue fading into straw colour. The frieze represents the black and white archers of the bodyguard of the great king. A striking decoration is the symbol of Ormuzd, the Persian spirit of creation and of good, presenting wide wings in deep turquoise blue enamel tiles with a very fine effect. To appreciate fully the beauty of this exquisite court of dazzling white marble, with its walls flooded with tender enamel tints, it is necessary to supplement description with inspection, and it certainly affords an interesting example of a type of architecture peculiarly Persian." It is presumed that at the termination of the "banquet," to maintain ancient form, the custom of the introduction of some *memento mori* was followed, though in this case the place of the skeleton might well have been taken by a pauper suitably clad to moralise on the vagaries of recently-acquired wealth. We trust that those who were privileged "to supplement description with inspection" made the most of their opportunities.

Capsuloids.

DOUBTLESS many of our readers have seen, from time to time in the advertisement columns of the lay press, glowing advertisements of a preparation bearing the euphonious title of "Capsuloids," which profess to be the scientific remedy for the falling out of hair and for prematurely grey hair, and doubtless, too, they have lately received a booklet on the same subject from the Capsuloid Company. It is little less than astonishing that a commercial company which advertises a preparation of this kind to the public can be so ignorant of the usages and sentiment of the medical profession as to try to engage their co-operation

in the sale of goods which are exploited as "Capsuloids" have been. Nor will medical men be less astonished if they take the trouble to read the booklet sent to them. They will learn that medical practitioners, especially family physicians, have frequent occasion to regret their inability to prescribe for patients who consult them for the purpose of checking "falling" hair, and that in obstetrical practice there is a great demand for a remedy for this condition. Their "inability to prescribe" apparently arises from ignorance of dermatology, a defect which the Capsuloid Company endeavour to remove by a dissertation on the pathology of "falling" hair. Of this dissertation we can truthfully say three things: that it does contain a good deal that is new to us, that what is new is not true, and that what is true is not new. The whole wonderful secret that the Capsuloid Company reveal to the profession is that "falling" hair is due to malnutrition, and to microbial invasion of the hair-follicles, and that "Capsuloids," being a preparation containing hæmoglobin, is the long-sought cure. "We are well aware," with this enterprising Company, "that it is an *absolute innovation* for anyone to suggest to a physician that there is a cure for the falling out of hair." For ourselves we can only express the hope that any further innovation of the kind will come from accredited sources.

A Criminal Lunatic.

A SHOCKING tragedy was revealed at the trial of one, Edward MacQuire, at the Old Bailey last week. The prisoner had been an inmate of St. Pancras Workhouse, where he was found to be insane, and after detention in the mental ward of that institution he was removed to Colney Hatch Asylum. While at the workhouse he had conceived a grudge against the superintendent of the mental ward, and on his discharge from Colney Hatch he threatened him several times with violence. Last December MacQuire found an opportunity, and when Skinner, the object of his dislike, was entering his house, the wretched lunatic shot at him and wounded him fatally. At the trial the defence relied on an *alibi*, which was easily seen through and discredited by the jury, who found the prisoner guilty but not responsible for his actions. He was consequently ordered to be detained during the King's pleasure. Occurrences such as these demonstrate a lamentable hiatus in our lunacy laws and administration. An asylum superintendent cannot detain a patient whose reason has become restored, or apparently restored, while under care, though he knows that to discharge him is probably to expose society to a dangerous and irresponsible pest at some date in the future. There seems to be a morbid fear in the minds of our legislators that the freedom of the subject will be trenced upon by restraints on persons who have temporarily recovered from mental disease or who, though mentally weak, have not committed any outrageous act. Surely the science of preventive

medicine should be extended to embrace these contingencies, and in so doing have the warm-hearted support of all good citizens.

Exclusion of Scotch and Irish Qualifications from English Hospitals.

THE grievance under which medical men holding Scotch and Irish qualifications suffer in being excluded from hospital appointments in most of the large London and many provincial hospitals is likely to be much in evidence in the near future. It represents the survival of a trades unionism of the least desirable kind on the part of the London Colleges. The matter has long been one of the standing subjects for discussion in the large and important Irish Medical Schools and Graduates Association. In their dinner at the Hotel Cecil on St. Patrick's Day, the president adverted to the exclusion of Irish and Scotch graduates and diplomates, and, in the hope of common action, welcomed the presence of the secretary of the Association of Scotch Diplomates among their guests.

The Medical Defence Union.

THE Medical Defence Union deserves the undying gratitude of the medical profession. Where others grumble and do nothing the Union prosecutes. Last week it secured the conviction of a man whom the magistrate spoke of as "a particularly impudent impostor," in the person of Thomas William Tyrrell, for unlawfully pretending to be a doctor. The defendant carried on an extensive illegal practice under the title of "Dr. Muschik," at Marble Arch and two other addresses in London. A man in perfect health consulted "Muschik" and was told he was suffering from fever. He obtained a certificate to enable him to stay away from business and was charged a fee of five guineas, afterwards reduced to three. The wonder is that the Government and the police permit such gross frauds to be carried on in the full light of day. Greater still is the wonder that irresponsible newspaper editors and proprietors play into the hands of such rogues and impostors and share their profits by accepting their nefarious advertisements. We are glad to say that this particular swindler had to pay a fine of £60, with £10 10s. costs. If the police would only follow up Tyrrell his career as a bloodsucking charlatan could, with little difficulty, be effectively cut short.

Too Much Light.

THERE are times in science as well as in politics when a reactionary wave of thought threatens to disturb the peaceful sea of settled convictions. The potent influences of light, whether that of the sun itself or that derived from the electric current, and the wonderful effects of the invisible rays of the spectrum in alleviating human suffering have never been doubted for a single moment, even by those who are not professed advocates of radiotherapy. Careful observers, however, with-

out seeking to decry the benefits to be obtained by the use of light as a therapeutic agent, are beginning to find out that it is quite possible and not at all uncommon to have too much light as of any other good thing. In other words, excessive light acting upon the human organism may, and does, under certain conditions, produce effects which cannot be called other than pathological. The effects of tropical light upon white men have been fully worked out by Major Woodruff, who has shown definitely that the blond races which migrate southward do not permanently survive. More recently the same observer has described neurasthenic states which he believes are accounted for by nothing less than the increased metabolism caused by excessive light. Thus, it has been found that in the Philippines the mortality among infants is much less when they are kept indoors than when taken out and exposed to sunlight. In adults, gloomy and dull weather is also shown to have an exactly opposite effect to that which it is popularly supposed to have. The harmfulness of light upon the human skin has been noted by many modern French writers, and from America we have Dr. Nevins Hyde speaking out very strongly upon the influence of light in the production of cancer of the skin. Physiological pigmentation of the skin, as in the coloured races of mankind, appears to confer upon them a relative immunity against malignant disease of that organ. The whole question is one of intense interest at the present moment, and it is not impossible that many of the existing views with reference to actinotherapy will have to be considerably modified in the light of recent communications.

Examination of Motorists.

WE understand that the French Government is about to introduce some new and rather startling regulations with regard to motorists. If these be carried it will be necessary for everyone who wishes to drive a motor to produce evidence of having passed a thorough test as to his capabilities to manage a car, and also of having passed a medical examination. We are not surprised that the latter should be in contemplation. It has long been necessary that railway men and sailors should be able to demonstrate the acuity of their eyesight, for it is a known fact that many people are quite ignorant that their vision is defective, and not a few appalling accidents by land and sea have resulted therefrom. That a motorist, who in France is under no restriction as to speed, should be myopic is a public danger of no small degree, and no less so that he should be a drunkard or the victim of a grave organic disease. In England, though the rate of motor progression is defined by law, it is competent for

a person to take out a driver's licence without anyone knowing or caring if he can drive or not, whether he is trustworthy or not, whether he is the subject of disease or not. And for a man to drive a motor even at fifteen miles an hour who is not both capable and sound is a serious matter. On the whole, we are inclined to agree that a medical examination for motorists, at least as regards eyesight and general physiology, would be an excellent thing. We hope the point will receive the attention of the Automobile Club.

"Truth" on Testimonial-Mongering.

ALWAYS in the track of the charlatan, our vigorous contemporary *Truth*, in its issue of March 8th, gives some vivacious revelations of American methods for getting testimonials for quack medicines. The worst of it is that it appears that now our home nostrum-market has been invaded by the sharks from the States their methods are being employed over here. It is asserted that a regular business is carried on by recognised agents for obtaining testimonials, but so far Great Britain has not adapted itself to this trade, and that testimonials are either pure forgeries, or given in return for a present of photographs, or signed by relatives or friends of the proprietors. One lady is apparently retained by a patent medicine firm at a retainer to answer questions addressed by customers, and she proceeds on application to give her experiences of a preparation which she has never needed and never used. Another "ghost" is known who acts on similar lines from an address where he cannot be found when wanted, and in a third case the person who supplies photographs and testimonials lives in a block of almshouses. The American patent medicine that pays best is one that creates a habit of some kind by supplying the purchaser with a drug such as morphia, or cocaine, or alcohol, to which he may become addicted, and many ladies' medicines are popular for this reason only. A cynical magnate of the patent medicine trade, who advertised to cure rheumatism, informed our inquirer that he did not want to cure rheumatism, but only to give a medicine "full of hope," which made people want to buy more and more of it. We may be innocent, but we believe we are still free from this particularly heartless kind of knavery. Let us hope we shall never meet with it over here.

Lead an Abortifacient.

THE medical and lay papers alike have paid much attention during the past few weeks to the growing custom of using lead in some form or other to produce abortion. It appears that within the last eight or ten years, the working classes over a wide district in Northern Yorkshire and the Northern Midlands have gained knowledge of the ecboic effects of lead, and medical men have from time to time drawn attention to the putting of this knowledge into practice. The evil seems to be spreading, and curiously enough is spreading so slowly but so continuously as to

justify the belief that information passes from person to person, without, at any rate to any extent, the aid of print or of quack vendors. The usual form of lead employed appears to be diachylon, the purchaser concocting pills therefrom herself, according to some crude recipe. While lead is probably a fairly efficient ecboic, its use is, apart from all moral considerations, accompanied by such serious consequences of poisoning to the woman herself that no effort should be spared to prevent the further spread of the custom. Medical men must be on the watch to detect lead poisoning in all cases of anæmia or colic, and steps should be taken to warn druggists against the indiscriminate sale of lead, and particularly of diachylon.

The Police and Prescribing Herbalists.

A RECENT tragedy at Cefn raises some important issues regarding herbalist practices. A married woman of that place died after a miscarriage and a Coroner's inquiry revealed the fact that she had been taking medicine prescribed ostensibly for bronchitis by a local herbalist. Analysis, however, revealed the significant fact that the herbalist's stuff contained abortifacient drugs. Under such circumstances it is inexplicable how the herbalist escaped a criminal prosecution. He may, indeed, consider himself lucky to have experienced nothing more discomfoting than a severe censure from the coroner. Upon men of his kidney reproof of that kind leaves no more impression than the proverbial water on a duck's back. But, where are the police? Apart from the question of procuring abortion there is a strong assumption that the herbalist might be prosecuted under the Apothecaries or the sale of Poisons Acts. A reference to the case, which is reported in another column, will show that the man admitted in open court that he wrote prescriptions and ordered chloroform. Surely if he has sold and prescribed dangerous and poisonous drugs he could be proceeded against under the Sale of Poisons Act. It is a public scandal that an ignorant man, "unable to spell ordinary words," should be permitted to prescribe dangerous drugs and play with the lives of his fellow citizens. We trust that the Medical Defence Union and the Apothecaries Company will look into this particular case.

PERSONAL.

ON the 31st instant the Mayor of Bath, C. P. Oliver Esq., J.P., and the Corporation will receive the members of the British Balneological and Climatological Society in the famous Pump Room of that city. The Roman baths will be open for inspection.

MR. R. HENSLOWE WELLINGTON has been appointed Lecturer in Forensic Medicine at the Westminster Hospital Medical School. In addition to his medical qualifications, he is a practising barrister of the Middle Temple and South Eastern Circuit. He is deputy-coroner for the City of Westminster, and for the County of London, and the author of "The King's Coroner."

SEÑOR MANUEL GARCIA, the inventor of the laryngoscope, on March 17th completed his 101st year.

A CLINICAL LECTURE

ON

ANGINA PECTORIS: TRUE AND FALSE.

By Professor BUCHARDT, M.D.,
Of the Faculty of Medicine, Paris.

[Specially reported for this Journal.]

ANGINA PECTORIS, as you are doubtless aware, is a syndrome characterised by attacks of paroxysmal pain, of sudden onset, in the region of the heart, or along the left sternal border, associated with intense anguish and the apprehension of impending death. It usually supervenes during or after an effort, such as climbing or rapid walking against the wind. The victim is, so to speak, immobilised by the pain, he is pale, and his face is expressive of intense anxiety. The pain radiates in the direction of the left shoulder, the neck—the jaw, the tongue, and the left arm, right to the ends of the last two fingers. It may involve the pharynx, giving rise to a sensation of constriction followed by aphonia, nausea, and vomiting, with hiccough the pain may even find an echo in the testicle. The patient feels that he is on the verge of death and that the heart will infallibly cease beating if the crisis be prolonged.

These striking features of angina pectoris are familiar to all medical men, and there is no divergence of opinion as to the clinical aspect of the syndrome. Opinions only begin to clash when we make an attempt to elucidate the cause of the affection, and to trace it back to its particular source of origin. Yet we cannot dispense with this investigation, for it has an important bearing on prognosis. It is highly important that we should know whether we are dealing with a case of grave angina pectoris, likely to have a fatal issue because consequent upon some irremediable anatomical lesions, or whether the case is a comparatively benign one due to purely functional disturbance, and therefore amenable to treatment. The question we have to discuss is whether there is anything in the clinical examination of the patient that will enable us to arrive at a conclusion in one or the other direction. Incidentally we must inquire what light is shed on the question by pathological anatomy.

The anginal syndrome is met with in connection with a large number of very different affections. Andral has met with it in pericarditis; Corrigan and Hirtz in acute aortitis; Hugenin in myocarditis, dyscrasic affections (diabetes, gout), and diseases of distant organs—liver or kidney—infectious diseases, malaria, rheumatism, hysteria, intoxications by tobacco, lead, tea, oxide of carbon, and so on.

In presence of so many etiological varieties, it is difficult to resist the assumption that the same physiologico-pathological mechanism must be at work, since the clinical manifestations are approximately the same in all. Gilbert and Garnier, after a close scrutiny of the opinions of various authors, arrived at the conclusion that the anginal syndrome is always of neuralgic origin or the result of a toxic neuritis of the cardiac plexus, the gravity of the evil varying according to the cause. According to these observers a rigid milk diet is the sovereign remedy. This opinion coincides approximately with that of Peter and Lancereaux, who assign the cause of the malady to a neuritis of the cardiac nerves. The nervous theory, indeed, has numerous partisans apart from those already mentioned—Laennec, Trousseau, Axenfeld, Parrot, Jaccoud, Bouchut, &c.

Personally, I am convinced of the coronary origin of true angina pectoris. In my experience, there is invariably stenosis of the two coronaries or blockage of one of them. It is true that *post-mortem* examination sometimes fails to reveal this narrowing, but we

must not forget that the existence of arterial spasm, secondary to a neighbouring inflammatory lesion (pericarditis, aortitis, &c.), may result in cardiac ischæmia and determine the characteristic symptoms. This theory was formerly defended by Kreysig, and in opposition thereto the following objections were formulated. To begin with, ossification of the coronary arteries may exist without any sign of angina pectoris; moreover, during the whole period of ossification and narrowing of the calibre of the vessels, no attack of angina may be observed, in spite of the defective circulation; and, lastly, physio-pathology shows that the symptoms observed in animals consequent upon experimental obliteration of the coronaries differ markedly from those observed in human beings. We may mention also the theory formulated by Professor Potain, who likened the anginal attack to intermittent paresis of the extremities.

According to Professor Gilbert all cases of angina pectoris are dependent upon the same mechanism, and he locates the mischief in the cardiac plexus. The disturbance may be merely functional, and consist in reality in a sort of neuralgia, or, on the contrary, there may be a genuine neuritis with obvious structural changes. But, says this observer, though the pathological physiology is the same in all cases, the etiology differs in each case. As a rule the cause is toxic, and of all intoxications the commonest is that of uræmia. It may, however, be reflex, or it may be toxic-infectious and associated with a pericarditis or aortitis. Lastly, in some cases, the nervous symptom must be invoked, since hysteria does sometimes give rise to the complete syndrome. The toxic form of angina alone is of grave import, and the principal factor in determining its gravity is its cause. When the latter is of a fugitive character, as in poisoning by tobacco or caffeine, recovery will take place promptly enough when the underlying cause has been obviated. When permanent, as, for instance, when it is dependent upon irremediable changes in the kidneys, the attacks are sure to recur at more or less distant intervals.

To sum up, there does not seem to be any trustworthy character that will enable us to distinguish between true and pseudo-angina. We diagnose severe or benign angina according to the cause that has brought it about and the pathological importance of this cause, but the syndrome is always the same and does not admit of any clinical classification.

Certain features have, however, been suggested as more characteristic with mild anginas rather than the graver variety; indeed, Huchard enunciates four clinical rules which he asserts will never be found wanting:—

- (1) Whenever an attack of angina pectoris is precipitated by any sort of effort—a quick walk, for instance, it is true or coronary angina.
- (2) When the anginal attack comes on spontaneously, *i.e.*, is not the result of a physical effort, the case is one of pseudo-neuralgic angina.
- (3) When a patient who has attacks consequent upon muscular effort also has spontaneous attacks during the night the first rule is not invalidated, for it is always a case of true angina.
- (4) Thoracic pain produced by pressure is not anginal. Pain provoked by effort, then, is characteristic of coronary stenosis; pain provoked or aggravated by pressure is due to phrenic intercostal or

diaphragmatic neuralgia. Spontaneous pain so frequently met with in dyspeptic, neurasthenic and hysterical subjects presents no importance, and stands in no relationship to a coronary lesion; in other words, it does not constitute real angina.

Whatever the precipitating cause of the anginal attack, we must bear in mind that the victim may succumb. In smokers and in hysterical subjects we sometimes meet with mixed cases in which the grave element is associated with the benign form, as, for instance, when sclerosis and some form of intoxication (sclero-tabagic intoxication) are working on parallel lines.

Tobacco angina pectoris holds a foremost place in the numerous category of pseudo or benign anginas. It resembles the coronary variety so far as its pathological mechanism is concerned (arterial spasm), viz., by the etiological part played by muscular effort in its production and by the possibility of sudden death, which, however, is fortunately the rare exception. It differs from the true coronary form by the more marked spontaneity of its onset, by the greater duration of the attacks, by the præcordiac and not retro-sternal situation of the pain, by its association with other vaso-motor disturbances and the presence between the attacks of various uncomfortable symptoms familiar to most smokers, such as vertigo, faintness, and cardiac intermittences.

We discuss some of these symptoms more in detail in another paper. Tobacco angina is abnormal in respect of its site. The pain is referred to the præcordium and not to the true angina pectoris, to the retro-sternal region, the attack often lasts half an hour or more; moreover, vomiting, epistaxis, vertigo, cold sweats and coldness of the extremities not present in angina pectoris are also present in tobacco angina. Then, again, the antecedents of the patient will always afford valuable information. We must always bear in mind the pro-association of tabagism with cardio-sclerosis, and therefore so seeing that, according to Renon, nicotine poisoning is itself an influential factor in the production of aortic aortitis and arterio-sclerosis.

Hysterical angina pectoris presents certain peculiarities which I think deserve special attention. Together with it, it is hereditary and occurs in the offspring of hysterical parents. It may supervene at any age, more particularly at the menopause; it often occurs in association with certain cardiac affections, of which, however, it is usually quite independent. It may be excited by auto-suggestion, the patient having been misled by the dyspnoea of a real cardiac patient, accentuating her emotivity. Numerous instances of this form of pseudo-angina have been observed by Peter, Talamon, and others. According to them, the same disease may manifest itself in grave abortive attacks. The attack is usually at the præcordium and is accompanied by præcordiac distress and intense pain. It is preceded by a cardiac aura, which is vaso-motor or neuralgic. In the neuralgic form the pain starts at the finger-ends, mounts up the arm, reaches the trunk, and lastly the heart. It may start in the loins, the lower limbs, the ovary or the testicle, though the last-named is rare.

The vaso-motor aura is characterised by a feeling of coldness, with "goose-flesh" and pallor of the skin, cyanosis, faintness, enfeebled heart-beat, and even actual syncope. This applies to the grave forms. In the cardiac aura there is violent palpitation with irregularity of cardiac rhythm, or slowing-down of the pulse.

The auras take origin in hyperæsthetic zones of which the irritability has, so to speak, been suddenly intensified. On close examination we find tender spots in the præcordia, over the apex of the heart, along the spinal column, or over the ovary. From these points the pain radiates into the arms, the hypochondria, the ovaries, &c.

Along with these symptoms we get emotional disturbances, mental anxiety and respiratory troubles, which are usually absent in true angina pectoris.

By looking out for these phenomena we shall derive material assistance in arriving at a correct differential diagnosis. Nevertheless, we must not trust this form with contempt, for Potain records having seen two instances of death from hysterical angina, which confirms what I have already said as to the possible fatality of all forms of angina.

Now for a few words as to treatment. If the attack is recognised to be of toxic origin the proper treatment is milk diet and removal of the cause (tabagic angina). The iodides are of great service, and, according to Gilbert, act as an antitoxic rather than as a resolvent in respect of the arterio-sclerosis. In any case, whether we are dealing with a grave or benign form of the disease, the lacto-vegetarian regimen is indispensable, the more so as it is extremely difficult to make out for certain whether there are or not co-existing coronary lesions.

Medicinal therapeutics will be guided by circumstances. If we are dealing with neurasthenic or hysterical patients we may employ suggestion and sedatives (bromides, valerian and antipyrine). We may prescribe the phosphates, the cacodylates, kola, with iron for anæmic patients. Alkalies and lithia are indicated in arthritic and gouty persons. In dyspeptics we must attend to the gastric functions. Organic lesions of the heart must be dealt with by the usual means—rest, milk diet, digitalis, &c. The same remark applies to renal disease and dyscrasic maladies. The thermal treatment is very efficacious in certain cases, not only by reason of the direct action of the waters, but also on account of the change of air, of habits, &c.

The attack in being must be treated by the administration of nitrite of amyl, drop doses of a 1 per cent. solution of trinitrine, subcutaneous injections of morphine, hot compresses over the præcordium, local counter-irritation, blisters, and the like.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The lecture in next week's will be by Mr. A. B. Mitchell, F.R.C.S.I., Surgeon to the Royal Victoria Hospital, Belfast, on "Acquired Flat Foot."

ORIGINAL PAPERS.

TWO CASES OF APPENDICITIS DUE TO OXYURIS VERMICULARIS.*

By H. W. CARSON, F.R.C.S.ENG.,
Surgeon to the Tottenham Hospital.

THE first case was that of a single girl, æt. 19, who gave the following history:—She had had excellent health until one month before admission to hospital. She then had pain after food "like indigestion," and occasional vomiting during the last week.

On August 15th, early in the morning she was seized with violent pain in the right side of the abdomen, accompanied by vomiting. The vomiting continued during the day, but ceased at night, and did not recur. In the evening she was seen by a medical man, who reported a rapid pulse rate and a temperature of 103°.

On August 16th she had a rigor and was admitted to hospital.

Condition on Admission.—Temperature 103·8°, respirations 32, pulse 116. Patient anæmic; tongue moist, but slightly furred. She complains of severe pain and tenderness on the right side of the abdomen. The bowels were opened on the day before admission.

On Examination.—The abdomen moved with respiration, and was not distended. There was no rigidity of the abdominal walls. Superficial tenderness was marked over a large area of the right side of the

* Paper read before the Clinical Society of London, February 23rd, 1906.

abdomen, extending from the edge of the ribs to the iliac fossa, with tenderness in the right loin most marked above the crest of the ilium. There was much tenderness on deep pressure over McBurney's point. There was no swelling, but an area of dulness could be made out under the right rectus muscle extending two inches above and one inch below the level of the umbilicus. The rectum was full of *faeces*, but after these had been removed by enema nothing abnormal was found on rectal examination.

The heart and lungs were healthy.

The abdomen was opened and the appendix found to have a bulbous tip and slight recent adhesions between its proximal half and the cæcum. It was removed. The mucous membrane of the distal half inch was deeply congested, but not ulcerated. A single female oxyuris vermicularis was found in the congested area.

Subsequent History.—The patient at once lost all pain, and on the day following operation expressed herself as feeling quite comfortable. The temperature and pulse rate, however, returned to normal very gradually, the evening temperature reaching normal only on the ninth day. Repeated examinations of the lungs were made but nothing was discovered. The bowels were confined, but daily evacuations were obtained by enemata. The wound healed perfectly, stitches being removed on the ninth day, and at no time was there any distension or abdominal discomfort.

On August 30th, after the temperature had been normal for six days, the patient complained of headache and drowsiness. The temperature rose to 102.6° at 7 a.m., and was 104.4° at 7 p.m.; pulse rate 120. Examination of the abdomen and chest was negative. The temperature reached normal again on September 2nd, no physical signs having developed during this time.

On September 6th, the temperature rose again to 102.6° (7 a.m.), reaching 104.8° at 7 p.m., patient feeling drowsy, but otherwise not uncomfortable. Nothing was found to account for the temperature, which fell to normal on September 9th, and the patient left the hospital a few days afterwards. At no time during her stay in hospital did she pass any worms, and as far as she was aware she never had passed any. She writes to say that she has a "very sharp pain with the changes of the weather and cannot have action without medicine." She has not passed any worms.

The second case was that of a married woman, *æt.* 24, who gave the following history:—Her health had been good except for an attack of abdominal pain occurring one year before, which lasted for three weeks.

On November 29th patient was seized with a severe pain in the lower part of the abdomen, accompanied by slight vomiting. She was seen by a medical man, who diagnosed appendicitis and advised her removal to hospital. She was admitted on November 30th.

Condition on Admission.—Patient's general condition was good, but she was apparently in considerable pain. Tongue moist but slightly furred; temperature 100.6° , pulse 118 regular, respirations 28. The heart and lungs were healthy.

The patient complained of severe pain in the lower part of the abdomen, most marked in the left iliac fossa. The abdomen moved well with respiration; there was no rigidity of the abdominal wall, and no tumour could be felt. Percussion gave a tympanitic note. There was tenderness on deep pressure in the right iliac fossa, but this was at a lower level than is usual in appendix cases and resembled the tenderness occurring in pyosalpinx cases. *Per rectum* there was some general tenderness. *Per vaginam*, there was acute tenderness in both fornices but nothing abnormal was discovered, though bimanual examination was difficult owing to the pain elicited. There was not at the time, nor had there been, any vaginal discharge.

A provisional diagnosis of pyosalpinx was made, and as the patient was in great distress immediate

operation was decided on. The abdomen was opened in the middle line. The uterus and appendages were found to be normal, and the appendix was apparently normal. Mindful of the case three months before, I removed the appendix, and found three thread worms in the distal end of it. There was no injection or ulceration of the mucous membrane.

The temperature fell to normal on the evening of the day of operation, but the pulse rate was somewhat rapid for two days. Stitches were removed on the eighth day, the wound being soundly healed. At 11 a.m. on that day the temperature rose to 100.8° , with a pulse rate of 98. There were no symptoms and both temperature and pulse were normal next morning, but on the eleventh day after operation the patient complained of headache and abdominal pain, and the temperature rose to 102° , with a pulse rate of 112. Nothing could be found to account for this. The bowels were not confined. Next morning the temperature and pulse rate were normal again, and from that point convalescence was uninterrupted. She writes to say that about a month ago she had severe pains lasting about one week. She has not noticed any worms in her motions.

Both cases present certain features in common. In each case the patient was an adult woman in whom there had been no previous signs of thread worms. In each case the subjective signs were more marked than the objective, that is to say, that though tenderness and hyperæsthesia were well marked, there was no abdominal distension, no rigidity, no tumour. In both cases also the convalescence was interrupted by attacks characterised by elevation of temperature and pulse rate, and headache. Compared with ordinary cases of appendicitis, these two cases present certain unusual symptoms.

Onset.—The only point of difference with regard to the onset is, that in the first case a temperature of 103° occurred on the first day and a rigor occurred on the second day. As far as my experience goes a temperature of 103° on the day of onset is unusual, and the occurrence of a rigor at an early stage in appendicitis is quite a rarity.

Symptoms.—The most striking symptom was the degree of hyperæsthesia in both cases. In the first case the tenderness was limited to the right side, but extended far back into the right loin. In the second case tenderness was complained of in both iliac fossæ, worse on the left side, but the most acute tenderness was felt on vaginal examination, especially in the left fornix. Indeed, so much pain was caused that a thorough bimanual examination of the uterine appendages was impossible.

The general condition of both patients was also misleading. The first patient was apparently seriously ill, the temperature approaching 104° , with a weak pulse of 116. In fact, the case resembled one of those severe gangrenous appendix cases without marked physical signs such as one sees occasionally in children. The second patient, though not apparently so seriously ill, was in great pain, with a pulse rate of 118, and as this condition had lasted for 24 hours and was increasing in severity, it was looked upon as an indication for immediate laparotomy. In the second case there was a history of abdominal pain occurring a year before and lasting for three weeks, but whether this was appendicitis or not it is of course impossible to say.

Signs were practically absent in both cases. There was no abdominal distension, no rigidity of the abdominal wall, no interference with the respiratory movements and no tumour. In the first case an area of dulness was found under the right rectus at the level of the umbilicus, but this had no relation to the position of the appendix. Had one met with this hyperæsthesia with absence of physical signs in a child, especially if associated, as in the first case with a temperature of 104° I think one would have suspected that the case was one of pneumonia with abdominal

pain, but repeated examinations of the chest failed to find any pulmonary complications. The occurrence in both cases during convalescence of a sudden rise of temperature with headache is curious. It may, of course, have been merely a coincidence resulting from a sudden chill or a slight attack of influenza, or it may conceivably have resulted from the irritation of thread worms in the cæcum or colon, though no more were seen during the patient's stay in hospital or since. The after history of these two cases is unimportant, except that the second patient has had an attack of abdominal pain since leaving hospital which lasted for one week.

The question as to whether intestinal parasites do or do not cause appendicitis has given rise to very different opinions. On the one hand Dr. G. F. Still (1) quotes Heller as saying that there is no evidence that thread worms give rise to appendicitis; on the other there are a definite number of published cases in which thread worms have been found in diseased appendices. Metchnikoff (2) writes on "Worms as the cause of Appendicitis," and Von Noty (3) goes so far as to say that oxyuris and trichocephalus give rise to chronic appendicitis, while ascariides give rise to gangrenous appendicitis. There is no doubt that thread worms may exist in the appendix without giving rise to symptoms. Dr. Still (4) reports that in 200 necropsies on children under 12 he found the oxyuris in the appendix 25 times, and in 6 instances they were found in the appendix alone. In only one, apparently, were there any signs. This was the case of a boy of nine, who died of pericarditis, and in whose appendix 111 worms were found. He had complained of pain in the appendix region without tenderness.

I have been able to find only a few reported cases, where thread worms have been found in an appendix removed during life for the cure of appendicitis, and, unfortunately in only a few of these are any details of the symptoms given. All seem to be cases of relapsing appendicitis. Frazier (5) reported a case of a female, æt. 2, in whom there had been a five months' history of appendicitis. Thread worms were found in the appendix, without ulceration.

In the discussion which followed, Dr. H. D. Beyea gave details of the case of a married woman of 22, who had suffered for 2½ years, since the birth of a child, with back-ache, headache, and nervousness. Six weeks before operation she had severe pain, lasting for a week, in the appendix region; three weeks before operation a "convulsion" occurred, followed by others of an hysterical type. There was extreme tenderness but no tumour. A single oxyuris was found in the inner one-third of the appendix without hyperæmia. Erdmann (6) reported four cases containing between 6 and 30 thread worms. He gives no account of the symptoms. In *Pædiatrics* (May 15, 1900, p. 411) there is a report of a case occurring in a boy of 8, but no details are given. Guinard (7) reports a case of thread worms giving rise to symptoms which occurred in Routier's practice. A case is reported by Professor Bégouin (8) of a woman, æt. 24, who had had for four or five years attacks of right iliac pain occurring at long intervals, and lasting three or four days. There was a slight tender tumefaction, the size of an almond at McBurney's point. The appendix was slightly turgid; 15 thread worms were found with four small ulcerations. In the "Inter-Colonial Medical Journal of Australia," commented on by the *Lancet*, (1902, vol. 1, p. 539), Mr. R. Hamilton Russell reports the case of a boy in whom the chief symptom was severe pain. Some correspondence followed in the *Lancet* (1902, vol. 2, p. 58), and a case was reported by Mr. F. Bolton Carter (9) as having occurred at the Leicester Infirmary. The patient was a boy. In September, 1902, Mr. Jonathan Hutchinson, jun., (10) reported a case of a young woman operated upon for relapsing appendicitis in whose appendix many live thread worms were found. Morkovitch (11), reports a case of a man æt. 22, in whose appendix twelve live thread worms were found.

This makes a total, with my two cases, of 15, of which 6 were females, all, with one exception, young adults, 4 were males, all except one boys, and in 5 cases the sex was not stated. In the few cases where symptoms are given, severe pain and tenderness without local signs seem the rule, and in only one case was there any ulceration of the appendix. While it is certain that thread worms may exist in the appendix without giving rise to recognisable signs, it seems that we must believe either that thread worms may cause appendicitis or that the presence of the parasites is a pure coincidence. The latter theory is, I think, untenable, in view of the fact that the symptoms in these cases are much more severe than the lesions found would warrant, and I prefer to believe that thread worms may cause appendicitis, and that the attack is characterised by exaggeration of symptoms and absence of physical signs.

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NOTES ON PSORIASIS.

By TOM ROBINSON, M.D.,
Physician to the Western Skin Hospital.

THE subject of these remarks is a malady in my experience second as regards frequency in those who attend the Western Skin Hospital. For I find that out of each 100 cases, not less than 9 have had psoriasis, whilst 13 were the subjects of eczema. Psoriasis is a malady which stands out as a distinct clinical entity. You will find, as a rule, that in large families it commonly—I was about saying usually—attacks only one member of the family. You may, and I believe you do, always find in any family from which a psoriatic person springs others who suffer from other cutaneous conditions, but I repeat it is common for only one person in a family to have psoriasis. The disease is never co-æval with, but appears, as a rule, about the age of 11 years; once and only once have I seen true psoriasis at 7 years of age.

The psoriasis spot, from its first appearance, is a papule which is scaly. To this rule there is no exception. You may demonstrate this fact in spots no larger than a pin's head. When the superficial scales are scratched off, we come down to a translucent membrane (*stratum lucidum*), and, when this is detached, bleeding points (the *papules*) are obvious; so that any papule which shows silvery scales when scratched with the nail or a knife, which has below it a semi-transparent membrane and bleeding points is a psoriasis. As the spots first appear we speak of the case as *Psoriasis punctata*. The spots increase rapidly in size until they become as large as lentils, resembling very closely mortar in colour. We then speak of the case as *Psoriasis guttata*. The two processes usually go on side by side, so we may be sure that when we find *Psoriasis guttata* we shall also find *Psoriasis punctata*.

The spots go on gradually extending from their circumference until they become as large as a florin, without undergoing any change; so that at this stage of psoriasis we find a number of spots varying in size,

*A Lecture delivered at the Western Skin Hospital.

and as their size varies we use a word to indicate their resemblance to a coin, *Psoriasis nummularis*.

When these spots increase in size they must of necessity come into contact with each other, and as others continue to make their appearance we find curious patterns. Thus, if three circles coalesce we see a trefoil pattern; in other cases a number of segments of circles will run into each other in such a manner as to produce different patterns, many of which have received fantastic names, such as *Psoriasis gyrata* or *Psoriasis orbicularis*.

Although we may find an enormous distribution of psoriasis, still we seldom—from my experience, I should say never—find a case of *Psoriasis universalis*. You will, I think, find in every case parts of the cutaneous area free from the characteristic eruption. A patch of psoriasis will grow at times until its diameter is quite two inches, usually it is much less. Long before it reaches such a dimension the scales in the centre commence being shed, and we find a ring-like appearance, the scales at the margin of the surface being raised and adherent (Willan described these cases as lepra). Following the natural course of a psoriasis spot, in some cases we find the eruption disappears spontaneously, leaving behind a reddened skin. This usually vanishes in time, and the skin assumes its normal aspect. Neither scar nor pigmentation remains after the disappearance of a psoriasis.

I think we always find more or less itching in cases of psoriasis, although a few patients will deny that there is irritation. We may demonstrate when itching is a predominant symptom, because the silvery crusts are interspersed with black or brown blood crusts.

The location of psoriasis presents some interesting problems. To assert that in every case of the disease we find the eruption clustered in greater abundance about the tips of the elbows and knees is misleading; because in some well-marked instances we have not found any spots in these situations, although there has been an abundant crop on other parts of the body. The eruption is seldom, if ever, seen on the palms of the hands or on the soles of the feet, nor commonly on the face.

The eruption is sometimes very limited in its distribution. Cases will be met with where well-marked spots of the malady will be found in such situations as the sacral region, the extension surfaces of the arms or legs, and the front of the thorax. These constitute some of the most obstinate cases we meet with.

The disease is common on the scalp, where it occurs in discrete spots. The hair is always influenced, being shed to a certain extent, and losing its lustre. Psoriasis of the scalp often spreads over the frontal bone and behind the ear. In these situations it loses its characteristic appearance, and is often cracked and formed like an old eczematous spot.

If we strip a case of psoriasis where the eruption is general, it will usually be found that the spots are larger and of a higher colour in the lower extremities than elsewhere.

Besides the eruption itself, in many cases the nails suffer from an altered appearance. The condition does not affect all the nails, neither is it symmetrical. The diseased nails are brittle, coarse on the surfaces, and look like cocoa-nut matting. We often find beneath the nail hid a spot of psoriasis which pushes up the nail, so that a probe may be passed beneath the nail without pain.

I have not time to enter into the question of the pathology of psoriasis. Unna strongly suggests that the disease is parasitic in origin. There is no evidence, to my knowledge, that psoriasis has ever been induced by artificial inoculation. Lang, of Innsbruck, claimed that he discovered a certain fungous element in the disease. I think we may rest satisfied in the knowledge that in cases of psoriasis there is an inflammation of the papillæ, and as a result of this inflammation we have an exaggerated epithelial growth which gives rise

to the varied canvas of the psoriatic process, a process which is unique.

Differential Diagnosis.—For usual clinical work we find in this hospital three diseases resembling psoriasis on first inspection, namely, pityriasis rosea, seborrhœa, and syphilis. Some would add lichen ruber.

If we remember that pityriasis rosea is practically limited to the trunk, that there is very little scaliness, and that the eruption vanishes in about eight weeks, we shall not fall into error.

There is much more difficulty in distinguishing between a general seborrhœa and a psoriasis. So much so is this the case that many dermatologists are of opinion that the two diseases are identical, one being an acute disease and the other chronic. There may be cases where the diagnosis is impossible between the two; if so, we have not met with them in the practice of this hospital. Seborrhœa is a much more acute malady than psoriasis. The particles of eruption have not the character of poisonous spots, and they yield much more readily to treatment.

It would require a thorough knowledge of the history of a case and a consideration of all the groups of symptoms to make a differential diagnosis between a scaly syphilitic and psoriasis, besides which, the scaly syphilitides do not advance in size like psoriasis; they are seldom more than half an inch in diameter. Sometimes we have been puzzled in late syphilitic manifestations because the *serpiginous* variety of the eruption, if not ulcerating, has in many instances a heaped-up edge which resembles the edge of a chronic psoriasis spot, but it is never a complete circle even when standing alone. It is invariably crescentic.

The cases which are most puzzling are those in which a syphilitic virus mingles with a psoriatic state. When this occurs we meet with an eruption which it is often difficult to designate—I was almost saying impossible—and most rebellious to treatment.

The Effect of other Diseases on Psoriasis.—If a patient with psoriasis contracts any of the acute blood diseases, the scaliness may entirely disappear. It will always do so, if the disease continues for any length of time. Should the patient recover, the psoriasis always reappears. It is well to be acquainted with this fact, otherwise we may lead our patient to believe he has got rid of his trouble. In point of fact, any conditions of health which cause depression of the vital force will cause a diminution of the psoriatic eruption. This is notably observable in some cases of pregnancy.

On one occasion a *post-mortem* was made by the late Dr. Sutton in the London Hospital on a man who had died with double pneumonia. He had a very copious psoriatic eruption. The usual appearance of psoriasis had disappeared. The scales had, to a large extent fallen off. The red patches which support the scales had paled until they nearly resembled the adjacent skin.

Treatment of Psoriasis.—However great the interest of the study of disease may be—and it is, indeed, a fascinating process—our patients will stand before us and ask this very awkward question: "Can you cure me?" It is best to answer with absolute frankness, and say: "In our present knowledge of psoriasis we can promise to get rid of the eruption, if you will persevere with your treatment; but we must warn you that in all probability your eruption will reappear at some future time." I am afraid we cannot say more.

We have next to ask ourselves what is the best treatment to follow. We may, I think, lean upon three internal remedies—arsenic, salicylate of soda, and thyroid extract. It will be some guide if you will remember that you will probably succeed best with arsenic in those cases which have been in existence for some years, and especially cases where the spots have not grown to any great size. I am not able to prove to you that arsenical solution is in any way inferior to the arsenic pill, but I use in my own practice the latter, and I am satisfied with the results. The pill consists of 1-20th of arsenic, 1 gr. of black

pepper, and 1 gr. of sulphate of iron. In most cases it is sufficient to give three pills a day; but in other cases, where the disease is obstinate, it may be increased. I cannot remember any cases where the drug has proved pernicious in its effects. We need not fear any accumulation of poisons in the organism. Hebra asserts he has given as much as 160 grs. of arsenic (?) acid in one case. In recent cases of psoriasis we find 5 grs. of salicylate of soda apparently of efficacy.

The cases of psoriasis which are influenced in quite a remarkable manner are those which exist in women at the menopause. At this period of a woman's life, when there is a deposit of fat in the tissues, either myxoedema or an analogue of that disease, a tablet of thyroid extract given three times a day will produce a change in the whole organism, and in the psoriatic spots.

We will now discuss the external treatment of psoriasis. On the remedies applied to the skin we must depend to get rid of the manifestation of the disease. The first object must be, to get rid of the scales. To accomplish this, wet packing, if possible, is by far the most efficacious. But it is tiresome, and means confinement in bed.

For practical purposes the immersion of the body in baths at a temperature of 100°, with the free use of pine soap, will clear off a quantity of the scales. After the bath the patient should have rubbed into every spot an ointment composed of equal parts of tar, ammoniated mercury, and salicylic acid ointments. When the psoriasis appears on the scalp, we get good results by a vigorous washing of the scalp with soap and afterwards rubbing in the ointment already mentioned, omitting the tar.

CLINICAL RECORDS.

A CASE OF ADVANCED CARCINOMA OF BOTH OVARIES.*

By HY. JELLETT, M.D., B.Ch., F.R.C.P.I.,
Gynaecologist and Obstetric Physician to Dr. Steevens' Hospital.

A patient, æt. 40, was admitted to Steevens' Hospital on August 17th, 1905, complaining of a gradually increasing swelling in abdomen, with occa-



FIG. 1.—Carcinomatous tumour of Right Ovary.

sional attacks of violent pain. She had been in good health up to Christmas, 1904. The menstrual periods were regular, lasting four days, and were preceded by pain. She was married four years ago, and first noticed

* Read at meeting of British Gynaecological Society, March 8th, 1906.

a swelling in her abdomen at Christmas, 1904. At first there was no pain, but latterly violent paroxysmal attacks came on which were temporarily relieved by treatment. On examination the lower abdomen and pelvis were occupied by a hard irregular-shaped mass, found adherent to pouch of Douglas, and to uterus in front so as to suggest malignant disease of ovaries. It was decided to make an exploratory incision five days after admission, when the mass was found to consist of two separate tumours in pelvis, presenting the appearance of glandular cysts of both ovaries being adherent below but free above. The abdominal opening was enlarged by a transverse incision through the left rectus out to the left anterior superior iliac spine. The tumour on the left side was removed without much difficulty; that on the right was more adherent and consequently removed with considerable difficulty. An abscess was found between the tumours, and there was extensive infiltration of the ligaments so that the uterus had to be removed at the same time. The uterus was removed between clamps passed up from the vagina and the pelvis packed with iodoform gauze, which was drawn through the vagina.

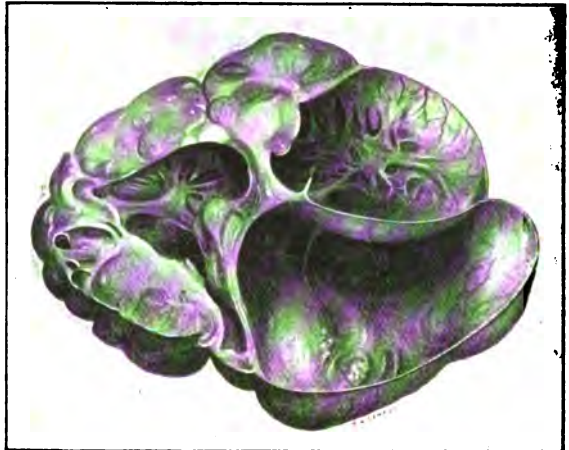


FIG. 2.—Tumour of Left Ovary shown in cross Section

The adhesions between the tumours and the pelvis were very vascular, so that the patient lost a considerable quantity of blood. She, however, rallied well. The plug and clamps were removed three days later and the patient subsequently returned home with three small sinuses in abdominal wall. Four months later the patient returned to hospital when the sinuses were still found open. These sinuses were scraped with a sharp spoon and some sutures were removed, and iodoform emulsion poured into the cavities. They then closed completely. On examination of the rectum, at the same time, it was found to be surrounded by a hard mass which is presumably further infiltration by the growth. The patient however, has increased in weight and appears well.

The report of the pathologist on the tumour was that the solid growths consisted of carcinoma of irregular-celled type, and that the ovaries likewise contained glandular cysts.

CASE OF DOUBLE PYOSALPINX ASSOCIATED WITH THE PRESENCE OF A FOUR MONTHS EXTRA-UTERINE FÆTUS.

By HY. JELLETT, M.D., B.Ch., F.R.C.P.I.,
Gynaecologist and Obstetric Physician to Dr. Steevens' Hospital.

The patient, æt. 27, was admitted on September 16th, 1905, complaining of bleeding during coitus, pain in lower abdomen and back. Menstrual periods were too frequent, and the discharge was offensive. There were

no children, but patient said she had had a miscarriage at about the eighteenth or twentieth week eighteen months previously. On examination, an erosion of the cervix was found which bled freely.

Four days after admission, on making an examination under an anæsthetic, the uterus was found to be retro-deviated and drawn to the right. A hard, irregular mass about the size of a hazel nut was detected in the region of the right ovary, which extended outwards to the wall of the pelvis. The appendages on both sides were considerably enlarged. The uterus was curetted, and a portion of the erosion removed for examination.

About one month later, on opening the abdomen, the omentum was found thickened and adherent to the

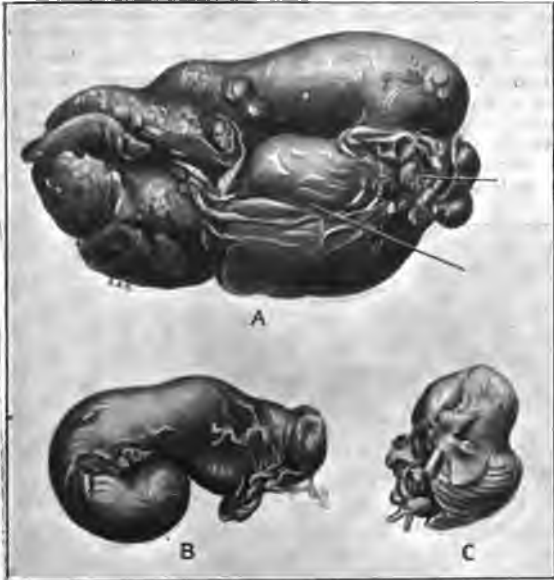


FIG. 3.—Double Pyosalpinx and Skeleton of Extra-Uterine Foetus. (A) Right appendages. (1) Site of attachment of fetal skeleton. (2) Right Ovary. (B) Left Fallopian Tube. (C) Foetal Skeleton.

Fallopian tubes. The right tube was enlarged to the size of a sausage, distended with pus and bound up with the ovary. The skeleton of a four months' foetus projected from the ampulla. The left tube was dilated to the size of a finger and contained pus, while the left ovary was cystic. Both tubes and right ovary were removed. Vento-suspension of the uterus was performed after Kelly's method. The sutures were removed on the eighth day with the exception of one which broke and left a piece about three inches in length behind. The patient was discharged in three weeks. In three months she presented herself for examination, when the uterus was found in good position and convalescence established.

The pathological report on the portion of cervix removed stated that the erosion was covered with squamous epithelium, being very vascular, and infiltrated with small round cells. The scrapings from the uterus showed columnar epithelium on surface, increased number of glands, and extravasation of blood interstitially as in glandular endometritis.

St. George's Hospital Medical School.

We are asked to announce that a private subscription dance in aid of the endowment fund of the Medical School attached to St. George's Hospital will be held at the Hotel Metropole, on May 2nd, under the patronage of H.R.H. the Princess Christian, the Duchess of Bedford, &c. Tickets for the dance (including champagne supper), £1 5s., can be obtained from the patronesses, or from Mrs. Humphrey Rolleston, 55, Upper Brook Street, and Mrs. G. R. Turner, 41, Half Moon Street, London, W.

THE OUT-PATIENTS' ROOM.

METROPOLITAN HOSPITAL.

Graves' Disease.

By LEONARD WILLIAMS, M.D., M.R.C.P.

DR. LEONARD WILLIAMS made the following remarks on the case:—

This woman is suffering from exophthalmic goitre. This may seem somewhat surprising, for she has no exophthalmos, nor has she any goitre. These two symptoms are, however, by no means essential to the diagnosis of the condition, which is, for this and other reasons, better called Graves' disease. Some people lay great stress on certain eye symptoms in Graves' disease, such as Von Graefe's sign and Stellwag's sign. These two are, in reality, quite valueless as soon as the existence of exophthalmos has been established, because they are both of them entirely dependent upon, and are produced solely by, the protrusion of the eyeballs. Von Graefe's sign is that the upper lids tarry in their descent when the patient looks down, Stellwag's sign is the widening of the palpebral fissures. A moment's consideration will show that these two follow inevitably if there is, as it were, a force inside the cranium which pushes the eyeballs forward against the lids. Von Graefe's and Stellwag's signs are, therefore, unable to help us when exophthalmos is absent, and when it is present we can make our diagnosis without their assistance. There are, however, two ocular phenomena which are of real value in doubtful cases. One is definite diminution of the conjunctival reflex, which this patient has; the other is ptosis of the right eyelid. The latter is a curious sign which is seldom present, partly because it is rare and largely because it is transient. It does not generally last longer than a day or two at a time. It may affect the left lid, for aught I know, but in my own cases it has always been the right. The absence of thyroid enlargement is important. The gland is generally enlarged, frequently unilaterally, but the absence of any enlargement must not lead one to suppose that the case is therefore not one of Graves' disease. The presence of an enlarged thyroid to the exclusion of other obvious symptoms (exophthalmos, for example), is even more important, because if the physician forget that a goitre may exist for years without other obvious signs, he may be tempted to hand his patient over to the tender mercies of the surgeon with results which all parties will have cause to regret, because these people bear operations very badly.

Exophthalmos and goitre are, therefore, unreliable symptoms so far as diagnosis is concerned. If they are present, even in slight degree, they are both immensely helpful, but if either or both are absent the case may still be one of Graves' disease. There are, however, two symptoms upon which one can rely, namely, tachycardia and tremors. This patient has both in a very pronounced degree. Her pulse is 125, and on extending her arms and spreading out her fingers, you see that very decided coarse tremors are developed. The tremors in these cases are seldom coarse. They are, indeed, as a rule, so fine that it is easier to feel them than to see them. If the medical man place his finger-tips on the backs of the outstretched hands, he will often become conscious of tremors, very rapid and very fine tremors, which his eyesight may have failed to detect. Tremors are very characteristic of this disease. And not physical tremors only. These people suffer from a species of mental tremor, inasmuch as they are nearly always in a state of suppressed excitement. Not a few of them ultimately develop definite forms of mental alienation, especially women at or about the menopause. There are a great many other symptoms which may be expected in a case of Graves' disease, but I want to emphasise the fact that if the physician find a combination of tachycardia and tremors in a patient (even if that patient be a man), he should always be on his guard, for in ninety-nine cases out of a hundred he is in the presence of a case of

exophthalmic goitre. There is only one drug which has ever seemed to me to do much good in these cases, and that is belladonna. It frequently does a great deal of good, but, as frequently, it fails. Hygienic treatment is very important. If possible, these patients should be removed from large towns into quiet country districts where the wheels of being can be made to move slowly. Bracing climates are very injurious, so are stimulating foods. Meat should be deleted from the dietary and all forms of excitement or fatigue forbidden. Tepid salt water baths are very useful, especially when combined with gentle massage. Parents and friends should be told not to thwart or irritate these patients. This is in reality a counsel of perfection, because if sufferers from this complaint have no legitimate grievance they will always manufacture an imaginary one. They are generally very unreasonable.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

AN ACCUMULATION OF FLUID IN THE PROCESSUS VAGINALIS SIMULATING A RECURRENCE OF INGUINAL HERNIA AFTER A RADICAL CURE.—MR. WILLMOTT EVANS operated on a case of apparent recurrence of inguinal hernia after radical cure. The patient was a man, *æt.* 23, who had suffered from an inguinal hernia on the right side a few weeks after birth, and when *æt.* 8, a radical cure had been performed by another surgeon. From that period till a year before the present time he had been free from any sign of return of the disease. Within the last few months, however, he had noticed a gradually increasing prominence in the right inguinal region, and on account of this he sought relief. On admission he had in the right groin an oval swelling about the size and shape of a hen's egg; it was situated just below and internal to the external abdominal ring, and its long axis was directed downwards and inwards; it was soft on palpation, and gave an indistinct sensation of fluctuation; on coughing no well-defined impulse could be felt, and the swelling was only partly reducible; it gave rise to no pain and but little inconvenience, but the patient wished to have an operation performed to relieve him of it. An oblique incision through the skin was made over the long axis of the swelling and the tissues were dissected carefully until the "sac" was reached. When this was cleared from surrounding structures, it was evident that it passed from the external abdominal ring to the upper part of the testis. As the contents could not be returned into the abdomen, the "sac" was opened, and it was found to consist of a thin-walled cavity not communicating with the general peritoneal cavity, but formed of the remains of the unobliterated processus vaginalis. On making traction on the wall of the cyst the contents of the inguinal canal were brought down and it was clear that the "sac" was a constituent of the spermatic cord. The "sac" was ligatured at its upper part, and again just above the testis, and the cyst removed. The wound was closed and dressed. Mr. Evans said that it seemed to him clear that the condition which had been found was due to an accumulation of fluid in a processus vaginalis which had been obliterated near the internal abdominal ring and also just above the testis, but the intermediate portion had remained open; in fact, the condition was structurally identical with that known as hydrocele of the spermatic cord, but in this case the closure of the processus vaginalis was due to surgical interference. In his opinion, what had happened was this: At the operation fifteen years previously, the funicular process had

been ligatured as high up as possible, but apparently no attempt had been made to remove the portion of the processus vaginalis which lay in the spermatic cord. The processus had spontaneously become blocked immediately above the testis, but not elsewhere, with the result that fluid had accumulated in the unobliterated portion. So far as the cure of the congenital inguinal hernia was concerned from which the patient had suffered, it must be acknowledged, he said, that it was successful, but the moral of the case was, he thought, that it was not sufficient merely to tie the funicular process at its upper extremity or even just above the testis also, but it was desirable to dissect out all that portion of the processus which had no permanent function. The operation of the radical cure of congenital inguinal hernia in childhood, he pointed out, was so simple and so easily performed that the slight lengthening of the proceedings by removal of the processus from the cord could not be considered to increase materially the risk of the operation. The situation and the characters of the swelling pointed strongly to some form of recurrence of the hernia, but the present operation demonstrated that the hernia had indeed been radically cured.

Except for a slight collection of blood in the wound, the patient made an uninterrupted recovery.

ITALIAN HOSPITAL.

SQUAMOUS EPITHELIOMA.—MR. LENTHAL CHEATLE operated on a man, *æt.* 54, the subject of a squamous epithelioma on the edge and somewhat on the dorsal surface in the middle of the anterior two-thirds of the right side of the tongue. The patient was anæsthetised and the neck purified. An incision was made from the mastoid process to the sterno-clavicular articulation. The lymphatic glands in the anterior triangle were removed, the lingual and facial arteries were ligatured. A curved incision was then made in the skin from the symphysis of the lower jaw to join the first incision. The submaxillary, salivary, and lymphatic glands were removed, and also the submental lymphatic glands. The mylo-hyoid muscle and the anterior belly of the digastric muscle were retracted upwards and forwards. The posterior belly of the digastric muscle with the stylo-hyoid muscle were retracted backwards. The attachments to the hyoid bone of the hyo-glossus, genio-hyo-glossus, and inferior lingualis muscles of the right side were then cut away quite close to the bone. The stylo-glossus muscle was cut far back as it left the styloid process. The lingual artery and vein were divided and pushed upwards with the divided muscles, but otherwise left in their normal conditions. The rest of the right side of the tongue was then removed by cutting the tongue in half and cutting the mucous membrane away from the mouth by scissors. Mr. Cheatle said that the patient whose right side of the tongue had just been removed had been prepared for the operation in two ways—(1) decayed stumps had been extracted and his teeth thoroughly scrubbed and cleaned for a week beforehand; (2) he had been injected with a dose of dead staphylococci, and his opsonic index tested by Professor Wright's method, and his operation was performed when the index was high and not in the negative phase. The attempt to render him immune to staphylococcus was made because in examination of the discharge in two previous cases after excision of the tongue, staphylococci were the only micro-organisms present. Mr. Cheatle remarked that he quite saw it might be advisable to render the cases immune against other micro-organisms as well as staphylococci, but the matter required

further work and study. But the post-operative results when working against staphylococci only had been very encouraging. The next point to which Mr. Cheatle referred was the question as to when one ought to limit the operation to excision of half the tongue. It was by no means an easy question to answer. But, roughly speaking, he always adopted the following plan:—By two imaginary longitudinal lines he divided the half of the tongue in question into three imaginary spaces. If the cancer occupied the outermost space, only half the tongue could be safely excised, and even if the middle space were invaded half could be excised; but if the internal space were involved then the whole tongue must be removed. In the present case the cancer involved the outermost space, so it was quite safe to attack the corresponding half only. Mr. Cheatle pointed out that the method of attacking the tongue from its attachments to the hyoid bone was based upon the following observations made by him. He found that in many cases which died soon after operation for excision of the tongue secondary deposit was left behind in the hyo-glossus muscle, in the glossal fibres of the genio-hyo-glossus and also in the fibres of the inferior lingualis muscle. Although he cut the stylo-glossus muscle far back in this case, he has not found any secondary deposits in this muscle. Another reason for paying particular attention to these muscles individually, he pointed out, was the fact that primary growth of the cancer spreads in them and the formation of the primary growth corresponds to the size and shape of these muscles. The cause of this fact he put down to trophic influences. He drew attention to the further fact that the extent and depth of the downgrowth were often greater than the area occupied by the malignant ulcer on the tongue's surface; another fact supporting the view that trophic influences were inducing a greater spread of the growth in its depth than at its surface. Further, there are often absolute middle-line limitations of cancer of the tongue at its surface that, he believed, could only be explained by a neuro-trophic limitation as there is no mechanical or lymphatic causes that might account for it. The median septum does not reach the sub-mucous tissue, but ends in the muscles of the tongue.

SPECIAL ARTICLE.

UNIVERSITY EDUCATION IN IRELAND.

[FROM A CORRESPONDENT.]

WHEN Irishmen with a natural love of contention are provided at one and the same time with three such bones as education, politics, and religion, it is only natural to expect that the outside public will be invited to witness the strife. This is exactly what is happening in Ireland at the present moment. On March 7th, the Senate of the Royal University met and passed the resolution which we published in our last issue, calling attention to the necessity for reorganising the Royal University in such a manner as to constitute it a teaching body. On March 9th, His Grace, Archbishop Walsh, made at a Dublin Hospital meeting a serious attack on the School of Physic of Trinity College, Dublin. This attack was based upon sundry reports of inspectors sent by the General Medical Council to inspect the examinations of the School, and we think that we are not representing it unfairly when we say that it dwelt on every unfavourable criticism that could be found, and neglected all others. On Wednesday, March 14th, the Council of the Royal University Graduates' Association met in Belfast and adopted a series of resolutions which we publish in our present issue, condemning lock, stock, and barrel the resolution of the Royal University. On Thursday, March 15th, appeared in the daily press a letter from Professor Francis Dixon, University Professor of Anatomy in Trinity College in defence of his school. We trust that all those who have read Archbishop Walsh's speech at St. Vincent's Hospital will now in turn read the letter of Professor Dixon. The latter is studiously moderate in his tone, wonderfully

so, many people will think in face of the provocation he has received.

As a medical man and a graduate of Dublin University, the writer does not desire to enter into such controversies. He has also had numerous opportunities of making himself familiar with the manner in which examinations are conducted in three of the four licensing bodies in Dublin, but, from that very fact he is debarred from entering into details.

The impression that is left upon his mind by His Grace's speech is that, for some purpose best known to himself, His Grace has decided to ride for a fall in the eyes of those who are familiar with examinations in general and who know the opportunities which the reports of inspectors offer for *ex parte* criticism. He also appears to voluntarily ride for a fall in the eyes of those who, knowing nothing of examination method, yet know something of the principles of fair comment. It is inconceivable that an able and most highly educated gentleman could suppose that either of these two classes could be influenced by such a speech, save, perhaps by its element of ridicule. The one class knows that not alone was there never yet an educational body that escaped comment at the hands of outside inspectors, but that every medical licensing body in the United Kingdom could be criticised with equal facility were similar methods adopted; while the other class knows that fair comment is hardly couched in the form adopted by His Grace, and that, when only praise of one examining body and only blame of another are brought to light, there must be omissions and there must be animus. Can it be that His Grace intended his speech, not for his educated listeners, but for the larger democratic body to whom its suppressions and inaccuracies will not be apparent?

No one, and certainly least of all the writer, will deny that there are faults in the examinations of Trinity College. Every educational body has its faults, and many of these were noted and adversely criticised by the *inspector*—for on the last occasion to which Archbishop Walsh refers there was but one, and we regret to say that the medical profession has since been made the poorer by his death. At that inspection, although he was a most able inspector, several criticisms were made through a misconception either of methods or of facts. He was at the time placed in the difficult position of discharging the duty of an absent colleague as well as his own, and, possibly, in the hurry of discharging both, mistakes occurred. Were he alive and free to express his opinions, we doubt if His Grace's deductions would be allowed to pass uncorrected.

To the writer, as an outsider, there is a sad point in the affair that has been overlooked. Do such attacks by Irishmen on Irish Institutions redound to the credit of Irishmen? What would be thought of an Archbishop of Canterbury, if perchance he was a graduate of London University, had he gone to a London hospital and criticised the Oxford Medical School with a spirit and a purpose similar to that of His Grace of Dublin? Had he looked over the reports of the Inspectors on that School, he would have found his material. Nay, had he turned to the report of any examining body he would have found sufficient material for a similar purpose. What would have been said of the Provost of Trinity College, if he had made a visit to the Adelaide Hospital an occasion for a vitriolic attack on the School of Medicine of the Catholic University, and took for his text any of the slips or accidents which may take place in that excellent institution, as in any similar institution, from time to time? We venture to say that such attacks would have met with the condemnation not alone of the friends of the Bodies into which the attackers stuck their verbal darts, but by their own colleagues.

His Grace uses dangerous weapons. Were Trinity College what he painted it, they might return to him poisoned, instead of as Professor Dixon has handed them back.

[We shall be glad to publish any further expressions of opinion on this important subject.]

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, FEBRUARY 16TH, 1906.

SIR THORNLEY STOKER, President of the Academy, in the Chair.

ABDOMINAL AND PELVIC TUBERCULOSIS.

DR. LITTLE, having briefly referred to some elementary facts in connection with the pathology of tuberculosis, discussed the symptomatology and treatment of tuberculous disease as it affected the peritoneum, the intestines and the mesenteric glands.

SIR WILLIAM SMYLY said that the study of tuberculosis of the female genitals during life has only been rendered possible since the use of the curette and abdominal section have come into vogue. The Fallopian tubes are the organs by far the most frequently affected, the uterus fairly often, other parts but rarely. The most interesting points connected with this subject are the possibility of infection through spermatic fluid, and also the infection of the fetus by its mother. The difficulties attending diagnosis are so great that until the parts have been examined by the microscope it can rarely be attained with certainty. Neither the shape of the tumours, nor the thickening of the uterine end of the tube, to which so much importance has been attached by Hegar, nor the nodules on the folds of Douglas, being peculiar to this disease. As regards treatment, the removal of the diseased organs is an operation amongst the most difficult and dangerous in surgery, and not infrequently leaves the unfortunate patients with incurable fistulae.

Professor McWEENEY referred at first to his experience with regard to the urine in cases of genito-urinary tubercle. He found tubercle bacilli without difficulty in about 90 per cent. of purulent urines, with a distinctly acid reaction. The tubercle bacilli are usually agglutinated, owing to the saline concentration of the urine, and accompanied by polynuclear pus cells, owing, no doubt, to liberation of their proteins by osmosis or plasmolysis. He next dealt with the hypertrophic variety of tuberculosis of the ileocolic region of the bowel, and exhibited naked eye and microscopic preparations illustrating its morbid anatomy. He emphasised its resemblance to cancer and its manifold differences from the ordinary tuberculous ulcerations; met with in consumptives who swallow their sputum. He suggested that it might be due to ingestion of bovine bacilli. Finally, referring to the results of the most recent work in this department, he observed that Behring's belief in the intestinal origin of pulmonary consumption had received confirmation at the hands of Calmette, of Lille, and his pupils, who found that pigment ingested by adult animals found its way at once to the lungs, whilst in young animals it was at first stopped in the mesenteric glands. Calmette had, moreover, succeeded in producing pulmonary tuberculosis, without lesion of the gastro-intestinal *mucosa* or of the mesenteric glands, by introducing suspension of tubercle bacilli into the rumen of adult goats. These results, if confirmed, together with the disproof of Koch's assertion—that bovine bacilli are innocuous for the human race—should put us more on guard than ever against the dangers of infected ingesta.

Mr. T. E. GORDON said that there had not been any notable advance in the surgery of abdominal tuberculosis during recent years. Laparotomy was frequently successful in curing the ascitic form of tuberculous peritonitis, but was not invariably so—perhaps it was less frequently successful than generally supposed. In the fibrous form the results of operations were almost uniformly bad, except in cases of well

localised abscess; even in these an intestinal fistula was likely to result. It seems reasonable to hope that some of these cases of fibrous and caseating tuberculous peritonitis will be cured by tuberculin.

Mr. GORDON read an account of a case of chronic abscess successfully treated by tuberculin (Dr. Gunn's case). When extensive adhesions have formed, the cure by tuberculin or any other treatment cannot be complete, for matted intestines are in themselves a source of distressing symptoms and danger. Speaking of tuberculous growths in the intestine giving rise to fibrous overgrowth and causing chronic obstruction, Mr. Gordon related the case of an old man for whom he had short-circuited a portion of ileum with temporary success. Some months later the man returned to hospital with fresh obstruction and died. At the autopsy no less than five different tuberculous masses were found in different parts of the small intestine. It seems clear that tuberculin treatment can never replace surgery in cases of this type, but it seems possible that by its use, as an after-treatment, what was only palliative may become curative. The speaker had not himself met with a case of tuberculous appendicitis. He had seen a case of tuberculous stomach ulcer, and he suggested that some of the cases of chronic ulcer with marked fibrous thickening, which are now regarded as simple, may prove to be tuberculous. Mr. Gordon concluded by saying—"Looking forward we may, with reason, hope for better results (in tuberculous disease of peritoneum and intestine) aided by tuberculin. Still it seems improbable that here the new treatment will have its greatest triumph, for neither in fibrous peritonitis nor in intestinal obstruction can it be expected to remove the mechanical disablement caused by the tuberculous disease."

Professor WHITE dealt with Wright's recent work, and stated that the good effect of operations in certain cases of tuberculous peritonitis depended mainly on two factors—the first being the replacing of a fluid containing little or no protective substances by a fresh fluid containing a much larger amount, and the second being the rise in the opsonic index due to auto-inoculation which results from operation. He illustrated both factors by several curves of the opsonic index in cases of a tuberculous nature which had been operated upon. He also demonstrated a fall in the opsonic index in four cases of tuberculous peritonitis which had relapsed, and in the only case which he had examined where the patient remained well the opsonic index was above normal. He considered that in future the treatment of tuberculous peritonitis would consist in raising the index prior to operation, and, subsequently, after the effect of the auto-inoculation produced by the operation had passed off, in keeping the opsonic index high, by suitable interspaced inoculations, until the local condition was quite healed.

Dr. PARSONS drew attention to the occurrence of tuberculosis in hernial sacs, and said he had a patient suffering from that affection who showed no signs of abdominal tuberculosis. He recently saw an account given, by Dr. Carmichael, of 154 cases of hernia in children. Four of these were tuberculous, and in one of the four there was found general infection of the abdominal cavity.

Dr. COLEMAN said he thought that both the diagnosis and treatment of tuberculosis had been placed on a very satisfactory footing by Wright's method. Wright had treated severe cases of tuberculous peritonitis with success. That method, however, was not suited for every case.

Dr. PUREFOY said he saw tuberculous conditions of the genital tract in two puerperal cases. Both patients died a few weeks after delivery of advanced pulmonary phthisis. One of these had borne several children.

In her case he found projections, like yellow pustules, on the posterior vaginal wall. One case of tuberculous nodules on the uterine end of the Fallopian tube has been reported.

Sir THORNLEY STOKER said that Dr. Coleman seemed to be curing by Wright's method patients that he had failed to benefit by operation. Two years ago a patient came to the Richmond Hospital with a tumour in her right iliac region. He explored it, after incision, and found a hypertrophic tuberculous mass in the ascending colon, which he removed. The patient never got a rise of temperature, and left the hospital well.

Mr. J. M'ARDLE said, in reference to tuberculosis in a hernial sac, that where a hernia had been present for some time the intestinal wall was weakened, and it was this condition that allowed the tubercle bacilli to permeate it. As to the possibilities of the tuberculin treatment, we were now employing no haphazard method. He did not think, however, that we had yet got a panacea for the lesions caused by the tubercle bacillus.

Dr. TRAVERS SMITH said in his clinical experience diarrhoea was not a constant symptom of tuberculous ulceration of the intestine. Dr. Earl made a *post-mortem* examination of a boy, æt. 14, who died from pulmonary tuberculosis, whose large and small intestine were extensively ulcerated. He also expressed surprise at Professor McWeeney's statement that 90 per cent. of acid urines containing pus were tuberculous.

Mr. E. H. TAYLOR mentioned the case of a man who came to hospital about a fortnight ago with pain in the abdomen and swelling in the right side. Opening the abdomen, he found a tumour as big as an orange in the ascending colon, above the cæcum. The muscular coat of the ileum was hypertrophied, and some of the neighbouring glands were caseating. We regarded it as tuberculous. After operation the patient got well.

Dr. MOORHEAD spoke of a case of hypertrophic tuberculosis of the cæcum, which had been remedied by complete excision of the cæcum and ileum.

Dr. LANGFORD SYMES said tuberculous ulceration of the genital tract, even in children, was said to have occurred. There was a variety of tuberculous peritonitis in children in which infection was brought about by means of the umbilical cord. The abdomen was enormously distended by gas, the child wasted considerably, but there was no ulceration of the bowel. Extensive miliary tubercles were present. A foul and fetid discharge from the umbilicus in young children was connected with tuberculous affections.

BRITISH GYNÆCOLOGICAL SOCIETY.

SPECIAL MEETING HELD MARCH 8TH, 1906.

MR. BOWREMAN JESSETT, President, in the Chair.

The resolutions carried at the special meeting of the Society held on February 8th were unanimously confirmed, and the Articles of Association of the Society altered by adding the following resolutions:—“(1) That in the event of any vacancy occurring amongst the officers of the Society or in the Council, by death, resignation, or in any other manner, the Council shall have power to fill such vacancy from amongst the Fellows of the Society. And any Fellow so appointed by the Council shall hold office until the next Annual meeting. (2) That in view of the proposed amalgamation of London Societies recently brought before this Society and approved of, ‘The Examination of Nurses be discontinued.’

The ordinary monthly meeting of the Society followed.

Dr. JELLETT showed specimens (1) Advanced carcinoma of both ovaries, and (2) Double pyosalpinx, associated with the presence of a four months' extra-uterine fetus, which will be found, with illustrations, on page 307.

The PRESIDENT said they were very much indebted to Dr. Jellet for showing these interesting specimens. He considered the operation in the first case was undoubtedly justifiable, and the result proved it to be so. He asked whether there was any glandular mischief present?

Dr. C. H. F. ROUTH said the first case exhibited the finest technique. No man who thoroughly understood his work could have dealt with the case otherwise than had been done. He maintained that the operation was perfectly justifiable. If a patient was certain to die without an operation, he considered one ought to operate as the only hope of saving life. He had seen cases admitted as hopeless, and yet after being operated on complete recovery ensued. He remembered one case at a general hospital, where five members of the staff gave their opinion that it was inoperable, while he advocated operation; the advice was acted on, and the patient recovered.

Dr. SLIMON asked whether a transverse incision was absolutely necessary; also whether ventral suspension in the second case was necessary.

Dr. MACNAUGHTON-JONES, in showing some specimens illustrative of Dr. Jellet's case, said that he had no doubt as to the justification for this operation. In one of his cases (ovaries shown) the patient weighed only five stone before operation—one ovary was converted into the huge carcinomatous mass (shown) the other was a large fibro-adenoma—the patient was in as bad a state as she could be. She grew strong after the operation, but about six months after she died of obstruction of the bowel, which was due to secondary infection of the bowel. In the other case the two large cysts (carcinomatous ovaries, shown) were removed, and the two myomata enucleated, when the patient was in a very hopeless state, but she made an excellent recovery and lived for over a year, the disease, as in the last case, recurring in the bowel. He showed an adeno-sarcoma of the ovary recently removed from a patient æt. 62, who was doing remarkably well. A few practical points in relation to these cases were worth remembering. First, that in bimanual examination under an anæsthetic, if too much force be used the cysts, adenomatous, sarcomatous or carcinomatous, were apt to be ruptured, and if not immediate peritonitis, secondary metastatic infection might follow. He had known this occur rapidly in one case. Secondly, many of these carcinomatous and sarcomatous ovaries caused so little pain that the presence of malignancy, or indeed of anything serious being wrong, was not suspected until a short time before operation, and, in the absence of any constitutional signs, malignancy was not suspected or discovered until operation. In regard to the ectopic gestation, he fancied the salpingeal trouble preceded the gestation.

Mr. RYALL remarked the case was one of double cancer of the ovaries and the after-history would be interesting. As far as peritoneal infection was concerned he did not believe it was so serious to damage a malignant ovary during operation. It was not as serious as breaking into a malignant growth in other organs. A short time ago he operated upon a case of malignant ovary. At first he thought it was a simple cyst. The patient had also a mass in the pylorus, and it was just an ideal case for pylorotomy, but she had many other growths elsewhere, therefore nothing further was done. She died about a month later as the result of abdominal invasion.

Dr. HODGSON said he did not think there could be any doubt about the advisability of operating on a patient who was about to die if there was any chance of benefit resulting.

Mr. H. OVERY said the second case was one of incomplete abortion. The interesting point to him was its etiology. It seemed that the pyosalpinx was probably subsequent to the extra-uterine foetation. He asked whether there was any history of discharge from the vagina during the latter months. There was no doubt that a tumour might subsequently become

malignant. Recently he did a *post-mortem* examination and on opening the abdomen found a large ovarian cyst, apparently a simple one, but one part of it had become malignant and was attached to the bowel. The bowel was invaded and intestinal obstruction had taken place. The carcinoma was probably a primary one of the ovary and not of the bowel. There was no doubt that an ovarian cyst might become malignant later.

The PRESIDENT thought the opinion that operation was not justifiable in these cases to be untenable. He knew several cases in which the patients who were practically dying had been operated upon and lived for years afterwards. He had a case under his care of a large growth of the pylorus, apparently malignant, where the patient would undoubtedly have died in a few hours, upon whom he performed gastro-jejunostomy and she lived for twelve years afterwards, when she died of another disease altogether. He had another case, one of carcinoma of the breast, so bad that it was given up as absolutely hopeless. At the express desire of the patient he removed the whole of her breast, pectoral muscles, and cleaned the axilla. That was sixteen years ago and she was alive and well to-day. He thought it most absurd to say that because a patient is *in extremis* one is not to give her a chance of life by operation. It has been stated that if an erosion bled freely on examination it was malignant, but that was not his experience. He understood the erosion in this case bled very freely, but yet was not malignant. As to the variety of incision which should be made in cases of cysto-carcinoma of the ovary, he thought it should be free, and that the cyst should be removed in its entirety. He had no experience in transverse abdominal incisions, as he always found longitudinal incisions to be sufficient.

Dr. JELLETT, replying to the President, said that in the case of advanced carcinoma of both ovaries, by the time the latter had been removed, the patient's pulse was 160, as she had been bleeding very profusely. There was consequently no time to examine the lumbar glands to ascertain whether they were affected. He did not make a transverse incision at first, because it was exploratory. The transverse incision which he subsequently made was about the only instance in which he had made that class of incision, and in this case it was necessary. He could not retract the abdominal walls sufficiently to get round the tumour, neither could he separate the latter in front or behind, so that he thought a transverse incision was the best to make with the object of getting outside the tumour. The incision healed well in spite of infection from the pus in the pelvis. He was glad there had been a unanimous opinion that the operation was advisable and justifiable. With regard to the case of double pyosalpinx, he granted there might have been a salpingitis previously to pregnancy but not a pyosalpinx. As to the question of bacillus coli infection from the rectum, there was no peritonitis subsequent to the operation. The pus at the time of the operation was apparently sterile as shown by the fact that the patient had no elevated temperature subsequently. The President had asked a question with regard to bleeding of the erosion. The section of the cervix which he removed was examined, and it consisted of an adenomatous growth. It bled because there was probably considerable uterine congestion, and though it suggested malignant disease, nevertheless it proved to be non-malignant.

Notes of cases were subsequently read by Mrs. Scharlieb, and a paper by Dr. Jellet, these with illustrations and discussion will appear in our next.

HARVEIAN SOCIETY OF LONDON.

CLINICAL MEETING HELD ON MARCH 8TH, 1906 (at the Hospital for Epilepsy and Paralysis, Maida Vale).

Dr. LEONARD GUTHRIE showed a case of Congenital Ataxy in a boy, *æt.* 5½. There was inco-ordination and intention tremor of the upper extremities, and the gait was unsteady. The knee-jerks were exaggerated.

Instruments had been used at birth. He attributed the condition to cerebellar meningeal hæmorrhage. He also showed two cases of Infantile Paralysis.

Dr. CAMPBELL THOMSON showed a case of Paralysis Agitans, with a peculiar gait which he termed intermittent claudication.

Dr. J. BROADBENT considered the condition to be functional.

Dr. GUTHRIE also held that the gait was functional. Mr. BARKER (for Dr. Ogilvie) showed a case of Tabes Dorsalis, in which great improvement in co-ordination had resulted from physical exercises.

Mr. MAYOU showed a case of Double Congenital Ptoxis in a child, and also a case of Paralysis Agitans in which rigidity without tremor was present.

Dr. BARKER (for Dr. Wilfred Harris) showed a case of Spasmodic Torticollis in a man, *æt.* 41, in which improvement had resulted from excision of a portion of the spinal accessory nerve, but the spasm was not completely arrested.

LARYNGOLOGICAL SOCIETY OF LONDON.

MEETING HELD FEBRUARY, 1906.

The President, Mr. CHARTERS SYMONDS in the Chair.

CASES were exhibited by the President, Drs. J. Donelan, Dundas Grant, Furniss Potter, Scanes Spicer, W. H. Kelson, and Stuart Low.

The PRESIDENT and Dr. DUNDAS GRANT exhibited cases of Frontal Sinus Suppuration, which had been treated by intranasal methods including dilatation of the infundibulum by means of bougies, and irrigation after removal of a part of the middle turbinal body. Skiagrams were exhibited showing the canula *in situ*.

The PRESIDENT considered that in a certain number of cases where there was pure frontal sinus disease it seemed possible to effect a practical cure.

The PRESIDENT also exhibited a case of Suppuration of the Left Frontal and the Left Maxillary Sinuses, in which irrigation alone had not effected a cure. The frontal sinus was opened externally, the lining membrane was entirely removed; the wound closed and the sinus treated by irrigation. The nasal suppuration was of eight years duration, and no recurrence had followed the operation. He considered the method superior to packing or the use of drainage tubes through the nose.

Dr. DUNDAS GRANT also exhibited a case illustrating the use of injections of cold paraffin for overcoming nasal deformity. The point in its favour was the immense convenience of being able to inject it without heating and without scalding the patient. It was urged on the contrary that the results would not be so permanent.

CORK MEDICAL AND SURGICAL SOCIETY.

MEETING HELD WEDNESDAY, FEB. 28TH, 1906.

The President, Dr. R. P. CROSBIE, in the Chair.

VESICAL CALCULUS IN A GIRL *ÆT.* 9.

Dr. COTTER read notes of this case. Patient did not complain of pain until December last, but the urine was "heavy" for some time previously. The pain was increased by jolting, and blood appeared in the urine, whilst vesical tenesmus and sudden stoppage of the flow occurred. Examination revealed a greatly enlarged clitoris, and per rectum, as well as by using the sound, he found that a large calculus was present. He decided to do suprapubic cystotomy, and in order to raise the bladder as high as possible, put the patient in the Trendelenburg position, which proved more convenient than the rubber bag in the rectum. He had no difficulty in removing the stone, which was as big as a Brazil nut, and, as its section showed, composed of phosphates laid down on a nucleus of uric

acid. The bladder was drained with a rubber tube, and the wound closed in eighteen days.

Dr. CUMMINS, Dr. O'BRIEN, and the CHAIRMAN spoke approvingly of the adoption of the Trendelenburg position in this operation. Dr. O'Brien thought that the use of a rubber catheter, passed into the bladder through the operation, would have ensured more satisfactory drainage, and cited a case of his own in support.

REPEATED EXCISION OF THE KNEE-JOINT.

Dr. CUMMINS showed a girl, *æt.* 16, on whose left knee he had done, four years ago, an excision. He used Allingham's method—*i.e.*, longitudinal section of the patella, and removed all the affected tissues. The patient made a good recovery, and he showed her to the Society at that time. Unfortunately, some time after this she injured the joint in a fall, and presented herself again with the knee flexed at right angles; he again operated, this time adopting the transverse U-shaped incision, with transverse section of the patella, and removing a wedge-shaped piece of bone. The result was that the patient had an excellent limb, which was only 1½ inches short.

Dr. COTTER preferred the U-shaped incision, as it gave better access to the joint, and thought that it was of the utmost importance to fix the joint carefully after operation. He recommended House's splint for that purpose.

Dr. CUMMINS, replying, disagreed with Dr. Cotter about the incision. Having tried both, he found Allingham's method more satisfactory.

Dr. BARRY gave an account of "Secretin: its Preparation and Use in the Treatment of Diabetes Mellitus."

CASE OF ADDISON'S DISEASE.

Dr. CUMMINS showed suprarenal glands of a patient affected with this disease. The patient, a woman, showed the classical signs and symptoms, pigmentation and grave asthenia. There was no deposit of pigment in the buccal mucous membrane. *Post mortem* fibro-caseous disease of the suprarenal glands was discovered, with evidence of considerable inflammation around them, the right organ being adherent to the liver. Emphysema of both lungs existed, and a healed nodule, probably tuberculous, was found in the left lung. He commented on the extraordinary way in which the suprarenals at both sides had alone become affected, the small deposit in the lung excepted, and thought there must be some selective action at work in such cases.

PERFORATED GASTRIC ULCER, WITH RECOVERY UNDER MEDICAL TREATMENT.

Dr. BOOTH read notes of a young lady, with a history of indigestion, who had suddenly been seized with intense pain and collapse followed by vomiting. Examination revealed intense tenderness in the epigastric angle, the seat of the pain, board-like rigidity of the recto muscles, and disappearance of the liver dulness. The temperature was 97° and pulse 115, respiration rapid, shallow, and thoracic, whilst the patient had a very anxious expression of countenance. Recognising the gravity of the case, and suspecting a small perforation of a gastric ulcer, a second opinion was asked for, and Dr. Cummins came and confirmed the diagnosis. The friends refused to put her into hospital, and would not hear of an operation should such prove necessary. Accordingly, morphia was given hypodermically for forty-eight hours, saline enemata, which were well retained, given twice daily, and nothing at all given by the mouth for a week, patient being fed on nutrient enemata, given every four hours. At the end of a week hot water in small quantities was given by the mouth, subsequently albumin water and chicken broth, and finally peptonised milk. The temperature varied between 99·2° and 100·8° for the first week or ten days, the pain and tenderness gradually disappeared, and patient made a good, if tardy, recovery.

ULSTER MEDICAL SOCIETY.

LABORATORY MEETING IN THE ANATOMICAL DEPARTMENT, QUEEN'S COLLEGE, HELD ON THURSDAY, MARCH 15TH.

The President, Dr. Wm. CALWELL, in the Chair.

PROFESSOR SYMINGTON gave a demonstration of the "cerebral hemispheres in apes and man," illustrated by specimens and lantern slides. He traced the development of the brain from its simplest form in the marmoset upwards, paying special attention to the motor and visual areas. The very beautiful figures which he showed, which were all but one from specimens in his own possession, will, it is understood, be used in the forthcoming edition of "Quain's Anatomy."

Dr. W. J. WILSON gave a demonstration of "bacterial pleomorphism," illustrated by micro-photographs. The organisms dealt with were the *B. Coli*, Friedlander's pneumonia bacillus, and the plague bacillus, and the effects on each of these produced by urea in the culture medium was shown.

Dr. KIRKHOPE gave a demonstration of "infarcts of the placenta," illustrated by a series of micro-photographs.

Dr. CECIL SHAW gave a demonstration of the use of Zeiss's new projection microscope with micro-planar lens. Various microscopic sections of the eye were shown on the screen. The apparatus can be used in an ordinary class-room with lime-light, but if the electric arc light can be used it gives a much finer result.

Dr. LOWRY read a paper on "IRREGULAR CONTRACTIONS OF THE STOMACH AND THEIR RELATIONS TO HOUR-GLASS CONTRACTION." During the winter, Dr. Lowry has observed a number of cases in the anatomical rooms which at first sight seemed pathological, but were soon found to be too numerous to be so, in which the stomach had assumed a shape which in life would be considered pathological. These specimens were shown, and Professor Symington also showed a number of casts made by him from similar conditions observed by him.

A lively discussion on these specimens took place. Professors Symington, Lindsay, Symmers, Drs. Mitchell, McKisack, Fullerton, Dempsey and Calwell taking part. Several members considered these appearances due to rigor mortis, while others agreed with Dr. Lowry that they supported the theory of Canon, that the cardiac portion of the stomach acts as a reservoir only and the pyloric portion is the gastric mill where digestion proceeds.

Professor MILROY showed sections illustrating new methods of staining for the study of the central nervous system.

Professor SYMMERS showed a number of pathological preparations.

Professor SINCLAIR showed a series of tumours of the superior maxilla, and an osteo-sarcoma of the thigh.

Mr. A. B. MITCHELL showed (a) a cystic kidney mounted in glycerine; (b) a herniated appendix in a child; (c) an enchondroma of the scapula.

Mr. T. S. KIRK exhibited (a) a thyroid tumour; (b) a huge lipoma; (c) a carcinoma of the rectum; (d) a myxo-sarcoma.

Dr. J. SINGLETON DARLING exhibited (a) a malignant uterus removed by total hysterectomy; (b) a sarcoma involving the inferior maxilla.

Mr. ANDREW FULLERTON exhibited (a) a large kidney tumour; (b) a mixed carcinoma and sarcoma of the breast; (c) a carcinoma of the rectum.

Mr. R. J. JOHNSTON exhibited (a) three uteri removed by Wertheim's method; (b) a simple adenoma and a malignant adenoma; (c) several myomatous tumours.

Dr. BLAKELEY exhibited various microscopic sections.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS. ABROAD.

FRANCE.

Paris, March 17th, 1906.

TREATMENT OF EPILEPSY.

THE treatment of epilepsy consists, according to Prof. Rauzier of Montpellier, in first calming the hyper-excitability of the brain and secondly in avoiding everything that might provoke this hyper-excitability.

The first indication is met by the administration of bromides and particularly of bromide of potassium. The salt should be as pure as possible, that is to say without any mixture of chlorides, iodides, sulphate or carbonate of potash. Bromide of sodium was formerly recommended as a substitute to avoid the toxic action of potash salts; but it is inferior to them and the same may be said of the bromides of ammonium, strontium, lithium, gold, arsenic; bromide of camphor however, in doses of five grains three times a day, appears to possess an elective action on vertigo and loss of memory.

Ball and Charcot came to the conclusion, after repeated experiments, that the association of several bromides gave results superior to those furnished by an equivalent dose of one of them and recommended the use of poly-bromides, a mixture of bromide of potassium, sodium, and ammonium, the former predominating.

In what dose must the bromide be given? The answer depends on both the frequency of the attacks and the age of the patient. For the adult the average dose is one drachm or a drachm and a half a day, in aggravated cases the dose might be carried to two and three drachms. In one instance a daily dose of one ounce was given without causing any inconvenience.

By what sign can one know that the dose of the bromide in a given case is sufficient? Formerly anaesthesia of the pharynx was considered as the criterion, but that fact is not proved. Gilles de la Tourette demonstrated the value of another sign, that of the pupil. When the organism has been saturated with the bromide, the pupils dilate largely and are sluggish to the influence of light; where the dose is weak, on the contrary, the pupils either remain stationary or are but slightly dilated.

To avoid saturation and to prevent the patient from getting accustomed to the prescribed doses, it is the rule to administer the bromide by increasing and decreasing doses alternately.

For that purpose, the month is divided into two or three periods, each of them corresponding to the number of drachms prescribed, the larger doses coinciding with the period of the month in which the attacks generally come on.

The usual means of penetration for the solution of bromides is the mouth, the rectum is reserved for cases of gastric intolerance or during the attack. To mask the taste so disagreeable to some patients, Prof. Rauzier recommends the bromides to be taken in Vichy Water, milk, or beer.

How long should the treatment be continued? Voisin fixes the duration at ten years, but Gilles de la Tourette and M. Rauzier consider that that period should be considerably reduced, though a great deal depends on the intensity of the malady. In any case the treatment should be continued without interruption for a whole year. If the case is not a very severe one, the dose might be decreased progressively during the succeeding six months and finally suspended for a time. If on the other hand the form is grave, if the attacks follow closely on each other and resist the treatment, its duration should be considerably prolonged.

The results of the bromide treatment are generally favourable; with the first doses the number and

intensity of the attacks diminish; frequently they are suppressed for long periods and sometimes radical cures are effected. Unfortunately it is not always so; in a certain number of cases no result is obtained in spite of the most rigorous treatment.

The accidents termed bromism are well-known and with a view of minimising them Prof. Rauzier recommends (a) intestinal antiseptics; (b) arsenical preparations; (c) periodical purgatives; (d) diuretics, and particularly milk. One or two of these agents might be associated with the bromides as follows:

Bromide of potassium, 40 grm.;
Bromide of sodium, 20;
Bromide of ammonium, 10;
Benzoate of soda, 7;
Arsenical of soda, 0.08;
Water, 1 litre.

Three tablespoonfuls a day during the first week, four the second week, and five the third and fourth week.

To be continued without interruption for at least one year.

The second indication that of avoiding all excitability of the nervous system will be fulfilled by a lacto-vegetarian regime, frequent purging, and an absence of salt from the food. Besides, the patient will be enjoined to take physical and mental rest and to avoid any; over-exertion, excesses, or emotions.

GERMANY.

Berlin, March 17th, 1906.

At the Medical Society, Hr. O. Hauser discussed
OVERFEEDING OF INFANTS.

He said that although the feeding of infants had made great advances during the past few years in the better families, so that serious cases of diarrhoea with vomiting were becoming rare occurrences, yet in these same classes cases were frequently seen in which, without question, over-feeding had taken place. This was often begun during intra-uterine life, and huge children were born into the world, the birth of whom was hindered by their colossal size. That this intra-uterine fattening was not desirable, the experience of agriculturists with their cattle had shown.

It was still the end and aim of mothers to increase the weight of their children, and the only criterion of their thriving was the weighing scales. In the dilution of the milk in the first months of life, not enough attention was paid to the amount of fat contained in it; this was subject to the greatest variation in the different samples of such milk; later on foods were used, such as good butter, chocolate, sweets, artificial food preparations, and the like, all substances highly concentrated and containing no ballast. No wonder, therefore, that the digestion became upset and the children lost their appetites, even if these poor creatures had never learned the feeling of hunger. In infancy the child, up to this well nourished, suddenly became restless, began to take its food badly and to cry. Digestion ceased. With the idea that the food had been poor, it was made stronger, and the difficulty of getting it down became greater and greater until the usual growth-rate stood still. If food poor in fats was now given, the condition improved in a short time.

For the so-called exudative diathesis (urticaria strophulus, weeping rashes, &c.) the fatty constituent of the food was of importance. Experience also taught that fat-bodied children with rickets learned to run later than those normally nourished, and they got bow-legged.

General fattiness injured the heart, as we know in adults. Over-feeding threw more work on the bowels, for these did not develop; laxity followed, and finally function ceased; it was therefore a condition that might have the most severe consequences, and should be avoided. In the selection of food for infants, therefore, more attention should be paid than was

done to the calories of the food given, and to the individual constitution of the child.

Hr. Langstein remarked that an earlier work of Gzerny's was on this subject. Over-feeding was observed among children of poor people treated in the out-patient departments of hospitals, where food was given too often. In contrast to Breslau, where over-feeding was mostly from carbohydrates, it took place from milk in Berlin and was therefore accompanied with fat.

At the Laryngological Society, Hr. Grabower showed a youth, æt. 17, suffering from

PARALYSIS OF THE RIGHT RECURRENT NERVE FROM EXTIRPATION OF THE THYROID.

Immediately after the operation the voice was good, but the breath was short. Four days later this shortness of breath disappeared, but hoarseness took its place. On the seventh day the right vocal cord took the position of that of the cadaver; the left, on phonation, reached to the middle line. It was not until two or three weeks after that it passed the middle line, and it now lay alongside the paralysed cord. As in experiments on animals, it must be assumed that the cord was held tense by the crico-thyroid, and that it only assumed the cadaveric position on paralysis of this.

The speaker observed that it was usually the right recurrent nerve that was severed in thyroid operations, and that this occurred through the text-books giving incorrect information that the recurrent on its return passed between the trachea and the œsophagus. This was so as regarded the left nerve, but the right passes into the groove only at the level of the ninth or tenth tracheal ring.

THE SERUM TREATMENT OF SCARLATINA.

The *Deutsche Med. Zeitung*, No. 11, contains a reference on this subject to a paper by Dr. C. Zuppinger. He recommends the use of Moser's scarlatina serum in severe cases of the disease, and reports on thirty-eight cases treated by it during two and a half years. Ten of these were severe cases, of which six recovered and four died; there were further five cases in which the prognosis was almost fatal four of which recovered, and lastly, three cases with an absolutely fatal prognosis, all of which recovered.

It was of the utmost possible importance to inject early, and best during the first three days of the disease, and before general sepsis supervened. The treatment proved most effective in those cases in which the throat symptoms were the most pronounced; its action was less marked on the local processes in the nose and throat, although it did exert influence on these localities.

In most cases a critical fall of temperature took place (1° to 3° C.), with a succeeding sub or afebrile stage, the general condition improved, the pulse and respiration frequency fell.

The autopsies on the fatal cases showed, as regarded the first, purulent peritonitis, pneumonia, pleurisy, nephritis; death seventeen days after the injection. Second, scarlatina intoxication with hæmorrhagic nephritis and purulent cellular infiltration of the injection site on the left thigh. Three and four died of extensive inflammation of the lungs on the eighteenth and thirtieth day respectively.

Five after sixteen days of septicæmia and pericarditis, purulent and hæmorrhagic nephritis.

Nephritis took place in six of the twenty-eight cases; in fifteen a serum exanthem between the fourth and sixteenth day an urticaria-like rash, partly with and partly without fever. As regarded the quantity of serum injected, it was 100 to 300 ccm. in the severe cases. Several times along with diphtheritic serum when there was diphtheria as well. The writer claims that when injected in full dose and at the right time Moser's serum has a powerful specific action on the scarlatina poison, and that in severe cases "it alone has saved life up to the present."

AUSTRIA.

Vienna, March 17th, 1906.

GRIPPE-ENDEMIC.

JEHLE brought the subject of epidemic Grippe before the "Gesellschaft" for internal medicine, which he had investigated at the St. Ann Hospital. This investigation arose in consequence of a repetition of similar cases coming into the institution during the months of October and November last year, and running the same course with similar symptoms, viz. high fever, sneezing and running at the nose without any other clinical symptoms or sequelæ except the rapid fall off in weight. In October the first was admitted as a simple fever which continued ten days and then subsided. Before the defervescence occurred other three were admitted, rapidly succeeded by others in greater number. In November a pause intervened, but the beginning of January brought five new cases, succeeded by another rush of new cases. This occurred three times with the same results. The children in the hospital were isolated and thus escaped the infection which evidently persisted at these periods. The nasal secretion and the presence of the micrococcus catarrhalis regularly present in the discharge confirmed the diagnosis. Cultures of the micrococcus produced the same result.

All treatment at first took little or no effect. On the 13th January, everyone of the little sufferers had 10 minims of Pyocyanase run into the nasal cavity with a douche. Forty-eight hours later not a single micrococcus catarrhalis could be found in the secretion and the children rapidly recovered.

TUBERCLE IN THE NASAL MUCOUS MEMBRANE.

Panzer showed a boy, æt. 13, who came to him complaining of stoppage in his nose which had troubled him since the summer holidays. The organ had a swollen appearance externally as if œdematose, but more accentuated about the point or alae. The bones of the nose were entire and normal in appearance, but the mucous membrane over the cartilage of the septum near the point on the right side was ulcerated exuding a yellow discharge with which it was covered. Around the margin of this ulcer were fine nodules, but the other parts of the mucous membrane were normal. At the angle of the lower jaw the glands were swollen to the size of hazel nuts and tender. Is it a gummosus ulcer? was the first question. The ulceration and yellow nodules in the margin, the site being confined to the point of the nose, while the bones are free and normal, and existing for months without any change were against gumma.

From its local attack the conclusion was tubercle, and that it had been infected by the patient rubbing and scratching the mucous membrane with unclean fingers and infecting himself.

The treatment might be surgical, but he thought this case might undergo Escherich's injections with tuberculin, which he purposed trying.

EMBOLISM IN POST-DIPHTHERIA.

Escherich at this point produced several preparations which he had taken from patients, where injections had been administered for diphtheria, and death resulting in cardiac paralysis which happily was not a common accident.

The first was a female child, æt. 13 months, who died on the sixteenth day. Apart from the morbid changes met with in the pharynx and bronchi, there was a fatty degeneration of the cardiac muscle; the left ventricle distended, and in the apex of the organ was a round mulberry clot, fixed in the trabeculæ, which when cut, had a greyish appearance, while fresh infarcts were found in both kidneys.

Case 2 had œdema of the cellular tissue, peritoneal dropsy; heart enlarged, soft, and valves intact. In the apex of left ventricle a clot about the size and consistence found in the preceding case. In the right ventricle were a few small clots entangled in the trabeculæ in a similar manner.

In all the branches of the pulmonary artery were emboli, while fresh infarcts were found in the kidneys.

The third case had dilatation and fatty degeneration of the cardiac muscle, thrombi in the right auricle, and fresh infarct in kidneys, but besides this there was chronic tuberculosis in the tracheo-bronchial lymphatics.

The fourth case developed cardiac weakness on the eleventh day; on the sixteenth paralysis of uvula; from the 29th to the 36th day, hæmaturia, which soon passed off, leaving the patient much improved and finally without albumen in urine.

In all these cases the thrombi and emboli are the result of post-diphtheritic enfeeblement of the heart, which would reduce the circulation and allow the coagula to form in the vessels. Whether the changes in the cardiac muscle is the cause of the formation of the clot, or the clot the cause of the enfeeblement of the heart is not easy to determine. The most practical point to be borne in mind is the danger attending a post-diphtheritic heart weakened by the poison and liable to give way at any moment. Everything should therefore be done to avoid the impediment of the heart, in our treatment of diphtheria.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

ADMINISTRATIVE CONTROL OF PHTHISIS.

THE Local Government Board issued on March 10th an important circular bearing on the administrative machinery and organisation of special measures for the control of phthisis. The circular is too long to quote in full in this column, and only a short synopsis will be given.

I.—The first section emphasises the infective nature of consumption, and shows that consumptive advanced in the disease are sources of danger to healthy persons. The concluding paragraph runs: "Accordingly, the sections of the Public Health Act applicable to other infectious diseases are equally applicable to pulmonary phthisis, and the obligation resting on the Local Authority to deal with and control infectious disease extends to pulmonary phthisis.

II. DISINFECTION.—All the provisions of the statute with regard to disinfection are available for dealing with phthisis, and should be enforced if necessary. Disinfection should not be left to friends, but should be carried out by experts, especially in the case of rooms which have been occupied by consumption for long periods. Places of public resort—schools, churches, halls, markets, stations, &c., and public conveyances ought to be disinfected periodically. The ordinary precautions should be taken with regard to sputum. The provision of the Act prohibiting the exposure of infected material, and prohibiting infected persons from exposing themselves without taking proper precautions against spreading the disease, should be enforced in the case of tuberculosis. Local authorities should also exercise the powers conveyed by the Act and see that no person living in an infected house shall milk any animal, pick fruit, engage in any occupation connected with food, or carry on any trade likely to spread the disease.

III. ISOLATION AND TREATMENT.—The provisions of the Public Health Act as to hospital treatment for other infectious diseases are equally applicable to phthisis. Hospitals for pulmonary phthisis may be classified as follows:—

(a) *Curative Hospitals for Early Cases (Sanatoria).*—The point insisted on in reference to these is that to obtain good results highly specialised medical supervision is essential, and that therefore local authorities, instead of trying by themselves to provide the trained medical skill and scientific laboratories necessary, should either utilise existing sanatoria or combine with other authorities to erect a thoroughly well-equipped one. The local authority (or its Phthisis

Committee") should aim at keeping in touch with all available sanatoria, either in the locality or at a distance. The circular adds that "sanatoria may be of the simplest and cheapest form."

(b) *All-day Hospitals.*—Where the patient's home is suitable he may attend the sanatorium all day for treatment and return home at night. Thus the resources of the hospital are made more widely available without increased ward accommodation being needed. Extra shelters alone are necessary.

(c) *All-night Hospitals.*—For some patients, whose occupation is out of doors and in every way compatible with the treatment of the disease, but whose homes are unsuitable, arrangements can be made whereby they work during the day and sleep in the sanatorium at night.

(d) *Convalescent Homes, Colonies.*—Work colonies or homes are desirable to complete the cure begun in the sanatorium. If well organised these might be almost self-supporting. Patients would be specially selected and provided with light labour.

(e) *Hospital Wards for Educative Treatment and Control.*—In several towns vacant wards of ordinary fever hospitals have been used for the educative treatment of phthisical patients. The case of Brighton is instanced particularly; there the patients are admitted to full sanatorium treatment for one month and are taught the value of fresh air, &c., and the best means of preventing spread of infection. Meanwhile, their homes are disinfected, and on their return they are visited periodically by the local authorities.

(f) *Hospital Wards for Isolating Advanced Cases.*—Vacant wards of a fever hospital should be utilised. The isolation of such dangerous cases is a primary duty of the local authority.

(g) *Dispensaries for Pulmonary Phthisis.*—The work of these includes (1) medical examination of the patients; (2) inquiry into the economic and social aspects of the cases with reference to the best means of treatment (home or hospital); (3) medical treatment and nursing of patients at home, in suitable cases; (4) dispensing medicine and disinfectants; (5) arranging for periodic disinfection of clothes, &c.; (6) selection of cases for any of the enumerated forms of hospital treatment; this is one of the most important parts of dispensary work; (7) distribution of printed information relative to phthisis; (8) examination of sputum, blood, &c.; (9) arranging for removal of cases to hospital; (10) general medical supervision and control of cases of phthisis not removed to hospital. The district or municipal phthisis dispensary should be a central bureau of information. It should keep a register of sanatoria, hospitals, and other institutions and organisations which can be made available for the inhabitants of the locality.

IV.—NOTIFICATION OF PHTHISIS.—The Board are prepared to sanction the addition by any local authority of phthisis to the list of notifiable diseases, provided the local authority are prepared, and able, to deal effectively with the cases notified. Notification alone is of no administrative value.

V. ORGANISATION.—It has been shown that the Public Health Act applies to phthisis, and the agencies which can be employed in controlling the disease have been indicated. But so highly specialised an organisation demands the services of a sub-committee of the Public Health Committee. This sub-committee—the Phthisis Committee—should have charge of the dispensary, which should be the administrative centre of the whole organisation. The dispensary will normally be under the direct management of the Medical Officer of Health, and will constitute a special department of his work.

VI. CONCLUSION.—The concluding paragraph of the circular reminds local authorities that these direct measures of prevention and cure must be supplemented by indirect measures in the shape of unremitting attention to general sanitation. Altogether, the Circular is a most ably drawn document, and covers the whole field of the administrative treatment of tuberculosis in a

most exhaustive and systematic fashion. To read it, and recollect the state of public and professional opinion as regards phthisis fifteen or even ten years ago, is to become conscious that we have covered much ground since then. Who knows what another ten or fifteen years may see?

EDINBURGH UNIVERSITY STUDENTS AND THE PRINCIPAL.

At a meeting of the Representative Council on March 9th it was unanimously agreed to issue an appeal to the students to mark in some tangible way the respect and appreciation in which they held Sir William Turner, who has now completed fifty years of active official academic service in the University of Edinburgh. Mr. J. Ian Macpherson, in seconding the resolution, said that Sir William Turner took a deep and sincere interest in everything that concerned the welfare of the students. The resolution was carried by acclamation, and a committee appointed to carry it into effect.

BELFAST.

FEVER AND FURNITURE.—A case of considerable interest was heard in the Summons Court last week, when the Belfast Corporation brought a suit against certain furniture dealers, whose names suggested that they were aliens, for having removed a quantity of furniture from a house where there was infectious disease, namely, typhoid fever. The furniture had been obtained on the hire system, and was removed during the illness of a child in the house, though the furniture dealers were informed of the illness. A fine of £3 and costs was imposed.

PUBLIC HEALTH.—The executive sanitary officer is showing a commendable vigilance in the matter of the sale of unwholesome shell-fish in Belfast. There is no doubt that typhoid has been caused by the consumption of shell-fish gathered on the shores of Belfast Lough, where they flourish in the dilute sewage of the city. Arrangements have been made for the bacteriological examination of specimens from different parts of the lough, so that rules may be laid down as to the localities from which they may or may not be gathered for sale.

LETTERS TO THE EDITOR.

THE OPSONIC INDEX.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your correspondent "Criticus," has not gathered the gist of my letter of March 7th, if he thinks I condemn Wright's Opsonic Index simply because it is technical. My contention is very different, merely that in its present form it is too complicated, technical and expensive to be used widely either in hospitals or in private practice. "Criticus" tackles me about the cost, which he says in some place he does not mention he places at a guinea and a half, instead of ten guineas, the usual charge in a London laboratory. Does "Criticus" think seriously that tests on hospital and other patients are likely to be used extensively at thirty-one shillings and sixpence apiece, when the general practitioner has often to whistle for his half-crown? If Professor Wright's ingenious index stands the test of time it will have to emerge in a cheap, simple, speedy and practical form. This is the deliberate verdict of not a few well-informed men who have investigated the matter impartially in London. "Criticus" evidently looks at the thing through the rose-coloured glasses of a young enthusiasm. Nothing else could have prompted his remarks that the end of my letter dismisses the subject with "sneers and gibes." With some curiosity I referred to that letter, and mention that the opsonic index of normal blood varies between 0.5 and 1.3, and I call that "a fine standard for a system that aspires to finality in accurate estimation." This may be a sneer, but what I wrote in haste I repeat at leisure, and state my deliberate opinion that it is not only "fine," but in less able hands than those of Professor Wright it would have been final at the outset. The system

is beset with fallacies, as "Criticus" will one day discover if his ardent researches extend over a sufficiently long period.

I am, sir, yours truly,

CUNCTATOR.

Balham, London, S.W.

VACCINATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Bitter complaints have been made to me by practitioners in Dublin who are not on the Poor-law Service on account of the issue of notices for vaccination, such as the enclosed, to their patients. They have stated that the notice contains an illegal threat to their private patients, who, instead of being told that they must have their child vaccinated (by their own doctor, or by any doctor), are unlawfully terrorised into the belief that the child must be brought to the dispensary, and the operation performed there under pain of prosecution. They allege that a triple injustice is done—to the private practitioner, who is deprived of that fee which the patient is willing to pay; to the ratepayer, who is saddled with the charge which the parents of the child are ready to bear, and to the mother, who is alarmed by the threat into taking the child to the dispensary much against her will.

I have been asked to draw the attention of the Local Government Board to the matter, but I should like to have your opinion as to whether the notice, in its present form, is justifiable. So far as I can see from the Act it is not, and, of course, it is a serious thing to procure a fee under threats made by quoting an Act of Parliament which gives no such authority.

I am, sir, yours truly,

Dublin, March 15th.

L.R.C.S.I.

[The wording of the communication to which our correspondent takes exception is as follows:—

"COMPULSORY VACCINATION ACTS, IRELAND (26 & 27 Vict., cap. 52; and 42 & 43 Vic., cap. 70). Dispensary.—I have to acquaint you that if you do not bring or send your child to this dispensary on or before next Thursday morning, at 11 o'clock, for vaccination, your name will be returned as a defaulter for prosecution, after that date.—Signed, Medical Officer."

It would be interesting to know whether this notice is sent only to parents in whose case the legal period within which vaccination must be performed has been greatly exceeded, or whether it is sent as a preliminary notice in all cases. In either case its wording is perhaps not judicious, as it is obvious that if the parents produce a certificate of vaccination from their private medical adviser it will answer equally as well as the production of the child.—Ed.]

THE CENSUS OF THE EMPIRE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Publication of what you rightly style a great and historic blue-book—the census of the entire British Empire—ought to bring to the front discussion of some aspects of the population question which, by your favour, I have been allowed to examine from time to time in your valuable paper. How many Englishmen, even among the best-informed classes, are there to be found who have fully realised the fact that the total of the white population in these islands, our colonies, and India, does not exceed fifty-four millions, a number actually less than Germany possesses at home. Is it to be supposed that in the future such a handful of white men will be able to dominate the peoples you refer to—four hundred million human beings made up of every race, creed, language and cast. The white man's burden will become too great unless his number can be proportionately increased. There is room in our colonies for hundreds of millions, and unless we become prepared to avail ourselves of the limitless fertile lands now our property, they will in the end be overrun by more prolific or more virile races. If the yellow peril do not in time become a

reality it will be only because Germany and Russia, the two nations at present least affected by the most destructive vices of civilisation, shall have conquered and peopled the lands we may have shown ourselves incapable of properly utilising. Within a very few generations the French have gone far enough along the road towards race-suicide to show us what must be the end if we continue to follow their example. The French have, so to say, constructed a social system based upon the hypothesis that no more than two children, on an average, shall be produced by any married couple. This idea is too deep-rooted to be conquerable. The population for thirty years has remained stationary. France has lost for ever her predominant place in Europe, and as soon as Europe ceases to protect her against her virile neighbour, she will surely lose the vast oversea territories which, from the population point of view, are useless to her, whilst virtually essential to her hereditary enemy. At home and in our colonies we are rapidly adopting the French idea. The birth-rate at home during the last quarter of 1905 was the lowest on record. If this goes on it is possible, although by no means certain, that some amelioration in the lot of individuals saved from the care of numerous offspring may be effected, but the British Empire will be doomed to destruction. The Empire for its maintenance must have an exuberant population of an imperial type. The egoism which prevents the procreation of children through hatred of stress and toil, and through love of ease and pleasure will tend to develop a race not only few in numbers, but of a type devoid of the highest manly qualities. Such a race must in the end go down before any people with whom it is in permanent contact, and who, by accident or wise direction, have escaped the effects of those destructive agents which seem always to threaten the vitality of highly-civilised communities.

I am, sir, yours truly,
Mar. 19th, 1906. A STUDENT OF SOCIOLOGY.

REVIEWS OF BOOKS.

WORKS ON NURSING.

A STUDY IN NURSING. (a)

THIS suggestive little manual is not intended to be a technical guide to nursing, but is, as the authoress states, "the retrospect of an old worker which may be of use as a study to her juniors." As the review and admonition of a veteran, these pages will be welcomed by all those who recognise that nursing is not to be followed as a mere profession, but cultivated as a high art, in which sympathy as well as science must prevail. Text-books containing instruction in all nursing matters are numerous, but in the delightful little literary effort before us, we have the human, rather than the mechanical, side of work presented. Miss Pringle, with her unique experience and wide mental outlook, emphasises her convictions that a woman's qualifications for nursing do not lie solely, or even mainly in the direction of mere technical acquirements. These pages would seem to show that though in many respects we have travelled far during the last generation, yet the needs of nurses, and the means best calculated to produce the highest type, are as yet but imperfectly realised and seldom attained. There is no mistaking the high standard and intense seriousness of the work before us, and the holy example of service expected alike of those who direct and those who serve must prove in this utilitarian age an incentive and inspiration. We venture to think that no member of the profession will lay down this little book without feeling that, though "the ministering angel must have her wings tied under her apron," she is called to the dignity and duty of a divinely-appointed mission. Miss Pringle graphically

describes the evolution of nursing, indicates the nature of the many fields of service for nurses, discusses the organisation of a nursing staff, and enumerates the requirements and duties of the various members. Where so much is of the best, we are loth to find fault, but surely the authoress breaks through her own teaching of strict obedience to medical orders, when she suggests that the Sister, in receiving the new patient should, on her own responsibility arrange for him to be "surrounded with hot jars, and *fed with brandy and water*, or hot milk or beef tea." The italics are ours to mark our regret at the perpetuation of an antiquated and unscientific procedure. Miss Pringle advocates the use of nuns as nurses in Irish workhouse infirmaries. We commend this instructive and invigorating little manual, with its motto "Amare et servire," to all matrons, nurses, and those interested in the elevation of nursing in this country.

MCGREGOR'S SURGICAL NURSING. (a)

THIS is more than a mere text-book of nursing. In fact, it is a manual of surgical affections, for the diseases of the various systems are carefully described in a manner well suited to the requirements of nurses. There are also chapters on such subjects as bacteria, antiseptics and anæsthetics. Full details are given of routine work such as bandaging, feeding, massage, and electrical treatment. The preparation of various kinds of dressings, instruments and sutures is minutely described, nothing of importance to the nurse being omitted in their consideration. When we say that the book contains forty-two chapters, and possesses a double-column index extending to fifteen pages, some idea may be formed as to its scope and completeness. In some respects, indeed, the volume appears to us to be somewhat too encyclopædic in character. Nurses seldom care to read large books, and besides, they rarely have the necessary time or opportunity. At the same time we are bound to admit that the writer's teaching is sound, and his book easily read. The last chapter, dealing as it does with the arrangement of nurses' duties, may be read with profit by every hospital nurse, for it contains a vast amount of very helpful and, at the same time, suggestive information. In another edition more space might be devoted to massage, especially as this is now being largely employed in cases of fracture. Otherwise we consider that the writer has been judicious in his allocation of space to the various subjects brought under review. This will long remain a standard work on surgical nursing, as its teaching is authoritative.

DRUMMOND'S SICK NURSING. (b)

THIS is essentially an apron-pocket book, and one which, as the writer himself says, is "quite elementary." It contains a number of useful facts, but some of the directions given are somewhat peculiar. Thus, on page 34, in speaking of how to pour out a medicine, the author instructs the nurse to withdraw the cork "with the little finger of the left hand," not a very easily acquired mode of procedure, we should imagine. Again (p. 17) for cleaning paint, he recommends the use of "warm soap and water." Evidently what the writer means is warm water and soap, but he does not unfortunately say so. Regarding the annoyance caused by too much sunlight in a ward he says: "This may sometimes be remedied by moving the patient's bed slightly." This surely is not to be recommended in hospital nursing. Nurses affected with soreness of the feet are advised to bathe them in cold water several times a day, but we would remind the author that this is not by any means easily carried out by hospital

(a) "A System of Surgical Nursing: With an Appendix, containing useful Formulae, Emergency Drill, &c." By A. N. McGregor, M.D., F.F.P.S.G., Assistant Surgeon to the Glasgow Royal Infirmary. Glasgow: David Bryce and Son. Pp. xli-554. Price 9s. net. 1905.

(b) "Golden Rules of Sick Nursing." By W. B. Drummond, M.B., C.M., &c., Assistant Physician to the Royal Hospital for Sick Children; Physician to the Western Dispensary, Edinburgh, &c. Price 1s. Bristol: John Wright and Co.

(a) "A Study in Nursing." By Miss A. L. Pringle, formerly Matron of St. Thomas's Hospital. Pp. 98. London: Macmillan and Co., Ltd. 1904.

nurses. The direction given on page 55 to "apply liniments by rubbing them gently with the skin" evidently needs correction. The list of words and phrases given as occurring "frequently" in prescriptions contains one or two which are seldom employed, and therefore would have been better omitted. This little monitor will, however, be found useful by probationers during their period of training; but we can hardly hope as the author does, that even "some at least of the sections may be of service to nurses of greater experience." We doubt very much if even the most experienced medical man is able to write a book of this kind without feeling that he is traversing somewhat untried ground.

VOYSEY'S NURSING. (a)

THIS is a model of what a small handbook on nursing should be. It contains just the sort of information the probationer longs for. Bristling with hints and warnings, this book is sure to prove of great service to the junior nurse, who is often in need of advice. Thus it tells how to make a bed, take a pulse, give an enema, as well as how to use the hypodermic syringe, and to fix up the aspirator. In every case the directions given are short, simple and very explicit. A few pardonable errors, however, have crept into the text such as "inter-uterine," douches (p. 66), but on the whole the book is free from important mistakes. In fact, it is with feelings of pleasure that we have read it, and were also favourably impressed with the boldness of the type, and the well-planned arrangement of the subject matter. We know of no better guide to nursing for beginners than this, and feel certain that it will be appreciated by the probationer who is often at a loss as to what to do when an order has been given her. With this little book at hand she will be able to carry out her instructions with intelligence and even with credit to herself.

DISEASES OF CHILDREN. (b)

IT is with sincere pleasure that we welcome the fifth edition of Dr. Ashby's and Mr. Wright's Diseases of Children, for in the sixteen years that have elapsed since the book first appeared it has established for itself a commanding position in the domain of Pæchatties. And it has done so in virtue of its intrinsic worth. If we were asked in what this worth principally consisted, we should say in its evident sincerity, its fidelity to the clinical observations of two painstaking and thoughtful minds. The authors have founded their work on their own experience at the Manchester Children's Hospital, and in private practice, and the book throughout is redolent of the bedside. It is palpably not a made-up book, brought out to meet a demand, but one that is the outcome of much travail and patient labour. Its fault—if fault it be—is that 900 pages are too few for the adequate presentation of all the medical and surgical diseases to which children are liable, and consequently some of the topics have to be treated hurriedly. This is especially noticeable in the chapters on special subjects, such as the ear and the skin; whilst the eye is not dealt with except incidentally. On the other hand we especially commend the excellent chapters on the diseases of the digestive and nervous systems, by Dr. Ashby, and those on diseases of the bones and joints by Mr. Wright. The authors are evidently thoroughly at home when treating of these subjects, and their descriptions are lucid, informing, and thoroughly sound. It is perhaps unreasonable to expect all the sections to be of the same amplitude as those mentioned, for if they were the book would have to be considerably enlarged, and the authors have

certainly assigned more space to the most important matters. But one cannot help feeling that the book would be well nigh perfect if all the maladies of children were dealt with in the same masterly fashion. Certain points suggest themselves for criticism, such as the use of the word "stoved" on page 293, as a synonym for "disinfected," but they are so few and the work has been so thoroughly revised from time to time that there is no room for serious objection. Besides criticism is disarmed by the authors' method, which is to assert facts observed by themselves—and the conclusions that these facts suggested to their minds; generalisations in the main are avoided, and besides silencing criticism their comparative infrequency invests the writing with a personal air of considerable charm. Besides the text proper, certain useful features will be found—a chapter on "Anæsthetics for Children," by Mr. Alexander Wilson, which is the best thing on the subject we have read for some time; an appendix on nvalid foods for children; and ten pages of capital formulæ for prescriptions. We can say emphatically that no practitioner in any sphere of medicine could invest a guinea to better purpose than in the purchase of this able and fascinating book.

Poisonous Drugs Prescribed by a Herbalist.

AT Cefn yesterday week, Dr. W. R. Jones resumed the inquest on the body of Margaret Thomas, a married woman, of Lower Vaynor Road, who died recently after a miscarriage. At the original inquiry, it was alleged that the woman had purchased medicine containing deleterious drugs from a herbalist named Arthur Roberts, and that there were several packets of herbs found about the house after her death, there being no proof, however, that of these Roberts was the seller.

Dr. Flood said he attributed death to gastric ulcer in the stomach causing peritonitis.

The Coroner: Can you give us any idea how these symptoms were brought about?

Witness: I think they may have been assisted by the irritating medicines which the deceased had periodically taken.

The Coroner said there was a weak solution of a herb in one of the samples. Was that herb used for criminal purposes?—Witness: Yes.

The Coroner said the man Roberts alleged that he sold the medicine for bronchitis, but that was all nonsense.

Roberts was re-called, and he was asked what he meant when he described himself as a herbalist.—"A man that practices by herbs," was the reply. You prescribe chloroform?—Yes.

What herb is that?—Chloroform is a mixture made or sold by the chemist, not by me.

But you prescribe it, don't you?—I prescribe it in the prescription when I write it down.

Answer me definitely. Do you prescribe chloroform?—Yes, in my mixture for bronchitis.

The Coroner in addressing the jury, said that Dr. Flood did the proper thing when he refused to give a certificate of death. These certificates were given by medical men too readily. The doctor showed moral courage, and did his duty to his profession. He thought this inquiry had been productive of some good in exposing a man of the character of Arthur Roberts. The drugs were constantly advertised in the papers as calculated to produce miscarriage, and it was a great shame that such advertisements should be allowed to appear. Roberts had escaped the clutches of the law, but he, nevertheless, thought it would have been well if he had been brought within its claws. Roberts was unable to spell ordinary simple words, and was ignorant in every shape and form, and yet he practised with drugs to deal with which required the experience of a lifetime. He hoped that what had transpired at the inquest would be a lesson to all the people of Cefn not to admit such men inside their doors.

The jury returned a verdict in accordance with the medical testimony, and asked the coroner to administer to Roberts a severe censure.

(a) "Nursing: Hints to Probationers on Practical Work." By Mary H. Annesley Voysey. London: The Scientific Press, Ltd. Price 1s. 6s. 1906.

(b) "The Diseases of Children—Medical and Surgical." By Henry Ashby, M.D., F.R.C.P., Physician to the Manchester Children's Hospital, and G. A. Wright, B.A., M.B., F.R.C.S., Consulting Surgeon to the Manchester Children's Hospital. Fifth edition. Thoroughly Revised. London: Longmans, Green and Co., 21s. net.

MEDICAL NEWS IN BRIEF.

The Graduates Association of the Royal University of Ireland.

THE Council of the Royal University Graduates' Association issued last week a series of resolutions which have been unanimously adopted at a meeting held in Belfast. These may be summarised as follows:

(1) We have observed with profound distrust the resolution proposed by the Most Rev. Dr. O'Dwyer, and carried at the meeting of the Royal University Senate on the 7th inst.

(2) Having regard to the facts, we are forced to the conclusion that this latest move of the majority of the Senate is an insidious attempt to have the University re-constructed on denominational lines.

(3) We consider that henceforward full and complete reports shall be issued of all business conducted at the Senate, save the ordinary work of routine administration.

(4) We affirm our determined opposition to any settlement of the University question involving the expenditure of State money upon ecclesiastical or sectarian institutions, and in particular we deprecate the scheme suggested by Sir West Ridgeway.

(5) We demand that any grant in aid of University education in Ireland shall be allocated only after full discussion in Parliament, and we call upon his Majesty's Ministers when dealing with the educational affairs of Ireland to give effect to the principle so emphatically declared by them during the recent election, viz.—that State education must be freed entirely from ecclesiastical and sectarian control.

Central Criminal Court.

CHARLES FOXLEE (on bail) pleaded guilty to publishing a false and defamatory libel concerning Dr. Arthur Robert Waddell, of Potter's Bar. Mr. Leycester said the libel was in a circular in which the defendant accused the prosecutor with being intoxicated and neglecting his duties when attending his wife in January, 1898. He also said the doctor had performed a cruel and unnecessary operation upon his infant child, and had permanently injured the child. As a fact, the doctor was and had been a total abstainer, and on the night of the wife's illness he had been attending two ladies, who would have been witnesses on his behalf had it been necessary. Before the publication of the libel the accused had subjected the doctor to all kinds of annoyance, with the object apparently of compelling him to pay some sort of compensation for what he said was his neglect. On two occasions the doctor had been compelled to eject him from his house. Foxlee had threatened the doctor with personal violence and in an anonymous letter he sent to the doctor the latter was advised to settle the matter with the view of preventing the scandal being made public. These letters culminated in the publication of the libellous circular.

Mr. Percival Hughes said the accused desired to express his deepest regret for his publication of the libel, for which there was no justification whatever. No doubt the accused was misled by the statements of his wife and the nurse, and for a long time he intended to take civil proceedings against the doctor upon those statements, which he then believed. It was while brooding over this fancied grievance, for which he had since found there was no ground whatever, that his mind became temporarily unhinged, and he did that which he now much regretted.

The Recorder said after the defendant's expression of regret and under his promise not to repeat the libel he would accept two sureties in £50 each for his appearance to come up for sentence if called on. The defendant was extremely fortunate in not having been tried upon the indictment charging him with threatening to publish the libel with the view of extorting money, for if he had been convicted of that

he would have been sent to prison. The defendant had admitted that the scandalous, false, and malicious libels were entirely without foundation. He earnestly hoped that these libels would not have any injurious effect upon the doctor professionally.

Irish Medical Schools' Graduates Association.

SOME three hundred ladies and gentlemen assembled at the Hotel Cecil on Saturday, March 17th, on the occasion of the annual festival dinner of the above Association. The presence of the fair sex lent a grateful relief to the rather ponderous appearance which is one of the characteristics of the Grand Hall, and the ladies themselves fully upheld the reputation for beauty generally associated with the daughters of Erin; it must be confessed, however, that even this failed to stimulate the after-dinner oratory to the heights of geniality and wit which the Saxon always expects from the Celt. After the President Dr. E. Terrin Scott, had given the usual loyal toasts, Dr. George Stokes, C.M.G., proposed "Our Defenders" this being responded to by Inspector-General W. H. Lloyd, and by Lieut.-General Sir John French. The next toast, "Our Guests," was entrusted to Sir William Whitla, but this distinguished physician having been called away, Dr. Macnaughton-Jones stepped boldly into the breach and made some very flattering but none the less true remarks about Sir John French, who in his response gave the best speech of the evening, referring in laudatory terms to the medical officers of the army, and paying a graceful tribute to the civil surgeons who went out to the South African war, notably to the late Sir W. MacCormac. Messrs. Mayo Robson and Arbuthnot Lane also responded to the toast, the former drawing particular attention to the fact of the fellowship of the R.C.S. (I.) not being a sufficient qualification for the appointment of surgeon to a London hospital. The last toast, "Ourselves," was proposed by Mr. R. G. Webster, who infused a little more humour into his speech than the former speakers, but here again there was the same absence of a "trifle of the brogue" which we had been longing for all the evening. Some charming Irish songs were efficiently rendered by the Hon. Mrs. Julian Clifford, and Mr. A. Bovett; Mr. Arthur Prince gave his ventriloquial entertainment, and Mr. G. H. Snazelle was funny in his "humorous tales," although one of them was the well-worn "Bill Adams."

The Forthcoming International Congress of Medicine at Lisbon.

A MEETING of the National Committee for Great Britain and Ireland of the Fifteenth International Congress was held at the Medical Society's rooms on March 13th. Dr. Pavy, F.R.S., President was in the chair. The honorary secretaries (Dr. Clive Riviere and Mr. D'Arcy Power) reported that the railway companies had made important concessions to members attending the Congress. The British Association at Oporto invited twenty members of the Congress to dine in the Factory House on April 25th, and they also extended hospitality to the other members. The following communication was read from the German National Committee:—"The German National Committee beg to submit the following proposition:—

"That an International Bureau be established which should continue in activity in the intervals between the meetings, with the headquarters in Paris. Its business should be to maintain the continuity of the Congress, and to co-operate with the organising committee in the arrangement of the programme as far as concerns the division into sections, and the choice of themes, of reporters, honorary presidents, &c.

"2. That in future the International Medical Congress should be held, not as hitherto, every three, but every five years"

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specialty compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT LITERATURE OF PHYSIOLOGY AND PATHOLOGY.

Primary Cancer of the Bronchi.—Nanu-Muscal (*Spitalul*, 1905, No. 7) points out that primary cancer of the bronchi is a rare affection, inasmuch as only thirty-six cases have been recorded. He himself reports a case which he had observed in a man, *æt.* 50, who had suffered from syphilis at the age of twenty years. Six months previous to his coming under observation the patient had been troubled with persistent hæmoptysis and with general weakness. On examination, the patient appeared cachectic, and a small tumour could be felt above the left sterno-clavicular articulation. Percussion dulness was present in both supraspinous fossae, especially the left, and also at the base of the left lung, while a slight tubular note could be made out on auscultation at the right apex. The sputum was yellowish and muco-purulent, and did not contain any tubercle bacilli. Weakness rapidly increased and the case came to autopsy. A large carcinomatous mass was found taking origin from the termination of the left bronchus and extending into the lung, while a similar growth was found involving the lower end of the trachea. M.

Sudden Death in Acute Rheumatic Fever.—Gouget (*Presse Méd.*, 1905, No. 39) distinguishes three clinical varieties of sudden death occurring in acute rheumatism, as follows:—(1) Cerebral congestion, which without warning, suddenly appears at the commencement of the attack, is accompanied by delirium, and leads to death in a few hours. Anatomically one finds in these cases only slight hyperæmia of the meninges, while clinically a history of alcoholism is usually obtained; (2) sudden death from syncope, without previous appearance of heart weakness or heart disease having been present. P. m., dilatation of all the cardiac chambers and diffuse myocarditis are usually met with; (3) death from asphyxia, including cases of acute pulmonary œdema, cases of embolism of the pulmonary arteries, and cases of intracardiac thrombosis. The author describes a case coming under the third heading, in which extensive intra-cardiac thrombosis had taken place, apparently caused by a staphylococcal infection. M.

The Cytorrhyses Luis.—Freund contributes a paper (*Wien. Klin. Woch.*, No. 38) on the subject of the protozoan parasite, which Siegel has described under the term Cytorrhyses Luis, and which the last-named author regards as the causal organism of syphilis. Freund found the protozoan in the blood of ten persons, of whom seven had syphilis without doubt, and three were suspected to be suffering from the disease. He has never found the parasite in the blood of healthy individuals. In some cases a marked effect on the flagellated organisms was noticed during the course of an inunction treatment. They were observed, in fact, to diminish in number and almost to disappear. Freund has also injected the blood of syphilitics into rabbits, and has separated the cytorrhyses from the blood of the infected animals after eight days, and has moreover observed large numbers of the organisms within the blood after the lapse of twenty days. No definite symptoms of sickness were, however, present in any of the animals experimented on. M.

The Blood of Epileptics.—Onuf and Lograsso (*Amer. Journ. Med. Sci.*, Feb., 1906, p. 269) have studied the blood of epileptics with the object of determining (1) The condition of the formed elements of the blood in the intervals between seizures; (2) the behaviour of the formed elements in connection with seizures. The conclusions at which they arrive are as follows:—(1) A leucocytosis may be present

before a seizure, but a seizure is not necessarily preceded or ushered in by a leucocytosis; (2) there is no absolute parallelism between seizure and leucocytosis, in so far as even when a distinct leucocytosis is present, such may reach its height at different periods in different seizures; (3) no notable change in the red cells takes place in connection with the fits. M.

Amputation of the Thigh with Re-plantation.—Carroll and Guthrie (*Amer. Journ. Med. Sci.*, Feb., 1906, p. 297) have performed experiments on dogs with the object of seeing if it were possible to immediately replant an entire limb after amputation. After some preliminary operations with a view to obtaining the necessary skill, amputation of the thigh was performed on an 8-kilometre dog. A few minutes after the amputation the severed limb was replaced in position, the femoral artery and vein were carefully united, and also the various nerves and muscles. Before the dressings were applied, it was noticed that pulsations in the popliteal and posterior tibial arteries could be felt. The next day the replanted limb was much warmer than the other, and there was considerable œdema. Nine hours later the limb was found to be quite cold, and a little dark blood escaped from an incision made in the foot. Fifty hours after operation the animal was chloroformed as gangrene seemed unavoidable. The subsequent examination showed the artery to be quite normal and seemed to point to the gangrene being caused by venous obstruction, the result of constriction by a celloidin dressing. The authors remark on the ease with which arterial circulation was restored and maintained, and believe that with more care replantation would be quite possible and successful. M.

Yellow Fever and Mosquitoes.—Marchaux and Simond of the French Mission to Rio de Janeiro, publish (*Annales de l'Institut Pasteur*, January 25th, 1906) a report on their researches into the causation of yellow fever, preceded by notes on recent advances by other observers. Of the latter two are of importance. (1) Otto and Neumann were able to bring alive to Hamburg from Brazil several specimens of *Stegomyia fasciata*. The race speedily died out when exposed to the open-air in that climate, though in a temperature of 27° it multiplied freely. It is easily killed by cold or by absence of moisture. These observations may abolish all fear of importing infectious insects to Northern Europe in ordinary baggage. (2) It has been shown that while virulent serum is rendered innocuous by passage through a Chamberland B. filter, if the serum be first mixed with an equal quantity of normal saline it retains its virus. Marchaux and Simond's own observations, which contain many new points may be summarised—(1) The virus of yellow fever may be transmitted from adult *stegomyia* to the egg; such infection probably plays but a slight part, if any, in the propagation of the disease; but it may cause the recrudescence of an outbreak all but extinct. (5) The virus of yellow fever may be artificially transmitted from mosquito to mosquito; but such transmission does not take place in nature. (3) The *stegomyia* does not become infected from the hæmorrhagic vomit or dejecta of yellow fever. (4) The larvæ of *st. f.* reared in water containing the fresh bodies of infected mosquitoes do not contract the infection. (5) An infected mosquito kept at a temperature of 20° appears to lose its infectivity. (6) Experiments on the possibility of transmission of infection by other mosquitoes than *Stegomyia fasciata* have given entirely negative results. (7) The female of *st. f.* does not, in this differing from many other

species, die after laying eggs, it is because of the power to lay several sets of eggs that she is able to serve as the intermediary host of yellow fever. It will be observed that search for the actual germ of yellow fever has as yet been entirely negative. R.

Vascular Theory of Epilepsy.—Turner (*Brit. Med. Journ.*, March 3rd, 1906) returns to the view of Hughlings Jackson, that the pathology of epilepsy is vascular, and consists in part of intra-vascular clotting in the cerebrum. Together with the vascular condition, however, there is necessary a defectively developed nervous system. Of the peculiarities which have been noticed in the nerve cells of epileptics, Turner emphasises two (a) the presence of a variety of nerve cells which represents an embryonic form, and is common in imbeciles; (b) the persistence in the brain of sub-cortical nerve cells. With regard to the effect of vascular changes he recalls certain experiments showing that clotting is a *vera cause* of convulsions. (1) Kussmaul and Turner showed that sudden ligation of the left subclavian and innominate arteries of a rabbit produced general convulsions in from three to forty-five seconds; compression of both carotids in six mice produced in two of them epileptiform seizures (2) Leonard Hill by sudden occlusion of one carotid was able to produce in certain cases a march of epileptic spasm preceded by an aura. (3) Introduction of oily substances to the vascular system produces in some cases epileptiform convulsions, the action of the oil being probably mechanical. In every case of epilepsy examined, (4) Turner found small cortical meningeal hæmorrhages, and these he believes to be due to rupture of small vessels consequent on clotting. While intra-vascular clotting is not peculiar to epileptics, Turner has met with it in 90 per cent, of epileptic brains, and in only 35 per cent, of control brains. Further, the maximum amount of clotting in the later series rarely, if ever, surpassed the minimum amount in the former. He regards the tendency to the formation of clots as associated with an increase in blood-platelets, which he has also observed in epileptics. R.

Placental Origin of Eclampsia.—Liepmann (*Münchener Med. Woch.*, Dec. 19th, 1905) makes an important communication on the toxicity of the placenta of eclamptic women. The placenta were minced, dried, and ground up, and a suspension in normal saline prepared, with the addition of a few drops of toluol. Injections were made in the peritoneal cavities of rabbits. The typical result was coma within a few minutes, accompanied by greatly accelerated breathing, widely dilated fixed pupils, and loss of reaction to sensory stimuli. In many cases convulsions ensued. Most of the animals, 113 in all, died within twelve hours. Experiments were then made bearing on the manner in which the toxin exists in the placenta. It was found that whereas the extracted placental juice was innocuous, injection of the placental pulp proved fatal. It was further found that the toxin is very labile and difficult to preserve, a powder which proved fatal one day being innocuous the next. When the relative toxicity of different placenta were studied, a curious result appeared. It was found that in cases where many fits had occurred the placenta was comparatively non-toxic, whereas in cases where only a few fits preceded delivery the placenta was highly toxic. From this it would follow that fits occur as a result of the passage of the toxin to the maternal circulation, and that they are a measure, not of the amount of toxin present, but of the amount which has thus passed over. As the most marked clinical phenomena depend on changes in the brain, Liepmann investigated the relation between brain substances and the toxic placental powder. He found that injection of a mixture of these substances gave rise to no disturbance. He therefore assumes that, as in the case of tetanotoxin, the toxin is fixed by brain cells. Liepmann's experiments will require careful verification. If his conclusions are supported, they constitute the most important

advance, both as regards theory and practice, made in recent years in the pathology of eclampsia. R.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "Recent Medical Literature."
- (2) "Recent Surgical Literature."
- (3) "Recent Gynaecological and Obstetrical Literature."
- (4) "The Recent Literature of Physiology, and Pathology."

OBITUARY

GEORGE HENEAGE PEARCE, M.A.CANTAB.,
M.R.C.S., L.S.A.

WE regret to announce the death of Mr. G. H. Pearce, of the Borough Asylum, Leicester, as the result of an accident. While riding on a motor cycle with a friend on the 17th instant, near Rugby School, he came into collision with a cart. He was knocked off the machine, and the wheel of the cart passed over him. He died shortly afterwards while being conveyed to the Rugby Hospital. Deceased received his medical education at Cambridge and at St. Thomas' Hospital. He took the M.R.C.S. England in 1898.

THOMAS DUDDINGSTON WILSON, M.A., M.D.ED.,
F.R.C.S. ED.

THE death of Dr. Duddingston Wilson, at the age of fifty-five, occurred on March 8th, after a brief attack of pneumonia. Dr. Wilson was the eldest son of the late Dr. David Wilson, who for many years had a large practice in the City. He was educated at Edinburgh Academy, and studied medicine at Edinburgh University and in Paris. In 1875 he received his degree from Edinburgh University, and for a time thereafter he was resident physician in the Leith Hospital. Subsequently he held, for a few years, the post of medical superintendent at Craiglockhart Hydropathic. In 1883 he commenced on his own account, and soon acquired an extensive practice.

HENRY MATTHEWS TUCKWELL, M.D.,
F.R.C.P. OXON.

WE regret to announce the death of Dr. Henry M. Tuckwell, who had long retired from practice, last week in his seventy-second year at Oxford. Educated at Lincoln College, Oxford, and at St. Bartholomew's Hospital, London, he also studied on the continent. Dr. Tuckwell took the M.A. degree at Oxford in 1856, and was admitted a member of the Royal College of Surgeons, England, in 1858, and of the Royal College of Physicians, London, in 1862. He had been elected Radcliffe Travelling Fellow at Oxford, in 1859, and in 1863 took the M.D. degree. Seven years later he was elected a Fellow of the Royal College of Physicians, London.

MR. J. J. VEZEY.

THE death occurred suddenly on Tuesday of Mr. J. J. Vezey, F.R.M.S., chairman of the committee of the Miller Hospital, Greenwich. He was about to administer medical treatment to a patient at the institution, when he became unconscious, and died before aid could be summoned. Although the notices in the public press would suggest the contrary, Mr. Vezey was not a medical man, but interested in X-ray work, and held a lay appointment in the hospital. We believe the letters F.R.M.S. refer to the Microscopical Society.

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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 reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

M. O. H. (Ireland).—Special courses in meat and food inspection are arranged by the Royal Sanitary Institute, and examinations held in the same subject. If your authority is seriously contemplating the enforcement of a rigorous civic meat inspection it would be wise to send the special inspector to London for a course of instruction. Nothing in his department wants clearer and sounder knowledge.

MORPHIN.—The light treatment of lupus, so far from replacing ordinary methods, is neglected by many eminent and practical dermatologists. The same may be said of the X-ray treatment. Both methods are tedious and uncertain, while the X-ray is dangerous and the light-ray often followed by recurrence.

TRAINING ON EGGS.

A correspondent has drawn our attention to the fact that the Cambridge crew are training for the Boat Race on a staple diet of eggs. Five eggs a day is not a bad allowance for a man in training, that is to say, if he can take that number day after day without inconvenience or repugnance. There is, in our opinion, a vast deal of nonsense talked about diet in training. A full and varied dietary, without too much sweetstuff and rickshaws, and no alcohol, is about all that is required for the average Phillistine athlete. If he has to diet like a dyspeptic he had better keep away from the lists.

M.C.—If B was aware that C had been attending the case of suspected typhoid, and had given directions regarding its isolation, he should have advised the patient that a consultation with C was necessary before removing the embargo on his milk. If the patient refused to consent to this, then B should have reserved his diagnosis until all element of doubt had disappeared. It is, of course, possible that B was not informed that C had been in attendance, in which case B cannot be blamed for his action. C appears to us to have taken very commendable steps with the object of stamping out the fever.

CORK MEDICAL AND SURGICAL SOCIETY.—A CORRECTION.—It was erroneously stated in the notes of a case of nephrectomy for tuberculous kidney and ureter, published in our issue of Feb. 3rd in the transactions of the Cork Medical and Surgical Society, that clamp for ops were allowed to remain on the renal vessels for forty-eight hours. The actual time was eight hours.

Meetings of the Societies, Lectures, &c.

[WEDNESDAY, MARCH 21st.]

ROYAL MICROSCOPICAL SOCIETY (29 Hanover Square, W.)—8 p.m. Papers:—Mr. C. F. Rousselet: A Contribution to our Knowledge of the Rotifers of South Africa.—Mr. E. M. Nelson: On the Revolving Limbs for the Telescope and the Microscope.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m. Arris and Gale Lecture:—Mr. J. H. Watson: The Viscosity of the Blood.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chemist Street, W.C.)—4 p.m. Mr. H. L. Barnard: Clinique. (Surgical). 5.15 p.m. Lecture:—Dr. R. Jones: Evolution in the Treatment of Mental Diseases.

THURSDAY, MARCH 22nd.

CHILDHOOD SOCIETY AND THE BRITISH CHILD-STUDY ASSOCIATION (Parkes Museum, Margaret Street, W.)—8 p.m. Lecture:—Mr. J. C. Medd: Proportion in Education. (Arranged by the British Child-Study Association.)

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.)—8.30 p.m. Harveian Lecture:—Dr. J. S. R. Russel: Myelitis (illustrated by lantern slides).

ROYAL COLLEGE OF PHYSICIANS OF LONDON (Pall Mall East).—5 p.m. Lumsden Lecture:—Dr. D. Ferrier: On Tabes Dorsalis.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chemist Street, W.C.)—4 p.m. Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m. Lecture:—Dr. C. R. Box: Congenital Diseases of the Heart.

FRIDAY, MARCH 23rd.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.)—8 p.m. Clinical Evening for the Exhibition of Clinical Cases. Patients in attendance from 8 p.m. to 9 p.m.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—5 p.m. Arris and Gale Lecture:—Mr. S. W. Curl: The Arterial Pulse, its Physiology and Pathology.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chemist Street, W.C.)—4 p.m. Dr. D. Grant: Clinique. (Ear.)

Vacancies.

Bristolington House Private Asylum, Bristol.—Assistant Medical Officer. Salary £160 per annum. Applications to the Resident Licenses.

London County Asylum, Colney Hatch, New Southgate, N.—Fourth Assistant Medical Officer. Salary £180 per annum, with board, furnished apartments, and washing. Applications to H. F. Keene, Clerk to the Asylums' Committee, Asylums' Committee Office, 6 Waterloo Place, S.W.

Metropolitan Borough of Battersea.—Medical Officer of Health. Salary £200 per annum. Applications to W. Marcus Wilkins, Secretary, Town Hall, Battersea, S.W.

North Staffordshire Infirmary and Eye Hospital, Hartshill, Stoke-upon-Trent.—Senior House Surgeon, Salary £100 per annum, with furnished apartments, board, and washing. Applications immediately to the Secretary and House Governor.

West Norfolk and Lynn Hospital, King's Lynn.—House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications immediately to the Chairman of the Hospital.

Valkenberg Asylum, near Cape Town.—Assistant Medical Officer. Salary £250 per annum, with board, washing, and lodging. Applications to the Agent-General for the Cape of Good Hope, 10 Victoria Street, London.

Surrey County Asylum, Brookwood, near Woking.—Third Assistant Medical Officer. Salary £120, with board, lodging, laundry, and attendance. Applications to the Medical Superintendent.

Manchester Royal Infirmary.—Resident Medical Officer at the Infirmary. Salary £150 per annum, with board and residence. Applications to W. L. Saunder, General Superintendent and Secretary, Manchester Royal Infirmary.

Manchester Royal Infirmary.—Resident Medical Officer at the Convalescent Hospital, Cheaseid. Salary £150 per annum, with board and residence. Applications to W. L. Saunder, General Superintendent and Secretary, Manchester Royal Infirmary.

East London Hospital for Children and Dispensary for Women, Shadwell, E.—Medical Officer for the Casualty Department. Salary £100 per annum. Applications to W. M. Wilcox, Secretary.

Appointments.

BLAKISON, ARTHUR ALEXANDER, M.R.O.S., L.S.A., Medical Officer of Health of Glastonbury (Somerset) for three years.

BROWN, R. B., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Howden District of the county of York.

BRUNWIN, ALAN DEED, M.B., B.C.Cantab., House Surgeon at the Denbighshire Infirmary, Denbigh.

DALBY, AUGUSTUS WILLIAM, L.R.C.P., L.R.C.S.Edin., Medical Officer of Health for the Frome (Somerset) Rural District Council.

EDMUNDS, EDGAR, F., M.B., B.S.Durh., House Surgeon at the Chester General Infirmary.

FAIRBANK, H. A. T., M.S.Lond., F.R.C.S.Eng., Assistant Surgeon to the Hospital for Sick Children, Great Ormond Street.

FLITCROFT, THOMAS E., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Medical Officer to the Newcastle-on-Tyne Dispensary.

FOREMAN, BERRY JOSEPH, L.R.C.P. and S.Edin., House Surgeon at the Rawcliffe Hospital and Dispensary, Chorley, Lancs.

LACE, FREDERICK, F.R.C.S.Eng., F.R.C.P.Lond., an Honorary Consulting Surgeon to the Chippendale Cottage Hospital.

MUNRO, W. E., M.B., M.S.Aberd., Certifying Surgeon under the Factory and Workshop Act for the Burghead District of the county of Elgin.

PRICE, D., M.R.O.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Castle Cary District of the county of Somerset.

RANDOLPH, CHARLES, M.R.C.S.Eng., L.R.C.P. and L.M.Edin., Medical Officer of Health for the Wellington (Somerset) Rural District.

SAWYER, JAMES, E. H., M.D.Oxon., M.R.C.P.Lond., Physician to Out-patients at the Birmingham and Midland Free Hospital for Sick Children.

STOLTENFOTH, C. S., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Stokenchurch District of the County of Buckingham.

WALLIS, E. WHISHAW, L.D.S., R.C.S.Eng., Assistant Dental Surgeon to the Italian Hospital, Queen Square, London.

Birth.

COPEMAN.—At 24 Marine Parade, Brighton, the wife of Alfred Heathcote Copeman, M.A., M.D., M.R.C.S., L.R.C.P., D.L., of a son.

Marriage.

MATTHEWS—BELL.—On March 14th, at St. Peter's, Stockton-on-Tees. Craufurd Tait Matthews, M.B., Ch.B., of Huddersfield, son of the Rev. J. H. Dudley Matthews, Rector of Purley, Berks, to Dora, youngest daughter of J. Hyslop Bell, Esq., J.P., St. Fillan's, Stockton-on-Tees.

Deaths.

HEDGES.—On March 13th, at Rutland House, Leighton Buzzard, John Alexander Hodges, M.R.C.S.Eng., L.R.C.P., aged 65 years.

PERKIN.—On March 16th, at Bulawayo, South Africa, Robert Frederick Thornton Perkin, M.R.C.S., L.R.C.P., and L.M., elder son of the late Captain H. Hilton Perkin, aged 45.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX"

VOL. CXXXII.

WEDNESDAY, MARCH 28, 1906.

No. 13.

NOTES AND COMMENTS.

The International Medical Congress. THE life of the medical profession is strenuous and exacting, and no man better deserves his holiday. Nay, more than that, there is no profession in which the occasional rest of mind and body is more absolutely essential to the long continuance of a high standard of work. Barristers spend three months over their long vacation; solicitors have to take what they can get, and so have medical men. Under these circumstances there is a peculiar value attached to the occasional colonial jaunt of the great medical associations and to the international scientific meetings held in various parts of the world. Lisbon is now a centre of attraction to medical visitors from many countries. Those who can spare the time can have a thoroughly enjoyable yachting cruise. The "Booth" line have control of hotel accommodation at Lisbon, and offer the whole trip of twenty-eight days at an inclusive fare of £22.

Oporto, Lisbon, Cintra. ANOTHER excellent plan is that which takes the visitor to Lisbon and keeps the ship as his headquarters. The last visit of the International Medical Congress found Lisbon sadly lacking in hotel accommodation, a deficiency that will be this year more than remedied by utilising ships. Apart from the scientific aspect of the meeting, the country itself is interesting and picturesque. There is much to see in the old Roman and Moorish city of Oporto, which everyone will do well to linger at for a day or two *en route*. Then, again, there is Cintra, of all places one of the most romantic and beautiful. The official language of these meetings is French. In future it is proposed to hold these great International Congresses at intervals of five years instead of three. As we all know, it is possible to have too much of a good thing.

Life Insurance without Medical Examination. THE "Sun" is one of the oldest of British life insurance offices, and holds a deservedly high reputation. Of late years, however, its policy in offering to insure applicants without medical examination, is hardly consistent with the highest ethical standards. First of all, it is to inflict an injury upon medical men, for it constitutes the life insurance officer into a species of unqualified medical detective. On the other hand, applicants find themselves vastly deluded if they go to the "Sun" with a family or personal history of any of half a dozen maladies—pleurisy, for instance—for they are at once haled off to a medical man for examination. Only those

candidates who look robust and can answer an exhaustive examination paper in a satisfactory way can escape the doctor. So that the "Sun" escapes paying fees for the examination of a certain number of apparently sound lives, while in all cases where the least doubt is suggested they have a medical reference like all other offices. What is the morality of this transaction?

The Nervous Insurance Applicant.

FOR some reason or other, as all medical examiners know, the applicant for insurance in nine cases out of ten gets a "stage fright." There can be no reasonable doubt that a certain percentage of persons never insure at all because of their dread of the medical ordeal. This insurance-phobia—to coin a word—may be foolish, but it is none the less real, and the "Sun" has treated it in a businesslike way, and made capital out of it. If that office can advance sufficiently sound arguments to uphold its position, well and good. Recently the office in question has issued to medical men a pamphlet which appears to us to be simply adding insult to injury, for it not only shows the number of persons attracted by the non-medical examination scheme, but also insinuates that medical men approve both of the *suggestio falsi* proffered to the public and of the injury done to the medical profession. The attitude may be gathered from the following extract from the pamphlet already alluded to, published under the title "More Signs of the Times." It occupies the next paragraph in this column, and needs no comment.

Signs of the Times. "Sun" Edition. "The Society's plan of assurance without medical examination has been in operation for upwards of four years, and I am now authorised

to tell you that it has proved satisfactory to the Society and attractive to the public, upwards of 7,500 policies having been issued. I am also pleased to be able to say that its aims and objects having been recognised, it has commended itself to many members of the medical profession throughout the country, for it has been shown to be not inimical to their interests, but rather calculated to relieve them from the difficulty so often felt of doing justice to all concerned when examining and reporting on the life of a patient or neighbour. The Society's system is novel and framed to meet popular requirements, but, in so far as it relies upon the medical attendant's confidential report of the applicant's medical history it reverts to an old and successful practice."—*Signs of the Times.*

LEADING ARTICLE.

PUBLIC NEWSPAPERS AND QUACK ADVERTISEMENTS.

THE question of the publication of fraudulent quack advertisements in lay newspapers has reached the House of Commons. Last week a question elicited from Mr. Herbert Gladstone an opinion to the effect that the evil results arising from the sale of quack medicines would be better met by the spread of education than by Government prosecutions for fraud. We confess that to us the principle thus laid down is somewhat of an Egyptian mystery. Government does not wait for ideal intellectual and physical developments to protect the community against—let us say—garotters, postage-stamp forgers, and long-firm swindlers. Why, then, put off dealing with the equally pernicious set of quacks and quack medicine vendors, whose roguery inflicts incalculable damage upon the health, happiness, pockets, and even the lives of His Majesty's subjects? Our contemporary, *Truth*, takes a sensible editorial view of the question in the following passage in its issue of March 22nd, 1906:—"It seems to me that if a man commits a fraud by means of a quack medicine, he is as fit a subject for a Government prosecution as the man who commits a fraud by selling adulterated food or shines in bogus companies. I should like to think that the Home Secretary is right in expecting that the spread of education will render people less likely to fall victims to this particular form of fraud, but I am sorry to say that I see no evidence for expecting much in that direction." The underlying sentiment of our contemporary with regard to quack medicines is excellent. Let us see how his theory works out in his own practice. The first objectionable thing that catches our eye in the above-quoted issue, is a notice in a column headed "Girls' Gossip," praising Mrs. John Strange Winter's "Hair Food." Knowing the ways of such writers, we turned to the advertisement columns and there found a carefully-worded notice of the "food," describing it as a "rich stimulant and scurf remedy." As a matter of scientific fact, there is no such thing as a hair food, and any preparation claiming to nourish the hair directly is based on a physiological impossibility. In other words, a "hair food" is worthless, and the Editor of *Truth* is receiving money for helping to push the sale of a self-proclaimed sham. Following the hair food advertisement (page 722) is an advertisement by one "Mrs. Adair," who sells a variety of wares of a transparently fraudulent nature. There is a "Patent Ganesh Forehead Strap," sold at £1 5s. 6d., to cure the deep lines between brows and about eyes; it is "stuffed with powdered herbs most healing and beneficial" (*sic*). Then come "Ganesh Muscle Oil," to fill out hollows and remove lines, at £1 10s. 6d.; the Ganesh Eastern Cream, the greatest skin food and muscle producer in the world, at 10s. 6d.; the "Ganesh Diable Skin Tonic," at £1 1s. 6d., to close the pores and

cure puffiness under the eyes; and, lastly, the "Ganesh Chin Strap," at £1 1s. 6d., made of "a specially prepared silk elastic steeped in a preparation known only to Mrs. Adair, is a certain cure for double chins, and takes away the line running from the mouth to the chin." All this is sheer arrant quackery of the worst and most fraudulent description, which, under any decently framed and decently administered Medical Act or Pharmacy, would not be permitted to exist for a week in any sane civilised community. Surely so accomplished a man of the world as the Editor of *Truth* need not await the spread of a more general education on these matters to learn that nothing short of a radical surgical operation is any cure for double chins and wrinkles and other natural and acquired lines and furrows about a face; that no oil can remove such lines; that no cream can feed the skin and produce muscle; that no tonic can cure puffiness under the eyes; in short, that the whole of the Ganesh remedies are obviously unable to perform what they profess to bring about, in other words, they are fraudulent. But *Truth*, the great *ensor morum* of Society, takes money for advertising Mrs. Adair's worthless nostrums. Without advertisement her nefarious business could not exist. *Truth*, therefore, is, in point of fact, assisting in the creation and the maintenance of a traffic in trade nostrums of an obnoxious nature, and is, moreover, sharing the profits. On the whole, we have pleasure in acknowledging that the columns of *Truth* are remarkably clear from pernicious advertisements. What can we hope for if the mirror of social ethics be itself sullied? Our respect for the journal in question has been frequently expressed, and is sincere enough to lead us to hope that in future a more rigorous attention will be given to the exclusion of objectionable patent medicines from its advertisement columns.

NOTES ON CURRENT TOPICS.

Risks and Uses of Ethyl Chloride as an Anæsthetic.

SINCE ethyl chloride was introduced to the profession in these countries in 1902 by Dr. McCardie and others it has rapidly increased in favour as an anæsthetic for short operations. The reasons for this are not far to seek. It is easy of administration, rapid in its action, portable, and not unpleasant to the patient. The consequence has been that its adoption has taken place a little faster than the growth of the necessary skill in using it. Coming to us with a reputation of entire safety, it has naturally enough been taken up by dentists and others almost to the exclusion of the use of nitrous oxide. The result has been that not a few fatalities have occurred, and at the present moment there is a revulsion of feeling which tends to drive it even from its legitimate uses. There is little doubt that there is no justification for the employment of ethyl chloride where nitrous oxide anæsthesia will suffice, as, for instance, in nearly

all dental operations. In children, however, nitrous oxide is not a trustworthy anæsthetic, and in them ethyl chloride is indicated. On the other hand, it is hardly to be relied on as a substitute for ether in prolonged operations, since changes taking place during its use occur so rapidly as to leave little time to guard against serious conditions. In ordinary "good" subjects, without fatty heart, and in alcoholics, it is a convenient and safe preliminary to ether. Whatever plea may be urged in favour of the administration of nitrous oxide by other than medical men, we entirely agree with Dr. McCardie in his view that ethyl chloride is an anæsthetic which no one should employ who is not prepared to perform immediate tracheotomy or to take such other steps of urgency as serious spasm or rigidity may require.

Chinese Labourers and Sanitation.

WHILE the question of Chinese labour is agitating the public mind so deeply, it is interesting to note that a special report on the sanitary circumstances of the Chinese employed within the Johannesburg municipal area has just been issued by Dr. Charles Porter, the Medical Officer of Health for that city. From this report it appears that certain recommendations of the Transvaal Medical Society with regard to the living space, ventilation, lighting, and treating of the labourers' quarters have been adopted, and that consequently the Chinamen are in clover, enjoying not only the amenities of clean, well-aired rooms, but such hitherto unknown luxuries as hot baths, steam cooking ranges, and expert cooking. The food is excellent in quality and generous in quantity; rice and salt in unlimited amounts, half a pound of fresh meat and bread and twelve ounces of fresh vegetables being supplied daily. Medical attendance, too, is provided, the choice of a Chinese or English doctor being afforded, and well-equipped hospitals are ready to receive all the sick. Dr. Porter, recalling his English experiences, expresses an emphatic opinion that the conditions under which the Chinese live in their compounds are very much superior, as regards housing, food, and payment, to those which the unskilled white labourer at home, either in town or country, can command. It will be satisfactory to those to whom the good name of the Empire is dear to know from the testimony of a competent medical official that the Chinese are so well provided for, but the report cannot but fail to raise the question why the unemployed at home were not given the chance of enjoying these Elysian advantages.

Clinical Pathology in its Relation to Medicine and Surgery.

MR. MAYO ROBSON discussed a subject of some interest to the profession in his recent address to the Bristol Medical Society. The day has passed when each physician or surgeon can himself make the investigations in clinical pathology necessary for the proper diagnosis and treatment of the diseases of his patients. He can neither afford the time required for learning the elaborate technique

of the modern laboratory nor can he, in the course of his practice, even were he possessed of the requisite methods, set aside sufficient time for the conduct of the various investigations as they are required. It is necessary for him, therefore, to have at hand the assistance and advice of a skilled pathologist, and it is a question at the present moment in what way such assistance and advice can best be obtained. Mr. Mayo Robson rightly points out that the system which has held up to the present of obtaining reports from a clinical laboratory at so much a report is lowering to the dignity of the profession and derogatory to the responsibility of the pathologist. He is right, too, in believing that the complete severance between the clinician and the laboratory worker, inherent in this system, is a serious disadvantage to the value of the work done. If a pathologist can give aid to a physician or surgeon by his examination of a morbid specimen, the physician or surgeon can on the other hand give him help in the formation of his opinions by full information as to the clinical aspects of the case. Mr. Robson looks to the springing into being of a new race of consultants—the consulting pathologist, who will be willing not merely to examine a specimen and give a report, but to meet a physician or surgeon at the bedside beforehand, and after examination, not merely of those specimens the clinician may think of submitting, but of all that he himself, on a full consideration, thinks of demanding, furnish his opinion. We believe with Mr. Robson that some such plan as this is required in order to bring together two branches of work, either of which is imperfect without the other.

Liverpool School of Tropical Medicine.

THE completion of seven years' work finds the Liverpool School of Tropical Medicine in a position of which it and its promoters may indeed be proud. The school is an established success. It is well and comfortably housed in the laboratories presented by Mr. William Johnston; it has command of a "Tropical" ward at the Royal Southern Hospital; and it is staffed by a band of brilliant workers. In the short time since it came into being it has equipped and sent out no less than sixteen expeditions to warm climates to investigate disease or to advise the local authorities in preventive measures, and it has issued twenty-one publications on tropical pathology and hygiene. The energy and enthusiasm of the school and its staff seem sufficient to carry them through all difficulties, financial and other, and perhaps it may be accounted as one of their greatest triumphs that they have succeeded in getting £500 a year for five years out of the Government. The Liverpool merchants and citizens, among whom Sir Alfred Jones stands conspicuous, have shown a commendable spirit of local patriotism by the support they have given to the school, but needless to say, although the annual report does not contain more than a reminder that funds are short, the work could be

much extended and developed if more generous donations were forthcoming. It is highly appropriate that a part of the importance of Liverpool, which trades with so many unhealthy regions, should possess its own School of Tropical Medicine, but there is none the less an obligation on all imperially and humanely-minded people to help forward its good work.

Snails, Dietetic and Therapeutic.

ONE of the stock subjects wherewith the journalist stimulates the jaded curiosity of nineteenth century mankind, is that of snails as food. As a deep student of human nature, the penman knows the thrill that runs through the mind and body of the average citizen when he is advised to eat some tabooed food such as snails, horseflesh, or frogs' legs. Now, apart from prejudice those food-stuffs are one and all cheap, nourishing, and toothsome. They are all, for instance, prized by our French neighbours, who know a good eatable when they see it. It would certainly be of service to our rural population were they to adopt snails as an article of ordinary food. Meanwhile the newspaper man is making reams of copy out of the ancient and modern history of the edible snail. Many cures, especially of consumption, are attributed to snails. Their value, as with cod liver oil, is probably due simply to their nourishing qualities. A correspondent to a London journal tells how at six years of age he was "cured" of hopeless consumption by being sent out into the fields every morning, where he had to eat two dozen dew snails. This is clearly a sagacious anticipation of the open-air cure, with its forced exercise and feeding. The writer says he is now between seventy and eighty years of age, and has not drunk a glass of cold water for thirty-five years. He omits to state what the latter method has "cured."

Police Methods at Leeds.

THE Leeds police-court proceedings, arising out of the summons of five medical students, have taken an extraordinary turn. The magistrates dismissed the summons, whereupon a counter-charge of assault was laid against the police. It will be remembered that the original plaintiffs were turned out of the Tivoli, where they had demonstrated against the notorious "Electricity Emperor," "Dr." Walford Bodie. The evidence in the counter-charge alleges official conduct resembling that of Russia rather than of England. It appears that the four students were charged with disorderly conduct in the street half an hour after being ejected from the hall. So far as we can gather, there was no evidence whatever of outside disorderly conduct obtainable from the police, who had secured the names of the men inside the hall. Another extraordinary allegation is that the superintendent refused the names of the constables accused of assault, and referred the prosecuting solicitor to the Chief Constable. So much delay resulted that a summons was taken out by de-

scription. Other extraordinary allegations were made against the police. The Stipendiary has reserved judgment for a fortnight. If the police methods of Leeds even remotely resemble the picture drawn by the prosecution, the citizens may thank "Dr." Bodie for having by accident done them one good act in drawing attention to so intolerable a system.

Prosecution of "Professor" Richard.

THE police prosecution of a "medical electrician" at Wolverhampton, has brought forth a shoal of witnesses and a mass of extraordinary evidence. As the case is still under investigation, comment is not permissible. At the same time, there can be no objection to pointing out that Richard has for years past been relentlessly exposed by *Truth*. Further, the "Professor's" operations have been carried out on a scale truly Napoleonic for last week no less than twenty-two specific charges were preferred against him of obtaining money under false pretences. The charges presumably cover only a portion of the electrical treatment business, and as they involve fees amounting to £270, the total receipts must have represented an income that many a gifted medical specialist would envy. Incurable deafness and blindness were treated at fees ranging from three to thirty guineas. The hopeful fact about this prosecution is that the police are acting on general penal laws apart from the Medical Acts.

Military Hygiene.

Now that real Army reforms are in the air it is a hopeful sign that military officers have been induced to take interest in matters of military hygiene. We are reminded of a lecture on the subject given by Major Davis, R.A.M.C., at the United Service Institution a few months ago, before an audience that included a good array of officers of both branches of the Service. The lecturer did not break much new ground, but pointed out that, in view of the fact that the Japanese lost 57,000 men from wounds in their late war as against 15,000 from disease, whereas our troops in South Africa had 400,000 admissions to hospital from disease to 18,000 in respect of wounds, something radical was wrong. The two chief remedies he proposed were the formation of a special sanitary corps to arrange and supervise all hygienic matters on a campaign, and systematic instruction of military officers and men in the preservation of health on service. Authorities will agree that these two proposals are at the root of all hygienic reform in the Army, and we were correspondingly surprised at the time to find Surgeon-General Keogh, Director-General of the Army Medical Corps, opposing the formation of a special sanitary corps. Possibly he had sound reasons for that attitude, or perhaps he was prepared to advance a sounder alternative plan. From our point of view, however, there is little doubt that each army doctor should be well trained in the prevention of disease, but it is

of the greatest importance to have in addition a corps of experts specially organised for preventive work during a campaign. No doubt military officers are opposed to such a change, but we hope the Director-General will see his way to some such reform.

Medicine in Korea.

If trade follows the flag, as Mr. Rhodes once said, medicine perhaps more than any other single calling welds Empires. At any rate, no civilisation of a modern character can advance far without the aid of scientific medicine, and now that Korea is ceasing to be a stock puzzle at geographical examinations and is now coming to take its place in the comity of nations, the need of medical education is being experienced. From a letter by Dr. Vinton in the *Medical Record*, it appears that Korea has hitherto followed in many respects the practice of China with regard to its medical arrangements. Thus, practitioners are paid by results and not according to the number of visits—a system which may have some advantages from the point of view of the public. Payment is usually moderate even for a complete cure, and it is usually made in kind, the successful physician being rewarded with rice, eggs, poultry, nuts, fruit, and seaweed; occasionally a coin is forthcoming, and a pig or two, or even a bullock, may be added if great gratitude is stirred. The most trustworthy source of income for the physician, however, is the vending of medicines; these he dispenses himself, and as he charges so much per ingredient, one is not surprised to hear that poly-pharmacy is on the ascendant. In Korea, representatives of the pathological school of therapeutic Nihilists are as rare as white black-birds. The old order, however, is changing, and American pioneers are already attempting to establish a native school of medicine. Gray's "Anatomy" has been partly translated into the vernacular for its use, and other standard works are being undertaken. We trust they will be duly appreciated by the local profession.

PERSONAL.

LORD ROTHSCHILD has become President of the Royal Dental Hospital, London, *vice* the late Duke of Cambridge, and Sir Frederick Treves, Bart., has been nominated consulting surgeon to the same Institution, *vice* Mr. Christopher Heath, deceased.

DR. JOHN C. M. M'VAIL, Medical Officer of Health for the Counties of Stirling and Dumbarton, has been appointed "Lane Lecturer" for 1906 in the Cooper Medical College, San Francisco. This lectureship was founded some ten years ago and consists of ten lectures delivered on five consecutive days in August, one in the morning and one in the evening of each day.

WE understand that Lieutenant-Colonel J. M. Irwin, Royal Army Medical Corps, now on the Aldershot Staff, has been nominated for the appointment of Assistant Director-General of the Army Medical Service.

MISS SIDNEY BROWNE, the matron-in-chief of Queen

Alexandra's Imperial Military Nursing Service, retires into private life early next month. She holds many decorations, including the Egyptian medal and clasp and the Khedive Star, and the King's and Queen's medal for South Africa.

IN connection with the next year's forthcoming second International Congress on School Hygiene, to be held in London, a meeting will be held, under the Presidency of the Duke of Northumberland, at the University of London on Friday, March 30th, at 5 p.m.

HIS MAJESTY THE KING has conferred a Knight Commandership of the Royal Victorian Order upon Lieutenant-Colonel H. H. B. Charles, I.M.S., Surgeon to the Prince of Wales in India.

SIR LAUDER BRUNTON will preside over the Second International Congress on School Hygiene, to be held in London from August 5th to 10th, 1907.

DR. A. H. F. BARBOUR has been appointed Lecturer on Gynæcology, both systematic and clinical, to the University of Edinburgh to fill the vacancy caused by the resignation of Dr. Berry Hart.

DR. J. M. STIRLING has been appointed to the vacant chair of Ophthalmology in McGill University. Dr. Stirling graduated in Edinburgh, where he was house surgeon to Dr. Argyll Robertson.

THE name of Mr. W. B. Taylor, M.R.C.S.Eng., has been placed on the Commission of the Peace for the County of London.

LAST week Professor Sims Woodhead was entertained at a banquet given by the Corporation of Glasgow in his honour as President of the Temperance Collegiates' Association.

It is widely stated that Miss Olga Nethersole will retire from the stage in eight years' time or sooner, and devote her life to fighting tuberculosis. She has lately, says a Laffan's New York message, taken up the study of medicine, in which she became interested through Sir Alfred Frupp.

THE distribution of prizes at the close of the winter session of Anderson's College Medical School was made last week to the successful students by the Lord Provost of Glasgow and Mrs. Bilsland.

THE wills of three members of the medical profession have been proved during the past few days, that of Deputy-Surgeon-General Sir Joseph Ewart, of Brighton, under the sum of £33,263, that of Dr. A. B. Paterson, late of Beaumont Street, London, W., under £65,271, and that of Mr. Wm. Moxon, J.P., M.R.C.S., L.S.A., late of Northampton, under £48,042.

PROFESSOR T. C. HAYES, M.D., having resigned the Chair of Obstetric Medicine, in King's College, London, the Council have appointed Dr. John Phillips as his successor. Dr. G. F. Still has been elected Professor of Diseases of Children at the same institution, Dr. W. E. Dixon to the Chair of Materia Medica and Pharmacology, and Dr. Frank E. Taylor Demonstrator of Bacteriology.

FIVE of the Scarborough Board of Guardians' medical officers expressed themselves unreservedly in favour of the inclusion of phthisis in the Compulsory Notification of Diseases Act, 1899. The board, which consists of seventy-two members, decided almost unanimously to support a petition to the Local Government Board in favour of the recommendation.

A CLINICAL LECTURE

ON

ACQUIRED FLAT-FOOT—TALIPES VALGUS.

Delivered at the Royal Victoria Hospital, Belfast, February 16th, 1906.

By A. B. MITCHELL, M.B., F.R.C.S.I.

GENTLEMEN.—When a young person, æt. between 14 and 20 (though I do not mean to exclude other years) complains of pain in one or both feet, which gets worse towards evening and is relieved by rest, be sure to examine carefully for flat-foot. This condition is very common, and is very frequently overlooked, especially in the early stages, when, though pain may be very intense, deformity in the sense of flattening of the arch, may be slight or even absent.

The pain from which these patients suffer is often hastily regarded as rheumatic, and with some justice, for this deformity is frequently the direct result of acute rheumatism. So common is this association that when you meet with a case of flat-foot you must never neglect to examine the heart for evidence of that disease.

A young man, a striking example of this combination, was a patient in one of our medical wards about a month ago. He was admitted for heart disease, and his feet were markedly flattened.

Omitting all reference to the paralytic variety, I shall confine my remarks to what is known as static flat-foot. It occurs most commonly in young people whose muscular tone is below par, whose vitality has been lowered by improper nourishment, whose work has not uncommonly involved prolonged standing, it may be, in over-heated, imperfectly ventilated rooms. Sometimes they have a rickety diathesis, at others the starting point of the trouble is a direct injury—Traumatic flat-foot; whilst one of the most severe cases I have seen was due to Gonorrhœal Rheumatism. These young people, as the result of prolonged standing in faulty positions, exhibit signs of muscular exhaustion. The muscles which support the ligaments on the sole of the foot relax their vigour, the most important in this respect being the tibialis posticus, which, as you know, has a very extensive attachment to the bones of the foot. Soon the inferior calcaneo-scapoid and other ligaments, deprived of their normal support, begin to yield and stretch. A curious rotation takes place at Chopart's joint; the head of the astragalus comes downwards and inwards, projecting on the inner border of the foot, the scaphoid is pushed forward and rotated so that its tuberosity also projects. In this rotation the anterior part of the foot partakes, so that the sole is everted, its outer border raised, and the peronei tendons become prominent.

If you examine this bony specimen, which, through the kindness of Professor Symington I am enabled to submit for your inspection, you will observe how the bones become affected in advanced cases. Note especially—

1. The astragalus is rotated so that its head is directed too much inwards and that its trochlear surface looks upwards and inwards instead of directly upwards.

2. The os calcis is rotated so that only its inner tuberosity rests on the table, its outer surface looks obliquely upward and has come into contact with the tip of the outer malleolus, and a new articular facet has been formed on each of these bones.

3. The position of the scaphoid and the rotation at Chopart's joint.

If you now examine this patient you will observe that she walks badly, with a characteristic stiffness and want of spring. She states that towards evening she gets worse, and that she gets some puffiness about her ankles, especially the right. For the past two months walking or standing has become more and

more painful, till she has been compelled to give up work. Her right foot is everted and rigid, the outer border is raised, the inner malleolus is very prominent, the outer much less prominent than in the sound foot. On the inner side the head of the astragalus projects, but the arch is only slightly flattened. Her chief complaint is of pain. The foot is so stiff that you cannot invert the sole nor completely extend the ankle.

The case is an example of spastic flat-foot, a very troublesome form. Three other points are to be noted :

1. If we smear the sole of her foot with ink and ask her to stand on a sheet of clean paper we get a foot-print which shows that too much of the sole touches the ground; but hers is not a very striking print, and, indeed, this test so commonly employed is of little value in the early stages of the disease.

2. If we draw a triangle on the sole of her foot by joining the centre of the heel with the head of the first and fifth metatarsal bones and a transverse line between these latter points—Von Meyer's triangle—you will see that a perpendicular through the centre of articular surface of the astragalus would fall almost half an inch inside of the inner border of this triangle, whereas in the normal foot it falls on the line or just outside it.

3. Mr. Golding Bird has pointed out that the joint between the first metatarsal and internal cuneiform bones corresponds exactly to the middle of the inner border of the foot; that in cases of flat-foot the inner border is increased in length, and that this increase is entirely in the posterior half of this border the anterior half remaining normal. You will note that in our patient this cannot be demonstrated. It is, I think, only applicable to advanced cases, but I have more than once found over half-inch increase in the posterior half.

Time only permits a very brief reference to the question of treatment.

1. It is very desirable to arrange if possible for a change of occupation which will involve less standing.

2. Attention must be paid to the general health; correction of anæmia or similar condition.

3. Pain and spasm is to be relieved by complete rest, preferably in bed.

4. If, as is the case in the patient I have just shown you, pain and spasm persist in spite of rest, an anæsthetic must be administered, the foot freely manipulated, and encased in plaster of Paris in the *varus* position for two or three weeks.

5. The next thing is to provide some artificial support for the weakened arch. The simplest and most efficient is to have the boot made without an instep, the inner border of the sole running straight to the heel; at the same time the inner side of the sole and heel is made thicker than the outer, so that patient must walk on the outer border of the foot.

Any of the special pads or supports I now exhibit—of which Whitman's brace, though uncomfortable at first, is decidedly the most efficient—may be ordered.

6. Systematic exercises calculated to strengthen the calf muscle should be vigorously carried out, *e.g.*, the feet being slightly adducted, the patient standing erect should slowly raise the heel till the weight of the body is supported on the balls of the toes, maintain this position for a moment, and then slowly come back to the original position; the exercise to be repeated till a slight sense of fatigue is experienced. This

should be done several times daily. Massage is very beneficial where it can be obtained.

For the more severe cases operation may be considered; but I advise you not hastily to recommend active interference. The results even in the hands of the best surgeons are often disappointing, convalescence is slow, and three to four months must elapse before the full weight can safely be borne on the foot. Several procedures are in vogue, a fact which shows that none is entirely satisfactory. I shall merely indicate a few:—

1. Stokes removes a wedge from the neck of the astragalus.

2. Ogston excises the astragalo-scapoid joint, and secures permanent ankylosis.

3. Many surgeons remove a wedge from the inner border of the foot without special regard to the bones removed.

4. Where the valgus has followed fracture of the tibia and fibula, Trendelenburg performs osteotomy on these bones.

5. A very ingenious suggestion has recently been made by Wilson and Patterson ("American Medicine," Vol. IX., May 6th, 1905). Having excised the astragalo-scapoid joint, they divide the tendon of the extensor proprius pollicis, the proximal end of which is brought down over the inner border of the foot, carried through a hole specially drilled in the tuberosity of the scaphoid, and secured by sutures; the tension on the tendon being sufficient to ensure its acting as an additional support to the newly-formed arch. They claim that the results are satisfactory and permanent. The method certainly seems worthy of a trial.

None of these operations is very simple. All of them involve a compound fracture. The foot is difficult to sterilise, and suppuration is, I fear, more frequent after operation than is generally acknowledged. Therefore, I advise you only to fall back on them when simple measures have failed, and when your patient is seriously inconvenienced by the deformity.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The lecture in next week's will be by William Alexander, M.D., F.R.C.S., Surgeon to the Royal Southern Hospital, Lecturer on Clinical Surgery in the University of Liverpool, "On Cancer of the Uterus."

ORIGINAL PAPERS.

NOTES ON TWO RARE CONDITIONS MET WITH IN THE PELVIS DURING OPERATION.*

By HENRY JELLETT, M.D., F.R.C.P.,
Gynaecologist and Obstetric Physician to Dr. Stevens' Hospital,
Dublin.

I DESIRE to bring to your notice two abnormal conditions which occurred in my practice at Dr. Stevens' Hospital, Dublin, that are of sufficient rarity to be of interest.

The first case is one of anatomical, rather than of clinical, value. M. S., æt. 26, was admitted to Dr. Stevens' Hospital on October 19th, 1905. She stated that she had been married five years and had had two children. The second of these was born three years ago, and her illness dated from that time. Apparently, she suffered after her confinement from an attack of pelvic infection, as a result of which a pelvic abscess had been opened and drained in another hospital. After this, her health improved for a time, but the symptoms had gradually returned until they became so serious as to require further advice.

On bi-manual examination, the uterus was found to occupy an almost vertical position in the pelvis, and was slightly displaced to the right side. Douglas's pouch was occupied by two swellings, each the size of a small orange. The right swelling appeared to contain some fluid. A diagnosis of double salpingo-oophoritis was made.

On September 22nd, I opened the abdomen, and found the condition of the pelvic organs to be very much as described. The steps of the operation were of no great interest, and I may sum them up by saying that the appendages were freed from their adhesions with considerable difficulty; that between them lay a cavity containing pus, which escaped during the operation; that the pelvic tissues were extensively infiltrated on the right side between the uterus and the pelvic wall; and that, under the belief that I was dealing with a tuberculous case, I removed this infiltrated tissue as well as some enlarged pelvic glands; and that, then, in consequence of the diseased condition of the uterus, my belief in the tuberculous nature of the case, and the necessity for obtaining free drainage, I removed the uterus by Doyen's method, opening the anterior cul-de-sac first. The pelvis was then plugged with iodoform gauze and drained into the vagina.



FIG. 1.—Diverticulum coming from Pelvic Colon.

I now come to the interesting feature of the case. When I opened the abdomen in the first instance, I noticed the presence of a tube running from the large intestine into and between the enlarged appendages in Douglas's pouch. I assumed this tube to be the appendix, and, as I could not free it from the appendages, I ligatured it and cut it across, intending to return to it subsequently, and, if necessary, remove it entirely. To my surprise, however, on looking for the supposed appendix, at the close of the operation, I found the real appendix and cæcum in its normal place, and in no way involved in the pelvic inflammation. I then looked for the remainder of the tube which I had divided and found that, instead of coming from the cæcum as I had at first assumed, it came from the pelvic colon, which

* Paper read before British Gynaecological Society, March 8th, 1906

crossed the pelvis from left to right. The accompanying drawing, which was made from my description, gives a good idea of its nature. The tube was some two and a half to three inches in length, and about a quarter of an inch in diameter. It possessed a lumen which I presume communicated with the lumen of the pelvic colon, and its walls were structurally continuous with the walls of the latter. I was at the time under the impression that the lower end of the tube was still attached to the uterine appendages, and that it would be available for microscopical examination; but I regret to say that, on subsequent examination of the specimen, it could not be found, and had apparently been rubbed off during the course of the operation.

I have been unable to obtain any explanation or information regarding this rectal diverticulum, either with regard to its origin or to a previous description of a similar condition.

Kelly, (1) in describing Meckel's diverticulum says that it may be found "outside the classic region, either high up (jejunum, duodenum) or low down (cæcum, colon)," but he does not say anything that could be taken as expressing his belief that it occurs so low as the pelvic colon. I may add that the patient made an uninterrupted recovery, and that, on microscopical examination of the removed appendages, no evidence of tuberculous disease could be found.



FIG. 2.—Absence of Left Appendages in Association with Cystic Right Ovary.

The second case which I wish to bring to your notice is of clinical, and, I think I may say, of medico-legal, interest. M. B., æt. 32, but seemed to be æt. 45 at least, was transferred to me by my colleague, Mr. Haughton, on March 21st, 1905. She stated that she had been married for five years, and had had one child fifteen months before in the Rotunda Hospital. She left the hospital in three weeks, but in eight or ten days afterwards was again admitted, complaining of pain and swelling in her left side, her leg, and her thigh. A few days after admission one of the deep veins of the neck

became thrombosed, and apparently there was also a suspicion of thrombosis of a pelvic vein. In addition to these symptoms, her abdomen became distended, owing to the presence of a very large quantity of free fluid, which was found to be due to cirrhosis of the liver. The Master of the Rotunda sent her to Steevens' Hospital to my colleague, Mr. Haughton, who performed a Talma-Morrison operation for the ascites. Previous to the operation, he had tapped the abdomen on five occasions, removing each time about 150 ounces of fluid, and at the operation a further quantity escaped. The patient's condition improved in a marvellous manner, and no further accumulation of fluid occurred, nor has occurred up to the present date (February, 1906). However, in May, 1904, she began to complain of pain in the lower part of the abdomen, and of irregular and profuse menstruation. On examination, the uterus was found to be slightly enlarged, and, on the right side, a firm, rounded swelling corresponding to the right ovary was felt, about the size of a small orange.

On March 29th, 1905, I opened the abdomen and found the right ovary enlarged to some four or five times its normal size, and cystic. I removed it, leaving the tube. On the left side, there were some small and soft adhesions between the intestines and the back of the uterus. I separated these with the object of examining the appendages, but to my surprise I found that the only structure representing them was the stump of a Fallopian tube some half an inch in length. The end of this stump was adherent to part of the small intestine. There was no trace of an ovary and the peritoneum of the broad ligament was absent, save for a small fold corresponding in length to the tubal stump, and adherent to the surrounding structures. On freeing the adhesions, no scarring of the peritoneum could be found. I assumed that the patient had had a previous operation of which I knew nothing, and closed the abdomen. There was no free fluid in the peritoneal cavity. The condition of the pelvis is well shown in the accompanying drawing.

As soon as the patient had recovered from the operation, I made careful inquiries to elicit any history of a previous operation. There was no abdominal or vaginal scar, but still I thought that perhaps a vaginal operation had been performed, the scar of which had disappeared. The patient however, stated in the most definite manner that, save for the operation performed by my colleague, Mr. Haughton, and of a slight operation on her neck at the Rotunda Hospital, she had never been operated upon, and as this statement is substantiated by the absence of all trace of an incision I think it must be regarded as correct.

Excluding, as I do, the removal of the appendages by operation, two explanations of their absence suggest themselves:—either the left appendages were congenitally absent or they were removed by absorption after some form of strangulation had deprived them of vitality. I think the former of these explanations may be dismissed, as it is impossible, in view of what we know of the development of the tube and uterus, to understand a congenital defect which would leave a conical stump of tube half an inch in length projecting from its normal position on a normally developed uterus. With regard to the second explanation, we know that torsion of the pedicle of an ovarian

tumour is of relatively common occurrence, and Veit, (2) Freund, (3) and Breisky (4) have recorded cases of consequent complete disappearance of the tumour. Further, Hirst, (5) in his work on the "Diseases of Women," has a drawing of a specimen, preserved in University Hospital, Philadelphia, which very closely resembles the condition I found in my case, and Ballantyne and Williams (6) have described a case of absence of the outer two-thirds of the tube in association with genital tuberculosis.

In my case, the right tube was considerably elongated, as also were the ovarian attachments, with the result that the enlarged ovary and ampulla of the tube lay in approximation with the cæcum. They were thus in a most favourable state for the occurrence of torsion, and if we assume the missing left tube and ovary to have been in a similar condition we can account for the predisposition to torsion, while the comparatively small size of the ovarian tumour would facilitate its complete absorption. This is, of course, all surmise, but the fact remains that the left appendages have completely disappeared, that the patient had a history of an attack of pain in her left side, and of circulatory disturbance, and that the remaining appendages were at the time of operation in a condition calculated to facilitate torsion.

Martin, of Berlin, (7) endeavours to account for the separation of ovary and tube by a different mechanism to that of torsion. Braun (8) recorded a case which was very similar to mine, and in which all trace of the adnexa on one side had disappeared save the interstitial portion of the tube; and Martin suggests that this result was brought about by the fixation of ovary and tube by adhesions to an intestine or a piece of omentum in such a way that the ligaments were kept on a continuous stretch, and their blood supply gradually compressed and lost. Martin, however, admits that it is difficult to understand how this could occur in such a way as to lead to the occlusion, not only of the uterine blood supply to the broad ligament, but also of the blood supply coming through the infundibulo-pelvic ligament. Klob, (9) in his work on the pathological anatomy of the sexual organs, says that such a condition can occur when, after pregnancy, the ovary and tube become fixed high up in the abdomen, while the uterus gradually descends into the pelvis. I have myself seen a case which fulfilled these conditions. A patient, confined for some weeks, died with symptoms of septic peritonitis. At the autopsy, the uterus was found in the pelvic cavity, with the tubes and broad ligaments running straight up towards the kidneys. On tracing them upwards, the ampullæ of the tubes were firmly fixed in the region of the lower margin of the kidneys, and were surrounded by inflammatory tissue and pus. On further examination the case turned out to be one of tubercular infection. The tubes and broad ligaments were elongated, and it is possible that, had the patient lived, the continual tension on the supplying blood-vessels might have led to the obliteration of the latter. It is, of course, both possible and probable that, in such a case, some remains of ovary would be found at the spot where it had been adherent, and that therefore we should speak of such cases, not as absence of the tube and ovary, but rather as one of *apparent absence*

Whether, to revert to the case before us, such a process as that described by Martin and Klob is compatible with the slight amount of pelvic scarring and of intestinal adhesion that were present in this case is a point on which it is difficult to give an answer. I incline to the view that it is not compatible, and that the more likely explanation is to be found in torsion of the elongated pedicle of an enlarged ovary.

It will probably suggest itself to some of you that, if my explanation is right, it also accounts for the presence of free fluid in the abdominal cavity, and that the disappearance of this fluid is to be attributed to the completion of the process of absorption and not to a successful Talma-Morrison operation. Mr. Haughton's evidence is, however, very clear on this point. Prior to the operation the patient had been tapped some five times, and large quantities of fluid were withdrawn. At the time of operation, the liver was found to be paler in colour than normal, of a fibrous consistence, and slightly reduced in size. Subsequent to operation, she improved with great rapidity, and no further accumulation of fluid occurred.

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THE ROLE PLAYED BY THE TONSILS IN ORGANISATIONAL DISEASES.

By STEPHEN J. ROSS, M.D., Ch.B.,
 Surgeon to Out-patients, Bedford County Hospital.

It has often appeared to me that we general practitioners are often apt to overlook the important part played by the tonsils as the points of entrance of organisms in specific diseases.

A child, æt. 14, developed a slight nasal catarrh and tonsillitis. The mother regarded the case as one of "cold," and no further notice was taken of the case, until three weeks afterwards, when weakness of the legs was noticed, I then saw the child, which was suffering from post-diphtheritic paralysis. The knee-jerks were absent.

This points to the absolute necessity of never treating as trivial a case of tonsillitis, however slight. A more instructive case is that of a woman, æt. 49, the subject of heart disease in the form of mitral regurgitation. She developed a tonsillitis. I made cultures from a throat sweep and discovered streptococci and staphylococci, the former largely predominating four days afterwards, when the throat symptoms had subsided and she had a rigor. Her spleen enlarged, and she passed through a typical attack of infective endocarditis. From her blood I cultivated streptococci. Had I not seen the case when suffering from this apparently slight attack of tonsillitis the source of the infection would have remained obscure.

Take again the case of scarlet fever.

I have frequently cultivated streptococci from the tonsils of patients suffering from scarlet fever, also from the nasal discharges and from otitic discharges. Frequently have I attempted cultivation from the scales of a desquamating case and have invariably failed. Is this to be wondered at, as these scales are more or less dead epithelium, the result of hyperæmia, which we see in cases of urticaria, measles, or any other hyperæmic condition? I am convinced that scarlet fever is spread by the tonsils and nasal or ear discharges. There is far more danger in allowing a patient with a discharging ear, to mix with the community at large than a patient who has not quite completed desquamation.

A youth, æt. 16, had a chill, and complained of "sore throat." Forty-eight hours afterwards he had a rigor, temperature 104°. He passed through a sharp attack of pneumonia. Crisis occurred upon the tenth day. Diplococci were present in his sputum. Repeatedly have I seen a very painful form of tonsillitis associated with high fever, which in three or four days' time has been followed by an attack of rheumatic fever. Here, again, the tonsils were clearly the site of entrance of the organisms.

Lately I have had a case of acute pulmonary tuberculosis in a youth, æt. 21. Notwithstanding frequent mouth cleansing he developed a temperature of 106°. I felt sure it was a case of "mixed infection," from mouth sepsis. I made a tonsillar sweep and discovered streptococci, staphylococci, micrococci and bacteria. I determined to try the effect of anti-streptococcic serum. I injected 10 c.c. After the injection he fell into a sound refreshing sleep. His morning temperature was 99°. The following evening his temperature was 101°. It, never rose above this up to the time of death, which occurred ten days after his attack of hyperpyrexia. Many more similar cases could I cite, and I am sure that many of your readers could amplify my notes.

In most cases of infectious diseases tonsillitis forms a prominent symptom. So also it is from the tonsils that we have to fear the spread of infection. Your whole energies must be concentrated upon disinfecting the tonsils by the naso-pharynx. We can leave such problematical causes of the spread of the disease by scales to look after themselves.

I have omitted to refer to the tonsillitis which precedes an attack of influenza. Often the only complaint for twenty-four hours is that of a sore throat, then surely follows the aching of limbs, and too often the tedious recovery with which we are all too well familiar.

THE INTRA-VENOUS INJECTION OF FOR- MIC ALDEHYDE FOR PULMONARY TUBERCULOSIS.*

By F. W. BAKER YOUNG, M.B., CH.B.,
Resident Surgeon to the Hospital for Children and Women, Leeds.

IN this paper the author referred to the lecture delivered by Dr. Robert Maguire before the Harveian Society and published in the medical journals

(* Abstract of paper read before the Liverpool Medical Institution, March 15th., 1906.

during November, 1900, wherein Dr. Maguire's method of injecting hæmasepsin, a solution of formic aldehyde in normal saline, and the strength of the solutions used might be found. The treatment of an advanced case took about six months; at the end of six weeks, if the treatment was going to be of any service, the patient showed a marked improvement both in physical signs and symptoms. The immediate results of injection were (1) pain over the vein, which, if severe, could be relieved by firm pressure; (2) increase of moist sounds in the chest for a short time; (3) suffocative cough of a few seconds duration; (4) taste of formaldehyde; (5) odour of formaldehyde in the breath; (6) rigors, which occurred in every case, but not after every injection, varied considerably in their severity, and were to be treated by hot-water bottles, hot drinks, &c. Formaldehyde could be recognised in the urine and sputum by the following test:—If .05 grms. of resorcin, 5 c.c. of a 50 per cent. solution of carbonate of soda, and 5 c.c. of the solution of formaldehyde were well boiled, a permanent red colour was formed distinguishing formaldehyde from all other aldehydes. This reaction would take place in a dilution of 1 in 10 millions (*Journal of the Chemical Society*). Formaldehyde could be detected in the urine one week after, and in the sputum two days after, an injection of the 1 in 500 solution.

If it were objected that formaldehyde would be rendered inactive by reacting with other substances, he would reply that, since the velocity of any reaction was proportional to the concentration of the reacting substances, and that with injections of the strength of 1 in 500 the dilution would be, in the pulmonary circulation, 1 in 25,000, and in the systemic circulation still greater, reaction with other substances in the blood, if any, must be extremely slow; that very little reaction did actually take place was proved by the appearance of formaldehyde in the urine a week after the injection. Dr. Baker Young then read notes of a case of phthisis of nine years' duration, which he had treated by this method for seven months. The chronic course of the case had been interrupted by three acute attacks marked by high temperatures and hæmorrhages (in 1896, 1900, and the fall of 1904). Injections were begun February 26th, 1905. At that time the physical signs were well marked and bacilli were abundant in the sputum. A steady improvement took place until, in August, no bacilli could be found in the sputum. The injections were continued until October, when examination revealed no signs of active tuberculosis, though a small area of dulness existed where formerly a pleuritic rub could be heard. The urine had never contained albumen, and the Diazo reaction, tried twice towards the end of the illness, was negative. The patient was now sheep-farming in Punta Arenas, and reported himself free from recurrence.

THE annual meeting of the Medical Graduates' College and Polyclinic was held on the 23rd inst. at 22, Chenies Street, Gower Street, Dr. C. Theodore Williams in the chair. The report for 1905, which was read, stated that 1,224 cases of disease, many of extreme rarity and interest, were shown at the clinics, and the attendance of medical practitioners at these clinics and the lectures numbered 14,891 for the year.

CLINICAL RECORDS.

CASE OF ENDOTHELIOMA OF THE UTERUS.*

By MRS. SCHARLIEB, M.D.LOND., M.S.,
Senior Physician for Diseases of Women to the Royal Free Hospital,
London.

Mrs. S., æt. 50, November 3rd, 1905. Nine children, youngest 16. Periods regular to the end of 1904, since then much discharge, which lately has been thick and blood-stained. Three months ago noticed a lump in abdomen. Complains of feeling weak. There is much urgency of micturition, with scalding; the bowels are badly constipated.

On examination a very large, hard tumour was felt in the abdomen; it was markedly irregular and suggested papillomatous growths. On vaginal examination the cervix uteri was irregular, the os uteri partly dilated, there protruded through it a papillomatous mass.

Nov. 10th, 1905.—*Operation*.—The parts removed consisted of the uterus and appendages.

The Pathologist's report was as follows:—"The specimen consists of an enlarged uterus with its appendages, and weighs 31 ozs. The uterus is the size of a 4½ months' pregnancy; it measures after fixation from the fundus to the external os, 6½ inches. The transverse measurement across the widest part of the fundus equals 4½ inches. The antero-posterior diameter at the same level equals 4½ inches. The outer surface of the body of the uterus is smooth and covered with peritoneum. The surface shows a few dilated venules, but is apparently healthy, except over the posterior surface, where it is roughened by the attachment of numerous short, fibrous tags. The growth does not involve the surface at any place in the body of the uterus. The cervix is much enlarged from the internal os to within ½ inch of the external os. The enlargement involves the whole circumference of the cervix. In front it is more marked and forms a rounded swelling covered by a smooth surface, the remnant of the uterine wall. On the left side, the growth has perforated the left wall of the uterus, and forms an irregular mass projecting from the surface into the left broad ligament. The growth has been cut through during the removal of the uterus. The external os is dilated and measures ½-inch across. Several ragged pieces of growth project through it. The anterior lip of the cervix is thickened and invaded with growth, the posterior lip is of normal size.

On Section the uterus is found occupied by a large mass of solid growth filling the body of the uterus and extending downwards, and involving the cervix. The main mass of the growth is attached to the anterior wall of the uterus and measures 3 inches in its antero-posterior direction. There is also a mass of growth involving the anterior wall of the cervix continuous with the former and measuring 1 inch from before backward. The posterior uterine wall is lined by a much thinner, but very irregular layer of growth. The growth is firm and uniformly yellowish white in colour. The cavity of the uterus is 9 inches long, and is situated near the posterior surface. At the upper end it turns forward over the upper surface of the growth. It is lined throughout by growth, the surface of which is very irregular and ragged. On the posterior side the uterine wall it is ½ inch thick; at the fundus it measures ½ inch, at the anterior surface the growth has almost reached the outer aspect of the uterus, and was only separated from it by a thin layer of muscular tissue.

The uterine appendages are healthy.

Microscopical Examination.—Sections were taken from several parts of the body of the uterus and from the cervix. Microscopically the growth is an endothelioma. The sections taken from different parts vary

considerably in appearance. In the most typical places, the growths consist of columns of cells embedded in interstitial tissue. The cells are arranged in the manner of the tumours described by Dr. Lazarus-Barlow as peritheliomata. There is a central cavity containing blood and lined by endothelium. This is bounded by a vascular wall of varying thickness, which is again surrounded by a thick layer of cells of the neoplasm, giving the appearance of a growth composed of a collection of vascular tubes, the outermost walls of which are formed by masses of the cells of the new growth. The cells have a fairly large amount of clear protoplasm. They have round, deeply staining nuclei, in which a nucleolus can usually be made out. The interstitial tissue varies much in amount in different parts of the growth. In places it is large in amount, and consists of well-formed fibrous tissue. In parts also it is very scanty, and the cells of the growth have no very definite arrangement, giving here the appearance of an alveolar sarcoma.

Course.—Wound healed by primary union, and no trouble occurred with the bladder. Mr. Berry examined patient on November 29th, but thought that no removal of rectum was feasible on account of the extent of the growth involving it. He advised colotomy should signs of obstruction supervene.

CASE OF PERITHELIOMA OF THE UTERUS.

Miss W., æt. 44, November 16th, 1905. Three years ago had a flooding when in Edinburgh, for which she was curetted. For the last six months every period has become more profuse, but not painful.

On November 3rd, was suddenly taken ill with a flooding which subsided after a few days, but as soon as she got up moderate hæmorrhage recommenced and persisted. On examination the uterus was not very large, was slightly irregular, the irregularity being apparently due to small fibroids which were best felt per rectum.

The Pathologist's report was:—

"The slide prepared from one of the blocks shows nothing of importance, there is fibro-myxomatous tissue overlaid by a slight amount of hypertrophied mucosa. The second slide is important on account of the changes in the endometrium. The tubules are actively proliferating, and their epithelium in one particular area has burst its basement membrane, and forms irregular masses of malignant looking cells; the latter are seen lying amidst fragments of tubules, the whole presenting a very complex and irregular appearance. It is noteworthy that the uterine muscle is not invaded by gland tissue, either malignant or benign. The above signs of early malignancy apply to a more or less circumscribed area of the mucous membrane. The bulk of the mucosa shows a benign hypertrophy of glands."

THE OUT-PATIENTS' ROOM.

WESTERN OPHTHALMIC HOSPITAL.

Fascicular Keratitis.

By G. W. THOMPSON, M.B., F.R.C.S.

AMONGST the out-patients was a boy, æt. 4, who was suffering from one of the rarer forms of phlyctenular ulcer of the cornea, "so-called Fascicular Keratitis." Mr. Thompson said that this condition generally commenced at the limbus of the cornea as a small, greyish yellow ulcer; this ulcer extends in a radial direction towards the centre of the cornea, and as it extends it heals at the periphery, carrying with it a leash of vessels. This condition may continue until the ulcer has reached the centre of the cornea, and even beyond towards the opposite side. The final condition, when the progressive course of the ulcer has been arrested by natural or therapeutical means, is a narrow, greyish white superficial snail-like track across the cornea, considerably impairing visual acuity when the track has invaded the pupillary area of the cornea, a condition which is very much to be regretted. When an

* Read at meeting of British Gynecological Society, March 8th, 1906.

ulcer of this type has to be dealt with in addition to the usual local treatment, which in his opinion should consist of a simple cleansing lotion and rarely, if ever, atropine (as it only increases the photophobia), the general treatment, which in these cases is of far greater importance than the local, consists of cod liver oil and maltine, and iron and arsenic. The great point is, if within a week or a fortnight the ulcer is seen to be making progress (this can only be judged by always carefully marking the usual corneal chart each visit) to put the child under an anæsthetic, scrape the ulcer, and carefully apply two drops of pure carbolic acid, taking care, by the use of a small piece of blotting paper, that the acid does not touch healthy tissues. By these means the progress of the ulcer is certainly arrested and a permanent scar, which is so often seen encroaching on the pupillary area of the cornea, is avoided. A fairly recent drug, dianine, in a 3 to 5 per cent. solution, frequently instilled, Mr. Thompson pointed out, often relieves photophobia and blepharospasm. If atropine is employed it rarely ought to be used more than two or three days.

The treatment mentioned was carried out on this patient; the local application of dianine, &c., and the general treatment having proved inefficient to entirely arrest the progress of the ulcer within seven days, the ulcer was scraped and touched with carbolic acid. This proved quite effectual, the ulcer healing rapidly, leaving only a very small scar in the outer third of the cornea which will not in any way impair vision.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

INGUINAL COLOSTOMY.—Mr. T. P. LEGG operated on a woman, æt. about 50, who had been admitted for chronic constipation; she stated she had had increasing difficulty in getting the bowels to act for several months, and had been in the habit of taking purgatives regularly; these now had ceased to be effective. She had not vomited, and there had been no discharge of blood or mucus per anum. During the last few weeks she had had an intermittent colicky pain most marked on the left side of the abdomen. She did not think she had lost much flesh. On examination, the abdomen was distended, especially in the left iliac and lumbar regions; the amount of distension varied, and from time to time the peristaltic wave was readily observed to pass from above downwards in these regions. During this time, the distension increased, and the patient suffered from the colicky pains above mentioned. On palpation the sigmoid was easily felt to be distended and thickened. On making a rectal examination, a hard nodular fixed mass was felt high up on the left side of Douglas's pouch. There was nothing else abnormal to be detected, the right side of Douglas's pouch being quite normal. A diagnosis of malignant disease of the sigmoid flexure was made. An incision as for left inguinal colotomy was made; the hypertrophied sigmoid presented in the wound and was at once drawn out so as to expose the growth; this was found to be situated in the lower part of this portion of the gut, to involve about an inch and a half of its length, and to have produced a very tight stricture as if a piece of string had been tied round the intestine, there being a distinct furrow visible on the peritoneal aspect. At one part a coil of small intestine had become adherent to the growth, and in the wall of this piece of small bowel a nodule of growth the size of a small nut was found directly continuous with that in the sigmoid. The upper part of the sigmoid was fixed to the margin of the incision in such a way that a U-shaped loop of bowel projected on the surface; this loop was fixed to the margin of the incision by three

stitches, a middle one transfixing the meso-sigmoid, and the two edges of the incision; the upper and lower limbs of the loop were fastened to the incision by stitches passed through the muscular and peritoneal coats of the bowel, and the whole thickness of the parietes. This completed the first stage of the operation, the bowel not being opened as there were no urgent symptoms. Mr. Legg said this was a fairly typical case of its kind, namely, of carcinoma of the upper part of the sigmoid flexure. This form of carcinoma was comparatively mild in its malignancy, and not infrequently the patient comes under observation when obstruction, very often complete, has set in, but a careful inquiry into the previous history will generally elicit such symptoms as those this patient complained of. In all these cases of chronic constipation occurring in people advancing in years a rectal examination should never be omitted, and this was specially important on account of the absence of rectal symptoms. The present case, he thought, was a good example of the treatment to be adopted in the first instance, namely, a colotomy which should always be done to relieve the obstruction, and if the local conditions are favourable for removal of the growth this latter can be undertaken two or three weeks later. Excision of the growth should never be done whilst the patient is suffering from obstruction. If removal can be carried out, the prognosis is very good. In this particular instance removal would not be undertaken, first, because intestinal obstruction was present, and, secondly, because a double resection of the intestine would have been necessary on account of the involvement of the small intestine, and Mr. Legg did not think that the growth in the small intestine would give rise to any severe symptoms. As to the method of doing the colostomy, the most essential point, he thought, was to obtain a good spur, which was accomplished by placing a large U-shaped loop of intestine in the wound as he had done. When the projecting portion of bowel was removed, the upper opening would be entirely separated from the lower opening by the intervening portion of meso-sigmoid, and this first opening would be completely surrounded by the muscular coats of the bowel, the circular muscle developing into a sort of sphincter. The patient very often gains some amount of control, the bowels acting only twice or thrice in the twenty-four hours. It was considered unnecessary to open the bowel at the time of operation because the abdomen was not generally distended, and the patient was not vomiting; in the absence of either or both of these symptoms the bowel, he remarked, would not be opened for four or five days; during this time adhesions would have formed between the intestine and the wound, thus shutting off the general peritoneal cavity. It was, he considered, best to make only a small opening at first and to tie a Paul's tube into the lumen, the contents of the bowel being thus carried away into a receptacle at the side of the bed and risk of infection would be diminished. At the end of a week or ten days the whole of the projecting loop would be removed. There was one other point, Mr. Legg said, to be considered in the after treatment of these cases; in the piece of intestine in which the growth is situated a certain amount of intestinal mucus and secretion accumulates above and below the disease, and if this is allowed to go on accumulating it causes considerable discomfort. This can be entirely obviated by regularly irrigating this part of the bowel from the lower opening of the colotomy wound and from the anus.

The patient made a satisfactory recovery; the bowel was opened on the fifth day and she left the hospital at the end of the month.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, MARCH 23RD, 1906,
MR. CLINTON DENT in the Chair.

REMOVAL OF MEDIASTINAL SARCOMA BY THE X-RAYS.

DR. J. T. ZUM BUSCH showed a mediastinal sarcoma which disappeared after treatment by the Röntgen rays. The patient, a man *æt.* 37, suffered from syphilis in 1896 and had been almost continually under mercurial treatment for years. Altogether he used 4800 grms. of grey ointment for inunction, and took a large number of mercurial pills; he also had thirty-five intra-muscular injections of hydrarg. salicyl. In spite of this vigorous treatment psoriasis palmaris recurred in September, 1904, when he came under my treatment. The patient at that time was very anæmic and looked ill; his breath was very short. The face and neck were very swollen and cyanosed; the superficial veins of the whole body, and especially the right epigastric veins, were enormously enlarged. He complained of pains in the right half of the thorax, which had for the first time occurred about four years ago. The pains came in attacks, always at night-time, and lasted for two or three hours. At first the intervals between the attacks had been very long; gradually, however, they had become shorter and shorter. Two years ago he began to complain of giddiness and pain in the left half of the head and pressure in the left eye. About this time the veins commenced to swell; the swallowing became difficult. During the winter 1903-1904 the condition became worse; the attacks occurred almost every night. The spring and early summer brought a slight improvement. In August, 1905, he had a very severe attack of pain, which lasted five hours and left a swelling in the region of the second and third sternocostal joints. The swelling increased in size and became painful. About four weeks later a large lump was noticed in the right supra-clavicular space. There were frequent rises of temperature and patient lost weight rapidly. When seen in September, 1904, his condition was as above described; there was a large mediastinal tumour, which pushed the second and third rib on the right side of the sternum forward; this tumour could easily be made out by percussion, and was seen by examination with the Röntgen rays. The breathing was very short and the swallowing difficult; distinct sound could be heard when the patient tried to force some food down. There were some hard, irregular glands to be felt above the clavicle, and a deep resistance on pressure over the jugulum. An examination of the blood gave a normal count. The present state seemed to warrant the diagnosis of a malignant tumour of the mediastinum. In view, however, of the co-existence of a typical syphilitic eruption, and of the nocturnal attacks of pain, the possibility of a large gumma was thought of and the patient treated accordingly by intra-muscular injections of hydrarg. salicyl. and by the internal administration of 1.0 gm. potassium iodide three times daily. The skin eruption disappeared rapidly; the tumour, however, remained quite stationary. In January, 1905, the patient caught a slight cold, which was followed by an unusually severe attack of pain, by coughing, hoarseness, still greater difficulty in swallowing, and paræsthesia over the left half of the body. The pulse rose to 120 and has remained more frequent since that time. At the beginning of the Röntgen ray treatment (February 10th) the condition was as follows: Area of dullness extending to both sides of manubrium sterni (more to the right) 14.5 cm. broad; at the level of the third rib it is only 11 cm. broad. Second and third costal cartilages on the right side very prominent. Hard,

irregular glands in supra-clavicular space on right side. Veins greatly dilated. Pupils of equal widths and normal reaction. Heart sounds normal. pulse frequent. The blood count was normal. The skiagraphic examination confirmed the diagnosis of a large mediastinal tumour. A gelatine capsule filled with bismuth, which the patient tried to swallow during the examination, did not pass further than to the level of the jugulum, where it stuck. In view of the syphilitic history an inunction treatment (2.0 *per diem*) was begun, and the tumour was exposed to the Röntgen rays in the following way: From February 11th to 18th the prominent part of the tumour was treated daily from five to six minutes. After the first two sittings the patient felt greatly improved; the pain had disappeared and the difficulties in breathing and swallowing were much less. After the sixth sitting the prominence had disappeared. From February 10th to 25th the intra-scapular space was treated in the same way. From February 27th to March 2nd the lateral parts of the thorax were treated. From March 18th to 28th and again from April 2nd to 14th the anterior wall of the thorax was exposed. The patient came back to London and was seen on April 20th. His condition was greatly improved; the dullness over the sternum was only 8.5 cm. broad, the prominence of the ribs and the enlarged glands had entirely disappeared, the veins were normal in size. The patient had gained 3 klg. in weight, slept well, was entirely free from pain, and had no difficulty in breathing or swallowing. On May 10th he again came to be seen, and complained of some giddiness. It was found that the glands in the supra-clavicular space had become again enlarged and hard. As one of the glands felt fairly movable, it was removed for diagnostic purposes. The gland was slightly adherent to its surroundings, looked homogeneous and glassy on section, and showed no trace of caseation. Microscopically it proved to be a sarcoma, which showed in some parts an alveolar structure. The patient was advised to return to Vienna for further treatment. He had five further exposures between May 22nd and 26th, after which the glands had almost disappeared. Since that time the patient had remained in very good health; he is quite able to do all his work as an engineer, he has gained in weight, and is quite free from pain.

A very similar case has been published by A. Cloppatt in the *Deut. Med. Woch.*, No. 29, 1905.

MR. LUNN asked whether there were any sections to be seen of any secondary deposit.

MR. W. G. SPENCER thought that the difficulty lay in distinguishing between sarcoma and lymphadenoma. Undoubtedly many cases that would be termed the latter in England were called sarcomatous in Germany. He referred to the danger of treating operable cases of malignant disease with the X-rays.

DR. ZUM BUSCH showed sections of the gland.

DR. H. G. TURNEY showed a case of bony tumour of skull. The patient was a man, *æt.* 42. He had noticed the swelling on the top of his head for seven or eight years. For the last eighteen months he had had headache, which is getting more severe. The headache was worse during the day; in fact, he slept well at night. He had had three "fits," at intervals of about two years, during the last six years, and four or five years ago he had right-sided facial paralysis of infra-nuclear type. *On examination.*—A large smooth bony growth occupying the right and anterior portion of the calvarium and extending across the mid-line for some distance. No optic neuritis; no signs of nerve involvement. No vomiting nor slowness of pulse. The tumour was probably a simple osteoma.

Dr. BERTRAM ABRAHAMS showed a case of sudden paralysis of the third cranial nerve. The patient was a married woman, *æt.* 47. Exhibited at the last clinical evening of the Society, January 26th. Paralysis of the left nerve was then total. It was suspected that the lesion was of specific origin. She was accordingly treated with potassium iodide for between two and three weeks without the slightest obvious effect. She was then put, instead, upon mercurial inunctions, and soon began to show improvement, which is now steadily progressing. The original attack occurred suddenly on January 20th. Visible improvement had begun by the middle of February, and by the middle of March the ptosis had virtually disappeared. *Present condition of left eye.*—Ptosis very slight. Pupil moderately dilated; inactive to light and accommodation; backward deviation has decreased. There is some recovery of action of internal and inferior recti, less of superior rectus. The diplopia is now as follows: Crossed diplopia to right of mid-line, with increasing separation of images with movement to right. Diplopia above level of centre of eyeball, with false image below line, and distance between images increasing with movement upward. No diplopia below level of centre of eyeball.

Dr. BERTRAM ABRAHAMS showed a case of adipositas dolorosa. The patient was a married woman, *æt.* 40. Rheumatic fever at 20; in hospital three months. No menstrual disturbance. Two sisters and one daughter stout; remainder of family slight. No history of syphilis. Patient was slight until her last child was born, three years ago. Since then has become steadily stouter and has had constant aching pain in the lower part of the back on left side. As the stoutness progressed tender places have gradually developed about the body. She is clothed universally with a thick adipose layer. Over certain areas—(1) back of right arm, (2) outer aspect of right arm just below shoulder, (3) outer aspect of left forearm, (4) right hypochondriac region, (5) inner aspect of left thigh just above knee. The patient complains of tenderness, and some additional thickening of the subcutaneous tissues can be felt. On the outer side of the left leg there is tenderness, but no such thickening can be felt: here there are varicose veins. There is no disturbance of sensation. Heart sounds distant and feeble. Thyroid natural; mental activity good; skin healthy.

Dr. TURNER recalled a similar case in which the pain appeared only late.

Dr. JOHN J. DOUGLAS showed a case of dislocation of the metatarsus. The patient, a man *æt.* 24, was thrown from a cart on January 19th, 1906, the wheel going over his right foot. When first seen the foot was much swollen, but there was no very striking deformity. As the swelling subsided, the internal cuneiform bone was seen to be unduly prominent. On February 6th, a skiagram showed the whole metatarsus dislocated outwards, the first metatarsal being in apposition to the middle cuneiform and the fifth almost off the cuboid. Reduction under the anæsthetic was attempted, but failed, on February 8th. On February 12th an incision was made along the inner margin of the foot, and the joint between the first metatarsal and internal cuneiform exposed. It was then found that the portion of the tibialis anticus internal tendon inserted into the base of the first metatarsal had got between that bone and the internal cuneiform, and was seemingly the obstacle to reduction. This being pulled out and replaced, the metatarsus was pushed into position with comparative ease.

Mr. NITCH described a similar case he had seen under Mr. Clutton's care, and showed a cast of the foot.

Mr. W. B. SPENCER showed a case four years after fixation of omentum for ascites. The patient was a woman, *æt.* 54. In hospital four years ago with alcoholic hypertrophic cirrhosis and ascites; pigmentation of legs; no other signs of syphilis. Tapped

and refilled, drained and refilled, drained and omentum fixed in epigastrium. Liver found enlarged, nodular. Has continued to take alcohol as before, but no fluid has collected since. No œdema. No albuminuria. Re-admitted for complete removal of fungating cancer of left breast, including pectoral and axillary glands. Right supra-clavicular gland enlarged. Liver felt as much below ribs as at first.

Dr. STONE described an autopsy he had carried out on a successful case of this operation.

Mr. J. G. GIBB showed a sporadic case of Friedreich's disease. Boy, *æt.* 13, school standard II. No history of any nervous or mental disorder in the family. Father and mother healthy, but are first cousins; one sister strong and well, *æt.* 14. Nothing unusual noticed till he was five years old. Then in walking up hill and after walking rather far he complained of pain in the small of the back; in walking he rolled from one side of the path to the other. He is bright and intelligent, although the expression is a little vacant. Muscular development is poor. He stands with a forward inclination of the trunk, neck bent to the right, arms forward, hands supinated, and feet apart. There is some static ataxia. His walk is swaying, staggering and irregular. There is a slight stamping, but rather of the ball of the foot than the heel. He turns with difficulty. Speech is slow, and sometimes blurred. The spine shows slight curvature, with convexity to the right in the mid-dorsal and to the left in the lower cervical regions. There is pes cavus when feet are off the ground. Romberg's sign with tendon movement is marked. Knee, ankle, supinator and biceps jerks are absent. There is some inco-ordination of the upper extremities and slight lateral nystagmus, more to right than to the left. Sensory functions are not disturbed.

Mr. W. G. SPENCER recalled a case of Friedreich's disease due to parental consanguinity.

Dr. ARTHUR VOELCKER showed a case of splenomedullary leukæmia (myelæmia) in a boy. The patient, a boy, *æt.* 10½, had been admitted to the Hospital for Sick Children. *Present illness.*—Patient was quite well till four months ago, when he began to lose weight and became pale. The abdomen had been enlarging for two months. No abdominal pain. Several attacks of epistaxis lately. *Previous history.*—Unimportant. *Present state.*—Rather pale, but lips and beds of nails of very fair colour. Spleen very large, extends down to pelvis. Liver extends ¼ inch below costal margin. Glands in groins and axilla slightly enlarged. No tenderness about the bones. Urine contains a trace of albumen. Soft hæmic murmur at pulmonary cartilage. No retinal hæmorrhages. *Blood.*—Report by Dr. J. Graham Forbes. Hæmoglobin, 70 per cent.; colour index, 1.06; erythrocytes, 3,302,000 per c.m.m.; leucocytes, 400,000 per c.m.m. *Differential count.*—Polymorphonuclear, 36.8; large mononuclear, 3.6; small lymphocytes, 9.6; large lymphocytes, 8.4; eosinophiles, 7.6; basophiles, 13.6; myelocytes, [(1) finely granular eosinophilic, 14; (2) coarsely granular eosinophilic, 6; (3) basophilic, 0.4 = 20.4].

Dr. ARTHUR VOELCKER showed a case of functional hemiplegia in a boy. The patient, a boy *æt.* 9 yrs. 8 mos., two and a half years ago suddenly lost power in his legs. He was admitted as an in-patient at Great Ormond Street, where it was noted that he could not sit up; he had very little power in his legs, less in the right than in the left. Slight tremor in the upper limbs. Some nystagmus on extreme outward movement of the eyes. Knee-jerks exaggerated. Ankle clonus present on both sides. Plantar reflex extensor on both sides. Occasional incontinence of urine. A provisional diagnosis of disseminated sclerosis was made. The boy contracted scarlet fever, was sent to the Fever Hospital, from which he returned quite well, and has continued so till March 9th, 1906. Present illness began suddenly, with weakness of the left arm and leg. He could not sit up when brought up to the hospital; there was left hemiplegia. Face not affected. The

forearm muscles were most affected. Grip very weak on left side. Knee-jerks exaggerated. No ankle clonus. Extensor reflex on both sides, but next day on left side only. Sensation natural. Lateral nystagmus on looking to the right. Speech natural. No optic neuritis or atrophy. No incontinence of urine.

Mr. T. H. OPENSHAW showed a case of congenital absence of the fibula and malformation of the head of the femur (congenital coxa vara) simulating congenital dislocation of the hip. The patient was a girl, *æt.* 6. Mother and father healthy; no deformity in the family; seven other children, all perfectly formed. Liquor amnii abundant; good time when carrying; no fright or injury; natural birth; normal labour; vertex presentation. Child walked first when two years old. Now walks very well, but drops down on to the left foot. Right leg, 19½ ins.; left leg, 13½ ins. The left foot is valgus at the ankle. The internal malleolus is prominent. The tibia presents at the middle of the shaft a slight linear dimpling, situated exactly over and parallel with the anterior border of the tibia. The fibula is absent, except for a small portion at the lower end an inch to an inch and a half in length. The left knee-joint is normal, except that the internal condyle is a little prolonged. The patella is present and in normal position. The left femur is much shortened; it measures 6½ ins. from the great trochanter to the external condyle, the right femur measuring 10½ ins. There is marked thickening of the bone at the great trochanter. The whole lower extremity is rotated out through an angle of 35°, but there is no flexion, adduction, or abduction contraction at the hip-joint. Of the movements, reflexion is a little limited; abduction is only possible through a range of 10°; adduction is increased, the left knee crossing the upper third of the opposite femur in full adduction; rotation out is increased 20°, and rotation in is normal as compared with the right leg. When the leg is fully adducted the great trochanter and what appears to be the head of the bone are distinctly felt beneath the glutei muscles. The X-ray, however, shows the head of the femur situated in the acetabular cavity. The acetabulum appears to be well formed. The upper end of the femur consists of no less than seven pieces. The head of the bone is normal in shape, but is small. The neck of the femur is in a position of acute coxa vara, and is represented by two pieces of bone, as if there had been a fracture of the neck. On the under surface of the neck there is a thin plate of bone, and on the top of what is in all probability the great trochanter there are two other fragments. The X-ray showed a faint trace of ossification in the lower end of the fibula. The child stands with the right knee flexed almost to a right angle. There is drooping of the pelvis on the left side, and a little lordosis and left convex lateral curvature.

Mr. T. H. OPENSHAW showed a case of double coxa vara (rickety). The patient was a boy, *æt.* 12. There is no family history of any similar condition—no history of accident or injury. As a child, the legs were rotated out and abducted. Marked genu varum and curved tibiae were noticed at the age of eighteen months, with enlarged wrists and fontanelles late in closing. Except the coxa vara, there is no evidence of rickets at the present time. Lordosis was first noticed about the age of five years. *Present condition.*—There is extreme lordosis. The great trochanters are elevated and prominent. The legs are equal in length. The legs are markedly adducted and cannot be abducted. The right leg measures 28 ins. The upper border of the great trochanter is on the same level as the anterior superior spine. Flexion is only possible 40°. The leg is adducted to an angle of 45°, abduction impossible, rotation out through an angle of 25° and rotation in for 10° only. There is flexion of the right knee and valgus of the right ankle. The left leg measures 28 ins. The upper border of the great trochanter is slightly above the level of the anterior superior spine. Flexion only to an angle of 90° is possible, adduction to 45°, abduction impossible. Rotation out through an angle

of 25°. The thigh cannot be rotated in beyond the position in which the patella looks directly forward. The left knee is in a position of varus, with prominence of the head of the fibula, and the left ankle of valgus. An X-ray picture of the femur on each side showed the head of the bone situated in the acetabulum, and well formed. The upper edge would appear to be an inch and a half below the upper border of the great trochanter. The neck of the femur seems altogether wanting. There is a flattened surface at the root of the head which would appear to rest against the inner surface of the great trochanter. The upper border of the great trochanter is prolonged upwards and inwards, and impinges against the outer surface of the ileum, even when the femur is perpendicular, thus rendering abduction impossible. The angle made between the shaft of the femur and a line passing up long the upper border of the head and neck would appear to be about 60°, and is equal on the two sides. Another X-ray picture was exhibited, which was taken three years ago. In this condition the head of the bone is not nearly so much depressed, being only half an inch below the top of the great trochanter on either side, and there would appear to be a short thick neck to the femur. The angle made by the neck with the centre of the shaft of the femur would appear to have been 82° three years ago. The boy walks with extreme waddling gait, the lumbar vertebral column being flexed laterally with each step.

Mr. T. H. OPENSHAW showed a case of left traumatic coxa vara due to an extra-capsular fracture of the neck of the femur. The patient was a boy, *æt.* 12. On Christmas night he slipped on a stone and fell upon the great trochanter. He felt acute pain and was unable to stand. He was carried home and stayed in bed more or less for a fortnight. He then limped about for a week and came up to the hospital, where he was radiographed. The X-ray showed a fracture of the femur, so he was admitted into the London Hospital, under my care, on January 15th, 1906. On admission the left leg was shortened one inch, and the left great trochanter was half an inch above Nelaton's line. Bryant's triangle was half an inch shorter than on the other side. There was some thickening about the great trochanter, but there was no evidence of old bruising. From January 15th to March 7th, a splint was applied to the leg adducted at an angle of 45°. Since March 7th the leg has been in plaster-of-Paris. The X-ray showed a fracture at the outer extremity of the neck of the femur. There appears to have been no marked impaction. The upper edge of the head is level with the top of the great trochanter, and the angle formed by the neck with the shaft of the femur is 95°. The head of the bone is well shaped and normal as regards its epiphysial surface.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD MARCH 7TH, 1906.

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

DR. MACKENZIE showed a case suggestive of General Paralysis. The patient was a lad, *æt.* 19, who had always been somewhat backward, and only walked when *æt.* 5. He was the seventh of eleven children, and in none of his brothers or sisters, nor in his parents, was there any evidence of syphilis. As a boy of eight or ten, he had "fainting attacks," which were followed by increased mental impairment, and which suggested congestive injuries. For the last few months he had deteriorated mentally so much that he was unfit to perform his usual work as an errand boy. Memory was much impaired, but there were fairly well-marked grandiose delusions. Physically, the pupils were unequal, the speech slurred, Romberg's symptom was slightly present, and the muscular power was poor. The case was probably one of juvenile general paralysis.

Dr. EDWIN BRAMWELL showed (1) two cases of

Hemiplegia due to intra-cranial lesion, and (2) a case of Syringomyelia, which had come under observation on account of a painless whitlow with necrosis of the terminal phalanx. On examination evidences of similar occurrences previously were found in the shape of scars from burns, &c. The position of the hands was characteristic, and there was dissociated anæsthesia over the arms and part of the trunk. In addition, there was an arthropathy of the left shoulder, the joint being disorganised, much swollen, and causing loud grating on movement.

Dr. R. A. LUNDIE read a paper on

TRANSITORY BLINDNESS DUE TO SPASM OF THE RETINAL ARTERY.

Although such cases were in all probability not very rare, only a few had been reported in which the fundus had been examined ophthalmoscopically during an attack. His patient was a man, æt. 88, in whom the circulation was extremely feeble, and the arteries atheromatous. One evening he noticed that his sight had become defective, and then discovered that the vision of one eye was completely lost. Dr. Lundie saw him within half an hour of the onset of the symptoms, and already by that time vision had to some extent been regained in the upper half of the visual field. On ophthalmoscopic examination, the fundus and vessels were normal except the upper main branch of the retinal artery, the course of which was interrupted for a distance equal to a little more than half the diameter of the optic disc. While examining the vessel a fine thread of blood was seen gradually to appear in the portion of the artery which was previously empty. Within an hour of the first symptoms the vessel had returned to the normal size and complete vision was regained. The only feasible explanation was that a localized spasm of the artery had occurred. No thrombus or embolism could have disappeared so suddenly and completely. There had been no recurrence of the blindness. Dr. Lundie also described another case occurring in a lady, æt. 22, who had had numerous transient attacks of amblyopia. After one of these a contraction of the visual field remained, the corresponding part of the retina being œdematous, while on examination some years later a branch of the retinal artery was much contracted. From the transient nature of most of the attacks, it was inferred that vascular spasm was the cause; the spasm, however, had once lasted so long as to permanently impair the function of the retina. Each attack was preceded by vertical diplopia, also transient, and probably due to associated spasm of the artery supplying the extrinsic ocular muscles. There were not many records of cases showing this condition. The only other case (except that described by Raynaud) in which there was a localised transient arterial spasm verified by the ophthalmoscope, was one described by Benson in 1894. During each of three attacks of blindness the branch of the retinal artery corresponding with the insensitive area of the retina was found, as in Dr. Lundie's case, to be empty of blood. In Benson's case the small empty portion of the artery passed along by a sort of peristaltic movement and suddenly refilled. The importance of these cases was the light they threw on what was commonly called "embolism of the central artery of the retina." Probably many such cases were due to spasm, and if this were relieved, as by amyl nitrite or some other vaso dilator, before permanent injury was done to the retina, sight might be completely restored.

Drs. Sym, Ritchie, Church, and Affleck briefly discussed the communication.

Drs. H. M. GRAY and G. M. DUNCAN (Aberdeen) read a paper on

VACCINE TREATMENT IN SURGERY.

The communication consisted of a detailed account of the results obtained from the use of tuberculin (T. R.) as an adjunct to the operative treatment of various forms of tubercle—glands, bones, tendon sheaths, joints, &c. The observers found that it was

necessary to estimate the opsonic index of each individual case in order to determine the exact period of the negative phase. It was sufficient to administer the injections at intervals of ten days or a fortnight. Dr. Gray had also used streptococcal and staphylococcal vaccine with great benefit as a prophylactic against sepsis, particularly in cancerous affections of the mouth as a preliminary to extensive operations, which were otherwise so liable to be followed by pneumonia. The cases described by Dr. Gray were of a highly encouraging nature, and he strongly advocated a more extensive trial of T. R. and similar vaccines as an adjuvant to operative measures.

Mr. STILES was less sanguine than Dr. Gray as to the value of tuberculin; experience had taught him never to be surprised at what Nature could do in the way of curing extensive tubercle, and he recalled cases dismissed from his wards in the Sick Children's Hospital as hopeless which, after a year or two, had returned to hospital again practically healed so far as active disease went. He deprecated any treatment which tended to postpone operation from a favourable to an unfavourable period in the case.

Dr. LAWSON doubted whether clinical symptoms could be relied on to indicate the correct dosage of T. R. The negative phase was of very variable duration and could only be determined by accurate laboratory work.

Dr. J. F. DUNLOP read a paper on

OCCUPATION MORTALITIES IN SCOTLAND.

Having explained the statistical methods employed, Dr. Dunlop divided occupations into six classes, according to whether the death-rates in the two periods—25 to 45, and 45 to 65—exceeded, equalled, or were less than the corresponding death-rates of all males. Class I., low death-rate in both periods includes clergymen, farmers, graziers, agricultural labourers and farm servants. Class II., low death-rate in one period, approximately equal death-rate in the other. Class III., approximately equal death-rate in both periods. Doctors and dentists were among the occupations included in this class. Class IV., high death-rate in one period, low in the other. Class V., high death-rate in one period, approximately equal in the other. Class VI., high death-rate in both age periods, includes coachmen, chemists, tailors, masons, boilermakers, labourers, hotel keepers, publicans, &c. The paper was based on a recent study of the occupation mortalities in Scotland published in the decennial supplement to the forty-eighth detailed Annual Report of the Registrar-General for Scotland.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

MEETING HELD FRIDAY, MARCH 2ND, 1906.

Dr. FINNY in the Chair.

CIRRHOSIS OF THE LIVER.

Dr. DRURY, with Dr. TAYLOR, brought forward a case of the above, in which operation was performed for the relief of ascites. Patient developed acute ascites, apparently within a week, with great œdema of the legs and suppression of urine to three ounces. The abdomen was tapped, but no great increase of secretion of urine resulted, and it began rapidly to diminish as the ascites again collected. Talma-Morrison operation was then done; patient made a good recovery, and now is daily at work.

ANÆMIA SPLENICA INFANTUM.

Dr. T. GILLMAN MOORHEAD read a paper on the above subject and exhibited the organs from a case of the disease. The patient was a child, æt. 3, with a good family history, who had developed symptoms of anæmia, with abdominal distension, after an attack of measles a year previously. On admission to hospital the spleen was found to be enormously enlarged, extending down as far as Poupart's ligament, and

forward as far as the umbilicus. There were slight rickety signs, and the blood was in every way typical of von Jaksch's disease, except that there was no increase of white cells. Normoblasts were very abundant, and there was marked polychromatophilia. Iron, arsenic, and bone marrow were given at first, and the child was carefully dieted, but without any signs of improvement taking place. Later X-ray treatment was adopted, the rays being directed upon the spleen, but without any apparent effect, and the child died six weeks after coming under observation. At the autopsy the spleen was found to be extremely fibrosed; the liver showed slight fatty degeneration; most of the abdominal and thoracic lymph glands were enlarged, and light red in appearance, and showed fibrosis, plus congestion; the bone-marrow of both femur and tibia was normal, and there was no alteration in the thymus gland or other viscera.

Drs. Langford Symes, Travers Smith, and Peacocke discussed the case. The latter mentioned a similar case under his care which had got well.

UNRESOLVED PNEUMONIA TREATED BY PNEUMOCOCCUS VACCINE.

Dr. J. B. COLEMAN, C.M.G., read the notes of a case of unresolved pneumonia in which the inoculation of pneumococcus vaccine, according to Professor Wright's method, was followed by a satisfactory result. The patient, a labourer, æt. 50, was admitted to the Whitworth Hospital, on December 20th, 1905, suffering from a very severe attack of acute croupous pneumonia, the onset of which had occurred six days previously. On admission to hospital he was in a low typhoid state, his pulse ranging from 126 to 138; respirations, 44 to 48; and temperature, 102.6°. There was consolidation of upper and middle lobes of right lung. On December 23rd, the consolidation had involved the lower lobe of the right lung, and on December 26th, the lower lobe of the left lung was similarly affected. There was no critical fall of temperature, and though the patient's condition somewhat improved, convalescence was very slow. On January 4th, a painful inflammatory swelling developed in the left supraclavicular region; this subsided in three or four days. On January 20th, there was dulness and tubular breathing over the entire right lung, with, in addition, crepitus over the lower lobe; the left lower lobe was dull on percussion. At this date, thirty-seven days after the onset of the disease, the patient's general condition was very unsatisfactory, and there was no sign of resolution in the lungs.

On January 21st, the pneumococcus opsonic index was .60, and on 23rd it was .62, whilst the tubercle opsonic index was 1.

On January 24th, he was inoculated with 46½ millions pneumococci.

On January 25th pneumococcus opsonic index was .69. The inoculation was followed by no local nor constitutional disturbance. Physical signs in patient's lungs were such as might be present in pneumonia of five or six days' standing.

January 30th.—Pneumococcus opsonic index 1.17.

January 31st.—Patient looks and feels better. There is marked improvement in physical signs in both lungs.

February 3rd.—Pneumococcus opsonic index .89.

February 6th.—Pneumococcus opsonic index .91.

February 8th.—Left lung has cleared up. The only physical signs in right lung are dulness and tubular breathing at the apex, and diminished resonance over lower lobe.

February 9th.—46½ millions pneumococci injected.

February 12th.—Pneumococcus opsonic index 1.13.

February 20th.—Patient is in excellent health. He has increased in weight 8½ lbs. since February 1st. Physical signs in lungs as on February 8th.

February 22nd.—Pneumococcus opsonic index 1.09.

February 23rd.—Pneumococcus opsonic index 1.06.

March 2nd.—Pneumococcus opsonic index 1.07.

Dr. Coleman remarked that this was only a single case, and that it would not be fair to deduce too much from it; but the facts pointed to the favourable

result being due to the injection of pneumococcus vaccine administered by Professor Wright's method. In conclusion, he expressed his great indebtedness to Professor A. C. O'Sullivan for having made and supplied him with the pneumococcus vaccine used.

The CHAIRMAN expressed confidence in Dr. Wright's inoculation treatment.

Sir JOHN MOORE deprecated the treatment of pneumonic fever by antipyretics. He believed high fever, if not of too long duration, was followed by rapid resolution.

Drs. O'Carroll, Travers Smith, Moorhead and Stokes also discussed the case, and Dr. Coleman replied.

BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD MARCH 8TH, 1906.

MR. BOWREMAN JESSETT, President, in the Chair.

DR. JELLETT showed specimens (1) Advanced carcinoma of both ovaries, and (2) Double pyosalpinx, associated with the presence of a four months' extra-uterine foetus, which, with illustrations and the discussion thereon, appeared in our last issue.

Mrs. SCHARLIEB (M.D. Lond., M.S.) read notes of two cases (1) Endothelioma of the uterus; (2) Perithelioma of the uterus, which will be found on page 335 of present issue under the heading "Clinical Records."

In reply to Dr. Heywood Smith, Mrs. SCHARLIEB said that in the second case the uterus was removed by the abdominal route.

DR. SLIMON asked whether in such cases, Mrs Scharlieb had found phenol stop the hæmorrhage?

The PRESIDENT inquired whether the growth had been examined microscopically previous to operation?

DR. MACNAUGHTON-JONES remarked that early removal of the uterus when malignancy was determined by curettage or otherwise was the only course to adopt. Mrs. Scharlieb was to be congratulated on the most interesting and rare case of endothelioma of the uterus which she had brought before the Society. Mr. Maunsell, of Dublin, had shown a similar specimen last session. This disease had only been described of recent years so far as the uterus was concerned, though for the last twelve years or more it has been observed in the ovary.

The PRESIDENT said he thought it was very doubtful how far they could depend on examination of the tissues removed by the curette. On one occasion he submitted tissue removed in this way to a pathologist, who pronounced it to be non-malignant, but the subsequent history proved the case to be malignant, and he had to remove the uterus later. Another case was recorded which was stated to be malignant, but it turned out to be innocent. The President went on to say that in the case of perithelioma he would certainly have removed the uterus by the vaginal and not by the abdominal route. It would have come out very easily by the vagina.

Mrs. SCHARLIEB, in reply, said she had used carbolic acid for cases in which there was considerable hæmorrhage, but in which there was no distinct evidence of malignancy, and had found it useful. But in a case like that shown, where the uterus was certainly malignant, she was very glad it had been removed. The uterus could have been removed by the vagina, but she felt uneasy lest there should be some deposits in the broad ligament, and therefore she thought it best to get as wide a field as possible for the operation. There was no glandular affection in this case.

DR. JELLETT then read

NOTES ON TWO RARE CONDITIONS MET WITH IN THE PELVIS DURING OPERATION.

This paper will be found fully reported and illustrated on page 331.

The PRESIDENT stated that it was laid down by the late Lawson Tait that if a tumour in the abdomen was accompanied by ascites, it was certain to be malignant. There had often been cases of malignant

tumour where the abdomen had been opened and then closed again as the operator was unable to remove the growth, but where subsequently the tumour had ruptured. Possibly that might have happened in the case brought before them.

Dr. MACNAUGHTON-JONES said that the only case he remembered which resembled the one brought before them by Dr. Jellett was a case of ovarian tumour, where, after removal of the cyst, he found a long diverticulum of the colon extremely low down. About one and a half years ago he showed a fibroma of the ovary to the Society, which occurred in a patient with ascites. He tapped the abdomen, and noticed a small mass in the pelvis, which proved to be a fibroma about the size of a tangerine orange. He removed the fibroma and there had been no recurrence of the ascites. He thought that the deformity described was congenital.

Mr. RYALL asked if the diverticulum of the colon had been examined microscopically?

Mr. OVERY asked the same question, as he recently came across a cyst of the intestine much higher up, just below the duodenum. Three months later he found a diverticulum of the intestine with a short pedicle which was lined with typical intestinal mucous membrane and two muscular layers.

Dr. JELLETT said he thought the evidence was strongly in favour of the ascites having been of hepatic origin. It had been going on for a considerable time and it disappeared from the day of the operation and had not recurred. Moreover, it seemed to him impossible to account for the presence of a stump of tube in a case of congenital disease.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT LIVERPOOL, MARCH 16TH, 1906.

The President, Mr. R. FAVELL (Sheffield), in the Chair.

Mr. LLOYD ROBERTS (Manchester), showed a myomatous uterus removed by supravaginal hysterectomy after preliminary enucleation of four intramural fibroids. The patient, æt. 42, was anæmic after four years of menorrhagia, but was admitted for retention of urine; 40 ounces being withdrawn by catheter. Enucleation, as a preliminary step to hysterectomy, was recommended in certain cases as not only reducing the bulk, but also greatly increasing the mobility of the uterus and so facilitating its removal.

Sir W. J. SINCLAIR and Dr. FOTHERGILL (Manchester) showed a specimen with sections and drawing before removal of a sarcomatous growth of the labium majus in a girl, æt. 17. There was a large congenital pigmented mole over the labium and the right buttock. The growth was of two years' growth. It was not itself pigmented, and was composed of connective tissue continuous with that of the cutis vera, and very cellular in parts.

Dr. WALTER (Manchester) gave particulars of a case of abdominal hysterectomy for cancer of the body of uterus. The patient, æt. 58, was unmarried, and passed the menopause at 52. Although from the history the disease apparently extended over four years, no lymphatic infection was found in the pelvis during the operation.

Dr. WALTER also showed a specimen of intramural fibroid growing from the entire front wall of uterus and complicated by pregnancy at 3½ months. The patient's condition being serious on account of anæmia and increasing pain, abdominal hysterectomy had been performed. He did not advocate introduction of abortion in such cases, believing that abdominal section with enucleation or hysterectomy to be preferable, and less likely to be followed by septic infection.

Dr. A. W. W. LEA (Manchester) read a paper on the appendix vermiformis as a cause of pelvic inflammation, dealing with the literature of the subject

and analysing ten cases operated on by himself. He advised that the appendix should always be examined during gynæcological operations, and should be removed if "pelvic" in position, if pathological or adherent, or if near the stump of any removed organ. He had removed the appendix 35 times under such circumstances with no deleterious effect on the progress of the patients to recovery.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, MARCH 15TH, 1906.

FRANK T. PAUL, F.R.C.S., President in the Chair.

THE NEW LIVERPOOL CITY INFECTIOUS HOSPITAL, FAZAKERLY.

Dr. E. W. HOPE gave a short description, illustrated by numerous lime-light views, of the New City Hospital for infectious diseases at Fazakerly.

The hospital area was amply large, consisting of 118 acres, and had upon it two establishments, one for small-pox, containing 160 beds, another for the ordinary forms of infectious disease, containing 350 beds. The plan, construction, and arrangement were of the most modern type, and much advantage had been derived by visiting other hospitals designed with a similar object in other parts of the United Kingdom. The architect was Mr. Shelmerdine, the Corporation's surveyor. The institution would be officially opened in a few weeks, and would be under the supervision of Mr. C. Rundle, the Medical Superintendent.

THE TREATMENT OF CHOREA.

Dr. CHARLES MACALISTER read a note on chorea, in which he expressed the opinion that just as the rheumatoid fevers, which so closely resembled acute rheumatism, were due to an entirely different toxin, so chorea, which presented features associated with the rheumatoid diathesis, was probably due to a toxin different in its constitution, as well as in the effects it produced, from that of rheumatic fever. He discussed the various types of chorea, especially those which tended to be associated with endocarditis and joint pains as distinct from those which did not, and suggested that the conditions, although presenting symptoms in common, might be due to essentially distinct toxins. He referred to his view that the explanation of the long course of chorea depended on the poisons being neutral, as stimuli, to the organs of elimination, and that success in treatment would probably depend on the addition to the blood of some substance which would alter the constitution of the toxin and convert it into a stimulus for the skin or kidneys, which would then be able to remove it. Dr. Macalister had tried giving peroxide of hydrogen, especially in cases of chorea presenting skin eruptions (peliosis rheumatica), and he thought some benefit had followed its use.

CONGENITAL UMBILICAL HERNIA.

Mr. R. C. DUN read notes of a case of congenital umbilical hernia. The protrusion was large, being rather more than half the size of a child's head. It was covered, partly with true skin, partly by a thin membrane in which necrotic changes were taking place. The cord was attached to this thinned portion of the covering. The contents were irreducible, but not strangulated. Percussion gave a tympanic note. Operation was not attempted owing to the weakly condition of the infant, and he died of septicæmia on the sixteenth day after birth. An autopsy could not be obtained; the nature of the contents and coverings of the hernia was therefore not definitely ascertained. The large size of the hernia, its thinned coverings, and the wide separation of the recti muscles made it probable that the case in question was an example of the embryonal type of umbilical hernia, i.e., a persistency of the developmental condition which was normally present during the first three months of intra-uterine life.

Dr. F. W. BAKER YOUNG read a paper on the

INTRA-VENOUS INJECTION OF FORMIC ALDEHYDE FOR PULMONARY TUBERCULOSIS,

An abstract of which will be found on page 34. In the discussion that followed, Dr. ROBERT MAGUIRE, who was present as a visitor, in the course of an interesting speech, replied to his numerous critics, and stated that the method was entirely free from danger. It was not claimed that formaldehyde could cure all cases, but the results obtained were often very remarkable.

Dr. J. TORREY (formerly Professor of Chemistry in the University of Harvard), also a visitor, stated that in such dilute solutions any of the ordinary chemical reactions peculiar to formaldehyde would be extremely slow, and pointed out that it had been shown that condensation products of formaldehyde with more complex bodies were usually antiseptic; such reactions at least would not render formaldehyde inert toward bacilli.

Dr. A. G. GULLAN testified to the simplicity of this method. He thought the apparatus would be most useful in administering any kind of intra-venous injection. He had employed formalin in this way in three cases, and had never seen any harm follow, though about half the injections were followed shortly by rigors lasting about two hours. His first case was one of advanced acute miliary tuberculosis of the lungs which, after a slight temporary improvement, rapidly advanced and ended fatally. The other two cases were favourable ones in young men, in which beyond a diminution of moist râles, no improvement took place, and he doubted whether the same result could not have been got by other methods of treatment.

Dr. G. S. STANSFIELD said that he had welcomed Dr. Maguire's plan as a substitute for that of impregnating the air with formaldehyde. In January and February, 1901, he had treated six cases by this method, but was disappointed with the result. He quite agreed, however, with Dr. Maguire that there was no danger in the method, nor any great difficulty if the directions were closely followed. He thought hæmasepsin ought to be put on the market at a more reasonable price, considering the inexpensiveness of its constituents.

Dr. John Hay, Dr. R. J. M. Buchanan, Dr. C. Macalister, Dr. T. F. Young, Dr. J. Hill Abram, and Mr. W. Thelwall Thomas continued the discussion.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS. ABROAD. FRANCE.

Paris, March 24th, 1906.

TREATMENT OF CRUSHED LIMBS.

In cases of crushed limbs, amputation, according to Professor Reclus, should never be thought of; the treatment will simply consist in arresting hæmorrhage by tying any bleeding vessels or the placing of a few hæmostatic forceps.

After having immersed the wounded limb in a long bath of hot oxygen water (130°), the lesions should be irrigated with the same liquid and at the same temperature. The jet should be sufficiently strong to penetrate and clean out all the parts. Those which may seem to be almost destroyed could be removed by the scissors, but even here the greatest moderation should be exercised.

The chief point in the first part of the treatment is the employment of very hot oxygen water, which acts both as an hæmostatic and an antiseptic.

The second part consists in filling the wound with gauze coated with the following ointment:—

Antipyrine, 1½ drachms;
Salve, 1 drachm;
Boric acid, 1 drachm;
Iodoform, 20;
Phenic acid, 20;
Cor. sublimate, 2; Vaseline, 8 ounces;

and finally by a compressive dressing of absorbent wool. This first dressing should not be disturbed for several days, but as soon as the temperature rises or the dressing begins to smell the wound should be uncovered and immersed again in a bath of hot oxygen water.

If this mode of treatment did not appear sufficient to arrest infection, oxygen spray should be applied by means of the apparatus of Lucas Championnière, and be repeated frequently.

When the period of septic complications has passed attention should be turned to the process of elimination by nature, with a view of aiding it. For this purpose any parts that have lost sensibility should be removed as well as those which cannot be preserved.

Such is the treatment recommended by Professor Reclus, who for a long time back refused to practise amputation in traumatisms. It may be added that at present the majority of surgeons follow the example of the celebrated professor.

DYSPNOEA.

A new agent, termed "Oxafor," produced from the oxydation of camphor, gives excellent results in dyspnoea of every kind and from any cause. It is a white powder, little soluble in cold water, but more so in warm water; it may be given at the dose of one drachm daily. The following is a good formula:—

Oxafor, 2 drachms;
Proof spirit, 1 oz.;
Syrup of bitter oranges, 2 ozs.;
Water, 4 ozs.

The half to be taken during the day, or a tablespoonful every two hours.

Oxafor seems to diminish the irritability of the respiratory centres and regulates the respiration.

TREATMENT OF SCIATICA.

Who would not welcome an efficient and simple treatment for that affection, as frequent as it is troublesome, known as neuralgia of the sacro-lumbar plexus? Professor Launois, of the Tenon Hospital, furnishes the remedy which he now employs almost exclusively in his hospital practice. It consists in subcutaneous injections of a saline solution, approaching in its constitution physiological serum. It is as follows:—

Sulphate of soda, 10 grms.;
Chloride of sodium, 5 grms.;
Water, 1,000 grms. (1 litre).

Five grammes of this solution, slightly warmed, are injected over the painful points which Valleix has classified as follows: Lumbar, sacro-iliac, iliac, rotulian, femoral, retro-trochanterian, ischiatic, peroneal dorsal of the foot, malleolar.

It is in the neighbourhood of one or more of these points, where the painful sensations attain their maximum intensity, that the saline injections should be made.

Four, five, or six injections at different points may be made at the one sitting, while their depth varies naturally with the anatomical constitution of the regions and the situation of the nerve; while some are necessarily subcutaneous as near the ankle, others may be interstitial and deep as in the gluteal region. The injections may be renewed daily or every two or three days. They cause no pain.

Other forms of neuralgia, such as facial, intercostal, scapular, and lumbago can be relieved by the same simple treatment.

GERMANY.

Berlin, March 24th, 1906.

THE *Klin. Monatsch f. Augenhk* contains a report of a case of Extremely Acute Suppuration of the Nasal Sinuses, which affected the eyes also, by Dr. Cramer.

The patient, who had never had any trouble of the kind before, was suddenly attacked with severe frontal headache fever and reddening of the right half of the face. A fortnight later the right eye was so much chemosed that two sausage-like swellings, each the size of the thumb, protruded between the eye lids. The

projection of the bulb, however, was not great, nor was its motility much diminished. Near the inner corneal margin was a fistulous opening, from which offensive pus was freely excreted, the sound passed deeply into the orbit. Although percussion over the frontal sinus evoked no pains, empyema was more than suspected. Resection of the anterior wall of the sinus revealed an unusually large cavity; it contained no pus, but the mucous surface was raised by numerous vesicles. After curetting free opening and drainage through the nose were provided. In spite of this, free suppuration continued through the fistulous opening and the visual power steadily diminished. At a second operation the floor of the orbit was removed, on which the bulb burst, and the vitreous body escaped. The cribriform cells were full of pus and foul pus escaped from the antrum. In complete removal of the necrotic mucous membrane, chiselling of the anterior wall of the antrum was necessary. The enormous cavity was tamponaded from the *cavum fossæ* and also from the orbit. The case then went on well. The wound healed readily under frequent washings out. The conjunctival chemosis persisted a long time and was only overcome by temporary suture of the eyelids. The resulting disfigurement was now only slight. It was possible that the disease originated in a carious tooth, that was removed later.

PARAFFIN AND LIVING HUMAN TISSUES.

This subject is treated of by Dr. Eschweiler in the *Arch. f. Laryng. in Rhin.* Bd. 17. It had been reported by some observers that paraffin was not absorbed into the tissues, but that like other aseptic foreign bodies it became encapsuled by connective tissue. This was considered to be true as regarded hard paraffin, but as regarded soft paraffin connective tissues grew into it.

From microscopical examination of a saddle nose that had been "over corrected" by injection of paraffin and from which a piece had been removed for the correction of the "over correction," it appeared that the paraffin was completely absorbed and replaced by connective tissue, but that a long time was required for the process. The taking up of the paraffin was due to giant cells which "melted together from reactive proliferated fixed connective tissue cells." After the disappearance of the paraffin a backward transformation took place of the giant cells into epithelioid connective tissue, which on its part formed connective tissue fibres. Leucocytes and lymphocytes only played a subordinate role in the process.

The writer concludes from his observations that the definitive substitution of paraffin by connective tissue, and thereby the best surgical result, is brought about in the quickest and safest manner by making use of many small deposits of paraffin in place of larger ones.

At the *Verein f. Innere Medizin*, Herr A. Wassermann and C. Bruck gave

DEMONSTRATIONS OF THE ACTION OF TUBERCLE BACILLUS PREPARATIONS ON THE TUBERCULOUS ORGANISM.

They said that the cause of the specific reaction of tuberculous tissues after the injection of tuberculine was still shrouded in complete darkness. At present there were only hypotheses as to why the smallest dose of tuberculine reacted specifically on tuberculosis, how it rendered the tissues hyperemic and dissolved or melted them. They had now by the help of a new process succeeded in proving the presence of anti-bodies (antituberculine) in the human subject, in cattle and guinea pigs. These anti-bodies did not usually appear in serum, and never in healthy and non-tuberculous organs. This process was based on the phenomenon of complementary union on the coming together of "antigen" and anti-bodies, this being proved by an acceptor as indicator.

The appearance of anti-bodies gives easy conclusions as to the specific action of tuberculous preparations. By the "avidity" existing between tuberculine and anti-tuberculine, the tuberculine injected is drawn into the tuberculous organism which already harbours the antituberculine. The complementary combination

now taking place between tuberculine and anti-tuberculine explains further the specific reaction on the tuberculous tissues. By this combination the albumen-dissolving and digesting powers of the organism are concentrated on the tuberculous organ.

By the specific treatment of tuberculous individuals with tubercle-bacillus preparations, anti-tuberculine appeared in the blood circulation. If the anti-tuberculine in the blood is of sufficient amount the reacting power of the individual becomes extinguished, because the tuberculine injected is taken possession of by the anti-tuberculine and can no longer reach the tuberculous organ. In this point lay the limit of our present-day specific therapeutics with tubercle-bacillus preparations and further investigations, keeping these newly discovered relations in view, were necessary in order to carry our treatment a stage farther.

Hr. L. Michalis said he had made use of the same method in bringing anti-bodies into view after injection of organ cells. In association with Hr. Fleischmann he had injected an emulsion of guinea-pig's liver and he had obtained thereby a serum which, although it had no visible action on the liver cells of the guinea pig, neither *in vitro* nor *in vivo*, yet it was different from normal serum in that, brought into contact with the liver cells of the guinea-pig, it imparted to them the power of complementary combination. The method could therefore be made use of in many ways.

AUSTRIA.

Vienna, March 24th, 1906.

DUCTUS BOTALLI AND STENOSIS IN PULMONARY ARTERY.

At the *Gesellschaft für Innere Medizin*, Singer showed an anatomical preparation from a patient, æt. 26, who from childhood was white and bloodless, but never had palpitation till received into hospital. Five days before reception she was taken ill with fever pain over the region of the heart and difficulty in breathing. On reception she was pale, high temperature, frequency increased, but tension low.

There was pulsation in jugular with slight *voussure* or vaulting over the cardiac region; at the sternal ends of the second and third ribs on the left side were visible pulsations with a distinct systolic whirr. Percussion gave cardiac dulness two fingers breadth beyond the mamilla to the left, to the right, beyond the sternum below the fourth and fifth ribs.

Auscultation gave a systolic murmur at apex while the base gave murmurs with both systolic and diastolic. Both these murmurs were well marked in the right side as well as over the pulsating tumour in the second intercostal space on the left, where the systolic sound was louder, of a rushing, blowing character.

No sound was communicated to the carotid. In the left interscapular space both sounds were distinctly heard.

Shortly after her reception, dulness commenced in the left pulmonary apex, accompanied with all the symptoms of consumption. Fever, sweating, and hæmoptysis and subsequent infiltration with cavities.

Six weeks before death the vaulted swelling between the ribs subsided and the previous murmur could not be heard.

On opening the heart at the *post mortem* the ductus botalli was found persisting; the pulmonary valve was soft, but entire; but in the left side of the conus pulmonalis a firm, hard thrombus was closely adherent to the arterial wall. This clot extended down to the ductus botalli, which it closed. The origin being of recent date the presumption is that it coincided with the sudden disappearance of the tumour and murmur.

CONTENTS OF ERYTHROCYTES.

Schur exhibited preparations of blood with round, well defined bodies contained in the red blood corpuscle. These round bodies are of different sizes, but whose contents are of no definite structure. Their refractive properties make the peculiar bodies more prominent. They can be coloured with nuclear dyes such as

hæmatoxylin, methyl blue, gentian violet, pyronin, but not with methyl green or Erlich's tri acid. These bodies are found individually, scarcely ever duplicated. They are rarely central and usually found eccentrically. Beyond the discovery of this rare body the red cell corpuscle is quite normal and healthy.

Schur would hazard no hypothesis on the discovery. Nowhere in literature had such bodies been described nor apparently met with.

It might be well to mention the nature of the disease the patient suffered from, although he had examined many others suffering from the same disease but never met with the same phenomena. The preparations were taken from a patient suffering from morbus basedowii with well-marked exophthalmus and struma, but otherwise healthy. The large glands on the right side, and increased hepatic dulness were undeniable remnants of the disease, that had apparently much improved. Here and there a lymph cell could be seen in the blood, but these were rare.

He showed the blood of other four basedowii cases where their bodies were absent.

Sternberg thought the bodies were interesting to the profession, but attached very little importance to them, as they will be finally proved to be allied to the blood plates already found in the corpuscle.

Turk put a higher value on these round bodies than Sternberg, and assured him that they were not in any way associated with the blood plates.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

MUNICIPAL TREATMENT OF CONSUMPTION IN EDINBURGH.—The question of checking the spread of phthisis by the isolation of advanced cases in a special pavilion of the fever hospital is under the consideration of the public health authorities. In a statement on the subject, Councillor Gilson, Convener of the Public Health committee, remarks that the question is not one of philanthropy, nor is it one for the Parish Council. By far the greater number of those who die of phthisis are hard-working people, who pay their rates to the last. The town is justified, not on benevolent, but upon economic grounds, in protecting the lives of the citizens from the great danger of a powerful infection. If the dangerous cases which had got beyond the range of cure were provided for the prospect of a diminution of the disease in the city would be greatly improved. It is suggested that provision be made (in a disused scarlet fever pavilion) for 50 cases in the last stage of phthisis. The cost, upon the experience of the last five years, would not exceed one thousand pounds annually. The result would be the immediate abstraction of 50 sources of dangerous infection. In a similar institution under the municipality of Paris the experience is that the average duration of life of patients of this class is about 3 months, and thus some 200 cases would be received in a year. No expenditure of public money is more likely to yield an ample and immediate return. It is not unreasonable to suppose that in this way the mortality from consumption in Edinburgh would be reduced by 200 a year within the next ten years. Even taking it at half that, the average age at which we lose our people through consumption being 33, we may reckon that each life saved represents ten years of Labour. There is good authority for taking the wage earning power of each citizen at £35, and £35 capitalised at 10 years purchase means £350 for each saved life. A reduction of mortality, then, of only 100 lives per annum is cheaply bought by the expenditure named. In the report of the medical officer of health it is shown that the mortality rate from phthisis is 1.51 per mille—about 500 deaths per annum. A very considerable number are cases of respectable workmen and small tradespeople, and it is this class particularly who would be treated by the Council scheme.

ROYAL HOSPITAL FOR SICK CHILDREN, EDINBURGH. The annual general meeting of contributors was held in the Hospital on March 14th, when the usual financial and statistical statements were submitted. The principal resolution, expressing the duty of the community to support the hospital, was proposed by Lord Dunedin, the Lord Justice General. In his speech, moving the adoption of the report, Mr. Hall Blyth, Chairman of the Board of Directors, spoke of the need for a convalescent home in connection with the hospital. The institution has recently had bequeathed to it a very suitable house in the country, and it is hoped that the public liberality will enable the directors to convert this into a convalescent home.

WOMEN GRADUATES OF EDINBURGH AND ST. ANDREWS AND THE FRANCHISE.—The action brought against the Universities by representatives of the women graduates for nominal damages on account of their refusal to issue voting papers to women was before the court of session the other day. The case was sent to the Procedure Roll, and will be debated after the vacation, on the resumption of the Court, in May. The feeling among the women graduates is unanimously in favour of proceeding with the action and having their legal position defined. The contention of the Universities is that women, like peers, are under legal disabilities as regards the franchise.

LIBERTON COTTAGE HOSPITAL FOR INCURABLES.—In connection with the Longmore Hospital for Incurables there has just been opened in one of the southern suburbs of Edinburgh the above Cottage Hospital. The Longmore Hospital was itself opened in 1875 with 22 beds, extended in 1883 to 50 beds, and again in 1886 and 1898 until now it accommodates 150 patients. For various reasons it was inadvisable again to enlarge the Longmore Hospital itself, and the managers resolved on having a separate building outside the city. Funds were provided by a bequest by Miss Martha Brown of £20,000, of which £6,000 was to be employed for building a cottage home for incurables suffering from consumption. The managers accordingly procured a site which would give room not only for such a building as could be erected out of Miss Brown's bequest, but for additional accommodation. The present Hospital, which was opened on the 19th by the Earl of Dalkeith, is thoroughly up to date in construction and equipment. It will accommodate 42 patients in all, 18 of these being consumptives, the remainder suffering from other incurable diseases. The cost has been about £500 per bed.

SCOTTISH ASSOCIATION OF REGISTERED MEDICAL WOMEN.—This association, which numbers among its members most of the women practising in Scotland, came definitely into existence a few days ago, when the constitution which had been under consideration for some time, was finally adjusted and agreed to, and the office bearers elected. The objects of the association are in general to safeguard the interests of medical women, and to consider educational questions which may from time to time arise.

BELFAST.

CASE OF ACONITE POISONING.—An inquest was held at Larne last week on the body of a man who had died after a few hours' illness with symptoms of irritant poisoning. It appeared that he had stewed something in a saucepan which he told his sister was bog bean, and took it to his bedroom with him in a mug. In little over an hour the sister heard a noise in the room, and on going in found him very ill. She got help and sent for the doctor, who arrived soon, but found the man dead. Dr. Wilson said that the roots, some of which he found in the house, were those of aconite. The jury found that the death was due to aconite poisoning, probably taken in mistake for bog bean.

TUGHAN v. DARNELL.—THE BELLADONNA POISONING CASE.—This action, at its third trial, has resulted in a verdict for the plaintiff, with £65 damages. The case was one of belladonna poisoning from the use of soap and belladonna liniment in a boy suffering from

orchitis after mumps, and Dr. Darnell was charged by the plaintiff with negligence. At the first trial the jury disagreed, at the second they found for Dr. Darnell, but this verdict was set aside on the ground of misdirection by the Judge, and a new trial ordered. As it is not yet settled whether an appeal will be lodged, no comment is possible at present. The trial has excited the keenest interest in medical circles here, and the court was crowded with medical men and students. Evidence was given by Professor Sinclair, Drs. O'Neill, John Campbell, McKisack, Kirk, McQuitty, Mitchell and Dr. Darnell himself.

QUEEN'S COLLEGE, DINNER.—The annual dinner of the Queen's College was held in the College Hall on St. Patrick's night, and passed off most successfully. The chair was occupied by Professor Lindsay, and among the guests was Professor Lorrain Smith, of Manchester, who received a very hearty greeting from his old colleagues.

PREVENTION OF CONSUMPTION.—At a meeting of the Ulster Branch of the National Association for the Prevention of Consumption held last week in Belfast under the presidency of the Lord Mayor, an address was delivered by Professor Caton, of Liverpool. He dealt particularly with the methods which are in use in that city, and gave a very hopeful account of their results. Ireland lags far behind the rest of the United Kingdom in this matter, and Professor Caton attributed this mainly to the want of proper education on the subject of tuberculosis, and rested his chief hopes of future improvement on the education of the young in simple rules of hygiene. Several medical men spoke at the meeting, and agreed in the main with Professor Caton's views.

LETTERS TO THE EDITOR.

"CONTRACT PRACTICE" AND THE BRITISH MEDICAL ASSOCIATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In common with many others of the profession I have received a painful confession from your contemporary *The British Medical Journal*, that we should all form a public medical service, or in other words, a dispensary, in connection with our practice. A penny a week for adults, and half this amount for children may be a profitable adjunct, but it is surely anything but ennobling for a profession. With Private Dispensaries, Public Medical Service, and Hospitals the profession surely does not require to be told so late in the day that the "British Medical Association is a company," which endorses this practice, though it does not recommend it. This is a nice distinction and quite worthy of any quack remedy. The company has fallen to a very low level when this form of advertising has to be resorted to. If the company were of any use to the profession that body would soon discover its merits and the efficacy of "contract practice." We have too much of it already and long for the "company" that would save us from such depraved deterioration.

I am, Sir, yours truly,
WM. MACVIE, M.D.

Booth, Liverpool, March 25th, 1906.

PROFESSIONAL ADVERTISING IN THE NEWS-PAPERS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I cut the enclosed advertisement from *The Times* of Monday. Although I cannot hope that you will reproduce it in the very large type in which it appears, I trust you will give it publicity in your columns. It seems a pity that a book of such importance should not be brought to the notice of the President, Censors, and Fellows of the Royal College, which has the honour to claim the author as a diplomat, but this may be made certain by reproduction of the advertisement in THE MEDICAL PRESS. I have not noticed any announcement of any of the numerous editions of the work or reviews of it in the medical

papers; and this is a little astonishing in view of the fact that the book has been reviewed in terms of commendation by that great authority on science—and especially medical science—*The Queen*.

I am, sir, yours truly,

IGNORAMCS.

March 26th, 1906.

[The following is the advertisement to which our correspondent alludes, necessarily shortened to suit our space.—ED.]

New Edition (17th). Cloth, 1s. 6d. Boards 1s.
THE DIETETIC CURE OF OBESITY.

("Foods for the Fat.")

By DR. YORKE-DAVIES,
Roy. College Phys., London, &c.

Illustrates the dangers of Obesity, &c., &c.

OPINION OF THE PRESS.

The Queen says:—"The advice contained in this book will be invaluable."

REVIEWS OF BOOKS.

GILES ON GYNÆCOLOGICAL DIAGNOSIS. (a)

DR. GILES' work on gynæcological subjects is so well-known that a book from his pen on the subject of gynæcological diagnosis is sure to be received with approval on *a priori* grounds, and when the book has been studied it will be seen how deservedly the approval has been given.

The book consists of two parts. Part I. is entitled "General Considerations," and deals with case-taking, methods of examination, diagnostic instruments, and the interpretation of clinical signs. Part II. is entitled the "Diagnosis of Individual Cases." In it each chapter is devoted to a special "leading symptom"—amenorrhœa, pain hæmorrhage, discharge, pruritus, and so forth, and from this symptom the reader is carried back through the different conditions which can cause this leading symptom to the special condition from which the patient is suffering. Each chapter closes with a tabular synopsis of the causes of the particular leading symptom to which the chapter is devoted. There are thirty-five excellent illustrations, the work of the author. These serve their purpose admirably, and are worthy of special praise.

Dr. Giles has written this short work in a clear manner and in logical sequence, with the result that it is more valuable than we could have believed a work of the kind could be. Although it is short, almost all the essentials of diagnosis are included, the only omission of consequence which we have detected being the want of reference to the supreme importance of examination under an anæsthetic in doubtful cases. Personally, we never operate upon a doubtful case without first making such an examination, unless the condition of the patient forbids it, and therefore we should like Dr. Giles to make more pointed reference to its value in a second edition.

We strongly recommend the book to general practitioners and students who are desirous of obtaining a firm grasp of the principles of gynæcological diagnosis.

DISEASES OF INFANCY. (b)

THERE are few medical works which have given us greater pleasure or from which we have derived greater profit than we have received from the first edit on of the book before us, and it is therefore with sincere pleasure that we take the opportunity of reviewing its third edition. The most important changes which

(a) "Gynæcological Diagnosis: a Manual for Students and Practitioners." By Arthur E. Giles, M.D., B.Sc., F.R.C.S., Ed., Gynæcologist to the Tottenham Hospital; Surgeon to Out-Patients, Chelsea Hospital for Women. With thirty-five original illustrations. Pp. x. and 212. London: Baillière, Tindall and Cox. 1906. Price 7s. 6d.

(b) "The Diseases of Infancy and Childhood." By I. Emmett Holt, M.D., Sc.D., LL.D., Professor of Diseases of Children in the College of Physicians and Surgeons (Columbia University), New York. Third Edition, revised and enlarged. Pp. xix. and 1,174. With 241 illustrations, including eight coloured plates. London: Sidney Appleton. 1905.

have been made in this edition are to be found in the articles upon the following subjects:—Examination of the Sick Child, Hypertrophic Stenosis of the Pylorus, Diarrhoeal Diseases and Dysentery, Vaginitis, Cerebro-Spinal Meningitis, Mental Defects, Chondro-Dystrophy, Status Lymphaticus, and Diphtheria. Most of these chapters have been entirely re-written, and some of them appear for the first time. The author has also wisely added to and otherwise improved the illustrations, and altogether has added twenty-five new ones.

The book itself is divided into ten parts, which deal respectively with General Conditions; Diseases of the Newly-Born, Nutrition, Diseases of the Digestive, the Respiratory, the Circulatory, the Uro-genital, and the Nervous Systems; Diseases of the Blood, Lymph Nodes, Bones, &c.; Specific Infectious Diseases; and other general diseases. Perhaps one of the most interesting parts is that dealing with nutrition. In spite of the fact that it is just a little over-weighted with statistics, it furnishes most interesting reading, and at the same time is valuable to anyone who desires to look up a special point, so full is the information which it contains.

In the chapter on the care of premature and delicate infants, we are glad to see that Dr. Holt ascribes the incubator he depicts to its correct origin, inasmuch as an attempt has been made by an ingenious American to credit himself with its invention.

Space forbids us to review Dr. Holt's work at great length; suffice it to say that in style, arrangement, and subject matter it leaves little to be desired, and is, indeed, a model of what a text-book of the kind should be.

CONGENITAL MALFORMATION. (a)

THIS short monograph on congenital abnormalities of the limbs is an interesting account of a series of cases illustrating the rarer forms of mal-development of the arms and legs. The author's reason for publication is a desire to throw light upon the etiology of such conditions by adding to the number of recorded cases and by giving a full account of each. Most of the variations which he describes have been observed previously, but this pamphlet is none the less of value to readers of the German language, and for the sake of the illustrations alone is pretty certain to attract the attention of students of embryology and teratology. Most of the figures are excellent, but it is a pity that the author was so sparing in his reproductions of skiagraphs. Those that are figured are for the most part taken from the less rare abnormalities, while some of the most interesting cases of his collection are only illustrated by ordinary photographs. Examples of polydactylism and syndactylism are described, and also many cases of congenital absence of various bones, and cases of gigantism or dwarfism of limb or portions of limbs. A very good description and figure is given of an abnormality to which we think sufficient attention has not been directed, namely, tapering of the arm from the elbow down to a pointed extremity consisting of a single finger. Another rare defect is that described on page 3, and consisting of a club-shaped hand with a well-developed thumb and little finger situated in the lateral aspects of the tumour-like extremity.

THE BACTERIOLOGY OF PERITONITIS. (b)

THE work before us has been built up on the basis of the Erasmus Wilson Lectures of 1905, and is an attempt to place the bacteriology of acute peritonitis upon a sound basis. The authors in the course of their work have made systematic examinations of the peritoneum in 270 cases operated upon at St. Thomas's

Hospital during a period extending over some sixteen months. The subject which the authors have selected is, so far as British writers are concerned, an almost unbroken field. That they have made the best use of their opportunities will, we think, be obvious to anyone who carefully reads their valuable addition to medical knowledge before us.

The first chapter deals with the functions of the peritoneum, and it is perhaps one of the most important, as it gives the clue to the writers' ideas generally on the subject of peritoneal infection. It commences by referring to the power of absorption of the peritoneal cavity—a power which the writers are careful to point out is due not as was formerly held to be the fact that the entire peritoneal cavity is a huge lymph sac (which it is not), but to the extraordinary rapidity with which fluids can be taken up through the inter-tendinous pits of the diaphragmatic peritoneum. Any further absorption which occurs, occurs through the blood-stream, to which the fluid gains access through rents or stripped spots in the peritoneal endothelium. On the latter account, the writers deprecate the pulling off of fibrinous plaques at an operation, as opening thereby an additional route by which infection can reach the blood stream.

The virulence of micro-organisms is next mentioned, and the writers refer to the well-known fact that in some cases large quantities of pus make their way into the abdominal cavity without causing serious after-consequences. This is explained by the low vitality of the invading organism in such cases, an explanation which fits in well with the experience of clinical surgeons. The consideration of the relative virulence of the different organisms met with in acute peritonitis follows, and occupies some pages. The streptococcus is regarded as at once the most unusual and the most deadly invading organism. Next to it, in point of virulence, though of very much more common occurrence, comes the bacillus coli, and the authors definitely register their opinion that it plays by far the largest part in hurrying patients from the wards to the *post-mortem* room. The staphylococcus albus, on the other hand, receives a very different character. It is held to be the organism which is the first to make its appearance in the peritoneal cavity after the occurrence of a lesion; it is of very low virulence. It is found at the spreading edge of more acute infections, and so it is believed to exercise a protective action by determining the advent of phagocytes and the setting-up of limiting adhesions.

From the results of their experiments, the writers believe that it is possible to make a prognosis from the microscopical examination of films taken from a remote region of the peritoneum in cases of infection. If phagocytes are abundant and staphylococci are present, the prognosis should be favourable. If bacilli are also present, but cells and cocci abundant, the prognosis is more grave, but is still not hopeless. But if cells are scanty and disintegrated, and bacilli are alone present, or, if streptococci are found, the case may be regarded as hopeless.

We have dealt shortly with this opening chapter of the book before us. Chapters II. to XIV. are devoted to the different forms of infection and the different infecting organisms, but want of space forbids our entering into a similar discussion in their case. The last chapter deals with the treatment of acute peritonitis based upon its bacteriology. Stated in a few words, the authors consider that, in acute streptococcus infection, if there is any prospect of success, it must lie in the most thorough washing possible. In colon infection, on the other hand, they believe that limited operations should be the rule, because of the mechanical impossibility of cleansing the peritoneum, the risk of washing away the phagocytes in the limiting exudation, and the danger of spreading infection. Their view on drainage we must leave to our readers to ascertain for themselves, save to quote their aphorism that "the cases which it is most advisable to drain are the very ones where drainage is impossible, whilst in

(a) "Upon Congenital Malformation of the Extremities." By Prof. F. Klausner, Munich. With thirty-two illustrations in the text. Wiesbaden: J. F. Bergmann. 1905.

(b) "The Bacteriology of Peritonitis." By Leonard Dudgeon, M.R.C.P., Bacteriologist to St. Thomas's Hospital, London, and Percy Sargent, M.A. M.B. (Cantab), F.R.C.S., Surgeon to Out-Patients, Victoria Hospital for Children, Chelsea, &c. Pp. xii. and 243. London: Archibald Constable and Co., Ltd. 1905.

those where it is possible it is also unnecessary." On the subject of drug treatment, they are very definite—"It is obvious that the teachings of bacteriology harmonise with those of clinical experience, in pointing to purgatives, and not to opiates, as the right drugs to be given in peritonitis."

HANDBOOK OF PHYSIOLOGY. (a)

FLINT'S "Textbook of Human Physiology" appeared in America in 1875, and held sway in the land of its birth for well-nigh thirty years. In this country it also had, for several years, "a local habitation and a name" as a useful and reliable text-book of physiology.

The "Handbook" before us takes the place of the text-book of thirty years ago, and the author tells us that it contains little of the former text, except parts relative to descriptive anatomy and established views that have become classic.

It might be fairly asked at the outset, What has a present-day text-book of physiology to do with descriptive anatomy? It is, of course, true that without a knowledge of structure a proper knowledge of function is impossible to acquire. But the day is past when a text-book of physiology can assign more than one-third of its space to physiological anatomy and histology, notwithstanding the author's appeal to experience as his justification.

It is always difficult to put "new wine into old bottles" with satisfactory results, and while every one respects the venerable and distinguished author of the text-book, it must be confessed that his attempt to rejuvenate his work constitutes no exception to the rule. Reference is undoubtedly made to recent advances in the science of physiology, but the old Adam is revealed on every page. A few examples will suffice. Carbon dioxide is said either to diffuse from the venous blood into the lungs or to pass out by a process "known as dissociation." Along with deficiency of oxygen, "animal emanations" account for the distress and fatal results of breathing in a confined space. "No particular part of the body is endowed with the special office of calorification." "All physiologists are agreed that the quantity of heat produced by oxidation is the same, whether the combustion be rapid or slow." Urea is synthesised by combining ammonium sulphate with potassium without further detail, and the proposition that the amount of this substance excreted in the urine depends largely on the nature of the food it is supposed to require, and is given serious defence. Many similar "quaint conceits" appear throughout the work, but it is unnecessary to multiply instances.

The book is, however, by no means devoid of merit. Chapter XI., which deals with "Secretion," contains a goodly store of useful information not found at such length in recent physiological text-books. Many of the illustrations also are beautiful, particularly the frontispiece, and the four illustrations borrowed from Dalton's "Topographical Anatomy of the Brain." A useful atlas of histology and embryology, containing sixteen plates with over sixty figures in colours, is given at the end. Those borrowed from Sobotta's "Hand Atlas of Histology" have lost none of their beauty in reproduction; so much can hardly be said for those taken from Wilson's well-known atlas of Karyokinesis, &c.

The most serious defects of the book are that it seemingly evades the true inwardness of things, and does not reveal the trend of modern physiology to its readers. It awakens no interest in the problems that still remain unsolved—the living vital aims of physiology—many of which engage the thoughts and activities, not alone of physiologists, but of all medical men imbued with an interest in the advance of their sciences. In these respects it stands in marked contrast to some other recent American works on the subject to which the author possibly refers when, prior

(a) "Handbook of Physiology." By Austin Flint, M.D., LL.D. New York: The Macmillan Co.

to the appearance of the present Handbook, he felt obliged to use more modern works for class recitations, instead of his old "Text-Book" which had got out of date.

OBITUARY

SURGEON-GENERAL JOHN LUMSDAINE.

SURGEON-GENERAL JOHN LUMSDAINE, of the Indian Medical Service, retired, died on March 11th at Weston-super-Mare, aged 79. He served in a boat expedition against El Khatiff in the Persian Gulf. Later he served in the Bombay Horse Artillery during the campaign in Central India in 1857-58-59, under Sir Hugh Rose, was present at the capture of Ratghur, the action of Baroda, the relief of Saugor. He was specially mentioned in despatches, and received the medal and clasp. For the Abyssinian expedition of 1867-68 he received the medal, and was specially promoted to substantive rank of surgeon-major for "valuable services" in the field. He retired in 1883.

DR. J. M. H. MARTIN, OF BLACKBURN.

We regret to announce that Dr. Martin, of Blackburn, died suddenly at his residence on March 20th. Deceased, who was a Borough Justice, recently occupied the post of President of the Lancashire and Cheshire branch of the British Medical Association, and he had for many years been the leading surgeon of Blackburn. He was medically educated at Edinburgh University, and took the qualification of M.D. Vict. in 1892.

Conferring of Degrees at Leeds University.

A CONGREGATION of Leeds University was recently held, at the School of Medicine, for the purpose of conferring degrees. The vice-chancellor (Dr. N. Bodington) presided. Professor Grant (Dean of the Faculty of Arts) presented Mr. T. P. Sykes, of Bradford, for the degree of M.A., *Honoris Causa*. Mr. Sykes is this year the President of the National Union of Teachers, and he has a long and honourable record as a teacher and as an organiser of teaching in the city of Bradford. Professor A. Smithells (Dean of the Faculty of Science) presented for the degree of M.Sc., Mr. Charles Bothamley, Mr. Aldred Farrer Barker, and Mr. Walter Myers Gardner, former students of the Yorkshire College. Mr. Barker and Mr. Gardner are professors of the technical college at Bradford, and Mr. Bothamley is engaged in educational work (primary and secondary) in the county of Somerset. Dr. De Burgh Birch (Dean of the Faculty of Medicine) presented Mr. James Stirling Crawford, Mr. Roland Brooke Radcliffe, and Mr. Albert Latimer Walker for the degrees of M.B. and Ch.B.

The Survival of the Unfit.

THE Ulverston Guardians have referred to the Local Government Board the case of a family where the father died in an asylum, the mother was feeble-minded, there were seven daughters and about a dozen illegitimate children. Several were chargeable to the Union, and one of the daughters is now in the workhouse awaiting her confinement. The family have cost the ratepayers an enormous sum, and the guardians are of opinion that drastic measures should be taken to cope with such an evil.

The Government Vaccine Lymph.

IN reply to a question in the House of Commons last week, the President of the Local Government Board said:—The lymph supplied from the National Vaccine Establishment is, in all cases, derived direct from the calf, has been passed through a series of calves, and is in no instance directly derived from the artificial inoculation of calves with human small-pox. The usual method of renewing lymph for supply from the establishment is by vaccinating calves with vaccine lymph obtained from children, but it cannot be stated that this is always so.

MEDICAL NEWS IN BRIEF.

Honour to Professor G. Sims Woodhead.

DR. SIMS WOODHEAD, the distinguished Professor of Pathology in the University of Cambridge, was entertained to breakfast by the Temperance Collegiate Association on the 20th inst., in the rooms of the Christian Institute, Glasgow, where he delivered a stirring address on the evils of alcohol on the human body. Later in the day, he was entertained to dinner by the Corporation of Glasgow, where many of the leading medical teachers were present. He subsequently paid a round of visits to several of the hospitals and institutions.

A Hospital for Gentlewomen.

ON Thursday last, at a meeting held in London to consider a scheme for providing a hospital for gentlewomen, Sir Roper Lethbridge (Chairman) said that such a hospital was a necessity for ladies whose pride naturally prevented them from going to the ordinary hospital, where the environment was often distasteful. And even if they were able to afford three guineas a week as paying inmates, the accommodation was very limited, and they could not have their own medical men, as they would under the new scheme. The sum of £20,000 would make the hostel self-supporting, and they appealed to the public for that amount. Already £600 had been obtained, and with £5,000 the work would be begun.

University College Hospital.

At the annual meeting of the Council and subscribers of this institution on Thursday last, the chairman, Lord Monkswell, said that the number of out-patients treated had increased very considerably during the past year, partly owing to the temporary closing of two neighbouring hospitals, leaving them with a total indebtedness of £11,234 7s. 1d. The balance available to meet this large debt was £3,261 8s. 4d. The committee viewed the financial state of the hospital with much alarm, and feared that, unless liberal support was forthcoming very shortly, they would be compelled to resort to the sale of a further portion of the small remaining investments available for general purposes. The only alternative would be to close a portion of the hospital, and thus curtail the immense benefit which Sir Blundell Maple had conferred on the poor of the district and of London generally by his splendid gift.

Bequests to Medical Charities.

UNDER the will of Mr. Vyall Edward Walker, D.L., J.P., of Southgate, and a member of the well-known brewing firm of Messrs. Taylor, Walker and Co., the following bequests, all free of duty, go to the following medical charities:—£2,000 to the London Hospital, £2,000 to the Cancer Hospital, Brompton, £1,000 to the Middlesex Hospital, £1,000 to the City of London Hospital for Diseases of the Chest, £1,000 to the Royal Hospital for Incurables, Putney, £1,000 to the Poplar Hospital for Accidents, £1,000 to the Idiot Asylum, Earlswood, £1,000 to the Hospital for Consumption at Brompton, £1,000 to the Victoria Hospital for Children at Chelsea.

Commission on "Sleeping Sickness."

HIS EXCELLENCY the Governor-General of the Sudan has directed that a Commission be appointed to investigate the possibility of the extension of "Sleeping Sickness" into Sudan Territory. The Commission to be as follows:—Lieutenant-Colonel G. D. Hunter, D.S.O., P.M.O.E.A., Dr. Andrew Balfour, Director Wellcome Research Laboratories, Khartoum, a British medical officer, Egyptian Army, or medical inspector, Sudan Medical Department, or such members as may be hereafter appointed. Points to be investigated:—(1) To ascertain the distribution of various species of tse-tse flies or other biting flies in the Sudan; (2) to

ascertain if the disease at present exists in Sudan territory; if so, to determine the exact areas, and to what extent the distribution of the disease coincides with the presence of the tse-tse or other flies in these areas; (3) a systematic investigation of the blood of a population in an infected district; (4) a thorough and complete research into the character of the disease, specially as regards its origin and spread.

Hospital Sunday Fund.

THE question of applying for the incorporation of the Metropolitan Hospital Sunday Fund by Royal Charter or otherwise was considered at the Mansion House meeting. The Lord Mayor presided. The Rev. Canon Fleming said that at present the fund was without power to make by-laws, and generous contributors like Mr. George Herring (who gave something like £1,200 annually) had no vote. The Rev. Hardy Harwood pointed out the effect of the incorporation in safeguarding the continuity of the fund. There was no desire on the part of the council to close the door against frank and friendly discussion of the methods and the hospitals with which they were concerned. Dr. Adler, Chief Rabbi of the Jewish congregation in London, supported the resolution proposing incorporation, which was carried unanimously.

Trinity College, Dublin.

At the Hilary Term, 1906, the following passed the Preliminary Scientific Examination:—

Physics and Chemistry.—James H. Crane, George Halpin, Richard H. Mathews, William P. H. Smiley, Benjamin A. Molyneux, Beatrice M. Hamilton and Henry H. James (equal), Herbert V. Stanley, John T. M'Donnell, James Beckett.

Botany and Zoology.—John A. W. Ponton, Albert V. J. Richardson, and Desmond Drew (passed on High marks); Duncan F. Hunter, William H. Hart, James P. S. Dunn, Walter E. Adam, Brindly H. Moore, Hans Fleming, Charles O'Brien, Edward H. Murphy, Patk. F. Nunan, Samuel R. Richardson, and Bethel A. H. Solomons (equal); Edward Garland, Victor B. Kyle, and Hugh S. Metcalfe (equal); Gervase Scroope and William H. Sutcliffe (equal); John W. Flood and Frank R. Seymour (equal).

Intermediate Medical, Part I.—Samuel F. A. Charles, William E. Hopkins, Gerald G. Mcreedy, Norman P. Jewell, Dixie P. Clement, Alfred H. Smith; Charles W. Laird and Frank R. Seymour (equal); Ernest C. Lambkin, Henry H. Ormsby, and Robert de C. Wheeler (equal); James F. Clarke, Alexander S. M. Winder, Frederick A. Anderson, William H. McCarthy, Henry R. Kenny, John H. Morton, William E. M. Armstrong, Frank Smartt, Julian B. Jones.

At present, there are three vacancies on the surgical side and two vacancies on the medical side of the dispensary of the Glasgow Royal Infirmary. We hear there is a keen contest for the posts.

A COMMERCIAL traveller and eight medical students were summoned at Leeds last week for taking part in a disturbance at the Tivoli Music Hall on the 14th inst., arising out of a performance conducted by "Doctor" Walford Bodie, who operates upon persons suffering from paralysis. During the disturbance the police were called in, and the rioters, numbering nearly a hundred, were ejected after a severe struggle. Several of the officers received blows from the rioters, most of whom were armed with sticks, which they used freely, and considerable damage was done to the internal arrangements of the building. It was alleged that the police had used their batons, but this was denied, although it was admitted they protected themselves with sticks and other weapons, which they wrested from the rioters.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

Lymphatism as a Family Disease.—Hedinger (*Deut. Arch. f. Klin. Med.*, 1905) calls attention to the fact that the condition known as lymphatism may occur as a family disease. He mentions a case of a family of nine children, five of whom died suddenly during infancy. In some instances the child simply became cyanotic, lost consciousness, and died in a few minutes. In other cases the picture was that described as thymic asthma. Hedinger cites reports of a number of other observers recording the death under similar circumstances of from two to nine children in single families. The lesions found in such cases are constant, though varying in degree, and consist of enlargement of the thymus and of the lymphatic apparatus, the latter sometimes affecting single groups of glands, but more often involving also the lymphatic tissue of the spleen and the intestines. The microscopic lesions resemble in many ways those of an infection, though bacteriologic examination is negative. The pathogenesis is very obscure. The possibility of an auto-toxæmia has been suggested, but merely on the ground of the histologic resemblance of the lesions to those of a bacterial infection. D.

Sudden Death in the Course of Eczema.—Bernheim-Karrer (*Jahrbuch f. Kinderheilkunde*) discusses the mystery of sudden deaths in children with eczema of the scalp and face. In one such case the autopsy revealed an unsuspected streptococcal focus in one lung, the secondary action of these germs having induced slight endocarditis and pleural effusion. In another case an infant with eczema exhibited attacks of heart weakness, possibly from a similar action of the germs on the heart muscle. Another child of eleven months was under his care for recurring eczema of the scalp and face. The child was brought to him, after two months absence, on account of a new patch on the cheek, and he was impressed with the dull look in its eyes, but nothing abnormal could be detected in lungs or heart. The cervical glands were swollen. The child seemed unusually quiet, and was found dead the second morning. Staphylococci were discovered in the cutaneous lesions and in the internal organs. Their numbers were not arge, but it is possible that the eczema may have generated toxins, similarly to extensive burns, which may have induced an actual toxic form of staphylococcus mycosis. This assumption was confirmed by a number of experiments on animals. Infection with the staphylococcus alone did not cause, by any means such severe symptoms as when the staphylococcus infection was supplemented by a cutaneous lesion, such as a croton oil blister. The heart seemed to suffer particularly in these cases. The researches reported emphasise the importance of careful observation of the heart's action in cases of extensive eczema. Possibly the blood-pressure might afford useful information. D.

Treatment of Exophthalmic Goitre by a Specific Serum.—Rogers (*Journal of the American Med. Assoc.*, Feb., 1906) records ten cases of exophthalmic goitre treated by a specially prepared serum. He obtained two large soft cellular thyroids from cases of exophthalmic goitre. The glands were ground to a pulp, extracted with normal salt solution, and the coarse fibres strained off. After adding acetic acid, the supernatant fluid was syphoned off and the remaining nucleo-proteids and globulins, including thyroglobulin, were thrown down by half saturation with ammonium sulphate. These precipitates were combined and injected into rabbits. The rabbits showed a severe reaction and some died. After five weeks of this

treatment the rabbits were bled from the carotid, and the serum collected. Other rabbits were treated with the nucleo-proteids and globulins after the precipitates had been dried for some months. The dose of the serum used in treating the patients was about 1 cc., and two or three injections were sufficient. In every case benefit resulted, complete cure occurring in seven cases in the course of three or four months. Three of the cases thus cured were exceedingly bad. Both local and constitutional reactions followed the injections, but not of an alarming nature. Rogers points out that the utmost care in attention to detail in preparation of the serum is necessary. Owing to the difficulty in procuring diseased thyroids, this serum can hardly be put on the market. D.

Value of Lumbar Puncture in Diagnosis.—Gerhardt (*Grensgab d. Med. u. Chirurg.*, Bd. 13), as a result of his investigations, comes to the conclusion that lumbar puncture is of the greatest value in the diagnosis of tuberculous and purulent meningitis, since, by an examination of the fluid obtained, with reference to its bacteriological contents, its cytology, and its albuminous contents, one can not only determine whether meningitis is present or not, but also the form of meningitis. In acute febrile diseases lumbar puncture frequently enables one to distinguish the symptoms of severe toxæmia from those of actual inflammation of the meninges. The presence of blood in the fluid may confirm a diagnosis of hæmorrhage into the lateral ventricle of the brain, or fracture of the base of the cranium, or, more rarely, of spinal injury. In cases when doubtful brain symptoms are present, an excess of lymphocytes in the fluid may suggest syphilitic brain disease, but the author expresses doubt as to whether any information of value can be obtained in cases of suspected tabes. He lays stress also on the therapeutic value of the procedure, maintaining that in cases of cerebral tumour, headache and giddiness are often much relieved owing to the lessening of pressure produced. M.

Stokes-Adams Syndrome.—Lichtheim (*Deut. Arch. f. Klin. Med.*, Bd. 85, Heft. 3) reports a case of this rare disease. The patient presented very marked tachycardia (there being twenty-five pulse beats per minute in the radial artery as compared with eighty-five jugular pulsations), and he also suffered from giddiness and syncopal attacks. The cardiac dulness was increased in every direction, and a systolic bruit was audible all over the heart, but most intense at the base. The second sound was quite pure. Sphygmographic tracings showed that the jugular pulse was not a mere multiple of the arterial pulse, and that the rhythm of the auricular contraction was quite independent of that of the ventricles. Its independence was shown later in the pulse counts, namely, thirty radial pulsations to seventy-one jugular pulsations. Lichtheim regards the case as one of heart block, and believes that it is produced by a destruction of the connecting muscular band between the auricle and the ventricle, which extends into the ventricular septum from the posterior auricular wall. This was most probably brought about by arterio-sclerosis. Belski (*Zeitschrift f. Klin. Med.*, Bd. 57, Heft. 5) also reports a case, and expresses the opinion that the condition is a result of auricle-ventricle arrhythmia leading to independent action of the cardiac chambers. M.

The Use of Isoform in Dermatology.—Isoform is a non-poisonous, insoluble substance occurring in crystalline form and possessing strong antiseptic properties. It can be used as a powder mixed with an

equal part of calcium phosphate, and can be made up into a paste with glycerine. Necker (*Deut. Med. Woch.*, No. 38, 1905) reports that he has used it extensively in his surgical clinic, and especially in sixty cases of venereal ulcers. In most cases he used at first the 50 per cent. powder, and then later a 10 per cent. powder made up with the calcium phosphate, and he speaks well of the results. The ulcers healed up very quickly, and the tissue destruction soon came to an end. He has also employed it as a paste for the treatment of balanitis, but finds that it tends to irritate mucous surfaces. In one patient a scarlatiniform eruption followed by a pustular eruption followed the packing of an abscess with gauze impregnated with 5 per cent. isoform, and in five other cases he also saw unpleasant sequelæ to its use. On the other hand, when patients possess a good resisting power, the drug is most valuable as an antiseptic, and is especially good for mycotic skin affections, such as tinea versicolor and ringworm. In gonorrhœa also he has employed it as a $\frac{1}{4}$ per cent. emulsion, and has found it especially useful in treating post-gonorrhœal urethritis. M.

Treatment of Cancer of the Oesophagus by Radium.—

Max Einhorn contributes a paper on this subject to the Carl Ewald Fest-Number of the *Berliner Klin. Woch.* He points out that the nature of the affection naturally leads the physician to attempt its cure by experimenting upon it with every new remedy that seems at all likely to prove of use. Accordingly X-rays were largely employed soon after their discovery, but unfortunately proved of little value. The discovery of radium and of its wonderful properties suggested that it might be more successful, especially as from its nature it would be possible to bring the radium into close apposition to the growth. Einhorn then describes his apparatus, which consists of an œsophageal bougie provided with a hollow metal cap. Into this cap the radium is mounted and the bougie is then passed down as far as the stricture and is left *in situ* for from a half to one hour. Since a previous paper on the same subject in January, 1904, the writer has treated in all seven cases. In each of these the diagnosis was undoubted. One of them was a private patient, æt. 75, suffering from a very tight stricture. He was treated every second day during a period of two and a half months, the time of exposure to the action of the radium being half an hour on each occasion. His condition improved very much under treatment, and he soon became able to take fluids with comparative ease, and even semi-solid material, whereas before treatment, fluids could only pass the obstruction with the greatest difficulty. The six other cases were treated in hospital, and all of them showed improvement, the most pronounced effect being a widening of the stricture accompanied by a greater ease in swallowing, and by a general improvement in the condition of the patients. Pain also was relieved in most of the cases. The writer regards the results as very promising, and looks forward to a confirmation of his experience from other clinics. M.

Gout and its Causation.—Walker Hall (*Pract.*, March, 1906) reviews our knowledge of the causation of gout in the light of recent advances in pathological chemistry. Though we have still much to learn concerning the circulation of uric acid in the tissues and of its capacities for combinations in them, as an etiological entity, it must be definitely discarded. Hall then proceeds to discuss the new hypotheses which have been evolved to replace that which considered uric acid as the prime etiological factor. The view that gout is of bacterial origin, probably by infection through the intestinal mucosa, has been urged by many writers, but Hall says: "We are really not yet in a position to discuss this bacterial theory of gout. Except that adequate clearance of the intestinal contents diminishes the gouty symptoms, we have not much evidence to go upon." Kionka and Frey have put forward a very attractive hypothesis in which the presence of "gly-

cooll" plays an important part. Hall himself, and others have found that excessive meat feeding in dogs produces degenerative changes in the liver and kidneys. In man, anatomical changes have not been demonstrated in the liver in gout, but this does not negative the possibility of there being functional damage. It seems certain that glycooll or certain amino-acids from which glycooll can be readily split off, is formed during the proteid metabolism, and is normally converted into urea by the liver. It would appear from the result of Hall's investigations that some glycooll is present in the normal urine, but that it is found to a much larger extent in the urines of the gouty. "When a solution of glycooll is added to a neutral solution of dialkali-urate the appearance of the (acid) monoalkali-urate is hastened, the action being more pronounced when the sodium salt is used. Urea, on the other hand, inhibits the formation of the acid salt, but loses its powers when glycooll is added to a solution of neutral dialkali-urate and urea. If glycooll is present in gouty urine, it may be supposed that glycooll is also present in the tissue fluids, and thus the precipitation of urates may be favoured." It is, however, denied that glycooll is to be found in the damaged cartilages of the gouty, as stated by Kionka and Frey, and Hall has shown that the excretion of glycooll in the urine is by no means limited to gouty patients. Hall concludes by saying that in spite of these various and probably fallacious hypotheses our knowledge of the intermediate stages in gouty metabolism is making steady progress, and our increased knowledge can already be turned to good account in treatment. K.

Hydatid of the Lung.—Mould (*Jour. Roy. Army Med. Corps*, March, 1906) describes an interesting case of this condition which ended in complete recovery. The patient, æt. 40, had served six years in India. For about sixteen months he had had fits of coughing at irregular intervals during which he spat up some blood. Some seven months before admission to hospital he had been examined by two medical officers, but nothing was found wrong with him. Since that time till his admission to hospital he had not had another attack. The present attack came on while route-marching, when he was suddenly attacked by severe pains in the chest and coughing. The cough lasted about a quarter of an hour and was attended with some blood spitting, and then a piece of dense white membrane came away, after which he got relief. Examination of the chest showed that the expansion was equal on each side, but on the left side there was absolute dulness to percussion over an area extending from the clavicle down to the third interspace both in front and behind. Over the dull area the breath sounds were completely absent, and vocal resonance and tactile fremitus were also absent. The left radial pulse was much smaller than the right, and was scarcely perceptible when the arms were held above the head. The heart was considerably dilated, but the sounds were normal. Several further attacks of coughing occurred, and pieces of membrane with blood-stained mucus were brought up. The membrane was examined, and hydatid hooklets found, which established the diagnosis. He was treated with rest and inhalations of creosote. In about a month he was discharged from hospital quite well. The pulse was equal on each side, the heart was normal in size and the lung had completely cleared up, except for a small dull patch about two inches in diameter just at the outer end of the clavicle. K.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "Recent Medical Literature."
- (2) "Recent Surgical Literature."
- (3) "Recent Gynecological and Obstetrical Literature."
- (4) "The Recent Literature of Physiology, and Pathology."

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

DR. H. T. (Amsterdam).—We hope to refer to the subject of your communication in our next.

THE MEDICAL DEFENCE UNION.

In the annotation referring to the successful prosecution by this Society of a quack calling himself Dr. Muschik (page 300 of our last issue), the name of Mr. Tyrrell, "the man in perfect health," who consulted the quack and was treated by him as a fever patient, was, by an obvious slip of the pen, represented as the impostor who was fined, whereas he (Mr. Tyrrell) was the private detective employed by Mr. Hampson, solicitor to the Medical Defence Union, and was the means of bringing the quack to justice. We greatly regret the error on our part, and apologise to Mr. Tyrrell if it has caused him any annoyance.

OPSONIC INDEX.

MR. H. W. HAMILTON.—The statement was published some time back that exercise increased the opsonic index. If that be the case it explains the beneficial effects of routine walking exercise upon consumptives. We have not the exact reference at hand, but the series of observations upon which the above statement was founded was made by two medical men at a sanatorium for consumption. If you wish we will gladly furnish you with chapter and verse.

H. A. C.—We are unable to devote space to the matter, as it is not one of special interest to our readers.

THE CURABILITY OF EARLY PHTHISIS.

At the recent annual meeting of the Liverpool Hospital for Consumption, the resident medical officer of the Kaywood Sanatorium stated that whereas nearly 100 per cent. of quite early cases were restored to complete, or almost complete, health, and of those in the second stage a large number were very greatly improved, only a few of the advanced cases derived more than very temporary benefit, the benefit, as a rule, not extending greatly beyond the period the patient was actually under treatment at the sanatorium.

DR. JOHN A. M. (Ontario).—It will afford us much pleasure to accede to our correspondent's requests.

A SPECTATOR.—For obvious reasons we cannot comment on the case while it is *sub judice*, but we are unable to bring our mind to the idea that a man with such a record can have been guilty of such an inexcusable lapsus.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MARCH 28th.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.).—8.30 p.m. Pathological Evening.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. P. J. Freyer: Clinique. (Surgical.) 5.15 p.m. Lecture: Mr. F. J. Stewart: Bronchocele.

THURSDAY, MARCH 29th.

CHILDHOOD SOCIETY AND THE BRITISH CHILD-STUDY ASSOCIATION (Parkes Museum, Margaret Street, W.).—8 p.m. Lecture:—Mr. E. W. Wallis: Psychology of Reading. (Arranged by the Childhood Society.)

NEUROLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8 p.m. Exhibition of Clinical Cases, illustrating various kinds of Ocular Palsies.

ROYAL COLLEGE OF PHYSICIANS OF LONDON (Fall Mall East).—5 p.m. Lumenian Lecture:—Dr. D. Ferrier: On Tabes Dorsalis.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutcheson: Clinique. (Surgical.) 5.15 p.m. Lecture:—Dr. T. C. Shaw: The Connexion between Mind and Body.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—6 p.m. Dr. M. Dockrell: On the Usefulness or Otherwise of the Electrical Methods of Treatment in Skin Diseases. (Chessterfield Lecture.)

FRIDAY, MARCH 30th.

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

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m. Papers:—Mr. A. Barker: Treitz's Hernia complicating Gastro-enterostomy.—Mr. P. Paton: A Case of Right Duodenal Hernia in a Child aged Three Months.—Mr. F. Eve: Enormous Cyst of the Common Bile-duct.—Mr. F. C. Wallis: Three Cases of Gastro-jejunostomy.

Vacancies.

Aberdeen City (Fever) Hospital.—Resident Physician. Salary £100 per annum, with board and rooms. Applications to the Medical Officer of Health, 4½ Union Street, Aberdeen.

Charing Cross Hospital.—Resident Medical Officer. Salary £100 per annum. Applications to the Chairman of the Medical Committee.

London Hospital for Children and Dispensary for Women, Shadwell, E.—Medical Officer for the Casuality Department. Salary £100 per annum. Applications to W. M. Wilcox, Secretary.

Egyptian Government.—Kasr-Elainy Hospital.—Resident Surgical Officer. Salary £250 a year, with quarters, servants, washing, coal and light. Applications to the Director-General, Public Health Department, Cairo.

Humberstone Asylum, Leicester.—Second Assistant Medical Officer. Salary £180 per annum, together with furnished quarters and board. Applications to the Medical Superintendent.

Incorporated Dental Hospital of Ireland.—Two Anaesthetists. Immediate applications to W. A. Shea, J.P., Registrar.

Leeds Public Dispensary.—Junior Resident Medical Officer. Salary £100 per annum, with board and lodging. Applications to the Secretary of the Faculty, Public Dispensary, North Street, Leeds.

London County Asylum, Banstead, Sutton, Surrey.—Junior Assistant Medical Officer. Salary £150 per annum, with board, furnished apartments, and washing. Applications to H. F. Keene, Clerk of the Asylums' Committee, Asylums' Committee Office, 6 Waterloo Place, S.W.

Oldham Infirmary.—Senior House Surgeon. Salary £100 per annum, with board, residence, and washing. Applications to Rev. Philip Lancashire, Hon. Sec., Oldham Infirmary.

Valkenberg Asylum, near Cape Town.—Assistant Medical Officer. Salary £250 per annum, with board, washing, and lodging. Applications to the Agent-General for the Cape of Good Hope, 10 Victoria Street, London.

Appointments.

BERRY, FREDERICK CHAS, M.D., B.Ch.Dub., Medical Officer of Health of Burnham (Somerset).

BULLRID, ARTHUR, L.R.C.P., and **S. Edin., L.F.P.S.Glaag.,** Medical Officer of Health of Midsomer Norton (Somerset).

BURLAND, CHARLES, M.D.Brux., Medical Officer to the Board of Trade at the Port of Glasgow.

CANN, FRANCIS JOHN HUGHSTREDE, M.B.Lond., L.R.C.P.Lond., M.R.C.S., Admiralty Surgeon and Agent at Dawlish (Devon).

CART, ARTHUR JAMES, L.R.C.P., L.R.C.S., L.M.Irel., Medical Officer for the Bleasdon District by the Axbridge Board of Guardians.

DEAKIN, FRANK N., M.R.C.S., L.R.C.P.Lond., Surgeon to In-patients at the Walsall and District Hospital.

GREEN, J. W., L.R.C.S.Irel., L.K.Q.C.P.Irel., Certifying Surgeon under the Factory and Workshop Act for the Athboy District of the county of Meath.

HARNETT, W. G., M.B., B.Ch., B.A.O.Dub., Senior House Surgeon at the Royal South Hants and Southampton Hospital.

HUTT, C. W., M.R.C.S., L.R.C.P.Lond., Junior House Surgeon at the Royal South Hants and Southampton Hospital.

KEALY, JOHN WILLIAM GREGORY, L.R.C.P.Lond., M.R.C.S., L.S.A., D.P.H.Lond., Surgeon and Admiralty Agent at Priddy's Hard, Portsmouth.

LEGGATT, GERRARD S., M.R.C.S., L.R.C.P.Lond., Clinical Assistant at St. John's Hospital for Diseases of the Skin, Leicester Square.

OLDFIELD, CARLTON, M.D., B.S.Lond., Honorary Assistant Surgeon to the Hospital for Women and Children, Leeds.

POPE, HENRY SHARLAND, M.B., B.C.Cantab., Medical Officer of Health of Bridgwater, and also Certifying Surgeon under the Factory and Workshop Act for the Bridgwater District of the county of Somerset.

Births.

BOWER.—On March 19th, at Redlands, Sutton, Surrey, the wife of George Bower, L.R.O.P., D.P.H., &c., of a daughter.

CARMICHAEL.—On March 26th, at 76 Abnons Road, Cantonments, Bangalore, to Donald Gordon Carmichael, Lieutenant R.A.M.C., and Eileen Mona, his wife, a daughter.

CHAMBERS.—On March 21st, at the Priory, Roehampton, the wife of James Chambers, M.D., of a son.

NUNN.—On March 19th, at the White House, Hadley, Barnet, the wife of J. Wilfrid Nunn, M.R.C.S., L.R.C.P., of a son.

PEPPER.—On March 18th, the wife of Charles Edward Pepper, M.B., Ch.B., of Thornton Heath, Surrey, and Salisbury, Wilts, of a son.

Marriages.

ELLIS—WHEELER.—On March 13th, at St. Jude's Church, Belfast, Henry Reginald Ellis, M.B., West African Medical Staff, second son of W. H. Ellis, of Shipley Hall, Yorkshire, to Isabel, second daughter of C. G. Wheeler, of South Parade, Belfast.

GREAVES—RICE.—On March 20th, at the Church of St. John, Derby, Francis L. A. Greaves, F.R.C.S., elder son of Chas. Augustus Greaves, M.B., L.L.B., to Constance May, elder daughter of George Rice, M.D.

HIGNETT—MAOQ.—On March 22nd, at Childwall Parish Church, Lionel Watson Hignett, M.B., M.R.C.S., to Sarah Bayley (Dolly) Mack.

KAY—LAYER.—On March 20th, at St. Martin's Church, Scarborough, Walter Smith Kay, M.D., Medical Superintendent of the South Yorkshire Asylum, Wadley, Sheffield, to Elizabeth Mary Laver, widow of the late Arthur H. Laver, M.D., of Sheffield.

MCCLURE—BUE.—On March 24th, at St. George's, Hanover Square, James Campbell McClure, M.B., 9 Newton Place, Glasgow, to Louise Marie, younger daughter of the late Jules Bud, M.A. Chevalier de la Legion d'Honneur, Taylorian Lecturer at the University of Oxford.

Deaths.

HARTFORD.—On March 26th, Dora, the beloved wife of H. W. Hartford, M.D., of Christchurch, aged 55.

ROBERTS.—Of typhoid fever, after nine days' illness, John Howard Digby Roberts, M.B., C.M.Edin., of Hope House, Taglar, Morocco.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, APRIL 4, 1906.

No. 14.

NOTES AND COMMENTS.

The Central Midwives Board Again.

An unusually lively meeting of this much abused body will be held on Tuesday next for the special purpose of discussing certain questions on which Sir William Sinclair and Mr. Ward Cousins are endeavouring to make the Board register a sensible and business-like opinion. The answer to some of these questions will seem self-evident to our readers, but we fear many members of the Board will not consider them so. Apparently, a discussion will rage for hours round such a question as "Should utterly illiterate women be received as candidates?" Then "How far should any midwife be allowed to use instruments and drugs?" So far as instruments are concerned, it is difficult to see the necessity of this question either. A catheter and an enema syringe are the only "instruments" necessary in cases of natural labour, and to these with the addition of a syphon douche the midwife's instrumental outfit should be confined. The question of drugs perhaps affords a wider field for discussion, though most people will agree that purgatives, perhaps ergot, and alcohol in some form are all that are necessary. The third question to be laid before the Board is a highly important one, "How far should the wrong methods of teaching be allowed to continue without amendment in certain quarters." This is an important and, we fear, a vexed question, but we hope that in it, as in the other two, Sir William Sinclair and his colleague will be able to thrust common-sense into the minds of the remainder of the Board.

An Official Handbook for Midwives.

It appears that there is a desire that the Central Midwives Board should publish an official handbook for midwives. This matter was brought forward by Sir William Sinclair and we regret to have to differ from him upon it. In the first place, what evidence has he for stating that England is greatly behind the times in the matter of handbooks for nurses? We doubt if he will find many to agree with him, even amongst those who differ most widely on other questions. In the next place, who is to write such a book? Is one man to be given the task, and to enjoy a practical monopoly in the sale of handbooks? Are the opinions of one school alone to be represented and those of all others shut out? Even if the Board itself is to receive the profits, under what Act of Parliament is it entitled to become a bookseller and publisher? We believe that such a course would be entirely outside its statutory powers. It is a most invidious thing for a public board to take upon itself the prescribing of special books on which candidates

are to be examined, and for the Central Midwives Board to decide upon a step which would have the effect of killing all existing books on the subject and of preventing competition and improvement, would be a step of which we can hardly believe Sir William would approve. We have no doubt that he has excellent reasons for the suggestion he has thrown out, but they seem to us to be based on false premises.

Babes and Sucklings.

The vagaries of educational bodies are endless. Some of them engage our sympathy, even when they do not always appeal to our judgment. Others, again, demand our unqualified disapproval. Among the latter is the entrusting to small children dangerous drugs by way of chemical investigation. That particular phase of modern schoolcraft resulted in the death of an unfortunate little girl a few weeks ago at Plymouth. She was given a pipette to fill with dilute alkali for the purpose of neutralising an acid solution. By error she drew into her mouth a strong solution of caustic alkali, which she swallowed. She refused the antidotes offered by the teacher, and subsequently died. This sort of transcendental teaching is calculated to bring ridicule upon our education authorities. If the spirit of the kindergarten is to dominate our elementary schools, at least let us keep deadly drugs out of the hands of babes and sucklings.

Hospital "Scandal" at Hastings.

THERE is nothing dearer to the average journalist than a "hospital scandal." An affair of that sort goes deep down into the heart of things, and furnishes a fine field for sensational copy, not to mention strong and lurid headlines. But there is no smoke without fire, and in spite of every sympathy with the magnificent voluntary medical charities of the United Kingdom, it must nevertheless be confessed that, on the whole, newspaper criticism is not only a salutary but also a desirable and necessary discipline. In the case of a recent outcry at Hastings it must be admitted that some of the bearings of the case demand careful consideration at the hands of our profession. The facts, are, briefly, that a man, aged 31, was recently admitted to the East Sussex Hospital one afternoon. A few hours afterwards he was found to be suffering from acute erysipelas, and at half-past eight on the same evening, on a cold night, he was removed to the workhouse infirmary, where he shortly afterwards died. The removal was effected by the directions of the surgeon for the week, and there appears no doubt that it was done on account of the infectious nature of the complaint.

Was there a Scandal?

It may be fairly assumed that death, if not directly due to the removal, may have been accelerated thereby. Without going into that part of the case, of which the medical men in attendance are the only competent judges, we are entitled to ask if such a removal was absolutely necessary, and, if so, on what grounds? Therein lies the "scandal." Now, as we all know, erysipelas is only feebly contagious, and many persons scoff at its being included in the Local Government Board list of notifiable maladies. In the old days it was one of the grim terrors of that devastating scourge, hospitalism. Nowadays, erysipelas has been robbed of its sting. The streptococcus of erysipelas is no more dangerous in the wards of a well-ordered hospital than the staphylococcus or bacillus coli or any other pyogenic organisms. Listerism has seen to that. By all means exclude an erysipelatous patient, but there is no overwhelming need, so far as we can see, to turn out a patient who is found to be suffering from the malady.

Where was the Isolation Ward?

Has the East Sussex Hospital no isolation ward where this unlucky patient could have been placed instead of turning him out in a dying condition upon a freezing night? We are inclined to think there is some sort of a scandal here. Not much argument is needed to support the contention that every hospital admitting in-patients should be provided with an isolation ward. Infection is round us everywhere; no man knows when it may come upon him. If the East Surrey Hospital be so doubtful of its methods that it fears the spread of erysipelas to its surgical cases, then the need of an isolation ward is more than self-apparent. It is to be hoped that the good folk of Hastings will not miss the moral of this unhappy incident, and will insist that their otherwise excellent hospital be at once provided with ample isolation accommodation. If funds are available the simplest plan would be to secure a house for the purpose in the immediate vicinity.

LEADING ARTICLE.**THE TREATMENT OF CRIME.**

READERS of the daily press may have noticed that a new movement is taking place with regard to the treatment of certain criminals; indeed, in some quarters a note of alarm has already been struck at the innovation. Within the last few weeks two women undergoing penal servitude for murder have been released and committed, under certain conditions, to the care of the Salvation Army. It is understood that in these cases the Home Office took the initiative and asked the Salvation Army authorities if they were prepared to make the charge of these wretched women their special care, so that it may reasonably be assumed that at last a spirit of enlightenment and humanity has penetrated the rusted bars of our prison-cells, and that in the future one may look for a development of a policy which promises to place this country in the front rank of nations for the scientific treatment of depraved humanity. Moreover, as these conditional releases coincide with the advent of Mr. Herbert Gladstone at the

Home Office, it may be taken for granted that it is his lead in this matter which has brought these results about, and we venture heartily to congratulate him on his courage in starting so early in his administration an experiment which is likely to be fraught with momentous consequences. So far we have spoken only of the change in prison policy, for it is this change from the stupid or vindictive to the reasoned and humane which is the striking feature, but we must not overlook the method by which the practice is being accomplished. These prisoners, the first-fruits presumably of a numerous detachment, are being placed under the care and authority of the Salvation Army, a body primarily religious and secondarily philanthropic, privately managed and autocratically controlled. With every desire to speak fairly of the great social work that the Salvation Army has performed, work which has gained it wide respect in spite of its "corybantic Christianity," we hope that the merits and demerits of committing State prisoners to their charge will be carefully weighed and watched. Medical opinion with regard to the treatment of criminals is far in advance of that entertained by lawyers or other classes of men; first, because the medical man has constant opportunities of watching the inmost workings of the mind of men in all ranks of life, and secondly because he knows that persons who commit anti-social acts do so from motives and impulses as varied as their mental constitutions. It cannot fairly be said that medical opinion is totally opposed to severity; it is only opposed to stupidly-conceived and maladroitly-applied severity; severity, in fact, which by over-reaching itself neither deters the victim from repeating his fault nor presents to him better motives upon which to act in the future. Severity is the last resource, the power behind the Throne, and should be reserved for the malicious and dangerous characters, who are at the same time mentally sound and morally incorrigible. But this class will be found to shrink in dimensions as scientific methods of punishment, which are practical methods of reclamation, are pursued. The mode in fact to be pursued is that of making the punishment fit not the crime, but the criminal, and we maintain that as the criminal is a mental patient the proper person to carry out his regimen is not the super-annuated major who wants supplement to his retired pay, but the experienced doctor, who has studied the functions of the mind and body. Now, in so far as the Home Office policy marks a departure from old-time methods it is sincerely to be welcomed, especially as it gives evidence of the confidence engendered in moral management, such as has been exploited for the last few years at Borstal, where juvenile and adult prisoners have been trained into useful citizens instead of being buffeted into confirmed criminals. But it is a question of high policy whether the State is justified in ridding itself in any degree of the responsibility for the managing its own prisoners. Persons when condemned to gaol are the charges

of the State, and it is the duty of its officers to devise a system by which they may be returned to society purged of their vicious tendencies, or else maintained in a humane isolation where they may be as little noxious as may be to themselves and each other. It may well happen that voluntary agencies of trustworthy character form the best link between prison and honest employment, but the prison-system itself should be so designed that their aid is only invoked when the probationary period is past. There are many indications—among others these very acts of the Home Secretary—that steady and even revolutionary changes are taking place within prison-walls, changes dictated by an appreciation of the relative values of the mental and moral elements in crime, and making for the regeneration instead of the degeneration of the prisoner. It is to the expansion of these changes that we look for safety and reform rather than to the extension of responsibility from the prison to the voluntary agency, and we hope, not without good grounds, that we may eventually see first a plan of classification constructed according to the principles of morbid psychology, and secondly an educational ladder provided whereby the reclaimable may mount, from the time of commitment to the time of discharge, till they emerge on a moral par with their fellows. Not the least difficulty that prison authorities have to contend with is the attitude of the judges, who in the main are out of touch with modern criminology, but there are some at least who are amenable to medico-legal teachings, and these may in time leaven the whole bunch.

NOTES ON CURRENT TOPICS.

Sale of Poisons.

THE regulation of the sale of poisons is a matter of such importance that no good citizen should endeavour, from motives of self-interest or profit, to put any obstacle in the way of a stringent safeguarding of the general public. For some time past the chemists have been agitating to have the provisions of the Pharmacy Act of 1868 put into operation against agricultural agents, nurserymen and others who sell such poisonous preparations as insecticides, sheep dips, and weed killers, and last week Lord Crewe introduced a Bill into the House of Lords a clause of which provides that the local authorities may license such persons as they think fit to trade in these poisons. This is a distinctly retrograde step, though it is being hailed with joy in many agricultural circles. It is claimed as a great convenience that such goods can be obtained from various agencies instead of only from registered chemists, and the manufacturers of these articles maintain that their trade can be better pushed by means of florists, nurserymen and similar dealers than by pure pharmacists. Such no doubt is the case, but it is this very facility for obtaining poisons that lends itself to abuse, and we would earnestly appeal to right-minded people

to consider whether a little personal sacrifice which makes crime and suicide more difficult of accomplishment is not well worth the making. After all, if the profit on sheep dips and insecticides goes to the chemists, they are the people who, from their training and responsibilities, are morally entitled to it.

Vaccination of Teachers.

FROM a statement made by Mr. Birrell in the House of Commons last week it is not unfair to hazard a guess that an important change in vaccination policy is likely to occur. The Minister for Education was asked by Mr. MacDonald, the Labour member for Leicester, whether he had received an application from the Leicester Education Committee asking that teachers might be excused from being vaccinated against their will, and whether the conscientious-objector clause could not be extended to such teachers. In his reply, Mr. Birrell said that vaccination had always been made a condition of a teacher's appointment under the Education Board, but that in certain districts this provision made it difficult to obtain an adequate supply of candidates. Moreover, he proposed to consider whether it might not be possible to throw the onus of insisting on a relaxing of the vaccination provisions on the local authorities, but that he was not prepared to make a definite statement yet. His decision will be awaited with interest by the medical profession, for it will mark an epoch in the history of vaccination. It has always been held by Parliament that insistence on vaccination was a matter of high policy that could not be delegated to local authorities to decide, because the question of immunity concerned the country as a whole. The vaccination officer is directly under the Local Government Board as regards the enforcement of the Acts, and the Board have insisted in his prosecuting defaulters, even in defiance of local opinion. If Mr. Birrell decides to remit the vaccination of teachers to the local authority it will be impossible for other Government departments logically to insist on keeping vaccination in their own hands, and if this become so the Acts will not be worth the trouble their administration will cause.

Vivisection Inquiry.

THE Home Secretary has announced that he proposes at an early date to institute an inquiry into the Experiments on Animals Act and the regulations under it, but that he has not yet decided on what form the inquiry shall take. No scientific or medical man will be prepared to take exception to such a step. It is now over thirty years since the Act was passed and public opinion has been a good deal agitated ever since, mostly through the instrumentality of foolish and unscrupulous people. As scientific investigators have always claimed that there is no abuse of the powers granted them, and as no single case of cruelty has ever been proved, in spite of the shower of reckless statements made by the anti-vivisectionists, experimenters have nothing to lose

and everything to gain by an open and fairly constituted inquiry. Needless to say, Mr. Stephen Coleridge is to the fore at this juncture, and he writes to the *Daily News* of March 28th, saying that he and his supporters object to vivisection—"the infliction of torment upon animals," as he calls it—on moral grounds, quite irrespective of the effect of experiments on the ascertainment of scientific truths. Anti-vivisectionists generally find any stick good enough to beat their favourite dog with, and for a long time they have tried to convince scientific men that they know more about their business than these do themselves. In face of constantly-accumulating evidence that much sound and useful knowledge is derived from experimentation, they have apparently dropped that claim, and Mr. Coleridge now wants an inquiry directed "to the moral rather than the scientific aspect of vivisection." The idea of a Royal Commission inquiring into morality is a novel one; that question is usually left to the individual conscience; but, if appointed, we trust the report will have an educational value in helping people to arrive at a just conclusion.

Face Massage for Men.

VAIN and silly women have not hesitated to open their purses to the gang of face specialists and beauty-restorers who delude them with hopes of removing wrinkles and rejuvenating complexions that are seared by the hand of Time. A similar trap, we understand, is now being laid for the peacocks of fashion who combine the form of men with the attributes of the least desirable women. A further bait is offered by the announcement that face massage brings alertness and brightness to the mind, and that the mental faculties are increased in acuity by the practice. What is certainly true is that the class of person who believes such twaddle needs a good deal more mental alertness than he is likely to get from face massage or any other process that we are acquainted with, and that the "mug-catchers" who batten on such deception should receive their deserts. If we had not actually read the facts on which our comments are grounded in a leading daily contemporary, we should have thought we were being hoaxed by some clumsy practical joke.

The "Register," for 1906.

THE appearance of this official volume serves as a reminder of the lapse of another year. On opening its pages we are at once faced with the "important notice" that every registered medical practitioner should notify to the Branch Registrar by whom he was originally registered any change in address or in qualification. The neglect of this simple precaution is shown by the many addresses missing in the medical directories—as apart from the *Medical Register*, from which names of defaulters are expunged. The total number of medical men in register on December 31st, 1905, was 39,060, which shows an increase upon the average for the past five years—namely, 37,915. The radical defect in the British system of medical

registration, in our opinion, lies in the fact that registration is not compulsory. There is the usual mass of interesting and valuable information in the preface, such as a summary of the Medical and other Acts relating to the Medical profession. The volume is cheap, accurate, and comprehensive, that is to say, so far as its constitution permits it to comprehend.

The British Medical Association and its Charter.

FOR some time past the British Medical Association has had in contemplation the advisability of petitioning the Crown for a charter. What the precise advantages to be gained by the possession of a Charter may be we are not prepared to say, and apparently the members of the Association were also very much in the dark, since with a recent number of the *Journal* it was necessary to distribute a Supplement of some five-and-thirty pages dealing with the matter. But knowledge on the various points *pro* and *contra* seems to have been regarded as a minor consideration, since the representative Meeting at Leicester had already given the Central Council power to apply to the Privy Council for a Royal Charter. At the same time, however, the Council was directed to furnish the Divisions with an estimate of the probable expense. It appears that, up to the present, inquiries and preliminary investigations have cost £390, and it is forecasted that the cost of completing the application, if no opposition be offered, will be about £630. In cases of serious opposition it is impossible to estimate probable expenses. We understand that the principal advantage expected from the possession of a charter is freedom from the restrictions of company law. It is to be remembered, however, that these restrictions are for the most part imposed for the protection of the individual members or of a minority of the company or association, and it is a serious matter for the members to decide whether the problematical advantages of a charter counterbalance a possible usurpation of powers by a dominant majority.

The "Dr." Muschik Prosecution.

IN our issue of March 21st we commented on the successful prosecution of an electrical quack, who carried on an extensive practice in London, near the Marble Arch, and at other addresses. That notice spoke of the Medical Defence Union, by whom the action was instituted, as deserving the undying gratitude of the medical profession. In further comment, however, we regret to say that a ridiculous blunder was committed. The name of the quack Muschik was confused with that of the nominal prosecutor, Mr. Thomas William Tyrrell, clerk to Mr. W. E. Hempton, of King Street, Cheapside, E.C., the well-known solicitor to the Medical Defence Union. The latter gentleman has now secured many convictions against unqualified medical pretenders in the Metropolis. In nearly every one of them Mr.

T. W. Tyrrell has figured as what may be termed the stock patient! He deserves the gratitude of our profession, therefore, for the solid services he has rendered towards the consolidating and upholding of legitimate medical practice. Fortunately his name has become so closely associated with Defence Union proceedings that the confusion of his identity would in all probability be instantly detected by the majority of our readers. On inquiry, we find that the error was due to the serious illness of a valued and usually accurate contributor.

Greek at Cambridge.

WE are very glad to see that the friends of scientific education at Cambridge are returning to the charge after their recent defeat on the question of compulsory Greek. The University have now admitted the principle that a man may be eligible for Academic honours without possessing a knowledge of Greek by excusing certain Oriental students from presenting that language in the "Little go," on condition they take Sanscrit or Arabic in its place. The scientific men naturally ask why, if this class of students is excused the old-fashioned restriction, their own pupils should not be similarly treated. The present proposal of the Syndicate is that the B.A. degree should be given under two designations, "Bachelor of Arts in Letters," and "Bachelor of Arts in Science," and that whereas Greek should remain compulsory for the former, it should not be for the latter. We think it would be simpler to propose that two separate degrees, B.A. and B.Sc., should be given, and while candidates for the former should be compelled to take Greek in their previous examination those for the latter should present a modern equivalent if they desire. Anything which would break down the antiquated practice of the University in this respect would be greatly welcomed, for, with its busy, pushing, scientific school, Cambridge should be able to attract the best intellects in the country, were the present silly restriction removed. We have more hope of Cambridge giving way than Oxford, where mediæval dons still demonstrate their accomplishments in the humanities by strictly keeping out of touch with the realities of the outside world.

OUR WEEKLY PILLORY.

UNDER the heading of "Our Weekly Pillory" we propose in each issue to notice objectionable quick advertisements appearing in lay newspapers. To-day we take *Reynolds' Newspaper*, Sunday, April 1st, 1906. We find on page 9 a "cure for blindness" described as a new and marvellous discovery, and the guaranteed greatest remedy on earth. The address given is Leggett, Wisbeach. It seems hardly necessary to inform the Editor of *Reynolds'* that an advertisement of this kind represents the highest pitch of audacious and heartless quackery. As a barrister and an educated man of the world, the gentleman in question must be aware that the overwhelming majority of cases

of blindness are hopelessly incurable, and that of the remainder a small proportion may be saved by skilled surgical operation, and by that alone. Hence in taking money for the advertisement quoted he is assisting in the publication of a gross fraud upon the public. There are many other objectionable advertisements in the same issue of his journal. The only one we shall now mention is a wonderful remedy "to cure drunkards with or without their knowledge," advertised by the Ward Chemical Company, Regent Street, London. No such remedy is known to medical science, nor is such a remedy conceivable. Here again the Editor is assisting in another sham. As his paper advocates high and advanced ideals in social matters, it will be well if he sets his own house in order with regard to frauds perpetuated at the cost of the welfare of the poor, the weak-minded, the ignorant, and the suffering of our community.

PERSONAL.

WE are glad to note that Dr. Robt. A. Slessor, of Fraserburgh, has won the case brought against him by a chemist of the same town for alleged slander, and has been awarded costs in the action.

At a special meeting of the management of the Cardiff Infirmary, Dr. Paterson was appointed honorary surgeon to the ear, throat and nose department, and Miss Erie Evans, M.B., was elected to the post of honorary assistant physician.

FIELD-MARSHALL LORD ROBERTS presided yesterday at the festival dinner of the Ventnor Royal National Hospital for Consumption, held at the Hotel Métropole, London.

THE British Government is to be represented at the forthcoming Lisbon International Medical Congress by Colonel A. T. Sloggett, R.A.M.C.

MR. O'BRIEN FURLONG presided over the recent meeting of the supporters of the Royal National Hospital for Consumption for Ireland, among whom were His Excellency the Lord Lieutenant of Ireland and the Countess of Aberdeen.

PROFESSOR ANNANDALE was last week entertained at the first annual dinner of the Sheffield Edinburgh University Club, under the presidency of Dr. J. H. Keeling, the doyen of the Medical Profession in Sheffield.

A SCOTTISH Association of Medical Women has been formed under the presidency of Miss Emily Thomson. The Honorary Secretary is Mrs. Chalmers Watson.

A FUND is being collected to erect a monument to the late Professor Nothnagel, of Vienna, and to found a lectureship bearing his name.

WE regret to have to announce the death, at the Westminster Hospital, on April 1st, from septic poisoning, the result of a *post-mortem* wound, of Mr. R. Newman, a distinguished student and the editor of the *Broadway*.

A CLINICAL LECTURE

ON

CANCER OF THE UTERUS.

Delivered at the Royal Southern Hospital, Liverpool.

By WILLIAM ALEXANDER, M.D., F.R.C.S.I.,

Surgeon to the Hospital, and Lecturer on Clinical Surgery, University of Liverpool.

GENTLEMEN,—According to the returns of the Registrar-General, cancer of the uterus accounted for 3,869 deaths in the year 1902. Like cancer elsewhere, it is a fatal disease that kills its victims within one to two years of its onset, and attacks both married and single women from the age of 45 years and onwards. It occasionally occurs early in life. I have met with a case of carcinoma uteri in a patient, *æt.* 26, and there are other cases on record of early recurrence. These are interesting from their rarity, but are only exceptions that prove the rule that carcinoma is a disease of mature age. This is a point I wish you to remember, as we are building an important superstructure upon it which will be submitted for your consideration before the end of this lecture.

If we look at the uteri removed at my operations, or at their photographs, which I now show you, it will be seen that 28 are examples of epithelioma of cervix, and 13 of the body of the uterus. In all these 28 an irregular mass of newly-formed tissue grew from the cervix, variable in extent, sometimes sufficient to fill up the vagina, at others more moderate in size. The growths were soft, friable, bled readily when touched, and were generally accompanied by a profuse vaginal discharge that was often foul, sanguineous, and distressing to the patient. The uterus was movable in all the cases under consideration, and no pelvic glands could be felt, but I need not tell you that they were all early cases, and that the majority of cases you will meet with in practice will be quite different, except you are on the *qui vive* for early cases. For instance, during the six years ending December 31st, 1901, 98 cases of cancer uteri were admitted into the surgical wards of the Liverpool Workhouse Hospital with the uterus more or less fixed, and sometimes to the examining finger quite immovable, and with the pelvis filled with a hard, malignant mass. In other cases, deep ulcerating cavities existed with openings into neighbouring viscera, and where exhausting discharges and hæmorrhages soon destroyed the patients. It is rare to find an operable case admitted into the Workhouse Hospital, as pauper patients have great endurance, and think all ailments trivial until death stares them in the face. In some of these 41 operable cases, the vaginal wall was encroached upon, but never to any great extent. The diagnosis of such cases of epithelial cancer of the cervix is easy, and the attention of the patient is always called early to its presence. If a surgeon were immediately consulted when a patient first knows that she has something wrong with her uterus, not much time would be lost before the question of operation could be considered, but many patients put off such a course as long as possible, partly through feelings of delicacy, and partly in the mistaken belief that the symptoms indicate the condition popularly known as "the change of life," or "the whites." When the discharge is coloured, they incline to the "change of life" theory, when pale to the theory of "whites." Their confidants share with them the belief in such a diagnosis, and by so doing comfort the sufferer greatly, especially those who in their heart of hearts have a suspicion that they may be suffering from cancer, and who refuse examination lest the secret dread might be converted into a declared reality. I have been consulted by ladies suffering from internal polypi or simple erosions, who for a long time resisted all the efforts of relatives to induce them to see a surgeon. When at last they consented, and after examination they were told that

the disease was simple and not malignant, the mental relief was so great that they became almost intoxicated with joy. Such cases showed by the extent of the recoil the tremendous strain they must have endured in secret for a long time. It is only by education that such obstacles as are placed in our way by the patient can be overcome. As soon as she permits an examination, the epitheliomatous growths of the cervix are immediately recognised by their feel, their tendency to bleed, and their appearance, and if necessary a piece can be easily obtained for microscopical examination.

Early access to the disease is the *desideratum* in these cases, and the doctor called in to a patient complaining of uterine discharge should always advise a thorough examination, and should not depend on giving in a casual manner ergot internally and perchloride of mercury or other douches, as is too often the practice. Both the ergot and the douche relieve the symptoms for a time, but they only temporise with the disease until the period of local development, during which we can perform operations, has passed by, and the disease has gone beyond the limited area that we can deal with by operation. The other varieties of cancer of the body of the uterus, such as malignant adenoma, scirrhous and alveolar carcinoma, specimens and sections of which are on the table, are much more stealthy in their onset, and more difficult to diagnose. Fortunately, they do not spread to the lymphatics so rapidly as do the cervical cancers, so that we have more time to make up our minds. The uterus enlarges, the cervix may have become hard and stony in character. Hæmorrhages and unpleasant discharges may appear, and are early characteristics. The patient early exhibits signs of failing health, such as pallor and general feebleness, too indefinite to be noticed except by the eye of anxious friends or of an experienced family medical attendant of long standing. Curettings do not assist much in clearing up suspicions, indeed they often lead us astray by their negative evidence. There are no more difficult cases upon which we have to decide than these obscure cases of cancer of the body of the uterus. Failing health, hæmorrhages and discharges are the most common symptoms. The decision must, if possible, be made soon. The old plan of waiting for some decisive evidence to turn up should be abandoned, as probably by the time the case clears itself up an operation will be out of the question. All the evidence has to be carefully weighed, and microscopic evidence obtained if possible. If this is positive it is most satisfactory, but if negative is not of much value as compared with clinical evidence upon which most surgeons place the greater confidence. After operation the microscope is of great value, and to its bar the uteri removed on clinical evidence alone have to be brought for final decision. In many of my cases, the operation was performed on clinical evidence alone, but the post-operation classification was made only on microscopic evidence. Except in two cases of hæmorrhagic adenomatous growth, which we do not think now were microscopically malignant, in all the other cases the microscope supported the clinical diagnosis of malignancy. This photograph shows a case where the disease affected the mucous membrane only, and where the microscope showed a malignant adenoma, but Dr. Dimond, our pathologist, will show you the sections, and you will be able to study for yourselves the histological features of these morbid growths.

The questions I wish to bring before you to-day are practical questions. You all know that one character of malignancy in a cancerous growth is the tendency to recurrence after removal. Cancer of the uterus is no exception in this respect. Indeed, what with the difficulty of gaining early access to the disease through the reticence of the patient, in some cases to the difficulty of diagnosis, the results of hysterectomy, that is, the removal of the disease and with it the entire uterus, are still far from being as good and permanent as we may in the future expect. The operations performed at the present day are either vaginal hysterectomy or abdominal hysterectomy, and about these I will have a word to say afterwards. We will first of all refer to the results of operation.

In the *Journal of the British Gynecological Society* for May, 1905, Dr. Jacobs, of Brussels, an expert operator, gave the results of his operations for cancer of the uterus. In 80 cases of vaginal hysterectomy which he examined, 10 cases were lost sight of. In the remaining 70, 49 recurred within a year, 9 within 2 years, 11 within 3 years, and 1 within 4 years. Not one of the patients was alive four years after the operation. After such results he abandoned vaginal hysterectomy and adopted abdominal hysterectomy, in which operation after removing the uterus he cut out as much as possible "of the infected pelvic lymphatic territory." The results were that out of 89 cases of these extensive operations at the time he read his paper, 87 had died, 2 only were still alive and supposed to be cured. During the first year there were 40 recurrences, second year 20 recurrences, third year 4, fourth year 2, fifth year 2, sixth year 1. If Professor Jacobs' results are usual, the operation of vaginal hysterectomy should be abandoned, as they are not such as to justify the performance of a serious operation when we know that in a year or two recurrence will take place, and that all the misery will have again to be endured without hope of any relief. The abdominal operation, with its larger operative mortality, and only two women alive and supposed to be cured out of 89, does not encourage us, although, urged on by such miserable results as vaginal hysterectomy gives, many surgeons are now trying the abdominal operation. We can never desist from attempting relief, *in some way*, as it is only by perseverance we can hope finally to overcome the disease. Dr. Jessett at the same meeting gave the results in 170 cases who survived operation—35 had recurrence and died within the year, 23 cases died at intervals of 2 to 4 years, 8 are alive at periods varying from 5 to 13 years. Three cases were known to have died from other diseases, and had no recurrence, whilst 20 were lost sight of.

When I saw Dr. Jacobs' paper in print, I began to inquire about my past operations to ascertain if I was equally unfortunate in my permanent successes. The number of my cases of vaginal hysterectomy is small compared with that of pure specialists. I have only been able to unearth 41 consecutive cases who survived operation during the past ten years. Three died from the operations, or soon after, making about 7½ per cent. mortality, but the deaths mostly occurred among my earlier cases, some of which were too advanced for safety. Of the 41 cases, 16 up to the present cannot be found, although I am still hopeful of being able to complete the after history of many of these by further inquiries. Of those whose history can be followed, 16 are alive and well when seen—4 after a year, 5 after 2 years, 2 after 3 years, and 3 after 5 years, and 1 after 10 years. Another case I operated on six months ago is well so far. Of the 9 who died, 1 case died six months after operation, 4 died 18 months after operation, 2 died two years after operation, 1 died four years after, and 1 died five years after. Of course, time will sift these cases still further, but at present I think I am justified in continuing vaginal hysterectomy in suitable cases. I am very pleased at this, because vaginal hysterectomy is an operation that with practice becomes easy of performance, is safe for the patients, and leaves no external scar or

tendency to hernia. Earlier operation, not more extensive ones, should be our motto.

I now wish to call your attention to the method of operation that I carry out under the term vaginal hysterectomy, for there are several methods of performing the operation. No two surgeons operate exactly alike, and the method may influence the ultimate results. First, I cleanse the cervix as far as practicable, clearing away soft foul tissue, and making the vagina and vaginal cervix as clean as possible. A duck-bill speculum is now placed in the vagina and the uterus is brought down into the field by a vulsellum that grasps the cervix. The mucous membrane is now incised quite round the cervix and well clear of the disease, next the mucous membrane and bladder are separated from the anterior wall of the uterus, the friction of a piece of gauze being most effectual in completing the separation. When the peritoneum is in sight, and the bladder quite freed, not only in the middle line but at the sides, the most delicate part of the operation is over, as the bladder and ureters are the structures to be carefully respected. I now turn my attention to Douglas's pouch, which is easily opened right across by a few snips with scissors. A long piece of sterilised gauze is pushed into the pelvis to keep it free from infection. With a finger in the pelvis, through the opening, and an assistant keeping the bladder, ureters, &c., well out of the way outside, the lower part of the broad ligament of the left side is made prominent, by the finger behind, and a clamp is placed on it well outside any diseased tissue for about two inches. The right side is treated in the same way. Then by cutting the tissues on the distal sides of the two clamps, the cervix is released from its fixed condition below. The uterus is now freely movable, and can be easily pulled down and the peritoneum opened, until the fundus appears outside and the appendages can be reached and dealt with. You will have seen that I always use clamps. Clamps can be applied much more rapidly, and what is of more importance, much more widely than ligatures. The hæmostasis is more certain and the disease can be more widely removed. The piece of gauze in the pelvis is now withdrawn, the opening is packed with sterilised gauze, the speculum removed and the patient put to bed. The urine is drawn off every eight hours. The clamps alone are removed in 48 hours, and on the third day the vaginal packs are removed. Some sloughing of the clamped margins occurs, and we may regret the clean convalescence after the use of ligatures. But the greater freedom of removal easily counterbalances the æsthetic advantages, and I think my results justify the method of operation. I have not performed abdominal hysterectomy for cancer with removal of affected lymphatics. When I have reason to think that better results can be obtained in that way, I will adopt it.

You will have noticed, gentlemen, that before and after operation I administer to my patients dilute hydrochloric acid in as large doses as they can take without inconvenience. The grounds upon which I administer this drug are these:—First, as Professor Moore, Professor of Bio-Chemistry, has shown—largely by examination of test meals taken from the stomach of my cancer patients, by Dr. Kelly, one of the Alexandra Fellows at the Liverpool University—*there is a diminution, often an absence, of free hydrochloric acid in the stomach of cancer patients, no matter in what part of the body the cancer is situated.* I asked you to remember early in the lecture that cancer is a disease of mature age, when we know that many changes in the different systems of the body occur, and perhaps among these changes we may suppose a tendency to alkalinity in the tissues, either more so in some individuals, or to some extent in all people as they grow old, but the conditions have not yet been worked out among healthy people. Owing to this change in chemical reaction of the tissues, a rapid proliferation of epithelium, that was hitherto kept within bounds by a more acid state of the medium in which the epithelial cells lie, now takes place, and is promoted by the change from acid to alkaline surroundings, as Professor Moore

has shown from his experiments on the eggs of the sea urchin. Therefore if we can render the tissues of a cancer patient more acid, we can retard the growth of cancer; although we cannot hope to remove the elements of the cancer masses that have already been formed. By the administration of dilute hydrochloric acid in maximum doses cancerous tumours seem to us to become more movable, and more capable of removal by the knife, and when once the mass of disease has been removed we may hope by persevering with acid treatment, that weak colonies of cancer cells that hitherto, after escaping the knife grew strong and became prominent recurrent tumours in one to four years after operation, may instead wither away and hence recurrence may become a more and more rare result of operation for cancer. I hope to bring before you the clinical evidence favourable to this view in an early lecture, but whether there is anything in the idea or not, the drug is cheap and wholesome, and until we have proved or disproved the theory we may as well give every cancer patient the benefit of the doubt.

NOTE.—A clinical Lecture by a well-known teacher appears in each number of the journal. The lecture in next week's will be by William S. Haughton, M.D., B.Ch., visiting Surgeon to Steeven's Hospital, Dublin, "On Fractures of the Shaft of the Femur."

ORIGINAL PAPERS.

CHRONIC DIARRHŒA.*

By ROBERT HUTCHISON, M.D., F.R.C.P.,

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

MR. PRESIDENT AND GENTLEMEN,—I admit that the subject of chronic diarrhœa is not at first sight an attractive one. It fulfils, however, the conditions which are likely to lead to a good discussion, for it is a common condition, and one of which we have all had experience. Further, I hope to show that it is not so devoid of scientific interest as might be supposed. It is a disorder, too, which lends itself very well to treatment and for which patients urgently seek our aid, realising as they do, with an eminent physician and philosopher, that "people who have relaxed bowels have seldom strong thoughts, or strong bodies."

Now the first thing for us all to realise thoroughly about our subject is, that frequent action of the bowels, like frequency in micturition, is not a disease in itself but a symptom of some disorder in the alimentary tract, which disorder it is our business to detect and to remedy, if we can. I should, perhaps, apologise for putting this very obvious consideration before you, but I cannot help thinking that such a caution is needed, for in the rush and hurry of daily practice we are all apt to be tempted to regard chronic diarrhœa, when occurring in an otherwise apparently healthy person, as simply a disease in itself and to treat it by one or other of the recognised "astringent" drugs. That such practice is sometimes successful I do not deny, but that it is often bound to fail is equally indubitable, for in the long run the only satisfactory way of removing a symptom is to strike at its cause, and chronic diarrhœa is a symptom which may result from many different causes, each requiring appropriate remedies. I purpose, therefore, in this paper to consider one by one the different morbid conditions in the

alimentary canal which are capable of causing chronic diarrhœa and to point out how they may be dealt with.

OBSTRUCTIVE DIARRHŒA.

In the first place it may be well to remind ourselves that chronic diarrhœa is sometimes the result not of a too free action of the bowels but of their obstruction. This is impressed upon all of us, I think, from our earliest student days, but still it is apt to be forgotten. I was asked not long ago, for instance, to give advice regarding the dieting of a woman who had suffered from diarrhœa for some months. On inspection, the abdomen was found to be rather distended, and on examination by the rectum a large malignant growth was felt not very high up. One does not like to make such a mistake as that. It is well to remember, too, that malignant disease of the rectum or sigmoid may cause chronic diarrhœa even in the absence of any actual obstruction. The following are illustrative cases :—

A woman, æt. 51, came under my care at the London Hospital in September, 1904, complaining of diarrhœa of one year's duration. Her attack—and this is the misleading point in the history—had started with acute purging and vomiting after eating some fish, and the alvine discharges had continued since. She had seven to eight motions daily which were sometimes fermenting, sometimes contained slime and blood. She had lost upwards of one stone in weight. On examination she proved to be moderately wasted and an apparent thickening of the transverse and descending colon could be made out. Nothing was felt by a finger in the rectum. I believed her to be the subject of ulcerative colitis, an opinion in which one of my surgical colleagues who saw her with me agreed, but at the exploratory operation which was undertaken a large malignant growth was found in the upper part of the rectum.

A lady æt. 51, had suffered from diarrhœa for two years, but without any marked loss of flesh or strength. The number of actions fluctuated greatly from day to day, but were often as many as eight. They were mostly passed in the night and were often attended by pain, and had sometimes contained dark blood and visible mucus, but more often were abundant and light coloured. Examination showed no sign of cachexia, and abdominal palpation revealed nothing. A finger in the rectum could just reach the edge of an ulcer, which did not seem indurated, and from which there was no malignant fœtor. Subsequent examination under an anæsthetic with the sigmoidoscope, however, showed that the ulcer was undoubtedly malignant.

Cases such as these might deceive the very elect, but in order to avoid being led into error by them one should remember the old admonition: Put your finger in the rectum and you will never put your foot in it. Better still in these later days use the sigmoidoscope. By its aid the nature of the second of the above cases was made clear, and doubtless it would have done the same for the first also had it been employed.

ULCERATIVE COLITIS.

Another condition of the large bowel which may give rise to chronic diarrhœa is ulcerative colitis. Sometimes this is the result of chronic dysentery, as in the following case :—

Wm. M., æt. 30, a sailor, had suffered from diarrhœa with blood and slime in the motions for seven months. He had been abroad a good deal, and ten months previously had an attack of dysentery. The motions were unformed, most of them containing visible mucus, and some of them blood. He was rather thin and sallow, but the abdominal examination was negative. Per rectum the mucous membrane felt roughened and ulcerated. A cæcal fistula was established, and the

* A Paper read before the Kensington Division of the British Medical Association, March 27th, 1906.

colon irrigated daily with a solution of nitrate of silver (18 per cent.). Under this treatment the condition of the stools improved greatly, but he finally developed symptoms of abscess of the liver, from which he died three months after he first came under observation. At the autopsy the colon contained a few unhealed dysenteric ulcers and the scars of a great many others, which had apparently healed under treatment.

Sometimes the ulceration is not of dysenteric origin, as in the following case:—

Chas. P., æt. 44, a farm labourer, was sent to hospital in January, 1904, for "proctitis." Four years before he began to suffer from a discharge of blood-stained mucus from the rectum. He was at that time troubled with constipation. Lately, however, he has had morning diarrhoea, four or five motions coming in rapid succession. He was a well-nourished, healthy-looking man. On abdominal palpation nothing could be made out except some thickening of the sigmoid. Examination with the sigmoidoscope showed extensive superficial ulceration of the mucous membrane as far as it could be inspected. The stools were putty-like and contained visible mucus and some blood. On January 24th, Mr. Furnivall found a cæcal fistula and inserted a tube. This tube he wore till the month of October, and through it the bowel was daily irrigated with nitrate of silver solution. As the motions by that time were practically normal, the tube was removed and treatment discontinued. The bowels at the present time are natural and regular, and he is in better health than he has enjoyed for years.

A word about the treatment of these cases. If the ulceration be of dysenteric origin, treatment with ipecacuanha in the usual way should be sufficient to effect a cure. This was not tried in the first case described, but there is no doubt that it should have been. In the non-dysenteric cases high irrigation of the colon with a solution of argyrol or protargol (1 per cent. of either) should be tried first. If this fails it is advisable to perform cæcostomy or appendicostomy, and wash out the bowel with the solution from above, as this is the only way by which one can be sure of reaching the whole of the mucous membrane. The second case narrated is a good example of the successful employment of this method.

CHRONIC CATARRHAL COLITIS.

Sometimes after an attack of acute colitis the diarrhoea does not disappear, but passes into a chronic form with the passage of mucus and sometimes of blood. Such cases are commonest in children in whom the acute disease is also most frequently seen. The following is a typical example:—

Ernest W., æt. 6, had an attack of acute diarrhoea and vomiting in the hot weather of the summer of 1904. The motions were very frequent, and attended by straining and the passage of mucus and blood. The vomiting subsided, but the diarrhoea became chronic and resisted treatment by drugs. The colon was irrigated with a solution of peroxide of hydrogen, but without success. A half per cent. solution of nitrate of silver was then employed instead, with the result that the diarrhoea immediately ceased, and a fortnight later he was discharged quite well.

Cases such as this are naturally more easily dealt with than those which have gone on to ulceration. Many of them will subside under treatment with bismuth and opium, but where the symptoms persist the use of astringent irrigations is strongly to be recommended. The above is a good example of their beneficial effect. Surgical interference should rarely, if ever, be called for.

CHRONIC ENTERITIS.

Passing from affections of the large bowel one may go on to speak of chronic diarrhoea which is

due to catarrh of the small intestine. Such cases are less easy to diagnose than those in which the diarrhoea is due to some affection of the colon, but a careful inspection of the stools should help to reveal the nature of the disease with which one has to deal. The dejecta in such cases show the presence of undigested fragments of food and of particles (often only to be seen under the microscope) of bile-stained mucus. Not infrequently too, the motions are pale and yeasty. It is difficult to be sure in such cases that one is not dealing with ulceration of the small intestine, but it is well to remember that ulceration alone apparently does not lead to diarrhoea, except when it coexists with some degree of catarrh. Hence it is that one may find extensive ulceration of the bowel in cases of tuberculous peritonitis, for instance, in which there has been no diarrhoea during life. The following case belongs to this group:—

Anne R., æt. 32, at the age of fifteen had an attack of "inflammation of the bowels," and has had chronic diarrhoea ever since. Her nutrition is wonderfully good considering the duration of her illness. There is no anæmia. The abdomen is distended and tympanitic, and coils of small intestine are sometimes visible. From four to six medium-sized motions are passed daily of a pale colour, frothy and very offensive, containing undigested food and small particles of mucus. Nothing can be felt by the rectum. A test-meal showed normal digestion. She was treated in bed on a diet of peptonised milk and farinaceous foods. Cyllin in 5 minimis doses every four hours removed the factor of the stools, and the administration of cuttle-fish bone and vegetable charcoal reduced them in number to one or two a day, and that of a solid consistence. They were still, however, very badly digested, a circumstance which pancreatine given in 5 gr. doses in keratin capsule every six hours failed to remedy. After the improvement in the consistence of the stools the abdominal distension became much less and the patient was discharged without, however, having materially gained in weight.

This case illustrates very well the long duration and the stubbornness to treatment which characterise chronic enteritis. It is easy enough to suppress the diarrhoea, which is the chief symptom of the intestinal catarrh, but it is much more difficult to restore the mucous membrane of the bowel to a normal condition. It is doubtful, indeed, if, when once its surface layer has been destroyed one can hope ever fully to restore the integrity of the intestinal epithelium. One is most likely to succeed by keeping the patient for a long time at rest in bed, on a bland diet, and by using bismuth in large doses, or better still, perhaps, salts of calcium, such as the phosphate or carbonate. I have had more success, as in the above case, with powdered cuttle-fish bone than with any other preparation. If there be much factor in the stools antiseptics are of help, cyllin being probably the most efficient, and if fermentation causes meteorism *fresh* vegetable charcoal is an aid. For colicky pains belladonna internally, and hot fomentations externally, are the best means at our command. When all is said and done, however, chronic catarrh of the small intestine is not a condition in which therapeutic triumphs are likely to be scored, and the patient is apt to suffer from it to a greater or lesser degree for years, though his sufferings may be much mitigated by minute attention to diet and by the avoidance of chill. Fortunately the condition, does not seriously impair health even when it counts its

duration by years, and nothing is more astonishing than to see how well nutrition is maintained in such cases in spite of a persistent and apparently severe diarrhoea.

GASTRIC DIARRHOEA.

I now pass on to speak of a form of chronic diarrhoea which is not so well recognised as it should be, and which, as it is primarily due to defective digestion in the stomach, may be appropriately termed "gastric" diarrhoea. A recital of two cases will make its nature clear:—

Constance R., *æt.* 20, had suffered from diarrhoea and occasional vomiting for two years. Her illness began with an acute attack of vomiting after eating some plums, and in spite of much treatment at various hospitals, she has suffered from more or less constant diarrhoea since. Any slight indiscretion in diet would also bring on vomiting. She was a fairly nourished girl in whom nothing abnormal could be made out by the ordinary methods of examination. The stools were at times pulsatous; at others liquid and bilious, containing undigested particles of milk curd and small portions of mucus tinged with bile or blood. A test-meal was badly digested and showed a low degree of acidity, with the presence of an excess of mucus but no free hydrochloric acid (chronic gastritis). She was kept in bed and put upon a milk and farinaceous diet. Bismuth, chalk, and calcium phosphate were all given in full doses, but without benefit. She was then put upon 20 minims doses of hydrochloric acid with 3 minims of tincture of opium, given half and again one hour after food thrice daily. On this great improvement resulted. The stools became solid and she gained in weight rapidly. One month after admission a test-meal showed that the gastric functions were normal. Six months later she came up to report herself in blooming health.

Abel K., *æt.* 56, a labourer, complained of diarrhoea and nocturnal incontinence of *fæces* of eight weeks duration. He was a man of excellent character and habits, a total abstainer, and had always enjoyed good health. *He made no complaint of any stomach symptoms.* The motions numbered six or more in the twenty-four hours, and were of a lightish yellow colour and their passage was often attended by scalding. He seemed to be a vigorous healthy man, and abdominal and rectal examinations were negative. He was treated as an out-patient with restricted diet and mixtures of chalk and opium, bismuth and opium, dilute sulphuric acid and lead and opium, but without any marked success. He was then admitted to hospital and the stomach functions tested on two occasions by a test-meal. Both examinations showed almost complete absence of gastric digestion, the total acidity of the contents being very low and [free hydrochloric acid entirely absent. He was then put upon full doses of hydrochloric acid after food, with the result that his diarrhoea ceased, and he was soon passing only one formed motion daily. Since that time—now two years ago—he has a few slight relapses which, however, have always yielded immediately to the same treatment.

We have here, then, two cases of chronic diarrhoea both of which resisted ordinary methods of treatment, until it was discovered that the gastric secretion was at fault. As soon as this was remedied the diarrhoea ceased.

How it is that a defective secretion of hydrochloric acid in the stomach results in diarrhoea in some cases it is not easy to say. It might be supposed that the badly-digested food, which enters the intestine excites a catarrh of which the diarrhoea is a symptom. This explanation, however, will hardly hold good, for in the first place the stools in such cases do not have the characters which are associated with enteritis, nor does catarrh of the small bowel yield so readily to treatment as is the case in gastric diarrhoea. It may be

that the absence of hydrochloric acid which is the normal antiseptic of the stomach, and to some extent of the intestine also, allows of an abnormal degree of intestinal fermentation and putrefaction which results in diarrhoea. It is probable, too, that direct stimulation of the small intestine by imperfectly digested food excites an exaggerated peristalsis. It is true that the pancreas should in ordinary circumstances be able to compensate for the action of the stomach and reduce any food which escapes digestion in the latter to a fluid form. It may well be, however, that in some individuals this compensatory action is not able to meet the demands upon it, and in such persons diarrhoea results. Be the explanation what it may, there can be no doubt that diarrhoea of gastric origin does occur, and that it can only be treated successfully when its source is recognised. One point about such cases must be emphasised—namely, that they do not always exhibit any symptoms which would lead one to suspect their gastric nature. In the second of the two cases mentioned the patient distinctly stated that he had never suffered from indigestion in any form, and yet examination showed that his secretion of gastric juice was greatly impaired. The moral is, that in every case of chronic diarrhoea one should investigate the functions of the stomach by a test-meal. In this way only can the nature of such cases be revealed and successful treatment instituted.

NERVOUS AND LIENTERIC DIARRHOEA.

You are aware that when no other plausible explanation of any morbid condition is forthcoming, there is a tendency to ascribe it to "nervous" influences. To this tendency chronic diarrhoea is no exception, and, consequently, one finds cases of so-called "nervous diarrhoea" described in the text-books. It is a wise rule, however, never to assume that a disease is due to purely "nervous" influences unless one can eliminate every other possible explanation of its occurrence. I do not wish to assert that "nervous" diarrhoea does not exist, but I am fairly sure that it is not a common complaint. It is customary to refer to this category cases of diarrhoea in which the increased frequency of the motions tends to be brought on by emotional excitement of any sort. It must be remembered, however, that any form of chronic diarrhoea is apt to be aggravated by such influences, and there can be little doubt that in many cases of supposed purely nervous diarrhoea there is an organic lesion at the root of the disturbance, usually, perhaps, a slight degree of chronic catarrh of the bowel. Notwithstanding this, it must be admitted that in a few cases no other explanation of a long-standing tendency to looseness of the bowels may be forthcoming other than that it is due to unusual nervous excitability. The following seemed to be a case of this sort:—

Alex. S., a schoolboy, *æt.* 14, had suffered from diarrhoea for about a year. The motions only occurred when he was up and about and amounted sometimes to as many as five daily. The evacuations were sometimes watery, sometimes formed, contained no blood nor mucus, nor was their passage attended by any pain or tenesmus. He seemed a perfectly healthy boy, and examination of the abdomen, stomach functions, and lower bowel was alike negative. Treatment outside had but little effect on the diarrhoea, although opium seemed to control it to some extent, but so soon as he was admitted to hospital the diarrhoea straightway ceased, even without any special treatment, and, indeed, gave

place to a condition of constipation. Inquiry some months later showed that he was remaining well.

The absence of any other apparent cause for the diarrhoea in this case and its immediate disappearance under the changed surroundings and "moral discipline" of hospital life strongly suggest its nervous origin.

The form of chronic diarrhoea to which the term "lienteric" is commonly applied may also be reasonably regarded as of nervous causation. In this variety, as you know, there is a tendency for the bowels to act immediately upon food entering the stomach. It is a condition most often met with in children and in the words of the mothers "The food seems to run through them!" We have here, I think, an exaggerated sensibility of the nervous mechanism of the alimentary tract, as a result of which the entry of food into one section of the canal leads, probably reflexly, to an immediate discharge of the contents of the section below. In favour of this view is the fact that the administration of small doses of opium before meals has an almost specific curative influence in them. Arsenic and nuxvomica are often recommended in such cases, but I have found them far inferior to opium in their power of controlling the diarrhoea.

THE HEREDITY OF OSTEITIS DEFORMANS.

By S. MAYNARD SMITH, M.B., B.S.LOND.,
F.R.C.S.,

Surgical Registrar to St. Mary's Hospital.

ALTHOUGH it is now some thirty years since Sir James Paget first described the disease we know as Osteitis deformans, we have in reality added no material facts to his observations—in fact, his original paper might well stand as a complete record of our present knowledge. In the series of articles published in the *MEDICAL PRESS AND CIRCULAR* of 1890, full and careful descriptions are given of a considerable number of cases, and since that time more and more instances of the disease have been published until now its recognition is frequent, and the cases met with receive little notice and but cursory investigation. There is, however, a point indicated by the title of this paper which has, I believe, never been insisted on, and indeed the fact involved, if it be a fact, has been explicitly denied. Sir James Paget (a) found no evidence of heredity in twenty-three cases. Joncheray (b) in an elaborate monograph says: "L'hérédité n'y est pour rien." What evidence is there then to justify a belief in the heredity of the disease? Amongst sixty-four cases collected from various sources I find the following records:—

(i.) Pickering Pick (1), in recording a case in a woman *æt.* 67, says that she remembered that her father's legs were very much bent and much in the same condition as her own for seven years prior to death.

(ii.) Stephen Mackenzie (2) describes a typical case and states that an elder brother had died with a crippling deformity of the lower limbs and was believed by the family to have had the same disease.

(iii.) Lunn (3) records the occurrence of the disease in two brothers.

(iv.) Kilner (4) describes with photographs a brother and sister suffering from the disease.

(v.) The writer of this paper showed a case of Osteitis deformans last year (5) in a man whose father was at the time in the Camberwell Infirmary, and an exceedingly good example of the same disease.

If the hearsay evidence in the above list be accepted, there was evidence of heredity in five pairs of cases out of a total of sixty-four cases. It is difficult to obtain any information as to relatives from the average hospital patient with this disease, coming under observation as he does at about the age of fifty. His parents are dead, his children are not old enough to show signs of the disease, his brothers have often been lost sight of. Again, since it is the bending of the legs which is the usual point to attract the attention of others, the demands of modern costume will cause the existence of the disease in a man's female relatives to pass unnoticed by him. Remembering these facts and recognising that in less than half of the recorded cases is there any definite statement of inquiry into family history, I think that the above figures give strong evidence of the existence of an hereditary factor in the causation of Osteitis deformans.

There is a condition found in the same disease which is unusual yet present in seven of the sixty-four cases. This is enlargement of the facial bones. The lower jaw and the alveolar margin of the upper jaw are the parts most involved. This is of particular interest, as the absence of affection of the facial bones is usually considered to constitute a striking feature of Osteitis deformans as distinguished from acromegaly.

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CLINICAL RECORDS.

CASE OF

CHRONIC DIARRHŒA SIMULATING SPRUE.

*Under the care of P. T. O'SULLIVAN, M.D., B.Ch.,
Senior Physician to the South Charitable Infirmary, Cork; Physician
to St. Vincent's Hospital for Women and Children.*

Mrs. C., *æt.* 30, a 4-para., suffering from chronic diarrhoea for two years. She was thin, sallow, and worn, with very depressed expression. The diarrhoea was principally in the morning, no pain, but a good deal of discomfort. The motions were always large, and numbered four to eight in twenty-four hours.

Condition on Examination.—Teeth good, lips excoriated and pallid, tongue small, dry and glazed, split by fissures into small plaques. Anything acid or salt smarted considerably. Appetite fair, no thirst. She complained occasionally of distress after food, particularly vegetable food. The motions were large, white, and not very offensive, alkaline in reaction, exceedingly bulky and out of proportion to the food ingested. Under the microscope they showed no special features. Urine was normal, and although examined several times chemically and microscopically, nothing abnormal was detected, except that the excretion of urea was markedly reduced, the percentage being '47. Lungs normal, cardiac first sound feeble, accentuation of the second sound by contrast. Blood examination revealed marked diminution in hæmoglobin, but no other change in the cellular elements.

On examining the abdominal viscera, I could not

find the liver at first, but eventually a strip of dulness, two inches long, about the level of the nipple, was elicited, and palpation of the very flaccid abdomen revealed a hard band running up to the diaphragm. This condition gave the key to the disease. It was evident that the diarrhoea was due to the absence of (1) bile; (2) of the other functions of the liver. The patient was put on a rigid diet, getting her food practically dry, very little fluid, and that sterilised milk. Beta-naphthol in petroleum emulsion had no effect. Fat globules were subsequently detected in the fæces, and the patient was accordingly put entirely upon Benger's liq. pancreaticus, and in three or four days she had the first formed motion for two years. The size and number of the motions diminished, and after ten days bile appeared in the motions.

He considered that the case illustrated the interdependence of the functions of the liver and pancreas. His reasons for comparing it to sprue were:—(1) Morning diarrhoea; (2) its quantity; (3) condition of mouth and tongue, etc.; (4) the diminution of the liver. Sprue had never been known in this country, except in imported cases.

REPORTS OF TWO CASES OF COMPLICATIONS OF PURULENT EAR DISEASE.

By J. STODDART BARR, M.B., Ch.B.

Assistant Surgeon to the Glasgow Hospital for Diseases of the Ear, Nose, and Throat.

CASE 1.—A fatal case of septic thrombosis of the lateral sinus, secondary to chronic otitis media purulenta in left ear, and complicated with septic infarctions in the right lung.

The patient was a little girl, æt. 7 who had had a continuous discharge from the left ear for a year. During the eleven days before admission she had a dozen severe rigors, with violent oscillations of temperature from normal to 104° F. There was also frontal headache and pain in the left side of the neck. She vomited once or twice at the beginning of the illness. The discharge from the ear was profuse and fetid. There was evidence of the early stage of optic neuritis in both eyes. The breath was accelerated with frequent cough. A few moist rales were heard and also tubular breathing over a restricted area around the inferior angle of the right scapula. The radical mastoid operation was performed, clearing out pus and granulation tissue. The sigmoid sinus was exposed, and found converted into a yellowish sloughy-looking mass surrounded by, and partly filled with pus. The bulb of the internal jugular contained solid thrombus. The sinus was slit open backwards and cleared of septic disintegrated thrombi to within 1½ inches of the torcular when a gush of blood appeared. After the operation the pulmonary symptoms continued to increase, and the patient died two and a half days after admission to the hospital. *Post-mortem* examination was conducted by Dr. James Walker, and showed well-marked septic infarctions of the right lung. Bacteriological examination showed the presence of pneumococci and streptococci and also a large bacillus, which did not grow on the culture media, and did not give the staining reactions of the acid fast group of organisms.

In this case it is highly probable that had operative treatment been employed a few days earlier, before the pulmonary infection had supervened, a different result might reasonably have been expected. It should be emphasised that, when rigors with violent oscillations of temperature appear in connection with a purulent middle ear disease *operative treatment is urgently called for*. Judging from this case, and others of a similar kind, the grave significance of this symptom in these ear cases is not yet duly recognised by some practitioners. Operation carried out early is probably more successful than in any other form of intracranial complications due to ear disease; hence the vital importance of early recognition of the condition present.

CASE 2.—A case of Otitic Extra-Dural Abscess

associated with Paralysis of the Sixth Cranial Nerve, and Double Optic Neuritis. Operation and Recovery.

The patient was a lad, æt. 17, who suffered from purulent right middle ear disease for sixteen months before admission. He came to hospital owing to headache, diplopia, paralysis of external rectus (6th nerve) and double optic neuritis. The radical mastoid operation cleared out cholesteatomatous masses from the antrum, auditus and the attic of the tympanum. The opening of the sigmoid groove gave exit to a collection of pus between the sigmoid part of the lateral sinus and the bone. The sinus wall was involved and covered with granulation tissue, but there being no signs of general septic infection, it was not opened. There had been no pain over the mastoid area nor behind, and the temperature was normal from the time of admission. After operation the paralysis of the sixth nerve gradually but slowly passed off. The optic neuritis for a few weeks became more marked, with occurrence of hæmorrhagic spots and now, four months after the operation, the discs are undefined, with white spots and a tendency to atrophy, but the vision is so far unimpaired.

Remarks.—The pathological connection between the septic pachy-meningitis at the sinus and the lesions causing the ocular phenomena is not very clear. The most ready explanation is that a limited basal lepto-meningitis originated in the region of the sigmoid groove and extended and involved the sheath of the sixth nerve, or the more distant optic commissure, either by pressure or by producing an infective neuritis. There is also the possibility of the formation of a thrombus in the cavernous sinus, originating in the sigmoid and, by pressure involving the sixth nerve as it lies in the cavernous sinus, or by producing stasis of the blood from the eye, causing optic neuritis. It is also to be remembered that optic neuritis seems to occasionally occur in connection with simple purulent middle ear disease presenting no intracranial symptoms.

THE OUT-PATIENTS' ROOM.

WEST-END HOSPITAL FOR DISEASES OF THE
NERVOUS SYSTEM.

Cerebral Diplegia.

By FREDERICK S. PALMER, M.D., M.R.C.P.

THE three cases briefly described below have been recently brought to the out-patients' department of the Hospital with cerebral palsies of bilateral distribution.

CASE 1.—D. W., female, æt. 7, the second of nine children, of whom five were stillborn. Both parents are living and apparently healthy. The mother states that during the whole of her second pregnancy, which terminated at the eighth month, she never felt well. She suffered from intermittent abdominal pain, and had a succession of family troubles and worries. Four days before her confinement she fell downstairs and cut her left foot so severely that six sutures were inserted to bring the edges of the wound together. The labour was quick, and not attended with any difficulty or complication. The child was, however, more or less asphyxiated at birth, and had convulsions shortly afterwards, followed by snuffles; but she never observed any rash. The fits continued at irregular intervals until the seventh month, but have not recurred since then. She began to talk at fifteen months, but she has never been able to walk or to stand alone. The cranial circumference is 18 inches. Her intelligence is good, she answers questions correctly at once, and has been able to learn a few easy lessons. Her disposition is said to be amiable and affectionate. She is able to feed herself, but has no control over the sphincters. She has well-marked spastic paraplegia, the knees are pressed firmly together by the adductor spasm, and the toes are over extended. In any attempt to flex the legs the so-called lead pipe resistance is encountered. The knee-jerks are much exaggerated, and the plantar response on each side is of the extensor type. The ankle jerks are obtained, but ankle clonus is absent. On

being supported by her mother, the child attempts to walk in the typical, spasmodic, cross-legged, digitigrade manner, with the heels raised, and the toes just touching the ground. The muscles of both legs are small, but there is no evidence of marked vaso-motor disturbance. She has also considerable weakness of the left upper extremity with hyperkinesis. The post-plegic athetoid movements are chiefly tentacle-like in character, the digits being widely separated, and over-extended, but the excursions are of short range and cease during sleep. There is no involvement of the facial muscles, nor any affection of the cranial nerves.

CASE 2.—F. F., æt. 6 (the youngest of six children), was born prematurely between the seventh and eighth month. His mother died eight months ago from carcinoma of the breast. According to the statements of the father, the other children were all born at term, and are healthy and well. A few days before the birth of this child, his mother had a severe fright from the children setting fire to some shavings in the room, which she had difficulty in extinguishing. The labour was precipitate, and the child was born before either a doctor or a nurse could be summoned. He has never had any convulsions. The cranial circumference is 18½ inches. His mental condition is slightly below the normal, but he has full control over the sphincters. He did not begin to talk till three years ago, but since then his intelligence has improved. He has never been able to stand or walk alone, and he has difficulty in raising himself into an upright position without assistance. On examination, he presents the same physical disabilities as the last child, spastic paraplegia, adductor spasm, exaggerated knee-jerks, extensor type of plantar response, scissor-like digitigrade progression, lead-pipe resistance to passive movements, with some slight rigidity of both upper extremities. The cranial nerves are normal. There are no athetoid movement and ankle clonus is not obtainable.

CASE 3.—L. M., female, æt. 4½, the second of three children, born at time. The mother admits she was in bad health during her pregnancy, suffering from what she described as a "nervous breakdown," and that her confinement was rapid. Her first child was still-born at the seventh month, and she miscarried with the last between the fourth and fifth month. No history of convulsions can be elicited. The patient is very backward, and it is not long since she commenced to talk. Her cranial circumference is 18½ inches. She is unable to stand alone. Her intelligence may be described as distinctly inferior to the previous two diplegics, although she quite understands what is said to her. She repeats her name and address quite correctly, but evidently does not appreciate the attention of strangers. The organic reflexes are perfectly normal. Her knee-jerks are only slightly exaggerated, there is no ankle clonus, but the extensor type of plantar response is at once provoked by the least stimulation of the soles. When made to stand and to attempt to walk she advances very slowly in the usual cross-legged fashion, in the position of talipes equino-varus. The adductor spasm in this case is very marked, holding the knees tightly together. On careful examination a tendency to post-plegia movements is observable in both upper extremities, but there is no definite evidence of motor weakness in the arms, nor any defects to be noticed in the cranial nerves.

Remarks.—The three cases just described may be regarded as good examples of cerebral diplegia, varying slightly in degree, of the type designated by Freud "paraplegic rigidity." They follow the rule that in the majority of these unfortunate children some grade of mental enfeeblement is usually present, in association with the physical disability. Two were born prematurely, and one at term. In all, the labour was precipitate. There is the history of previous ill-health during the pregnancy of two of the mothers, and also of shock and fright, a few days before delivery—not uncommon factors in the etiology. In one, if not in two, the suspicion of specific disease in the

parents, which is known to play an important part in these affections, is suggested as a possible explanation of the previous ill-health.

The diagnosis of these cases, as a rule, is not difficult, but in those that are not well marked, they may have to be distinguished from anterior polio-myelitis, spinal caries with compression paraplegia, Friedreich's ataxia, insular sclerosis (rarely seen in children) pseudo-hypertrophic paralysis, Thomsen's disease, intracranial neoplasms, and the rigidity sometimes seen in rachitic children. The points which distinguish the infantile cerebral palsies are the history, mode of onset, distribution of the paralysis, spasticity of the affected limbs, behaviour of the reflexes, the presence of mental impairment, or post-plegic automatic movements, and the absence of marked amyotrophy, or change in the electrical reactions. The pathology of these cases is at present more or less obscure—opportunities of investigating the morbid processes in their earlier stages is seldom afforded. Those revealed on necropsy relate chiefly to secondary or terminal conditions. Briefly, they may be summed up as follows:—Developmental anomalies, vascular lesions, meningeal, and intra-cerebral, or inflammatory changes, leading to atrophy, and sclerosis of the convolutions, areas of softening, and cavity formation (porencephaly). The view most commonly accepted is that of primary progressive degeneration of the neurons of the cerebral cortex from toxic causes. The disability is not in any way dangerous to life, the anxiety chiefly concerns the growth and mental condition of the child, or the onset of epilepsy. Attention to the general health, passive movements of the affected limbs, regular and systematic gymnastics, and the individual training, and educational methods practised in the institutions for the feeble-minded, together with appropriate surgical measures for the prevention, or restoration of deformities arising from contractures are the principal indications in the treatment.

OPERATING THEATRES.

GUY'S HOSPITAL.

TWO AMPUTATIONS OF BREAST.—MR. CLEMENT LUCAS operated on a woman, æt. 60, who was suffering from an extremely retracted and adherent nipple of the left breast. She was a married woman who had borne several children, now grown up, but she had never suckled them with either breast owing to the inversion of both nipples. She had after some of her labours had the milk drawn off by artificial nipples; she was in other respects a healthy woman, with a good family history. She had had an attack of influenza about Christmas time, and it was about this period that she noticed some alteration in the left breast. She said nothing about it, however, till March, when she was persuaded to tell her doctor of it, who referred the case to Mr. Lucas. The breasts were both small, and the left one different from the right only in the fact that the inverted nipple was adherent to the parts beneath and had a firm marginal areola, the breast being thus pinned down in the middle; the rest of it felt soft and free of all tumour growth, but when an attempt was made to move it over the pectoralis major muscle it was clearly adherent to the parts beneath. No enlarged glands could be felt in the axilla. M. Lucas stated that retracted nipples bore a double relation to carcinoma. They might be either a cause or a consequence of the disease; he always regarded retracted nipples as a serious defect, more especially in married women as greatly increasing the tendency to carcinoma as age progressed. This defect he considered acted in two ways; in the first place the fossa always present secreting an unctuous substance, in which minute organisms would tend to collect and

procreate in association with dust and dirt, afforded a direct means of entry to the substance of the breast; in the second place, lactating women failed to empty their breast at the call of the infant, and thus in the breast substance undischarged secretion often collected and was imperfectly absorbed. The natural physiological action of the breast was therefore never properly carried out during the lactating periods. The diagnosis of carcinoma, he pointed out, in this case rested on three facts; (a) the hard margin of the fossa caused by the inverted nipple; (b) the adhesion to the deeper parts; and (c) the age of the patient. The retraction of the nipple, he said, had preceded any growth, and was present also in the other breast. There were no enlarged glands to be felt in the axilla to aid in the diagnosis. The age of the patient suggested carcinomatous rather than inflammatory adhesion. Mr. Lucas, therefore recommended removal of the whole breast and clearing out of the axilla. In doing this it was found necessary to remove the fascia and some of the muscular substance of the pectoralis major muscle. In clearing out the fat of the axilla a few small glands were found apparently not enlarged or infiltrated. On cutting a section of the nipple a narrow white margin corresponding to the areola was shown, and on microscopical examination this proved to be carcinoma; the pathologist subsequently reported that the glands in the axilla showed no indication of growth. This was, Mr. Lucas remarked, a so-called atrophic cancer of the older writers, in which the growth proceeded slowly in an aged person without any great tendency to spread by the lymphatic channels.

The second case was that of a married woman, *æt.* 43, who also had borne children many years previously. She had a very prominent left breast in which she had discovered enlargement some months before, but within the last month the swelling had rapidly increased in size. When examined a fluctuating swelling was found at the upper and inner part of the breast just external to the areola; the nipple in this case was well developed. Irregular masses were to be felt in the breast on the axillary side of the organ; these swellings were firm, but not hard, and the organ itself moved freely upon the muscle beneath. There were no glands to be discovered in the axilla. Mr. Lucas regarded this as a degenerate breast undergoing involution with cystic formation, and possibly sarcomatous growth. The fluctuating spot was tapped, the fluid drained off, and examined microscopically. It was a grumous turbid fluid, not like true pus, and under the microscope showed for the most part broken down granular material and also some blood and pus corpuscles. Mr. Lucas advised the removal of the whole breast as the proper course to be adopted in all cases of tumour of the organ in women over forty years of age. This was accordingly done. After removal the breast was cut in sections to determine whether it would be necessary to explore the axilla; it was found that there was a large cavity above the nipple containing degenerate material; growths were discovered in other parts of the breast, which showed no glistening surface, but which might have resulted from mastitis or adeno-cystic formation. The axilla was therefore left unexplored. The microscopic examination of the growth showed it to be a myxo-adenoma in which inflammatory or degenerate changes were taking place. Mr. Lucas said it was obvious that any other course than the complete removal of the breast would in this case have led to no satisfactory result. Supposing the degenerate part had been incised and drained, a similar condition would have continued in the tumour growth in other parts;

fresh incisions would have been required there and after suffering months from open wounds the patient's condition would have remained unsatisfactory, and even if the wound had afterwards healed, the degenerate breast with its cicatricial tissue would have been a source of danger in later years from carcinoma.

As the result of complete removal primary union took place, and the patient was able to resume her ordinary occupation in the course of a fortnight.

ST. THOMAS'S HOSPITAL.

OPERATION FOR DEFLECTED NASAL SEPTUM.—Mr. H. BETHAM ROBINSON operated on a man, *æt.* 30, who had been admitted with nasal obstruction of some years' duration, especially affecting the right nasal cavity. On examination it was found that externally the nose was deformed with a distinct bend in the bridge to the right side; internal examination showed on the right side that the septum was bent so much as to completely touch the external wall. On the left side the upper part of the septum was deeply concave, corresponding to the convexity on the other side; this concavity ended below in a very sharp angled spur which practically filled up the whole of the inferior meatus. The spur or ridge traced backwards joined behind another sharply marked vertical angle which was just in front of the anterior end of the middle turbinate. Behind this the left middle turbinate was slightly enlarged. On operating on this case a submucous resection of the septum was done. Owing to the very limited room on the right side, contrary to the ordinary practice, it was decided to resect from the concave side. An incision was made down the vertical angle and then forwards along the spur; a triangular flap of muco-periosteum was raised from behind forwards with a raspatory exposing the bare white cartilage; a small incision in the front of this cartilage was made, an elevator passed through the hole in the cartilage and the muco-periosteum of the right side carefully separated. A large piece of the cartilage was then removed with a Kilian's knife. As in many of these cases, some difficulty was experienced in removing the thickened bent vomer, especially at the junction behind of the two angles; the bone, after separation of the soft parts with an elevator, was removed with a gauge; it was then found that good patency of the right nostril was obtained. The flap of muco-periosteum was then placed back in its proper position, and no stitches were put in. A rubber nasal splint was introduced into the right nostril to push the septum into a median position, and on the left side against the wound a couple of strips of cyanide gauze powdered over with aristol were placed. Mr. Robinson commented on the satisfactory nature of this form of operation for deflected septum; he had adopted in all similar recent cases the method of raising the flap of muco-periosteum from behind forwards as suggested by Freer of Chicago. The most difficult part of the operation he considered was the removal of the septum at the junction of two angles, it usually being bony, and then composed of the lower part of the perpendicular plate of the ethmoid, and the adjacent thickened upper part of the vomer. With the reflection of the flap from behind forwards and the incision into the cartilage as far forwards as possible, if a perforation should be here made through the muco-periosteum of the opposite side, the hole would be covered over when the reflected flap was replaced. Mr. Robinson said he preferred to do this operation under a general anæsthetic. He pointed out also that he used support to the septum for a very short period; the patients generally leave the hospital at the end of a week. He said that the septum formed by the approximated two layers of muco-periosteum—which, of course, is at first quite flabby—gradually becomes more rigid from the formation of fibrous tissue, so firm in some cases does it seem that it has been a point of discussion whether true cartilage is not reproduced.

The splint and the gauze were removed on third day, and no further treatment was required: the patient left the hospital at the end of a week.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD MARCH 30TH, 1906.

President, MR. CLUTTON, in the Chair.

MR. A. E. J. BARKER narrated a case of Treitz's Hernia complicating gastro-enterostomy. On opening the abdomen with a view to doing [gastro-enterostomy for carcinoma of the stomach, no small intestine was found within the peritoneal cavity. At first this was difficult to explain, but when it was seen that the colon was higher up than usual and that the anterior layer of its mesentery was bulged forward the position of all the small intestine behind the latter and a Treitz's hernia were recognised. The relation of parts rendered it necessary to open the sac of the retro-peritoneal hernia in order to examine the posterior aspect of the stomach with a view to the retrocolic gastro-enterostomy. In the sac was all the small intestine. The stomach was too extensively infiltrated with cancer for the anastomosis. Mr. Barker commented on the difficulties which would be met with in such a case in completing a gastro-enterostomy. Fortunately these cases were comparatively rare.

MR. E. PERCY PATON narrated a case of Right Duodenal Hernia, in which the hernia was reduced but death followed in seven days, due apparently to gut re-entering the sac. The patient was an infant, æt. three months. The illness started suddenly with symptoms similar to those of intussusception. A swelling could be felt in the abdomen. Laparotomy revealed considerable length of small intestine which appeared to be engaged under a peritoneal band. This gut was drawn out. No further investigation was possible owing to the general condition of the child. The patient was at once relieved by the operation, but was taken suddenly worse on the seventh day and died. At the *post-mortem* a right duodenal hernia was found into which a considerable quantity of gut had returned, which, however did not seem to be strangulated. There was no peritonitis. The paper was illustrated by photographs and also by the specimen which is now preserved in the College of Surgeons' Museum.

MR. F. EVE related the case of a woman, æt. 64, in which he had met with a duodenal hernia during the performance of a colotomy for chronic obstruction.

MR. FREDERICK EVE read a paper on Large Cysts of the Common Bile Duct.—A woman, æt. 46, was admitted in November, 1902, with an abdominal tumour and jaundice, which had existed for three years. The tumour extended from the right costal margin to the iliac crest and across the abdomen to the left of and below the umbilicus; it was evidently elastic. It was thought to be a cyst of the pancreas. At operation the cyst was opened, and it was attached to the parietis. It contained 7½ pints of clear fluid, pieces of grit, and clinical examination showed bile pigment. The fistula remained open and seven months later a communication was made between the cyst and the hepatic flexure of the colon (choleoducto-enterostomy). She recovered from the operation, but died two weeks later of progressive emaciation and exhaustion.

Autopsy.—The abdomen was normal, with the exception of the large cyst of the common bile duct, 4½ inches in diameter. The junction with the colon was firm. Within the cyst and just above the papilla biliaris was a papilloma which had acted as a ball-valve. Commenting on recorded cases, Mr. Eve did not think that the condition was extremely rare, for in only a cursory examination of records he had found 24 cases. As regards causation the cases fell into three groups:—

(1) Those in which the obstruction was due to a vascular formation, to stenosis, or to obliteration; (2) obstruction due to calculus; (3) obstruction by a growth. Only one case besides that recorded had been

found. *Treatment:* In the great majority of cases the cyst had been opened and drained, with the exception of those, including the writer's, with a fatal result, which was mainly due to progressive emaciation and weakness from persistent jaundice. Some cases had been treated by uniting the cyst with the duodenum, jejunum, and in the cases recorded, the colon. The writer thought that this was a matter of choice; and in the majority of cases the colon was indicated on account of the extensive adhesions and the alteration of relationship of parts.

MR. F. C. WALLIS read notes of Three Cases of Gastro-jejunosotomy. The first case was that of a female patient, æt. 91, who made an excellent recovery, losing all the symptoms for which the operation was done. The patient died twelve months later from cerebral thrombosis. The other two cases were both instances in which chronic inflammatory thickening around an ulcer simulated a new growth both in appearance and to the touch. In both cases a posterior gastro-jejunosotomy was done. In the one case when the abdomen was re-opened a month later to do a partial gastrectomy the "growth" had almost entirely disappeared, and an ulcer on the posterior wall could be felt through the anterior. The patient has quite recovered and gained weight. In the other case the supposed growth occupied the cardiac half of the stomach. The operation relieved the pain which was the main symptom complained of, but the patient died on the fourth day from hæmorrhage. A *post-mortem* showed a large ulcer situated on the posterior wall, a large vessel ran along the floor of the ulcer, and in the middle of the vessel was an oval opening. Mr. Wallis remarked that the first case illustrated the fact that even very old people stand operations well, when their tissues are young. The lessons he learnt from the other two cases were (1) that in the majority of cases when partial gastrectomy is under consideration a posterior gastro-jejunosotomy should be first performed. (2) That delays are dangerous in cases of gastric pain which do not readily yield to medical treatment. Under such circumstances the abdomen should be opened and the stomach examined. A gastro-jejunosotomy can be done, and if there has been hæmatemesis to any marked degree, the stomach should be opened through healthy tissue in the neighbourhood of the ulcer, and the ulcer either cut out, cauterised or ligatured to prevent further hæmorrhage.

MR. HALE WHITE emphasised the fact that old age should not in itself be a bar to even serious operations. He had seen Mr. Wallis's first patient, and was much impressed by the relief she had experienced. The second group of cases was extremely important, and he wished to refer in this connection to masses of inflammatory material arising from the gall passages and simulating new growth, by causing pressure on the pylorus. He had seen such a case recently, and was convinced of the presence of pus owing to the high leucocytosis present; he had great difficulty in inducing the surgeon to incise the mass, which closely resembled cancer, but after evacuation of the pus the patient made a complete recovery.

DR. DE HAVILLAND HALL related a case recently under his care in which great benefit was obtained by simple laparotomy alone.

MR. W. G. SPENCER referred to the anomalous course often pursued by gastric cancer, and warned against too soon assuming that the diagnosis of cancer was incorrect, merely because great improvement followed operation.

THE authorities of the War Office have appointed Mr. W. J. F. Middlemiss, L.D.S.Ed., as Dental Surgeon to the Troops in Ireland, and Mr. E. H. Wyand, L.D.S.Eng., in a like capacity to the troops at Aldershot.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD MARCH 16TH, 1906.

DR. G. A. SUTHERLAND in the Chair.

DR. ERIC PRITCHARD exhibited a case of Symmetrical Dimpling of the Skin on the dorsal aspect of the extremities of both acromial processes in a girl *æt.* 8, the condition being noticed at birth.

DR. KENNETH R. HAY exhibited a case of Achondroplasia. J.K., *æt.* 2, may be considered to be a typical example of the condition called achondroplasia. He is the elder of two children. The younger is *æt.* four months, and is to all appearances normally shaped. The father suffers from phthisis and has been subject to fits, probably epileptic in nature. The mother is not a robust woman but says she has always enjoyed good health. There is no history of syphilis. His intelligence is perhaps rather below the normal for a child of his age. He can pronounce the words "daddy" and "mummy" but otherwise does not talk. He is inclined to be irritable and to resent any interference. He can stand, and also walk a little with aid but is very unsteady. In the standing position the typical lumbar curve is well seen. The head is decidedly large, and the frontal bones prominent. The root of the nose is depressed. The anterior frontanelle is open. The circumference measures 20½ inches. The body is long relatively to the limbs, and the chest rather narrowed. There is slight beading of the costochondral joints of the ribs. The heart and lungs are normal, and the sexual organs well developed. The limbs are shortened in a characteristic manner. The hands and fingers are dumpy. The humerus and ulna each measure 3¾ inches. The femur measure 4½ inches, and the tibia 5 inches. The bones feel thick and hard and are not apparently curved.

MR. HUGH LETT exhibited (1) a case of Erb's Paralysis in a child, *æt.* 4½ months, involving the fifth, sixth, and seventh cervical nerves; and (2) a case of precocious development in a boy, *æt.* 4. He had been rather backward until he was two years old, the pubic hair then appeared, and development took place with extreme rapidity. There was a remarkable growth of hair all over the body, especially over the pubes and in the lumbar region. The penis and testicles were large and resembled those of a young adult. His voice was deep and like a base voice, not yet under full control. His muscular development was remarkable, especially in the thighs, and he was possessed of proportionately great physical strength. A skiagram of the wrist showed ossification taking place in all the bones of the corpus, and one of the knee presented the appearance of the joint in a boy 17 or 16 years old. No enlargement of the thyroid or suprarenal bodies could be made out. His appetite was voracious. Intellectually he was bright, but had a terrible temper. He had nocturnal enuresis. He had had no fits, and was not subject to headaches.

DR. POYNTON exhibited a case of Acne-Scrophulorum. D.W., *æt.* 5½ a delicate child with somewhat large cervical glands, and a history of tuberculosis on the mother's side. The rash commenced upon the arms and legs, in the form of discrete papules, which at first itched very slightly. Since that time these papules have been coming out in crops, some of them appearing on the trunk, and an occasional one upon the face.

MR. SIDNEY STEPHENSON showed a case of Congenital Coloboma of the Eyelid in a boy, *æt.* 3 months, who was brought to the Evelina Hospital on account of a deformity of the right upper lid, present since birth. Upon examination a quadrangular gap was seen in the right upper eye-lid. It involved the inner half of the lid with the exception of a small nodule at the inner end, and extended about half way from the orbital to the palpebral margin. The puncta lacrymalia were present, the upper one being situated on the nodule mentioned above. When the baby shuts his eyes, the right cornea and pupil can be seen through

the gap in the eyelid, thus producing a somewhat weird effect. There is no particular thickening of the palpebral conjunctiva, no lipo-dermoid of the conjunctiva, no dermoid of the cornea, and no coloboma of the iris.

MR. H. S. CLOGG exhibited a case of Congenital Deformity of the Hands. Baby, *æt.* 4 months at present time. The infant is one of twins, the other child being perfectly well formed. There is nothing in the family history of any importance. The *right hand* is shortened and comparatively broadened. Some power of flexion appears present in the terminal stump. The fingers of the *left hand* are curiously bound together at their distal extremities. The proximal portions of these are free from one another, and the webs are not unduly prolonged down upon the interdigital clefts. The distal halves of the digits are fused together, apparently by soft tissues only, and overlapped in a curious way.

MR. DOUGLAS DREW exhibited a case of a Congenital Unilocular Cyst of the Neck.

DR. W. EWART exhibited drawings of a child recovering from "Chorea" and read a short paper on the treatment of chorea by strychnine. He said that strychnine is to be prescribed as a nervine and general tonic, and though it has to be pushed, any approach to toxic symptoms is carefully avoided, this is best secured by the combined influence of ammonium bromide. Obvious benefit has been obtained in children of 6 to 12 years of age from doses of the liquor from mm. x to m. x. administered three times daily and guarded by bromide.

DR. EDMUND CAUTLEY showed a specimen of Congenital Hypertrophic Stenosis of the Pylorus removed from a child, *æt.* 9 weeks, one of twins born somewhat prematurely. Symptoms began at three weeks of age. The child came under treatment a week before death, weighing 3 lbs. 7 ozs. The vomiting was by no means marked. A normal stool was passed a few days before death. The case illustrated moderate pyloric hypertrophy which had not produced complete obstruction, nothing in the history suggestive of spasm.

DR. C. O. HAWTHORNE read notes on a tumour of the Pons Varolii in a boy, *æt.* 8.

DR. C. O. HAWTHORNE read notes on specimens from a case of small white kidney from a girl of 12. The microscopic changes are those of chronic interstitial nephritis.

GLASGOW OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD WEDNESDAY, MARCH 28, 1906.

The President, DR. KELLY, in the Chair.

DR. WILSON, of Calderbank, read notes of an interesting case of

PURPERAL ECLAMPSIA

in a young woman, *æt.* 22. She was six months pregnant, when convulsions set in, with involuntary passage of urine. Some urine was procured by means of a catheter, but there was no albumen present. There was no oedema discernible. She vomited dark-coloured material. She was treated with chloral, which relieved the fits for a time. Pilocarpine and saline transfusion were also tried. But the coma deepened, and on the third day of the illness she died.

In the discussion that followed no definite or general finding of the members was arrived at as to the cause of the eclampsia in this young woman, who was supposed to be healthy in every respect. But there was no information as to the state of the pulse tension, and whether the specific gravity of the urine was low, which would have pointed to renal insufficiency. In not a few cases, an early history of scarlet fever with renal dropsy can be made out on close investigation of the history of the case.

DR. WILSON showed two small masses of a bifurcated tumour which he had removed from the roof of an infant's mouth. The tumour had grown from the base of the skull, penetrating a cleft palate, and pre-

venting the baby from sucking the breast. It proved to be a dermoid tumour, on microscopical examination.

Dr. FREW read a paper on the

RESUSCITATION OF STILL-BORN BABIES.

criticising the various well-known methods practised, and laying particular stress on hot-water douches over the region of the heart.

Dr. MACLACHLEN related his experience in dealing with profound cases of alcoholic poisoning, where the pupils were dilated, and insensitive to light, the pulse not perceptible to the touch, and no appearance of respiratory movement. In such cases he contended that the first thing to do was to start oxidation by stimulating the respiration, by flagellation of the chest, with a wet towel. This flagellation may have to be kept going off and on for ten to thirty minutes. The first effect noticeable is that deep inspirations are taken, and the strong odour of alcohol, being exhaled becomes pronounced. Patients brought into the Northern Police Office stony-cold from alcoholic poisoning, are generally "brought round" at the outside in half an hour.

Several specimens were shown. The PRESIDENT exhibited a large sarcoma of the uterus, with a portion of a fish-bone lying on the ovary.

Dr. LINDSAY showed an amorphous foetus of a cow, which was not unlike a hedgehog.

Dr. JARDINE produced the uterus of a woman who had had Cæsarian section performed twice.

BRITISH LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL ASSOCIATION.

MEETING HELD FRIDAY, MARCH 9TH, 1906. (Rooms of the Medical Society of London.)

The President, Dr. WOODS, in the Chair.

Mr. STUART-LOW showed a case with greatly enlarged Eustachian tubes, the remarkable feature of the case being the absence of symptoms of nasal or of pharyngeal obstruction.

Mr. STUART-LOW also showed a case of

ULCERATION OF THE AURICULAR LOBULE of fifteen years standing. The patient said that fifteen years ago the lobule of the ear had been pierced with a stocking needle by a friend for the purpose of wearing an earring. Ever since there had been trouble with it, as it never healed and had gradually a red scaly patch over the posterior surface of the lobule. A small piece was removed for microscopical examination, when it was pronounced to be lupus vulgaris. But under treatment with the ointment of nitrate of mercury it had nearly disappeared in two weeks.

Mr. DENNIS VINRACE favoured the diagnosis of lupus, and laid stress on the absence of local glandular enlargement and the chronicity in support of his conclusion.

Dr. NELSON thought it was a patch of chronic eczema, on the following grounds. (a) There was hardly any scarring after fourteen years. (b) There had been very marked improvement under dilute nitrate of mercury ointment. (c) Although the patch had never healed it had very nearly done so, and then relapsed.

The PRESIDENT, while recognising the difficulty of the case, was inclined to regard it as one of lupus.

Mr. MAYO COLLIER showed a case of

SYPHILITIC DISEASE OF THE LARYNX,

the object being to accentuate the fact that under ordinary syphilitic treatment the larynx did not heal. When this case came under Mr. Collier's care, after some months of general treatment, he ordered calomel fumigations or inhalation every second day, stopping the internal administration of medicine. The larynx healed well in three weeks.

Mr. HAROLD BARWELL thought the larynx was now healed, though some inter-arytenoid out-growth was present. He considered that the patient appeared to be more ill than would be expected from the laryngeal condition alone.

Mr. HAROLD BARWELL showed a case of

LUPUS OF LARYNX, PALATE AND PHARYNX.

Mr. LACK said this was a most interesting case, it resembled the condition of a patient who had been under his treatment for about three or four years, and who did exceedingly well after removal of the affected epiglottis, &c., by punch, forceps, and the after application of lactic acid. The patient was a girl now about fourteen years of age, and differed from Mr. Barwell's case in having lupus also of the vestibule of the nose.

Mr. DRINKWATER remarked that in Mr. Barwell's patient, on the border of the left inferior turbinal at the junction of the middle and posterior third, there is a nodule, and the mucous membrane of the inferior meatus below this point looks very suspicious.

Mr. CHICHELE NOURSE exhibited two cases showing the result of the "Radical mastoid operation."

CORK MEDICAL AND SURGICAL SOCIETY:

MEETING HELD MARCH 14TH, 1906.

DR. P. G. LEE in the Chair.

TWO CASES OF MYOMECTOMY.

PROFESSOR PEARSON showed fibroid tumours, removed from two unmarried women, æt. about 30. In the first case he diagnosed either ovarian tumour or a sub-peritoneal fibroid. The uterus was of normal size. On opening the abdomen he found a large fibroid attached to the uterus by a short pedicle two inches wide. The great size of the vessels in it, and their thin walls, negated the use of the ligature, so he made two peritoneal flaps, and used a continuous suture. This failing to make the stump staunch, he put on a Braithwaite's clamp, and stitched the stump to the parietal peritoneum, in order to prevent dangerous adhesions. He left the clamp on for six hours. Recovery was uneventful. The tumour was of the kind described by the late Lawson Tait as "œdematous." In the second case there were three tumours. The largest, about the size of an orange, lay over Poupart's ligament, and simulated a hernia. It was attached to the right cornu of the uterus, and was easily removed. The second, on the anterior wall behind the bladder, had to be enucleated, whilst the third, on the posterior wall, had a very short sessile pedicle. Recovery uneventful. As a rule he was averse from the operation of myomectomy, preferring hysterectomy in such cases, but he was reluctant to deprive these women of their uteri so early in their sexual life.

Professor CORBY agreed that the major operation was the more satisfactory as a rule, but thought it only fair to choose the minor in these particular cases.

CHRONIC DIARRHŒA SIMULATING SPRUE.

Dr. O'SULLIVAN read notes of a case, which will be found in another column under the heading of "Clinical Records."

LARYNGOLOGICAL SOCIETY OF LONDON.

MEETING HELD MARCH 2ND, 1906.

DR. WATSON WILLIAMS, one of the Vice-Presidents, in the absence of the President, occupied the Chair.

Mr. H. BARWELL showed two cases of Tuberculous Laryngitis, which had benefited by local active measures and sanatorium treatment.

Dr. H. J. DAVIS exhibited a case of Atrophic Rhinitis.

Dr. WALKER DOWNIE showed recent photographs of some cases of paraffin injection for nasal deformity, as well as others taken immediately after treatment, four years ago. In the discussion which followed, there was a consensus of opinion that with such good results from the use of paraffin for overcoming definite nasal deformity, the theoretical objections put recently forward by a German doctor, and quoted by Sir Felix Semon at the previous meeting, need not be taken too seriously. Dr. BROWN KELLY exhibited a sketch of a

larynx and the microscopic section of the uvula from a case of hyperplastic congenital syphilis.

Mr. BETHAM ROBINSON showed a case of Fibro-Angioma of the Nasal Septum, and Mr. H. SMURTHWAIT exhibited again for further diagnosis a patient previously shown to the Society in June, 1905. Several opinions were expressed at that time in favour of malignant disease of the larynx. The improvement which had taken place in the interval, without operative measures; had negated the opinions previously expressed.

Cases were also shown by Dr. H. Pegler, Mr. E. G. Waggett, Dr. Furness Potter and Mr. de Santi.

THERAPEUTICAL SOCIETY.

MEETING HELD (in the Apothecaries Hall, Blackfriars) TUESDAY, MARCH 27TH.

SIR LAUDER BRUNTON, President, in the Chair.

DR. GORDON SHARP, of Leeds, read a paper on NATIVE AND OTHER PLANTS HAVING SOME RELATIONSHIP TO CURARE,

including (1) *Anchusa officinalis*, Alkanet, an imported plant containing an alkaloid; (2) *Echium vulgare*, Viper's Bugloss, an indigenous plant, containing an alkaloid; (3) *Cynoglossum officinale*, Houndstongue, a common plant, containing two alkaloids. All belong to the Boraginaceae. *Anchusa* renders a frog's skin moist and hyperæsthetic at first, but afterwards insusceptible to stimulation, while the stimulus to the sciatic nerves or the muscles themselves causes contraction. The heart stops in diastole, and atropine only produces a few contractions of the left auricle. *Echium* causes the same symptoms with more hyperæsthesia, and greater weakness of the muscles. After a large dose no stimulation of the sciatic nerve causes any contraction, though the muscles react to direct stimulation. The heart stops in diastole. *Cynoglossum* renders the skin moist and very hyperæsthetic, but stimulation to either the sciatic nerves, or the muscles directly, only affects the unpoisoned side. It often acts somewhat like curare, but frequently death occurs suddenly with the heart in diastole. Among foreign plants the *Delphinium bicolor* and *occidentale* from North America, and the *Delphinium scopulorum* from Mexico, resemble somewhat curare. Their extracts are bitter, with a slight smell, and turn red with sulphuric or nitric acids, though Delpho curarine, their alkaloid, gives no colour with either acid. The extract of *D. bicolor* acts like curare. At first it increases the reflex action of the skin, but in two hours the muscles of the poisoned side only contract on direct stimulation, though on the unpoisoned side they are acted on by stimulating the sciatic nerve. *D. occidentale* at first acts like aconite, increasing all secretions, but later the muscles become insensible to any stimulation, either direct or through the nerves. *D. scopulorum* differs from the others, inasmuch as the nerve centres of the cord are greatly depressed, more than the nerve trunks or the motor ends. *Delphinium staphisagria* or *stavesacre* first stimulates the secreting organs and the nerve centres, then depresses, and at last paralyses both the nerve centres, the motor nerves and the muscles, and finally the nerve centres of the heart.

CENTRAL MIDWIVES' BOARD.

MEETING HELD MARCH 29TH, 1906.

The President, DR. CHAMPNEYS, in the Chair.

A LETTER was read by the Secretary from Dr. Meredith Young, M.O.H., Stockport, asking on behalf of the Incorporated Society of Medical Officers for information as to the proceedings of the Board, as far as they affected Local Supervising authorities.

The PRESIDENT thought it would be good to keep in touch with such bodies and suggested sending a report for the Society named to circulate as far as was necessary.

Sir WM. SINCLAIR hoped that as the desire had been

expressed by the officers of health of an important borough, such desire would be acceded to. The motion was therefore passed unanimously.

Dr. J. E. NEVINS of Liverpool, also wrote raising certain points as to the training of midwives and the construction of rules relating thereunto, particularly those concerning uterine douches, the use of drugs &c., as at present they might give opium or castor oil at their discretion.

The PRESIDENT thought answer should be returned that the Board gave no special procedure. The Liverpool people must use their own judgment.

Sir WM. SINCLAIR remarked that such questions proved what he had always said about incompetent teachers. The Board could not undertake to supply them with common sense.

It was agreed that answer should be sent as the President suggested.

Another letter from Dr. E. Walford, M.O.H., Cardiff, was read, asking the Board to make Cardiff a centre for examinations.

Sir WM. SINCLAIR objected to this, as it was necessary to keep down the number of centres, so why should one be held at the end of the earth, and in the Welsh tongue for the sake of a few women.

The matter of a new centre was referred to a standing committee, also that of a Welsh-speaking examiner, though at the meeting of examiners the latter motion had been carried by 7 to 5.

The question then arose of an official handbook for midwives, for which only 7 as against 17 had voted at the recent meeting of examiners.

Sir WM. SINCLAIR, who, at the previous Board meeting, had strongly urged the publication of such a book, said the objecting examiners ought to have stated their objections to the Board, or in the medical press. England was greatly behind the times in the matter of handbooks, and he should bring up the question again. The examiners had simply been asked to meet and prepare suggestions, yet they had even objected to having the President of the C.M.B. at their council and asked that neither he nor any member might again attend.

The Board then passed to the consideration of the Rules, as amended by a special committee. Among the points discussed was that of deleting "registered medical practitioner" with regard to signing of certificates.

MR. WARD COUSINS urged that it implied that practitioners had been present at each labour, which was not the case, they using medical students at their convenience, especially at night.

Sir WM. SINCLAIR agreed, saying it would be unpopular but wise to make the deletion. This was accordingly done.

Another point was the number and duration of lectures to midwives.

Sir WM. SINCLAIR gave it as his opinion that lectures ought to be more frequent, shorter, and no class to consist of more than 20. The room at Manchester was built to hold 120, and the fact of 120 illiterate women all probably going to sleep under the influence of a monotonous voice was pitiable.

Dr. PARKER YOUNG asked why a higher standard should be required for midwives than for medical students. Once a week was enough.

The PRESIDENT remarked that students had at least three lectures a week.

But Sir WM. Sinclair's motion was lost on being put to the vote. This member also wished to propose that women should first give proof of some elementary education. He had had women so ignorant that he was quite sure they ought never to have appeared, and would certainly never make intelligent midwives.

The PRESIDENT said as this was a very big question it would be better to consider it after the smaller amendments had been agreed to.

The words "suitable antiseptic lotion" for the eyes of the infants evoked a remark from

Dr. PARKER YOUNG that "warm water" would

be a better substitute as many antiseptics were unsafe in the unskilled hands of a woman who would probably use the same lint for both eyes. He knew of many cases also where one instrument had been used for two purposes.

Sir Wm. SINCLAIR added that women should either be thoroughly instructed in the use of appliances or struck off the roll for not knowing. It was a monstrous and unjustifiable proceeding to let uneducated women have any power, and it generally proved how inefficient the teaching had been.

At this stage, it being late, the Board had to adjourn, it being resolved to have an extra meeting to consider Sir Wm. Sinclair's motion as to illiterate women as candidates, and some other very important points such as the administration of drugs, &c.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS. ABROAD. FRANCE.

Paris, April 1st, 1906.

TREATMENT OF BULLET WOUNDS.

PROF. PAUL RECLUS, in one of his clinical lectures, spoke recently of the treatment of wounds produced by revolver shots, and said, "During the last five months we have received in our wards six cases of bullet wounds, and you have seen me proscribe all attempt to probe the wounds; I also refused to attempt to extract the balls, and you have understood my good reasons.

"Simple as it was successful, the doctrine of systematic abstention was gaining ground. Heretofore, the magnificent results of antisepsy and the discovery of the Röntgen rays diminished the interest in the question. Since the large incisions necessary to the discovery of the projectile had lost a great part of their gravity, and that erysipelas did not follow in the wake of the bistoury, the surgeon was able to operate with more or less impunity. Again, his researches were singularly facilitated by the radioscope, which directed the instrument to the precise spot where the foreign body lay.

"All this is true, yet I consider that the doctrine of systematic abstention is superior to interference. We will study for a moment the reasons for and against my attitude. First, to remove the projectile, an operation is necessary, and every operation is equivalent to a malady, slight or serious. Sometimes, also, it is necessary to chloroform the patient where the region is too extensive to be covered by injections of stovain or where the operator—and it is frequently the case—disdains local anaesthesia. The patient, consequently, has to face the dangers of chloroform, and in spite of intelligent antisepsy, infection is always possible, and, in any case, the cicatrix is much larger than the primary wound and the cure is less rapid.

"On the other hand, the inconvenience presented by systematic abstention is very slight, if it exists at all. In the immense majority of cases, the ball becomes encysted. As to the possibility of infection or suppurating fistulae kept up by the foreign body, such complications were, it is true, dreaded formerly when the wound was inoculated by repeated probing with soiled hands and instruments; but abstention proscribes those dangerous manoeuvres, and if any infection is observed it is provoked rather by fragments of the clothing drawn into the wound by the projectile, a rare accident in itself.

"Take the six cases I have mentioned. In four of them—a ball in the hand, in the thigh, in the thorax, and in the bones of the face a few antiseptic precautions were sufficient, and in a few days the patients left the hospital cured and the projectiles encysted. In the fifth, where the ball had drawn into the orifice a piece of clothing, we contented ourselves by making a small incision to remove the cloth, but took care to go no farther. You saw how easily the patient recovered.

"The sixth case was that of a young man who got a bullet into his left forefinger. When he arrived at the hospital the wound was already infected. We tried to arrest the progress of the infection by plunging the finger into a bath of warm oxygen water and succeeded for a few days, but it returned, and we decided on operating. After injecting stovain around the root of the finger ($\frac{1}{2}$ per cent. solution), and so rendering it insensible, we extracted the projectile.

"We only extract the projectile in very rare cases; where it is can be seen or felt, that is under the eye and hand of the surgeon, or where it becomes or might become an element of inconvenience (articulations), or where the ball or fragments of clothing provokes infection. But in all other cases I abstain, whether the ball has penetrated into the muscles or becomes incarcerated in a bone.

"I know of several persons who have lived very comfortably with a projectile for the last five, ten and twenty years. In some of them the bullet is lodged in a bone, the index, the internal condyle of the femur, the head of the tibia, the pelvis, the vertebrae and the maxilla. At an autopsy recently a revolver bullet was found by chance embedded in the frontal bone, where it had remained unnoticed for years.

"Where the projectile becomes dangerous it is when it cuts a tendon, a nerve, opens an artery or a vein and provokes hæmorrhage into a viscera as the brain, the lung, the liver or the spleen, or where it wounds a natural reservoir: stomach, intestine, bladder. In such cases an operation is imperative, not, however, to remove the foreign body, which in itself is harmless, but to repair the damage caused by its passage.

"To resume the foregoing, in spite of antisepsy and the Röntgen rays, which have rendered less dangerous and more easy the research of projectiles from firearms, I maintain that the best practice consists in systematic abstention from extraction."

ANTISEPTIC OINTMENT.

Through a printer's error, the formula of Prof. Reclus' antiseptic ointment which was given last week, is misleading and incorrect. It should be as follows:—

Antipyrin, 1 drachm;
Salol, $\frac{1}{2}$ drachm;
Boric acid, $\frac{1}{2}$ drachm;
Iodoform, 15 grs.;
Phenic acid, 15 grs.;
Corrosive sublimate, 2 grs.;
Vaseline, 7 ozs.

GERMANY.

Berlin, April 1st, 1906.

At the Society for Innere Medizin, Hr. Hans Kohn reported

A CASE OF VERY ADVANCED SYPHILIS OF THE CEREBRAL ARTERIES.

A bank official, æt. 26, was admitted into the Hospital "am Urban," with acute mania one evening and was transferred to the asylum the next morning. On being examined on admission into the asylum there were found to be slowing of the pulse, papillary stasis, and slight rise of temperature, symptoms therefore of an anatomical lesion of the brain. In the absence of all history or other indications, treatment by inunction was considered allowable, the result being that in about six weeks the patient had recovered. As, however, both then and subsequently he denied the possibility of any syphilitic infection, the chances had to be taken into account that his recovery was not due to the mercury, but that it was merely an accidental *post hoc*, the disease having been a mild acute encephalitis. Two years later the patient, who had been quite fit for work in the meantime, had an attack of complete right-sided hæmiplegia with loss of speech. The diagnosis and *lues cerebri* were now considered to be no longer doubtful, as it was very unlikely that any young man of thirty, with heart and kidneys sound, should suffer from any other disease of the brain than a syphilitic one. The treatment—*injection of hydrarg. salicyl. and pot. iod. internally*—brought about complete

recovery, and as the speaker now considered himself justified in doing he instituted an intermittent-anti-syphilitic course of treatment which was kept up until quite recently. In this way the patient retained his health and his capacity for work for nine years longer.

During later months he complained of giddiness, but still followed his employment. The first serious trouble occurred three weeks ago, a transient loss of consciousness, then on the following day there was twice paresis of the left arm with clouding of consciousness and disturbance of speech, which was remarkable on account of the participation on the part of the left arm; in the course of the night there was complete paralysis of the left arm and of the left facial, with disturbance of speech, but the power of writing still remained and power to understand words. There was also Cheyne-Stokes respiration with extreme tension of pulse. There had been traces of albumen in the urine about a year before, and this, along with the arterial tension, pointed to intestinal nephritis. The heart was enlarged. After fourteen days of deep coma and rapid but regular breathing, death took place.

The autopsy showed the most extreme arteriosclerosis and calcification of the cerebral arteries, in the smaller in the shape of nodules, in the larger so that they formed rigid tubes. There was a large extravasation of blood in the left peduncle that reached to the medullary layer forwards and posteriorly into the right half of the pons. Besides this, there was a cyst fully the size of a bean in the right temporal lobe. There were some larger and smaller prominences in the aorta, which on being cut into showed participation of the media and adventitia, on which stress had recently been laid in regard to arterial syphilis. Hypertrophy of the heart and commencing contracting kidney.

The speaker observed that although it was gratifying that treatment had so far served the patient as to prolong his life and render him fit for work for eleven years, yet it was depressing that regular specific treatment could not ward off the sad termination. That was depressing, but at the same time explainable when one considered that on the one hand an intermitting treatment has no certain preventive value and on the other no *restitutio ad integrum* followed the disappearance of a gummatous process in the arterial walls, but that non-elastic cicatricial tissue took the place of the gummatous infiltration. In Thomas' view the loss of elasticity resulted in a reactive growth in the walls, resulting in a thickening, a sclerosis. As further such sclerotic thickenings showed a disposition to retrogressive changes, such as a deposition of chalk the syphilis was still indirectly the cause of sclerosis and atheroma of the arteries. One could therefore, understand why a regular intermitting course of treatment should fail in severe cases to bring about complete recovery.

At the meeting of the Freie Vereinigung der Chirurgen of March 12th, Hr. Rinne spoke on the

OPERATIVE TREATMENT OF GENUINE EPILEPSY.

He showed a man, *æt.* 39, of healthy family, who had been healthy himself up to his eleventh year. Since then he had suffered from epilepsy, always commencing with right arm and becoming more frequent as time went on. The patient was quite incapable of work, he had paralysis of the right arm, his speech was affected, his memory lost, and he bid fair to become imbecile. After talking the matter over with Eulenburg, who had had the man in charge, first of all a bloody stretching of the brachial plexus was performed. After this the fits ceased for seven days,—*i.e.*, so long as the paresis resulting from the stretching lasted; they then returned. In 1894 trepanation was performed, the central convolution was exposed, and as nothing was found by electricity or otherwise the whole left central convolution for the thickness of two to three mm. was removed. The bony flap was then replaced as well as it could be.

For a week after the operation there was loss of consciousness and paralysis of the right arm and facial nerve. When consciousness returned the paralysis disappeared and the patient remained free from any

attack for seven months. Since then slight attacks had recurred at about monthly intervals and without loss of consciousness. The patient had been able to follow an independent occupation. He had occasional pains in the right arm, the temperature of which was always lower than that of the left. The Röntgen image showed a small slit in the skull, which served as a Kocher "safety ventilator."

AUSTRIA.

Vienna, April 1st, 1906.

SCLERODERMA.

NEURATH showed a girl, *æt.* 6, affected with scleroderma in the initial stage. Two months previous she had a swelling, which commenced without any attributable cause in the left parotid region. From this point the skin of the face grew thick, hard, and dark in colour; now this condition has extended to the hips and lower extremities, accompanied with oedema. The superficial integument of the skin seems to be less affected than the deeper structures, being loose and free, with the fine hair still present, notwithstanding the presence of deeper oedema.

Neurath remarked that this rarely appeared in young children, more particularly the oedematous form, which was rare, even in adults.

SARCOMA IN CEREBELLUM.

Rach exhibited a preparation taken from a child, *æt.* 8, who was apparently well up to four weeks before the exitus, when he had a fall on the back of his head, followed by vomiting and pain in the head.

He was received into hospital on February 3rd, and died the same night. The *post mortem* revealed a tumour in the left hemisphere of the cerebellum about the size of an apple, of a greyish-white colour, having a central necrosis. The rest of the cerebellar substance on the left side was infiltrated. In the thorax and lumbar regions of the cord a form of metastasis about the size of peas were to be found both posteriorly and anteriorly.

The microscope proved these to be polymorphic-celled, and vascular sarcoma.

Schlesinger expressed surprise that a fall would develop such a diffuse form of multiple sarcoma in such a brief period. He did not know of another case on record with such convincing results of multiple sarcoma in so short a time. From a forensic point of view, it is important and worthy of careful consideration.

SODIUM CHLORIDE IN DROPSY.

Gruner next gave the Gesellschaft a history of his experiments with common salt, and its power of retention in the case of dropsy. Chloride passing through the kidneys disturbs the osmotic function, and produces a pathological retention of water in the body which leads to oedema.

His experiments were carried out on children with non-chloride diet, which had the effect of relieving oedema when it existed. He experimented on a cardiac case—incompensatory vitium with oedema; two acute and two chronic cases of parenchymatous and interstitial nephritis, along with two healthy children.

At first 10 grammes of salt was given daily. The body weight increased in proportion to the retention of water, but the nephritic cases more rapidly than any of the others. Dropsy was easily induced in these cases, and not so easily relieved when the non-chloride diet was commenced. In the interstitial form there was an increase in the elimination of chloride, but a corresponding increase in the weight, which was evidently a retention of the *Chlorurée sèche* of Ambard. This was soon relieved by a non-chloride diet. It would seem that the chloride disturbance is not always constant in the osmotic equilibrium. In a healthy 2½ months child he could suddenly raise the weight of the child by the retention of the water. In many conditions he assumed the kidneys were not able to eliminate the normal amount of chloride, which, suddenly accumulating in the body, led to water retention, and finally oedema.

Theoretically, he considered this an important clinical advance in the treatment of many diseases of dropsy, such as nephritic and cardiac, where a non-chloride diet was indicated.

MANITOBA.

THE QUESTION OF COLONIAL DEGREES AND DIPLOMAS IN CANADA AND JAMAICA.

THE Council of the College of Physicians and Surgeons of Manitoba are petitioning the Legislative Council of the Province to amend their Act in certain particulars. Among these is the following: "The clause defining those entitled to Registration under the Medical Act is sought to be amended by giving the Council the option of refusing registration (without examination) to any person who seeks registration solely on the ground of his being registered in Great Britain." The reason given for this interesting amendment is sufficiently naive to command our admiration when we consider that the medical education imparted at the Medical College affiliated with the University of Manitoba scarcely soars above mediocrity. Further, the examinations of the University are confined to simply a written one, and that in many subjects a dozen or more questions are set, so that he must be a weak candidate indeed, who cannot pick out among so many questions enough to get the fifty per cent, of marks to pass. Here is the reason as set forth by the Council of the College of Physicians and Surgeons of Manitoba which should make the members of the General Medical Council of Medical Education and Registration in Great Britain rub their eyes and ask, "What next?" "Under the Act, as it is at present, the Council cannot legally refuse to register any such person, notwithstanding the fact that some of the licensing bodies whose qualifications are acceptable by the General Medical Council in Great Britain, exact a standard notoriously lower than that demanded by the Manitoba Council from students educated in this Province and in the other Provinces of the Dominion." While this effort is being made in Manitoba to protect the Province from the inroad of men who have qualified on a "standard notoriously lower" than the Manitoba standard, a discussion is going on in Jamaica with regard to the admission of Canadian medical graduates to practise in the Island on the score of their unfitness. It appears from Jamaica papers to hand that Dr. Ker, the Superintending Medical officer sent out by the Colonial Office, has it is presumed, the sanction of the governor to bring forward a motion to enable Canadian graduates to practise in Jamaica on the same footing as British graduates. I quote from a leading article in one of the leading papers of the Island of recent date. "At one time," says the article, "Canadian medical graduates were allowed to practise in Jamaica on the same footing as English, Irish and Scottish graduates; what was the result? To use a colloquial expression, most of them 'made a hash of it.' So notoriously inefficient did some of these imported medicos prove themselves, and so much dissatisfaction was created by their work that the concession was withdrawn by Law 28 of 1885, which enacted that only holders of British diplomas, or graduates from the Colonies and foreign nations who passed an examination before the local Medical Councils should be allowed to practise their profession in Jamaica. Of course, it may be said that the standard of Canadian degrees is now much higher than it was thirty years ago. The truth of this may be admitted at once, but that does not settle the matter finally. For it must be known to the Superintending medical officer and the ruling officials of the colony that, within recent years, several Canadian graduates have failed to pass the very elementary examination which is set by our Medical Council." The article winds up by pleading delay in pronouncing judgment on the motion.

It is a strange coincidence that a discussion on almost the same lines should be going on in two distant colonies with this difference that in Manitoba the protective spirit is in favour of the graduates of the

Manitoba University, who dread that the increase of immigration may bring along British graduates; in Jamaica the object is to protect the people from incompetent practitioners. It would doubtless be of advantage to the General Medical Council in England if the Council of the College of Physicians and Surgeons of Manitoba would state specifically the British qualifying bodies with a standard "notoriously" lower than theirs.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

GLASGOW.

OPENING OF A NEW INFECTIOUS DISEASES HOSPITAL.—On Friday last, March 30th, 1906, the Lord Provost of Glasgow opened a reception house in Baird Street, for contact cases. The energetic convener of the Health Committee, Bailie W. F. Anderson, gave a sketch of the building, stating that it consisted really of three different divisions, each of which could be completed to shut off from its neighbours, as occasion might arise. A special feature of the new institution is the provision of a number of rooms, where a whole family can be accommodated. There are dormitories for men, and dormitories for women. There is accommodation for 190 adults, exclusive of the staff. The total cost, including furnishings, is estimated at about £11,000, while the cost per adult bed will be about £57.

GLASGOW EASTERN MEDICAL SOCIETY.—At a meeting of the above Society, held on Wednesday, March 21st, Dr. Leonard Findley gave a very interesting and instructive demonstration by means of the microscope and the lantern on the various abnormalities of the red and white blood corpuscles, discussing briefly their significance. Dr. John Dunn showed microscopic specimens, illustrating the different stages of the plasmodium in the tertian, and malignant forms of malarial fever.

GLASGOW OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.—Our correspondent has furnished a report of an interesting meeting of this Society held on Wednesday last, which will be found in another column, under the heading of "Transactions of Societies."

BELFAST.

QUEEN'S COLLEGE.—Dr. James Wilson has been elected Riddel demonstrator in pathology and bacteriology, in the room of Dr. Wm. Mair, resigned. Dr. Wilson had a most distinguished career at college, and has just vacated the Dunville Studentship. He has for some time been working in the pathological laboratories under Professor Symmers. The plans for the additional buildings (which gave rise to several questions in Parliament lately) are now being settled. They include the completion of the chemical buildings, the enlargement of the physiological and pathological laboratories, and the provision of more lecture rooms. These additions will be an immense boon to professors, and students alike, as the present rooms are quite too crowded.

ROYAL VICTORIA HOSPITAL.—The annual meeting of this hospital was held last week, and the medical report, read by Dr. McKisack, showed increased work all round. The internal patients numbered 3,018, and the external 25,967. There were 1,117 surgical operations, with 50 deaths after them, a mortality of 4.4 per cent. Excluding the cases moribund on admission the mortality in the medical wards was 5.30 per cent, and in the surgical 2.8 per cent., giving a general average of 3.7 per cent in the hospital. New beds to the number of 32 were opened last April, but the accommodation is still quite insufficient for the cases applying for admission.

ULSTER MEDICAL SOCIETY.

ADDRESS TO THE LORD LIEUTENANT.—On the occasion of the visit of His Excellency the Lord Lieutenant to Belfast last week, an address was presented to him by the Ulster Medical Society. The deputation present-

ing it consisted of Dr. Wm. Calwell (President), Professor Byers, Drs. Dempsey, Davison, McCaw, and Thos. Houston (hon. sec.).

TUGHAN v. DARNELL.—A special joint meeting of this Society and of the Ulster Branch of the British Medical Association was held in the Medical Institute, Belfast, on Thursday evening, March 29th, to consider this case. The question of an appeal against the decision in the late trial was discussed at length, and the bearing of the learned judge's interpretation of the law as regards negligence on the members of the profession generally. It was agreed to adjourn the meeting till counsel's opinion could be obtained on certain points. The question of raising a fund to assist in defraying the expenses of the three trials was also postponed.

LETTER TO THE EDITOR

EYE-STRAIN AND IMPERFECT LIGHT.

To the Editor of the MEDICAL PRESS and CIRCULAR.

SIR,—I have often wondered why reading in an imperfect light tired the eyes. Of course, it is easy to adduce as a reason that "it is a much greater strain reading by candle light than by daylight," but that, after all is only re-stating the same fact in different words. Moreover, I do not remember having seen anything beyond the mere statement in books on refraction—that is to say, anything that explains exactly where the strain comes in.

It occurs to me that a photographic experience will serve the purpose. When we wish to photograph a view comprising near as well as distant objects and desire all of them to be in focus, the plan is to make use of a very small diaphragm. Now, when we read in a good light the pupil is of course contracted, and cuts off the marginal rays, so that very little effort of accommodation is necessary and we read with comfort. In twilight, however, the pupil is naturally dilated, and it becomes necessary to focus with greater precision just as with a camera when we employ a large aperture. I take it that it is the constant effort to maintain the exact focus that proves so fatiguing, and of course the larger the type the less is the strain on the accommodation.

The strain is exaggerated by the fact that one is tempted to bring the object nearer to the eye when the page is inadequately illuminated, thus adding to the focal effort and throwing more work on the apparatus of convergence.

Yours truly,
ALFRED S. GUBB, M.D.

Mustapha Supérieur,
Algiers, March 31st, 1906.

OBITUARY.

LIONEL SMITH BEALE, F.R.S.

We regret to announce the death of a distinguished member of the medical profession in Dr. Lionel Beale, who died on March 26th, at the age of seventy-eight years. He was educated medically at King's College, and was connected with that institution for more than forty-three years. He qualified as M.B. of London University in 1851, became a member of the London College of Physicians in 1856, and a Fellow in 1859. In 1871 he was appointed Baly medallist of the Royal College of Physicians, of which body he was Lumelian Lecturer in 1875. In 1865 he was chosen Croonian Lecturer to the Royal Society. At King's College he held many important posts, the chief being that of consulting physician, and on his retirement that of Emeritus Professor of the Principles and Practice of Medicine. From his student days Dr. Beale was an ardent worker with the microscope, and perhaps the best known of his many works is "The Microscope in Medicine," a large volume that reached a fourth edition. Dr. Beale was an authority on protoplasm, and made many valuable contributions to medical

science and medical literature. As a teacher and as a man of science, he was strenuous, untiring, and full of high purpose. His life has indeed been well spent in the service of a noble profession. His son, Mr. Peyton Beale, is surgeon of King's College and of the Great Northern Central Hospital.

MR. WM. R. H. STEWART, F.R.C.S.ED.

WILLIAM ROBERT HENRY STEWART, F.R.C.S.ED., of Wilbet Crofton, Orpington, and 42, Devonshire Street, London, W., who died on March 7th, 1906, aged 54, was the eldest son of the late William Edward Stewart, of 16, Harley Street, W. Studied at the University College Medical School, and was admitted a Member of the Royal College of Surgeons, England, in 1874, a Licentiate of the Royal College of Physicians, Edin., and of the Society of Apothecaries in 1876, and a Fellow of the Royal College of Surgeons, Edin., 1878. Mr. Stewart devoted much time and study to affections of the ear and throat, and had been surgeon and surgeon-in-charge in the throat and ear department of the North-West London Hospital, and Surgeon to the Throat Hospital, Golden Square, and to other public institutions in London. He was surgeon-in-charge of the throat and ear department of the Great Northern Central Hospital, consulting surgeon to the London Throat Hospital, and a member of various societies. Mr. Stewart was the author of several works on professional subjects.

DR. THOS. EVANS, M.D., NEWQUAY.

DR. EVANS, who died last week at the age of 65, obtained the degree of doctor of medicine (Edinburgh) in 1865. Whilst studying there he contracted typhus fever, on which, towards the close of his university career he wrote a thesis which won for him the warm approbation of his professor. He left the university for Ystradgynlais, and then became house surgeon of Portsmouth Hospital. Obtaining the appointment some years later of medical officer of health for the lower division of the Aberayron Union, he settled down to practise at Newquay, where he was greatly respected. He was twice married, and leaves a widow and five children.

DR. LOGAN, WHITEHEAD, CO. ANTRIM.

DR. WILLIAM LOGAN, who died last week at his home at Whitehead, was well known in the North of Ireland, and greatly respected. He graduated at St. Andrews in 1862, and practised in Belfast, and then in England, but some years ago his health began to fail, and he retired to a country cottage in a lovely position overlooking Belfast Lough. Dr. Logan was never inclined to appear much in public, or take part in public affairs, but to all who knew him he endeared himself by his unflinching kindness and geniality. His children, two sons and a daughter, have all entered their father's profession.

NEW PREPARATIONS.

WELLCOME BRAND PILOCARPINE NITRATE.

CERTAIN recent statements in pharmaceutical and analytical reports have been to the effect that it is extremely difficult to obtain essentially pure Pilocarpine. We know that the standards of purity adopted by both the British Pharmacopœia and United States Pharmacopœia are below the standard generally referred to, viz.:—melting point of 174–178° is that proposed some years ago by Dr. Jowett. On the other hand it has been shown that the melting points of commercial specimens range from 162–168°. In the course of the exhaustive enquiry on the Jaborandi Alkaloids conducted in the Wellcome Chemical Research Laboratories, the necessity of an absolutely pure Pilocarpine Nitrate was demonstrated, and it was also shown that the associated alkaloids differed considerably in physiological activity. In connection with these researches the manufacture of Pilocarpine salts of the highest degree of purity was

undertaken by Burroughs Wellcome and Co., and in order to demonstrate the purity of their product and the fact that none is issued under the above standard, the melting point of the batch is indicated on the label of each "Wellcome" brand package. This melting point is 175-176°, a figure which represents chemically pure Pilocarpine Nitrate.

HÆMOSTASIN.

MESSRS. BURGOVNE, BURBIDGES AND CO. have introduced a new and trustworthy preparation of suprarenal gland under the name of "hæmostasin." It is made according to the method of Aldrich and Takamine, who first produced the active substance of the gland in the form of crystals. In this way many of the technical difficulties of isolating and of preserving the active principle are overcome. Besides its use as hæmostatica, this drug has an important application in urogenital practice. For minor operations it acts well as a pre-operative ischæmic, and can be combined with cocaine so as to procure in addition local anæsthesia. Hæmostasin also acts as a valuable cardiac stimulant. An excellent short account of the history, preparations and uses of hæmostasin is published by Messrs. Burgovne, Burbidges and Co.

CHIVERS' PRESERVED FRUITS.

THE cry for home productions could hardly be better directed than in the case of fruit, vegetable and dairy produce. In the case of fruit, we are glad to see that the well-known firm of Messrs. Chivers and Son have come to the rescue with a new process in which English fruit is preserved in tins. This trade in foreign tinned fruits is enormous, but there is no fruit in the world to equal the delicate flavour and attractiveness of that grown in our own country. Messrs. Chivers own 2,000 acres in Cambridgeshire, where they grow the finest fruit in large quantities. By a process of their own they preserve the greengages, raspberries, and what not in such a way that each keeps its particular flavour and remains sound and wholesome for an indefinite number of years. The samples we have examined in our opinion represent the perfection of preserved fresh fruit. We congratulate this enterprising firm on having added materially to the resources of a wholesome and important branch of agriculture.

REVIEWS OF BOOKS.

CABOT ON PHYSICAL DIAGNOSIS (a)

THE object of this volume, as the preface informs us, is "to present an account of the diagnostic methods and processes needed by competent practitioners of the present day." It differs, we are told, from similar books in that no attempt is made to describe technical processes with which the writer is not familiar, and in that no space is given to description of tests which he believes to be useless. We congratulate the author on his candour and courage, and might add that it differs also—or rather in consequence—in being practical and readable. We are not, in fact, acquainted with any book which gives in so pleasant a form all the essentials of the diagnostic art, while eliminating at the same time those methods which, however useful, must remain more as limited specialities than as aids to the general practitioner. It is, we presume, to the qualified and practising physician that the writer addresses himself, and it is such, no doubt, who will derive most value from a perusal of the book, but at the same time we express the hearty wish that every medical student should be compelled to learn and practise the more elementary methods described before admitting him to hospital lectures. Once they were learned the lectures would have a meaning and the time and patience of both teachers and taught would

be saved. As matters at present are, many a student obtains his qualification without having any real knowledge of the physical principles underlying the methods of examination he has learned, and hence is liable to go hopelessly astray when confronted with any unusual case. This results not from any real difficulty in the subject, but rather from the lack of any systematic teaching of it. The student learns to recognize disease by certain signs, but does not grasp the meaning of those signs. If now at the beginning of his course he was compelled to recognize the body as a physical machine, subject, more or less, to ordinary physical laws, this trouble would be obviated, and more time would be available for the all-important study and appreciation of symptoms. These remarks may perhaps appear out of place in the review of a book, but as they embody our fixed opinions with reference to the importance of an early study of the subject treated of in the volume they may be allowed to stand.

While all sections of the book show considerable merit, most praise is, we think, due to the section which deals with the examination of the chest. We are in agreement with the author that percussion is the most difficult of all the arts of examination to acquire, and that none is so seldom thoroughly learned. His own methods appear to us in general to be sound, though to descend to details we entirely disagree in his estimate of the value of the area of deep cardiac dulness. Our own opinion is that its value is nil, and we have almost entirely given up the attempt to map it out, though we, of course, admit that many observers place considerable reliance upon it as a diagnostic sign. On page 264, we find Osler quoted as defining palpitation as "irregular or forcible heart action perceptible to the individual." It is surely unnecessary to quote anybody in support of this definition nowadays, but if a name is wanted the writer might we think go further back in his search of authority. On page 291, we are told that in cases of doubtful diagnosis between aneurism and empyema necessitatis, "it is perfectly safe to insert a hollow needle." However safe this procedure may be in very careful hands, we can hardly believe that it is one to advise in a text-book. Though many aneurisms may be punctured without danger, there are some in which puncture would be attended by a fatal result, and so we think that the reader should be informed of the dangers and advised rather to endeavour to perfect his diagnosis by other means. We must in all cases endeavour to prevent medicine becoming like surgery, a pursuit in which diagnosis is made by operation. There are a few other points which we might find fault with; for example, we do not ourselves perform the nitric acid test for albumen in a wine glass, but these matters are very small, and, on the whole, we have nothing but praise for the work.

The illustrations are numerous, and, for the most part good. We could hardly have believed that the picture on page 148 was required, but doubtless there are some to whom it will appeal; on page 173, the aortic valve is figured as being at a higher level than the pulmonary; and on page 429 a trivial illustration is introduced. The great majority of the figures are, however, practical, and illustrate important clinical conditions. They greatly add to the appearance of the book, though a dash of colour in the blood pictures would make them more attractive.

THE CLINICAL SOCIETY'S TRANSACTIONS. (a)

ONCE again the Transactions of the Clinical Society make their appearance in their familiar garb to remind us of the good work done by the society and to bear witness to its continued vitality. The volume does not differ in any respects from its predecessors, consisting as it does, of a series of short papers upon cases of interest, and of notes upon clinical cases which were exhibited at the various meetings throughout the session. The latter number fifty-one in all, and as

(a) "Physical Diagnosis." By Richard C. Cabot, M.D., Instructor in Medicine in Harvard University. Third Edition, Revised and Enlarged. Plates 5; figures 240. London: Baillière Tindall and Cox, 1906. Price 10s. 6d. net.

(a) "Transactions of the Clinical Society of London, Vol. 33. London Longmans, Green and Co. 1905.

they are picked, we presume, from a very much larger number of exhibits they throw an instructive light upon the numbers of rare and interesting cases which pass through the general hospitals of London within the year.

The present volume opens with an address by the President, Dr. Frederick Taylor, in which he deprecates the fact that therapeutics have not kept pace with the extension of our etiological and pathological knowledge, and urges the members to pay more attention to the therapeutical side of their cases, when exhibiting and reporting them. With this exhortation we are only in partial agreement, for while admitting the crying need of an extension of therapeutical knowledge, we believe that such an extension must logically follow, and not accompany the increase in our pathological and etiological data. While, therefore, the patients of the present day may perhaps suffer through our ignorance, we believe that the patients of the future will gain through our methods of seeking knowledge, and that when the time is ripe therapeutics will once again come to the fore, but as a rational science and not as an empirical application of often ill-founded and of single observations.

The communications which constitute the bulk of the Transactions are thirty-three in number, and it is no exaggeration to state that each one of them is of unusual interest. The collection as a whole forms in fact one of the most readable books of this nature that we know. The rules of the society forbid lengthy articles, and for the most part confine their contributors to the record of single clinical cases. The result is that each communication is in the form of a graphic clinical picture, tersely worded and clear, and devoid of the long historical and theoretical discourses which so often labour similar records in the various journals. From among so many papers, however, we can only select a few for special notice. On the medical side, the paper by Dr. Box on "The Crises of Posterior Basic Leptomeningitis calls attention to the pyæmic character which a chronic non-suppurative meningitis may assume, and also to the length of time that these cases may last. Five cases are reported, one of which lived for nearly four months after the initial symptoms, and presented during that time a daily rise of temperature to from 102-104° F., followed in a few hours by a fall to subnormal. The autopsy in each case showed slight posterior basic meningitis and chronic hydrocephalus. We regret that a more careful bacteriological examination of all of these cases was not made, as we believe that some of them would have proved to be chronic infections by the colon bacillus.

Dr. Ewart does good service in calling attention to what he terms "soft valve" mitral stenosis, in which no murmur is audible, and Dr. Hale White records an interesting case of "Acute Rheumatoid Arthritis," while the whole subject of arthritis deformans is discussed by Abrahams in the immediately succeeding paper. Among the surgical communications the most striking is the report by Harris and Low, of "The Cure of Infantile Paralysis of the Shoulder by Nerve Grafting." The essential steps in the operation consist of determining by experiment, after exposure of the brachial plexus, what trunks are degenerated, and then grafting the distal end of such trunks into healthy nerves. The results have on the whole been most successful and reflect much credit on the operators. The paper by Barker on the "Condition of the Small Intestine some Years after Extensive Enterectomies" is of real physiological importance, though, perhaps of minor interest from a practical point of view; while as a curiosity amongst the complications or sequelæ of appendicitis we find recorded by Weber a case of "Localised Flushing and Sweating of the Cheek." Of the other papers we need only mention "Urinary Paraplegia" (p. 80), "Intermittent Hydrops of the Joints" (p. 147), and "A Case of Kaposi's Disease" (p. 238), while advising our readers to purchase the volume and enjoy it for themselves.

"Food and Diet" and National Health.

THE Hon. Sydney Holland presided on Wednesday last, at the rooms of the Medico-Chirurgical Society, over an interesting lecture delivered by Dr. Robert Hutchison on "Food and Diet." The lecture was the first of a series of three, being delivered under the auspices of the National Health Society on Wednesdays at 5 p.m. They are principally for the Members and Students of the Society, many of whom are training to become women sanitary inspectors, &c., but visitors can obtain tickets at a nominal charge of 1s. per lecture, by applying to the Secretary, at 53, Berners Street, Oxford Street, London, W. On Wednesday, March 28th, Prof. G. Sims Woodhead lectures on "Temperance," Sir Thomas Barlow, Bart., M.D., K.C.V.O., presiding; on April 4th, Sir Dyce Duckworth, M.D., LL.D., lectures on "Dust," when Dr. J. F. W. Tatham presides. The Chairman in introducing Dr. Hutchison said that no one was better qualified or able to lecture on "Food and Diet" than he, as he had taken and analysed every patent medicine and food which had been brought out. The Lecturer said that what was wanted was to know which foods for a particular person were most suited to him. Hard and fast rules were impossible. The principal need was the repair of the tissue of the body and the supply of energy to it. **Trinity College, Dublin.**

The following candidates passed in the subjects indicated during Hilary Term, 1906:—

Final Examination in Medicine—Part I.—Thomas O. Graham (passed on high marks), Francis W. H. Bigley, Cecil T. Conyngnam, Henry D. Woodroffe, Ernest C. Crawford, Charles G. Sherlock, Arthur E. Knapp, Albert T. J. McCreery, Francis O'B. Kennedy, Wilfred L. Hogan, Henry B. Leech, John A. Hartley, Joseph C. Ridgway, Wallace D. Mitchell, and George H. Slack.

Intermediate Medical Examination—Part II.—William Pearson, Johannes C. Pretorius, Robert E. Wright, William E. Hopkins, John A. W. Ponton (the foregoing five passed on high marks), William S. Thacker, David J. Miller, Dixie P. Clement, James F. Clarke, Wilfred J. Dunn, Thomas P. Dowley, Alfred H. Smith, James C. C. Hogan, Gordon A. Jackson, John H. Morton, Thomas P. S. Eves, Norman P. Jewell, Allan T. Powell, Julian B. Jones, James R. Yourell, Ernest C. Lambkin, Oliver Gogarty, Edmund H. Sheehan, Alexander S. M. Winder, William Knapp, Frank R. Seymour.

Final Examination in Medicine—Part II.—Samuel G. S. Houghton, Gustav W. Thompson, John D. Sands (the foregoing three passed on high marks), Robert A. Askins, John C. P. Beatty, Basil G. Brooke, Thomas H. Peyton, Francis Casement, Francis Coppinger, George Dougan, George G. Vickery, Ralph S. Oldham, Edward Gibbon.

Conjoint Examinations in Ireland.

CANDIDATES have passed the First Professional (March) Examination, as undernoted:—Messrs. P. White (with Honours), S. Campbell, R. Charles, D. F. Curran, J. Donoghue, J. W. Flood, F. R. Jones, L. C. King, J. Mitchell, T. Murray, J. T. MacDonnell, C. McDonnell, M. O'Brien, P. O'Farrell, W. R. O'Keefe, G. Sheehan, and R. A. Wright.

THE annual general meeting of the Medical Graduates' College and Polyclinic was held at 22, Chenies Street, London, on March 23rd, the chair being occupied by Dr. C. Theodore Williams, who, in moving the adoption of the report and balance sheet, said that though the College was spending less money than formerly, it was nevertheless making about the same. The number of members was satisfactory, and the number of temporary subscribers was large. He referred with pride to the lectures delivered during the last year dealing with surgery, medicine, and all specialities. A new departure was the formation of tutorial classes started by Captain Pinch. The following five new members of council were elected:—Dr. H. Campbell, Dr. W. Ewart, Dr. E. N. Féré, Dr. Dundas Grant, and Dr. R. Purdie.

MEDICAL NEWS IN BRIEF.

Action Against a Cork Medical Man.

AN action of considerable importance to the medical profession was heard at the recent Cork Assizes before the Lord Chief Justice. A midwife of the name of Harvey attended a lady in her confinement, which passed off normally. A couple of days later the midwife went to another case, in which, according to the evidence, the body was born in a state of decomposition, and the mother subsequently died of sepsis. For several days the nurse attended both cases, and after she had ceased attendance on the first the infant developed an acute suppurative omphalitis, of which it subsequently died. Two days prior to its death, when it was in a moribund condition, it was brought to Dr. Dalton, the defendant in the action. He recognised that it was dying, and in a very serious condition, and amongst other measures ordered hydrarg. cum Creta in half-grain doses with the object of producing its purgative effect and of stimulating the action of the liver. On the child's death, he gave a certificate of death from "spreading cellulitis." The parents of the infant asked what this term meant, and Dr. Dalton replied that it meant "blood-poisoning." The father immediately connected the death of his infant with the death of the former patient of the nurse who had died of sepsis, and said that the nurse had communicated the infection and that he would take an action against her. He also went to the public health authorities and acquainted them of the case, with the result that they sent for the nurses's clothes to have them sterilised. The nurse considered that this was detrimental to her practice, and brought an action for slander against Dr. Dalton, the parents of the dead child, and two relatives. The case proved a long one, and cannot be fully discussed. The chief point relied upon by the plaintiff was that Dr. Dalton had first made a diagnosis of syphilis, which diagnosis, actuated by spite against the nurse because she had advised patients of his to seek advice elsewhere, he had changed to blood-poisoning, and that in fact the child did die of syphilis. The reason given for saying that Dr. Dalton had diagnosed syphilis was that he had administered mercury. This notion was, of course, easily combated, and the jury returned a verdict for the defendant on all points. We congratulate Dr. Dalton on the result of the case because it appears to us that he acted throughout in a proper and straightforward manner. He was confronted at the same time with an angry father and with a nurse who, from what transpired at the trial, was not as careful as she ought to have been. Each of them expressed the desire to take legal proceedings against the other and Dr. Dalton endeavoured to arrange matters amicably. So well did he try to do this, that the only occasion on which he could have been proved to say anything reflecting upon the nurse was in his own study to the nurse and her mother alone, and at a time when he was trying to give them both good advice. If the well-meant efforts of medical men are to be used as an occasion for promoting a slander action, it will have the effect of rendering them very careful as to the persons on whose behalf they make such efforts.

The Drug Contracts Question in Ireland.

MR. FIELD, M.P., asked the Chief Secretary for Ireland in the House of Commons on the 27th ult., whether he was aware that, owing to the recent action of the Local Government Board, about three-fourths of the tenders for drugs and medicines to Irish Unions are necessarily supplied by English firms of wholesale druggists; would he say whether Irish firms were allowed to tender for similar contracts in England, and whether he would take the necessary steps to enable Irish firms to tender for supplies on equal terms in both countries?—Mr. Bryce replied that one-

third of the drug contracts, and not three-fourths was obtained by an English firm last year. As regards the latter part of the question, it must be remembered that one-half of the cost of these medicines is defrayed from public funds. It is the duty of the Guardians to obtain the best return for the money of the ratepayers, whose trustees they are; and similarly it is incumbent on the Local Government Board to see that no unnecessary charge is placed on public funds. Moreover, any attempt to confine tenders to Irish firms might have the effect of prejudicing Irish tenders for various articles from being accepted in England. So far as the Local Government Board for Ireland are aware, there is nothing to prevent Irish firms from tendering for similar contracts in England upon equal terms with English firms.

The International Congress of Medicine at Lisbon.

WE are informed by the National Committee for Great Britain and Ireland that the London, Brighton and South Coast Railway Company gives notice that it will issue return tickets from London to Irun to members of the International Congress of Medicine, their wives and children. The tickets are available for sixty days *via* Dieppe, Paris, and Bordeaux at fares, £5 15s. 5d. first-class; and £4 18s. second-class. They can be obtained at the Victoria and London Bridge Stations of the L. B. & S. C. R., the only formality necessary being the presentation of the *carte d'identité*.

The South Eastern and Chatham Railway Company has arranged, conjointly with the French railways, to issue return tickets from London to Irun at the greatly reduced rates of £6 13s. first class and £4 12s. second class, for members who propose to travel overland to Lisbon. The tickets will be available *via* Dover and Calais or by Folkestone and Boulogne, but members are advised very strongly to take the 10 a.m. service from Victoria *via* Folkestone and Boulogne, as that service is the least crowded and reaches Paris at 6.4 p.m. in ample time to dine before continuing the journey by the 8.7 p.m. express. This train reaches Irun at 8.50 a.m. on the following morning. The tickets are available for 45 days, and will also be issued to the wives and children of members, but not to other relatives. They can only be obtained at the Victoria S.E. and C.R. on production of the Membership certificates, from April 1st onwards.

Medical Salaries in Wales.

THE Guardians of the Bangor and Beaumaris Union, having lost their workhouse medical officer, have advertised for a successor, fixing the salary at £50, out of which he will have to supply the drugs required. This remuneration naturally is not considered enough for the importance of the post and the duties involved, and last week a meeting of local medical men was held when the following resolution was passed:—

"That this meeting of the medical men of Bangor resolves that the salary of £50 offered by the guardians of the Bangor and Beaumaris Union for the post of workhouse medical officer is totally inadequate for the services demanded, and that after the passing of this resolution, any medical practitioner applying for the post at a smaller salary than £70 per annum will be guilty of disloyalty to his profession."

Death by Misadventure.

AN unfortunate occurrence at Caerphilly, Wales, resulting in the death of a medical man from an overdose of chloral, took place last week; and at an inquest held on Friday, the jury returned a verdict of "Death by Misadventure," after evidence had been given that the deceased, Mr. Chas. Dolman, L.R.C.P.Ed., was in the habit of taking drugs for insomnia, and a bottle of chloral-hydrate was found in the room.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

Recent Surgical Methods in the Treatment of Certain Forms of Paralysis.—Tubby (*British Medical Journal*, March 3rd, 1906) discusses the treatment of the deformities arising from anterior poliomyelitis, spastic paralysis, ischæmic paralysis, and some traumatic lesions of nerves, by the various methods of tendon and muscle transplantation, and by nerve anastomosis. The author describes a number of operations he performed. A case of paralytic equinovaglus associated with paralysis of the tibialis anticus was treated by grafting a strip of the extensor proprius pollicis tendon into the tibialis anticus, and the two outer tendons of the extensor communis digitorum were severed and attached to the periosteum of the internal cuneiform bone. The tendo Achillis and plantar fascia were divided at the same time. The foot was put up at right angles and somewhat inverted, in Scarpa's shoe for six weeks, and after the wound had healed massage was applied to the grafted muscles. The result was excellent. The outer border of the foot on standing pressed firmly on the ground, and the inner border was raised. There was a good arch formed with no eversion. A girl, æt. 13, suffering from paralysis of the extensors of the thigh, causing the leg to hang at right angles at the knee, was treated by grafting the semi-membranosus tendon into the extensor cruris. A useful limb resulted. In the upper extremity the author has operated for the relief of pronator and flexor spasm of the fore-arm in spastic paraplegia, by detaching the tendon of insertion of the pronator radii teres, passing it through the interosseous membrane, and fixing it to the outer side of the radius, so that it may assist in supination. A gentleman, æt. 26, with a contracted and entirely useless spastic hand, was so much improved by operative treatment that he was able to use the hand in writing. In this case the carpal flexors were divided, their tendons lengthened by means of silk attachments, and then transferred to the extensor surfaces of bases of the second and fifth metatarsal bones. Subsequently the digital and thumb flexors were lengthened at the wrist. In discussing nerve anastomosis the author describes a case of traumatic facial paralysis. The distal end of the facial nerve was inserted by lateral implantation deeply into the hypoglossal nerve. A week after the operation the palpebral fissure was lessened in size, and the eye could be temporarily closed. In less than four months the patient had recovered very fair movement of the facial muscles, with only slight impairment of speech, due to interference with the hypoglossal nerve. Nerve grafting has also been used for the treatment of infantile paralysis. In a case of paralytic talipes calcaneus grafting of the nerves to the soleus and gastrocnemius from the internal popliteal to the external popliteal was followed by recovery. S.

A Preliminary Report on a Study of Fractures of the Head of the Radius, with Special References to its Frequency, and to Fractures of the Neck of the Radius.—Thomas (*St. Louis Med. and Surg. Journ.*, Jan., 1906), calls attention to the difficulties in diagnosis, and the uncertainties of prognosis, of this variety of fracture at the elbow-joint. The literature on the subject is scanty. The fracture is usually caused by a fall on the hand. The head of the radius is broken off by striking against the capitellum of the humerus, the fracture extending through the neck of the radius. Clinically in these cases the head of the radius is found to move with the shaft. There is no crepitus or deformity. The principal signs are pain at the elbow and limitation of movement, more particularly of

pronation and supination. The fracture may easily be missed in a skiagram if an antero-posterior view alone is taken, as the rays then pass at right angles to the line of fracture. A lateral view usually shows the fracture clearly. Fracture of the head and neck of the radius are frequently associated with posterior dislocation of both bones of the forearm at the elbow. This condition is liable to be overlooked in skiagrams, as the radial head is obscured by the ulna and condyles of the humerus. Skiagraphic statistics are important in establishing the frequency of this fracture, and also show that fracture of the head and neck are essentially the same, both being very frequently associated, both giving rise to very much the same symptoms, prognosis and treatment, and especially since both involve practically the same part of the radius, and are due to the same cause. According to these statistics fractures of the head and neck of the radius are more frequent than fractures of the patella. In some experimental work performed by the author, six fractures were produced with comparative ease, each one corresponding to the fracture most frequently reported as occurring during life. The only failure that occurred was produced by using excessive force, and in this case Colles' fracture resulted. S.

Pyloroplasty with the McGraw Ligature.—Carstens (*Lancet Clinic*, March 3rd, 1906) reports two cases of dilatation of the stomach due to pyloric stenosis, which were successfully treated by this method. The author describes the technique as follows:—"With a round needle threaded with fine silk, I sewed the duodenum to the stomach from the pylorus downwards for two and a half inches. A curved, Hagedorn's needle threaded with McGraw's (elastic) ligature I now insert into the stomach about two and a half inches from the pylorus, and then down the duodenum for two and a half inches, bringing it out, also about one-third inch from the row of sutures. The ligature was pulled through and made fast in the usual way. I now continue the row of sutures at the end and the other side, and the operation is finished." The patient is given full diet about a fortnight after the operation. In both cases the gastric symptoms were relieved and the patient regained health. S.

Diagnosis of Tuberculosis of the Iris.—Gouriein, Geneva (Soc. Franc. d'Ophthal., Mai, 1905) recommends a method to differentiate tuberculosis of the iris from other nodular diseases of that part. He makes a puncture of the anterior chamber of the diseased eye, and having drawn off the aqueous humour he injects it into the eye or under the skin of a rabbit or guinea pig. Whether he gets a positive or negative result he considers the results are equally useful as an aid to differential diagnosis. He records four cases. Two gave positive results, in which other symptoms developed, one of the cases dying of tubercular meningitis. One with a negative result was put on antisyphilitic treatment with a satisfactory result. M.

Full Correction of Myopia.—Bourgeois, Reims (Soc. Franc. d'Ophthal., Mai, 1905), having studied recent literature gives his conclusions as follows: Most oculists are of the opinion that excessive convergence for near work is the principal cause of the origin and increase of myopia. Full correction has a beneficial effect on myopia. There is a doubt as to the advisability of correcting fully the cases known as malignant myopia. In young people with myopia up to 6D full correction should be ordered and will be well borne. In children with myopia amounting to a fraction of

1D. glasses should be ordered, as it is probable that the myopia is arrested thereby. In myopes of high degrees (over 6D) final full correction has to be reached by easy stages commencing with 7 or 8D, which will be generally acceptable to young adults. In cases over 12D no definite rules can be laid down. In all cases astigmatism should be accurately corrected. Where insufficiency of the internal recti exists the lenses, which should be large, round and perisopic, must be appropriately decentred. The author urges the importance of a correct reading distance (30 or 40 cm.) being observed in the cases of school children, even if it necessitates the use of a head-holder. In progressive myopia the general health of children must be carefully attended to. Javal, in discussing Bourgeois's paper was in favour of all school children being carefully tested as to vision, and of the introduction of vertical writing desks into schools. M.

Collargol in Ophthalmia Neonatorum.—Demits, Anvers (Soc. Franc. d'Ophthal. Mai, 1905) pins his faith to this salt after twelve months trial in these cases, just as others have pinned theirs to protargol and argyrol. He says that it can hardly be questioned that the use of nitrate of silver during the first week of ophthalmia neonatorum may have an injurious effect upon the nutrition of the cornea already endangered by chemosis, and further, it must be applied by skilled hands for a lengthened period. This is not always possible, and it is dangerous to entrust its application to lay hands. Collargol Demits found of equal therapeutic value with the nitrate, and free from the above disadvantages. In a discussion Armagnac, Lagrange and Wickerkiewicz maintained that nitrate of silver still held its reputation in the treatment of this disease in spite of the keen rivalry of the newer organic silver salts. M.

The Surgery of the Thyroid Gland.—Under the head of surgical diseases of the thyroid gland Max Ballin (*New York Med. Jour.*, Feb. 10th, 1906), mentions first injuries and malformations of the gland, then goes on to discuss inflammation occurring in an otherwise healthy gland—i.e., Thyroiditis, and the results of the same process when it occurs in a previously enlarged gland—i.e., Strumitis. The former nearly always subsides, but abscesses may form which should be at once opened. The varieties of goitre and their appropriate treatment are then fully dealt with. The author finally goes on to the subject of exophthalmic goitre. This affection is characterised pathologically by, (1) a thick fibrous capsule, which is not separated as easily as is commonly done from an ordinary goitre; (2) by an increase in the size and number of the blood vessels; (3) a very broad isthmus; (4) the epithelium of the follicles is in a state of proliferation and degeneration. The medical treatment of this disease is not satisfactory. Are surgical measures justified? The author believes they are; he has operated on six cases, removing the greater portion of the gland; three are cured, two are much improved, and one is slightly improved. Recent statistics from 291 cases of this disease operated upon show 165 cures, 77 improved, 12 not improved, and 37 died. Thyroidectomy seems to give better results than either ligature of the thyroid arteries, or excision of the sympathetic nerves. G.

Prostatic Albuminuria as a Cause of Error in Diagnosis.—E. G. Ballenger states in the *New York Med. Journ.*, Jan. 24th, 1906, that albumin in the urine does not always indicate a lesion of the kidney; the secretion from hyperæmic or chronically inflamed prostate glands are a not infrequent source of error in many of the cases of apparently harmless albuminuria. The secretion from a diseased prostate contains a proteid material giving the tests for albumin; this secretion frequently passes back into the bladder and may mix with the urine, leaving it quite clear; as much care should be taken to avoid this secretion as is taken to avoid uterine or vaginal discharge. The author emphasises the following points: (1) the secretion from

an inflamed or hyperæmic prostate is albuminous while that from the normal gland is not, or is present in such small quantities that, unless the seminal vesicles are massaged, the urine passed will not give the tests for albumin; (2) this is apparently a constant symptom of chronic prostatitis and may be depended upon in the diagnosis; (3) prostatic albuminuria seems to be an appropriate name for this condition; (4) in making insurance examinations as well as in the diagnosis of obscure forms of albuminuria, this possibility should be eliminated with the other sources of contamination, before reaching a positive conclusion as to the significance of albumin; (5) the periodic increase in the prostatic discharge, along with the striking similarity between the symptoms of intermittent, postural, orthostatic, and cyclic albuminuria, and prostaticorrhœa makes the possibility of mistakes in the diagnosis extremely likely, when this fluid flows back into the bladder and does not appear at the meatus; (6) this regular increase of this secretion every ten to thirty days, and the analogy between the uterus and the prostate, suggest a relation between the causes of this condition and menstruation. G.

Gastric Surgery.—In a lecture on this subject Mr. H. Paterson (*Lancet*, Feb. 24th, 1906), refers in detail to the operation of gastro-jejunosotomy—more particularly to its immediate and late results; he believes that in most cases "the vicious circle" occurs as a result of faulty technique. The author has been able to follow the histories of 116 cases in which gastro-enterostomy had been performed for non-malignant disease of the stomach, at periods varying from three to twenty years previous to the time of the inquiry. From these cases he draws the following conclusions: (1) That the use of mechanical appliances is attended with uncertain results; (2) that a small opening between stomach and intestine is apt to prove unsatisfactory; (3) that if the mucous membrane of the stomach and the jejunum are not brought into apposition, undue contraction or even complete closure of the opening may result; (4) that about 85 per cent. of the patients suffering from simple pyloric stenosis or gastric ulcer are completely relieved, while in about 7 per cent. of the remaining cases relief is almost complete. Eliminating cases in which a mechanical appliance had been used, or a small opening made, the proportion of cases subsequently relieved is about 92 per cent.; (5) that the risk of subsequent perforation of a peptic jejunal ulcer is under 2 per cent.; (6) that as patients have regained their normal weight, and have lived for years in perfect health, there is no reason to suppose that the operation of gastro-jejunosotomy tends to shorten life. G.

Glaucomatous Cloudiness of the Cornea.—Silex, Berlin (*Arch. of Ophthal.*, July, 1905) believes that in acute glaucoma the cloudiness of the cornea does not depend on an œdema, as has hitherto been supposed to be the case, but upon a stretching of the cornea whereby doubly refracting elements are induced to appear which cause a multiple reflection of light. This theory is based on experimental, clinical observation and pathological anatomy, and a cloudiness of the cornea is produced by injection of fluid into the vitreous which is similar in appearance to that of acute glaucoma. M.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "Recent Medical Literature."
- (2) "Recent Surgical Literature."
- (3) "Recent Gynecological and Obstetrical Literature."
- (4) "The Recent Literature of Physiology, and Pathology."

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

MR. MACLAHLAN.—Tynemouth had the highest aggregate mortality last week of all the large towns with 25.0 per 1,000, Dublin and Belfast came next with 24, Liverpool following with 21, and Glasgow with 20.

BIRTH-RATE AT BRIGHTON.

In his annual report for the year 1905, Dr. Arthur Newholme says the birth-rate has steadily declined for many years. In 1881 it was 30.6 per 1,000, in 1891 it was 28.2, in 1894 it had fallen to 23.5. Stated more accurately, after corrections have been made for the varying proportion of married women and of women at child-bearing ages, the legitimate birth-rate declined from 29.05 in 1881 to 23.34 per 1,000 in 1901, the illegitimate birth-rate from 1.72 to 1.30 per 100, and the total birth-rate from 30.77 to 24.63, which is equivalent to a reduction of 20 per cent. The death-rate works out at 13.6 per 1,000, considerably lower than the death rates of 15.7 and 15.6 in the 76 great towns and in London respectively. A table is given showing that since the year 1861 the death-rate of Brighton has been steadily decreasing.

L. O. B. is thanked, but his communication is hardly suitable for our columns.

POST-CARD.—Our correspondent does not enclose his card or give his name. This is a necessary rule, to which we strictly adhere, as establishing the *bona-fides* of the writer, and we cannot entertain the writer's suggestion in the non-fulfilment of this condition.

MODERN THERAPY.

NOSTRUM AND CO.'S NEW PREPARATIONS.

The following skit anent our attacks on patent medicines and quackery has been sent us by a correspondent:—" 'Humbugaline' and codologine. 'Humbugaline' is angeliatic and haemostatic, suitable for small operations, viz., removal of corns, toe-nails, chilblains, and superfluous hair. Mode of use:—One quarter grain to be dissolved in a bucketful of hot water and used hypodermatically every half-minute. 'Humbugaline' is less toxic than 'codologine' and other vaunted local anaesthetics, but, perhaps, not quite so effective in other particulars. Used with most gratifying results in cases of ingrowing toe-nail. Samples and literature on request. Please specify Nostrum and Co."—A. D.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, APRIL 4th.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. A. Routh, Dr. Boxall, Dr. Blacker, and Mr. J. Bland-Sutton. Short communication:—Dr. E. J. Maclean: Case of Ectopic Gestation in which the Fetus was removed Six and a Half Months after Spurious Labour at Term. Demonstration:—Dr. A. W. Addison: Chronic Infective Metritis.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (23 Chancery Street, W.C.).—4 p.m. Mr. C. Ryall: Clinique. (Surgical.) 5.15 p.m. Lecture:—Dr. E. F. Buzzard: Some Acute Infective Disorders of the Nervous System.

THURSDAY, APRIL 5th.

ROYAL COLLEGE OF PHYSICIANS OF LONDON (Pall Mall East).—5 p.m. Oliver Sharpey Lecture:—Dr. E. I. Spriggs: The Bearing of Metabolism Experiments upon the Treatment of Some Diseases.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (23 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical.) 5.15 p.m. Lecture:—Mr. E. Jones (Liverpool): Internal Derangements of the Knee.

FRIDAY, APRIL 6th.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY (West London Hospital, Hammersmith, W.).—8 p.m. Clinical Meeting.

LARYNGOLOGICAL SOCIETY OF LONDON (20 Hanover Square, W.).—5 p.m. Exhibition of Cases, Drawings, and Specimens.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (23 Chancery Street, W.C.).—4 p.m. Mr. N. MacLehose: Clinique. (Eyes.)

MONDAY, APRIL 9th.

BRITISH GYNAECOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Exhibition of Specimens: Dr. A. E. Giles, Dr. Frederick Edge, Mr. F. Bowman Jessett, and Dr. Macnaughton-Jones.

Vacancies.

Friendly Societies Medical Aid Association, Kidderminster.—Assistant. Salary £150 per annum. Applications to Dr. Martin, 4 Lion Street, Kidderminster.

Carlisle Non-Provident Dispensary.—Resident Medical Officer. Salary £150 per annum, with apartments. Applications to the Hon. Secretary, Mr. G. A. Lightfoot, 23 Oastie Street, Carlisle.

Egyptian Government.—Kaar-El-Ainy Hospital.—Resident Surgical Officer. Salary £250 a year, with quarters, servants, washing, coal and light. Applications to the Director-General, Public Health Department, Cairo.

Borough of Reigate.—Reigate Rural District Council.—Medical Officer of Health. Salary £500 per annum. Applications to the Town Clerk Municipal Buildings, Reigate.

Gartloch Asylum, Gartloch.—Assistant Medical Officer. Salary £155 with board and lodging. Applications to Medical Superintendent.

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.

Kingseat Asylum.—Assistant Medical Officer. Salary £110 per annum, with board, &c. Applications to C. B. Williams, Clerk, City District Lunacy Board Chambers, 20 Union Terrace, Aberdeen.

Somerset and Bath Asylum, Cotford, Taunton.—Assistant Medical Officer. Salary £140 per annum, with furnished apartments, board, fuel, lighting, washing, and attendance. Applications to the Medical Superintendent.

Royal Halifax Infirmary.—Second House Surgeon. Salary £100 per annum, with residence, board, and washing. Applications to Oates Webster, Secretary, Royal Halifax Infirmary.

Nottingham General Hospital.—Assistant House Physician. Salary £100 per annum, with board, lodging, and washing. Applications to the Secretary.

Cork Branch of the Irish Drapers' Association.—Medical Officer. Emolument, duties, &c., on application to the Hon. Sec. (see advt.).

Appointments.

BUCKLEY, J. C., M.D., Ch.B., Vict., Honorary Assistant Physician to the General Hospital, Nottingham.

CADDICK, C. J., M.B., F.R.C.S., Edin., D.P.H. Camb., Surgeon to the Out-patient Department at the Walsall and District Hospital.

DIXON, W. E., M.B., B.S. Lond., to the Chair of Materia Medica and Pharmacology at King's College Hospital.

DUBOIS, D. J., L.R.C.P., and S. Edin., L.F.P.S. Glasg., Medical Officer to the Cottage Homes, Hornchurch, of the parish of St. Leonard, Shoreditch, London.

HEWITSON, W. A., M.B., Ch.S., L.R.C.P. Edin., Certifying Surgeon under the Factory and Workshop Act for the Haswell District of the county of Durham.

MILNE, L. J., M.D. Aberd., Certifying Surgeon under the Factory and Workshop Act for the Mirfield District of the county of York.

PHILLIPS, JOHN, M.D. Cantab., F.R.C.P. Lond., to the Chair of Obstetric Medicine and Diseases of Women and Children at King's Coll. ge.

POLLOCK, A. K., HALLIDAY, M.B., Ch.S., L.R.C.P. Lond., Medical Officer to the East Indian Railway, India.

SINGER, CHARLES, M.B., B.Ch. Oxon., Resident Medical Officer in Charge of the Government General Hospital, Penang.

Births.

CARRUTHERS.—On March 29th, at 44 Central Hill, Norwood, the wife of S. W. Carruthers, M.D., of a daughter.

LOW.—On April 1st, at 146 Harley Street, the wife of Vincent Warren Low, F.R.C.S., prematurely of a son (stillborn).

NANKIVELL.—On March 29th, at "Woodstock," West Cliff Road, Bournemouth, the wife of Bertram Wright Nankivell, M.R.C.S. Eng., L.R.C.P. Lond., of a son.

PENNINGTON.—On March 25th, at Sandown, Isle of Wight, the wife of Drury Pennington, M.B., B.C. Cantab., of a daughter.

Marriages.

ALEXANDER—GRIMSHAW.—On March 26th, at Caledon Church, Oana Alexander, Esq., only son of Colonel the Hon. Charles Alexander, of Caledon, to Gladys Constance, younger daughter of the late Thomas W. Grimshaw, O.B., M.D., late Registrar-General for Ireland, and Mrs. Grimshaw, Annaghroo House, Caledon, Tyrone.

BRANWELL—BERRY.—On March 31st, at St. Peter's Church, Ealing, Charles Branwell, M.R.C.S. Eng., L.R.C.P. Lond., only son of Charles Branwell, of Penzance, to Eleanor, only daughter of the late John Berry, of K nyon, Ashburton, Devon, and Mrs. Dobell, of Bishopsley Avenue, Ealing.

STUART—LUMSDEN.—On March 28th, at St. Mary's Chapel, East Church, Aberdeen, William Lumsden Stuart, M.D., B.A. Lond., of Oakdene, Camberley, Surrey, to Jean Abernethy, eldest daughter of John Lumsden, Esq., J.P.

Deaths.

ARCHER.—On March 30th, at The Rowells, Manor Road, Sidcup, Ross, widow of the late Edmund Archer, M.D., M.R.C.P., F.R.C.S., of King's Lynn, Norfolk, in her 74th year.

BEALE.—On March 28th, at his residence, Bentinck Street, Manchester Square, London, N., Lionel S. Beale, M.B., F.R.C.P. Lond., F.R.S., Consulting Physician to King's College Hospital, Emeritus Professor of the Principles and Practice of Medicine in King's College, London.

BUCHANAN.—On March 22nd, at Sowerby, Thirsk, John Hamilton Buchanan, M.D., J.P., in his 74th year.

DOLMAN.—On March 28th, at Caerphilly, Charles Dolman, F.R.C.S., fourth son of Frederick Dolman, Woodland Road, Clifton, Bristol, aged 44.

GIBBES.—On April 1st, at Oxford, Catherine Gibbes, widow of Francis Richard Gibbes, M.R.C.S., late of Anerley and St. Leonard's-Sea.

HARFORD.—On March 30th, at Christchurch, Henry William Harford, L.R.C.P. and L.R.C.S., aged 52, youngest son of the late Captain Augustus Harford, 59th Regiment, of Rose Court, Queen's co., Ireland.

HILL.—On March 27th, at Thornton House, West Horsham, William Byron Hill, M.R.C.S., aged 81.

WALKER.—On March 28th, at his residence, Atydos, Longfellow Road, Worthing, Charles Rotherham Walker, M.D. (late of Gainsborough House, Leytonstone), aged 48.

WRIGHT.—On March 29th, at Southsea, Sarah, widow of George Wright M.R.C.S., L.S.A., some time of Fovant, Wilts.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, APRIL 11, 1906.

No. 15.

NOTES AND COMMENTS.

Insurance without Medical Examination.

A correspondent writes us in reference to our remarks upon the scheme of life insurance without medical examination adopted by the "Sun" Office. He uses language a little stronger, perhaps, than that warranted by the facts of the case. At the same time we cannot help agreeing with him so far as the illusory nature of the central proposal is concerned. In the vast majority of cases the questions are so framed that applicants are ultimately bound to undergo the ordeal of a medical examination. Those admitted without such an examination we regard as representing so many guineas of which the medical profession has been unfairly deprived. At the same time we believe we are correct in stating that the company protects itself by keeping out of benefit for several years those who are admitted on the non-medical examination scheme. While the "Sun" persists in methods that we believe are unjust to the medical profession and not absolutely and positively candid to the public, so long shall we make it our duty to draw notice to the matter from time to time.

A Prescriptive Right to Pollute a Creek.

The judgment delivered by Lord Justice Vaughan Williams, and concurred in by Lords Justice Stirling and Moulton, affirms a conclusion that will be welcome to all sanitary reformers. It is true that they arrive at their journey's end by circuitous routes, but could lawyers do otherwise in dealing with ancient vested rights and privileges? Since time immemorial Warblington has assumed the right to pour its sewage into the neighbouring creek. That right the Law Lords confirm, and say in so many words that it could do that so long as it causes no injury to anyone. If the plaintiff or any other person, however, could show injury resulting therefrom, it was quite competent for such a person to sue for damages. This is a modern version of the classic judgment delivered against Shylock. You may pollute your neighbouring stream, my good Council, but all the same you will be liable if you injure other persons by its poisoned waters. The far-reaching nature of this legal decision it is hardly possible to estimate. It will greatly strengthen the hands of all who suffer from sewage polluted waters. Will it help to restore prosperity to the diminishing oyster trade

Oysters and Sewage.

At the Appeal Court last week a great victory was scored in the conflict between public health and vested interests. The case arose out of the tragic banquet held at Winchester in November, 1902, when some of the guests contracted typhoid fever from

eating oysters supplied by a Mr. Foster from the Emsworth beds. After this episode the owner of the incriminated beds naturally found his oyster trade ruined. He then brought an action to restrain the Urban District of Warblington from continuing to discharge sewage in the neighbourhood of his oyster beds and at the same time he claimed damages. Mr. Justice Walton found he was not entitled to an injunction, but was entitled to damages. From that judgment the defendants appealed, and after long and costly litigation the solemn verdict of the Lords of Appeal has been delivered. Henceforth, according to this decision, a sanitary authority may poison adjoining waters at its own free will, but it may not poison oysters, and if it can be shown to have caused indirect injury in that, or any other way, it must be held responsible.

Methylene Blue in a Evidence.

The curious property possessed by methylene blue of colouring the urinary secretions of a cerulean hue has placed a practical joker—for such he presumably must be—in a somewhat serious position. At a London police court last week a gentleman with an Army title was charged with administering a noxious drug with intent to annoy. Professing to have a remedy for indigestion in a certain tabloid he persuaded two barmaids to swallow a sample of his medicaments. The result was horribly alarming to the women, and shortly afterwards the "Major" found himself figuring in the dock of a police court. Counsel for the defendant alluded to the remarkable property of methylene blue, and stated that the drug was given not for the purpose of doing harm, but merely as a stupid joke. Even if that explanation be accepted we hardly wonder that the magistrate adjourned the summons while he communicated with the Public Prosecutor. The practical joker must take care not to sail too near the wind or he may find the tables turned upon himself in an unexpected way.

The Crusade Against Consumption.

THE campaign against consumption is being carried on in a fitful way hardly worthy of its early promise. At the recent annual meeting of the National Association for the prevention of that malady the great central feature was the complaint about the smallness of support accorded to the movement. Yet a vast deal has been done and is being at the present moment accomplished by way of checking the ravages of tuberculosis. But when all is said and done it is to official rather than to charitable effort that we must look for the ultimate extinction of the disease. Public health measures go to the root of things, while voluntary charitable missions for the most part simply deal with the accom-

plished evil. For all that, it is true that the National Association has undertaken a supremely important task in the attempt to educate public opinion upon the subject. Sooner or later a fully-informed nation will insist on scientific and universal methods of prevention.

LEADING ARTICLE.

ARMY SURGEONS AND PROFESSIONAL SECRECY.

Two cases involving professional secrecy occurred last week. In one a private medical practitioner was informed by a judge that he was compelled to disclose under oath facts that had come to his knowledge professionally. Under such circumstances, and if the evidence be required in order to prevent a miscarriage of justice, few members of our profession would adopt the extreme view that information acquired under the seal of professional secrecy should not be divulged in a court of law. Should the police apply to a medical man for such information, they are grossly exceeding their powers, and any practitioner foolish enough to play into their hands in that way is breaking one of the most ancient and the strongest traditions of his profession. Then, clearly, there is no obligation to preserve inviolate professional confidences with regard to the patient if the latter consent to their being divulged. The ethical offence consists in a medical man betraying confidences that have come to his knowledge by reason of his relationship with another person in his capacity of medical attendant, in the absence of any direct authorisation by the patient to impart such information. The point, simple and obvious as it may seem, is apt to escape full recognition. It comes strongly into relief as regards the relation of the Army medical officer to those under his charge. The "ragging case" in the Scots Guards, inquired into at Aldershot last week by Court-Martial, raises various points of importance as regards the Army Medical Service. The victim of the horse-play of his brother subalterns was charged at a mock inquiry with being "in an absolutely filthy condition," with not having cleaned his teeth for a month, and with having a loathsome skin disease, to wit—scabies. As the matter is now *sub judice* with the Army Council, under the chairmanship of Mr. Haldane, we cannot discuss the legal and social aspects of the affair. It is a matter for the nation, through its representative government, to determine whether paid public servants are to establish a virtual class monopoly and a happy exclusive hunting ground out of the higher grades of military service. We may ask, however, with perfect propriety, by what authority, official or otherwise, Surgeon-Major Whiston, medical officer in charge of the Guards at Aldershot, reported to his commanding officer that he found one of the subalterns in a very dirty condition—in other words, that he had scabies? Owing to some incomprehensible relic of the days of class privilege in Army adminis-

tration, the medical officers of the Household Troops are not selected from the Royal Army Medical Corps. Surgeon-General Whiston was thus appointed, and it is significant that his evidence as to the condition of Lieutenant Clark Kennedy, the subaltern implicated, was traversed by a Captain, a Lieutenant, and a private of the R.A.M.C. The question that will probably suggest itself to the medical man hearing of these proceedings is whether Major-General Whiston was justified under any circumstances in disclosing the fact, or what he considered to be the fact, that a patient under his care had contracted scabies. As all medical men know, scabies may attack the cleanly as well as the uncleanly, and, moreover, when masked by secondary signs and symptoms, its diagnosis may present at times well-nigh insuperable difficulties. By what code of Army discipline can a medical officer be called upon to disclose such purely professional and delicate information. The crux of the matter, we take it, is the consent of the patient. If information be requisite as to fitness for service, then it may be assumed that the medical officer reports with consent of the individual soldier. But how about scabies, which does not disable, and if scabies is to be reported why not gonorrhœa and syphilis and other conditions due to recklessness and immorality? It is not easy to see how an Army medical officer is to claim immunity from the sacredness of professional confidence any more than his civilian brethren. Were a medical man in general practice to betray a professional confidence he would be forthwith scouted by society and would render himself liable to actions for damages. We fail to see how under any code, official or professional, the Army surgeon can contract himself out of the observance of the conditions of secrecy laid down in the Hippocratic Oath, which have been hitherto the sheet anchor of professional honour and without which it would be difficult, if not impossible, to maintain any permanently staunch relations between medical men and the community at large.

NOTES ON CURRENT TOPICS.

The Normyl Treatment Association.

WHEN, we wonder, will good people and philanthropic people consent to take medical advice on medical questions as they take legal advice on legal questions. More harm, says the old saw, is done by want of thought than by want of heart, and it is pitiable to see benevolence plunging in morasses where it would never have been led under experienced guidance. It appears that one of that most unsatisfactory class of "treatments," namely, a chronic alcoholism and drug habit treatment, has been brought over to England, and under the name of the "Normyl Treatment Association," a society has been formed to apply it at a reduced price! Among the members of this association are many able and well-disposed persons who pledge themselves to make no profit

out of the practice of this treatment, and whose only desire is to reclaim the drunkard. In the light of past experience is it, we wonder, too late to appeal to these people to place themselves in the hands of a Committee of disinterested medical men before recommending a treatment, invented by a "Canadian chemist," of whose operations they can have little scientific knowledge? Mr. Owen Seaman is the treasurer of the Association, and we would entreat him not to lend the influence of his great name to this scheme without authoritative medical advice. Medical men could no more write the inimitable parodies of Mr. Seaman without his skill and erudition than can the distinguished editor of *Punch* judge of a technical professional problem without the experience and training of a medical man.

The Fight against Consumption.

We have received from the Dublin Branch of the National Association for the Prevention of Tuberculosis copies of a poster published by them, and posted in the national schools throughout the country by the authority of the Commissioners of National Education. The death-rate from tubercular diseases in Ireland shows practically no sign of abatement, and there is no doubt that little can be hoped for until the public mind is thoroughly alive to the importance of using every effort to prevent the spread of the disease. In attempting to give plain and simple instruction to the young, the Dublin branch is doubtless proceeding on proper lines. The poster we refer to, which is based on handbills drawn up by Dr. Birmingham, of Westport, is well calculated to fulfil its purpose, since it is couched in language everyone can understand. It is possible that a few of the maxims may be regarded as counsels of perfection, such as the advice "to grind your own corn," and "always to boil the milk before using it." Nevertheless, it would be hypercritical to find fault on such trivial grounds.

The International Congress of Medicine.

THE Seventh Bulletin of the International Congress of Medicine shows that the Lisbon Committee is working hard to make the Congress a success. The Bulletin contains the programme of sittings and discussions, and of fêtes, in addition to much useful information as to lodgings and routes. Among the fêtes, of which the Committee are unable as yet to give a complete list, are a garden-party given by the King and Queen and a dinner to the chief guests, a reception by the President of the Congress and a ball by the City of Lisbon. The list of subjects and papers for discussion promises matter of great interest, and the authors include men of eminence from every country in Europe as well as from beyond the seas. Thus, to take a single example from the section of pathology, we find that the reporters on the question of the parasitic origin of tumours are Dr. Bashford, of London, and Dr. Doyen, of Paris, while contributions on other points in regard to malignant disease are promised from Professor

von Housemann, of Grunewald; Dr. Neves, of Lisbon; Dr. Foulerton, of London; Professor Borst, of Göttingen; and Dr. Gaylord, of Buffalo. The programme is accompanied by very useful plans of the school of medicine, where the Congress is to sit. The railway and steamship fares are extremely moderate, and we are sure those of our readers who can spare themselves a week's holiday cannot do better than go to Lisbon. The Congress meets on the 19th instant.

Dr. Hutchison on Food.

IN selecting "Food and Diet" for his lecture to the members of the National Health Society, Dr. Hutchison found a subject on which it is of great importance that the public should be instructed. At no time has more general interest been taken in such matters, and the many fads and "isms" at present in vogue are evidences rather of this ill-informed interest than of any particular tendency towards foolishness. It is well, therefore, that as far as they can the public should learn the principles underlying the choice of human diet. Two points are essential in deciding on any diet—that the requisite food-stuffs be supplied in proper quantities, and that they be supplied in a form suited to our digestive organs. This latter demand does not at all mean that the most easily assimilable food is the most wholesome. Our digestive organs to remain in health must perform their normal functions and must therefore be supplied with proper material for the exercise of those functions. On the other hand, the "wholemeal bread" craze, and other similar follies depend on views of the other extreme, which assume that waste material must be present in large quantity in order to call forth gastric and intestinal activity. While not prepared to adopt an exclusively vegetarian diet, Dr. Hutchison is quite right in saying that people as a rule eat too much animal food. In this he is probably thinking particularly of the English middle classes, for the remark does not hold with nearly the same force in other parts of the Kingdom than England, and in many parts of the Continent it would be quite untrue. The virtue in matters of diet, as in many other spheres, is temperance—the mean between too much and too little.

Juvenile Smoking.

No one, we presume, would advocate the use of tobacco by unbearded urchins. Smoking is an artificial habit and not an invigorating one, and as such it is best left alone, at any rate till man's estate is reached. But at the same time a good deal of exaggeration is employed by many people in dealing with the subject, and if we were to believe some of them, legislation to abolish the use of the fag-end by newspaper boys would cure half the ills that national physique is heir to. Dr. Macnamara is trying to get a Bill through Parliament to prevent young people being served with tobacco, but it is hardly likely to get Government support this session. Knowing that boys

are imitative animals, and that while their elders smoke they will do likewise when they get a chance, it is doubtful whether such a restriction would have much effect on the total quantity of smoking; it would be perhaps more likely to lead to the surreptitious abstraction of the paternal tobacco, and thus turn a stupid habit into a moral crime.

Lincoln Typhoid Epidemic.

THE official account of the Lincoln typhoid epidemic has just been published in the form of a special report by Dr. Reece, one of the Local Government Board inspectors. The chief value of this report is that it supplies overwhelming evidence in favour of water-infection as the means by which the outbreak was caused, and this epidemic can now take its place alongside those of Worthing and Maidstone as a typical example of its class. The characteristics of a water-borne epidemic are that after a few cases of enteric fever or diarrhoea have been occurring for a short time, a sudden rise takes place in the number of notifications of the former over the area supplied by the waterworks. This condition, as in the cases of the other two towns mentioned, was fulfilled at Lincoln, but owing to the prompt and energetic measures taken no large secondary wave took place. A feature of great interest is that a bacillus was recovered from the waterworks which was in all probability—at least, in the opinion of Dr. Klein—Eberth's bacillus. One of the paradoxes of water-borne outbreaks of typhoid in the past has been that the specific organism of the disease has been conspicuous by its absence, although its congeners of the coli group have been found in more or less abundance; sufficient at any rate to prove sewage-contamination. The experience at Lincoln with regard to the efficacy of anti-typhoid measures brings strongly into prominence the suggestion that has been made that a "typhoid corps" of medical men and trained attendants should be available at a moment's notice to help any town that may be stricken.

Mr. Troutbeck as Pathologist

THE extensive experience that Mr. Troutbeck has gained in connection with pathologists and their functions has evidently led him so far into the subject of pathology, that perhaps it will soon be unnecessary for any medical witnesses to be called at his inquests. We ourselves have always held that the man who was at once a barrister and a doctor made the most suitable coroner, though it must be confessed the majority of appointing authorities seem to think otherwise. But if a coroner as learned in pathology as he is in law is able not only to conduct an inquest but to supply the jury with medical views, without at the same time taking the trouble to qualify as a medical man, a new and economical arrangement of the ratepayers' money may be looked for in the near future. Last week Mr. Troutbeck held an inquest on the body of a student at Westminster Hospital, who, to the grief of all his associates,

had died from septicæmia contracted at a *post-mortem*. Dr. Burnsteyn, assistant pathologist to the hospital, in the course of his evidence, said that it was not the custom of the Westminster men to wear gloves when doing *post-mortems*—a statement that caused Mr. Troutbeck some surprise. Mr. Troutbeck then put a series of questions, tending to show the folly of not wearing gloves, a position which Dr. Burnsteyn met by saying that his predecessor had lost his arm through infection contracted as the result of wearing gloves, and that the practice, in his view, was opposed to common-sense. Mr. Troutbeck, in his summing-up, told the jury what in effect amounted to the opinion that Dr. Burnsteyn did not know what was the best way to manage his own business. Opinions, of course, are divided on the question of wearing gloves at *post-mortems*; perhaps Mr. Troutbeck thinks the best way is to get an assistant to open the body and remove the organs before the pathologist arrives.

Food Adulteration.

THE London County Council have lately been considering the difficult question of how to catch the real culprit in cases of food adulteration. Under the Food and Drugs Acts it is a sufficient defence for a person accused of retailing adulterated articles to prove that he bought them under a warranty and purveyed them in the same condition as he bought them. It now happens that many prosecutions, especially those for the adulteration of milk, fail owing to this defence, and when the authorities seek to get hold of the wholesale vendor it is often found that he cannot be touched as his liability ceases six months after selling his article. Now as many retailers buy their goods under contract, and as many of these contracts run for a long time, the warranty they get is only a general one, and in practice it happens that by the time the blame is shifted on to the wholesale man the six months during which alone he can be prosecuted have expired. Consequently, the game of adulteration and evasion is kept merrily going and the public suffer in health and purse. After long deliberation the Council have decided that the only way to secure an offender is to have the retailer made liable for adulteration and to leave him to take what steps he can against the wholesale dealer; consequently the Council propose to ask Parliament to endorse this decision by amendment of the present Acts. No doubt such a provision will press hardly on certain small retailers, but it seems the only way to put a stop to this nefarious practice.

Shallows in Excelsis.

AT Loughborough last week a painter dressed in clerical attire was charged before the local bench with brawling during a confirmation service conducted by the Bishop of Peterborough. The newspaper report states that this man had previously "greatly shocked" the clergy and churchgoers by issuing circulars stating that he had twice been offered the Bishopric of Peterborough, but

that owing to unforeseen circumstances he had been unable to accept. A year ago he told the churchwardens that the Bishop had been opening his letters, and the churchwardens told him that they would see that it did not happen again. The brawling incident in question consisted in the clerically-attired painter walking up the aisle during the service and shaking his fist before the great ecclesiastical functionary, shouting "Bishop of Peterborough, you are a thief." If the clergy and church-goers were "greatly shocked" by the circulars, one can only conjecture what their feelings must have been at this painful incident. At any rate, the painter was removed, sheep's clothing and all, and hailed before the bench. The report proceeds with unconscious *naivete*—"It was suggested the man was not sane, but the magistrates said the state of his mind was not before them. They fined him 10s." Surely no shallow ever more completely vindicated his right to have a dozen white luses on his coat of arms! If the state of the painter's mind was not before the magistrates, we can only express the fervent hope that the state of the magistrates' mind will soon be before the Lord Chancellor.

OUR WEEKLY PILLORY.

THE journal selected for this week's comment in the matter of the advertisement of undesirable quack medicines is the issue of the *Daily Express* April 9th, 1906. The most objectionable notice of the kind is that of "The New French Remedy—Therapion," which appears in the shape of a twelve line advertisement modestly placed at the end of the last column but one of the journal. The editor may well relegate this nostrum to an obscure corner of his newspaper, for it carries on its face the characteristics of charlatany of a reckless and cruel type. It begins with the statement that this popular remedy was used in Continental hospitals by Ricord, Rostan, Jobert, Velpeau, and others. It is a standing disgrace to our journalistic laws that the names of great medical men should be dragged through the mire in this way by unscrupulous vendors of proprietary medicines. In this case it is obviously false to imply that any of those great men mentioned habitually used "Therapion" or any other secret medicine, or that they, when alive, would have sanctioned the use of their names in connection with any advertised remedy, whether secret or open. To make use of the name of a deceased leader in the medical world by introducing it into an advertisement is one of the cunning devices of the patent medicine proprietor. In our opinion the proceeding should be made a felony, or at any rate an offence for which heavy damages might be recoverable by the medical man himself, if living, or by his heirs and executors, if dead. We can fancy Ricord turning in his grave at the infamy of his name being fathered on a remedy to cure "impurity of blood, blotches, pain and

swelling of joints, derangements of liver and kidneys, pain in back, gout, rheumatism, and sleeplessness," which Therapion claims to do. Surely a man occupying so prominent a journalistic position as that of Editor of the *Express* need not be told that any medicine claiming to do all that is a lie and a sham. Let us point out further that all the persons who buy this worthless stuff on the strength of the advertisement in the *Express* are induced to do so by the paid co-operation of the editor and the publishers of that paper, who, with the rest of the staff and the proprietors, share in the money extracted from the public in this dishonest fashion.

PERSONAL.

THE Armstrong College, at Newcastle-upon-Tyne, is now completed, and will be opened by King Edward before next winter, but the exact date of the ceremony is not yet settled.

TICKETS for the Jubilee Dinner of the Society of Medical Officers of Health can be obtained from Dr. Priestley, 22, Telford Avenue, Streatham Hill, London, S.W.

A NUMBER of former friends and pupils of Sir Henry Littlejohn have decided to present him with a portrait on the occasion of his retirement from the Chair of Forensic Medicine in the University of Edinburgh, Sir William Turner is chairman, and Dr. Francis D. Boyd, Honorary Secretary of the Presentation Committee.

DR. W. T. DEARDEN, is about to resign his position as a Councillor for Crumpsall Ward in the Manchester City Council, having been appointed Medical Officer of the Manchester Port Sanitary Authority.

It is announced that his Excellency Professor von Bergmann, the celebrated German surgeon, is to be invested with an honorary degree of laws by the University of Edinburgh.

PROFESSOR CARL O. JENSEN, of Copenhagen, has been awarded the "Walker Prize for Cancer Research" by the Royal College of Surgeons of England. The Council's reasons for the award are given fully in another column.

MR. REGINALD CHEYNE ELSMLIE, M.S., F.R.C.S., of St. Bartholomew's Hospital, has been awarded the Jacksonian prize by the Royal College of Surgeons, England, for his essay on "The Pathology and Treatment of Deformities of the Long Bones."

THE first appointment to the newly founded "Begley Student Prize" has been made by the Council of the Royal College of Surgeons, England, to Mr. Walter Burford Johnson, of St. Thomas's Hospital, London, in accordance with the report of the Examiners.

MR. JUSTICE GRANTHAM took the chair at the forty-sixth annual dinner of King's College Medical School, held on Monday, the 9th instant, at the Hotel Cecil, London.

DR. LOUIS CHAMPIONIERE, Surgeon to the Hotel Dieu, Paris, has been elected honorary fellow of the English Royal College of Surgeons.

AN Honorary Medal has been bestowed by the same College on Lieut.-Colonel Sir Richard Havelock Charles, in recognition of his gift of anthropological specimens.

A CLINICAL LECTURE

ON

FRACTURES OF THE SHAFT OF THE FEMUR.

By WILLIAM S. HAUGHTON, M.D., B.Ch.
Visiting Surgeon to Stevens' Hospital, Dublin.

GENTLEMEN,—Since the architecture of bone is constructed to resist such strains as compression, bending, and twisting; and since the lamellæ of bone can generally be sub-divided into two systems, one taking up "compression," and the other "tension" strains, it is natural to suppose that these two systems of lamellæ play a very important part in determining the planes of fracture, when a bone is submitted to abnormal strains.

That this is true in the case of double fractures of the femurs under consideration, I think may be proved, by comparison with the normal lamellar structure of the femur as revealed in the Röntgen stereoscope.

Sawn sections of the femur can only show the structure of the bone in a single plane, that of the saw-cut. This shows correctly lamellæ running vertically or transversely; but yields little information as to which lamellæ are rising up to surface of section, and which are passing down from it. In other words, it only shows the structure in the length and breadth of the plane of section. But the structure in the third dimension of space, namely, depth, can at best only be guessed at.

There is no method with which I am familiar which gives a correct reproduction of lamellar bone structure so well as that of Röntgen stereoscopy. By it, at a glance, the whole fabric and mechanical model on which the bone is built may be systematically and accurately studied as a beautiful "transparency," in which length, breadth, and depth stand out in bold relief and accurate perspective. The stereoscopic method which I employ for the study of bone structure is that devised by Mr. McKenzie-Davidson. Working by this method, in conjunction with Professor A. F. Dixon, we were enabled to follow out the details of a spiral arrangement of lamellæ in the shafts of long bones which I believe furnishes a correct explanation of the frequency of "oblique" fractures occurring in such bones, notably the femur, tibia, and humerus. Further, most typical fractures follow a definite rule, in which the plane of fracture coincides with one or other system of lamellæ when these are submitted to abnormal strains.

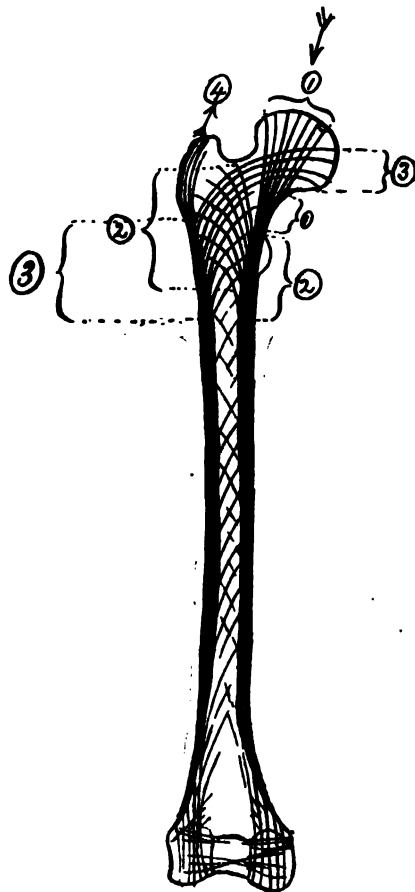
When the normal femur is viewed in the McKenzie-Davidson stereoscope, an appearance is seen which I have attempted to represent in the accompanying diagram.

Surrounding the medullary canal we have the thick tubular wall of dense, compact bone, which at either end expands and becomes thinned out to a mere shell in the articular regions.

Where this expansion and thinning out occurs, we find the lamellæ (which in the medullary canal region are not prominent, and are confined to its periphery) stretching inwards towards the central axis of the bone, meeting converging lamellæ, with which they are welded at the points of intersection, and passing onwards again towards the surface of the bone. The whole arrangement being on a well-defined mechanical model, whose component system may be readily analysed into "compression" and "tension" systems, admirably adapted at once to take up "compression" on the articular surface, and to resist the "stresses" of muscular "tensions," when the muscles come into action.

On referring to this diagram, in which the femur is represented as seen from the front, we see that the lamellæ in the upper end may be conveniently sub-divided into four systems—two arising from the com-

compact tissue on inner side of bone, and two from that on the outer side.



On the inner side, a system (Nos. 1, 1) of straight lamellæ arises from the compact bone near the lesser trochanter, and under side of neck (opposite to the dotted lines of lower bracket 1), and these pass in radiating form straight to the upper half of head, where they receive the weight of body, acting in "compression" (upper bracket 1 under right-hand arrow).

Just below this straight system, a short curved system of lamellæ (lower bracket 2) arch upwards and outwards (upper bracket 2) to support (also under "compression") as buttress arches, a long curved system, which arises from the compact bone on outer side of shaft, below great trochanter.

This third system of lamellæ (lower bracket 3) arches inwards in a long easy curve through the neck, and emerges on the articular surface of lower half of head (upper bracket 3). The weight of the body applied to the inner end of this long arching system, throws some of its members at least into "tension."

A fourth system of lamellæ passes nearly vertically upwards into the great trochanter and becomes continuous in direction with the pull of the glutei inserted there, when thrown into "tension" (left-hand arrow pointing to figure 4).

When the muscles operating the hip-joint are thrown into action, there is a sort of "shearing stress" established in the upper end of femur, in the inter-trochanteric region, as the result of the combined "compression" of inner side of bone, and "tension" on outer side. Where this stress is greatest, there spiral lamellæ are most evident, and they form a right and left-handed intersecting system.

A closer inspection of the upper end of femur in the stereoscope, from different points of view, suggests that the first three systems mentioned are really members of the spiral systems (seen in shaft of femur) coming up from below, and becoming distributed over articular surface in the manner best suited for mechanical support.

As we pass down the shaft, the compact walls of medullary canal assume a more or less cylindrical form. And applied to the internal surface of the wall of this canal are seen oblique lamellæ passing round the bone in spiral form; generally there are two systems, right-handed and left-handed spirals. This arrangement braces the structure of the bone very firmly together, and confers the maximum rigidity, with the minimum of bony material.

As we approach the lower end of femur, these spiral lamellæ alter their direction, and pass by easy curves, finally almost vertically downwards into both condyles, emerging perpendicularly to articular surface of pressure. In addition there are two systems of straight perpendicular lamellæ, of great strength, passing from the compact bone of supra-condyloid regions above, down into the articular surfaces of the corresponding condyles. These are arranged chiefly in antero-posterior planes. Thus they take "compression" on their ends.

Above and through the condyles we see some transverse lamellæ, passing across at the epiphysary level, which prevent the bone from spreading, when the condyles are under pressure. This system acts as "tie-beams" and represents "tension" lamellæ.

This arrangement is practically constant near the articular surface of all long bones, offering a wide surface of pressure.

Now fractures of the shaft of the femur are usually oblique, often presenting sharp V-shaped extremities. And their obliquity closely corresponds with the direction of these spiral lamellæ. When V-shaped, the angle included by the V is very closely related to the intersecting angle of the right and left-handed spiral lamellæ. Further, some fractures of the shaft, chiefly at upper end, are spiral. All of which facts suggest that the visible plane of fracture is very largely the outward expression of the internal structure of the bone. The line of cleavage representing the path of least resistance under a given combination of abnormal strains.

Illustrations of this fact might be cited in connection with almost every typical fracture, with which we are familiar.

Now let us consider the recent skiagrams of the case under consideration.

I am indebted to my colleague, Dr. Stevenson, for skiagrams of the right and left femora, both of which were fractured. The right at junction of middle and upper thirds, and the left just above lower third. In these the planes of fracture are oblique, and their obliquity closely corresponds with that of the spiral lamellæ seen in the stereoscope. Further, in one of these there is distinct evidence of a spiral fracture passing half-way round shaft.

This patient's case is a remarkable one. The boy, M. H., æt. 6, was admitted to Steevens' Hospital some four months ago, with a history of having been pushed by his brother, while playing in the street, against the wheel of a passing dray. Both legs passed through the spokes of the wheel, and in this position rotated with the wheel, getting crushed against the springs and body of cart.

On admission, he was in a state of considerable shock, and suffering from the following injuries: Simple fracture of right femur, upper third; compound

fracture of left femur, lower third; rupture apparently of all ligaments of left knee, except internal lateral; compound very oblique fracture of left tibia just above middle of bone; compound fracture of left fibula, about two and a half inches above external malleolus; both ends of fibula were protruding and partially denuded of periosteum. This last fracture (fibular) was complicated by a very extensive lacerated skin wound passing obliquely more than half-way round leg above ankle, exposing both bones, and a large extent of lacerated and contused muscles and tendons. The foot hung at right angles with leg, and appeared to be attached merely by a strip of skin and the tendons.

On being called to see the patient, the case appeared to be one for primary amputation. But after a rapid examination, as I found good circulation present in the toes, and the child being young and strong, I decided to give the foot a chance, and rely on a very careful cleansing of the skin, and an aseptic treatment of the compound wounds, which is my usual practice. That the treatment was justified in this case, I think the result proves. Of course, the usual signs of fracture of the shaft of femur were present, *i. e.*, shortening, and swelling of the thighs due to muscular contraction of quadriceps and hamstrings; and both legs lay helpless on the operating table, rolled outwards; crepitus and abnormal mobility at the seats of fracture being only too apparent. In addition, the left knee was a "flail," and the left foot was pendant.

Having decided to spare the foot, there were now two things to be done. (1) To disinfect the skin of legs, and cleanse the compound wounds as thoroughly as possible; and (2) to immobilise the multiple fractures. To carry out all this thoroughly in a serious case, it is very necessary to give an anæsthetic, which I find not only permits better work being done, but also greatly diminishes the shock due to the necessary handling of extensive and painful injuries of bone. Where an adult is concerned, with powerful muscles, this is still more needful.

Accordingly, my colleague, Dr. C. M. Benson, induced ether anæsthesia. Before doing so, full operation preparation of hands, &c., was gone through, including boiled rubber gloves and sterilised overalls, by operator and assistants, as it is very essential to preserve intact the aseptic chain of treatment for success in such cases.

The skin of legs was then thoroughly scrubbed with soap and hot water, followed by ether and alcohol. Then all visible particles of dirt were picked out of all the compound wounds with sterilised forceps. And then the wounds were very thoroughly irrigated from below upwards by rubber tubes, with "normal-saline" at body temperature, till, about three gallons had been flooded through wounds.

It is very important to admit no antiseptic inside wounds, using saline alone. If this point is observed, and absolute fixation obtained by plaster, the majority of compound fracture wounds heal by first intention, or, when contused, by primary granulation.

Drains of silkworm gut were then passed to bottom of each wound, and a few points of suture applied to the wound above ankle.

Next came the fixation of these multiple fractures. Many appliances have been used for fixing fractures of the femur, amongst which I may mention Liston's long splint, Mackintyre's double-inclined plane, and Hodgen's sling splint. In careful hands each of these have yielded excellent functional results. But Hodgen's splint is the only one of these which promises recovery without shortening. All suffer from the necessity of frequent adjustment of bandages, and demand from the surgeon and assistants considerable mechanical skill. Where the dressing of compound fractures is necessary, pain to the patient and great trouble to the surgeon are entailed.

Where plaster of Paris is employed as a primary treatment, all these difficulties disappear; and in a case like the one under consideration, I believe it to be the only form of treatment which could have yielded such a good result.

Accordingly, a pair of plaster of Paris "breeches," like fishing "waders," was applied, having first covered all wounds with sterile dressings, and swathed both legs and abdomen and thorax with a single layer of absorbent wool. Two assistants being posted, one at each foot, making gentle traction, with the feet at right angles to legs; another assistant making counter extension with a long towel under thorax, coming up each side at axillæ.

The child being suspended all the while in an apparatus, devised by my friend, Dr. Robert Halahan, of Buenos Ayres, while house surgeon of Steevens' Hospital, which consists of two iron rods in the form of a V, slung between two tables, and fixed by two cross-pieces of iron one on either table, at any desired angle of abduction, the distance between feet in this case being eighteen inches. Plaster was applied in the form of a broad roller spiral bandage, and extended from both feet nearly up to axillæ. A broad cleft was left for urination and defæcation, and a window cut in the plaster while soft over the principal compound wounds. A cross-piece of wood was attached from one foot to the other, by firmly applied bandages. This afforded further fixation, preventing independent motion of the two legs, and diminishing the tendency to cracking of plaster at the joints. This tendency was further prevented, by the incorporation of long wooden strips in the plaster bandages at each joint level.

The addition of the cross-piece of wood to the plaster "breeches" forms a rigid "triangle," which greatly simplifies the nursing and handling of such cases, especially when turning the patient over for cleaning-up purposes.

The mechanical principle of this plaster "breeches" provides "extension" by the grip which the plaster holds in ankles and feet. "Counter-extension" is maintained by the plaster V pressing on perineum, and its general grip all over pelvis. This "counter-extension" was further reinforced, very efficiently, by tight slings from wooden cross-piece and legs to foot of bed, which was raised some eight inches. The weight of the trunk, head, neck, and upper extremities, in addition to the upper part of thighs, all sliding down an inclined plane towards head of bed. And thus maintaining a continuous pull of counter-extension away from the lower extremities.

The convalescence of this case was uneventful. He slept six hours the first night without any opiate. He never had any pain. His temperature rose to 100° F. the first two nights, and remained normal after. The compound wounds were all healed in a fortnight, with the exception of the contused and lacerated wound above ankle, which was healed in six weeks. And the total number of dressings amounted to five or six. He can now walk, and run about, and bear his full weight on either leg; and has a full range of motion in all the joints. The only resulting deformity is a knob of callus marking each fracture, and a subcutaneous V point of bone on left tibia. All of which results emphasise the value of an aseptic treatment of wounds in compound fractures, combined with the splendid fixation afforded by primary plaster of Paris splints.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The lecture in next week's will be by H. D. Rolleston, M.D. Cantab., F.R.C.P. Lond., Physician to St. George's Hospital and Physician to the Victoria Hospital for Children, "On Mitral Stenosis."

News comes to hand that a case of plague has been declared at Port Said.

It has been decided that the administrative duties of Senior Medical Officer of the London Recruiting Area shall in future be performed by the Principal Medical Officer of the London District, who will also be Medical Inspector of Recruits.

ORIGINAL PAPERS.

THE BACTERIOLOGY OF AURAL AND NASAL DISCHARGES IN SCARLET FEVER AND OTHER DISEASES.*

By C. J. LEWIS, D.Sc. (Public Health), M.D., F.R.C.P.,

Lecturer on Public Health, School of Medicine of the Royal Colleges, and Medical College for Women, Edinburgh.

IN the course of a research into the micro-organisms associated with inflammatory diseases of the upper respiratory tract, it appeared that an examination of the discharges from the nasal chambers and ears in scarlet fever and other infective diseases formed an important branch of the subject, and might possibly yield fruitful results. For the provision of material for this investigation I am indebted to the kindness of Dr C. B. Ker, Superintendent of the Edinburgh City Hospital. Also I desire to acknowledge with gratitude the help accorded by Drs. Prichard and Monnington, Resident Physicians to the Hospital, in taking swabs for me from the various cases. The research may be most briefly set forth by first describing the methods employed. (a) These did not differ materially throughout the investigation. Thereafter the results will be stated in regard to individual diseases, and some general conclusions may be formulated from these results.

Methods.—Specimens of the discharges were obtained by means of sterile swabs. The specimens were collected with careful precautions, so as to obviate, as far as possible, contamination by contact of the swabs with anything but the discharge. Particularly was this the case in rhinorrhœa, where hairs and crusts in the vestibule need to be avoided, though it was not always easy to obtain the specimen from the interior of the nasal cavity of young children. On receipt of the swabs at the laboratory, it was sometimes possible to prepare direct films and, on staining these, to determine approximately the various kinds of organisms present. But much more than this was necessary to disclose the particular organisms in each case, and cultivations on artificial media were always made. The swab was rubbed over the surface of blood serum or agar in tube and the medium was incubated at 37° C. The swab itself was then immersed in sterile broth and also incubated at 37° C. Next day the cultures on solid media were examined and the broth plated out. The plating out of the broth was required, as it seldom contained only one variety of organism. The plates were made of serum-agar, of agar, or of jelly, and it may be noted that the serum should not be omitted in a thorough investigation, owing to the frequent presence of the pneumococcus in the discharges. It is difficult to isolate this organism if serum be absent from the media. Consequently, I found the serum-agar plate the most satisfactory medium; it best reveals the pneumococcus and diphtheria bacilli in impure cultures. The serum-agar plate may be made in two ways: either (1) by adding serum, such as hydrocele or ascitic fluid, to the melted agar just before pouring the plate; or (2) by spreading the serum over the surface of the cold agar after it has solidified in the plate. The former is the better method. The impure broth culture which is being plated out may be spread over the surface of the plate with a platinum spreader. This gives only superficial colonies in the plate, and from these pure sub-cultures may easily be obtained. The original broth in which the swab has been immersed for eighteen to twenty-four hours at 37° C. may be used for spreading the plate, but as the growth in this broth culture is frequently too copious, it is well to use instead either (1) a dilution, in sterile broth or water, of this original broth, or (2) a sub-culture of this original broth prepared by

* From the Laboratory of the Royal College of Physicians, Edinburgh. (a) "The Scottish Medical Journal," Nov., 1905.

inoculating a fresh broth tube and incubating it at 37° C. for one hour.

In each case submitted to examination the organisms present were isolated by this method in pure culture, and their characters determined by staining and by subcultures on various media. In many cases the pathogenicity of the organisms thus isolated was tested on animals, such as the rabbit and guinea-pig.

Scarlet Fever—Otitis media suppurativa.—There were forty-six cases of this nature from which swabs were taken. It was quite exceptional to obtain a pure culture, or to find present only one organism to which the condition could conceivably be due. In only three of the cases were the cultures practically pure, and each of these exhibited a different organism. In one case, in which the swab was taken at the very commencement of the discharge (on the first day of discharge and very early after its discovery), the only pyogenic organism present was the pneumococcus. *Sarcina flava* also appeared in the plate, but nothing else, and it may have been a contamination from the air. In the second case the only organism present was a diphtheroid bacillus, which was non-pathogenic to a guinea-pig, but otherwise much resembled true *B. diphtheriæ*. In the third case the streptococcus pyogenes was present with only *sarcina flava* as a companion. Of the other forty-three cases, ten showed two varieties of organism, twenty-four showed three, eight showed four, and one case showed five varieties present. There are four great groups of organisms which far exceed in frequency of incidence all others. These are the pneumococci, the staphylococci, the streptococci, and the diphtheroid bacilli. Every case shows one or more of these four groups. The three former need no exposition; but in regard to the diphtheroid bacilli, it is advisable to explain that included in this term are the true *B. diphtheriæ* (Klebs-Löffler), the pseudo-diphtheria bacillus, and the bacillus of Hofmann. The bacillus of Hofmann does not produce acid in glucose broth, but most of the other members of this group of bacilli have this power. Of the forty-six cases, thirty showed staphylococci, thirty showed diphtheroid bacilli, twenty-nine showed streptococci, and twenty-six showed pneumococci. Other organisms occasionally met with were the bacillus mesentericus, proteus vulgaris, bacillus coli communis, and sarcina. The bacillus of Hofmann was present in twelve cases, and in five of these it was the only bacillus of its group present; in the other seven it was accompanied by diphtheria or pseudo-diphtheria bacilli. Thus there were twenty-five cases showing diphtheroid bacilli, other than *B. Hofmann*, and the great majority of these organisms produced acid when cultivated in glucose broth. In only four of these twenty-five cases were there organisms present which morphologically resembled diphtheria bacilli, but which failed to produce acid in glucose broth cultures. The most common bacilli were those akin to *B. diphtheriæ* (Klebs-Löffler) in morphology and in acid production, but differing from it in pathogenicity to guinea-pigs and in typical reaction to Neisser's staining method. These bacilli, isolated from ten cases, were injected into guinea-pigs, but without any pathogenic effect.

The pathogenicity of the pneumococci was tested in nineteen of the twenty-six cases in which their presence was ascertained. The organisms were virulent in five, or a pathogenicity of 26 per cent. The streptococci, similarly investigated in eighteen cases, proved pathogenic in eight. This gives a pathogenicity of 4 per cent. The staphylococci were tested in sixteen of the thirty cases, and proved pathogenic in four—a pathogenicity of 25 per cent. In analysing the results of the experimental injections of cultures of these organisms, it was noticed that when the swab had been taken near the onset of the discharge the organisms possessed greater virulence. Limiting our consideration only to those cases in which the swabs were obtained within a week of the commencement of discharge, it appeared that the pathogenicity of the pneumococci, staphylococci, and streptococci was respectively 55, 50, and 77 per cent.

That is to say, that during the first week of discharge the pus contains virulent organisms, and in later weeks the organisms are seldom sufficiently virulent to produce illness in the animals tested. Of the seventeen pathogenic cultures referred to above, fifteen were obtained from cases in which the discharge had lasted less than a week, and two from cases in which the discharge had lasted from one to two weeks. In cases of longer duration than a fortnight, none of the organisms tested proved virulent to animals.

Scarlet Fever—Rhinitis.—There were twenty-six cases of this nature from which swabs were taken. In only four of these was the discharge mono-organismal. The organisms present in these four cases were the streptococcus conglomeratus, the streptococcus pyogenes longus, and the staphylococcus pyogenes aureus (twice) respectively. The other twenty-two cases showed various combinations of organisms, there being two varieties present in ten cases, three varieties in ten cases, and four varieties in two cases. The organisms present included many different kinds. The pneumococcus was present in six of the twenty-six cases, staphylococci in seventeen cases, and streptococci in eighteen cases. Diphtheroid bacilli were present in fifteen cases. In seven of these the particular organism proved to be the bacillus of Hofmann, and in seven the pseudo-diphtheria bacillus; while in one case both of these were present. Other organisms occasionally isolated from these cases of scarlet fever rhinitis included the bacillus mesentericus and proteus vulgaris. In two of the cases the pus contained neither streptococci nor staphylococci, but only the pneumococcus and the bacillus of Hofmann in combination.

The pathogenicity of the organisms present in rhinitis resembles fairly closely that of those met with in otitis media. Thus the pneumococci showed virulence in 25 per cent., the streptococci in 44 per cent., and the staphylococci in 33 per cent. of the cases tested. Further, it was in the first week of discharge that most of the pathogenic varieties were met with, and the percentage pathogenicity at this stage amounted to 50, 75, and 60 per cent. for the pneumococci, streptococci, and staphylococci respectively. While the pneumococci and staphylococci were not recovered in a virulent state when the discharge had lasted longer than a week, the streptococci were sometimes virulent at later periods. Pathogenic streptococci were isolated during the second and third weeks of discharge, and in one case even after the discharge had persisted for more than one month. This contrasts somewhat forcibly with the absence of pathogenicity in the specimens from the ear discharges of similar duration.

Whooping-Cough—Rhinitis.—In four cases of whooping-cough there was a discharge from the nasal chambers which was examined bacteriologically. The pus in each case contained staphylococci, and in no case contained streptococci. In two of the cases pure cultures of staphylococci were the only organisms isolated from the pus. In one of these, the staphylococcus pyogenes aureus and in the other the staphylococcus pyogenes citreus was present. Both these staphylococci were non-pathogenic on injection into guinea-pigs. The pneumococcus was found in two cases and a diphtheroid bacillus in one case. This bacillus did not stain by Neisser's method, and was non-pathogenic to a guinea-pig, but produced acid on cultivation in glucose broth. In all four cases of whooping-cough the rhinitis was of short duration. The discharge had lasted in one case less than a week and in the other three cases under a fortnight.

Diphtheria—Otitis media.—Five cases of otitis following diphtheria were examined, and in four of these the discharge had only lasted from three to ten days. In no case was the pus mono-microbic, and usually it contained two or three kinds of organisms. The pneumococcus was present in three cases, staphylococci and streptococci in two each, and diphtheroid bacilli in all cases. These bacilli did not stain by Neisser's method. One case showed the bacillus of Hofmann, and two cases exhibited diphtheroid bacilli

which produced acid in glucose broth. In three cases there was present a bacillus morphologically diphtheroid, but incapable of producing acid in glucose broth. This organism on agar plates grows as a dark smear or dark grey-green colonies, which $\times 105$ show a granular substance with dark nuclei scattered throughout it. The organisms, $\times 800$ in hanging drop, appear as long, non-motile rods, often at an angle with each other. These rods stain irregularly with Lömer's blue stain and appear barred and segmented. They are stained positively by Gram's method, but do not stain by Neisser's method. The bacillus mycoides was present in one case.

Diphtheria—Rhinitis.—Six cases of rhinitis following diphtheria were examined. Staphylococci were present in five, streptococci in three, and the pneumococcus in one case. Bacilli of the diphtheria group were present in all cases. These diphtheroid bacilli included a virulent *B. diphtheriae* (Klebs-Löffler) in one case, while in three cases the bacilli were non-pathogenic and negative to Neisser's stain, but capable of producing acid in glucose broth. The bacillus of Hofmann was present in three cases, and bacillus mesentericus in two cases. No case was mono-organismal, and there were seldom less than three varieties of organisms in the pus.

Measles—Otitis media.—Five cases of otorrhœa complicating measles were examined, four of these within two to five days from the commencement of the discharge. In the fifth case the duration of discharge had been between two and three weeks. This latter case should, perhaps, be excluded, as in reality it was scarlatinal otitis, the measles attack having followed scarlet fever. The streptococcus pyogenes was present along with *sarcina flava*, and the streptococcus was pathogenic to a guinea-pig. The other four cases, all recent in origin, and all in children ranging from two to five years of age, showed no streptococci, but all yielded staphylococci. In one of the cases, which had only lasted two days, the pus contained staphylococcus pyogenes aureus and albus. The former proved fatal to a guinea-pig in three days after the subcutaneous injection of 2 c.c. of broth culture, and was recovered from the pus of an abscess at the site of injection in the flank. It was not recovered from the heart blood, but there was serous effusion in the pleura and peritoneum, and the blood was fluid or semi-fluid. The staphylococcus albus also proved fatal to a guinea-pig, but only after twelve days, and the organism was recovered from the heart blood. In the second case the pus yielded a non-pathogenic staphylococcus pyogenes aureus and the bacillus mycoides. In the third case the pus contained the pneumococcus and the bacillus of Hofmann in addition to the staphylococcus pyogenes aureus. In the fourth case the organisms present were the staphylococcus pyogenes albus and a bacillus, diphtheroid in morphological character but incapable of producing acid in glucose broth.

Measles—Rhinitis.—Five cases of rhinitis following measles were examined bacteriologically. The pus from one of these cases, which had lasted a fortnight, gave a pure culture of the pneumococcus, but the pus in the other four cases was polymicrobial. Of the five cases the pneumococcus was present in four, staphylococci in three, streptococci in two, and the bacillus of Hofmann in two. Diphtheroid bacilli, other than the bacillus of Hofmann, were present in two cases accompanied by that organism, and in one case without it. These bacilli were all negative to reaction with Neisser's stain, but produced acid in glucose broth. The pathogenicity of the organisms present in these cases of measles rhinitis was not tested. The duration of the discharge in the five cases varied from one week to one month.

Otitis media not associated with an Acute Infectious Disease.—Swabs were obtained from three cases of otitis media occurring independently of infectious disease. These were utilised for comparative purposes, and exhibited organisms of similar kinds to those

already noted in cases following infectious diseases. Staphylococci were present in all three cases, streptococci in two, the bacillus mesentericus in two, while proteus vulgaris and a diphtheroid bacillus were found in one case. The pus was derived in one case from an acute suppurative otitis occurring in a child, æt. 3. The organisms present were the staphylococci aureus and albus, the streptococcus pyogenes and the bacillus mesentericus. Notwithstanding the acute nature of the illness, none of these organisms proved pathogenic on injection into guinea-pigs.

Mastoid Abscess.—In six cases of mastoid abscess, pneumococci were present in five, streptococci in five, and staphylococci in three. With the exception of one streptococcus, all these were tested as to virulence in culture, but none were found pathogenic to animals.

Frontal Mucocele.—In one case of suppurating frontal mucocele both staphylococci and streptococci were present. At the time of operation the pus contained streptococcus pyogenes and the staphylococci aureus and citreus. Ten days later a swab from the discharge on the dressing contained the streptococcus pyogenes and the staphylococcus albus. The streptococcus after isolation in pure culture was not pathogenic to a guinea-pig.

General Conclusions.—From the examination of the aural and nasal discharges in these 107 cases of varied origin, the following conclusions appear justifiable:—

1. Purulent discharges of aural and nasal derivation exhibit a variety of bacteria, and do not depend upon a single micro-organism common to all cases.
2. There are four main groups of organisms which exceed all others in frequency of occurrence in such discharges, viz., pneumococci, streptococci, staphylococci, and bacilli of the diphtheria group. These, however, do not comprise all the varieties which the pus may contain.
3. Pure cultures from these discharges are the exception rather than the rule, yet they occasionally occur, and may be met with in about 10 per cent. of the cases.
4. While the discharges are not usually monomicrobial, and do not always contain the same organisms in particular diseases, nevertheless the bacterial contents of such discharges associated with individual diseases present distinctive differences. For example, in this series of cases the aural and nasal discharges in diphtheria always contained bacilli of the diphtheria group, the nasal discharges of whooping-cough always contained staphylococci, and the aural discharges of measles likewise always contained staphylococci. The absence of streptococci in the rhinitis of whooping-cough, and in the otitis of measles, may be accidental, but is certainly suggestive in contrast to their prevalence in the otitis and rhinitis of scarlet fever. In the pus from a mastoid abscess, pneumococci and streptococci are more common than staphylococci.
5. In scarlet fever, aural suppuration is not always due to the same organism. Either the pneumococcus, the streptococcus pyogenes, or a bacillus of the diphtheria group may be responsible, and, having regard to the frequent presence of staphylococci in such pus, there is no reason to doubt that cases occur in which a staphylococcus is similarly responsible, though, as it happened, no case in this series showed a pure culture of a staphylococcus.
6. In scarlet fever, nasal suppuration may be of streptococcal, staphylococcal, or pneumococcal origin. Probably it may sometimes be due to bacilli of the diphtheria group.
7. In scarlet fever the pneumococcus is present in otitis much more frequently than in rhinitis. It occurred in 56.5 per cent. of the former, and only in 23 per cent. of the latter cases.
8. In scarlet fever the organisms present in aural and nasal discharges are less virulent in the later than the earlier stages of the suppuration.
9. In the rhinitis of scarlet fever, streptococci may

retain their pathogenicity even when the discharge has lasted for more than a month.

10. If the infectivity of post-scarlatinal discharges bears any relation to their source and duration, or depends upon the pathogenicity of the organisms present, these observations suggest that otitis and rhinitis are equally dangerous in their early stages, but that the nasal discharge is more likely to contain virulent streptococci in its later stages. Perhaps one may go further and suggest that rhinitis may be the most fruitful source of consecutive and "return" cases. I am not aware whether this indictment of rhinitis coincides with the general experience of hospital physicians, but some confirmation of it is afforded by the opinion expressed by Dr. Pugh in a recent address on the infectivity of scarlet fever.

11. The frequency with which bacilli of the diphtheria group are present in the aural and nasal discharges of scarlet fever is very notable. It suggests that scarlet fever and diphtheria may bear a closer relationship than is commonly assigned to them. The epidemiology of these diseases in particular localities requires, and would probably repay, more thorough comparative study.

THE ALCOHOLIC CRAVING.*

By HARRY CAMPBELL, M.D., F.R.C.P.Lond.,

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Mankind all the world over shows a liking for stimulants in one form or another, and sometimes this liking may amount to a veritable craving. This widespread desire for things stimulating must have a physiological basis, and can best be explained by the fact that stimulant substances are normally present in the blood and lymph and exercise a beneficial influence on function. A stimulant may be defined as something which renders pent-up energy available for use, and at the same time tends to evoke a feeling of well-being, exhilaration, or even slight intoxication. Reference was made to chemical stimulants only. There is evidence that the blood normally contains stimulants. Many kinds of food contain them in abundance; but of all foods meat is the most stimulating. In the making of beef-tea the stimulating substances are dissolved out of the meat, while the foodstuffs are for the most part left behind, so that this beverage is essentially a stimulant; and there can be little doubt that the popularity of a meat diet is largely due to its stimulant effects. Bird is somewhat less stimulating than butcher's meat, and fish much less so than either. Some vegetable foods are highly stimulating; a purely vegetable meal may suffice to make children hilarious and excited. It is well known that maize, beans and oats have a stimulant effect on horses, and there can be no doubt that the vegetable-feeding animals select their food as well for its stimulating as for its nutritive properties. Apart from the stimulants, which are normally ingested with the food, it was suggested that the animal organism normally elaborates these substances; and that their essential function is to stimulate the nervous system. By means of them the sensory system of the skin and deeper structures, but especially of the viscera, is played upon, and there ensues a feeling of well-being, ill-being, or apathy, according to the nature of the chemical substances present in the body fluids. These may be divided into (a) the stimulating and tonic, which tend to create a sense of well-being, with its emotional accompaniment of happiness and elation; and (b) those which depress the nervous system, inducing a feeling of ill-being with its emotional accompaniment of gloom, irritability, and the like. They play upon the nerve instrument, and according to the preponderance of the one or the other class there is discord, while if they neutralise one another there is simply apathy or a negative feeling. In their absence there would presumably be merely a feeling of indifference. Many considerations support the view that the organism is capable of generating

stimulants. Such a substance as uric acid, which some have supposed to be a poison pure and simple, produces, when swallowed, a stimulating effect. Again, it sometimes happens that a nerve-storm—such as megrim—is preceded by a period of exceptional well-being and unusual good spirits. It is difficult to explain this preternatural elation—for to such it may amount—except on the assumption that it is produced by some stimulant or stimulants which act like opium or alcohol, and it is on similar lines that we can best explain the occurrence in subjects of general paralysis of the insane of a sense of exuberant well-being. It seems not unlikely that the intoxicated joy of youth and the inspired moments of genius may also be brought about by autogenetic stimulants. *Practical Deductions.*—When there is perfect health the blood is well provided with its proper stimulants and not overcharged with depressants, and there is no craving for extraneous stimulants, such as alcohol or tea; but when it is defective in the one or surcharged with the other then is felt the desire for the glass of wine or the cup of tea. In order to obviate this desire we should seek to keep the body at the highest level of health. When man ceases to rely on his own proper physiological stimulants, and resorts to artificial ones, he is playing with double-edged tools.

TROPICAL ABSCESS OF THE LIVER.

By G. P. NEWBOLT, F.R.C.S.ENG.,

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The author stated that his paper was based on cases seen in the tropical wards of the Royal Southern Hospital, Liverpool. In all his cases there was a history of dysentery. Amœbæ were found in the sloughs from the abscess wall in several instances, but only once in the motions. The tendency was for the abscess to point posteriorly through the chest wall. In two patients the abscess opened into the lung, and the pus was expectorated, but it was necessary to drain the abscess freely by resecting rib; both cases recovered. The material expectorated was brownish in colour and contained broken-down liver cells. One of these patients had three abscesses opened and drained during a period of four years, but made a perfect recovery. In another two abscesses were opened during life, but a third lay between them and was not discovered. Mr. Newbolt laid stress on the importance of exploring with a long needle of large calibre, and also drew attention to the fact that a man with a liver abscess might go about with a normal temperature, without much discomfort, but that the pulse was usually quickened. He considered it most important that the dysentery should be cured before the patient was discharged, as this disease was often made light of at the time and might cause fresh infection. In one case the dysenteric pain was so acute that exploratory laparotomy was performed, nothing abnormal was found in the liver, and the patient was cured by syphoning the large intestine with a solution of nitrate of silver, 20 grs. to the pint. In the cases which recovered the pulse rate declined directly after the abscess was opened; if the pulse-rate kept up it was probable that there were other abscesses present, or the dysentery was very severe. Experiments in the *post-mortem* room showed that the healthy liver would not hold stitches, but after opening the abscess through the abdominal wall in most cases, the liver being inflamed, the stitches held; though

* Opening address to a discussion before the Society for the Study of Inebriety, Tuesday, April 10th, 1906.

* Abstract of Paper read before the Liverpool Medical Institution, March 29th, 1906.

in one case packing was used for a week prior to incision. In operating through the chest wall the abscess was emptied with the aspirator, and its wall pulled up and fixed to the edges of the superficial wound, large rubber tubes were used for drainage, and in some instances the abscess cavity was scraped with a blunt lithotomy scoop and irrigated. In order to show how rapidly the cavities close up, Mr. Newbolt said that eight days after the removal of 50 ounces of pus the cavity would only hold four ounces of lotion. In one case the liver abscess was tympanitic, owing to the escape of gas from the adjoining colon.

THE FATE OF CHEMICAL MATERIAL FOREIGN TO THE BODY IN THE HUMAN ORGANISM.*

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[SPECIALLY REPORTED FOR THIS JOURNAL.]

It is clear that material introduced into the system is, in a short time, expelled again, either in a changed or an unchanged condition. We have to do with two processes that act on the body, namely, the physical and the chemical, and the fate of such substances introduced has been attributed to such physical and chemical processes. This general knowledge is often veiled by vital views, but we must hold fast to the fundamental principle that a substance introduced into the system will not behave differently from what it does outside the system. At present we have but little insight into the chemistry of the animal body, but what we do possess serves to support indisputably the dictum above expressed. Microscopical anatomy has imparted to us very little as to the essentials of life; the little piecemeal knowledge we do possess we owe to chemical investigation. This imperfect insight into the chemistry of the animal body hinders also our insight into the action of foreign bodies in the organism. The end of a ganglionic cell by means of morphia, for example, is as little understood as the origination of the ganglionic cell itself. We know further, without being at all clear as to the phenomenon, that substances introduced excite the greatest functional powers of the system, and still pass away in the urine unchanged.

We are only in a position to understand the whole of the process when the substance is very simple. For example, we know that sodium bicarbonate when introduced into the stomach becomes decomposed chemically, the carbonic acid is set free, and the sodium unites with the hydrochloric acid. But how the mucus of the stomach is dissolved by the sodium bicarbonate is not comprehensible.

The same with the later fate of iron introduced into the system, even if its immediate fate is known to us. It has been proved recently that the configuration of certain substances, such as the varieties of sugar has an influence on the fate of the further chemical action. Then we know that exudative processes act on the substances introduced; so many alkaloids reach the stage of the latest products, for example, atropine up to 60 per cent., cocain up to 95 per cent. There are

also reducing processes in the system; for example, nitro-benzol that is not attacked in the animal organism is changed by vegetables into amino-benzol. We recognise the simultaneous oxydising and reducing change in the animal body. There is no form of iodine that acts in the animal body in any other way than by the splitting off of the iodine. But besides the oxydising and reducing property for many substances, the organism possesses synthetic properties, yea synthesises at times even with decomposition bodies.

What now have these painful discoveries in regard to the changes in substances introduced into the system gained for us as regards the knowledge of life? Only very insignificant particles; concerning the aim of the processes we know very little. There theory must help us out. There is the intoxication theory that has been much dwelt on. This pre-supposes, however, that the organism is capable of striving according to a regular plan. It is true that it may with an aim, but that is by no means always the case. Thus a combination that takes place in the organism is often without object, and on the other hand a moderate dose of carbolic acid introduced into the system is not poisoned by a mere aimful combination with sulphuric acid. There is here, then, a failure of the organism, it does not work with an aim. In the same way material injurious to the body should undergo the same chemical change into harmlessness, which, however, is not the case. Thus ethyl-alcohol is burnt up in the body. Methyl-alcohol on the contrary is only partly converted into ameisic acid. The latter is, however, far less agreeable for the body than ethyl-alcohol. Another way in which the aimfulness of the body is shown is when a comparatively insoluble substance is converted into a soluble one, so that it can the more readily be excreted. But, for example, the less soluble metallic arsenic is converted in the body into a soluble combination that can exert a destructive power. One cannot call that aimful. From all these facts there results this conclusion, that all the processes of the organism of a chemical nature are independent of its consciousness.

More important than the conversion of chemical bodies in the animal organism is their excretion. In respect of this there are two possibilities:— Either the bodies are excreted within a short time, or they become fixed or deposited. The excretion is, therefore, an aimful process. Life without excretion is impossible. The facts are to be extracted by observation, and these when put together give a greater insight into the processes. The organism strives to get rid of unassimilable bodies as quickly and agreeably as possible. This excretion takes place first through the glands, which by their structure are peculiarly fitted for the office. This glandular activity is very varied, not only that of the different glands, but also that of similar glands from individual to individual. In general one may say that each gland excretes foreign material, introduced in or originating in the organism in proportion to size, its excretion of fluid and its warmth. This excretion takes place when osmotic conditions within the system do not prevent it. The height of the activity is increased by stimulation or pressure. Abnormally placed glands can do more according to their size, but only to a certain degree, not more than that

* An address delivered before the Verein f. Innere Medizin, Jan. 15th, 1906.

for beyond this derangement of the secretion takes place. This fact is of clinical importance, for example in the administration of diuretics.

In association with this stands the question whether all substances pass into all glands, or whether there is a specific attraction in glands for particular substances? The question is answered by pointing to the introduction of nutrient material into the cells. These had a specific power of selection, but this power was not outside chemical laws; there was no place for vitalistic views here. It cannot be different in the case of foreign material so we are driven to the view that certain physical-chemical properties of the body are related to the structure of the tissues. In the lense there is a purely osmotic life. As, however, nutrient material cannot be introduced into the lense by way of experiment, may we speak then of a specific power of selection? No power of selection steps in, for that pre-supposes a will on the part of the cells, and that has not been proved, but it is a product of the given factors. Why, with an equal osmotic equivalent of two substances does only one enter? We have no decided explanation for this, undoubtedly individuality enters in, for example, of the glands. A gland may act vicariously and without any special stimulation. But so much stands fast, every gland when it is healthy takes part in the excretion of the foreign bodies. The reason why a gland does not act with uniformity, but in intervals, lies in this, that another gland has become active. Thus the secretion of the breast is interrupted by vicarious activity of other glands. We recognise two kinds of excretion:—(1) The abrupt rise and fall of excretion; (2) the abrupt rise, the broad shoulder of the curve, and slow fall; thus bromide of potassium takes weeks to get expelled from the system. This fact is of importance clinically. For instance, is dose after dose to be given to produce a rapid effect? Frequently that would not be proper, as the organism has already had to strive to get it out of the system as quickly as possible.

All glands excrete, and so (1) the kidneys. Every substance has a capacity for urination (ist Harnfähigkeit). The substances frequently retain their poisonous properties during excretion. (2) The salivary glands participate in the excretion. That was shown by Ambrose Paré, who records that a patient had a bitter taste in his mouth when bitter material had been introduced into his pleural cavity. We saw the same after subcutaneous injections of quinine, as well as after mercurial inunctions; we also find an intermitting action here. We recalled an earlier custom when patients treated with mercury kept a gold ring in their mouth which became white from mercury deposited from the saliva. The alkaloids also are excreted in the saliva. (3) The stomach also excretes, and so in cases of poisoning from subcutaneous injections of morphia, we find morphia in the washings out of the stomach. Iodine goes into the stomach. If starch is introduced into the stomach of an animal and iodic acid is then injected subcutaneously, the iodine is set free and colours the starch in the stomach blue. A large number of bodies are excreted by the stomach, such as albuminous bodies. Typical poisoning is caused by the wash-out water of the stomach, after poisoning by snake-bite. (4) The intestines

excrete a number of substances, even when the bile has been cut off. Here the glands of both small and large intestine act. This has been proved with certainty with regard to Brunner's glands, but not decisively as regards the crypts of Lieberkühn. The free excretion of the gland of the large intestine is a fact, a proof of this is the facile production of changes in the colour after external dressings of sublimate. (5) The mamma belongs to the excretory glands. It excretes the most heterogeneous substances, such as arsenic after taking Fowler's solution, potassium chromate, mercury, lead, senna, antipyrine, and chloral hydrate. This property is of great importance as regards children fed at the breast, as lead or arsenic may be passed on to an infant from mothers poisoned by these substances. (6) The cuticular excretory glands. Thus, excretion of urea through the skin along with profuse sweating or retention of urine. The skin further excretes iodine, mercury, arsenic and iron. Thus may well be explained the production of exanthems in infectious diseases as the product of irritation from excreted infective material, and the critical sweat be brought into connection with the excretion of injurious substances. (7) Excretion through the lachrymal glands. Thus sharp conjunctivitis has been seen from iodide of mercury after insufflation of calomel into the eye, and the internal administration of iodide. (8) Finally, the lungs excrete gaseous bodies, but not ammoniacal gas, which, on the contrary, is found in the vessels of the lungs. A reason for this peculiar behaviour of the lungs towards ammoniacal gas has not yet been given. Croupous changes even have been seen in the lungs from the internal administration of ammonia. Every mucous surface excretes foreign substances, and in this way salicin is found in the synovia and in the peritoneal fluid.

The deposit of foreign material that has been introduced into the system is of great interest as regards poisoning in parenchymatous organs, through an occupation or trade. Then, for instance, in old lead workers who have long left a lead atmosphere lead symptoms appear for a year and a day when the lead deposited becomes soluble again. I have seen lead poisoning 17 years after a shot in the tibia with healing in of the leaden bullet. What physicians for thousands of years have practised without our scientific knowledge, viz., an extensive unloading or eliminating method of treatment with partial participation of many glands should, perhaps, have clinically more attention devoted to it. Undoubtedly we possess in this method of procedure a rich possibility.

THE OUT-PATIENTS' ROOM.

THE ROYAL EAR HOSPITAL.

Case of Fixation of the Malleus.

By Mr. MACLEOD YEARSLEY, F.R.C.S.

MR. YEARSLEY made the following remarks:—This patient, æt. 41, came here a week ago, complaining that he has been deaf for six years, and that he is worse when he is suffering from a "cold," a trouble to which he is distinctly subject. He does not complain of any tinnitus; his deafness, which used to get well as soon as his "cold" got better, has now "settled in his right ear." Inspection shows that his left tympanic membrane is white and thickened, and the tympano-malleo

lar folds are accentuated. In the right ear the posterior tympano-malleolar fold is seen very prominently, and there is a light reflex below it. The normal cone of light is broken and reduced in size, and there is a small calcareous patch in the anterior segment of the membrane. If we examine carefully with a Siegle's pneumatic speculum, it will be found that the malleus does not move.

Examination of the throat shows a chronic pharyngitis with flabby oedematous uvula and fauces. In the nose there is a deflection of the septum to the right, and a large ledge growing from it at the left inferior aspect.

This man is suffering from a chronic catarrhal condition of the tympanum, complicated in the right ear with fixation of the malleus. This fixation is generally due rather to shortening of the malleolar ligaments than to any adhesion to the inner tympanic wall, although the latter condition may occur. He has come up to-day with a view to mobilising this fixed malleus, a small operation, the results of which are usually very satisfactory. As it is somewhat painful, it is more satisfactory to perform it under suitable anaesthesia, such as may be obtained by means of nitrous oxide gas. The ear having been purified, pressure is made with a modified Luca's probe, tipped with gutta percha, on the short process of the malleus, until the fixation is overcome. Usually there is an immediate improvement in the hearing. The house surgeon, Mr. Jones, has just tested this patient's right ear, with the following result:—The C fork shows that Weber's test is positive for the right ear. Rinne's test is negative, and bone conduction is neither increased nor diminished. The voice is heard at 2 feet 5 inches, the whisper at 8½ inches, and the watch only on contact.

The right ear was then purified with antiseptics, nitrous oxide gas was administered by the house surgeon, and Mr. Yearsley mobilised the malleus. The patient's right ear was again tested some five or ten minutes afterwards, when the hearing was found to be: Voice, 4 feet; whisper, 16 inches; watch, 9½ inches.

OPERATING THEATRES.

KING'S COLLEGE HOSPITAL.

PYLORECTOMY.—MR. BOYCE BARROW operated on a man *æt.* about 50, who had been admitted on account of sickness and pain in the epigastrium. On examination a lump could be felt a little above and to the right of the umbilicus; this was thought to be a malignant growth of the pylorus and an exploratory laparotomy was performed. Finding it possible to remove the malignant mass the operation of pylorotomy was at once proceeded with. Separation of the diseased mass from both the small and the great omentum was fairly easily effected, but the posterior connections of the growth could not be satisfactorily recognised at this stage; therefore the duodenum was clamped and divided and the exposed mucous membrane of this portion of intestine, having been purified and covered, the proximal end was raised so as to disclose the posterior attachments of the growth satisfactorily. These involved the head of the pancreas, and great care was necessary in liberating the diseased mass in this region. The vessels having been tied the stomach was clamped, and the diseased portion, with about a quarter of the pyloric end of the stomach itself was removed. The opening into the stomach was next stitched up perfectly by a double row of sutures, and then a gastroduodenal junction was effected the duodenum being attached on the posterior aspect of the stomach, a fresh opening into the latter having been made. The abdominal wall was finally closed and the wound dressed, no drainage being employed. Although the

whole operation took two hours to perform, the patient's general condition at the end was highly satisfactory, his pulse being quite steady and good, only 80 per minute. Mr. Barrow specially drew attention to this fact, which he attributed to the careful manner with which Dr. Flux had administered the anaesthetic, very little anaesthetic having been used after the abdominal incision had been made, and Mr. Barrow pointed out that all the manipulations within the peritoneum—such as, amongst others, the tedious suturing of the bowel—were not painful, and therefore did not require profound or complete anaesthesia. The shock of an operation was greatly added to, he thought, by the prolongation of complete anaesthesia, and the poisoning effect of large doses of anaesthetics administered. There was, he considered, more shock in very complete anaesthesia, but less when a small quantity of the anaesthetic was administered. He said it might seem extra trouble to close one opening in the stomach and then make a fresh one, but the experience of other surgeons had shown the advisability of this procedure, inasmuch as the liability of leakage likely to occur from imperfect fitting of the duodenum into the original opening into the stomach was obviated.

ST. THOMAS'S HOSPITAL.

OPERATION FOR A COMPLICATED CASE OF IRREDUCIBLE HERNIA.—MR. BATTLE operated on a single woman, *æt.* 43, for a tumour in the left groin. She stated that it had appeared about twelve months before as a small, hard swelling, and had since gradually increased in size; more especially had it increased in size during the last two months; it had not been very painful. The swelling was situated in the position of the inguinal canal. It was pear-shaped, the upper part being hard and evidently solid, whilst the lower part was rounded and fluctuated; the skin about the swelling was very sensitive, but showed no change. There was no impulse on coughing and the tumour was not reducible. On the skin of the abdomen were numerous flattened pigmented moles. The diagnosis made was that the patient had an irreducible hernia, and a hydrocele of the hernial sac. An operation was performed for the radical cure of this hernia, which was supposed to be an oblique inguinal one. An incision was made over the inguinal canal running in the long axis of the swelling; the cystic portion was opened and found to contain blood-stained serous fluid. Above that, however, was a mass of inflamed glands which were matted together and adherent to the abdominal wall above Poupart's ligament, and these had to be separated with the knife from the external oblique. Towards the outer part of the lump a flattened extension was found running over Poupart's ligament into the femoral canal. An incision was made through the outer part of this and carried quite round it; by this means the sac of a femoral hernia was thoroughly opened up, and the omentum, which it contained, separated from the lining of the sac and afterwards from the fundus of the sac, where it was intimately adherent to the glandular mass. By this means the glands and attached omentum were removed, after which the neck of the sac, which easily admitted the forefinger, was ligatured and pushed out of the canal. A radical cure was then performed by the method which Mr. Battle employs for femoral hernia (this has already been described in "Operating Theatres"). Briefly, the outer covering of the inguinal canal was divided from the centre of the external ring outwards for two inches; the pillars of the ring were then clearly defined and Poupart's ligament seen from

above. Immediately above this the transversalis fascia over the femoral canal was divided and as the neck of the sac had been pushed out of the canal, the internal pillar of the ring, with the portion of external oblique continuous with it, was brought down through the slit in the fascia and sutured to the fascia covering the pectineus. Other stitches were also inserted, an outer one fastening the same structure to Poupart's ligament and another one fastening it to Gimbernat's ligament. The internal pillar of the ring was then sutured with its portion of the external oblique on to the external oblique higher up. By this means, Mr. Battle pointed out, any pull was transferred to Poupart's ligament and not to the flap, which had been secured to the pectineal fascia. In the present case two sutures were required to hold the pectineal flap in position; in addition, a reinforcing stitch was placed between the compartment of the femoral sheath lying to the inner side of the vein and Poupart's ligament. The external wound was then closed. Section of the glandular mass showed that some of the glands of which

it was composed were pigmented, and it was very possible, Mr. Battle said, that the glandular change was one of melanotic sarcoma, more especially taking into consideration the numerous pigmented moles which were present in the neighbourhood, although none of these were conspicuous by their size or ulcerated. Mr. Battle remarked that it was somewhat difficult to give the right order of events in the formation of this swelling. The patient herself was not a woman of much intelligence and could not give a very clear account of the exact sequence of events. It was very probable that as the glands became inflamed, and there had certainly been inflammation of them, the one in the femoral canal which had been pushed forwards by the femoral hernia also became inflamed, and the inflammation extended through the sac and caused adhesion of its contents, and when contraction came the hernial sac and omentum were pulled up on to the abdomen and flattened against Poupart's ligament, so as to present no definite swelling which could be distinguished in that situation.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, MARCH 16TH, 1906.

The President, JOSEPH F. O'CARROLL, M.D., F.R.C.P.I.,
in the Chair.

AN UNCOMMON FORM OF RENAL DISEASE.

DR. PARSONS exhibited kidneys which had all the appearances of the congenital-cystic form, only a small portion of the kidney substance being left intact. The patient, a labourer, *æt.* 40, was in his usual good health until the day before his death. Suddenly becoming ill he was admitted to hospital, where he died in twelve hours. Clinically he exhibited symptoms of gastro-intestinal irritation, with suppression of urine. The autopsy revealed nothing amiss except the kidneys shown.

DR. O'CARROLL said it would be interesting to know whether the condition was congenital or not.

Professor SCOTT considered the condition as being of the nature of hypertrophic cirrhosis, due to a pathological change that must have begun within the last ten years at least.

DR. TRAVERS SMITH said that some brain trouble might possibly account for the sudden death of the patient.

DR. PARSONS said the brain was examined, and was found normal. He considered it to be more a case of congenital cystic kidneys than of chronic interstitial nephritis.

AORTIC ANEURYSM PERFORATING PULMONARY ARTERY AND CAUSING PERFORATION OF PULMONARY VALVE.

Professor O'SULLIVAN said the patient from whom the specimen was taken was brought in a dying state to hospital. The *post-mortem* showed an aneurysm of the aorta on the right side, half-an-inch above the attachments of the valves, and perforating the pericardium. It had also perforated the pulmonary artery above the valves, and the valves themselves showed evidence of perforation. This latter condition, he said, was caused by the blood-stream that had passed from the aorta into the pulmonary artery.

DR. O'CARROLL mentioned a case, almost identical, that had been shown him by Dr. Earl, but he was not certain as to the involvement of the valves.

EPITHELIOMATOUS PENIS.

Mr. E. H. TAYLOR exhibited a penis removed for epithelioma.

EPITHELIOMA INVOLVING PART OF THE DUODENUM WHERE THE BILE-DUCT OPENS INTO THE INTESTINE.

Mr. E. H. TAYLOR said: The man, *æt.* 40, had several attacks of jaundice, which gradually disappeared after each attack. When he came to hospital his liver was somewhat enlarged, and his skin slightly jaundiced. On opening the abdomen the gall-bladder was distended, and a great number of gall-stones were found in the common bile-duct. Found a hard mass in the duct where it opens into the duodenum, which he removed. On the ninth day the patient's temperature rose and he developed pneumonia, from which he died. Dr. O'Sullivan made the *post-mortem*, and found a cancerous mass at the mouth of the duct. There was no obstruction to the flow of bile, and the liver was enlarged and cirrhotic.

CANCER OF THE OVARY.

Mr. E. H. TAYLOR said: This tumour was removed from a woman, *æt.* 55. On examination it seemed like circumscribed peritonitis, and could be felt just above the pelvis. The tumour was more easily palpated when the patient was under the anæsthetic. On opening the abdomen a quantity of bloody fluid poured out. The patient would be able to leave hospital the following week.

DR. O'CARROLL said the jaundice in the case of the epithelioma of the duodenum was due to the gall-stones, and not to the cancer.

Professor O'SULLIVAN said the duodenal epithelioma resembled a papilloma in many respects. As to the development of pneumonia, it was interesting to note that the diplococcus of pneumonia was found in the bile duct before any trouble appeared in the lung. It was held that croupous pneumonia did not originate from the blood, but through the air passages. It was probable in this case, however, that the diplococci might have reached the lung by extension from the under surface of the liver through the diaphragm.

URTICARIA PIGMENTOSA.

DR. WALLACE BEATTY exhibited a boy, *æt.* nearly 4, the subject of urticaria pigmentosa, dating from a month after birth, and he showed microscopic sections of a nodule excised from inside the knee. He demonstrated the interesting fact that the granules of the mast-cells, which are stained red by polychrome methylene blue in alcohol—fixed and hardened preparations—are stained also by eosin if the skin is fixed

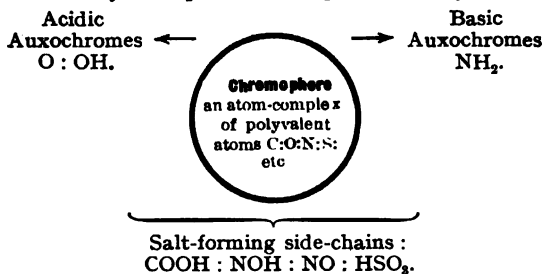
in Zenker's fluid (*i.e.*, Muller's fluid saturated with corrosive sublimate plus 5 per cent. glacial acetic acid) before final hardening with alcohol. Three considerations present themselves—(a) Has Zenker's fluid so altered the granules of the mast-cells as to render them acidophilic instead of basophilic, as they appear to be when alcohol alone is used for fixing and hardening? (b) Are the granules of the mast-cells really basophilic? If the red colour of these granules is due to the methylene azure of the polychrome methylene blue, it is to be noted that methylene azure is an oxidised methylene blue, and contains the SO_2 group—*i.e.*, a less basic body than the methylene blue from which it is derived. (c) Perhaps the true explanation of the red colour of the granules of the mast-cells, when the sections are treated with eosin, followed by Löffler's methylene blue, is that these granules are really stained by methylene azure. Nocht and Robin (*c.f.*, Mann's Physiological Histology) found that on bringing methylene blue and eosin together there is formed methylene azure along with other compounds. If so, the stain is practically the same as if polychrome methylene blue were used. However, the fixing agent is not without some influence, as the mast-cell-granules in sections made from the portion of the skin fixed in Zenker's fluid do not take the characteristic red colour, but a bluish colour, with polychrome methylene blue.

Dr. O'CARROLL said there were two fundamental theories regarding the origin of this disease—*viz.*, that it is either (1) a structural or anatomical lesion, or (2) a chemical one.

Professor SCOTT said on examining the blood he found the lymphocytes existed in almost equal amount with the polynuclear leucocytes. The granules were of a proteid nature, and would be acted upon by reagents. They would be altered by such chemicals as corrosive sublimate.

Dr. WALTER SMITH thought it not improbable that in the near future, the closer study of stains and dyes might throw some light upon the important problem of the nature of proteid substances. He pointed out that an efficient stain usually included or was made up of three constituents:—(1) a nucleus, or chromophore, with a feeble acid or basic tendency. The chromophore usually belongs to the aromatic series, and includes polyvalent atoms—*e.g.*, C : O : S : N. (2) Auxochromes, represented by NH_2 (basic group), or (OH), and oxygen (acidic radicals), tacked on the chromophore, and, correspondingly, modifying its properties. (3) Salt-forming groups—*e.g.*, carboxyl, COOH : sulphonic group HSO_3 , NOH : NO_2 .

This may be represented diagrammatically:—



The general theory of staining depends upon physico-chemical interactions between the stain and the tissue.

Dr. O'BRIEN said that any side-light that could be thrown on the pathology and etiology of the disease would be productive of good results as regarded the treatment and diagnosis.

Dr. WALLACE BEATTY briefly replied. He said—Some thought urticaria pigmentosa might possibly be of congenital origin, like naevi. The child he exhibited was in the stationary phase of the disease; and he had never seen a further advanced case. In his experience he had only met with two cases in the early stage.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, MARCH 29TH, 1906.

FRANK T. PAUL, F.R.C.S., President, in the Chair.

THE DIMINISHING BIRTH-RATE.

DR. HUGH R. JONES read a note on the diminishing birth-rate. Although artificial means of preventing conception were being more generally and systematically adopted, it must be remembered that families had always been limited by prudential self-restraint to an extent not generally realised. The influence of the later age at marriage and the lower marriage-rate and of the employment of women in intellectual and industrial occupations was being under-estimated. The death-rate had also fallen, and this fall began before the fall in the birth-rate. The former was due in part to the high birth-rate in former years, but it also indicated an improvement in the social condition of the population. Improvement in the social status was always attended by a fall in the birth-rate. The natural increment of the population was still high. The low death-rate was masked and compensated for by the low birth-rate. It was to be regretted that, except in 1904 and 1905, the rate of infant mortality had been persistently high. He hoped that the present low birth-rate was only a temporary phase in the history of English civilisation. For a high birth-rate and a robust young population were necessary to continue the past policy of England. The growth of the population of a country depended on the sustained systematic policy of the mass of the people, which was guided by the action and teaching of the educated classes, and upon them was the responsibility.

Dr. COLIN CAMPBELL attributed the decreasing birth-rate among the working classes to the creation of the lower order of practitioners in midwifery. They had been taught the use of the uterine sound—with "strict antiseptic precautions"—and they utilised the knowledge. The *Lancet* had recently directed attention to advertisements of "preventives" in journals such as *Myra's*. He had exhibited, some years ago, samples of preventives sent to a midwife to retail to her patients.

Drs. W. Macvie, Moffat, and G. C. Walker also spoke.

THE OPERATIVE TREATMENT OF UTERINE FIBROMYOMATA.

Dr. T. B. GRIMSDALE read a short note on the operative treatment of fibroid tumours of the uterus, and pointed out the wonderful improvements that had been made in abdominal hysterectomy of late years, and contrasted the mortality at present with that of ten years ago. He also showed that the mortality from operation was now less than that of the disease.

Dr. H. BRIGGS thought the present safety of abdominal hysterectomy in the treatment of fibroids at an early stage was an encouragement to the gynaecologist, but the operation could be often declined to the patient's advantage.

Sir JAMES BARR exhibited Dr. Oliver's new hæzma-nometer.

Mr. G. P. NEWBOLT read a paper on "Tropical Abscess of the Liver," which will be found on page 391 of the present issue.

Mr. K. W. MONSARRAT spoke of the difficulties of the evacuation and satisfactory drainage in cases where the abscess bulged directly downwards from the under surface of the right lobe at considerable depth from the anterior abdominal wall. He considered that an incision below the twelfth rib in the loin was the only route for satisfactory drainage under such circumstances. He mentioned the case of a woman who had always lived in Cheshire on whom he had operated for a single abscess in the right lobe; there were no symptoms of any intestinal disorder, there was no fever, the pus was sterile bacteriologically, but contained amœbæ in large numbers.

The following members also took part in the discussion:—The President Drs. T. R. Glynn, H. W. Carter, Nathan Raw, R. J. M. Buchanan, C. J. Macalister, J. Lloyd Roberts.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

CLINICAL MEETING HELD ON FRIDAY EVENING,
APRIL 6TH.

Under the Presidency of Mr. L. A. BIDWELL.

The following cases were shown:—

By Mr. HOWELL EVANS: Two cases of Congenital Pigmented Wart (Acanthoma), remarks on these cases were illustrated by a series of lantern slides.

By Dr. ARTHUR SAUNDERS (for Dr. Seymour Taylor): Two cases of *Tabes Dorsalis* in women.

By Dr. PHINEAS ABRAHAM: A case of *Dermatitis Erythematosa* which commenced as an irruption indistinguishable from *Pityriasis Rubra Pilaris*; an infant the subject of several *Cornua Cutaneum*, and a case showing an unusual form of *Impetigo Contagiosa* which has sometimes been designated *Impetigo Annulata*.

Dr. ARTHUR SAUNDERS showed a case of *Sclerodermia* involving a localised area on the back, which had followed, and appeared to be the result of an injury; a case of syphilis in a man, with great enlargement of the skull and also of the liver; and a child of 12 with greatly enlarged head and spleen, the result of hereditary syphilis.

Dr. DONALD ARMOUR exhibited a woman from whom he had removed a large polycystic kidney sixteen months before; the specimen was shown at the same time; the patient was in perfect health; he also showed a patient for whom he had excised both temporo-maxillary joints for bony ankylosis some months previously, with a very satisfactory result.

Dr. LEONARD DOBSON showed a case of *Epithelioma of the Auricle*.

Mr. E. PERCY PATON: A case of well-marked *Mollusum Fibrosum*.

Mr. ASTLETT BALDWIN: A case of *Hereditary Ataxia* with marked deformity of both feet.

Mr. L. A. BIDWELL showed a case of *Rodent ulcer* in which the ulcer had developed in the situation of an old syphilitic. There was a large attendance of members of the Society, and an interesting and instructive discussion followed the exhibition of the cases.

ULSTER MEDICAL SOCIETY.

MEETING HELD IN THE MEDICAL INSTITUTE, BELFAST,
THURSDAY EVENING, APRIL 5.

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

Dr. CECIL SHAW showed a case of *Myxo-sarcoma*, involving the nasal cavity, the antrum, and the orbit on the right side, and demonstrated the extent of the growth by transillumination. The patient was a woman, *æt.* 45. A section of the growth was showed under the microscope.

Professor SINCLAIR described three cases of successful nephrectomy, and showed the diseased kidneys. In case 1, the patient was a woman *æt.* 24, and the right kidney was affected with a lympho-sarcoma. There was a great trouble in removing it, owing to adhesions. The operation was done by the transperitoneal method. The kidney, when removed weighed 2½ lbs. The clinical interest of the case lay in the fact that there had been painless hæmaturia two and three-quarter years ago, so that the growth must have begun before that time. Such cases have been known to last for ten or twelve years. The urine was normal, except when blood was present. For five out of the first twelve months the patient was confined to bed by the hæmaturia, but there had been complete freedom from it for the past year. Case 2 was one of carcinoma, and was much more rapid and with more pain. The patient was a woman, *æt.* 41, and the right kidney was diseased. She was aware of a tumour for four months before operation, movable at first, with pain and bleeding for the last three months. The kidney was removed through a lumbo-abdominal incision, and a large part of the fatty capsule was

removed with it. The mass measured 9 by 5 by 3½ inches. The patient did well, and left hospital in a month, and had over a year's respite. The mortality in this operation used to be 70 per cent., but was now reduced to 20 or 30 per cent., and this improvement was probably partly due to our now being alive to the necessity of speed in operating, since ether and chloroform both have a bad effect on the kidney. He preferred the anterior route in cases where the kidney was large and adhesions were present. Case 3 was a caseous tubercular kidney of long standing. It was the left kidney in a man, *æt.* 38, and when removed weighed 3 lbs. It was a pure caseous deposit. The man knew he had a tumour for ten years, but there were no urinary symptoms and no tubercular symptoms elsewhere. Symptoms of intestinal obstruction occurring in a rather acute form on several occasions were the only symptoms present. It was a remarkable thing that there was no mixed infection, and all the more so as the patient was liable to attacks of boils, so the micro-organisms were ready on the premises. The operation was by the transperitoneal route, and was not nearly so difficult as the cancers. After a year there is no sign of other trouble; the man has put on weight, and is at business every day. In all these cases prolonged vomiting gave the greatest trouble, lasting for three, five or seven days. It was an interesting question whether this was due to uræmia or some other toxæmia.

The cases were discussed by Messrs. Mitchell and Fullerton, and Drs. Calwell, McKisack and Fielden.

Dr. H. L. MCKISACK read a paper on

ALBUMINURIA.

He said that he would confine himself to the diagnostic value of albuminuria. There were two main groups—(1) Where the urine rises free from albumin and gathers it on its way; and (2), where the albumin is secreted with the urine. In the first group an admixture of pus with the urine was generally the source of the albumin. The most interesting to the physician was that form of pyelitis sometimes seen in young female children due to infection with the *bacillus coli*. The second group included most of the forms that are of constant interest to the physician, and might be considered in three sub-groups:—(a) Physiological or functional albuminuria, so-called. Many varieties are described: hyaline casts occur in all, but there are no cardio-vascular signs. These cases are of great interest in connection with life insurance. Professor Saunby would pass many of them, and Professor Wright says that to consider these as pathological is one of the antiquities of medicine. Till further light is forthcoming on them, Dr. McKisack would be inclined to say that albuminuria of renal origin denotes some change in the normal epithelium. A certain proportion of these cases ultimately develop nephritis. (b) In the second sub-group there is some disease of another part, but no nephritis. The renal epithelium is slightly affected, as in febrile disease, lead poisoning, and various nervous lesions. In all these it seems to be temporary. (c) The third sub-group includes the more serious affections of the kidney—congestion and real nephritis. These cases cannot be clearly cut off from those in the last sub-group, for a slight febrile albuminuria may occur in scarlatina, and run into a true nephritis, or in pregnancy there may be a mechanical albuminuria which runs into a more serious form. There is a large margin of safety in renal secretion, so that there may be no evidence of the morbid condition, except the albuminuria, a sort of compensation somewhat analogous to what occurs in cardiac disease, hiding all symptoms except on special examination. The small red kidney is not a nephritis at all, but a form of arterial degeneration. The name, gouty kidney, is only half a truth; granular kidney is not correct, for other forms may be granular too, and chronic interstitial nephritis is a name to avoid. It might be called chronic arterial renal sclerosis. Dr. McKisack concluded his paper by a brief résumé, showing how the various forms of albuminuria might be divided either according to the quantity of albumin

usually present, or according to the source of the albumin.

The paper was discussed by Drs. Trimble, Sinclair, Houston, Robert Campbell, and the President. Dr. Houston defended Professor Wright's views on physiological albuminuria, and described the effect of treatment by calcium chloride on many of these cases. In replying, Dr. MCKISACK said that he thought that the presence of albumin showed at least a certain vulnerability in the renal epithelium.

GLASGOW EASTERN MEDICAL SOCIETY.

MEETING HELD WEDNESDAY, MARCH 4TH, 1906.
Dr. T. BARNES, Vice-President, in the Chair.

Dr. J. K. KELLY read an interesting and lucid paper on

STERILITY,

and dealt with the subject chiefly in regard to women. He pointed out certain anatomical considerations, such as the proper position of the os uteri, lying on the posterior vaginal wall, and how flexions, and displacements of the womb tend to displace the natural position of the os, as well as indirectly to set up secondary inflammatory changes inimical to conception. Three conditions, he said, were necessary for impregnation: 1, healthy ovum; 2, healthy spermatozoon; 3, healthy state of the mucous membrane of the uterus. Dr. Kelly pointed out that there was a circulation of peritoneal fluid through the Fallopian tube to the uterus, which carried, like a tide, the ova to meet the spermatozoa, which had to swim up stream. Any mechanical hindrance interfering with the union of these elements would be a bar to pregnancy. It was important to see that there was no impediment, such as atresia, elongated and stenosed os, with endo-metritis. Pyosalpinx, by bringing about adhesions of the fimbriated mouth of the Fallopian tubes, generally brought about sterility.

Dr. Kelly laid considerable stress on operative interference with the cervix and the endometrium, by amputation and curretting, in case of stenosed and elongated cervix with endo-metritis.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD. FRANCE.

Paris, April 7th, 1906.

SUTURE OF THE HEART.

At the meeting of the Société de Chirurgie, M. Querin communicated two cases of wounds of the heart. In the first case, the wound was produced by a knife. M. Querin opened the thorax, evacuated the blood from the pericardium, and discovered a wound in the left ventricle, which he sutured. The patient made a rapid and complete recovery and left the hospital on the thirteenth day. The second case was treated by M. Savariand; the wound, produced by a stiletto, was situated in the right ventricle. The part was sutured two hours after the accident, but the patient succumbed on the fourteenth day from infection of the pleura.

Wounds of the pericardium and the heart are divided into penetrating and non-penetrating. Non-penetrating wounds, says Terrier, concern the muscular fibres and the vessels, and have been observed several times. The wound frequently bleeds abundantly producing compression of the heart, which, if not relieved by opening the pericardium, renders the prognosis particularly grave.

Of all the non-penetrating wounds of the heart, the most important are those which concern the coronary arteries. However, the lesion is not absolutely fatal as in some rare cases spontaneous cure has been observed, but more frequently the patient succumbs

to hæmorrhage and the resulting compression of the heart.

Penetrating wounds of the pericardium and the heart are much more frequent, and here also the prognosis is not necessarily fatal; wounds produced by a pointed instrument are less grave than those produced by a knife or a bullet. Wounds of the auricles are the most dangerous, as the hæmorrhage is very abundant and immediate.

Wounds of the heart, without opening the pericardium, are rare; they are never produced by sharp instruments; they result from fire-arms, contused wounds, and traumatic ruptures.

An interesting fact in connection with heart wounds is the rapidity with which they become cicatrised. M. Tillaux relates a striking example. A lunatic introduced into the region of the heart a piece of wire about five inches long. When M. Tillaux saw him, the foreign body had disappeared, but it could be felt by the fingers rising up and down with the rhythm of the heart. The circulation was by no means disturbed. Thinking that the piece of iron was acting as a plug, he did not dare extract it, and the following day it could not be felt; the patient recovered completely. He died, however, the following year, and at the autopsy the wire was found to have gone through the anterior border of the left lung, the posterior wall of the ventricle, and become fixed in the right lung. In another case a bullet was found encysted in the ventricle.

Launay cites the case of a revolver bullet which had traversed the heart, entering by the left ventricle a little above the point and came out by the same ventricle, but higher up. The patient recovered completely after suture of the heart.

The symptoms of wounds of the heart are sometimes deceptive. They depend on the gravity of the wound, the importance of the hæmorrhage, and the consequent compression, and also on the nerve troubles due to a lesion of the ganglions of the heart.

Sometimes the general condition of the patient is almost normal, but more frequently he is pale, plunged in a state of anguish and prostration, and becomes rapidly cold, or he falls into prolonged syncope and succumbs. According to Fischer, syncope was observed in 87 of 452 cases published. The hæmorrhage as a consequence of the wound may be both external and internal; the former is generally insignificant, but the latter is very grave, for obvious reasons. The signs of compression of the heart are: precordial anguish, cyanosis, smallness and rapidity of the pulsations. Percussion reveals an increase of the normal dullness, and by auscultation the beats are found to be muffled. Respiratory disturbance is constant; dyspnoea, passive pulmonary congestion, and, when the lung and the pleura are wounded, hæmoptysis or pleural effusion may be observed.

According to Fischer, 18 per cent. of wounds of the heart recover, and 51 per cent. when the pericardium alone was concerned.

The treatment of wounds of the heart is both medical and surgical. In a certain number of cases medical treatment suffices, which consists in absolute rest, in order to encourage the formation of the clot and to prevent it from becoming detached. The patient should be kept in a half-sitting posture to make breathing more easy, and to prevent pulmonary congestion. Cardiac agents—digitalis, caffeine, &c., are absolutely counter-indicated as well as injections of serum.

The Surgical Treatment.—It is not many years since surgical interference in wounds of the heart was considered possible. Pegrol and Block said in their classical works that the surgeon was disarmed before cases of the kind. To-day the treatment of wounds of the heart may be regarded as one of the finest conquests of modern surgery, as by an early operation a patient otherwise condemned may recover.

The first thing recommended to be done in wounds of the heart is to close the orifice antiseptically. Later,

if there be signs of compression from hæmorrhage into the pericardium, it should be evacuated by tapping. To suture the cardiac wound, a "shutter" is made over the region by an incision in the form of the letter U. According to Foutau, the incision commences in the third intercostal space near the anterior axillary line, and following the upper border of the fourth rib, it is brought to the border of the sternum, and descends parallel to that bone to the sixth cartilage, and extends outwards to the sixth intercostal space. The fourth, fifth, and sixth cartilages are cut across close to the sternum, and by cutting through the ribs, the shutter can be thrown back, bringing into view the pericardium.

GERMANY.

Berlin, April 7th, 1906.

At the Freie Vereinigung der Chirurgen, Hr. Rinne showed a young man who had been brought to him on account of

EXTREME SWELLING OF THE RIGHT FRONTAL BONE. Six years before he had had an injury to the part, after which the swelling had come on gradually. He suffered from extreme congestion of the whole of the left side of the head, and with such severe headache, coming on at intervals of some weeks, that he was unable to follow his employment, and begged urgently for relief. The speaker decided to chisel out the frontal bone, and came down in doing it upon a sclerosed bony mass about 8 cm. in thickness, and which he cut away down to the dura mater. Below this nothing pathological was found. The wound healed by granulation without the deformity returning, and the patient again became fit for work. The operation was performed two and a half years back, and the patient still felt quite well. There was no tumour in the ears, but simply a sclerosed bony mass.

Hr. Borchards said that under a similar thickening of the frontal bone he had found a small angiosarcoma of the dura mater. The subsequent course in H. Rinne's case excluded such a condition as that.

At the Verein für Innere Medizin, Hr. v. Leyden related a

CASE OF CHALKY METASTASES IN THE HEART AND OTHER ORGANS.

A servant-girl, æt. 19, was admitted into the klinik on January 10th, 1906. The patient had felt ill for some days, complained of tearing and dragging in the limbs, she had slight fever and the joints were somewhat swollen. A diagnosis of articular rheumatism was made, and the patient put on salicylic preparations. She felt better after this, but exhibited a peculiar stupid behaviour. She soon took to bed again, and when desired to remain up opposed this with a certain passive resistance; the stupidity became more pronounced; she complained of violent dragging in the extremities. Examination showed leucorrhœa in which there were no gonococci. Then left-sided paralysis of the abdomen came on; over the heart a systolic murmur was audible. Then serious symptoms appeared, violent headache, dragging in the feet and arms, but no other disturbance of mobility. The sensorium, with the exception of the stupidity, remained free. In the following days excessive vomiting took place, with increasing headache, and soon afterwards the patient was found dead in bed one morning. No decided diagnosis could be made; endocarditis with cerebral complications, was thought of &c. The autopsy revealed a condition that could not have been diagnosed. Sarcomatous infiltration of the surface of the brain. The skull covering showed extreme porosity and atrophy, the inner lamina was perforated in numerous places, and sarcomatous tissue was found in the cavities. The heart was small and flaccid, the auricle, especially the left, infiltrated with bony, hard masses that proved to be chalky infiltrations; there were also similar infiltration in other parts of the heart. Nearly all the internal organs showed similar infiltration, but not to the same extent; the kidneys, lungs and stomach.

The cerebral condition could not have been diagnosed from the symptoms, especially as the fundus oculi was normal. The course of events was this, therefore: The sarcomatous tumour had caused partial resorption of the bony skull, the lime constituents had become softened, and been carried into the blood current and had caused the metastases. It was remarkable that the sarcomatous layer, which had caused no special pressure in the brain, had caused absorption of bone where, from higher pressure from other causes, such a condition had scarcely ever been observed. The malignant tumour, therefore, exerted an especially powerful specific action.

Hr. Davidsohn drew attention to the microscopical preparations. He had seen a similar case six years ago. In that case three organs showed the metastases: the lungs, the kidneys and the stomach, and in that case, as in the present, only in the middle glandular layer. In the present case the heart was affected also. Anatomically there was no visible reason for the excessive deposit. The growth of the tumour into the skull was peculiar. There could be no internal cerebral pressure, as the tumour was situated exclusively outside the dura mater.

Hr. Plehn related

TWO CASES OF LEUCÆMIA.

The first case was that of a girl, æt. 15, very much emaciated, having an enormously spleen. The leucocytes consisted mainly of myeloblasts; there were also nucleated red blood corpuscles. Röntgen ray treatment was instituted. Even in the course of a few weeks a considerable diminution in the size of the spleen was effected and also in the number of the leucocytes, whilst the erythrocytes increased to 5,900,000. The body-weight had increased by 6 kilos, the enlargement of the glands and the albuminuria had disappeared. The spleen had at last contracted to the size of the fist, where at first its length was 37 cm. and its breadth 35 cm. A dermatitis was caused at first by the X-rays, but later on this ceased. The patient now felt well, and the improvement was attributed to the X-ray treatment.

The second case was that of a very much emaciated woman, æt. 76. She had felt weak for four weeks, and for three had had no appetite. A week ago she had hæmorrhagic spots on the haunch. There was no enlargement of either spleen or glands. Examination of the blood showed almost pure myelocyticleucæmia, (numerous small medullary cells). Two days after admission the patient became suddenly somnolent, and died from multiple cerebral hæmorrhages. The case might be taken as a proof that every leucæmia proceeded from the bone marrow. The disease had lasted so short a time that secondary changes in the lymphatic apparatus had not had time to develop.

Hr. Brenda observed that there were no other leucæmia disease of organs than that of the bone marrow.

AUSTRIA.

Vienna, April 7th, 1906.

NOMA OF THE CHEEK.

EISELSBERG exhibited to the members of the Gesellschaft, a young girl, æt. 10, who developed a noma on the cheek that involved the bony structure of the jaw also. The child had always been healthy and took typhoid in her seventh year, after which the noma rapidly developed, destroying a large portion of the cheek.

She was received into hospital two years ago in a hopeless condition, as shown by a photograph. Bart's apparatus was first applied with the hope of binding the bony structure of the joint but without effect.

The defect in the cheek was next tried. A flap was taken from the breast and turned up on the opening and the defect restored in the soft tissue. Nothing remains but to try a prothesis to restore the continuity of the bony structure.

PARALYSIS THROUGH MUSCULAR COMBINATION.

Gersuny presented a patient in whom a peculiar

phenomenon in plastic operations occurred—viz., the deltoid and trapezius. He found it necessary to take a flap from the deltoid for the face. After the deltoid healed he found it paralysed from loss of innervation.

He thought this could be corrected by another operation which he performed on a man, *æt.* 40. This patient commenced with great pain in the region of the right shoulder without swelling or pain in passive movement when received into hospital. He had no power to move it himself.

Hochwart examined him on February 23rd, 1905, and found all the cerebral nerves healthy and normal, but the right deltoid muscle quite atrophied, while the supra and infra-spinati were flat; the right arm was weaker than the left, and he was unable to raise the hand and arm to the level of the shoulder, although he was able to rotate and abduct it. All the other muscles seemed to be normal. Corresponding with the insertion of the nerve in the deltoid was a hypo-æsthetic and algesic zone. Faradic current was lost, but slight contractions were obtained by the galvanic.

On May 6th, 1905, abduction and rotation of the right shoulder was quite lost, while the infra and supra-spinati were distinctly atrophic. The defective sensibility was still present, and the electric condition unchanged.

On June 10th, Hochwart determined to operate by making an incision from the front of the neck over the middle of the acromion outwards, freeing the attachments of both the trapezius and deltoid. The acromion with the lateral part of the spina scapulae were removed with the chisel. The tendinous insertion of the deltoid was removed and its cut end inserted into the lower surface of the trapezius, for which purpose the arm had to be raised and supported in that position during the process of healing. The parts were well kept together with stitches, and care taken to prevent adhesion to the scapula. The wound was closed and healed up in eleven days. In fifteen days the bandages were removed and electric treatment commenced to the deltoid. On the twenty-first day after the operation the patient was dismissed with advice to continue the electric treatment. He returned in September, three months after the operation, slightly better in the movement of the arm. With more energetic movement he was able to lift his arm to the level of the shoulder by the end of the month. By the end of November he was able to perform all the natural movements with perfect ease and freedom but lacked in strength.

On February 20th, of the present year, Prof. Hochwart again examined him, and found the right arm about half a centimetre less than the left; deltoid slightly atrophic; trapezius slightly weaker than the left. Movements in right arm perfect, but all much weaker. Tactile sensibility and feeling of pain normal. Contractions strong in trapezius, nothing from brachial plexus. Faradic and galvanic current, acting on accessories, contract trapezius violently on both right and left. The axillary nerve, when stimulated; does not affect right deltoid with either current, which shows that the innervation is through the accessory nerve which justified the operation.

Hochwart remarked that it was an error to conclude that no motor power was present in a nerve when no current activity was demonstrated. There are cases on record where no electric phenomena could be obtained in muscles, yet the motor activity was perfect.

HUNGARY.

Budapest, April 7th, 1906.

At the recent meeting of the Budapest Interhospital Association Dr. Tuszka Odón reported the case of a woman, *æt.* 28, who had an attack of typhoid fever seven years ago, accompanied by hæmorrhage from the bowel and vomiting of blood, followed by phlebitis of both lower extremities, and nausea and vomiting occurring three or four times a day and induced during the latter time, not only by taking food but by nervous excitement. These were worse near the menstrual period. During the seven years she

had subsisted mainly upon infant's foods, and had undergone various treatments, including rest, lavage and dilatation of the uterus, the latter being followed by some temporary benefit. Upon admission to the hospital, the right kidney was found to have descended to the level of the umbilicus, replacement of which and the removal of the left tube, ovary and appendix was followed by complete recovery.

Dr. Müller Vilmos, speaking on EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS.

said it was his opinion that the profession must go back to old and well-tried methods—clinical history and physical examination—in making the early diagnosis of this disease. Of the newer methods, sputum examination does not inform early enough, tuberculin may give a reaction when no active tuberculosis is present, and may fail to give a reaction when active tuberculosis is really present. While the X-rays may confirm what physical examination has already discovered, it does not reveal anything that cannot be ascertained in other ways. Sources of error in diagnosis may be set down as three: (1) Preconceived ideas—the physician's mind is made up beforehand that the patient has or has not tuberculosis. (2) Inattention to details, the changes that are dealt with in the early stages of tuberculosis are slight, and there are many little things that by themselves mean nothing, but put together mean everything, that in a diagnosis must be reached. (3) Lack of persistence in the examination is often at fault. One investigation is not sufficient, and the evidence must be gone over several times.

Dr. Koranyi Sandor discussed the subject, whether increased molecular concentration of the blood warrants a diagnosis of bilateral kidney disease? He had a case of carcinoma of the left kidney, with the right perfectly normal and a freezing point of the blood 0.635°C. He believed that this concentration of the blood, in spite of the efficiency of the right kidney, was caused by the suddenness with which the additional work was thrown upon it through the rapid growth of the tumour of the other kidney. He concludes that unilateral kidney disease (excluding other causes) can exist together with increased molecular concentration of the blood, and that it is not justifiable in cases in which a lesion of one kidney can be proved, to conclude that the other organ is also diseased, because the molecular concentration of the blood is raised.

DEFECTIVE VACCINATION LAW.

Decision in a case of a physician accused by the State Health Committee of issuing a false vaccination certificate has freed some hundreds of the same charge. The certificate was based on a vaccination of a child of four years, the mother stating it had been successful; it appears not to have been. The magistrate censured the physician for carelessness in giving the certificate, but could not hold guilty of violation of the law, as no time limit is specified. The decision will probably result in legislative amendment of the act relating to vaccination.

LETTERS TO THE EDITOR.

INSURANCE WITHOUT MEDICAL EXAMINATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The medical profession and the public should be alike grateful to you for having taken up the above subject in your usual straightforward fashion. It is time someone spoke out on this barefaced attempt to deprive medical men of their just rights. The manager of the Sun office actually sends a circular to the medical profession boasting how he has outwitted them in the case of 7,500 applicants who have been insured in his office in a single year without medical examination. That is seething the kid in its mother's milk with a vengeance! However, it is comforting to reflect that out of that number a certain percentage are bound to be afflicted with deadly disease that can

be detected only by skilled medical experts. Everyone versed in insurance work knows that a sound medical adviser saves them scores, or, it may be, hundreds of thousands of pounds in a single year. I myself know of a case where a referee rejected an applicant who had been insured by another company a year before. That applicant died within three years, and the company was saved several thousand pounds. But the attempt remains to make money at the expense of medical men, and to delude the public by a system that proffers non-medical admission in substance, but not in fact. The medical profession and the public will, I trust, be kept reminded of the facts of the case by your able and fearless attitude.

I am, sir, yours truly,
A COUNTRY REFEREE.

THE FORTUNES OF QUACKERY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Referring to your articles on quackery, it may not be uninteresting to your readers to learn that the maker of "Pink Pills for Pale People," to which you have on more than one occasion referred, has recently died, leaving property to the value of £1,311,000. This individual, George Fulford by name, twenty years ago, kept a small chemist's shop. Among his customers was a country doctor who was in the habit of making up for his patients an iron pill with a pink coating. His patients had firm faith in the merit of his pills, and he was quite unable to cope with the demand; so he sent the recipe to Mr. Fulford, and directed his patients to that druggist's shop. This induced the chemist to advertise, and the money so spent came back to him many times over in orders for pills, until a short time ago, when he was fatally injured in a motor-car accident, and his estate was found to be worth this enormous sum, made from a country doctor's prescription coupled with his own enterprise. Truly, quackery spells riches, and honest practice not infrequently poverty.

I am, Sir, yours truly,
A PRACTITIONER.

NEWSPAPERS AND QUACK ADVERTISEMENTS.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—The campaign you have started has done much good. The pages of at least one first-rate paper, the *Tribune*, have been purified in consequence of the exposure you have made of the infamous character of the quack medicine trade. It seems, however, hopeless to expect anything like full success so long as the leading papers show so bad an example. It is especially deplorable to see the *Times* continuing to admit the advertisements of men repeatedly denounced in the very strongest terms by its editors within recent years. The *Times* has upon its staff, either permanently or as occasional contributors, distinguished members of the profession well able to advise the manager in this matter. It is grotesque to read an able series of articles on "Infantile Mortality" in which the part played by the dosing of infants with "soothing" mixtures as a lethal factor is exposed, whilst at the same time quack preparations of this class are largely advertised in the paper. How many innocent mothers have been led to depend upon fraudulent nostrums with fatal results by such advertisements? The fact that they appear in the *Times* is enough with simple readers to establish the truth of any plausible statement the advertisements may contain. Then there are the *Telegraph*, the *Morning Post*, and the *Daily Mail*. Each of these papers is owned by a Peer of the Realm. Each of these noblemen has gained his position through his journal. Their wealth has been accumulated by the same means. They ought not to stoop to augment their incomes by helping, however remotely, in a traffic so cruel and cowardly as that upon which you have thrown so clear a light. If these noble proprietors of great organs that take upon themselves the role of censors of public and private morality do not realise the infamy of

medical quackery, if they are not aware of the misery to which the quack medicine trade gives rise, they can easily ascertain the facts by inquiry, and your articles have shown them at any rate their duty in this latter respect. It seems to me that from the mere point of view of money-making it would pay these papers to exercise the strictest supervision over their advertising columns. If it were known that no advertisement which could be legitimately objected to would be allowed to appear in the paper a large number of advertisers of the better sort would surely be attracted. Many of these must object to the publication of their announcements in juxtaposition to those of blatant impostors and knaves. If the *Tribune* can, as now seems possible, make widely known the fact that it has taken the new departure which I suggest, the fortune of the paper ought to be ensured. I make the proprietor a present of the suggestion.

I am, Sir, yours truly,
Cavendish Square.
April 5th, 1906.
HENRY SEWILL.

THE TREATMENT OF CANCER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In "A Clinical Lecture on Cancer of the Uterus," by Dr. William Alexander, in THE MEDICAL PRESS AND CIRCULAR of April 4th, 1906, I notice that he recommends the administration of dilute hydrochloric acid in maximum doses. "We may suppose" he states, "a tendency to alkalinity in the tissues. . . . Owing to this change in chemical reaction of the tissues, a rapid proliferation of epithelium that was hitherto kept within bounds by a more acid state of the medium in which the epithelial cells now lie, now takes place, and is promoted by the change from acid to alkaline surroundings, as Professor Moore has shown from his experiments on the eggs of the sea-urchin. Therefore if we can render the tissues of a cancer patient more acid, we can retard the growth of cancer. . . ."

It would be interesting to know how Dr. Alexander is able to reconcile his recommendation with the full views expressed by himself and others with Professor Moore(a), in relation to the growth of the eggs of the sea urchin, in a paper read before the Royal Society, viz., "It is only a trace of additional alkali which causes the increased growth, more than a trace stops it entirely."

I am, sir, yours truly,
J. A. SHAW-MACKENZIE, M.D.LOND.
London, April 6th, 1906.

(a) "On the Absence or Marked Diminution of Free Hydrochloric Acid in the Gastric Contents in Malignant Disease of Organs other than the Stomach." By Benjamin Moore, M.A., D.Sc.; in collaboration with Messrs. W. Alexander, M.D., F.R.C.S.; R. E. Kelly, M.B., B.Sc.; and H. E. Roaf, M.B.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

ULSTER HOSPITAL FOR CHILDREN AND WOMEN.—The annual meeting of this hospital was held last week, Mr. Edwin Hughes, J.P., in the chair. The medical staff reported increasing work in all departments. There were 216 children and 81 women admitted to the wards, and 126 operations in the former and 58 in the latter. In the extern department, 2,386 children and 623 women were seen; 172 maternity cases were attended by the hospital nurses. The total number of visits paid by or to patients was 9,493. Drs. Leslie, Williamson, and Howard Stevenson, with Dr. Cecil Shaw, the hon. sec. of the staff, were appointed representatives of the medical staff on the Board of Management. In the report of the Board of Management reference was made to the want of a new hospital to meet the needs of this large and growing working-class district. The present hospital is an old dwelling-house converted to hospital purposes,

but can never be thoroughly satisfactory, and in any case is far too small for the work that is being done.

ROYAL VICTORIA HOSPITAL.—At the first meeting of the new committee for the year, held last week, the following were elected representatives of the Medical Staff on the Board of Management:—Sir Wm. Whitla, Professor Byers, Drs. Mitchell, Calwell, and McKisack.

THE HEALTH OF BELFAST.—Serious attention is being called in the daily press to the question of the health of the city. It appears that for the last eight weeks the death-rate has varied from 20 to 27, being from 4.5 to 10.8 in excess of the average of the great towns. The chairman of the Public Health Committee has endeavoured to reassure the public by pointing out that fluctuations are to be expected, and compares Belfast, which has about 350,000 inhabitants, with Ballymena, which has 11,000, and Lurgan, which has 13,000! It would be hard to find a better instance of the misuse of statistics, for in small towns like these a very small number of cases will affect the rate in a way that is impossible in a large city. During the previous four weeks there had been notified in Belfast 269 cases of zymotic disease, including 115 scarlatina, 57 typhoid, 37 each simple continued fever and erysipelas, 17 diphtheria, 3 puerperal, 2 membranous croup, and 1 typhus. During the same period there were 62 deaths from zymotic diseases and 224 from respiratory affections. The authorities are evidently becoming a little alarmed at the attention that is being called to the state of the public health, and at their last meeting the Committee had a serious discussion on the high death-rate. It appears that in the week ending March 31st, there were no less than 21 deaths from whooping-cough, and 18 from pneumonia. The question of making whooping-cough a notifiable disease was discussed, but for the present at least this step will not be taken.

OBITUARY.

JAMES WILSON, M.A., M.D.

ON March 30th, Dr. James Wilson, M.A., of Govan, died at his residence of apoplexy, at the age of fifty-three. Dr. Wilson was born in Glasgow. He had a distinguished career at Glasgow University, where he graduated M.A., with honours, winning among other distinctions the Blackstone medal for Latin. He practised in Govan for over twenty years, and for several years served on the Town Council (then the Police Commission Board), and also on the County Council.

CHARLES QUINTON, M.R.C.S., L.S.A.

We regret to record the death of Mr. Charles Quinton, M.R.C.S., L.S.A., of Sandy, at the age of seventy-six. He was a member of an old Staffordshire family. The third son of the late Charles Quinton, of Newbolds, Wolverhampton, he was born on January 9, 1830, and received his professional training at the Sydenham College Medical School, Birmingham, where he had a distinguished career, being awarded two first prizes for medicine, anatomy, physiology, midwifery and general proficiency, and was appointed prosector of anatomy at the College. He obtained his M.R.C.S. diploma in 1854 and that of L.S.A. in 1867. His first charge after leaving college was at Tettenhall, Staffordshire, where he carried on a successful practice for some years. Removing to Grosmont, Yorkshire, he remained there for twenty-nine years, holding the appointments of district medical officer of health to the Whitby Union and public vaccinator and surgeon to the Grosmont Ironworks. His large private practice at length proving too much for his strength, he relinquished it and came to Sandy in 1895, and practised there until within a short time of his death.

JAMES PARSONS THORNTON, M.D.DUR., L.S.A. LOND., OF SOUTHPORT.

The death occurred at his residence, Lord Street,

Southport, on Saturday evening of Mr. James Parsons Thornton, at the age of fifty-eight. Deceased was the son of the Rev. John Thornton, Stockport, and was M.D. of Durham (1889), and L.S.A. of London (1872). He commenced practice at Southport, and continued it up to his death, with the exception of a brief period of a few years ago, during which he resided at Torquay.

REVIEWS OF BOOKS.

ESSENTIALS OF HUMAN PHYSIOLOGY FOR VETERINARY STUDENTS. (a)

THE author's aim, as stated in the preface, is to put before medical students as succinctly as possible the facts of human physiology, essential to the study of medicine and surgery, and in this he has succeeded. Pascal has said that "the last thing we find in making a book is to know what we must put first," and writers of physiological text-books seem to have experienced the truth of this saying in full. Dr. Paton's method of beginning and pursuing his subject differs in some respects from most others. The book is primarily divided into three parts. Part I. treats of the Tissues; Part II., of the Nutrition of the Tissues; Part III., of Reproduction. There are no chapters; each part is divided into sections, of which there are twelve in all.

In dealing with the Tissues in Part I., they are somewhat artificially divided into "vegetative" and "master" tissues. The account of the former (Epithelium and the connective tissues) is mainly confined to structure, with short references to chemical composition and function. A useful feature, considering the aim of the work, is the advantage taken in this and other sections of every legitimate occasion to introduce minor doses of physiological chemistry, where connection can be established with the matter in hand. In a few instances exception might perhaps be taken to the terminology, as, for instance, "proteates," applied to acid-albumin and alkali-albuminate, also "formed" material applied to ground substance in connective tissue.

Under the head of "Master Tissues" is given the structure, chemistry and physiology of muscle and nerve. In connection with the latter and under the head of "Sensation," the author introduces the physiology of vision, hearing, smell and other special senses. Following the special senses comes the chief account of the nervous system, both sympathetic and cerebrospinal. That of the former, though much compressed, is distinctly good.

In Part II., the section on Lymph, considering its undoubted clinical importance, might be somewhat enlarged. That devoted to the circulation conveys a useful and judicious amount of information clearly imparted. The reader will probably abandon the attempt to reconcile in all cases the subject treated of, with the heading or sub-heading to which it is allocated. Fortunately this can be done without impairing the usefulness of this part of the book. The physiology of respiration and voice production are included in a section which treats of the "supply of nourishing material to the blood and lymph, and elimination of waste material from them." It is not stated whether the latter function comes under the head of elimination or supply.

The remaining sections of this part are devoted to "food and its digestion," "internal secretions," "excretion from the body." They are relatively short, that on digestion proper being perhaps the most condensed of all.

Part III. comprises eight pages devoted to the structure of the organs of reproduction, and to a short account of development. An appendix of four pages, in which are given some elementary but useful facts of organic chemistry, concludes the work.

(a) "Essentials of Human Physiology for Veterinary Students." By D. Noel Paton, M.D., &c. Edinburgh and London: William Green and Sons.

The book as a whole is pleasing. It is attractively got up, its instruction, so far as it goes, is sound. Its teaching is emphatic, and the selection of matter is judicious. More, perhaps, might have been done to furnish reasons for the statements given, and thus early awaken the student's attention to the all-important fact. That knowledge of function, or derangement of function, is seldom absolute, but has to be deduced from groups of opposing data, which in many cases almost counterbalance each other.

By the addition of four and a half pages, chiefly on muscular movements in the horse, and four on digestion in herbivorous animals, with the omission of ten pages on the senses, four on the nervous system, three on the circulation, four on respiratory movements, and three on articles of diet, the second edition of the work has been neatly transformed into the "Essentials of Physiology for Veterinary Students." *

THE STUDY OF DISEASE. (a)

THAT this comparatively young society is doing good work, a cursory perusal of the reports before us serve at once to show. The Wightman lecture on "Some Neuroses of Early Life" is most interesting, as is also the discussion on the question of sudden death occurring in children. Mr. Tubby contributes a comprehensive paper on the question viewed from its surgical aspect, while the editor himself surveys it from the more strictly medical side. The value of such a discussion cannot be over-estimated, and we regard its record as one of the most important sections of these reports. A paper of much interest is that on appendicitis, contributed by Mr. H. A. Whitelocke. Dr. Grünbaum's paper on Congenital Tropic Edema contains an account of three cases of this curious and somewhat rare form of Edema. Such are a few of the excellent things contained within this volume which, by the way, is well illustrated. Altogether the society must be congratulated on being able to produce such a praiseworthy record of work accomplished by its members. Under the editorship of Dr. Carpenter the volume is assured of every care in its production, and even general practitioners will find its perusal helpful and instructive. To the specialist this volume of reports is an absolute necessity to enable him to keep pace with the progress made in the study of pædiatrics in this country.

HEBBLETHWAITE'S GENERAL PRACTICE. (b)

Who has not derived help from listening to the account given by an experienced practitioner of the interesting cases he has met with in practice? The writer of this little book gives his readers the benefit of his own experiences in a chatty style, free from anything like verbosity or presumptiveness. His remarks and notes cover the entire range of general practice. He has a good deal to say on the subject of peritoneal catastrophes and his words are very much to the point. His treatment of ulcer of the stomach is based upon practical experience, and he does not believe in withholding mouth feeding in every case. "It is somewhat surprising how the regulation of the quantity of food and the times of feeding is successful in curing the symptoms." He believes that urine-testing is very much neglected in general practice, and gives a brief account of his own method together with the conclusions to be derived from results obtained. The notes on fractures and their treatment will be specially useful to the newly-fledged practitioner, as will also the advice given on infant feeding. Dr. Hebblethwaite speaks very temperately regarding the use of infants' "foods," but on the whole does not seem to encourage their adoption generally in practice. The obstetrical notes are good as far as they go, but in another edition we would advise the author to extend them, as this is

the very subject on which young practitioners require most help and guidance. The little book contains a number of hints and ideas of considerable value, and we have no doubt that by increasing the number of topics dealt with it will become a general favourite with those who are starting upon their life's work.

LITERARY NOTES.

DR. J. W. BALLANTYNE, of Edinburgh, who is but 44 years of age, has, says *Medical Notes and Queries*, written nine volumes on Obstetrics, Gynæcology, and Antenatal Pathology; two volumes of a Journal of Antenatal Pathology; sixteen articles in medical encyclopædias and dictionaries; 129 articles in medical journals; 101 shorter contributions to medical journals, and numerous annotations, abstracts, &c.

WE understand that the fourth edition of the manual on "Heart Disease," by Sir Wm. Broadbent, Bart., the third edition of which has been out of print for some time, is now free of the press, and will be ready in a few days. Sir William has been assisted in the revision by his son, Dr. John Broadbent, and chapters have been added on the pulse, disease of the coronary arteries, bradycardia, and atheroma of the arteries; and important additions have been made to the chapters on "angina pectoris" and functional affections of the heart.

"THE BLOODLESS PHLEBOTOMIST" is the extraordinary title chosen for a medical journal recently started in New York. This title, however, is the only part of the programme to which exception may be taken on conservative grounds, supposing the April number to be a fair specimen of future issues. In this we find some interesting articles by well-known American writers, among which we may cite "Proprietary Remedies from the Physician's Standpoint," by W. J. Robinson, Ph.D., M.D.; "The Lesson of the Yellow Fever Epidemic," by Daniel Lewis, M.D., LL.D.; and "Delirium Tremens," by T. D. Crothers, M.D.

DR. LOUIS SEAMAN, an American surgeon, who volunteered his services to the Japanese in the late war, has contributed an interesting account of the thoroughness and skill of the Japanese medical department. In the Japanese archipelago, he says, no fewer than twelve sets of main hospitals were organised, to each of which from one to five branch hospitals were attached. The 25,000 beds which these originally provided were increased rapidly in number as the campaign was prosecuted. In the field every practical precaution against disease was taken. All milk used in the army was sterilised, all the water used was boiled. Every bandage was disinfected. Chemists went ahead of the army with the vanguard, and after testing the water of every well, labelled it drinkable or undrinkable. The surgical and medical treatment was scarcely less remarkable than was the sanitary system. Only one and a half per cent. of the soldiers died of gun-shot wounds, although twenty-four per cent. were wounded.

Glasgow Royal Infirmary.

DRS. HENDERSON and McNair have been promoted from the position of extra-dispensary physicians to dispensary physicians at the Glasgow Royal Infirmary. And Drs. Key, Faulds, and McEwen have been promoted to be dispensary surgeons. The posts thus rendered vacant will be duly advertised.

DR. EDWARD MAGENNIS has been selected as a candidate for the vacancy on the Senate of the Royal University of Ireland. Dr. Campbell, of Belfast, has also come forward as a candidate. The vacancy was caused by the resignation of his Honour Judge Shaw, who was a representative of the Convocation of the University of the Senate.

(a) "Reports of the Society for the Study of Diseases in Children." Vol. V. Session 1904-05. Edited by George Carpenter, M.D. London: J. and A. Churchill, 12s. 6d.

(b) "Notes on General Practice." By S. M. Hebblethwaite, M.D. Lond. 3s. 6d. London: The Scientific Press, Limited.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons of England.—Important Awards.

A QUARTERLY meeting of the Council was held at the College on Thursday, the 5th instant, Mr. John Tweedy, President, in the chair.

Walker Prize for Cancer Research.—The Walker prize of £100, founded by the late Mr. Charles C. Walker, of Lilleshall Old Hall, Newport, Salop, to encourage investigation into the pathology and therapeutics of cancer, was awarded to Professor Carl O. Jensen, of Copenhagen. The Committee appointed to advise the Council of the College in reference to the award of the prize reported as follows:—After receiving valuable advice and assistance from eminent American, Belgian, Danish, French, German, Italian, Swedish, Swiss, and British surgeons and pathologists, regarding the work carried out in their respective countries, and after making careful examination of papers dealing with the pathology and treatment of cancer published in various languages during the last five years, it became evident to the Committee that in any report to be presented to the Council much important work could not be considered, because it had not been done within the prescribed time limit; it had no direct bearing on the treatment of cancer; it was still being pursued and the prize could scarcely be awarded to it at this stage of its progress, although it will fall under the consideration of the Council when the Walker Prize is next awarded.

The Committee were of opinion that Professor Jensen should receive the prize on this occasion. His work is described in a letter from Professor Salomonsen of the State Serum Institute of Copenhagen, and the Committee felt that they could not do better than cite this.

The inoculation of cancer from animal to animal had been made in comparatively few cases, and therefore afforded no decisive material for the study of cancer. Professor Jensen first succeeded in discovering a tumour in the mouse, which made the experimental investigation of cancer on a large scale possible.

Professor Jensen first carried out a large series of inoculations through thirty-five generations, comprehending about 1,000 mice, and thus gave the impulse to certain experimental investigations which are now carried out in many laboratories in different parts of the world. He thus made it possible to investigate, and was himself the first person to investigate systematically, the effect of different factors (heat, light, chemical agents, radium, etc.) on these cancer cells. He has further demonstrated the possibility of producing an anti-cancer serum for mice by the injection of the crushed tumour into rabbits. The serum of rabbits which have been thus prepared has been injected into mice suffering from cancer, with the result that the cancer-tumours in many of them have disappeared absolutely and permanently.

In proposing Professor Jensen to the Council as a fitting recipient of the Walker prize, the Committee have been influenced by the not merely actual work which he has himself done in investigating the nature of cancer, and the effect of treatment upon it, but also by the extent to which he has opened up a field of research to those engaged in the study of cancer on certain lines, enabling them to carry out their investigations over longer periods of time and under better and more determined conditions than have up to the present time been possible.

Jacksonian Prize.—The Jacksonian prize for 1905 was awarded to Reginald Cheyne Elmslie, M.S., F.R.C.S., for his essay on "The Pathology and Treatment of Deformities of the Long Bones due to Disease occurring during and after Adolescence." The prize-subject for the year 1907 will be "The Operative

Surgery of the Heart and Lungs, including the Pericardium and the Pleura." The John Tomes and Cartwright prizes were not awarded. The following was selected as the subject for essays to be submitted in competition for the Cartwright prize for the period 1906-1910—"Prevention of Dental Caries."

First Begley Student Appointed.—Mr. Walter Burford Johnson, of St. Thomas' Hospital, was appointed the first Begley student in accordance with the report from the Examiners in Anatomy and Physiology at the recent Second Examination of the Conjoint Board.

Elections.—Dr. Lucas Championniere, Surgeon to the Hotel Dieu, Paris, was elected an Honorary Fellow of the College. Surgeon-Gen. Arthur Mudge Branfoot, C.I.E., President of the Medical Board, India Office, and Mr. Herbert M. Ellis, R.N., Director-General of the Medical Department of the Royal Navy, were elected Fellows of the College under the rule relating to members of twenty years' standing.

Honorary Medal.—The honorary medal of the College was awarded to Lieut.-Col. Sir Richard Havelock Charles, K.C.V.O., I.M.S., in appreciative recognition of his gift of anthropological specimens, an addition to the Museum of special value and importance, not only on account of the number and variety of the specimens presented, but also on account of the authentic particulars attached to them.

Medico-Psychological Association of Great Britain and Ireland.

THE next meeting of the Northern and Midland Division will be held, through the courtesy of Dr. Macphail, at Derby Borough Asylum, on Thursday, April 19th, at 2.30 p.m. Dr. Macphail kindly invites members to lunch on the day of the meeting, and it is proposed that members should dine together afterwards at the Midland Hotel, Derby, should a sufficient number intimate their intention of being present to Mr. Bedford Pierce, hon. sec. of the Division, The Retreat, York. The election of several new members will be proposed at this meeting, and Drs. Nathan Raw, John Richards, and Wm. Harding will read papers.

The Brighton's Council's Consumption Scheme.

A declaration of trust is being arranged so that the Brighton Corporation may administer the income of £20,000, part of the Hedgcock Bequest, for the treatment of consumptive patients in the town during the next ten years. The following are the principal heads of the scheme which the Sanitary Committee recommend should be embodied in the declaration of trust:—

1. The Corporation shall provide at the Sanatorium suitable accommodation, nursing and medical attendance, for the treatment of resident consumptive patients admitted under the provisions of this scheme.

2. The income received from the investments of the sum of £20,000, part of the Hedgcock Bequest allotted by the Council for this purpose, shall be placed to a separate account to be termed the "Hedgcock Bequest (Consumption) Account."

3. The income of the said fund shall be applied in payment towards the general expenses of the Borough Sanatorium of the sum of £1 per week in respect of each consumptive patient admitted to the Sanatorium for treatment in pursuance of this scheme, such weekly sum representing the cost of maintenance and treatment of each patient.

4. The class of patient to be admitted for treatment, and the duration of treatment of each patient, shall be decided by the Sanitary Committee of the Council on the advice of the Medical Officer of Health, subject to the following conditions:—(a) That each patient

has been resident in the county borough of Brighton for not less than two years immediately prior to the proposed admission, except in cases where, for special reasons, the Sanitary Committee decide by resolution to dispense with this condition. (b) That the patient is unable to pay for treatment, and is a fit person to receive the benefits of the charity.

Royal College of Surgeons, Ireland.

THE following is the prize list for the winter session, 1905-1906:—

Descriptive Anatomy.—Junior—W. A. Swan, first prize (£2) and medal; A. A. Pellissier, second prize (£1) and certificate; Senior—G. C. Sneyd, first prize (£2) and medal; I. Scher, second prize (£1) and certificate.

Practical Anatomy.—First Year—H. D. Gasteen, first prize (£2) and medal; H. G. P. Armitage, second prize (£1) and certificate. Second Year—H. J. Hedley, first prize (£2) and medal; Miss I. M. Clarke, second prize (£2) and certificate.

Practise of Medicine.—H. W. White, first prize (£2) and medal; D. Adams, second prize (£1) and certificate.

Surgery.—H. W. White, first prize (£2) and medal; T. Sheehy, second prize (£1) and certificate.

Midwifery.—H. C. Carden, first prize (£2) and medal; W. E. M. Hitchins and T. Sheehy (equal), second prize (£1) and certificate.

Physiology.—H. J. Hedley, first prize (£2) and medal; J. Menton, second prize (£1) and certificate.

Chemistry.—J. J. Lyons, first prize (£2) and medal; R. White, second prize (£1) and certificate.

Pathology.—H. W. Kay, first prize (£2) and medal; G. S. Lewis, second prize (£1) and certificate.

Physics.—R. White, first prize (£2) and medal; R. H. Weir, second prize (£1) and certificate.

The Summer Session commenced on Monday, April 2nd.

Hospital Saturday Fund.

At the annual general meeting of the Hospital Saturday Fund Association held on Saturday last, Sir Savile B. Crossley, in the chair, the report of the council showed that the receipts from the workshops and business houses had reached £25,930, as compared with £24,344 in 1904, an increase of £1,586. The total was the highest recorded in the history of the movement. The expenses of management amounted to 9.49 per cent. of the gross receipts. The Board of Delegates in January last distributed the sum of £23,631 among 202 hospitals, dispensaries and convalescent homes, &c., this amount being £1,766 more than in any former year. The council noted that the National Association for the Establishment and Maintenance of Sanatoria for workers suffering from tuberculosis was making satisfactory progress; and the Fund has voted the sum of £500 towards its work. The pressing need for increased accommodation for patients of this class is generally admitted, and it is hoped that the Association will be in a position to receive patients by the end of the present year, when the new buildings are completed at Benenden, in Kent.

Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of the Medical Sickness, Accident and Life Assurance Society was held at 429, Strand, London, W.C., on the 30th ult. There were present Dr. De Havilland Hall, in the chair, Dr. Mayn Greenwood, Dr. F. S. Palmer, Mr. F. S. Edwards, Mr. Wm. Thomas (Birmingham), and Dr. J. B. Ball.

The accounts presented showed that the business of the Society for this year had so far been exceptionally good. During the first quarter of the year the sickness claims received are usually largely in excess of the average, but so far is this from being the case in 1906, that in the months of January and February there was a margin in favour of the Society, and in March the claims received, though numerous, are of a slight nature, and causing a very moderate draft on the funds of the Society, which now amount to more than £200,000. Prospectuses and all particulars on

application to Mr. F. Addiscott, secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

A Physician's Salary in Parliament.

IN the House of Commons last week Mr. Gilhooly asked the Secretary to the Treasury whether it is proposed to fix the salary of the acting physician to the Youghal Auxiliary Lunatic Asylum at £100 per annum, for a limited time; and whether the Board of Governors are to have any control in determining the amount of this salary.

Mr. Bryce replied that the power of fixing the salary of the visiting physician to this institution is vested by statute in the Committee of Management, subject to the concurrence of the Lord Lieutenant. The Committee have fixed the salary at £100 per annum, with the proviso that the physician may, after eight years' satisfactory service, receive an increase not exceeding £25 per annum. The Lord Lieutenant, however, has not yet signified his concurrence, owing to the fact that certain temporary difficulties have arisen in framing regulations for the management of the institution.

University of Aberdeen.

At the Graduation ceremony on Thursday last, April 5th, the following degrees were conferred:—

DOCTOR OF MEDICINE (M.D.).

** Cruickshank, Lewis Davie, M.B., Ch.B., Darlaston, Staffs.

**Galloway, John Charles, M.A., M.B., Ch.B., Banff. Holt, Thomas, M.B., C.M., Burnley.

Johnston, George Hall, M.B., C.M., Wath-upon-Dearne.

Mackenzie, Dudley Macdonald, M.B., Ch.B., Ealing, W.

Mitchell, Robert, M.B., C.M., Hooton Pagnell. ***Pearse, Wilfrid William, M.B., C.M., Acting.

Medical Officer of Health, Hong-Kong.
Rose, Alexander, M.B., C.M., South Norwood, S.E.
Sutherland, Arthur Leslie, M.A., M.B., Ch.B., Darwin.

**** "Highest Honours" for Thesis.

*** "Honours" for Thesis.

BACHELOR OF MEDICINE (M.B.) AND BACHELOR OF SURGERY (Ch.B.).

With First Class Honours.

*Gill, John Frederic, B.Sc., Ackworth, Pontefract.

**McKerrow, William A. H., Workington.

* Passed Final Examination with "Distinction."

** Passed Final Examination with "Much Distinction."

Trinity College, Dublin.—Conjoint Examinations in Ireland.

CANDIDATES have passed the First Professional (March and April, 1906) Examination as undernoted:—
R. White (with honours), S. Campbell, R. Charles, D. F. Curren, J. Donegan, J. Donoghue, J. W. Flood, F. R. Jones, L. C. King, J. Mitchell, T. Murray, J. T. MacDonnell, F. McDonnell, M. O'Brien, P. O'Farrell, W. R. O'Keefe, and R. A. Wright.

Second Professional Examination.—Messrs. G. C. Sneyd and J. T. McKee (with honours), E. M. Donovan, D. J. Lyne, J. O'L. Murray, J. M. Smythe.

At Hilary Term, 1906, the following candidates passed the final examination in Medicine Part II.:

Surgery.—John D. Sands (passed on high marks), Basil G. Brooke, Robert B. Jackson, Ralph S. Oldham, Samuel G. S. Haughton, Alfred G. Alexander, Hercules J. Knox, Gustav W. Thompson.

PROFESSOR KOCH left Berlin on Saturday for Naples, whence he sails for Tanga on the 16th inst. From Tanga he will set out for the interior of Africa at the head of a German Imperial expedition to investigate "sleeping sickness."

THE last meeting of the Society for the Study of Inebriety was held on Tuesday, April 10th, 1906, in the rooms of the Medical Society of London, 11, Chandos Street, Cavendish Square, W., when Dr. Harry Campbell opened a discussion on "The Alcoholic Craving," which will be found in another column under "Original Papers."

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Tuberculous Nephritis and Cystitis in the Female.—Mirabeau (*Monats. f. Geb. u. Gyn.*, February, 1906) concludes after several years' investigation: (1) That tuberculosis of the bladder in women is, without exception, a secondary process, descending from the kidney, and stands in no direct relation to genital tuberculosis; (2) in at least 50 per cent. of all cases, renal tuberculosis is unilateral; (3) by means of the cystoscope, and ureteral catheterism, diagnosis may be made absolute; (4) detection by palpation of a thickened ureter is practically sufficient, and can be detected by practitioners not specially experts in renal and vesical surgery; (5) in unilateral renal disease descending to the bladder, the full functional activity of the healthy kidney can usually be determined by clinical observation and by chemical and microscopical examination of the urine isolated by ureteral catheterism and the segregator, if not, examination of the kidney itself may be necessary; (6) early removal of the tuberculous kidney is sometimes the best treatment. Mirabeau performed nephrectomy on a patient suffering from unilateral renal tuberculosis in the fifth month of pregnancy. The patient was delivered at term of a healthy child, and was in very good condition two and a half years later.

Appendicitis Complicating Pregnancy and Parturition.—E. Davis (*American Journal of Obstetrics*, March, 1906) cites cases of appendicitis of an acute and chronic nature operated on during pregnancy with normal convalescence and delivery at term. From his experience and the literature of the subject, he concludes appendicitis is not predisposed to by pregnancy, and if it occurs it may happen at any time during pregnancy, and may be primary or secondary. In mild cases the vomiting which accompanies the attack may be mistaken for the vomiting of pregnancy, and in cases complicating early pregnancy and the puerperal period pain is apt to be referred to the region of the liver, and even the left side of the abdomen, rather than to the affected region. Appendicitis during pregnancy runs a rapid course, and suppuration in a majority of cases will develop. Where pus is formed it should be evacuated at the earliest possible moment, and it should be remembered that the uterus and tube usually form one of the walls of the abscess. In evacuating pus, tissues should be disturbed as little as possible to avoid abortion or premature labour, and to prevent pus becoming disseminated throughout the abdomen. The occurrence of premature labour is unfortunate in these cases, and always adds greatly to the gravity of the situation owing to the breaking up of the abscess wall. Davis, in conclusion, draws attention to the fact that adhesions following appendicitis may bring discomfort and danger to a patient who becomes pregnant after she has recovered from disease of the appendix, and urges, in view of the serious consequences which follow appendicitis in pregnant women, the appendix be removed as soon as inflammation is diagnosed; remembering the impossibility of differentiating between inflammation of the right tube and ovary and of the appendix, operation should be done without waiting to make a positive diagnosis. F.

Acute Cholecystitis in the Puerperium.—Vineberg (*Amer. Med.*, March, 1906) says that, taking into consideration the frequency with which women suffer from gall-stones, and bearing in mind the statement made by reliable authorities that pregnancy and labour favour the occurrence of biliary colic, acute cholecystitis in the puerperium ought to be of more frequent occurrence than the literature would seem to warrant. It is probable that the disease is often

overlooked, or is mistaken for puerperal sepsis. The author cites two cases with symptoms of acute abdominal inflammation, occurring on the ninth and tenth days after delivery respectively, ascribed to sepsis by the attending physicians, but at the operation the diagnosis of acute cholecystitis was confirmed. Christiani also reports two cases and points out the importance of bearing this complication in mind with regard to differential diagnosis, as the danger to which, where the condition is not made out, the woman is exposed, on the one hand from useless, if not injurious, intra-uterine interference, on the other from the possible empyæma of the gall bladder not being dealt with by timely operation, is very considerable. F.

Enucleation of Fibro-myoma of Uterus during Pregnancy (*Brit. Med. Journ.*, March 10th, 1906).—J. Stewart, Leeds, records a case under this heading pointing out how infrequently fibroids of the uterus require enucleation during the pregnant state and mentions that Schroeder was the originator of the idea. Dr. Stewart was sent for at night to see a patient between five and six months pregnant, complaining of severe pain in the back, constant in character with exacerbations. A vaginal examination showed the cervix to be normal and as there was no hæmorrhage, he gave the patient an injection of morphine and diagnosed a threatened miscarriage. The following morning, upon making a thorough examination, revealed a tumour about the size of the fist, hard, smooth, dull on percussion, and tender on handling, tympanitic all round and a well-marked dulness between it and the uterus. Nothing distinctive was made out by vaginal examination. The patient stated that she became pregnant five months previously and had enjoyed good health till three days before, when she was seized with violent pain in the lower part of back, which remained constant and was unassociated with hæmorrhage, vomiting ensued, caused by the ingestion of food. The temperature at the time of examination was 101° F., and the pulse 110. A fortnight before she had noticed a movable lump in her left side. After this examination the diagnosis of ovarian cyst, probably dermoid, which had undergone axial rotation, was made. Mr. Moynihan saw the case in consultation and agreed with this view. The following day the abdomen was opened and, a sessile tumour was found attached to the left of the fundus uteri. There were no adhesions and no discolouration of the peritoneum covering the tumour. The uterus was rotated so that the tumour appeared in the incision. A third of the tumour was found embedded in the wall of the uterus. A circular incision was made and the fibroid shelled out. Hæmorrhage, was severe and difficult to control, but was finally checked by pressure and drawing the sides of the uterine wound together with Pagenstecher's thread and overlapping stitches. On section the tumour showed no signs of hæmorrhage into its substance nor beneath its capsule. Dr. Stewart believes the pain was due to the malignant influence all fibroids have upon the pregnant state—a tendency to produce abortion or miscarriage. The patient was confined at full term of a living male. H.

Lumbar Puncture in Puerperal Eclampsia (*Brit. Med. Journ.*, March 24th, 1906).—Proud, Maryport, while considering the pathology of infantile convulsions and their recent treatment by lumbar puncture, was led to speculate on its value in the analogous conditions of some parturient adults. Eclampsia, he considers, arises in cases with marked symptoms of renal disturbance, but whether the convulsions are due to toxæmia or to pressure on the cerebral centres has

not been established by pathologists. In two cases of eclampsia he carried out lumbar puncture with gratifying results. In the first case the convulsions came on after labour, and were very numerous and severe. Chloral, salt solution, croton oil, and packs were tried without avail. The coma was deep and the pulse irregular and feeble. Puncture was made in the third lumbar interspace and a rapid dropping of fluid followed for some minutes. The fits ceased and the patient gradually came round. The second case was one in which a primipara was affected. She had had several fits during eight hours before being seen by the doctor. As the head of the child was on the perinæum, forceps were applied and the child delivered. After this the patient remained deeply comatose with stertor and cyanosis. An hour later the pulse was scarcely perceptible. Hot packs, croton oil, and pilocarpin, &c., were tried. Puncture was made in the third lumbar interspace, when there was a quick gush of fluid, evidently under pressure, about half an ounce in amount. The patient becoming unruly, the needle was withdrawn; her breathing was now regular, and no more fits occurred. She gradually recovered consciousness and convalesced normally.

H.

Vaporisation of the Uterus.—Karl Baisch (*Zentralblatt f. Gynäk.*, January 6th, 1906) says it is not to be denied that curettage fails in a large number of cases, especially in the forms of metro-endometritis observed about the menopause. Among the material of the Frauenklinik in Tübingen, only one-third of the patients between 40 and 50 years of age have been cured by curettage. It is among these cases, which frequently call for total extirpation, that vaporisation proves itself of benefit. As the result of the microscopical examination of a very large number of uteri in which vaporisation had been employed, the author declares that the temperature of the steam and the length of time of its application have very much less influence on the effect than is generally supposed. The inner surface of the uterus is always scalded to a depth of about 2 mm., and this burnt stratum protects the deeper layers from further injury. Subjacent to the burnt stratum, one can recognise macroscopically an intensely hæmorrhagic zone, which is also about 2 mm. thick. According to the histological nature of the burnt tissue the therapeutic effect varies. When the steam works on a fungous hypertrophic mucosa the glands are preserved to a considerable degree, and after a short time the former condition returns. If the mucous membrane is thin and atrophied it will be completely destroyed and the uterus obliterated. Thus the different opinions of authors are to be explained. Now as one does not know the thickness of the mucous membrane before vaporisation, the latter is contra-indicated during the reproductive period of the woman's life. A reliable result is obtained when curettage precedes the vaporisation either at the same sitting, when, owing to the painfulness of the procedure an anæsthetic must be given, or, better, five to seven days after the curettage, when with the regeneration of the mucous membrane the vaporisation causes no pain and can be done without anæsthesia, and there is no bleeding to hinder the deep action of the steam. The combination of curettage and vaporisation is the better method for production of the menopause. A graduation of the effect so that after the vaporisation the periods become weaker and more regular is never to be obtained with certainty. Without the preceding curettage success must be completely left to chance. The vaporisation is only to be used in smooth-walled, regularly built, uterine cavities. Myomata contra-indicate it. It is usually not only unsuccessful in their presence, but also very dangerous owing to the possibility of gangrene. Every infection, whether septic or gonorrhœal, of the uterus or of its adnexa, must be considered a strict contra-indication to vaporisation. There remains, therefore, for the method only the simple uncomplicated cases of premenstrual hæmorrhage for which it gives, when com-

bined with curettage, a most satisfying result—and is thus a rich addition to conservative therapy. G.

The Prevention of Fever in the Puerperium.—Zweifel (*Zentralbl. f. Gyn.*, January, 1906) again proposes that the blood clots which regularly collect in the posterior fornix *post-partum*, should be removed because they can become a breeding ground for pathogenic micro-organisms, and from the extension of the latter to the uterus fever arises. A speculum is introduced into the vagina during the first visit to the lying-in woman, that is, several hours *post-partum*, and the clots removed with a dry sterile sponge or forceps. It is a quite painless and harmless procedure, and gives better results than douching. The best method of all is when the woman is able to press out the clot herself. The results of this treatment in his Klinik are that there is a large decrease in the number of septic cases, because spontaneous infection is less likely to occur, and that the lochial discharge is only very lightly bloody for a few days. Rubber gloves must always be worn, and as few internal examinations as possible should be made before the delivery of the child. G.

The Technique of the Cæsarean Section.—Olshausen (*Zentralbl. f. Gynäk.*, January 6th, 1906) contributes, among others, the following observations on this subject based on his experience of 118 Cæsarean sections performed in his Klinik. The operation was performed for contracted pelvis in 91 cases, and the remaining 27 were for eclampsia, myomata, carcinoma, vaginal fixation, nephritis, vitium cordis, and stenosis due to cicatricial tissue in the cervix or vagina. As regards the technique, the abdominal incision must extend from a good distance above the umbilicus to about 8 cm. or more from the symphysis pubis, so that the uterus can be raised outside the abdominal wall. A sponge is then put behind it, and the wall drawn temporarily together with two forceps. The uterine incision must avoid the placenta. The position of the latter is discovered when one observes the injection of the uterine wall, which is most marked over the placental site. By this means, the author was uncertain of the position in only two of his cases. If the anterior wall is much more prominent than the posterior, the placenta is nearly certain to be on the former. The same does not stand for the normally more prominent posterior wall. One can open the posterior wall just as well as the anterior. There is no longer any need to fear hæmorrhage if a large dose of ergotinine is hypodermically injected about twenty minutes before the operation. The uterine incision must be made in the middle line. When this is done and the placenta is avoided the hæmorrhage is never dangerous. Compression of the cervix is superfluous; in fact, it should be avoided because more severe hæmorrhage takes place when it is removed. The sutures are of catgut, and are inserted so that as much muscle as possible without peritoneum or decidua is seized. The interrupted sutures are then carefully tied, and the peritoneum is closed with a continuous suture above them. In seven women the operation was performed twice, in two three times, and in three four times. All these twelve recovered. Among the 91 operations for contracted pelvis, nine died. The author operated personally on 65 cases with three deaths, his assistants on 26 cases with six deaths. G.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "Recent Medical Literature."
- (2) "Recent Surgical Literature."
- (3) "Recent Gynecological and Obstetrical Literature."
- (4) "The Recent Literature of Physiology, and Pathology."

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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 reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

CLAPHAM PRACTITIONER.—We quite agree with you that in admitting a notice of a "beauty" show to its advertisement columns a certain esteemed and distinguished medical contemporary is establishing a somewhat doubtful precedent.

SIR JOHN B.—A considerable sum of money is needed to found the proposed Institute of medical sciences in connection with the University of London. The scheme promises well—in fact more than any yet advanced—as regards unification and sound organisation of medical teaching in the metropolis. We shall be pleased to give you the names of persons authorised to receive subscriptions to this most excellent educational project.

ARRIVAL AND DEPARTURE (BUT NOT BY COOK'S EXCURSION).

By "motor" and "steamboat" and "train"
We leave home, and we come back again.
But to enter this world, and leave it, we're bound
To come in by the "Tube" and depart "Underground,"
Except for the few who are otherwise fated
To be drowned, blown to bits, peradventure cremated.

—A. D.

RUSTICUS SENIOR (Hants).—It is impossible to answer such a question without fuller knowledge of the facts of the case. Many persons of unsound mind, for instance, do not require asylum supervision, nor, indeed, for that matter, constant personal care. For your own protection we should advise you to consult one or more leading alienists.

MR. J. ANJO (St. John's, Antigua).—We are quite unable to accede to our correspondent's request. Our contemporary, *The British and Colonial Chemist and Druggist*, would more likely be able to carry out his request.

DR. H. H. E. is thanked for his note. Enquiry is being made and the result will be communicated.

H. S. (Carlsbad).—The report should first be officially vouched for.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, APRIL 11th.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.).—8.30 p.m. Discussion on Syphilis (opened by Mr. J. Hutchinson): Syphilis considered in connection with—(1) Mental Disease, Dr. Savage; (2) The Nervous System, Dr. P. Stewart; (3) The Viscera, Dr. H. White.

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

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. J. Pardee: Clinique. (Surgical). 5.15 p.m. Lecture:—Mr. J. Cantile: How to Recognise and Treat Abscess of the Liver.

Vacancies.

St. George's Union.—Second Assistant Medical Officer. Salary £120 per annum, with board, residence, and washing. Applications to Dr. J. C. Muir, at the Infirmary.

Borough of Beigate.—Beigate Rural District Council.—Medical Officer of Health. Salary £250 per annum. Applications to the Town Clerk, Municipal Buildings, Beigate.

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.

Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer. Salary £130 per annum, with board and lodging. Applications to the Medical Superintendent.

Maestfield General Infirmary.—Senior House Surgeon. Salary £100 per annum, with board and residence. Applications to the Chairman of the House Committee.

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

Salop Infirmary, Shrewsbury.—House Surgeon. Salary £100 per annum, with board, washing, and residence. Applications to the Board of Directors.

Gartloch Asylum, Gartcosh.—Assistant Medical Officer. Salary £125 with board and lodging. Applications to Medical Superintendent.

Royal Halifax Infirmary.—Second House Surgeon. Salary £100 per annum, with residence, board, and washing. Applications to Oates Webster, Secretary, Royal Halifax Infirmary.

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.

West Riding of Yorkshire.—Assistant to County Medical Officer. Salary £250 per annum. Applications to Trevor Edwards, Clerk to the Committee, County Hall, Wakefield.

Carlisle Non-Provident Dispensary.—Resident Medical Officer. Salary £150 per annum, with apartments. Applications to the Hon. Secretary, Mr. G. A. Lightfoot, 23 Castle Street, Carlisle.

Liverpool Infirmary for Children.—House Surgeon. Salary £100 per annum, with board and lodging. Applications to Arnold J. Cleaver, Government Buildings, Liverpool.

Royal College of Surgeons of England.—Election of Board of Examiners in Anatomy and Physiology for the Fellowship. Application to the Secretary, 8. Forrest Rowell (See advt.).

Royal College of Surgeons of England.—Election of Examiners under the Conjoint Examining Board in England. Application to the Secretary, 8. Forrest Rowell. (See advt.).

Holloway Sanatorium, St. Ann's Heath, Virginia Water, Surrey.—Junior Assistant Medical Officer. Salary £175 per annum, with board, lodging, washing, &c. Applications to Dr. W. D. Moore Medical Superintendent.

Appointments.

BURLAND, CHARLES, L.R.C.P. and S.Edin., Medical Officer to the Board of Trade for the Port of Glasgow.

DAVIS, F. H., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Dawley District of the county of Salop.

ENGLAND, G. F., M.D. Cantab., Certifying Surgeon under the Factory and Workshop Act for the Winchester District of the county of Hants.

FAIRBANK, H. A. T., M.S.Lond., F.R.C.S.Eng., Orthopaedic Surgeon to Charing Cross Hospital.

FLETONER, J. P., F.R.O.P.Edin., L.F.P.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Sherston District of the county of Wilts.

HOWARD-JONES, J., M.R.C.S., L.R.C.P.Lond., Certifying Surgeon under the Factory and Workshop Act for the Worthen District of the county of Salop.

LAMBERT, FREDERICK SAMUEL, M.R.C.S., F.R.O.P.Lond., Medical Officer to the Lincoln Post Office.

LEWIS, CYRIL, M.D., C.M.Edin., Honorary Assistant Physician to the Cardiff Infirmary.

PATERSON, DONALD ROSE, M.D., C.M.Edin., M.R.C.P.Lond., Honorary Surgeon to the Ear, Throat, and Nose Department at the Cardiff Infirmary.

RIDOUT, C. A. SCOTT, M.S., M.B.Lond., F.R.C.S.Eng., Honorary Pathologist to the Royal Portsmouth Hospital.

SHEPPARD, ARTHUR LEWIN, M.B., B.S.Durh., House Physician at the Bristol Royal Infirmary.

SMITH, L. BRINGLETON, L.R.C.P.Lond., M.R.C.S., Junior House Surgeon at the Bristol Royal Infirmary.

WRIGHT, A. J., L.R.O.P.Lond., M.R.C.S., Casualty Officer at the Bristol Royal Infirmary.

Births.

BROOKS.—On April 4th, at the Elms, Penn Road, Wolverhampton, the wife of J. Pratt Brooks, M.R.C.S., of twin sons.

HYALOP.—On April 1st, at Castle Hill House, Settle, the wife of B. B. Hyalop, M.B., of a son.

SMITH.—On April 4th, at 204 Selhurst Road, S. Norwood, the wife of W. H. M. Smith, M.R.C.S., L.R.C.P., of a son.

THOMPSON.—On April 2nd, at The Marlowes, Hemel Hempstead, Herts, the wife of Maitland Thompson, L.R.C.P., M.R.C.S., of a son.

Marriages.

COTTER-MUSSON.—On April 7th, at St. Peter's Church, Fulham, George Edmond Westworth Cotter, M.A., M.B., B.C.Camb., M.R.C.S., L.R.O.P.Lond., son of the late Duncan Donald Darroch Cotter, West Indies, to Muriel Isobel, youngest daughter of Samuel James Musson, of Norwood.

HURST-BAUMANN.—On March 10th, at Savannah, Georgia, U.S.A., Walter Hurst, M.D., B.Sc., L.S.A., and Alice Heselbine Baumann, M.D.

Deaths.

BRETtingham.—On March 31st, at Lyndhurst, Oldfield Park, Bath, Charles Brettingham, M.R.C.S., L.S.A., late Surgeon Bengal Army.

EVANS.—On March 28th, at Zanzibar, Wilfred F. Evans, M.R.C.S., L.R.O.P., fifth son of the late Nicholl Evans, M.D., of Chestnut, Herts.

HILBERS.—On April 7th, at 60 Brunswick Place, Hove, Brighton, Louisa Susannah, widow of George James Hilbers, M.D., aged 88 years.

KIDDLE.—On April 7th, at Locks Heath House, Salisbury, Hants, John Nelson Kiddle, L.R.C.P., formerly of Albert Hall Mansions, London.

SHIPLEY.—On March 16th, at Secunderabad, India, of peritonitis, Edith, wife of Major C. T. Shipley, Royal Fusiliers, and daughter of the late Surgeon-General J. T. C. Ross, C.I.E.

STONEV.—On April 6th, at The Heath, Abbeyleix, Mary Anne, wife of Hugh B. Stoney, M.B.

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"SALUS POPULI SUPREMA LEX."

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WEDNESDAY, APRIL 18, 1906.

No. 16.

NOTES AND COMMENTS.

The Central Midwives Board and Ward Cousins from the last meeting of the Central Midwives' Board, the resolution standing in their name was postponed. This reads as follows: "No one shall be permitted to begin the course of instruction, either theoretical or practical, until she has produced evidence satisfactory to the Central Midwives' Board that she has received sufficient elementary education to enable her to read a text-book and take notes of cases. But this rule shall not apply to pupils who have received training in general nursing for at least one year." It is a curious commentary on the composition of the Board that such a resolution should not only be necessary, but that opposition to it must be expected. Its opponents apparently believe that seeing there is a dearth of properly qualified midwives, it will be well for the Board to cast its net so wide as to include the mentally halt and maimed. One lady member of the Board apparently does not think much of "registered medical practitioners," and reasoning from her opinion of them, advocates the introduction of any class of nurse.

Alice in Blunderland—A New Edition. An unpublished fragment of this caustic work has recently reached us, and may be of interest:—"Next moment Alice found herself in the middle of a large plain, entirely occupied by rather overgrown cabbages, the Red Queen was by her side. Each cabbage held out an attenuated side-stalk, with which it supported a book. 'Please,' said Alice, 'What are these funny cabbages doing?' 'Doing,' said the Red Queen, 'can't you see? They are learning their lessons.' 'But,' said Alice, 'some of them are asleep, and such a crowd of them have their books turned upside down. And, oh! look at that poor old dear, I think she is blind.' 'It's no matter,' said the Red Queen sarcastically, 'they couldn't read even if they were awake. They never learnt how.' Alice felt inclined to say 'Rubbish,' but she prudently held her tongue instead, and, on releasing it, murmured plaintively, 'Then, how *can* they learn their lessons?' 'They can't,' said the Queen, 'but the Board like it. They make a crowd, and that is so useful, you know. And then,' she added, as an after-thought 'they pay fees.' Alice said nothing."

The Normyl Cure for Drunkenness. Is there any drug cure for drunkenness? Most medical men of experience would answer "No," without a moment's hesitation. The only hope for the chronic inebriate is to brace up his moral fibre and to help him by placing him in an

environment as free as possible from temptation. But where medical men pause on the brink there are always laymen ready to plunge in. Curiously, some of the most ardent of these amateur practitioners are clergymen, who by some strange freak of providence seem to assume a divine right of knowledge of medicine, albeit one of the most difficult, technical, and absolutely responsible of all the learned professions. If there be one thing above all others that is daily forced upon the attention of the medical man, from the first day he enters the hospital to the last day of his active professional life, it is the subject of alcoholism. Its effects, physiological and pathological, upon mind and body are ever before him in the human wreckage of the out-patient and casualty rooms, the wards and the *post-mortem* theatre.

Medical Men know no "cure" for Alcoholism. Yet in spite of the careful study of alcoholism medical men have no cure by drugs. The usual clergyman, however, has rushed into the breach, in the shape of the Reverend Hugh B. Chapman, Secretary of the Normyl Treatment Association for the Cure of Alcoholism. Recently, at a public meeting in Newcastle, he stated that before becoming connected with the society he had tested the treatment upon 230 patients, of whom 220 were cured. If that be a true statement Mr. Chapman deserves a municipal statue in enduring brass, as one of the great benefactors of humanity. Alas! the Normyl physic is a secret remedy, and it is not easy to accept the statement of the Secretary that no pecuniary benefit is obtained from the sale of the medicine. In that case, why keep the composition secret? Medical men keep nothing secret; why, then, should a clergyman observe a less humane and generous code in his ethical relations to society? If no one makes any money out of Normyl, why not give drunkards all over the world a chance of getting salvation?

Proprietary Drink Curses. The reverend gentleman, we believe, appeared on the scene at a somewhat advanced stage of the Normyl Company's development. In its earlier days we were amazed at seeing the names of several leading members of the medical profession connected with the venture. We wrote to them and some approved the "cure," and stated they had sent patients for treatment. This is a sober statement of fact, and yields an extraordinary glimpse of the inner life of our profession. The Normyl method is one of many that have been advanced from time to time. Unlike Normyl, most of these nostrums are based on a frankly commercial footing. Nearly all of them depend upon the administration of narcotic drugs, at

times hidden under the cloak of some rare or costly medicament. We are glad that several Newcastle medical men attended the meeting and told their fellow townsmen what they thought about drink cures in general and the Normyl plan in particular. There is nothing more likely to appeal to the weak and the gullible than these so-called cures for inebriety. If Mr. Chapman is so firmly convinced of his results let him organise an authoritative medical investigation. The subject is important enough.

LEADING ARTICLE.

ANTISEPTICS IN MEDICINE.

THE supreme importance of Listerian methods in modern surgery is so universally recognised that it seems trite to point out that next to the discovery of anæsthetics, that of antiseptics has probably conferred the greatest boon upon suffering humanity. The malign influence of pathogenic organisms is, however, equally at work in those affections which do not directly fall within the province of the surgeon. There are many purely medical disorders which owe their origin to the development of germs and their elaborated toxins within the body, but it is only within comparatively recent times that oral sepsis has been proved to be the cause of such grave affections as pernicious anæmia. The better observance of oral hygiene, together with the application of antiseptic principles to the buccal cavity, is now, happily, being carried out by an increasingly large number. As far as the alimentary canal is concerned, it cannot be denied that the bacterial flora of the human intestine is of considerable importance, and it would appear that even the *bacillus coli* itself has certain functions to perform in connection with undigested food which are advantageous to the body as a whole. The virulence of these intestinal organisms may be enormously increased under abnormal conditions, whereby such affections as peritonitis, colitis, and dysentery may be set up. The administration of the so-called "intestinal antiseptics" may be of doubtful value theoretically, but the fact remains that such substances as β -naphthol or salol are not altogether without salutary effect in states of severe intestinal sepsis. The application of the antiseptic principle to medicine is a subject of very wide importance, touching, as it does, many common diseases which come within the ken of the physician. As Sir Richard Douglas Powell pointed out some time ago, it is septic organisms which cause such havoc in pulmonary tuberculosis by interfering with the natural tendency of the disease to become fibrotic. Similarly, the same germs are responsible for keeping up what would otherwise be a simple bronchitis. The position at which we have now arrived in the treatment of tuberculosis of the lungs in sanatoria may, indeed, be said to consist in an organised attempt to deprive the patient of all added infection in the shape of septic organisms and to preserve his environment in as aseptic a condition

as possible. The creosote preparations are of indisputable value in assisting to bring about the desired end, and where the open-air cure is out of the question saturation of the system by these compounds up to the limit of toleration is one of the best modes of treating the disease. We know that if the tubercle bacillus be rigorously let alone it will almost surely become surrounded by an area of fibrosis which, in other words, is Nature's effort to cure the complaint. The principles of antiseptics may well be said to belong equally to medicine and surgery. Modern observers have also laid stress upon another point of practical importance, namely, that too careful a preparation for any surgical operation, especially a major one, cannot be made. A few days of rigid dieting and attention to the functions of the bowels may make all the difference between the success or failure of an operation, and it would frequently seem that when the latter is undertaken in a hurry without such preparation septic complications arise, no matter how aseptic the surgery may have been. The physician who fully recognises the part played by septic organisms in non-surgical affections is far more likely to meet with success in his treatment than the practitioner to whom antiseptics is a name only.

NOTES ON CURRENT TOPICS.

Cremation.

THE progress of cremation is matter of no little interest and concern to medical men. With the flocking of people into towns, and the consequent expense of land in the neighbourhood of towns, the difficulty of getting suitable sites for cemeteries is an increasing one, and it is impossible on hygienic grounds to justify the practice of burying the dead deep in the earth in strong or impermeable coffins, which must sooner or later give way and pollute the subsoil in the neighbourhood of living-houses. Earth to earth burial in the living humus of the soil is doubtless the most economically and hygienically unobjectionable way of disposing of the dead, but practice and sentiment are all against such a plan. Cremation is, therefore, the most convenient half-way house, and it is slowly creeping into favour with the public of the Western world. From a paper read by Dr. Killick Millard, at the provincial sessional meeting of the Royal Sanitary Institute at Leicester, it appears that in Paris up to the end of 1903, the number of cremations was 3,147, and since then it has largely increased. In the United States the number for 1902 was 3,160, and in Germany in 1903, 1,074. So far in Great Britain 5,020 cremations have taken place, of which 476 were in 1903, 506 in 1904, and 604 in 1905. The bodies have practically all been those of people in the upper and middle classes, probably by reason of the expense as much as by reason of education; but the figures suggest that the primitive custom of burning the dead will soon become a popular one in the present century.

London Consumptives.

THE difficult question of how to deal with the London consumptive, that is, if he has to be dealt with officially, has passed through one phase of its existence. It will be remembered that a short time ago an influential deputation, led by Sir William Broadbent, waited on the Metropolitan Asylums Board with the suggestion that the Board should become the tuberculosis authority for the metropolis in the same way that it is now the fever and small-pox authority. The Board have evidently been much exercised over the enormous responsibility of such a charge, as indeed they well might be, and lately they applied to the Local Government Board for advice. The latter have just replied that the information before them at the moment does not appear to afford sufficient justification for the heavy outlay which would be involved by the proposal, and we learn that Sir William Broadbent himself has seen reason to modify his suggestion that the Metropolitan Asylums Board should be the authority for the purpose. All thinking men who are sensible to suffering and to the devastation consumption is causing in London wish to see the problem of tuberculosis tackled firmly, but it is certainly a matter for deep reflection as to whether the wholesale provision of sanatoria at a crushing expense to the ratepayer would do more than touch the fringe of the evil. It is necessary to keep clearly in mind that unless the prospects of restoration to health for the tuberculous were very much greater than appears at present from sanatorium returns, no scheme that was even approximately self-supporting could be expected. And if the community is to take on its shoulders the care of its consumptives, it should do so with full knowledge of what it has to expect. Otherwise only disappointment and chagrin would result.

International Congress of School Hygiene.

A PRELIMINARY meeting has been held in the London University Buildings with a view to attracting interest in the proposal that the second International Congress of School Hygiene shall be held in London next year. The resolution to that effect was moved by Lord Reay, and carried unanimously, and we hope that the necessary sum, namely, £4,000, will be forthcoming to ensure the success of the undertaking from the financial standpoint. As Mr. Birrell aptly remarked in introducing the Education Bill, the interest of people generally seems to centre in the sectarian controversies connected with elementary education rather than in the measure for promoting the attainments and health of the children. The medical profession can afford to let the various religious bodies fight their own battle on the subject of denominationalism, if they can attract the sympathies of all parties towards the study of the mental and physical health of the rising generation. It is beyond question that Great Britain and Ireland are far behind many Continental and Colonial countries in their arrange-

ments for the improvement of the conditions of elementary school-children, and the bringing together of a number of educational experts from those countries to London would supply a keen incentive to the study of school hygiene over here. It would be lamentable to have to record that for want of funds so rich a city as London was unable to entertain the proposed Congress.

Home Spas

BIG Englanders and Little Englanders can congratulate each other in the attempt that is being made at the International Health, Food and Hygienic Exhibition, at the Crystal Palace, to bring before the people of this country the striking fact that Great Britain contains certain spas and watering places at least as conducive to health as the fashionable resorts of the Continent. Our enterprising neighbours in Germany, France, Italy, and Switzerland have long realised the potentialities of the spa-business, and any little town or village that possesses a spring or a peculiar species of mud knows how to make a fortune out of them, and our own people are beginning to wonder why English sulphur and Scotch chlorides should not prove equally profitable. In the *Health Resort* this month, it is stated that £15,000,000 is spent annually by visitors, most of whom are British, in travelling in Italy. If this be so, there would seem to be no logical reason why Italians should not spend at least half that sum in exploring the benefits of our Northern clime. There is, however, fashion in health-seeking as in drugs and treatments, and we fear that until the German Emperor or the King of Spain can be induced to take a course of baths at Harrogate or Buxton people will prefer Homburg and Marienbad to the attractions of their native spas.

Expert Pathologists and Medico-Legal Cases

A CONFERENCE of pathologists was convened some time ago at the instance of the Medico-Political Committee of the British Medical Association to discuss the position practising pathologists should adopt in regard to inquests and other medico-legal inquiries. The conclusions arrived at are published in a recent number of the *Supplement* to the Association's *Journal*, and are such as will receive general approval. It is suggested that the employment of expert pathologists to assist in *post mortem* examinations in cases of special difficulty is highly desirable, but that the employment of such an expert is to be regarded as in addition to, and not in substitution of, the employment of the medical man who has attended the patient during life. This is quite as it ought to be. The medical man in attendance is, or may be, in possession of evidence which may be of the highest importance, and without which the pathological findings would be meaningless. The truth is best discovered in medico-legal as in ordinary medical cases by a collation of the clinical and pathological facts. The conference also demands that proper

remuneration should be given for expert work and a minimum fee of five guineas for *post mortem* examination and evidence is suggested.

National League for Physical Education.

THE National League for Physical Education and Improvement lately sent a deputation to the Minister for Education for the purpose of urging on him the duty of initiating a scheme for the systematic medical inspection of school-children, and for the establishment of a regular record of anthropometric observations in the rising generation. Mr. Birrell, in reply, expressed his sympathy with the objects of the league, but said that, considering the expense of setting such a scheme on foot the Government would have to be convinced of its practical utility and its general approval. From the point of view of the medical profession, such approval will be generally given on the principle of the old maxim that prevention is better than cure. But it follows as a necessary corollary to such a plan that the result of the observations so made should be something more than a pious record which would be filed in the spacious cellars of a Government office. Observations on the physical condition of children connote steps that should be taken to remove defects and to prevent degenerative processes continuing. If the league could work out a good, economically sound scheme by which work of this kind might be carried out, they would deserve well of their fellows. The cost of medical inspection, if made by qualified practitioners, should be easily recouped by the diminution in the cost of infectious disease administration, and it should not be impossible on these lines to devise a plan which would earn general regard.

Nursing Home Charges.

THE expenses attached to the maintenance of the ordinary "nursing home" are necessarily heavy, especially in fashionable town quarters, where rents are forced up by landlords to the highest possible pitch. At the same time in many such private institutions the charges are often excessive, not to say extortionate. A correspondent has sent us the account tendered by the proprietress of a well-known private nursing home in a smart town on the banks of the Thames. The patient was a small boy some five or six years of age, suffering from German measles. He was in the home for ten days, and the account tendered was for £23 18s. 6d. The fees were two guineas a day for the patient, with £3 3s. a week for a special night nurse, and £1 1s. for her board. The latter items were charged for the first week only, and the total amount was made up of various small fees. Most middle-class folk would agree with the mother in regarding a charge of £23 18s. 6d. for ten days nursing of a small boy with a trivial complaint as excessive. Compared with average medical charges, the scale is simply one of stupendous liberality. The moral is that, before sending a patient to a nursing home, the

medical practitioner will do well to ascertain precisely the scale of fees and to see that the patient's friends are fully informed of the liabilities they are incurring. In this way a deal of trouble and vexation will be prevented.

Barber's Rash.

A RECENT County Court case in which a customer obtained £15 damages against a West End barber, naturally raises the whole question as to the origin and prevention of that cutaneous affection of the face usually known by the name of "barber's rash." Strictly speaking, the term is applicable only to that form of ringworm of the beard region formerly known as "tinea barbæ," or "barber's itch." Sycosis of the face is known to be either hyphogenic, due to lodgment of a trichophyton, fungus in the hair-follicles, or coccigenic due to microbic infection of the skin with pyogenic cocci. The latter organisms find no difficulty in gaining access to the dermal tissues through the minute abrasions inflicted by the razor. It is an established pathological fact that the ordinary white coccus of the human skin, in itself harmless, may, under certain conditions, take a virulent form, so that even if the razor be sterile this germ might be inoculated into the skin, there to produce all its evil effects. The papules and pustules characteristic of the disease do not always appear immediately, though patients sometimes state that they have experienced a sensation of itching after returning home from a barber's shop. The diagnosis between the two different forms of sycosis is not always an easy matter, the microscope being generally necessary for examining thickened hairs, &c. Some people will say, of course, that any skin eruption whatsoever coming on after a visit to a barber is a "barber's rash," though this by no means follows. A too hasty pronouncement of infection from shaving implements may lead an innocent individual into serious trouble, for, given a sterile razor and all the appurtenances of the rasorial operation strictly in accordance with modern aseptic methods, it does not follow that the customer may not develop some irritation, the cause of which lies in his own skin.

Home-Made Galenicals.

FOR a generation or more the making of pharmaceutical preparations has been steadily going out of the hands of the dispensing chemist and druggist into those of the wholesale manufacturer. On the whole, the public gains by a supply of cheaper and better drugs. In the single instance of pills, an enormous saving of time and far greater precision of dosage is effected by the substitution of machine for hand-made labour. At a recent meeting of the Sheffield Pharmaceutical Society, Mr. W. H. Stiles, of Doncaster, read a paper on "Home-Made Galenicals." He deplored the fact that the practice of making pharmaceutical preparations was rapidly going over to the wholesale houses. That state of things, he maintained, was neither creditable to the improved educational

facilities possessed by the modern therapeutical student, nor advantageous to his pocket nor his self-respect when he became a principal. While accepting his statement that with intelligent care galenicals at least equal to those sold by the wholesale manufacturer could be made by any retail pharmacist worthy of the name, we doubt if they could be furnished at anything like an equal cost. Division of labour is an inexorable law, and has settled this question long ago. At the same time it seems more than likely that an energetic chemist might save himself a great deal of money by making many of the simpler galenical preparations in his own pharmacy.

The Gynæcological Bath.

THE examination of the pelvic organs of women is always a more or less disagreeable business, both to patient and doctor, and for accurate diagnosis and the relief of discomfort the administration of an anæsthetic is frequently resorted to. But every anæsthetic has its risks, and in any case the patient has to be confined to bed for a day or two to get rid of the effects. Moreover the administration of an anæsthetic does away with an important factor, namely, the woman's sensation, and in many cases tenderness on palpation is in itself a valuable guide to diagnosis. Dr. Profanter, in a recent number of the *Wiener Klinische Wochenschrift*, proposes a way out of these difficulties which is as original as it is refreshing. He suggests that women should be examined in a semi-recumbent position in a bath filled with warm water. The heat of the water relaxes spasm of the abdominal muscles and allays local tenderness, whilst at the same time the vagina may be distended with water so that the finger can be easily inserted. There is a *naïveté* about the plan which almost moves us to mirth. The idea of a gynæcologist having his consulting-room fitted up as a kind of aquarium, whilst he, suitably attired, pursues his patients, also suitably attired—we trust, through the deep waters of his tanks, is capable of considerable extension. Sir James Barr, of Liverpool, still adheres to his tank treatment of typhoid, we believe, and if the system were applied on Dr. Profanter's lines to other departments we might eventually conduct our confinements in baths and teach children to swim before they could walk. But at present, at the risk of being thought to be reactionaries, we cannot declare ourselves adherents of the blue-water school of gynæcology.

A Prescribing Chemist.

IN the long run dispensing chemists who take upon themselves the illegal prescribing of drugs will inevitably bring their calling into disrepute. After all it is to medical men that they should look for their main support, but they are not likely to strengthen the bonds of good feeling with the profession by usurping their proper function. It would be well for all concerned were coroners to speak out freely upon the subject of irresponsible

prescribing. Not long ago the Manchester Coroner held an inquiry upon an aged woman who died from peritonitis shortly after taking a pill prescribed and dispensed by a chemist who had not even seen the sick person. In the report in the *Manchester Guardian* we find the statement that "the chemist told the coroner he had been in the habit of prescribing for simple cases, and from the information given him by the woman's daughter he did not think he would be doing his duty had he not given her something to relieve the old lady." Medical evidence showed that the drugs given "would tend rather to aggravate her condition than do otherwise." The fact remains that this chemist prescribed for a woman drugs that probably hastened if they did not cause her death. His act was illegal, and does not in substance materially differ from that of any unqualified charlatan who has not passed an examination in pharmacy.

PERSONAL.

WE offer our sincere congratulations to Sir William and Lady Crookes, who celebrated their golden wedding on April 10th.

H.R.H. THE PRINCESS ROYAL has consented to receive purses with donations to the fund now being raised to build the first wing of the reconstructed Bolingbroke Hospital, on the occasion of the laying of the foundation-stone on Saturday, May 5th.

DR. W. J. SIMPSON has left for India, having been asked by the Colonial Office, on behalf of the Government of the Straits Settlements, to inquire into, and to report on, the sanitary condition of Singapore.

UNDER the presidency of Sir Frederick Treves, President of the British Red Cross Society, an International Congress of Red Cross Societies will be held in London for one week in June, 1907.

MR. PETER WILLIAMS, M.R.C.S., of Ferryside, Carmarthenshire, was recently presented with a cheque for £300, and his wife with a silver salver, by a number of friends and patients as a mark of their esteem and respect.

ON May 25th, Dr. Leonard Hill will deliver a lecture at the Royal Institution of Great Britain, on "Compressed Air and its Physiological Effects."

WE regret to learn that Lieutenant Forbes Tulloch, of the R.A.M.C., a popular young officer, accompanying the Royal Society's Commission sent to Uganda to investigate the mysterious "sleeping sickness," has accidentally contracted the disease while dissecting a rat.

MR. GERALD QUIN LENNANE, L.R.C.P., F.R.C.S.I., was elected on Wednesday last as medical officer of health for Battersea, at a salary of £600 a year. There was keen competition for the post, but as the successful candidate had been in private practice in Battersea many years, and was formerly a member of the Battersea Vestry, his election was considered to be fairly assured.

DR. ROBERT JONES, M.D., M.R.C.P., has been appointed Lecturer on Mental Diseases at the Westminster Hospital. Dr. Jones is the Resident Physician and Superintendent of the London County Council Asylum at Claybury, and President-Elect of the Medico-Psychological Association. He is the author of many works and papers on delusions and other forms of insanity.

A CLINICAL LECTURE ON MITRAL STENOSIS.

Delivered at St. George's Hospital on March 20th, 1906.

By H. D. ROLLESTON, M.D.Cantab., F.R.C.P. Lond.,

Physician to St. George's Hospital, Physician to the Victoria Hospital for Children.

This patient, a boy, æt. 14, came in with an acute articular rheumatism, which rapidly yielded to salicylates. He was given 15 grains of salicylate of soda, with double the quantity of bicarbonate of soda every hour for six hours, and then once every four hours. The addition of a full dose of alkali is a remnant of the "alkaline treatment of rheumatism" originated by the late Dr. Fuller, of this hospital, which was the most successful method of treating rheumatic fever before the days of the salicylate. The addition of full doses of an alkali probably has the great advantage of diminishing the incidence of cardiac complications; thus a series of cases in this hospital ten years ago, tabulated by the late Dr. Lee Dickinson, showed that cardiac complications were more frequent in a series of cases treated with salicylates alone than in a corresponding series of cases treated with salicylates and alkalis. For this purpose I much prefer to use bicarbonate of soda rather than bicarbonate or citrate of potash, because the soda salt is less depressing than the potash. Frequent doses of salicylates alone, such as are required in order to combat the acute stage of rheumatic fever, not uncommonly set up vomiting. Some years ago the sister of the ward told me that she always expected cases of rheumatic fever treated with salicylates alone to vomit after the medicine. Very probably this vomiting is due to the irritation of the stomach, set up by the liberation of the salicylic acid; if this be so, the addition of alkali should prevent the formation of free salicylic acid, and so obviate vomiting. In addition, I now always give tincture of capsicum, 1 minim, which, probably by producing slight counter-irritation of the stomach, neutralises the irritating effect of salicylates. At any rate, vomiting is seldom seen in cases treated in this way. In passing, we may refer to the other toxic effects of salicylates. As they relieve pain, it is not unnatural that they should modify sensation in other ways; thus, as is well known, salicylates produce deafness and ringing and buzzing in the ears. Sometimes the nervous effects are more marked, and the mental depression, which often follows salicylates, may pass into a peculiar form of aberration, most commonly seen in women, and accompanied by manifestations of suspicion, such as the belief that the food or medicine is poisoned. We may compare the alteration of taste, which probably is the basis for this delusion, with the impairment of auditory sensation mentioned above. In some cases salicylates cause marked shortness of breath, thereby arousing a suspicion of cardiac dilatation.

When this patient was admitted his heart was found to be definitely affected with established but compensated mitral stenosis. Although there was no history of previous rheumatic fever some form of rheumatic infection must have occurred in the past to account for this mitral stenosis; for this form of heart disease takes months to develop, and therefore could not have developed on this occasion. In this way mitral stenosis contrasts with mitral regurgitation, or with aortic regurgitation, though this is less commonly seen in these circumstances, both of which may develop within a few days of the commencement of an attack of acute rheumatism. In the vast majority of cases mitral stenosis is rheumatic in origin, but it often occurs in cases in which the articular manifestations were slight, and as a result there is no history forthcoming to point to rheumatism. In a number of patients it follows chorea, which we may

regard as rheumatism of the cortex of the brain. This probably accounts for the fact that, whereas ordinary rheumatism is, if anything, commoner in males, mitral stenosis is much commoner in females, the increased incidence of chorea and mitral stenosis in the female sex being thus correlated. Other causes of mitral stenosis are of subordinate importance. Chronic valvulitis, due to long-continued high blood-pressure, such as occurs in the left ventricle in cases of arteriosclerosis and glandular kidney, sometimes leads to a certain amount of narrowing of the mitral orifice, though as a rule there is retraction of the segments of the mitral valve which of course produces dilatation of the orifice. It has been thought that anæmia may be the cause of mitral stenosis in the following way. Anæmia gives rise to dilatation of the left ventricle and mitral regurgitation, and, as a result of the irritation thought to be thus set up, to a certain amount of chronic valvulitis, the chronic valvulitis resulting in the welding together of the segments and eventually in stenosis. This hypothesis, however, is very doubtful and it is perhaps more probable that both the anæmia and the stenosis are the effects of the rheumatic virus, which has not given rise to any articular manifestations. In a few cases, practically pathological curiosities, an adherent clot, forming a pedunculated mass in the auricle, may become so elongated as to project into and narrow the mitral orifice. Lastly, it is often said that mitral stenosis is congenital; if so, it is of the greatest rarity; in short, it is safe to assume that in the vast majority of cases mitral stenosis is rheumatic in origin.

The physical signs of mitral stenosis are of great interest, both because they are variable and because of the interpretation which may be put upon them. In a pure case of mitral stenosis the apex beat of the heart is internal to the normal position. This depends on the fact that a smaller quantity of blood than normal passes into the left ventricle, the left ventricle has less work to do and therefore undergoes a certain amount of atrophy. At the apex there is a presystolic thrill. It is important to distinguish a thrill produced inside the heart from one which is produced in the chest wall, and is due to the greater pulsation of the intercostal spaces than of the rigid ribs, a condition which often occurs in cases of forcibly beating hypertrophied hearts. A thrill of this kind which may be called an exocardial, false, or pseudo-thrill, is often felt when the palm of the hand, as distinguished from the fingers, is placed lightly over the chest wall. A true thrill is one produced inside the heart, and can be felt when the individual fingers of the hand are separated from each other and placed over the intercostal spaces. If a thrill which is felt by the whole hand disappears when the fingers are placed separately over the intercostal spaces, we may conclude that it is produced in the chest wall and not in the heart.

In mitral stenosis the cardiac dullness is increased upwards, and instead of beginning at the lower border of the fourth costal cartilage on the left side occupies the third, or second left, intercostal space close to the sternum. This upward extension of the cardiac dullness, which used to be referred to dilatation of the left auricle, is undoubtedly caused by dilatation of the upper part, or conus arteriosus, of the right ventricle. Pulsation can often be felt over this area of the pulmonary artery, and a shock, due to the more forcible closure of the pulmonary valves, is perceived.

The murmurs of mitral stenosis occur during the

diastole of the heart; there may be a long continuous murmur, occupying nearly the whole of the diastole; in other cases there may be a murmur occupying the commencement, the middle, or the end of the diastole. The presystolic murmur—which, being produced by the contraction of the auricle, has been called the auricular systolic—has also been termed the crescendo murmur by those who wish to avoid committing themselves to the view that it is presystolic in time. It has the characteristic harsh vibratory character of other obstructive murmurs, such as those of pulmonary stenosis and aortic stenosis, the vibrations being so coarse that they can be felt as the presystolic thrill, as well as heard. The presystolic murmur is very variable, and may come and go, so that it may be audible in the morning and absent in the afternoon. It may be well to point out that a presystolic murmur, though generally evidence of mitral stenosis, is not absolutely pathognomonic of that condition. It may occur in other cardiac lesions. The most frequent of these is free aortic regurgitation, in which a murmur, called Flint's murmur, is produced, although there is no organic narrowing of the mitral orifice. As just mentioned, it occurs in cases of free aortic regurgitation, and is explained on the supposition that the column of blood, regurgitating from the aorta, impinges, when entering the left ventricle, on the anterior or aortic cusp of the mitral valve and either bulges it inwards, producing temporary narrowing of the mitral orifice at a time during which blood is flowing from the left auricle into the left ventricle, or sets up vibrations in the mitral valve which are audible as a murmur. A presystolic murmur is also occasionally heard in cases of adherent pericardium, especially in children, and in some cases in which dilatation of the left ventricle is all that is found after death.

The mid-diastolic murmur is audible at the apex as a short murmur immediately following the second sound, so that the condition resembles that of reduplicated second sound at the apex. In order to distinguish between a reduplicated second sound and a mid-diastolic murmur, the condition of the second sound at the base of the heart must be examined. If there is no reduplication of the second sound at the base of the heart, where the second sounds are produced, what appears to be a reduplication of the apex must be due to the addition of the abnormal sound or murmur after the second sound. This mid-diastolic murmur is also rather unfortunately called the post-diastolic murmur, the term "post-diastolic" meaning *after the diastolic or second sound*, and not after the whole period of diastole. It might, perhaps, be naturally thought that "post-diastolic" means after the period of diastole, and so was equivalent to systole. But if the term "post-diastolic" is used at all, it means *after the second sound and before the first*, just as the term "post-systolic" means a murmur *after the systolic or first sound*, i.e., a murmur between the first and second sounds, a condition which is sometimes spoken of as reduplicated first sound. A mid-diastolic murmur is very common in mitral stenosis, especially in cases like this one, where the compensation is good. The causation of a mid-diastolic murmur is, I believe, that during diastole the negative pressure which is produced by the expansion of the left ventricle, sucks the blood in through the narrowed orifice and so produces a murmur.

The early diastolic murmur of mitral stenosis replaces the second sound, is audible on the left side of the sternum, is soft in character, and resembles a regurgitant aortic murmur heard in an abnormal position. This murmur, which is the least common of the three diastolic murmurs met with in mitral stenosis, was described, before the presystolic murmur was recognised, by Dr. Hope, who was the first assistant physician appointed (in 1834) at St. George's Hospital. It is therefore called Hope's murmur. It is probably produced as the result of temporary pulmonary regurgitation (Graham Steell), due to over-stretching and dilatation of the pulmonary artery, which prevents

the valve segments, although they may be perfectly healthy, from coming in contact.

From this description of the diastolic murmurs of mitral stenosis, it is obvious that difficulty may arise in deciding (1) whether in a case of aortic reflux a presystolic murmur present points to concomitant mitral stenosis or is only a "Flint's murmur"; and (2) whether in a child with mitral stenosis a soft early diastolic murmur on the left side of the sternum is to be regarded as evidence of some degree of aortic regurgitation or is only "Hope's murmur," due to temporary pulmonary regurgitation. In cases of this kind a decision may only be possible after most careful consideration of all the cardiac signs.

The other modifications of heart sounds, in mitral stenosis, are accentuation or reduplication of the second sound in the pulmonary area. The importance of recognising accentuation in the pulmonary second sound is that it gives a guide to the state of compensation. As long as the compensation, namely, the hypertrophy of the right ventricle, is able to hold its own, the pulmonary second sound is accentuated. When the compensation begins to fail, in other words, when the right ventricle begins to dilate, so that the tricuspid regurgitation follows, the blood-pressure in the pulmonary artery falls, and the second sound, from being greatly accentuated, becomes weak. The first sound of the heart at the apex is generally short and sharp in mitral stenosis; so that in cases where the presystolic murmur and a short first sound are audible, the mistake sometimes arises of regarding the murmur as systolic and the short first sound as being a normal second sound.

Three stages of mitral stenosis are usually described. In the first stage the compensation is perfect and we hear a presystolic murmur, a fairly normal first sound, followed by a second sound at the apex, an accentuated second sound over the pulmonary artery, and a rather feeble second sound over the aortic area. In the first stage of mitral stenosis the patient has few or no symptoms, and the condition may be found accidentally in a patient who comes to the hospital for some other cause. In the second stage of mitral stenosis the compensation is strained, the patient is short of breath on exertion, and prone to get bronchitis. Such a patient attends in the out-patient room, and is not sufficiently ill to be admitted as an in-patient. The physical signs are a presystolic murmur, followed by a short, sharp first sound, but no second sound, at the apex; great accentuation or reduplication of the pulmonary second sound, some dilatation of the right ventricle, as shown by the epigastric pulsation, and increase of cardiac dulness to the right of the sternum. In this stage the mid-diastolic and early diastolic murmurs may alternate with the presystolic murmur, so that at one time a presystolic murmur may be present at another time absent and replaced by one of the other two. In perhaps the great majority of cases of mitral stenosis there is concomitant mitral regurgitation and a systolic murmur is also present, but for simplicity we have dealt with pure mitral stenosis. As Dr. Graham Steell pointed out some years ago, the murmur most often present in cases showing mitral stenosis after death is a systolic apex murmur, which differs from that of uncomplicated mitral regurgitation in not being audible at the inferior angle of the left scapula.

In the third stage of mitral stenosis, or in the stage of ruptured compensation, the signs strictly characteristic of mitral stenosis have disappeared, and the patient is really suffering, not merely from mitral stenosis, but from the effect of that disease—namely, tricuspid regurgitation.

I will make a few remarks only about some of the results and complications. From backward pressure the left auricle becomes dilated, and by pressing on the left bronchus it may give rise to cough, and, as a result of a certain amount of narrowing of the bronchus, to harsher breathing over the left bronchus than over the

right. This sign may often be found, if looked for, in cases of mitral stenosis. Dilatation and stagnation of blood in the left auricle may be followed by clotting of the blood, especially in the auricular appendix. Blood clots so formed are adherent, but they may become detached, and, by passing into the general circulation, give rise to embolism, and so to important complications.

Embolism of the first branch of the aorta—namely, the coronary artery—very seldom occurs in mitral stenosis; when one of the main branches of the coronary artery is blocked in this way sudden death results. Embolism of the middle cerebral artery, by cutting off the blood supply to the brain, gives rise to anæmic softening of the brain, and hemiplegia. The arteries at the base of the brain being badly supported, the impact of an embolus, although the embolus is simple, or non-infective, may be followed by the production of an aneurysm. This production of an aneurysm is analogous to the formation of an aneurysm at the site of ligature, a very rare event. Embolism of the arteries at the base of the brain, occurring in young women, should always be regarded as probably of embolic origin. Embolism of a cerebral artery may be followed by rupture of an aneurysm. So that a patient with mitral stenosis may have one attack of hemiplegia, due to embolism, followed subsequently by a severe epileptiform attack, due to rupture of an aneurysm and extravasation of blood on the surface of the brain. As a rare but interesting incident, embolism of the central artery of the retina, giving rise to loss of vision in the part of the retina affected, may be mentioned.

Embolism occurring in the kidney and spleen gives rise to the production of infarcts; as the organs have end-arteries anæmic necrosis occurs in the area supplied, by the blocked vessels, and absorption of cell-débris from, or possibly microbic activity in, these areas gives rise to elevation of temperature. In the case of the spleen an infarct shows itself clinically by enlargement and tenderness of the organ, with pain on breathing, due to local peritonitis, over the surface of the spleen, thus imitating left-sided pleurisy. In the case of the kidney there may be albumin in the urine, and in rare cases red blood-corpuscles.

Embolism of the mesenteric artery is followed by intestinal obstruction. Embolism of the main arteries of the limbs gives rise to sudden pain, followed by coldness, loss of sensation, and inability to move the limb. As mitral stenosis usually occurs in young subjects whose arteries are healthy, a collateral circulation rapidly develops, and gangrene of the limbs never occurs, as it would do in older subjects, whose rigid arteries are unable to dilate, and so render establishment of an efficient collateral circulation possible. Detachment of a clot formed in the right auricle will produce pulmonary embolism; if one of the main branches of the pulmonary artery be thus occluded, sudden death follows; if a smaller branch be occluded a pulmonary apoplexy or infarct may or may not result. Pulmonary apoplexy is comparatively common in mitral stenosis, and may be brought about as just described; in many instances, however, no embolus can be found, and it appears that the localised extravasation of blood into the air vesicles is due to rupture of one of the dilated, varicose, and atheromatous branches of the pulmonary artery. However produced, it shows itself clinically by hæmoptysis; in fact, hæmoptysis in a patient with mitral stenosis is nearly always due to this cause, and hardly ever to pulmonary tuberculosis. The moist, œdematous condition of the lungs in mitral stenosis seems to prevent the settling down of tubercle bacilli, which are thus removed before they can establish themselves. After hæmoptysis in mitral stenosis pleurisy with effusion is apt to occur. It is important to examine the lungs carefully with this sequence in mind; otherwise increasing dyspnoea may be put down to the heart, on which the observer's attention is exclusively fixed.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The lecture

ORIGINAL PAPERS.

THE PHARMACOLOGICAL ACTIONS AND THERAPEUTICAL USES OF FORMALDEHYDE.

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

Physician to the Westminster Hospital, Lecturer on Medicine and Clinical Medicine; Examiner in the University of Aberdeen.

THIS paper deals not with the whole subject of the pharmacological action and therapeutical uses of formaldehyde, but with certain phases of it which seem for the moment to be of interest. The literature of the subject is extensive, comprising many hundreds of papers, to give a critical review of which would occupy much space.

Formaldehyde (CH_2O) was discovered by Hoffman in 1869, and during the last decade has assumed a prominent place as a therapeutic agent. It is made by the oxidation of methylic alcohol, the process employed being to pass the vapour over red-hot metal or carbon. It is a gas soluble in water, forming a colourless fluid having a peculiar odour and an exceedingly irritating taste. The 40 per cent. solution is commonly employed, and is usually spoken of as formaldehyde. It has an acid reaction due to the presence of formic and acetic acids and a specific gravity 1.070. "Formalin" is a proprietary article having the same composition.

Formaldehyde is a powerful disinfectant, more powerful than carbolic acid and only slightly less active than corrosive sublimate. It is not only a germicide, but destroys the toxins of diphtheria, tetanus and other diseases. It is extensively employed for the disinfection of rooms and for this purpose various forms of portable apparatus have been devised for manufacturing the gas on the spot. It is chiefly a surface disinfectant, and has a limited range of penetration; for example, it will not disinfect closed books. Its vapour is not injurious to fabrics, metals or woods, nor does it discharge any of the ordinary colours with the exception of violet and light red. Though destructive to micro-organisms it is innocuous to the higher forms of life, and will not kill animal parasites.

It is employed commercially as a preservative of fish, meat and other foods. In the case of milk, 1 in 25,000 or 30,000 is commonly used, but added to milk as drawn from the cow, 1 in 75,000 suffices. The quantity must of necessity be small on account of its taste. The addition to cold milk of 1 in 2,000 is readily recognised, and to milk warmed to drinking temperature, 1 in 5,000 imparts a characteristic taste.

Against the use of formaldehyde as a preservative it is urged that it renders food less capable of digestion, but the evidence on this point is far from conclusive. In investigating the subject it is necessary that attention should be paid (1) to the nature of the food; (2) to the amount of formaldehyde added; and (3) to the length of exposure to the action of the preservative. Under the first heading it may be noted that egg and serum albumin are not rendered insoluble by formaldehyde. Under the second heading it may be stated that with respect to fibrin the addition of 1 in 1,000 of formaldehyde lessens its digestive power by about 5 per cent., and of 1 in 2,000 by about 3 per cent., percentages so small as to be of no importance. Under the third heading it is found that formalisation (1 in 100,000) of beef steak for twenty-four hours has practically no retarding action on digestion. Moreover, formaldehyde in 5 per cent. solutions exerts no inhibitive action on pepsin. Tunnicliffe has shown that in healthy children 1 in 5,000 in milk and 1 in 9,000 in total food and drink exert no influence on the nitrogen or fat metabolism or on fat assimilation.

in next week's number will be by Thos. Gelston Atkins, B.A., M.D., M.Ch., Consulting Surgeon to the Cork Maternity, Surgeon to the Cork South Infirmary, and County Hospital, on "The Treatment of Hamaturia of Renal Origin."

Respecting the pharmacological action of formaldehyde comparatively little is known except that it is a local irritant. Paul Rosenberg, of Berlin, has shown that it can be detected in the blood. In his first experiment 0.48 grammes of formaldehyde were given to a rabbit weighing 1,670 grammes. At the expiration of twenty-three hours blood drawn from the carotid artery gave the reactions of the drug. In a second experiment a rabbit weighing 1,600 grammes was given 0.38 grammes at a single dose, and blood drawn from the carotid artery at the expiration of twenty-three hours gave the characteristic action. In a third experiment a rabbit weighing 1,450 grammes was given in the course of fifteen hours 0.76 grammes of formaldehyde. Eight hours after the last dose the blood was examined and was found to contain 0.775 per cent. of formaldehyde. From these experiments it is clear that free formaldehyde exists in the blood after the administration of adequate doses. That it is eliminated with the milk is shown by an experiment by the same observer. A suckling woman was given in divided doses, in less than twenty-four hours, 0.15 grammes of formaldehyde. On testing the milk, its presence was distinctly shown. It is probable that in the blood formaldehyde enters into combination with albuminous bodies, and that a portion is oxidised into formic acid. That it is eliminated by the kidneys is well-known, and Jacobson has found that 27.6 per cent. could be recovered free in the urine and 3.4 per cent. in combination, probably with ammonia. When one recalls the powerful disinfectant action of the drug, the application of this fact in the treatment of cystitis and other conditions associated with alkalinity of the urine is apparent.

Some years ago investigations were carried out by Dr. F. R. Blaxall and myself with the view of determining the action of formaldehyde on the growth of tubercle bacilli and its value clinically in the treatment of phthisis. The laboratory experiments, which lasted over a period of some months, were part of a series, having for their object the investigation of the action of certain essential oils and other volatile substances on the growth of tubercle bacilli. Incidentally it may be remarked that both oil of cinnamon and oil of peppermint had no retarding action, and were for our purpose useless; formaldehyde, on the other hand, proved most satisfactory. The apparatus used for the experiments was arranged as follows:—

A flask (A), containing a 1 in 1,000 solution of perchloride of mercury, was fitted like a wash-bottle—that is, with two pieces of glass tubing bent at right angles. The lower limb, the lower part of which was immersed in the fluid, communicated with the outside air. The shorter limb connected the flask with flask B, containing sterilised distilled water, fitted in the same way and connected by its shorter limb with a small gas washing bottle (C), which held the fluid to be experimented with. This gas-bottle again communicated with an empty sterilised glass bottle (D), and this again with a large sterilised glass jar (E), covered with an air-tight disc perforated with two holes, through which the ingress (opening at the bottom) and egress (opening at the top of the jar) tubes passed. One egress tube passed thence to a wash-bottle containing sterilised distilled water (F), similar to B, and then to a wash-bottle containing a solution of 1, in 1,000 perchloride of mercury (G). The whole of this apparatus was contained in an incubator kept at 37° C. constantly. The egress tube from flask G was connected through a perforator in the incubator with a water-pump. The water-pump being set in motion, air would enter flask A, and be freed of its organisms in passing through the mercury solution, thence pass to flask B, where any possible splittings of the mercury solution would be taken up, and thence to the gas-bottle C. Here the air would become impregnated with the volatile oil or chemical experimented with, and, passing on to the empty flask D, would leave there its superfluous moisture and enter the jar E. The current of air

would then pass through the wash-bottles F and G, and thence to the water-pump. The two flasks F and G were intended to act as a check to the outgoing of the volatile oil in the impregnated air, and also to prevent any return current of air from the water-pump. Any leakage in the apparatus could at once be seen by the cessation of bubbling in one or more of the flasks.

The apparatus was used in this way:—A dozen sterilised tubes, each of blood serum 6 per cent., glycerine agar-agar, and 6 per cent., glycerine beef-broth, were inoculated carefully from a recently-isolated culture on glycerine agar-agar of the B. tuberculosis. Two tubes each of these culture media thus inoculated were at once sealed with paraffin to serve as controls, and these tubes, with eight other tubes of each culture medium, were placed in the sterilised jar E. The remaining two tubes of each medium were capped with india-rubber caps and placed in a distant incubator, to serve as further controls. The aspirating apparatus was then started, the air bubbling through the liquid in the flasks and through the experimental fluid in the gas-bottle D, so that through the jar E circulated a current of air permeated with the vapour of the experimental fluid. The jar E at this time contained eight tubes of each medium inoculated with a pure culture of tubercle bacillus, plugged only with their sterilised cotton-wool plugs, and two tubes of each medium similarly inoculated, but hermetically sealed with paraffin. After twenty-four hours the jar was disconnected, and under a sterilised cover the cotton-wool plugs from the eight tubes of each culture medium were expeditiously removed. The lid of the jar was then carefully resealed, the apparatus connected, and the aspiration restarted, so that now the eight tubes of each medium inoculated with tubercle bacilli were fully exposed to the influence of the experimental fluid. Forty-eight hours from this time the aspiration was stopped, the jar disconnected, and one tube of each culture medium carefully withdrawn under cover, plugged with sterilised cotton-wool, capped and placed in the distant incubator to await growth. The apparatus was then reconnected and the aspiration restarted, and after another forty-eight hours, or ninety-six hours from the start, two tubes of each medium were withdrawn under the same conditions and placed in the distant incubator, and with them those controls that had been hermetically sealed in the jar.

The experiments with formaldehyde were made with a 6 per cent. solution in sterilised distilled water, an ounce of the solution being placed in the gas-bottle, so that the air bubbled freely through it. The results arrived at were as follow:—

- (a) No contaminations occurred in any of the tubes.
- (b) All the controls grew well except in the agar-agar tube sealed with paraffin in the jar; in this case the plug had been forced out and loosened and no growth occurred.
- (c) None of the tubes kept under the influence of formaldehyde vapour for forty hours, for ninety-six hours, or for ten days, showed any growth whatever.
- (d) Sub-cultures were made from several tubes of the solid media, and from all the tubes of fluid media; all of these failed, with the exception of one glycerine beef-broth tube exposed for forty-eight hours, which, re-inoculated on to blood serum, commenced, after three weeks, to grow feebly. This growth, however, did not progress, and sub-cultures made six weeks afterwards entirely failed.

To obviate the possibility of error after re-sterilisation of the apparatus, another experiment was made which, with certain modifications, was a repetition of the previous one. In this instance, no contamination occurred in the tubes. An alteration was made in this experiment. Tubes were removed from the jar after two days' exposure to the formaldehydised air, after four days, after six days, and after ten days. None of these tubes showed any growth up to six weeks from the date of inoculation, but after that date two tubes of 6 per cent. glycerine agar exposed for forty-eight hours commenced to grow; one developed

a very meagre growth, the other a fairly vigorous growth, and both were sub-cultured with success. None of the other tubes showed any signs of development, and sub-cultures from them all failed with the exception of a 6 per cent. glycerine beef-broth tube, which, after exposure for forty-eight hours, was carried on successfully.

From these experiments it is seen that even a weak solution of formaldehyde, such as 6 per cent., exerts a very marked retarding and inhibitive influence on the growth of tubercle bacilli inoculated on to favourable culture media, and that this influence prolonged over forty-eight hours entirely prevents the growth and future development of the bacilli.

In these experiments no attempt was made to estimate the amount of the volatile vapour in any given quantity of the circulating air at any given time. In the case of the formaldehyde experiments, the irritating odour of formaldehyde was most marked in the earlier stages of the aspiration, and diminished as the experiment neared conclusion. The possibility that the formaldehydised air might condense on the under surface of the disc of the jar, and fall into the open test-tubes, was obviated by inverting some of the tubes.

The clinical observations have been carried on intermittently over a period of nearly ten years, most of them in hospital practice, but some in private. Twenty cases were observed with great care, and for a long period of time, and a much larger number occurring in the ordinary routine of work have been less carefully recorded. The 40 per cent. aqueous solution was employed and it was found that patients could inhale a 2.5 solution without inconvenience. No apparatus of any kind was employed, but the drug was simply inhaled continuously from a piece of lint. No set formula was used, and the composition of the solution was varied from time to time in order to suit the exigencies of the case. Glycerine was sometimes added to prevent too rapid evaporation and it was found that oil of cinnamon rendered the vapour less irritating. The treatment was employed both in men and women, and both in early and advanced cases of tuberculous phthisis. Bacteriological examinations of the expectorations were carried out systematically, for without their aid little or no progress can be made. I give no statistics, for I attach little importance to them in a complicated investigation of this kind, but the results were most satisfactory; better, I think, than can be obtained by any other method of treatment.

It is not my intention to give details of cases, but I will mention one of many years' duration.

A man, *æt.* 46, consulted me in November, 1896. His family history was bad, several members of his family having died of phthisis, and one brother of genito-urinary tuberculosis. He had had a cough with expectoration for some months, was rapidly losing flesh, and had profuse night sweats. His evening temperature ranged from 100.5° to 102°. At the left apex in front was bronchial breathing with moist *râles*. The breathing over this region subsequently became cavernous. Specimens of the expectoration were submitted to Dr. Blaxall, who reported: "Both specimens contain tubercle bacilli. The bacilli are very slender and in clumps, and are fairly numerous. I should consider it to be an early case rather fiercely attacked, and should imagine that the prognosis was unfavourable." The patient was placed on the formaldehyde treatment, and had an inhalation almost continuously until the end of February. The expectoration was examined twice a week, but the bacilli, although fewer in number, were always present. The patient's condition speedily improved, the night sweating ceased, he gained in weight, and in March, 1897, was free from cough and expectoration. A corresponding improvement took place in the physical signs in the chest. In February, 1899, another examination of the sputum showed numerous tubercle bacilli, both isolated and in clumps, with streptococci in fair amount and a few staphylococci. The mixed infection was regarded as a favourable sign indicating

that the tubercle bacilli were being ousted. Three months later the report stated that the tubercle bacilli were all in clumps, that there was no isolated bacilli, and that they stained badly and were smaller than usual. This showed that the patient was improving under treatment. During the whole of this time he lived in England and was able to follow an active life. A couple of years later he retired from business and since then has wintered abroad. He has now passed out of my hands, but he is still alive, and continues to enjoy his ill-health. The result, considering the acute onset and the fact that the patient was but little inclined to take care of himself, may be regarded as satisfactory. The case is not put forward as one of cure, but as one in which the patient, although hampered by phthisis and other conditions not conducive to the maintenance of robust health, was for some years enabled to follow his occupation and in due course retire into private life.

I could give details of many other cases in which the formaldehyde treatment has proved of value. Some are of many years' duration, but it must be remembered that when observations are spread over a long period the patient invariably resorts, from time to time, to other modes of treatment, so that many disturbing factors are introduced, some favourable and others prejudicial. It is apt to be forgotten that, however successful a mode of treatment may be, the interval of a decade in the life of a middle-aged man means much and that at the end of that period he is not so robust, physically or mentally, as at its commencement.

I have found the vapour of formaldehyde useful in the treatment of bronchiectasis, and in a case of this description, due to the aspiration of the fang of a tooth in a dental operation, the patient was kept for many days in a small ward impregnated with this substance with manifest advantage.

Formaldehyde, from its pungent odour and taste, is by no means an easy substance to prescribe in a palatable form, and as some difference of opinion exists as to its medicinal dose I have recently made some observations on this point. To a man suffering from genito-urinary tuberculosis I gave 2½ minims of the 40 per cent. solution flavoured with spirit of chloroform and an emulsion of oil of cinnamon. This was administered in a wineglass of water and produced no inconvenience. The dose, after two days, was increased to 5, then to 7½, and finally to 10 minims. The last dose produced a certain amount of local irritation in the oesophagus, and was followed by the frequent passage of flatus. When, however, the dose was increased to 12½ minims the patient suffered from nausea and vomiting, and the administration of the drug was stopped. The same patient was given an injection into the bladder of a ¼ per cent. dilution of the 40 per cent. solution mixed with a ½ per cent. solution of cocaine. The quantity introduced was about 4 ounces, warmed to the temperature of the body. It gave rise to a considerable amount of pain and discomfort which, however, was speedily relieved by copious irrigation with boracic acid. Subsequently the injection was decreased to ¼ per cent. of the 40 per cent. solution, with the addition of a larger proportion of cocaine, but this, too, gave rise to pain. The attempt to relieve the patient of his sufferings was justifiable, for he had been treated previously, without benefit, with tuberculin, guided by frequent observations on his opsonic index.

A woman, *æt.* 28, who had been operated on for empyema, was given a single dose of 10 minims of the 40 per cent. solution, flavoured as before, immediately after a meal. There was no nausea, but in three minutes the contents of the stomach were evacuated. Another woman, suffering from bronchiectasis, was given 5 minim doses three times a day. After the first dose she complained of nausea which increased with each subsequent dose. There was no vomiting, but after the sixth dose the administration of the drug was stopped.

From these observations, it may be concluded that

the maximum medicinal dose of the 40 per cent. solution is about 10 minims.

Formaldehyde is usually said to be destitute of toxic action and it is certainly not an active poison. A man who took $\frac{1}{2}$ oz. of the 40 per cent. solution recovered; in addition to the signs of local irritation, the lips and extremities were cyanosed, no urine was passed for twenty-four hours, and the specimen first voided contained albumin but neither blood nor sugar. In the case of a man who swallowed a teaspoonful of the 40 per cent. solution, the symptoms were less severe, but he was collapsed, and no urine was passed for nineteen hours, that subsequently voided contained formic acid for two days, but neither albumin nor sugar. In another case, in which a man took a teaspoonful of the 40 per cent. solution, the symptoms were relieved by the administration of liquor ammoniac acetatis. The only recorded fatal case is that of a man who took from two to three ounces of a 4 per cent. solution, death ensuing in thirty-four hours. This would give the fatal minimum dose at somewhere between 0.66 and 2.4 drachms.

It will be well to compare this with the amount of formaldehyde contained in the dietary of a patient fed on formalised milk. In typhoid and other acute specific diseases the usual allowance is 3 pints in the twenty-four hours, that is, 480 drachms or 28,000 minims. Taking the proportion of formaldehyde at its highest, 1 in 25,000, this gives only about 1.1 minims, which is far removed from the range of toxic action. Even if the patient took ten pints of milk a day, there would still be no danger.

Formaldehyde is easily converted into a polymeric solid modification, and combines readily with starch, dextrin, sugar, menthol and all terpenes. Paraform or trioxymethylene is a colourless crystalline powder which when heated readily gives off formaldehyde. In Germany a preparation known as Formamint is largely employed and is favourably spoken of by Zwilling, Rosenberg, and others. It is a combination of formaldehyde with thymol and lactose, the former predominating. Each gramme contains 0.01 grammes of formaldehyde. I prescribe it in the form of lozenges or tablets flavoured with citric acid, and find that they are useful in pyorrhæa alveolaris and a most valuable remedy for flatulence, whether due to atonic dyspepsia or dilation of the stomach, the result of pyloric obstruction. From their local antiseptic action they have been used with benefit in tonsillitis and the sore-throat of scarlet fever and diphtheria.

Formaldehyde has a wide range of usefulness, and will be found a valued addition to our list of active remedial agents.

A NOTE UPON SOME UNUSUAL FORMS OF MIGRAINE IN CHILDREN.

By SYDNEY STEPHENSON, F.R.C.S.,

Ophthalmic Surgeon to the Kensington General Hospital, the Evelina Hospital, and the North-Eastern Hospital for Children, London.

It would be a truism to say that many, perhaps most, of the headaches of children belong to the migrainous type. That fact, of course, is known to every medical man who has much to do with children. It is, I suppose, equally well recognised that juvenile migraine offers certain peculiarities, as examples of which one need merely mention the common bilaterality of the headaches, the marked tendency to periodicity, the relative frequency of tinnitus as a sensory manifestation, and the comparative rarity of premonitory hemianopsia or teichopsia. In fact, like some other diseases, migraine, as it occurs in childhood and in later life, offers several points of contrast, two or three of which it is the purpose of the present paper to

illustrate with cases drawn from my practice. I can entertain no doubt that these forms of migraine, although perhaps uncommon, are perfectly familiar to most physicians, so that I wish to disclaim the least originality for my subsequent remarks. I do not purpose to touch upon that peculiar condition in children which has been described (somewhat unfortunately) as "hemianopsia with third nerve paralysis," the *migraine ophthalmoplégique* of Charcot, since such cases have an entirely different pathology from the vaso-motor cortical changes believed to lie at the root of ordinary migraine. (a) In all the cases examined after death of this rare and curious affection, organic changes—as tumour or tuberculous or inflammatory exudation—have been found to involve the third nerve itself at the base of the brain (see A. W. Stirling, *Archives of Ophthalmology*, July, 1905).

The particular cases to be described may be grouped under three heads as follows:—(I) migraine preceded, accompanied, or followed by temporary aphasia; (II) migraine replaced by bouts of vomiting; and (III) migraine associated with alterations of sensation or disturbances of mobility in the upper or the lower extremities.

(I.)—*Migraine preceded, accompanied, or followed by temporary aphasia.*

CASE No. 1.—George D., a neuropathic lad of 10 years, was brought to me in December, 1900, because he was backward in reading and complained of "colours" before his eyes. There was a family history of migraine preceded by hemianopsia, on his mother's side. The relative visual acuity was R. $\frac{6}{12}$; L. $\frac{6}{12}$. Under atropine, the refraction was found to be R.V. = $\frac{6}{18} + \frac{0.5}{+ 0.25 \text{ 180}^\circ}$ $\frac{6}{6}$; L.V. = $\frac{6}{12} + \frac{0.75}{+ 0.25 \text{ 180}^\circ}$ $\frac{6}{6}$. The external muscular balance was perfect ("orthophoria"). According to the history given, the lad had suffered from three attacks of migraine, the first of which occurred some two months before he was brought to me. Each bout began with an alteration in speech and numbness in the right arm, and was followed by persistent vomiting. The boy, it may be noted, was right-handed. Glasses were ordered for constant use, and it is gratifying to report that the migraine soon became a thing of the past.

CASE No. 2.—Gertrude S., æt. 12, had been subject to attacks of migraine for three years. They occurred about once a month, and were induced by excessive use of the eyes upon near objects. There was a marked history of migraine, with hemianopsia, on both sides of the family. The attacks in this child began with tinnitus and vomiting and "colours" before the eyes, and during the time they lasted (usually the entire day) the child either refused to speak at all, and became very irritable if pressed to do so, or if she attempted to speak jumbled her words together. Orthophoria. Vision two-thirds normal. Under atropine, R.V. = $\frac{6}{60} + \frac{1.5 \text{ Sph.}}{+ 0.5 \text{ Cyl. } 90^\circ}$ $\frac{6}{6}$; L.V. ditto. Constant use of glasses almost fully correcting the compound hypermetropic astigmatism that was present, reduced the number and severity of the headaches, and at the same time relieved the aphasia.

(a) Although the third is the most commonly attacked, yet other cranial nerves, as the 4th, 5th, 6th, and 7th, may be affected.

CASE No. 3.—Alan P., æt. 8, was seen in October, 1905, with the following history:—for the last two years the lad had been subject to violent headaches, occurring on the average, once in two weeks, and generally lasting twenty to twenty-four hours. The attacks terminated in an access of vomiting, and for several hours thereafter the boy could scarcely speak and tended to call common things by their wrong names. The correction by spectacles of the small amount of hypermetropic astigmatism ($+0.25$ D. Cyl. axis 180°) that existed in this patient was without effect upon the migraine.

(II.)—*Migraine replaced by bouts of vomiting.*

CASE No. 4.—Samuel H., t. 8, was brought to the Eye Department of the North-Eastern Hospital for Children on March 15, 1906, with the statement that since he was two years of age he had been subject every fortnight or so to fits of violent and prolonged vomiting. These attacks generally came on at 5 or 6 o'clock a.m., and lasted as a rule the entire day, although on occasion they had been known to persist for as long as three days. The emesis took place independently of food, and the vomited matters consisted mainly of "frothy white water." Upon close inquiry, the lad himself stated that now and then the vomiting was preceded by headache, although usually the former occurred alone. Samuel H. was one of seven children, of whom six survived. None of the others were affected in a similar way, but it is significant that two of them wore spectacles. His mother, maternal grandfather, and a maternal aunt suffered from so-called "sick-headache." Vision was equal to one-half normal. Under atropine, R.V. = $5/60$ $\frac{+5.0 \text{ Sph.}}{+1.0 \text{ Cyl. } 90^\circ}$ $5/9$; L.V.

= $5/60$ $\frac{+5.0}{+2.0}$ 90° $5/12$. The sight could not be brought above this point, even when a pin-hole diaphragm was placed in front of the optical correction. The media of the eye were clear. There was well-marked "pseudo-neuritis"—that is to say, the nasal edge of each optic disc was imperfectly defined, and could not be rendered sharp with any glass. This condition, as I have pointed out elsewhere (*Reports of the Society for the Study of Disease in Children, Vol. III., 1903, p. 342*), is common among children. Thus it was present in as many as 26 (22.80%) of 114 children whom I examined ophthalmoscopically when investigating the condition a few years ago. In the present patient it might excusably have led to an error in diagnosis unless one were familiar with this ophthalmoscopic appearance. The combination of persistent vomiting and blurred optic discs would, under the circumstances, have been suggestive of some intra-cranial mischief.

In Cases Nos. 4, 5, and 6, of which I do not purpose to give details, headaches formed an insignificant feature of the migraine, while vomiting was the symptom that led to the patients, all children between the ages of 10 and 14 years, to seek medical advice.

(III.)—*Migraine associated with alterations of sensation or disturbances of mobility in the upper or the lower extremities.*

The first case quoted in this paper furnishes an instance of alterations in sensibility under the guise of numbness in the right arm, ushering in an attack of migraine. The next case, No. 7, is an example of disturbance of mobility following

migraine. The facts are as follow:—Harriet T., æt. 17, came under my notice early in March, 1906, on account of headaches severe enough to incapacitate her temporarily from her work, that of a domestic servant. The headaches had commenced when she was six years of age, and even then were severe enough to cause her to be dismissed from school when they came on. They could be induced by reading or by straining the eyes in any way. The patient belonged to a large family (six brothers and five sisters), none of the other members of which suffered from frequent or severe headaches. Her mother, however, was affected with "sick headache." Harriet T.'s headaches began with mistiness of the sight, followed by pain in the left side of the brow, and by retching and vomiting. The headache, as a rule, lasted for two days. It was invariably followed by marked twitching in the left arm and slight twitching in the corresponding leg, lasting for about a day. No alterations in speech had been noted. The patient was affected with a considerable degree of compound hypermetropic astigmatism ($+5.0$ Sph.

$\frac{+2.0 \text{ Cyl., axis } 60^\circ}{+2.0 \text{ Cyl., axis } 60^\circ}$) the correction of which by glasses brought sight to about two-thirds normal. The constant use of suitable spectacles gave a considerable amount of relief to the hemicrania. It should be noted, finally, that this patient had suffered from rheumatic fever and chorea about a year before she fell under my notice.

Remarks.—If we accept the current views as to the causation of migraine we shall experience little difficulty in understanding the several types of the affection described in this paper. Vasomotor changes of the cerebral cortex or of the meninges of the occipital region are commonly believed to be the immediate cause of the visual manifestations of migraine. These can readily spread over to, or for that matter originate in, the cortical areas concerned with speech or hearing, or with movements of the arm and leg. Gonzalez (*Annales de Ophthalmologie, July, 1905*) has recently published two cases of migraine, each associated with aphasia only when the hemicrania was left-sided. When the pain was on the right side of the head, there was no aphasia. The first case mentioned in this paper, which was observed in a right-handed boy, was associated with aphasia and numbness in the right arm. Unfortunately, my notes do not make it quite clear whether the pain was in the left side of the head.

A similar train of reasoning would explain the sensory changes occasionally met with in migraine. With regard to vertigo as an accompaniment of migraine, that may be explained by assuming that the nerve storm has assailed the cortical centre of hearing in the temporal region. I may take this opportunity of stating that I have met with a few cases in which severe vertigo, not associated with any particular headache, or with organic disease, occurred in children, under such circumstances as to lead me to suspect that it was nothing more or less than a manifestation of migraine. I only regret that I am not in a position at this moment to give precise details of the cases.

THE King of Italy has conferred upon Mr. Guy Francis Laking, M.V.O., the Royal Order of the Crown of Italy, and the consent of his Majesty King Edward has been given to accept and wear the same.

CLINICAL RECORDS.

CARCINOMA CUTIS, WITH NOTES OF TWO CASES.*

By C. M. O'BRIEN, M.D., L.R.C.P.,

Physician to the City Hospital for Diseases of the Skin and Cancer, Dublin.

BELIEVING the subject of carcinoma cutis to be of equal interest to the surgeon and physician, I am induced to bring forward the two following cases:

CASE I.—A woman, æt. 39, married, no family, was admitted to Skin Hospital on June 4th, 1904, complaining of slight soreness of right breast with stabbing pains. Personal history.—The patient stated she always enjoyed excellent health until about a month previously, when her attention was directed to the right breast, which appeared fuller and heavier than normal, with darting pains occasionally. The pains were often relieved by pressing the breast with her hands. A fortnight before her admission to hospital she presented herself at one of the city hospitals, where the visiting surgeon and his colleagues, after examining her, declined to operate.

On admission to Skin Hospital, on June 4th, 1904, the skin over the right breast, to the extent of two square inches, including the nipple and areola, was thickened, dry, leathery, and of a darkish green colour. On manipulating, it was found adherent to the gland, but the breast moved freely over the underlying ribs, the glands in the axilla were not perceptibly enlarged. The left breast was perfectly normal. In the hope of mitigating her suffering, which was daily becoming more pronounced, she got ten minutes exposure to the X-rays four times weekly; and although the pain almost entirely subsided, nevertheless the disease continued to spread so rapidly that in a month after her admission almost the entire skin over gland was involved. A fortnight later the skin over upper surface of left breast, to the extent of a five-shilling piece, was attacked, first assuming a pale, glassy appearance, somewhat thickened and strongly suggesting scleroderma, but afterwards changing to a dark green. The gland and superficial tissues of the left breast were in the early stages quite free, later becoming involved, forming a rigid casing continuous with that of the opposite side, giving rise to laboured breathing, pallor, and very progressive weakness, the patient describing her hapless condition as if her chest were pressed in a vice. She left hospital on August 27th, after a stay of about ten weeks, the disease by this time having spread to the right axilla and skin over inferior angle of scapula, forming a complete casing for right side of chest, front and back, on auscultating over which greatly diminished breath sounds were perceptible. The heart and internal organs generally were healthy, no family history of cancer. She died in extreme agony on December 4th, 1904. There was no *post-mortem*.

CASE II.—Mr. R., æt. 53, unmarried, managing director of a large flour mill and bakery. Consulted me in January, 1904, for a patch of roughness found right nipple, which had persisted for nearly eighteen months, notwithstanding his having applied various ointments and later tincture of iodine, thinking he was suffering from ring-worm which affection he contracted as a boy. There was slight discharge, but no actual pain.

On examination in January, 1904, the right nipple, although not perceptibly retracted, was covered with branny scales, as was also the areola, the base of the nipple was slightly fissured and presented some oozing, and there was considerable pain on manipulating it. The treatment for eczema was prescribed and carried out. I next saw him early in February, but could not detect any marked change. Between February and July I saw him twice, I again saw him in October, when he

complained of its becoming itchy, and of its having bled slightly, the fissure of nipple before referred to had by this time extended to areola, the patch had increased in size, redness had become more pronounced, especially at circumference, while, towards the centre, there was oozing, with a sodden condition of epithelium. Some of the adherent scales were now removed, by forceps, and placed under microscope in a 40 per cent. solution of caustic potash with negative results. The fissures were now touched with nitrate of silver stick, while the usual remedies for eczema were further persisted in. I saw him again in January and July, 1905, there was more oozing, the eroded patch was studded here and there with bright red spots, which bled freely on being touched, the margin though well defined was not raised, the nipple was not retracted. He consulted me again last month, when the sore presented pretty much the same characteristics as those mentioned as having been present in July. Careful examination on each occasion could elicit no tumour in breast nor involvement of glands in axilla. There was no history of cancer, or psoriasis, in family. The patient never had specific disease.

CONCLUDING REMARKS.

CASE I.—*Cancer en Cuirasse*.—This case interested me because of (a) the age, which was much below the average at which recorded cases of this nature occur; (b) the non-involvement of the lymphatics, as evidenced by the absence of œdema of the upper extremities; (c) the absence of ulceration throughout; (d) the slowness with which it caused fatal results.

CASE II.—*Paget's Disease*.—My case as above recorded may admit of discussion, because the positive exclusion of chronic eczema being difficult in this, as in all such cases at an early stage. Possibly its presence in the male may lead to some increased facilities of controversy, and even excite in the minds of others opinions perhaps unfavourable to, or suspicious of, the diagnosis, even though in the literature of the affection—from 1874, when first described by Sir James Paget, down to the present—nothing can be discovered to explain why it should not occur in the breast of a male.

I have based my diagnosis on the age of patient, the short limitation of patch, with its red raw granulating appearance, coupled with the fact that for nearly two years it has failed to yield to almost every well-known remedy for eczema; whether subsequent events in its history confirm or disprove that diagnosis I am not prepared to say, but, for the sake of humanity, I shall hope for and welcome the latter.

Apròpos of this, my friend Professor Gaucher, of Paris, recently showed me a case "Maladie de Paget," under his care at the Saint Louis Hospital, which I consider a parallel one to mine, excepting perhaps that his was slightly more advanced and occurring in the female.

THE OUT-PATIENTS' ROOM.

WESTMINSTER HOSPITAL.

The Differential Diagnosis of Tabes and Peripheral Neuritis.

By PURVES STEWART, M.D., M.R.C.P.

AMONG the out-patients on February 19th were two men, both of whom complained of difficulty in walking, obscure pains in the legs, and in both patients the knee-jerks were absent. The clinical facts were as follow:—

The first patient, an insurance agent, æt. 60, complained of aching pains in the legs, of some ten years' duration; the pains were aggravated by exertion, and when the patient walked he found himself very unsteady. The previous history was unimportant; he denied venereal disease and stated that he was temperate in alcohol. On examination, his pupils and cranial nerves were normal, there was no cutaneous anæsthesia of the trunk or limbs; there was no muscu-

* Read before the Medical Section, Royal Academy of Medicine, Ireland.

lar wasting or tenderness, and beyond a slight feebleness in the gait, the motor functions were normal. There was no sphincter trouble. The supinator-jerks knee-jerks and ankle-jerks were absent.

The other patient, a labourer, æt. 44, complained of some unsteadiness of walking of about six years' duration, precipitancy of micturition and occasional shooting pains in the leg. Nine years previously he had a venereal sore which was treated for five weeks, but was not succeeded by any cutaneous rash, or sore throat. On examination, the patient's pupils, although not circular, reacted normally to light, and on accommodation; his cranial nerves were otherwise normal. There was no cutaneous anæsthesia, his gait was practically normal, he did not sway with his eyes closed and his feet together. The right supinator-jerk was present, the left absent; the knee-jerks and ankle-jerks were both absent.

These two cases presented several points of resemblance. In both of them there were pains in the legs, both complained of some unsteadiness in walking, and in both the deep reflexes were absent in the lower limbs. In one case, however, there was some sphincter trouble, whilst in the other the bladder was normal; moreover, the irregularity of the pupils in the one case suggested the probability that the venereal sore had really been syphilitic. The two most likely diseases which fell under consideration, Dr. Stewart pointed out, were tabes and peripheral neuritis, and the diagnosis between the two might be a matter of dispute; fortunately, however, the physician nowadays possesses a means of distinguishing between the two without possibility of error: this being accomplished by examination of the cerebro-spinal fluid. Normal cerebro-spinal fluid, Dr. Stewart said, even after prolonged centrifuging, contains practically no cellular elements beyond an occasional endothelial plate and perhaps one, or at most two, lymphocytes in a field of 400 diameters, but in tabes there is constantly present from the earliest stage of the disease an enormous excess of lymphocytes. In a recent series of twenty-five cases of tabes Dr. Stewart had found an average of 130 lymphocytes to the field, the lowest count being 46, and the highest over 300. In peripheral neuritis, on the other hand, the cerebro-spinal fluid is normal. Dr. Stewart therefore performed lumbar puncture on both of these patients. In the first case the fluid was normal; tabes could therefore be confidently excluded. In the second patient, on the other hand, there were no fewer than 177 lymphocytes to the field, the diagnosis of tabes was therefore established. It was no longer necessary to wait for the appearance of all the classical symptoms, such as Argyll-Robertson pupils, ataxic gait, &c., in order to diagnose tabes dorsalis, inasmuch as examination of the cerebro-spinal fluid enabled the physician to recognise the disease in its incipient stage. The prognosis in these two cases was, of course, entirely different; tabetic degeneration being from its nature incurable, whilst the peripheral neuritis, with massage, electrical treatment and the administration of strychnine, would probably recover completely.

OPERATING THEATRES.

NORTH-WEST LONDON HOSPITAL.

TWO CASES OF RETURN OF CANCER IN REMOTE PARTS AFTER A LAPSE OF YEARS.—*First Case.*—Mr. MAYO COLLIER operated on a case of obstruction of the upper part of the rectum due to malignant disease appearing five years after a posterior gastro-enterotomy for malignant disease of the pylorus. The patient, a man, æt. 48, consulted Mr. Collier some five years ago for vomiting, general discomfort after meals, and much wasting. The case was fully reported in the *Lancet*, and at the time some doubt was expressed in the annual review of the *Lancet*, as well as by the well-known authority, Mr. Moynihan, as to

the nature of the obstruction, from the fact that on examination some twelve months after operation the growth had almost entirely disappeared, and from the fact that the patient had increased in weight from nine to fourteen stone. At the original operation in 1901 Mr. Collier had the advantage of the assistance of the well-known surgeon and pathologist, Mr. Jackson Clarke, who expressed an opinion that the growth was undoubtedly malignant; the truth of this opinion and the fallacy of the criticisms as expressed in the *Lancet* and elsewhere were fully borne out by the fact that an extension of the malignant growth of the pylorus to the abdominal wall in site of the operation wound took place some eighteen months ago; the whole time, however, the short circuit has remained efficient and has fully performed its functions, and the man has enjoyed a fair measure of health and strength. The present condition dated from just before Christmas, when the patient complained of great distension and discomfort in the lower left pelvic region and great difficulty in getting the bowels open. The fact that obstruction in the upper part of the rectum was present was apparent by the swollen and markedly clear outline of the sigmoid flexure. The patient being anxious to attend to his duties as a blacksmith as long as possible, postponed the proffered offer of admission into the hospital until absolutely forced to seek relief. On admission, the patient's general condition was fair, although he was very much thinner than when at his best. The malignant growth in the wall of the epigastrium had scarcely, if anything, increased, and the amount of sickness associated with the obstructed rectum was inconsiderable, always being satisfactorily relieved by daily enemata; the abdomen was somewhat distended, tympanitic, and showed clearly the outline of the distended and active sigmoid flexure. On examination per rectum a mass as large as half a cocoa-nut could be felt in the anterior wall of the rectum high up, and extending into the left iliac fossa; the lumen of the bowel was now narrowed and admitted only the tip of the index finger. Mr. Collier said that in this case there was only one course to pursue, and that was to open the bowel above the obstruction. The question as to where the bowel should be opened was, he thought, a matter for urgent consideration; he feared that left inguinal colotomy would be associated with much difficulty, as the disease had apparently extended into the first part of the sigmoid flexure and the walls of this intestine would probably be affected for some distance. A lumbar colotomy was not a desirable procedure, for the patient would have to rely to a large extent on himself for assistance in dressing the new outlet for his evacuations. Transverse colotomy was quite put out of court by the extensive invasion of the abdominal walls in the epigastric region. A right inguinal colotomy would probably finish the patient off earlier than if no operation were performed. Mr. Collier opened the abdominal cavity on the left side by an incision parallel to the upper part of Poupert's ligament, midway between the iliac spine and the outer edge of the rectus abdominis muscle in a line with the umbilicus. On reaching the peritoneal cavity some stained fluid exuded, and the colon was at once found immediately below the incision. Mr. Collier's worst fears were realised, for the whole colon within reach was not only invaded by growth, but was held firmly within the abdominal cavity. The only course to pursue now was to extend the incision upwards and outwards to the left, and to endeavour to find a portion of healthy bowel that could be brought

out of the wound. With the able assistance of Mr. Templeton this was achieved with some considerable difficulty. The bowel was stitched to the abdominal wall in the usual manner, and the patient returned to bed. Mr. Collier said that he had no fear in stating that this was an unusual and very instructive case, not only from the length of time that the original affection of the pylorus must have existed, but from the unusual position of the secondary growth, and from the unusual fact that a re-infection had taken place in a remote part. This case, he considered, was also extremely encouraging in showing the excellent effect that prompt gastro-enterostomy has in cases of pyloric obstruction, if done sufficiently early, in apparently arresting the headlong course of the cancer growth and restoring the health and vigour of the patient for a considerable period of time. In this case, he said, the original operation had secured comparative immunity from the condition of things that pertained at the first operation. Even now if the rectum were not obstructed, the patient would have a fair prospect of enjoying a further period of health and activity.

Case 2.—Mr. Collier operated on another case which he said was to some extent on all fours with the main points of the preceding one. The patient, *æt.* 64, had presented himself at the hospital some four years ago complaining of soreness on the upper surface of the front part of the tongue; this condition had existed some eighteen months and was not abated by previous treatment. On examination, the tongue was found to present several raw patches on the left border and upper surface and two well-marked plaques were present near the median raphe; there was no history of syphilis, but the patient had complained off and on for the last few years of rheumatic pains in various parts of the body, and was of a gouty and rheumatic temperament. Mr. Collier advised that no further time should be lost, but that the anterior half of the tongue be removed. The patient would not consent to this, but agreed that the plaques should be removed so as to leave him a thoroughly useful tongue. A large oval piece was excised from the centre of the tongue well down to the muscles; this on examination was found to be commencing epithelioma. The patient was warned to keep himself well under observation by attending once a month for examination of the tongue and surroundings. Twelve months afterwards some suspicious thickening was evident in the fore part of the tongue near the tip; no glands could be felt in either submaxillary region or in the floor of the mouth. Mr. Collier again urged that the whole of the tongue should be removed, as well as the glands in both submaxillary regions. To this the patient would not consent. A less extensive operation was performed by removing the whole body of the tongue, but leaving two side flaps near the base, so that when these were brought together a small but useful stump would be left. This operation was performed, and the patient made a rapid and complete recovery. The man had been kept under observation for the last three years, and no recurrence had taken place in the tongue or neighbourhood. Some six months ago the patient sought treatment elsewhere for a crop of warts on the prepuce and glans penis; these warts, when first seen by Mr. Collier, were apparently such as one often sees as the result of want of cleanliness in hospital cases; the foreskin was studded by a number of flat, discrete patches, and the whole of the surface of the glans was red and excoriated, apparently from

the secretion from the prepuce. The free use of soap and water with the subsequent application of nitric acid to each individual wart was for a time sufficient to greatly improve matters. Healing of the prepuce took place, and the majority of the warts disappeared. Subsequent applications of nitric acid were required but it was found that successive crops of warts appeared, not only on the foreskin, but also on the glans penis and in the sulcus of the corona. No glands could be felt at this period in either groin. Mr. Collier urged that, considering the patient's age and the previous condition of his tongue, no time should be lost in removing the whole penis. The man was adverse to this procedure and was lost sight of for several weeks. On lately presenting himself again at the hospital, a condition of things was present that could leave no doubt as to the propriety of the previous advice. The glans penis, as well as the prepuce, was now a fungating mass of granulations; the body of the glans was distinctly hard, and there was a large gland in the right inguinal region. The patient now consented to operation, and Mr. Collier removed the penis close up to the pubes by the usual flap operation. The gland in the groin was also removed. Here, again, Mr. Collier said the interest of the case centred on the fact that the original malignant disease of the tongue after the second operation had become more or less quiescent, and that a recurrence had taken place in a remote organ far from the original site of the trouble, and in no lymphatic connection with the original growth. The same question, he remarked, presented itself: Is this a recurrence or a re-infection?

The Sale of Poisons.

THE Earl of Crewe's Poisons and Pharmacy Bill was issued as amended in Committee immediately before the adjournment of the House for the Easter recess. An important clause restricts the sale of sulphuric acid, nitric acid, hydrochloric acid, soluble salts of oxalic and similar poisons, without, however, limiting the class of persons by whom such poisons may be sold.

Trinity College, Dublin.

THE following candidates passed the final examination in medicine during Hilary term, 1906:—Midwifery.—Ralph S. Oldham, John Du P. Langrishe, Francis O'B. Ellison, passed on High Marks; William Hutcheson, Ernest D. Caddell, Thomas D. Graham, Thomas King Edwards, Henry D. Drennan, Michael P. Leahy, Alfred C. Elliott, Ernest C. Phelan, Reginald Holmes, Dudley F. Torrens, John Gray, Francis Casement.

Dublin Hospital Sunday Fund.

THE annual meeting in connection with the Dublin Hospital Sunday Fund was held on the 9th inst., when the reports of the Council and Committee were submitted. The former stated that collections for the fund were made on November 12th, 1905, in 274 places of worship. The "Hospital Sunday Fund Football Match," instituted by Mr. R. M. Peter, in 1878, took place on Saturday, January 6th, 1906, and yielded the sum of £27 3s. for the benefit of the Fund. The amount contributed to the Fund for 1905 was £3,765 1s. 11d. (which includes a generous donation of £100 from R. P.) being a decrease of £112 2s. 7d. as compared with 1904. The awards to the various hospitals amounted to £3,600, and were distributed as follows:—Sir Patrick Dun's £295 16s. 1d.; Royal City of Dublin, £469 0s. 6d.; Stevens', £140 14s. 10d.; Meath, £402 0s. 6d.; Mercer's, £251 17s. 3d.; Drumcondra, £45 12s. 6d.; Coombe, £95 16s. 3d.; Rotunda, £167 8s. 4d.; Royal Victoria Eye and Ear Hospital, £377 16s. 9d.; Convalescent Home (Stillorgan), £195 3s. 11d.; Cork Street, £161 17s. 7d.; Adelaide, £502 11s. 8d.; Monkstown, £139 14s. 4d.; Orthopædic, £191 19s. 5d.; National Children's £198 10s. 1d.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF SURGERY.

MEETING HELD FRIDAY, MARCH 23RD, 1906.

The President, SIR ARTHUR CHANCE, P.R.C.S.I.,
in the Chair.

TREATMENT OF ACUTE PERITONITIS.

MR. EDWARD H. TAYLOR read a paper on the above. After some introductory remarks concerning certain clinical and pathological types of acute peritonitis Mr. Taylor laid emphasis upon the importance of accurate diagnosis of the starting point of the infection. He discountenanced the administration of morphia before a diagnosis had been made, owing to the way in which it masked symptoms. Mr. Taylor then discussed the principal indications for prompt surgical intervention and the points upon which reliance should be placed in arriving at a conclusion as to the necessity or advisability of operation. In connection with the operation itself, he strongly advocated general anaesthesia, but recommended that it should not be unduly pressed. Local anaesthesia might suffice if it were desired merely to evacuate an encapsuled collection of pus or establish a faecal fistula. The conditions likely to be encountered on opening the abdomen were then briefly alluded to and their significance explained. The exact means which should be employed for removing the peritoneal exudate—viz., dry mopping or flushing—were considered in detail, and their advantages as well as their drawbacks pointed out. In conclusion, he reviewed the subject of peritoneal drainage—viz., the best means for ensuring it, and the difficulties which had to be encountered. He regarded drainage of the general peritoneal cavity as practically impossible owing to the rapidity with which drains of all kinds were encapsuled. When acute peritonitis had reached an advanced stage, the abdomen being greatly distended, the extremities cold and livid, the heart's action weak, and the pulse very frequent and feeble, it was doubtful if operative measures could hold out much hope. Abstention from operation in such cases would probably afford evidence of a wise discretion. If intestinal paralysis were impending the caecum might, with advantage, be opened and drained (typhlotomy). Incision and evacuation of the small intestine (enterotomy) or drainage by one or more apertures (enterostomy) too often proved disappointing measures.

The PRESIDENT regarded the administration of morphia in peritonitis cases, as a rule, unwise; it might, however, be useful before operation. Flushing of the peritoneum tended to revive the patient and stimulate the peristaltic action of the intestine. He was inclined to sanction operative measures even in desperate cases, as they alone appeared to offer any prospect of recovery. He related the clinical history of a patient under his own care in whom recovery followed operation, although everything pointed at first to a speedily fatal issue.

MR. R. CHARLES B. MAUNSELL considered morphia before operation harmful, as it tended to cause flaccid distension of the intestines. His own practice was to mop out and dry the peritoneum with gauze, and drain in cases of diffuse (not generalised) peritonitis. He did not flush under such conditions. He described the method which he usually carried out when flushing was indicated. Two openings were necessary, one above and the other below the umbilicus in the hypogastrium.

DR. GOULDING was not strongly opposed to the use of morphia, he regarded it of enormous value in relieving pain. He was in favour of flushing as a means of cleansing the peritoneum.

VOLVULUS OF THE CAECUM TREATED BY REDUCTION AND APPENDICOSTOMY.

MR. R. CHARLES B. MAUNSELL read a paper on the above. The appendix was used as a means of fixation and drainage. Mr. Maunsell advocated closure of the appendicostomy opening by excision or invagination of the mucous lining leaving the muscular portion of the stump to cicatrise. He did not consider it necessary to formally excise the stump from the caecum. The indications for the operation were then briefly enumerated, and attention was drawn to its obvious use as a means of combating ileus in peritonitis.

The communication was discussed by Mr. Wheeler and Mr. Edward H. Taylor.

GLASGOW MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD FRIDAY, APRIL 6TH, 1906.

The President, DR. LINDSAY STEVEN, in the Chair.

OPERATION FOR ASCITES.

DR. A. N. MCGREGOR read notes of a case, in which he had operated, for Dr. T. K. MONRO, for troublesome ascites, by stitching the omentum to the parietal layer of the peritoneum. The patient was shown at the meeting, and although it was seven months ago since the operation was done there was no ascites present. The lower border of the liver was practically in its usual position. The cause of the ascites was found, on inspection of the liver at the operation, to be cirrhosis of the liver. The symptoms generally pointed to interference with the portal circulation and back pressure. One remarkable feature of this case was that the man was strictly temperate in his habits, only taking a bottle of beer daily with his supper.

CASE OF SYRINGOMYELIA.

In the absence of Dr. T. K. MONRO, DR. JOHN FINDLAY showed a man who had for several years been suffering from that comparatively rare disease—syringomyelia. The muscles of the right hand and arm were wasted, and the anaesthetic area was pronounced over the right arm and right lateral half of chest and neck, skirting the face at the lower border of the lower jaw. Scoliosis, inequality of the pupils, ankle clonus, and wasting of the muscles of the right leg were also demonstrated.

DR. HUGH MCLAREN showed a number of sections of the cord at different levels, which exhibited the pathological appearances in a case of syringomyelia who was also a patient of Dr. T. K. MONRO.

DR. W. F. SOMERVILLE read an instructive paper on the influence of

HIGH FREQUENCY CURRENTS ON THE SURFACE TEMPERATURE OF THE BODY.

He was led to undertake this investigation from patients expressing that they felt warmer after electrical treatment. He found the surface rise of temperature greatest on the flexor side of the right forearm. With 500 M.P.'s he had got as big a rise as 9.2°F. The internal rise of temperature was never very great—a few degrees.

DR. SOMERVILLE thought this rise of temperature connected with the vaso-motor system and an increased blood supply, and considered that these changes might account for the great beneficial action brought about by the use of high frequency currents in cases of nervous exhaustion and allied diseases.

CENTRAL MIDWIVES BOARD.

MEETING HELD APRIL 10TH.

The President, DR. CHAMPNEYS, in the Chair.

THE first business of the Board on this occasion was the appointment of President and Treasurer. Dr. Champneys was re-appointed as the former, and Mr. Fordham appointed as Treasurer.

The SECRETARY then read a letter from the President and Fellows of the R.F.C.P.I., and from the University of Dublin, asking if it would be possible to have examinations there.

The PRESIDENT pointed out that both Ireland and Scotland had placed themselves outside the Act, and, on the motion of Mr. Fordham, it was agreed to send answer that the Board was not prepared to take the Act out of the area defined by Parliament.

The revision of rules was proceeded with, and letters were read expressing regret from Sir Wm. Sinclair and Mr. Ward Cousins that work had prevented their coming, but the President urged that the revised rules were already overdue, and it would be wise to discuss Sir Wm. Sinclair's motion concerning wholly illiterate candidates presenting themselves for examination.

Mr. FORDHAM suggested adding the words, "That she possess sufficient knowledge to read and take notes of cases" to the existing rule.

The PRESIDENT was of opinion with Sir Wm. Sinclair that there ought to be some sort of test. He had interviewed the head of the Education Board, but had been told there was nothing available. Certainly the candidate ought to be stopped early in, if not before, the examination.

Dr. DAKIN asked what "read the text-books" meant in the rule as it stood?

Mr. FORDHAM thought interpretation were better left to the presiding instructor.

Miss WILSON asked if any complaints had been sent in by examiners or any candidate rejected.

The SECRETARY answered, that examiners never gave grounds of rejection.

The PRESIDENT said Sir Wm. Sinclair would like to stop illiterate candidates from appearing at examinations by pointing out to them that they were hopelessly illiterate.

Miss WILSON, regardless of the fact that Sir Wm. Sinclair had given personal evidence of many such women coming under his notice, said it would be different if they had had complaints from examiners. It would not do to raise the standard too suddenly. She opposed the motion.

Dr. PARKER YOUNG argued that measures ought to be taken early. It would not be fair to take a woman's fee and then refuse to sign; but

The PRESIDENT answered that was merely a prophecy, and the words suggested by Mr. Fordham were added to the existing rule.

With regard to the laying-out of the dead by midwives, it was agreed that she must not lay out anyone she had not been attending, and a letter was read from the L.C.C. asking that any midwife who had laid out a body must "undergo adequate cleansing and disinfecting to the satisfaction of the local supervising authorities," which request was carried.

The rule relating to the administration of drugs was passed as read:—"A midwife must notify each occasion on which she is under the necessity of administering any drug other than a simple aperient; the dose, time, and cause."

The question of fee to a medical practitioner summoned by a midwife was discussed. Letters from the Privy Council and the Local Government Board stated that it was a mere matter of arrangement. There were plenty of patients able to pay who would not. In the case of the necessitous poor, the money should come out of the rates at the discretion of the local authorities.

Dr. PARKER YOUNG said he presumed the doctor had his fee for notifying puerperal fever.

Miss PAGET replied that was so, but the midwife should have one too, and that would encourage her to notify.

The PRESIDENT: The nurse has to call in the doctor and the matter is then in his hands. Suppose the midwife notifies it as puerperal fever, and the doctor says it is not. Clearly the decision and the fee are his.

The rules re "Calling in a registered medical practitioner," were slightly revised, it being agreed to add

"white leg and mania" as "emergencies," and, on a suggestion from the L.C.C., "primary and *post-partum* hæmorrhage also. The Privy Council had written saying they thought it would be better if midwives told their patients at the beginning, "that there might be a necessity of sending for the doctor at any moment."

Mr. FORDHAM objected that the poor had always a great fear of sending for the doctor, and if the fact of such a possible necessity be hinted at the beginning it would destroy confidence in nurses and result in resorting to uncertificated women.

Dr. PARKER YOUNG thought the patient ought to be told. But

Miss PAGET added that, as the necessity did not arise in more than three per cent. of the cases, she saw none for making the rule. Whereupon

The PRESIDENT arranged that answer should be sent saying the Board did not think it advisable to follow the Privy Council's suggestion.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD. FRANCE.

Paris, April 14th, 1906.

AN INTERESTING CASE OF TUBAL PREGNANCY.

PROFESSOR POZZI had a case under his care recently at the Hospital Broca, Paris, which presented somewhat unusual features; and for the report of which we are indebted to Dr. L. Montaigne. The patient was a married woman, the mother of two healthy children; her two labours had been quite normal, and she had always been regular. Two days before admission to the hospital she had, after her mid-day meal, a fainting fit, accompanied by an abundant hæmorrhage; during the next day fainting fits occurred at intervals of two hours, and on the following day, after having been treated for twenty-four hours by serum injections (500 grammes in all), she was admitted as an urgent case to the Broca Hospital, under Prof. G. Pozzi. Dr. Dartigue was immediately sent for and diagnosed tubal pregnancy (the patient acknowledged that methods of abortion had been practised) and decided on immediate laparotomy. The hysterectomy which was performed took twenty-two minutes. The uterus when removed showed all the characteristics of an extra uterine pregnancy; hypertrophy, very apparent, decidua, an evident tubal pregnancy; the left tube was open and full of blood clots. The operator said that the case under observation presented very rare features, especially with reference to diagnosis and also to the importance of immediate operation. In his opinion it proved the absolute necessity of immediate surgical intervention.

Five days after operation there had been no rise of temperature and the patient was progressing favourably.

SUICIDE OF A POLICE SURGEON.

Considerable mystery surrounds the suicide, at his residence, of Dr. Georges Bellemain, who for many years past has been the official medical attendant to the Paris Prefecture of Police. When the wife of deceased, on returning from a dinner-party, found the door of her husband's study locked, she had the door broken open, and found the dead body of her husband stretched on the floor. On the table lay a letter, which stated that the deceased had poisoned himself with cyanide of potassium. Dr. Bellemain appeared to be in the best of health and spirits when she left him, and his suicide has caused considerable sensation.

GERMANY.

Berlin, April 14th, 1906.

DRS. MORITZ, Oppenheim, and Otto Löw have a paper in Virchow's *Archiv*. Bd., 182, on

THE PATHOGENESIS OF GONORRHEAL EPIDIDYMITIS. It should be sufficiently determined by the present time that the gonococci are the sole exciters of the

disease in question, and that the vas deferens is the usual route by which the parasite passes from the urethra to the epididymis. There are two clinical facts, however, of which examples were seen that appear not to harmonise with this assumption, viz., that the inflammation frequently misses the vas deferens and attacks the epididymis first, and, secondly, that the first symptoms of epididymitis not infrequently appear immediately after infection. As the gonococci have no proper movement of their own, and as their spread over the mucous surface can only result from growth, it is difficult to understand how they can pass the long canal of the vas so quickly.

All these difficulties disappear when we bear in mind that the virus is passed on by the antiperistaltic action from the colliculus seminalis to the epididymis. Such movements were first discovered by Loeb, and they were later on studied thoroughly by Akatsu in the guinea-pig. The question now arises whether clinical observation shows these factors that easily lead to epididymitis are capable of exciting antiperistalsis in the vas deferens. The factors alluded to are all kinds of instrumental treatment of the urethra. Massage of the prostate, pollutions and coitus and bodily exertions. The authors have succeeded in exciting such antiperistaltic movements of the vesiculae seminales and the vas both by electrical and mechanical stimulation. They also satisfied themselves by careful feeling of the cord separated from its surroundings that similar antiperistaltic movements also took place in the human subject.

It now remained to show that these antiperistaltic movements were capable of carrying the micro-organism from the urethra to the epididymis. They inserted powerful cultures by means of a catheter near to the colliculus seminalis, and then, with the abdomen opened, by irritation of the hypogastric nerve excited contraction of the corresponding vas deferens. In a short time inflammation of the epididymis was actually set up, and the organism (*streptococci*) found within it.

The practical teaching of this is that in acute posterior urethritis instruments should not be made use of, that exploration of the prostate should only be made with the greatest caution, and that the patient should abstain from all sexual excitement and severe bodily exertions. In cases of unilateral epididymitis no local treatment of the posterior urethritis should be resorted to in order to avoid disease of the opposite side. In subacute and chronic gonorrhœal urethritis posterior irritating injection should not be employed.

Die Deutsche Med. Zeitung (23, 1906) reports

THREE CASES OF MERCURIAL POISONING.

The first was that of a young woman in the early stage of syphilis. At weekly intervals four injections of oleum cinereum, each containing 94 mgrms. of metallic mercury had been injected. A week after the last injection, the patient, who had excellent teeth, began with violent stomatitis, and on the day but one after a dangerous dysenteric diarrhoea set in. The extremities were cyanosed and collapse was setting in, when the disease was mastered by large doses of opium. As the dysentery improved, however, the stomatitis got worse, and the interchange of bloody diarrhoea and violent stomatitis repeated itself three times. After this, rapid recovery took place, and not only this, but the patient underwent three similar courses of injection treatment without any further trouble.

The second case was that of a young man who, in the course of five hours took five pills each containing 0.02 gr. of calomel. He had repeatedly taken a similar dose before. The following morning he had mucous stools with blood, sometimes passing almost pure blood. The attack lasted for two days, and was then relieved by opium.

Another case was that of a midwife who had disinfected her hands two days running with sublimate, according to the new regulations and subsequently suffered from all the symptoms of mercurial poisoning

(stomatitis, eczema, diarrhoea, a scarlatina-like rash, general feeling of illness and rigors). After a fortnight's interval began a period of intermittent intestinal disturbance, colic, constipation, vomiting, rapid pulse, jaundice, so that the patient, who was previously healthy, was confined to bed for weeks. As, however, the gall bladder was tender at this time, it was difficult to differentiate between this and an inflamed colon. It was held to be certain, however, that the severe symptoms were due to mercurial poisoning, whatever the latter might be.

Hartung observes that mercurial poisoning is not so rare. He has seen several cases of great severity. He was at first afraid to treat such cases with opium, fearing that that evil might follow the non-elimination of the poison. He overcame this fear, however, on reading in Kobert's "Intoxikationen" that opium eaters could bear the enormous dose of 1.8 grms. of calomel (about 27 grains) a day without any ill effects, which could only be explained on the hypothesis that the opium formed an insoluble combination with the calomel in the bowel. Since then he has always treated mercurial hæmorrhagic diarrhoea with large doses of opium, and with excellent results. The threatening symptoms were always cut short in a short time. In private practice he was accustomed to warn his patients against the appearance of toxic symptoms, and on their first appearance to provide them with tincture of opium so that they could take it if the symptoms became severe.

AUSTRIA.

Vienna, April 14th, 1906.

THE PHYSIOLOGICAL EFFECTS OF LEAD POISONING.

TELEKY showed five cases of lead poisoning at the last meeting of the Gesellschaft, and pointed out the effect produced by certain active muscles that are first acted on by the poison. He concluded that the straining of certain groups of muscles was an active factor in producing the paralysis.

Zappert remarked that this opinion was confirmed by his own observations in the cases of children who suffered from lead poisoning where the legs were first attacked and subsequently the hands and arms. The legs in these cases were the most active, while the hands and arms came next in order.

TETANUS AND ANTI-TOXIN.

Lotheissen next exhibited a man, æt. 46, whose right foot had been run over by a street-sweeping machine and badly lacerated. On the second day, as a prophylactic, he injected tetanus anti-toxin. In spite of this early treatment of the dreaded disease tetanic symptoms soon afterwards appeared. He affirmed that this was a very unusual occurrence, as the literature on the subject assured us that very few cases of this kind escaped.

HEPATIC CIRRHOSIS.

Neurath brought forward an interesting case of a child, æt. 6½, suffering from alcoholic cirrhosis of the liver from the excessive drinking of apple wine, of which it took a half to two litres a day.

The child showed symptoms of severe dyspnoea, a colossal increase of the abdomen, whose surface was knobby; enormous œdema of the abdomen, lower extremities, and scrotum. The superficial veins of the abdomen were greatly increased, and a considerable amount of fluid was present in the peritoneum. The right under lobe of the liver was the most affected, and the marginal percussion extended down to a line midway between the xiphoid and the umbilicus. The spleen was also hard and greatly increased in size.

The heart was normal, but the relative amount of urine was small and contained no albumen. The most prominent symptom was the persistent vomitus matutinus. The child slept badly and had intercurrent febrile attacks with terrifying dreams and frequent attacks of delirium.

The treatment first adopted was a free use of diaphoretics and diuretics, and a perfect abstention from all alcoholic and fermentative fluids. This treatment

seems to have had little or no effect and Neurath now proposes to operate and perform Talma's operation, which is an extraction of the liver and fixing in the abdominal wall.

SARCOMA OF THE LOWER JAW.

Spitzer presented a patient who had suffered from sarcoma of the left lower jaw. The bony structure as far forward as the canine tooth had been entirely removed and a prosthesis substituted. With this artificial arrangement, which was fixed to the upper jaw with a hinge, the patient could now speak and eat with his former ease and comfort.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

SCOTCH ASYLUM REPORTS.

CRICHTON ROYAL INSTITUTION, DUMFRIES.—The Commissioners, in their annual report, refer to the gratifyingly low rate of mortality in this institution, and point out that this is not a mere temporary condition, as is seen from the fact that the percentage of deaths, reckoned on the average numbers resident, has during the past two years been only about one-half of the Scottish asylum average, and state that there are two circumstances in the administration of this asylum which probably tend towards producing those healthy conditions of life upon which alone such a low death rate can depend. These are, first, the extensive segregation of the patients; second, the nutritious dietary which is provided for all classes of inmates. The average age at death was, for males 57, and for females 59. One old lady died at the age of 96, after 60 years' residence. She was the last of ten patients, whom Mrs. Crichton, the foundress, reserved her right to nominate during her lifetime. Three gentlemen died after 47 years' residence, and 22 died after 10 years. The average daily number resident during the year was 377 males and 429 females—total, 806.

Dr. Rutherford states that the sanatorium for consumption has been most useful during the year, and that the death rate for consumption last year has been lower than for many years. The average number who died annually during the past five years was ten; last year it was six; but whether this is due to the sanatorium, the experience of one year cannot determine.

The new reception hospitals have been recently completed, where the recently admitted, the acutely insane, and the sick of the pauper section of the inmates are now provided for in a manner which will do everything that is possible to promote the recovery of the curable and alleviate those suffering from bodily diseases.

The Commissioners state that the impression produced by their visit, considering the large-minded and liberal manner in which the institution is managed, and the unmistakable way in which patients benefit from methods of management, could not fail to be favourable.

ARGYLE AND BUTE DISTRICT LUNATIC ASYLUM, LOCHGILFHEAD.—The admissions to this asylum numbered 64, as compared with 73 in the preceding year. Dr. Cameron states that since 1898, when it attained the maximum, the admission rate has shown a tendency to decrease and the low rate of last year has been equalled on only one former occasion. The average age of the patients admitted was 42·8; last year it was 48 years. The proportion of aged persons received has been lower than usual. The percentage of recoveries, calculated on the admissions, was—for the men 47, and for the women—24·3. The total number under care and treatment during the year was 503. Twenty deaths occurred during the year—namely, 6 men and 14 women; and of these 8 were over 70 years of age. The death rate is considerably lower than that of the previous year and 2·8 below that of the District Asylums of Scotland for the same period. No death was due to either accident or suicide.

New workshops have been erected and are now in use. The old workshops are being converted into mortuary chapel, a mortuary, and a room for pathological work. This work has been entirely carried out by the patients and the artizan staff. A most laudatory feature in this asylum is the large amount of excellent work done by the patients and the artizan staff. The Commissioners in their report state that everything that was seen in the course of their visit indicated that the care of the patients is adequately and conscientiously undertaken by Dr. Cameron and his staff.

MURRAY'S ROYAL ASYLUM, PERTH.—Dr. Urquhart in his report states that during the year 44 were admitted, of whom 15 were men and 29 women. Thirty three persons were discharged—17 men and 16 women: The total number of persons under treatment was 181, and the average daily number on the Registers, 142. The average age on admission was 40·9 years, compared with 42·6 in the previous year. One patient was admitted at the age of 84. The causes of insanity as discovered on admission are stated to have been ascertained more or less precisely in every case; 23 were hereditarily predisposed to mental derangement; 9 belonged to families of neurotic tendencies, and the parents of 4 were alcoholic; 12 had been subjected to mental stress of a severe nature, but 8 of these presented such a family history as showed that they were inherently unable to withstand the anxieties under which they had succumbed. The usual list of physical diseases was noted as causative of, or complicating, the mental malady—special diseases of the heart, kidneys and digestive system. One case admitted became insane consequent upon an operation for appendicitis. The recovery rate on the number of admissions is 22·72, as compared with 45·94 last year. The percentage of deaths on the average number resident was 6·34. The amusements and occupations of the patients have been maintained as usual, and this asylum claims to have constituted a record for asylum theatricals, inasmuch as the chaplain produced a farcical comedy entitled "His Way and Hers." We regret that such chaplains are rare. The Commissioners state that the asylum was found everywhere in excellent order, comfortably heated and well ventilated, and draw special attention to the boilers, which supply steam for various purposes to the asylum, having been fitted with a patent furnace through which a steam blast can be passed. By this means the smoke issuing from the chimney stalk is reduced to a minimum, and the consumption of coal is greatly economised and coal of a cheaper class can be used with efficiency. They consider that this system is worthy of consideration by all those who are charged with the administration of public institutions.

PERTH DISTRICT ASYLUM, MURTHLY.—Dr. Bruce states that the admission rate for the year is the lowest since 1892, with the exception of 1900-1901, when there were only 80 admissions. The recovery rate is below the average and the death rate only 3 above the average for the last 4 years.

Hereditary predisposition to mental diseases was ascertained to be present in 23 of the patients admitted and 27 had suffered from previous attacks of insanity. Nine patients were admitted suffering from general paralysis of the insane, but every one of these cases had contracted the disease after leaving the country and taking to town life. The exciting cause of the mental disease in 13 cases was stated to be alcoholic excess. Out of 84 admissions, 27 were recurrent cases. Dr. Bruce observes that many of these recurrent cases recover again and again and have to be discharged; some are of the class which gravitate between the asylum, the prison and the workhouse, most undesirable patients who present undoubted symptoms of mental disease and are in some instances cases of sub-acute chronic insanity—the result of an acute attack of mental disease acquired in early life. He advocates the establishment of special wards in general hospitals for the admission of incipient cases as one worth considering from the point of view of the ratepayer

Attention is drawn by the Commissioners to the high order of the medical work of this asylum and to the scientific and original investigations so ably carried on by Dr. Bruce.

ACTION FOR SLANDER AGAINST A MEDICAL PRACTITIONER.—Sheriff Robertson has now given his decision in the action at the instance of a Fraserburgh chemist against a medical practitioner of the town. The Sheriff finds for the defender, with expenses. The facts of the "regrettable dispute," as the Sheriff in a note calls it, are, briefly, these: It seems that there is a custom in Fraserburgh that each practitioner has particular chemist with whom he chiefly deals, and who has the formulæ of any private prescriptions the medical man may use. The defender in this case ordered a prescription of his own devising to which he gave the name of Mist. Bis. Comp. The prescription was taken to be dispensed to the pursuer, who, not being the defender's particular chemist, had not the formula of the mixture, and dispensed a mixture which was acid, instead of being alkaline. As the result of this, certain telephonic messages passed between the defender and pursuer, and the former wrote a letter which the pursuer complained of as slanderous. The defender in it used such phrases as "false pretence," and complained to the inspector of police, as inspector under the Food and Drugs Act, and altogether seems to have behaved somewhat foolishly. On the other hand the pursuer alone published the letter, and so far from regretting his action in dispensing a prescription the formula of which he did not know, actually dispensed it a second time. His Lordship finds that the defender was privileged in writing the letter, and that malice cannot fairly be inferred from the terms of the letter. It seems to us highly regrettable that a personal dispute of this kind should have been dragged through the law courts. The affair was in itself unspeakably trifling, and a quarter of an hour's frank explanation at the outset would have settled such a difference between any reasonable men. It is pre-eminently the sort of quarrel which is likely to arise through a young practitioner standing too much on his own dignity, and is just one of the instances in which the advice of an older head would probably have saved the situation.

BELFAST.

BELFAST OPHTHALMIC HOSPITAL.—The annual meeting of this institution was held last week, the High Sheriff of the city, Mr. W. F. Coates, presiding. The medical staff report was read by Dr. Cecil Shaw, and gave particulars of a large amount of work. The cases in the extern department for the eye numbered 1,518; those in the ear and throat department 695; and the intern patients 122. The total number of visits paid by patients was 7,280. A sum of £50, asked for in last year's staff report, to complete the furnishing of the operation theatre, had been given by Mr. J. Milne Barbour, and a lady had handed to Dr. Walton Browne another £50 for the further equipment of the theatre with new instruments.

THE CONSUMPTION PROBLEM IN BELFAST.—At a late meeting of the Corporation, the Chairman of the Public Health Committee said that his committee would welcome any suggestion for lessening the death-rate or improving the health of the city. The invitation has been accepted by Professor Byers, who deals with the whole subject in an article of four columns in one of the daily papers. He has obtained figures from the Registrar-General showing the annual death-rate per 1,000 from phthisis in Dublin, Belfast, and Cork for the past twelve years. These figures are 3.6 in Dublin City, 3.3 in Belfast, and 3.9 in Cork, and show no marked change during the twelve years in any one of the cities. After explaining the meaning of the figures, Professor Byers takes as his text the circular issued by the Local Government Board for Scotland on March 10th, 1906, and shows how the excellent suggestions contained in it might be applied to Belfast. His final suggestions are: (1) A special consumption sub-committee of the Public Health Committee, with power to co-opt additional members.

(2) A dispensary for phthisis "at the head of which should be a young capable medical man who would throw his whole energies into the work." (3) The compulsory notification of phthisis. (4) The co-relation of the hospitals which accept consumptive patients, so that the most may be made of the provision they afford.

LETTERS TO THE EDITOR.

THE NORMYL TREATMENT FOR ALCOHOLISM AND THE DRUG HABIT.

SIR.—It can only be lay readers of your paper who can need telling that alcoholism is not a simple condition always due to one and the same cause; that the cases vary widely, and that their causation is extremely complex, being made up of various distinct physical, moral, and mental factors. Anyone with a sufficient knowledge—knowledge easily acquired by a cultivated intellect—of the pathology and psychology of the drunkard, must recognise that cure by a drug of the habitual excessive use of alcohol would approach the miraculous, something like the casting out of a demon of the olden days. The discoverer of such a remedy would rank among the greatest benefactors of mankind—with Jenner, Pasteur, and Lister. Wealth and fame would surely be his. All he would need to do would be to demonstrate the quality of his remedies before a competent scientific tribunal. It would be easy to name many such tribunals. I would suggest the Royal Society, or the College of Physicians, as a choice for the promoters of the Normyl treatment. The inventor of the Normyl treatment not only undertakes to cure alcoholism; he, so to say, throws into the bargain a cure for "the drug habit" as well, thus making his miracle doubly miraculous. It is not necessary to question the inventor's good faith or to doubt his confidence in the efficacy of his method. Such a belief would form only one more instance among scores of similar illusions in the history of medicine. The wonderful fact is that not only the Editor of *Punch*, who from his position must necessarily be a consummate man of the world, but a whole string of noblemen, theological dignitaries and public men should be easily found at this period of the twentieth century to give their support to a theory which can have not much more solid foundation than the belief in witchcraft or the evil eye. There does not seem to be a single man of science among them. They seem to represent not the cultivated classes from which they are drawn, but rather the uneducated mass of the public which unfortunately scorns, distrusts, or hates science and prefers often to subscribe to a belief which is evidently impossible, or even to accept it the more eagerly because it is impossible. It must surely be rare to find in such a connection a string of names of such distinction as composes the committee of the Normyl Association. I trust you will immortalise them in your columns. They are as follow:—

Chairman—Mr. Cecil M. Chapman (Metropolitan Magistrate.)

The Primate of Ireland. The Bishop of Chichester.

The Bishop of Southwark. Lord Armstrong.

Sir Arthur Wilson, K.C.I.E. Canon Scott Holland.

Mr. Stephen Simeon. Mr. Arthur W. Bartlett.

Hon. Sec.—Rev. Hugh B. Chapman.

Hon. Treas.—Mr. Owen Seaman.

I am, sir, yours truly,

HENRY SEWILL.

Cavendish Square, April 11th, 1906.

[It would be of interest to learn how many of the above persons have given their names through personal pressure, knowing little or nothing of the matter.—Ed.]

DR. E. SYMES THOMPSON, F.R.C.P., Gresham Professor of Medicine, will deliver a course of lectures on "The Nervous System" on April 24th, 25th, 26th and 27th, at six o'clock each day, at Gresham College, Basinghall Street, London, E.C. This course is open to the public, and will be illustrated by diagrams.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons in Ireland.

A MEETING of Fellows of the College will be held on Tuesday, May 1st, at 4.30 p.m., pursuant to the provisions of the Supplemental Charter, to witness the election of the following examiners:—Court "A."—For examinations under the management of the Conjoint Committee:—Two Examiners in Anatomy, to examine in Surgery when directed; four Examiners in Surgery, to examine in Anatomy when directed; one Examiner in Physiology and Histology; one Examiner in Pathology and Bacteriology; one Examiner in Midwifery and Gynæcology; one Examiner in Biology; two Examiners in Ophthalmology; one Examiner in Sanitary Law and Vital Statistics; one Examiner in Engineering and Architecture; one Examiner in Languages; one Examiner in Mathematics, Physics, Dictation, and English Essay; one Examiner in Dutch.

Court "B."—For examinations conducted by the College, and not under the management of the Conjoint Committee, viz.:—Two Examiners in Anatomy, to examine in Surgery when directed; four Examiners in Surgery, to examine in Anatomy when directed; two Examiners in Physiology and Histology; two Examiners in Pathology and Bacteriology; one Examiner in Midwifery and Gynæcology; two Examiners in Chemistry and Physics; two Examiners in Dental Surgery and Pathology; two Examiners in Mechanical Dentistry. "Graduates of any University which may be from time to time recognised by the College shall be eligible for election as Examiners in the subjects of General Education. All the other Examiners shall be Fellows or Licentiates of the College, or Professors or Lecturers in any School of Medicine recognised by the College."

"Examiners permanently residing more than one hundred miles from Dublin shall receive (in addition to their examination fees) first-class return railway fare for each occasion on which they are summoned to Dublin to conduct examinations in connection with this College."

Candidates are requested to clearly indicate whether they seek election on Court "A" or Court "B," or on both. In the latter event, they are advised to send separate applications.

Candidates are requested to lodge their applications in writing with the Registrar, at the College, on or before Tuesday, April 24th, at 10 a.m.

International Medical Congress at Lisbon.

THE Booth liner "Ambrose," left the Mersey on Wednesday evening with a large complement of passengers for the International Medical Congress at Lisbon. This steamship company have perfected arrangements for combined sea and land tours, and are now able to frank the passengers right through Portugal, by road or rail, and on *via* Badajos to Seville, Granada, and other places in the South of Spain, and Madrid, giving the option of return from Gibraltar by a P. and O. liner or from Lisbon by one of their own homeward South American mail boats. The company some time ago secured three floors at the most modern hotel at Lisbon, so as to ensure its passengers attending the Congress being comfortably provided for.

The West African Medical Staff.

In the House of Commons on Wednesday last, Mr. Churchill informed Mr. Nolan that coloured medical men of African origin or descent are ineligible for the West African Medical Staff, but are eligible for certain other public appointments in the Gold Coast, Sierra Leone, and Lagos. The West African Medical Staff is constituted principally for the purpose of safeguarding the health of the European officials of the Colonial governments; and West African native medical officers would not, as a rule, command the confidence of the Europeans.

Giebler v. Manning.

THIS was a case stated by a metropolitan magistrate on a summons taken out by the respondent, Manning, a sanitary inspector, on behalf of the Fulham Borough Council, against the appellant, Frederick Giebler, under the Public Health (London) Act, 1891, section 47 (2), for having on his premises 5lb. of meat which was seized by the respondent as being unsound and ordered by the magistrate to be destroyed. It appeared on the face of the summons, and was stated in the case to be the fact, that the information was laid by, and the summons issued to the respondent, expressly on behalf of the Borough Council. The respondent, before applying for the summons, did not report the facts to the Borough Council or to any committee appointed by them. He had never received any express authority by resolution or in writing, general or special, from the Council or any such committee authorising him to make complaints or take proceedings on their behalf. It was contended on behalf of the appellant that by section 107 (3) of the Act it was necessary that the inspector should report to the sanitary authority, and that they should authorise their inspector to apply for a summons and act as prosecutor against the alleged offender. No such report was made, nor did the Borough Council or any committee expressly direct or authorise the respondent to make the complaint and take the proceedings. The magistrate was of opinion that the reports required by section 107 (3) were confined to (a) nuisances discovered by the inspectors themselves under section 1 and other sections; (b) inquiries by them into complaints which were made as to nuisances and offences against the statute and against the statutory by-laws by private individuals under (amongst others) section 3 and 21, and as stated in evidence at the hearing these two classes of reports were always made, and as a fact consequent process was always applied for by the Council's solicitor. The offence in the present instance did not appear to fall into either class. But even if it did, the language of section 107 (3), "subject to the direction of the sanitary authority or of a committee thereof," was, in the magistrate's opinion, capable at least of meaning such direction as it might choose to give, but, however this might be, there was nothing in section 107 (3) or as regards committees in section 99 (4) compelling the authority to give directions in any particular form or manner, and, if so, he thought that the course of business adopted by the Council and committees might well justify the action of the respondent as resting on an implied direction and authority or on ratification. The magistrate accordingly convicted the appellant. Mr. Clarke Hall, for the appellant, submitted that section 107 (3) made it a condition precedent that the inspector prosecuting should have the express authority of the sanitary authority. He cited "Isle of Wight Ferry Co. v. Ryde Commissioners" (25 J.P., 254). The fact that the summons was taken out on behalf of the sanitary authority was important as regards liability for costs. Mr. Danckwerts, K.C. (Mr. W. J. Jeeves with him), for the respondent, argued that any body could take proceedings under section 47 (2), and the words, "on behalf of the Fulham Borough Council," in the summons were quite immaterial. The Lord Chief Justice, in giving judgment, said that the appeal must fail, as the case was practically covered by authority. The really important question was whether an individual could take proceedings under section 47 (2). The other learned Judges agreed, and the appeal was accordingly dismissed, but without costs.

DR. PURVES STEWART, assistant physician to the Westminster Hospital, has been appointed Physician to the National Orthopaedic Hospital.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT LITERATURE OF PHYSIOLOGY AND PATHOLOGY.

The Pathogenesis of Malignant Tumour.—The *Deutsche Medizinische Wochenschrift* of March 22nd contains a synopsis of an important communication made by Prof. Ehrlich on the subject of the pathogenesis of malignant tumours. The material used by Prof. Ehrlich and his collaborators consisted of 230 spontaneous tumours occurring in mice, which were, with a few exceptions, of an epithelial character. Of these, 94 were successfully transmitted to other animals, but only 11 could be successfully transplanted from one animal to another *ad libitum*. In these cases there appeared an extraordinary increase in the energy of proliferation, which rendered full experimental study of them possible. By artificial mixture of carcinoma and sarcoma, genuine mixed tumours were produced which, after two generations, were completely freed from carcinoma, and became pure sarcomata. This elimination was accelerated by heating the inoculation material to a suitable temperature. An intraperitoneal chondroma, occurring spontaneously in a mouse, produced, on subcutaneous inoculation, huge hæmorrhagic growths, while intraperitoneal inoculation led only to the formation of small free bodies, resembling the corpora oryzoidæ found in men.

The first result of these experiments is to show that the infectivity of primary tumours in mice is very slight, the successful inoculations constituting only $\frac{1}{4}$ per cent. of the whole number. Hence the normal organism of the mouse must contain a mechanism which hinders the growth of the developed tumour cell. Prof. Ehrlich considers that we have to make a sharp distinction between the original carcinomatous transformation of the cell and the further growth of this modified cell into a tumour. In transplantation the first moment is excluded, the developed cancer cell being used in the material for inoculation. The large proportion of negative results indicates the important part played by the resistance of the organism to tumour formation.

In general, tumour cells can only be successfully transplanted from a given animal to one of a species so closely related to it that the two can breed together. If, however, highly virulent mouse tumours be transplanted into rats, in the first six to eight days a definite tumour forms. After eight days a degeneration begins which soon leads to complete absorption. If this tumour in the rat be transferred, at the most active period of its growth, to another rat, it fails to grow, while, if transferred back to a mouse, it develops into a typical tumour. This "zig-zag" inoculation from mouse to rat and from rat to mouse can be repeated *ad libitum*, the tumour retaining its power of growth unaltered. The hypothesis which best explains this phenomenon is that the tumour cell requires for its growth a certain substance which is only present in the organism of the mouse; when the quantity of this material which has been transferred into the rat in the first inoculation is exhausted, a second inoculation into a mouse is required in order that the power of growth may be kept up. The natural immunity of the rat depends then, on the absence of this indispensable substance, and may be called an "atreptic" immunity.

In mice, if a successfully inoculated animal be again inoculated on the other side, the result is generally negative, which Prof. Ehrlich explains by assuming that the material necessary for tumour growth has been so completely exhausted by the original tumour, that there is not enough left to enable the second tumour to grow. The facts which have been determined with regard to the active immunisation of

mice against carcinoma are as follows:—The inoculation of mice with the above-mentioned hæmorrhagic tumours, which were not malignant, nor capable of growth by transplantation, resulted in the production of a considerable degree of immunity against highly virulent growths. Still more favourable results were obtained in the case of mice which had been unsuccessfully inoculated with highly virulent material. These animals were found to be immune to subsequent inoculations with any tumour material, no matter how virulent. Prof. Ehrlich attaches special importance to the fact that this immunity is not specific, but holds for the different forms of sarcoma and carcinoma. Investigations which have not yet been concluded, go to show that the animals which are immune to carcinoma and sarcoma are also immune to chondroma. O'S.

Precipitin of Snake Antivenom and Antisera.—Hunter (*Journal of Physiology*, December 19th, 1905) gives the results of experiments regarding the precipitating properties of antisera and antivenom of the cobra and daboia. With rabbits as the animals employed, he arrives at the following conclusions:—(1) Specific precipitin are produced by the injection of snake venoms, and these precipitin have no action on snake sera. Lamb had already discovered precipitin in the case of cobra venom, but regarded them as non-specific; (2) specific precipitin are also produced by the injection of snake sera, but these precipitin have a positive action on the corresponding venoms; (3) there is no constant relation between the precipitating and the antitoxic power of an anti-venom, nor between the quantity of toxic bodies and of precipitable bodies in a venom. The toxins are therefore not the precipitin-producing bodies. R.

Recent Literature of Endothelioma.—Carless (*Practitioner*, February, 1906), summarises in a somewhat haphazard fashion the more recent reports on endothelioma. (1) *Endothelioma of the salivary glands.* The salivary region is the site of many tumours of a complicated nature, of which the so-called "parotid tumour" is the best known. While there has long been discussion as to the correct pathological placing of this tumour, opinion is coming more and more to agreement that it is an endothelioma. On this theory, the cartilage which is so often present, is to be explained as a hyaline degeneration of the cells and stroma of the growth. The cells are usually arranged in well-defined columns and masses, and in some of the columns a lumen is present, the cells nearest it being flat, while those outside are spheroidal or polyhedral. It is impossible to decide whether, if these tumours be endotheliomata, the cells originate in the walls of blood or lymph vessels. (2) *Endothelioma of the testis.* Krompecher believes that endothelioma is the most common form of malignant disease of the testicles. It presents great varieties in histology, the two main types being the *alveolar* and the *diffuse*. The latter is probably what has been described by some writers as "lymph sarcoma testis," and by others, mostly French, as "lymphadenomata." The former is the most common tumour of the testicle, and has often been described as a carcinoma. In addition, tumours of the testicle are sometimes met with containing great nucleated protoplasmic masses, resembling those met with in chorion-epithelioma. (3) *Endothelioma (or perithelioma) of bone.* Histologically, these tumours conform generally to one of two types—(1) vascular tumours with alveoli filled with cells of varying character (2) gland-like structures, the alveoli of which are lined with one or more rows of cells of epithelial type.

These two forms are not infrequently conjoined in the same growth. The tumours vary greatly in vascularity, and are subject to mucoid, hyaline, and colloid regenerations.

The Importance of the Colon.—Monier-Williams (*Brit. Med. Journ.* April 7, 1906) recounts the history of a case from which we may learn something of the importance of the normal functions of the colon. For several years the patient had suffered from colitis, and in 1900 it was decided to make an artificial anus in the ascending colon. Some eighteen months after the operation the patient again became emaciated, and began to lose weight rapidly, so much so that his position became one of grave danger. It seemed reasonable to suppose that the cause of his retrogression was the failure to absorb sufficient water. To remedy this, injections of saline fluid, and later of distilled water, were made into the large intestine. The results were most satisfactory, and although the injections had to be discontinued, owing to the occurrence of severe attacks of purpura hæmorrhagica, nutrition was markedly improved. Notwithstanding the hæmorrhages, the patient improved steadily in health, and continued to increase in weight week by week. Later on, as the intestinal injections were inevitably followed by attacks of purpura, hypodermic injections of saline fluid were substituted. The effects both as regards nutrition and the occurrence of purpura, were the same. Finally, a way out of the difficulty was discovered. By blocking the artificial anus throughout each night the intestinal contents were for several hours of the twenty-four directed into the great intestine. The colon was thus given a chance of absorbing sufficient moisture. This plan was adopted nearly three years ago, and the patient has remained in excellent health during that time. Monier-Williams concludes that absorption of water from the colon is a necessary part of nutrition.

The Mechanism of Protection of Intestinal Worms.—Hamill (*Journ. of Physiology*, February 5th, 1906), details some experiments bearing on the mode by which intestinal worms protect themselves against the action of the digestive juices. Weinland, who was the first to undertake investigations of the sort on the supposition of the presence of an anti-ferment in the body of the worm, came to the conclusion that the protection of the worm against digestion was in the main due to its power of secreting an anti-trypsin. On the other hand, Dastre and Stessano, in the case of *Ascaris*, satisfied themselves of the presence of an antikinase. Like the latter observers, Hamill confined his work to *Ascaris*, of which he obtained a supply from the intestinal tracts of horses. An extract was made by grinding the worms with sand, and extracting with chloroform water. It was proved by a series of experiments that when varying quantities of this extract were added to a fixed quantity of trypsin, the digestive power of the latter as exerted on gelatine varied inversely with the quantity of extract added. The trypsin used was proved to be free of enterokinase. A series of experiments was next conducted to decide whether worm extract, in addition to its antitryptic qualities, might not also possess antikinasic properties. On the one hand, worm extract was mixed with enterokinase, and after four hours, pancreatic juice was added; on the other, worm extract was mixed with pancreatic juice, and after four hours enterokinase added. The digestive powers in the two cases were equal, showing that the worm extract exerted no powers prior to the formation of trypsin. Having thus established the relation of the antibody to trypsin and enterokinase, Hamill proceeded to investigate other qualities of the antibody. His conclusions are—(1) The antibody in the tissue juices of intestinal worms is antitryptic in its action, and not antikinasic; (2) the antibody, in neutral or acid extracts, is uninjured by boiling; in even the mostly faintly alkaline extracts, its action is immediately destroyed by boiling; (3) the antibody is soluble in weak alcohol, but is precipitated when the concentration is increased to 85 per cent. The pre-

cipitate dissolves easily in water, and diffuses readily through colloid membranes.

Ovarian Tumours and Malignancy.—Norris (*Amer. Journ. of Obstetrics*, January, 1906) discusses, with reference to the literature, the nature of ovarian tumours, paying particular attention to the question of malignancy. The frequency with which malignant disease of the ovaries occurs is stated very variously by different operators. Thus, to mention only a few, Kelly finds 8 per cent. of all ovarian tumours malignant, Olshausen 15 per cent., Schroeder, 16 per cent., Freund 21 per cent., and Leopold 23 per cent. Of Norris's 63 cases operated on since 1899, ten proved to be malignant disease, giving a percentage of 15.8; in this series, parovarian as well as ovarian tumours are included. Norris insists strongly on a thorough microscopic examination of all ovarian tumours, since in few, if any of his cases, was there anything in the gross appearance suggesting malignancy. In many cases, indeed the cancerous nature of the tumour would have been undetected unless several sections from different parts—in some cases eleven or twelve—had been made. Of a complete series of 16 malignant tumours of the ovary examined by Norris, 6 were bilateral, 4 being bilateral carcinoma, and 2 carcinoma of one side and multilocular cyst of the other. Norris calls attention to the fact that he encountered no case of sarcoma, although Pick had reported 12 out of 26 cases of malignant disease of the ovary as sarcoma. The term "sarcoma" of the ovary is, however, one which requires more exact definition.

Hæmatoma of the Ovary.—Savage (*Brit. Gynaecological Journ.*, February, 1906) contributes a careful study of the pathology of hæmatoma of the ovary, based on seven cases. The characteristic change due to this condition is the conversion of the ovary into a firm shell of œdematous or hæmorrhagic tissue, enclosing a cyst of viscid, chocolate-coloured blood; adhesions to neighbouring parts are always present, most marked where the cyst-wall is thinnest; the Fallopian tubes rarely show any gross change. Savage thinks hæmatomata of the ovary may be grouped into two classes—(1) Hæmatomata of the Graafian follicle, (2) Hæmatomata of the corpus luteum. In the first group the membrana granulosa is represented, and the process is a multiple cyst formation. The probable cause of this change is an increased amount of blood in the ovary, giving rise to premature ripening of Graafian follicles; into the follicles blood is poured, and the cysts coalesce. Cases of the second group are due to an excessive exudation of blood into the retrogressing corpus luteum. Savage finds no reason for regarding hæmatoma of the ovary as in any way associated with fibroma of the uterus.

Hepatic Cysts.—Dr. Sharp records (*South African Med. Record*, Feb. 25th, 1906) a case of solitary cyst of the liver occurring in a boy, æt. 7. During convalescence from an attack of measles a prominence in the upper part of the abdomen was noticed, which gradually enlarged and was found on examination to be tense and fluctuating. Operation was decided upon, and a large cyst was found growing in the left lobe of the liver, bulging forwards beyond the hepatic margin. It was bounded by a very thin translucent cyst wall, and contained over three quarts of bright yellow fluid. Recovery took place and no recurrence of the cyst was noted. Dr. Sharp points out the rarity of this variety of cyst, and calls attention to the fact that it has not, previous to this, been found in males.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "Recent Medical Literature."
- (2) "Recent Surgical Literature."
- (3) "Recent Gynaecological and Obstetrical Literature."
- (4) "The Recent Literature of Physiology, and Pathology."

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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.

CHARGE AGAINST MEDICAL PRACTITIONERS.

To a certain class of mind nothing appears to give greater pleasure than an attack upon the medical profession. Of this tendency we may presume Mr. Vivian possesses a more than usually virulent share. In the debate on the second reading of the Prevention of Corruption Bill in the Commons, on April 3, he alleged that a certain number of medical men received commissions on patients' coffins. It is curious that a man should go out of his way to malign a noble and self-sacrificing profession in that manner. We venture to say that there is no class of society, even including politicians, to which set Mr. Vivian belongs, that attains the general level of high and virtuous thinking and living which governs the medical community.

STUDENT (Westminster).—You will find the Edinburgh Stereoscopic Atlas of Anatomy (F. C. and S. E. Jack) a most useful aid in reading anatomy. It will probably be obtainable in your school library.

BRISTOLIENSIS.—Unfortunately we know of no means of stopping the irregular practice of a prescribing chemist. A strong combination of medical men in a district, by marking the offenders, might do a great deal to check the offender.

Ms. J. S. (Leeds).—The season on the Riviera usually ends with April, as the weather after this month becomes uncomfortably hot. We think, however, your patient would do well at Grasse, which is 2,000 feet above the sea level of Cannes and Nice, and in a beautifully-wooded district. The weather at Grasse is charming during May and June, and we have known convalescents to quickly recover their health in the pure air at this season. The best and most comfortable hotel there is the Grand Hotel, and there is a frequent train service from the railway station at Cannes to the plateau at Grasse, occupying about twenty minutes in the ascent.

F.R.C.P. (Midlands).—The best apparatus for gastrodia-phany is that devised by Einhorn. It consists essentially of an electric lamp carried on the end of a somewhat stiff bougie. Although the method is technical, costly, and troublesome, it yields results that can as a rule be attained by far simpler means.

A REMEDY FOR NIGHT-SQUALLS.

"DOCTOR," said a patient, "I'm a victim of insomnia. I can't sleep if there's the least noise, such as a cat on the back fence, for instance."

"This powder will be effective," replied the physician, after compounding a prescription.

"When do I take it, doctor?"

"You don't take it. You give it to the cat in a little milk."—*Exchange.*

Mr. CLEMENT H. S.—Your communication was unavoidably held over at press.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, APRIL 18th.

ROYAL MICROSCOPICAL SOCIETY (20, Hanover Square, W.).—8 p.m. Exhibition of Lantern Slides of Plant Structure prepared by Mr. A. Flatters.

FRIDAY, APRIL 20th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11, Chandos Street, Cavendish Square, W.).—5.30 p.m. Clinical Cases will be shown by Dr. T. B. Whipple, Dr. W. O. Chapman, Mr. S. H. Wareham, and others. Papers:—Dr. J. McCaw (Belfast): Chloroma in a Young Subject.—Mr. R. Campbell (Belfast): The Treatment of Hernia in Children, with an Analysis of 300 Cases of Operation for Radical Cure.

EPIDEMIOLOGICAL SOCIETY (11, Chandos Street, Cavendish Square, W.).—8.30 p.m. Paper:—Dr. B. Farrar: The Infectivity of Cerebro-spinal Fever.

MONDAY, APRIL 23rd.

ODONTOLOGICAL SOCIETY OF GREAT BRITAIN (20, Hanover Square, W.).—8 p.m. Casual communications: (1) Mr. W. H. Dolamore, M.R.C.S., L.R.C.P., L.D.S.: Two Cysts; ? Dentigerous. (2) Mr. J. G. Turner, F.R.C.S., L.D.S.: Effects of Abscesses arising from Temporary Teeth. (3) Mr. E. J. M. Phillips, M.R.C.S., L.R.C.P., L.D.S.: (i.) Hypertrophy of the Gums; (ii.) Dentigerous Cyst. (4) Mr. N. G. Bennett, M.A., M.B., L.D.S.: Teeth Devoid of Enamel. (5) Mr. W. J. May, L.R.C.P., M.R.C.S., L.D.S.: Absorbed Roots. (6) Mr. W. S. Nowell, M.A., L.R.C.P., M.R.C.S., L.D.S.: Models showing Delayed Eruption of Temporary Teeth following Rickets.

Vacancies.

Surrey County Asylum, Brookwood, near Woking.—Junior Assistant Medical Officer. Salary £120 per annum, with board, lodging, laundry, and attendance. Applications to the Medical Superintendent.

Essex and Colchester General Hospital.—House Surgeon. Salary £100 per annum, with board, washing, and residence. Applications to Alfred C. Buck, Secretary, The Hospital, Colchester.

Wallasey Dispensary and Victoria Central Hospital, Liscard.—House Surgeon. Salary £100 with apartments, board, and service. Applications to Mr. E. Russell Taylor, Kingscourt Liscard, Cheshire.

University of Birmingham.—Assistant Lecturer on Pathology and Bacteriology. Salary £250 per annum. Applications to Geo. H. Morley, Secretary.

Inverness District Asylum.—Junior Assistant Medical Officer. Salary £100 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

East Sussex County Asylum, Hellingly.—Second Assistant Medical Officer. Salary £200 per annum, with board, furnished apartments, and washing. Applications to the Medical Superintendent.

City of Liverpool.—Infectious diseases Hospital, Fazakerley.—Assistant Resident Medical Officer. Salary £120 per annum, together with board, washing, and lodging at the hospital. Applications to the Chairman of the Port Sanitary and Hospitals Committee, Municipal Offices, Liverpool.

Cornwall County Asylum, Bodmin.—Third Assistant Medical Officer. Salary £135 per annum, with board, furnished apartments, washing, etc. Applications to Medical Superintendent.

Gartloch Asylum, Gartcosh.—Assistant Medical Officer. Salary £125 per annum, with board and lodging. Applications to the Medical Superintendent.

Manchester Hospital for Consumption and Diseases of the Throat and Chest.—Resident Medical Officer. Salary £100 per annum, with board, apartments, washing, and railway contract. Applications to C. W. Hunt, Secretary, Hardman Street, Deansgate, Manchester.

Royal National Orthopedic Hospital, 234, Great Portland Street, W.—Resident House Surgeon. Salary £200 per annum, with rooms. Applications to the Secretary.

Liverpool Infirmary for Children.—House Surgeon. Salary £100 per annum, with board and lodging. Applications to Arnold J. Cleaver, Government Buildings, Liverpool.

Holloway Sanatorium, St. Ann's Heath, Virginia Water, Surrey.—Junior Assistant Medical Officer. Salary £175 per annum, with board, lodging, washing, etc. Applications to Dr. W. D. Moore, Medical Superintendent.

London County Asylum, Colney Hatch, New Southgate, N.—Third Assistant Medical Officer. Salary £180 per annum, with board, furnished apartments, and washing. Applications to H. F. Keene, Clerk of the Asylums Committee, Asylums Committee Office, 6, Waterloo Place, S.W.

Cork Branch of the Irish Drapers' Association.—Medical Officer. Emolument, duties, etc., on application to the Hon. Sec. (see advt.).

National Maternity Hospital, Dublin.—Extern Assistant Physician. Salary £50 per annum. Applications to Secretary, Holles Street (see advt.).

Appointments.

HAY, JOHN, M.D., Ch.B.Vict., Honorary Physician to the Hospital for Consumption and Diseases of the Chest, Liverpool.

HODGSON, STANLEY, M.D., B.S.Lond., M.R.C.S.Eng., Medical Officer to the South Salford Division of Manchester.

LEGG, T. F., F.R.C.S.Eng., Assistant Surgeon to the Italian Hospital, London.

MACLAREN, WILLIAM MACLAREN, L.R.C.P. and S.Edin., L.F.P.S.Glasg., House Surgeon at the Royal Cornwall Infirmary, Truro.

PRICE, DAVID THOMAS, M.B.Lond., Medical Officer for the Castle Cary District, by the Wincanton (Somerset) Board of Guardians.

TONKING, JOHN HERBERT, M.B.Lond., M.R.C.S., L.R.C.P., Public Vaccinator for Camborne (Cornwall).

Births.

BENTLEY.—On April 6th, at Hrowth, Mitcham, the wife of Harold Bentley, M.R.C.S., L.R.C.P., of a son.

STEPHENS.—On April 11th, at Seaforth House, Hoylake, Cheshire, the wife of J. W. W. Stephens, M.D. Cantab., of a son.

WARD.—On April 6th, at Milverton, Brighton Road, Sutton, Surrey, the wife of Richard Robert Ward, L.D.S., R.C.S.Eng., of a son.

Marriages.

COTTER-MUSSON.—On April 7th, at St. Peter's Church, Fulham, George Edmond Wentworth Cotter, M.A., M.B., B.C., Camb. M.R.C.S., L.R.C.P., Lond., son of the late Duncan Donald Darroch Cotter, Co. Cork, Ireland, to Muriel Isabel, youngest daughter of Samuel James Musson, of Norwood.

Deaths.

TOMLIN.—On April 13th, at Wood Green, Robert Francis Tomlin, M.R.C.S., L.S.A., aged 52.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX"

VOL. CXXXII.

WEDNESDAY, APRIL 25, 1906.

No. 17.

NOTES AND COMMENTS.

Religion and Vivisection.

CAN a man of deep religious conviction be a vivisector? The overwhelming majority of medical men would answer in the affirmative. There are many worthy folk, however, who think otherwise. To them the practice of vivisection is a thing accursed, and they refuse to regard its practice as consistent with the higher moral attributes. In an obituary notice of the late Sir John Burdon Sanderson, we said of that distinguished man of science: "In private life he was imbued with deep religious convictions, and was a member of the Presbyterian Church. In spite of his gentleness and humanity, he has been fiercely assailed by the anti-vivisectionists." That notice brought us a letter from one of that band of restless critics, who regretfully asked how anyone could possibly possess deep religious convictions and humanity and be at the same time a vivisector. The writer might just as well ask, Can anyone be possessed of deep religious convictions and shoot a partridge, or hook a trout, or cut the throat of a calf or a bullock? All those things are done continuously to supply sustenance—and haply "sport"—to mankind; yet, viewed in cold blood, they are acts of revolting cruelty or of despicably mean cunning.

The Evil Spirit called Satan.

DOES our critic—we wonder—eat of the partridge or of the trout, or of the beef brought to his table as the result of abominable cruelty and treachery to lower animals? If so, he does it to preserve his own life and well-being; and yet, from the tone of his letter, he evidently assumes that he, at any rate, is better than men like Sir Burdon Sanderson, who assume the right of experimentation upon the lower animals in order to lessen the sum-total of human suffering. "Can it be thought," pursues our critic, "that it pleases the Deity for men to seize the dumb creatures he has made and torture them in the hope of improving the health of the human species? If it does, where is the difference between the Deity and the evil spirit we call Satan." Well, it seems to us that if man is entitled to seize dumb creatures and "torture" them with an eye to sport, food, personal ornament, bodily service, and so on, that he is equally justified in subordinating their welfare to his own by way of experimentation. If a man, to be religious and humane, must keep his hands off "defenceless creatures" in the laboratory, he must do so equally in field and forest, in pigeon-shooting enclosures, in streams, rivers, and lochs, in the slaughterhouse—in fact, everywhere. If there must be a law for this branch of morality, let it be applied all round, dear Anti-Vivisector.

The decision of the War Office in the notorious "ragging" case and Army Reform. The decision of the War Office in the notorious "ragging" case and Army Reform. Its outcome will be regarded by the majority of law-abiding citizens with approval. It relieves the Commanding Officer and the Adjutant of their appointments, and deprives the four lieutenants concerned of a year's seniority. Any less rigorous treatment of the scandal would have rendered the situation intolerable to the average man in the street. As it is, this speedy and decisive handling of a thorny incident right in the heart of military privilege makes us hope that the era of reform has at last really begun to illumine the gloomy recesses of the Horse Guards. Army abuses and scandals have often been brought to light, but inquiry has been either scotched or punishment evaded. In this case investigation has been prompt and public, and the subsequent sentence fair and fearless. The decision promises well for the future of Army administration.

What about Army Medical Reform?

So encouraging is the prospect that it infuses fresh hopefulness into the desire for Army Medical reform. The inherent rottenness of the present system was shown by that vast exposure of Army shams—the Boer war. Something has been done since then to mend matters—but not a tithe of that which is urgently needed. Were a great war to come upon us to-morrow the Army Medical Department would be hardly a whit better prepared than it was in South Africa. The British mortality from enteric fever, to take one point only, was enormous. The Japanese have recently gone through an infinitely greater campaign with a nominal loss from that malady. In other words the Japanese Army Medical Department was perfectly organised from the standpoints both of science and of administration. The British Army Medical department, on the other hand, presented a complex muddle of rival interests, compounded of official jealousy, incompetence and *laissez faire*, the outcome mainly of the starvation and stern suppression of the medical department by the military authorities.

Mr. Haldane the War Minister.

Clearly, a strong man is now at the head of the military arm. The strength of a Hercules, for that matter, is required to clear the Augean stable. It is to Mr. Haldane, the War Minister, that we must in future look for reform in Army Medical Administration. As a minor but not unimportant matter it would be well for him to inquire into the system that permits civilians to be appointed to surgeoncies

in the Household Troops. Then there is the important question of professional secrecy to which we alluded last week. We expressed our opinion that Surgeon-Major Whiston, in reporting to the Colonel that a person under his command in his opinion suffered from scabies, was thereby committing a serious breach of professional confidence. It may be that the Army authorities think they have a right to such knowledge, but we can conceive no responsible code of medical ethics that would permit of the divulging of such purely professional information. It would be well for Mr. Haldane to point out to the military authorities that they have no right to ask for such information except with the consent of the soldier involved. Besides, the individual surgeon may be wrong. Surgeon Major Whiston's view was contrary to that of several other military surgeons.

LEADING ARTICLE.

PUBLIC NEWSPAPERS AND CERTAIN ADVERTISEMENTS

IN our crusade against the advertisement of remedies of questionable character in the lay newspapers, we pointed out various advertisements of the kind in our contemporary *Truth*. The good work performed by that journal in exposing quackery has always been freely and gratefully acknowledged by us, but we considered it none the less our duty to draw attention to what appeared to be inconsistencies between the editorial creed and the editorial performance. The tone of the answer vouchsafed to us by the Editor is simply amazing. Instead of one of the calm, judicial and closely reasoned articles in which our contemporary is wont to express his views, he has favoured us with four columns of explosive rhodomontade under the elegant title of "Keeping Your Hair On." Even with pen in hand the writer is constrained to utter a half apology for his vulgarity, in advising the Editor of the MEDICAL PRESS AND CIRCULAR to "keep his hair on." However, disputes are not settled by the elegancies of Billingsgate, so we pass on to notice the gist of his defence. Our first criticism was directed against proprietary applications sold under the title of "hair food." We had assumed that all educated persons would be aware of the fact that hair could not be nourished by external applications. Hairdressers, of course, assert the opposite, partly through sheer ignorance, and partly, no doubt, because that teaching favours the sale of their nostrums. The Editor of *Truth*, apparently, has adopted the views of his barber, and possibly also those of John Strange Winter who advertises with him to the same effect. He says that the information as to the inherent worthlessness of any application as a hair food is news to him, and he has no doubt it will be to 999 people out of every thousand. So great was our respect for his journalistic and worldly acumen, that we should have imagined him to represent the odd man in this connection. Instead of that, however, he comments on the impertinence of an unknown journalist to pronounce *ex cathedra*

what tens of thousands of persons believe, on the strength of their own experience, to be a physiological fact. We may remind *Truth* that the efficacy of Count Mattei's remedies in cancer and other serious maladies were vouched for by a host of persons whose *bona fides* was above suspicion, yet analysis showed those remedies to consist of nothing but water. But in framing his tirade the Editor of *Truth* has wandered from the hair food, which is arrant nonsense, and has got on the firmer ground of a hair stimulant, assuming, that is to say, that an old-established medical journal may speak confidently about such simple matters. Years ago we believe the Editor of *Truth* challenged another editor who had assaulted him to fight a duel. He has not on this occasion faced us with so fierce an issue, but nevertheless threatens us with a proxy in the shape of Mr. George R. Sims, whom he advises us quite gratuitously not to fall foul of. The eminent journalist in question, as everyone knows, is interested in a hair lotion, but we are not aware that he has ever advertised it as a hair food, so that the introduction of his client's name hardly strengthens the case for *Truth*. At the same time we may remark incidentally that writers whose names are household words are not likely to add to their ultimate reputation by embarking in trade ventures connected with the sale of nostrums. So much for hair food; now for the "Ganesh" remedies, about which the Editor of *Truth* has little to say. So reticent does he become that he makes no specific allusion whatever either to Mrs. Adair or to the Ganesh remedies—and their prices. In making a quotation from our original article he actually replaces Mrs. Adair's name with a dash. Now, supposing the Editor of *Truth* to be excusable for not knowing the impossibility of feeding hair as one would feed rabbits or white mice, is he to be excused for not recognising the hollowness of the claim to cure wrinkles by wearing a "Ganesh" strap stuffed "with fragrant herbs," and sold at £1 5s. 6d.? His answer to that is simply to drop Ganesh and drift away into vague generalities. We presume he is more or less in honour bound to stick by his advertisers. It is not usual, however, for *Truth* to be reticent about names in leading articles. As a rule names are dragged into the light of day with relentless hand, and the arguments connected with them developed with the closeness and care of a mathematical demonstration. Here a show of refuting us is made by a quotation from a popular writer, Dr. Andrew Wilson. That gentleman, however, cannot for a moment be accepted as a scientific medical authority. Above all, the quotation given (source not stated) simply asserts that the growth of hair may be promoted by suitable lotions. What bearing has that upon hair food as apart from hair stimulation, substituted for fairly obvious reasons by the Editor of *Truth*? In conclusion we can only say that *Truth* has now received due warning as to the medical view of such things as "Ganesh" muscle oil, and wrinkle straps, and other Ganesh remedies, sold at prices varying from 3s. 6d. to £1 1s. and £1 10s. 6d. each (the fragrant strap costs a guinea and £1 5s. 6d. each.) and advertised at rates known only to publishers and their clients

NOTES ON CURRENT TOPICS.

Danger Signal for the Deaf.

In these days of motor-cars and motor bicycles some outward and visible indication of hardness of hearing has become well-nigh indispensable if the victims of that infirmity are not to be slowly but surely exterminated by unwary *chauffeurs*. In steering these too progressive vehicles the driver naturally acts on the assumption that his noisy advent will elicit certain reflexes on the part of pedestrians and drivers of horse-drawn conveyances, and he naturally expects his trumpet warnings to receive some formal recognition by a change of location or direction. An unexpected failure to respond thereto by the prospective victim is extremely likely to lead to his conversion into what the American poet has likened as "trod-upon raspberry tart," and under such circumstances it would be hardly just to saddle the horrified chauffeur with the whole of the blame. There was nothing to indicate to him that his sonorous appeal for space had fallen upon unreciprocative ear-drums, and before that fact had dawned upon him the accident would have happened, and there is one deaf person the less in the world. This special added liability of the deaf to the risks of the road, a liability which will become greater as years roll by, suggests the propriety of the hard of hearing—for it is not only the stone-deaf that we have in view—adopting some distinctive mark of their infirmity. There is nothing dishonourable in being hard of hearing, and even in ordinary social intercourse it would often be a boon to be made aware of the defective auditory condition of one's interlocutor. We must leave it to the afflicted to select the differential mark. a coloured hatband, a red umbrella, or what not, Only it were well done if it were done quickly.

The Tragic Fate of M. Curie.

In these modern days a great scientist occupies a place among the heroes of mankind. The discoverer of Radium, for instance, ranks in the minds of the present generation in much the same way as Christopher Columbus, or Alexander the Great, or Mark Antony did in those of bygone ages. It is indeed an irony of fate that one of the world's greatest scientific discoverers should be cut off in his prime by a street accident. While walking in the streets of Paris on the 19th instant he was unfortunately knocked down by a cab. At the same instant a heavy van coming from the opposite direction ran over his prostrate body and crushed him to death upon the spot. It is characteristic of the simplicity of a great mind that M. Curie refused the Cross of the Legion of Honour offered him by the French Government upon the announcement of his famous discovery. It is no less characteristic of the nobility of true science that he published his discovery freely to all mankind. The sympathies not only of France, which has prematurely lost one of her most distinguished men of science, but also of the whole

world, which shares in that calamity, will be accorded to Madame Curie, who divides with her late husband the glory of the discovery of radium. It is to be hoped that the world generally will be afforded an opportunity of contributing to the erection of an international monument in the shape of a Research University.

Dusty Throats.

THE recent spell of dry weather and the multiplication of motor vehicles raises the question as to the best means of laying the resulting dust. Those who career blissfully and rapidly throughout the country do not see one tenth of the trouble they are creating in their wake, for it is not exaggerating in the least to say that there are certain localities, right in the midst of pure country air, where the dust never settles until long after nightfall. Irritating the eyes of pedestrians and cyclists, hiding the green of the hedgerows beneath a greyish-white film, penetrating houses, ruining furniture and books, contaminating food, and depreciating house property, the dust-fiend wields his unholy sway unlet and unhindered. From the medical aspect, we hear of epidemics of a peculiar variety of sore-throat, due partly to actual mechanical irritation by dust particles and partly to germs. It is true that the nose acts as a natural filter, but it cannot be expected to keep back every dust-particle, not to mention micro-organisms. The remedy is hard to find and doubtless many experiments will have to be undertaken before any practical solution of the dust problem is forthcoming. Some form of tar treatment of main roads appears to have been fairly successful in those places where it has been adopted. The evils of dust are too well-known for any pains to be spared in combating this new danger of modern life.

Success in Failure.

It is not possible accurately to compare Medicine as a career with that of the Bar for there are obvious differences between the two callings; but if taken in their higher branches it may truthfully be said that they share in common the advantages and disadvantages presented by the influence, wealth, and social connection of their adherents. We lately drew attention to the surprising statement in Sir Frederick Treves' vigorous rectorial address at Aberdeen to the effect that success in medicine depended on merit and merit alone, the possession of money and influence operating rather to the disadvantage of the possessor. Our readers may be interested to compare this utterance of perhaps the most successful surgeon of modern times with one made by probably the most distinguished lawyer of to-day. The Lord Chancellor presiding at the annual meeting of the Barristers' Benevolent Association appealed for subscriptions from the more fortunate members of the Bar in favour of the less fortunate. "For," said he, "I am not one of those who think that success at the Bar is even approximately proportioned to merit." This may have sounded a hard saying to an audience of legal peers, high-court judges,

and distinguished K.C.'s, but who will deny that it is far nearer the truth than would have been a jaunty reference to the principles of self-denial and hard-work as the sole factors in success? In Medicine, as at the Bar, worth and ability have their chance, but the handicap is great. Perhaps some day a Cabinet of Labour Legislators will change all this.

Typhoid at Fulbourn Asylum.

A SIGNIFICANT report by Dr. Monckton Cope-man on the late outbreak of typhoid at Fulbourn Asylum, near Cambridge, has been issued by the Local Government Board, and it brings to light a state of affairs which reflects little credit on the sanitary organisation of this country. In 1902 the Local Government Board while sanctioning some loans for the extension of the asylum wrote to the Town Council of Cambridge, pointing out the danger caused to their water-supply through the proximity of the asylum sewage farm. After considerable delay the town council reported the matter to the waterworks company, and the latter wrote to the Board asking for their advice. The Board replied that they were not responsible for advice, but sent copies of the correspondence to the Asylum Committee, to the Town Council of Cambridge, and the Lunacy Commissioners. The Lunacy Commissioners wrote a strong, courteously-worded letter to the Asylum Committee pointing out that the danger was a real one, and urging that the advice of a sanitary expert should be taken and a consultation with the directors of the waterworks arranged. Three weeks later the clerk to the Asylum Committee replied that they did not admit the danger, but if the directors liked to propose a consultation they were prepared to meet them. After this, nothing was done till the inevitable outbreak of typhoid occurred, the irony of fate being exhibited in the fact that it was the asylum itself that suffered from the contamination of their own water. The whole story reflects about as little credit as could be on everyone concerned.

A Successful Action.

It is always pleasant to be able to record the success of medical men in vindicating their character and competency, and we are again able to do so in a recent case at Wolverhampton. The plaintiff had attended the daughter of the defendant for scarlet fever in October, and being convalescent in November the child was allowed to get up and go into a tower adjoining her bedroom. Some days later she developed rheumatism with cardiac complications, and of these she died two months later. No allegations of negligence or want of skill were made till the doctor sent in his account four months later, when the defendant suggested that it was the doctor's fault that the child had contracted rheumatism, and he refused payment. After medical evidence had been called to show that rheumatism was a well-recognised complication of scarlet fever and that there was no negligence in the doctor's action, the jury found

for the plaintiff, and judgment was given in his favour for the full amount. It is significant of the attitude of people of the type of the defendant that the doctor was allowed to continue attendance throughout the illness, and that the trouble only arose when the bill was sent in.

Bald Novelists.

IT is a general cry of a certain section of the literary world that novel-writing does not pay, and one can only be thankful that the public taste is even as good as it is if the bulk of trashy stories that are put on the market fail to attract many readers. One thing, however, that does seem to pay is for a novelist to be bald, but the right way to make money out of this affliction is first of all to deplore the fact in public and secondly to induce people to buy the stuff that cured the defect. Mr. George R. Sims boldly led the fashion among bald novelists, and stimulated by his success the lady who writes under the name of "John Strange Winter" has followed suit. A brochure, entitled "Comely Woman," is now being sent out broadcast to tell how the writer suffered from all sorts of hair ailments and how she found salvation in a preparation of her own elucidation! With a generous desire not to keep a good thing to herself, Mrs. Stannard now offers this stuff to the world at half-a-crown a bottle. Moreover, if it should miss fire she has other shots in her locker, and a whole whirligig of hair foods, creams, and washes may be run through before the sufferer either finds herself supplied with a headful of bushy hair or exhausted in patience and pocket. The only thing necessary to success in the hair-producing and baldness-curing business seems to be ignorance of pathology and ability to advertise, and now that the bald novelists have realised these facts we may expect them to abstract large sums from the credulous.

A Hospital Dodge.

THE difficulties which hospitals in certain cases experience when they wish to inspire confidence in the public mind sometimes lead them into devious paths, but we imagine that nothing done in this country ever equalled in impudence a dodge that was recently perpetrated in America. A certain institution calling itself the "Christian Hospital"—whether for the practice of scientific or unscientific Christianity does not appear—wishing to gain prestige elected *in absentia* the well-known Chicago surgeon, Dr. John B. Murphy, as President of the Medical and Surgical Staff. The honour was one undreamed of by Dr. Murphy and one which he promptly disowned, but the Christian Hospital, imbued with the spirit of their religion, continued to give honour where honour was due, without regard to the feelings of the recipient. Dr. Murphy, therefore, took the prosaic course of going to law, and we are glad to learn that he obtained an injunction restraining the hospital from using his name, together with £50 damages for their having done so in the past. Dr. Murphy is sincerely to be congratulated not

only in having effectively exposed the trick that was played him, but also on having demonstrated that the law in America gives a medical man some guarantee against the improper use of his name. The way that some well-known names in this country are exploited by unscrupulous people for commercial purposes is a scandal.

Phrenology.

AMONG the curious survivals of the unfit is the continued existence of the "science" of phrenology, which still possesses a society, and, presumably, members to subscribe to its funds. Mr. James Webb, the President of the Society, gave an address last week on "Bumps and their Meaning," in which he maintained that the salvation of our national mentality lies in the study of phrenology. If this be the only hope, we fear there is little prospect of the national sanity of the future. It is not a little curious that with the development of neurology and the elucidation of the functions of the different cerebral areas that the stupid empirical myths about bumps and their mental significance should not have perished, as belief in witchcraft and the evil eye have, in the light of fuller culture. The anthropometrical conclusions of the phrenologists have been shown over and over again to have no basis in fact, and to be unworthy of credence by serious people, but as a monument to human gullibility the Phrenological Society survives. Mr. Webb would like to see the study taken up in earnest by medical men, especially those engaged in asylum work; our lunacy records, says he, are seriously increasing and there is no proportionate increase in cures. Granted that doctors in asylums should have plenty of material on which to study clinical phrenology, we fail to see how their work in this direction would influence the number of cures. If they could begin by the abolition of the Phrenological Society, one cause at least of mental instability would be removed from our midst.

The Historical Medical Exhibition, London.

It is now some time since the scheme for a comprehensive historical medical exhibition was announced. It is gratifying to learn that the proposal, so far from being abandoned, has been in the meantime gathering strength and completeness. The scope of such an undertaking is simply enormous, covering as it does the whole history of medicine from prehistoric days up to the present period. Its organiser, Mr. Henry S. Wellcome, may be congratulated upon the inception and the carrying out of so gargantuan a project. In a circular addressed to the medical profession he asks for the loan of articles of interest of any age and any clime. It is to be hoped that medical men who have in their possession anything of the kind will at once place it at the disposal of Mr. Wellcome. The result of this collection should be to reduce, as it were, in panoramic form the evolution of the great science and art of healing. The precise date of the forthcoming exhibition is

not yet definitely announced, but that omission can hardly be wondered at in view of the vastness of the undertaking. It is to be hoped that the main features of the whole thing will be embalmed in some enduring form for the pleasure and instruction of future generations. With the completion of this project Mr. Wellcome will have done much to render his name remarkable in the annals of medical history.

PERSONAL.

"AN expression of the displeasure" of the Army Council is to be conveyed to Surgeon-Major P. H. Whiston in disapproval of his action in the recent case of "ragging" in the 1st Battalion Scots Guards.

PRINCESS CHRISTIAN will open a bazaar at Doncaster to-morrow, Thursday, in aid of the Doncaster Infirmary. The Corporation will present an address of welcome to the Princess.

DR. JOHN CAMPBELL, of Belfast, has been elected a Representative of Convocation on the Senate of the Royal University of Ireland.

LAST week Mr. C. G. Wheelhouse, J.P., received a handsome presentation on the occasion of his retiring from the Presidency of the Filey Club, which he had held for thirteen years. The inscription on the salver was as follows:—Presented to Claudius Galen Wheelhouse, LL.D., J.P., for 13 years President of the Filey Constitutional Club, by the members and their friends, as a token of their respect and esteem.—April 16th, 1906."

THE late Mrs. Mary Day, of Lulsley, Worcestershire, bequeathed £2,000 to the Worcester Infirmary, £1,000 to the Brompton Hospital for Consumption, and £500 each to the Worcester Dispensary and the Birmingham Blind Asylum.

THE annual meeting of the British Association for the Advancement of Science, which is to take place this year in York, will begin on August 1st with an address by the President-elect, Professor Ray Lankester, F.R.S.

A COMPLIMENTARY dinner to Dr. T. F. Dewar, Arbroath, who is leaving the town to take up the duties of medical officer of health for the county, is to be held on the 26th of this month.

MR. BRYDEN GLENDINNING, M.B., has been appointed physician to H.R.H. Princess Ena of Battenberg, the bride elect of the King of Spain. He was formerly house physician at the British Hospital in Paris.

DR. ARCHIBALD R. DOUGLAS, resident medical officer at the Royal Albert Asylum, Lancaster, has been appointed Medical Superintendent.

At the recent graduation ceremonial at the University of Edinburgh, on April 12th, the following distinguished persons, amongst others, received the degree of Doctor of Laws (LL.D.):—His Grace the Duke of Bedford; Dr. Alexander Graham Bell, the inventor of the telephone and a native of Edinburgh; His Excellency Wirklicher Geheimrat, Dr. Ernst von Bergmann, professor of surgery and director of the Royal Surgical Clinique in the University of Berlin; Dr. David Christison, son of Sir Robert Christison, and known for his archaeological attainments; Professor George Dancer Thane, of University College, London; Mr. A. Taylor Innes, Mr. William Crawthorne Unwin, F.R.S., and Miss Louisa Stevenson.

A CLINICAL LECTURE ON THE TREATMENT OF HÆMATURIA OF RENAL ORIGIN.

By T. GELSTON ATKINS, B.A., M.D., M.Ch.,
Surgeon to the Cork South Infirmary and County Hospital.

A Summary of Cliniques delivered in the South Infirmary during the Session 1905-1906.

In applying ourselves to the treatment of hæmaturia of renal origin we must in the first place inquire as to the various pathological causes which produce bleeding from the kidney, for no sound and rational line of treatment can be adopted with any degree of success that has not for its basis the exact pathological causative condition of the hæmaturia.

The various pathological causative conditions of renal hæmorrhage may be divided into (a) traumatic, (b) toxic (drug) and dietetic, and (c) disease. We will, therefore, discuss the treatment of each of these conditions, pre-supposing that only a few remarks on the diagnosis of each condition is sufficient, as, otherwise, it would lengthen this paper to an unjustifiable degree. And, first, with regard to traumatic causes, they are usually due to severe crushings, falls that produce more or less laceration of the renal substance, partial or complete, and manifest this to us by a profuse bright red hæmaturia, which is usually recognised by the local evidence of pain or some external visible local injury. If the convex border of the kidney is lacerated there is a perirenal hæmorrhage, which manifests itself by a sudden swelling in the loin, which, from its sudden onset, must be a hæmatoma. The quantity of blood lost usually varies from slight bleeding to a most profuse hæmorrhage, which may so blanch the patient and produce such collapse that death from this hæmorrhage may ensue. When called to a case of moderate severity, the following treatment I have found very successful. Perfect rest, and continuous cold, in the shape of Leiter's coil, to the loin, with internal styptics. I have seen good follow the use of ergot, given as ergotin g. 1-50 every two, three, or four hours, or oftener. I have also seen good from ergot combined with gallic acid, but I think I have seen more good from twenty-drop doses of adrenalin chlor. (1 in 1,000) every hour than from any other internal remedy. I have also seen benefit from opium. If the bleeding is so profuse as to fill the bladder quickly with blood, it coagulates, and when coagula and urine become mixed, there is great pain set up, which is aggravated by any attempt at the act of micturition, until finally a clot gets impacted in the urethra, which completely prevents any urine being voided. Under these conditions I have found that aspiration of the bladder with the largest possible litholapaxy cannula that will pass breaks up the clot, and so enables, after a time, the bladder to expel its own contents. During this period I usually suggest the exhibition of some urinary antiseptic, as uriform, urotropine, helmisthol, as it is most important to prevent sepsis in the urinary tract. In the meantime the patient sucks ice freely, or takes iced milk, or iced milk and salutaris, or other simple plain non-irritant mineral water, no solids being allowed until the hæmorrhage is controlled.

Should the hæmorrhage be not arrested by these means, or should the patient's condition from the first show that some large vessel must be bleeding, as evidenced by the rapid formation of hæmatomas, in the loin, in the bladder, &c., I would strongly urge that the kidney should at once be explored, through the usual loin incision, and then dealt with according to the conditions found, by a thorough cleansing of the laceration and possibly suture of the renal substances by deep catgut sutures, passed with blunt round (no cutting edge) needles. In addition to this, you could then pack in sterilised gauze, plain, or saturated with sterilised adrenal chlor. solution, which would act

as a drain as well. Should, however, the kidney be so severely lacerated as to be incapable of suturing it with the certainty of arresting hæmorrhage, or should a large branch of the renal artery be lacerated (that branch may possibly be ligatured), then you must have recourse to nephrectomy, and, in severe cases, when the patient seems rapidly losing ground, where the pulse is getting faster and weaker, I would not delay. I should, however, considering the necessary shock of the operation, give an intra-cellular or intravenous injection of normal saline, either before the operation or during its performance, and, generally speaking, treat any complication that might arise by the means that seemed best suited for that particular complication in the individual cases now being dealt with.

(b) CASES OF TOXIC, OR DRUG, OR DIETETIC HÆMATURIA.

It is well known that certain drugs, as turpentine and cantharides, irritate the kidney and produce hæmorrhage. The withdrawing of these drugs is usually sufficient to arrest the bleeding set up by them, and simple rest and a fluid diet completes the cure. So, also, with the hæmaturia of diet. There are certain articles of diet, such as rhubarb and asparagus, or vegetables generally speaking that contain large quantities of oxalates that produce renal hæmaturia. I have at present under my care a gentleman, now æt. about 75, who for as long as I have known him—fifteen years or more—bleeds from his left kidney whenever he eats even one blade of asparagus. The cessation of the asparagus always cures the symptom.

It is more than doubtful that kidneys so easily affected are themselves the subject of some chronic affection; for, in the instance noted above, this gentleman in the last few years has developed a gouty kidney, so that in the pre-stages of this disease, his renal vessels (capillaries) were evidently easily ruptured by the irritant action of the oxalates contained in the asparagus.

We now have to discuss the treatment of the third group.

(c) THE HÆMATURIAS OF DISEASE (RENAL).

The appearance of blood in the course of such general diseases as typhus fever, measles, small-pox, rheumatic fever, or the hæmaturia after cholera, do not seem to call for any special treatment, unless they become excessive, when probably only cupping over the kidneys and a gallic acid mixture or adrenal chlor., will suffice to moderate or check the hæmorrhage, which is due to a toxic congestion of the kidney.

We must now come to that large and important group of hæmaturias which are due to diseased or disorganised states of the kidney itself.

The hæmaturias which accompany kidney disease may be *symptomless*, or they may be accompanied by a series of symptoms, as pain, pyuria, abnormal urination, &c. This serves as a basis of classification of the renal group (A). Symptomless and painless hæmaturia: We find the onset may be sudden, and may be repeated at frequent or infrequent intervals, and the quantity of blood lost may vary from a mere trace to a very profuse and persisting hæmorrhage. This may be the local expression in the kidney of such general systemic diseases as (1) granular kidney, (2) renal syphiloma, (3) cardiac disease; or, it may occur in purely renal conditions as (4) cirrhotic kidney, or (5) angioma or capillary nævus of a renal papilla, or in (6) benign or malignant disease of the kidney, or in (7) rare cases of embedded aseptic renal calculus, or in (8) submucous deposits of crude tubercle (Fenwick).

Of the renal group (B): We find the hæmaturia pronounced and combined with other symptoms, as pain, local or referred, pyuria, abnormal urination, and altered chemical states of the urine. These conditions, more or less, we find in the following states: (1) Chronic granular nephritis (infected); (2) local interstitial nephritis (3) movable kidney (ureter), to twist or narrowing of, or obstruction of, the ureter. (These are all conditions I have frequently seen). (4) Benign or malignant growth of the kidney; (5) renal calculus; (6) renal tubercle; (both common). (N.B.—Renal tubercle I believe to be far more common than was formerly supposed.)

In dealing with the treatment of the hæmaturias of the above conditions, it would be a serious omission to omit any mention of the cystoscope—that marvellous instrument which has practically revolutionised diagnosis, and hence has given precision to methods of treatment of all the diseases of the urinary organs. By its use the blood can be seen flowing from the ureter, the various conditions of the ureteric orifices can be ascertained, and very often from these conditions the affected kidney can be localised, the ureters can be catheterised, and the urine from each kidney obtained separately, which can then be submitted to careful chemical, microscopic, and bacteriological examination; the pelvis of the kidneys can be washed out, and, if necessary, topical remedies can be applied to the pelvis of the kidneys. In this way sterile hæmodynamic agents can be brought into direct contact with the interior of the kidney with good hope of arresting hæmorrhage from the pelvis and calyces.

The hæmaturia of chronic granular kidney, if not excessive, will usually arrest itself without any very special treatment, as it is usually due to increased arterial tension; the loss of blood lowers this and hence is a "curative hæmaturia." If, however, it should become excessive or persistent, as it sometimes does when an acute nephritis is superadded to the chronic disease, then dry-cupping to the loins and hot packs will be of benefit. I have seen iron-alum in 5 grain doses do good; I have also seen ergot and gallic acid apparently arrest the bleeding. Opium is a drug which may no doubt at times arrest the bleeding but it also arrests the action of the kidney, and so may be in this respect injurious.

So also is it with the hæmaturia of cardiac disease. It may be a conservative action, and is not to be unnecessarily interfered with. Should it become excessive the treatment of the cardiac condition will usually suffice to arrest it, and, if not, any of the usual medicinal methods may be tried.

In the treatment of hæmaturias depending on renal syphilomas, the exhibition of rapidly increasing doses of iodides, with or without the addition of adrenal chloride, will rapidly cause a diminution of the bleeding and finally its arrest.

Referring again to the treatment of the hæmaturia of chronic granular nephritis, we may now and then, when ordinary treatment fails, and when it is apparent from the advancing anæmia that unless some means be adopted to bring the bleeding to an end the patient will die, be called upon to ask ourselves whether operative treatment should be adopted. It is a well-known fact that, since the routine use of the cystoscope in those cases, the bleeding has been seen to proceed usually from only *one* kidney, and that cutting into the cortex of this kidney has caused the bleeding to cease. Since Edeboh has introduced the method of renal decapsulation, for the cure of chronic nephritis, hæmaturias have been controlled, and hence we may say that in obstinate cases of renal hæmaturia due to chronic nephritis surgical intervention should be adopted at a much earlier stage of the disease than was formerly the case. Time alone will tell, when large numbers of such cases have been operated upon, of the exact value of this method of treatment.

We now have to discuss the treatment of that rare and obscure form of hæmaturia depending on angioma or capillary nævus of a renal papillæ (Fen-

wick). Some three or four years ago I was consulted with reference to a severe but intermittent bright-red hæmaturia occurring in the person of a girl, æt. 19, and which usually commenced without any apparent cause, about a week after the cessation of the menstrual period. The hæmaturia was symptomless, and the urine did not contain pus. Tubercle bacilli were not then examined for with the certainty in which they can now be detected. With the cystoscope the blood was seen pouring out of the right ureter. The right kidney was explored and its interior freely examined for ureteral stone, with the finger, with a negative result; but in twenty-four hours after the hæmorrhage ceased, and had not recurred when the patient was last heard of about eighteen months ago. The exact pathology of this case was not discovered at the operation, but in all probability it was a case of capillary nævus or a renal papillæ or angioma, as described by Mr. Fenwick.

In such a case as this, where a microscopic examination of the blood shows that it is leaking from the mucous surfaces of the pelvis or calyces, I would be strongly inclined to wash out the pelvis of the kidney, by means of the ureter catheter cystoscope, with sterile salt solution containing either adrenal chlor. or hazeline, and I should any way expect some temporary cessation of the hæmorrhage, which would at times be most important, pending the arrangements, &c., for an operation. These cases are some of the most obscure, in the whole range of kidney disease, both from a diagnostic and prognostic point of view, as well as from the point of view of treatment.

Fenwick has been able in several cases to cut into the kidney and excise, by sharp spoon, the angiomatous papillæ, and he states that in his experience these are usually found in the inferior pole of the kidney, but that they may be tucked very high up in a calyx, and so may be missed by the incision; so he suggests that the exploration should be done somewhat roughly. This seems to be what I unconsciously did in the case already cited, when after the exploration the bleeding ceased.

The exact pathology of such cases is extremely interesting, but is not a subject for the present remarks except in so far as it suggests the above methods of treatment.

In the treatment of hæmaturias of benign and malignant growths, we are able to locate by means of the cystoscope the side from which the hæmorrhage proceeds. In the early stages of these cases there is usually not any renal tumour or renal pain, which would enable the kidney from which the hæmorrhage proceeded to be localised. By examining *during* an hæmaturial period, we can note which ureteric orifice the bleeding proceeds from, or, if the hæmorrhage has ceased, we can notice the condition of the ureteric orifice, which is usually elongated, with its lips swollen, not unlike the orifice of a swollen male urethra, stained a reddish yellow colour, or, in the absence of this, we sometimes find that well-marked small vessel twigs proceed up to the orifice of the ureter, and this enables us to say that the corresponding kidney has been the seat of the hæmorrhage; but we must also remember that in these cases the bleeding may proceed *through* a perfectly normal ureteric orifice. I have now been watching a case of severe intermittent renal hæmorrhage, due to renal carcinoma for several years, and the ureteric orifice is still perfectly healthy on cystoscopic examination in the intervals between the attacks of hæmorrhage.

I would here strongly protest against any operative interference being undertaken, until the kidney from which the hæmorrhage proceeds is located. If on cystoscopic examination there is no blood seen issuing from the ureter, and the condition of the ureteric orifices do not give *exact* information as to which is the diseased kidney, then *no* operative treatment should be undertaken until another examination is made *during the next attack of hæmaturia*, when the blood can be detected issuing from the ureteric orifice corresponding to the diseased kidney. Nephrectomy is

the operation in malignant disease, when that can be done with a due hope of being successful, *i.e.*, before there is any evidence of general systemic infection.

In the hæmaturias of advanced malignant disease, where there is a renal tumour and systemic infection, operation may have to be undertaken with a view to simply arrest the hæmorrhage; and so for the time being prolong the patient's life. If operation is either declined or if other conditions seem to contra-indicate it, I have seen the hæmorrhage arrested by ergole in combination with large doses of calcium chlor. In the case cited, adrenaline, even in large repeated doses failed to even moderate the hæmorrhage; nevertheless, it is one of the drugs that should be fully and freely exhibited in such cases. Hypodermics of ergot in one of its many preparations should receive a trial, and so should turpentine. This is also a class of case where I think direct astringents might be tried by means of the ureter catheter. These solutions should be sterile and should be slowly syphoned in, in such quantities as not to produce severe renal pain.

In benign growths the kidney must be explored, and if it is considered possible to excise the growth this can be done, or a free incision into the renal pelvis, breaking up the capillaries freely, may suffice to arrest the bleeding, and if this fails then recourse must be had to extirpation, partial or complete, of the kidney.

Passing now to the treatment of hæmaturia of embedded aseptic stone, I may remark that, according to Fenwick, this class of symptomless hæmaturia occurs in only 2 or 3 per cent. of all such cases in adults, though it is much more frequent in children. The treatment consists in exploring the kidney and removing the stone, when, as a rule, the hæmorrhage ceases.

In the bleeding of deposits of crude tubercle under the mucous membrane of the pelvis, immediate removal of the kidney—to remove the tuberculous foci as quickly as possible—is the line of treatment to be adopted. It may be possible, with increased knowledge as to the limitations of the tuberculous foci, to excise them, and leave the remaining healthy portions of kidney substance. This, of course, implies that the disease is not extensive, and that it is more or less localised.

We must now turn to the treatment of hæmaturia in group (B), that is, in hæmaturia accompanied by symptoms of pain, pyuria, &c. It is absolutely necessary that we should accurately localise the source of the bleeding, for it often happens that one sees cases of hæmaturia accompanied by renal pain, referred to one or other kidney, but that when such a case is examined by the cystoscope during a hæmaturial attack the bleeding is seen to come from the ureter on the side opposite to that of the painful or aching kidney. I have seen many cases of slight hæmaturia occurring in right movable kidneys, when the pain was complained of altogether in the left side, which hæmaturia and pain were completely cured by fixation of the right kidney. Doubtless this pain is produced by some back pressure through the left ureter, causing slight distension of the pelvis of the kidney.

In this group (B) we find cases of chronic granular nephritis of the infected type. The treatment of the hæmaturia would be the same as that of a similar condition, grouped under the symptomless hæmaturias. There is, however, considerable difficulty in diagnosing whether the hæmorrhage is due to an infected granular kidney or to an aseptic stone.

I have at present under my care a man, æt. about 60, who for several years has complained of left loin pain (renal), with intermittent attacks of severe hæmaturia. The microscopy of the urine, which is acid, and of sp. gr. 1018, usually gives a few hyaline casts, a few oxalates of lime crystals, some cells, apparently from the renal pelvis. Skiagraphy gives a negative result, and cystoscopy only shows a somewhat enlarged middle lobe of his prostate, no change in the ureteric orifices, and the efflux seems normal. He has no cardio-vascular changes. Some months ago, he states that during an attack of hæmaturia he passed some calculous material,

Here is a case, then, that it is almost impossible to say whether the hæmaturial attacks are due to infected nephritis or to embedded aseptic stone. Clearly it is a case for exploration of the kidney, which I hope shortly to do.* The hæmorrhage and superadded pain may be due to irritation of the oxalate crystals, or to some shifting of the kidney, or to infection from the bladder. In either of these cases exploration, followed by free separation of all adhesions and incision of cortex, or decapsulation after Edebohl's method, if the case be not due to oxalate stone, ought to relieve the hæmaturia and pain.

But there is another class of nephritis that causes both hæmorrhage and pain—"patchy nephritis," I call it. You will frequently find on exposing a movable kidney, whitish patches with sharply defined margins, and these may be solitary or multiple. I have seen as many as six distinct such patches. The cortex is thickened and roughish, and when stripped usually brings away a little of the cortical substance with it, which has a granular looking appearance. In several such cases I have seen the hæmaturia fairly profuse. This condition is probably due to intermittent blood supply to the area, which again is due to the strain of the renal by the movable or kidney vessels. In another class of case, the nephritis seems due to a previous pyelo-nephritis. Here is a case: A man, æt. 25, consulted me for very severe attacks of intermittent hæmaturia, recurring, without any warning, about every three or four weeks for the past seven or eight years. In the intervals he was perfectly well, but his urine always contained large quantities of oxalates. He had some left renal pain, more or less continuous, but it got much worse during the attacks of hæmorrhage. The attacks simulated nephritic colic. On exploration of this case, the kidney was a hollowed-out sack, the ureter was not half its normal diameter, and was implanted into the upper part of the pelvis. This malposition and decrease in size of the ureter evidently produced pelvic distension, which led to the pyelo-nephritis and the entire destruction of the kidney. Nephrectomy cured the case, but he still passes large quantities of oxalates in his urine. We see, then, that this form of hæmaturia may be due to this patchy nephritis, which again is due to (1) infection from lower urinary tract; (2) kink—narrowing of—or (3) mal-implantation of the ureter into the pelvis; or to (4) strain in the renal vessels in a movable kidney, producing an intermittent blood supply. To cure the hæmaturia, then, the exact cause must be ascertained, and we either fix the kidney, remove the narrowing of the ureter by incision and suture at right angles to line of incision, or correct the mal-implantation, and this will usually bring the hæmaturia to an end.

In the remaining causes (a) benign and malignant growth of the kidney, (b) renal calculus, and (c) renal tubercle, the remarks made with regard to the treatment of the hæmaturia in the symptomless variety equally apply here.

In conclusion, gentlemen, I would strongly urge on you the necessity of thorough and accurate diagnosis, before any successful treatment can be undertaken. This, in a large number of cases, can now be successfully accomplished by close inquiry into the history of the case, laying special stress on the onset symptoms, and working up the history, step by step, then by careful examination of the patient, and inquiry into the cardinal symptoms—hæmaturia, undue frequency of micturition, pain, and abnormal characters of the urine, by frequent chemical and microscopic examination of the centrifugal urinary deposits, and by bacteriological examination. By careful and repeated accurate cystoscopy, by direct catheterisation of the ureters, either by Howard Kelly's method, in the female, or by Luy's method in the male, or by ordinary

* April 20th, 1906.—This case was examined four weeks ago, and no calculus found, but there were numerous adhesions at both poles. The kidney was decorticated and returned into the loin. He has lost all pain since the operation, and both albumen casts have so far disappeared from the urine, but whether this will be permanent or not it is too soon to speculate.

cystoscopic catheterisation, by segregation of the urine (Luy's method), and possibly by cryoscopy of the urine, and finally by skilled radiography. By any, or all of these means, a correct diagnosis is made, and a sure basis for treatment is arrived at.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The lecture for next week's number will be by Dr. G. M. Variot, Physician to the Paris Hospital for Sick Children, on "The Diagnosis of Pneumonia in Children."

ORIGINAL PAPERS.

THE PATHOGENESIS OF TUBERCLE IN APEX.

By Professor HOFBAUER, M.D.,
Vienna University.

[SPECIALLY REPORTED FOR THIS JOURNAL.]

FROM a very early period in the history of this disease the influence of some germ life has been adduced as the cause and propagation of so intractable a malady. As time went on, susceptibility or the loss of resistance in the tissue itself was blamed more than the bacillus, but how the latter obtains access to the apex of the lung remains for speculation. Why was the lung not as frequently attacked by the microbe in other parts as in the apex? Search was made, but no satisfactory reason could be advanced. Speculation again turned to the anatomical construction of the bronchi, which, by their mechanical action, allowed the germ to be easily carried into the apex where it lay and fructified, destroying the tissue in the immediate neighbourhood. This theory was soon confirmed by physiological experiments showing how substances were easily taken into the apex, but by no physiological effort could it be thrown out again. This explanation sufficed for the time, but another advance in our knowledge upset this theory when it was announced that the germ was non-aerogenic. For a time confusion again reigned, till Rindfleisch earnestly endeavoured to solve the problem by avowing that the real cause was due to an altered condition of the vascular system in the apex. By a method of laborious reasoning, he demonstrated the difficulty the heart had to contend with to pass the necessary amount of blood through this part of the lung. He concluded therefore that the apex in this anæmic condition was exposed to great risk, and therefore could not withstand the ravages of the microbe when it reached this part of the lung. In his arguments the upright condition of the human thorax militated against its proper supply of blood to nourish the part sufficiently.

It was soon discovered that apes, baboons, giraffes, and kangaroos were also frequently the objects of tuberculosis in the lungs, but strange to say, rarely ever in the apex. This again destroyed the cogency of the vascular theory being the correct explanation, as these animals spend the greater part of their existence in the upright position, and must by some means overcome that difficulty referred to by Rindfleisch. However, as no better explanation could be given, a compromise was made, with the arrangement of the bronchi and the deficient vascular supply, which was generously accepted by the profession for a

long time as ample explanation for the apex being the primary source of the disease.

Later, Gessner made another effort to prove that the predisposition of the apex to tubercle was due to a hernial arrangement of the lungs rising up into a narrow part of the thorax, where it was strangulated when coughing or sneezing. He compared the apex of the lung with the physiological action of the gall-bladder and appendix, but differing insomuch as the apex had its vascular supply cut off, thus producing congestion on the part of both blood and lymph.

At this time, Bier had demonstrated that congestive hyperæmia took on the tuberculous condition readier than in the normal state. With these facts disclosed it was impossible to resist the conclusions to be arrived at, although the simile of the gall-bladder and appendix did not meet with universal acceptance as conclusive proof that this was the correct theory. These organs were both free in the abdomen and neither of them was predisposed to tubercle, and therefore gave no assistance to the hypothesis. No anatomical difference could be discovered in the upper lobes of the lung to the lower, whereby a disposition of the one was greater for tubercle than the other, yet it was maintained that condition must exist to favour statistics on the subject, as there was no denying the fact that the apex was more frequently attacked than any other part of that organ.

Within the last decennium closer investigation has demonstrated a physiological difference between the upper and lower part of the lung. In laboratory experiments it is found that quiet breathing only affects the lower portion of the lung—*i.e.*, the upper part of the lung is physiologically dormant during shallow breathing, leaving the upper part quiescent, reducing the pressure and diminishing the blood and lymph supply. When the lungs are well filled and actively engaged, the tissues are more healthy and resistant against disease, which seems to be the explanation of the upper part of the lung becoming the primary seat of tubercle. To accentuate this theory, Sernberg avers that we have not only a congestive stasis in the upper part of the organ, but by the lowered blood supply a sort of atrophy is induced that hastens destruction and favours tubercle. Against this theory we have the argument of why is the whole of the upper lobe of the lung not affected with tubercle instead of the apex alone? If the whole of the upper lobe be badly nourished with blood and the lymph remain stagnant, it is quite reasonable to assume that the entire part of the organ would be equally non-resistant, which is not the case. To meet this it is assumed that the more remote part of the organ, *viz.*, the apex, would be the first to yield to the invading germ. Exner thinks that the ventilation of the lower part of the lung explains the whole case. This is another way of saying the lower part of the lung is more active than the upper.

But we may again ask if this state of affairs exists why do other infectious diseases not affect the upper part of the lung first? Some pathologists do affirm that this part of the lung is so affected.

Grossmann has given us the results of many

experiments carried out in the laboratory to prove that different parts of the lung had different coefficients of ventilation. By inspiration the veins and auricles are emptied and anæmia produced in the lung tissue; in expiration this is reversed and the lung again filled with blood. Grossmann's deductions led him to conclude that the apex of the lung was not subjected to these violent changes and would therefore be more constantly supplied with blood. This is contrary to the theory of perfect rest being the safest for those suffering from hereditary predisposition. It is observed that tubercle in the apex is not so frequent in females as in the male, while costal breathing in females is the only practicable method; thus we have ventilation with freedom from tubercle; but here again Grossmann argues that the whole lung is in a quiescent state and free from unequal pressure that seems to predispose to tubercle in the apex. Against the theory of unequal pressure we have anthracosis regularly distributed throughout the lung both in the human subject and in animals which should not be the case if the theory were true. There is yet another theory put forward by Braun, but the connection is so remote that few have received it with favour. His opinion is that the proximity of the cervical gland to the apex by the intervention of the pleura is sufficient to account for this primary affection of the apex. He attempts to demonstrate this connection by percussion, and the changes that take place in the membrane.

In the face of all these hypotheses Loebl is forced to ask how all these theories have to be reconciled with anthracosis where the fine coal dust is found evenly distributed through the lung tissue if one part of the organ is inert? The answer to this is quite relevant and consistent with the foregoing as those suffering from anthracosis are usually employed in heavy work where deep breathing is practised. Deep breathing alters the circumstances, but it is to shallow breathing the theories apply.

Where the breathing is deep the apex becomes as active as the lower portions, although experiments favour a more active movement in the lung at its base, gradually diminishing as it proceeds towards the apex, and therefore always proportionately less active at the apex even when the lung is most active. Again, females in pregnancy may be illustrated by a case given by Hirschfeld, who found that the tuberculous infection commenced at the base of the lung and not at the apex, because the upward pressure of the uterus impairs the basal movement, and prevents due ventilation of the lower portion of the organ where the bacilli settle and germinate rapidly.

This also disposes of the theory of proximal scrofulous glands in the neck being the primary cause. We may, therefore, accept the diminished aeration of the apex of the lung being the primary cause, although many contributory causes may aid in its completion. If the blood circulation be low and lethargic, and the breathing shallow during the period of bone formation, it is conceivable that the impaired function will reduce the nutrition. The lungs are not exactly bladders or air-bags that fill evenly when inspiration or expiration take place, but are modified by the fibrous septa that affect portions of the lung more adversely than others, and thus reduce the nutrition or even pro-

duce atrophy in one part as a centre of destruction.

If expansion and contraction of the lung be effected during the growth of the bony structure, while the pulmonary function is freely performed, the proper nutrition will be supplied and tubercle at the apex averted.

NOTES ON A CASE OF BRADYCARDIA, WITH ARHYTHMIA AND EPILEPTIFORM FITS.*

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THE case was that of a seemingly healthy married woman, æt. 42, the mother of three children, in whom there was no evidence of any cardiac or arterial disease, or organic disease of any of the viscera. Her illness began fourteen months before admission to hospital by a fit of unconsciousness in which she fell, which was followed by many similar slight syncopal attacks. She was delivered of a healthy child three months before being under my care. The child died, at the age of seven weeks, of convulsions, and since his death the "weaknesses" had become more frequent—as many as twelve occurring in a day. Her pulse-rate on admission, June, 1905, and all through, was very slow, or infrequent, usually ranging from 20 to 28 in a minute. This slow pulse was unattended by any consciousness on the patient's part, but when the pulse-rate was retarded 6 to 10 seconds she had an epileptiform fit, lasting 5 to 10 seconds, in which her face became at first pallid, with the eyes turned up, then flushed, and with a sigh or hem she came to, her eyes filling up with tears and with an anxious, frightened, and dazed look. Sometimes the attacks were more severe, and there were twitchings of the hands and movements of the legs. A third degree occurred more rarely, when she fell back unconscious and was more confused and dazed after it was over. This last variety was preceded by an aura, as of heat rising from the epigastrium round her heart and up to her head. The worst variety, which came on during the last four days of her life, was sudden and prolonged unconsciousness, in which, to all appearance, she was dead—all the limbs relaxed; no pulse at the wrist for seven minutes; and no respirations for four minutes; and only an occasional flutter of the heart gave any indication of life, and encouragement to the house surgeon to persevere in artificial respiration, injection of strychnine, and oxygen inhalation. This prolonged pulselessness was followed by semitonic spasm, restless and purposeless movements, and cries and groans, and unconsciousness. The attack lasted for four and a quarter hours. On the day but one before death a similar attack occurred, but not so severe; and the last attack occurred twenty-seven hours later, out of the syncopal state of which she could not be snatched.

Remarks.—I may here call attention to the observation frequently repeated during her stay in hospital—that the unconscious attacks were preceded by marked arrhythmia, and claim that their cause lay in the cerebral anæmia, produced by the long periods of ventricular arrest, and not

* Read before the Section of Medicine, Royal Academy of Medicine in Ireland, March 30th, 1906.

that the epileptiform attack caused the arrhythmia or heart block. Simultaneous tracings of the jugular vein and the radial artery made by Professor W. H. Thompson gave undoubted evidence that the tracings of the jugular vein were three times as frequent as those of the radial artery. I would emphasise the advantage we had obtained by the X-rays, in demonstrating that for each beat or shadow of the ventricles three auricular shadows could be counted.

In discussing the want of agreement between the auricular and the ventricular systoles, the myogenic theory of Gaskell of the heart's movements and rhythm was referred to, and the term "heart block" explained. The author's case clearly demonstrated that, for some reason unknown, the contracting muscles of the auricles did not convey their stimulus to the muscles of the ventricles except once in three or even ten contractions. It also showed that the want of agreement of the pulse and auricular contractions was not explainable on the theory that the left ventricle did not contract while the right did—hemisystole—a theory propounded by Broadbent. The principal theories of the causation of the condition exhibited in this case (to which the term "Stokes-Adams Syndrome" is more or less applicable) were passed in review, but were considered as being wanting in precision in the case recorded, however justified they may be in cases of senile heart with arteriosclerosis.

SOME FUNDAMENTAL CONSIDERATIONS CONCERNING DIET.*

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INACCURATE diagnosis of the dyspepsias and their haphazard treatment is responsible for part of the opprobrium still attached to medicine in the minds of a considerable section of the public. It is not to be denied there is some reason in this, for the estimate of medical wisdom is determined by the knowledge and skill of individual practitioners and the newer knowledge of the digestive processes and of foods has not yet been widely taught, nor has it been universally assimilated by teachers themselves. In no department is it more necessary than in this to have a clear and accurate knowledge of normal function, of the needs which it is the duty of function to supply, and of the material suitable for function to deal with. Knowledge of digestive processes has in the past been crude, ideas regarding diet must be held to have been extraordinarily inaccurate, and ignorance of the food values of many ordinary foods very great.

Taking into consideration, in the first place, the question of the kind of food required to maintain strength and vigour, enormous changes have taken place in the food-habits of the country and the highland people of Scotland. They must be well within the knowledge of many of our members. My own recollections I have checked by conversing with people older than myself, and who were probably in a position to have more accurate knowledge than myself on the matters referred to.

The recollections which interest me most bear upon the habits of the farm-servant class—married men with families, and working on large arable and pasture farms. These men had a free house, and free fuel was supplied by the peat stack. They had an allowance of oatmeal and of potatoes, and a cow was provided as a milk-supply for one or more families. Oatmeal, potatoes, and milk formed the great bulk of the

family food. In the part of Scotland to which I refer this was in some cases supplemented by a limited supply of herrings, cured and salted by the female head of the family. Occasionally there was a piece of cured pork. The ordinary daily dietary consisted of oatmeal porridge, or oatmeal brose, three times a day; an occasional meal of potatoes and herring supplemented this and provided some variety. In some cases the potatoes and herring, or even pork, formed more regular part of the daily menage. There might sometimes be eggs, and cheese might be made from some of the milk.

The bothy hands lived almost entirely on oatmeal, in one or other form, and milk. In Perthshire the farm hands lived in much the same style—indeed, I am assured that a Perthshire ploughman lived on oatmeal porridge, or brose, with milk. This was his food morning, noon, and night—for breakfast, dinner and supper.

As regards my personal experiences in the matter of food, children had porridge and milk morning and night, and did not expect, nor, so far as I recollect, did they want anything else. Dinner was in the main a fish or flesh meal with potatoes, barley broth and nutritious soups being included in this. It may be stated that the supply of milk was distinctly limited, for in those days it had to be sent for to some farm not too far away, and, although paid for, it was supplied almost as a favour. The milk-cart had not appeared in these regions at that date.

The meaning of these examples is that the kind of food sufficient for the maintenance of an active adult life may be extremely simple. This is an elementary truth that requires to be repeated with much insistence to-day, presumably because our social and domestic arrangements are so much more elaborate and complex that we hardly realise that our elaborate and complicated culinary arrangements are *necessary* only for the perverted or the jaded palate. We have come to regard a certain kind of food as essential to modern comfort, as the knife and fork are; not only essential to comfort, but necessary for the maintenance of that virility of mind and body which are rightly regarded as necessary for the strain of life, particularly in our large commercial and industrial centres. There can be no question that the *general* idea is that animal foods in abundance are absolutely necessary for the production and maintenance of this high degree of virility; this idea has permeated all classes, and has saturated the minds of the high and the low, the rich and the poor. The average three meal-a-day person considers that he in no way oversteps physiological requirements if his breakfast consists largely of proteid with a very moderate quantity of bread; his midday meal again proteid, with bread or potato; and his evening meal again largely proteid. Under the term "proteid" is, of course, included eggs, fish, and flesh of all kinds, and we have only to consider the diet of those around us to recognise the extent to which proteid enters into our present method of feeding. The amount of other food consumed varies greatly in individual cases. Some eat largely of bread in one form or another; some eat freely of potatoes and vegetables; and some eat what are known as "milk puddings," and which contain, in addition to milk and eggs, some one of the carbohydrate foods as sago, rice, tapioca, &c. It may, I think, be asserted, that all these are widely looked upon either as not belonging to the essentials in a meal or as occupying an entirely subsidiary place to the proteids. Let this be illustrated thus. Take potatoes—they are eaten with meat usually in very small quantity. Who, save the poor of Ireland, thinks that potatoes might be the main item for a meal, with milk, or a salt herring as kitchen, and yet this would constitute a physiological meal, and such a meal as appears to have been very common in Scotland in past times. There are traditions in Edinburgh which tell of Highland students living and flourishing mainly on oatmeal, potatoes and cheese supplied from the not overfilled

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home stores. From the physiological standpoint, these traditions are not necessarily mythical.

Further facts in support of the contention that extreme simplicity in diet is not inconsistent with the performance of ordinary functions, and some degree of activity, might be found in various directions. I heard a description of one of the late famines in India from a man who had worked through it, and he stated that the lowest and poorest caste, in the district in which his experience was acquired, lived on one of the poorer cereals, which was made into a cake mixed with some herb; that this cake was the only food those people had, and they had only one meal a day. That was their normal food supply, and, as he pathetically put it, take that away and famine to those people meant that they had no food of any kind whatsoever. If this story is correct, and I have no reason to doubt it, it shows how very meagre the supply of food may be without leading to complete physical inability. This was not a story of isolated individuals, but of an entire class of people, a section of the community under British rule in India.

The popular belief has been that only peoples who ate largely, or, at least, considerably, of flesh were physically strong, capable of physical effort, of prolonged toil, and could manifest endurance. The evidence of this, in most persons' minds, was found in the physique and character of Oriental peoples, particularly in the rice-eating peoples of India and China. The entrance of Japan into European politics in the East, and the physical and moral qualities which the Japanese have so strikingly displayed in their armed contest with a European power, may be said to have produced in our minds a somewhat startled sense that our ideas and standards have been totally wrong, or, at least, grossly inaccurate. The belief that victory and endurance belonged to the flesh-eating peoples was deeply ingrained into our minds, and it was confidently held that free flesh-eating was essential for the manifestation of prolonged physical and mental effort. Not only was this the general conception in regard to material result, but flesh-eating had actually become a standard of what was popularly called "comfort." The amount of flesh consumption increased with the increase in comfort in housing, in clothing, and in other directions as well. Official returns showed that, with increase of wages, flesh consumption proportionately increased. I imagine that this was not from any great craving for flesh food, but, to a very large extent, was the result and outcome of the popular and general idea, such as has been indicated. The popular idea was the result of ignorance and of wrong teaching. Upon whom the responsibility for the wrong teaching lay need not be inquired into; the responsibility for the belief and habits of a generation belong, seemingly, to the generation, not as individuals, but as a whole, and it is often merely a phase in the movement towards a goal which is neither seen nor even sought for. It would be interesting to look into the question of the relation between increased material prosperity, as measured by an increase of money in the hands of the community, and the amount of this new wealth which different peoples and nationalities expend on augmenting and elaborating their feeding arrangements. Does the French peasant depend upon the baker's and the butcher's van as many of the peasantry or farmservants in some parts of Scotland depend? Do the miners of Germany and Austria spend money on what they eat and drink in the same proportion as they do in some districts in Scotland? Are increased wages to be regarded largely as a stimulus to gluttony and self-indulgence, and the very cheapness of plain food a reason for pampering the palate with more expensive articles? Is the object of feeding, the supplying of the body with necessary sustenance, or the providing of the palate at stated periods with articles to titillate its nerve-endings? although the latter of these propositions is applicable to individuals in all classes, from the labouring class upwards, there are others whose dietary has been de-

termined by what has been referred to as bad education and inaccurate knowledge, or pure ignorance. It is this class who may be expected to be benefited by instruction in more modern knowledge—showing them what the true needs of the body are, how these can be supplied, and what the true food values of the more common foods are. With this large class, the ordinary feeding arrangements are really due to the traditions of their class, or if they are hardly deserving of the measure of dignity associated with the idea of tradition, it may safely be said that they are the result of custom which has grown up into its present form for want of proper guidance and of accurate knowledge.

To estimate aright the question of diet, it is necessary to differentiate clearly between what is necessary for the maintenance of the adult body in health and vigour on the one hand, and, on the other hand, all that goes beyond that and which belongs, therefore, to the category of luxuries. The necessity for this distinction cannot be too strongly insisted upon.

The flavour of food and its attractiveness to the palate is considerably mixed up with the foregoing question, and yet the two factors ought to be kept separate in our minds. The flavour of cooked food depends largely upon the mode of cooking which has been employed, and it is this artificially produced property which makes flesh not only eatable but stimulating and attractive to the sense of taste. The flavours of cooked flesh are, on the whole, stronger than those of other kinds of food, and their use, doubtless, brings the palate into a condition in which less strong flavours cease to be appreciated. There is, however, a further side to this, and that is, that the knowledge of cooking in general is of the most elementary kind, while ideas concerning the use of cooking vegetable and cereal food is of the crudest possible description. As a consequence of this lack of skill vegetable and cereal foods are often presented in a form or in a condition in which only the strongest sense of duty or impelling hunger would ever ensure their consumption. Amongst vegetables it is only necessary to single out the potato to support the foregoing statement. Compare the waxy-looking insipid article often offered to you at private or public tables with what the potato can be when properly cooked in its skin. Instead of the damp, sodden article it is dry and floury, and is as different in flavour from the badly-cooked article as to have no resemblance to it. The well-cooked potato might well be given a place to itself as a separate course in a scientifically arranged menu; and the potato so treated would not have to be so frequently excluded from the diet of the dyspeptic as is at present necessary. Many persons have experienced the joy of eating the roasted potato of the "hot-potato man," and have found it, with the addition of salt, or a piece of butter and some milk, an ample repast. And yet comparatively few cooks or housewives have acquired the elementary art of roasting potatoes aright. When we turn to look at cereals and their use in the domestic economy, much the same condition of matters is found. White bread made by the baker is in almost universal use, and few housewives supplement it or vary it by home baking; variety is found in the relatively expensive small breads also provided by the baker.

If we consider the position of the best of the cereals, namely, oats, the position is still worse. Very few cooks can make oatmeal into cakes that are in the slightest degree attractive to the average palate, and yet oatcakes can be so made as to be acceptable to the most critical. As for oatmeal made into porridge, the product under which this name may be presented to you from the kitchen of a private house or at the breakfast table of a London hotel is food fit only for hens or pigs. And yet oatmeal porridge can be so prepared and cooked as to bring out all the rich nutty flavour which characterises oats above all other cereals, and makes them not only a wholesome but a delicious food.

Mention may be made of one other cereal, namely, vice. It is well known that it is the staple food of

millions of people in our Indian Empire and in the further East, and great quantities are imported into this country, but much of it—what proportion of the whole I do not know—is used to make starch. It is, however, also widely used for making puddings; and boiled rice and milk is known in the nursery and in public institutions. Plain boiled rice is never used as the staple and chief part of a meal, and, when it is provided in lieu of vegetables or potatoes, it is often either insufficiently cooked or served as a sloppy pul-taceous mess. Rice, with some curried fish or vegetable to serve as kitchen to it, has no place with us corresponding to the place it has in the East. This is not altogether a question of cooking, but a further illustration of the fact that all this class of food has been given a second place in our feeding arrangements, the first place having been given to animal foods. So extravagantly has the public mind been turned to these that potatoes and cereals are largely regarded as mere accessories or garnishing; they have been given the place that ought to be held by the latter, and which the latter ought to occupy in a scientifically adjusted dietary.

FOOD CONSTITUENTS.

The food constituents required by man are comprised in the four great groups of (1) proteid or albuminous substances, (2) fats, (3) carbohydrates, and (4) salts.

Proteid.—The first of these, the proteid or albuminous substances, are present in varying proportions in vegetable substances as distinguished from animal, but it is from the latter, namely, animal substances, that we obtain the great part of this class. Animal substances are very rich in proteid material. It forms a large part of the nutrient elements in the flesh of animals, of birds, of fowls, of fish, of eggs, and of milk.

The term "animal food" is often used to distinguish the flesh of four-footed animals, while the members of the feathered tribe are excluded. The term *proteid food* is more comprehensive, and it is the one which requires to be used in the consideration of man's requirements. People who eat freely of the flesh of birds and of fish assure you that they take very little "animal food." What they mean is that they do not eat beef, mutton, or pig in any form. It is further to be borne in mind that eggs and milk are animal products, and are rich in proteid.

Many members of the vegetable kingdom used commonly as food also contain proteid, although in a relatively small proportion as compared with flesh of all kinds. The vegetables most rich in proteid are the legumes, as lentils, peas and beans. The cereals contain a varying proportion of proteid, the poorest being rice, while oatmeal is the richest by reason of its mode of preparation. The tubers, as potatoes, contain but a small proportion of proteid.

Fat.—The fat of man's food is derived mainly from the animal kingdom. The cereals contain a certain proportion of fat, but so small as to constitute an insignificant part of the total fat commonly consumed. Animal fat is present in flesh of various kinds, and it thus forms more or less a constant constituent of flesh food. With many persons, however, the greater proportion of the fat consumed is supplied by butter and milk.

Carbohydrates.—The carbohydrates are the starches and sugars, and are obtained from a large number of vegetable substances. At the head of the list are found the cereals, comprising wheat, oats, barley, rye, rice, and Indian corn. In all these, the main nutrient element they contain is starch. They individually also contain a varying proportion of proteid and of fat. The next great source of carbohydrates is potato. Then come arrowroot, sago, and tapioca; while a number of other substances on the market, and more or less widely used, are prepared by special processes from the cereals, and largely from wheat or Indian corn.

Salts.—Salts are present in both animal and vegetable food substances; but certain staple articles of food are

very deficient in this respect, and from amongst them ordinary white bread may be singled out as a striking example.

THE USES OF THE VARIOUS FOOD CONSTITUENTS.

With reference to the uses to which the constituents of food are put, it is imperative to have correct ideas regarding the part they respectively play in the vital economy before any attempt is made to arrange the diet of our patients with any reasonable expectation of success. Taking the *proteid* or *albuminous* first, they are necessary for the supplying of material for the growth of the growing and enlarging body of childhood and youth, while in adult life, with its fully grown body, they are required for the repair of the waste, consequent upon, and due to, vital activity. Formerly, it was thought that the measure of physical activity determined the measure of tissue waste, but this has been found not to be exactly the case. The waste in the tissues is represented in the urine as urea, and it is not found to increase in proportion to the amount of muscular work done. There is, of course, a measure of waste; all that is sought to insist on here is that it is not as great as used to be thought. The waste has to be replaced from the albuminoid or nitrogenous constituents of the food, so a sufficient supply of these is absolutely essential to the maintenance of body-weight and vigour. Beyond this amount, however, there is no need of further proteid; in fact, any further amount cannot be used, and has to be got rid of. The recognition of this fact is of supreme importance when dealing with disordered conditions, and yet it has only comparatively recently been recognised. It is still very far from being adequately accepted, acted upon, and applied to the treatment of many conditions where its application would be invaluable. The matter is even more important than this. It would appear from recent American investigations that this extra and unnecessary amount of proteid is not merely to be regarded as waste or unnecessary material which can be easily excreted, but that for its chemical transformation from the original proteid into the excretory product urea, much unnecessary strain and stress are developed, and energy expended without any compensatory benefit to the body. It is maintained that not only is this the case, but the energy thus called forth is detrimental and injurious; that it can be conserved and directed into infinitely more profitable channels in the direction both of physical and mental activity. If this be approximately correct, and I have little doubt that it is, it becomes at once apparent how immensely important the matter is, especially in adult life, and still more so after middle age. The effect of an excessive proteid supply will be again referred to.

Carbohydrates and fats may with advantage be considered jointly. They are commonly regarded and referred to as "heat-givers" or "energy-producers." It will, however, lead to a clearer understanding of the value of these substances if they are regarded as "proteid-sparers," or "proteid-savers." The explanation of these terms may be stated thus:—During the physiological activity of cells the cell can use up carbohydrate material, burning it up as in a miniature furnace, thereby saving and conserving its own more highly organised proteid material. In this burning-up process heat is produced, and it is upon this process that the temperature of the body depends. The combustion of carbohydrates may, however, also be regarded as facilitating the metabolic process in the cells, and furthering, possibly in a very important measure, the removal of the waste or excrementitious products which result from cell activity. In the performance of this very important *role* the carbohydrates and fats are interchangeable. The fats, indeed, act more powerfully than the carbohydrates, in something like the proportion of 2½ to 1. In the ordinary methods of feeding, however, both carbohydrates and fats are used, and the former in much larger amount than the latter. In the Arctic regions fat is mainly used. If the supply of carbohydrate or fat is in excess of what

is physiologically required, it tends to be stored in the body as fat, leading to ordinary obesity.

Salts.—The salts are also of vital importance, but it is not proposed to deal with them at present.

THE REQUISITE PROPORTIONS.

We are thus naturally led to the consideration of the proportions of the various food elements which are requisite for the upkeep of the body in a vigorous condition. The figures of various authorities might be given, but we may meanwhile use Church's.

In these the ratio between albuminoids and carbohydrates, including fat, ought to be 1 in $4\frac{1}{2}$; that is to say, for each ounce of albuminoids present in the daily food there should be $4\frac{1}{2}$ ounces of carbohydrates, including fat.

From tables published by various authorities it will be seen how very superior in proteid and fat oatmeal is to wheat-flour, rice, and potato. It will thus be apparent that certain plain and cheap articles of food can be combined, so as to constitute a strictly scientific dietary. Further, that various dietaries to which reference has already briefly been made supply, notwithstanding their simplicity, all the essentials for maintenance and vigour. The oatmeal and milk of the Scottish farmservant of former times, the potatoes and flesh or fish, either fresh or cured, the bread and cheese of the labourer of to-day and of the past, all fall into this category. The rice, vegetables, and fish of the Japanese fulfil the requirements. The rice and curry of India may also do so, for the curried accompaniment may be rich in proteid, although not always so. In most of these the proteid necessary for repair and the carbohydrate and fat necessary for the production of energy are abundantly present. This seems to me, however commonplace it may appear to many, to be very imperfectly realised. I am not specially concerned at present with the question of flavour, but it can certainly be insisted upon that oatmeal, fish, bread, cheese, and milk are all capable of being presented in a manner that, if ignorant prejudice were excluded, would be acceptable to the average palate. As has been already indicated, it is when the physician seeks to regulate diet on the broad principles of physiological requirement that he realises how deeply rooted the prevalent customs are in people's minds. While I have taken the above as examples of simple and yet correct relations, it must not be thought that it is necessary to confine ourselves to the particular substances specified above. The point I seek to make clear is that the popular custom has put proteid out of its scientific relation to the other food ingredients. So much has this been impressed upon me that I am disposed to think that the extraordinary prevalence of constipation amongst all classes must be largely due to the prevailing food habits. This prevalence of constipation is an important one from the public health standpoint, for it, too, leads to vessel and tissue changes sooner or later in a large number of persons, and leads to great loss of energy and of working power in multitudes of men and women. There are probably other factors in operation as well as the factor of bulk, for it can readily be assumed that the great difference in chemical constitution between animal and vegetable foods becomes a very potent factor in determining this habit.

It must, I think, be acknowledged that in a proportion of people, how large or how small it is impossible to say, all excretory functions are so efficiently performed that the effects we have referred to are not readily recognised, and that it is only in advanced life that the vascular and other changes are brought under our notice, and that we recognise in them the cumulative though slow operation of the causes under consideration. This point is of practical importance at the present time. On the question of diet for man, there are always persons holding extreme views, who preach their gospel out of season as well as in season, and who, by their fanaticism, impede the acceptance of new knowledge. It is only necessary to mention the fanatical vegetarian in proof of this statement. He is often a person who almost, if not altogether,

regards the eating of flesh as sinful. If he does not go quite so far, he is strong in the denunciation of the habit as injurious to the health of everyone who indulges in it. There is no doubt that, as has been said, many persons have excretory functions in such perfection that they easily get rid of surplus proteid. On the other hand, it is equally certain that the great majority of people who are in comfortable circumstances eat proteid beyond their physiological requirement, are not endowed with good excretory functions, and suffer accordingly. That the consumption of flesh in physiological quantity is universally hurtful is not a sound proposition. What is required is reform on true physiological lines, not revolution based on the painful experiences of pathological types.

CLINICAL RECORDS.

CASE OF FIBROMATOUS TUMOUR OF THE CAPSULE OF THE KIDNEY.

By N. H. HOBART, F.R.C.S.,
Surgeon to the North Infirmary, Cork.

MRS. C., æt. 26, primipara, was delivered on February 4th, 1906, labour normal. Three days after delivery, a tumour about the size of a small orange was noticed on the right side of the abdomen, at the level of the navel. It was tender, with smooth surface and of firm consistency. She had not noticed any tumour before or during pregnancy, but had had pain and tenderness during the last three months. On February 28 I saw patient for the first time, and found a large, oval, smooth tumour extending from the right iliac fossa to about two inches above the umbilicus. I thought it was a tense cyst. On March 4th, as the temperature had been about 102° F. for some days, I aspirated, and withdrew a small quantity of dark serum. On March 5th I opened the abdomen by a median incision, the tumour covered with peritoneum presented. A trocar was used, and about a quart of dark fluid came away. The peritoneal covering was then freely incised longitudinally and the lower pole shelled out, but the upper pole could not be stirred and the incision in the belly wall had to be lengthened by three inches. On freeing the upper portion, the kidney was exposed, and it was seen that the capsule of the tumour was firmly attached to the capsule of the kidney. As several large vessels from the cyst wall were seen apparently entering the renal vessels, and as the kidney itself seemed not to be involved in the growth (about the malignancy of which there was some doubt), it was decided to clamp the cyst wall as close to the kidney as possible. This was done, and the clamp allowed to remain *in situ*. The retro-peritoneal flaps were then united by a continuous catgut suture, any redundant tissue being removed. The cæcum and ascending colon were attached to the inner portions of this layer. The united edges were then sutured to the parietal peritoneum, and the wound as far as the umbilicus sutured in two layers. The peritoneal covering of the upper portion of the cavity was then united to the upper portion of the abdominal wound, which was left unsutured. The cavity was packed with a Mickulitz bag, by the side of which the handles of the clamp, and those of two pressure forceps, which had to be applied to the kidney where it was accidentally wounded, were allowed to emerge. The solid portion of the tumour was about the size of a small adult head. During the operation patient became greatly collapsed, and two pints of saline were injected subcutaneously under the breasts. The Mickulitz bag and pressure forceps were removed in twenty-four hours, and the pedicle clamp twenty-four hours later. The patient made an uneventful recovery. Only a small quantity of clear serum now discharging from the sinus.

Dr. Moore reports that the tumour is a pure fibroma of the capsule of the kidney, and that there is no trace of sarcomatous tissue in it.

OPERATING THEATRES.

ST. BARTHOLOMEW'S HOSPITAL.

TENDON ANASTOMOSIS.—Mr. McADAM ECCLES operated on a boy, *æt.* 5, with localised infantile paralysis. The left leg was affected, the patient having pronounced talipes varus, with a slight degree of equinus. On examination of the muscles by the make and break of the constant current, it was found that there was only reaction of degeneration in the peronei, longus and brevis, and that all the other muscles responded normally. Mr. Eccles therefore looked upon the case as a very favourable one, in which an anastomosis might be carried out.

Accordingly, after very careful preparation, an incision was made on the posterior aspect of the leg towards its outer side, extending for about two and a half inches. Through this incision the tendons of the peronei, and the outer part of the tendo Achillis were exposed. The tendon of the peroneus longus having been lifted out of its sheath, a portion of the tendo Achillis was obtained in the following manner:—An incision was made in the tendon, so as to split it vertically, separating off one-third of its breadth, and close above the insertion of the tendon this strip was divided transversely. Next this portion of the tendo Achillis was passed through a small longitudinal slit in the tendon of the peroneus longus, and firmly secured by fine silk stitches. The wound in the sheath of the peroneus longus was carefully sutured over the tendon anastomosis, and the superficial wound was closed.

Mr. Eccles remarked that the cases of infantile paralysis, in which tendon anastomosis or tendon transplantation was feasible, were not very many. The object of the operation was to diminish the action of the opposing active muscle and to induce some action in the paralysed muscle. In this instance these conditions were eminently fulfilled, because a part of the tendon attached to active muscles was engrafted into the tendon of a paralysed muscle. Mr. Eccles considered that the passing of the strip from the active muscle through a vertical slit in the passive muscle, before the two were held together by sutures, was the best method, as it ensured the greatest possible chance of firm union. Asepsis was an absolute essential for success. The wound healed soundly, and the patient was allowed to walk a fortnight later, when it was found that the anastomosis had been instrumental in diminishing the amount of varus to a very appreciable degree.

CHELSEA HOSPITAL FOR WOMEN.

OVARIOTOMY FOR A PAROVARIAN CYST.—DR. ARTHUR GILES operated on a single woman, *æt.* 31, who had been admitted as a case of urgency. When he first saw the patient with Dr. Withers Green, she was suffering from acute abdominal pain, which had been going on for several days. For three or four days she had been vomiting almost incessantly. On examination the abdomen was greatly distended by a large, tense, cystic tumour. On vaginal examination, the uterus was of normal size, drawn up behind the pubes, and the pouch of Douglas appeared to be filled up by an extension of the tumour. The diagnosis arrived at was: ovarian cyst with a twisted pedicle, and in view of the urgency of the symptoms, it was decided to operate as soon as possible. She was admitted the same day into the hospital, and the operation was performed in the evening. On opening the abdomen, the tumour proved to be a

parovarian cyst situated in the left broad ligament; it had stripped off the peritoneum and the meso-sigmoid in such a way that the bowel was spread over the surface of the tumour. The peritoneum was incised and an endeavour was made to enucleate the tumour; this proved to be a matter of very great difficulty, because the cyst had burrowed downwards between the vagina and the rectum, and the lower end of it could hardly be reached. Eventually, by emptying the cyst and making strong traction on its wall, so as to raise the whole pelvic floor, separation was effected. A large raw surface was left which was covered over as far as possible by suturing together the cut peritoneal edges. A rubber drainage tube was passed down to the bottom of the sac, and the abdominal wound closed, after shutting off the sac from the general peritoneal cavity by a process of marsupialisation. Dr. Giles said that it was very unusual for a parovarian cyst to cause symptoms simulating the torsion of an ovarian pedicle; as a matter of fact, the symptoms in this case were virtually those of acute intestinal obstruction, except that the bowels had acted. Another remarkable feature of the case, he pointed out, was the manner in which the cyst had burrowed downwards. He had not infrequently seen a parovarian cyst dissecting the peritoneum upwards, but he had neither seen, nor read of, a case in which such a cyst separated the vagina from the rectum. The dissection here was so complete that the left ureter was freely exposed for a distance of four inches, lying loose over the brim of the pelvis; in such circumstances the ureter was naturally exposed to great danger during an operation, but fortunately in this case it appeared to be undamaged. Such a large raw surface as was presented in this case was, he remarked, a source of great anxiety to the operator, because it might easily lead to adhesions and consequent intestinal obstruction. The only way to deal with the condition was to bring the peritoneum together in such a way that the raw surfaces were all contained in a sac shut off from the general peritoneal cavity and separately drained. When this drainage was effected through the abdominal wound the process was known as marsupialisation of the sac.

Society for Relief of Widows and Orphans of Medical Men.

At a quarterly meeting of the directors of this Society, held last week, Mr. Alfred Willett, F.R.C.S., vice-president, in the chair, it was shown that since the last meeting three widows, annuitants of the charity, had died; one had received the sum of £697 in grants, another £372, and the third £651 10s. Their husbands had each paid in subscriptions only £52 10s., being the amount representing twenty-five years' subscription, after paying which no further payments were required. The death of one of the directors was reported. An application for relief was received from the widow of a late member, and a grant at the rate of £50 per annum recommended. Ten letters had been received since the last Court, from widows of medical men, asking for relief, but this had to be refused, owing to the fact that their husbands had not been members of the Society. Proposals for membership from three medical men were considered and the three were duly elected. The amounts received by the annuitants, compared with the aggregate sum of subscriptions, are striking evidence of the great advantages of this Society, which cannot be too strongly urged upon the members of the medical profession, resident within twenty miles of Charing Cross. Full particulars will be sent on application to the secretary. The annual general meeting will be held on Thursday, May 3, at 5.30 p.m., at the offices of the Society, 11, Chandos Street, Cavendish Square, London, W.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

MEETING HELD FRIDAY, MARCH 30TH, 1906.

GEO. PEACOCKE, M.D., in the Chair.

KERATOSIS.

Dr. W. J. THOMPSON exhibited a case of the above which had been under his care. The patient's personal and family history was good, and before Christmas he was quite well. Then the palms of his hands and soles of his feet became rough, thickened, and swollen. The inside of the mouth became very much swollen, and the gums covered the teeth. His eyes were bloodshot; the skin thickened in the axilla, and about the elbows and chest. All the openings of the body, ears, eyes, &c., were swollen; that of the nose sometimes became ulcerated and painful. His organs, nervous system, reflexes, and thyroid were normal.

Dr. WALLACE BEATTY considered it to be an example of acanthosis nigricans, and exhibited a plate illustrating the affection.

Dr. W. J. THOMPSON said the patient was under thyroid treatment for the past three weeks with considerable benefit. He added that the man's genital organs were completely atrophied.

BRADYCARDIA, WITH ARHYTHMIA AND EPILEPTIFORM FITS.

Dr. FINNY read notes of a case of the above, which had been under observation for nine months, and which ended fatally after very severe and prolonged fits of syncope. These notes will be found under the heading of "Original Papers," on page 442.

LEUKÆMIA.

Dr. PARSONS read notes on a case of the above. The patient, a man, æt. 38, was admitted to the Royal City of Dublin Hospital on September 8th, 1905, complaining of swelling in his abdomen, shortness of breath, and palpitation of the heart. On examination the spleen extended three inches to the right of the umbilicus, and as low down as the anterior superior spine of the ilium. There was practically no enlargement of the lymphatic glands, and no tenderness on percussion over the long bones. The blood-count made on September 21st showed red blood corpuscles 3,070,000, white blood corpuscles 260,800, and hæmoglobin 57 per cent. A differential count of the white blood cells disclosed 85 per cent. of myelocytes and 20 per cent. of polynuclear neutrophiles. The changes in the blood counts were indicated on large diagrams specially prepared. The diminution in the size of the spleen was demonstrated by photographs, and detailed observations on metabolism were discussed. When discharged on March 14th, the spleen had greatly diminished, the red blood corpuscles had increased to 3,900,000, and the white blood corpuscles had fallen to 9,000. The myelocytes were present in only 8 per cent. of the total leucocytes. The treatment consisted of arsenic, iron, phosphorus, and the X-rays.

Dr. FINNY said the paper gave rise to a very interesting question—viz., What value was to be given to the X-ray treatment in this affection as regarded the red corpuscles and the size of the spleen?

Dr. C. M. BENSON said he was associated with Dr. Parsons in this case. The patient did not suffer from any nausea or giddiness. The dermatitis was slight after the X-ray treatment. The X-rays were said to have an antiparasitic action, and to cause partial destruction of the white cells without affecting the red corpuscles.

Dr. WATSON said he saw some cases treated in London a few weeks ago. The dermatitis did not cause much concern, although in two or three cases it seemed to have been very severe after the application of the X-rays. As regarded the action of the X-rays

on the spleen and other glands, he believed that a gland, after prolonged exposure to the rays, would become fibrous.

Dr. A. R. PARSONS, in reply, said that the dermatitis resulting from the X-ray treatment gave rise to no inconvenience, while the size of the spleen and number of white cells were diminished.

GLASGOW EASTERN MEDICAL SOCIETY.

MEETING HELD WEDNESDAY, APRIL 18TH, 1906.

The Vice-President, Dr. BARRAS, in the Chair.

TREATMENT OF FRACTURES OF THE HUMERUS.

Dr. JOHN GRANGER showed two cases of fracture of the lower end of the humerus. The fractures were treated, first by reducing and coaptating, under chloroform, the broken ends of the bone, and then fixing the forearm, acutely flexed, to the upper arm. The patients had perfect use of their arms, and there were no joint adhesions.

Dr. JOHN PATRICK showed a case in which, when the jaws were locked, the upper and lower molar teeth met first, leaving a considerable space between the upper and lower incisors and canine. There was difficulty in taking solid food. The front teeth were condensed very much together, and the hard palate deeply recessed. The question of congenital syphilis was raised.

Dr. J. W. MATHIE read notes of a very interesting case of

ICTERUS NEONATORUM.

The baby gradually pined away, and died on the thirteenth week. The urine was saffron-coloured, and the stools of a putty character.

Dr. ANDERSON, who performed the *post mortem*, demonstrated sections of the liver. The bile ducts had been the seat of cirrhosis, and there was likewise a catarrhal state present. The liver was engorged, and the hepatic cells bile-stained.

CORK MEDICAL AND SURGICAL SOCIETY.

GENERAL MEETING, HELD MARCH 28TH, 1906.

The President, Dr. R. P. CROSBIE, in the Chair.

Dr. P. T. O'SULLIVAN read notes of two cases of poisoning, one by strychnine, the other by phosphorus. In the first case he had occasion to order a strychnine mixture for D. C., æt. 62, who had suffered from diabetic glycosuria for four years, and gave him 2 drachms of liq. strychninæ, B.P., in a 4-ounce bottle; dose, one teaspoonful (by measure) in a wineglassful of water after meals. Patient, whilst writing letters after dinner, poured out a wineglassful of the mixture, and drank it off. An hour later, getting alarmed, he sent for Dr. O'Sullivan, who found him in a state of great excitement, but showing no symptom of poisoning except some slight trembling of the leg muscles. He watched him for an hour, and saw him frequently during the evening, but no other signs appeared, and next morning he was all right. Commenting on the case, Dr. O'Sullivan said patient had swallowed 3.5 gr. of strychnine, and there were instances where $\frac{1}{4}$ gr. had proved fatal. He thought (1) that the strychnine was bad; (2) the full meal prevented the rapid absorption if the drug; (3) that owing to the advanced diabetic condition the drug was tolerated in larger doses than in the normal subject. He said his reasons for masterly inactivity in treatment were (a) absence of symptoms; (b) if the alkaloid were absorbed the treatment would be merely symptomatic, and one could not hope to eliminate the poison.

In the case of phosphorus poisoning, that of a child that swallowed the heads of several matches, there was jaundice, with enlargement and tenderness of the liver. The stools were clayey, and smelt of phos-

phorus, and in the dark showed faint phosphorescence. The urine was scanty and bile-stained, and showed small trace of albumin, but no leucin or tyrosin. Patient was restless, and did not sleep at first, but afterwards got stupid and had to be aroused. There was no trace of bile in the stools for twenty-nine days. Patient made a good recovery, being carefully nursed and treated expectantly.

A discussion followed, and the general opinion was that the pharmacopoeal dose of strychnine was too small, and reference was made to the huge doses given hypodermically in shock. Referring to the phosphorus case, Dr. PEARSON stated that the authorities considered jaundice a sign of fatal import.

Dr. N. J. HOBART then read notes on a case of Fibromatous Tumours of the Capsule of the Kidney. They appear in another column.

Dr. HOBART next showed a hat-pin which he had removed from the urethra of a man, æt. 22. He first tried to secure the point; this failing, he pushed the point through the skin until the head alone remained in the urethra; next altering the direction, he pushed the pin out through the meatus.

Dr. HOBART also read notes of a case of perforated gastric ulcer treated by laparotomy. The symptoms were great pain, collapse, dyspnea, rapidity of the pulse and straining. The liver dulness had not disappeared. He operated four and a half hours after the onset of the symptoms, and found a hole $\frac{1}{4}$ -inch. in diameter in the anterior wall of the stomach. Having mopped up the extravasated fluid, he stitched up the rent with two layers of Lembert's suture, draining with a wick tube. Patient made a good recovery.

CASE OF EMPYEMA TREATED BY ESTLANDER'S OPERATION.

Dr. CORBY read notes of this case, and showed the patient. J. D., æt. 26, a man of phthisical appearance, was transferred from the medical wards to his care suffering from a localised right side empyema. He did a thoracotomy, only to find that the pressure of the drainage tubes induced necrosis of the contiguous ribs. He then removed pieces of four ribs, and the thickened pleura over the cavity, and evacuated a large quantity of foul-smelling pus. Hæmorrhage was free, necessitating plugging with gauze, and shock was severe. Later he found it necessary to adopt the following procedure in order to empty the cavity:—The patient, with hips raised high, resting on his shoulders, was instructed to cough repeatedly in that position, and the pus flowed out freely. He was then put in a half-sitting posture, and again repeatedly coughed, with similar result. This was done at each subsequent dressing, and in five days the pus had completely disappeared, there being now only a little serum issuing from the minute sinus left. Patient gained greatly in weight, and had lost the phthisical appearance.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, April 22nd, 1906.

TRAUMATIC RUPTURE OF THE URETHRA.

A COLLEGE professor, run over by an automobile, was carried to one of the Paris hospitals in a state of coma. Besides possible internal injuries he was found to have a fracture of the pelvis and the humerus, while the urethra was ruptured. In spite of the most active treatment the victim of the accident never recovered consciousness, and succumbed in less than twenty-four hours after the accident.

Professor Reclus, in speaking on this case, said he seized the occasion to draw the attention of the students to cases of rupture of the urethra, of which there were three varieties: Rupture of the prostatic portion, of the middle or bulbo-perineal, and of the anterior portion of the canal. The first variety, that of the patient, was rare, and could only occur in fracture of

the pubis. In general, the traumatism was so great that the victim of the accident succumbed before any treatment of the complication could be instituted.

Rupture of the urethra was easily diagnosed by the abundant hæmorrhage from the canal, the distension of the bladder felt above the pubis, and the fact that a catheter passed with the greatest care was arrested at the point named. Two methods of treatment were proposed, each one having its partisans. The first consisted in introducing a large, soft catheter up to the obstacle, and after disinfecting the perinæum, making an incision in the form of an inverted T with the cross branch just enough in front of the anus so as to avoid touching the sphincter. The parts were cut through until the end of the catheter was reached, and with the finger placed in the wound, the catheter was guided to the posterior end, and with a little patience it passed into the bladder. Sometimes, in order to find the ruptured end, it was good practice to press on the bladder so as to expel a few drops of urine. The wound was plugged with antiseptic gauze and allowed to heal by granulation.

If in spite of the most patient research, the posterior end had not been found, and consequently the continuity of the canal had not been re-established, recourse should be had to cystotomy, which was the second method and which many surgeons preferred.

The operation, as is well known, consisted in an abdominal incision going from the pubis to the neighbourhood of the umbilicus, according to the degree of *embouppoint* of the patient. The linea alba was cut through and the bladder brought to view, and opened for the space of an inch and the contents evacuated. An attempt should then be made to pass the catheter from behind forwards and crossing the rent it penetrated into the canal and finally appeared at the meatus. The bladder should be always drained by large tubes passed into the surgical wound.

These operations were very complicated and rarely successful, from the fact that fracture of the pelvis was almost equivalent to an open fracture, and consequently exposed to infection which carried off the patient from septicæmia, embolus, or diffuse suppuration.

Ruptures of the penis were still more rare; they were almost solely produced when the organ was in a state of erection, and were caused by a false and violent movement in copulation or by the stupid effort of an individual suffering from gonorrhœa, who, in order to "break the cord," forcibly bent the organ.

If the rent was incomplete, a soft catheter might succeed in passing; otherwise a button-hole should be made in the perinæum or supra-pubic cystotomy performed. Consequently, when the obstacle could not be overcome, when one or two capillary punctures of the bladder have been practised and the permeability of the canal has not been re-established, the best surgery was cystotomy as in the previous case.

Both of those varieties of rupture of the urethra—posterior and anterior rupture—were exceptional. Those met in practice were ruptures of the middle portion and were generally produced by a kick in the perinæum or a fall straddle-legged on some hard substance, and presented the usual signs—hæmorrhage from the canal, retention of urine and swelling in the perinæum. The first thing to be done was to pass a large catheter, and if it were stopped by the obstacle, no further effort should be made for the moment; the bladder should be tapped, and then the catheter tried again, and frequently success crowned the effort. Otherwise external urethrotomy should be performed.

Sometimes the rent in the urethra was only partial, a strip of mucous membrane maintained the continuity of the canal. That strip was of great service as it acted as a guide to the operator in conducting the catheter over the chasm. Where the rupture was complete the two ends of the urethra were frequently separated by a space of half an inch by reason of retraction. The point of the catheter revealed the anterior end but the other required great patience and delicate manœuvring to find.

If urethrotomy was done early, and the tissues

were not inflamed, the wound in the canal might be closed at the same time, but if the urine had had time to infiltrate the parts, large incisions should be made by the thermocautery into the inflamed tissues, penetrating right to the urethra. Later on the canal could be reconstituted and the fistulæ closed.

GERMANY.

Berlin, April 22nd, 1906.

FRAUDULENT CARLSBAD SALTS.

I HAVE been asked by the Municipal Council of Carlsbad to bring the following notice to the knowledge of the medical profession in Great Britain.

A chemist at Weissenfels obtained from a Leipzig drug merchant artificial Carlsbad Salts which proved to be a chemical compound containing admixtures of a highly poisonous nature. Several deaths have already occurred through taking this compound. This, like other imitations of genuine natural Carlsbad Sprüdel Salt, was described as "Carlsbad Salts," although it had nothing whatever to do with Carlsbad. The use of such compounds for medical purposes always involves a risk, as the purchaser is not afforded any guarantee of the harmlessness of the remedy, nor is any indication given as to its ingredients. It should be noted that genuine natural Carlsbad Sprüdel Salt is never supplied or sold loose, but only in original packages, the label, bearing the signature of the lessee of the springs, Löbel Schottländer, and this constitutes the most reliable guarantee that the purchaser will only obtain the medicament produced from the natural mineral water under the constant official supervision of the authorities. The regrettable incident at Weissenfels should serve as a caution to those who are in the habit of purchasing imitations without the advice of medical men, as it has been demonstrated by the Government and Police authorities in the present instance that the product was merely an artificial "Carlsbad Salt."

ACCIDENTS AMONG TELEPHONE GIRLS.

A brochure on this subject has lately appeared from the pen of Dr. M. Bernhardt. The writer first gives a glance over the literature of the subject, which is becoming somewhat copious, and adds thereto over sixty cases that have come under his own observation. Of these he gives a more careful account of ætiology and symptoms which leads naturally to treatment and prophylaxis.

The special injurious factor in the so-called accidents lies not infrequently in an electric current passing over the body of the operator, but the more regular course is an abnormally loud sound from the ear-piece, occasioned either by a too rapid turning of the handle for calling a person up, or one due to the weather or an atmospheric discharge.

The morbid symptoms that have been set up as the effect of a single intense sound have been described by Gradenige, Jacobson, and Passow, amongst others.

The writer's patients, whose listening ear was affected by the sharp sound, had mostly normal hearing power, and in two only out of fifty was the ear used less sharp than the other. But pain was set up in the ear and its neighbourhood, and this lasted a very long time; on some occasions the opposite ear was the site of the pain. The other symptoms of disease were paræsthesias and hyperæsthesias on the face, neck, chest, limbs, more rarely anæsthetic pareses of the upper limbs, less frequently of the lower, twitching of the muscles of the face, chorea-like movements of the arms, almost constant acceleration of the heart-beat, and, above all, psychic changes (melancholy, weeping, horrible dreams, &c.), which often resembled hypochondria with neurasthenia, whilst serious hysteria was rare.

After accidents attributable to atmospheric discharges, patients often acquired keramophobia (dread of storms), so to speak, telephonophobia.

The author believes that imitation plays a part in such nervous manifestations.

The whole group of symptoms may be classed as traumatic neuroses, and naturally prophylaxis and

treatment must correspond. When such a case comes under treatment the examination of both bodily and mental conditions must be most carefully conducted. Some protective measures should be adopted, such as isolation of the ear-piece during a storm, &c. Therapeutically, a chief theory is to calm the patient and remove fear as much as possible along with, if deemed necessary, a soothing hypnotic (veronal) pyramidon in case of pain, tonics and the employment of paradic and galvanic currents. Tepid baths he also recommends. The subject does not appear a very important one, but it would be a hardy thing to say that the slightest shock was unimportant, when the patient was an impressionable neurotic.

At the Hufeland Society Hr. Grawitz spoke on

THE FUNCTIONAL IMPORTANCE OF LEUCOCYTES.

The question was one of great practical importance. The attempt was being made to draw important conclusions as regarded proposed surgical measures from their increase or diminution. Many surgeons considered the counting of the leucocyte to be as important as taking the temperature and the pulse. From this point of view the question of the function of the leucocytes was important.

The question of their origin was not yet answered with certainty. The sharp distinctions of the various kinds of leucocytes could not justly be maintained at the present day. Their morphology had been elaborated under the ægis of Ehrlich, and his dried, coloured preparations. But the clinician, after the example of Virchow, should first examine the blood in its native state, and this should be done with every patient.

It was agreeable to chronicle a step in advance. After we have come to our limit as regarded refined microscopical technique, but using the ultra-violet rays of decomposed white light—i.e., the short, waved rays, we get a clearing up of structure twice as sharp as before. As these rays do not pass through glass, a quartz object-carrier was required. They also allowed conclusions as to the chemical composition of the preparations. Probably they were metallic substance that refracted light. (The various kinds of cells were then projected on to the screen and the different kinds described.)

We must ask what these cells signified. The nucleus of the cell must have a special function, and especially when the nucleus formed the chief mass of the cell. Where the protoplasm was further developed, the function of the nucleus became less important. In the embryo there were but few leucocytes in the blood. Lively development and activity of the nuclei first came into play at birth. This was probably connected with the function of digestion. There were from 5 to 10,000 leucocytes in the cubic millimetre. Up to recently, it was taught that leucocytes were protective organs against the entrance of foreign material. But their function must be looked upon as having a much wider range. The following might be looked upon as certainly among their properties:—(1), phenomena of movement, wandering of leucocytes; (2) phagocytism; (3) oxydising properties; (4) reducing powers; (5) absorbent properties in regard to material in solution (iron, iodine, lead, atropine, &c.); (6) assimilation; the leucocytes not only took up the bodies, but assimilated them; (7) fermentative action on break up of the leucocytes; (8) absorption of albumen, the phenomenon of digestive leucocytosis; (9) transportation of the glycogen; (10) transportation of material also outside the tissues; (11) plastic activity of leucocytes, no repair of tissues; (12) antitoxic powers as regarded clinical results. We must, for the future, go to work a little more cautiously in our judgments.

AUSTRIA.

Vienna, April 22nd, 1906.

NEPHRITIC TUBERCULOSIS.

ZUEKEREKANDL showed a case on whom he had operated for tuberculosis of the right kidney, but the point he wished most to impress on the members of the Gesellschaft was the difficulty and danger when

complicated with tuberculosis of the ureter. The semiology of the complication was not easily diagnosed, but important in the treatment. After a centre of tuberculosis is formed in the pelvis of the kidney, it is quite reasonable to expect the ureter to be affected. In all his operations for tubercle of the kidney he never once found the ureter free. The principal signs to be met with were thickening of the walls of the ureter itself as well as a fibrous fatty accumulation in the paraureteral region. This thickening of the ureter reduces the lumen of the canal often leading to obliteration and dilatation at parts in the tract. In many cases the ureteritis is in a forward state of development when the nephritic process is limited to a very small area. It is no confirmation to assume that ureteritis is not present when the bladder is found perfectly free. It will often be found that the ureter immediately above the bladder is infected when the bladder itself is perfectly free from disease. This can often be clinically diagnosed during life by attempting to get a sound into the canal. Another symptom present in all cases is the pain and tenderness along the line of the ureter, which may be found passing down behind the vagina as thick as the finger and very painful when pressed.

When the ureter is catheterised the firm resisting wall of the canal is very noticeable. The unilateral pain right or left with located cystitis would be a pathognomonic symptom in the diagnosis of tubercle in the kidney. If bacilli were present in the urine in addition to this the diagnosis would be confirmed and operation undertaken at the earliest opportunity to extirpate both ureter and kidney.

In some local cases the ureter might be left, but as a rule when thus left ulceration usually continues after the operation till death ends the suffering. In his early operations for tubercle of the kidney he seldom ever had healing of the wound by first intention, but since practising the removal of the ureter he scarcely ever has ulceration. In the literature on the subject he observes that other authors experience the same difficulty.

Kapsamer said this confirmed his own experience that he published two years ago on the subject when he removed the ureters along with the kidneys.

BACTERIA URINE.

Kornfeld next exhibited a case, æt. 25, with bacteria in the urine. He had gonorrhœa 4½ years ago, which was subsequently cured, but cloudiness of the urine still persisted, and the bladder was unable to retain more than half a litre. He was treated for some time with urotropin and helmitol—two to four grammes daily—but without any beneficial result.

In January of the present year he was received into hospital with severe gastro-intestinal disturbance, viz., loss of appetite, gaseous belching and constipation. Associated with this condition he had rigors and extreme prostration. After diagnosing bacteria urine from a presumed cysto-pyelitis, 700 cubic centimetres of residual urine was drawn from the bladder, which was afterwards well washed with a solution (1 in 5,000) of the oxide mercury. After five washings, the urine was perfectly normal in colour, which it had not been for the last four years. This condition of the urine continued six weeks. The catheter was again used, and only 200 cc. of residual urine could be taken off. The bladder was again washed and fourteen days later the residual urine of only 60 cc. could be taken off. This operation was repeated several times till no residual urine could be obtained with the catheter; urine clear and health good.

HUNGARY.

Budapest, April 22nd, 1906.

At the recent meeting of the Royal Medical Society, Professor Bókay Tános demonstrated a recovered case of

SUCCESSFUL TREATMENT OF SPORADIC CRETINISM.

First he showed projected photographs taken during the progress of a case of myxœdemetic idiocy, in which thyroid tablets were administered. The case under-

went treatment when the child was only two years of age, and after four years hardly any traces of cretinism could be found. Professor Bókay referred to the interesting cases reported in English and American periodicals as agreeing with his own extensive experience, gathered in similar cases after the systematic administration of thyroid tablets, and warmly advocated its use. In no case did he notice any pathological by-effect of the drug. He further mentioned that in exceptional cases of sporadic cretinism, when the thyroid gland was found to be in a wholly normal state, the administration of thyroid tablets would, of course, be of no avail.

A NEW PHARMACOPEIA.

Regarding the fact that since the publication of the Hungarian Pharmacopeia seventeen years have elapsed, during which period innumerable valuable drugs have been introduced into practice, and also that Hungary has been preceded by other nations in the publication of a Pharmacopeia of recent date, the Sanitary Committee of the city of Budapest has decreed that a new Pharmacopeia shall be compiled and issued as soon as possible. Substances used for preserving foods, even if they do not prevent decomposition, but only delay it, will be withdrawn from trade. The Board of Industry and Commerce requested from the Sanitary Committee the allowance of the free sale of washing soda, with the restriction that grocers must supply their customers with printed cautions as to its being poisonous. This request, however, has not been complied with, and both poisoning and adulteration will be made more difficult on the advent of the new Pharmacopeia.

THE FIGHT AGAINST CONSUMPTION

is being waged here with the greatest possible energy. Lately the post and telegraph offices with the largest traffic have been instructed to supply the premises frequented by the public with waterproof washable side-walls (cement, linoleum, asbestos), and to hang on the walls, on a visible spot, printed warnings to the public to use the spittoons. It has also been decreed that all the greater hospitals in towns shall be instructed to adopt every possible precautionary measure. In the year 1905 infectious diseases were fewer in number than in the preceding year; this particularly holds true in regard to typhoid as shown by the following table:—

YEAR	CASES.	DEATHS.
1899	909	183
1900	798	175
1901	310	75
1902	258	57
1903	217	30
1904	242	33
1905	216	29

A considerable increase has been observed in cases of diphtheria and croup. Against 830 cases in 1904 there were 1371 in 1905, the increase being 371 cases. No cases of small-pox occurred in Budapest during last year.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

SCOTLAND.

SPRING GRADUATION CEREMONIAL AT EDINBURGH UNIVERSITY.

Among the recipients of the honorary degree of Doctor of Laws at the recent graduation ceremonial on the 12th inst. were Dr. Alexander Graham Bell, Professor Bergmann, Dr. David Christison, and Professor Thane. Sir Ludovic Grant, in presenting Dr. Bell for the degree alluded to his two-fold achievement in removing the barriers which disease and distance alike present to the transmission of human speech. Professor Graham Bell was the son of a citizen of Edinburgh, Alexander Melville Bell, who gained celebrity by his scientific analysis of the elements of speech. By the application of his father's system, Professor

Bell has done much to further methods of imparting hearing to the deaf and means of expression to the dumb. But it is through his invention of the telephone that Dr. Bell has gained most fame, and it is a noteworthy circumstance as showing that the telephone is of truly academic origin, that on the first occasion on which the infant instrument emitted intelligible utterance, the Professor stood at one end of the wire and a student at the other. Of Professor Bergmann, the promoter commemorated his lengthy record on the field of battle—in the Bohemian war, in the Franco-German war, at the siege of Paris, in the Russo-Turkish war, and at Plevna, and spoke of his great career as a teacher, a surgeon, and an author. Dr. David Christison is a son of the great "Sir Robert"; he was prevented by illness contracted in the Crimea from prosecuting the medical profession, and diverting his activities into other channels, has been a pioneer in scientific archaeology. Professor Thane, said the promoter, has read all that has been written on anatomical science, and remembers all that he has read. His stores of accumulated erudition have been made accessible to a far wider circle than the students who follow his lectures, for he has incorporated them in the editions of "Quain's Anatomy," which he has brought out in collaboration with other scientists. Physiology is no less beholden to him than anatomy, for he has discharged for many years difficult and delicate duties as Inspector of the Physiological and Pathological Laboratories throughout the country, with a conscientiousness and tact which have won for him the confidence of the Home Office and the medical profession.

The spring graduation is that at which arts degrees are conferred, as well as those of the faculties of science and divinity. At the conclusion of the "capping" the graduates were addressed by Professor Eggeling, the Professor of Sanscrit, who discussed recent changes in the arts curriculum.

CARNEGIE TRUST AND THE PAYMENT OF CLASS FEES.—As was mentioned in this column a week or two ago, the Carnegie trustees are no longer in the position of being able to pay the fees of all qualified students without more ado, but find it necessary to retrench, in view of the increasing demand made upon them. Certain provisional changes in the regulations will, therefore, come into force in the approaching summer session. Regulation IV. now provides that no beneficiary who has twice failed to pass one of the ordinary professional examinations will receive further class fees until he has done so. Regulation V. provides that only such students as have already passed the ordinary examination in the relative subjects or groups of subjects shall receive fees for extra classes beyond the required curriculum for the ordinary degree. Unless a satisfactory reason be given, fees will not be paid for a course of study in more than one faculty. Beneficiaries who fail to obtain certificates that they have attended the classes and duly performed the work, will be called upon to refund the corresponding fees, and fees will not be paid for classes where such certificates are not given.

POOR-LAW AND MENTAL DISORDER.

IN view of the suggestion made by the Departmental Committee on Poor-law Medical Relief, &c., that in certain poorhouses it might be desirable to treat cases of temporary mental disorder not requiring immediate removal to an asylum, the Scottish Local Government Board has issued a circular giving the conditions on which they are prepared to approve of the establishment in poorhouses of wards for the observation and treatment of temporary mental affection. These conditions may be summarised as follows: (1) Observation wards should resemble ordinary hospital wards modified to suit their special purpose; they should be separated from other wards, and no inmate who is not medically certified as suitable for treatment shall be lodged therein. (2) There should be small single rooms in proximity to the men's ward for patients whom it is desirable to isolate; where the

patients are comparatively numerous the wards should be arranged so as to admit of the inmates being grouped in accordance with their mental condition. (3) Wards should accommodate not fewer than four patients of each sex. (4) No patient shall remain in an observation ward longer than six weeks, unless under special conditions, to be reported to the Local Government Board. (5) Special registers of the patients shall be kept. (6) Where the observation wards contain sixteen beds or more, there must be at least one resident medical officer in the poorhouse. (7) The patients shall be treated on ordinary hospital lines. (8, 9, and 10) regulate the ratio of nurses to patients. (11) The consent of the Local Government Board is required before any part of a poorhouse is set apart for the observation of cases of temporary mental disorder.

From a "contributed" article in the *Scotsman* of April 13th (a day or two after the foregoing circular was issued) we extract the following:—"The Parish Council of Glasgow have recognised this"—i.e., the ready curability of certain forms of mental disorder accompanying bodily disease—"for some years, and in the old city poorhouse much good was done in the way of preventing such cases from finding their way to the asylum, and subsequently to the ranks of the unemployed. But in designing their hospitals, which are quite separate from the ordinary poorhouse, they went a step further, and at the District Hospital in Duke Street they erected a separate block specially designed for the reception and treatment of cases of mental disease, and capable of holding some 50 beds. In this matter the Parish Council were greatly helped by Dr. Carswell, the specialist in lunacy, whose services are retained by them. Dr. Carswell, indeed, may be regarded as the pioneer of this type of ward. He holds the unique, and, in a professional sense, enviable position of being at once the medical officer in charge of the mental diseases block of the district hospital, and the certifying out-door medical officer, who out of the many cases of lunacy that pass through his hands selects those that he thinks most suitable for the treatment in question. It is generally recognised that most excellent results have been obtained from the wards in Duke Street—not better, perhaps, than would have been obtained in a first-class asylum, but the stigma of lunacy is averted and the sufferer is able to return to his former calling without being exposed to the reproach that inevitably attaches to incarceration in an asylum."

Govan and Paisley have already followed the example of Glasgow by opening such wards in their poorhouses; the new Renfrewshire combination poorhouse, to be opened next month, is equipped with mental wards, and Dundee Parish Council is also moving in the matter. No doubt the Local Government Board's circular will help to ripen the opinion of parish authorities, and to bring this important matter to public notice.

LETTERS TO THE EDITOR.

CRIMINAL RESPONSIBILITY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—*Apropos* of your able and interesting article under the above headline, a work has lately been published—"Not Guilty: A Defence of the Bottom Dog," by Robert Blatchford—in which the author demonstrates a problem which has occupied the human mind for centuries, and that is the freedom or non-freedom of will, seeing that we live in much more enlightened times than our forefathers, and as the question necessarily influences legislators in framing criminal codes of law, may I offer a suggestion or two?

Sir Oliver Lodge, in the current number of a lay contemporary, the *Clarion*, altogether repudiates the notions held by the author; indeed, goes so far as to express his amazement that any sane man could hold such views. It would therefore be interesting to hear what any of your correspondents of psychological research might think on the subject.

It would appear to me that, in order to approach the problem with an unbiased mind, the individual should concentrate his attention solely on the operations or workings of some other mind, which prevents confusion of thought, and, moreover, eliminates that element of egoism and strong sentiment, or prejudice, which in nine cases out of ten overpower the reasoning faculty. With a view to this, let me suppose that any given individual is seized with the idea of committing, say, a theft and, further, that the brain of such a one, assuming it sane, perceives, as he thinks, its advantages and disadvantages, moral and material. It seems evident that these ideas—i.e., the impulse to steal, with the probable consequences, arise spontaneously in the brain, hence we have two opposing and conflicting factors at work in the mind at the same time—viz., the conceived advantages and disadvantages—and suppose the theft be committed, the conceived advantages, therefore, having conquered the disadvantages. In what logical sense can free will be said to exist in this instance, seeing, as I have stated, the idea of stealing with the advantages and disadvantages occur involuntarily?

It is, of course, obvious, notwithstanding one's ideas on the problem, that criminal law could not, under the present state of society, be abruptly dispensed with, although its severity may be minimised in the future, as, indeed, it has been in the past.

I apprehend, moreover, that no sane person would be haunted with the idea that non-freedom of will implies a licence for the committal of immoral acts, as might *prima facie* appear to some. On the contrary, a strong disposition to conform to law and order would still exist, if pre-existing, because it is the very essence of sanity or common sense to foresee the advantages of moral over immoral conduct, which reason dictates, and from which any remarkable deviation constitutes moral insanity.

I am, Sir, yours truly,

CLEMENT H. SERS.

Brighton, April 9th, 1906.

NEWSPAPERS AND QUACK ADVERTISEMENTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I admire your pluck; I trust you may do some good; but I cannot see any hope of a cure for the evils you lay bare, so long as the whole newspaper press—headed, alas! by the *Times*—is against you. Not so long ago we had a truly leading journal. To have the *Times* on one's side in any fight on behalf of the public, in the exposure of any abuse hurtful to the people, gave the certainty of the battle being half won. If anyone wishes to see and appreciate how low the *Times* has in some directions fallen, he must look at page 5 of the issue of to-day (April 19th). He will there find an article headed "The Redemption of the Inebriate," prefaced by the following note:—

"These notes have been written by a member of the *Times*' Advertising Staff after thorough investigation, conducted with the assistance of an independent and registered Medical Practitioner of long experience."

This article, two columns in double-ledged leader type, is a paid puff of the "Keeley Institute." It is uncommonly well written. It is a cunningly worded sophistical argument disparaging medical science and medical men in regard to the treatment of drunkenness and lauding the efficacy of the Keeley "cure." As seems now usual with "cures" of this kind the Keeley treatment is under the special guardianship of Church dignitaries. Of these the most prominent seems to be the Rev. Canon Fleming, Chaplain in Ordinary to the King. The Keeley "cure" is, of course, merely an older variety of the several similar systems which are having their day. It is apparently precisely the same in essential characters as the newest, the "Normyl" treatment, which has lately been dealt with in your columns. It is not necessary in a medical paper to examine the claims of these cures. My sole purpose is to call attention to the deplorable fact that the *Times* is willing for money payment to give its sanction to statements such as that to which I draw

attention. This will be appreciated by anyone who cares to examine the article. One wonders what can be the feelings of the editorial staff, the champions of truth and honour, attached to a great journal, the proprietors of which have now adopted such elastic ideas as to what may be considered legitimate business.

I am, sir, yours truly,
CYNICUS.

April 19th, 1906. 1

HOME SPAS.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—The editorial note on the above subject in your issue of April 18th will no doubt be read with interest by the promoters of the Exhibition at the Crystal Palace, as well as by many of those affected by the prosperity of our home spas. As one who in his time has repeatedly visited most of the principal foreign springs, and is tolerably well acquainted with British resorts, I am able to recognise how much might be done to attract visitors, at any rate from among our own people, to our native cure establishments, if the managers would only strive to bring them so far as possible up to the level of their Continental rivals. At the same time, it must be recognised that our home bath establishments are in some respects hopelessly handicapped. First with regard to climate. The period during the year in which it is possible to spend much time in the open air at any season in these islands must be reckoned in days. Abroad everywhere this period is counted in weeks if not months. Then again, foreign spas are nearly all placed in the midst of, or close to fine or magnificent natural scenery; and this with the complete change of environment is naturally recognised as an advantage to most invalids. Furthermore, the amenities of all the principal Continental watering places so far surpass those of our home spas, that vast sums of money would be needed to bring them up to the same level. This especially applies to the German spas. Up to 1870, Baden Baden, Ems, Wiesbaden and Homburg were all gambling places, and for many years a large percentage of the gains from the tables had been devoted to erection of magnificent establishments surrounded by beautiful gardens. The sanitation of all these places has within late years been brought up to a high level; and indeed in this respect the Germans everywhere, if not advancing by leaps and bounds, are progressing by steady steps to the front. In France at places like Aix-les-Bains, great expenditure has been incurred in late years in improvements. It must be also admitted that foreign hotels and restaurants are ahead of those at home in many essential respects, among which the variety and excellence of the cooking, and the provision of suitable dietary for the different classes of invalids, stand out prominently. In the way of brightness derived from amusements, the foreigners are also able to in many ways beat us, and especially with regard to music. A really high-class orchestra is too costly in these islands; it can, as a rule, be easily supplied abroad. The taste for superior music has widely extended within recent years, with the growth of dislike of anything below a certain level. Inquiry will prove that a notable proportion of people are driven abroad by the consideration that they will there enjoy good music, or at least be saved the torment which the hyper-sensitive ear of an invalid often experiences, when compelled constantly to listen to the ill-played dreary selections of popular tunes which too often form the repertory of our native bands.

I am, Sir, yours truly,

VIATOR.

April 21st, 1906.

THE MEDICAL ELEMENT IN THE RECENT "RAGGING" CASE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Now that sentence has been pronounced in the recent case of "ragging" in the Scots Guards, and the incident is open to comment, I should like to know the views of the profession upon Surgeon-Major Whiston's conduct in the affair from a medico-ethical

point of view. He saw Mr. Kennedy as a patient, and as one who, from his own evidence, was in a febrile condition, and suffering from a sore and tender mouth. Was he at liberty to report to the Colonel as he did? Evidently it was not his duty, or the Army Council would not have expressed their displeasure with his conduct. The results of his conduct are far reaching and painful, and will not make his life a bed of roses as he looks back upon "the might have been," had he been gifted with a little more of the milk of human kindness, and not dealt so harshly with a young fellow who may have been at fault and to blame, but, who might have been reformed in other ways with a little more tact and kindness, or have been got rid of quite as effectually by other and less reprehensible ways.

I am Sir, yours truly,

"ENQUIRER."

Sheffield, April 24th.

OBITUARY.

PROFESSOR GEORGE BUCHANAN, OF GLASGOW

DR. GEORGE BUCHANAN, formerly Professor of Clinical Surgery, in Glasgow University, died at Stirling on April 19th, in his eightieth year. He was over seventy years of age, when he sought retirement from the active duties of a surgeon. He graduated in the year 1849, as L.R.C.S. Edin., and M.D. St. Andrews, receiving the honorary degree of L.L.D., for his distinguished services to surgery. He was a great practical surgeon and his surgical work rested on a profound knowledge of anatomy, which he had obtained as teacher of anatomy in Anderson's College, in his younger days. He edited the tenth edition of Wilson's "Anatomist's Vade Mecum." His father, Dr. Moses Buchanan, was also a Professor of Anatomy in Anderson's College, being succeeded by his distinguished son. Dr. George Buchanan was, in his younger days, surgeon to the Royal Infirmary, where the great Lister was solving the problem of how to stop suppuration in wounds by the use of antiseptics. Dr. Buchanan transferred his services, later, to the Western Infirmary, on the opening of the latter institution, and was appointed Professor of Clinical Surgery. His great rival through life—and it was a friendly emulation—was the late Sir George H. B. Macleod. Sir George was tall and handsome, was kindly in presence, and possessed charming manners. The "wee" George, as he was called by the students, was a plain man, rather small of stature, with great roundness of figure, and blunt, quick, and incisive in speech and manner. He did everything quickly, active in his habits, swift in the execution of a surgical operation, and undaunted when confronted with difficulties. He was a bold and fearless operator, opening into the brain and the abdomen, when most surgeons were deterred by the bogey of the "peritoneum," and the danger of meningitis. As a teacher of surgery and of clinical surgery, he was pre-eminent, portraying diseases in bold outlines, and rapidly explaining the main facts without labouring at minutiae. By his death thousands of people, all over the country, who had found in him a friend in need and in the hour of danger, will be saddened; while to the vast array of students who passed through his hands, and learned from his lips the pithy words of wisdom and caught something of his manly spirit, his death will come as a shock at the loss of the great surgeon whose memory will ever be held dear to those who knew him and loved him.

J. T. M.

HENRY ALEXANDER GOGARTY, M.D., L.R.C.S.I.

THE death occurred at Canterbury on the 18th inst., of Dr. Henry Alexander Gogarty, from heart trouble. He obtained his medical education at Trinity College, Dublin, and Paris, qualifying L.R.C.S.I. in 1853. M.D. in 1878, and M.B. 1867. Formerly a surgeon-major in the Rifle Brigade, he spent the latter

part of his life in Canterbury, where he became a prominent and respected citizen. For nearly 30 years he held the position of honorary physician at the Kent and Canterbury Hospital; and upon his retirement in April, 1904, owing to failing health, was elected honorary consulting physician, and thanked for the services which he had rendered to the hospital for more than a quarter of a century. He was also for many years lecturer on practical medicine at St. Augustine's Missionary Training College, Canterbury.

THE CHEMISTS' EXHIBITION.

THIS annual function which opened on Monday last, and is continued during the present week at the Royal Horticultural Hall, Westminster, is organised by the *British and Colonial Druggist* journal, and is attended by chemists from all parts of the United Kingdom, the Colonies, America and the Continent of Europe. Special excursions are run by the railways from every considerable town in Great Britain. The exhibitors include the most prominent wholesale firms supplying chemists and druggists, and the exhibition is so popular that every inch of space is let within a few days of the issue of the plan. There are over one hundred stands, some of a very costly description, and whilst it is an important mart, it constitutes the largest social reunion of the drug trade. Various meetings connected with the chemists' trade being held during the week.

Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh and Faculty of Physicians and Surgeons of Glasgow.

THE quarterly examinations of the above Board, held in Edinburgh, were concluded on the 11th inst., with the following results:—

First Examination, Four Years' Course.—Messrs. Richard Burrows Sephton, and Tirunarur Arunachala Ramaswami Aiyar, passed the examination.

First Examination, Five Years' Course.—Of 32 candidates entered, the following 19 passed the examination: Harry Ellison, Richard Dorset, Walter Crosse, Herbert Christian Bankole-Bright, Richard Parry, Baldey Singh, John William Hitchcock (with distinction), Harold Gordon Chouler, Ralph Christopher Fuller, Hugh Clement de Souza, Ernest Justin Vaillant, Dakshina Ranjan Das Gupta, George Nicol Groves, Henry Ernest King Fretz, Gordon Beveridge, Donald Morrison, Charles Gordon Timms, Arthur Lidgely Salmon, and Munchersha Byramji Irani; and four passed in Physics, three in Biology, and one in Chemistry.

Second Examination, Four Years' Course.—Mr. Aiknath Visajee Bam passed the examination.

Second Examination, Five Years' Course.—Of 19 candidates entered the following six passed the examination: Louis Nathaniel Robertson, Samuel Middleton Ware, Daniel Murphy, Ishmael Charles Pratt (with distinction), Frederick Robert Watson, Edward Peake Maitland, Thomas James George, and John Patrick Synnott; and three passed in Anatomy and one in Physiology.

Third Examination, Five Years' Course.—Of 36 candidates entered the following 26 passed the examination: James Haig Johnston (with distinction), Andrew Johnstone Brown; George Hector Urquhart, Owen Thomas Jones, William Taylor, Percival Thomas Rutherford (with distinction), Oliver Carlyle (with distinction), Joseph Henry Bennett, William Roberts Ellis, George Whitfield Knipe, Charles Liston Stewart, John Albert Henry Muller, John Henry Morris-Jones (with distinction), Jane Hall Filshill, William Francis Gordon Scott, Arthur Patrick O'Connell, Khorshed Sorabji Kanga (with distinction), Michael Joseph Hayes, Cecil Berry, Dora Robbins, Secosene Piarroux, Cowan Jones, Peter Stewart, Munchersha Byramji Irani, Jitendre Nath Rai, and Vinayak Shantaram Sanzgiri; and one passed in *Materia Medica*.

DR. ROBERT DENMAN is returning this week to resume his work as Medical Officer of Health in the Seychelles Islands.

MEDICAL NEWS IN BRIEF.

Suicide of a Medical Man on a Golf Link.

AT New Southgate on Saturday, Coroner Thomas held an inquiry into the death of Mr. Frederick Stephen Alford, 55, L.R.C.P.Lond., M.R.C.S.Eng., surgeon to the Haverstock Hill Dispensary, whose body was found on the links of the Hampstead Golf Club. Deceased, a well-known North London medical man, had been in practice in Hampstead for over twenty-five years. A nephew said he had no trouble, and had never threatened to take his life. On the previous Sunday morning deceased took a number of prescriptions to a chemist, from whom he purchased an ounce bottle of hydrocyanic acid, saying it was for an "animal case." Then he went to the golf links, and after chatting for some time with the steward, walked to a small wood close to the links. The steward found his dead body there on Wednesday, and by his side was a medicine glass. The bottle which had contained the poison was found in his waistcoat pocket. The jury returned a verdict of "Suicide whilst of unsound mind."

A Fortunate Next of Kin.

AFTER four years litigation in the Australian Law Courts, intelligence has been received by a shoemaker in the South of England that a fortune of £100,000 has been decided in his favour, subject to certain allowances to other relatives, as next of kin by marriage under the will of the late Mr. Osmand. It appears that in the early years of the last century, Dr. James Osmand, a naval surgeon, who had been engaged in the battles of Trafalgar and Algiers, retired from the service, and went to live at Plympton, a few miles outside Plymouth, where he spent the rest of a long life in private practice. His son, William H. Seville Osmand, emigrated to Australia in the days when the gold fever was at its height. He was successful in his mining operations, and with the capital acquired thereby he embarked in sheep farming on a large scale, and ultimately became the owner of three large estates, one at Sydney, another at Melbourne, and a third in Western Australia. Entering public life, he became a member of the Legislature of Victoria. He married an Australian lady, but his wife predeceased him, and there was no issue of the marriage. His death took place in Victoria on March 11th, 1901, and in accordance with his last request, his body was brought to England, and buried in the same burial ground as that containing the bodies of his parents.

King Edward the Seventh's Coronation National Fund for Nurses in Ireland.

A QUARTERLY meeting of the above society was held at 86, Lower Leeson Street, on the afternoon of Wednesday, the 11th inst. The minutes of the quarterly meeting held January 10th were read and confirmed. The Hon. Treasurer's accounts were read and passed. Applications for memberships from fourteen nurses were considered and accepted. An application for assistance having been made by one of the Nurse Members, the Council, after considering the case, granted her the sum of £12. A letter from Her Excellency the Countess of Aberdeen, in which she graciously signified her willingness to accede to the request of the Council to become Patroness of the Society was read, and a vote of thanks to Her Excellency was passed unanimously for so doing. The annual general meeting was fixed for Monday, May 14th next at 4 p.m.

The Election at Dromore West Union Dispensary. Alleged Bribery.

IN November last, the Guardians of this Union elected Dr. Clarke to the vacant post of medical officer, selecting him from two candidates, of whom the other was Dr. Denis Maguire. Dr. Maguire has now applied to the King's Bench for an order of *quo warranto* with a view to establishing his objection to the election. Dr. Maguire, who appeared for himself,

read an affidavit in which he stated that during the election he and Dr. Clarke were the candidates, and that the applicant received one vote and Dr. Clarke 28 votes. The affidavit stated that a short time before this election Dr. Clarke had been in possession of an evicted farm known as Sweeney's boycotted farm, that all branches of the United Irish League in the Dromore West Union were put in motion, and a conference was called to take steps in reference to the election in question, and eventually the election resulted as above. The applicant alleged that Dr. Clarke was elected by bribery, and the applicant also alleged that Dr. Clarke was at the time of election disqualified, and that as a result the applicant was the only real candidate for the office, and should have been elected. In answer to Judge Andrews, Dr. Maguire said he wanted the order addressed to Dr. Clarke. This the Court refused to do, and said that Dr. Maguire must serve notice of the application on Dr. Clarke and any other party to the election, and then the matter could at once be fully heard. Dr. Maguire then intimated his intention of going to the Court of Appeal.

Lisbon Medical Congress. Opening Speech by King Carlos.

THE fifteenth International Medical Congress was opened by the King on April 19th. His Majesty alluded to the religion of duty, solidarity and fraternity, and remarked that the nations were fighting in the laboratories evils by which more people were killed than by wars. Himself an ardent student of natural sciences, the King could admire the work of the congress, while his beloved Queen by her participation in the struggle against tuberculosis had proved that her heart was with the congress. He was proud to preside over a gathering the presence of which was an honour to Portugal. After the President and Secretary had spoken, the official delegates of twenty-four nations in turn addressed the congress. Then followed Professor Posner, of Berlin, the President of the International Association of the Medical Press, which has been holding meetings during the last two days at Lisbon, and will assemble in London next year. An address by Senhor Luciano de Castro, the Prime Minister, concluded the proceedings.

The Port of London.

DR. HERBERT WILLIAMS, the medical officer of the Port of London, in his annual report to the City Corporation, makes a lengthy reference to the working of the Aliens Act, and to the filthy condition under which many hundreds of Russian immigrants reached these shores. The facts were reported to the Board of Trade and as the vessels carrying the immigrants were under the Russian flag, representations were made, through the Russian Consul, to St. Petersburg. Cases of infectious disease to the number of 211 were treated last year at the Port Sanitary Hospital at Denton, near Gravesend. Dr. Williams expresses a fear that cholera may re-appear on the Continent this year, especially if the weather is very warm, in which case, he says, it will be necessary to observe strictly every possible precaution to ensure that persons coming from infected parts are kept under observation after landing in this country. It may even be necessary to place greater restrictions on the landing of alien immigrants. During the period under review 385,162 rats were destroyed in dock warehouses, and on board vessels. Packages of unsound food numbering 32,673 were seized and destroyed, as also were 181,838 loose articles.

Royal College of Physicians of Ireland.

AT the last meeting of the College, Dr. E. J. M. Watson, M.D. Dublin, and Dr. T. G. Moorhead, M.D. Dublin, were elected to the Fellowship of the College. Mr. J. Spencer Sheil, L.R.C.P. and S.I., having passed the necessary examinations has been admitted to the Membership of the College.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

Utilisation of Different Varieties of Sugar in Diabetes.—Petitti (*Berlin Klin. Woch.*, 1906, No. 6) has experimented with different sugars in diabetic patients, giving them by the mouth and also in the form of enemata, and has made observations on the amounts excreted in the urine and fæces. He found that sugar given per rectum was absorbed just as well, or even better, than that given by the mouth. No matter what sugar was given, there always resulted an increased output of dextro-rotatory sugar. Lactose appeared to be best utilised, and grape sugar worst. In severe cases of diabetes, the existing acidosis, and also the sugar output, was quite unaffected by the sugar intake. Sugar clysters, he thinks, may find a place in the diabetic diet. The sugar introduced in this manner passes for the most part *via* the superior hæmorrhoidal vein to the portal system and liver, while only a small part gets directly into the inferior vena cava through the inferior hæmorrhoidal vein. The transference of all carbohydrates that reach the liver, into glycogen, and the subsequent change of glycogen into dextrose, explains the excretion of dextrose even after the administration of lævulose. M.

Calcium Chloride in the Treatment of Headaches.—Dr. George Ross (*Lancet*, Jan. 20th, 1906) describes a peculiar form of headache most often found in women, to which he applies the term "lymphatic type of headache." Its characteristics are as follow:—(1) It is most severe on waking, and gradually diminishes during the next few hours; (2) it usually manifests itself as a dull, heavy ache, and it is exceedingly chronic; (3) it is associated with a deficient coagulability of the blood; (4) complications, such as urticaria, chilblains, and localised œdema, usually co-exist; (5) it can generally be relieved by the administration of large doses of calcium chloride. This treatment was suggested in one case by the finding of deficient coagulability of the blood and of urticaria, and proved so successful as to lead Dr. Ross to regard the headache as caused by a "serous hæmorrhage" into the brain. This opinion has been confirmed by the observation of other cases, in all of which he found improvement to take place, when the coagulation time of the blood had been shortened by the aid of calcium chloride in large doses. M.

Bronzed Diabetes.—Hess and Zurhelle (*Zeitschrift Klin. Med.*, 1905, Bd. 57) report two cases of this rare condition. As in most previously recorded cases both patients were young men, and had been accustomed to drink beer freely. They died ultimately from diabetic coma, after a long duration of the illness. The liver cirrhosis was clinically and anatomically a hypertrophic form of Lænec's cirrhosis. The hæmochromatosis consisted in the laying down of iron containing and iron free pigment in the skin and internal organs. The liver contained in one case 7.1 per cent. of iron after drying, *i.e.*, 38.7 grammes. In the other case hæmoglobinuria had existed during life, and also marked lipæmia. The authors believe that the various pigments are all the result of a general hæmolysis. They also think that the liver cirrhosis is not secondary to the deposit of pigment, but must be regarded as an independent process. Probably both pigmentation and cirrhosis result from the metabolic disturbances caused by alcohol; the diabetes is a secondary disease. M.

Renal Opothrapy.—Choupin writes (*Revue de Med.*, 1905, Nos. 1 and 2) on opotherapy for renal disease, and points out that three methods of it exist, namely—(1) treatment with nephrin, or kidney extract; (2) treatment with blood serum obtained from the renal vein; (3) treatment with pulverised kidney sub-

stance. He himself employs Renaul's method, which consists of macerating fresh, raw kidney substance in saline solution. The solution is strained through linen, is then suitably flavoured, and can be drunk cold or lukewarm. Two pork kidneys daily furnish the requisite quantity of kidney substance, provided they have been obtained from young, full-grown animals. Choupin has treated many cases of Bright's disease in this way, and regards the method as an important therapeutic agent. The fluid is not disagreeable, and is easy to take. It is a powerful diuretic, and acts in this way by direct stimulation of the renal cells, instead of by increasing the blood pressure, while its other beneficial properties are ascribed to an internal secretion of the kidney. M.

Gastro Myxorrhœa.—Kuttner, writing in the *Ewald Festnummer of the Berlin Klin. Wochenschr.*, describes under the above name a hypersecretion of the gastric mucus occurring in the empty stomach. Whilst we normally only find about 1 cc. of mucus in the empty stomach, one may in this pathological condition find as much as 25 cc. These cases are by no means rare, but one should not make the diagnosis of mucous hypersecretion, unless a large quantity is constantly present, or returns after a short interval. The reaction of the mucus is neutral, alkaline or slightly acid. Hydrochloric acid is usually absent, unless *gastrosuccorrhœa* is also present. Two forms of *gastro-myxorrhœa* are distinguished, namely, an intermittent and a chronic form. The first begins with headache, anorexia and nausea, setting in in the morning before breakfast. These cases last about a day, and resemble the gastric crises of *tabes dorsalis*, and the best treatment for them is a hypodermic injection of morphia. The chronic form may have few or no subjective symptoms. Usually there is chronic catarrh and various nervous manifestations. Lavage, alkaline waters and regulation of the diet so as to avoid vegetables and alcoholic drinks, constitutes the best line of treatment. M.

Treatment of Warts.—Hall (*Brit. Journ. Dermat.*, March, 1906) publishes a note on the treatment of simple warts by internal remedies. He had previously written on the subject and suggested the use of magnesium sulphate, but is now rather inclined, with Dr. Chalmers Watson, to attribute the successful result to the free purgation, and not to the particular drug. A child, æt. 14, the backs of whose hands had literally been covered with warts since childhood, was first treated with *mist. alba*, but no change was produced in the warts, and the bowels remained constive. Subsequently she was given *conf. sulphuris* and *conf. sennæ*, but with no better result. The treatment was now changed to *pil. aloin* (gr. $\frac{1}{2}$), *c. nux vomica* (gr. $\frac{1}{2}$), and almost at once distinct improvement was noticed. The bowels became regular and the warts diminished in size so that in about ten weeks only quite a few shrunken warts were left on the fingers. K.

The Results of Anti-enteric Inoculation.—Ward (*Journ. R. Army Med. Corps*, April, 1906) records the results obtained from this inoculation in the case of the 7th Hussars. The regiment embarked for South Africa on November 30th, 1901, with a strength of 26 officers and 524 N.C.O.'s and men. Out of these, 20 officers and 213 N.C.O.'s and men were inoculated twice, and 75 N.C.O.'s and men were inoculated once; the others were not inoculated. Among the uninoculated officers three were over 30, and had already been on active service, while one had already had enteric fever. The first dose was 0.5 cc. of vaccine fluid supplied by Professor Wright; the second dose was 1 cc. given after an interval of eight days. Very few of those inoculated suffered any inconvenience and

in no case was there any severe reaction. It was noticed that the general reaction was most marked in those who had previously had enteric and least in those who were heavy smokers. During the six months which the report covers the regiment was engaged on active service under every condition of trekking and in towns. During the six months there were in all 29 cases of enteric fever; six in those inoculated twice; three in those inoculated once, and 20 in those uninoculated. No officer contracted the disease. There were three deaths from enteric fever, all in those uninoculated. During the last five months covered by this report the 2nd Dragoon Guards, an uninoculated regiment which had landed a few months before the 7th Hussars with a strength of 357 N.C.O.'s and men, were with this latter regiment and under exactly similar conditions; they are, however, known to have lost one officer and over 20 men from enteric fever during this period. April 13th, 1902, a draft of forty-eight men arrived for the 7th Hussars; they were uninoculated, and on June 20th there had been among them four cases of enteric fever with one death. Between June, 1902, and December, 1905, only one case of enteric fever occurred among those inoculated twice, one among those inoculated once, and 16 among the uninoculated. K.

Rhythmic Displacement of the Heart as a Sign of Pleural Effusion.—Green (*Amer. Journ. M. Science* March, 1906) discusses the value of a rhythmic lateral displacement of the heart synchronous with respiration as a sign of unilateral liquid exudate in the pleural cavity. He has observed many cases of effusion from different causes, and has estimated the movement of the heart by means of auscultatory percussion, combined with the fluoroscope. In all cases of unilateral effusion he was able to demonstrate the rhythmic lateral displacement of the heart though this phenomenon was not observed in any other conditions of the pleura examined. Green has been unable to confirm the correctness of the observations leading to the statement that in certain cases of this sort the diaphragm is absolutely paralysed and in some instances forced downward so as actually to bulge into the peritoneal cavity. Green offers the following conclusions as the result of his investigations: (1) A rhythmic lateral movement of the heart occurs in unilateral liquid pleural effusions. (2) Such movement is most marked in medium-sized effusions. (3) The heart approaches the affected side in inspiration and moves outward in expiration. (4) The extent of the movement is variable but often amounts to two inches. (5) It may be measured by fluoroscopic examination, auscultatory percussion, or, in the case of right-sided effusions, by simple deep percussion of the free cardiac border, or in some instance by mere inspection of the apex beat. (6) Deep breathing and especially forced expiration are essential to the success of the manoeuvre, and to obtain this morphine must sometimes be administered. (7) Marked rhythmic lateral movement has not been found in pneumonia, tuberculous infiltration of the lung, malignant disease of the pleura or lung, or in subdiaphragmatic abscess. This sign may then be looked on as of considerable diagnostic value in the differential diagnosis of intrathoracic disease. K.

New Method of Testing Functions of Digestive Apparatus.—Einhorn (*Med. Record*, New York, February 10th, 1906) attaches solid food stuffs to glass or porcelain beads, by drawing them through the opening in the bead and tying them on with silk thread. Examination of the beads found in the fæces will reveal the indigestible substances, while those which are digestible will have disappeared during their course through the gastro-intestinal tract. In order to test the work of the stomach alone, a thread is attached to the beads, which are placed in a gelatine capsule. At the end of from four to six hours the beads are withdrawn. By these two methods both the digestion in the stomach and bowel may be judged. Einhorn sums up the results of his experiments as follows: "In the case of individuals catgut and fish bones

are digested in the stomach, whereas boiled or raw meat (beef), raw chicken skin, and raw as well as boiled potatoes do not disappear altogether in this organ. The muscles show a swelling and loosening of the fibres. Raw muscle fibre and chicken skin disappear in the intestines; tendons remain undigested. Raw potatoes show a varying condition, sometimes disappearing entirely, sometimes going through unchanged. Boiled potato usually seems to be digested in the bowel, but the skin of the potato, raw or boiled remains unchanged. Fats with a very high melting-point, such as lard are not absorbed in the intestine; suet and mutton fat are digested in the bowel. Fish bone is not changed in the intestinal tract. If the intestinal functions are normal albumin (raw meat) and starch (potato), boiled two minutes, and mutton fat will disappear during their passage through the digestive tract. Disturbance of these functions may be recognised by the reappearance of food substances attached to the beads. Raw thymus has been used to test the pancreatic function. When the intestinal and pancreatic functions are intact, the thymus will disappear. D.

X-ray Diagnosis of Thoracic Aneurysms.—Bætjer (*Johns Hopkins Hosp. Bull.*, January, 1906) reports four years' experience at the Johns Hopkins Hospital with X-rays in the diagnosis of thoracic aneurysm. This diagnosis was made 104 times. In 70 to 75 per cent. of the cases the diagnosis had already been made by other methods. The X-rays practically always confirmed the medical findings. In 20 to 25 per cent. the diagnosis was doubtful, but, in many instances, the subsequent course of the disease proved the X-ray diagnosis to be correct. In 5 per cent. of the cases the aneurysm was found by accident, there being no physical signs. Eighteen per cent. of the cases came to autopsy, and the X-ray findings were always confirmed. D.

Syphilis or Mercury.—Wolter (*St. Louis Courier of Medicine*, February, 1906) holds that the theory that paralytic dementia and tabes, in 90 per cent. of all cases, are meta-syphilitic conditions, is not so sound as the theory that the diseases are usually a meta-mercurial condition. He does not deny that paretics and tabetics are syphilitic, but believes that it is equally true that they have been mercurialised. As a result of considerable study he inclines to the belief that mercury and not syphilis is responsible in the etiology of paralytic dementia and tabes. He says there are important reasons for the belief that syphilis plays a minor role in the etiology of sclerosis of the brain and cord. Although the negro is very prone to contract syphilis, paresis and posterior spinal sclerosis are seen rarely in the coloured race. The average negro most frequently receives no treatment for lues, and the most severe secondary and tertiary lesions are found in the coloured man. Having become a syphilitic, he allows the disease to run a typical course without interference. If he does take mercury, it is with no system; it is taken irregularly and for no prolonged period of time. Yet in spite of all this, he does not become the victim of paresis and tabes. On the other hand, the man of brains, the professional man, the highly educated man, falls a ready victim to paresis. The requisites of thorough antisiphilitic treatment are brains and money, and since these are the essentials in obtaining the treatment, Wolter believes that there is the reason why paretics and tabetics are usually individuals of prominence. D.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "Recent Medical Literature."
- (2) "Recent Surgical Literature."
- (3) "Recent Gynecological and Obstetrical Literature."
- (4) "The Recent Literature of Physiology and Pathology."

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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.

CAUTION TO OUR READERS.

We understand that an individual, representing himself as Dr. Robinson, at other times as Dr. Williams, has been calling on medical men professing, by way of introduction, a personal friendship with some well-known New York physicians, finally winding up a hasty interview with a regret that he has suddenly found himself to have been robbed of his purse, and would Dr. — kindly loan him 5s. to get back to his hotel, when the money will be immediately returned. This man we have ascertained is a Russian Jew, speaks English fluently, and is partial to umbrellas and such like portable articles when not personally shown the front door.

T. B. A.—We hope to deal with the subject in our next.

ONE OF YOUR READERS—Your communication reached us while the journal was "at press."

DR. WINTER—We understand that a meeting will be held the last week in May, when previous references will be reported on and decisions arrived at.

B. (Liverpool)—According to the official returns of the Registrar-General, Glasgow has the next largest population in the United Kingdom to London. Liverpool comes next, with a population of about 100,000 fewer than Glasgow.

DR. W. A. S. (Galway)—In answer to your inquiry, the Easter Session of the Medical Graduates' College and Polyclinic (Chenies Street, Gower Street, London) begins on April 30th.

THE "DAILY MAIL" AND ADVERTISEMENTS.

Our attention has been called to certain observations relating to Rile Beans contained in a leading article, entitled "The Daily Mail and Advertisements," which appeared in our issue of March 14th. The Manager of the Rile Beans Manufacturing Company assures us that Mr. Thomas Oxhill's testimonial, to which we referred, is genuine, and he further assures us that the analysis of the composition of Rile Beans quoted by us from Dr. R. H. Hutchinson's work in that article is incorrect. This being so, in common fairness we must admit that our deductions as to the medicinal value of Rile Beans are inaccurate, so far as founded on that analysis. Further, we are informed that the Judge in the case referred to in no way dealt in his judgment with the composition of Rile Beans, his verdict being based on certain advertisements issued by the Rile Beans Company. We readily give this explanation, and express regret if our criticism was based upon incorrect premises.

G. WYATT (Lancs.)—The existence of the "bonesetter" forms a scathing comment on the methods of our rulers, who are content to frame more or less drastic laws for the education and control of qualified medical men, but who at the same time allow all kinds of unqualified persons, to hatter upon the community. It is likely that anyone who had suffered injury at the hands of a "bonesetter" would be able to recover heavy damages in a court of law. Such persons, however, are loth to come forward.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, APRIL 26th.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus, E.C.).—8 p.m. Annual Meeting. Election of Officers for the ensuing year. 8.30 p.m. Adjourned Discussion on Syphilis (resumed by the President, Dr. F. J. Smith). The following, amongst others, are expected to take part:—Dr. T. Shennan, Demonstration of *Spirochæta Pallida*; Dr. G. F. Still, The Disease as met with in Children; Dr. J. H. Sequeira and Dr. M. Dockrell, Syphilitic Affections of the Skin; Dr. W. J. McC. Eccles, General Treatment.

THURSDAY, APRIL 26th.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.).—8.30 p.m. Paper:—Dr. G. W. Hill: Artificial Aids to Hearing.—Mr. W. H. C. Greene: Simple Tumours and their Relation to Malignant Disease.

FRIDAY, APRIL 27th.

BRITISH ELBROTHERAPEUTIC SOCIETY (11 Chandos Street, Cavendish Square, W.).—8 p.m. Council. 8.30 p.m. Dr. D. Arthur, will show the West London Hospital X-ray Table. Paper:—Dr. W. F. Homerville (Glasgow): The Influence of High Frequency Currents on the Surface Temperature of the Human Body (illustrated with lantern slides).

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m. (Clinical Evening for the Exhibition of Clinical Cases followed by Discussion. Patients in attendance from 8 p.m. to 9 p.m.

Vacancies.

Seamen's Hospital, Cronstadt.—Resident Medical Officer. Salary £180 per annum, free lodgings, lights, fuel, and attendance. Applica-

tions to Chairman of Hospital Committee, British Consulate, St Petersburg.

The Royal Albert Asylum, Lancaster.—Junior Assistant Medical Officer. Salary £125 per annum, with board, apartments, and washing. Applications to Archibald R. Douglas, Medical Superintendent.

Littlemore Pauper Lunatic Asylum, Oxford.—Second Assistant Medical Officer. Salary £120 per annum, with furnished rooms in the Asylum and board. Applications to Thomas M. Davenport, Clerk of the Visiting Committee, County Hall, Oxford.

Macclesfield General Infirmary.—Senior House Surgeon. Salary £100 per annum, with board and residence. Applications to the Chairman of the House Committee.

Carlisle Non-Provident Dispensary.—Resident Medical Officer. Salary £150 per annum, with apartments. Applications to the Hon. Secretary, Mr. G. A. Lightfoot, 23 Castle Street, Carlisle.

University of Birmingham.—Assistant Lecturer on Pathology and Bacteriology. Salary £250 per annum. Applications to Geo. H. Morley, Secretary.

West Herts Infirmary, Hemel Hempstead.—House Surgeon and Assistant Secretary.—Salary £110 per annum, with furnished rooms, board, fire, lights, washing, and attendance. Applications to the Hon. Secretary.

The Barbados General Hospital.—Junior Resident Surgeon. Salary £200 per annum, with quarters. Applications to Mr. N. E. Sargeant, School Registrar, St. Bartholomew's Hospital, London.

Warrington Infirmary and Dispensary.—Junior House Surgeon.—Salary £100 per annum, with furnished residence and board. Applications to J. H. J. Hampton, Secretary.

Cornwall County Asylum, Bodmin. Third Assistant Medical Officer. Salary £135 per annum, with board, furnished apartments, washing, &c. Applications to Medical Superintendent.

Montrose Royal Asylum, Sunnyside, Montrose.—Senior Assistant Medical Officer. Salary £200 per annum, with board, lodging, &c. Applications to Dr. Havelock, Medical Superintendent.

Essex and Colchester General Hospital.—House Surgeon. Salary £100 per annum, with board, washing, and residence in the Hospital. Applications to Alfred O. Buck, Secretary, the Hospital Colchester.

Appointments.

LENNANE, GERALD QUIN, F.R.C.S. Eng., L.E.C.P., Medical Officer of Health of the Borough of Battersea.

MACGILLVEAY, W. J. HOOKER, L.R.C.P., L.E.C.S., L.M.Edin., L.F.P.S., L.M.Glasg., Medical Officer to the Fallowfield and Withington District of the Royal Rusholme Provident Dispensary, Manchester.

Births.

CHANNING PEARCE.—On April 19th, at 88 St. James' Road, West Croydon, the wife of A. Channing Pearce, M.D., of a daughter.

CURTIS.—On April 20th, at Lynde's, Redhill, the wife of Frederick Curtis, F.R.C.S., &c., Eng., of a daughter.

HIGSON.—On April 12th, at "Oakmers," Honor Oak Park, London, the wife of J. Russell Higson, M.B., C.M.Edin., D.P.H. Camb., of a daughter.

Marriages.

DONNAN—MAGEE.—On April 19th, at St. Matthias' Church, Dublin, Wm. Dunlop Donnan, M.D., eldest son of Wm. Donnan, Holywood, Co. Down, to Alice Caroline Isabella, only daughter of D. Magee, Esq., D.I., Taghmao, Co. Wexford.

FOX—FOX.—On April 19th, at All Saints' Church, Holbeton, Edward Hamilton Bruce Fox, M.R.C.S., L.R.C.P., of Woolston Lodge, Southampton, son of Francis Edward Fox, J.P., of Upland, Tamerton Foliot, and Maude Geradine, second daughter of Charles Alfred Fox, of Battisborough House, Holbeton.

HEARDER—STEWART.—On April 18th, at St. Issell's, Saundersonfoot, Frederic Pollington Hearder, M.D., of Whitley, Yorkshires, to Catherine Frances, third daughter of Alexander Stewart, of Saundersonfoot, Wales.

HODSON—HY E.—On April 21st, at the Parish Church, Burton, Thos. George Smith Hodson, M.D., of 10 Terrace Road, to Margaret Mary Mallalieu Hyde, only child of the late Samuel H. de, M.D., of Lisamore House, Buxton.

PEATING—BARROW.—On April 19th, at All Saints' Church, Cershalton, Albert Victor, M.B., B.O., B.A., youngest son of the late Frederic Peating, J.P., and Mrs. Peating, of Levington Hall, Wisbeck, to Muriel Palliser, only daughter of Samuel Barrow, junr., of The Grove, Cershalton, Surrey.

RHODES—SANDERSON.—On April 19th, at Ardingly, T. Basil Rhodes, M.B., B.S., of Bagley Sanatorium, Timperley, Cheshire, second son of T. E. Rhodes, Esq., formerly of Brewod, to Mary Sanderson daughter of the late Christopher Sanderson, Esq., of York.

Deaths.

CHIPPERFIELD.—On March 13th, at Ladysmith, Natal (thrown from his horse), William Richard Hopkins Chipperfield, M.L.C.E., second son of the late Surgeon-Major W. N. Chipperfield, I.M.S., and only brother of Pearce Chipperfield, M.R.C.S., L.R.C.P., of Hampton Court.

WALTER.—On April 17th, at Peterborough, Jane Emmonson Walter, eldest daughter of the late Odiarne Coates Walter, M.R.C.S., of Broadstairs, aged 68.

SPACKMAN.—On April 21st, in London, Coniston Spackman, M.R.C.S., L.R.C.P., of Maidenhead, eldest son of the late Dr. Frederick Charles Spackman, of Faringdon, Berks, aged 44.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, MAY 2, 1906.

No. 18.

NOTES AND COMMENTS.

The Insane Patient.

THE risks of the medical profession are multifarious and universal. A remarkable case recently heard at the Aston Police Court illustrated in typical fashion the danger of the patient afflicted with delusions of personal injury. Some while ago a mysterious and unwarrantable assault was committed by a woman upon Dr. Fairley, of Birmingham. The unfortunate victim was thrashed with a horse-whip, which he fortunately managed to take from his assailant's hands, but not before he had been grievously maltreated. The woman he had known for sixteen years, but had refused to treat her professionally. She was full of extraordinary delusions—as, for instance, that Dr. Fairley visited her in the middle of the night, when she was sleeping with her husband; that he (the doctor) was constantly talking into her left ear, and making suggestions to her; and that he exercised a mysterious hypnotic influence over her. The poor woman is now placed in an asylum. There could be no more typical instance of this particular kind of professional risk. The wonder is that matters were not brought to their only logical issue long before the police court stage.

Leicester and Small Pox. THE ancient city of Leicester, alas! is pluming herself upon the comparative freedom of her citizens from small-pox, in spite of the great unvaccinated population which she is not ashamed to flaunt in the face of society. A petition has been forwarded to the parliamentary Member for the borough by the local Anti-Vaccination League. It points out that the infantile mortality of the town has fallen during the past thirty years from 240 to 150 per 1,000 births. The improvement, it is claimed, is not due to vaccination, because between 1901-1904 primary vaccinations numbered only 5 per cent. of the total births, and there is now an unvaccinated child population of 60,000. The conclusion of the document is that small-pox, having failed to decimate this inflammable material, it proves that the "Leicester system" of treating infectious disease by vigorous sanitary measures is alone sufficient to exclude small-pox: *ergo*, compulsory vaccination should be everywhere abolished. We fear that one day the day of reckoning will fall upon Leicester in the avenging disaster of a terrible small-pox epidemic, and these abstract denunciations will fall to the ground like a castle of cards. Anyway, the country generally is not likely to be

led away by so foolish an example. Leicester loves anti-vaccination now as Lincoln once tolerated a bad water-supply.

The Cinematograph in Medicine.

ONE of the interesting novelties of the Lisbon Congress was the demonstration of epileptic convulsions by means of the cinematograph. The value of that modern method of graphic reproduction of living movements in medical teaching is obvious, although the field is not likely to be an extensive one. The exhibitor, Dr. William Chase, of Boston, showed pictures of no less than thirty separate epileptic seizures, whereby the action of the muscles was shown in detail. Clearly, if reference can be made to photographs registering the exact state of the muscular contractions at any given instant of an attack, evidence of value may be thereby secured, especially where localisation of the central lesion is desirable. Dr. Chase also showed a number of cinematographic pictures illustrating various gaits and other disturbed movements due to pathological changes. As these pictures can be packed in a box and despatched to any part of the world, we may hope to have an opportunity of seeing them some day in London.

Another Doyen Cure for Cancer. DR. DOYEN is not easily beaten. After a long and patient investigation, his claims to have discovered a cure for cancer have been authoritatively dismissed as worthless. That fact, however, has not prevented the enterprising physician from treating by his methods a great number of patients in Paris, and he has even extended the sphere of his activities so as to include London. The Lisbon Medical Congress has brought Dr. Doyen to the front with a new "cure" in the shape of the inoculation of the patient with the yeast of beer. The scientific world will naturally look askance at a method advanced by an observer whose previous claims have proved so unfounded. At the same time, a fair trial will doubtless be afforded to the proposed remedy. It is a matter of regret that any member of the medical profession should be found ready to spring premature announcements of this kind upon society. In Dr. Doyen's case he cannot plead inexperience, for he has had every possible sort of warning in the long series of incidents that led to the final condemnation of his "cancer serum" by the French Academy of Science.

LEADING ARTICLE.

PROFESSIONAL SECRECY.

In a letter published in the present issue of the *MEDICAL PRESS AND CIRCULAR* a correspondent calls attention to the conduct of Surgeon-Major Whiston in the recent "Ragging" case in the 1st Scots Guards. As our readers know, we have taken up somewhat firm ground as to the breach of professional ethics committed by that officer in communicating to the commanding officer of the regiment facts that had come to his knowledge as a professional confidence. The discovery that a patient had scabies can only be regarded as information of the most private and confidential kind that could conceivably be acquired by a medical man. So great is the horror with which that particular malady is looked upon generally that to proclaim any person afflicted thereby would be to inflict upon him in many cases a species of social ostracism. The question arises would an Army medical officer think it his duty to report officially that any soldier under his charge was suffering from gonorrhœa or syphilis? Those diseases are more degrading and dangerous than scabies, and are notoriously the result of immoral acts, whereas the "itch" in the vast majority of cases is contracted innocently. We have little hesitation in claiming that no Army medical officer is entitled to divulge such purely personal and private information without the consent of his patient. When medical reports are required by the War Office as to a soldier's fitness for service, that is quite another matter, for presumably both explicitly and implicitly the consent of the individual reported upon is given to the whole transaction, which is often as much to his personal interest as to that of the military authorities. It is another matter, however, when we come to purely private professional information, the divulgence of which may seriously affect the reputation and wreck the future career of some unfortunate soldier. There can be no obligation, surely, for the surgeon to inform the commanding officer of the fact that a subaltern or other soldier under him has scabies. The malady is curable within a few days by appropriate treatment, and the danger of its spread amongst persons who are ordinarily clean and decently housed is so small as to be practically hardly worth considering. That a single subaltern thus affected should spread the disease among his brother officers in a British regiment is an incredible proposition. Worse than all a doubt is thrown upon the diagnosis of scabies by the direct negative of more than one officer of the Royal Army Medical Corps. Possibly the whole truth of the incident will never be known, whether, for instance, the report as to the alleged condition of the subaltern in question was voluntarily furnished by the surgeon or under pressure from the commanding officer. In the first case we consider a medical officer acting in that way would be breaking the most sacred principles of his profession. In the second case we should

instantly condemn the action as one of military arrogance, in attempting to usurp a right to obtain special information that may legally be demanded only by a court of law. Dr. Saundby in his work on *Medical Ethics*, observes: "While members of the medical profession must obey the law, and aid the course of justice, they are not called upon to act the part of detectives or informers." We do not for a moment suggest that the Army surgeon is not, as a rule, a man of scrupulous honour. We do suggest, however, that he may at times, under pressure of military discipline or from a want of due appreciation of the unwritten laws of his profession, be unwary enough to disclose private personal matters that have come to his knowledge by reason of his professional relations with a patient. Members of the medical profession in the United Kingdom have no statutory duty imposed upon them to maintain the rule of professional secrecy, but they are bound by a higher law to maintain that honourable line of conduct which has been recognised by their predecessors since time immemorial. Evil, indeed, will be the day when the Hippocratic oath ceases to be binding upon our profession. Readers may be reminded once more of its simple and yet comprehensive terms:—"Whatever," it runs, "in connection with my professional practice, or not in connection with it, I see or hear in the life of men which ought not to be spoken abroad I will not divulge, as reckoning that all such should be kept secret."

NOTES ON CURRENT TOPICS.

The Central Midwives Board and its Relations with Ireland.

DURING the past month the Irish Hospital Matrons Association has been making strenuous efforts to induce the Central Midwives Board to hold examinations in Dublin. The Association has pointed out to the Board the manifest hardship which it causes to Irish trained nurses to be obliged to go over to London and stay there for some days in order to pass the Board's examination. In order to support their case, the Matrons Association has approached several bodies in Dublin, notably the Royal College of Physicians of Ireland and the Royal Academy of Medicine, with the request that they will also petition the Lord President of the Council and the Central Midwives Board. Both bodies were only too willing to comply with this request, but, as it was doubtful whether it was possible for the Board to act as desired, the College of Physicians wisely decided to ask for information on the point before addressing what would have been useless petitions. The result has been that the Board has informed the College that it is impossible to hold examinations in Ireland. We fear that even had it been possible to hold these examinations, the same spirit of jealousy which prompted the Board at first to refuse to allow Irish nurses to present themselves for its examinations would

have led to a similar refusal to examine nurses in Ireland. In the present case, however, there was no room for the exhibition of such a spirit, as it is evident that the Midwives Act, which applies only to England and Wales, could not be so stretched as to allow examinations to be held in Ireland. We quite agree with the Matrons' Association as to the hardship which the present state of affairs causes to Irish nurses, but we think that if it directed its energies to having an examination centre established at Holyhead, Chester, or Liverpool it would probably succeed, whereas its present request is impossible of fulfilment. It has been pointed out that the cause of the present position is the non-application of the Midwives Act to Ireland, and that some years ago more strenuous efforts ought to have been made to have it so extended. We certainly should like to see a wisely-framed Act applied to Ireland and worked under the directions of a qualified Board, but, so far from regretting our non-inclusion in the present Act, we confess to a feeling of devout thankfulness that neither the Act nor the Board has any authority in this country.

An American Form of Gout.

THE influence of race habits upon diseases forms an inviting subject for some future Darwin of medicine. Even so strangely marked a malady as gout may be modified almost beyond recognition under the transforming touch of a national environment. On the British side of the Atlantic the mention of gout conjures up the picture of red and swollen great toes, pillowed and swathed in flannel, while the luckless sufferer, ruddy and well-fed, swallows draughts countless and pills innumerable. That is the classical disease begotten of ale and roast beef and plum pudding and port wine and other excess or good cheer among our robust citizens. In America, on the other hand, the rush and hurry of life render the average individual spare and neurotic, and his gout appears to affect his whole organism with a general irritability rather than by local precipitation in the neighbourhood of the great toe and other joints. To a great extent the curious craving of our Transatlantic cousins for pies, iced water, baked beans and pork, together with over-heated rooms and "quick luncheons" accounts for the American form of gout, which, by the way, in many points closely resembles the "suppressed gout" on our side of the Atlantic.

The Wearing of Gloves at Autopsies.

WE referred a few weeks ago to the unfortunate incident at the Westminster Hospital whereby a medical student lost his life by sepsis contracted in a *post-mortem* examination performed without the protection of gloves. It would be of some interest to know whether the custom exists in many pathological departments of handling infective material thus unprotected. Judging from the evidence given at the Coroner's inquest in the case referred to, the Westminster staff have on definite grounds

abandoned the wearing of gloves. There is no doubt that the manual difficulties of the autopsy are increased by the wearing of gloves, more especially as many gloves sold for the purpose are distinctly clumsy. Moreover, as a result of the discomfort produced by clumsy coverings, there may be a greater chance of an inexperienced operator wounding his hand with needle or knife. Nevertheless, if the hands are, as commonly occurs, the site of abrasions or scratches, suitable gloves appear to offer a protection unattainable by other means. Of course, many pathologists still refuse to adopt gloves, but we think that the opinion in their favour is gradually growing. It is just as in the case of surgical operations there are still some surgeons who regard the wearing of gloves as unnecessary, although received opinion is decidedly in their favour. It is notorious, too, that medical men are not so careful where risk to their own health or lives is concerned as in that regarding the health and lives of their patients. This is perhaps the reason that the general adoption of gloves in work on the dead body lags behind the practice in surgical operations.

Sleeping Sickness.

IT is announced that Lieutenant Forbes Tulloch, one of the officers engaged in making investigations on behalf of the Royal Society in Uganda, has contracted sleeping-sickness and is to be brought back to England for treatment. In view of the invariably fatal issue of this little-understood disease, we all must hope that through some error of diagnosis or some mistake in transmission the nature of the malady is other than that reported, though we fear the hope is a faint one. Sleeping-sickness has hitherto been considered to be confined to natives, but since the discovery of trypanosomes in the blood of various Europeans and the presumption that sleeping-sickness is the result of trypanosomiasis, it has not been clear why Europeans should escape, and Lieutenant Forbes Tulloch apparently supplies a case in point. Sleeping-sickness is causing undue anxiety to the Government and English mercantile community in Uganda and British Central Africa at the moment. The disease, far from being a pathological curiosity, is now found to be infectious, probably through the medium of *glossina palpalis*, and to be spreading with alarming rapidity beyond the areas in Uganda and East Africa to which it was thought to be confined. Sleeping sickness has been met with among the natives west of Lake Tanganyika, and is reported now to have reached the borders of North-East Rhodesia, where a large susceptible population exists. The British Central Africa Chamber of Commerce and Agriculture is seriously alarmed and has made urgent representations to Mr. Sharpe, the Commissioner for British Central Africa, as to the desirability of instituting a thorough examination into the distribution of *glossina palpalis* and *glossina morsitans*—with a view to the extermination of these pests if possible. The situation is undoubtedly serious

A Year's Poisonings.

THE Registrar-General's Report for 1904 gives us some interesting information regarding the number of cases of death by poisoning which took place in England and Wales during that year. It appears that of the total of 1156 deaths, 520 were accidental, 628 suicide, and 8 murder. Of the 520 accidental deaths, no less than 161 were due to anæsthetics, and this is probably an understating of the total mortality due to this cause. The anæsthetic agents responsible were—chloroform, 92 deaths; A.C.E. mixture, 4; chloroform and ether, 3; ether, 7; ethyl chloride, 2; nitrous oxide, 5; unnamed agents, 48; it will therefore be seen that chloroform was the agent in by far the greater number of fatal cases, being employed in 99 out of 110 cases in which the agent is recorded. The number of deaths from gas is probably larger than most medical men would have expected but it is to be remembered that gas is given much more frequently by unskilled persons than any other anæsthetic. The eight murders by poisoning were committed by the aid of arsenic, belladonna, potassium cyanide, laudanum, and prussic acid. It is curious to note that whereas opiates and carbolic acid have become much less common agents of crime or suicide than formerly, oxalic acid appears to be yearly increasing in favour. There are doubtless fashions in poisoning as in other things, and a study of these would doubtless reveal many points of interest. Lead is returned as responsible for 13 deaths, a number probably much exceeded during the past year. In this connection we cannot but deplore the refusal of Lord Crewe to add diachylon to the list of scheduled poisons, since experience has shown that the scheduling of a poison has almost invariably been followed by a diminution in the number of catastrophes due to its use.

A Bloodless Duel.

WE read in the public press that Mr. H. A. Barker, whose name we seem to remember, and who is said to practise "bloodless surgery," is challenging the surgical profession to a bloodless duel. It is said that he is willing to give £10,000 to any needy London Hospital if his methods prove inferior to those of what we may term the sanguinary school. He is willing that a representative body of surgeons should submit the conditions under which experiments are to be carried out, and in the event of his triumph he only asks that his methods shall be generally adopted. All this, of course, sounds so fair that the readers of the *Daily Express*, from whose issue of April 24th we have derived our information, may be inclined to think that the orthodox profession is hopelessly prejudiced if it does not accept Mr. Barker's challenge. A moment's consideration will show that the challenge is mere "bluff." The medical profession is one that exists for the purpose of applying the best known methods and its own best skill to the treatment of patients, not for the purpose of exploiting different systems of "cure" on those who seek its advice.

In spite of the statements of some of the most virulent of hospital detractors, these institutions are not used as laboratories for experiments on men, but as refuges where the sick or maimed may get the greatest possible relief from their ailments. It is cruel, wicked, and immoral to treat any patient as the *corpus vile* of an experiment for the pleasure of demonstrating that a particular theory is wrong, unless indeed the patient is willing to be made the subject of the experiment and it is known that the experiment involves no risk to life or limb. As these conditions would not be fulfilled by the competition proposed, the "challenge" will only stir the contempt and indignation of medical men.

Insanity Problems.

THE articles on insanity that have been appearing in the *Times* will, we hope, do something to attract attention to the grave and pressing problem and give the Government the impetus needed to translate into action the conclusions that all men acquainted with the subject have long formed. The first and most important reform is that the Lunacy Commission should be immediately and substantially increased. We have much admiration for the Commissioners, who do hard work well, but no person outside the institutions that the Commissioners govern can possibly expect the work to be properly done under present conditions. Inspections have to be undertaken by the Commissioners in person, and though this is theoretically an important safeguard against the abuse of personal liberty, practically it amounts to little or nothing, owing to the hurried and infrequent visits that the Commissioners have to put in. For instance, to take a case cited, how is it possible for two Commissioners in a three days' visit to inspect a large institution and converse personally with two thousand patients? What is needed, and urgently needed, is that a good staff of medical inspectors should be appointed to act under the Commission in London, and that while the Commission regulated the general policy of lunacy administration, frequent personal visits should be made to asylums and patients under private care by these inspectors. This requirement is at the root of all reform in the present unsatisfactory state of things.

Another Hospital "Scandal."

GUY'S HOSPITAL, which does so much good work for the sick poor of London, is most unfortunate in the number of "regrettable incidents" which occur in its administration, or at any rate are boomed into copy for the press. An inquest held on April 23rd has been published at length in the leading newspapers, and has attracted a good deal of attention. It appears that the woman, the subject of the inquest, was sent up to Guy's by her private doctor because of a swelling behind the ear. The house-surgeon who saw the patient said that there was only one bed available, and that was being reserved for emergencies. In his opinion the

swelling was due to a glandular abscess, and not of sufficient urgency to justify him in parting with his last bed. The patient's husband brought the woman up the next day on instructions, and was told that the hospital was still unable to admit her. She was then taken to St. Thomas's, where her state was found to be very serious, and where immediate operation was performed. The abscess was found to be due to mastoid disease accompanied by meningitis, and the woman died fifteen minutes after the operation had begun. The jury passed a rider condemning Guy's Hospital for not having more experienced officers to examine cases for admission, and also for inadequate examination of the particular patient. As we understand the authorities at Guy's are investigating the case officially, we forbear to comment on its obvious features, beyond saying that we hope that their attention will be directed as much towards the methods in which their out-patient department is conducted as into the admitted error of judgment on the part of a junior official.

The Royal College of Surgeons, Edinburgh.

It is now nearly twenty-five years ago since we pressed upon the College of Surgeons of Edinburgh the necessity of instituting an examination for that fellowship, so as to bring that body in a line with other colleges. Feeling ran strong on the subject at the time, but now, a quarter of a century later, the College may be congratulated on the wisdom which prompted it to act up to those suggestions. The chief objection raised was that the income of the College would suffer by the change. This fear has proved unfounded, for the appreciation of the Fellowship has increased tenfold instead of diminishing. In the year 1884, the year before the change was made, the Fellowships granted were about thirty-nine. This was the largest number for many years, and was probably due to the rush to take advantage of "the year of grace." In 1903 there were sixty-seven Fellowships granted, all by examination, and Fellows without examination are so rare that within the last five years only one solitary individual signed the roll of the College by election. In the absence of direct information as to the nature of the examination or the severity of the tests we cannot speak decisively, but the rejections appear to show a fairly high standard. At a time when the question of appointing Fellows of the Edinburgh College to hospital appointments in London and elsewhere is becoming acute, it must be evident that it is an advantage to candidates to show that the Fellowship has been obtained by examination. The College must be now sincerely grateful for the far-seeing policy which has had such beneficial results, both from a pecuniary point of view and also from the increased professional status of its Fellows. In conclusion, the College may also be congratulated on the better equipment of its examining board. By the old system the examiners annually elected themselves, but that anachronism, like the election fellowship, has become a matter of history.

An Objectionable Advertisement

A FAVOURITE trick of the quack-medicine trade is to insert the name of some deceased medical man of eminence, so as to stamp some particular quackery with a false air of authority. This species of sharp practice, bad as it is, pales into insignificance beside the insertion of the names of living members of our profession. The highest conceivable flight of audacity of that kind has surely been reached by *Lloyd's Weekly News* for April 29th, 1906. On page 9 of that issue is a two-column advertisement of Page-Woodcock's pills, under the title of "Famous Consultations." It shows a portrait of the late Sir Morell Mackenzie, and another of the illustrious Page-Woodcock! The place of honour, however, is devoted to what purports to be a portrait-group of Sir Francis Laking, Sir Thomas Barlow, and Sir Frederick Treves. The nature of the remedy to which their sanction is thus indirectly implied may be gathered from the assertion that the pills in question "positively cure indigestion and all liver troubles, no matter of how long standing; also biliousness, spasms, constipation, severe headaches, heartburn, anæmia, and female ailments, as over fifty years' experience has proved, and are as valuable to men as to women." Clearly, claims of that kind are fraudulent, and merit the attention of the police. *Lloyd's News*, by inserting the advertisement, is co-operating in a scheme for obtaining money under false pretences, and by taking money for the advertisement is sharing in the proceeds. As to the outrage upon the three baronets whose names have been thus shamefully misused, we imagine that no more scathing comment could be obtainable as to the defective state of the laws regarding the patent-medicine trade. The three gentlemen implicated have no doubt a remedy at law, probably in the shape of an injunction in Chancery. That legal process, however, is costly and unsatisfactory. What we want is a short and sharp amendment of the law so as to bring the quack-medicine trade under stringent control.

PERSONAL.

THE Grand Prize of £100, awarded by the International Medical Congress for the greatest scientific work for the benefit of humanity, has been conferred upon Dr. Severan, of Paris, in recognition of his great work in isolating the malaria germ.

THE Murchison Scholarship of the Royal College of Physicians of London, founded in 1880 to perpetuate the memory of the late Dr. Charles Murchison, has been awarded to H. P. Bell Walker, M.B.Lond., a student of Guy's Hospital. The award is made alternately by the London College and the University of Edinburgh.

H.M. THE KING has granted to Dr. R. G. Kirton, principal medical officer of the Egyptian prisons, authority to wear the Imperial Ottoman Order of the Osmanje.

THE recent death of Dr. Corbett, of Droitwich reminds us of the fortunes of a remarkable family. On April 22nd, 1901, his brother, the "Salt King," and the founder of the Corbett family's fortunes, died leaving nearly a million pounds, to his brother, Dr. Corbett, and on the same day of this year, and very nearly at the same time, the death of the brother who had inherited the largest share of his fortune occurred.

A CLINICAL LECTURE ON THE DIAGNOSIS OF PNEUMONIA IN CHILDREN.

By M. G. VARIOT, M.D.,
Physician to the Hospital for Sick Children, Paris.

(Specially Reported for this Journal.)

THE clinical study of pneumonia in the child deserves consideration because of its frequency, although seen in infants it is more frequently met with in children between two and three years of age. The accidents that accompany the pneumonia of childhood are frequently alarming, not only to the doctor but also to the parents, for the case invariably appears worse than it actually is and sometimes, at the outset, it is impossible to arrive at a diagnosis. I remember seeing a little girl, 22 months old, who was admitted into the ward with the following history: She had been ailing for four days, being feverish, with loss of appetite. The evening temperature varied from 104° to 105·8 F., and in the morning from 99·8 to 100·5. The daily oscillations were not at all typical of lobar pneumonia, besides which there was no cough, the respiration rate was not accelerated, and, on the whole, there was no theory to lead one to suppose that the lungs were involved.

On examining the chest some impairment of resonance was noticed in the left supra- and infra-spinal fossæ, with tubular breathing and bronchophony in the left axilla. The signs remained localised and unilateral, so that we diagnosed a lobar pneumonia, in spite of the absence of symptoms and the irregular course of the temperature. It is not at all uncommon to find oscillations of 4° or 5° F. between the morning and evening temperature in the pneumonia of infants, and, moreover, on the fifth or sixth day a drop occurs, suggesting a crisis, but it is only temporary, for the fall is succeeded on the following evening by a temperature as high as before or even higher. This rise does not correspond to a fresh pneumonia focus, for after one or two such oscillations the temperature settles down to normal, or may even be subnormal on several subsequent days. It is, however, unusual for these oscillations to persist during the whole course of the disease.

Last year I was called in consultation with two colleagues to see a boy, five years old, who had oscillations of 3° and 4° F. for six days, although the most careful physical examination of the different organs failed to reveal anything abnormal. I tried to examine the child's chest, but patient was so refractory that it was extremely difficult to make out anything. I thought, however, at the time there was some impairment of resonance in the infra-clavicular region, so I risked the diagnosis of a central pneumonia. It was supposed that the fever might be due to some gastro-intestinal disturbance, or to some intermittent quotidian fever, but two days later I heard from the doctor in charge of the case that a patch of bronchial breathing had appeared on one side of the chest, thus confirming my diagnosis. These facts tend to show how difficult it is to diagnose pneumonia in a child, the difficulty being still further enhanced by the impossibility of making a proper examination.

The contrast between pneumonia in the adult and the infant is striking, for in the former the diagnosis usually presents no difficulty whatever. The functional trouble and the physical signs giving a well-defined clinical picture; whereas in infancy it is liable to run an abnormal course, so that the clinical picture is incomplete and the interpretation of the symptoms and signs is most laborious.

In the adult the onset is sudden, with a rigor, pain in the side, vomiting, cough with typical expectoration even in the cases of central pneumonia, dyspnoea, temperature of 104·2 and well-marked physical signs together with a definite history which can be elicited from the patient. In children under three any one of these signs and symptoms may be lacking—has the child had a rigor? One cannot be certain of it; the pain in the side must frequently be absent, for the dyspnoea is less marked than in the adult. In children of five or six years of age this pain in the side is more constant, though they do not always localise it in the chest wall but refer it to the abdomen or to the right iliac fossa, so the pain, vomiting, and temperature make the case resemble one of appendicitis, and it frequently happens that these patients are sent into surgical wards by mistake.

I recall one case vividly—that of a little patient who for three days had suffered from uncontrollable vomiting, accompanied by severe pain in the abdomen and a temperature of 104°, with rigidity of the abdominal wall. The vomited matter was partly bilious and of a light green colour, so that the medical man thought he was dealing with a case of peritonitis. On auscultation I discovered a localised patch of bronchopneumonia in the axilla. This turned out to be a case of pneumonia which has been called "emetic," because of its association with reflex vomiting.

But let us come back to the point of contrast between pneumonia in the adult and in the child. Dyspnoea is almost constant in the pneumonia of adults, the respiratory movements are increased in frequency, difficult and painful. In infants dyspnoea and increased frequency of respiration are less constant, in fact, they are sometimes entirely absent, while the respiratory rate of 30 to 40 may be due simply to hyperthermia and independent of any affection of the respiratory apparatus. In cases of double pneumonia, and in children of ten and upwards, the dyspnoea may be very intense. Still we must not rely on this functional trouble to establish the diagnosis. The great rapidity of the respiratory movements in a bronchopneumonia is more or less constant, therefore it is a valuable sign in the differential diagnosis.

The cough during the first couple of days of the illness in the child is frequently absent or so insignificant as to escape attention; it is in the latter part of the illness, when the physical signs reach

the surface of the lung, that the cough becomes more troublesome.

The expectoration is the most constant and characteristic symptom in the adult, and when this is rusty or the colour of plum juice the diagnosis is certain. But here again no sputum can be obtained from an infant. In the course of five years in only three out of 300 cases of pneumonia have I noticed this rusty sputum in patients under twelve years of age. Must we, therefore, give up the idea of examining the expectoration of a child in whom we suspect a central pneumonia? As a matter of fact this examination is not so troublesome as might at first sight be supposed. It has been proposed to evacuate the contents of the stomach for this purpose, but the same end may be attained more readily. It is only necessary, by means of a tongue depressor, to touch the walls of the pharynx, this will make the patient cough and the sputum will be seen at the back of the throat, when, by means of a tampon of cotton wool, it can be collected. This little manœuvre is almost invariably successful and can be repeated without inconvenience. We have been able in this way to obtain sputum which could be examined for the pneumococcus, so settling the diagnosis.

Hyperthermia is in reality the most constant accompaniment of the pneumonia of infants. I have already mentioned the irregular temperature curves, characterised by great oscillations which give so much trouble to the doctor, these fortunately are not the rule. As a rule the temperature rises suddenly to 103° or 104° F., with small oscillations between morning and night, and remains so for five or six days, the crisis occurring between the fifth and seventh days. The temperature, however, may remain up longer than this with more or less pronounced remissions—this form is not at all common. If the temperature remains up in this way after pneumonia, we must always bear in mind the possibility of the development of an empyema and examine again and again very carefully. In fact, the temperature may be the chief symptom that reveals an infantile pneumonia, with its usual concomitants—gastric disturbance and prostration. If the pneumonic area is limited and not larger than a tangerine orange, if it remains central, the physical signs may be so poorly developed that the diagnosis remains uncertain for five or six days—it only becomes certain when a crisis occurs.

In a febrile illness with digestive and nervous troubles, with an absence of physical signs in the lungs and no dyspnoea, a diagnosis of enteric fever suggests itself, and if at the same time there is repeated vomiting, with convulsions at the onset, followed by delirium or unconsciousness, the picture looks very much like one of meningitis. Moreover, Widal's reaction does not help us in the diagnosis at this early stage, so that often the ordinary practitioner overlooks an early infantile pneumonia.

Rilliet and Barthez describe a cerebral pneumonia, which may be either eclamptic or meningitic according to the predominance. In convulsions or coma one meets with the utmost difficulty in arriving at a diagnosis, partly of course on account of the impossibility of properly examining the little patient. I remember one case in particular where I was called in to see a little girl of seven, who had an acute otitis of two days' duration, and

who was under the care of a specialist. After the last visit of the specialist, the temperature rose suddenly to 104° F., and the child became delirious and unconscious. A surgeon was called in, who diagnosed the onset of meningitis to the consternation of the parents. In the course of the evening I saw the child, who was unconscious, and had rigidity of the muscles of the neck, the eyes were fixed, the pupil contracted but equal, and the temperature 104° F. I examined the chest as carefully as possible under the circumstances, and though the result of auscultation was negative, percussion revealed a very slight impairment of resonance below the right clavicle. There was no dyspnoea and no alteration of respiration—the child in addition had been sick several times. I made a lumbar puncture and withdrew five or six grammes of a clear, limpid fluid, which on examination showed nothing abnormal, so I was of opinion that the case was one of a central pneumonia taking a meningitic form, and told the parents there was still hope. The following day the symptoms became more severe, in spite of cold baths and the application of leeches to the mastoid processes, the child screamed, ground its teeth, and refused all food. Three days after my first visit, there was a convulsion followed by coma. I was called in once more though by then all hope had been abandoned by the parents. The pulse was strong and regular, the left arm and leg were spastic and as the child was noisy and delirious, I ordered a hypodermic injection of 1-12th of a grain of morphia, which had a wonderful effect, succeeding where every other means had failed. The child slept for five or six hours, and on waking was able to recognise the persons round the bed. The following day a patch of bronchial breathing was heard in the upper lobe of the right lung, so the diagnosis was settled. This shows how much earlier percussion indicated the part affected. The lesion cleared up in the ordinary way.

The differential diagnosis between the pneumonia of infants and the various forms of cerebrospinal meningitis is even more difficult than that of tuberculous meningitis, and in connection with this I may recall a baby, 14 months old, whom I saw in consultation with the family physician. The patient had a temperature of 104° F., which remained high without oscillations; in spite of an absence of physical signs, we thought of a central pneumonia, but later the advent of repeated attacks of vomiting, convulsions, and papillary troubles left no doubt as to the diagnosis and its fatal prognosis.

In examining the child, try to distract its attention by a sweet or cakes, place the patient on the back with a small pillow under the head, this manœuvre renders the infra-clavicular fossæ more prominent. Lightly percuss the clavicular regions on both sides, and often you will notice an impairment of the note on the side of the lesion—in children the apex is the seat of election—but sometimes the note is tympanitic over the affected area, due to the development of compensatory emphysemas. On auscultation the breath sounds on the healthy side appear feeble in comparison, so that it is quite easy to make a mistake as to which side the lesion is.

I wish to lay stress on the importance of percussion, because it reveals the nature of the case two or three days before auscultation comes to

our aid, and sometimes even is the only sign indicating a pulmonary lesion. It is useless in infants to rely on finding vocal fremitus, but tubular breathing, bronchophony and crepitations may be heard, and then, of course, there is no more difficulty in diagnosing the case than in adults. But often only one or more of these signs may be present. In 1898 Chicotat found that it was possible to identify a patch of consolidation in the lung by means of X-rays—a means of great importance when physical signs are wanting.

The foregoing clinical details show that it is quite easy to distinguish between a lobar pneumonia and a broncho-pneumonia dyspnoea, acceleration of the respirations which may reach 70, 80, or 90 a minute, and the cyanosis is more marked in broncho-pneumonia. The physical signs are bilateral, no impairment of resonance can be detected on percussion, but auscultation reveals fine, moist crepitations on both sides accompanied or not by patches of bronchial breathing. Radioscopy does not help in these cases.

The diagnosis, however, becomes difficult if the case is one of double pneumonia, and the pseudo-lobar form of broncho-pneumonia presents many points of resemblance to the preceding variety, and it is more by the evolution of the disease than by the help of the physical signs one can settle the question. In difficult cases the bacteriological examination of the sputum should be made, and I am of opinion that the presence of the pneumococcus renders the prognosis more favourable, although the areas of consolidation may be bilaterally distributed.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The lecture for next week's number will be by John Lindsay Steven, M.D., F.F.P.S.G., Physician and Lecturer on Clinical Medicine, Glasgow, Royal Infirmary, on "General Cystic Degeneration or Transformation of the Kidneys in the Adult."

ORIGINAL PAPERS.

THREE CASES OF UTERINE MYOMA.*

By ARTHUR E. GILES, M.D., B.Sc., F.R.C.S.,
Surgeon to Out-patients, Chelsea Hospital for Women and Gynaecologist to the Tottenham Hospital.

THE three specimens to be discussed here have this in common—that they are all cases of uterine myoma; apart from this feature they present widely different clinical and pathological features; but it happens that all three were operated on within a month.

CASE I.—*Uterine Myoma with Suppurating Carcinomatous Ovarian Cyst.*

In September of last year Dr. Kenneth Frazer, of Eastbourne, sent up a lady to see me with the following history.

Miss G., æt. 37, suffered from abdominal pain which came on in the form of "attacks." There had been three such attacks, namely, in January, June, and August, 1905. Each attack began with a sense of dragging all over the abdomen, followed by acute pain in the right side. Since June, pain had been constant, extending from the abdomen to the right groin and hip. The patient suffered from constipation, which was more pronounced during the attacks; after an action of the

bowels the pain was easier. Leucorrhœa came on in June, giving place to xanthorrhœa at the end of July. Menstruation was regular; the loss was moderate and diminishing, and was not associated with any special pain. On examination of the abdomen, a hard tumour was found, rising nearly to the umbilicus; it felt fairly smooth and uniform. The breasts were normal, and contained no secretion. On vaginal examination a tumour was felt, apparently part of the tumour felt by the abdomen; it seemed to be a single tumour connected with the uterus. The cervix was normal; no softening, but the external os was slightly patulous. The uterine appendages could not be distinguished. A diagnosis of uterine myoma was made, and operation was advised. This was carried out at Eastbourne, with the assistance of Dr. Frazer, on October 6th.

On opening the abdomen it was evident that the case was not so simple as I had supposed. The uterus was the seat of several myomata; but the greater part of the swelling consisted of a right-sided ovarian cyst so closely adherent to the uterus as to be almost incorporated with it. The left tube was salpingitic. The operation was rendered very difficult by dense adhesions between the sigmoid and upper part of the rectum, and the back of the uterus and cyst; and when these had been separated, the sigmoid was completely stripped of its serous coat for a distance of three inches. The cavity of the bowel was, fortunately, not opened. The uterus with its tumours, the ovarian cyst and the left appendages were all removed. I had some fear that the patient might develop a faecal fistula, and left a gauze drain in the pelvis, in case of accidents. The nurse was instructed to use the greatest caution in the administration of enemata. Cases in which the nature of the operation leaves one with the gravest forebodings as to the patients' progress have sometimes a pleasant way of giving no trouble at all; and so it proved in this case, as the patient made a rapid and uninterrupted recovery.

On opening the cyst immediately after the operation I found that its contents were suppurating; and my anxiety about the patient's welfare was further increased when I received the following report from Dr. Easte's laboratory:—

"The wall of the large cyst contains some solid adenomatous material with a malignant distribution. It is much inflamed, and consequently mixed with granulation tissue. No tubercle is to be found in the latter. The cyst appears to be of ovarian origin. The parametrium in front of this large cyst contained a suppurating body the size of a Kentish cob-nut. It resembled an oval lymphatic gland in appearance. Microscopically it is made up of fibrous tissue, granulations, and carcinomatous cells. A second body similar in all respects but less degenerate and purulent was shelled out from the same situation, and in this there is a good demonstration of a secondary deposit of tubular carcinomatous cells. From the back of the uterus, low down, two degenerate masses were removed and examined, and both these prove to be degenerate cancerous metastases. Note.—The distribution of the adenomatous tissue in the wall of the large right-sided cyst suggests malignancy. This, therefore, is no doubt the seat of the primary focus."—(Signed) C. L.

I saw the patient two months after the operation

*Paper read before the British Gynaecological Society, April 9, 1906.

and she was then looking and feeling well ; and I have not so far heard of any recurrence.

The association of ovarian tumours with uterine myomata is interesting and not very uncommon ; of 124 cases of uterine myoma dealt with by abdominal operation, 12 cases or 10 per cent., presented this combination. The ovarian tumours were as follow : Cystic adenoma, 5 cases—one of which had a twisted pedicle ; dermoid, 1 case ; cystic adenoma on one side and dermoid on the other, 1 case ; fibroma, 1 case ; papilloma, 2 cases ; carcinoma 2 cases, including the present one. The other case of ovarian carcinoma was also a single woman, æt. 38, and the operation was done exactly a year ago (April 10th) ; I have not heard of any recurrence in her case.

CASE II.—*A Large Cervix-Myoma.*

On September 24th, 1905, Dr. W. H. Slimon asked me to see with him a lady with the following history :—

Mrs. S., æt. 32, had one child, 5 years ago. Six months after the confinement she noticed an increased menstrual flow, which became progressively more abundant up to the present time. The periods now last 10 to 15 days, and are followed by great exhaustion for a few days. Two years ago she noticed that the abdomen was enlarging. She consulted Dr. Slimon on September 15th, when he noted that she was a stout florid woman of medium height, who slept well, and was able to walk well once the exhaustion following menstruation had passed off. The bowels acted regularly, urine normal, with sp. gr. 1020. On examination a hard mass could be felt, rising out of the pelvis as high as the umbilicus. The uterus could not be differentiated from the mass. On vaginal examination the cervix was thinned out and the external os dilated over a hard mass which was continuous with the tumour felt per abdomen. The pelvis appeared to be quite filled up by the tumour. Dr. Slimon diagnosed uterine myoma, and when I saw the patient I confirmed the diagnosis, and we agreed in advising an operation which was undertaken the following day. On opening the abdomen the tumour presented. On the summit of it was the body of the uterus, somewhat flattened down over the tumour ; the tubes ran out at the sides, well above the main part of the tumour, and both of them were dilated, with sealed abdominal ostia. It was evident that we had to deal with a large cervix-myoma impacted in the pelvis, and it was quite impossible to raise it out of the pelvis. The distal portion of each broad ligament was therefore clamped and divided between the clamp and the tube ; and the divided portions of the two sides were connected by incisions through the tumour-capsule, in front of the uterus and behind it. By shelling out the tumour from the lower portion of the capsule the whole thing could be raised out of the pelvis and the tumour was then removed by a pan-hysterectomy. The vaginal vault was brought together by mattress-sutures and the peritoneum united over the stump. The patient made an uneventful recovery and went home on October 11th, being the sixteenth day after the operation.

Cervix-myomata are an interesting variety of myomata, whose chief characteristics were first fully dealt with by Mr. Bland-Sutton. He found that they formed about 5 per cent. of uterine myomata, and my own more limited experience

is in harmony with this, as out of 124 cases of uterine myomata dealt with by abdominal operation, five were cervix-myomata. At one time the removal of a cervix-myoma was regarded as a very formidable matter ; but the principle of enucleating the growth to start with has greatly simplified the procedure, although even now, as in the present instance, the operation may be a difficult one. When the old clamp method was in vogue, a cervix myoma was an irremovable tumour.

It is a point of some interest that in this case, in spite of the fact that the tumour practically filled the pelvis, there was no disturbance of the bladder and bowels. This is partly explained by the curious fact that while these tumours mould themselves so as to form an almost complete cast of the pelvis, the sigmoid appears to have the faculty of making itself respected by the tumour ; and there is always found on the left posterior surface of the tumour a flattened area corresponding with the space occupied by the bowel.

CASE III.—*Intra-Uterine Myoma Removed by Abdominal Myomectomy.*

The case was that of a nurse, æt. 36, single, who had suffered from menorrhagia for over two years before operation. She had been curetted with only temporary benefit. I had her under treatment for fifteen months ; at first the uterus only presented a moderate enlargement, but it gradually increased in size ; and it was evident that a definite myoma had developed. The uterus was quite uniformly enlarged, and I came to the conclusion that there was a single intra-uterine myoma which could probably be removed by myomectomy, leaving the uterus behind. I operated in September of last year. On opening the abdomen the large globular uterus presented, and I at once made a median incision over the anterior wall, opening the uterine cavity, and removed a myoma, the size of a large orange. The uterine wall was sewn up again as after a Cesarean section. The patient made a good recovery.

The interest of the case lies chiefly in the operative procedure, which was an abdominal intra-uterine myomectomy, or, as it has also been called, hysterotomy. I have done this operation three times in twenty-four myomectomies. The first case was a young single woman, of twenty-three, and I reported the case in the "Obstetrical Transactions" for 1900 ; up to that time I could find only very few cases reported.

SOME REMARKS ON UTERINE SUSPENSION AND SHORTENING ROUND LIGAMENTS.*

By JAMES S. ASHE,

Professor *Materis Medice*, Ph.S.I. ; Gynaecological Assistant, Adelaide Hospital, Dublin.

I HAVE chosen as the subject of this short paper the cases of uterine suspension and shortening of round ligaments which have come under my notice as clinical assistant to Sir Wm. Smyly, at the Adelaide Hospital, to whom I am indebted for his courtesy in allowing me to write on his cases.

Having diagnosed retro-versio flexion, the question we have to face is this, Are we dealing with a case for palliative or radical treatment ? For I firmly believe cases are operated on which need

* Paper read before the Obstetrical Section of the Royal Academy of Medicine in Ireland on April 6th, 1906.

not be, and cases which should be operated on are let run too far or left over altogether. I have looked up a lot of authorities on this matter, and, in my humble opinion, Jellett states the case more concisely and to the point than any of the others I have seen. He says:—"Palliative treatment is at first indicated in all cases, as it may bring about the cure of the condition." Under this heading I would be inclined to group (1) those cases which are accidentally discovered and cause no apparent symptoms, these cases ought, of course, to be left severely alone; (2) those post-parturition cases which are due to atonic relaxation of the ligaments; (3) and those similar cases which are seen after long illness, such as typhoid and the fevers generally. This class of case does very well with a pessary, tonic, and change.

There is a class of cases which I have not yet seen described which may be tried under this heading, but usually fail. Those congenital or hysteroptotic cases which are associated with enteroptosis of the abdominal organs generally, and which run in families—I have seen two sets of sisters thus; and again, those cases which I would describe as resilient uteri, which, having put into position and inserted a pessary, keep returning to a mal-position and mean operation probably later.

"Radical treatment is indicated" (and I still quote Jellett) "(1) When no pessary will be found which will keep the uterus in position." Those resilient and hysteroptotic cases I have mentioned. "(2) When the pessary causes discomfort and vaginitis"; and I have noticed a peculiar kind of vaginitis which goes with pessaries, the mucous membrane has a mottled appearance like a piece of Castile soap, the discharge thin and watery, and the sensation described as burning; the condition rapidly improves on taking out the pessary and putting in glycerine and ichthyol plugs for a few days. "(3) When the patient cannot pay the necessary periodical visits"; those cases which are going to some out of the way place abroad, and also under this head may be grouped the poor, such as frequent our dispensaries, who cannot find time to come regularly and be looked after, and who are willing to undergo an operation and be done with it.

This classification does not say anything about time and duration under the palliative treatment, and which has to be left to the discretion of the gynaecologist and the merits of each case.

We now come to the question of operation. Are we to do shortening of round ligaments or a suspension? The former, of course, seems the more natural and lessens the subsequent danger (?)—and I put in a note of interrogation here—if the patient becomes subsequently pregnant as against suspension of the uterus by Howard Kelly's method. Now, from what I have seen I think suspension the more reliable, less difficult, and shorter operation, and I wish to state from what I know anatomically and clinically no operator can definitely say, "I will shorten the round ligaments in this case and give a good prognosis." Why? Because the result will altogether depend on the state the round ligaments are in, they may be badly developed or attenuated, and this cannot be diagnosed till they are seen. I have seen them normal on one side and attenuated on the other, so on these grounds Alexander's operation can never be a certainty, for if small and attenuated

the ligaments will stretch and the retroversion occur.

So perhaps the best rule would be to operate with an open mind, use the usual abdominal median incision if the patient be young and likely to have a family, and the round ligaments well developed, give her the chance and shorten them in the manner I will describe later. If the ligaments are not suitable, do a suspension.

Now to comment on those cases which were operated on at the Adelaide Hospital last year.

In doing uterine suspension the incision is always the mesial one, no muscles are cut, the transverse incision has been given up as limiting space too much, and one can never absolutely make certain that a retroversion will be the only trouble found, and it hampers matters too much under such circumstances to have too limited space. Sir Wm. Smyly used as suspensory ligature silkworm gut, two of which are usually passed transversely through the anterior and upper portion of the fundus; closure of the abdominal wound is carried out by a slight modification of Kelly's method; of nine such cases they all had an aseptic recovery. I have seen six and they are in perfect health, as are the other three who wrote to me from the country in answer to my inquiries. This is certainly a record that cannot be beaten—cure 100 per cent. I may mention in passing that Howard Kelly's percentage was 99.

VAGINAL HYSTEROPEXY.

Three such operations were performed, in one the retroversion has recurred; another I have seen and she is all right, and a third writes from the country to say she is in excellent health—cure in 66½ per cent.

SHORTENING OF ROUND LIGAMENTS.

This was in all cases done by the abdominal route, and Sir Wm. Smyly combines Wylie's and Dudley's methods. Wylie, of course, seizes the ligaments in the middle and pulls them out, vivifying the opposing parts of the ligaments, then passes three encircling cat-gut sutures. This is a mistake, I think, in two ways. First, there are more ligatures than necessary; secondly, the danger of the stump sloughing, so that one good ligature which will perforate both ligaments is to be preferred.

Dudley's operation slightly differs from this; he vivifies the anterior surface of the uterus and stitches the ligaments with cat-gut. The method adopted at the Adelaide Hospital, you will see, is a modification of both, instead of pulling the ligaments out, as in the case of Dudley's operation, they are drawn in, but before this is done the ligaments are seized with a forceps as near the internal abdominal ring as possible and the ligament put well on the stretch, and again as near the cornu of the uterus as possible; when these forceps are brought together there is a loop of round ligament formed which can easily be drawn in and a perforating cat-gut ligature applied; the same is done on the other side; now we have the two free genu or "sheep shanked" ligaments to deal with and the chief essential is done, the ligaturing of the genu together and then to the anterior and upper portion of the uterus. I hope you will understand my meaning from the diagrams on the board.

Of six such cases three have been quite satisfactory; one has again retroverted (and I may mention at the time of the operation it was

remarked what attenuated round ligaments they were). Of the other two both have cystic trouble. One of the cases cannot retain urine for more than thirty minutes at a time and finds it very trying, for she is in business; the other case is not so bad. I have examined the urine of both sent up to me from the country and am afraid the first case must be put down to cystitis; this is not to be wondered at, as she had to have a catheter passed every day during her convalescence, and only had it discontinued just before leaving. The other case of this nature may prove interesting. It may be due to pressure of the pulled forward uterus on the bladder when it is filling, and we hope to have this case examined later on cystoscopically.

I would like to ask any of the Fellows of this Section, Have they noticed any after trouble in cases of shortening of round ligaments? Also what are their experiences in cases which have afterwards become pregnant when abdominal suspension has been performed, as from what I know now as regards both the operations I would prefer to do a suspension, if such were required, to shortening the round ligaments, the latter, in my opinion, being a longer, more difficult, and tedious operation, and which from all statistics does not give as good results as those done by suspension.

A NOTE ON SUPRAVAGINAL AND PANHYSTER- ECTOMY: WITH THREE OPERATION CASES.*

By FREDERICK EDGE, B.S., M.D., F.R.C.S.,
Surgeon, Birmingham and Midland Hospital for Women.

In the course of further experience there is a natural tendency to change, and I have been no exception to this tendency. I had a strong predilection for panhysterectomy at first, but gradually came to favour supravaginal hysterectomy more and more. During the last twelve months I have had two deaths after supravaginal hysterectomy, which have profoundly impressed me that the operation has a more limited field than I held it to have.

The first case was one of secondary hæmorrhage when the left ovarian vessel bled, although the pedicle was ligatured twice at the operation. The abdomen was opened and the vessel found with slack ligatures on it. It was re-ligatured, but owing to the severity of the primary operation, when there was much loss of blood from adhesions, and the great loss again the patient died.

I shall not discuss this case except in so far as it relates to the method of operation. Had panhysterectomy been adopted I think that the secondary hæmorrhage would have shown itself per vaginam, and intervention would have been much earlier and with better chances of success. The question of how much drainage, by keeping the parts dry, tends to prevent secondary hæmorrhage also enters here. It may be said that an opening through the pouch of Douglas would have served to drain and to give early warning of secondary hæmorrhage, but I question this if the opening be plugged with iodoform gauze or if the bleeding were subperitoneal.

The second death was almost as tragic. I per-

formed supravaginal hysterectomy for pelvic deformity at term. The patient did well for five days, when the pulse rose to 110, and temperature to 101° and 102°, I did not feel alarmed as I put the fever down to cellulitis about the cervix and ligatures. However, next day symptoms of acute general peritonitis ensued and the patient died on the tenth day. *Post mortem* there was marked purulent peritonitis which had arisen from a left broad ligament abscess, and instead of this abscess opening into the vagina it had flooded the peritoneum. I shall not discuss where the sepsis came from. Suffice it to say that on the same morning I had done a similar case (cases of like character seem to come to the surgeon in pairs), which recovered without any sepsis or peritonitis. Either sepsis was present in the second case or was introduced. The same procedure was adopted in each case and the cervix was closed with fine silk sutures. The peritoneum being stitched continuously from side to side. I feel that, had this case been treated as a breast case with free drainage, she would have stood a good chance of recovery, after perhaps a tedious convalescence with free suppuration.

This question of local and general peritoneal sepsis and infection of the peritoneum has not been sufficiently pressed. The question of malignant degeneration of the cervical stump has occupied too much of the ground; but I feel that the immediate trouble of sepsis will eventually have more weight in deciding the balance between the complete and the partial operation than any fear of malignant degeneration.

Our President has several times expressed the view that it is not wise to close the cervical canal, and that one often regrets not having drained but very seldom regrets having used a drain for some hours. Dr. Macnaughton-Jones records a case where the whole cervical stump sloughed away, happily with no evil effect.

Mr. Bland Sutton employs panhysterectomy in cases where sepsis may be present as in parous married women, when the patient is over forty and cancerous degeneration of the stump may follow, while he reserves supravaginal hysterectomy for cases with a long cervix in spinsters and nulliparous married women. Quotations may be multiplied, but these occur to my mind.

In the case of the specimen of myomatous uterus shown I removed the posterior half of the cervix and, in future, I shall always leave free vaginal drainage by operating as follows: The vagina is thoroughly disinfected and the cervix seized and cleaned out. An incision is made posterior to the cervix and parallel to it, but not opening into the pouch of Douglas. A sterilised compress is inserted into this incision as a point to aim at from above. The abdomen is then opened and the myomatous uterus drawn out if possible. The ovarian and round ligament pedicles are ligatured, leaving plenty of peritoneum. The anterior peritoneal flap is carried well up the anterior uterine wall, so as to get a good large flap. The posterior flap runs from one ovarian pedicle to the other and is dissected down before the uterine arteries are tied, as otherwise the peritoneum is apt to be caught by the ligatures. The uterine arteries are then tied and a second ligature on each side takes up branches to the cervix and vagina. Now the vaginal compress

* Paper read and cases shown at the British Gynecological Society, April 9th, 1906.

is cut upon and the cervix removed, either before or after supravaginal section, as is found convenient. The pedicles are all turned in and the peritoneum sutured from side to side, a drain being inserted previously into the vagina. In this way the wound is shut off from the peritoneal cavity and every part of it is freely drained. Any secondary hæmorrhage will show at once as in vaginal hysterectomy, and any pus will have a free outlet. The final result is practically the same as in Doyen's classical method, but this method can be applied to all forms and situations of the myomatous uterus. Even if one case in a hundred be saved by this method it will be justified.

SPECIMENS.

(I.)—*Strangulated Myoma of the Uterus simulating Cancer of the Fundus.*

This case was seen by Dr. Lycett, our local secretary in Wolverhampton, and as there was such a strong family history of cancer it was feared that cancer of the uterus was present, although the symptoms pointed to strangulation of a tumour in the pelvis. The cervix had an expanded feel, which ran into a rounded mass in the pouch of Douglas. I have had three cases of cancer of the fundus in elderly women when the fundus was retroflexed and felt like a myoma in the pouch of Douglas.

I extract from Dr. Lycett's notes as follows :—A.S., æt. 58, unmarried, menopause at 50. Previous history good. Father died of cancer of stomach, and an aunt died of cancer of bowels. Patient has suffered from slight pelvic pain this winter, but nothing severe until after a walk on February 23rd, when she was seized with acute pelvic pain. Dr. Lycett saw her next day with Dr. Crear. She had severe pain in the lower abdomen, pulse rate 120, and temperature raised, 104° was the highest. There was no vomiting. A full examination was impossible owing to tenderness, but the uterus was felt fixed and a mass in the pouch of Douglas and to the left. The cervix was thick and expanded. Although the symptoms pointed to axial rotation of an ovarian cyst, carcinoma was not excluded, as the lump was so small and intimately united with uterus, and the family history was so suggestive. With rest she improved, and on March 22nd I saw her with Dr. Lycett when my opinion was that an exploratory operation would decide between cancer, myoma, and twisted ovarian cystoma, with possibly a complicating pus tube. On March 23rd the abdomen was opened and dense adhesions found in the pelvis. These were separated carefully and the appendages were traced out and found adherent, but healthy. The fundus was retroverted and seemed globular. By insinuating my finger cautiously down the back of the right broad ligament I felt the hard rounded myoma, and it was now evident that there was no danger of rupturing any foul cancerous growth. The sphacelated myoma was removed and two small myomatous nodules also. It is difficult to convey views held in the midst of operating, but I should like it to be clearly grasped that the pelvic viscera were so glued together that at one period I considered I was running great risks of doing more harm than good, and perhaps of needlessly hastening the end by breaking down protective peritoneal adhesions such as I have seen in cancer of fundus or rectal wall. The convalescence has been uninterrupted. I have seen fatal sepsis

from strangulated sloughing myomata, and as this was so adherent to the rectum it is probable that infection would have taken place.

Dr. Crear wrote after the operation :—"I thank you for your letter. I was very pleased everything had gone on so well and especially pleased to know there was no malignant growth. The presence of these small growths explains the expanded feel of the cervix all round in addition to the larger mass posteriorly."

(II.)—*A Pregnant Uterus with an almost Sessile Myoma removed by Supravaginal Hysterectomy.*

Patient, æt. 45, with history of amenorrhœa for three months. The patient had severe abdominal pain and on examination a large hard mass, continuous with a cystic globose uterus, was found. Torsion of a myoma or ovarian cyst was diagnosed. The myoma was found intimately adherent to bowel, and after this had been separated and several small arteries tied on the bowel surface the myomatous base was ligatured with No. 5 silk as this seemed quite feasible. However, the suture cut through the soft uterine tissue and opened the venous sinuses. I have often removed ovarian cysts and several pedunculated myomata from pregnant uteri without interrupting pregnancy. In this case I found the uterine bleeding difficult to check and decided that removal of the uterus was the safer procedure, especially as the patient had expressly desired the uterus and ovaries to be removed so as to be rid of any chance of future disease. It was not my intention to do so, but as things turned out I was compelled to satisfy her wishes. This case was sent by Dr. Lycett and Dr. Bard.

I have generally made flaps from the myomatous capsule in such cases, but in this case the myoma had an irregular knotty surface and sarcoma was suspected. It has not yet been examined.

(III.)—*A Myomatous Uterus with Expanded Cervix removed by Abdominal Hysterectomy.*

The cervix was removed after supravaginal hysterectomy, but not entirely, as the anterior wall was left. This specimen is merely shown as a sample of those cases in which I consider free vaginal drainage essential, because the wound surface is so large and so vascular that, however carefully hæmorrhage is carried out, I think that the oozing is likely to be more than can be safely left in a closed wound or trusted to the absorptive capacity of the peritoneum.

CLINICAL RECORDS.

CASE OF ECTOPIC GESTATION.

UNDER THE CARE OF J. COTTER, M.D., R.U.I.,
M.Ch., F.R.C.S.,

Senior Surgeon, Cork North Infirmary, &c.

MRS. L., æt. 36, married nine months. Menstruation was regular up to November 20th, when she missed a period then due. A week after this the period came on, heavier than usual, and lasted four or five days. On December 4th, she experienced severe pain in the lower part of abdomen, and felt as if something had given way inside. She got very faint and vomited. A week after a swelling in the lower abdomen appeared, which gradually increased. When first seen by him she was profoundly anæmic, with raised temperature, and pain in the lower abdomen, where there was a fluctuating tumour. Per vaginam fluctuation could be felt over a swelling in Douglas's pouch, and the uterus was pushed forward. He operated on December 24th.

first tapping the tumour through the posterior fornix, and got nothing but pure blood. The abdomen was then opened by mesial incision, and what looked like a large ovarian cyst immediately presented. On opening it a large collection of blood, fluid and clotted, escaped, the clots being ladled out with the hands. At one side of the cyst wall, somewhat in the situation of the outer end of the left Fallopian tube, was what appeared to be a lump of organised lymph. Portion of this was removed, and Dr. Moore reported that it showed chorionic villi, and decidual tissue. The cavity was packed with iodoform gauze, and recovery was uninterrupted.

Dr. Cotter remarked on the great rarity of such cases, and thought that this was a tubal abortion, as there was no evidence of a rupture of the tube.

THE OUT-PATIENTS' ROOM.

KING'S COLLEGE HOSPITAL.

Tuberculous Glands of the Neck.

By Mr. PEYTON BEALE, F.R.C.S.

AMONGST the out-patients was a boy, *æt.* about 15, suffering from enlarged lymphatic glands of both sides of the neck. The history of the case was as follows:—When seven years of age the boy suffered from measles followed by bronchitis, during which he expectorated some blood on two or three occasions. At this time it was noticed that his glands were somewhat enlarged, and as there was a very well-marked tuberculous family history it was assumed that he was suffering from phthisis, and that the enlarged glands were also tuberculous. He was sent away to the sea-side, where he was in due course apprenticed to a carpenter; from then till the present time he has had no signs of phthisis, but the glands have always remained somewhat enlarged, becoming larger whenever he suffered from a cold. Recently he had an attack of influenza, and noticed that the glands remained larger than usual. On examining the patient it was found that all the superficial lymphatic glands were considerably larger than they should be, but otherwise the boy appeared to be in perfect health. Mr. Beale remarked that in these cases it was not easy to lay down any definite rules of treatment; it seemed to him that in cases where there was a marked tuberculous family history it showed that the individual was not necessarily infected with tubercle from the time of his birth, but that he was suffering from a condition which resulted in the leucocytes of his blood being unable to destroy tubercle bacilli when they had infected any tissue or organ of his body, so that when exposed to a risk of tuberculous infection he became infected and the infection, moreover, spread, ultimately involving all his lymphatic glands. So long as he kept in good health nothing further appeared to happen, for directly the tubercle bacilli multiplied to an alarming extent in any particular place they were carried to the nearest lymphatic glands, where there were phagocytes sufficiently active to destroy most of them; but when the individual's health was in any way below par the phagocytes were not so active, and as a result the glands enlarged, the enlargement being at first inflammatory, caused by the bacilli or their toxins, or both, and subsequently passing on to caseation. In such cases it frequently happened that one or more of the glands underwent suppuration. Mr. Beale did not believe that this was due to tubercle. It meant that such gland or glands had received septic organisms, and being already tuberculous, the phagocytes in them were unable to cope with the septic infection. His view was that purely tuberculous glands never suppurated; they might get fairly large; they might caseate in the centre or in several places; they might even be converted into a mass of caseous material enclosed by the gland capsule, but they did not suppurate. The caseous material often became calcified and it was not uncommon to find the remains of such a lymphatic gland consisting of a capsule containing

simply a calcareous nodule. In a case like the one before him, what was the proper line of treatment? He thought it was as follows: (1) To make certain that the glands were tuberculous by removing one or its contents and examining in the clinical laboratory; (2) to examine the patient and find out if there were any lesions on skin or mucous membrane such as would be likely to allow of the entrance of septic organisms, and to treat them efficiently and tell the patient to avoid as far as he possibly could the formation of such lesions; one of the commonest was carious teeth, and if any existed they should be dealt with by the dental surgeon; (3) to take every precaution in the way of keeping up the patient's general health by obtaining plenty of fresh air, exposure to sun's rays, good feeding and tonics. If under these conditions one or more glands should unfortunately become infected with septic organisms and form one or more abscesses, the latter should be dealt with by incision and draining under strict antiseptis, when they would in nearly every case heal up satisfactorily. He said that in a few cases they did not heal up, but that the skin over them became undermined, a typical tuberculous ulcer resulting. Under good hygienic conditions and the application of mercury, such as *lotio nigra*, or *ung. hydrarg. ox. rubri dil.*, or an ointment containing iodoform, this would heal up, providing it were kept aseptic. If it was found that superficial lesions were continually recurring, for instance, eczema of the face, carious teeth, ulcers in the mouth, then the right thing to do was to remove the whole of the glands likely to be infected, carefully choosing a time when they were not suppurating. He laid stress upon the fact that every gland should be removed; it was often not possible to do this through one incision, in which case they should be removed in groups until all glands near the seat of infection had been extirpated. It was, of course, quite impossible to remove all the tuberculous glands all over the body, and he did not see the use of removing, say, all the tuberculous glands in the neck and leaving tuberculous glands in the axillæ and groins, but any group of glands which were likely to become septic as the result of a neighbouring skin lesion should be excised; he considered it bad practice to attempt to remove one or two which were septic, because as long as the risk of local septic infection existed so long would the tuberculous glands that remained be liable to form abscesses.

OPERATING THEATRES.

NORTH-WEST LONDON HOSPITAL.

HERNIOTOMY AND LAPAROTOMY—STRANGULATED HERNIA AND SECONDARY VOLVULUS OF THE SMALL INTESTINE.—Mr. JACKSON CLARKE operated on a man, *æt.* 61, who had been admitted for urgent symptoms of intestinal obstruction. The history of the case was as follows: The man had been at his work as assistant in a shop until four days previously; then he experienced a feeling of sickness which he attributed to a bilious attack such as he was subject to, and in consequence there was considerable delay in seeking medical aid. Towards the end of the second day, the symptoms having become more pronounced, a message was sent to the doctor requesting him to send a remedy for a bilious attack. The doctor, who was accustomed to treating such attacks in the patient, sent some medicine and said he would call next morning, when he found the patient was vomiting and slightly jaundiced. He examined the abdomen, where he discovered an irreducible inguinal hernia on each side of many years' standing; neither of these, however, presented any unusual feature, there being no tension appreciable to the touch or tenderness. An enema was administered which brought away some small scybalous masses. After this the patient seemed to improve, the vomiting becoming less urgent and the jaundice disappearing.

On the fourth day the vomiting still persisting, the doctor recommended the patient's immediate removal to the hospital, where he arrived late in the day. On examination the man, though weak, was not urgently distressed, the pulse was about 85 of somewhat high tension; his extremities, however, were cold, and it was evident that shock was beginning to be felt. The abdomen was especially prominent in front, the coils of bowel showing clearly upon it. Basing his opinion on the shape of the abdomen, Mr. Clarke expressed his conviction that the distension concerned only the small intestine, the sides and the upper part of the abdomen being less prominent than the front. The only other form of obstruction which in his experience produced so great an anterior protrusion of the belly was a volvulus of the sigmoid flexure, but in the latter case the prominence was usually even more pronounced than it was in obstruction of the small intestine, and the visible coils in the present case, from their position, direction and size, could only be coils of small intestine. No time was lost, but the patient was at once prepared for operation, which was begun twenty minutes after he reached the hospital. Seeing that there were two hernias, and after the long lapse of time since the commencement of the symptoms that there might be some abdominal complication, Mr. Clarke decided to open the abdomen in the middle line. This was done, and on examining the hernial orifices from the inside a loop of bowel was traced to that on the right side; that of the left consisted only of sac and fatty tissue outside it. The hernial sac on the right side was then opened from the outside as quickly as possible, the internal ring divided, and a loop of congested bowel having been freed from some adhesions

which bound it to the sac and its neck examined and found to be free from ulceration, the loop was returned to the abdominal cavity and the inguinal canal closed in the usual way. On examining the bowel from within the abdomen it was found that gas would not pass from the distended to the collapsed portion of the small intestine; this was seen to be due not to any persistence of constriction at the neck of the previously herniated bowel, but to a twist of the mesentery which had doubtless taken place by the distended coils of small intestine accommodating themselves to the abdominal space and in so doing twisting the mesentery on its own axis. In order to undo the twist it was necessary to turn the distended coils of bowel out of the abdominal cavity, where they were received in a towel wrung out with hot saline solution. The twist undone, gas began to pass into the previously collapsed bowel, and the intestines were rapidly returned to the abdominal cavity and the wound sewn up. During the operation the patient's shock had naturally been increased, and on being returned to bed he was given an injection of strychnine and a large hot saline enema was administered. Mr. Clarke said that the moral of the case was very obvious: the long delay on the part of the patient and his friends in seeking medical aid was responsible for the difficulties met with in the case; had the man been seen on the first day, a simple herniotomy would no doubt have relieved all his symptoms, but after the volvulus of the small intestine had supervened the herniotomy alone would have been quite useless. The patient's prospects, owing to the exhaustion of four days' intestinal obstruction followed by an operation that lasted three quarters of an hour were, he considered, far from hopeful.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD APRIL 27TH, 1906.

The President, Mr. CLUTTON, in the Chair.

DR. G. A. SUTHERLAND showed a case of (?) Von Recklinghausen's Disease in a male, *æt.* 5. Nothing in the family history save that his mother and maternal grandmother have spots of pigment on the body similar to those of patient.

At the age of six months a swelling the size of a bean was noticed on the right temple, and the right cheek and eye appeared to be growing out of proportion to those on the left side. All these swellings have greatly increased.

Special Features.—A swelling over the right frontal bone, firm and nodular. Right upper eyelid much hypertrophied and hanging over the eye. Right eye enlarged and apparently proptosed. Right cheek enlarged and contains nodular thickenings in its substance. Pigmentation is present over the frontal swelling, the right upper eyelid, the trunk, the axillæ, and the groins. Skiagrams show great enlargement of the orbit on the right side.

Negative Features.—No evidence of visceral disease, save a trace of albumen in the urine. No pain or tenderness, nor evidence of central nervous disease.

Mr. CLUTTON suggested the diagnosis of leontiasis ossea, in spite of the age.

Mr. W. G. SPENCER contrasted the condition with the reverse one of morphœa, and considered that it was a simple hypertrophy of trophic origin.

Mr. G. PERNET considered the case to be an anomalous one of Von Recklinghausen's disease. This sometimes went on to sarcoma formation, as in cases described by Rolleston and others.

DR. PARKES WEBER thought that the neuro-fibromata on the side of the head, together with the typical pigmentation stamped the case as being one of Von Recklinghausen's disease.

DR. SUTHERLAND commented on the limitation of the bony condition to the territory of the 5th nerve, and queried whether it was sarcomatous.

DR. F. PARKES WEBER showed a case of "Spontaneous" Fracture in the Tarsus in a woman with Argyll-Robertson pupils. The patient is a married woman, *æt.* 45. About twelve months ago the right foot became swollen and painful. On admission there was a great swelling of the right foot, especially of the dorsum, and crepitus could be felt. A skiagram showed that a portion of the head of the astragalus was broken off and displaced. There were Argyll-Robertson pupils on both sides. The knee-jerks were present. Under rest in bed there has been great improvement in the condition of the foot, but mercurial inunction had likewise been employed, followed by the internal use of iodide of potassium.

Mr. CLUTTON pointed out that the joint certainly had all the local features of a tabetic arthropathy.

DR. WEBER said Argyll-Robertson pupils meant old syphilis, though not necessarily tabes, and he considered whether the joint condition might be gummatous.

Mr. G. PERNET showed a case of Ringworm cured by the exposure of X-Rays. The boy, *æt.* 7, was first seen in October 1905, with a patch of ringworm occupying the greater part of the occiput. On October 19th, 1905, he had one exposure of the X-rays, according to the Sabouraud-Noiré method (platino-cyanide of barium pastille). This was followed by the falling out of the stumps and hairs on parts exposed, followed by growth. The results had been excellent, the hair having grown well. No disease could be now made out.

Mr. PERNET pointed out the advantage of the Sabouraud method over fractional X-ray treatment, and referred to the extensive benefits that the Paris schools had received from its application.

Mr. G. PERNET showed a case with Lymphangiectodes. The patient was a young woman, *æt.* 26. The disease had commenced at the age of five months. When first seen there were nine or ten groups of deep-seated vesicles occupying the right side of the chest from the neighbourhood of the posterior axillary fold downwards and forwards, but not reaching as far as the right nipple line. The lowest and largest group was situated on a deeper-seated mass (lymphangiectatic pachydermia of Rindfleisch), and some hæmorrhage had occurred into the vesicle-like lesions.

Mr. CAMPBELL WILLIAMS thought that the early stage of such conditions were to be seen frequently in surgical clinics as lymphatic nævi.

Mr. W. H. BATTLE showed a case of Post-Auricular Fistula. The patient, a girl, *æt.* 11, was admitted to St. Thomas's Hospital on April 19th, 1906. There was a minute opening in the fold behind the right ear, half an inch above the level of the lobule, which only admitted a small probe; from this there was an intermittent distillation of a clear fluid. There was no redness to indicate the orifice, which it was difficult to find when there was no flow of the fluid. The parotid gland was normal. The flow is not increased during meals, but is increased when an acid-drop is given. The opening was in a small, hardly perceptible, linear cicatrix. The fluid was of the nature of saliva. There was a history dating back to the time when she was a year old; at that time it is said that an abscess behind the ear was opened by a medical man, but no further particulars can be obtained.

Mr. W. H. BATTLE showed a patient after operation for perforation of a second Simple Ulcer of the Jejunum into the general peritoneal cavity.

K. C., a single woman, *æt.* 30, was admitted to St. Thomas's Hospital on March 14th, 1906, for symptoms which she herself diagnosed as due to "perforation."

There was some pain in the abdomen on the 12th, which she could not localise. At 9 a.m. on the morning of admission there was a sudden increase of pain, which was now in the upper part of the abdomen, and she vomited.

At 3 p.m. she was lying on her back, with eyes slightly sunken, but not at all anxious-looking.

The abdomen was moving fairly on respiration. It was tender, especially to the left of the umbilicus, and still more so near the lower end of the scar. In that region the muscular rigidity was most marked, and there was distinct swelling. The usual operation was performed.

She left the hospital on April 12th, having made a very satisfactory recovery.

Microscopical examination of the edge of the ulcer showed only an acute inflammation.

It is of interest to note that there were no adhesions found at this operation, also that there is now no hernial protrusion of any of the scars.

The previous history of this case was as follows: She was admitted in March, 1903, for perforated gastric ulcer. This ulcer was situated in the anterior aspect of the stomach, near the pylorus, and was surrounded by a good deal of thickening. It was sutured, the peritoneum cleansed, and a drainage-tube left in the lower wound. Anterior gastro-enterostomy was performed on April 9th, 1904, for pyloric stenosis.

On May 6th, 1905, she underwent operation for perforation of a simple ulcer of the jejunum; this had given into the general peritoneal cavity. It was a circular, clean-cut ulcer, situated about 1½ inches from the line of junction of the bowel with the stomach. The ulcer was sutured, the peritoneum cleansed, and the two wounds through which this was done closed without drainage.

Mr. W. G. SPENCER said that ulcers of the jejunum had been thought to be commoner after anterior gastro-enterostomy, but Mr. Patterson and others had disproved this.

Mr. W. H. BATTLE also showed a Deformity of the Ulna, with Dislocation of the Head of the Radius associated with Multiple Osteomata.

Dr. LEONARD GUTHRIE showed a case of Extreme Obesity with Precocious Puberty in a girl *æt.* 3. The child had always been rather plump, but had been rapidly growing fatter during the past six months. Height 2 ft. 9½ ins.; weight, 37½ lbs. She had grown an inch and increased 6 lbs. in weight in three months. The fat was fairly evenly distributed and also existed in pads or rolls round the neck and about the chest and flanks. The features looked small, and the temporal regions were masked owing to masses of fat in the cheeks.

Measurements.—Round neck, 12½ ins.; chest, 25½ ins.; abdomen, 26½ ins.; upper arm, 8 ins.; lower arm, 7½ ins.; thigh, 13½ ins.; calf, 8½ ins.

The breasts were beginning to develop and hair has appeared on the pubes during the last three months. There had been no discharge of blood as yet. *Assimilation* was poor and the heart-sounds were weak. The pulse was usually intermittent and irregular and averages 120–130 per minute.

Temperature was usually subnormal—97°–98°.

Urine was normal. Intelligence was good.

Dr. SUTHERLAND had seen this case six months ago, when there was only obesity. He contrasted the present condition with the commoner one of obesity, combined with mental deficiency.

Dr. PARKES WEBER said that probably the condition was due to a hypernephroma of the adrenals.

Mr. CLUTTON thought that most cases of precocious sexual development were male.

Dr. GUTHRIE referred to a collection of cases made by Drs. Bullock and Sequeira. Of the two males and twelve females with sexual precocity, all had obesity except six of the females. All had hypernephromata usually of a carcinomatous nature.

Dr. A. E. GARROD showed a case of Muscular Atrophy in a child (case for diagnosis). The patient was a girl, *æt.* 11, who exhibited somewhat extensive muscular atrophy, and a condition of the limbs of the left side which was said to date from a paralytic attack at the age of one year. There was some affection of the facial muscles—fibrillary twitching around the left angle of the mouth and a tendency for the right side of the mouth to be drawn down when the teeth are shown. In the attempt to whistle the right side of the mouth is not pursed up. The tongue is protruded straight. There is atrophy of the lower portions of both pectoral muscles and of the deltoids. The most extreme wasting is in the first dorsal interossei of both hands, which do not react at all either to the Faradic or galvanic current. None of the wasted muscles showed any reaction of degeneration. There was some scoliosis and deformity of the thorax. Babinski's sign was obtained on the left. The left triceps jerk was well maintained. The left arm was small, and its muscles were generally wasted. There was conspicuous atrophy of the thumb muscles and interossei—*main en griffe*. The forearm was held in a position of extreme supination, and could not be pronated. The left leg was an inch and a quarter shorter than the right, and there was *pes cavus*. The wasting was most pronounced in the muscles of the thigh.

Dr. FARQUHAR BUZZARD thought the most likely diagnosis was one of myopathy grafted on an old hemiplegia.

Dr. A. E. GARROD showed a case of Angio-Neurotic Edema. The patient was a girl, *æt.* 20. At the age of fourteen she began to have recurrent attacks of acute circumscribed œdema of the right cheek. The attacks recurred at quite irregular intervals. The patch of œdema was always in the same position, on the right cheek. In some of the more severe attacks

constitutional symptoms were present, such as shivering at the onset, and "pains all over." There have been no articular troubles. The patches were not the seat of any burning sensation or itching. Polyuria had been noticed to accompany the attacks. Three months ago a severe attack began in the usual situation, but the œdema extended to the nose, both eyelids, and the forehead. This attack also differed from all previous ones in the fact that, instead of subsiding in three days, the œdema has persisted up to the present time, and has not been influenced by treatment. The urine contained a cloud of albumen, but there is no œdema elsewhere than in the face.

Dr. PARKES WEBER considered that the continuance of the œdema and its limitation to one part were against Dr. Garrod's diagnosis.

Mr. W. G. SPENCER suggested a local lesion, such as a chronic streptococcal infection of nasal origin.

Dr. LEONARD GUTHRIE showed a case of Paralysis of Left Sixth and Paresis of Left Seventh Nerves. Patient was a girl, æt. 3. About six weeks ago she was noticed to squint and to turn her head to the right side. She began to limp and did not care to walk. On admission to Paddington Green Children's Hospital, April 19th, 1906, her condition was as follows: The head was almost constantly inclined towards the right shoulder, her eyes twisting in the same direction, downwards, and to the right. When she looked towards the left side there was marked internal strabismus of left eye, but the right moved normally inwards. The left external rectus was paralysed, but no other ocular muscle was affected. There was no optic neuritis. The whole of the left side of the face was parietic. Beneath the left zygoma there was a prominent swelling about the size of a five-shilling piece, slightly tender, ill defined and elastic, or indistinctly fluctuating on pressure. There was a tuberculous nodule on the back of the right hand, said to have existed for three to four months. The child was dull and apathetic, never spoke, cried in a half-hearted way if examined, or spontaneously, but did not seem to be in pain. Gait was slow, rather shuffling, and unsteady. Kneejerks were active. No ankle-clonus. *Diagnosis*.—Probably tuberculous disease of bone in malar region, involving left facial nerve externally and left sixth nerve internally. The deviation of the head was probably adopted to avoid diplopia.

Mr. W. G. SPENCER remarked that the position of the head might be due to a lesion of the eleventh nerve.

Dr. FARQUHAR BUZZARD thought the most probable diagnosis was a tuberculous mass in the left pontocerebello region.

Mr. BATTLE also showed a case of extensive Ulceration of the Mouth in a man of 38. The duration was eighteen months.

Mr. W. G. SPENCER thought the ulceration was of a tuberculous nature.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, APRIL 6TH, 1906.

SIR ARTHUR MACAN in the Chair.

Dr. J. S. ASHE exhibited a "new cystic ovary perforator and forceps."

Dr. HORNE showed a "myoma of the uterus showing cystic and calcareous degeneration." He said the patient was æt. 45, and the mother of six children, and had menstruated regularly. The tumour occupied the whole abdominal cavity. It resembled an ovarian tumour, as there was considerable feeling of softening about it. Notwithstanding the large size of the uterine cavity, the clinical history revealed no menorrhagia. A loud tympanitic note could be elicited in front of the abdomen. On removal of the

tumour he found it contained a large degenerative cystic cavity, with a number of small cysts and calcareous areas. The report of the pathologist (Professor McWeeney) showed that the organ was enormously enlarged owing to intra-mural fibroids, and in the centre is a cavity resembling a cyst. The microscope shows the tissue of the tumour to consist of unstriated muscle, and the cyst to be a "pseudocyst," i.e., one due to ischæmic necrosis of the muscle and its gradual softening. There are no genuine cysts in any of the sections, and no evidence of malignancy.

Dr. H. TWEEDY said he would like to know was a pedicle looked for through the rectum in this case? He did not believe that the size of the uterus was a necessary feature of distinction between ovarian cyst and myoma. Sub-peritoneal myomata were not likely to enlarge the uterus.

Dr. R. J. ROWLETTE said he had examined some specimens which simulated the appearances of the one shown.

Sir ARTHUR MACAN said he had come across a case in which a true fibro-cyst was manifest, the fluid of which coagulated on exposure. He did not know whether the pathology of this coagulable condition was thoroughly determined or not.

Dr. HORNE, in reply, said the patient after admission to hospital had a febrile attack, and had the facies of a person suffering from ovarian tumour. The muscles of the chest and forearms were wasted. The tumour and the cervix uteri were one body. He did not make a rectal examination for a pedicle, as the case admitted of no doubt, though he appreciated the value of that procedure in ovarian disease.

CANCER OF OVARIES.

Dr. HASTINGS TWEEDY exhibited a specimen of "cancer of both ovaries." He said the patient was a girl of twenty-one, who had been operated on in a City hospital some weeks previously for an ascitic collection, supposed to be the result of tuberculous peritonitis. She entered the Rotunda Hospital five weeks afterwards, in an apparently dying state, and enormously distended by peritoneal dropsy. On opening the abdomen, he found the intestines tucked up under the diaphragm and very adherent to each other; they, together with the entire peritoneum, were studded with coarsely granular masses, which he remarked at the time of the operation resembled endothelioma rather than tubercle. The ovaries appeared papillomatous, and were both removed. The abdominal cavity was drained with five wicks of iodoform gauze in the hope that they would be the means of causing an adhesive peritonitis, and so obliterating the weeping surfaces. For several days she poured fluid through the drains, but this gradually became less, and she left hospital symptomatically cured, and declaring that she was feeling better than she had done for two years. Dr. Rowlette, who examined the pathological condition of the parts removed, would be able to deal more fully with the microscopic findings.

Dr. R. J. ROWLETTE said the tumours were of a nodular character, the nodules varying from the size of peas to that of beans. In the substance of the nodules there were small cysts, some of these being filled with a clear, and others with a blood-stained, fluid. Both ovaries were similarly affected. Microscopic examination revealed masses of large cells, with a slight fibrous stroma. He regarded the tumour as an endothelioma, originating probably from the endothelium of the peritoneum.

Sir ARTHUR MACAN said he recalled a case in which, when the abdomen was opened, a large tumour thought to be malignant was apparent. On removing the tumour the patient got quite well; but the diagnosis of malignancy was possibly not correct. It was interesting to note how drainage, in the case under discussion, had the same beneficial effect as excision had on tubercle.

Dr. H. TWEEDY said he had examined the patient

that morning. Her abdomen was hard, and the cancer seemed again advancing.

HERNIA OF THE GRAVID UTERUS.

Dr. ARTHUR HOLMES read a paper on a "Case of Hernia of the Gravid Uterus" through an old abdominal scar. The patient had become pregnant shortly after the operation, and had noticed a lump protruding from the lower part of the abdomen. This after the confinement had almost disappeared. She again became pregnant, the lump steadily increasing, and circular ulcers formed where the clothes and thighs had rubbed. After delivery in November, 1903, the tumour remained, though smaller in size. On December, 22nd, 1905, she came to the Rotunda Hospital. On examination there was found a tumour springing from between the umbilicus and symphysis, which, falling forward, reached more than half-way down the front of the thigh. This proved to be the uterus, and the fetal movements were felt. The skin was very thin, and large circular ulcers were distributed over its surface. Some of these extended to the uterine muscle. The patient stated positively that she was at full term, and that labour pains were beginning. She delivered herself suddenly without any trouble of a live child, which presented all the appearance of being up to full term. Its weight was $3\frac{1}{2}$ lbs., and its length 14 inches. The placenta was removed manually on account of hæmorrhage. Reduction of the uterus was impossible on account of the adhesions. The diminutive size of the child was thought to be due to the diminished blood supply, consequent on the abnormal position of the uterus, and the constriction caused by the ring of the sac.

Dr. HORNE said he had never seen a case of this kind. It was hard to conceive how the child was born through so great a constriction.

Dr. A. HOLMES said the woman delivered herself, and had no pain. The tumour was about the size of a man's head. Dr. Purefoy told him that the woman is going about her work and is apparently well. The child died shortly afterwards of an attack of green diarrhoea.

Dr. J. S. ASHE read a paper entitled "Some Remarks on Uterine Suspension and Shortening Round Ligaments" which will be found in another column under the heading of "Original Papers," page 467.

In the discussion that followed, Dr. HORNE remarked that when the uterus was retroflexed after delivery, it rarely recovered its position; and it was a question whether it should be left alone severely unless some symptom demanded interference. He had rarely ever seen any untoward results follow the use of pessaries; and if such did occur, it was possible the pessaries had not been properly applied.

Dr. HASTINGS TWEEDY said it was not uncommon to observe retroflexions which did not give rise to symptoms. These were often congenital cases, and in such this backward position must be considered normal. It is almost unnecessary to state that these cases were best left untreated. Pessaries might well be compared to trusses; they had a narrow sphere of usefulness, but were by no means harmless. He did not think enough stress was laid on the mental ill-health likely to be engendered by the constant wearing of a pessary in the case of neurotic patients. He had personally seen nothing but good follow the fixation of the uterus by operative measures.

Sir ARTHUR MACAN said it was obvious there were no serious symptoms connected with retroflexion of the uterus, whether congenital or acquired, when a woman could go about in that condition for twenty years without knowing that anything was amiss. There was a theory that it brought the ovaries into Douglas' pouch. He rather favoured the use of pessaries. A woman came to him who had worn a pessary for eight years. She had no vaginitis, and the pessary showed no signs of wear. If pessary treatment was at all beneficial, it was preferable to operation.

Dr. ASHE briefly replied.

BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD APRIL 9TH, 1906.

Mr. BOWREMAN JESSETT, President, in the Chair.

Dr. MACNAUGHTON-JONES read the following notes on

THE USE OF VIOFORM.

At a meeting of the Society in February, 1904, I brought before its notice a case in which most unusual results followed the use of iodoform. It was a case in which I ventro-suspended the uterus and resected an ovary. Many years previously most severe consequences had followed in this same patient from the dressing of an ulcer in the leg with iodoform, viz., œdema of the limb, with an extensive slough. Of this I was in ignorance at the time of my operation. The preparation used by me was moist sterilised 10 per cent. iodoform gauze. Briefly, the results were extensive vesiculation of the skin of the abdomen, the occurrence of bullæ simulating those of pemphigus, extensive eczematous vesiculation on all the extremities, and a papillary eruption on other parts of the body, followed by free desquamation. The same patient was again brought under my notice recently for a large cyst of the same ovary that I had resected on the previous occasion. On operation, it was found that both ovaries were diseased, with attendant salpingitis. In the toilet of the patient I had forgotten the previous effects of the iodoform, or I should not have used any covering but plain sterilised gauze. The wound was, however, freely dusted with vioform, and finally dressed, before I remembered the patient's idiosyncrasy.

In February, 1905, I brought the use of vioform before the Society, having seen it first at Professor Fritsch's clinic at Bonn, drawing attention to its greater diffusibility, its capacity for sterilisation, and the odourless nature of the powder. Suffice it to say, that this patient's wound healed without the least trouble or irritation. The Michel's clips were removed on the fifth day, and the wound was dressed throughout with vioform. Dr. Macnaughton-Jones added that he had brought some of the powder, which was perfectly odourless. So far he had had perfect results with it.

Dr. EVERTSMANN (Bonn) remarked that the powder had been used in Professor Fritsch's clinic for three or four years now, and there never was any trouble with it. He thought it was a very fine powder for the abdomen because, being very dry, it absorbed the fluid well. It was an excellent powder for use in draining an abdominal cavity.

MYOMATA OF THE UTERUS.

Dr. A. E. GILES showed three specimens of myomata of the uterus and read notes of the cases, which will be found fully reported on page 466 of present issue.

Dr. FREDERICK EDGE brought before the Society three specimens:—

1. Strangulated myoma of the uterus simulating cancer of the fundus.
2. A pregnant uterus with almost sessile myoma; removed by supravaginal hysterectomy.
3. A myomatous uterus with expanded cervix, removed by abdominal hysterectomy.

Dr. EDGE then read a short communication on "Supravaginal and Panhysterectomy." (This paper, together with the cases, will be found on page 469.)

Dr. SMALLWOOD SAVAGE showed a large myomatous uterus which Professor Taylor had removed by supravaginal hysterectomy from a diabetic patient. The patient was 46, married, and was enormous in size. She had had one child nine years ago, and one miscarriage eight years ago; she was regular, but complained of menorrhagia, the last period being three weeks before. Diabetes had been noticed for over a year, and there had been a rapid enlargement of the abdomen for several months. The urine was acid in reaction, 1038 specific gravity and contained much sugar and some albumin. As Professor Taylor

could find no statistics of hysterectomy occurring in patients the subjects of diabetes, he thought that the publication of this case might lead other operators to relate similar ones, so that the relative dangers to life might be recorded where the tumour had been left alone on the one hand, and on the other where, owing to serious symptoms arising from the growth, it would be thought advisable to remove it.

Dr. HEYWOOD SMITH wished to see a sagittal section of the specimen of cervical myoma as it did not show the site of origin at present. He inquired as to the method of suturing adopted in the case where myomectomy had been performed.

Mr. RYALL asked how Dr. Giles made the incision in the case of hysterectomy, whether vertically or transversely. He (Mr. Ryall) considered that a transverse incision would give rise to more hæmorrhage. He should like to know the after history of these cases. With reference to the two cases of hysterectomy, he did not think there was sufficient evidence in favour of panhysterectomy rather than supravaginal amputation. With regard to the other case in which peritonitis occurred, that peritonitis might have been due to, possibly, some septic material in the cervical canal, and less probably to anything produced at the time of the operation. If the operation was a clean one, there ought to be no reason for sepsis. Professor Taylor's case was an interesting one, and he admired the courage which prompted him to remove such a large tumour from a patient suffering from diabetes. He performed hysterectomy on a patient suffering from diabetes five or six years ago. She was suffering from pressure symptoms, and he operated. From a surgical point of view two great risks were run in operating on patients with diabetes, one being shock and the other sepsis. In his case the patient died from shock.

In regard to Dr. Edge's specimens, Dr. MACNAUGHTON-JONES said that the most important question connected with the hysterectomy in the case of the pedunculated myoma complicating pregnancy was the justification for the interference. The rule almost universally followed in such cases was not to interfere unless the symptoms absolutely demanded operation, and with certain rare exceptions this rule was also applicable to other forms of myoma complicating pregnancy. He had operated on almost a similar case to that brought forward by Dr. Edge. The patient had two attacks of peritonitis, and was suffering from pain, with considerable distress; the patient recovered, but the death of the ovum compelled him to empty the uterus. As regards his remarks on supravaginal hysterectomy, it was generally accepted that in malignant and septic conditions, cervical myomata, myoma complicated by adnexal tumours, pyo-salpinx, and with tumours in the broad ligament, the supravaginal operation was contra-indicated. If it were a thoroughly aseptic operation, he did not consider that there was any necessity to drain. With regard to Dr. Giles' case, of myoma removed by myomectomy, he did not think that there was anything particularly novel as regards the method of operation. He had seen some years since Zweifel remove a large tumour the same size as that shown by Dr. Giles in the same manner. The tumour was shelled out through the anterior incision in the uterine wall. Professor Fritsch, of Bonn, operated in many of these cases by morcellation. He had seen him removing several very large myomata in this manner. In doing so he did not divide the cervical wall. His dexterity in operating by this method was great, and it was surprising to see the rapidity with which the operation was completed, and the comparatively small amount of blood lost.

Dr. HODGSON considered the mortality in the removal of the uterus was principally due to hæmorrhage and sepsis. He should like to know whether the case of diabetes had temporary or permanent glycosuria.

Dr. SLIMON congratulated Dr. Giles on the success of his case of cervix myoma in which he had assisted. The operation was not a very simple one, but occupied a considerable time to carry out. The lady vomited only once, her temperature was normal, and she left the home on the fifteenth day perfectly well.

Dr. EVERSTMANN said he did not remember Dr. Fritsch to have lost a case of intra-uterine myoma. He did not see why in these cases there was any great danger. In the operation they did not open the peritoneum, but only brought the tumour out of the inside of the uterus. Then they could drain with gauze. If there was any fever douching removed it.

Dr. OLIVER remarked that about six months ago he removed, without any trouble a tumour by morcellation, which reached the umbilicus. He had previously done five or six similar operations.

The PRESIDENT said he thought that, as a rule, there was certainly no objection to drain through the cervix in cases in which sub-peritoneal hysterectomy was performed. There was very often some oozing going on in the stump, and if there was a drain through the cervical canal it would remove what might cause trouble afterwards. In such cases the septic mischief might arise from the vagina and therefore, he thought that the vagina should be disinfected before the operation commenced.

Dr. GILES, in reply to the criticisms on his specimens, remarked that, in the second case, the myoma occupied the anterior wall of the uterus. This was not really a matter of any difficulty because, supposing the tumour were simply in the anterior wall of the uterus, by making an incision over it the capsule was exposed, and the tumour could be removed. Of course if the tumour projected a great deal into the uterine cavity then in all probability the uterine cavity would have to be opened in any case. He used mattress sutures in closing the uterine wall after myomectomy. In the case of hysterectomy the incision through the uterus was vertical. Of course, a transverse incision would probably give rise to a great deal of hæmorrhage, but in making a vertical incision in the median line of the uterus there was practically no hæmorrhage at all. He had done altogether twenty-four myomectomies and exactly a hundred hysterectomies. He had not known any of his cases of myomectomy return with another growth. Unless the tumour was obviously solitary, or unless there were only one or two he should never do myomectomy; it was a risky thing to do with multiple myomata. With regard to the question of enucleation *versus* morcellation, he fancied that these things were partly a matter of training. He had operated by morcellation in several cases. In one case he removed a tumour about the size of a full term foetal head, but that was a case in which he was forced to do it. The tumour was partly outside the uterus, in the vagina. He went on knocking off chips of it until he eventually found he was inside the uterus right up to the umbilicus. If one could do a simple abdominal myomectomy or a hysterectomy, it struck one as a cleaner and more surgical operation than doing it by morcellation. The question of morcellation and enucleation was a large one, but if one commenced with morcellation there might be multiple fibroids which would afterwards also have to be removed in the same way, and this might be a very troublesome and lengthy procedure.

Dr. EDGE, in the course of his reply, said it was his custom in cases of sessile or pedunculated myomata to make flaps. But in the case he had shown that night the peduncle tempted him to ligature it. He tried to check the bleeding, but considering that he had cut into the venous sinuses in the uterine wall he did not think it was safe to leave the uterus, and therefore he removed it, especially as the patient had expressly desired him to do so. With regard to the ovarian pedicle he generally tied it, transfixing the broad ligament, and took as little tissue as possible. He tied it with stout silk (No. 5). He took up the arteries and tied them separately. The question of

drainage after operations of supravaginal hysterectomy was, he thought, a case of personal opinion. He would drain practically every case. Of course, if one had a myoma with a long cervix like an ovarian pedicle which could be absolutely correctly sutured, no doubt he would be tempted to go on with the supravaginal. Because he had published two deaths, he did not want them to think that all his supravaginal hysterectomies died. They did not all die by any means. At the same time, he felt that if he had done a pan-hysterectomy in those cases they would have stood a better chance. But if the surgeon were convinced that he had done such things as would probably lead to abortion, and if the patient had strongly expressed a desire to have the uterus removed if it were pregnant, he thought he was justified in leaving the uterus. Disinfection of the vagina was carried out in both cases, but he thought that the danger lay in the impossibility of disinfecting the cervix. In many of those cases the infection was in the cervical canal, and although every care might be taken in covering the canal, he thought the safer method was to have free and efficient drainage just as they should in any operation outside the abdomen. As to morcellation, Professor Taylor and himself had removed a good many fibroids by that method, and he had seen it done in Germany and Paris. But the fact that they had ceased to do it was strong proof that they had found grave reasons against it. In the first place, the loss of blood in these cases was exhausting. Professor Fritsch was perhaps more of an adept at it, but he (Dr. Edge) had seen that method result in far greater loss of blood than hysterectomy. Again, the shock in long-continued operations of the kind was very great. Further, the injuries done were uncertain, and that, he thought, was one of the strongest reasons against morcellation. Lastly, one was not sure that there were not other myomata.

Dr. MACNAUGHTON-JONES read notes on a specimen of malignant adenoma of the ovary. This, with a case shown by the PRESIDENT, of sarcoma of the left ovary, we hope to publish in our next.

LIVERPOOL MEDICAL INSTITUTION

MEETING HELD THURSDAY, APRIL 19TH, 1906.

FRANK T. PAUL, F.R.C.S., President, in the Chair.
SCABIES.

Dr. F. H. BARENDT read a note on "Scabies," emphasising certain points in diagnosis, mode of infection and treatment. In cases where the primary eruption was incapable of detection—cuniculi not being recognisable—but the sites of the secondary eruption due to the pruritus were well defined, the patient should be treated for scabies. The nipple area in women and the genital region in man, should always be carefully examined especially where the eruption between the fingers, in the case of cleanly individuals, was absent. Dr. Barendt drew attention to the method of distribution which thus accounted for the universality of the lesions in long-standing scabies. He considered that infection was almost always nocturnal, and the result of prolonged contact with an infected person, and that the handling of bed or body clothes or shaking hands with a scabetic, could communicate scabies was, to say the least, not proven. In ascertaining the source of infection it was necessary to question the patient upon his surroundings of the three weeks previous to the onset of itching. Dr. Barendt used the B-naphthol ointment first introduced by Kaposi. It was a superfatted, soft soap containing about 9 per cent. of B-naphthol. It had the advantage of neither staining nor possessing a disagreeable odour, and, above all, did not aggravate the secondary lesions, which sulphur ointment, especially in long-standing scabies, was apt to do.

Dr. G. STOPFORD TAYLOR stated that the treatment was unsatisfactory unless all underclothes and bed-linen were boiled, and those clothes which could not

be so treated were stoved. The Liverpool sanitary authorities would undertake the stoving free of charge.

Mr. COLIN CAMPBELL showed a patient after twelve weeks' treatment by intra-tracheal injections of izaral.

A CLINICAL ANALYSIS OF TWENTY-TWO CASES OF INTRATHORACIC TUMOUR.

Dr. T. R. GLYNN classified twenty-one cases of intrathoracic tumour under the following heads:—Hodgkin's disease, with implication of the mediastinal glands, four cases; sarcoma of some groups of superficial glands, with implication of the mediastinal glands, four cases; primary sarcoma or cancer of the mediastinal glands or thymus, six cases; primary cancer of the lungs, six cases; sarcoma of the pleura, one case. The complications included pleuritic effusion in six cases, in two of which it was hæmorrhagic; invasion of the vertebral canal by growth in six cases, causing paraplegia of sudden onset in four and of gradual onset in two cases. The secondary changes in the lungs were illustrated by drawings; the earlier symptoms in these cases were pain and cough, the later—cancer of the lung (three cases)—sanguineous expectoration. Physical signs of intrathoracic pressure were present in thirteen cases. The remaining physical signs and the duration of life were discussed, and a short account of the individual cases given.

TREATMENT BY HYPNOTIC SUGGESTION.

Dr. A. BETTS TAPLIN said that hypnotism had been evolved in the past from such a labyrinth of superstition and nonsense that he almost felt inclined to apologise for introducing the subject to the notice of a professional audience, as an acknowledged branch of therapeutics. Its history during the last 170 years was full of absorbing, even of tragic, interest here and there, and was ably told in the works of many medical men, both in England and on the Continent. Hypnotism was generally acknowledged by all observers to be a physiological and not a pathological condition, and to be absolutely free from danger in competent hands. It had been found most useful in those many cases which were the despair of the profession, and which were characterised by pain, spasm, or other nervous phenomena, in which no organic cause could be found, and for which no other therapeutic measures seemed to be of any avail. The time for its study and reception by the medical profession was ripe, and to prevent its possible abuse in ignorant or unscrupulous hands, it was much to be desired that, as soon as possible, its use should be limited by legal enactment by properly qualified persons under proper control.

Dr. K. GROSSMANN thought that no advance had been made in our knowledge of the subject for twenty years. The account he had given before the Medical Institution sixteen years ago was based on a visit to Professor Charcot at the Salpêtrière, and a stay at Nancy, where he studied the methods and saw the patients of Dr. Liébault and Prof. Bernheim. Prof. Charcot's patients were all hysterical, while at Nancy every sort of patient was treated; three phases were distinguished—lethargy, catalepsy and somnambulism. The Nancy school recognised nine different degrees of susceptibility, ending with somnambulism followed by amnesia. All the phenomena were explained by suggestion, and the mode of producing the various stages of hypnosis employed by the Paris school were recognised as suggestions. The Nancy school considered the hypnotic state as analogous to sleep, with the difference that the subject was *en rapport* with the operator, hearing and understanding him. Dr. Grossmann had no difficulty in hypnotising subjects, but he had never seen any therapeutic results in his cases—paralyses of ocular muscles, restricted fields of vision, &c., nor had he himself seen the extraordinary trophic phenomena, blisters and burns, so graphically described by Prof. Krafft-Ebing. It was always a difficult matter to find out how far the subject was really under the influence of the operator and to what extent he was shamming. For his own part, he thought Braid's motto, "Unlimited scepticism is equally the child of imbecility as implicit credulity," was all very well,

but the following one was safer—"When you see a fact, doubt it."

Dr. A. E. DAVIS agreed that subjects often deceived the hypnotiser, but could not accept the statement made by one of the speakers that hypnosis was produced in hysterical neurotic soil, which, in his experience, was the least fruitful of all. He agreed with the theory of the late F. W. Myers that the phenomena were produced in the subliminal consciousness, and which was supported by the fact that the acuity of the senses could be enormously increased. He pointed out that the thirteen patients mentioned by Dr. Taplin, two only were males. The objection of males to trying hypnosis was a great drawback to its practice and study. Though he believed it was not possible to instil viciousness into a subject who had no natural inclination to it, the dangers of being *en rapport* with some women subjects were obvious. He had repeatedly produced trophic changes. Convulsions, in hysterical subjects could be obviated by self-confidence and knowledge on the part of the hypnotiser.

Dr. S. WHITAKER said that a better description of the treatment would be "treatment by suggestion, with or without hypnosis," for it was usually unnecessary to hypnotise the patient more deeply than the lightest lethargic stage when he would accept suggestions, and the operator could obtain good therapeutic results." During treatment there should be no distressing sounds and sights. He used the method of "monotony." The cases suitable for this treatment were those in which there were functional disturbance, including most cases of organic lesion, and so far as this element existed it was possible to benefit the patient. He had obtained excellent results in the attacks of palpitation of exophthalmic goitre, headache, insomnia and pain generally. Owing to the depth of hypnosis acquired to produce anaesthesia, the method was not likely to compete with ordinary anaesthetics.

Dr. C. T. STREET said probably all were agreed that there was such a thing as hypnotism, but were divided as to its usefulness. He asked, was not treatment by suggestion without hypnosis preferable? Those who worked among the insane knew what beneficial results could be produced by suggestion; how the melancholic was encouraged to look on the brighter side of things; how the maniac was calmed by suggestion and example, and how it could be suggested to the hysterical that she could exercise self-control if she tried. The result from this form of treatment might be slow, but it was certainly more sure and lasting than that produced by hypnosis.

Drs. T. S. Glynn, Stanley Gill and T. B. Warrington also took part in the discussion.

CORK MEDICAL AND SURGICAL SOCIETY.

GENERAL MEETING HELD WEDNESDAY, APRIL 11TH, 1906.

The President, Dr. R. P. CROSBIE, in the Chair.

Dr. COTTER read notes of a case of Ectopic Gestation which will be found on page 470, under "Clinical Records."

Dr. Cotter also read notes of a case with obscure abdominal symptoms. A man, D. T., *æt.* 20 years, after a few days of malaise, got an acute pain in the belly, with vomiting and great collapse. There was tenderness, and some rigidity over the right iliac fossa. Thinking the appendix implicated, he opened the abdomen, and beyond some serous effusion, found nothing abnormal. He removed the appendix, which was healthy; patient sank and died the next day. *Post mortem*: The pancreas was found greatly enlarged, and somewhat bile-stained, with a peculiar "marbled" marking of its surface. Dr. Moore found no evidence of inflammation or degeneration. Dr. Cotter remarked that he was at a loss to know the

cause of death. Dr. Moore's report negated the diagnosis of acute pancreatitis, as also did the absence of fat necrosis. On the other hand, there was cyanosis of the skin of the face and belly, and localised tumescence of the upper half of the abdomen.

Dr. H. R. TOWNSEND read notes of a case of acute appendicitis in a girl *æt.* 10. He saw her the day after onset of symptoms. There were severe paroxysms of pain, referred at first to umbilicus, later to McBurney's point. He found a deeply congested appendix, which he removed. Dr. Moore examined the viscus, and found unmistakable evidence of early pus formation.

Dr. TOWNSEND said the case illustrated the necessity for instant operation in acute cases.

Dr. COTTER thought that the only exception to this rule was in cases known to be of the relapsing variety.

CENTRAL BOARD OF MIDWIVES.

MEETING HELD APRIL 26TH, 1906.

The President, Dr. CHAMPNEYS, in the Chair.

AFTER several minor matters had been settled, the Secretary read a letter from a certified midwife complaining of the increased fees charged by doctors when called in to a case attended by a midwife.

Mr. WARD COUSINS said this matter of fees was a serious one and ought to be thoroughly discussed. It was a fact that medical men did demand fees from midwives, and the members of the Board ought to express an opinion. There were cases where a fee was asked before a doctor would assist in an emergency. It did not seem to be understood that they expected to be paid. Of course, if the patient could pay that obviated the difficulty, but they could not always do so, and the matter ought to be brought under the notice of the Local Supervising Authorities.

The SECRETARY remarked that doctors often said to patients: If you employ a midwife, and then send for me, the fee will be two guineas; but if I take the case it will be only one.

Mr. WARD COUSINS added that Cardiff and Liverpool had made definite arrangements, and there ought not to be such hesitancy to settle a question so critical to the medical profession.

The CHAIRMAN reminded the speaker that the Privy Council would not help them. They had answered it was a matter of local legislation.

Miss WILSON asked how Cardiff and Liverpool had arranged.

The SECRETARY answered that counties submissive to the Local Government Board and boroughs were on a very different footing. The Borough Council could report what it liked and the County Council could not. The chief complaints came from country districts where the doctor was perhaps called up in the middle of the night to make a long journey, and no fee was forthcoming.

Dr. PARKER YOUNG added that doctors could not be expected to do this, and were justified in making sure of their fee beforehand, though such necessity was often hard on the patient, the midwife, and considerably hindered the proper working of the Act, therefore something definite would help every side. As there was now a new Government, he proposed sending in again all the former requests and pointing out the inefficiency of the present arrangements. There were still untrained midwives practising and a labourer earning, say, fifteen shillings a week, could not pay the doctor, and certainly would not want a certified midwife if he knew she was likely to burden him with a fee for extra help.

Mr. WARD COUSINS proposed, and Dr. PARKER YOUNG seconded a motion to hold a special meeting on the subject shortly.

The question of extra fees for examiners' travelling expenses was again discussed, and the secretary was instructed to calculate the average duration of the journeys undertaken by provincial examiners.

The Standing Committee having arranged at its last meeting that Shoreditch Infirmary might be

recognised conditionally on furnishing a syllabus satisfactory to the Board.

Mr. WARD COUSINS asked if a proper inspection had been made. Where were the maternity wards? He had heard that women were kept in the general wards until labour had commenced. The former wards might be next the fever wards for aught they knew. Those for maternity ought to be isolated. Hospitals were starting up all over the country with such wards for teaching purposes. Were the Board allowed to inspect and criticise?

The CHAIRMAN said the Board was not responsible. They could not sit in judgment on structural defects, and only two hospitals in London had isolated maternity wards. Shoreditch had only had one case of puerperal fever in five years out of 100 lying-in yearly.

Dr. PARKER YOUNG said it was evident Mr. Ward Cousins did not respect the rate-payers. The Government allowed the Board to pass women who could neither read nor write, and it would not do to entertain such a very high ideal yet for infirmaries.

It was agreed to consider this question again, and the proceedings then came to an end.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, April 30th, 1906.

SYMPTOMATIC TREATMENT OF STITCH IN THE SIDE.

CHARACTERISED by sharp pain coming on rapidly and even brusquely, situated on one of the sides of the thorax in a point generally well defined, increased by deep respiratory efforts and by the cough, stitch in the side is one of the symptoms most frequently observed and one of those for which the patient solicits the active intervention of the physician. Almost always the pain is the manifestation of divers lesions and is produced by very different causes: *Skin*: No special pain, only painful zones. *Muscles*: Pleurodyna. *Bones*: Fractures of ribs, costal caries. *Intercostal Nerves*: Intercostal neuralgia, mastodynia, cough, pulmonary tuberculosis, traumatic neuritis. *Phrenic nerve*: Phrenic neuralgia, diaphragmatic pleurisy, subphrenic peritonitis, pericarditis.

Intra-thoracic Organs: Pleura: Dry pleurisy, pleurisy with effusion, pneumo-thorax. Lung: Pneumonia, gangrene. Pericardium: Aorta, heart.

Abdominal Organs.—Fixed or flying pains provoked by an hepatic lesion (cardiac liver, perihepatitis). This complex ætiology indicates that the rational and efficacious treatment of stitch in the side is above all that of the cause.

Externally.—No time should be lost by applications of such anodynes as belladonna, hyoscyamus, opium, etc., while a blister will be proscribed. Revulsion: Tincture of iodine, generally inefficacious, warm poultices, mustard leaves, applications loco dolenti of a few drops of spirits of chloroform, thermo cautery, chloride of ethyl spray. Dry cupping, wet cupping (pleurisy and pneumonia).

Internally:—

Pyramidon, vi. gr.;
Carbonate of lime, iv.;
Veronal, iv.;
Diodine, †;

For one wafer, 2 to 3 a day. In rebellious cases, injections of morphia.

INTERNAL TREATMENT OF APPENDICITIS.

The medical treatment of appendicitis is, as every one knows, very important, frequently rendering surgical intervention unnecessary.

A confrere of no mean reputation goes so far even as to insist that this fashionable affection is always amenable to medical treatment. Exaggeration apart, nearly every practitioner has had amongst his patients very successful cases which encouraged him not to abandon the patient to the knife until he has exhausted the means at his disposal. The confrere in question

affirms that out of 80 cases he only lost two patients, and these were lost from the very beginning where no operation could have been successful.

His treatment, which is worth a trial, consists in warm poultices to the region and the administration *intus et extra* of collargol, according to the method of Cr  d  .

Collargol, 15 grs.;
Water, 7 oz.

A teaspoonful every hour.

If the general condition of the patient is grave, vomiting, tympanitis, he increases the collargol to 30 grs., and two teaspoonfuls should be taken every hour. Externally and twice a day, a half a drachm of the following ointment is rubbed in for 25 or 30 minutes into the folds of the elbow and thigh.

Collargol, 4 drachms;
Lanoline, 1½ oz.;
Axunge, 1½ oz.

If vomiting prevents giving the mixture by the mouth, it may be administered in enema but in larger doses.

GERMANY.

Berlin, April 29th, 1906.

THE TREATMENT OF PULMONARY TUBERCULOSIS BY MARMOREK'S SERUM.

THIS subject has lately been discussed by Prof. Stadelmann and his assistant Dr. Arnold Benfy, their opinion being very unfavourable. They write to the following effect:—Since Marmorek made his first communication on his antituberculous serum in November, 1903, at a Session of the Academy of Medicine in Paris, numerous publications have appeared in various countries, some for and some against the usefulness of the serum. A discussion arose in the last International Tuberculosis Congress in Paris on the subject, and whilst the communications on the remedy were rather coldly received, some speakers in the Congress expressed themselves very favourably as to the results obtained. From the observations made on it in our own department, we cannot agree with these favourable judgments. We do not disguise from ourselves the fact that the number of cases observed is too small to allow a final judgment to be formed; but in the meantime our experiences were so unfavourable that in the interests of our patients we felt ourselves obliged to discontinue further investigation in the matter. The serum has been employed by us in five cases of pulmonary tuberculosis in all three stages of the disease. No improvement in the objective condition was observed in any case, but on the contrary there was almost without exception a deterioration that compelled a discontinuance of the treatment. As regarded temperature, no fall in a moderate temperature was ever seen, but on the contrary the temperature rose under the injections. In non-febrile cases the temperature was repeatedly raised by the injections; a fall took place when the treatment was omitted, a rise again taking place on resumption of treatment. Rises of temperature up to 39° C. were observed. In some cases the temperature fell immediately after leaving off the treatment; in others again it persisted for as much as six to eight days. One patient after each injection had a remitting fever of a hectic character that disappeared when the injections were left off. It was certain that the injections of serum had as consequences rises of temperature, the character and duration of which varied very much. Further, in most of the cases, although the injections were made with the greatest caution, there were very irritable eruptions of uric acid, redness and painful infiltrations, and in some cases even slight cutaneous hæmorrhages around the point of injection. Painful glandular swellings followed the skin trouble several times. No suppuration took place, and the urticaria wheals disappeared in the course of a few days, but they were the source of a good deal of trouble to the patient. These cutaneous and glandular troubles must be

looked upon as toxic symptoms, which by their frequency seriously complicated the injection treatment. In no case was there any subjective or objective improvement after the injections. In one case there was even giddiness associated with nausea after the injections. The chest symptoms, cough, expectoration, night sweats, &c., remained unchanged. On the other hand, the general condition was influenced unfavourably, so that patients several times objected to the repetition of the injections.

Geh. Med. Rat. Dr. A. Hoffa relates his impressions of the treatment as regards tubercle of the bones and joints, and these are much more favourable than those of Prof. Stadelmann. He employed the treatment in about 40 cases of tuberculosis of the bones and joints, in some cases the injections being repeated for months. No unfavourable symptoms were set up by the treatment. Serious advanced destructive processes were not arrested, although he observed unusually rapid cicatrization on recovery in extensive osteomyelitis processes that could only be put to the credit of the serum. In many cases the serum had a decidedly good effect on the temperature, the general conditions, and the local disease. Already in the first series of 10 cases the good effect of the serum was observed in the resorption and retrocession of abscesses that recovered more rapidly than by other measures. More or less strong local reaction was observed in about one-third of his cases, but in no case was there any permanent damage. The condition of local irritation at the point of injection had generally disappeared within twenty-four hours. These irritations caused the course of treatment to be interrupted, but the difficulty was got over by giving the serum as a rectal enema. This method of administration he had now employed for six months, with the result that no local or general serum reaction had been met with since. The simple small enema was always retained and well borne. This method of administration had the advantage that it could be kept up daily for weeks and without losing its effects. The best marked of his observation of recovery of extensive superficial tuberculous disease was in a case that was treated by rectal medication.

It did not appear to the writer that the time had yet arrived for the formation of a definite judgment on the matter, but he thought this apparently valuable method of treatment of tuberculous diseases deserved more attention than it had hitherto excited.

AUSTRIA.

Vienna, April 29th, 1906.

GIGANTISMUS INFANTILIS.

Redlich presented a giant to the Gesellschaft, *æt.* 31, and measuring 71.9 inches or approximately 6 feet. According to his history he had suffered twenty-one years from lung affections, which probably account for the increase in stature. Notwithstanding this great length none of the secretory or genital organs were developed. Sexual activity was quite abrogated. The arms, hands, and legs were very long; the feet plump; scoliosis, cranium moderately large, but no signs of acromegalia. The epiphyses were not ossified; no hair on the face, which was wrinkled and lined, giving him a senile appearance.

The pelvis was not enlarged; the genitals very infantile, small, soft, and only a few rudimentary hairs on the pubis, with a right-sided inguinal hernia. The larynx was high, giving a boyish sound to the voice, while imbecility was present.

At the present time there is difficulty in the classification of these, as few giants are rarely normal in all the vegetative characters and are therefore characterised as pathological giants to distinguish them from the normal.

It may be noted that this case approaches perilously near acromegalia, but the infantile genitals, absence of the secondary function, non-union of the epiphyses compelled Brissand, Lannois, etc., to place them under a separate head as "Gigantismus Infantilis."

Redlich related the history of another, case that came

under his notice some time ago. His length was 185 centimetres with infantile genitals and no secondary sexual characteristics. In this case, however, progressive paralysis intervened, which finally brought about the exitus. This hypoplasia of the genitals may be accepted as peculiar to giant growth, as eunuchs are noted for extension of bone after castration, especially a lengthening of the lower extremities, with the same opening at the epiphysis as in infantile conditions. It is peculiar to note here also that dwarfs have a similar condition known, as nanismus infantilis, where the epiphyses are open and the genitals atrophied. We might therefore conclude that the absence of internal secretion reduced the development of the organ, while it increased the length of the long bones in gigantism infantilis, but acts as an inhibitory nanismus infantilis. The relation of acromegalia seems to be closely allied to the above, as not infrequently the hypophyses begin to increase and end in an enormous enlargement of the bony structure. It would seem that a new stimulus is originated at a later period, which causes more ossification, while the infantile state is only inhibitory.

PITYRIASIS LICHENOIDES CHRONICA.

Neumann showed a patient with small elevated efflorescent patches on the body of a circumscript character covered with scurf on a red base. Neumann said this was a rare affection, which he first described twelve years ago. It is closely related to papular syphilides and psoriasis, which led Brocq to designate it parapsoriasis.

FROM OUR SPECIAL CORRESPONDENTS AT HOME. SCOTLAND.

UNIVERSITY OF EDINBURGH.—REFORMS IN THE MEDICAL CURRICULUM.—At the forthcoming statutory half-yearly meeting of the General Council of the University there will fall to be considered a very important report of the Business Committee, containing, among other matters of university interest, the result of the committee's deliberations on a draft ordinance by the University Court changing the regulations for degrees in medicine. Four years ago the General Council requested the University Court to consider the feasibility of re-organising the medical curriculum on the lines suggested by the Pathological Club of Edinburgh, and in consequence a joint committee of the Council and Court drew up a memorandum suggesting reforms of the matters complained of. The present draft ordinance embodies the result of the deliberations on this memorandum by the Court, the Senatus, and the Medical Faculty. In 1902 the Council formulated the alterations required as (1) division of the academic year into three terms instead of two as at present; (2) the holding of all professional examinations thrice a year; (3) no student who has failed to pass an examination to be permitted to attend the succeeding classes of the course until he has been successful; (4) a prescribed order of classes, arranged in rational sequence must be followed; (5) a timetable so adjusted as to get lectures and hospital teaching over by lunch-time, and leave the afternoon free for practical work. To a large extent these alterations, so far as legislation is required to carry them into effect, are embodied in the proposed ordinance, the general idea of the scheme being that students should be allowed more freely than hitherto to pass the first three professional examinations by instalments, so that having been instructed in a particular subject they may be forthwith examined in it, and thus enabled to concentrate attention on subjects in which they are immediately undergoing tuition without being distracted by examination requirements on subjects previously studied. Under the new scheme a medical student beginning his curriculum in summer might pass his examinations in the following order and at the end of the following periods:—

First Division.—First Summer: Botany and Zoology

or Physics; First Christmas: Physics or Zoology; First Winter: Chemistry.

Second Division.—Second Winter: Physiology; Third Christmas: Anatomy.

Third Division.—Third Winter: Practical Pharmacy; Fourth Summer: Pathology; Fourth Winter: Therapeutics.

Final Division.—Fifth Summer: Forensic Medicine and Public Health; Fifth Christmas: Midwifery; Fifth Winter: Medicine and Surgery; Sixth Summer: Clinical Medicine, Surgery, and Gynaecology.

As compared with the present system the principal changes (in addition to the splitting up of the individual examinations by allowing students to pass them by instalments) are the lightening of the second professional by the transference of *materia medica* and therapeutics to the third, while this subject is again so divided that the "druggists" and elementary parts—recognition of drugs, practical pharmacy, &c.—are got over early, therapeutics being postponed until some experience has been gained in clinical medicine. Apparently the ordinance practically concedes a three term session and by implication another of the demands supported by the General Council for a system of three examinations a-year. The ordinance also empowers the Faculty of Medicine to prescribe the studies of a student who has been rejected before he is again allowed to sit for examination, and it is suggested that they should also be able to restrain him from entering upon new subjects. As the Business Committee characterise it, the ordinance is a "large and large-hearted measure of reform," and all interested in the Medical School of Edinburgh will join with them in hoping that it may soon become law. Like all other reforms, this one has to a great extent been thrust on the University from without, as the committee's report states it arose in the Edinburgh Pathological Club, and it is no secret that Professor R. J. A. Berry, now of Melbourne University, was the initiator of the discussion there which led to the matter coming before the Council. Edinburgh owed much to Dr. Berry while he was with us; it seems as though we shall soon see the reform he had so greatly at heart.

POST-GRADUATE STUDY AT EDINBURGH.—The reproach that there are no organised post-graduate courses at Edinburgh is to be removed this year. Arrangements are being made, and are now rapidly approaching completion, for an annual post-graduate course, to be held in September. Great interest is being taken in the scheme, and it is to be hoped that this attempt may prove successful and not be allowed to lapse as its predecessor did.

BELFAST.

THE DARNELL CASE.—A joint meeting of the Ulster Medical Society and the Ulster Branch of the British Medical Association was held in the Medical Institute Belfast, on Wednesday, April 25th, when it was reported that Dr. Darnell had decided not to proceed with an appeal against the recent decision in the case of *Tughan v. Darnell*. He was advised that even if the case were carried to the House of Lords, and the verdict upset on the ground of misdirection by the learned Chief Baron, it would only mean the fight beginning again from the first, probably on new grounds. The expense of an appeal is, of course enormous, and not to be lightly undertaken. Dr. Darnell's out-of-pocket expenses will probably amount to about £800, and it was decided to start a fund to assist him. A large General Committee was appointed, Dr. Leonard Kidd of Enniskillen (President of the Ulster Branch), and Dr. Wm. Caldwell (President of the Ulster Medical Society) being treasurers, and Dr. Cecil Shaw and Dr. Thos. Houston being secretaries.

ROYAL MEDICAL BENEVOLENT FUND OF IRELAND.—The annual meeting of the Belfast and co. Antrim Branch of this Fund was held in the Medical Institute, Belfast, on Friday, April 27th., Dr. Joseph Nelson, President, in the chair.—Dr. Purdon read the annual report, which showed the amount received from all

sources as £433, while recommendations for grants amounting to £145 had been made. Professor Lindsay was elected President for the ensuing year, Dr. Purdon was re-elected hon. secretary and treasurer, and the following form the Committee of the Branch:—Sir Wm. Whitla, Drs. St. Clair Boyd, Nelson, Dempsey, McKisack, McCullagh, J. W. Taylor, Whitaker, Leslie, W. Gibson, John Campbell, Fielden, and Cecil Shaw (all of Belfast), MacArthur (Greyabbey), St. George (Lisburn), Darnell (Bangor), Donnan (Holywood), Nolan (Downpatrick), and Gausson (Dunmurry).

THE HEALTH OF BELFAST.—The subject of the health of their city is being kept well before the Belfast public at present, partly on account of the very high death-rate, and partly on account of the rumours of a very gross piece of jobbery said to be contemplated by the Corporation in connection with the office of Medical Officer of Health. As noted in this column a fortnight ago, Professor Byers made a vigorous attack in a daily paper on the authorities for their attitude in regard to consumption specially, giving elaborate statistics from all over the United Kingdom to show the bad position of Belfast in the matter. The Chairman of the Public Health Committee, Dr. King-Kerr, has now replied, and charges Professor Byers with carelessly throwing statistics at the head of the public without proper collating, study, and analysis. Professor Byers may be trusted to take care of himself, and probably before he has finished with the worthy chair man that gentleman, like the historic parrot, will be "sorry he spoke."

Dr. King-Kerr's apologia occupies more than two columns of the daily paper, and is devoted first to proving that his committee held the most enlightened ideas on the subject of tuberculosis, but are prevented by the Corporation from carrying their plans into effect, and secondly to showing how mistaken Professor Byers is in his conclusions. It is impossible to condense the communication, but it is a very pretty example of the different conclusions to be drawn from "raw" statistics, and those "carefully collated, studied, and analysed"—some people might briefly call it "cooked"—by intelligent officials.

LETTERS TO THE EDITOR.

THE LUNACY QUESTION.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—It is probable that those who read the letter signed "S." in the *Times* of Tuesday, April 24th, will agree with the views and opinions he expresses on the subject of Lunacy, and how to deal with those who suffer from it. The question, of greatest interest, however, wants to be treated with a little care and consideration. We must divide the class of lunatics who have little or nothing, financially that is, from those who have enough or far more than enough to provide them with all they want. The poor lunatic is a very different creature from the rich lunatic. The one depends entirely on others, the other does not depend on anyone. The rich lunatic is liable to suffer from those who can rob him; and so the law steps in to protect him from such influences.

The poor lunatic is a very different person, that is, in his relations to those who must support him. The question of Lunacy is not so much a medical question as a legal and social question.

When a poor creature's mental balance is disturbed and he becomes incapable of taking care of himself, and may be a danger to others, the chief question is to prevent others suffering, much in the same way that a small-pox case is isolated.

All that the law thinks of is to prevent the poor lunatic from being treated cruelly, and the rich lunatic from being robbed.

It would be well if "S." and others of our profession should consult with their lawyers and listen to their opinions when dealing with the difficult question of Lunacy.

It rests with the doctor to say when anyone is insane or not, and then with the law to decide what is best to do for them.

I am, sir, yours truly,

L.

THE MEDICAL ASPECT OF THE RECENT "RAGGING CASE."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR.—Your correspondent "Enquirer's" letter in your last issue goes to the root of the matter. For my own part I most unhesitatingly affirm my opinion that Surgeon-Major Whiston, in disclosing to his commanding officer the facts, or what he supposed were the facts, as to Lieutenant Kennedy's skin trouble, was absolutely unjustifiable. The point that concerns the medical profession is whether Surgeon-Major Whiston volunteered the information, or was dragooned into giving it by his colonel. After what one has learned about the lack of ordinary decency, to say nothing of military discipline, in the Scots Guards one would be surprised at no abuse of military authority in the interests of class privilege. It is to be hoped, Sir, that the matter will not be allowed to rest here, and that Mr. Haldane will not rest until the privileges and relations of Army medical officers are clearly defined. Meanwhile one trusts that the lesson of the "ragging" case will be taken to heart by every Army surgeon in the British Army.

I am, sir, yours truly,

AN EX-ARMY OFFICER.

Hampstead, April 30th, 1906.

OBITUARY.

DAVID SIMPSON, M.A., M.D., I.M.S.

WE regret to announce the death of Surgeon-Major David Simpson, Indian Medical Service, which took place in Madras on 19th ult. He studied Arts and Medicine at the University of Aberdeen, and afterwards attended the London Hospitals. Entering the home Army, he resigned and passed for the Indian Medical Service. He entered the Indian Service in 1887. In 1889 he was transferred to Burma, and afterwards served in the Chin-Lushai Expedition, for which he received the medal, and afterwards a clasp for the Manipur affair. In July 1891 he was appointed Second Surgeon at the General Hospital, Madras. He was transferred in 1900 as Civil Surgeon to Coonoor. In October 1903 he returned to the General Hospital, Madras, where he was appointed to succeed Colonel Sturmer, I.M.S., as Superintendent of the Maternity Hospital. He was buried with military honours by his regiment in Cathedral Cemetery, Madras.

LABORATORY NOTES.

THE CLAIRET VIERGE.

FROM the well-known importers, Messrs. Ingram and Royle, we have received samples of a new brand of a virgin claret, which we have found by laboratory tests to be of absolute purity, pleasant to the taste, and possessing an attractive bouquet.

To render it acceptable to even the most delicate stomachs, it has been subjected to a special treatment to eliminate any possible excess of tannin, and as will be seen from the analysis, the preparation is free from excess of alcohol, showing the process of fermentation has not been artificially arrested by the addition of some concentrated form of alcohol.

Our analysis shows this wine to have the following composition:—

Alcohol, 10.04 per cent. by volume.

Extractives, 2.22 per cent.

Mineral matter, 0.27 per cent. We find it to be free from foreign colouring matter.

As a light table wine at an extremely reasonable price, this should be highly appreciated by the great majority of claret drinkers.

PARANGANGLIN.

It is now some months since Messrs. Burgoyne Burbidge & Co. placed the new preparation, paranganglin, upon the market. They claim for this drug a remarkable therapeutic effect in gastro-intestinal atony, and in general asthenia. It is also used as a hæmodynamic in various hæmorrhages, as epistaxis, hæmaturia and hæmoptysis. In those forms of constipation which are due to intestinal torpidity, enemata of 100-200 cc. water containing 20-50 drops of paranganglin are recommended. If that troublesome condition can be relieved thereby, paranganglin will prove an invaluable drug. It is certainly worth the attention of practical physicians.

NEW BOOKS AND NEW EDITIONS.

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

- BAILLIERE, TINDALL AND COX. (London.)
 The Dental Annual and Directory for 1906. A Year-Book of Dental Surgery and a Diary of Society Meetings. Fourth Year of issue. With 14 illustrations. Pp. 628. Price 7s. 6d. net.
 The Philosophy of Voice. By Charles Lunn. Tenth (Standard) Edition. Illustrated. Pp. 237. Price 6s. net.
 A Practical Guide to the Administration of the "Nauheim" Treatment of Chronic Diseases of the Heart in England. By Leslie Thorne Thorne, M.D., B.S. Durham, &c., &c. Second Edition. Illustrated. Price 3s. 6d. net.
 Aids to Surgical Diagnosis. By H. W. Carson, F.R.C.S. Pp. 140. Price 3s. 6d. cloth, 3s. paper.
 A Manual of Diseases of the Eye. By Charles H. May, M.D., New York, and Claud Worth, F.R.C.S. Edg. With 335 illustrations (20 coloured plates). Pp. 400. Price 10s. 6d. net.
 JOHN BALE, SONS AND DANIELSSON, LTD. (London.)
 Modern Surgical Technique in its Relation to Operations and Wound Treatment. By C. Yelverton Pearson, M.D., M.Ch., F.R.C.S. Illustrated. Pp. 392. Price 10s. 6d. net.
 On Means for the Prolongation of Life. By Sir Hermann Weber, M.D., L.R.C.P. Second Edition, enlarged. Pp. 104. Price 2s. 6d. net.
 P. BLAKISTON'S SON AND CO. (Philadelphia.)
 The World's Anatomists. By G. W. H. Kemper, M.D. Illustrated. Pp. 79.
 J. & A. CHURCHILL. (London.)
 An Essay on the General Principles of the Treatment of Spinal Curvatures. By Heather Bigg, F.R.C.S. Ed. Pp. 240. Price 4s. net.
 The Pharmacopœia of the Evelina Hospital for Sick Children, Southwark. Third Edition. Pp. 62. Price 1s. 6d. net.
 Heath's Manual of Minor Surgery and Bandaging. Thirteenth Edition, revised by Bilton Pollard, F.R.C.S. Pp. 409. Price 6s. net.
 On Physical Training in Schools. By W. P. Herringham, M.D., F.R.C.P., and The Influence on National Life of Military Training in Schools. By T. C. Horsfall. Pp. 20. Price 1s.
 Pathology, General and Special. By R. Tanner Hewlett, M.D., &c. Pp. 540. Price 10s. 6d. net.
 Rational Organotherapy. By Professor Dr. A. von Poehl, Professor Prince J. von Zurchanoff, Dr. Alf. von Poehl, Dr. P. Wachs. Translated from the Russian Text. Vol. 1. Pp. 239. Price 7s. 6d. net.
 HENRY J. GLAISHER. (London.)
 The Anæsthetic Technique for Operations on the Nose and Throat. By A. De Prenderville. Pp. 87. Price 3s. 6d. net.
 CHARLES GRIFFIN AND CO., LTD. (London.)
 A Handbook of Medical Jurisprudence and Toxicology. By William A. Brand, M.A., M.B., &c., &c. With Frontispiece. Pp. 287. Price 8s. 6d.
 HENRY KIMPTON. (London.)
 The Science and Art of Prescribing. By E. H. Colbeck, B.A., M.D., &c., &c., and Arnold Chaplin, B.A., M.D., &c., &c. Second Edition, revised and enlarged. Pp. 198. Price 3s. 6d. net.
 J. B. LIPPINCOTT CO. (London.)
 International Clinics: A Quarterly. Edited by A. O. J. Kelly, A.M., M.D. Vol. 4. Fifteenth Series. 1906. Pp. 312. Price 33s. yearly.
 LONGMANS, GREEN AND CO. (London.)
 Plant Response as a Means of Physiological Investigation. By Jagadis Chunder Bose, M.A., D.Sc. Illustrated. Pp. 781. Price 21s.
 MASSON ET CIE. (Paris.)
 Éléments d'Électrothérapie Clinique. Par A. Zimmern. Pp. 393.
 DAVID NUTT. (London.)
 The Frog: An Introduction to Anatomy, Histology, and Embryology. By the late A. Milnes Marshall, M.D., &c., &c. Edited by F. W. Gamble, D.Sc. Ninth Edition, revised and illustrated. Pp. 172. Price 5s.
 OBSTETRICAL SOCIETY OF LONDON.
 Transactions of the Obstetrical Society of London. Vol. 47. For the year 1905. Part 4, for October, November, and December. Edited by Herbert R. Spencer, M.D., and M. Handfield-Jones, M.D. Pp. 473. Price 10s.
 SMITH, ELDER AND CO. (London.)
 St. Bartholomew's Hospital Reports. Edited by A. E. Garrod, M.D., and W. McAdam Eccles, M.S., F.R.C.S. Vol. 41. Price 8s. 6d. With General Index. Vols. 21-40. Price 5s.
 SPOTTISWOODE AND CO., LTD. (London.)
 The Dentist's Register for 1906. Pp. 248. Price 3s. 4d.
 VEDDON AND PRITCHARD (Adelaide.)
 A Text-Book on Plague. By Dr. Tōlien Ishigami. Translated, enlarged, and illustrated by Donald Macdonald, M.B., C.M. Pp. 180. Price 22s. 6d.
 JOHN WRIGHT AND CO. (Bristol.)
 The Medical Annual: A Year-Book of Treatment and Practitioner's Index. 1906. 24th year. Pp. 654. Price 7s. 6d. net.

MEDICAL NEWS IN BRIEF.

The Cork District Hospital.

THE Cork Board of Guardians have decided to increase the staff of this hospital, and propose to appoint the present resident physicians to the posts of assistant visiting physicians at a salary of £100 a year each. They further propose to appoint two new resident medical officers at a similar salary. The latter gentlemen will be required to learn the Irish language within a year. In the course of an acquaintance with most parts of the County of Cork for nearly thirty years we have met in all perhaps some half dozen people who were unable to speak English fluently. If the Dublin Guardians were to act on similar grounds they should insist on the resident officers in the Workhouse Hospitals becoming acquainted with Yiddish. As the Cork medical officers will have the care of some 1,200 patients, we doubt if their professional duties will allow them sufficient leisure to carry out the requirement of the Board.

Temporary Mental Cases in Poorhouses.

THE Scottish Local Government Board have issued a circular to the governors of poorhouses in relation to the Departmental Committee on Poor Law Medical Relief. In certain poorhouses, it was suggested by that body it might be desirable to provide for the observation and treatment of persons showing symptoms of mental disorder believed to be temporary, and not to necessitate removal to an asylum. The Board think it right to bring this matter specially under the notice of House Committees, and to assist them in arriving at a decision, should they be disposed to favour the recommendation, a note of the conditions under which the Board are prepared to sanction the reception of such cases in a poorhouse is enclosed. These conditions provide in detail for the treatment of the patients on hospital lines.

PASS LISTS.

University of Durham.

THE following candidates have passed the Second Examination for the Degree of Bachelor in Medicine:—

Anatomy, Physiology, and Materia Medica.—Eldred Curwen Braithwaite (Honours—Second Class).

Pass List.—Harriett A. R. Apps, Charles E. L. Burman, Leslie W. Evans, Charles W. Greene, Arthur C. Greene, Claude P. R. Harvey, Edmund Hudson, M.R.C.S., L.R.C.P., Annie V. Mack, Herbert R. McAleenan, Stanley L. Randolph, Joseph A. Sacco, Rev. Robt. H. Smallwood, M.A., Theodore W. Stallybrass.

The following candidates have passed the Third Examination for the Degree of Bachelor in Medicine.—*Pathology, Medical Jurisprudence, and Public Health.*—Gertrude E. O'Brien and Stanley D. Metcalfe (Honours—Second Class).

Pass List.—Charles M. Brown, Gilbert I. Cumberlege, Ronald M. Davies, William H. Edgar, Helen M. Gurney, Hubert Shield, and John F. Young.

The following candidates have passed the First Examination for the Degree of Bachelor in Medicine.—

1.—*Elementary Anatomy and Biology, Chemistry and Physics.*—Jabez E. Dainty and Charles Marks (Honours—Second Class).

Pass List.—Frederick E. Chapman, Herbert E. Fullerton, William Reynolds, William R. E. Unthank, and Charles L. Wigan.

2.—*Elementary Anatomy and Biology.*—Everard C. Abraham, Isaac Bainbridge, John A. Caulcrick, Robert V. Clayton, Helen G. Clark, John Hare, John P. Higham, Howard T. Hunter, Laurence H. W. Iredale, George Eric W. Lacey, Herbert V. Leigh, Samuel Littlewood, George C. M. M'Gonigle, Charles O'Hagan, Eric H. Shaw, Henri R. G. Vander Beken, Stanley Worthington, and James Young.

3.—*Chemistry and Physics.*—Eliot W. Blake, Alexander H. Bower, Francis F. T. Hare, John H. Owen, Eliot J. Ramsbotham, Charles E. Reindorf, Madeline R. Shearburn, and Olivia N. Walker.

Royal College of Physicians, London.

At the ordinary quarterly Comitia of the college on Thursday last, April 26th, the following members of the college were elected to the Fellowship:—J. Hill Abram, M.D.Lond., of Liverpool; C. R. Box, M.D.Lond.; F. W. Burton-Fanning, M.D.Camb., of Norwich; E. F. Buzzard, M.D.Oxon.; M. Craig, M.D.Camb.; R. T. Hewlett, M.D.Lond.; J. Horder, M.D.Lond.; E. G. G. Little, M.D.Lond.; G. H. D. Robinson, M.D.Lond.; J. Purves Stewart, M.D.Edin.; J. H. Thursfield, M.D.Oxon.; and S. W. Wheaton, M.D.Lond.

The following licentiates of the college, having passed the required examinations, were admitted members of the college:—F. S. Langmead, M.D.Lond., St. Mary's; C. H. Miller, M.A., M.D.Camb., London Hosp.; and A. I. Simey, M.A., M.D.Camb., London Hosp.

The following candidates for the college licence, having conformed to the by-laws and regulations and passed the required examinations, received the licences to practise physic at this meeting:—C. B. M. Aldridge (L.R.C.P.Lond.), G. D. Alexander, G. Hely-Hutchinson Almond, J. S. Austin, A. S. B. Bankart, G. N. Bartlett, S. J. A. Beale, E. Beaton, W. Beck, C. J. E. Bennett, F. C. H. Bennett, C. M. Bernays, J. B. Binns, R. A. Bowling, S. J. Boyd, J. H. R. Brodrecht, H. G. Brown, R. Brown, O. Bruce, A. S. Burgess, P. Butler, H. Charles, W. W. D. Chilcott, J. Clarke, W. J. Cowan, D. Davidson, E. T. H. Davies, R. Davies-Colley, E. M. Dolan, J. J. W. Evans, H. W. Farebrother, R. V. Favell, S. Field, C. Fletcher, J. R. Foster, C. F. Fothergill, E. T. Glenny, H. Bootch, C. W. Greene, R. A. Greeves, A. H. Hardcastle, R. S. Harper, P. B. Harrison, A. Hawkins, G. M. W. Hodges, C. J. R. Hoffmeister, R. Holtby, E. T. C. Hughes, C. H. T. Illott, H. M. Inman, W. A. James F. S. Jones, T. J. Latham, T. St. L. Leyshon, A. R. Litteljohn, J. McAsh, C. M. MacLean, I. C. Maclean, E. A. Mascarenhas, G. P. Mills, A. Mülberger, H. C. Mulkern, J. O. Musson, A. H. Norris, J. J. Paterson, P. H. H. Pereira, A. R. Phelps, H. G. Phippen, P. A. Reckless, J. E. H. Roberts, F. S. Rood, A. M. Roome, S. J. Rowntree, D. W. Roy, A. Salmon, D. R. C. Shepherd, J. Smalley, H. Smith, J. E. Smith, L. E. M. Smith, H. S. Souttar, J. H. Spencer, C. Stanley Clarke, W. J. E. Stuttaford, G. W. Sudlow, A. K. B. R. W. Taylor, A. G. J. Thompson, G. S. Thompson, H. L. Tidy, J. F. Trewby, T. Turner, H. F. Vandermn, G. T. Verry, H. S. Vivian, G. Wachter, M. D. Wadia, H. R. S. Walford, J. Wallace, H. F. Warner, E. Wight and E. J. Wyler.

The Scotch Conjoint Board.

At the April meetings of the Scottish Conjoint Board of the Royal Colleges of Physicians and Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow, held in Glasgow, the following candidates passed the respective examinations:—

First examinations (five years' course)—Samuel R. Waugh, Hofmeyr Schimper, David L. Hutton, Joseph L. Pinto, Gideon du Preez, Willoughby E. P. Briggs.

Second examination (five years' course)—John C. Hawkes, Harold P. B. Tait, Franklin Joseph de Souza, Henry W. Turner, George W. Mason, David Welsh, Maurice E. Kayton, Samuel Abeyesundere, Thomas N. Wilthew, George F. Walker, Ferdinand Byrne, William R. Mackenzie, Robert M'Connell Blair.

Second examination (four years' course)—William C. Newton, Patrick J. A. Curtin.

Third examination—James F. Jeffries, Matthew H. Fleming, Thomas R. Eames, George Coats, Walter E. Barrett (with distinction); Graham Smith, John M. Muir, Evan A. S. Shaw, Alex. O'Flaherty.

APOTHECARIES' HALL OF IRELAND.—Mr. D. J. Boyle, having completed his Final Examination, has been granted the Diploma to practise Medicine, Surgery, Midwifery and Pharmacy.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS, ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

The importance of the Colon, as shown by a Case of Ulcerative Colitis treated by Operation. — Monier-Williams (*Brit. Med. Journ.*, April 7th, 1906) reports a case of severe ulcerative colitis, which was unimproved by three years of medical treatment. In 1900 the large intestine was opened close to the cæcum by G. R. Turner, as the patient passed 10 to 20 hæmorrhagic stools daily, was very emaciated and lost control of the sphincter ani. A specially devised plug and celluloid receptacle were constantly worn by the patient, so that very little fæces passed through the large intestine. A year after the operation the patient's general health was good, but the colitis was not quite well. After six months the patient commenced to lose flesh, became emaciated again without any apparent cause, and commenced to go down hill rapidly. As the serious hæmorrhages from the large bowel, which two years previously had necessitated the formation of an artificial anus, was now practically cured, it occurred to the author that the patient was in danger of losing his life for want of use of his colon, especially that most obvious of its functions, the absorption of water. To supply the necessary liquid, daily injections of saline were administered through the cæcal opening, about half a pint of which was absorbed per diem. The patient's condition soon improved. The injection treatment was continued for eight months, during which time the patient gained nearly a stone in weight. Twice the treatment had to be discontinued on account of severe attacks of purpura hæmorrhagica. On one occasion six and a half pints of blood were collected in thirty-six hours. On account of the hæmorrhages it became impossible to resume the colonic injections, and daily hypodermic injections into the right and left axillæ alternately were tried. These latter caused the patient much distress. To overcome this difficulty the patient was instructed to completely block the cæcal opening at night time. During the day the tube and celluloid receptacles were retained. The colon had therefore twelve hours of absorption and twelve hours of rest, its working hours being of sufficient duration to keep the patient in health, and its resting hours being of sufficient duration to keep in check the colitis, which though still not absolutely well, caused no inconvenience. This plan of blocking the plug at night-time was adopted in May, 1903, and the patient is still, nearly three years later, in perfect health. The author raises three points in connection with this case:—(1) The hæmorrhages seemed to be undoubtedly dependent upon the saline injections, though it took three and a half months to produce the effect. (2) Are we not justified in fearing that the scant respect shown by some surgeons to the colon may possibly be followed by disaster? (3) Do not those people who take every night an aperient pill of such a character as to produce on the following day a liquid evacuation interfere seriously with their own nutrition by not giving the large intestine a chance of useful absorption? S.

A Further Series of Cases of Congenital Obstruction of the Pylorus Treated by Operation. — Nicoll (*Glasgow Med. Journ.*, April, 1906) reports six cases of operation on infants, whose ages were 6, 3, 3, 6, 21, and 10 weeks respectively. The children were weakly and emaciated. The author considers gastro-enterostomy, lasting as it does from thirty to sixty minutes, a serious undertaking. Its mortality rate runs from 50 per cent. upwards, and it does nothing to remedy the stenosis unless combined with divulsion, which adds to the strain on the infant's feeble vitality. The operation performed in all six cases consisted in the application of the well-known

V-Y method, so widely useful in plastic surgery in general. The V incision in four of the cases penetrated the muscular coat only, and was closed (as a Y incision) by a single row of sutures. If this "submucous" plastic operation be adopted, it is necessary to combine with it divulsion, by means of a pair of forceps passed through an incision in the anterior wall of the stomach near the pylorus. In the two remaining cases the V incision was carried through into the lumen of the pyloric passage, and was closed (as a Y incision) by the customary two rows of the Czerny-Lembert suture. In a case so treated divulsion may be effected by forceps traction, the gastric incision being unnecessary. Clamps were used on the stomach and duodenum in all six operations. The operations took place between December, 1904, and September, 1905. Five of the patients are apparently cured. The infant five months old died from shock.

Case of Acute Uremia in which Decapsulation of the Kidneys was Performed. — East (*Canada Lancet*, March, 1906,) describes a case of acute nephritis in a girl, æt. 19. After suffering for some weeks from pain in the head and back and general malaise, the patient's urine suddenly became completely suppressed, none being obtained by the catheter. Convulsions, which became almost continuous then occurred, and marked Cheyne-Stokes breathing was present. Temperature 101°, pulse 120. When suppression of urine had lasted about 48 hours Dr. Groves operated without an anæsthetic. An incision was made over the left kidney and the kidney exposed. The capsule, which was very tense and congested, was incised along the whole length of the outer border of the kidney, and completely separated from it by the fingers. The right kidney was similarly treated. Both wounds were stitched up, and the patient returned to bed. The temperature rapidly rose to 104°. Five hours after the operation one drachm of urine was passed per catheter, at the end of six hours half an ounce, and at the end of seven hours, the same quantity. Throughout the next day and night the temperature remained at 105°. The urine increased slightly in amount at each catheterisation. Forty-eight hours after the operation the patient was in a semi-conscious condition. On the second day after operation eleven ounces of urine were voided, and the temperature became normal. On the third day twenty-two ounces were passed, and the patient was quite conscious. The patient made a rapid recovery. S.

A New Experience in the Diagnosis of Chorioidal Sarcoma in the Second Stage. — Buchanan (*Ophthalm. Review*, April, 1906) relates the following experience. In January, 1905, he saw a woman, æt. 56, who had cataract in both eyes, the right being the more advanced. In June, while waiting for maturation to be complete, she returned to hospital complaining of great pain in the right eye. Subacute glaucoma with very high tension was found. Eserine did not reduce tension, although pupil reacted readily to the drug. A large iridectomy was eventually performed, but the tension still remained high, and the eye was removed a week later. On dividing the eye a small pigmented sarcoma was seen growing from the neighbourhood of the optic disc, the retina was detached completely and pressed firmly against the back of the lens and ciliary body. To this latter condition of retina is due the non-reduction of tension on the anterior chamber being opened. The tension of the globe is always reduced by the opening of the anterior chamber in cases of pure glaucoma, and the second or glaucomatous stage of chorioidal sarcoma is

practically always the result of separation of the retina. If, then, a case is seen in which there is not satisfactory reduction of tension after opening the anterior chamber in a glaucomatous eye, it is probable that the condition is intra-ocular tumour. M.

Eye Injuries following Injection of Salt Solution—Dr. L. Alexander, Nuremberg (*Arch. of Ophthalmology*, January, 1906), in summing up his paper under the above title, says that the subconjunctival injections of 5 to 10% solution of Na Cl are followed by various injuries to the eye. Not only adhesions between bulbar conjunctiva and sclera, and partial gangrene of the conjunctiva (complications which have been seen to follow bichloride injections), but also transient changes in the cornea and lens occur. The subconjunctival injection of Na Cl and mercurial salts is very generally employed for various corneal and intra-ocular diseases, and so far no bad results or side-effects have been reported. Although, of course, many are prepared to admit that very often no good is gained by this method of treatment, Alexander expects that we shall soon hear more on this question from others who have had bad experiences, and he ventures to predict that distilled water will, in the future displace the Na Cl solutions. Pagenstecher has seen as good results following the use of distilled water, especially in cases of purulent corneal ulceration as with injections of sodium chloride solutions. M.

The Technique of Spinal Analgesia.—In a communication on this form of anaesthesia, Dr. Hackenbuch (*Zentralblatt f. Chirg.*, April 7, 1906), with an experience of eighty-five cases, recommends the use of stovain combined with suprarenal extract. It is not always easy to puncture the membranes of the spinal cord, if the patient's skin is thick and tough it grips the needle, if the patient is very stout it may be difficult to feel the space between the spinous processes of the lumbar vertebrae, for these reasons the author advises in all cases the following technique:—(1) The skin over the lumbar region should be thoroughly disinfected and well washed with normal saline solution. (2) Infiltrate the skin in the middle line just below the spine of the second lumbar vertebra with a cocaine solution. (3) Divide the skin in the middle line below the tip of the spinous process of the second lumbar vertebra, making an incision about half a centimetre long through the infiltrated area. (4) Introduce the puncturing needle through the wound for the depth of about one centimetre. (5) Remove handle of the needle and push the instrument steadily forwards until an abundant flow of cerebro-spinal fluid shows that the membranes of the cord have been pierced. (6) Inject the stovain and suprarenal solution. (7) Withdraw the needle with the syringe still attached from the wound, and immediately cover the incision with a small piece of leucoplast plaster. By taking these precautions, on the one hand, the danger of infecting the spinal canal is reduced to a minimum, and, on the other hand, it is scarcely possible to fail in obtaining spinal analgesia. Should, however, in a rare case the analgesia not prove to be sufficient, there is nothing to prevent a repetition of the stovain injection through the small wound, and in this way producing full analgesia without any danger to the patient. G.

Remarks on Acute Intestinal Obstruction.—In the course of his paper, H. Lillenthal (*New York Med. Jour.*, April 7th, 1906) touches first on the diagnosis of this condition, then urges the necessity for early operation in all cases, showing clearly the danger of delaying, he closes his paper with a few hints on the technique of operations for acute intestinal obstruction. General anaesthesia is almost always to be preferred to local anaesthesia, except where the patient is almost moribund. Preoperative gastric lavage should always be practised. If there is a mass, make a small incision over it, and explore before enlarging the incision. If there is no mass and no point of maximum tenderness then open in the middle line. It is of first importance to locate the seat of the obstruction, the accurate diagnosis may come later. If the gut is

under very high tension it is dangerous to manipulate it; such gut had better be emptied at once and the obstruction sought afterwards. To empty the gut, first pass a purse-string suture round a small area, then incise with a knife the centre of this area, turning the patient over on one side, Allow as much as possible of the bowel contents to flow out; when no more can be got away, tie the suture and turn the patient on to his back again. Repeat this procedure at two or three points if necessary. The obstruction, as a rule, can then be readily found, and the surgeon must then decide whether it is better to treat the case radically or to make a temporary enterostomy. Death from obstruction is rarely, if ever, due to the mere fact that the bowels do not empty themselves; it is usually due to strangulation and peritonitis, in which the distension plays an important role. Gastric lavage should never be practised before making the diagnosis and laying out the plan of action. G.

Remarks on the Diagnosis and Present Status of Treatment of Congenital Dislocation of the Hip-joints—Thienhaus (*Lancet-Clinic*, March 10th, 1906) reports three cases of congenital dislocation of the hip in children, treated by the bloodless method. Two of these were followed by perfect cure. In one case, six months after successful reduction, the child developed cerebro-spinal meningitis, followed by anterior polio-myelitis. This necessitated removal of the plaster and a relaxation of the congenital dislocation took place. The author has obtained many gratifying results from Lexer's method. Lorenz overcomes the obstruction of the adductor muscles by breaking or tearing them, which he accomplishes by striking the stretched adductors with the ulnar border of his hand. Lexer on the contrary finds that the resistance of the adductor muscles during reduction can be overcome by stretching these muscles gradually, and when reduction has been obtained, these untorn muscles are the most essential factor for the retention of the head within the acetabulum. The following conclusions are drawn by the author:—1. Congenital dislocation of the hip-joint is at the present time perfectly curable in 60 to 80 per cent. of all cases treated within the time-limit by so-called bloodless or bloody methods. 2. The best time for treatment is from the second to the fifth year. 3. The upper time-limit for bloodless reduction is ten years in unilateral cases, and eight years in bilateral cases. 4. In every case of congenital dislocation within the time-limit, the bloodless methods of reduction have to be tried first, and only after two or three attempts at bloodless reposition have been made without success or with bad functional results, the bloody methods come into play. 5. Cases over ten years of age with considerable shortening of the leg, and extreme adduction, can be benefited only by palliative operative procedures. These are for unilateral cases, the subtrochanteric osteotomy, and for bilateral cases, the pseudo-arthritis operation as advised by Hoffa. S.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "Recent Medical Literature."
- (2) "Recent Surgical Literature."
- (3) "Recent Gynaecological and Obstetrical Literature."
- (4) "The Recent Literature of Physiology and Pathology."

London School of Tropical Medicine

THE following is a list of students who passed the examination in Tropical Medicine during April, 1906:—Capt. S. Anderson, I.M.S.; Capt. B. H. Dutcher, U.S. Army; Dr. G. J. Pirie (Colonial Service); and Dr. H. E. Arbuckle—with distinction. Dr. A. G. Eldred (Colonial Service), Dr. H. Kramer, Dr. P. H. MacDonald (Colonial Service); Dr. B. Moiser (Colonial Service); Dr. A. Reid, Dr. W. Rogers (Colonial Service), Dr. W. E. Rutledge, Dr. A. L. Wykham.

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

MR. E. L.—Crowded out of our present issue; we hope to find room for the note in our next.

DR. TERRY.—Write to Messrs. Duncan, Flockart & Co. for their pamphlet on Ethyl Chloride.

L. S. H. (Buxton).—The average salary now obtainable by a locum tenens is four guineas (with second-class railway fares). Of late years the rate of remuneration has increased for that particular kind of work. The best plan is to put your name on the books of a good medical agency.

POOR LAW OFFICER.—The practical value of a diet estimation in regard to workhouse, prison, and other official administration is great. Brilliant results have been attained in that direction by simply estimating the output of nitrogen in relation to the nitrogenous input. There is no storage of nitrogen in the system, and in the healthy individual the one is balanced by the other. On these premises it is possible to detect errors in the input—otherwise, in the diet. A good authority on this subject is Dr. Wynter Blyth's book on "Foods."

H. S. R. (Liverpool) should refer the matter to his medical adviser, and ask him to recommend a specialist.

TU QUOQU.—We regret that our correspondent is dissatisfied. The matter was treated solely on its merits; but there are generally two sides to most questions.

MR. R. M.—Application must be made direct to the Home Office.
M. B. C. M. (Shrewsbury).—From inquiries, which we have made, we find that our correspondent has been misinformed.

THE EVERLASTING MICROBE.

What if "Baedili" roam about within
And fight the "Leucocyte" from day to day,
If they don't irritate the outer skin
We're bound to let the microbes have their way
("Alexins present on baedili prey")
Or poison them, the writers sometimes say,
If troublesome, we have the Rontgen Ray.

The jovial dustmen on the refuse boats—
No thoughts of microbes seem to trouble them,
The playful wind blows millions down their throats,
And yet they're more robust than many men—
Correct me if untruthful seems my pen;
But if you are unable to correct me,
No doubt you have the wish to disinfect me.

Then let bacteriologists arise,
The dustmen's ways consider and be wise.

A. D.

Meetings of the Societies, Lectures, &c

WEDNESDAY, MAY 2nd.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. Lewers, Dr. McCann, Dr. Tate, and Dr. J. I. Parsons. Short Communication:—Dr. Lewers: Three Cases of Epithelioma of the Vulva with History subsequent to Operation. Paper:—Dr. Herman: A Case showing (1) Uterine Contraction without Retraction; (2) Prolonged High Temperature of Nervous Origin.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. J. Cantile: Clinique. (Surgical). 5.15 p.m. Lecture:—Dr. G. E. Herman: The Prevention of Difficult Labour.

THURSDAY, MAY 3rd.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM (11 Chandos Street, Cavendish Square, W.).—8 p.m. Oard Specimens will be shown by Mr. S. Stephenson, Mr. W. Roll, Mr. A. L. Whitehead, Mr. F. W. Edridge-Green, Mr. J. B. Lawford, Mr. L. V. Cargill, and Mr. M. S. Mayor. 8.30 p.m. Papers:—Mr. J. Taylor and Mr. T. Collins: Congenital Malformed Cystic Eye.—Mr. M. Davidson: Radium in the Treatment of Rodent Ulcer.—Mr. R. Pickard: Implantation Tumour of Iris.—Mr. Cargill and Mr. Mayor: Tuberculosis of Choroid.

NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital, N.).—4 p.m. Discussion on Asthma (opened by Dr. E. F. Willoughby).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m. Lecture:—Mr. A. H. Tubby: Surgical Diseases of Children.

FRIDAY, MAY 4th.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY (West London Hospital, Hammermith, W.).—8.30 p.m. Discussion on Influenza, its Varieties and Sequels.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, Cavendish Square, W.).—5.30 p.m. Pathological Meeting. Specimens will be shown by Dr. E. C. Mackay, Dr. J. P. Parkinson, Dr. L. S. Dudgeon, Dr. E. Cantley, Dr. F. Langmead, Dr. G. Carpenter, Dr. J. G. Binnsell (Birmingham), Dr. E. Hobhouse (Brighton), Mr. G. Pernet, and others.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Dr. H. Tilley: Clinique. (Throat).

Vacancies.

Down County Infirmary.—House Surgeon. Salary £60 per annum, with board and residence. Applications to Dr. Tate, Infirmary House, Downpatrick. (See advt.)
Killarney District Lunatic Asylum.—Assistant Medical Officer. Salary £100 per annum and allowances. Applications to E. V. Griffin, Resident Medical Superintendent. (See advt.)
Littlemore Pauper Lunatic Asylum, Oxford.—Second Assistant Medical Officer. Salary £120 per annum, with furnished rooms in the Asylum and board. Applications to Thomas M. Davenport, Clerk of the Visiting Committee, County Hall, Oxford.
Royal Albert Hospital, Devonport.—Resident Medical Officer. Salary £100 per annum, with board and lodgings. Applications to the Chairman of the Selection Committee at the Hospital.
City Asylum, Gosforth, Newcastle-on-Tyne.—Assistant Medical Officer. Salary £140 per annum, with furnished apartments, board, and laundry. Applications to the Superintendent.

Appointments.

BELL, T., M.R.C.S., L.R.C.P. Lond., Certifying Surgeon under the Factory and Workshop Act for the Uppingham District of the county of Rutland.
BERGIN, W. M., M.B., B.S. Lond., Ophthalmic Assistant, Registrar and Tutor at Guy's Hospital.
BIRD, GEORGE WILLIAM HARVEY, M.B., B.O. Cantab., Medical Officer of Health to the Bridgwater (Somerset) Port Sanitary Authority.
GARDINER, PETER, M.D., C.M. Glasg., D.P.H. Lond., Medical Officer for the Camborne District by the Redruth (Cornwall) Board of Guardians.
HORGAN, J., L.R.C.P. and S. Edin., L.F.P.S. Glasg., Certifying Surgeon under the Factory and Workshop Act for the Kenmare District of the county of Kerry.
JOHNSTONE, JOHN LLOYD, M.R.C.S., L.R.C.P., Clinical Assistant to St. John's Hospital for Diseases of the Skin, Leicester Square.
KERRAWALLA, M. P., M.D. Brux., L.R.C.P. and S. Edin., Clinical Assistant to the Evelina Hospital for Children.
LAMB, J. S., L.R.C.P. and S. Irel., Certifying Surgeon under the Factory and Workshop Act for the Cretway District of Queen's County.
LONGRIDGE, C. J. NEPMAN, M.D. Vict., F.R.C.S. Eng., M.R.C.P. Lond., Registrar and Pathologist to Queen Charlotte's Lying-in Hospital, Marylebone Road, N.W.
MAY, WALTER, J., L.R.C.P., M.R.C.S., L.D.S., Lecturer on Dental Mechanics at the Royal Dental Hospital of London, Leicester Square.
PEARSE, JAMES, M.D., C.M. Edin., Medical Officer in charge of Troops at Trowbridge (Wilts).
RICHARDS, P. A. ELLIS, F.I.C., F.C.S., Lecturer on Dental Metallurgy at the Royal Dental Hospital of London, Leicester Square.
RICHMOND, JAMES ROBERT MARR, L.R.A., Medical Officer of Health of the West Penwith Rural District (Cornwall).
ROLSTON, JOHN R., M.R.C.S. Eng., Honorary Ophthalmic Surgeon to the Royal B. I. sh Female Orphan Asylum, Devonport.
SHEEHAN, M., M.R.O.S., L.R.C.P. Lond., Certifying Surgeon under the Factory and Workshop Act for the Mallow District of the county of Cork.
TROM, GEORGE, M.R.C.S., L.S.A., Honorary Consulting Surgeon to the Royal Albert Hospital, Devonport.

Births.

GATES.—On April 21st, at Via Palestro A., Florence, Italy, the wife of Edward A. Gates, M.D., M.R.C.P., of a son.
INMAN.—On April 28th, at The Lower Mill House, Bedhampton, Havant, the wife of William S. Inman, M.B., of a son.

Marriages.

BARBER—HOWLETT.—On April 24th, at St. George's Tomland, Norwich, Hugh Barber, M.D. Lond., son of Mr. and Mrs. Christopher Barber, of Sheffield, to Ethel Mary, daughter of Mr. and Mrs. J. G. Howlett, of 36 Bracondale, Norwich.
HEFFERNAN—TURNER.—On April 18th, at the Church of St. Michael and All Angels, Croydon, William Hilton Heffernan, L.R.C.P. Lond., M.R.O.S. Eng., of Wimbledon Park, eldest son of John Harold Heffernan, C.B., of Liverpool, to Gladys Lloyd, third surviving daughter of James Turner, Netherton, Croydon.
PENDRED—MATTHEW.—On April 23rd, at St. Barnabas, Addis Road, Kensington, Vaughan Pendred, M.D., F.R.C.S. Eng., of Coventry, eldest son of Vaughan Pendred, M.L.M.E., and Mrs. Pendred, of Orailth, Streatham, to Beatrice Elisabeth, daughter of Dr and Mrs. Mordaunt Matthew, of 22 Holland Road, Kensington.
STEELE—ROGERS.—On April 28th, at St. Peter's, Eaton Square, London, Charles Fran' is Steele, M.B. Lond., M.R.O.S., L.R.C.P., eldest son of Charles Steele, M.D., of Clifton, to Anita Russell Rogers, youngest daughter of the late Mr. Edward Dresser Rogers, D.L., of Rockley, Denmark Hill, London.

Deaths.

HUTTON.—On April 24th, at Lulworth House, Birkdale, Lancashire, the residence of her son, D. M. Hutton, M.D., Eliza Peddie, widow of David Hutton, Esq., of Parkfield Road, Liverpool, in her 69th year.
JAMIESON.—On March 8th, at Dalwin, Falkland Islands, Lowther A. Jamieson, L.R.C.S.I., youngest son of the late Edward L. Jamieson, of Heriotage, Orkney.
SCOTT.—On April 24th, at Bury Lodge, New Malden, Surrey, John Scott, F.R.C.S., late of Harley Street, London, aged 95.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

Vol. CXXXII.

WEDNESDAY, MAY 9, 1906.

No. 19.

NOTES AND COMMENTS.

A Public Medical Protest. Obviously much good work may be done by the medical profession in the education of the public as to the worthlessness of quack medicines and methods. Some time last year an effective protest was raised in a north country town at a public lecture given by a notorious electrical charlatan, who professed to cure many maladies, curable and incurable, by the exercise of powers bordering upon the omnipotent. A medical man in the audience asked a number of awkward questions as to diagnosis and other precise details, and the meeting broke up in confusion. Last week a well-known Llanelly resident, Dr. Williams, attended a lecture by a faith-healer, Mr. Howton. The latter is reported to have said that Christ was about to revisit the earth, as evidenced by recent earthquakes and other upheavals. He stated that recently he himself visited an asylum and cast out a devil from one of the patients. Dr. Williams thereupon promptly demanded the name of the patient and of the asylum where this miracle was performed. Howton replied he would give the information privately. A heated argument ensued and eventually the lights had to be turned out to clear the hall. Well may we crave for higher standards of State education!

Gold Scalpels. The golden sickle of the ancient Druids is a traditional implement strangely at variance with modern ideas. As a soft, ductile metal, gold has never appealed to mankind as fitted for the making of cutting weapons. However, Dr. J. F. Vaughan, of Los Angeles, says the *Tribune*, has invented a means of tempering gold, and has made scalpels, hypodermic and suture needles, and other surgical instruments from the hardened metal. The advantage claimed for the gold blade is, that it is almost perfectly smooth and makes a clean incision that unites without a scar, in contrast with the wound left by the serrated edge of the ordinary steel knife. The latter, moreover, is liable to rust spots, which are apt to lodge bacteria and hence to convey infection to the tissues. Should the advantages of Dr. Vaughan's invention be confirmed, he will have bestowed a valuable boon upon our surgical *armamentarium*.

More Caution. The dismissal last week of the extremely grave charge against a young London physician will be received with much general satisfaction throughout the profession. From the

first it seemed absolutely incredible that a young man of exceptionally brilliant attainments should abuse a position of trust by assaulting children under his care. The fact that the whole of the evidence came from defective children clearly imposed both upon the investigating magistrate and the prosecution an unusual amount of responsibility. The outcome of the inquiry has been the complete vindication of the accused. The magistrate accepted without reserve the medical testimony that charges without foundation were often made by mentally defective children. The London County Council were under the circumstances justified in bringing the matter forward. In future, however, that body will in our opinion act wisely by taking the obviously prudent precaution of having a nurse present at all medical examinations. Such a step would prevent the future possibility of bringing unfounded charges of the kind. As a matter of simple caution it would be desirable for all medical men to ask for the invariable presence of a nurse in dealing with patients of deficient intellect.

Students and Casualties.

The recent unfortunate occurrence at a leading London hospital raises once more the question as to the methods in force in the casualty rooms of what are known as "teaching hospitals." In this particular instance a patient with a large abscess pressing on the œsophagus was sent away on the ground of there being no room for admission. On being taken to another hospital the patient died shortly after operation. The gravity of the condition could hardly have been overlooked at first by an experienced man. Without a full knowledge of the facts of the case it would be impossible to pronounce any judgment as to its merits or demerits. It may be pretty safely asserted, however, that there is considerable room for improvement in the casualty departments of many of the great hospitals. Too much responsibility is left in the hands of students or of newly-qualified residents. Under the constant supervision of an experienced senior man there would be little likelihood of turning away patients in a dying condition. If in a great hospital a few beds cannot be reserved for urgent cases the administration of that particular charity stands more or less self-condemned. That there are serious difficulties in dealing with a never-ending stream of casualties we must all recognise.

LEADING ARTICLE.

THE WATER SUPPLY OF LONDON.

THE task of supplying a vast city like London with water is truly gigantic. Some years ago the remittent failure of the supply in the East End of the Metropolis gave rise to a vast deal of annoyance and discomfort, to say nothing of the injury to trade and the danger to the public health. The problems presented to us in the water supply of London run on much the same lines as those in the great cities of the rest of the United Kingdom. The questions of purity and quality, of adequacy in amount, of sufficiency of pressure, of constancy of supply, and of the hundred and one details connected with collection, storage, and distribution are no less vital to the citizen of Manchester, of Glasgow, of Dublin, and of all other great centres than they are to the Londoner. As things stand the London water supply cannot be regarded as satisfactory. As everyone knows, the supply is drawn practically from two sources—the Thames and the Lea. Both those waters are extensively polluted with sewage above the intakes of the water companies. In the light of modern scientific knowledge that state of affairs cannot be accepted as safe or salutary. It is perfectly clear that sewage polluted water can be rendered safe by sterilisation, but no attempt has ever been made by the companies to sterilise the water before delivery. They trust to sand filtration, a method that is not only subject to various fallacies, but may at any moment break down. Last year the question of the Thames as a source of drinking water supply was brought forward at the London meeting of the Public Health Congress. The author of an article on the subject dwelt on the fact that Londoners were content to drink water from that river after it had undergone extensive sewage contamination. He proved that such pollution was constant and universal, and quoted specific instances of accidental sewage pollution on an extensive scale. The main conclusion arrived at was that if Londoners are content to go on drinking diluted sewage they should at least insist on having it sterilised. We are glad to see that the question is not to be allowed to drop out of sight. Sir Alexander Binnie, the eminent engineer, has recently stated the emphatic opinion that if the present pollution of the water supply continues the time will come when there will arise an epidemic which will startle the world. That view will be unhesitatingly endorsed by the great majority of medical experts in public health. The history of water-borne typhoid and cholera is alone sufficient to condemn any system that supplies water that has been once polluted by bowel bacteria, pathogenic or otherwise. Were a single case of cholera to be imported into the

Thames Valley above the companies' intakes the only obstacle in the way of a vast and terrible outbreak of cholera would be the admittedly imperfect chain of sand filters. As it is there is a vast deal of enteric fever in the metropolis the origin of which is unknown. While it is true that there is no evidence to prove that this infection has been distributed through the domestic water supply, yet, on the other hand, there is the positive fact that in the course of an extensive sewage contamination much typhoid excreta must necessarily reach the Thames. In view of the fallacies that surround the bacteriological examination of water the reports of individual experts must be received with some reserve. It would be a matter of great scientific interest as well as of sound value to the community were a Government investigation by a body of the best scientific experts obtainable appointed. One of the fundamental necessities of a good standard of public health is a pure water supply, and no amount of favourable reports by more or less interested expert examiners can do away with the primary fact of sewage contamination. One member of the Metropolitan Water Board is reported in a London paper recently to have stated with regard to the Lea:—"The effect of the present system is this, that about two or three million gallons of sewage effluent is actually being drunk every day in the East End of London alone. The question arises, therefore, whether it is desirable for financial reasons that this state of things should continue." The last sentence strikes at the root of the matter. Should private enterprise be permitted to control so important a matter as the water supply of a country? Further, if private enterprise be necessary, to what extent should the State insist upon a well-considered standard of purity and carefully guarded sources of origin before granting a monopoly in the provision of one of the necessities of life?

NOTES ON CURRENT TOPICS.

The Story of a Heart.

We drew attention a few months ago to the interesting story of the autopsy on the body of Paul Jones, performed more than a hundred years after his death. This period, long as it is in proportion to the usual time that elapses between death and autopsy, is brief enough when compared to that which elapsed between the death of Rameses II. and the microscopical examination of his heart in Paris in the present year. Assuming that the heart in question is indeed that of Rameses II., then some thirty-one centuries have elapsed since it ceased to beat. The organ reached the Louvre recently in one of a series of vases reputed to contain the viscera of the monarch named, and was found to be of horny hardness, requiring the use of the saw for section. Fine slices made with a razor showed, however, that the section was undoubtedly composed of heart-muscle. The hardening was due to embedding in

natron and various resinous substances. We understand that there is some question as to whether the organ is that of Rameses II. or of one of his sons, but there seems to be little doubt that it comes at any rate from his period.

The Election of Direct Representative to the General Medical Council.

We have always been forward in advocating the extension of the principle of direct representation of the profession on the General Medical Council, and we have taken our part in directing professional opinion to the point. The great fault of the present constitution of the Council is that the members are nominated not by the members of the medical profession, but by certain limited bodies, to wit, the various licensing corporations. What is required is election on a fair democratic basis. A danger which threatens all democracies, however, is "caucus" rule, or "bossism," and the medical profession has need to exercise great care in guarding itself against a pseudo-democracy which would be little or no improvement on the aristocracy to which we are subject at present. We believe that the recent tendency to pre-arrange by caucuses the elections of direct representatives is one fraught with danger to our freedom. We view with grave suspicion the decision of the British Medical Association to "run" a candidate or candidates at the next election, since the choice of such candidates is sure to fall into the hands of a clique who will be able to impose their will on the more or less indifferent masses of their fellow members. Direct representatives should win their seats by personal merit, and not because of their nomination by any society or group of the profession, no matter how wealthy or important that society or group may be.

Dust.

A LECTURE, interesting in matter and vigorous in delivery, was given by Sir Dyce Duckworth before the National Health Society on "Dust." It is precisely by diffusing among the public exact ideas on such subjects as the nature and dangers of dust that good educational work in domestic hygiene is done, for the traditional notions prevalent are as unscientific as they are vague. The sources of town dust and the evils to which it gives rise were brought under review by the lecturer, and the inaction of local authorities in the prevention of smoke and their carelessness in the way they collect and remove dust were strongly condemned. To those who possess libraries the problem of preventing books from harbouring dust and the difficulty of keeping shelves properly clean is an ever-present one, and to such Sir Dyce Duckworth gave a tip of great value which he had learned from the librarian at 20, Hanover Square. The plan adopted at that library is to remove the books *en masse* and to sprinkle the shelves with wet sawdust. The latter readily catches the dust, and when it has done its work

it can be raked on to the floor and thence swept up without parting with its burden. Sir Dyce Duckworth is evidently no lover of motorists, and he spoke in strong terms of the selfishness of those who drive their cars through the country roads raising clouds of dust and deluging gardens, crops, and cottages with debris from the road. It is difficult to conceive of a more effectual method of scattering road-germs than is adopted by motorists, and now that the automobile is becoming so popular one would not be surprised to hear of widespread outbreaks of diarrhoea and other alimentary complaints owing to the contamination of food and drink by motor-raised dust.

Rate-aided Hospitals.

At a special luncheon at the Mansion House, the other day, held to inaugurate the preparation for a bazaar in connection with the Royal Waterloo Hospital, an important speech was made by Mr. Walter Long. Speaking before the Duchess of Albany, and a distinguished company, Mr. Long took occasion to deplore the fact that in London, the richest city in the world, it was hardly possible to find a hospital that was not in want of funds. That, indeed, is unfortunately true, and it leads to the still more deplorable fact that it is necessary for hospitals to try to raise money by the mercenary method of bazaars and festival dinners. No sober citizen can but regret that it is only possible to minister to the needs of the sick poor by tickling the appetites of the healthy rich, but that this is so is amply demonstrated by the frequency with which these entertainments succeed one another during the periods when fashion ordains that its devotees should reside in London. Mr. Long expressed his belief that the time was at hand when the majority of the hospitals would have to seek support from the rates as they could not go on for ever depending entirely on voluntary support. It is well that this prospect should ever be before the minds of the people of London, for the opinion of a shrewd public man like Mr. Long is not to be passed lightly by. The burden on the rates of contributing wholly or partially to hospital support would be heavy indeed, and the elasticity of administration which, intelligently worked, secures so many advantages would give way to the hide-bound red-tapeism of Government machinery. Medical education undoubtedly would suffer, and all personal interest in individual hospitals would be submerged in the common apathy with which the London ratepayer regards the manner in which his money is expended.

Vanity, Quackery, and Death.

WE frequently have occasion to comment on the vanity of women and the rapacity of those who trade on that weakness, but though such women may waste their money, quacks secure it and newspaper proprietors cut in for a big slice, it is seldom that more than moral harm is done by their transactions. Two recent cases of violent

death draw attention rather forcibly to certain traits distinguishing these classes of the community. An inquest was held on a shoe-operative in the Midlands who was foolish enough to have believed certain advertisements of pills and cream for the complexion, and to have treated herself with them in order to remove freckles which Nature had ordained she should be possessed of, but which evidently stood in the way of connubial advancement. After taking the pills the girl became exceeding ill with hæmatemesis, and soon after died of exhaustion. At the autopsy a gastric ulcer was found, but no signs of irritant poisoning, so that the jury returned a verdict in accordance with the medical evidence. It is of course impossible to say with certainty that the pills were the direct cause of death, but it is just probable that a hard body such as a pill lodging in or about a gastric ulcer might determine rupture of an artery. At any rate the folly of self-medication and the danger of quack advertisements was abundantly illustrated. In the second case a woman at Bristol, having one leg shorter than the other, put a salt cellar in her shoe to supply the deficiency. By this means was caused a fatal fall. These are some instances in which the modest fee of a general practitioner may be sufficient to prevent people losing their lives unnecessarily.

The Doyen Cancer Cure.

THE news that Dr. Doyen had formally adopted the yeast cure for cancer was cabled from the Lisbon Medical Congress, and published in leading newspapers in various continents. It appears, however, that the news was unfounded, and that Dr. Doyen has not abandoned his well-known method of anticancerous vaccination. We have been favoured with the text of M. Doyen's communication to the Congress, in which he gives his most recent results with vaccines prepared from the *micrococcus neoformans*.

The Opium Traffic.

As alcohol is to the Western World, so is opium to the East. Traced to their ultimate principles both intoxicants are narcotic poisons, and both minister to some mysterious morbid craving of mankind. Both are valuable medicinal agents, and both, alas! are on the other hand answerable for a vast toll of misery, disease, and death entailed upon their victims. Curiously enough, the United Kingdom is directly or indirectly responsible for much of the mischief in both cases. As a vast producer and consumer of alcohol she becomes answerable for an untold sum of human woe. The vast dependency of India, again, is the chief centre of the opium trade. The total value of that drug exported from India in 1904-5 was £7,082,295, of which amount no less than £5,541,040 was consigned direct to China. Those who know anything of the baneful effects of opium upon the human frame can to some extent realise the sum total of moral and physical degradation

involved in those statistics. There is a good deal to be said, indeed, in favour of the contention held by many philanthropic persons that the Indian opium traffic forms an indelible stain upon our imperial escutcheon. Unfortunately, India is a poverty-stricken country. The opium revenue for the years mentioned amounted to £4,050,266, a colossal sum that renders the task of the reformer extremely difficult. If money can be found for punitive expeditions, surely it should be forthcoming to combat a great social canker.

A Curious Professional Accident.

THE risks attached to the exercise of the medical profession are manifold indeed, but there appears to be always room for some fresh combination of the old factors. A curious accident in connection with the extraction of a tooth occurred not long since at a village near Craig-y-Nos. Dr. Richards, a local man, in performing the operation, splintered a small portion of the tooth, which flew off and struck him in the eye. In the evening the eye became inflamed, and it was then found that the cornea had been pierced by the fragment, which had set up septic infection. Unfortunately, the course of an ophthalmitis of that kind is no less rapid than serious. In this case we regret to learn that Dr. Richards will almost certainly lose an eye.

A Rebellious Local Authority.

THE Chipping Sodbury District Council seem bent upon drawing the eyes of the nation upon their affairs. They have planted the revolutionary standard and hurled defiance at the Local Government Board. The latter central authority issued a provisional order uniting eleven neighbouring urban and rural districts for the purpose of appointing a medical officer of health. This arrangement did not secure the approval of the Chipping Sodbury Council, who, insisted upon their right to retain their own medical officer—Dr. Bond. After a long discussion, the following amendment was carried by 12 to 4:—"That inasmuch as we have before pointed out that we are in a very large and important district, we still adhere to our original expression of opinion that we should have a medical officer of health of our own, and beg to protest against the attitude that the Local Government Board have taken up against this Council, and again ask them to allow us to sever our connection with the combination." Should the Council push matters to the bitter end, there will be a good deal of interest in the near future to occupy the minds of the good folk of Chipping Sodbury.

The Budget.

MR. ASQUITH'S first Budget did not come as a surprise, and therefore can hardly be said to have provided a disappointment to the professional classes. Men of all political complexions are prepared to give the Chancellor of the Exchequer a

chance before criticising his work, and a chance of doing anything heroic he certainly has not yet had. On the other hand, it is necessary that voices should be raised in good time before any further proposals are entered upon with regard to the national finances. It is held in a general way by democrats that direct taxation of the rich is achieved with rough justice by the imposition of the income-tax, but we can only say that such justice as is achieved is very rough indeed. The well-to-do dividend-drawer can well afford to give a twentieth part of his income to the general funds of the State, but it is far otherwise with the small professional worker who gains his living by the sweat of brow and brain. An income-tax of a shilling in time of peace has been pronounced by so great a fiscal authority as Mr. Gladstone to be a standing danger, and though it is four years since we were at war the tax has not yet been brought below that figure. On the Committee Mr. Asquith is appointing to deal with the graduation of the income-tax it must be impressed by every available means that the doctor who wrests a bare living by attending the ailing poor is a far poorer man than many of his income-tax free patients and lives a life that the majority of them would never cease to grumble at. If the income-tax be not graded to distinguish between the dividend-earned income and the sweat-acquired income, and if it be not adjusted so that the small man pays proportionately less than the rich, the financial policy of the Government will not only be illiberal but flagrantly unjust.

Oyster Depreciation.

WE cannot affect the slightest sympathy with the oyster-dealers who are deploring the falling off in their trade. Mr. George Tabor, a leading Billingsgate dealer, is reported to have said recently that £4,500,000 was lost to the trade yearly through lack of a little commonsense, and that we ought to imitate the Dutch Government and have an official inspection of oyster-beds every year, so that every oyster should bear a Government certificate of soundness. Remarks of this kind show the utter lack of responsibility that pervades the minds of many of those who cater for the public wants. It is a disgrace and a scandal that certain oyster-dealers should for years have purveyed contaminated oysters to the British public and caused a yearly death and sickness bill which it is impossible to estimate with any accuracy. The least possible punishment for such heinous carelessness is that the culprits should suffer in pocket; for ourselves we can think of few sentences consonant with humanity which would be too bad for them. The Government should be under no obligation to put themselves to expense in order to prevent disease-germs being foisted on their subjects by wealthy merchants who will not set their own houses in order. Local authorities who allow their sewage to contaminate oyster-beds are amenable to the common law, and without excusing them we un-

hesitatingly condemn the conduct of the proprietors of such beds in putting their death-dealing wares on the market. The oyster trade is said to be reviving. We can only express the hope that when the mollusc that our contemporaries delight to call "the succulent bivalve" regains its popularity, it will do so purged from the bacteria passed from the human intestine.

Meeting of the General Medical Council.

WE understand that the Spring Session of the General Medical Council will commence on Tuesday, May 22nd, under the presidency of Dr. Donald MacAlister, when the reports of Committees, Amendments as to Standing Orders, and other important matters will be considered.

PERSONAL.

ON May 5th, H.R.H. the Princess Royal laid the foundation stone of the new buildings of the Bolingbroke Hospital, Wandsworth Common, London.

WITH deep regret we notice amongst the list of the victims of the recent Guernsey wreck the name of Miss Frances Waller aged 12, the daughter of Professor Augustus Waller, F.R.S., Director of the Physiological Laboratory in the University of London.

The next half-yearly dinner of the London-Glasgow University Club will be given at the Trocadero Restaurant on May 25th, under the presidency of Sir Thomas McCall Anderson, Regius Professor of Medicine in the Glasgow University.

THE President of the Royal College of Physicians of London will represent that ancient body at the forthcoming quarter-centenary of the University of Aberdeen in September next.

ONE of the most striking pictures in the Royal Academy's exhibition in London this year is the portrait group, by Mr. J. S. Sergeant, of Professors William Welch, Halstead, Osler and Howard Kelly, painted for the Johns Hopkins University.

DR. CHARLES A. WIGAN has been elected Chairman of the local District Council of the Portishead (Somerset) District.

THE annual dinner of the Volunteer Ambulance School of Instruction will take place in the Trocadero Restaurant on May 17th (the anniversary of the relief of Mafeking), under the presidency of Surgeon-General Keogh.

BARON TAKAKI, surgeon-general of the Imperial Japanese Navy, is giving a course of three lectures on May 7th, 9th, and 11th, from 5.30 to 6.30 p.m., at St. Thomas's Hospital, on "The Preservation of Health Among *Personnel* of the Japanese Army and Navy," based on his experiences in the late Russo-Japanese war.

DR. THOS. F. DEWAR, of Arbroath, was last week entertained at a banquet given in his honour by his fellow townsmen previous to his assuming the important post of Medical Officer of Health for Forfarshire. The company numbered about 100, among whom were several members of the profession.

A CLINICAL LECTURE ON THE GENERAL CYSTIC DEGENERATION OR TRANSFORMATION OF THE KIDNEYS IN THE ADULT.*

By JOHN LINDSAY STEVEN, M.D., F.F.P.S.G.,

Physician and Lecturer on Clinical Medicine, Glasgow Royal Infirmary; Honorary Librarian, Faculty of Physicians and Surgeons, Glasgow.

ABOUT sixteen years ago, when I first, as pathologist, became intimately acquainted with the contents of the Pathological Museum of the Glasgow Royal Infirmary, two specimens in the section devoted to renal disease arrested my attention and excited my astonishment. They were the kidneys of a patient who had suffered from enormous cystic disease of these organs; the description of the specimens is to be found in the present printed catalogue, p. 295, Series vii., O, 3 and 4. The specimens are at least thirty-five years old, and the account of them, which is very brief, has been continued from that contained in the first printed edition of the catalogue published by my old teacher, Professor Joseph Coats, in 1872. The right kidney weighed when removed from the body 84 ounces, and the left appears to be about the same size.

"The cysts vary in size from a line to 1½ inch in diameter. The contents of the cysts are very varied; some contain clot with calcareous matter mingled.

"History.—Removed from the body of a man, æt. about 60. A private case. The cause of death was unknown and no renal disease was suspected."

Such is the brief account that has come down to us of these two remarkable specimens, which I show you to-day. There are now some seventeen or eighteen specimens of cystic disease of the kidneys in the museum, many of which have been added by my friend and colleague, Dr. David Newman, who has written a valuable chapter on the subject in his book, entitled, "Renal Cases: a Series of Selected Clinical Reports and Surgical Studies" (Maclehose, Glasgow, 1899). The only specimens, however, at all approaching in size to these I have just referred to were added in 1899 by my friend and successor as pathologist, Dr. Charles Workman. If you compare Dr. Workman's preparations with the older ones you will see that they are quite evidently specimens of the same disease. As Dr. Workman has made a very careful examination of these specimens it will be instructive if I read to you the account of them, which he has published in the last edition of the Catalogue of the Museum. Specimen numbered "VII. O. 17, consists of the left kidney with its capsule stripped off to show the great alteration of structure. It weighed 65 ounces. VII. O. 18 consists of half of the right kidney. The other half has been presented to the Museum of the Western Infirmary, Glasgow.

"The kidneys have a remarkable appearance, resembling masses of pudding-stone made up of pebbles of very various colours. This seems to be due to the fact that into some of the cysts hæmorrhage has occurred, and this in varying degree in different cysts. In some there is caseous material; in some even calcareous deposit. Microscopic sections were made from several parts of the kidney and stained in various ways (Van Giessen's method and alum carmine). These show that the cysts are mostly lined with a single layer of epithelium, and that between the cysts there is still a considerable amount of comparatively healthy kidney substance with tubules and Malpighian tufts.

"In the liver in this case careful examination showed areas translucent from the presence of cysts. These were generally about the size of small peas, were scattered singly, and numbered in all about a dozen. Microscopic sections of these showed them to present a structure identical with the cysts of the kidneys.

"History.—Patient was admitted as 'an urgent

abdominal case' on February 27th, 1899. He had been ill for the last three months, but had become much worse during the days previous to admission. He had no vomiting, no diarrhoea and no headache. Frequent enemata were given on admission, and they gave great relief. Abdomen was greatly distended, and hard masses were felt on either side, but more especially on the right. Urine was bloody, abundant in albumen, without casts, and small in amount. Patient did fairly well till the evening of March 1st, 1899, when he became drowsy. Twitchings succeeded, and later he became blind. Twitchings increased, and ended in convulsions about 4.5 a.m., March 2nd, 1899, in spite of active treatment. Symptoms were typically uræmic."

During life the patient was under the care of my colleague, Dr. James A. Adams.

It is obvious, I think, that all the specimens of cystic kidney in our museum (most of which I have placed upon the table for your inspection) are not of the same nature, but there can be little doubt that the two cases to which I have specially directed your attention are illustrations of the same affection. I have referred to them in detail, so that you may have some idea of the renal lesion which I believe to be present in the patient whom we have carefully examined together in Ward 8, and whose clinical history and physical signs I am now about to relate to you in full. In my experience cystic transformation of the kidney of this kind is rare, and in twenty-five years of pathological and clinical work I cannot remember to have met with a case before. Dr. Newman has found 105 cases recorded in literature, and Dr. George F. Still has "been able to collect together thirty-five cases of cystic liver associated with cystic kidney" (*Path. Soc. Trans.*, 1898, Vol. XLIX., p. 158). You will see, then, that though comparatively rare the condition is well recognised, and latterly has been minutely investigated and described. Indeed, if you refer to Sir William Robert's "Treatise on Urinary and Renal Diseases" (4th edition. London, 1885, p. 560), you will find that cases have been put on record since the time of Richard Bright, in 1835, and on page 567 you will see a woodcut which might serve as an illustration for one of the specimens I have been showing to you to-day. No doubt the great advance that has been made in renal surgery during the last twenty years has led both to a more accurate knowledge of the clinical history, and a greater skill in the diagnosis of this affection. I shall now relate to you the clinical history of our case, for which I am indebted to my house physician, Dr. W. B. Jack. Dr. Jack's report is dated November, 1905, and the patient has been re-admitted (March, 1906) for observation, and for this clinical lecture. The physical conditions and the symptoms are practically unchanged, and so the account which I am now to submit to you sufficiently describes this patient's present condition, which you have also had an opportunity of investigating for yourselves.

CLINICAL HISTORY OF CASE.

Mrs. M., æt. 33, housewife, was admitted to Ward 8 of the Glasgow Royal Infirmary on November 25th, 1905, complaining of pain in the left side of the abdomen of eleven, and of swelling of four months' duration.

About eleven months ago the patient was delivered of a six months' child, still-born. During the last six

* Delivered to the Author's Post Graduate Class in the Glasgow Royal Infirmary, March 29th, 1906.

weeks of her pregnancy she suffered from swelling of her feet and legs as high as the knees, but this disappeared after the labour. No medical man was in attendance, and she was assisted by a neighbour. So far as she is aware, everything was natural. Soon after her recovery, however, she began to be troubled with a pain in her left side, dull in character, but sufficient occasionally to keep her awake at night. She did not pay much attention to the pain, and went about her ordinary household work. About four months before admission, she noticed a swelling in her left side, and the pain became more severe. The pain in the left lumbar region tended to shoot down into the inguinal region, but did not affect the act of micturition, which was not increased in frequency. There had been progressive loss of strength and of appetite in the last four months, and for a week before admission she vomited a great deal after her food; latterly also headaches have been troublesome. Menstruation has been normal, and the bowels have been regular.

Her previous health had been very good, and the six-months' child mentioned above is the only one she had borne. She has had no miscarriages.

The family history is unimportant. She is an only child; her mother is alive and well. Her father is dead, the cause of his death being unknown. Her circumstances are comfortable.

PRESENT CONDITION, NOVEMBER 26TH, 1905.

The patient lies on her left side, breathing easily. The face is rather pale, and there is puffiness under the eyes. The pupils are dilated, but react to light and slightly in accommodation. The lips and conjunctivæ are well coloured; the tongue moist and clean, the teeth carious. The general condition is very poor, and there is complaint of slight pain in the abdomen.

The abdomen is somewhat irregularly distended. It bulges a little forwards at the umbilicus and at the sides. The abdominal wall is loose, poorly developed, and easily moved on the underlying structures. On palpation, two large swellings are made out, one situated in either flank and definitely separated from each other. They are, roughly, about the same size, larger than a cocoa-nut, and, if anything, the left is the larger. They extend from about the level of the tenth rib in front to rather lower than the level of the anterior superior spines of the ilium. The swellings approach one another towards the middle line anteriorly, but the fingers can easily be pushed between the anterior borders of the two tumours. They have a fairly firm consistency, and an irregular lobulated outline. No fluctuation can be made out in them. On palpation behind, they are easily felt in the region usually occupied by the kidneys, and are somewhat freely movable. There is tenderness on pressure over the tumour of the left side, the pain shooting downwards into the inguinal region. Percussion over the tumours is dull.

Hepatic dulness is separable from the tumour dulness, and measures three and a half inches in the mid-clavicular line, the lower border of the liver not being palpable below the costal margin. The splenic dulness measures about 2½ inches.

The heart and lungs present quite normal characters, the apex beat being situated in the fourth interspace 3½ inches to the left of the middle line, and the sounds being of normal quality.

Urine.—During the first twenty-four hours of residence the patient passed 72 ounces of pale urine, sp. gr. 1006, reaction acid, slight flocculent deposit, albumen a distinct trace. No blood was ever observed; no sugar.

The microscope reveals numerous vaginal epithelial cells. A few leucocytes, but no tube casts. The accompanying table gives the details of the daily quantity of urine, and of the chemical analysis for eleven days.

The patient was examined yesterday (December 3rd, 1905) by my surgical colleague, Mr. J. Hogarth Pringle. Nothing was found in the bladder, and the urine was

obtained separately from each kidney by catheterising the ureters. Less urine was obtained from the left ureter, and that from the left contained 1¼ gr. of urea per ounce, as against 3½ gr. per ounce obtained from the right kidney. In both specimens a trace of albumen was found. The diagnosis of double cystic kidney was confirmed by Mr. Pringle, who did not recommend operative interference.

Date.	Amount.	Sp. gr.	Reaction.	Albumen.	Urea, Grs. per oz.	Urea, Grs. p. day.
1905.	Ozs			P.c.		
Dec. 3rd. . .	72	1010	Slt. ac.	'025	3½	252
4th, Day . .	40	1010	ac.	—	4	252
" Night . .	23	1010	"	'025	4	248
5th, Day . .	28	1009	"	'025	4	254
" Night . .	34	1009	"	—	3½	254
6th, Day . .	36	1008	"	'025	3½	240
" Night . .	43	1008	"	Less than	3	343
7th.	80	1007	"	'025	3½	251
9th, Day . .	43	1008	"	—	3½	308
" Night . .	55	1008	"	—	3½	291
11th, Day . .	23	1010	"	—	3½	308
" Night . .	44	1010	"	'025	3½	291
13th, Day . .	36	1008	"	'025	3½	308
" Night . .	52	1008	"	—	3½	291
17th, Day . .	36	1008	"	'025	3½	308
" Night . .	42	1008	"	—	3½	282
19th.	88	1007	Slt. ac.	'025	3½	308
20th, Day . .	38	1006	"	—	3½	282
" Night . .	46	1006	"	'025	3½	282

On December 4th, 1905, I entered the following note in the ward journal:—On inspection of the anterior abdominal wall this morning it is found to be irregular in shape, this irregularity being due to the presence of two prominent swellings, one, the larger, on the left side, occupying the whole of the lumbar and the left part of the umbilical region. The other, the smaller, causes a distinct prominence in the right lumbar region, and is situated as nearly as possible in the space between the anterior superior spine and the costal margin. In the anterior axillary line the vertical measurement of this prominence is three inches, and its anterior margin is situated in the line of the point of the eighth rib. Both swellings when palpated are found to be due to the presence of large rounded masses in the abdomen, with somewhat irregular and finely nodulated surfaces. On bimanual palpation, the swellings are felt to pass deeply into the lumbar regions posteriorly, whence they can be freely moved forwards by pressure from behind. The fingers can be passed quite easily between the costal margin and the surface of the tumour on the left side, which could not be done were the swelling due to an enlargement of the spleen of similar size. It is further quite obvious that the tumour is related to a part more deeply situated in the abdomen than the spleen. On the whole, the phenomena indicate greatly enlarged, and probably cystic kidneys.

December 8th, 1905.—The patient feels better, and there is much less tenderness on the left side of the abdomen than before. The edge of the liver can now be felt just below the costal margin on deep breathing.

December 22nd, 1905.—The patient went home to-day.

Such, then, are the physical signs and the clinical history of this very interesting and comparatively rare case. I propose in conclusion to make a few

remarks on the pathogenesis and diagnosis of the affection.

Cystic disease of the kidneys may be of various kinds—viz.: (1) Simple unilocular urinary cysts, a very frequently-occurring condition, of no great clinical importance, and apparently of congenital origin. (2) Multiple cysts due to chronic interstitial nephritis, also a frequent condition, whose pathology is well understood, and in which the cysts do not attain to any great size. (3) Hydatid cysts of the kidney, on the whole a less frequently met with condition, but of which I have published one case, in which the daughter cysts of the parasite were discharged *per urethram* during life, and of which the clinical diagnosis was confirmed later by *post mortem* examination (*Glasg. Med. Journ.*, vol xxii, 1884, p. 427). (4) General cystic degeneration or transformation of the kidney, the rarest form of all, of which the case you have examined to-day is, I believe, a typical example.

Considerable difference of opinion has all along existed as to the pathogenesis of cystic transformation of the kidneys. I do not think that any theory which attributes this condition to chronic interstitial nephritis or to obstruction of the uriniferous tubules, however caused, can now be entertained. There are two theories of the causation of cystic transformation of the kidneys which are deserving of careful consideration. First, there is the theory of congenital malformation, which has been well stated by Dr. George F. Still in the following paragraphs from the paper in the *Pathological Transactions* to which I have already referred you:—

"It seems, therefore, only reasonable to attribute the condition to the same cause at all ages, and the most satisfactory explanation which has yet been suggested is, I think, that of Mr. Shattock (*Path. Soc. Trans.*, Vol. XXXVII., p. 287), that the cystic condition is the result of a congenital malformation, the mesonephros having blended with the metanephros in the development of the kidney (p. 159). In view of this fact it seems reasonable to suggest that the cystic liver associated with cystic kidney in adults is, as in the infant, a congenital condition, and further, that as the cystic kidney is almost certainly a malformation, so the cystic liver also is simply a malformation, and not the result of disease" (p. 163).

In this connection then, the association of cystic transformation of the kidney with a similar condition of the liver, as in Dr. Workman's case, which I have described to you, is of importance in the pathology of the affection. It is worthy of note, however, that in Dr. Workman's case the cystic transformation of the liver was very slight as compared with that of the kidneys, and that in our patient there was no enlargement of the liver, phenomena which might be advanced in support of the second theory, which is that the cystic transformation of the kidney may be of the nature of a neoplasm, an opinion supported by Dr. Workman, who has written to me as follows upon the subject:—

"With regard to cystic degeneration of the kidney, my opinion of its being a neoplasm and not an ordinary degeneration is in part from the histological appearance of the cysts, showing a well-developed secreting membrane resembling the lining membrane of the cysts of the thyroid, while the kidney tissue exists in fair amount between the cysts showing both Malpighian bodies and various forms of tubules, though these are, of course, compressed to some extent by the cysts. The cysts are not just degenerated and dilated tubules. Another reason for this view is, that the disease is not confined to the kidneys, but I believe nearly always involves other organs, such as the liver, the pancreas, or suprarenals. In the case you refer to there were a considerable number of small cysts in the liver, and in another case which I saw there was a greater cystic development in the liver than in the kidneys."

These statements give some idea of current opinion as to the pathogenesis of this interesting affection,

and I think that there are cogent arguments which might be advanced in support of either. In support of the congenital hypothesis it is of interest to remember that cystic transformation of the liver and kidneys is sometimes associated with other congenital malformations or deformities, such as undescended testis, polydactylism, webbed fingers, &c. (Still). On the other hand, the small amount of cystic change in the liver in Dr. Workman's case (about a dozen small cysts in all) might be taken as indicating that the affection of the liver was secondary to that in the kidneys.

As regards diagnosis, I have not very much to say. In a case such as I have demonstrated to you there could not be any great difficulty, as a study of the clinical history and physical signs of our patient abundantly proves. The chief difficulty of diagnosis would of course be experienced in the earlier stages of the affection, before the organs were palpable. At this stage it is probable that the symptoms would resemble those of chronic interstitial nephritis. When, however, the double renal tumour is palpable the question of cystic transformation at once arises. I believe the affection is always double, though the greater advancement of the lesion on one side may occasionally lead to only one kidney being palpable. Under such circumstances the difficulty of diagnosis might be very great, and perhaps could only be removed by catheterisation of the ureters or an exploratory incision. There are two symptoms of importance which should be taken carefully into account in estimating the diagnosis of a doubtful case, more especially as they may be leading indications of totally different affections—viz., hæmaturia and renal pain. Dr. Newman has pointed out that in cystic kidney hæmorrhage may occasionally be very profuse, although it was not present in our case. Renal pain resembling renal colic may be present, as it was in our case. Taken by themselves, then, these symptoms do not help us much, but if they are associated with the presence of a double, slightly nodulated renal tumour, there should be no great difficulty in the diagnosis.

Treatment, except on general principles, in cases of cystic transformation of the kidney must always avail very little; if the affection be congenital, the fact that a man may live with the lesion present in an advanced degree till the age of sixty years would indicate that there is not necessarily any immediate danger to life. Certainly any radical operative interference, in view of the extreme probability of the lesion being double, is not to be recommended.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of this journal. The lecture for next week's number will be by George Palmerton Newbolt, M.B., F.R.C.S.Eng., Surgeon to the Royal Southern Hospital, Liverpool, and Dean of the Clinical School, on "Tropical Abscess of the Liver" (Illustrated).

ORIGINAL PAPERS.

THE MODERN TREATMENT OF GONORRHEA.

By ARTHUR BALL, M.D., F.R.C.S.I.,
Assistant Surgeon, Sir Patrick Dun's Hospital, Dublin.

GONORRHEA, although one of the commonest of diseases, is still a much more serious affection than the general public or, indeed, many of the medical profession seem to realise. While many cases get well with little or no treatment, yet it must be admitted that gonorrhœa sometimes produces serious complications and is the most potent cause of sterility in both sexes. Now that the declining birth-rate is becoming yearly a more serious problem, the treatment of gonorrhœa by some method which will cure without complications, and render the patient free from infection in the shortest possible time, is a matter deserving considerable attention.

Gonorrhœa may be defined as an acute specific

urethritis caused by inoculation with the gonococcus. The disease commences in, and at first involves, the anterior urethra in the male—that is the urethra in front of the compressor urethræ muscle, and is called acute anterior urethritis. When the gonococci pass the compressor urethræ muscle posterior urethritis follows; this frequently comes on without any increase of the symptoms. A neglected or badly treated anterior gonorrhœa usually invades the posterior urethra by the end of the first week. The frequency of this extension is variously given by different observers. Gadassohn holds that 60 to 70 per cent. of anterior gonorrhœas invade the posterior urethra. Finger places the extreme figure at 80 per cent.; Taylor between 80 and 90 per cent. This frequent extension of the disease to the posterior urethra is largely responsible for the seriousness of the disease, for gonococci may, once they have infected the deeper parts of the genital tract, remain for almost any number of years alive and still capable of transmitting the disease indefinitely.

As gonorrhœa starts as a purely local disease involving a delicate mucous membrane, it is reasonable to treat this by local applications in such a manner that the inflamed surface is cleansed and soothed without being irritated, thus allowing the patient's normal powers of resistance to the organism to act to greatest advantage.

Of the multitude of cures for gonorrhœa which seemingly have been so widely exploited, the great majority are wholly inefficient. The irrigation method largely used in America and on the Continent, but as yet little practised in this country, gives results unquestionably better than any other form of treatment at present known.

Goldberg has summed up the publications of all who have written favourably or otherwise on this method with the following results:—

60 per cent. of acute gonorrhœas were cured within ten days.

30 per cent. of acute gonorrhœas were cured within fourteen days.

10 per cent. of acute gonorrhœas were not cured.

Of the last mentioned the failure was clearly attributed to indulgence in alcohol and coitus in half the number; the remaining 5 per cent. were not explained. During the past three years, in the out-patient department at Sir Patrick Dun's Hospital and in private I have treated almost every case of acute gonorrhœa by this method, and am fully satisfied with the results obtained. The following is the method adopted, being a modification of that of Janet popularised in America by Valentine. As soon as the patient presents himself the discharge is examined for the gonococcus; this is important with a view to treatment and prognosis. I have recently met with three cases of acute urethritis which were not caused by the gonococcus; these readily yielded to treatment different to that necessary to cure gonorrhœa.

Apparatus.—A glass irrigator capable of containing a quart of fluid is suspended by a cord passing over a pulley fixed to the ceiling, so that the height of the irrigator can be rapidly adjusted according to the part of the urethra under treatment: about ten feet of rubber tubing; some form of urethral irrigating nozzle such as Valentine's, which is provided with a semi-circular metal shield, which prevents the fluid returning from the urethra splashing the operator or the patient. A convenient shield to an ordinary glass nozzle can be made by cutting in half one of the all-rubber bulb urethral syringes and passing a glass nozzle through each half, thus making two complete nozzles which can be sterilised by boiling. Nozzle and shield combined, made of one piece of glass, can be obtained from Gentile of Paris; these are very convenient, but are, unfortunately, easily broken.

Solution.—The best results are obtained by using an extremely weak solution of permanganate of potash, 1 gr. to the quart being sufficient to commence with; the most suitable temperature is 100° F. According to Janet the permanganate of potash has a peculiar

action on the urethra. "It occasions a slight œdema of the mucous membrane: while this lasts not a single microbe can be found in the secretion. The success of the permanganate treatment seems to show that the gonococci are so influenced by the alteration of their culture ground, dependant on the œdema, that they cease to grow, hence if this condition of the urethra is sufficiently maintained, the complete destruction of the microbes is sure." (White and Martin).

The strength of the solution recommended above is much weaker than that advised by Janet, for Valentine has found that Janet's solution "for some reason seems too strong to use in this country"—i.e., America. This same holds good for Ireland, and the above strength of the solution is even weaker than that recommended by Valentine. The antiseptic powers of the solution used in irrigations must be practically nil, and I have for some time held the opinion, but have not yet carried it into practice, that irrigations with sterilised normal saline solution two or three times daily would probably cure the disease as quickly, or perhaps quicker than permanganate of potash, but to carry out this treatment one would almost require the patient to remain in hospital during the treatment. A continuous irrigation of normal saline, for some hours at a time, with the patient lying quietly in bed might considerably shorten an acute gonorrhœa.

Treatment of acute gonorrhœa.—The diagnosis having been established, the anterior urethra is irrigated with permanganate of potash, 1 gr. to the quart. The reservoir being only two feet above the urethra the patient may, when the anterior urethra alone is under treatment, stand, or sit on the edge of a chair. The glans, prepuce, and urethral orifice are cleansed by allowing the stream from the nozzle to flow over them. The nozzle, with the stream still flowing, is then inserted into the meatus; the fluid is permitted to run gradually at first, with full force later. In anterior urethritis the fluid is allowed to run out of the meatus by the side of the nozzle. It is advisable to continue the irrigation until the entire quart is used up, and with a conical nozzle the amount of distension of the urethra can be so adjusted that very little pain is caused, even with an acutely inflamed urethra. The first irrigation sometimes causes a slight amount of pain, but the relief given to the distressing symptoms is such, that even the most troublesome class of patient to treat—i.e., the lowest labouring class, who object as a rule to any treatment other than "a bottle"—will readily return for further treatment.

This treatment should be carried out once or twice daily, gradually increasing the strength of the solution until 4 grains to the quart is reached by the end of the second week, before which time the discharge has usually ceased. If the gonorrhœa does not appear to be rapidly subsiding at the beginning of the second week, the possibility of involvement of the posterior urethra must be considered. The diagnosis of posterior urethritis is best made by the "two glass test" of Sir Henry Thompson, which is as follows. The patient is told to pass about half the urine into one glass and the remainder into the second. The first urine passed in the morning should be used for the test, so as to observe all the discharge which has accumulated during the night. In this way a much more accurate indication of the actual state of affairs is presented than if the test is performed later in the day, when the patient may have swallowed large quantities of fluid and so diluted the urine. If the first specimen of urine is turbid and the second clear, the indication is that the anterior urethra alone is affected and that all the purulent discharge has been washed out of the urethra by the clear urine coming from the bladder. If both the first and second specimens of urine are turbid, the indication is that the gonococcus has extended backwards and infected the posterior urethra, the compressor urethræ muscle preventing the discharge formed in the posterior urethra passing forwards into the anterior urethra; during the night the discharge accumulating behind this muscle easily enters the

bladder, mixing with the urine collecting there. Cystitis, of course, will produce this turbidity of the urine, but in this case the turbidity is constant. In posterior urethritis the turbidity of the second portion is very variable, and if the "two glass test" is made during the day the second portion may be quite clear, enough discharge not having collected to flow backwards into the bladder. Hence the importance of obtaining the first urine passed in the morning when testing for posterior urethritis.

When the posterior urethra is found to be infected the entire urethra should be irrigated. This is most readily done with the patient in the recumbent position. The anterior urethra first having been irrigated, the reservoir is raised from 6 to 9 feet above the urethra in order to give sufficient pressure to overcome the compressor urethræ muscle. The meatus is held tightly about the nozzle, and the flow of fluid is gradually increased by relaxing pressure on the rubber tube until it overcomes the compressor muscle and bladder sphincter, and the fluid enters the bladder. If the muscles do not quickly relax, continue the hydrostatic pressure and order the patient to breathe deeply and make efforts at urination, until the fluid enters and fills the bladder; the nozzle is then withdrawn and the patient micturates. This procedure is repeated two or three times at each sitting.

No doubt it may be said that treatment such as I have outlined above is unsuitable for out-patient hospital work, as the patients frequently cannot attend regularly for treatment, and of course it is undesirable, or impossible, to supply them with the necessary apparatus. If a patient attends for treatment three times a week he is usually well in three weeks. I generally prescribe benzoate of soda in ten grain doses; this drug relieves the pain on passing water and renders the urine slightly antiseptic, and is considered by the lower class of patients to be the important part of the treatment.

Space prevents us entering into all the arguments in favour of the irrigation treatment, but not the least is the fact that I have not yet seen epididymitis develop in a patient treated by this method. I think that injections of irritating fluids in the hope that the gonococci will be killed is largely responsible for this complication, especially when the patient is given a syringe and a bottle of lotion and performs these injections himself, without in many cases using any method of sterilising the syringe. In most cases of chronic gonorrhœa it is usual to find other organisms present, probably in many cases the result of septic applications of treatment.

Chronic Gonorrhœa.—If the patient is not well in three weeks, it is desirable to examine the urethra with the urethroscope, when certain areas of mucous membrane will be found still inflamed. This condition should be treated with a solution of silver nitrate, 8 grs. to the ounce of water, which is increased in strength (according to the reaction on the inflamed area) to 10 or 15 grs. This quickly renders the urethra healthy in most cases, but occasionally some infected follicles are seen when the general redness has subsided; these may be cauterised with solid silver nitrate, pure carbolic acid or the galvanic cautery. The occasional passage of a large bougie if the meatus will admit it, or the dilatation of the urethra with an expanding dilator, often hastens the cure, but the passage of a number 12 bougie is of very little use, as this will not distend the bulbous or prostatic portions of the urethra. Bougies up to 18 or 20 English scale have often to be used.

I have now outlined the treatment for acute gonorrhœa, and for one which passes into the chronic stage. Frequently cases come for treatment with a slight morning drop or gleet. When this condition has existed for a long time (sometimes several years), and has resisted almost every form of treatment, it takes a very careful urethroscopic examination to locate the seat of disease; when this is found to be the prostate gland, massage per rectum and dilatation of the prostatic urethra are indicated. Recently I have had satisfactory results with high frequency electricity

applied by an electrode passed into the prostatic urethra. The frequency of micturition in one case, in which cystitis was also present, was completely relieved by two applications of this current.

From the literature of the subject one would gather that the cause of gleet is usually to be found in the involvement of the posterior urethra. But in almost all the cases I have examined I have found a tender granular spot in the anterior urethra; in three cases this was ulcerating and commencing to cicatrise, and the position in all was about an inch and a half from the meatus. If this spot is treated first it sometimes happens that when it is cured the patient is well; and if not, it renders the treatment of any lesions further back much easier both for the patient and the surgeon.

When the gonococci have penetrated the deeper parts of the posterior urethra they seem to remain almost indefinitely, and the treatment to effect a cure is very prolonged. Some recent work offers great possibilities of curing these difficult cases. When they have existed for a long time they seem always to render the subjects victims of almost hopeless neurasthenia, which renders treatment a matter of great difficulty, as a prolongation of treatment tends greatly to increase the neurasthenia.

The address in Surgery, at the seventy-third meeting of the British Medical Association last year at Leicester, by C. J. Bond on "Ascending currents in mucous canals and gland ducts," offers the explanation of the tendency for gonococci to penetrate deeper and deeper into the affected individual when the normal powers of resistance to infection are lowered. It also suggests the solution of the question of treatment once the condition has become chronic. For if these ascending currents carry the gonococci into the inaccessible ducts and glands we may use them for carrying something which will destroy the gonococci. I myself, and I am sure many others, have been working on these lines for some time, but so far I have not hit on a suitable substance which will act this way. Some insoluble powder seems most suitable, and with insufflations of calomel into the urethra I got one apparently good result which was, however, not permanent, and I have not been able to confirm it. Silver nitrate is undoubtedly the most efficient substance in chronic gonorrhœa, but is turned into silver chloride almost immediately it is applied, and its beneficial action was supposed to be due to its stimulating antiseptic action; but in view of the work of Bond it is reasonable to suppose that the insoluble particles of silver chloride are carried up the ducts and into the infected glands and inhibit the growth of the organisms. Acting on this hypothesis I am at present trying the effect of silver chloride powder applied through a urethroscope tube, and I hope to publish the results on another occasion. Meanwhile I hope that others with larger opportunities of treating these cases will investigate further on these lines.

The Oponic Theory of Wright of St. Mary's Hospital offers hope for some of these cases. Possibly the patient's powers of resistance to the organism can be raised by inoculation with a killed culture of the gonococcus. Wright has shown that massage of a joint affected with gonorrhœal rheumatism frequently increases the "protective substances" in the patient's blood for this organism, by causing an auto-inoculation of the patient's body. This possibly gives the explanation of the undoubted fact, that passing a large bougie sometimes cures a troublesome chronic gonorrhœa, for the bougie may cause an auto inoculation with gonococcus products. In treating these very chronic cases by inoculation I am sure it would also be necessary to isolate the other organisms usually present, and inoculate with the organisms which it is found the patient has least resisting powers to; this will possibly not always be the gonococcus.

Lastly, the question of complete cure must be considered. By cure freedom from infection is understood not freedom from symptoms. Although unfortunately amongst hospital out-patients, the latter is considered all that is necessary, they generally cease attending as

soon as this has been attained. To decide that a patient is free from infection is often difficult and may involve a great responsibility. The following, in brief, are the important points.

A week after all evidence of gonorrhoea has ceased, treatment should be stopped and all restrictions as to diet and alcohol removed. If the morning urine is then found to be clear and free from shreds, the patient is probably cured. A few days later the contents of the prostatic glands should be expressed, by massage per rectum; if the secretion contains no gonococci the patient may safely be considered cured. Many cases present greater difficulty; when the posterior urethra has been attacked the urine will be found to contain shreds day after day. When these consist of pus and epithelial cells, but contain no gonococci, the urethra should be irritated by an irrigation of the anterior urethra with one per cent. silver nitrate, or corrosive sublimate 1,5000. This will produce a discharge lasting from 8 to 36 hours. If no gonococci are found on three successive mornings after the irritation, the patient may be pronounced to be cured with reasonable certainty.

THE TREATMENT OF SCIATICA AND NEURALGIA BY SUBCUTANEOUS INJECTIONS OF SALT WATER.

By R. P. E. LAUNOIS,

Physician to the Hôpital Tenon, Professor of Medicine.

[REPORTED BY OUR FRENCH CORRESPONDENT.]

It was in 1889 that for the first time I had recourse to the subcutaneous injection of small quantities of artificial serum for the relief of sciatica, and since that time this therapeutical procedure, which was suggested to me by an article in a foreign periodical, has been in constant use at the Hôpital Tenon. This method, moreover, has for a long time been turned to account in the out-patient department of the hospital and the favourable results thereby obtained have been published in the thesis of one of my students. (a)

It is hardly necessary to point out that sciatica (neuralgia of the lumbo-sacral plexus) possesses an individuality of its own, so that it may fairly be treated as a morbid entity. In spite, however, of its autonomy it may assume very different characteristics, sometimes indeed it appears to involve all the branches of the nervous plexus, sometimes it is limited to the trunk of the nerve or its two principal divisions, the internal and external popliteal nerves, or it may affect only the terminal ramifications of the nerve. Moreover, and this is of very great importance, by remarking the nature and intensity of the disturbances to which it gives rise one may sub-divide the cases, as Landouzy does, into sciatic neuralgia and sciatic neuritis.

The therapeutical method which I am about to describe applies exclusively to the former of these two conditions, that is to say, cases in which pain and functional trouble predominate and in which there is no amyotrophic process. This, indeed, is the form most frequently met with as shown in many collected statistics, notably those brought together by Samuel Hyde (*Lancet*, May 9th, 1906). It occurs mostly in adults and is more frequent in men than in women. It seems to have a predilection for the right side. Lastly, sciatic neuralgia is very prone to recurrence, at long or short intervals.

Without dwelling on the symptomatic manifestations of sciatica it may be well to insist on the fact that the permanent pain is liable to be aggravated by paroxysmal exacerbations, involving the whole nerve or its branches, that it may elect domicile, so to speak, in particular spots, pressure on which determines more or less painful sensations. These spots, which correspond to the *points douloureux* localised by Valleix, possess some clinical importance; they are as follows—following the direction of the lumbro-sacral plexus we

have: the lumbar sacro-iliac, iliac, gluteal, ischiatic, retro-trochanteric, femoral, popliteal, patellar, peroneal, malleolar, dorsal of foot, and external plantar. The subcutaneous injections should be made just over such of these spots as correspond to the maximum of pain.

The operative *technique* is simple enough. The skin is sterilised by washing with soap in distilled water, followed by friction with a tampon of cotton wool steeped either in alcohol or in ether, pure or containing a suitable proportion of perchloride of mercury. The syringe must be sterilised and should have a capacity of 10 cc. The needle, which should be of irido-platinum in order to allow of its being heated, must not be of too large calibre or too long.

The liquid to be injected consists of sterilised water containing a certain proportion of chloride of sodium. To begin with, and for some time, we made use of what is commonly known as Hayem's physiological serum, which contains seven parts per thousand of chloride of sodium. Recently, however, we have modified its composition by the addition of sulphate of sodium according to the following formula:

Sodii chloride, 5 grammes.

Sodii sulphatis, 10 grammes.

Aquæ dest, 1,000 grammes.

The addition of the sulphate of sodium presents the advantage of doing away with the trifling pain that usually follows the injection of the solution of pure chloride.

The solution to be injected should be tepid or slightly warmed, and 5 cc. should be injected over each painful spot. The same patient may receive at the same sitting, without inconvenience, four, five, or six injections. The depth to which the needle is introduced will vary of course with the anatomical structure of the part and the situation of the nerve trunk. In some cases the injection is really hypodermic, while in others it is deeply interstitial, as for example in the gluteal region.

After the injection there remains a slight tumefaction over the spot which can be made to disappear at once, by gentle massage with the finger tips.

The method may be applied for several days following without hesitation, but in refractory cases it is well to repeat it only every other day.

We have naturally tried to explain to ourselves why the introduction of salt water into the tissues should be virtually painless, whereas the injection of pure water often gives rise to more or less disagreeable sensations. The outcome of modern research in biological chemistry appears to afford the desired explanation by enabling us to appreciate the importance of the isotonia of solutions employed for injection into the organism.

In his extremely interesting researches into the metamorphism of the nervous system, Constensou endeavoured to elucidate the mechanism of the action of revulsions applied over the points of maximum pain or along the track of the nerve. He points out that in order to bring about the subsidence of the painful crises which are characteristic of neuralgic affections we may act upon two important segments of the nervous metamera, the central and the peripheral segments. Substances introduced by the epidural method act upon the former, whereas it is on the latter that liquids act, especially those holding saline constituents in solution, when injected in the neighbourhood of nerve trunks or, still better, into contact with their peripheral terminations.

Many other forms of neuralgia can be relieved by this simple method such as facial neuralgia, intercostal neuralgia, lumbago, &c.

AFTER a squabble extending over six months, the Aberystwyth Guardians have agreed to increase the salary of Dr. Bonsall from £30 to £45, as house-surgeon. Left to their own resources, boycotted by the local medical men, and finding no sympathy from the Local Government Board, the guardians recently gave a committee power to appoint Dr. Bonsall at the advanced sum, provided all posts were amalgamated.

(a) Pierre Bernard. *Traitement des névralgies par les injections sous-cutanées de sérum artificiel*. Thèse de Paris, 1901.

INGUINAL HERNIA IN CHILDREN.*

By ROBT. CAMPBELL, M.B., M.CH.,
F.R.C.S. ENG.

THE author's paper was founded on an analysis of three hundred and five operations for the radical cure of hernia in children. He said that it was generally admitted that treatment by trusses was uncertain in its results, prolonged and irksome to the patient; whereas by operation a permanent and complete cure could be obtained within a fortnight. The great advantages of operative treatment being admitted, he said the question then arose, "At what age should the operation be performed?" He thought the only logical answer to this was, "As soon as the patient is presented for treatment, provided the general state of health be satisfactory." Some surgeons who had published articles recently on the subject had advocated treatment by trusses until the age of three or four years. He quoted statistics to show that 34 per cent. of his cases were operated on under six months; 44 per cent. under one year; and 77 per cent. under three years. He thought that the danger of sepsis in infants had been greatly exaggerated. Only two out of 305 cases had suppurated. He also called attention to the nature of the sac. In not more than 5 per cent. of the cases did it communicate with the tunica vaginalis testis. In other words, the common hernia of children was a hernia into a patent funicular process, which was, of course, as much entitled to be described as a congenital hernia as that in which the sac and tunica vaginalis were continuous. In referring to the contents of the sac he said that the frequency with which the cæcum and vermiform appendix descended in children was remarkable. He mentioned two cases in which the appendix was found adherent at its tip to the bottom of the sac; and another case in which a large Meckel's diverticulum was in the same condition. Strangulation was not frequent or acute in children. He had operated on sixteen cases, most of them were under one year of age, two being twenty-one and twenty-four days old. In one case the ovary and Fallopian tubes were found strangulated and gangrenous in the lower part of the sac, while the bladder and uterus were lying intact in the upper part. His experience of ovarian hernia had led to the following conclusions:—(1) That the operation in the abdominal wall is larger, rounder and nearer middle line than in intestinal herniæ; (2) that strangulation is due to twisting of the broad ligament, and not to constriction by neck of sac; (3) that the ovary involved tends to become enlarged and cystic; (4) that strangulation in these cases is common.

As regards after treatment, his usual plan is to remove stitches on fifth day, and paint wound with collodion; the patient, if under two years, is sent home on sixth day; if over two years, he is kept until ninth day. His own experience is that the operation is practically free from risk. The mortality should certainly not exceed 3 per cent. Radical cure of hernia in children might, therefore, as regards risk, be classified with many so-called minor operations.

* Abstract of paper read before the Society for the Study of Disease in Children, April 20th, 1906.

CLINICAL RECORDS.**REMOVAL OF A LARGE ADENO-CARCINOMATOUS TUMOUR FROM AN ELDERLY UNMARRIED PATIENT.***

By H. MACNAUGHTON-JONES, M.D.

IN this case a large adeno-carcinomatous tumour was removed from an unmarried patient, æt. 56, who had suffered for years from disorders of menstruation. The abdomen became greatly distended after a fall in December, 1905, and since then she suffered pain. A large quantity of ascitic fluid having been evacuated, two ovarian tumours of considerable size were found. The left was larger, more solid and multilocular, while the right was about the size of a small cocoon, the contents fluid, and its wall was thin. It had no appearance of malignancy. Subsequently, however, on careful examination of the wall the pathologist found that it contained spheroidal cells of the carcinomatous type. These tumours of an adeno-serous and adeno-mucin type were of considerable interest in regard to prognosis. Professor Hans Schroeder has written a monograph on the subject and shown, with Pfannenstiel and others, that those tumours in which the contents were serous were of a benign nature, whereas those containing mucin had a greater tendency to malignancy and to metastases. Schroeder had published a most interesting case verifying this conclusion, and other similar cases had been recorded. He showed, in this connection, a tumour which he had removed, in which the omentum was completely plastered over the surface of the tumour, so that he had to remove a large portion of it. At the time of operation there was little doubt in his mind that the tumour was malignant. There were some small metastatic deposits on the omentum, and on the pelvic ligaments, but the microscope did not reveal malignancy. The patient recovered from the operation, but subsequently suffering from uncontrollable vomiting, he re-opened the abdomen and removed some omental adhesions, after which she made an apparently good recovery. There was, however, a recurrence of growth, and she died within six months of the operation from metastatic growths.

There were other very interesting points connected with these cases in regard to a malignant growth appearing in the abdominal wound. In benign cases it would appear that the less the peritoneum was injured the better. In some instances the peritoneum so adhered to the surface of the cyst wall as to form a capsule for the tumour.

Professor Hans Schroeder's paper was one of considerable interest, and was well worthy of perusal. The differentiation of these various forms of adenoma in relation to transitional changes of a malignant character, was of the greatest interest and well worthy of further investigation.

SPINDLE-CELL SARCOMA OF LEFT OVARY.

By BOWREMAN JESSETT, F.R.C.S.,
Surgeon to Brompton Cancer Hospital, London, &c.

THE patient, A. H., æt. 50, was admitted into the Cancer Hospital for an abdominal tumour on March 5th, 1906.

She first noticed pain of a stabbing character in the hypogastric region, and soon after this found that her abdomen was getting larger. The pain increased in severity, especially during the last month, and the abdominal swelling had rapidly increased, and on admission caused shortness of breath on exertion. Micturition normal. Bowels constipated. Climacteric occurred six months ago. Prior to this menstruation was not excessive.

Objective Examination.—Abdomen prominent, especially in lower part. It feels tense and in hypogastric

* Specimen shown at the British Gynecological Society, April 9th 1906.

and left iliac regions a solid hard tumour can be felt on dipping hand into abdomen and displacing fluid in front of it. Side to side thrill was obtained. Percussion—Dulness in hypogastric and lower umbilical areas extending into left lumbar region. Above the umbilicus is intestinal resonance; also to the right of mid-line. No change occurs on rolling patient on her side. The fluid does therefore, not appear to be free in the abdomen. Liver not felt. By rectum tumour cannot be felt in pelvis. Vaginal examination not made.

Operation took place on March 20th, 1906.—Median Laparotomy—A large amount of dark, ascitic fluid escaped. Parietal and visceral peritoneum were found very congested and reddened. All the fluid was soaked up with sponges and then a solid left ovarian tumour of the size of a fetal head was drawn up out of the wound. The posterior part was necrotic, and it appeared as if a cystic portion might have ruptured and set up the peritonitis. The pedicle was found twisted at least twice. The broad ligament was pierced by a silk ligature, tied, and the tumour removed. The stump of the pedicle was then oversewn with fine catgut. The right ovary was found fibrous, but was not removed. No secondary deposits of growth were seen. The abdominal wound was sewn up in layers: (1) peritoneum, catgut; (2) aponeurosis and muscle, catgut; (3) skin and fascia, salmon gut and fine silk.

On March 30th the stitches were removed, leaving a healthy scar.

On April 2nd, 1906, patient vomited. Wound now well. Bowels not moved for two days. Colocynth and hyoscyamus pill ordered.

On April 3rd, patient well; bowels had been moved. On April 4th, scar perfect. Patient well.

Pathologist's Report.—The morbid changes are confined to the stroma, and show all the characters of a spindle-cell sarcoma. There are large areas of necroses and hæmorrhage, and the tissues show active growth.

THE OUT-PATIENTS' ROOM.

METROPOLITAN HOSPITAL, KINGSLAND ROAD.
SEROUS APOPLEXY.

By LEONARD WILLIAMS, M.D., M.R.C.P.

AMONG the out-patients was a woman about whose case Dr. Williams made the following remarks:—This woman, æt. 45, was an in-patient here four years ago, when she had both ovaries removed. She nevertheless continued to menstruate until last November. Since then she has had a great deal of trouble with the blushings and perspirations which so frequently afflict women at the menopause. She comes to us to-day because last week she had what she calls a fit. She has had similar attacks before, the first being about sixteen years ago, while she was pregnant. Since that time she has had about twelve, including last week's attack, the majority of which have been since her double ovariectomy four years ago. All the "fits" have been substantially of the same character. She does not lose consciousness completely, she does not bite her tongue or void her urine, and she is not convulsed. Each attack is, however, characterised by giddiness and nausea, by blindness on the right side, by pins and needles in the right half of the tongue, in the right arm and leg, and is accompanied by difficulty of speech. The duration is from ten minutes to a quarter of an hour, and every attack has been followed by a very severe headache.

Now, we have to consider what it is that gives rise to these fits or seizures. The problem is not by any means a simple one. We may, however, at once exclude any so-called functional, neurotic or hysterical element. Such an element is by no means rare in those who have had their ovaries interfered with, and in women at or about the menopause it is exceedingly common. It is only necessary to look at this woman and to hear her tell her story, to appreciate

the fact that she is not the stuff of which hysterics are made. She is a straight-forward, common-sensical hard-working woman who has always made light of her fits; and she tells us that she would not herself have troubled about the one which occurred last week, but her husband, who had never previously witnessed a seizure, was so alarmed at her condition during and after this one that he insisted upon her seeking advice. That she has never lost consciousness, bitten her tongue, or voided her urine in her fits enables us with some confidence to exclude epilepsy as their cause. Epilepsy, especially in the form of petit-mal, may of course occur without any of these features, but there is nothing in the concomitant symptoms to suggest its presence, so we may safely leave it out of consideration. Have, then, these attacks been due to apoplexy? Before answering such a question we must understand what we mean by apoplexy. Loosely, apoplexy is spoken of as any condition which may give rise to a hemiplegia or a hemiparesis. Now such conditions are recognised as three in number, namely, cerebral hæmorrhage, cerebral thrombosis and cerebral embolism. Of these three we may dismiss the first and third for the reason that it is practically impossible for her to have had twelve attacks of either without there being now some definite signs of their occurrence. For, as you have seen, the examination for physical signs in her nervous system has been entirely negative. She presents nothing of any kind which the most captious critic would venture to describe as abnormal. Moreover, against hæmorrhage we can urge the invariable retention of consciousness, and against embolism the complete absence of any cardiac difficulty. Can it, then, be thrombosis which is causing her attacks? We have only to think of her age—45 years—to look at her sturdy, well-nourished frame, and to satisfy ourselves of the vigour of her heart's action to answer such a question in the negative. The existence of any suspicion of syphilis might well give us pause in this matter, but there is no such suspicion, such evidence as is available being, indeed, all in the other direction.

Apoplexy, therefore, as the term is now commonly used is evidently not the cause of these attacks. But there is another kind of apoplexy, a kind which was much in the minds and frequently on the lips of our forefathers, but which a too exclusive attention to *post-mortem* findings has almost driven from our nomenclature. I mean serous apoplexy. That some such condition has a very real existence has been an article of faith with me for some time, and this patient presents a very good example of the operation of this factor. For serous apoplexy means the increase of pressure inside the cranium. It may not be a strictly correct term, but it is one which conveys with considerable force and sufficient accuracy, the idea that the inter-cranial vaso-motor action is disturbed or deranged, to the extent of causing or permitting undue pressure upon the important structures grouped in or about the internal capsule. I am not now prepared to dogmatise about the exact nature of this disturbance, but there is good ground for believing that it is associated with high blood pressure. We know that high blood pressure may cause an œdema or "serous apoplexy" in other parts, and there seems to be no reason why it should not produce an over-fulness of the cerebral ventricles. Why the effects of such an over-fulness should show themselves more on one side of the brain than on the other, it is not easy to say, but we may suppose, I presume, that the vessels on the left side, being those which supply the more active groups of cells, are probably larger, and that their dilatation or contraction would therefore produce a greater disturbance than alterations of calibre in the corresponding vessels on the other side.

The lesson, then, that we may learn from this woman's case seems to be this. There are undoubtedly a large number of people who come to us with very definite histories of hemiplegia; so definite and circumstantial that it is impossible to believe that there had been

any mistake about a correct diagnosis at the time of the occurrence of the symptoms. Nevertheless, when we come to examine these people for definite signs, we find no rigidity, no excess of knee jerk, no ankle clonus, and no extensor response. It is hardly conceivable that if the hemiplegia had been due to a hæmorrhage, causing destruction of brain substance, or to a thrombosis or an embolus, leading to softening of the brain substance, that there would not be some descending degeneration leading to definite physical signs.

It is a common experience with all of us to come across such cases, and the facts connected with this woman's seizures suggest to my mind very strongly that not only she, but various other people, who have attacks of hemiplegia or hemiparesis may be the subjects of "serous apoplexy," due to an increase of blood pressure within the cranium.

OPERATING THEATRES.

TOTTENHAM HOSPITAL.

CASE OF INTUSSUSCEPTION.—Mr. H. W. CARSON operated on a male child, æt. 3 months, who had been brought to the hospital with the following history:—The child had been in perfect health until three days before admission, when it was apparently seized with severe abdominal pain; vomiting occurred, but was not repeated; the boy continued in pain and on the day following the seizure passed a motion consisting chiefly of blood-stained mucus. On admission the child was seen to be well-nourished, but had a somewhat pinched expression, with sunken eyes. The abdomen was slightly distended and resistant to examination, so that no tumour could be felt. Rectal examination showed relaxed sphincter, and within an inch of the internal sphincter the apex of an intussusception could be plainly felt. Immediate operation was decided upon, and under the anæsthetic a long firm mass could be felt in the situation of the descending colon. The abdomen was opened, and the intussusception reduced by manipulation. The operation was completed in twelve minutes, in spite of some difficulty in starting the reduction owing to the position of the apex of the intussusception which was deep down in the pelvis, and in spite of some slight difficulty in reducing the last half inch. Mr. Carson said that it was now generally recognised that the best treatment for intussusception was immediate laparotomy, as attempts at reduction by hydrostatic pressure frequently failed, owing to the adhesions between the serous coats of the invaginating bowel as the result of local inflammation; these adhesions always occurred at the apex of the intussusception, and this, he pointed out, leads to the difficulty frequently found in reducing the last half inch. It was obvious, he thought, that if the abdomen were not opened the surgeon might easily imagine that reduction had been complete, seeing that the small portion of unreduced gut would not give rise to a palpable tumour. He pointed out that success in these operations depended on certain factors:—(1) *Duration of the intussusception*: the earlier a case of intussusception came under treatment the better the prognosis, other things being equal, as intestinal obstruction is very badly borne by infants; (2) *the condition of the intussuscepted gut*: with few exceptions, any condition requiring prolonged operative measures such as resection of gut was fatal to success; (3) *rapid operating*: this he considered was a most important point and in an uncomplicated case the operation from start to finish should certainly not take longer than a quarter of an hour, as babies are notoriously bad subjects for operation, owing to their

susceptibility to shock; (4) *skilful anæsthesisation*: upon this depends very largely the ability of the surgeon to complete the operation rapidly, as it is most important that there should be no rigidity of the abdominal wall, which would perhaps lead to protrusion of gut and consequent difficulty of manipulation. In discussing the details of the operation Mr. Carson pointed out that fortunately intestinal distension was not a marked feature in these cases, so that usually there was no difficulty in locating the intussusception after the abdomen had been opened. The most advanced part of the intussusception should be drawn into the wound if possible, as this rendered manipulation more easy. Reduction of the intussusception was brought about by pressure on the apex of the invaginated part which was thus pushed backwards; it was not wise, he said, to pull upon the intestine above the intussusception. Attention must be paid to the condition of the peritoneal coat in the ensheathing layer which may give way if there is much tension during reduction.

The child passed a motion containing blood soon after the operation; from that point recovery was uninterrupted, and the patient was sent out of the hospital in a fortnight.

FRENCH HOSPITAL AND DISPENSARY.

EXTENSIVE SYPHILITIC CONDYLOMATA.—Mr. DE MERIC operated on a girl, æt. 19, who had been admitted three weeks previously in a pitiable condition. The whole of the pubes, the external or muco-cutaneous parts of the labia majora, the contiguous portions of the thighs, the anal region and the internal surfaces of the buttocks were covered with condylomata; nearly all of the papulous tumours were exuding a thin discharge and many of them were conglomerated. A very foetid condition had thus been established, which had probably been much increased by the patient's neglect of herself. The girl could hardly walk, and every movement even in bed caused her very great pain. She was weakly and anæmic, the weakness being evidently the result of the constant irritation and pain set up by the disease. She had syphilitic teeth; but was well developed for her age. There was a nebulous history of syphilis having been contracted some three or four months previously. There was no sign of any secondary eruption, nor of "plaques muqueuses," in the mouth. The glands in the left groin were slightly enlarged. No loss of hair. For some days after admission the odour set up by the exudation from the diseased part was very disagreeable, but by means of constant hip baths containing a weak solution of carbolic acid, by keeping the parts dressed with black wash and occasionally with red wash and well dusted after the baths with a powder of iodoform and oxide of zinc the local condition was very much ameliorated, but the condylomata still remained in the same state, and, as far as could be ascertained by examination (which was rendered extremely difficult by the pain it caused), seemed inclined to spread, in spite, too, of anti-syphilitic internal treatment. It was therefore decided to endeavour to get rid of them by operation. The patient was anæsthetised and placed in the lithotomy position, an extra support being placed under the buttocks so as to raise them thoroughly. With scissors, knife and scraper Mr. de Méric removed the whole crop of condylomata, having literally to shave them off where he could not get at them with the scissors. They extended above the pubes on to the abdomen, the pudendal hairs having to be shaved during the operation as it was not possible to do so before. At the side of the right labium majus

in the fold of skin two extensive and deep ulcerations were found after removing the condylomata in this situation, the ulcers being about the size of a penny and a halfpenny respectively. To these Mr. de Méric applied nitrate of silver freely. The whole extensive raw surface was thickly powdered with oxide of zinc and iodoform, and dressings applied. Mr. de Méric said that he had never before seen a case in which condylomata had invaded such a large surface, the only one at all approaching it being that of a woman on whom his father, Victor de Méric, performed a similar operation many years ago. He pointed out that neglect and dirt were generally responsible for such severe cases. The two extensive ulcerations he had found were caused, he considered, by several of the condylomata becoming confluent, because, as the roots are on a level with the skin, these papular erosive syphilides do not extend into the derma, but grow outwards, but when several of them coalesce, a deep ulceration may result. He commented on the very little effect that ordinary anti-syphilitic treatment had on these growths. Neither mercury nor iodide of potassium seems to produce the slightest effect on them. On the other hand, when they have not much extended, they are easily amenable to external remedies, but in a case like the present one, and especially in a hospital patient, the only way was to perform the small operation he had just done. He said that as the raw surface was so great he did not feel justified in applying nitric acid as was always his custom when only a few condylomata have been removed.

Three weeks after operation the wounds had all healed up, the two ulcerations having granulated healthily; the girl can walk without pain; there is no scarring.

SPECIAL ARTICLE.

UNIVERSITY EDUCATION IN IRELAND.

FROM A CORRESPONDENT.

AN article from a correspondent of this journal (March 21st), interesting in itself, is, perhaps, more so as raising the question as to the interest Irish medical men take in university education. Judging by expression of opinion coming from them, it is apparently not very great, and for reasons, some on the surface and some to be looked for as truth at the bottom of a well. Only a small fraction of them hold Oxford, Cambridge or Dublin degrees, and, to speak the truth, the majority probably set only the value of social distinction on what they lack. They hold, and not without reason, that, apart from that adventitious value, they lose nothing, and perhaps gain something, by their studies having been pursued outside of the historical universities and their atmosphere.

The writer of the article referred to asks, What would be thought of an Archbishop of Canterbury if he had criticised the Oxford Medical School with the spirit and purpose of his Grace of Dublin in dealing with the Trinity College School. What would be thought by medical men would be, that he would do so under the impression that medical education should be controlled by ecclesiastics. And what informed medical men must know is, that Anglican ecclesiastics did actually aim at controlling such education, dictating what it should be in detail, and that such liberty of teaching there may be now is the result of a struggle by medical men against them, and particularly in Oxford. The spirit and purpose of his Grace of Dublin is exactly the spirit and purpose which medical men have had to meet more particularly as animating Oxford ecclesiastics and the university they had under their thumb.

In his evidence before a Royal Commission on

University Education, Bishop O'Dwyer is reported as saying that Huxley might teach biology all his life, but that if, under cover of teaching biology, he propagated among his students the opinions given in his Lay Sermons he should be stopped.

But Huxley was stopped, or a serious attempt made to stop him when he taught purely technical biology long before he was tempted or forced into the field of theological controversy. It was probably because of the attempt to stop him that he entered the alien field. He taught comparative anatomy, including embryology on the basis of the doctrine of evolution as a working hypothesis giving coherence to an otherwise incoherent and inexplicable mass of facts. It is matter of history that in doing so he found himself opposed by a body of public opinion sedulously fostered by university men, whose competence to criticise vertebrate morphology was vouched for in the public mind alone by the M.A.'s and D.D.'s appended to their names. He was far too good a teacher to drag irrelevant matter into a technical science, and he was far too good a logician not to know how to deal with irrelevant matter when he found it forced into his science with would-be deadly effect. As a logician he dealt with the intrusive matter, and by doing so, carried the war into the enemy's camp; it was, anyhow, the man's nature to do so. It was a case of necessity; sermons, tracts, ponderous tomes by the hundred were aimed at discrediting evolution not by criticism in the true sense, but by appeal to prescriptive ideas and traditional prejudices. It is idle to think that what is now understood as biology would have come into existence if what Huxley called ecclesiasticism had its way. That ecclesiasticism blocked the science as Huxley understood it, and all there was left him to do was to deal with what would not give his science the right to exist and develop on its own lines.

It is matter of regret that he wasted his abilities in going over what theologians themselves have gone over *ad nauseam*. If, however, there were not Huxleys to raid on due occasion on ecclesiastical property, the domain of science would be very small and singularly barren.

If now Prof. Gaskell and a dozen other anatomists are free to build up a concept of the genetic formation of the human body without ecclesiastical interference, Huxley and some others have to be thanked for it. The lesson, however, remains that the ecclesiastically-controlled universities trained and inspired the men who challenged Huxley on his own ground, only to be challenged by him on their ground. It is evident that the question is not of any particular type of Ecclesiasticism, Roman Catholic, Anglican, or Presbyterian. Darwin and Huxley were assailed from every point of the ecclesiastical compass by representatives of every denomination. That, of course, in an age of religious toleration could be passed over; what could not and cannot be passed over is that the sciences in which medical men are peculiarly interested should be asphyxiated in the atmosphere of Oxford ecclesiasticism in which Huxley found them. What medical man would submit to have views, however problematical, of pathology as depending on the assumption of functionless or vestigial cell-groups prohibited expression by ecclesiastics? If vertebrate morphology points, however obscurely, to a genetic evolution of the human body, are we to allow the line of inquiry to be discountenanced because disagreeable to the ecclesiastical mind?

It ought to be regarded as an open question whether there is any advantage gained by grouping schools of medicine, law and engineering together in a university. On the face of it, there is absurdity in a university practically devoted to giving lads a rather superficial knowledge of mathematics, Greek and Latin, and governed to that end, undertaking medical education. The thing places such education far too much under the control and influence of outsiders, and thereby leaves the door open for ecclesiastical interference. Medical education should be left in the hands of the

medical profession. If the public or the State claim an interest in it, the claim is not met by leaving it to the governing bodies, such as they are, of the universities. As so left, individuals like Huxley have had the task of saving its freedom, of really emancipating it from the influences dominating the universities, imposed on them, and have had to discharge it by means medical men have little sympathy with. Most of us would agree with Bishop O'Dwyer in saying that Huxley ought not to have attacked religious opinions under cover of teaching biology—that is, if he ever did

so. I believe, however, that the theological blizzard which blew so hard from Oxford justified his action as one of necessity, and that it was altogether direct.

Medical men are well inclined enough to keep within their own province, but their province must be secure to them. The better their knowledge of the historical teaching universities is the clearer, probably, it will appear to them that control of medical education by the profession requires not association with, but complete dissociation from, these institutions.

TRANSACTIONS OF SOCIETIES.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD THURSDAY, MAY 4TH, 1906.

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

MR. MACKENZIE DAVIDSON read a paper on RADIUM IN THE TREATMENT OF RODENT ULCER. He gave a short description of radium and its source, and then gave details of how he applied it, and the results he had obtained in the somewhat large number of cases which he had had under his care. As a rule, he found it unnecessary to apply the radium very frequently. In many cases cure had been effected with one or two applications with several weeks' interval between the applications. In other cases more frequent application was necessary. The radial activity of different specimens of radium varied, but it was possible by means of an electroscope to measure this. He preferred to use it when encased in a sealed glass tube, for the glass shut off some of the harmful rays which would burn the skin, and which were of no use for destroying the rodent cells. The power of radium was for practical purposes a fixed quantity in any one specimen, so that the dose given was known absolutely; in this way it differed considerably from the X-rays, which were not constant, but depended upon a variety of circumstances.

Mr. RANSOM PICKARD (Exeter) described a case of Implantation Cyst containing wood fibres. The patient was a girl *æt.* 14, and the tumour had been noticed for nine years. It was 3 mm. in diameter, and was situated below the pupil. The growth was removed, and its base was found to be composed of granulation tissue containing three wood fibres of coniferous origin. The tumour consisted of epithelial cells, and contained several cysts, some of which were formed by degeneration of the cells, and others by the formation of fissures. There was no history of injury to the eye; the cornea was quite normal; but in all probability the cornea had become perforated ten years ago by a fine splinter, for at that time she fell and struck her nose against a table.

Messrs. TREACHER COLLINS and JOHNSON TAYLOR (Norwich) described a case in which there was a cystic swelling occupying the position of the left eye, and apparently mainly formed by a bulging forward of the conjunctiva of the upper lid. It was present at birth, and had steadily increased since.

Mr. Johnson Taylor first saw the child when three weeks old. He then tapped the cyst with a fine trochar and canula; it refilled the following day. When next seen, about a year later, it had increased considerably in size in all dimensions, it stood out $2\frac{1}{2}$ inches from the orbital rim and gave a most unsightly appearance. Blood and discharge had also been exuding from it for two months. Under a general anæsthetic Mr. Johnson Taylor removed it entirely, and handed it over to Mr. Treacher Collins for examination.

The examination showed that the cyst was due to an enormous distention of the whole globe, the sclerotic forming its outer wall. The inner coat corresponded to the retina, but in no place did that portion, derived from the secondary optic vesicle, lie in contact with

that developed from the outer layer. The anterior portion of the cyst was lined by the former, and the posterior part by the latter. The cavity of the cyst was composed of a space between these two layers, the cavity of the primary optic vesicle.

The explanation of the formation of the cyst was apparently the imperfect involution of the primary optic vesicle which forms the secondary optic vesicle. There had been some attempt at involution both anteriorly and below. Anteriorly the inner wall of the cyst was prolonged backwards in a fold, at the bottom of which was a rudimentary lens, so that at one stage there must have been some downgrowth of surface epiblast. Below was a mass of a typically developed vitreous, and the expansion of the cyst below must have been checked by this upgrowth of mesoblast, hence the chief distention upwards into the upper eyelid. As the whole of that portion of the retina which normally forms the inner layers was in the anterior part of the cyst, it is not surprising that no optic nerve was developed. The lens showed a defect in its posterior capsule, and through this gap mesoblastic tissue had extended forwards, and become mixed with the lens fibres. A nodule of hyaline cartilage was found in the sclerotic at the posterior part of the specimen.

THE SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD APRIL 20TH, 1906.

Dr. J. PORTER PARKINSON in the Chair.

MR. W. MILNER BURGESS showed a case of "Psoriasis Guttata" in a healthy-looking boy, *æt.* 6 $\frac{1}{2}$. The spots commenced when the child was *æt.* 5, few in number at first; they are best marked on the chest, abdomen, anterior, and inner surface of the thighs and back.

Dr. CAUTLEY exhibited a case of "Atelectasis" of both upper lobes. Female, *æt.* 31 days, born in full time. No history of cyanosis at birth or attacks of lividity. Cough for two weeks. Weight, 6lbs. 12 ozs. Temperature a little irregular. The note is impaired over both upper lobes and the air entry is very feeble. Good resonance over the rest of the lungs. Occasionally goes very blue, chiefly after coughing.

Dr. CAUTLEY exhibited a case of "Hæmatemesis and Melaena" due to gastric ulcer. A girl, *æt.* 5. Quite well until March 17th. She then vomited about a pint of dark clotted blood and shortly afterwards passed a tarry stool. Next day she again vomited blood, about half a pint, brighter in colour, containing clots. Next day passed a black stool. No history of pain after food. Anæmic on admission. Spleen and liver a little enlarged. Uninterrupted recovery. Gain of 28 ozs. in last two weeks. Blood count.—Red cells 3,512,000; white cells, 28,250 of which 63 per cent. were polymorphonuclear leucocytes.

Dr. CAUTLEY exhibited a case of "Sarcoma of the Lung." Male, *æt.* 10. Early in January had an attack of (?) pneumonia of right lower lobe. Ailing since. February 12th—Physical signs of pleurisy at

right base. February 16th.—The screen showed a horizontal shadow on the right side and no movement of the right half of the diaphragm. February 23rd.—Explored under an anæsthetic, but no pus found. March 6th.—Breath sounds feeble and note still impaired at right base. March 16th.—Has gained about 4lbs. in weight. Still dulness, deficient air entry, and diminished vocal vibrations over right lower lobe. Signs of a cavity subjacent to right nipple. March 23rd.—More extensive signs of breaking down of the lung, but no expectoration; very deficient movement and air entry. March 31st.—Signs of a large cavity over right lower lobe behind. April 17th.—The signs of excavation have cleared up; dulness is more extensive and extends on to the sternum; breath sounds are weak from the third to the fifth rib, and almost absent below that in front. Dulness, feeble breath sounds, feeble bronchial breathing, and bronchophony. For about ten days he has had some vomiting, cough, and slight hæmoptysis. The heart does not appear much displaced. Practically free from fever for seven weeks.

Dr. BEATTY (Belfast) read notes of a case of "Chloroma," in a young child for Dr. McCaw (Belfast). F. J. K., æt. 18 months, was admitted to Belfast Hospital for Sick Children on October 30th, 1905, with a history of having been ill for three weeks. *On admission.*—Child seems well developed and well nourished. Is markedly anæmic, and has a peculiar froglike appearance due to proptosis and to swelling and echymosis of eyelids, and also to swellings about the size of a tangerine orange in each temporal fossa. The proptosis and swelling are greater on the right side than on the left. The swellings are hard, dark-coloured, and give no evidence of fluid contents. A tumour the size of an egg is situated over the upper part of the sternum, similar to those in the temporal fossa. The glands in the groin are swollen, hard, and black coloured, but not tender. The axillary glands are slightly enlarged. The lower end of the left femur is swollen and very tender at movement. The gums are not healthy, but not swollen or spongy. The heart and lungs are healthy, no enlargement of the liver and spleen is present. The urine is normal and the bowels are open. The temperature is 99.4° F. *Progress.*—The child got gradually worse and died three days later. No *post-mortem* examination could be obtained. *Blood examination* by Dr. Beatty.—Red, 1,150,000 per c.m.; whites, 16,000 per c.m.; H.C., 34 per cent. *Differential Count.*—P.M.M.'s, 28.8; S.L., 59; L.L., 8.6; T. L., 1.2; Myelocytes, 2.6; eosinophiles, 0; normoblast equalled 5.4; megaloblasts, 0.6. Marked variation in size of red cells, varying from 5u—11u. Two-fifths were over the average size, and some were undoubtedly megalocytes. Many of the normoblasts were in mitotic division.

Mr. ROBERT CAMPBELL (Belfast) read a paper on "Inguinal Hernia in Children, Giving an Analysis of 305 operations for Radical Cure." An abstract of this paper will be found on page 498.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, APRIL 26TH, 1906.

The President, FRANK T. PAUL, F.R.C.S., in the Chair.

Dr. J. LLOYD ROBERTS read a note on "Ankylostomiasis," based upon the case of an English sailor, recently under his care at the Royal Southern Hospital. He described the parasite which was the cause of the disease, the mode of infection, the symptoms, the blood changes and the treatment. He also showed specimens of the adult worms, and lantern slides of the worms and of fæces containing ova.

UNUSUAL CASES OF GALLSTONES.

Mr. RUSHTON PARKER related two very different cases of gallstones. (1) A woman, æt. 45, suffered from pain, vomiting and dyspeptic symptoms, suggestive of gastric ulcer. An exploration made in the middle line of the epigastrium revealed adhesions between the pylorus and the liver; when these were

freed a gallstone was felt in the gall-bladder. The stone, of the size of a small marble, was removed and the gall-bladder sewn up at once. The patient went home in a few weeks apparently cured. The patient returned saying that the immunity from symptoms had only lasted two months. On March 8th, 1906, Mr. Parker opened the original scar again, and extended the wound downwards to give easy access to the biliary passages. A stone in the gall-bladder was removed, the cystic duct tied and cut and the gall-bladder removed. Another stone was found impacted in its neck. The patient made a complete recovery in five weeks. (2) A stout and apparently vigorous woman æt. 71, was admitted on December 30th, 1905, with symptoms of intestinal obstruction of three days' duration. Three similar attacks in two years had yielded to copious enemata which brought away large faecal accumulations. Jaundice was set up in each attack after twenty-four hours. A small slack umbilical hernia was apparently not involved in the symptoms. The abdomen was opened through the hernia by a transverse incision. General peritonitis with adhesive yellow lymph and inflammatory thickening of several feet of the small intestine. A hard object felt in the gut one foot above the ileo-cæcal valve was found on removal through an incision to be a gall-stone 1½ inches long and ½ inch thick. The intestinal incision was sewn up and the abdomen closed. The patient died three hours later. At the necropsy the liver was found enlarged and fatty, the gall-bladder exceedingly small but filled with a second calculus less than half the size of the one that had escaped. A perforation in the gall-bladder led to a space under the liver and thence into the duodenum. This suppurating space was shut off from the peritoneum and did not account for the peritonitis. The latter more probably resulted from transudation of septic intestinal contents during the impaction of the larger calculus in various parts of the small intestine. The state of the patient's viscera, her age, and the duration of the disease together completed the hazard of the situation.

THE AFTER TREATMENT OF HERNIA IN CHILDREN.

Mr. R. C. DUN read a note on "The After Treatment of Cases of Radical Cure of Hernia in Infants and Young Children." The growing tendency to adopt early operative measures was commented on, and a comparison drawn between the results of operative treatment and those obtained by the use of trusses. The chief points in favour of early operation were the certainty of cure and the short duration of treatment. Many children apparently cured by trusses subsequently developed hernias in later life, and these recurrent ruptures were apt to be looked upon as acquired. The strongest evidence existed that the majority of cases of inguinal hernia occurring in adult life were of congenital origin. The simplicity and safety of operations for the cure of hernia in infants and young children were explained. Stress was laid upon the importance of obtaining primary union of the wound. The supposed difficulty of preventing contamination by the evacuations in children too young to have obtained control had up to the present stood in the way of a more universal recourse to early operation. The open method of after treatment devised and published by Stiles of Edinburgh had, after 15 months' trial, given thoroughly satisfactory results in Mr. Dun's hands. This method was described in detail. Its simplicity and the certainty with which it prevented soiling of the wound rendered it the best form of after treatment.

Mr. R. W. MURRAY read a paper on the ETIOLOGY AND TREATMENT OF OBLIQUE INGUINAL HERNIA.

He said that although the presence of an inguinal hernia must be due to some weakness of the structures through which the abdominal contents escape, the question yet to be answered was, "What are the chief factors which cause this weakness and so determine the descent of the bowel?" He did not agree with the generally accepted division of inguinal hernia into

Congenital and Acquired, and after pointing out the marked difference between a typically congenital and a typically acquired hernia said that the sac of an ordinary inguinal hernia at all periods of life closely resembled the former and bore little or no resemblance to the latter. He maintained that the main factors in the causation of oblique inguinal hernia at all ages were firstly the presence of a congenital or preformed sac and secondly want of strength in the muscles guarding the internal abdominal ring. Evidence derived from a study of comparative surgery, *post-mortem* observations and clinical experience were adduced in favour of this belief. As to treatment, Mr. Murray said the cure obtained by means of a truss must always be uncertain, for he did not believe that the funicular process ever became completely obliterated by this method. He strongly advocated operation during infancy, when a permanent cure could be assured. In operating he usually adopted the same method irrespective of the age of the patient. The essential points of the operation were that the inguinal canal was opened up and the sac excised after applying a ligature to it at the level of the internal abdominal ring. The divided aponeurosis of the external oblique was united by overlapping. In exceptionally large herniæ in adults he had obtained satisfactory results by inserting a rubber pad which rested on the Transversalis fasciæ beneath the internal oblique and Poupart's ligament. A hole in the pad transmitted the spermatic vessels and the cord.

The PRESIDENT thought the statement that all inguinal herniæ were due to the presence of a congenital sac was too sweeping.

Mr. RUSHTON PARKER thought that the terms congenital, infantile, and acquired should be abolished. He had advocated the early operation in infants more than eleven years ago. The sac should be obliterated but there was no need to remove it and there was no need to close the inguinal canal in children. He considered that the length of the mesentery was an important factor in the Etiology of hernia.

Mr. K. W. MONSARRAT said that Mr. Murray had added considerably to the already strong evidence in favour of the view that in the great majority of cases, at any rate, hernial protrusions took place into preformed sacs of congenital origin. He thought that all the evidence pointed to the importance of dealing in the most thorough manner with the sac in all operations, and to do this he considered that it was necessary to slit the external oblique from the external ring upwards to a greater or less extent in all cases. Bassini's operation had given excellent results in the hands of many surgeons; he thought its chief merit was the perfect access it gave to the neck of the sac. There was no doubt that in a considerable proportion of cases there was defective origin of the internal oblique from Poupart's ligament, a defect which had to be remedied by suture. Mr. Monsarrat left the cord undisturbed and sutured the internal oblique to Poupart's ligament in front of it and not behind it, considering that it was a mistake to bring the cord through the muscular layer immediately superficial to the internal ring. The recurrences that took place after Bassini's operation did so at this point—a fact which supported the view that the weak point in the several layers of the wound should not be super-imposed.

Mr. G. P. NEWBOLT considered that though the majority of cases of oblique inguinal hernia had a congenital origin yet there were undoubtedly cases in which the condition was acquired. The radical operation in infancy was practically always successful, but the mortality was a factor to be considered and was higher than that in adults.

Mr. DOUGLAS-CRAWFORD agreed with Mr. Murray that all oblique inguinal herniæ were probably due to persistence of a funicular process, this view being supported by four cases of hernia occurring in boys about æt. 17; the first appearance being associated

with strangulation, and at operation each was found to possess a patent processus vaginalis with an extremely narrow neck about one inch in length, which had produced the strangulation. He used a simple colodion protection in children, instead of a heavy dressing and spica bandage, which being difficult to keep dry increased the risk of suppuration.

Mr. G. G. Hamilton, Mr. Damer Harrison, and Mr. T. C. Littler Jones also took part in the discussion on Mr. R. C. Dun's note and Mr. R. W. Murray's paper.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

CLINICAL MEETING HELD AT MANCHESTER, APRIL 27TH, 1906.

MR. R. FAVELL (Sheffield), President, in the Chair.

DR. J. T. GEMMELL (Liverpool) showed—(1) A fibroma of the labium majus, as large as an orange, which had considerable diffuse extensions into the buttock and towards the inguinal ring. (2) A large cervical fibroid, whose central portion was undergoing degeneration closely simulating sarcomatous change. It was removed by enucleation by the abdominal route. An opening was then made into the vagina, and the bed of the tumour was packed with gauze. The peritoneum was then closed, the gauze being subsequently withdrawn per vaginam. (3) A fibroma of the ovary weighing 4 lbs., removed from a patient, æt. 47, who had had seven children and who menstruated regularly. The abdomen contained some ascitic fluid.

DR. LLOYD ROBERTS (Manchester) showed the uterus with the bladder, ureters, and kidneys, from a patient who died of cystitis and necrosis of the bladder wall, with rupture into the utero-vesical pouch. She was admitted when five months pregnant with a retroverted uterus. There had been dribbling for five days, and 8 ozs. of urine were withdrawn by catheter. The bladder was kept empty subsequently, but the patient died five days later, soon after rupture of the bladder was diagnosed.

DR. BLAIR BELL (Liverpool) showed light and useful retractors for pelvic surgery, the blades being of stiff wire and having large fenestræ.

DRS. H. BRIGGS and J. H. WILLETT described two cases of fibromyoma, in which operation was required for symptoms due to the spontaneous extrusion of fibroids into the uterine cavity. In each case the endometrium was found to be the seat of adenocarcinoma.

DR. A. STOKES (Liverpool) mentioned a case of Cæsarean section for contracted pelvis, in which the pulse suddenly rose to 160 at the end of the operation. The same evening the temperature was 103 and the pulse 140. No cause for these manifestations could be discovered, and the patient's condition became quite normal during the next six days.

DR. W. WALTER (Manchester) showed a specimen of pyosalpinx with removal of an adherent appendix. The use was complicated by a tubo-ovarian and pelvic abscess. Microscopic sections of tube and appendix were shown. The appendix was thickened and measured half an inch in diameter. The microscopic appearance showed the mucous membrane was not involved, the muscular coat was thickened, and signs of inflammation, especially in its outer layers, were evident. The chief change in the appendix was due to a deposit of new-formed tissue outside the muscular coat, which was very vascular and resembled granulation tissue. Dr. Walter thought that removal of the appendix in cases of inflammation of the appendages on the right side was occasionally necessary, but believed in the majority of cases the appendicitis was secondary to the salpingitis, and that unless the appendicitis was well marked the appendix need not be removed simply on account of slight adhesions that could be readily separated.

THERAPEUTICAL SOCIETY.

MEETING HELD IN THE APOTHECARIES' HALL (Blackfriars), TUESDAY, APRIL 24TH, 1906.
SIR LAUDER BRUNTON, BART., M.D., F.R.S., in the Chair.

DR. JAMES BURNET, of Edinburgh, read a paper on the

THERAPEUTIC ACTION OF THE IODIDES, showing that they are alteratives, which influence metabolism and secretion. They have long been used against syphilis and scrofula, and more recently for gout, rheumatism, aneurism, and arterio-sclerosis. They were formerly supposed to act by dilating the arterioles and diminishing the blood pressure but they have no effect on the blood pressure or pulse, though they promote the coagulation of the blood. The author has found iodipin, that is iodine with sesame oil, most effectual when injected under the skin, as it does not cause any gastric disturbance, and the iodine is slowly set free by oxidation. It relieves arterio-sclerosis by diminishing the uric acid dissolved in the blood, and thus relaxing arterioles, and relieves aneurism if syphilitic by removing pathological effusion and counteracting the poison. In angina pectoris it must be given in large doses—60 grains daily for months.

He considered it decidedly most useful in chronic pulmonary diseases, especially fibrosis and emphysema, relieving dyspnoea and liquefying the bronchial secretion, and it is best given in doses of 15 grains at bed-time. In bronchial asthma doses of 10 grains every two hours are very useful, either by relieving spasm or freeing the blood from uric acid. In syphilis it is most useful from its antitoxic powers and its eliminative action, particularly in affections of the nervous system and headache. In locomotor ataxy 120 grains have been given daily with the best effect. It has also been used in cases of intermittent fever, puerperal fever, and erysipelas with success. In chronic rheumatism, neuralgia, lumbago, and sciatica potassium iodide is often useful, probably by diminishing the uric acid dissolved in the blood. It is best combined with salicylic acid which eliminates this acid. In cases of effusion, especially from interstitial nephritis or cirrhosis iodides are often of service. In lead or mercurial poisoning they remove the metal from the tissues. In simple goitre they are of great service, if used early, but not in exophthalmic goitre. The iodide of sodium is less depressing than that of potassium, while iodipin, given by the mouth or hypodermically, should be kept in mind as a useful substitute for the iodide of potassium.

CENTRAL BOARD OF MIDWIVES.

MEETING HELD MAY 3RD, 1906.

The President, Dr. CHAMPNEYS, in the Chair.

MIDWIVES' QUALIFICATIONS.

A LETTER was read from the Privy Council, asking if the question of the Irish Maternity Hospitals could not be settled by altering Rule D2, which says:— . . . "must have nursed 20 lying-in women during the ten days following labour" to eight days.

DR. PARKER YOUNG said he would like to have all the hospitals reduced to eight days instead of ten, but

The PRESIDENT reminded him that the midwives were ignorant enough without having their practical work shortened. He added that the concession made to the Irish Maternity should not in any sense include all the Irish hospitals.

It was finally arranged to accede to the request of the Privy Council by adding the words:—"Except in specific cases where the less period has been sanctioned by the Board."

The PRESIDENT gave notice of an intention to send to the Privy Council, asking for liberty to restrict midwives putting anything save "certified midwife" after their names. Some of them wrote L.O.S. and C.M.B. and one of such had sent him a letter adding

"artificial feeding and delicate children a speciality." It was bad enough when doctors had a crowd of letters after their name, but for ignorant women it was simply absurd and misleading.

DR. PARKER YOUNG and all present agreed to the proposal, which was accordingly entered on the minutes.

The Clerk of the Privy Council also wrote asking that the injunctions on midwives to send for a doctor be made more stringent by substituting in Rule E 18, for "she must advise that the attendance of a registered medical practitioner is required," the words "she must advise that a registered medical practitioner be sent for."

This was accordingly done, and Rule F 2, deleted in accordance with an intimation that no power of suspension of midwives is in terms conferred upon the Board, the only mention of suspension in the Act being in Section 8 (3) which confers that power upon Local Supervising Authorities.

CORRESPONDENCE.**FROM OUR SPECIAL CORRESPONDENTS
ABROAD.
FRANCE.**

Paris, May 6th, 1906.]

EXTRACTION OF FOREIGN BODIES FROM THE EAR.

THERE is hardly a practitioner of some years' standing who has not met, one time or another, with cases of a foreign body penetrating into the ear. The patient is generally a child and the foreign body a bead, pebble, pea, haricot, etc. Attempts have already been made by the patient or the parents to extract the offending body, but have failed. At first sight the case appears simple, but successful extraction is a really delicate operation. An inexperienced practitioner should learn first what not to do; it is a safeguard against complications. When the operator, with a laudable desire, introduces blindly, without the aid of a mirror, instruments into the ear, he risks penetrating into an ear containing no foreign body, and wounding it by his manoeuvres; entering an empty ear, that is to say, from which the foreign body has been already removed; pushing the foreign body farther in. Frequently, by reason of the smooth surface of the object, the forceps cannot take a good hold on it; it slips and sinks more deeply into the canal. After another and more violent attempt at extraction, the foreign body becomes impacted. A series of accidents becomes possible: retention of purulent matter, if it previously existed (suppuration of the middle ear), traumatism of the auditory canal with consecutive lymphangitis, etc., penetrating wound in the tympanum, fracture of the small bones, facial paralysis.

The chief danger, says M. Laurens, is in the retention of pus and the cerebral or mastoid complications which might result. In one case of Dr. Consteau the labyrinth had to be trephined in a patient in whom a practitioner, in his efforts to extract a pebble from the ear, broke his curette. The first indication is to ascertain by means of the otoscope the presence of a foreign body, as well as its *nature*, for it might be animate or inanimate. In the former case the insect (larvæ, mosquitoes, flies, etc.) must be first killed by instilling glycerine or oil into the canal so as to prevent it from holding on to the walls.

(b). Its *consistence*.—If it is a soft body (haricot, pea) which has become swelled. In this case retraction is obtained by instilling proof spirit for a day or two before proceeding to its extraction.

(c). The situation it occupies in the canal.

(d). The condition of the walls of the canal. Frequently, and by reason of attempts at extraction, there exists considerable inflammation, the parts are red, inflamed, and ulcerated. In such a case, and if there exists no reason for immediate interference, the operator should wait until the inflammation has subsided.

Extraction.—No matter what may be the nature, consistence, situation, or form of foreign bodies in the

ear, the mode of procedure is the same, viz., injections first, instruments afterwards.

In the immense majority of cases, injections made with a large syringe, repeated three or four times and for several days, are sufficient. The liquid used should be warm water that has been boiled. The jet should be directed as much as possible between the wall of the canal and the foreign body. The liquid insinuates itself between these points, and passing behind pushes the object from within outwards. A quart or more of liquid should be used, and frequently, if the body is not impacted, it is expelled at the first sitting. Otherwise the injections are repeated the following day, and for several days if necessary. Success will eventually crown the efforts made.

Where the body is impacted, proof spirit should be instilled, to retract the walls of the canal, several times a day, and for several days, and finally the injection should be renewed. However, if, after a fair and patient trial of this simple treatment, no ground has been gained the removal of the foreign body must be effected by the aid of instruments. A description of this mode of extraction is found in every work on otology and need not be mentioned here.

PROLAPSUS OF THE RECTUM IN CHILDREN.

Prolapsus of the rectum in children, similar to hernia, only needs to be maintained after reduction for some time until the patient grows stronger.

Nevertheless, the affection is very serious; the patient suffers in his general condition, and the parents are weary of having to reduce it at every moment.

Various are the methods proposed against the affection, but one of the best seems to be that practised by Dr. Roux, of Lausanne; it consists in injecting into the ano-rectal sub-mucous membrane three or four syringes (hypodermic) of proof spirit. The inflammation set up produces proliferation of the cellular tissue, prevents sliding, and cures the prolapsus.

GERMANY.

Berlin, May 6th, 1906.

At the 35th meeting of the German Society for Surgery, the papers on "Military Surgery" occupied a prominent position. After one on "First Aid" by Hr. Zoega von Manteuffel, and one on "Fitness for Service after Wounds with Modern Firearms," by Hr. Schaefer, Hr. Goldammer related his experience in the

DRY TREATMENT OF WOUNDS

in the South-West African War. The care and transport of the wounded was very difficult. The field lazarettos in that dry and arid land could only be established where there was a plentiful supply of water, and the troops might be frequently days' marches from it. The search for the wounded and their removal by the lazaretto officials was not possible; this must be done by the soldiers themselves, who must search them out and send them off on the provision wagons. In this way weeks might elapse before the injured could get into hospital and change their clothes. First aid must therefore be limited to what was most necessary. An absolutely dry treatment was the only means by which a moderate success had been achieved. A first dressing could only be applied *lega artis* when strict asepsis was possible, otherwise only a protection in the form of iodoform gauze and fixing it on with adhesive plaster was allowable. The wound itself should not be explored. The minimal bleeding in consequence of small entrance and exit wounds admitted of this. Later, when the pads had dried, a bandage could be put on, and in the case of fractures a simple splint could be applied. Everything then remained untouched until a thoroughly suitable dressing could be put on. In this first needful dressing there could be no question of even the most elementary disinfection, frequently even the hands could not be cleansed through absence of water, and the dressing must be applied just as it was taken out of the pocket. Rubbing the hands with raw spirit of soap was useless, as with crawling about the hands only got the dirtier for it. Every bony injury must be fixed up simply and

as quickly as possible, either with splints or plaster of Paris. The good results obtained in fracture were due to this speedy fixing up. Fractures of the thigh healed up as quickly as subcutaneous fractures. Infection was generally absent in consequence of the early dressing, and the refraining from interference with the wound itself. In 103 gunshot injuries, with 30 fractures of bone, healing by first intention took place in 87 cases. In 13 suppuration took place, but 7 of these were not brought under treatment at once; 4 died, and 58 became fit for service again.

Hr. Bornhaupt spoke on

WOUNDS OF JOINTS.

He saw 2,265 cases of injury in the Red Cross Lazaretto. They were not recent injuries, as the transport of the wounded with their first aid dressings applied had lasted six days. Of the wounds, 157, or 7 per cent., were joint injuries. As regarded the joints implicated, there were 87 of the knee, 32 of the elbow-joint, 19 of the shoulder-joint, 10 of the ankle-joint, 6 of the hip, and 5 of the wrist. In 108 cases the wound was caused by "mantle" bullets, 39 by shrapnel shots, and in 10 by grenades. The projectile remained in the wound in 14 per cent. of the bullet cases, and in 69 per cent. of the shrapnel wounds. Suppuration very rarely followed a perforating bullet wound, a little more frequently a perforating shrapnel wound, but it took place in 50 per cent. of the cases in which the projectile was in the wound.

Thirty-seven of the cases were operated on. The operations on the knee-joint were 4 resections with 1 death, 6 arthrotomies with 1 death, 7 amputations with 3 deaths. From the speaker's experience he was in favour of conservative treatment.

Hr. Brentano spoke on

GUNSHOT WOUNDS OF BLOOD VESSELS.

Eight cases were seen in the Charbin Lazaretto. The wounds had one thing in common—the skin wound was already healed or nearly so when the patients were received into hospital. Of the eight cases, 7 were operated on. The eighth case was one of wound of the aorta that was discovered accidentally at the *post mortem* examination. The patient had survived the injury 70 days, and died in consequence of subsequent hæmorrhage, which, as far as could be ascertained, did not come from the aorta but from the liver (preparation shown). In the other cases the wound was opened up and the vessel resected after ligature above and below. The injury was a grazing one in 4 cases, and in 3 was a perforation. He considered the perforation wound to be less favourable as regarded spontaneous healing than the grazing injury, as in 2 of the latter cases the wound was found closed six days after the receipt of the wound. The closure had been brought about by the adjoining nerves and fasciæ along with the injured vessels being bound into a whole by plastic exudation. That the artery must have been injured in these cases was proved first by the direction of the wound, and, secondly, by enteric absence or weakening of the pulse on that side. Then there was the striking hardness of the wound track and disturbance in the region of the nerves affected. Operation was performed when it was feared that an aneurysm might form later on at the seat of injury, as was observed in the Boer War. In 3 cases so-called false aneurysms formed which were operated on eight, eleven, and fourteen days respectively after reception of injury.

A wound of the external iliac artery which had missed the accompanying vein had led to an aneurysm the size of an egg. This was extirpated 83 days after the injury was received, the vein being left.

An arterio-venous aneurysm caused by simultaneous perforation of the femoral artery and vein in Scarpa's triangle was resected nineteen days after the injury. (The preparations from six of the cases operated on were shown.)

DR. ABERCROMBIE, having resigned the Curatorship of the Museum of the Royal College of Physicians, London, Dr. W. H. Allchin, consulting physician to Westminster Hospital, has been elected to the post.

AUSTRIA.

Vienna, May 6th, 1906.

PROTAGON.

At the Gesellschaft, Stoerk gave the members a history of Liebreich's discovery in 1865 of an element which he isolated from the brain substance. Of its history we hear nothing until 1897, when Schmidt and Müller drew attention to the similarity between this and Virchow's myelin drops, which he obtained from sputa. Kayserling and Orgler about the same time obtained from the supra-renal bodies a pathological substance which they term "myelinogene necrobioso." More recently Löhlein has demonstrated that protagon is a pathological product of the kidney also, and met with in the cortical substance of the organ with a double refractive power. It is found in greatest quantity in nephritis, particularly in that form known as hæmatogenous nephritis, probably having an arterio-sclerotic or amyloid basis. The substance appears as a crystalline in small particles in the canaliculi with the epithelial of the protoplasm and easily detected by polarised light and its tinctorial property. It is somewhat difficult to differentiate protagon from fat by the osmium darkening in alcohol, but can be more readily detected after freezing and washing with alcohol. In the hardened preparation small holes will be observed resembling fine drops of fat cells that have been washed out. In the course of nephritic changes these granules extend from the canaliculi into the inter-cellular tissue where the foreign groups finally assume a white mass with stellate margins. In the tuberi contorti these white specks may be seen in the cortex of the organ. This substance when found in the kidney is a pathognomonic symptom of nephritis, and may be of practical use when found in the urine. It is absent in fatty degeneration of the kidney, diabetes and chronic cachexia. The urinary sediment when polarised with the assistance of the microscope and the tinctorial reaction is sufficient to distinguish the presence of protagon. It is also present in atheroma of the vessels, as white patches on the altered intima as well as different tumours such as adenoma xanthoma, tuberosum, and the flat epithelial cells or cylindrical in cancer. It is worthy to note that the crystalin form never appears in the latter cases, but the proportion of nitrogen and phosphorus is the same in nephritis as met with in the brain, but, strange to say, the refractive power of the same substance in the kidney differs from that met with in the brain and analytically acts more like an ester of cholesterol.

AMAUROSIS AFTER PARAFFIN INJECTIONS.

Mintz records two cases of blindness which he attributes to the plastic injections of paraffin, into the nose to relieve a saddle-back appearance of the organ. He pointed to a third case which he feared would end with the same disaster. He thought it the duty of every practitioner to warn the patient against any such risk.

PROSTATIC HYPERTROPHY.

Lichtenstern showed a patient on whom he had operated seven years ago by removing the prostate gland. He was now perfectly able to micturate naturally and with ease, which he considered justified prostaticectomy.

HUNGARY.

Budapest, May 6th, 1906.

At a recent meeting of the Royal Hungarian Medical Society, Professor Dr. Tuszkaï Odön of Marienbad read a paper on the

EMPLOYMENT OF HEROIN IN GYNÆCOLOGY.

According to the statistics of the last three years, 375 patients out of 10,101 (3.87 per cent.), in the out-patient department, suffered from carcinoma. Among these only 105 (11 per cent.) were considered suitable for operation of any kind, and in only seventeen cases was total removal indicated. The other patients, who wander from one hospital to another, consult the

surgeon chiefly in order to obtain alleviation of their painful symptoms. The pain associated with cancerous affections of the womb soon defies the drugs in general use, and therefore I decided to administer heroinum hydrochloricum recommended by Dreser, Gerhardt, and others. Compresses soaked in a 1 per cent. glycerine solution of heroin were used in twenty hospital cases. In half the cases the pain was due to peritoneal irritation; in the other half to inoperable uterine cancer.

In cases of ascending gonorrhœal perimetritis, as well as in cases of diseases of the adnexa, I succeeded in diminishing the pain. In one case of inoperable cancer, I obtained a remarkably satisfactory result. Heroin proved useless in cases in which the cancerous degeneration involved the pelvic connective tissue and the glands. In cases of nervous restlessness and sleeplessness, and in hysterical women the administration of heroin gave little or no relief.

Professor Dr. Rona Samuel exhibited a case of EXANTHEMA UNIVERSALE TUBEROSUM ET FLANIUM, of seven years' standing, in a girl, æt. 8. He had shown the girl four years ago, and his object now is to demonstrate the subsequent course. The disease started originally in the skin of the forehead. As to the treatment, he said that in all such cases the only radical cure is the operative excision of the xanthoma, but this can be performed only in cases in which the affection is not universal, as in the present case. Electrolysis is sometimes followed by satisfactory recovery, even in certain cases where one would hardly expect it. Its only disadvantage is that recurrence of the xanthoma is common after its use. The patient exhibited by him in whom, by reason of the generalised nature of the affection, neither of the above mentioned methods was applicable, is taking phosphorus and turpentine internally, as recommended by Besnier.

Dr. Hudovering read a paper on the

TABES OF MARRIED COUPLES.

Up to the present twenty-seven cases of tabes conjugalis are recorded in the literature of the subject, Hudovering now placed on record three further cases of the kind. It must be premised that in all the three couples the tabes was subsequent to syphilis, a relationship which existed in the recorded cases; in fact, in twenty couples out of twenty-four, syphilitic infection was distinguished with certainty, in three couples there was reason to suspect it, and only one couple proved to be really free from syphilis. It follows that in 96.3 per cent. of the conjugal tabes cases there was antecedent syphilitic infection. The theory first brought forward by Lougard is that tabes and general paralysis, while the remainder are free from any sequelæ of the kind, is not to be sought in the above-named affinity of the syphilitic virus for the central nervous system, but that this special predisposition is to be sought for in another direction, perhaps in the congenital or acquired particular disposition of the nervous system.

LETTERS TO THE EDITOR.

THE "DAILIES."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is probable that most of us, when we find, in one of the dailies as we look through it every morning, an article on some medical subject, or some notice of a recent discovery, such as a new bacillus, or a new disease, or a new and wonderful process of treating something or other such as cancer or consumption, we read it with some attention. It is probable that many of us smile quietly to ourselves as we think how the poor Public may be deluded by this kind of literature. There does not seem to be any class of subjects which is dealt with in the same way in the dailies as matters medical. The law is treated differently, and religious matters are not advertised and put before the public in such exaggerated and misleading terms. So it is as well the question has been thought deserving of your attention of late. It is well that you

should be assured by some of your readers that you have every reason to give this subject your consideration, as it is in the interest of the public from every point of view that they should be protected from what can and does prove of more harm than good to them.

I am, Sir, yours truly,
ONE OF YOUR READERS.

MIDWIFERY FORCEPS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—As it seems desirable for several reasons to avoid the necessity of introducing the left lower blade first, I have devised a pattern of midwifery forceps, which seems to meet this requirement. In these forceps, it will be noticed that the blades do not cross, that the lock is not at the junction of the handle and the blade, but at the end of the handles, and that the lock can be fixed by a single turn of a stud. To prevent the blades from rolling one on the other, a guide peg in the lower blade fits into a slot in the upper. A small swivel screw attached at the junction of the blades and handle prevents the handles from flying apart; a traction rod

can be used if necessary, as in the illustration.

I have used these forceps in a great number of cases, and others as well as myself have been surprised at the ease of application. The forceps were made for me by the Medical Supply Association, 228, Grays Inn Road, London.

I am, Sir, yours truly,
H. TAYLOR MORGAN, M.D.

NEW MEDICAL PREPARATIONS AND APPLIANCES.

BURROUGHS WELLCOME'S THROAT PASTILLES

Much has been recently written about dust, especially in relation to sore throats and nasal catarrhs. The mechanical irritation of the throat by dust particles, and the action of pathogenic micro-organisms, may obviously be in appropriate cases, combated, if not prevented, by suitable topical applications. It would seem that in cases of sore throat resulting from dust particles, the protective soothing effect of mucin is indicated, and that in such cases the natural mucous secretion should be reinforced. This is effected conveniently by the use of Tabloid Mucin compound, which may be slowly dissolved in the mouth, or else made into solution with water and applied as a gargle or throat paint. The importance of maintaining a continuous suffusion of the mucous membrane of the mouth and throat with demulcent and antiseptic agents, is generally recognised. Pastilles which dissolve gradually in the mouth and provide a regular uniform strength of solution, afford the easiest and most pleasant form of obtaining such medication. The Tabloid Pastilles of Glycerin, Lemon juice, and of the valuable volatile stimulating antiseptic 'Pinol' red gum and cocaine, morphine and ipecacuanha, will be found acceptable and efficacious. Other Tabloid Antiseptic products are also beneficial. Such treatment, both preventive and curative, will commend itself as rational and worthy of trial to the general body of the medical profession.



CASTOR OIL POWDER.

THERE is always room for a new aperient—or, rather, in this particular case, for a new form of aperient. Our old friend castor oil has various disadvantages, chief of which is the unpleasant taste and smell, not to mention the ease with which it can be adulterated. A good substitute is offered in the shape of a castor oil powder, made by R. Demuth, 61, Mark Lane, London, E.C. It is a white, palatable powder, and in our hands has proved a safe, trustworthy, and mild, but efficient purgative. Like castor oil, it is specially suitable for children and delicate adults.

NEW LINEN BELTS AND BANDAGES.

WE have received from Messrs. John Clarke and Co., of Belfast, the well-known linen manufacturers, specimens of their latest productions in medical appliances. Within the last few months this firm have added to their former medical specialities the following: Many-tailed bandages of different sizes to be used instead of flannel. Square napkins to use as a final cover for dressings applied to wounds after operation; T bandages; Spica bandages, abdominal belts, and obstetric binders. The samples which we have received are all made of "Irish Linen Mesh," which may be described as a loosely woven and most elastic material, composed of linen yarn. It is porous to a high degree, and strong, and seems to us to be an ideal material for the purposes for which it is made. The bandages can be repeatedly washed and sterilised, and so can be made to fully repay their initial cost. We understand that Messrs. Clarke will be glad to send a specimen of the material to any medical man who applies for it. Messrs. Clarke also make a special form of twisted linen thread which is intended to take the place of other forms of non-absorbable suture materials. This material is at least as strong, if not stronger than silk of a similar thickness. It is put up in tiny balls, each of which contains a yard and a half, or in hanks of twelve yards in length.

Society for Relief of Widows and Orphans of Medical Men.

THE Annual General Meeting of this Society was held on May 3rd, Mr. Willett, Vice-President, in the chair.

The proceedings were opened by the chairman referring to the great loss the Society had sustained by the death of the late President, Mr. Christopher Heath, F.R.C.S., who had always taken the greatest interest in the Society's welfare, and had been a most regular attendant at its meetings. A formal resolution of condolence was passed from the chair. A cordial vote of thanks was moved to the Editors of the medical journals for their unfailing courtesy in inserting the reports of the Society from time to time; this was carried unanimously.

During the year six new members were elected, five members died, and two resigned. At the end of the year there were 148 life members and 146 subscribers. Four widows were elected, and two widows died, there being 54 in receipt of pensions at the end of the year. Three orphans were elected, making a total of 19 in receipt of pensions.

The income derived from the invested funds of the Society was £3,098 19s. 2d., from subscriptions £300 6s. 2d., from donations £23 1s., from life subscriptions £134 8s., and a legacy of £250 had been received during the year.

£3,241 had been distributed among the annuitants of the Charity. The working expenses of the Society for the year were £248 16s. 7d.

Dr. George Fielding Blandford was unanimously elected president, and Dr. F. de Havilland-Hall one of the treasurers. Six directors were elected in place of the six seniors who retired according to the Bye-laws.

Full particulars of the many advantages secured to members of the profession joining the Society, and proposal forms for membership can be obtained on application to the Secretary at the offices of the Society, 11, Chandos Street, Cavendish Square, London.

MEDICAL NEWS IN BRIEF.

The Royal Commission on the Care and Control of the Feeble-minded.

THIS Commission, which has already held a number of sittings in London, sat in Dublin on Saturday last to hear evidence. Amongst the witnesses examined were the Registrar-General, Dr. Stewart Woodhouse, medical member of the Prisons Board; Dr. R. G. Dowdall, Resident Medical Officer of Mountjoy Prison; and Mr. J. Fagan, F.R.C.S., Inspector of Reformatory and Industrial Schools. The Registrar-General's evidence showed that the increase of lunatics and idiots in Ireland was very great. In 1861 their proportion to that of the whole population was 1 in 411; in 1871, 1 in 328; in 1881, 1 in 281; in 1891, 1 in 222; and in 1901, 1 in 178. He considered that an important cause was the marriage of feeble-minded persons, and as this usually occurred during a supposed lucid interval of the person so afflicted he considered the law in this respect required to be changed. He also considered that feeble-minded women and girls frequently became the mothers of illegitimate children. He submitted a return showing the proportion of the insane per 10,000 of the population in England and Wales, Scotland and Ireland at the census of 1871, 1881, 1891, and 1901. In England and Wales the proportion of the insane per 10,000 of the population increased from 30.39 in 1871 to 40.78 in 1901, in Scotland the proportion per 10,000 increased from 33.97 in 1871 to 45.37 in 1901, and in Ireland the proportion of the mentally deranged per 10,000 of the population rose from 30.49 in 1871 to 36.18 in 1901. Thus Ireland occupied the unhappy position of having by far the highest proportion of insane in its population, Scotland coming next, while England and Wales stood third in the list. A considerable factor in the increase shown by the last census was in his opinion, the return of Irish immigrants from the United States who had lost their health and reason whilst working there. Dr. Stewart Woodhouse, F.R.C.S.I., medical member of the General Prisons Board, Ireland, in the course of his evidence said the number of feeble-minded in Irish prisons was not large. In Maryboro' Convict Prison out of about 240 convicts only 5 or 6 could be so described, and even in some of these few criminal mindedness was the more prominent characteristic. In Ireland, a Parkhurst was unnecessary. The number transferred each year from local prisons to district asylums was large, being 51 in 1903 and 102 in 1897. The largest Irish prisons, Mountjoy Male and Belfast Male, had a daily average population of under 400 each, and the number amongst them that could be classed as feeble-minded would be small and variable. Dr. R. G. Dowdall, D.Ph., Resident Medical Officer of Mountjoy Prison, stated in his evidence that the number of prisoners committed to that prison during the year ended December 31st, 1905, was 8,901—4,171 males, and 4,730 females. Of these 16 males and 4 females were mentally deficient, and quite unfit for prison discipline. Mr. John Fagan, F.R.C.S., Inspector of Reformatory and Industrial Schools in Ireland, set out in his evidence that, excluding voluntary cases, there were 7,951 inmates—3,670 boys and 4,281 girls—in industrial schools at the end of 1905, whilst at the same date there were 559 (520 boys and 39 girls) in reformatory schools. The Commission will not sit again in Ireland.

Royal College of Surgeons in Ireland—Election of Examiners.

At a meeting of the President, Vice-President, and Council, the following Examiners were elected:—
Court "A." For Conjoint License, Diploma in Public Health, and Preliminary: Anatomy—Alexander Fraser, F.R.C.S.; Bertram C. A. Windle, B.S., Univ. Dub. Surgery—Alexander Blaney, F.R.C.S.; F. Conway-Dwyer, F.R.C.S. John Dundon, F.R.C.S.; Richard Lane-Joynt, F.R.C.S. Pathology and Bacteriology—Arthur Hamilton White, L.R.C.S. Mid-

wifery and Gynæcology—Frederick W. Kidd, L.R.C.S. Biology—John J. Burgess, F.R.C.S. Ophthalmology—Arthur H. Benson, F.R.C.S.; Herbert C. Mooney, F.R.C.S. Sanitary Law and Vital Statistics—Edward Francis Stephenson, F.R.C.S., D.P.H. Languages—Woodroffe, L. J. Mathematics, Physics, Dictation, and English Essay—J. W. Tristram.

Court "B." Fellowship, License in Surgery (for registered practitioners), License in Midwifery (for registered practitioners), and License in Dental Surgery. Anatomy—Patrick Joseph Fagan, F.R.C.S.; Alexander Frazer, F.R.C.S. Surgery—Alexander Blaney, F.R.C.S.; F. Conway-Dwyer, F.R.C.S.; Thomas E. Gordon, F.R.C.S.; Richard Lane-Joynt, F.R.C.S. Pathology and Bacteriology—Leveson Gower Gunn, F.R.C.S.; Arthur Hamilton White, L.R.C.S. Midwifery and Gynæcology—Frederick W. Kidd, L.R.C.S. Chemistry and Physics—Edwin Lapper, L.R.C.S.; Robert J. Montgomery, F.R.C.S. Dental Surgery and Pathology—George M. P. Murray, F.R.C.S.; William G. Story, L.D.S. Mechanical Dentistry—Kevin E. O'Duffy, L.D.S. Edin.; Daniel L. Rogers, L.D.S.

University of Durham.

At the convocation held on Saturday, April 28th, 1906, the following Degrees were conferred, viz.:

Doctor in Medicine—Charles H. Clarke, M.B., B.S. Dur.; Ida E. Fox, M.B., B.S. Dur.; Harold L. Heslop, M.B., B.S. Dur.; Herbert L. Noel-Cox, M.B. Dur.; Thomas Y. Simpson, M.B., B.S. Dur.; James B. Waters, M.B., B.S. Dur.

Doctor in Medicine for Practitioners of Fifteen Years' Standing—Bennet H. Andrew, M.R.C.S., L.R.C.P., L.S.A.; Henry Buxton, F.R.C.S.E., L.R.C.P., L.F.P.S.G.; Ernest C. Freeman, M.R.C.S., L.R.C.P., D.P.H.; John F. Nall, F.R.C.S.; Richard R. Sleman, M.A., L.S.A.; James P. Walker, M.R.C.S., L.R.C.P.; Alfred W. Waller, M.R.C.S., L.R.C.P.

Bachelor in Medicine (M.B.)—Frederick W. Cheese, M.R.C.S., L.R.C.P.; James H. Cooke, B.Litt.; Hamilton Drummond, Horsley Drummond, Wilfrid Fairclough, Archibald Finlay; John Galloway, L.R.C.P. & S. Ed., L.F.P.S.G.; Sampson G. V. Harris, M.R.C.S., L.R.C.P., D.P.H.; Arthur B. Jones; John C. Pearce, A.Sc.; Robert B. Reed, William Seymour, Frank T. Simpson, Frederick J. Strachan, Edward Tate, Arthur J. Turner, Robert J. Weidner, Robert J. Willan.

Bachelor in Surgery (B.S.)—F. W. Cheese, M.R.C.S., L.R.C.P.; J. H. Cooke, B.Litt.; H. Drummond, H. Drummond, W. Fairclough, A. Finlay, J. Galloway, L.R.C.P. and S. Ed., L.F.P.S.G.; S. G. V. Harris, M.R.C.S., L.R.C.P., D.P.H.; S. H. Hawley, M.D., B.Sc., D.P.H.; A. B. Jones, J. C. Pearce, A.Sc.; R. B. Reed, W. Seymour, F. J. Strachan, E. Tate, A. J. Turner, R. J. Weidner, R. J. Willan.

Bachelor in Hygiene (B.Hy.)—John W. H. Morrison, M.B., B.S. Dur.; Henry Renney, M.D., B.S., D.P.H. Dur.; Herbert J. Slade, M.B., B.S., Dur., M.R.C.S., L.R.C.P.

And the following received the—

Diploma in Public Health (D.P.H.)—James A. Mitchell, M.B., Ch.B., Glas.; John W. H. Morrison, M.B., B.S., Dur.; Herbert J. Slade, M.B., B.S. Dur., M.R.C.S., L.R.C.P.

DR. J. LINDSAY STEVEN has been elected President of the Glasgow Medico-Chirurgical Society. A Clinical Lecture on "General Cystic Degeneration or Transformation of the Kidneys in the Adult" by Dr. Steven, will be found in our present number.

DR. G. FIELDING BLANDFORD was elected at the annual general meeting of the Society for Relief of Widows and Orphans of Medical Men, President, in the place of Mr. Christopher Heath, F.R.C.S., deceased.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specialy Compiled for THE MEDICAL PRESS AND CIRCULAR.

SUMMARY OF RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Death from Uterine Fibromyomata Pellanda (*These de Lyon de Lyon*) (*Journ. of Obst. and Gynaecology* April, 1906). In this thesis the writer has analysed 191 cases of death directly caused by uterine fibroids in which no surgical treatment was adopted. The causes of death are as follow:—1. Infection, 49·5 per cent. This is the most frequent cause of death and in the majority of cases appears to depend on association with labour or abortion. 2. Compression of abdominal or pelvic viscera, 25·8 per cent. 3. Thrombosis of the pelvic venous sinuses and pulmonary embolism, cardiac lesions (myocardites, valvular insufficiency) and sudden syncope, 11·1 per cent. 4. Hæmorrhage, 6·4 per cent.; this group is divided into two classes, intra-uterine and intra-peritoneal. 5. Cachexia, 5·2 per cent., a state brought about by many different pathological conditions such as compression of abdominal viscera, exhaustion from hæmorrhage, slow infection, coproæmia, phlebitis, cardiac and renal lesions. 6. Torsion of pedunculated subserous fibroids, 3 cases. The mean age at which death occurred was 44½ years, it occurred earliest (42½) from infection and latest from cachexia (59), compression coming between these, 47½. F.

Intra-peritoneal Hæmorrhage in Uterine Fibromyomata.—Perrier. (*These de Lyon Journ. Obst. and Gynaecol.* April, 1906). Bleeding into the peritoneal cavity is a rare accident when due to the presence of a subserous uterine fibromyoma, yet in the writer's opinion it accounts for many cases of hæmatocèle as due to rupture of an extra-uterine pregnancy. Such hæmorrhage may be caused by two different mechanisms—namely, 1. By rupture of subserous varices on the surface of the fibro-myomatous uterus. 2. By rupture of peritoneal adhesions. In the former case the hæmorrhage is diffuse and occurs into a healthy peritoneum; it is fulminating in type and demands immediate operative intervention. F.

Prophylaxis of Abdominal Adhesions.—C. G. Cumston, M.D. (*Amer. Journ. of Obst.*, March, 1906). It is quite impossible to prevent the formation of adhesions due to intra abdominal inflammatory processes, neoplasms and traumatism and in reality only adhesions following abdominal operations may be to a certain extent prevented. Strictest asepsis is, of course, the greatest requisite, and includes the well-known principle of not touching any parts with instruments or hands which are not surgically clean. The so-called toilet of the abdominal cavity, in getting rid of blood, or the contents of cysts is unnecessary in most cases, but when this is required flushing with sterile salt solution, followed by careful mopping, may be resorted to. Chemical solutions should always be kept at a safe distance from the operating table, and are only to be used for rinsing the hands during an operation. Another important point is keeping the peritoneum warm and moist during the operation, by covering it over at every point where it comes in contact with the air, with warm moist gauze sponges wrung out in normal salt solution or the following, which is used in Slinger's clinic where a marked decrease in intestinal disturbances following laparotomies has been observed: sodium bicarb, 2·5; sodium chloride, 9·5; distilled water, 1,000; suture of the abdominal walls requires articular care, because, to a great extent, it tends to the formation of adhesions; here the writer recommends the closure of the peritoneum with fine catgut sutures, applied according to Lembert's method, so that when the peritoneal wound is closed healthy peritoneum is approximated to healthy peritoneum. The fascia is united with a continuous kangaroo tendon suture and

the skin and fat with silkworm gut. In order to prevent adhesions between the peritoneal wound surfaces in all cases, and especially those where extensive surfaces remain after operation, secure the keeping of the serous surface in constant motion, so that no two raw peritoneal surfaces remain in contact with one another long enough to result in union between them; this is a more rational method than Muller's, of pouring large amounts of sterile salt solution into the abdominal cavity. The principal way to stimulate a constant change of contact of the peritoneal surfaces is to stimulate peristalsis immediately after an abdominal operation by some of the following means—subcutaneous use of physostigma immediately after operation and continued three times daily for three days. Ditzel's practice is to give a large soap and water enema soon after operation, and this is followed several hours later by an injection of glycerine. A less active means for continually changing the position of the intra-peritoneal surfaces is massage of the abdomen which increases peristalsis, deepens respiration, and is a prophylactic for post-operative pneumonia. Besides the above-mentioned means another method used by Ditzel is to excise a bit of fat from the abdominal wall, and, squeezing it out, to rub it into the raw peritoneal surface. F.

Extirpation of Bartholin's Cysts by a New Process.—Pozzi (*Annales de Gynecol. et d'Obstet.* Dec., 1905.)—Operators are aware of the difficulties met with in getting these tumours out whole, and that it is not easy to remove every portion of the living membrane when once such cysts are opened or burst during dissection. In order to facilitate their complete removal the writer injects spermaceti into the cavity the evening before the operation. This solidifies after injection, and the tumour can then quite easily be removed as a solid mass. F.

Malignant and Benign Degenerations of Uterine Myomata.—Winter (*Zeitschrift f. Geburtsh. und Gynak.* Band. 57.) says the myoma is greatly predisposed to secondary degenerations, since the uterus, its native soil, is so often attacked by disturbances of nutrition and diseases which can influence the life of the tumour. Carcinoma has an intimate connection with myomata. It occurs much more frequently with them than without them. Cancer of the body occurs just as often as cancer of the cervix in their presence. Otherwise cancer of the cervix is about fifteen times more frequent than that of the body, so that the inclination of myomata to induce cancer of the body must be particularly great. Cervical cancer occurs in 2 per cent., and cancer of the body in 1·2 per cent., of myomatous uteri. This combination is too rare to become an indication for operation in every case. Also the routine removal of the cervix during hysterectomy, for myomata, in order to prevent its becoming the seat of cancer, is not necessary, because in the 17 published cases of cancer of the stump the cancer really only originated 7 times after the operation. At the same time this combination must receive every attention, so that an early diagnosis may be made if cancer should arise. This is difficult and must depend on the characteristic symptoms, which are not usual with pure myomata. These are, above all, hæmorrhages in the menopause, sero-sanguineous discharge and uterine pains. In their presence the uterus must be curetted for microscopical examination. It is difficult to estimate the frequency of sarcomatous degeneration, because the microscope alone makes the diagnosis certain. Considering 753 cases, Winter estimates the frequency at about 2 per cent. in subserous, 4 per cent. in interstitial, and

8.7 per cent in submucous myomata. This frequency makes a certain clinical diagnosis most desirable. This is difficult in the submucous variety, because the symptoms of the sarcoma are so like those of the myoma; therefore every extirpated submucous myoma must be thoroughly examined microscopically. The diagnosis in interstitial myomata is still more difficult; it depends usually on the symptoms, irregular hæmorrhages, uterine pains, loss of flesh and strength. The occurrence of ascites, adhesions or metastasis points to sarcomatous degeneration. In the subserous myomata the diagnosis in three cases could only be arrived at microscopically. Benign degenerations are much more frequent. This is due to the changes in nutrition of the myomata during menstruation and pregnancy, and to the different diseases to which the uterus is liable. The degenerations may occur as atrophic or infectious conditions, necrosis or softening. Complete necrosis of the myoma arises from disturbances of nutrition, which affect the whole tumour at the same time. For example, in submucous from expulsion, in subserous from twisting of the pedicle. Complete necrosis of interstitial myomata has been little studied. In appearance the tumour is flesh red. Its cause must be sought for in the uterine wall from which the myoma receives its nutrition. One must particularly consider the very important changes in nutrition of the tumour bed during parturition, and also in torsion of the uterus, ergot treatment and diseases of the blood vessels. The symptoms consist of severe and usually irregular hæmorrhages, pain, and the general condition of the patient, which Freund has described as auto-intoxication. The results of necrosis are very severe and usually fatal, unless the myoma is extirpated in time. The diagnosis is difficult, and may be made when, closely following on parturition, the above symptoms develop. Treatment must always be operative and preferably radical. G.

The Bacteriology of Puerperal Infection.—A bacteriological contribution to puerperal infection is recorded by Hellendall (*Beiträge zur Geburtsh und Gynäk.*, Band x., Heft 1), who from the examination of fifty-two cases of abortion comes to the following conclusions. In every case of protracted abortion the uterus becomes infected in the long run. The bacteria either ascend from the vagina and vulva or are introduced on the hands or instruments. Spontaneous ascent of infection depends on the retention of dead matter in the uterus, and does not occur without it. The usual mode of ascent is that the bacteria infect the blood clots hanging from the uterine cavity. The infection ascends either between the membranes or extends from the liquor amnii through the amnion into the intervillous spaces. Consequently the temperature must be frequently taken during protracted or induced abortion and a rise indicates immediate emptying and disinfection of the uterus. With incomplete abortion the retained fragments are infected a long time before fever arises, and therefore in this variety the uterus should always be emptied at once. G.

The Connection Between the Appendix and the Lymphatic Apparatus of the Intestinal Tract.—Albrecht (*Monat. f. Geburtsh und Gynäk.*, Feb., 1906) writes that the appendix belongs to the group of the lymphatic organs of the body. In the pathology of the appendix there is a remarkable analogy between its diseases and those of the tonsil. Its position at the entrance to the colon, in connection with the follicular apparatus of the ileum, not unlike the position of the tonsil at the beginning of the pharynx, must make us consider whether physiologically it may not be looked upon as the tonsil of the colon. One finds everywhere in the intestinal tract an accumulation of lymphatic organs where narrowings of the canal and niches are present. Therefore from its localisation the intimate connection between the appendix and the lymphatic organs may be inferred. Moreover, it places at the beginning of the colon a large lymphocyte supply in the same way as Peyer's patches do higher up. G.

A Case of Central Rupture of the Perinæum (*Brit. Med. Journ.*, April 14th, 1906).—Dodson reports a case in which a laceration of this kind occurred in a primipara, æt. 21. The labour was rapid and the pains very strong. A central tear was noticed as the head came well down on to the perinæum; a strong pain then forced the child through the opening. Upon examining the condition it was found that the rectal and vaginal orifices were intact. The placenta was born through the opening. The wound was 5 in. long in the median line of the perinæum, from the anterior end it ran outwards and forwards to the left side of the vaginal orifice for about 2 in., while posteriorly, at about 1 in. from the anus, it was continued backwards and outwards for about 1½ in. by the side of the rectum. It is pointed out that usually such a laceration involves either vaginal or rectal orifice. The child weighed 6 lb. 12 oz. H.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "Recent Medical Literature."
- (2) "Recent Surgical Literature."
- (3) "Recent Gynecological and Obstetrical Literature."
- (4) "The Recent Literature of Physiology and Pathology."

OBITUARY.

SURGEON-GENERAL SIBTHORPE, F.R.C.P.I.

WE much regret to have to chronicle the death of Surgeon-General Sibthorpe, late of the Royal Army Medical Staff, on May 4th, at his residence in Dublin after a short illness. The late Surgeon-General was a member of a well-known Dublin family. Born in 1847, he qualified as a Licentiate of the Royal College of Surgeons of Ireland in 1869, and in 1880 became a Fellow of the Royal College of Physicians. He joined the Army Medical Service, in which he saw much hard work. His principal campaign was that in Burmah, in 1885, when he received the medal and clasp and was honourably mentioned in despatches. He was one of the few medical officers who was present at the capture of King Thebaw. He was advanced to the rank of Brigade-Surgeon in 1882, Brigade-Surgeon General in 1886, and as Deputy Surgeon-General served in the Afghan war, when he was again mentioned in despatches and received the medal. In addition to his military duties, Surgeon-General Sibthorpe found time for literary work, and was the author of an important work on Clinical Research in India. In 1897 he received the military order of Commander of the Bath. He died at the early age of fifty-nine, to the deep regret of a large circle of professional and other friends. His funeral, which took place on Monday last, was attended by the President and Fellows of the Royal College of Physicians.

Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of this society was held on the 27th ult. There were present—Dr. de Havilland-Hall, in the Chair; Mr. Frank Wallace, Dr. J. Pickett, Dr. St. Clair B. Shadwell, Dr. Fred. S. Palmer, Dr. J. Brindley James, Dr. W. Knowsley Sibley, Mr. J. F. Colyer, Dr. M. Greenwood, Mr. Edward Bartlett, and Dr. J. B. Ball. The Committee were mainly occupied in examining the draft of the report for the year 1905. It was resolved that the annual general meeting should be held as usual at the Medical Society of London, Chandos Street, Cavendish Square, on Thursday, May 17th, at 5. The report to be then presented shows that in 1905 the business of the society was in every way satisfactory, producing a large increase in the funds, which now amount to over two hundred thousand pounds. The number of new entrants was greater than in any previous year of the society's working. Prospectuses and all particulars on application to Mr. F. Addiscott, Sec., Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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 reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

PBS.—The last number of the Registrar-General's Returns would give the information required.

META.—Our correspondent has omitted to enclose his card. Mr. T. V. L.—We must see the work before making the statement you ask for.

PATERFAMILIAS (Leeds).—We sympathise with our correspondent in the extent to which his son has been victimised by the firm of quacks, but in the present state of the law, unfortunately, there is no remedy against them.

M.D.—The name does not appear in the current *Medical Register*. Probably the "degrees" are of American origin.

DR. L. R. C.—From the cases recorded in the third edition of Dr. Shaw-Mackenzie's work on "cancer," the trypan treatment for cancer has passed beyond the experimental stage. For particulars of the method of practising it we must refer you to the work in question.

A YOUNG PRACTITIONER is referred for answer to "Meta" and "Behind the Scenes" in this column.

THE KEELEY INSTITUTE FOR DRUNKARDS.

A CORRESPONDENT has cut out and sent some pages of advertisements of the so-called "Keeley Institute" for the cure of the drink habit, in the hope that we will take this in our list for exposure. Our correspondent apparently does not know that we have already done what he suggests. We went fully into the matter when it was first introduced from America to this country ten years since. We laid bare the whole scheme in these columns during 1896-97, and had to bear the trouble and expense of a law suit at the hands of its promoters. Before, however, the case was heard, Dr. Keeley withdrew his claim, and the proceedings were quashed.

L.R.C.P.LOND., M.R.C.S.—In our opinion the matter is more one of a breach of good taste than one of offence against ethical law.

A SLIGHT MISUNDERSTANDING.

DOCTOR (to Mrs. Perkins, whose husband is ill): "Has he had any liquid intervals?" Mrs. Perkins (with dignity): "E's 'ad nothing except what you ordered, doctor."—*Exchange.*

"**BEHIND THE SCENES**" has sent us two communications, but in neither has he given his name and address. No notice is taken by us of anything not vouched for by the name of the contributor, a rule from which we never depart.

DR. L. C. (Manchester).—The literature of the subject is voluminous. If there be any one point you wish to elaborate there are experts who can give you the list of necessary references. Any further information we may have is at your disposal.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MAY 9th.

DERMATOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.).—6.15 p.m. Meeting.

SOCIETY OF ARTS (John Street, Adelphi, W.C.).—8 p.m. Paper:—Prof. T. Oliver: Bridge Building by means of Caissons, including Remarks upon Compressed Air Illness.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. P. L. Daniel: Clinique. (Surgical). 5.15 p.m. Lecture:—Dr. G. H. Savage: Eccentricity and Insanity.

THURSDAY, MAY 10th.

HARVEIAN SOCIETY OF LONDON (Paddington Infirmary, Harrow Road, W.).—8.30 p.m. Clinical Meeting. Cases will be shown.

BRITISH GYNECOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Paper.—Mrs. Scharlieb: The Advantages of the Abdominal Route in Operations for Cancer of the Uterus.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m. Lecture.—Mr. C. Nourse: Some Points in the Diagnosis and Treatment of Frontal Sinusitis.

FRIDAY, MAY 11th.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m. Papers.—Mr. C. Wallace: Case of Cystic Tumour of the Spermatic Cord.—Mr. A. C. Hudson: Carcinoma of the Thyroid Gland.

—Mr. E. W. Boughton: Case of Perforated Gastric Ulcer treated by Evisceration and Irrigation.—Mr. J. D. Malocm: Complete Removal of a Multilocular Cyst of the Pancreas; Intestinal Anastomosis for Partial Obstruction 16 Days later.

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

Vacancies.

- Birmingham and Midland Eye Hospital.—Resident Medical Officer. Salary £100 per annum. Applications to the Chairman of the Medical Board.
- Brecknock County and Borough Infirmary.—Resident House Surgeon. Salary £100 per annum, with furnished apartments, board, attendance, fire and gas. Applications to W. Powell Price, Secretary.—The Bulwark, Brecon, South Wales.
- City of London Hospital for Diseases of the Chest, Victoria Park, E.—Resident Medical Officer. Salary £100 per annum, with board, &c. Applications to the Secretary.
- Devon County Asylum.—Third Assistant Medical Officer. Salary £125 per annum. Application to Medical Superintendent, County Asylum, Exminster.
- Hants County Asylum.—Second Assistant Medical Officer. Salary £175 per annum, with furnished apartments, board, washing, and attendance. Applications to the Visiting Committee, Hants County Asylum, Fareham.
- Killarney District Lunatic Asylum.—Assistant Medical Officer. Salary £100 per annum and allowances. Applications to E. W. Griffin, Resident Medical Superintendent. (See advt.)
- Metropolitan Asylums Board.—The Downs School, Sutton, Surrey (for Children with Ringworm).—Assistant Medical Officer. Salary £250 per annum and dinner daily. Applications to the Clerk, Metropolitan Asylums Board, Embankment, London, E.C.
- Somerset and Bath Asylum, Wells.—Second Assistant Medical Officer. Salary £130 per annum, with board, lodging, washing, and attendance. Applications to the Superintendent.
- West Riding County Council.—Scaleford Park (Private Asylum), Burley-in-Wharfedale.—Assistant Medical Officer. Salary £150 per annum, with board, furnished apartments, attendance, &c. Applications to the Physician Superintendent.
- West Kent General Hospital, Maidstone.—Senior House Surgeon. Salary £100 per annum, with board and residence. Applications to the Secretary.

Appointments.

- ASHWIN, R. H., M.B.Lond.**, Certifying Surgeon under the Factory and Workshop Act for the Market Weighton District of the county of York.
- BRISCOE, WILLIAM THOMAS, M.D., M.Ch.Dub.**, Medical Officer for the Pewsham District by the Chippenham (Wilts) Board of Guardians.
- CARDOZO, S. N., L.R.C.P.Lond., M.R.C.S.**, Medical Officer and Public Vaccinator for the Northampton District by the Southampton (Devon) Board of Guardians.
- HARDING, CHARLES HEADLEY, M.R.C.S., L.R.C.P.Lond.**, Medical Officer to the Northern Division of the Whittlesea Union and Public Vaccinator to the Whittlesea Rural District.
- HARTFORD, A. H. B., L.R.C.P.** and **S.Irel.**, Certifying Surgeon under the Factory and Workshop Act for the Christchurch District of the county of Hants.
- MAOKEOWN, W. J., B.A., M.B., B.Ch.R.U.I.**, Senior Assistant Medical Officer to the County Asylum, Fareham, Hants.
- OLLERENSHAW, ROBERT, M.B., Ch.B.Vict.**, Senior House Surgeon to the Liverpool Infirmary for Children.
- ROGDON, R. B., L.D.S., R.C.S.Eng.**, Assistant Honorary Dental Surgeon to the York County Hospital.
- RENTZSCH, SIGISMUND HANEY, L.R.C.P.Lond., M.R.C.S.**, Honorary Medical Officer to the Stratton (Cornwall) Cottage Hospital.
- ROBSON, JOHN R., M.R.C.S., L.R.C.P.Édin.**, Honorary Ophthalmic Surgeon to the Royal British Female Orphan Asylum, Devonport.
- THOMAS, H. MORTIMER, M.R.C.S., L.R.C.P.Lond.**, House Surgeon at the Royal National Orthopaedic Hospital.
- WAGGETT, ERNEST M.B., B.C.Ontab.**, Surgeon to the newly constituted Department for Diseases of the Throat, Ear, and Nose at Charing Cross Hospital.

Births.

- TYLOR**.—On May 3rd, at Mounpesson House, Wisbech, to Dr. and Mrs. Max Tylor, a daughter.

Marriages.

- DRUMMOND-RUSSELL**.—On May 3rd, at the Oratory, South Kensington, Henry Olpherts Drummond, younger son of the late James Drummond, M.D., of 5 Great Cumberland Place, to Hon. Lilian Russell, daughter of the late Lord Chief Justice of England, and of Lady Russell of Killowen, 6 Hyde Park Gate.
- PARKER-LLOYD DAVIES**.—On May 3rd, at Holy Trinity Church, Guildford, Herbert Francis Parker, M.D.Ontab., M.R.C.S., L.R.C.P., to Edna, daughter of the late David Lloyd Davies, of Wyre Court, Bewdley, and of Mrs. Lloyd Davies, Guildford.
- TINDALL-JACOB**.—On May 3rd, at St. Ann's Church, Dublin, by Rev. Paterson Smyth, D.Litt., vicar, assisted by Rev. Cecil Patton, Rector of Fethard, Tipperary, Albert Alfred Tindall, elder son of A. A. Tindall (MEDICAL PRESS and CIRCULAR, London), of Boughton-Monchelsea, Kent, to Blanche Phoebe, daughter of the late Archibald Hamilton Jacob, M.D., F.R.C.S. (late Surgeon-Oculist to H.M. Queen Victoria), of 23 Ely Place, and Mrs. Jacob, 47 Morehampton Road, Dublin.

Deaths.

- BAINES**.—On May 5th, at 11 Cranley Place, London, Matthew Baines, Esq., V.D., M.D., London, Knt. of Grace of the Order of St. John at Jerusalem.
- GIBBON**.—May 3rd, at 58 Warrior Square, St. Leonards-on-Sea, Harriet Susan Gibbon, eldest daughter of the late James Gibbon, M.D., of Swansea.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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WEDNESDAY, MAY 16, 1906.

No. 20.

NOTES AND COMMENTS.

The Darnell Defence Fund.

OUR readers would do well to consider the call on their generosity, which is made by a very representative committee of Belfast medical men, in the case of Dr. Darnell, the defendant in the late case of *Tughan v. Darnell*, to which we have referred on several occasions. As our readers may remember, Dr. Darnell was at first successful, but afterwards he was defeated on an application by the plaintiff for a new trial, and this new trial also went against him. The result is that he has been compelled to meet the expenses of some five distinct hearings of his case. The Medical Defence Union to which he belongs will pay all that it can legally pay to his defence, but even with this there will be a balance of some £800 still owing. Dr. Walton Browne is the Chairman of the Committee which has been jointly appointed by the Ulster Branch of the British Medical Association and the Ulster Medical Society, and Dr. Cecil Shaw and Dr. Thos. Houston are the Honorary Secretaries. Already close on £200 has been promised, but if the appeal is to be a success it must be supported by the medical profession in Ireland generally, and not merely by Dr. Darnell's Belfast confrères.

Trent and other River Waters.

NOTWITHSTANDING the fact that the United Kingdom still leads the world in practical sanitation, there are nevertheless many weak spots in our armour. Curiously enough, one of the most serious is that which concerns the pollution of rivers. Take three great English rivers, the Thames, the Severn, and the Trent. They are one and all extensively contaminated with sewage, yet each furnishes the drinking water supply of large populations, in some cases amounting to millions. To drink sewage-polluted water without sterilisation by heat is to court disaster. Sand-filtration simply remains as a monument of bye-gone effort that achieved a "best possible" under existing conditions of imperfect scientific knowledge. In some parts of the Trent Valley the river is little more than an open sewer, and landed proprietors have actually in more than one instance abandoned its malodorous banks. Dr. Sladen, moreover, the Medical Officer of the Gainsborough Rural District, reports that for years past the great majority of cases of enteric fever in the neighbourhood have arisen through drinking Trent water. Surely this benighted state of affairs must be known to the Local Government Board.

Dr. Freyberger as Expert.

It is to be hoped that the recent inquest upon the death of Major Whyte will bear its fruit in due season. The gallant officer in question paid for his credulity with the supreme penalty of his life.—nothing more nor less. His death resulted from a bed sore which was allowed to develop and to become septic by want of proper medical care and nursing. As every medical man knows, such sores are peculiarly apt to occur and to run a rapid and dangerous course after injuries to the spinal column. As a matter of common professional knowledge, any really qualified practitioner of medicine would be competent to make an authoritative statement to that effect for the guidance of a jury. Mr. Troutbeck, the Westminster coroner, however, who investigated the notorious Christian Science case, will have none of your ordinary general practitioners in his court if by any possibility they can be excluded. Acting on his now invariable rule, he handed over the *post mortem* to his trusty "expert" Dr. Freyberger, who with his usual sagacity discovered a number of gross lesions, and delivered a solemn opinion as to the cause of death—at the usual fees—usual, that is to say, in the case of "experts."

Why draw the line at Powders?

MR. TROUTBECK, in the course of the inquiry, pushed home several logical thrusts at the Scientists. In examining the gentleman described as Dr. George Adcock, who states he retired from medical practice about a year ago, the Coroner elicited the fact that in his Christian Science capacity Dr. Adcock had directed the bed sore to be dusted with "Ektagon" powder. The wound became sweeter, but this the witness attributed to Christian Science. "Then why did you give the powder?" was the inevitable counter-question, to which the quondam medico replied tamely enough, "I had to give something." He further admitted that he had written to Dr. Huxley saying he had opened an abscess while attending deceased. Clearly, if prayer alone can cure disease generally, it is absolutely superfluous to use drugs and open abscesses. In this case a huge collection of pus had formed round the hip joint, with purulent inflammation of the bladder and kidneys—all for want of ordinary medical treatment. The incident smacks of mediæval barbarism, or of the besotted superstitious medicine of the Chinese. It is saddening to find such fatuous folly in the land of Harvey, of Jenner, and of Lister at the beginning of the 20th century, and still more so to

find a qualified medical man pandering to such sinful ignorance.

LEADING ARTICLE.

CHRISTIAN SCIENCE.

ONE interesting characteristic of developing civilisation is the tendency to branch off into various fantastic fashions and other curious intellectual subtleties founded on foolishness as apart from reason. In all the vast range of human follies it would be hard to find one more fatuous than that involved in the extraordinary creed known as Christian Science. Briefly, its followers hold that disease exists simply and solely in the imagination, and that sufferers from this subjective phantom can be relieved by prayer offered by suitable persons—at a suitable fee, be it noted. As an inevitable corollary medical science is superfluous, and the fees payable heretofore to medical men should be accordingly transferred to those who pray. The whole "Science," therefore, clearly rests upon an impudent assumption as to the worthlessness of modern scientific medicine. It attempts to prove the security of its profession by adducing an imposing list of alleged "cures." Needless to say, in many cases there has been nothing but vague and fleeting nervous or hysterical complaints that need no cure. In many others the diagnosis cannot be accepted, as it has been made by untrained persons incompetent to form a judgment. It is the old story of cancer said to have been "cured" by violet leaves, or salt, or some other childish remedy. The assertion is worthless because the existence of the cancer has not been in the first place undeniably proved by the test of the microscope, and by other evidence that is only to be procured by a physician of the highest skill, training, and experience. In other words, the triumphs that the quack proclaims from the housetops are simple clap-trap and fustian, because he has just conjured up an imaginary disease to which he has applied a remedy which also owes its existence to his fertile imagination. When the Christian Scientist is brought to the only public test to which he can be subject, namely, that of a legal inquiry, the absolute hollowness of his claims is speedily exposed. He is shown to be a bogus medical practitioner of the worst type, a danger to the State, and a cruel parasite upon society. Curiously enough, the Christian Scientists include many wealthy and aristocratic followers. Their services are held in assemblages crowded with persons of rank, fashion, wealth and culture. As a form of emotional belief, it is no more subject to the cool analysis of

individual reason than many of the irrational and more or less fantastic observances and irrelevancies incidental to many creeds. A striking instance of complete surrender of individual judgment has come to light in a recent coroner's inquiry into the death of Major Whyte, D.S.O., late of the Lancashire Fusiliers, a man of wide accomplishments and possessed of a ripe experience of mankind. In February, 1903, he unfortunately broke his spine in a hunting accident, and like a wise man of the world at once put himself in the hands of a leading surgeon. In September, 1905, he went to the house of a Christian Scientist named Smith, of Elm Park, London, where he was treated by a course of prayers at a cost of a guinea a week. Before his death in May he was seen by Sir Victor Horsley, who described in graphic language the horror of a septic bed sore—"the most horrible case he had ever seen." The gentleman who appears to have been the actual agent of Major Whyte's conversion was Captain Baynes, who described himself as a practitioner of Christian Science, and stated he had been in the Indian Army for seventeen years. In view of the fatal issue of the case, the question arises whether Captain Baynes has not rendered himself liable to an action for manslaughter like any other irregular medical practitioner. The Solicitor of the Defence Union however, may be trusted to look after that part of the matter, just as it has brought to book a medical man named Adcock, who, after fifteen years' medical experience, appears to have joined the Christian Scientists a year or so ago. At any rate, under his care, also at a guinea a week, the bed sore in Major Whyte's pelvis developed and became septic—a result that would be deemed a standing disgrace to responsible medical treatment and nursing. Mr. Adcock now stands committed for trial on a charge of manslaughter. His adhesion to this grotesque sect of Christian Science is, in our opinion, simply inexplicable. It is to be hoped that recurrent scandals of this kind will be put an end to by the sharp legislative interference of Parliament, through the agency of an amended Medical Act rendering penal all irregular medical practice of this gross nature.

NOTES ON CURRENT TOPICS.

Midwives' Practice.

A REPORT appears in the *Sheffield Daily Telegraph*, May 12th, 1906, of an inquiry held by the Coroner of Sheffield into the death of a two weeks' old child at Hillsborough, a suburb of Sheffield, on Wednesday, May 9th. The child was born on April 26th, mother and infant being attended by a certificated midwife, Ada Loxley. The child appeared to be fairly well up to the day of

its death, when it became very sick, and was taken to a Dr. Rollinson's, and died as it was being carried home. The doctor said that the infant was in a dying condition when it was taken to him, and asserted that the death was due to neglect. The cause of death was said to be gangrene (presumably of the cord and navel, though not actually mentioned) brought on by neglect. Mrs. Franks, the lady inspector, elicited the fact that the midwife, a woman of eight years' experience, had only attended seven out of the ten visits required under the Midwives Bill. Her reason was that she lived a long way off, and that she had told the mother that she would not be able to visit every day. She said that the child was fairly healthy at birth, and although it had been ailing a little, she thought it was getting better. The doctor said that the child had not been properly attended to at birth, and that had a medical man been present, it would have been alive at the time the inquiry was being held. The case was one of the worst he had ever come across. The jury returned a verdict in accordance with the medical evidence, and expressed the opinion that the midwife was censurable for not having given proper and sufficient attention to the deceased.

The Medical Sickness Society.

THE 23rd annual report of the Medical Sickness, Annuity and Life Assurance Friendly Society— to give its full title—will be presented to members on the 17th instant. The continued prosperity of this most excellent undertaking is testified in many ways. First of all 183 new proposals have been received during the past twelve months, the largest number in any year of the Society's working. The amount paid away in benefit to members was £11,132 9s., as against £11,566 in 1904. Perhaps the most gratifying feature of all is the steady and continuous growth of the reserve fund, which, starting with £1,484 in 1884, has reached £196,283 in 1905. The average annual increase for ten years past has been from £10,000 to £11,000. These figures speak for themselves as to the stability and great field of usefulness of the Society. It proves, moreover, that medical men are capable of carrying out a commercial organisation on a sound and successful basis. Since the business was started in 1884 more than £100,000 has been disbursed in sickness benefit to members, and the unspeakable value of self-help has been once again vindicated. Great as the extension of members has been, there still remains a majority of the medical profession without the walls of this most useful organisation.

Another Cure for Sea-Sickness.

SEA-SICKNESS has been the curse of seafaring mankind since first we began to go down to the sea in ships. Like every other malady to which flesh is heir it has been the subject of much study, with a view to its prevention and cure. The task appears to] have been more or less aban-

doned by legitimate medical investigators, who are content to take what the barristers call "a watching brief" and await further scientific developments before grasping this thorny problem anew. Meanwhile sea-sickness forms a kind of Tom Tiddler's ground for inventors and others infected with the craze of curing their fellows of this, that and the other malady—for a consideration, expressed conveniently in terms of coin of the realm. If one could only believe in newspaper "cures" sea-sickness has been robbed of its terrors this hundred years and more. Yet hope lingers pathetically in the human mind, even in so apparently forlorn a case as sea-sickness. Possibly the latest "cure" may bring relief to the wave-tossed citizen. It is a steel cap, heated by electricity, to be applied to the head, and is the invention of a gentleman who bears the appropriate name of Herr Kappmeier, of Alsklosta. The idea is to correct the anæmia of the brain which is assumed to be the cause of sea-sickness. Many medical men, however, hold quite different views as to the causation of the malady. Indeed, the general misery and the violent behaviour of the stomach appear to be the only phenomena unanimously accepted by medical informed science.

Compensation for Trade Anthrax.

THE cause of public health is likely to be materially advanced by the wider application of the principle of compensation to workmen, especially in the case of the "dangerous trades." This happy result will be attained by the simple appreciation on the part of the employer of the fact that it will be cheaper in the long run to pay for prevention than for compensation. In a recent case of anthrax contracted by a Bradford operative the firm of woolcombers for whom he worked agreed to pay £140 under the Compensation Act. Although the spores of anthrax are resistant, it would not be beyond the power of sanitary science to devise some method of sterilizing the wool, or better still, of detecting infected hides and fleeces. Incidentally, the Bradford case furnished a vivid illustration of the birth-rate question among the poor. The widow had had eleven children, of whom six at least were living. One, a boy of seventeen, was paralyzed and unable to follow his occupation, a girl of fifteen was in a convalescent home suffering from phthisis, a girl aged twelve earned two shillings a week, and there were three other children, aged ten, nine, and four years respectively. In this little social drama the only sharply limited factor appears to be the wages.

Garden Cities.

THROUGH all the silly crazes of the moment which have for their ostensible object the improvement of health there may be noted one strain namely, a return from the artificial conditions of urban existence to the natural surroundings of the country. It is to the credit of the profession that it is through its influence that this healthy

reaction has taken place, though it may not be equally praiseworthy that the necessity of the change was not recognised till nearly nineteen hundred years of the Christian era had elapsed. Still, it is a distinct gain that public opinion is now awake to the fact that man is an animal who requires not only food and drink, but fresh air, sunlight, and elbow-room. The success which has attended the efforts of the promoters of the "Garden City Association" is a gratifying evidence that the laity are beginning to take a practical interest in the healthy planning and building of their towns, and gratitude is due in no small degree to Mr. Ebenezer Howard and his colleagues for demonstrating that some ideas that sound Utopian are reducible to practical realisation. It is then annoying in the extreme that certain persons have imitated the name but not the substance of the Garden City scheme, and that while seeking to attract shareholders and customers by using the term "Garden City" for their speculations, they should be so doing for their profit, and not for the benefit of their prospective tenants. The pith of the original plan is that over-crowding and high rates, those evils at the root of all city misery, are incapable of rising in the Garden City because of the system of land tenure which devotes all automatic increase in the value of the land to the benefit of the citizens themselves. Any "Garden City" that does not observe this condition is nothing more than a delusion and a snare, that is to say, so far as the first principle of the original scheme are concerned.

'Detailing.'

OUR contemporary the *Medical Record*, in its April 28th number, publishes a special article on the opportunities for the Recent Graduate, of course, in America. From it we glean much interesting information, and, generally speaking, we should say that the, public services in America seem to present advantages and opportunities for young men very similar as regards prospects and pay to those in this country. But we confess we read with some surprise that specific mention is made of a form of employment yclept "Detailing," which is happily rare in Great Britain. "Detailing" anglicised would seem to mean acting as a commercial traveller for drug, instrument and book firms, a position hardly deemed consonant with the dignity of the profession as understood over here. The detailer is assigned a territory by his employer, and in this district he is expected to beat up and canvass his brethren in buying the goods of the firm which engages him. As the detailer is usually paid by commission, it is obviously to his advantage to secure custom by every possible method, and we are told that he must, to be successful, cultivate "courtesy and tact," and that he will find the work "pleasant and fairly remunerative." Other advantages of the position are that "it gives the young physician an excellent opportunity to study manners and customs of the different pro-

fessional men with whom he is brought into contact. Whatever the detailer may learn in America, we fear that in England he would learn little from such study except the art of brevity of speech and chilliness of demeanour. We should imagine that the chief quality a detailer should possess would be a hide-bound indifference to snubs and bad words.

Medical Defence Union.

WE are glad to learn from the annual report of the Medical Defence Union that this useful and plucky body is not only continuing its good work, but that it is in a financially strong position in spite of the many calls made upon its funds. In a hundred and eighty-eight cases taken up by the Union on behalf of its members during the past year in only one was a verdict given against the member, and in that case the damages awarded were only one farthing. The law costs sustained by the Union are very heavy and form the chief outgoing, the other expenses being light, but it is the principle of the Union that every case which it takes up shall be fought irrespective of cost, and it is not therefore surprising that its expenditure under this head amounts to some £1,700. Needless to say the bulk of the litigants with whom the Union's clients are involved are men of straw, and the actual amount received from them in costs is very small. The most important case for the year landed the Union in some £400 for costs, of which it only recovered £40 from the offending party. We notice with pleasure that the name of the MEDICAL PRESS AND CIRCULAR is mentioned with gratitude by the officials of the Union for the support it has rendered to the Union, and we can only repeat what we have said before that it is incomprehensible to us how any medical man can fail to cover himself against possible ruin by not joining the Union or some similar society.

The Postmaster-General and the Press.

THE Postmaster-General last week, speaking at the annual dinner of the Newspaper Society, spoke of the happy relations that existed between his office and the Press. That indeed is the case, and though the fact may be one that in general may seem a matter for congratulation, we feel ourselves that the position is only maintained by a considerable sacrifice of principle on the part of the Post Office. Were the Postmaster-General to realise his responsibilities we fear some of his connections with the Press, which are now so happy, would be put to a severe strain. The Post Office has wide powers in dealing with indecent and fraudulent matter transmitted by post, and no doubt very happy relations might exist between that office and the purveyors of such matter if the postal officials closed their eyes to the nature of the transactions they forwarded. Mr. Buxton, in concluding his speech, wished all newspapers an increased circulation and more advertisements, but we note particularly that he made no reference

to the character of the advertisements he wished them. It cannot be that the Post Office is ignorant of the nature of the advertisements published by many periodicals, advertisements which are filthy, disgusting, and palpably fraudulent; neither can it be beyond the power of the Postmaster-General to refuse to transmit such matter. Much is done by the regulations to prevent any harm being done by sending pathological material by post, even to the point of hampering medical research, but they are administered in an elastic spirit when moral garbage alone is at stake. A new Postmaster-General has at least a chance to distinguish himself by the prohibition of such advertisements. Will he have the courage to rise to the occasion?

Sunday Observance.

A REMARKABLE gathering took place at Caxton Hall last week to discuss the question of national Sunday observance. The Archbishop of Canterbury was in the chair, and among his many supporters were people so widely separated in religious views as the President of the Free Church Council and the Chief Rabbi. The subject at issue was dealt with by the various speakers from different points of view, and although the religious aspect of Sunday was naturally much dwelt upon there was on the whole a disposition to regard the observation of Sunday as a day primarily of rest. Dr. R. Horton described Sunday as kept in England as a unique fact in the world's history, and said that the movement was not directed only to the promotion of worship, but to the maintenance of the health, welfare, and progress of the country. It is a great point gained when prominent divines are ready to deal with the question of Sunday observance in this spirit. It is of the utmost importance that the masses in losing touch with the ecclesiastical Sunday should not wander into paths which entail work for others on what should be a general holiday from work. The week's systole is as necessary for the recuperation of the energy of the country as is a stated period of sleep, or an annual vacation, and the maintenance of an occupation-free day is of primary importance to the public health. We should be most grateful to the Committee on the National Observance of Sunday if they could devise a plan which should give to the doctor that blessing which is the birth-right of every other of his Majesty's subjects.

The Taxation of Professional Incomes.

WE are glad to notice that in the terms of reference to the Parliamentary Committee on the Income Tax is included the question of the differentiation for purposes of taxation of incomes of a permanent and of a temporary character. We presume that what is meant is a distinction between incomes due to interest on property and incomes due to personal labour. This is a matter of the utmost importance to members of the medical profession, who, in common with other professional people, are at present extremely

unfairly treated in the matter of direct taxation. It is manifestly improper, from a merely economic standpoint, that any hindrance should be put in the way of personal industry, such as is done by the taxation of professional earnings. Under the present system a medical practitioner earning, say, four hundred pounds a year, has to pay exactly as much in income-tax as an idler who receives an unearned four hundred a year from ground rents. The whole question needs discussion, and an opportunity is now open to the medical profession of pressing their views. It is a matter which might well be taken up by the British Medical Association and evidence put before the Parliamentary Committee. We see, however, that although the Exeter Division has issued a memorandum on the question, the Association will not take it into consideration until July, when in all probability the Committee will have sent in its report.

PERSONAL.

PROFESSOR ELIE METCHNIKOFF will deliver three lectures at the Royal Sanitary Institute, 37, Russell Square, London, on May 25th, 28th, and 30th, at 5 p.m. The subjects are: (1) "The Hygiene of the Tissues" and (2) "Of the Alimentary Canal"; (3) "Syphilis."

DR. W. BARRIE DOW, of Dunfermline, was on the 4th inst. entertained at dinner by the Fifeshire Medical Association on the occasion of his retiring from practice. Dr. Dow, who was recently presented with the honorary degree of LL.D. in the University of St. Andrews, has been upwards of fifty years in practice.

The sixty-first annual dinner of the German Hospital, London, was presided over last week by the German Ambassador, Count Metternich, in the unavoidable absence of his Royal Highness the Duke of Connaught.

SIR WILLIAM RAMSAY has been elected President, and Sir Henry Roscoe Vice-President of the seventh International Congress of Applied Chemistry to be held next year in London.

THE directors of the Clerical, Medical and General Life Assurance Society have elected Dr. Percival Horton-Smith-Hartley, M.A., F.R.C.P., to a seat on the board, to fill the vacancy caused by the death of Dr. Lionel S. Beale, F.R.S.

DR. PHILIP HENRY MULES, M.D., the well-known surgeon, for many years ophthalmic surgeon at the Manchester Royal Eye Hospital and to the Wrexham and Altrincham Hospitals, inventor of what is now known as the "Mules' operation" for the removal of the eyeball, died on September 1st last, aged sixty-two years, and left estate of the gross value of £28,253.

HIS GRACE THE DUKE OF ARGYLL, K.G., K.T., will lay the foundation-stone of the new building of the South London Institute for the Blind at Borough Road, London, S.E., on Thursday, May 24th.

MADAME CURIE has been appointed to the vacant Chair of Chemistry at the Sorbonne, rendered vacant by the tragic death of her husband. She will be the first woman who has held a Chair in the Sorbonne.

A CLINICAL LECTURE ON TROPICAL ABSCESS OF THE LIVER.

By G. P. NEWBOLT, M.B., F.R.C.S.Eng.,

Surgeon to the Royal Southern Hospital, Liverpool, and Dean of the Clinical School.

As one of the surgeons to the Tropical Ward of this hospital one sees many cases of abscess of the liver arising from disease contracted in the Tropics, or in other words secondary to dysentery, and in all the cases I have seen a history of dysentery has been obtained. Two forms of abscess are met with, the large and usually solitary one, which lends itself to surgical treatment, and the multiple pyæmic abscesses which, as far as I know, are invariably fatal. In eight cases recently observed the amœba of dysentery was found in the scrapings from the wall of the abscess, but only once in the sloughs in the stools. The position of the patient on his back with the right thigh flexed and the body bent towards the right side was noticed several times. Pain was usually present and the peculiar yellowish tint of the skin and eyes, not exactly like jaundice, was observed more than once. Œdema of the side and back was marked in one case, and in two others the abscess was pointing through the chest wall. In some instances the liver was enlarged downwards, but generally speaking, the abscess was found towards the upper and convex surface of the organ, the tendency being for it to point towards the chest. Friction could be heard in this situation in several cases. Two patients were seen suffering from liver abscess who were going about without much discomfort, only the pulse was quicker than normal, but it is probable that early on in the disease the temperature was raised. Though when the dysentery is severe the symptoms of liver abscess may be obscured, yet the opposite may happen; and I explored one man in whom the pain caused by dysenteric ulceration was so intense that I felt sure he had a liver abscess. With regard to diagnosis, one has first to make sure of the presence of pus and then to determine the primary source of it; a definite history of dysentery helps matters, but patients often overlook slight attacks and in some cases are too ill to give any history at all.

Some cases present all the typical signs of liver abscess and cannot be mistaken, but the symptoms vary with the stage in which one sees the disease, and though acute at first the abscess may become more or less chronic and present few physical signs. The diagnosis may therefore be easy or on the other hand exceedingly difficult; and even though pus be suspected, yet it is not always easy to locate the abscess. Malignant disease of the liver, more especially if primary, as in carcinoma or more rarely melanotic sarcoma with a big tender liver and a high temperature, may easily be mistaken for acute hepatitis, and if the patient happens to come from the Tropics, or if there be a history of dysentery, the mistake is quite a natural one. Breaking-down gummata which are often attended by fever of a hectic type very much resemble liver abscesses. In malaria very often hepatitis of a non-suppurative type is present and may be mistaken, and a friend of mine had his liver explored ten or twelve times with a needle, the symptoms eventually clearing up. A suppurating hydatid is usually more tense than a liver abscess, and the history will probably point to the nature of the complaint. One recently seen was in a girl, æt. 12, who had never been abroad, she had had a lump in the region of the liver which had recently become painful, and which was drained through the chest wall. It is a fact, I believe, that abscess does not occur at this age. Empyema, especially when encysted, may be mistaken, and one must always be suspicious of a basal pneu-

monia when practising in the Tropics and on the look out for the condition described by Cantlie as the supra-hepatic abscess. I have been able to demonstrate the fact that pus comes more forcibly through the needle during inspiration when the abscess is sub-diaphragmatic, and more forcibly during expiration if the pus is above the diaphragm. One has to diagnose between rupture of a liver abscess through the diaphragm causing empyema and the perforation of a duodenal or pyloric ulcer, the contents of which have produced a sub-diaphragmatic abscess, and this has perforated the diaphragm, forming an empyema. In the first instance operation may save the patient, in the second it is hopeless. Again, a liver abscess may complicate appendicitis, and from two recent specimens which I have seen the condition can hardly be described as very rare. When the abscess has perforated the diaphragm and is being coughed up, one has to diagnose between liver abscess, empyema, hydatid and tubercle. An examination of the expectorated material may show broken-down liver cells or amœbæ, and in the absence of cysts or bacilli the diagnosis rests between liver abscess and empyema. This can be cleared up by exploratory incision. In some cases the chocolate brown viscid-like matter expectorated is quite characteristic. Amœbæ were not found in the pus from my cases, though it was examined at once, but they were usually found in the sloughs removed when dressing the patients two or three days later. In two cases examined the pus was not sterile, and it is hard to believe that it can be when secondary to dysenteric ulceration. In exploring for a liver abscess when it is likely that the needle will have to be introduced more than once, an anæsthetic is advisable, but if the patient is very ill a local anæsthetic can be used. The most important point is to use a needle large enough to draw off the thick pus which may be present, and it should be at least six inches long. I have opened all my cases freely and drained the cavity with large tubes, but if the abscess be deeply situated the use of a special trochar and cannula is advisable, this will save hæmorrhage, but there are objections in that the tube may slip out, get blocked, or may not drain sufficiently. When the abscess points towards the chest wall it is usually, but not always, necessary to remove rib. In a case recently seen the pus was so thick that it would not run through the needle, but there was a communication with the lung, and it was only after disconnecting the tubes of the aspirator that one saw pus in the needle. The latter moved freely in a cavity, the up and down movement pointed to its being in the liver. It is always well to be prepared to follow up your exploration by immediately operating if pus is found, and in exploring from the abdomen personally I prefer a preliminary incision with exposure of the liver. In one case when the needle entered the abscess cavity the tension was so great that pus escaped by the side of the needle and had I not incised the abscess, no doubt an empyema would have formed. I believe it saves time if, when operating, the walls of the cavity can be well cleaned with gauze dabs or scraped gently with a blunt lithotomy scoop. Many surgeons are opposed to this, as they say hæmorrhage occurs; this has not been so in the few cases in which I have done it. Washing out with disinfectants is useful though not by any means necessary, unless there is a high temperature, but must be avoided if there is any suspicion of a communication with the lung. The typical

anchovy sauce discharge was present in many of the cases, and in several bile-stained discharge appeared later on. When operating through the abdominal wall the liver not being adherent and pus lying deeply, it is necessary to shut off the peritoneal cavity. As a rule the surface of the liver is inflamed and the capsule will hold sutures, but in one case I had to pack with gauze and leave the patient for some days before opening the abscess. I tried stitching up his liver, but the sutures cut out. I have tried stitching the liver to the abdominal wall in the *post mortem* room, but the stitches will not hold unless one first buries a figure of 8 stitch in the liver substance, and then sews up with this as a basis. The presence of a second abscess is always to be looked for, but whether one is justified in exploring from the cavity of the first unless there are distinct signs is doubtful. It is probable that if the patient is not relieved at once by the opening of a large liver abscess there are others present, unless severe dysentery is complicating matters, but in exploring for them the puncture had better, if possible, be made in a fresh place, and not through the first wound. The few cases observed bear out the

completely curing the dysentery, which after the abscess is better is apt to be made light of.



PHOTO. II.

CASE I.—In this man three abscesses were opened during a period extending over four years, two through the chest wall, and one by laparotomy. The third abscess opened into the lung, and he was rapidly becoming exhausted by the constant cough—twenty-eight ounces of pus were coughed up in twenty-four hours. During the whole of his illness, slight dysentery



PHOTO. I.

statement that the favourite site for abscess is the upper convex surface of the liver, and that lung complication is common. In Case I. two abscesses were opened through the chest wall, and one of these communicated with the lung. In Case II. one abscess was opened through the chest wall. In Case III. two abscesses were situated at the upper and posterior surface, but were not opened. In Case IV. the abscess pointed through the chest wall. In Case VII. the abscess opened into the lung and was drained by resecting ribs, finally Case VIII. was opened through the seventh interspace.

In only one instance was the left lobe of the liver affected, and this also applies to the pyæmic cases. The method of allowing the abscess to burst through the lung as a means of cure we must hope is now obsolete, for if Cases I. and VII. had been left to Nature neither of the men would now be alive. The first man was rapidly being exhausted by his cough alone, and the second could not empty his abscess as the pus was too thick.

Prognosis.—Four out of eight cases got better, but in all these the abscess was single except in the first patient, where three were opened one after another; the pyæmic cases all died. It is probable that as long as a trace of dysentery remains the patient is liable to a fresh infection, and it is useless curing the abscess without at the same time

existed, and this was cured by injections of nitrate of silver, 20 grains to the pint of water. He made a good recovery.

CASE II.—Two abscesses were opened, one through the chest wall behind, and the second by laparotomy, a third abscess existed between the other two, but unfortunately was not detected, and the man died. His dysenteric ulcers were healing.

CASE III.—Had pyæmic abscesses, one large one was opened by laparotomy, six days later he was seized with uncontrollable vomiting and died. Two abscesses were situated at the back part of the liver.

CASE IV.—Was a good example of a man going about with an abscess of his liver without suffering much inconvenience. It was pointing below the ninth rib, which was necrosed. He made a good recovery, after resecting the diseased rib and draining the abscess.



PHOTO. III.

CASE V.—Here the only symptom was a quick pulse and a little uneasiness in the hepatic region. He had a high leucocytosis. After exposing the abscess by abdominal section the pus would not run through a big needle, and this I regard as an argument in favour of exposing the liver by laparotomy and then using the exploring needle. Recovery ensued.



PHOTO IV.

CASE VI.—Was one of multiple pyæmic abscesses in a soldier. He had been explored abroad by laparotomy, and it was thought he had a malignant liver. When admitted to the Southern Hospital it was evident that pus was present, the abscess was tympanitic. Gas escaped when it was opened. He died later on and *post mortem* there was only a thin wall between the abscess cavity and the transverse colon. The liver was full of pyæmic abscesses.

CASE VII.—Here the patient was merely skin and bone, and was expectorating the contents of his liver abscess. The expectorated material was reddish in colour, and contained liver cells. After resecting rib and draining the abscess, the pus in which would not run through the needle used, as it was of the consistency of thick cream, he made a good recovery.

CASE VIII.—Here the patient worked as a fireman until admission. His abscess was pointing through the chest wall. Photo I.—An opening was made through the seventh interspace, shown in Photo II. He, however, did not improve as his dysentery was very severe, and *post mortem* the whole of the large intestine was covered with sloughy ulcers which, in the sigmoid region, had caused adhesions to the pelvic walls. Photo III.—Though fifty ounces of pus were evacuated, ten days later the cavity would only contain four ounces of lotion. There were some infarcts in the liver substance around the abscess cavity—Photo IV.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The lecture for next week's number will be by Professor James Alexander Lindsay, M.D., F.R.C.P. Lond., Professor of Medicine, Queen's College, Belfast, Physician to the Royal Victoria Hospital, Belfast, on "Malignant Disease of the Lungs."

A SERIOUS epidemic of measles has broken out at Sedgley. Three children who contracted the disease were allowed by the parents to attend school, with the result that other children caught the contagion, and on Saturday about 150 children were, it is estimated, directly or indirectly affected.

A TELEGRAM from Philadelphia says that 200 police and fifty physicians have isolated nine blocks in the densely populated portion of the city, forcing 14,000 persons to submit to medical examination and 3,000 to vaccination.

ORIGINAL PAPERS.

THE QUESTION OF CANCER.

By DR. DOYEN, OF PARIS.

(Read before the International Congress of Medicine, Lisbon, April, 1906, specially translated for this journal at the request of author by Mr. H. de Meic, M.R.C.S., Surgeon to the French Hospital in London.)

What scientific proof exists in the present day of the parasitic nature of neoplasms, and more especially of cancer?

Cancer, whether as an epithelial or a sarcomatous tumour, and all neoplasms, whatever their histological variety, are of parasitic nature. The pathogenic agent is the micrococcus neoformans which I described in 1901. The cancer microbe can be obtained in a pure condition from all aseptic tumours that develop rapidly, and especially from neoplastic ganglia of recent formation. Three times I have succeeded in obtaining cultures of it by inoculating mammary tumours and a sarcomatous ganglion in a bitch.

The pieces removed with strict aseptic precautions from the tumours or the ganglia should be cultivated in tubes containing a very small quantity of bouillon from the udder of a cow to which is added 0.5 per cent. of chloride of sodium and 1.2 per cent. of Chapoteaut's peptone. The development of the micrococcus neoformans is better carried out if the neoplastic fragment is bathed by the bouillon without being entirely immersed in it.

The bouillon becomes turbid sometimes in 18 or 24 hours, sometimes only in two, three, four or five days. During the first phase of the culture, isolated microbes, diplococci, triads and tetrads, come especially under observation, later on numerous chains having from five to nine elementary parts are seen, which have a tendency to bifurcate in the form of a Y. The elementary parts of the micrococcus neoformans are of a very irregular diameter; their mean diameter is 0.5 m.m., the smaller ones being 0.2 m.m., the larger 2 m.m.

In tumours and fresh cancerous juice there are but a small number of micrococci that can be coloured by Gram's method. Excellent preparations can be obtained with Azur II. Eosine and Azur II. dissolved in methylic alcohol and of glycerine according to Giemsa's formula. The lamellæ are coloured during twenty-four hours by means of a 10 per cent. solution of Giemsa's reagent (Griibler) in ordinary sterilised water and the colour is removed by water either pure or with the addition of a few drops of methylic alcohol. The lower part of the preparation remains of a blue colour and the micrococcus neoformans is shown up by a reddish purple staining. Such preparations are very difficult to bring to a successful issue.

The microbe as soon as it is developed in the bouillon can be coloured by Gram's method, though it soon loses, at least partially, the property of remaining coloured under the action of iodine. Really, in old cultures, coloured by carbolised violet and Gram's method with double colorations by weak fuscine, only a small number of cells, sometimes the halves of micrococci, can be seen having a violet colour and the red staining predominates. The micrococcus neoformans is differentiated from all other kinds previously described by its morphology, by the character of its cultures on gelose and gelatine, and by its pathogenic properties.

1. *Morphology.*—To the educated eye the young cultures containing little else but diplococci of unequal beading are characteristic. At the end of from two to three days, the Y-shaped bodies and the little chains of 5 to 9 elements can be observed, rarely anything beyond these. The mean diameter of the cells is 0.5 m.m., and may vary from 0.2 m.m. to 2.0 m.m. and even more.

2. *Characters of the Cultures on Gelose or Gelatine.*—The bouillon culture transplanted on to ordinary gelose develops as a layer having a greyish white colour, shin-

ing, very thin, and fluorescent to light by transparence. At the end of from twenty-four to forty-eight hours it is seen that the culture is adherent to the gelose and has become fixed as viscous filaments to the platinum needle. As it gets older the culture becomes almost transparent. On gelatine, with stab culture, liquefaction commences about the fourth day and rarely reaches the whole of the centre.

3. *Pathogenic Properties.*—The micrococcus neoformans presents this peculiarity—namely, that it is an intra-cellular parasite. When injected into the testicle of a guinea-pig, it penetrates into the epithelial protoplasm which plays the part of phagocytes to the parasite. By experience it is found that the testicles should be removed on the third, fourth, or fifth day and coloured by carmine and Gram's method after fixation with acid sublimate. The most characteristic lesions are obtained with white mice and white rats. The following is the technique of the inoculations:—

A certain quantity of tumour and ganglion fragments should be cultivated, 10 or 20. After from 24 to 48 hours all these cultures are transplanted on to gelatine inclined at a certain angle to find out if there is no contamination by the staphylococcus aureus and if the cultures themselves become filamentous from contact with the platinum needle. Inoculations after twenty-four hours can be made in a same number of gelatine tubes of cultures on gelose. The bouillon tubes which have remained sterile should be again inoculated on gelose the next day or the day after. On the fifth or sixth day all the original tubes corresponding to the gelose tubes that have been verified as pure are emptied into a sterilised glass; the fragments of tissues in which the cells are dead are cut into small pieces and pounded in a mortar and the whole is passed through a fine metallic sieve. The corresponding cultures on gelose rendered diluent by twenty-four hours cultures on a cow's udder bouillon are then added. Of this emulsion a quarter of a cubic centimetre should be injected into the peritoneum of a white mouse and about three cubic centimetres into the peritoneum of a white rat. It is easy to effect these manipulations in sterilised vessels, strict aseptis being employed.

For each inoculation from 25 to 30 mice and as many rats are necessary. A certain series for example may be inoculated with cultures of ovarian cancer, another series with cultures of sarcoma or of encephaloid osteosarcoma. With the emulsion of quite young microbes can be mingled cultures on gelose of microbes collected at a more ancient date such as 15 or 20 days.

Cultures, when too old, seem to lose part of their virulence. Subcutaneous inoculations are less active, but may be carried out notably in the breast of the dog. It is easy to inoculate medium sized bitches in the peritoneum, and in the breasts, but in some animals the inoculation should be preceded by an injection of a sterilised mixture of paraffin fusible at 40° C., as an irritating agent.

I will not waste time in describing two subcutaneous lipomata which developed in two months in a bitch, or two cases of arborescent lipomata of the peritoneum accompanied by generalised visceral lipomatosis which supervened in one month and two months respectively in two female mice, or some other isolated results.

A series of the most typical lesions can be studied in the white rat. One of the difficulties in these experiments is to avoid secondary infections, especially by the staphylococcus aureus with which these naturally dirty animals teem, especially on the surface of the skin and in the sebaceous hair follicles. For this reason I have made a certain number of inoculations directly into the peritoneum through a small incision in the linea alba. It is rare for any interesting lesions to appear before the end of the second month. However, in animals that have died, the first nine days, the second and the third thirteen days after inoculation, I have found a lesion of the liver characterised by an intense perihepatitis in which the cellular tissue was crowded with the micrococcus neoformans undergoing the process

of phagocytal destruction, and by miliary and nodular foci of newly-formed cells. These foci destroy the hepatic tissue and have some analogy with small sarcomatous nodules. These hepatic lesions have also been observed in rats that have died after a longer period. I will not insist, however, on the importance of this miliary lesion of the liver because it is too easily criticised by being relegated to the rank of purely inflammatory lesions.

For the same reason I leave on one side the formation in the lungs and lymphatic ganglia of the same animals of nodules analogous to the hepatic nodules described above. In reality these lesions are not sufficiently characteristic for one to affirm that the process is not merely inflammatory.

The most interesting lesions are seen in the lung from two to four months after inoculation. The animals experimented upon must be closely watched many times each day, so that they may be killed at the exact moment when they are near to death. In fact, the specimens taken several hours after death are much less reliable for demonstration. These lesions present two distinct types.

1. A partial infiltration of the lung by nuclei, presenting all the characters of hyaline cartilage.

2. A sort of reddish grey hepatitis, affecting more often the inferior lobes.

We will leave on one side the cases in which the lungs are partially transformed into caseous alveoli, as these examples correspond to accidental secondary infections.

I.—MILIARY ENCHONDROMA OF THE LUNGS.

This lesion, of which, by means of Kaiserling's method, I have been able to obtain a very curious specimen, is sometimes limited to a small portion at the edge of the inferior lobe. More often are seen at the same time a cartilaginous transformation of the edge of one, or of several lobes, and also cartilaginous miliary nuclei about the size of a millet seed disseminated on the surface of the lungs. These cartilaginous nuclei are of a bluish white colour by reflected light, and of an opaline shade when examined by transparency. The microscopical sections show that these cartilaginous transformations are preceded by an infiltration of round cells in the intercellular passages of the lung, the hyaline substance occurs at the level of these foci, which are inflammatory in appearance, and fills up one after the other the neighbouring alveoli and bronchioles. The proper tissue of the lung and the skeleton of the alveoli disappear little by little, and at those points where the cartilaginous transformation is very advanced no trace of elastic fibres can be found. These lesions, being without exception of quite recent formation, only a small number of cartilaginous capsules can be made out. It is moreover known that the cartilaginous capsules do not exist in embryonic or newly-formed cartilage. In the vicinity of these cartilaginous nuclei can be seen epithelial neoformations that seem to spring from the dilated bronchioles, although they are met with even as far as in the neighbourhood of the pleura. These epithelial neoformations present the shape of irregular alveoli covered with cylindrical or cubical cells and into whose calibre penetrates at certain points the cartilaginous substance which here infiltrates in a like manner to a colloid exudate, capable of being organised and of tending to bring about the disappearance of the last remains of lung structure. These epithelial lesions are so accentuated that some of them may be looked upon as chondroepitheliomata.

II.—EPITHELIAL NEOFORMATIONS.

The epithelial neoformations, as has just been pointed out, always coexist with the cartilaginous neoformations, but they may often be observed alone. Some pulmonary lobes invaded by the greyish red hepatitis before mentioned are riddled with large irregular cavities lined with a single layer of cylindrical epithelioma and between these the pulmonary alveoli are weakened and compressed. These newly-formed epithelial alveoli with their cylindrical coating are identical with those that may be seen in some cases of

cylindrical cancer in the human being. The pulmonary lobes thus affected are invaded by newly-formed epithelial alveoli, the invasion extending to the neighbourhood of the pleura. These epithelial neoformations take birth, without exception, in the centre of small collections of round cells analogous to those which in before mentioned cases of enchondroma are most active in the formation of hyaline substance.

In other parts the cubical epithelial covering is transformed into stratified pavement epithelium and the epithelial cells, on their road to active proliferation, are seen to have multiplied either between the epithelium of a dilated bronchus and Reissen's muscle or, after having perforated and destroyed this muscular layer, in the adjoining peribronchial space. These peribronchial nodules infiltrated with neoformed epithelial alveoli can attain such a size that the pulmonary alveoli, weakened and compressed, are found to be thrown back on their periphery and then present but a potential cavity. It is easy to follow in the microscopical section the process of these epithelial neoformations.

Two types of epithelial lesions can therefore be observed, generally in juxtaposition; large alveoli with a cylindrical covering, and small alveoli full of cubical epithelia.

GANGLIONIC METASTASES.

The lymphatic ganglia of the thorax are generally hypertrophied. In a certain number of cases, the presence of small foci, sometimes confluent, of similar cells to the cells of the peribronchial epithelial neoformations cited above can be demonstrated; these neoformations seem to be epithelial metastases infiltrating and separating the lymphatic follicles or the medullary substance.

PROPORTION OF POSITIVE INOCULATIONS.

Epithelial or cartilaginous neoformations have been observed as the result of four series of inoculations, dated respectively March 16th, May 25th, July 1st, and October 25th, 1905, on more than 50 per cent. of white rats which had survived the inoculation more than two months. Cartilaginous neoformations have been observed, in a more or less accentuated degree, on eleven animals, whilst the epithelial neoformations existed in all cases of positive inoculation; the cartilaginous neoformations have thus been superadded to the epithelial neoformations in eleven cases.

The micrococcus neoformans is then a new species of microbe well characterized—

1. By its constant presence in spontaneous tumours of rapid evolution.
2. By its mode of development in various culture media.
3. By its morphology.
4. By its property of being an intra-cellular parasite. Its inoculation on animals, notably on white mice and white rats shows:
5. That this microbe is endowed with unquestionable pathogenic properties and that its inoculation provokes in a large number of the animals experimented upon neoformations of a conjunctive type (chondromata) or of an epithelial type identical with certain spontaneous neoplastic lesions of man and of animals.

These experiments necessitate great perseverance and require a very careful technique. The results, of which a description has just been given, are the fruit of five years' uninterrupted researches. Those of my colleagues who would desire to repeat them must multiply the number of cultures and inoculations so as to have more occasions of finding cultures not only very virulent but also endowed with accentuated pathogenic properties.

The organs of small animals should be collected immediately after death, cut up with the microtome into sections which should each be numbered and placed in a series, so that no particularity worthy of interest can possibly be passed over.

ETIOLOGY OF NEOPLASMS.

To discover in the most varied neoplasms having the conjunctive or epithelial type, a constant parasite,

should suffice by itself to establish a probable etiological relation between the tumour and the parasite.

It has just been seen that experiments on animals, notably on the white rat, have given results not only positive, but also sufficient to establish and characterise the pathogenic role of the micrococcus neoformans as well with regard to neoplasms of the conjunctive type (lipomata enchondromata) as to epithelial neoplasms (alveolar and cylindrical cancer).

The process that presides at the development of tumours is very simple; the pathogenic microbe is very abundant in nature; it can develop as well on the surface of the skin and mucous membrane as in the buccal cavity and in the digestive tract. The portal of entry is most often a fissure of the skin or mucous membrane, an erosion caused by a carious tooth, an old ulcer of the stomach, a fistulous track. The micrococcus neoformans can also penetrate through the excreting canal into the acini of the breast, of the pancreas.

Next to direct infection, which is generally the cause in epithelial cancers, infection by the vascular or embolic road produces in its turn nearly the totality of tumours of mesodermic origin and some epithelial cancers, for example, cancers of the thyroid body, of the kidney, of the ovary.

The micrococcus neoformans, an intra-cellular parasite, determines the proliferation of the epithelial and mesodermic cells into the protoplasm from which it has been introduced and in which it partially undergoes phagocytic destruction. The irritated cells proliferate and multiply whilst deviating at the same time more or less from their original type. It is an accumulation of neoformate cells that, through the tendency of these last to grow and to invade adjoining tissues, constitutes, according to their more or less penetrating and destructive evolution, benign and malignant tumours.

Slowly progressing tumours and those of a benign character are the seats of a latent microbism and are susceptible, on the slightest occasion, notably under the influence of a traumatism, of undergoing malignant transformation. An adenoma of the breast can develop, as well as an osteo-sarcoma of the limbs, after a violent blow, which acts as a fixator of the pathological process in the same way, for example, as in osteo-myelitis of young people. As soon as the neoplastic process is installed, all the parasitic cells are susceptible of contributing to the formation of the tumour. It is thus that in the production of epithelial tumours there is always neoformation of conjunctive tissue, and this last may even predominate in certain metastases in which the epithelia are rare and are, as it were, smothered by the neoformate fibrous tissue.

Mixed tumours and all the different varieties produced by a distant infection are equally explained by the fact that all parasitic cells are susceptible, when carried away in the lymphatic or sanguineous current, of proceeding a long distance to proliferate and form a secondary tumour, in the same manner as the development of the parasite outside those cells can infect the neighbouring cells, which in their turn become the point of departure of lesions superadded to the first.

Thus, I have observed in a sub-maxillary gland metastases of epithelioma, of the epidermic globus variety, coming from the tongue, whilst by direct contact the acini had been transformed into cylindrical cancer.

The neoplastic process is nothing more than a special inflammation in which the parasitic cells have the property of multiplying themselves *ad infinitum* and of invading the human organism either from near to near or by metastases until death is caused.

DR. GEO. R. ADCOCK, of Pimlico, said to be legally qualified, but whose name we cannot find in the "Register," was committed for trial at the Westminster Police court on Saturday last, bail being refused, in connection with the so-called "Christian Scientists" and the recent death of Major Whyte.

INGUINAL HERNIA IN A FEMALE.*

By E. SCOTT CARMICHAEL, M.B., F.R.C.S.E.,
Assistant Surgeon, Edinburgh Royal Hospital for Sick Children, &c.

In adults this form of hernia occurs in the female in from 5 to 10 per cent. of all cases, and in children the proportion is higher—just over 10 per cent. of 760 radical cures performed in the Sick Children's Hospital. In the majority of cases the rupture is noticed within the first few years of life, and is probably of congenital origin. As in the male, the hernia is more commonly right than left sided; in the series quoted 39 were right, 24 left, and 13 double. Contents were found lying in the sac in 28 cases, the relative proportions being as follow:—Tube and ovary, 17; tube alone, 5; small intestine, 2; omentum, 2; cæcum, ovary and tube, 1; appendix and ovary, 1. In two cases the sac contained a tuberculous nodule.

Hernia of the Ovary and Tube.—It is suggested that the persistence of the so-called canal of Nuck should be associated in so large a proportion of cases with malposition of the ovary and tube. In the young child the ovary may lie alongside the lumbar vertebræ on the psoas muscle as high as the lower angle of the kidney, or it may be as low as the internal abdominal ring. It is difficult to say how far the descent of the ovary depends on the action of the gubernaculum, or inguinal ligament, but probably this band is in some way responsible for the position of the organ. The tube and ovary were present in the sac alone or along with another viscus in 24 out of 28 cases, and this frequency cannot be explained on mechanical grounds, but must be associated with the development of the inguinal ligament. The origin of the canal of Nuck is disputed, but Mr. Carmichael was inclined, after operating on this series of cases, to regard it as an abnormal protrusion, associated in some way with the development of the inguinal ligament and caused by the same conditions as draw down the ovary and tube. These viscera do not lie free in the sac as intestine does, but are closely associated with its wall, one broad ligament or meso-salpinx springing directly from its posterior aspect. The ovary is rarely present when the canal is short, and almost invariably present when the canal is long. There is no evidence that ovarian hernia results from elongation of the meso-salpinx or mesovarium; in Mr. Carmichael's cases the mesenteric attachments were often so short as to render replacement a matter of some difficulty, and to require division of the structures. The tendency to bilateral inguinal hernia is greatest in young infants; thus, in babies under 1 year (21 cases), 8 were double; under 3 years (21 cases), 2 were double; over 3 years (34 cases), 3 were double. Similarly the younger the patient the more frequently are tube and ovary found in the sac—13 cases under 1 year, 7 cases under 5 years, 2 cases over 5 years. In order to replace the viscera it is necessary to divide the attachments freely, and the question arises as to whether the ovary should be removed to prevent future trouble. From an examination of the ovaries *post mortem*, in a number of young infants, Mr. Carmichael had satisfied himself that their macroscopic appearance varied so greatly in different instances that he had never felt justified

in removing a herniated ovary as abnormal. In adults the ovary had in some cases been found to be diseased, but in many instances there was evidence of its functional activity (swelling and tenderness during menstruation), hence it was not good practice to remove the organ as a matter of routine. In the adult there are often associated mal-development of the genital organs and sterility is the rule in double herniæ.

Hernia of the Uterus has been recorded, but Mr. Carmichael had no instance of it in his cases, though in one on traction on the tube the uterine horn appeared at the inguinal ring. Pregnancy has been observed in a herniated uterus; the organ is often malformed, and the rupture is generally left-sided.

Hernia of the Bowel and Omentum.—As the hernia is most frequently right-sided the appendix is a common content of the sac. When small intestine is present, it is usually the ileum, just above the cæcum, which prolapses. The omentum alone occurred in the sac in two cases.

Tuberculosis of the Sac.—This occurs in about 3 per cent. of herniæ in young subjects. It generally takes the form of a nodule at the apex of the sac, and in this case simulates an ovary. These nodules are simply isolated numbers of the nodules lining the abdominal cavity, for tubercle of the sac of a hernia is almost invariably associated with tuberculous peritonitis. Hence, when an oval swelling is detected in a rupture the examination of the abdomen for evidences of tubercle there is imperative. In the second, and less favourable, variety, the sac is thickened and converted into tuberculous granulation tissue. Examination of the abdomen reveals no abnormality, and there is little, if any, glandular enlargement. Mr. Carmichael reported a case of this nature in which operation was followed in six weeks' time by death from tuberculous meningitis. In these cases the abdominal peritoneum may be wholly converted into tuberculous granulation tissue, which may give no clinical evidence of its presence, even on examination under a general anæsthetic.

Clinical Features and Differential Diagnosis of Inguinal Herniæ.—Where a swelling is present in the inguinal region in a female subject, there are several possibilities in the matter of diagnosis. When the sac contains bowel the diagnosis is usually easy. When only a slight swelling containing an oval bean-like mass is felt we may have to do with (1) a superficial gland, (2) the ovary in the sac, (3) omentum in the sac, (4) encysted hydrocele of the canal of Nuck, (5) a tuberculous nodule in the sac. The ovary is generally mobile and can be displaced up into the canal; a gland is but slightly mobile; encysted hydrocele is also but slightly mobile, and is as well a rare condition. A tuberculous nodule is mobile and is situated at the apex of the sac, and there is generally also evidence of tuberculous peritonitis. Omental hernia is, as a rule, irreducible; it is rare in the child. The writer's conclusions are:—(1) Inguinal hernia in the female child occurs in about 10 per cent. of all cases; (2) it is associated in nearly 30 per cent. of cases with descent of the ovary and tube; (3) the presence of these organs is often associated with malformation and defects of the genital organs; (4) the condition most likely to be confused with hernia of the ovary is a tuberculous nodule of the sac.

* Abstract of Paper read before the Medico-Chirurgical Society of Edinburgh, May 2nd, 1906.

THE OUT-PATIENTS' ROOM.

FRENCH HOSPITAL AND DISPENSARY.
BY DR. LOUIS VINTRAS, M.D.

DR. VINTRAS said he would illustrate the minor philosophy of medicine by some cases in this department taken haphazard. How small injuries became of importance was illustrated by the case of a young man who had had a cut over the terminal joint of the forefinger of the left hand some time previously: the cut had been neglected and had suppurated, involving the joint; the wound was now perfectly healed, but the result was a stiff joint. This might seem trivial enough considering it was the left hand that was implicated, but it happened that the patient was a worker in metals; he used the thumb and forefinger of the left hand to steady the stiletto on which he hammers with the right hand. The fact of the terminal joint being stiff rendered it impossible for him to hold with any command the instrument in question, and therefore, like Othello, his occupation was gone. The man was much distressed, and the question was naturally of vital importance to him; he was ready to undergo any treatment or operation which would enable him to work again. It was ascertained that he could get command of his instrument by holding it between the thumb and the middle of the forefinger if the rigid end were not in his way. The treatment became obvious—the removal of the terminal phalanx. The treatment was accepted, and the result was quite satisfactory to the man. There is a certain knack, Dr. Vintras said, in seeing cases in the out-patient room, which is only acquired by long experience. For instance, two children coming from widely distant districts of London were brought in one after the other. Both were suffering from a very slight papular rash, with no temperature; there was no fever, no history beyond the sudden appearance of the rash the day before. Child No. 1 had a clean tongue and the mother said that its appetite was not impaired; child No. 2, had a tongue that was slightly furred, and it was noticed that its eyes were watering slightly; No. 1 was suffering only from a slight heat rash; No. 2 had measles and was notified by the R.M.O. The diagnosis was confirmed when, on the next visiting day, the first child was brought back quite well, while it was afterwards ascertained that the No. 2 child had a severe attack of measles. The out-patient department, Dr. Vintras remarked, is not without its tragedy. A woman, *æt.* 45, came bringing a letter from a local practitioner. She had been suffering for three weeks with incessant vomiting, with pain over the epigastrium. The vomiting had somewhat abated during the last three or four days, and she was able to keep food; she was a cook in a situation, and it had been thought that with some further treatment in hospital and rest at the Convalescent Home she might make a good recovery. She was put on the couch and the region of the stomach examined, with the result that towards the right end of the stomach on deep pressure a hard nodule was discovered. On calling her attention to this she said she had lately noticed it at times, but that it disappeared at others. On questioning her closely, it was found that she had lost flesh considerably during the last three months, and that what she had been vomiting had often been of a dark brown colour, and at other times tinged with blood; her breath smelt very bad. The surmise, of course, was carcinoma of the stomach. The supposed disappearance of the hardness of which she had spoken had been merely caused by the fact that when the stomach was dilated with wind, the nodule was pushed upwards and at other times it receded. The woman was admitted to the hospital; her condition appeared to improve, and she was sent to the Convalescent Home. As soon as she arrived there the vomiting began again; it had the typical coffee ground appearance, and the diagnosis was confirmed. Here is a woman who, when she came into the out-patient department, was under the impression that she was suffering from nothing worse than a transient gastric trouble. The examples, Dr. Vintras said, might be

multiplied *ad infinitum*, but the few he had given were enough to illustrate the variety and interest of everyday practice in the out-patient department.

OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

REMOVAL OF A CALCULUS OF THE BLADDER BY THE SUPRA-PUBIC METHOD.—MR. PRYTON BEALE operated on a man, *æt.* about 40, who had been previously sounded, a stone being detected in the bladder. The stone was computed to be about an inch and a-quarter in length, with a smooth surface, and it had given rise to very few symptoms, pain along the urethra after micturition being practically the only one. The presence of this stone was only detected in the routine examination of the case, that is to say, the urine was examined, the abdomen was palpated with a view of feeling the kidneys, the rectum was investigated, and lastly, the bladder was sounded, when the presence of a stone came rather as a surprise. The patient had a slight stricture of the membranous urethra, and although the lithotrite might have been introduced it would have been difficult or impossible to pass an evacuator. Thus supra-pubic cystotomy was decided upon. The operation was performed in the ordinary way, no difficulties being encountered. The stone was a flat one, measuring about an inch and a-half by an inch and a-quarter and three quarters of an inch thick. Mr. Beale remarked that this was an example of a case in which a stone was found, as it were, by accident. He considered that it was not wise to attempt lithotripsy where there was the slightest indication of a stricture, because, although the lithotrite might be introduced fairly easily, the passing of the evacuator might give a great deal of trouble; moreover, the crushing of a stone would be working in the dark, and in these days he ventured to think that the average surgeon had such a very slight experience of lithotripsy that he was hardly justified in undertaking it except for quite small stones. Supra-pubic cystotomy, he remarked, was so extremely simple that it was on the whole safer. He had had a case some years ago in which the stone was detected by a sound passed at the time of operation, but on opening the bladder supra-pubically no stone could be found. This turned out to be a case of hour-glass bladder, and the upper part of the viscus, which had been opened, was sewn up again without any removal being attempted. This patient was suffering rather severely from the stone in his bladder; but the operation, curiously enough, seemed to relieve him immensely, and at the present time, though the stone is still present, he has practically no symptoms; when symptoms do come on the stone will be removed by median perineal section.

STRANGULATED VENTRAL HERNIA IN A WOMAN

ÆT. 80.—The same surgeon operated on a woman *æt.* 80 who had suffered for more than twenty years with a large ventral hernia which had suddenly become strangulated about thirty-six hours previously. When the sac of the hernia was opened it was found to contain omentum and small intestine. Part of the latter was so doubtful in aspect with regard to its recovery that it was left just beneath the wound. However, it recovered completely and the patient progressed perfectly well. The chief difficulty with ventral hernia in Mr. Beale's experience was the presence of numerous adhesions between the omentum and the sac, but particularly in the inner aspect of the neck of the sac; he believed that it was not wise to attempt to separate these, but that the best plan was to cut off the sac at the neck and stitch the edges firmly together, leaving the adhesions intact. Of course, this could not be done if there was

any bowel of doubtful colour within the sac; if such were found to be the case he thought the best thing to do was merely to relieve strangulation at the time and then afterwards to remove the sac and stitch up the abdominal wall at a second operation. He had come across several large ventral hernia which contained the whole of the transverse colon together with small intestine. In most cases, he pointed out, it seemed that

it was the colon which suffered from strangulation. In one case he found the whole of the transverse colon absolutely gangrenous. This was merely opened freely and then at a subsequent operation the ends of the colon were approximated and dropped back in the abdomen. He was sure it was never wise to attempt an anastomosis at the time one operated on a strangulated hernia.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD MAY 11TH, 1906.

The President, Mr. CLUTTON, in the Chair.

CYSTIC TUMOUR OF THE SPERMATIC CORD.

MR. CUTHBERT WALLACE described a case of cystic tumour of the spermatic cord. A man, *æt.* 41, was admitted into St. Thomas's Hospital, with what appeared to be an irreducible inguinal hernia and gave a history of abdominal pain and vomiting. Operation showed that the tumour consisted of two main cysts with numerous smaller ones, the whole mass lying under the cremaster muscle and in the cord. At the internal ring the tumour disappeared within the abdomen and could be felt to form a considerable mass in the pelvis. The inguinal mass was excised. This case evidently belonged to those that were described by the older writers as "Diffuse hydrocele of the cord." Percival Pott, in 1773, was the first to describe the condition; he was of the opinion that it was of the nature of an oedema, and this view is the one still put forward in the English books which make mention of the subject. Mr. Wallace believed that this explanation could not be accepted. The so-called cystic adenomata of the testis and kidney were supposed to arise in remains of the Wolffian body and in their construction were very similar to the tumour under discussion. When the original relation of the testis and kidney was borne in mind it seemed that it would not be unlikely that the foetal remains found in these two organs should also be found in the spermatic cord. It appeared, then, that it was not improbable that the multilocular cystic tumour of the spermatic cord had a similar origin.

Mr. E. PERCY PATON had had a similar case four or five years ago in a woman, *æt.* 40. It was lined by endothelium. Clinically the case was diagnosed as one of hernia.

Mr. KELLOCK asked for a description of the fluid contents. He pointed out the resemblance between the condition and that found in the neck and called cystic hygroma.

Mr. H. H. CLUTTON referred to a case similar to that of Mr. Wallace's. The resemblance of the condition to cystic hygroma of the neck was only a superficial one. The walls of the cord tumours were very thin, and of quite different structure from that of a hygroma.

Mr. WALLACE, in reply, said that the fluid in the cysts was albuminous and contained no spermatazoa.

Mr. A. C. HUDSON read a paper on

CARCINOMA OF THE THYROID GLAND.

A description was given of eight cases of tumour exhibiting the characters of malignant invasion, and of six cases in which, although the ordinary clinical features of malignant disease were absent, the tumours showed the histological structure of carcinoma. Two tumours discovered at necropsy were also described. A brief reference was then made to the mode of origin of the capsule of the simple adenomatous thyroid tumour, and its possible significance in the study of the behaviour of carcinomata. The cases described pointed to the disease being somewhat commoner and at the same

time more amenable to surgical treatment than was perhaps generally believed; they also emphasised the difficulty likely to be experienced in correctly estimating the degree of malignancy of epithelial thyroid tumours solely from the type and arrangement of the epithelial cells. Evidence of metastasis and invasion of surrounding tissues was most important.

Mr. H. H. CLUTTON related the history of several cases that had been under his care. In his opinion the prognosis as regards life was considerably better than was usually thought. His first case—operated on in 1886—was still well. In diagnosis he attached importance to a high degree of fixity of the tumour to the trachea. These carcinomatous tumours were frequently overlooked, being mistaken for simple adenomata. He thought that thyroid metastases were rare.

Mr. C. W. WIRGMAN said that, on the contrary, there was a large literature of cases of such metastases. They usually occurred in the vascular bones, the skull or spine. Such growths may be the first symptoms to the patient, who might be unaware of the thyroid tumour. He had seen two such cases recently.

Mr. WALTER C. SPENCER pointed out that, in thyroid tumours, a perfect gradation might be traced between simple adenoma and the most malignant carcinoma. This applied to the metastatic growths as well as to the primary one.

Mr. HUDSON, in reply, said that the question of malignancy, and also of metastatic growths, in these cases might possibly be one of tissue resistance. In other words an apparently benign growth might invade the neighbouring structures in a malignant way if the patient was in a low state of health.

Mr. E. W. ROUGHTON narrated a case of

PERFORATED GASTRIC ULCER TREATED BY EVISCERATION AND IRRIGATION—RECOVERY.

A woman, *æt.* 26, had indigestion for three weeks, followed by symptoms of perforation. The abdomen was opened five and a half hours later and the perforation closed by sutures. As the stomach contents had escaped freely, soiling all parts of the peritoneum the small intestines were turned out and the abdominal cavity thoroughly irrigated. The irrigation was commenced in Douglas's pouch, so that the lotion might flow in the opposite direction to the extravasated stomach contents, thus minimising the risk of spreading the infection. The operation caused very little shock, and the patient made a good recovery.

Mr. W. G. SPENCER said that his objection to evisceration was not due to the shock that might be produced so much as to the fact that the procedure increased tympanites, which not only made it hard to return the intestines, but put an increased strain on the sutures. This was particularly so in the later cases.

Mr. JOHN D. MALCOLM narrated a case of COMPLETE REMOVAL OF A MULTILOCULAR CYST OF THE PANCREAS: COL-COLIC ANASTOMOSIS SIXTEEN DAYS LATER—RECOVERY.

The patient was a woman, *æt.* 50; malignant growth of the left kidney was diagnosed, but a multilocular cyst of the tail of the pancreas was found on operation, and removed. Healing caused no trouble, but symptoms of a partial obstruction of the intestine developed and the abdomen was re-opened on the sixteenth day

after the operation. The difficulty was at the splenic flexure, and was removed by forming an anastomosis between the transverse and descending colons after which there were no further urgent symptoms. The tumour, which is preserved in the Royal College of Surgeons Museum, was exhibited. It is a multilocular cystoma with a small amount of solid structure between the cysts. The fluid was not examined. The solid growth, described by Mr. Shattock, showed in parts an adenomatous and in parts a carcinomatous structure. Some of the proper glandular tissue suggested that of the pancreas. Another case (*Med. Soc. Trans.*, vol. XXI., p. 97) in which a similar tumour was removed by Mr. Malcolm was referred to; and one published (*Path. Trans.*, vol. LIV., p. 354) by Mr. Watkins Pitchford; also one recorded (*The Amer. Journ. of the Medical Sciences*, New Series 120, p. 184) by Dr. Reginald H. Fitz and eight cases collected by him—all those of "benign" multilocular cysts of pancreatic origin which he could find, but some of which showed no new growth. A case published by Dr. F. H. Dunning (*Amer. Journ. of Obstetrics*, 1905, p. 101) resembled the one now recorded in many details. The rarity of these tumours was noted, the two removed by the author and that from the case recorded by Mr. Watkins Pitchford being the only specimens in the Royal College of Surgeons Museum. The question of their origin was touched upon, and Professor Ambrose Monprofit's (*Gaz. Med. de Paris*, March 12th, 1904) case, in which it was necessary to remove the tail of the pancreas and the spleen to complete the operation, was referred to. The tumour in this case was said to arise from the remains of the Wolffian body because of its structure. On the same grounds many of the foregoing cases were attributed to the pancreas as the seat of their development, the author's first case containing fluid which was strongly amyolytic and the structure of the second very suggestive of that of the pancreas. The difficulty of diagnosis was also mentioned, most of the cases being regarded as renal or ovarian before operation. Complete removal was held to be the only rational treatment when it was possible, as drainage of a multilocular cystoma, especially if it should be malignant, was a futile procedure.

Mr. CLUTTON related a similar case that he had operated on some years ago. He had been forced to cut through the pancreas, thus causing a troublesome pancreatic fistula. Perhaps subsequent adhesions might owe their origin to the irritation of the fluid then secreted.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD MAY 2ND, 1906.

Dr. W. S. GREENFIELD, Vice-President, in the Chair.

MR. ALEXIS THOMSON showed a patient, æt. 60, suffering from chronic jaundice and distended bladder, with relief of symptoms after cholecystenterostomy. The case was interesting, inasmuch as it was an exception to Courvoisier's law. Courvoisier had laid it down as an axiom, and clinical experience had confirmed this, that when chronic jaundice was accompanied by a distended bladder it was not due to gall stones but probably to malignant disease. In the case in point the jaundice had lasted for five weeks and the gall bladder was much distended. Despite the unfavourable prognosis, an exploratory operation was performed, and about a pint of inspissated bile was withdrawn from the gall bladder; an anastomosis between the gall bladder and hepatic flexure was made, and the jaundice gradually disappeared, while bile was passed in the stools. For a time the patient went down hill, became emaciated, and a bed sore formed, and it was thought that he was dying from deep-seated malignant disease. Without any evident reason, however, improvement set in, and

now the patient was perfectly well. After leaving hospital, and while he seemed to be becoming worse daily, he began to take the glucoside of violets; whether this had anything to do with relieving him was uncertain. The lesion was probably a chronic inflammatory swelling of the head of the pancreas.

Mr. J. M. COTTERILL showed an aneurismal varix of the orbit, following an injury from a driving accident. The right eye was proptosed and the vision defective, while in the orbit a pulsatile thrill could be felt and a murmur heard. The aneurism was associated with the ophthalmic artery. The treatment proposed was ligature of the common carotid. Mr. Cotterill also showed a patient after operation for injury of the internal semilunar cartilage. It was commonly advised that in these cases the whole cartilage should be removed, but the speaker thought that it was quite enough to excise the piece of cartilage which had been split off, and to leave the remainder. He strongly advised a vertical, instead of the usual transverse, incision, as impairing the function of the joint less and not interfering with the integrity of the ligaments to the same extent. The process of treating was shorter when a vertical than when a transverse incision was employed.

Drs. ALEXIS THOMSON and WOODWARD gave a demonstration of Klapp's system of exercises for the treatment of scoliosis, which appeared to be the most rational yet introduced. They aimed at increasing the lateral mobility of the spine, and in strengthening its muscles, and took advantage of the fact that in four legged progression the spine curves first to the one side then to the other. The movements may be briefly enumerated as (1) creeping slowly on the hands and knees; (2) creeping on the hands and knees and bending the head laterally; (3) the same, but at each step forward looking back over the shoulder, first on one side, and then on the other; (4) a complicated creeping movement, consisting in crossing the limbs at each step forward.

Mr. L. C. PEEL RITCHIE showed (1) a new aluminium ligature winder, and (2) a portable rheostat for use with Kirstein's lamp for endoscopic examination, &c., and a special mirror for the lamp for purposes of demonstration.

Mr. COTTERILL showed (1) large hydronephrotic kidney and (2) hydatid cyst from the liver.

Dr. W. ROBERTSON read a paper entitled the

PRACTICAL SIDE OF AN INFANTS' MILK DEPOT.

He prefaced his paper by saying that a milk depot for the supply of sterilised milk was only an expedient rendered necessary until such time as the ideal milk supply was obtained. As to the present day milk traffic the obstacles thrown in the way of a medical officer of health in trying to improve matters were many and great. In towns the dairyman preferred to keep his cows in byres and sheds, while the scrupulous cleanliness which ought to be observed was almost impossible of attainment. Then again there was the great difficulty of securing convictions for adulteration with water, this, in Midlothian at least, was notorious. He narrated an instance of a diphtheria epidemic which was traced to a dairy in which several of the cows were found to be suffering from an eruption on the udder, and in which notwithstanding injunctions to the contrary, the milk from these animals was sold with that of the rest until a sanitary inspector was set to watch at every milking hour and personally see that the milk was thrown away. Dairyman as a class knew quite well what precautions ought to be taken; their technical journals gave them all the latest information, and until the public insisted on being supplied with clean milk in closed bottles, instead of from a pitcher which was opened fifty times in the streets, and was constantly in the way of being contaminated by all manner of dirt, the dairyman would go on in his present way. The reduction of infantile mortality from diarrhoeal disease and from malnutrition could be brought about, first and foremost, if breast feeding became more common; secondly, they had such agencies as the milk

depot. But in dealing with the ignorant classes, no matter how good the milk supplied, the ways in which it could be contaminated after leaving the depot were innumerable. He instanced such things as opening bottles and mixing one feed with another, keeping opened bottles incubating in the oven, mixing other foods with the milk, putting long tubes on the bottles instead of using the teat, &c. To prevent these, and to give the mothers instructions on feeding infants, a lady-visitor was employed by the Leith Corporation. One of the difficulties connected with a corporation milk depot was the securing of efficient medical supervision of the infants. This was a matter which ought to be undertaken by an expert, and did not fall within the province of the medical officer. In organising a milk depot the first thing was to ensure a supply of clean milk, and he had been fortunate in discovering a dairy farm from which milk containing only about 12,000 micro-organisms per c.c. could be supplied. As was known, this was a low number, and in ordinary milk there were often 250,000 or more. The milk was then pasteurised, and diluted, and had cream and sugar added in definite proportions, and was distributed in bottles containing enough for one feed. These were sent out in baskets holding 7 or 9—one day's supply, and a week's milk for an infant was charged at the rate of 1s. 6d. When the depot was first started the milk was sterilised, but there had been two cases of scurvy, and in consequence, pasteurisation had been adopted. The result of the depot had, on the whole, been extremely satisfactory.

Dr. LESLIE MACKENZIE spoke of the economic aspect of the question. Eighteen-pence a week was a sum which could not be paid by the very poor. He emphasised the fact that improvement in the milk supply would speedily follow a public demand for clean milk. He also alluded to an experiment which had been tried in Paris to increase maternal nursing—namely, the giving of free meals to nursing mothers.

Dr. JAMES CARMICHAEL spoke of the neglect of infant feeding by practitioners. Drs. Anderson, Robertson, Malcolm Campbell, and others also discussed the paper.

Mr. E. SCOTT CARMICHAEL read a paper on "Inguinal Hernia in the Female," which will be found on page 523.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, MAY 3RD, 1906.

MR. FRANK T. PAUL, F.R.C.S., President, in the Chair.

Dr. W. BLAIR BELL read a preliminary note on a NEW THEORY OF FEMALE GENITAL ACTIVITY. He argued that the uterus had a further function beyond the one usually attributed to it, viz., the secretion of an active agent which he called "uterin." He pointed out how clinical facts such as the results of complete hysterectomy, the results of complete oophorectomy, the condition of the uterus in superinvolution and the results obtained by conservation of the endometrium in supra-vaginal hysterectomy all supported his contention that the theory of ovarian secretion was inconclusive and insufficient, and that the secretion of "uterin" as an internal secretion was paramount in genital activity. He indicated the general effects of excess and deficiency of "uterin" in women. He believed that menstruation was the result of excretion of an excess of "uterin," and he thought it probable that ovulation was influenced by "uterin" circulating in the blood. The menopause was produced by atrophy of the uterus and consequent deficiency of "uterin." Dr. Blair Bell further gave an account of the methods of investigation, and laid stress on the marked effects obtained by the administration of an extract of the uterine glands.

Prof. B. MOORE having spoken, Dr. H. BRIGGS said that all the clinical statements made by Dr. Blair Bell had been well known in gynaecological clinics for

many years. As to the function of the glands of the uterine mucous membrane there was room for doubt. The great difficulty was to obtain reliable tests: catamenial and other hæmorrhages occurred under the most opposite physical conditions of the uterine mucosa.

Dr. T. R. BRADSHAW and Dr. E. E. GLYNN contributed a paper on

THE SIGNIFICANCE OF THE OPSONIC POWER OF THE BLOOD AND THE VALUE OF ESTIMATIONS OF THE OPSONIC INDEX IN THE DIAGNOSIS AND TREATMENT OF TUBERCULOUS AND OTHER INFECTIONS.

They said that in the subjects of infections attended with symptoms of general intoxication there was a tendency to produce immunity which, given a healthy organism and not too severe an infection, led to recovery. In local infections without constitutional disturbance there was but little tendency to the production of immunity. This was due to the fact that owing to the absence of toxins the immunising mechanism was not aroused to activity. To cure a local infection the right method was to imitate Nature by introducing toxins in suitable doses into the system so as to excite the immunising processes. The opsonic properties of the blood were explained and the technique employed by Wright and Douglas described. The authors confirmed from their own observations the statements of others that in normal persons the tuberculo-opsonic index is practically uniform, and that in local tuberculosis it is generally depressed. The results of treatment in their hands had been most encouraging, but they had not employed it long enough to expect any complete recoveries. They laid great stress on the importance of watching the index during the treatment as the only means by which the danger of over-dosing could be avoided. They had made observations on nine persons who had undergone the serum treatment for diphtheria, and found that in all the cases the tuberculo-opsonic index was below normal. The same was noted in a medical man who had a prophylactic dose of anti-tetanic serum.

Dr. G. E. LOVEDAY related his very favourable experience of Wright's methods in the treatment of local tuberculous and other infections.

Dr. G. STOPFORD TAYLOR said that he had obtained excellent results with Wright's vaccines in two cases of coccogenic sycosis and one of boils.

Dr. R. J. M. BUCHANAN said that in pulmonary tuberculosis the initial attack was, although it might be overlooked, always acute, the result depending largely upon the dosage of bacilli and the opsonic response of the blood. In chronic cases the opsonic content of the blood remained low, and by raising it with tuberculin injections, and judiciously exercising the patient, the prospect of recovery was increased. After inoculation it was desirable that the patient should rest from 24 to 72 hours to prevent any possible injurious effect during the negative phase arising from added auto-inoculation by exercise. People varied very much in their susceptibility to tuberculin. The negative phase occurred in experiments with bacilli and blood in hang-drop cultivations. Dr. Buchanan had observed this when working with typhoid bacilli and leucæmic blood as long as eight years ago. As a diagnostic agent, the estimation of the opsonic index should be done several times, as by a single observation the negative phase of an auto-inoculation might be incorrectly accepted as a persisting low index. Several cases of phthisis were related in which benefit followed treatment, and one in which all symptoms, physical signs and large masses of axillary glands had disappeared. The use of T.B. was followed not only by constitutional changes, but also by marked alteration in the physical signs. As a proof of local action in pulmonary phthisis he observed that in chronic cases prior to inoculation the bacilli were extra-cellular, while after inoculations phagocytosis were to be seen. He pointed out that possibly watching the phagocytic index in the sputum might be used as a general guide for inoculation. In acute phthisis phagocytosis in the sputum was common. He held that tuberculin

treatment in selected cases should be practised in conjunction with sanatorium methods.

Sir JAMES BARR related the case of a young lady who had been under the care of Dr. Blair Bell and himself. She was suffering from infective endocarditis of a very severe type due to streptococcal infection. A rigor occurred every 24 hours or oftener, during which the temperature ran up to 104° or 105°, and was followed by profuse sweating. There was an attack of pleurisy with pleuro-pericardial friction, but without any marked effusion. All the various brands of anti-streptococcal serum had been tried without much benefit. The assistance of Prof. A. E. Wright and Captain S. R. Douglas was obtained, and a vaccine was made from the streptococci obtained from the patient's own blood. Captain Douglas estimated her opsonic power twice daily, and by him the injection of the vaccine was regulated. Eventually the lady made an excellent recovery, and, with the exception of the effects of phlebitis of the left lower limb, she was now quite well. Sir James Barr attributed the success of the case to the vaccine, and he paid a high compliment to the dexterity and manipulative skill of Captain Douglas.

Dr. W. B. WARRINGTON alluded to the statement of Prof. Wright endorsed by Dr. Bradshaw that local lesions did not tend to spontaneous recovery. Dr. Warrington asked whether the tendency to local tuberculous lesions of the lungs and vertebræ was not notably towards recovery. It had been stated that though marked improvement might be noted in early phthisis, yet the opsonic index remained low. Dr. Grace-Calvert asserted the contrary. These statements required verification. Assuming that the index was increased by general treatment, should tuberculin be administered? Many, no doubt, would feel a difficulty in accepting the explanation of badly adjusted and ill-spaced auto-inoculations to explain the high opsonic index in the acuter cases; fluctuating, it seemed in many cases to remain above the normal. Dr. Warrington considered the cases related by Sir James Barr of great value, and one which showed the value of the vaccine treatment as opposed to that of anti-bacterial sera. The latter had proved of little value in his practice.

Dr. G. A. Grace-Calvert, Dr. Nathan Raw, Dr. Yorke, Dr. Oram and Professor B. Moore also took part in the discussion.

In replying, Dr. BRADSHAW said that none of the speakers who had any experience of the method had controverted the main points of the paper. He was inclined to attribute the remarkable results of the anti-sera to a specific influence imminent in the blood of the horse.

GLASGOW MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD FRIDAY, MAY 4TH, 1906.

The President, DR. LINDSAY STEVEN, in the Chair.

DR. JOSEPH N. GLAISTER read notes of two interesting cases of

CEREBRO-SPINAL FEVER

which had recently come under his observation in private practice. The patients were two sisters, one æt. 3, and the other æt. 6. The preliminary symptoms were ill-defined—feverishness, malaise being present. Then persistent vomiting followed with great restlessness. The head became sharply retracted, internal strabismus of the eyes became evident, and a tendency to coma revealed itself. Other symptoms present during the illness were tremors of both hands, contracted pupils, convulsive movements of arms and legs, a petechial eruption of the body, and incontinence of urine. Death was due to asthenia and coma. The temperature was not markedly elevated, although the pulse became very rapid during the later

stages of the disease. The diagnosis was verified bacteriologically by Dr. Robert Buchanan, by lumbar puncture, and the examination of a drop or two, which was thus obtained from the spinal canal. Film-preparations showed the specific micro-organism of Weichselbaum. It is a diplococcus found in the interior of the leucocytes, rather kidney-shaped, and not unlike the gonococcus. Cultures were made by Dr. Buchanan on glycerine agar and blood-serum. In twenty-four hours, a white growth appeared on the agar; that on the blood serum being whitish, dense and viscid. Prof. Glaister alluded to several cases that he had had occasion to investigate, and trusted the disease would be made a notifiable one, as he felt confident a number of such cases were not recognised in general practice.

Dr. ALEXANDER NAPIER communicated notes of AN UNUSUAL CASE OF TYPHOID FEVER

where the brunt of the disease had fallen upon the kidneys. The diagnosis in the early stage was difficult, owing to the absence of the usual and well ascertained signs, and symptoms. The President saw the case in consultation with Dr. Napier. An examination of the urine showed blood-corpuscles and the characteristic bacillus of typhoid fever.

The PRESIDENT (Dr. Steven) was inclined to the view that the case was one of hæmorrhagic nephritis followed by typhoid fever.

Dr. BROWNLEE, the Superintendent of Belvidere Hospital, had seen a number of cases where in some there was distinct nephritis present, with the usual casts in the urine. Another case with pus cells and blood corpuscles present in the urine, and in one case there was lobar pneumonia, the urine being bloody, with tailed epithelium in the urine, but no pus discovered.

In testing for blood in the urine, Dr. ALEXANDER NAPIER suggested the use of the plain tincture of guaiacum with the addition of acetic acid, as he had found it a more reliable method than the ammoniated tincture of guaiacum test.

GLASGOW NORTHERN MEDICAL SOCIETY.

MEETING HELD TUESDAY, MAY 1ST, 1906.

The President, DR. RITCHIE, [in]

DR. KAY read notes of a case of PNEUMOCOCCAL PERITONITIS

in a child. Dr. Kay said that the pneumococcus was now a well recognised cause of meningitis; but its power to set up peritonitis was not so generally known. If the peritonitis were diffused, the prognosis was bad; if it were encapsulated, the prognosis was good. The case he selected presented the characteristic symptoms of peritonitis, pain and tenderness, tympanitic abdomen, temp. 101·8°—a comparatively low temperature, respiration 38. He opened the abdomen and drew off 90 oz. of pus, and inserted two drainage tube. Temperature before operation was 102°F. and 99°F. after operation. The pus was examined and found to contain a pure culture of the pneumococcus. The child recovered.

Dr. A. J. CAMPBELL recorded a case which had a rapid termination. Pneumonia was present, followed by peritonitis. There was no cough or sputum. Pain was complained of in the left side of the head, followed by paralysis of the right side. This was thought to be due to embolism.

Dr. HOLME HENDERSON read an interesting and instructive paper on

ANÆSTHETICS.

He considered ether much safer to use than chloroform; and, if during an operation chloroform was giving trouble ether should be resorted to. It was a genuine stimulant to the heart. He alluded to the use of ethyl chloride. His main contention was that no one anæsthetic is universally the best, but discrimination

ought to be exercised in their choice, and great care in their administration. Dr. Henderson was of opinion that the deaths from the use of anæsthetics were much more numerous than was generally credited. In regard to methods of resuscitation; he laid stress on pulling out the tongue, artificial respiration and hot applications to the heart.

Dr. MACLACHLAN said that the late Professor George Buchanan was very fond of flicking a patient's chest with a wet towel, when the patient got into a bad state, and he considered that this was one of the best ways of rousing the respiratory centre. The head should be promptly lowered, or inversion of the body practised in those cases that got white in the face, and showed signs of death from heart failure. In the asphyxiated forms pulling the tongue out forcibly, with vigorous artificial respiration, seemed to be the best treatment. Dr. Maclachlan thought that chloroform should be given in drops at first, until one saw how the patient responded and then be pushed with care. He was of opinion once a patient was under chloroform no more should be given until slight signs of returning consciousness showed the patient could stand fresh inhalations, and thus the danger from chloroform poisoning would be averted.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD FRIDAY, MAY 4TH, 1906.

The President, Mr. L. A. BIDWELL, F.R.C.S., in the Chair.

AN instructive discussion took place on

THE VARIETIES AND SEQUELÆ OF INFLUENZA.

Dr. SEYMOUR TAYLOR in opening the discussion said that in his view the multifarious forms which attacks of influenza took were mainly due to the differing soils which the micro-organism found in different patients. He was accustomed to group the cases under five types, namely, the neurotic, the pulmonary, the circulatory, the febrile, and the gastro-intestinal. The sequelæ he thought were, at least in some cases, dependent on a mixed infection, and any constitutionally weak spot in a patient was particularly liable to be the one affected.

Mr. BIDWELL remarked that as far as his experience went, particular epidemics seemed to be characterised by special types of the disease; he was especially interested in those cases in which acute abdominal disorder was sometimes very closely simulated. He also spoke of those cases in which bone or joint disease might follow as a sequela, probably these were due to secondary infection.

Dr. ARTHUR SAUNDERS agreed with Mr. Bidwell that varying types occurred in different epidemics. One of the most serious sequelæ in his experience was severe cardiac depression, which was generally accompanied with a very slow pulse, which might also be intermittent, the danger of syncope in such a condition was very great. In his opinion this state was due in part to affection of the vagus, and in part to a toxin directly acting on the heart muscle. The very marked general depression which was so frequently seen after an attack was, he believed, a combined result produced both from the nervous and circulatory systems.

Dr. RUFENACHT WALTER said that in the sanatorium with which he was connected they saw little influenza, and he attributed this to the open air conditions, for it was a not infrequent trouble in villages in the neighbourhood. No doubt a certain number of phthisis cases owed their commencement to the disease, and also some cases which were quiescent, were re-awakened by an attack.

Dr. CULVER JAMES spoke of certain cases of infective pneumonia which he had seen antecedent to the time of the recrudescence of influenza in an epidemic form

in this country; these he now believed to be of influenza origin.

Dr. STANLEY SMITH observed that it seemed to him that neuritis of various kinds was much more common since influenza was such a frequent affection, and he thought that these diseases were most probably related to one another as cause and effect.

Dr. LEONARD DOBSON also referred to the frequency of neuritis, especially of the musculo spiral nerve. In his experience this trouble was best met by treatment with high frequency electrical currents.

Dr. FURNISS POTTER spoke of the severity of those cases in which the middle ear, and then the mastoid, became affected, the amount of bone destruction which resulted being often extreme. This trouble was, however, rather a complication than a sequela.

Dr. W. A. BONNEY, Dr. H. W. CHAMBERS, Dr. KINSEY MORGAN, and Dr. F. G. LLOYD, having taken part in the debate, Dr. Seymour Taylor replied. There was a large attendance of members and visitors.

NORTH-EAST LONDON CLINICAL SOCIETY.

MEETING HELD THURSDAY, MAY 3RD, 1906.

Dr. G. ANGUS HUNT, Vice-President, in the Chair.

Dr. E. F. WILLOUGHBY opened a discussion on Asthma. After limiting the term to those attacks of intense dyspnoea, distinctly paroxysmal and spasmodic, occurring with or without recognisable cause or premonition at more or less regular intervals, often at the same hour, the patient's breathing during the interval being normal, the speaker proceeded to discuss the principal causes of the affection. He laid stress upon the condition of vaso-motor rhinitis, which so frequently preceded or accompanied asthma, and he considered that of all the intrinsic causes the most important appeared to be influenza. The immediate causation of an attack being some irritative disturbance of innervation, the treatment, apart from general and personal hygiene, had been mostly directed to the inhibition of the stimulation locally or through the nerve centres. The drug treatment of the attack itself and of the intervals between the attacks was then reviewed.

Since it was the personal experience of the reader of the paper that led him to choose this subject for the afternoon's discussion, Dr. Willoughby then described the symptoms, course and treatment of his own case, one of exceptional severity and interest. It was preceded by years of "hay-asthma," the essential cause being the poison of influenza, the exciting cause of a month of bronchial catarrh and violent paroxysmal cough, with dilatation of the right ventricle as a sequela. This latter had passed off completely, and only some pulmonary emphysema remained. All medical treatment had been useless, and he had consulted many eminent physicians and surgeons. After much prolonged suffering, the only things that gave him relief were hypodermic injections of morphine, deprecated by all his medical advisers, with inhalations of amyl nitrite or one or two drops of nitroglycerine *per os*. He took several sea-trips and a voyage to Madeira, during which time the attacks became fewer and of less severity, but they always yielded promptly to the injections. He was now quite free from any asthma, only a little shortness of breath at times being present. On no occasion did the morphia cause any sensations of drowsiness or nausea, its sole effect being in his case to arrest or prevent the attack.

Dr. E. MURRAY LESLIE thought that the value of a personal testimony like this was very great, and he wished that more medical men could be prevailed upon to describe their own illnesses with such accuracy of observation. He was a strong believer in the value of caffeine as a preventative of the attacks. The danger

of giving morphia had, he was sure, been over-exaggerated. The action of ethyl nitrite was more lasting, and therefore more useful, during the actual attack than that of amyl nitrite. He was glad to hear that it was possible for such a dangerous complication as dilatation of the heart to be completely recoverable from, and this fact would doubtless lead to some modification in the prognosis of the disease.

Mr. H. W. CARSON reviewed the surgical aspect of the question, more particularly from the standpoint of the intra-nasal treatment. He pointed out that there had been considerable prejudice in the minds of laryngologists and surgeons as to the possibility of effecting real cures by the removal of any source of nasal irritation, but he thought that the attitude of the profession was gradually changing with regard to the matter. He referred to the work of Mr. Francis who had collected a series of 600 cases of asthma in which intra-nasal treatment was adopted with 60 per cent. of successes. It was impossible to ignore these good results, and even if the method, in some cases, might seem to be empirical he thought that it was fully justified.

Dr. A. J. WHITING discussed the pathology of asthma and compared the typical attack to that of laryngismus stridulus. He thought that some cases were certainly of a purely nervous origin, while in others circulatory disturbances were an important pathological factor. He considered that the treatment by morphia was not without its risks, whereas the nitrites were always useful. The extract of grindelia had proved of considerable value in his hands.

Dr. H. ALEXANDER spoke of the benefits to be derived from the inhalation of chloroform, and he referred to one case in which only a single whiff acted like a charm in relieving the spasms. He had used nepenthe with success on several occasions.

Dr. NORMAN MEACHEN alluded to the curious relationship which existed between certain skin eruptions and asthma. He quoted the opinion of Trousseau to the effect that eczema might replace the asthmatic attack or be replaced by it, and he had himself seen this alternation in patients affected with true asthma.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF ANATOMY AND PHYSIOLOGY.

MEETING HELD FRIDAY, APRIL 27TH, 1906.

PROFESSOR A. FRASER in the Chair.

SLIDES ILLUSTRATING THE DEVELOPMENT OF FAT.

PROFESSOR D. J. COFFEY exhibited and described a series of slides which illustrated, in a striking manner, the development of fat in a young animal. A discussion followed, in which Professor Milroy and Dr. Rowlette took part.

SPECIMENS SHOWING THE CRANIAL DURA MATER EXPOSED FROM BELOW.

Professor SYMINGTON showed two specimens in which, after careful hardening of the parts in formalin, the base of the skull had been removed piecemeal, so as to exhibit the cranial dura mater from below. The relationships of the cranial nerves, of the Gasserian ganglion, and several other points were most clearly brought out.

The CHAIRMAN spoke of similar specimens which he had himself prepared before the introduction of formalin after injection of chloride of zinc solution.

BULK STAINING OF THE CENTRAL NERVOUS SYSTEM WITH THIONIN.

Professor MILROY described a method of staining portions of the central nervous system in bulk with thionin. The advantages of the method were explained by Professor Milroy, and the beautiful series of slides which he exhibited, clearly demonstrated the success of the method which he advocated.

CORRESPONDENCE. FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, May 15th, 1906.

NÆVI MATERNI.

SIMPLE cutaneous angioma, known under the name of *nævi materni*, or wine patches, are generally of congenital origin. In the majority of cases they are to be found on the neck or face. Frequently these spots disappear spontaneously a few months after birth, but at a more advanced age such a happy result can scarcely be hoped for.

If in themselves cases of angioma are by no means grave, they give rise sometimes to more or less serious complications, under the influence of some irritation and, more especially, traumatism. Consequently, the practitioner, when consulted for a simple angioma, should abstain from all active interference where the patient is under two years of age, while above that age, and even in adults, he should prescribe treatment only where the angioma was limited in extent.

Numerous have been the methods recommended in the treatment of angioma, but only three deserve mention: vaccination, electro-puncture, and caustics.

Inoculation of vaccine enjoyed, and continues to enjoy, considerable vogue amongst the public more than with the doctors. Frequently these latter are solicited by mothers to employ this method to remove the disfiguring spots. These inoculations had the double advantage of being sometimes efficacious, and always inoffensive. But the success is subject to two conditions: first, they should be practised on a child which had not been already vaccinated, and, secondly, they should be made around the spots, and not on them, otherwise hæmorrhage would be provoked, which would sweep away the vaccine.

Electro-puncture was employed for the first time by Ciniselli half a century ago and has numerous partisans. It consists in pressing through the angioma a current from a battery which decomposes the tissues in its passage, sets free the acids which go to the positive pole, producing the formation of a dry slough which is slow in becoming detached; the alkaline bases go to the negative pole where they provoke the formation of a soft clot when the electrode is pushed into the tissues. The methods used are of two kinds, positive monopuncture and bipolar electro-puncture; the first is represented by a metallic plate of large dimensions, covered with moist chamois skin. This is the negative electrode. The positive electrode of the battery, represented by one or several platinum needles, is inserted into the tumour while the negative plate is applied at some distance from the angioma. Each seance last from 5 to 10 minutes, and where the wine stain is of considerable extent a large number of seances is necessary and frequently both patient and operator are discouraged before a complete cure is obtained. Besides, the passage of the current provokes considerable suffering, and in the case of children, anaesthetics might be necessary.

The other method was practised by Prof. Bergonié, of Bordeaux. Its principal advantage was the limiting of the electrolytic action to the space comprised between the two poles, and by this means the painful manifestations are suppressed and the duration of the treatment much abridged, as stronger currents could be employed.

Yet, in a recent communication, Prof. Bergonié confessed that electrolysis was a complete failure. "The treatment of angioma," he said, "was the most difficult and the most delicate that can be undertaken. For my part, I have tried electrolysis under every form and the length of the treatment wearied both patient and operator." Consequently, Prof. Bergonié renounced electrolysis.

Applications of caustics are condemned by all contemporaneous authors who have written on the treatment of *nævi*, on account of the impossibility of

limiting their action, and the consequent disfiguring cicatrix. However, a German professor recommends a method based on the employment of chloride of zinc, and of which he speaks wonders. By this method Neumann treated with success over 700 patients.

A band of sticking-plaster, with a hole cut in it corresponding to the region, is applied to the angioma, and thus the neighbouring parts are protected against the contact of the caustic preparation, which is as follows:—

Chloride of zinc, 1-5 drachm ;
Elastic collodion (strong), 4 ounces.

The mixture should be well shaken before being applied with a pencil.

The hole in the plaster should be a little less than the dimensions of the surface about to be destroyed. As soon as the collodion has hardened, the parts are covered with gauze and maintained by means of a few straps of adhesive plaster. The next day or the following the dressing is removed, and instead of the red or bluish stain of the angioma necrosis of the region is observed, surrounded by an inflammatory zone ; but on the third day this zone has disappeared, and after another dressing the slough is allowed to eliminate of itself, which generally arrives on the seventh day. A simple dressing is then applied every two or three days, and the wound cicatrises rapidly.

In case that any part of the angioma escaped the action of the chloride of zinc, Neumann applies the following ointment:—

Arsenious acid, 1 drachm ;
Precipitated sulphur, 1 drachm ;
Spermacetic ointment, 4 ounces.

The dressing should be removed after two or three days, and the mortified parts removed with some blunt instrument, and an antiseptic dressing applied.

M. Neumann avoids, however, as much as possible the arsenical applications, as they provoke pain and are ill suited to children.

GERMANY.

Berlin, May 13th, 1906.

THE INFLUENCE OF TRAUMA ON THE ORIGIN OF CARCINOMA AND SARCOMA.

AN interesting contribution to this subject is made by Dr. Röpcke in the *Arch. f. Kl. Chir.*, B. 78, H. 2.

Interesting as it is it would have been much more so, and at the same time much more valuable, if traumata had been specially looked for in the case investigated, and if we could safely assume that they were absent in all cases in which their presence was not noted. In the earlier days over which the investigation carries us we may take it that the investigation was not pushed so far, and that it was in this respect incomplete. The investigation covers the years from 1889 to 1904, and embraces a total of nearly 800 cases of carcinoma and 189 of sarcoma. The investigation was for the purpose of ascertaining in how many of these cases there was evidence of antecedent injury. The number is not so great as would have been anticipated, but, as suggested above, the original notes may not have been so complete as could be wished.

As regards carcinoma of the lip, the use of a tobacco pipe was registered as the cause in 5 cases, a music pipe in one case, a sharp tooth in 2 cases, repeated cauterisation of a wart in 1 case, and 7 were attributed to a single trauma.

The most frequent cause of carcinoma of the mouth and nasal cavities was sharp edged and carious teeth. It was so 5 times out of 16 cases of carcinoma of the tongue ; 5 times in 11 cases of carcinoma of the buccal mucous membrane ; 11 times in 18 cases of carcinoma of the jaw. A carcinoma of the parotid gland developed on a cicatrix, a carcinoma of the nasal septum on the cicatrix of a syphilitic ulcer. Cancers of the face and scalp were frequently preceded by seborrhœa senilis, warts and atheromata.

In carcinoma of the stomach and intestines previous chronic irritations were spoken of as significant. Gall stones were found in 12 cases of carcinoma of the liver.

In mammary cancer the disease was attributed in one case to mastitis, 6 times to anomalies of development, twice to chronic irritations, and 8 times to acute trauma. Cancer of the bladder was met with twice in cases of vesical calculi, and once complicating a case of non-malignant papilloma. Cancer of the urethra developed in one case as a sequence of a congenital narrowing of the urethral orifice, in another case as a result of a sharp edged stricture. Carcinoma of the extremities developed in 3 cases after chronic inflammations and once after a naevus.

Nasal sarcoma developed in 2 cases from polypi, sarcoma of the cheek once in a pediculated fibroma and once from a birth mark. A melano-sarcoma of the palate arose from an ulcer caused by pressure of a dental plate, 4 cases of sarcoma of the jaw from connection with carious teeth, 2 sarcomata of the trunk from warts, one from a pediculated fibroma, and 3 after acute trauma. Sarcoma of the testicle, twice in undescended testicle and once in a case of hypertrophy. Sarcoma of the extremities occurred 17 times after a single trauma.

The writer concludes with justice that in the case of carcinoma chronic irritations are more likely to play a part, whilst in the case of sarcoma a single injury is more likely to be the exciting factor.

In 44 cases carcinoma occurred in the same family (descendants), in 7 of those cases the like organ was attacked, the stomach 5 times, the gall-bladder once, and the rectum once.

At the Society for Surgery, Hr. Krönlein introduced THE SURGERY OF GASTRIC ULCER for discussion.

He asserts in the first place that in a certain number of cases the ulcer was not amenable to medicinal or other internal treatment, although he made an attempt to prove the point on which the whole question of surgical interference hangs. As regards indications he adopts that put forward by Mikulicz in 1897 as still holding good. The surgical treatment of gastric ulcer comes into view when a consequent or repeated course of suitable treatment has had no, or only a transient, effect, and the patient's capacity for work or enjoyment of life is considerably encroached upon by it. The outward circumstances of the patient must also be considered. According to Leube permanent recovery took place in 75 per cent. in 400 cases reported by him ; very considerable improvement in nearly 25 per cent., so that the proportion of failures was very slight, and the mortality only 2.4 per cent. The permanent results in the collected cases of others had been much worse than this, Schultz, for instance, gave (after 6 months) good results 77 per cent., failures 15.2 per cent., died 7.6 per cent. or a total of failures of 23 per cent.

As regarded the mortality from operation it should not be above 8 to 10 per cent., and the late results would be excellent ; the only chance of mischief being development of carcinoma on the cicatrix (3 per cent.). Between the years 1887 and 1906 he had operated himself in 112 cases with a perfect result in 84. In estimating the permanent results he had only included the years up to 1904—72 cases, and of these 67 had been examined more recently, 41 were perfectly well, 16 had slight troubles, 8 were uncured, and 2 had died from complications. The diagnosis was always made correctly, the only doubt was as to whether an ulcer was still present or only its sequelæ—more particularly stenosis. In about half the cases the ulcer was single, in the other half there were more than one.

AUSTRIA.

Vienna, May 13th, 1906.

INFANTILE MORTALITY.

At the Meran meeting this subject was prominently brought before the members by Hutzler, who affirmed that the Hebammen were principally to blame for the very high death-rate among infants. On the slightest pretence of the mother's milk not agreeing with the child the mother is implored to take the infant from

the breast, which is usually accomplished without much regret, and fed with any kind of artificial food that this ignorant midwife may suggest. Escherich has given in his report that 16 per cent. of the cases in his own town have been proved to be due to this very source—atrophy and marasmus. Hutzler said he had devoted a considerable time to this subject in the children's hospital to which he was attached, and found in every one that the atrophic condition dated from the midwife's advice to separate the infant from the mother.

The question next arises, Who is to blame? The midwife is not educated in the feeding of children, but because she can separate the fœtus from the mother she presumes to know how to nurse the infant! This destruction of life goes on daily and nothing is heard of the circumstance until the infant is brought to an ambulatorium in a dying condition.

The blame rests on our system of educating "Hebammen," who are the principal advisers of these unfortunate women who have no medical attendant. These midwives, before being allowed to practise, should undergo a pædiatric training for a year and certainly not less than six months in the nursing of children, after which a searching examination.

Escherich reminded Hutzler that this regulation already existed in Austria but was ineffectual. It is not enough for these women to be under the control of a professional midwife, as their duties, or rather their assumed duties, went further. They should also be controlled by an expert in pædatrophy for the protection of the infant.

Schlossmann complained of the ignorance of our present class of Hebammen, who knew of nothing but soups and beef teas for infants, or some other more unsuitable article recommended by an enterprising commercial firm of advertisers.

Seltner thought these women should go through a course of clinical medicine, as no artificial food could be trusted to the supervision of the ignorant.

Huebner thought our text-books were largely to blame for leading these poor midwives astray. In many of them great stress is laid on syphilitic women sucking their own offspring. With this dicta in their mind, we cannot wonder at the result. Again, early clinical advice is easily obtained in large towns, but in the country this is difficult, if not impossible, in many cases. It is therefore a necessity to have the midwives better educated and their text-books revised.

Kamerer thinks every midwife should pass through a course in a hospital for children.

MILK FAT SECRETION.

Engel introduced a discussion on the physiological secretion of milk. How much came from the mother's food direct. How much from her own body? It was true the fat came directly from cells thrown off in the lacteal gland, and with Hubel's iodine the quantity of fat taken into the stomach and passed from the gland might be estimated. If a portion of sesame oil be taken by the mouth it will be passed through the lacteal gland in three to four hours and will continue 24 to 44 hours after. He considered the mother's diet a potent factor in the feeding of children. Many substances pass easily through the gland.

Meyer thought this test fallacious, as farmers have proved. The iodipin is split up in its mutations and cannot be estimated.

Schlossmann thought there was a difference of results in the Herbivorous and Omnivorous. It is well-known that a breakfast rich in fat will increase the milk.

THE Drapers' Company have sent a cheque for £10,000 to the fund for the removal of King's College Hospital to South London. An appeal was made to the public for the sum of £300,000 in order to effect the removal of this hospital. The Drapers' Company generously promised £5,000 conditionally on the rest of the sum required being raised by the end of 1904; this promise was afterwards increased by another £5,000, and the time limit extended to the end of 1905.

FROM OUR SPECIAL CORRESPONDENTS AT HOME. SCOTLAND.

SCOTTISH POOR-LAW MEDICAL OFFICERS.—A deputation of the Scottish Poor-law Medical Officers' Association, consisting of Dr. Muir, President, Dr. Campbell, Dr. Parkinson, chairman of the Public Health and Poor-law Committee of the British Medical Association, and Dr. Whittaker, waited on the Secretary for Scotland at Westminster on the 8th inst., with reference to the position of Scottish Poor-law medical officers. Dr. Muir stated the case of the deputation. Poor-law medical officers, he said, were subject to a number of grievances which they wished to be remedied by legislation. In the first place they desired to have an appeal to the Local Government Board in case of unjust dismissal, there being many cases in which parish councils, who, particularly in the Highlands and Islands, were intellectually and socially unfit to be entrusted with absolute powers, had harshly and unreasonably dismissed their medical officers for causes other than professional incompetence, sometimes from personal animosity, or from medical officers refusing to comply with orders which were not connected with their duties as servants of the parish council, and which in some cases might have led to the medical officer being struck off the Register. The deputation further claimed the right to order invalid diet for paupers without appeal to the Inspector of Poor, who at present had the power of veto. In the next place, they urged that power should be given to erect from parochial funds dwelling houses for medical officers, as at present in many places suitable residences were unavailable. They also contended that a suitable annual holiday, with allowance for a *locum tenens* at the rate of four guineas per week, should be granted. They also asked that a uniform fee of 21s. should be paid for granting a lunacy certificate in place of the present diversity of fee; a special fee for long and difficult cases which they had to attend was also urged. They asked substantially, that they should be placed in the same position as Poor-law medical officers in England and Ireland. Dr. Parkinson said that the British Medical Association heartily backed up the demands which had been made. The Scottish medical officers did not ask that they should be protected against their own wrongdoing, but that they should be shielded from injustice or wrong on the part of other people.

Mr. Sinclair, the Secretary for Scotland, thanked the deputation, and said he had been greatly impressed by the statements they had made. While not coming under any specific pledge, he undertook to consult with the authorities of the Scottish Department on the subject of the complaints brought before him.

SCOTTISH VOLUNTEERS AMBULANCE TROPHY.—The competition for this trophy took place in the Drill Hall, Forrest Road, Edinburgh, on the 5th inst., before a large gathering of spectators who were drawn together to witness a contest in which teams from all over Scotland took part. At the conclusion of the examination it was announced that the trophy had been won by the 1st Lothian Bearer Coy., B Team, and it was accordingly presented to them by Lady Cranston. Of the eighteen teams who competed seven were from Edinburgh, four from Glasgow, two from Dundee, and one each from Hamilton, St. Andrews, Helensburgh, Inverness, and Haddington. The success of the occasion was to a large extent due to the careful preparations which had been made by Brigade Surgeon-Lieutenant Colonel A. D. Webster, S.M.O., 1st Lothian Brigade, President of the Scottish Volunteer Medical Officers' Association, Capt. A. Macdonald, commanding the 1st Bearer Coy., and to the able secretary of the Association, Captain C. B. Ker, 1st Lothian Bearer Coy. In the evening Surgeon-General Keogh, M.D., C.B., Director-General Army Medical Service, who had been present at the competition, was entertained to dinner by the Edinburgh Committee of the Association, and

in the course of a forcible speech urged the necessity of reorganising the volunteer medical service and placing it in the same relation to the volunteers as the R.A.M.C. does to the Army. Only by such a change could the service be of real value in mobilisation. The 1st Lothian Bearer Coy. might well form the nucleus of a field ambulance which could readily be officered by junior practitioners of medicine and surgery.

BELFAST.

PUBLIC HEALTH.—The recent agitation in reference to the health of the city culminated in a large and influential meeting held on Tuesday evening, May 8th, to consider the question. The meeting was summoned by the Belfast Citizens' Association, a body of recent formation, which has hitherto concerned itself chiefly with the economical working of the various public bodies, and now appears in a new light in advocating increased expenditure. The chief resolution was moved by Dr. Calwell, the president of the Ulster Medical Society, and seconded by Mr. Wm. Crawford, chairman of the Royal Victoria Hospital. It read as follows:—"That the alarmingly high death-rate of Belfast, especially from tuberculosis in its various forms, demands vigilant attention from the citizens, and vigorous action by the responsible authorities, and shows the urgency and imperative necessity that the City Council should secure the highest specialised professional skill and lengthened experience available in the United Kingdom for the oversight of our public health." In an able and vigorous speech Dr. Calwell claimed the right of freedom of speech and of legitimate criticism of the actions of those whom by our votes we had put in authority. While giving credit to the Public Health authorities for much good work done in the past, he maintained that the words of his resolution were justified, and that the death-rate was now alarmingly high. The question was no new one, for ten years ago a special committee of the Corporation was appointed to consider it, the death-rate being then 24.3. In 1902 we came seventy-seventh out of eighty-two large towns. In 1903 the same, and in 1904 we were 75th-77th out of eighty-two large towns, being equal to Hanley and St. Helens and only surpassed by Salford, Manchester, Wigan, Liverpool, and Dublin. A careful study of the death-rate from phthisis showed that in Belfast there was every reason to expect that proper measures would be followed by a fall of 2 per 1,000, which would mean a saving of 358 lives per annum. But if other forms of tuberculosis were included, these figures might at least be doubled, and he did not think he was guilty of exaggeration when he said that if tubercle were banished from Belfast a third of their hospital beds might be closed. After some remarks on the Belfast annual report for the past few years, and especially on what it left unsaid, Dr. Calwell said that he thought he had justified the statement that the death-rate was alarmingly high. He then dealt with the attitude of indifference displayed by such a large majority of the citizens towards those matters, emphasising the fact that no great improvement could be looked for till they took an intelligent interest in them. He did not think there was need to say much on the second part of the resolution. The care of public health was like any other business in life—the greater attention paid to it the greater would be the gain. But it was not for him to say what steps were to be taken to meet the various evils he had pointed out. He was not a skilled officer of health, and he did not know. But one piece of advice he could offer with the utmost confidence—"Get someone who can advise you, and who will, for his training, his experience, his skill, his reputation as a specialist in public health, command the respect of the Council, of the medical profession, and of the public. Do for the Public Health Department what you would have done for the Technical Institute, for the tramways, for the gas, and for the Electric Department."

Mr. John Murphy (Secretary of the Trades Council)

moved the second resolution, which was:—"That the impending resignation of the Medical Superintendent Officer of Health presents a unique opportunity to the City Council for the appointment of an experienced medical officer, possessed of the highest scientific knowledge and training in public health matters, and for such changes in the Public Health Department as may be required for carrying out necessary reforms, and this conference is of opinion that the City Council should take action accordingly."

The resignation of the Medical Officer of Health, Dr. Whitaker, was announced two days later, and it now remains to be seen whether the City Council will perpetrate their contemplated job, or whether they will be convinced that discretion is the better part of valour and climb down as gracefully as they can.

Mr. A. B. Mitchell, one of the surgeons to the Royal Victoria Hospital, Belfast, was last week operated upon for appendicitis by his colleague, Professor Sinclair. His progress since the operation has been quite satisfactory.

THE DARNELL CASE.—A circular has been sent to all members of the profession in Ulster, and to a very few in other parts, inviting subscriptions to a fund which has been started to assist Dr. Darnell in paying the expenses of the recent litigation in which he has been involved. It is stated in the circular that his out-of-pocket expenses will probably be about £800. The preliminary list of subscriptions amounts to nearly £150. The treasurers of the fund are Dr. Kidd, of Enniskillen, and Dr. Calwell, of Belfast, and the secretaries are Dr. Cecil Shaw, College Square, Belfast, and Dr. Thos. Houston, Great Victoria Street, Belfast.

LETTERS TO THE EDITOR.

UNIVERSITIES AND MEDICAL EDUCATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The discursive article from a correspondent on "University Education in Ireland" in your last week's issue, while it contains little that helps towards the solution of that difficult problem, raises some points of interest to those who care about medical education. I take it that your correspondent's main point is that medical training should be entirely dissociated from university education. In this contention I hardly see that he is much helped by his attempt to revive the dead hostilities of an obsolete controversy. Apart from that, however, your correspondent quite misses the meaning of the term education. He is of the opinion, apparently, that the medical curriculum in itself contains, or ought to contain, everything useful for the training of a medical man. It is possible that by diligent study of an ideal medical curriculum a man might become a competent practitioner, but it does not follow that he might not have been assisted, even in that aim, by a wider education. For education in the sense of training of a man's entire nature, the study of a wide range of things is necessary, and the limiting to a groove is fatal. It is not merely, however, in the "rather superficial knowledge of mathematics, Greek and Latin" that a university education is of value, though even that knowledge, being of subjects widely different from anatomy, pathology, and clinical medicine, has immense educative value. The "grouping-schools of medicine, law and engineering in a university"—a point which your correspondent despises, is of even greater importance. The chief value of university training is in the intercourse the student has with other students, and not merely others following the same pursuit, but more especially with those following widely different pursuits. In after life we are apt to become narrow through a lack of this intimate intercourse with men of various occupations. How much more so at the period of life when character is being formed! When the medical man has become a mere tradesman, when medicine and surgery have

descended from their position as learned and humane professions to become mere trades, then the contention of your correspondent will be true, and a university training will be not only useless, but harmful. In the meantime, while of course university study cannot be considered a part, much less an essential part, of the study necessary for a medical qualification, it is the most important adjunct such special study can have.

I am, Sir, yours truly,

CRITICUS.

QUACKERY AND GENERAL PRACTICE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The articles and correspondence on the subject of quackery which have been appearing in your valuable journal during the past few months must have proved of great interest to the majority of the profession. However personally affected by the popular readiness to accept any form of blatant fraud if advertised with sufficient pertinacity, the practitioner must look upon the public attitude towards scientific medicine more with a feeling of sorrow than of anger. It seems indeed that the suggestion made some time ago in your columns may be true; and that by injuring the public health, by aggravating simple diseases and creating chronic invalids, most of whom pass in the end into the hands of legitimate practitioners, quackery forms really a source of profit to the profession. Be this as it may, nothing is more certain than the fact that the man who is his own physician has a fool for a patient, and that the treatment of disease by nostrums based upon diagnosis formed by reading advertisements leads to a vast amount of suffering and misery, and often to death. That the profession is almost completely powerless to interfere seems also evident. It is impossible to convince the public that medical objection to quackery can be inspired by any save selfish motives, and, as you have pointed out, we have the whole newspaper press, headed by *The Times*, now against us. It is lamentable to observe the present conduct of that newspaper in encouraging a traffic which, as you have also shown, was formerly denounced in plain terms by it on every suitable occasion. I am an old subscriber to *The Times*, and am aware how honourably distinguished it used to be with regard to the purity of its advertising columns. This is now all over. I have before me the issues for the last few weeks. These contain samples of almost every class of quack advertisement, including those of unqualified pretenders who undertake to cure by miraculous means surgical lesions of purely mechanical character, and which as the smallest knowledge of their nature shows, cannot be dealt with except by elaborate operations. So long as *The Times*, and all the leading papers, including *Punch* and other organs which profess to devote themselves to exposure of humbug, gain an important percentage of their incomes from quack advertisements, so long will the evils you have exposed endure. At the present rate of progress, generations will have to pass before sufficient scientific knowledge has become diffused to enable the people to take care of themselves in this regard. In the meantime the blame and the shame lie upon the newspaper-press.

I am, Sir, yours truly,

May 10, 1906.

AN OBSCURE PRACTITIONER.

MR. BERNARD SHAW ON VIVISECTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The public as a mass are virtually without any knowledge of science, and are completely in the dark as to what is meant by the term, "scientific research." In no department—least of all, probably, in physiology, do the public understand what are the means and methods adopted by workers in pursuit of truth. Unequipped with necessary fundamental knowledge, the bulk of the people are unable to appreciate a logical statement built upon and composed of demonstrable fact, they are unable to form an independent opinion of their own; and if they trouble themselves

at all about questions, in which an acquaintance with scientific methods and with science is called for, they are obliged almost blindly to adopt the views of those they regard as authorities. A cant cry, a catchword, a plausible sophism, any blatant falsehood thinly veiled iterated and reiterated with sufficient persistency, seems at last to sink into the minds of the ignorant and to become accepted as unquestionable truth. The assured success of any quack medicine, if sufficiently advertised, however grotesque the powers ascribed to it, affords the coarsest example of popular credulity. In Christian Science and other forms of occultism, such as esoteric Buddhism, we see other kinds of anti-scientific superstition fitted for acceptance by great sections of the public who, if intellectual, have never had sufficient intellectual training to enable them to distinguish between the sham and the real, between concrete facts and illusions of the senses. This being the condition of the popular mind, we need not wonder at the success of the various anti-scientific cults of the day, which are promoted either by sincere convinced fanatics, or by those who, inspired by less worthy motives, devote their lives to the promotion of their objects. We see anti-vaccination societies and antivivisection societies disposing of large incomes, gaining more and more support from the public, and likely in the end to have their way. The only method to prevent such a consummation seems to lie through an active opposition propaganda, but whether the scientific world will display a willingness to enter into the contest is perhaps doubtful. In the meantime, it remains easy for Mr. G. Bernard Shaw to find a large audience ready to listen with delight to speeches such as that to which he gave voice at the meeting last week. This speech will be read with disgust, if not with anger, by members of the profession whom it so foully slanders. No doubt such utterances must damage the profession. At the same time they must give rise to a vast amount of preventible suffering and misery, and on this ground it appears the duty of the profession to break the almost complete silence which it has hitherto maintained, in the face of such constant libellous insults and inuendoes.

I am, Sir, yours truly,

A COUNTRY PRACTITIONER.

REVIEWS OF BOOKS.

ATMOSPHERE AND CLIMATES. (a)

THIS is the first fasciculus of the comprehensive *Traité D'Hygiene* undertaken by Brouardel and Mosny and which with its score of separate parts promises to be an invaluable addition to medical literature, and a most practical and serviceable directory to all readers of the French language who are engaged in the various branches of hygiene.

In the present fasciculus Professor Courmont deals with the Atmosphere in all its various features; while Dr. Lesieur undertakes the sections on Climatology. The work is well designed and so far has been well executed. We shall await the following numbers with interest.

LANDMARKS AND SURFACE MARKINGS OF THE BODY. (b)

THE appearance of a second edition of this little book within a twelvemonth of its first publication is proof sufficient that it has adequately filled the gap which the author, in common with many others, recognised as existing in the series of text-books, which the medical student must master. The general form of the book is maintained (*i.e.*, it is a note-book containing in a more or less tabular form the surface

(a) "Atmosphere et Climates. Par Jules Courmont et Ch. Lesieur. Pp. 124, with coloured plates and 27 figures. Paris: J. B. Baillière et Fils, 1906.

(b) "Landmarks and Surface Markings of the Human Body." By Louis Bathe Rawling, F.R.C.S., Senior Demonstrator of Anatomy, St. Bartholomew's Hospital. Second Edition, London: H. K. Lewis 1905. With 31 Illustrations.

markings of the various viscera, muscles, nerves, &c., of the body), and a few additional facts have been added. Thus we notice the introduction of some pages on the surface markings of the perineum, and the information to be gained by rectal and vaginal examinations, while to the appendix has been added a table, compiled from Gray's Anatomy, of the dates of ossification of the epiphysis of the long bones. Some of the illustrations have been altered, and for the better, but we regret to notice that the figures representing the lower limbs have not been replaced by others taken from more muscular and less graceful individuals. To the necessity of such replacement we drew attention in our review of the first edition, and the retention of the figures we cannot but regard as a blemish in an otherwise admirable book.

GYNÆCOLOGICAL DIAGNOSIS. (a)

To write a book on gynæcological diagnosis which will appeal both to students and general practitioners one must have the experience which can only be acquired through much practice in teaching. When we consider that Dr. Henkel is first assistant to Professor Olshausen, and that his courses in gynæcological diagnosis are the most famous and most sought after in Berlin, both from the excellence of his teaching and the wealth of his material, we expected much from his book. That our expectations have been fulfilled must be our verdict. The book is written in simple, clear language, and the diagnosis, especially from the clinical point of view, is thoroughly worked out. The section on Carcinoma uteri is very good and does much to impress the importance and means of early diagnosis. Great care also has been expended on the uterine displacements and on extra-uterine pregnancy. The illustrations are numerous and the majority of them instructive. The arrangements of the different sections could be better, otherwise the book is excellent and one which must prove of the greatest assistance to its readers.

LITERARY NOTES.

A NEW edition (the fourth) of Sir Wm. Broadbent's text-book on "Diseases of the Heart" and a new edition of Mr. Ernest Clarke's "Errors of Accommodation and Refraction of the Eye" are announced for publication this week by Messrs. Baillière, Tindall and Cox.

MESSRS. CONSTABLE & Co. announce as in the press "Recent Advances in the Physiology of Digestion," by Prof. E. H. Starling, M.D., F.R.S., Jodrell Professor of Physiology. Mr. H. K. Lewis has recently published a second edition of Rawling's "Landmarks and Surface Markings of the Human Body," and Mr. Pentland a second edition of Cunningham's "Text-book of Anatomy."

A PAMPHLET on "Natural Ventilation" before us relates to the Municipality of Odessa, who are erecting a general hospital in that city. One does not expect to hear of any over-anxiety in Russia for moral or material ventilation, [but the authorities of this Institution, which will be one of the largest in that Empire, have at least determined to set an example, and the plans of "Natural Ventilation" of Messrs. Robt. Boyle and Son, of London, so well known and appreciated by the medical profession in this country, are being carried out in the new Odessa hospital.

We have received an interesting little book entitled "Lectures to Teachers on the Prevention of Infectious Diseases," by Dr. Wm. Berry, Medical Officer of Health for Wigan (Bristol: John Wright and Co. 6d. net.). These lectures, five in number, give brief descriptions of all the more important infectious diseases as well as a clear account of the process to be followed in disin-

fecting rooms and clothing. The statements made are clear and uniformly accurate. This booklet should be put into the hands of teachers, and medical officers of health may safely recommend it as an introduction to the subject for use in schools.

In a recently published book, "The Care of Infants," the writer gives some excellent advice to mothers on the feeding of their children which should do something towards stemming the tide of infant mortality, if ignorant mothers could be induced to read it. He points out that there are three available methods of feeding an infant: (1) Breast feeding by the mother; (2) combined feeding, that is, from the breast and artificial food; and (3) artificial feeding, where Mellin's food is employed with cow's milk. For hand-reared infants the food best adapted must fulfil the following conditions: it must contain substances which closely resemble the components of breast milk; the components must be in proper proportion and in a form suited to the simple conditions of digestion during infancy; the total quantity given during twenty-four hours must be such as to represent the nutritive value of the amount of breast milk which would, under ordinary conditions, be given in the same time. Three-fourths of the infants who die under the age of one year are those fed artificially, and most of these deaths are solely attributable to unsuitable food.

OBITUARY.

EUPHEMIA STOKER, L.R.C.S. & P.EDIN.

WE regret to record the death of Dr. Euphemia Stoker at a comparatively early age, at her residence at Hampstead, London. Deceased served through the recent campaign at the Cape with distinction. At the first annual dinner of the Scotch Diplomates Association she made a speech clad in the then newly-granted gown of the Edinburgh Royal College of Surgeons. Dr. Stoker, who had been a widow for several years, leaves one child. Amongst other spheres of usefulness deceased for several years acted as lecturer to the London County Council.

MATTHEW BAINES, M.D.

WE regret to announce the death of Dr. Matthew Baines, M.D., late Surgeon Lieutenant-Colonel, of the 1st Middlesex Royal Engineer Volunteers, at an advanced age. He was formerly assistant surgeon to the West London Eye Infirmary, and afterwards physician to St. Paul's Home, Sydney Street, and the Training Home, Wharfedale Street. For many years he served with the 1st Middlesex Royal Engineer Volunteers, retiring with the rank of Lieutenant-Colonel and with the Volunteer decoration. Dr. Baines was an Associate of King's College and a Knight of Grace of the Order of St. John of Jerusalem in England.

FRANK SAMUEL GOULDER, L.R.C.P., M.R.C.S., OF DUDLEY.

WE regret to record the death, on the 9th inst., of Mr. F. S. Goulder, who for twenty-five years was in practice in Dudley. Mr. Goulder studied at University College, London, whence he qualified L.R.C.P., M.R.C.S. in 1877. He went to Dudley thirty years ago to the Guest Hospital. He then went as assistant to Dr. Carr, of Cradley Heath, and after remaining there a few years he returned to Dudley and set up practice for himself. He was one of the hon. surgeons at both the Dudley Dispensary and the Guest Hospital, and at one period was churchwarden at the Dudley Parish Church. Mr. Goulder was fifty-one years of age.

JOHN CLARKE, M.D. ST. AND.

DR. JOHN CLARKE, formerly of Mayfair, London, died on the 8th inst., at the age of eighty-two. He was the younger son of Sir Charles Mansfield Clarke, Bart., M.D., who was physician to her Majesty Queen Adelaide, was born in 1823, and was an M.D., of St. Andrews and a Fellow of the Royal College of Physicians London-

(a) "Gynäkologische Diagnostik in Zwanglosen Vorträgen für Studierende und Aerzte," Von Dr. Max Henkell, Oberarzt an der Kgl. Universitäts-Frauenklinik und Privat-Dozent an der Universität, Berlin. (Berlin: S. Karger, 1905.)

MEDICAL NEWS IN BRIEF.

A Medical Divorce Case.

A CASE of an exceedingly unpleasant nature, in which proceedings for divorce were taken against a well-known and esteemed medical man, Dr. Coleman, Physician to the Richmond and Hardwicke Hospitals, Dublin, has been at hearing during the past week. The allegations made by his wife were of a most serious nature, and were entirely at variance with the high opinion held of Dr. Coleman by the profession in Dublin as a whole. Amongst these mention may be made of attempted poisoning, attempted administration of chloroform, attempts to frighten his wife into a miscarriage, and attempts to hypnotise her, besides other charges. Various medical men were examined during the hearing, two in support of the charge of hypnotising and others amongst whom may be mentioned Mr. Lentaigne, F.R.C.S., and Dr. Martin Dempsey in support of Dr. Coleman. A statement by the petitioner that the wife of a well-known surgeon had made a remark, which, had it been made, would have been a most serious reflection on Dr. Coleman's personal character was contradicted on oath by the lady who was said to have made it. Although it seemed that at one time the jury would have stopped the case, it was adjourned on Friday until Monday, when, after hearing lengthy speeches which lasted all day from the respective Counsel, the Judge summed up in the defendant's favour, and the jury returned on Tuesday a verdict for him. We offer our sincere congratulations to Dr. Coleman on his complete vindication from charges which, if proved, would have ruined his professional career, and at the same time desire to express our deep sympathy with him in the trouble through which he has passed.

Royal College of Surgeons in England.

An ordinary meeting of the Council was held at the College on Thursday last, May 10th, Mr. John Tweedy, F.R.C.S., President, in the chair. Surgeon-General Arthur Mudge Branfoot, C.I.E., President of the Medical Board at the India Office, and Mr. Herbert Mackay Ellis, R.N., Director-General of the Medical Department of the Navy, attended, and were admitted fellows of the College. The Jacksonian prize was presented to Mr. Reginald Cheyne Elmslie, F.R.C.S. Mr. Walter Burford Johnson, of St. Thomas's Hospital, was admitted as the first Begley Student. A report was received from Mr. J. Ward Cousins, in regard to the proceedings of the Central Midwives' Board during the past year, and the thanks of the Council were given to him for his services as the representative of the College on the Board. It was determined to hold a Fellows' subscription dinner in the College on Thursday, July 5th. The President reported that Professor Jensen was unable to visit England to receive the Walker Prize, but that the Hon. Sir Alan Johnstone, K.C.V.O., British Minister at Copenhagen, had undertaken to present the prize to him on behalf of the Council. Mr. Edmund Owen (Vice-President) and Dr. H. Timbrell Bulstrode were appointed representatives of the College on the General Organising Committee for the Second International Congress on School Hygiene to be held in London in August, 1907. In accordance with the recommendation of the Committee of Management of the two Royal Colleges, it was determined to add the Bexley, Horton and Manor Asylums to the list of Lunatic Asylums recognised by the Examining Board in England for Clinical Demonstrations in Lunacy.

Staff Appointments at Guy's Hospital.

At the General Court of Governors, held on Friday week the following promotions and appointments on the medical and surgical staff were made:—To be a consulting surgeon, Richard Clement Lucas, B.S., F.R.C.S.; consulting ophthalmic surgeon, Charles Higgins, F.R.C.S.; to be a surgeon, Louis Albert Dunn, M.S., F.R.C.S.; to be ophthalmic surgeons, Herbert Light-

foot Eason, M.D., M.S., and Arthur William Ormond, F.R.C.S.; to be an assistant surgeon, Robert Pugh Rowlands, M.S., F.R.C.S.; to be an assistant physician, Herbert Stanley French, M.D.

The report of the hospital for 1905 was formally approved, and ordered to be issued; it shows a year's work of unexampled magnitude, 8,626 persons having been accommodated in the wards, and 137,792 persons treated as out-patients. The appeal for funds, issued in March, 1905, resulted in £57,000 having been received or promised up to the end of the year, leaving a balance of £43,000 still urgently required to clear the hospital from debt on capital account, and a deficiency of £15,000 per annum in ordinary income to be made good year by year. It, moreover, appeared that, although no building improvements or extensions were now in progress, the provision of new out-patient departments, of separate wards for children, and the rebuilding of the old clinical house were matters which it was highly desirable should be taken in hand when funds became available for the purpose.

Royal Sanitary Institute

THE annual dinner of the Royal Sanitary Institute was held on Wednesday last in London. The Duke of Northumberland, the president, occupied the chair, and the company included Sir F. S. Powell, M.P., Colonel J. Lane Notter, R.A.M.C., Surgeon-General A. Keogh, C.B., Sir Aston Webb, R.A., Sir Lauder Brunton, and Sir Shirley Murphy. The chairman, in proposing the toast of "The King" said the institute had lately been taking a great deal of interest in the second International Congress on School Hygiene, and the King, who was the patron of the institute, had consented to become patron of the congress also. Surgeon-General Keogh, responding for "The Navy, Army, and Auxiliary Forces," proposed by Sir Lauder Brunton, alluded to the question of sanitation in war, and particularly to the water question. There should, he said, be a definite method of providing an army in the field with pure water. He had come to the conclusion that the system of boiling water by a field army was impossible, and he was in favour of the adoption of a system of filtration by means of the ordinary filtration in field water carts. He considered it was a disgrace that there should have been 40,000 cases of enteric fever in the South African war; and he did not think we were one bit more efficient in the treatment of disease in the Army than we were in 1899. But he believed that the water problem, with regard to a fighting army, was on the eve of solution.

Long Vacation Course at Cambridge University.

THIS year the work of the Long Vacation Course in Pathology, Public Health, and Pharmacology will be divided into three sections: (1) (for D.P.H. Students) commencing on Monday, June 25th, and (2) (for Junior Students of Medicine) and (3) (for Advanced Students, Medical Men, &c.), commencing on Monday, July 2nd. In addition to the foregoing arrangements, we are asked to announce that the series of short courses of lectures and demonstrations on Pharmacology (Bronchial Asthma, "Vasoconstriction," the Specific Actions of Drugs, &c.), Pathology (Inflammation, Immunity, Antitoxins and Antibodies, Food Poisoning, &c.), and a course by Dr. Nuttall on Protozoal Diseases will be repeated this year. These courses will be open to medical men and senior students only; they will be held if a class of ten can be formed, and will not extend over more than four weeks. Particulars may be obtained on application to Mr. E. E. Stubbings, Pathological Department, New Medical School, Cambridge.

THE South London Institute for the Blind, the foundation stone of which will be laid on the 24th inst. by the Duke of Argyll, was founded in 1870 by the late James Hampton, "the blind man's friend," in Webber Row, S.E., in conjunction with the late Earl Shaftes-

bury, K.G., and the late Rev. C. H. Spurgeon. Since 1870 (thirty-six years ago) the work of the institution has been carried on by the aid of voluntary contributions. The scope of the charity during the last few years has greatly increased, and the committee find that the temporary hall in Westminster Bridge Road is quite inadequate to cope with the work. They have therefore acquired from the Corporation of London a site in the Borough Road on which it is intended to erect a building, to be called the South London Institute for the Blind Poor. The committee of this excellent charity have completed the foundations of the new building, but have only a small sum in hand, and they therefore make an urgent appeal for £2,500 to complete the new Institute and Home of Rest.

Legislation in Regard to Children.

THE Lord Mayor of London will open a conference at the Guildhall on Tuesday, the 22nd inst., convened by the International Congress for the Welfare and Protection of Children, for the purpose of considering pending legislation. Representatives of many important organisations throughout the kingdom will take part in the proceedings, over which Sir William Bousfield will preside. The first day's work will particularly refer to the methods of dealing with youthful offenders. A lively discussion is expected as to the free feeding of children in the elementary schools; Dr. Macnamara, M.P., and others, having promised to speak. The conference (of which Mr. W. G. Lewis, Barrister-at-Law, 8, Wells Street, Gray's Inn Road, W.C., is secretary) will discuss papers on "Remand Homes," "Children's Courts," and "Probation Officers," by Miss Adler, Miss Baker, Mr. Courtenay Lord, J.P., and a Report on "The Present Position of the Probation System in the United States," by Mrs. Ada Eliot Sheffield. Papers on "The Free Feeding of Children in Elementary Schools" will be read by Sir Charles A. Elliott, K. C.S.I., and Miss Margaret Frere. M. Marcel Kleine will describe the "Cantines Scolaires" of Paris. The discussion will be opened by Dr. Macnamara, M.P., and Sir Arthur Clay, Bart.

PASS LISTS.

Royal College of Surgeons, England.

THE following 102 candidates, whose names are arranged alphabetically, having previously passed the necessary examinations received their diplomas as members of the college on Thursday, May 10th:—Charles B. M. Aldridge, Gervase D. Alexander, G. Hely-Hutchinson Almond, John S. Austin, Arthur S. B. Bankart, George N. Bartlett, Stanley J. A. Beale, Edwin Beaton, William Beck, Claude J. E. Bennett, Frank C. H. Bennett, Charles M. Bernays, John B. Binns, Rowland A. Bowling, Samuel J. Boyd, John H. R. Brodrecht, John Horace, G. Brown, Ralph Brown, Oliver Bruce, Arthur S. Burgess, Percival Butler, Herbert Charles, Wm. W. D. Chilcott, John Clarke, William J. Cowan, Duncan Davidson, Edwin T. H. Davies, Robert Davies-Colley, Edmund M. Dolan, John J. W. Evans, Harold W. Farebrother, Richard V. Favell, Stephen Field, C. Fletcher, John R. Foster, Claud F. Fothergill, Elliott T. Glenny, Horace Gooch, Charles W. Greene, Reginald A. Greeves, Alfred H. Hardcastle, Raymond S. Harper, Percy B. Harrison, Arthur Hawkins, George M. W. Hodges, Cyril J. R. Hoffmeister, Richard Holtby, Ernest T. C. Hughes, Cyril H. T. Ilcct, Harold M. Inman, William A. James, Francis S. Jones, Thomas J. Latham, T. St. Leger Leyshon, Arthur R. Littlejohn, John McAsh, Charles M. MacLean, Ivan C. Maclean, Neil J. McLean, Eugene A. Mascarenhas, George P. Mills, Arthur Mülberger, Hubert C. Mulkern, John O. Musson, Arthur H. Norris, James J. Paterson, Patrick H. H. Pereira, Arthur R. Phelps, Harry G. Phippen, Philip A. Reckless, James E. H. Roberts, Felix S. Rood, Alfred M. Roome, Sidney J. Rowntree, Donald W. Roy, Albert Salmon, Douglas R. C. Shepherd, James Smalley, Hoyland Smith, James E. Smith, Leslie E. M. Smith, Henry S. Souttar, John H. Spencer, C. Stanley Clarke, Wm. J. E. Stuttaford, George W.

Sudlow, Alfred K. B. R. W. Taylor, Arthur G. J. Thompson, George S. Thompson, Henry L. Tidy, Joseph F. Trewby, T. Turner, Henry F. Vandermin, Guy T. Verry, Harold S. Vivian, Geoffrey Wachter, Maneck D. Wadia, Harold R. S. Walford, John Wallace, Howard F. Warner, Edward Wight, Edwin J. Wyler.

The Royal University of Ireland.

THE Senate met on Friday, May 4th, 1906, at 11.30 a.m. The results of the recent Spring Medical examinations were considered and awards made. The election by Convocation of Dr. John Campbell, M.A., was reported, and he was elected a member of the Medical Committee. The following resolution was adopted unanimously:—"That, having regard to the official pronouncement made in the House of Commons, on March 15th, by the Chief Secretary, that his Majesty's Government had been advised 'that the Senate of the Royal University of Ireland had the power to maintain order and to take all steps necessary to that end,' the Senate hereby direct the Standing Committee to prepare a draft of such statutes and regulations as shall provide the necessary means to enforce academic discipline and to punish academic misconduct." In reference to the disorder last October, it was directed that the minutes of the Senate meetings, &c., relating thereto be supplied to the Government. A meeting of the University was held afterwards at which the following awards were announced and degrees conferred:—

Second Examination in Medicine.—First-class Honours and a First-class Exhibition of £25, James M. O'Connor, Catholic University School of Medicine.

Third Examination in Medicine.—First-class Honours and a First-class Exhibition of £30, William D. O'Kelly, Catholic University School of Medicine; Second-class Honours and a Second-class Exhibition of £20, Marshall F. Huston, Queen's College, Belfast.

M.B., B.Ch., B.A.O. Degrees Examination.—First-class Honours in Medicine, Second-class Honours in Surgery and Midwifery, and a First-class Exhibition of £40, Robert Jamieson, Queen's College, Belfast; Second-class Honours in Medicine and Midwifery, and a Second-class Exhibition of £25, William J. Leighton, Queen's College, Belfast; First-class Honours in Medicine, and Second-class honours in Surgery, William A. McKee, B.A., Queen's College, Belfast.

Conjoint Examinations in Ireland.

Fourth Professional Examination.—Candidates who have passed this examination are:—John J. Hogan, with Honours; Charles J. D. Bergin, John Corboy, Reginald C. Galgey, Maurice R. J. Hayes, Henry M. Harrison, Daniel Hampson, Thomas Leonard, Leonard Lucas, Francis G. McCaughey, Robert M'Elroy, Patrick J. Rooney, William Sammon, George Sheppard, Sidney W. Talbot, George F. Wright, William G. Wright.

Army Medical Service.

AN examination of candidates for not less than forty commissions in the Royal Army Medical Corps will be held in London on July 26th and following days. Applications to compete should be made to the Secretary, War Office, 68, Victoria Street, not later than July 16, on which date the list will be closed.

MR. JOSEPH MILNTHORPE, J.P., of Bishopsdale Buxton, a well-known philanthropist, whose will has been proved at £88,375, after leaving bequests to his family and friends, has left the ultimate residue of his estate in equal shares to the following institutions:—The Sheffield Royal Hospital, the Sheffield Royal Infirmary, the Sheffield Jessop Hospital for Women, the Sheffield Children's Hospital, the Sheffield Deakin Institution, the Sheffield Institution for the Blind, the Manchester Royal Infirmary, Dr. Barnardo's Homes for Homeless and Destitute Children, and the Children's Home and Orphanage, Bonner Road, London, founded by Dr. T. B. Stevenson. These institutions seem likely to benefit by a sum of probably more than £60,000.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially Compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT LITERATURE OF PHYSIOLOGY AND PATHOLOGY.

Radium and the Virus of Rabies.—Danysz (*Annales de l'Institut Pasteur*, March 25th, 1906) traverses briefly but forcibly the conclusions of Tizzoni and Bougiovanni that the action of radium on the virus of rabies converts it into a vaccine, and that by making the rays of radium play on the eye one can cure rabies in a rabbit. Danysz exposed an emulsion of virulent spinal cord for twenty hours to the rays of 20 milligrammes of pure bromide of radium, and then inoculated rabbits. The inoculated animals died as soon as the controls. Further experiments showed that radium exerted no appreciable influence on the virulence of infective material. As regards the treatment of rabies by radium applied to the eye, Danysz is equally at variance with Tizzoni and Bougiovanni. Not only has radium, in his opinion, no curative action when thus employed, but it produces most serious lesions of the eye itself, ulceration of the lids, conjunctivitis with muco-purulent secretion, interstitial keratitis, congestion of the iris, and finally atrophy of the optic nerve. R.

Bacteriology of a Common Cold.—Benham (*British Medical Journal*, May 5th, 1906) reports his bacteriologic investigations in 21 cases of mild "common cold." He notes the scanty nature of all observations on the subject, the principal organisms previously noted being (1) *micrococcus catarrhalis*, described by Lord, De Jong, Dunn and Gordon, and others; and (2) the *bacillus coryzae segmentosus*, discovered by Cautley, and also observed by Gordon and probably by White. Benham's examinations were made on both the nose and throat and out of the 21 cases examined, he found organisms as follows:—a—(1) in 20 cases a diphtheroid organism; (2) in 10 cases, cocci negative to Gram's method of staining; (3) in 14 cases, cocci positive to Gram's method. Other organisms were found in small numbers, in much the same proportions as in normal noses and throats. (1) The diphtheroid bacillus is described in some detail and is believed to be identical with the bacillus described by Cautley. It grows easily on agar, on ascitic agar, and on nutrose-ascitic-agar, with difficulty on gelatine; the colonies are minute and circular. It has a slight tendency toward the formation of acid in carbohydrate media. It stains easily and by Gram's method; it is negative to Neisser's stain. It is a short bacillus, with rounded ends, in early cultures resembling a coccus, in later becoming cuneiform or club-shaped. It stains deeply at the ends, more faintly in the middle, so that it often resembles a diplococcus. (2) The cocci negative to Gram's method presented the features described by Dunn and Gordon as belonging to the *micrococcus catarrhalis*. It grows slowly and with uncertainty on ordinary media, and is easily overpowered by the common cocci. (3) The cocci positive to Gram's method were probably many of them pneumococci. They were always scanty, and the author did not succeed in isolating any of them. Benham concludes that the diphtheroid bacillus is probably causally connected with a cold, at any rate as affecting the throat, while the action of the micrococcus requires further study before any statement can be made. R.

An Antityphoid Serum.—Macfadyen publishes (*Brit. Med. Journ.*, April 21st, 1906) an account of successful experiments in the production of any antityphoid serum. He first separated endocellular toxins by a method previously described, viz., grinding live bacilli at the temperature of liquid air, and then extracting with dilute caustic potash. In this way a sterile bal-toxic fluid can be obtained. A goat was then injected with a very small dose (1-20 c.cm.) of

the juice, and at intervals of a week or more injected with gradually increasing doses. The animal's serum developed antitoxic agglutinative, and bacteriolytic properties. So high did the antitoxic power rise that 1-50 c.cm. of the serum was sufficient to neutralise 30 lethal doses (for the rabbit) of the endotoxin. The serum acted when injected simultaneously with, but separately from, the toxin; it also acted when injected at the onset of toxic symptoms. The investigation is one of great promise, since there is no reason to believe that such a serum should not have similar antitoxic properties in man to those demonstrated by Macfadyen in the rabbit. R.

Bacteriology of Summer Diarrhoea of Infants.—Morgan (*Brit. Med. Journ.*, April 21st, 1906) reports the results of a laborious bacteriological investigation into some 58 cases of infantile diarrhoea occurring in London. Up to the present most work on this subject has been done in America, and the association of two different organisms—the Saiga bacillus and the Flexner bacillus—with the disease has been definitely established. In Morgan's researches neither of these organisms was encountered, though in seven cases an organism presenting certain resemblances to Flexner's bacillus occurred. In 28 cases, however, one organism was found, which appears to have had a causal significance. Feeding with it proved quickly fatal to young rats and young rabbits, death being preceded by violent diarrhoea. The bacilli were recovered in every case from the spleen, and in a few cases from the heart-blood as well. On the other hand, injected intravenously and intra-peritoneally, this bacillus had no pathogenic effect. The filtrate, however, from a broth culture had a highly toxic action when injected intravenously. Morphologically the bacillus is a little smaller than the typhoid bacillus, multi-flagellated, and motile. Morgan can find no previous record of this organism, nor did Houston in extensive examinations of faeces, sewage and water, ever meet with it. The other organisms isolated and described by Morgan do not appear to be of importance. The interest of the investigation is in the suggestion that infantile diarrhoea occurring in this country may have a very different bacteriological causation from the parallel disease in the States. R.

Pathology of Rabies.—Frothingham (*Journal of Medical Research*, April, 1906) discusses the association with rabies of (1) the lesions described by Van Gebuchten as occurring in the ganglia, and of (2) Sargi bodies. The former change is typically a proliferation of the endothelial cells of the capsule of the ganglion cells going on to the destruction of the ganglion cells. This change Frothingham regards as invariably occurring in rabies, though it is possible that it also occurs in other conditions. The presence of Negri bodies on the other hand, i.e., the cell inclusions first described in 1902 by Negri, is only noticed in rabies, but is not noticed in every case of rabies. The author concludes that if Negri bodies be present, inoculation of animals is unnecessary as a diagnostic measure, while, on the other hand, if there be no lesions in the Gasserian ganglion, a negative report may be given. R.

Musculature of the Heart.—The *Johns Hopkins Hospital Bulletin* for April, 1906, contains a valuable review of the most recent researches on the musculature of the heart, contributed by Walter Baetger. Our knowledge of the arrangement of the muscle fibres in the heart wall dates, as he points out, from Ludwig's article in 1849, in which for the first time separate bundles of muscle fibres were recognised as existing. The next most valuable contribution was that of Krehl in 1891, in which the existence of a tendinous

band in the posterior aspect of the conus arteriosus was pointed out, thereby showing that three tendinous points exist at the base of the heart, the other two being the auriculo-ventricular rings. More recently MacCallum, by the study of semi-macerated embryonic hearts, has been able to more clearly trace the muscle fibre groups, and has divided them into main superficial and deep layers. The superficial fibres are further sub-divided into four muscles, the general course of which may be said to be a spiral one around almost the entire heart and crossing from one ventricle to the other. Each of these muscles takes origin from one of the tendinous points above referred to, and after a winding course terminates in one of the papillary muscles of the contra-lateral ventricle. The deep group of fibres is composed of three muscles, each of which describes an S-shaped course round the ventricles arising in a papillary muscle of one ventricle and being inserted in a papillary muscle of the other. In addition to the two main superficial and deep layers, certain intermediate fibres also exist which cannot be classified with the above, and which do not come into connection with the papillary muscles. They for the most part pass from the right into the left ventricle and form an important bond of union between the two chambers. M.

Circumscribed Abscesses of Bone.—Thomson contributes an important paper on Brochi's abscess of bone to the April number of the *Edin. Med. Journ.* He describes the lesion as being found in three different stages, namely (1) the quiescent form; (2) the ripe abscess; and (3) the abscess after it has ruptured and discharged externally. In the first stage a small cavity exists in the bone filled with serum and lined by a well defined membrane resembling the periosteum of young bones, and bounded externally by a layer of rapidly growing young bone. In the mature stage the cavity contains pus, and the lining membrane has become converted into granulation tissue, outside which the bone is being gradually eroded by the spread of the abscess. In the third stage the lining of the cavity reverts to the condition found in the quiescent stage, with the difference, however, that no new bone is being formed outside it. In discussing the cause of the transition from the first to the second stages, Thomson refuses to accept Gross's hypothesis that it is brought about by the physiological rarefaction that always succeeds sclerosis of bone, and inclines rather to the view that the change is caused by the virulence of the organisms present. Thomson also lays stress on the previous existence of an osteo-myelitis and in the long latent period that may intervene between such and the abscess formation. M.

The Pathology of General Paralysis.—Dr. Ford Robertson writes on his investigations into the pathology of general paralysis in the March number of the *Edinburgh Medical Journal* and gives a brief account of the facts which he has already made known in his Morison lectures. The writer has found that a diphtheroid bacillus is always to be found in the respiratory and gastro-intestinal tracts of general paralytics, and he supports the hypothesis that this organism is the main cause of all the nervous symptoms. The bacillus is not pathogenic to guinea-pigs, but proves fatal within ten days to rats, which animals develop nervous symptoms before death. The organisms have also proved fatal on injection into a goat. The animal became frantic, and its brain subsequently showed changes resembling those found in an early case of paralysis. The same diphtheroid organism has been obtained from the hair of ten general paralytics out of a total of twenty-four autopsies, and has been obtained from the blood of one case during life. The cerebro-spinal fluid, moreover, contains structures which resemble semi-dissolved Klebs-Löffler bacilli, while in two cases a culture of such bacilli has been grown from the fluid obtained by lumbar puncture. The last point in Dr. Robertson's chain of evidence is that the active polymorpho-nuclea

leucocytes of the general paralytic have, as a rule, a greater power of dissolving these diphtheroid bacilli than that possessed by the healthy leucocyte. This he regards as showing that to a certain extent some resistance is shown to the chronic toxæmia which he regards as causing the disease. M.

Etiology of Scurvy.—In the last few numbers of the *Sei-I-kwai Medical Journal* (Vol. xxiv., No. 10 and 12. Vol. xxv., No. I.) Professor Okada and Dr. Saito have published an account of an elaborate research which they have made into the etiology of scurvy. The main conclusion at which they arrive is that a micrococcus can be isolated from the blood of scorbutic patients, and this they believe to be the actual cause of the disease. In support of their belief they state (1) that the organism is readily agglutinated by the serum of patients suffering from scurvy, and even in dilutions of one hundred or more; (2) that the organism is pathogenic to animals, and produces in them symptoms somewhat resembling those of scurvy, namely, hæmorrhages in lungs and kidneys, loss of weight, hæmorrhage into muscles and general œdema. They have, moreover, in all fatal cases been able to obtain the cocci again from the heart blood of the inoculated animals. The cocci have been cultivated in most ordinary media, and both their cultural characteristics and their resisting power to heat and antiseptics have been worked out. M.

Suprarenal Diabetes.—Baron (*Russische Medicinische Rundschau*, No. ii., 1906) reports the results of his investigations into the glycosuria resulting from hypodermic injections of extracts of suprarenal glands. He has experimented on rabbits, guinea-pigs, dogs, and other animals, and has come to the following conclusions:—(1) Glycosuria invariably results from the hypodermic injection of suprarenal extracts. After a second injection the amount of sugar passed is less than after a first, but it is no less certain to appear. The intensity of the glycosuria largely depends on the state of the nutrition of the animal; (2) when a first injection is followed after some hours by a second, the sugar contents of the urine soon becomes diminished; (3) the glycosuria is always accompanied by glycaemia, and by increase of white and red blood corpuscles; (4) Suprarenal extracts diminish the general oxidation processes of the body and in this fact lies the probable explanation of the glycosuria produced; (5) suprarenal extracts given by the mouth do not produce glycosuria; (6) extracts of the suprarenal glands of such animals as have been previously treated by hypodermic injections of adrenalin, lose the property of producing glycosuria after injection into other animals. M.

Enterogenous Cyanosis.—Grutterink and Bergh describe cases of cyanosis in which investigation led to the conclusion that the symptom resulted from the absorption of toxic materials from the intestinal tract into the blood. In four cases, all of which were suffering from intestinal troubles, sulphohæmoglobin was found in the blood. In a second group of cases in which methæmoglobin was found in the blood, the clinical symptoms consisted of severe chronic enteritis, of long-continued headache, weakness of the limbs and general exhaustion. Absolute milk diet persisted in for twenty-four hours caused the cyanosis to lessen, but it returned again when the diet was altered. Examination of the fæces, urine and saliva did not reveal any cause for the methæmoglobinæmia, but in the blood nitrites were found to be present in large quantities within the red blood corpuscles. The authors think that the blood change is probably produced either by an increased production of nitrites in the intestines, or by an increased absorption through the diseased intestinal wall. M.

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

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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 reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

MATER.—Cycling, of course in moderation, is, in our opinion, the next best form of exercise to walking in which healthy persons of middle age, and onwards, can indulge.

ROSS-SHIRE.—We cannot vouch for the report. It reached us through a private source, with the request that we should not deal with it without further confirmation.

A MEMBER.—The appointments of examiners at the college are entirely in the hands of the Council.

A MEDICAL PRACTITIONER (Gloucester).—We are obliged to our correspondent for forwarding the newspaper cutting.

K. M. (Exeter).—It would be obviously unwise to express any opinion as to the honesty of an applicant in his presence, any more than it would be in the matter of his health. The medical examiner must form his own conclusions upon both heads, but any resulting information is the property of the insurance company. In this particular case divulgence is clearly with consent of the person examined.

R.A.M.C.—The opsonic index can be ascertained only by experts who have command of the necessary material and apparatus. The method is too complicated in its present stage of development to come into general use.

Mr. J. BANISTER (Bromesbury).—Your communication came to hand as we were "at Press."

DR. R. R. R. (Liverpool).—See reply to Mr. Banister.

QUACKERY IN ADVERTISING.

Two correspondents have sent us (1) *The Christian Banner*, and (2) *The Church Family Newspaper*. If these may be taken as fair specimens of the religious papers generally, we can only wish that lay publications were as well conducted in regard to quack advertisements. In the latter we found but one announcement to which we might take exception, viz., *Phosferine*, "The remedy of Kings, supplied by Royal command to the Royal Family; a proven remedy for premature decay, rheumatism, hysteria." In *The Christian Banner* there were one or two others, such as *Mother Seigel's Syrup* and *Vita-Ore*, of which "thousands have pronounced it the marvel of the century for curing such diseases as rheumatism, gout, Bright's disease," &c. This latter, say the advertisers, has been highly commended by *The Lancet*, *The Edinburgh Medical Journal*, *The Medical Magazine*, and *The Clinical Journal*. This point we leave our contemporaries to fight. Our correspondents are thanked for sending these publications, which we are glad to acknowledge are exceptionally free of the usual run of quack cure-alls.

J. P. WILSON (Portsmouth).—The deaths from snake-bite in India amount from 18,000 to 20,000 or 22,000 yearly. This corresponds roughly to about 1 in 10,000 of population. The only way of combatting the evil at all effectually is by the extermination of poisonous snakes. Government is carrying on the process at the rate of from 200,000 to 600,000 annually.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MAY 16th.

ROYAL MICROSCOPICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Exhibition of Pond Life.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Dr. A. H. Tubby: Clinique. (Surgical). 5.15 p.m. Lecture—Dr. G. H. Savage: Dementia Præcox.

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

THURSDAY, MAY 17th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m. Lecture—Dr. H. Campbell: Observations on Treatment.

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

FRIDAY, MAY 18th.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (11 Chandos Street, Cavendish Square, W.).—5.30 p.m. Wightman Lecture: Dr. A. Broca (Paris): Appendicitis in Childhood.

EPIDEMIOLOGICAL SOCIETY (11 Chandos Street, Cavendish Square, W.).—8.30 p.m. Paper—Prof. R. Boyce (Liverpool): The Yellow Fever Epidemic in New Orleans in 1905.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Dr. D. Grant: Clinique. (Ear.)
LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m. Operations. Dr. R. Bradford: Medicine. 3.15 p.m. Mr. McGavin: Surgery. Out-patient Demonstrations:—10 a.m. Surgical and Medical. 12 noon. Skin.

SATURDAY, MAY 19th.

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

Vacancies.

Birkenhead Union.—Resident Assistant Medical Officer. Salary £120 per annum, with board, washing, and apartments. Applications to John Carter, Clerk to the Guardians, Poor Law Offices, Birkenhead.

Birkenhead Borough Hospital.—Junior Resident House Surgeon. Salary £80 per annum. Applications to the Secretary.

Hants County Asylum.—Second Assistant Medical Officer. Salary £175 per annum, with furnished apartments, board, washing, and attendance. Applications to the Visiting Committee, Hants County Asylum, Fareham.

Killarney District Lunatic Asylum.—Assistant Medical Officer. Salary £100 per annum and allowances. Applications to E. W. Griffin, Resident Medical Superintendent. (See advt.)

Lancashire County Asylum, Winwick, Warrington.—Locum Tenens Medical Officer. Salary four guineas per week, with furnished apartments, board, attendance, and washing. Applications to the Medical Superintendent.

Leeds Tuberculosis Association.—Resident Medical Officer.—Salary £100 per annum, with board, lodging, and washing. Applications to Chas. H. Sedgwick, Secretary, 37 Great George Street, Leeds.

Portsmouth Borough Asylum.—Assistant Medical Officer. Salary £150 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

Appointments.

AIKEN, ACHESON, L.R.C.P.I. and L.R.C.S.I. Dub., Certifying Factory Surgeon and Medical Officer Irvinestown Workhouse and Dispensary District.

BULKELEY, L. A. H., M.B., B.S. Durh., Junior House Physician at the Royal Infirmary, Newcastle-on-Tyne.

CARTER, F. BOLTON, M.I., M.S. Lond., F.R.C.S. Eng., Assistant Surgeon to the Leicester Infirmary.

CUNNINGHAM, H. B., M.B., B.S. Durh., House Surgeon at the Royal Infirmary, Newcastle-on-Tyne.

DICK, W., L.R.C.S., L.R.C.P., House Surgeon at the Children's Hospital, Bradford.

DUFF, DONALD, F.R.C.S. Edin., F.F.P.S. Glasg., Extra Dispensary Surgeon to the Glasgow Royal Infirmary.

HEUSTON, FRANCIS T., F.R.C.S.I., Surgeon to the Adelaide Hospital, a member of the Board of Governors of the Rotunda Hospital.

JONES, HERRESFORD, M.B., B.S. Durh., House Surgeon at the Royal Infirmary, Newcastle-on-Tyne.

LEE, H. F., M.B., M.C. Edin., Clinical Assistant to the Chelsea Hospital for Women.

LUNN, W. E. C., M.B., B.S. Durh., House Surgeon at the Royal Infirmary, Newcastle-on-Tyne.

SHAW, CHARLES J., M.B., M.R.C.P. Edin., Senior Assistant Medical Officer at the Royal Asylum, Sunnyside, Montrose.

WILLAN, R. J., M.B., B.S. Durh., House Surgeon at the Royal Infirmary, Newcastle-on-Tyne.

Births.

BENNETT.—On May 9th, at Staverton, 33 Vancouver Road, Forest Hill, London, the wife of Collin E. Bennett, M.R.C.S., L.R.C.P. Lond., of a son.

COOKE.—On May 8th, at 65 Abington Street, Northampton, the wife of A. W. Cooke, M.R.C.S., L.R.C.P., of a son.

GOLDIE.—On May 9th, at "Longcombe," 17 Harcourt Avenue, Southend-on-Sea, Essex, the wife of A. Evelyn Goldie, M.B., Ch.B. Edinburgh, of a son.

PORTER.—On May 9th, at the Limes, Berkhamsted, the wife of Charles R. Porter, M.R.C.S. Eng., L.R.C.P. Lond., of a daughter.

RINGROSE.—On May 7th, at Lombard House, Newark-on-Trent, Notts, the wife of Ernest Ringrose, L.R.C.P. Lond., M.R.C.S. Eng., of a daughter.

STRACEY.—On April 23rd, at Sutton Bonington, Loughborough, the wife of Bernard Stracey, M.B., of a daughter.

Marriages.

GARDNER—SCRATCHLEY.—On May 10th at St. Michael's, Stockwell. Rev. Geo. Edward Gardner, M.A., of New Barnet, to Annie Rosalie Scratchley, widow of the late H. W. Scratchley, L.R.C.P., M.R.C.S. (née Norton).

WALKER—CUNLIFFE.—On April 17th, at Srinagar, Kashmir, by the Rev. A. L. H. Selwyn, Norman Duubar Walker, R.A.M.C., to Nora Dorothy, second daughter of Foster K. Cunliffe, Esq.

Deaths.

GOULDER.—On May 9th, at 74 Unthinks Road, Norwich, Frank Samuel Goulder, M.R.C.S., L.R.C.P. Lond., late of Dudley, aged 50.

MACLEOD.—On May 8th, at St. George's, Grenada, West Indies, Patrick Fletcher Macleod, M.D., I.S.O., aged 62.

STRACEY.—On May 10th, at Sutton Bonington, Loughborough, Jessie Mary, wife of Bernard Stracey, M.B.

WALLER.—On April 30th, in the wreck of the "Courier," of Sark. Frances Alice, aged 12, youngest daughter of Augustus D. Waller, M.D., LL.D., F.R.S., of 32 Grove End Road, London.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, MAY 23, 1906.

No. 21.

NOTES AND COMMENTS.

What the Lords Have Done.

LORD CREWE'S Bill, as it now stands, prohibits limited companies from carrying on the business of pharmaceutical chemists, or of chemists and druggists, unless they have the name of a registered qualified employee conspicuously displayed. His further proposal that companies were to be subject to the Pharmacy Acts as though they were individuals was rejected. The outcome of this rejection is that companies are entitled to use a description implying that they hold legal qualifications. It is difficult to realise the full extent of the danger to which the introduction of such a principle exposes the public. At one blow the whole fabric of protection of the interests of the community against unqualified or charlatan practice is demolished. If a state recognise legal qualification and pharmacy cannot be limited to those who have passed the necessary examinations, how can it be logically reserved for other special qualifications? Why, for instance, should not companies be permitted to practise law, just as freely as they may now perform the work of qualified chemists? So far as medicine is concerned, the present law is scandalously inadequate to prevent either companies or individuals from irregular practice to their hearts' content. What will the Lords say when medical men ask for protection similar to that they have now declined to grant to chemists?

The Chemists' War.

THE protest of the qualified chemists against the invasion of their calling by trading companies is based on principles of elementary justice. A fierce controversy is being waged by them in the public journals, Parliament, and on every other possible vantage ground. Their main contention appears to be that the term "chemist" applies simply to individuals, and cannot be legally employed as a loose general description tacked on to this, that, or the other trading company. They urge that the safety of the public, which is secured by the responsibility attached to individual qualification in pharmacy, is endangered when large commercial organisations are permitted to practise as chemists and to employ unqualified assistants. From the standpoint of the man-in-the-street that argument would be practically unanswerable. Those masterful capitalists, however, who dominate the chemist companies' enterprises, have

been able to secure an opposite opinion from the Lords. Will the individual chemists accept that verdict lying down?

When the Shoe Pinches.

It is all very well for the chemists to cry out when the shoe pinches. This experience, unpleasant as it is, should teach them the lesson that "live and let live" is a moral that must be applied all round, as well as to the individual case. We refer to the practice of counter prescribing, whereby an enormous injury is inflicted both upon the public and upon the medical profession. If, as the chemists argue, it is dangerous to the public to permit a pharmaceutically unqualified dispenser to make up physic and sell drugs, it is clearly a thousand times worse for a medically unqualified chemist to assume the function of a medical man. For the ancient and honourable craft of the chemist, as practised by its self-respecting members, we have a sincere respect. For the trespass upon legitimate medical practice, founded as it is upon a false assumption of special knowledge, we have nothing but condemnation. The chemists show themselves able to defend their rights. When will medical men unite for a similar purpose?

A Wise Suggestion.

THE recent action against a surgeon of a London special hospital and his house-surgeon raises a point of practical importance. The defendants appeared in the Court of King's Bench and denied liability for damages owing to their alleged negligence of the plaintiff. The facts, which do not appear to have been disputed, were that plaintiff underwent some uterine operation and that a pessary was inserted while she was still unconscious. The defendants allege she was told to return to the hospital in two months' time in order to have the instrument removed. The plaintiff denies that she was so instructed, and as a result the instrument was not discovered until some eighteen months afterwards, by which time she had sustained serious injury. The jury returned a verdict for defendants, adding a rider to the effect that they thought it desirable that in all such cases written instructions should be given to patients by the hospital authorities if they were required to return. With Mr. Justice Phillimore, we regard the suggestion as wise and prudent.

LEADING ARTICLE.

THE REDEMPTION OF THE INEBRIATE— VIDE "THE TIMES."

DURING the past few years we have published many letters from distinguished members of the profession, selected from a mass of correspondence, all couched in similar terms, protesting against the conduct of *The Times* in opening its columns to quack advertisements of a class formerly not to be found there. Not only were such advertisements excluded from that journal, but the whole system of medical quackery was on occasion exposed and vigorously denounced in editorial articles. *The Times* has now, it seems, taken up an entirely different attitude. In its advertising department it has adopted the motto *caveat emptor*; it leaves the ingenuous reader to take care of himself and shows itself willing for a consideration to publish any announcement, however deceptive or injurious to the public it may evidently be. Intense disgust has been excited during the past few weeks by the publication of a series of advertisements of the "Keeley Institute," headed "The Redemption of the Inebriate." These have been printed in the form now familiar to readers of *The Times*. In "double leaded" leader type they are inserted next to editorial matter, which as far as possible they are made to resemble, and prefixed is a note to the effect that "they have been written by a member of *The Times* advertising staff after thorough investigation, conducted with the assistance of an independent and registered medical practitioner of long experience." Short of editorial endorsement, these paid puffs, as they avowedly are, receive thus the approval and sanction of the leading journal. The concoctor of the puffs is, of course, not to be blamed; he has carried out his work as instructed in the way of business, and has done it uncommonly well. The literary quality of the puffs is superior, and accepting in good faith the information supplied, the writer is not to be blamed; it is the fault of his employers if they are calculated to mislead the public whilst casting gross slanderous and libellous imputations upon the medical profession. These effects are produced by an argument of which the transparent sophisms are evident to the instructed reader, but which is clever enough to satisfy or convince the simple public. The statements throughout are characterised by suppression of the truth and suggestion of the false. For instance, the fact is concealed that there is a commercial side to the "Institute," and that the patients are called upon to pay in advance twenty-four guineas for four weeks' treatment, whilst by the statement that the honorary committee are actuated by purely benevolent motives a false idea is suggested that the "Institute" is a purely philanthropic undertaking. If no commercial interests were at stake there could be no object in keeping secret any part of the method of treatment, and it would be at once fully disclosed for the benefit of suffering humanity.

Whatever pecuniary loss were incurred no true man of science would restrict the employment of so vast a boon; no medical practitioner could retain his professional position if he made of such a discovery a commercial speculation. It is, moreover, perfectly certain that he need not do so. The discoverer of a simple method of cure for drunkenness would rank among the greatest benefactors of mankind; wealth and honour, a monument in every civilised land, would surely be his. Seeing that drunkenness is not due to a single simple cause, and that the causation is extremely complex, being made up of many moral, physical and mental factors, no one with sufficient knowledge of the psychology and pathology of the inebriate could without rigid scientific proof accept a statement as to the efficacy of any advertised "cure." None of these cures is supported by evidence beyond the testimony of "grateful patients"—testimony of exactly the same kind and value as is put forth on behalf of all the new nostrums which enterprising manufacturers daily bring to the front. Drink cures all put forth claims not far short of the miraculous, and such claims being refuted by science and opposed to experience are treated with contempt by the mass of the profession. To suggest, as the puffs in question do suggest, that the hostility of medical men is due to some hard, selfish, and rigid code of etiquette is a gross calumny. There exists no written code of professional ethics, and everything in professional life is held to be subordinate to consideration of the welfare of the patient. To suggest that there exists a kind of conspiracy not only among practitioners but among the great body of scientific workers throughout the civilised world to ignore or suppress any method of treatment having the smallest claim to attention is to utter a baseless libel upon a great and honourable profession; and it is to this that *The Times* lends itself. It is possible that the new business methods adopted by the great journal may from the sordid point of view prove highly profitable, but we take leave to doubt whether in any higher sense of the word they will be found in the end to pay. It seems to us that the new departure involves degradation—degradation in which the high-minded, and eminent men who in the editorial columns are the daily preachers of private and public morality must share. They are at least knowingly deriving their incomes from funds gathered by their employers in part at least by unscrupulous if not shameful means.

ON reference to our "News" columns, it will be seen that the honorary gold medal of the Royal College of Surgeons of England was presented after the banquet on Friday last by the President to Lieutenant Colonel Sir Havelock Charles, I.M.S., K.C.V.O.

Society of Apothecaries of London.

THE following candidates, having passed the necessary examinations, have been granted the L.S.A. Diploma of the Society, entitling them to practice medicine, surgery, and midwifery:—J. W. Blooker, H. S. Chate, and F. J. Macphail.

NOTES ON CURRENT TOPICS.

Anti-Typhoid Inoculation in the Army.

WE learn from our contemporary the *United Service Gazette* that the interim report of the Departmental Committee appointed to inquire into the subject of anti-typhoid inoculation in the Army will shortly be published, and that it will prove satisfactory to the medical profession. The Committee have held a series of six meetings, and have carefully studied the available statistical material, and their report will make a strong recommendation that the practice of voluntary inoculation against typhoid fever be resumed, since the records available up to date prove that the practice has resulted in a substantial reduction in the incidence of and death rate from enteric fever among the inoculated. It further appears from the report that, in addition to the loss to the State through sickness and invaliding, the loss from deaths alone amount to half a battalion in the year. We trust that the present Government will listen to its Departmental Committee, but we fear that it is only too likely that a Government which flirts—to use the mildest terms—with the anti-vaccinator, and likes to mistake his bleatings for the voice of experience, will turn a deaf ear to other forms of serum prophylaxis.

The Modern Nurse.

AT Queen's Square Club last week a paper was read by a lady named Miss Genn declaring "that Mrs. Gamp is preferable to the modern trained nurse." From the report before us we gather that this lady said that Mrs. Gamp's conversation compared favourably with the pert self-sufficiency of the modern trained nurse. The training of a nurse in these days destroyed the charm of women. The nurse became hardened, unsympathetic, cock-sure, and her only aim was to marry a medical student, or a desirable patient. A number of nurses were among the audience, and we trust that they recognised that a railing accusation of this kind defeats its own purpose. That modern nurses are not perfect is a failing that they share with all other classes of the community, and that some of them are unworthy of their high calling is consistent only with the known facts of the fallibility of human nature. But sweeping generalities such as those made are the result either of ignorance or prejudice, or both, and are as unbecoming as they are untrue. There are a certain number of women who blossom out into magazine articles on the faults of nurses at periodical intervals, and seem to delight in slandering a class of the most self-sacrificing and noble of their sex. Such diatribes find no echo in the hearts of medical men who are associated with nurses in their daily work, and are resented as cruel and unfounded

aspersions of a particularly odious kind. The person who prefers Mrs. Gamp with her drunken habits and her atrocious vulgarity to a modern nurse must be, as Mr. Mould said of the lady in question, "A woman who observes and reflects in an uncommon manner." We will forbear to finish the quotation.

The Prevention of Syphilis.

THE ardent votary of modern medical science looks forward with simple faith to the time when all communicable disease shall vanish from the face of the earth. The first great step towards that happy end in any given malady is usually—though by no means invariably—the discovery of its specific cause. Plague and cholera have been practically banished from the United Kingdom by improved hygiene, and there is little doubt that small-pox might be stamped out of existence by universal vaccination in conjunction with an efficient public health service, even in the absence of recognition of a specific pathogenic organism. The discovery of the bacillus of tuberculosis has been followed by a marked diminution of the disease, and a similar statement applies to enteric fever. Oddly enough, the identification of the organism of diphtheria has been followed by an increased incidence, doubtless due to the creation of a wider educational system. The most notable recent conquest of science in this direction has been the discovery of the *spirochæte pallida*, the casual relationship of which to syphilis may be accepted as reasonably demonstrated. At the last meeting of the Académie de Médecine in Paris, Professors Metchnikoff and Roux communicated a striking observation with regard to the prophylaxis of syphilis. By thirteen experiments upon monkeys they showed that the development of syphilis might be arrested by rubbing the site of inoculation with calomel ointment. A medical student then submitted himself for experiment and was inoculated with virus from two hard chancres. An hour later the site of inoculation was rubbed with calomel ointment, and three months later no sign of the disease was visible. Several monkeys inoculated at the same time either died or developed syphilis, whereas one macaque treated with calomel eight hours after inoculation escaped, and another twenty hours after inoculation developed a chancre. These experiments, while, perhaps, not absolutely conclusive, nevertheless open up a brilliant prospect in the campaign against one of the deadliest scourges of mankind.

The Poisons and Pharmacy Bill.

THIS Bill, which came before the House of Lords on the report stage, as a Government measure, on May 11th, has, by the adoption of an amendment proposed by Lord Ebury, been so modified that it no longer meets with the approval of the Pharmaceutical Society. Clause 4 of the Bill contained a proviso which, if carried, would

have prevented the assumption of the title chemist and druggist by companies, and this clause has now been so modified that these companies can continue to practise as they have done in the past, provided they have in their employment a duly registered pharmaceutical chemist. A further amendment was also adopted by which the Bill was extended to Ireland. The Bill as amended came up for third reading yesterday, and will then go to the Lower House. The pharmaceutical corporations interested in the matter still hope that there the original clause will be restored, possibly with a further proviso that it shall not come into force for a term of seven years. The fate of the Bill in the Upper House was naturally a subject largely referred to at the annual dinner of the Pharmaceutical Society, and we are glad to see that the President of the General Medical Council and the President of the Royal College of Surgeons voiced the opinion of the medical profession in condemning with no uncertain voice the change which had been made. As Dr. MacAlister pointed out, the case for reform was unanswerable, since the state of the law, as it now exists, made illegal for a single person what was permissible when performed by seven men united to form a company. Further, as the President of the Pharmaceutical Society said, a company of unqualified persons would be under no obligation to make up prescriptions in accordance with the British Pharmacopœia, nor would it be incumbent upon them to keep strong poisons in accordance with the poisons regulations which are obligatory on registered chemists. We can only reiterate the hope of the Society that the House of Commons will restore this much-needed clause to the Bill.

San Francisco Doctors.

THE solidarity of the profession of medicine is illustrated very forcibly by an appeal that has just been issued by a committee appointed by the New York Academy of Medicine, the Medical Society of the County of New York, and of the County of Richmond for help in money and kind for the doctors of San Francisco. It is estimated that some five hundred medical men were ruined by the earthquake, and though their services are badly needed by the survivors, these latter being themselves mostly penniless are unable to pay fees. Moreover, the doctors are severely handicapped by lack of apparatus, instruments, and books, and special stress is laid on this point by the committee, who urge that those who are unable to contribute in the form of money will surely be able to spare something in the way of instruments or books. Thoroughly in accordance with the altruistic spirit of the appeal is the announcement that though all gifts will be acknowledged by the treasurer, no list of contributors will be published. It is to be hoped that a prompt and generous response will be made, and of that there can be little doubt, as a local appeal made by the King's County Relief Committee for Physicians

brought in \$1,200 in a few days. The present occasion offers a unique opportunity for American medical men to show that though it is necessary to earn fees in order to live, the practice of medicine has higher aims and greater opportunities than those of accumulating money.

Sweated Industries.

THE conditions and remuneration of labour are factors which lie close at the heart of all questions of public health; indeed, public health would present but few problems if all people were well housed, well fed, well paid, and well cared for. As it is, hygiene is bound up so intimately with social questions that it becomes practically a branch of sociology. For this reason medical men must look with a sympathetic eye at the Exhibition of Sweated Industries which, organised by the *Daily News* and carried out by a special Executive Committee, is now open to inspection. The revelations which that exhibition brings into relief are such as may well make a civilised country blush. Many of those who live in comfortable houses and eat good dinners are accustomed to look upon the burden of Tom Hood's "Song of the Shirt" as being as obsolete as the Curfew Bell or the Dodo. To such it may come as a shock to learn that 7d. a dozen is paid for "making up" shirts, a task which takes a woman six hours' work, and involves the finding of her own thread, and that the process known as "shirt finishing" is paid at a rate which enables the finisher to make from 12s. to 14s. a week if she works seventeen hours a day. Factory legislation has ensured to those who labour in large buildings a proportion of the amenities of life not inconsistent with human existence, and surely it is time that the Government took account of the condition under which home-labour is carried out. Doubtless the difficulties of control will be much greater, but such exposures as those of the Sweated Industries Exhibition turn one's eyes involuntarily from the "servile conditions of labour" in South Africa to the practical slavery at our own backdoors.

The Government and Experiments on Animals.

THE intention of the Government to appoint a Royal Commission to inquire into the subject of experiments on animals was announced last week by the Home Secretary in answer to a question by Sir Philip Magnus. As stated by Mr. Gladstone, it is now some thirty years since an inquiry was held, and we are quite in agreement with him that it is time further inquiry were made. Everyone in any way acquainted with the subject is aware how seriously scientific experiment is hindered in these countries by the irritation of the present restrictions, and the wonder is that England does not lag further behind Continental countries in scientific research. It is a matter of the utmost importance to science, and particularly to the sciences ancillary to medicine, that the views of responsible authorities should be impressed on the forthcoming Royal Commission. There is no

doubt that the "anti-vivisectionists" will seize the opportunity to impress their views on the Commission and the public, and if care be not taken there is some chance that, instead of gaining the exemption science requires, further restrictions may be imposed. The representation of the views of the medical profession on a matter which vitally concerns the future of medical science would naturally fall to the British Medical Association, if that body be not too busy in its search for a Royal Charter to pay attention to other matters.

Professional Neglect.

In view of an impending appeal we refrained at the time from commenting on some extraordinary passages in the charge of Lord Chief Baron Pallett to a County Antrim jury in the case of *Tughan v. Darnell*. It will be remembered that the action was taken to recover from Dr. Darnell, a medical man practising at Bangor, damages for injury resulting from the application of belladonna liniment. We understand that the intended appeal has been abandoned, so that we are no longer bound to silence. To put it briefly, the Lord Chief Baron has given an entirely new and stronger meaning to the "reasonable care, prudence, and foresight" a medical man is presumed to bring to the performance of his professional duties. "Coming," he said "to the usage and practice of the profession, he desired to give the jury a distinct direction upon that which was all-important in the case. The use and practice of the profession was evidence, but not conclusive evidence, in favour of the defendant on the question of reasonable care, prudence, and foresight. But if the defendant had omitted any precaution or warning which they might consider reasonably ought to have been given to guard the patient against the risk which, as a skilled physician, he ought reasonably to foresee and against which he could reasonably have guarded him, no usage of the profession could protect him from liability from the reasonable consequences of such omission. That was the law." As a matter of fact, Dr. Darnell had used all the precautions commonly adopted by medical men in regard to the treatment ordered, though some of the medical witnesses admitted that, in view of the knowledge brought to light in this case for the first time, they would think stricter precautions advisable in the future. The result of the Chief Baron's direction is that a medical man is responsible not merely for what is considered reasonable in advance by his colleagues—the only people competent to judge, but for what after the event a jury may consider reasonable. Undoubtedly the usage and custom of a profession were evidence for the consideration of the jury in favour of the defendant upon the question whether he used due care or not if he showed that he used the usual care; but the issue was to be determined not by the usage of the profession, as proved by expert witnesses, but was to be determined by that grand old tribunal, our refuge in all cases of importance—the opinion of twelve honest and experienced men.

PERSONAL.

THE Prince of Wales has been pleased to appoint Sir Richard Havelock Charles, K.C.V.O., M.D., to be a Physician in Ordinary to His Royal Highness.

PRINCESS CHRISTIAN presided, on the 14th inst., at a meeting of the special appeal fund of the National Committee for the Establishment of Sanatoria for Workers Suffering from Tuberculosis.

DR. NORMAN MOORE, F.R.C.P.Lond., Physician to St. Bartholomew's Hospital, has been re-elected for a further term of five years Representative of the Royal College of Physicians of London on the General Medical Council.

DR. JAMES W. B. HODSDON, F.R.C.S.Ed., Senior Assistant Surgeon to the Edinburgh Royal Infirmary, has been elected Representative of the Royal College of Surgeons, Edinburgh, on the General Medical Council.

THE Bathgate medal, which was founded by Colonel William L. Bathgate, in memory of his father, Mr. McPhune Bathgate, F.R.C.S.Ed., Lecturer on Materia Medica in the Extra Academical School, has been awarded to Mr. James H. Johnston, of Edinburgh.

MR. CHARLES A. BALLANCE, F.R.C.S., Surgeon to St. Thomas's Hospital, the National Hospital for Paralysis, and the Hospital for Sick Children, has been elected President of the Medical Society of London for the year ensuing.

DR. J. J. O'HARE has been presented with a valuable hunting watch, on the occasion of the conclusion of his term of office as Assistant Master of the Hoiles Street Maternity Hospital, Dublin.

DR. A. ROCHE has been appointed interim assistant physician to the National Lying-In Hospital, Dublin, in succession to Dr. O'Hare, whose term of office has just expired.

THE PRESIDENT, Mr. McArdle, the Chairman of Council, the Honorary Secretary, Sir W. Smyly, P.R.C.P., Sir Arthur Chance, P.R.C.S., Professor Kinkead, Sir W. Whitla, Professor Corby, Dr. Kidd, and Dr. Greene have been appointed as a deputation from the Irish Medical Association to wait on the Chief Secretary for Ireland in reference to the grievances of Poor-law medical officers.

SIR WM. MACEWAN, F.R.C.S., Regius Professor of Surgery in the University of Glasgow, has promised to deliver the Cavendish Lecture before the West London Medico-Chirurgical Society in the Town Hall, Kensington, on the evening of Friday, June 8th. The subject of the lecture will be "Some Points on the Surgery of the Lung."

THE Corporation of McGill University, Montreal, have resolved to confer the honorary degree of Doctor of Laws on Dr. Donald MacAlister, President of the General Medical Council.

THE honorary degree of Doctor of Civil Law has been conferred with much enthusiasm, at a special convocation of Durham University, on Baron Takaki. The Baron was drawn in a carriage from the railway station to the Castle Hall by a number of students.

GENERAL regret will be felt at the announcement of the intention of Professor McKendrick to retire at the end of the present session from the Chair of Physiology in Glasgow University.

THE twenty-sixth annual dinner of the British Dental Association was held at the Hotel Cecil last night, under the presidency of Mr. Leonard Matheson.

A CLINICAL LECTURE

ON

MALIGNANT DISEASE OF THE LUNGS.

By JAMES ALEXANDER LINDSAY, M.D., F.R.C.P.Lond.,

Professor of Medicine, Queen's College, Belfast; Physician to the Royal Victoria Hospital, Belfast.

GENTLEMEN,—Malignant disease of the lungs, though not extremely rare, is a sufficiently uncommon condition to make its diagnosis a matter of more than ordinary interest. In the earlier stages of the affection the diagnosis involves considerable difficulty, the physical signs being variable within wide limits, while the symptoms are not always characteristic. An affirmative diagnosis being synonymous with a death sentence, the practitioner is naturally reluctant to suggest the possibility of pulmonary malignancy; but, on the other hand, the possibility is one which for obvious reasons should be faced as promptly as possible, in order that we may be saved from holding out futile hopes or persisting in abortive treatment.

I have notes of seven cases of malignant disease of the lungs. In four of these cases the diagnosis was verified at the autopsy. In the remaining three cases the diagnosis was certain in two and highly probable in the third. I propose to give the results of my observations under the following heads:—

- (a) Previous history of the case.
- (b) Symptoms.
- (c) Physical signs.
- (d) Nature of the growth.
- (e) Duration of the case.

(a) *Previous History*.—This is a point of the first importance and often gives us the earliest clue to diagnosis. In the great majority of cases of pulmonary malignancy, the growth is secondary to tumour elsewhere. In two of my cases there had been excision of the mamma for scirrhus, in one case six weeks, in the other two years, before the advent of pulmonary symptoms. In a third case the patient had had his leg amputated for sarcoma, five years before coming under my observation, and in two other cases the disease began in the glands of the mediastinum. In the remaining two cases of the series of seven, no primary growth could be discovered, but it must remain a matter of doubt whether the disease really originated in the lungs, as this is well known to be rare.

We may take it as a point of the first importance to get a clue to a previous growth in a case where the symptoms and physical signs suggest the possibility of pulmonary malignancy.

(b) *Symptoms*.—As a rule, it is the symptoms which first attract attention and which give us the greatest help in forming a diagnosis. Persistent thoracic pain, gradually increasing dyspnoea, and cough were present in all my cases. This symptom-complex is highly suspicious in a patient who has had a growth elsewhere than in the lungs, above all, if the probability of aneurysm can be excluded. The prominence of pain and the increasing urgency of the dyspnoea are specially important, because these symptoms are, upon the whole, improbable in the conditions—e.g.,

tuberculosis of the lungs—most likely to be confused with malignant disease of the lungs.

Hæmoptysis was present in five of my cases, absent in two. Some authorities believe that the hæmorrhage often has a red-currant jelly-like appearance; others (e.g., Stokes) describe it as dark and mucoid. My own experience would lead me to doubt the validity of these rules. In several of my cases the hæmoptysis was not superficially distinguishable from that of phthisis. In one case the hæmorrhage was copious and uncontrollable. Pyrexia was also present in five out of my seven cases, and did not differ decisively from the pyrexia of pulmonary tuberculosis. Night sweating was prominent in two out of my seven cases, and emaciation was marked in four. Pulmonary malignancy may progress so rapidly that there is hardly time for much emaciation. In the last case which has come under my notice the patient remained plump and well-nourished until near the end. It is fallacious, therefore, to exclude malignant disease of the lungs because there is little or no definite cachexia.

(c) *Physical Signs*.—These are extremely variable and not at all to be relied upon in the earlier stages of the affection, while at an advanced stage they become pronounced and easily interpreted.

In one of my cases, the disease first showed itself by rhonchi and mucous râles in the right mammary region, which were suspicious from their localisation, from the fact that the lady in question had had the right mamma removed six weeks previously for scirrhus, and because tuberculosis was on various grounds improbable.

Râles of various kinds may occur in these cases; a pleuritic rub is not uncommon; but when the growth has become well-developed we generally get the following group of signs:—

Dulness in percussion, usually very pronounced.

Weak breathing.

Diminished vocal fremitus.

This group of signs suggests not only that a growth may be present, but that it is compressing one of the main bronchi. The localisation of these signs presents many variations and no definite rules are possible, but we may say that malignant growth in the lung is relatively common in the middle regions of the lungs, that it very rarely attacks the apices, and that it never exhibits those laws of more or less definite dissemination which are so frequently observed in pulmonary tuberculosis. Bulging of the ribs and sternum is frequent in pulmonary malignancy, but it is a late symptom.

In addition to the physical signs directly due to the presence of a tumour, it is common in malignant disease of the lungs to get the ordinary signs of pleural effusion at the base posteriorly. The effusion is often, but not always, hæmorrhagic in character. Some observers think the effusion is much oftener serous than blood-stained.

(d) *Nature of the Growth.*—Of the four of my cases where an autopsy was obtained one belonged to each of the following varieties of malignant growth, viz., encephaloid carcinoma, lymphosarcoma, squamous-celled carcinoma, while in the fourth case the nature of the growth was doubtful.

(e) *Duration of the Case.*—The following was the duration in the various cases: Case 1, four months; Case 2, eight months; Case 3, three months; Case 4, five months; Case 5, four months; Case 6, doubtful, but brief; Case 7, doubtful, but prolonged.

The above cases, few in number though they are, suggest the following observations:—

The history is a matter of the first importance in investigating any suspected case of pulmonary malignancy. Fortunately, from the nature of the case, the history is usually obvious and easily ascertained. We must beware of what is, perhaps, a somewhat natural error, viz., of too confidently diagnosing a growth in the lung in the presence of certain signs and symptoms because the history seems to make the existence of such a growth probable.

The symptoms are fairly consistent, and, on the whole, to be relied on, especially in the later stages of the affection, but at the outset they may be vague and inconclusive. The prominence of pain in the chest with oppression of the breathing is very significant in any case in which, on other grounds, the presence of a pulmonary new growth might be suspected. Aortic disease, which might give rise to similar symptoms, can usually be excluded without difficulty. Aneurysm may cause more difficulty, but here the patient's age, sex, occupation and habits, the history of syphilis, which is frequent in aneurysm, and the presence of vascular degeneration will assist in arriving at a correct diagnosis.

In several of my cases the presence of hæmoptysis, pyrexia, night-sweating and emaciation made the simulation of phthisis for a time close. In any case of doubt between pulmonary malignancy and phthisis, the following rules will be found helpful:—

1. The history of the two types of case is different. In phthisis we shall probably get a history of vague ill-health with debility and loss of weight; in pulmonary malignancy we shall probably get a history of removal of the mamma, or of operations upon bones, uterus, or rectum.

2. The age of the patient may present some contrasts in the two cases, though this rule is not to be definitely relied upon. Phthisis is more likely to occur in adolescents, pulmonary malignancy in middle life or later. The average age of my seven cases was 42; only one was under 30; two were over 60.

3. The progress of pulmonary malignancy is usually more rapid than that of phthisis; there are no remissions of symptoms or periods of rally and amendment, which are so common in phthisis.

4. The sputum should be frequently examined. The characters of the sputum in pulmonary malignancy are variable, and must be interpreted with caution. The detection of tubercle bacilli would, of course, at once settle the diagnosis.

5. Pain and dyspnoea are much more prominent in tumour of the lung than in phthisis, and much less under the influence of palliative measures.

6. Displacement of the heart would point

strongly to tumour, unless pleural effusion is present.

As to the duration of cases of pulmonary malignancy, Walshe gives the average duration as 13½ months. Osler thinks that from six to eight months is more probable, and my statistics would tend to confirm this view. It is, of course, difficult and often impossible to determine the actual beginnings of the invasion of the lung in these cases.

In some cases the history, signs, and symptoms point irresistibly to the presence of an intrathoracic malignant growth, but it is difficult to say whether its seat is mediastinal, pleural, or pulmonary. A careful analysis of the early symptoms may give some assistance in determining this point, but in not a few cases the differential diagnosis is for a time, at least, impossible. Early hæmoptysis would point to a pulmonary seat of the tumour, while late hæmoptysis would possess less significance. The physical signs might serve to differentiate these conditions, e.g., if the earliest physical signs were those of infiltration, rather than of compression, of the lung substance.

In one of my cases, the presence of malignant nodules upon the abdominal wall gave an important clue to the diagnosis. In any doubtful case, the search for evidence of malignant disease elsewhere in the body is, of course, a point of the highest importance.

It is important to remember that malignant disease of the lungs, as of malignant disease in any organ, may for a time be almost latent. The clinical picture of malignancy usually present to our minds is essentially a picture of the advanced, or at least the fully-developed, disease. We can not too carefully remember that malignant disease of the lungs may for a time be practically without symptoms; that pain, dyspnoea, and cough may be absent; and that the patient may retain a full measure of nutrition, until the case is far advanced.

The treatment of malignant tumour of the lungs gives little scope for therapeutic measures. The relief of pain may be effected by some of the usual measures. For the relief of dyspnoea, hypodermic doses of strychnine and inhalations of oxygen are of some value. Hæmoptysis is not usually excessive, but may be very intractable.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The lecture in next week's number will be by Geo. A. Gibson, M.D., F.R.C.P., Sc.D., LL.D., Physician to the Royal Infirmary, Edinburgh, Examiner in Medicine, Oxford University, Examiner in Clinical Medicine, Edinburgh University, on "Persistent Ductus Arteriosus" (delivered in the Edinburgh Royal Infirmary).

ORIGINAL PAPERS.

SIMPLE TUMOURS, AND THEIR RELATION TO MALIGNANT DISEASE.*

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We have been accustomed for a long time to divide our new growths into two classes—simple and malignant—by means of a hypothetical border line, but we have not as yet been able satisfactorily to ascertain those

* Read before the Harvelian Society, April 29, 1906.

factors which lead to the transgression of this imperceptible barrier and which institute a malignant change.

During the last few years the limelight of experimental research has been turned upon the various forms of malignant disease, and although we have undoubtedly learned many important details with regard to their structure and method of growth, we are still in the dark as to their causation.

While this prominent position has been occupied by tumours which are undoubtedly malignant, those growths which are still classified as simple have been left in obscurity, and we ourselves, content with text-book dicta, have come to regard them as of slight importance, unlikely in most cases to influence the life of their unfortunate possessor in an adverse manner.

It is somewhat surprising that so little attention has been directed to this subject, and how little the relationship between these simple and malignant forms of growth has been appreciated.

A few lines are found at the end of a text-book account to suggest that a malignant degeneration may occur, but no emphasis is laid on the fact that in a surprisingly large number of cases, where undoubted malignant disease is present, it has been preceded by some local tumour formation.

How often in cases of cancer of the breast do we obtain the history, "Oh, I had a small swelling there for a number of years, but I didn't think much of it!"

From a brief survey—and at present I cannot boast an experience worthy of any other adjective—I would venture to formulate three axioms with respect to simple tumours.

(1) That every simple tumour is an expression of tissue instability.

(2) That any so-called simple tumour is potentially malignant.

(3) That irritation is an important factor, not only in producing many forms of simple neoplasm, but in exciting them to transgress that arbitrary line of definition which separates them from malignant growths.

During the development of the body we find that from certain areas following ancestral laws, certain tracts of tissue, certain glandular or muscular territories, are formed; but how is it that these organs, so laid down, keep narrowly within their proper limits. Take, for example, the thyroid gland—an organ which is budded off from two distinct regions, into a sustentacular bed of embryonic connective tissue, to be fused, metamorphosed, and finally encapsuled off from the surrounding structures by the limiting action of the developmental process.

What power limits that process? Is it the nervous system? We have no proof. Is it that the cells of the gland impose restriction on their own growth? Is it because of some poor connective tissue capsule? The only factor which can influence the extent of the growth of an organ is the restraining action of surrounding structures, the mutual limiting action which different organs of the body exercise on one another. This is a wonderful mechanism over which we have no control, and about which we are still entirely ignorant. If this adaptive arrangement is interfered with, we meet examples of irregularities of growth in the detachment of certain organs from their normal position, or in the aggrandisement of one particular part, usually at the expense of another.

Consider for a moment the supra-renal capsules. These glands, complex in their development, are associated during their period of active growth with three surrounding organs—the liver, the kidney, and the testis—on the posterior abdominal wall. Under ordinary conditions a mutual defensive policy is established, whereby each zone of developing tissue is narrowly confined within its own appropriate sphere of action; but if the contract is not rigidly carried out, if the equilibrium is upset, what is the result? The wandering terminals of the embryonic supra-renal penetrate into the still undefined regions of the liver, the kidney,

or the testis, and remain there isolated from their parent gland, often springing into activity at a later date.

It is unnecessary to multiply examples. I have selected the above illustration, firstly, because it amply emphasises my point; secondly, because attention has recently been directed to the group of tumours springing from misplaced adrenals, to which I hope to refer later.

Now, it may be asked, What bearing has this on the subject under discussion? Well, I have touched on this aspect of development because it comes closely into relationship with the genesis of tumours. Not only during the active period of intra-uterine life are unseen forces skilfully concealed, influencing the rate and range of cellular activity, but after the fœtus has been discharged from the shelter of the maternal uterus, active growth and cellular reproduction is continued, and so long as the heart pumps blood new cells are being formed to take the place of those worn out in the wear and tear of functional metabolism. In other words constant reproduction is going on, governed and restrained by the same unknown forces that are at work in the fœtus. Look, for instance, at the sebaceous glands of the skin, where the casting off of the central cells in the one and the superficial cells in the other is, in the process of secretion, immediately made good by a young and active generation.

Just as in the embryonic cells of the fœtus there is an infinite capacity for reproduction, so in the case of the more developed being the same power is present, though less actively expressed, and the same influence which determines the limits that shall confine the fetal gland acts in restraining the reproduction of the adult cell.

What, then, is this modifying influence? If we can discover it we shall, I think, go a long way towards the discovery of the cause of cancer. At present I take it that by virtue of a state—which, for want of a better term, we will call, with Ribbert, "mutual tissue tension"—the various cells of a part are restrained from pursuing a policy of aggression; it may be that the nervous system exercises some influence, but that at least is one of the points which we have yet to investigate.

Turning to the pathology of the simple tumours, we find that they illustrate a departure from the natural conditions of a part by the over-activity of certain cells which enter into their composition.

The standard definition of simple tumours is that they grow slowly, possess a capsule, do not recur if completely removed, and do not infiltrate. Such a definition is insufficient, inaccurate, and misleading. The rate of growth varies and may equal that of a malignant neoplasm; the capsule is a fortuitous occurrence, depending upon the position of the tumour. Some do not possess it; while, on the other hand, a sarcoma or even a carcinoma in their early stages may possess a capsule defined enough to satisfy the most exacting critic. They do not recur if they are completely removed; nor, we may add, do malignant tumours; but in the latter case the obstacles to complete extirpation are more insuperable. Again, the fact that certain of these so-called innocent growths are dangerous to life from their position—papillomata of the bladder, or of the larynx—that many of them tend to ulceration, sloughing and decomposition, apart from other considerations, strongly suggests that we should reconstruct our views and definitions with regard to this group.

If we study the histology of these simple tumours we always find one or two elements in excess of the normal, either connective tissue or epithelium, or both. Now in the natural condition of the body, as I have suggested, an equilibrium is established, not only between different organs, but between the individual cells of an organ; and the presence of abnormal numbers of connective tissue or epithelium cells points at once to a disturbance of the controlling forces, and is, in fact, a condition of tissue instability.

And so, turning to my first proposition, I put it to you that the presence of any simple tumour, whether connective tissue or epithelium, is an expression of ill-ordered reproduction beyond that which is required in the ordinary economy of the body; it is an indication that the tissues in this situation lack that mutual balance, upon the careful adjustment of which the various cells of the body live in harmony with one another.

Every simple tumour is potentially malignant.—Such a statement is, I know, a sweeping one, but I believe that this is the attitude that we must adopt towards them. There is no form of simple tumour which cannot be held up as an example of subsequent malignant change, and there are sufficient illustrations to show that this potentiality is often expressed. The very presence of a simple tumour of any kind is, as I have urged, an indication of tissue instability; it shows that in this situation the tissue control is deficient; it is, in fact, a note of warning that our tissue tension is unduly strained; and while I am ready to admit that in the majority of cases this power of malignant alteration is never called into activity, I would insist that the power and tendency is there. If we study sections of the various forms of the adenomata, we shall be able clearly to define certain types.

(1) Fibro-adenoma, where the fibrous tissue is mature, and the whole process slow and quiet. All active irritative phenomena have subsided, and we have nothing but the stage of proliferation or new growth.

(2) The adenoma—where the epithelium is active, the stroma slender and not expressed. The appearances here suggest a greater activity of growth, a more energetic cell reproduction, as distinguished from the first.

From these two main forms we pass gradually to tumours, where the activity of the epithelium or connective tissue is so pronounced as to make us hesitate in declaring on the side of innocence. It seems to be a question of rate of growth, and we may take a series of tumours of the breast, and say—Such and such a one is innocent, such and such a one is malignant; but we cannot define the narrow limit which separates the two. *Facilis est descensus Averni.* It is an easy and gradual transition from the innocent fibro-adenoma to the carcinoma or sarcoma.

Now this short paper is the outcome of two cases which impressed me very deeply, and although I can relate a large number of cases where a simple condition has been replaced by a malignant one, these two will suffice.

(1) A., woman, æt. 35, who was admitted with a swelling, apparently a fibroma, over the left shoulder. It had been present for a number of years, but recently it had increased in size and had become painful. Removal was freely performed, and the microscope shows an old fibroma, a ring of leucocytes, and a periphery of sarcoma. The growth recurred within six months. I have no further notes.

(2) An old man, who had always (from birth) had a tumour on the right side. Six months before I saw him it became painful, and increased in size, and finally ulcerated. I saw it in the latter part of last year, told him its nature, and removed it freely. The microscope tells us that this is a spindle-celled sarcoma.

In our research as to the causation of tumours, we must, I think, take two stages; first, to consider those factors that are at work which enable the cells of a part to abnormally multiply while still confined within the narrow limits of an organ, and which in this manner constitute a tumour by no means so simple as its name implies; and secondly, those additional influences which enable the cells of that part, either with or without a previous stage of local development, to pass beyond all physiological boundaries and invade the body generally. It is an open question whether the same factors are present in both instances; personally I think they are, though it is possible that the cancer cell is endowed with some peculiar attribute which

the cell of the simple tumour does not possess. At any moment, however, it may acquire this attribute, and simple tumours, since they are early expressions of disordered reproduction, are especially favourable subjects for the acquirement of this power.

As to the origin of these simple tumours, I am whole-minded in the opinion that they arise—either, according to Cohnheim, from eccentricities in the germ cells of the part, as in the case of the adrenal rests, or as the result of a definite or circumscribed irritation. There are, I know, a number of objections which can be urged against these theories, but I would plead that there are two points strongly in their favour:—

(1) The absence of any tenable theory to take their place.

(2) The result of microscopic investigation.

With regard to this latter point let us consider some of the various histological phases of the fibromata and the fibro-adenomata. The fibroma, a connective tissue tumour, cannot be formed in mature fibrous tissue. The fibrous cell is the completed fibroblast, which itself has passed through a round cell stage. No fibrous tissue is ever laid down in the body without a previous period of round celled activity, and such round-celled activity is co-existent either with a condition of inflammation or with a phase in the development of embryonic connective tissue. Leaving out of account those conditions which are the result of irregular development, we may assume that in all these fibrous or connective tissue tumours a preliminary stage occurred, when certain changes compatible with a low form of inflammation were present, before the tumour could be completed in its final fibrous stage, and it is surely reasonable to argue therefore that some local irritative cause was responsible for its production. The fibrous epulis is never found without the carious tooth; the mucous polyp represents a retrogressive change in the connective tissue, and is always preceded by a hypertrophic inflammation of the nasal mucous membrane. And we have many instances where a local inflammatory condition leads to the development of an increase of fat, as for example around the kidney, and I believe that a Lipoma is a variety of connective tissue response to some local stimulus similar to the fibroma, but differing, as in the case of the polyp, in the form of its expression.

Where two elements are concerned in this abnormal reproductive process, epithelium and connective tissue, we shall find a varying amount of each, according to the activity of their response. If the connective tissue is the more affected while the epithelium remains at rest, a fibro-adenoma with a preponderance of fibrous tissue will be the result; but let the stimulus affect the epithelium and we shall find tumours with active acini and slender stroma, there being usually a tendency on the part of the epithelium to undergo a cystic change.

If sections of a chronically inflamed breast are studied a striking resemblance is at once noticed between their histological characters and those of the adenomata, and the only distinctions which it has been possible to draw are that the adenomata possess a capsule, in the inflamed breast the cells are round and appear more active, while the general features of the inflammatory changes are more pronounced.

What of these differences? The capsule, I argue, is purely fortuitous and due to the peculiarly limited area of the breast affected, the process in most cases being confined by a natural boundary of hyaline connective tissue, rich in nuclei, which surround each breast acinus, and which, under the influence of the stimulation, proliferates at the periphery of the active zone.

I have here a specimen, taken from a local tumour of the breast, which does not possess any such capsule; and yet it is clear from its microscopical appearance that an active inflammatory process is not at work. It in fact represents an adenomatous growth, where the connective tissue is especially vigorous, and in this instance the process has not been checked by the usual barrier of connective tissue at the margin of the area.

It is the missing link between these tumours, which possess a distinct surrounding capsule, and the cases of diffuse inflammatory changes in the breast, where the same phenomena in the main are present, but there is no attempt at limitation. The presence of spindle in the place of the round cells only points to a more mature stage of the pathological process.

Now it may be urged that it is a curious phenomenon, and somewhat at variance with my theories, that while inflammatory exudates tend to disappear, these tumours, if indeed they are the outcome of inflammation, still persist. I would ask whether in those cases where inflammatory changes have been pronounced all evidence of the struggle is completely removed? In fact, it would be no idle statement to say that where there have been very extensive disturbances brought about in a part as the result of inflammation some remains can always be found. But I admit that this alone is not a satisfactory explanation of the differences between the ordinary inflammatory residues and simple tumours, and I think that the true cause lies in the fact that, in some manner that we do not yet understand, the irritation, or the conditions that have led to the appearance of the tumour, has so upset the normal equilibrium between the individual cells that there is not a great attempt on the part of the tissues to revert to their original state.

I have already alluded to a relation which seems to exist between simple and malignant tumours, and I wish to discuss briefly some of the various theories which have been expounded as to the origin of this latter group. It is a convenient and a reasonable view to regard all new growths as infections, strictly comparable to an infection by bacteria; only in this instance the infecting agent is an epithelial or connective tissue-cell. Owing to the conditions under which they develop, these cells become parasites. I do not imply for one moment that they are foreign to the body and are implanted on it from outside, but that the very cells which should be normally performing natural functions have become perverted in their actions and pathogenic.

The pathology of the injurious action of one class of cells over another has been widely studied, and we know that there is a distinct antagonism between various cells of the organism, and we know also that a certain degree of parasitic action occurs in some of the blood cells. Now we may compare the simple tumour with an infection of low virulence; the whole process is localised, as for example in a circumscribed tubercular nodule, and there is no tendency while in this stage for the infection to proceed further. In cancer, on the other hand, the cell activity is much more marked; the cell infection spreads readily along the various anatomical paths and attacks the tissues of the body in a more general manner, being comparable in this form with a spreading bacterial infection of some virulence.

The points which have to be closely considered are whether this difference between these two types of growth is due to intrinsic or extrinsic factors; that is, do cancers depend upon some modified condition of the tissues themselves, such as a lowering of individual resistance to a cell infection, or to the advent of some agent from without? It is of course characteristic of malignant growths that their cells transgress the limiting basement membrane, but we cannot for a moment suppose that this membrane alone is responsible for the security of the part. We realise that there is a vast variety in the manner in which different patients respond to the cancer infection, so that the individual resistance has a good deal to say in the matter. But at the same time it is probable that the cells which go to form a malignant tumour are endowed with some special property, in virtue of which they exercise their peculiar influence. According to one authority it is the advent of the leucocyte which, in conjunction with an epithelial cell, forms a partnership for the production of cancerous change; and it is interesting to notice that in the specimen of the

fibroma which is showing malignant transformation the zone of leucocytes around the fibrous tissue is exceedingly well marked.

It is said that the union of the epithelial cell and the leucocyte renders the cell capable of reproduction in a peculiar manner, comparable to the more active reproduction of the ovum after fertilisation by the spermatozoon; and when this fusion has taken place the arrangement of the filaments of the nuclear network occurring in cancer cells is like that which is found during early development, and is quite different from that which occurs normally in the body, and what factor, other than some irritation, can stimulate the blood vessels to pour out leucocytes round the cells of a part?

Doyen has grown a cancer coccus, and it must be admitted, on the evidence of independent observers, such as Metchnikoff, that this organism is undoubtedly present, and it may be that this is the factor that we are in search of, which determines malignant transformation. At present there is no proof of this. Doyen's own hypothesis that the cancer cells are proliferated in order to repel the invasion of the tissues by this micro-organism is surely incorrect. If this suggestion were right, it would be difficult to explain why cells from the rectum have to wander away to lymph glands and liver in order to deal with organisms which have reached those situations where there are plenty of cells ready to do their duty. If his theory is correct, this form of inflammatory reaction is entirely foreign to our accepted ideas and shows fundamental difference from all the cardinal features of inflammation elsewhere.

We are unfortunately at present not in a position to decide which, if any, of these various theories is sound, but we are in a position to consider that the growth of cells in malignant disease is a more pronounced expression of irregular proliferation and tissue instability, which are the characters of the simple tumours, and that certain important factors, which influence the development of the innocent, have undoubtedly a share in the malignant. I would venture to suggest that the more thorough investigation of the life history of simple tumours will have some bearing upon the discovery of the cause of cancerous change, and the idea that all new growths are cell infections will in the meantime form a satisfactory working basis.

The particular form that malignant disease assumes is a matter of chance. Those agencies which excite abnormal proliferation of epithelium and connective tissue in simple tumours act in a similar manner in malignant disease. If the connective tissue responds the more actively to the stimulus a sarcoma is formed, but if, on the other hand, the epithelium is roused to action, a carcinoma. I believe, however, that there is often a tendency to the production of both forms of the growth, but that in the end one or other preponderates. (See *Lancet* March 31st, 1906, Pp. 921-922.)

The group of tumours which grow from the misplaced adrenals is especially interesting, obviously arising from some imperfection in the germ areas, and we can recognise three distinct types of response to the various stimuli. First, there is the local tumour occurring in the kidney, the testis, the liver, or the cord—in fact, in any region remotely connected with the developing adrenal, a form which remains quiescent, showing no tendency to grow, the so-called adenoma.

Secondly, there is a more active form where cellular reproduction takes place, and where infiltration and destruction of the surrounding tissues occurs without any metastatic growths. Thirdly, a most malignant type, with ready and rapid dissemination of the cells into distant parts. These three types illustrate excellently the main varieties in rate of growth and effect of neoplasms. In the case of the first, either natural resistance or some other factor is able to keep the alien cells completely under control, just as in the case of the simple tumour which has arisen as the result

of some irritative stimulus and which shows no tendency to progress.

The second represents a stage where this control is less perfect and irregular proliferation takes place, but there is still left some influence, or there is still wanting some factor in the cells themselves, which prevents them from passing freely along the lymph and blood vessels with the development of secondary deposits. These forms are described as being locally malignant.

The third variety obeys no natural laws. What better example could we take to show a relationship between quiescent and active tumours, or to show more clearly the three main phases of cell activity in them? The group of tumours springing from endothelium usually belong to the second type, but we do meet with instances where even these produce metastasis.

We must now unreservedly accept these teachings of pathology and look with profound suspicion upon all new growths. Indeed, I would banish the terms "innocent" and "simple" as applied to neoplasms wholly and irrevocably. As an eminent surgeon once said when lecturing on inflammation, "Some pus is called laudable—there is no such thing as laudable pus—all pus is damnable." So with respect to these tumours all tumours are evil—no tumour is innocent, that is, they can only be truly termed innocent after their possessor has died from other causes; during his life they may be quiescent, but they are certainly dangerous. Simple tumours are potentially malignant, in that they, as expressions of instability, show a weak spot in the body which may readily be attacked by cancerous change—many of them, from the earliest periods of their conception, tending to that end.

Just as an infection will select that part of the body where resistance is lowered by antecedent injury or disease, or where from some developmental or anatomical reason that part is more exposed or susceptible, so cancer will select for its beginnings those regions of the body where a weakness of the tissues has been expressed by the appearance of the simple tumour, or by the ill-ordered reproduction following chronic inflammatory change. We cannot feel proud of the results of surgery as applied to malignant disease. If these results are to be improved, attention must be paid to those conditions which precede the actual cancer. It may be taken for granted that extirpation of cancerous tumours is not the ideal treatment.

The surgery of the future will be prophylactic in many branches, above all, I trust, in cancer; so that the term "Preventive Medicine" will have a larger field of application.

In the early recognition of precancerous states we have a vast field of practical utility, and with regard to these so-called simple tumours the time has come—if I may make use of a topical allusion—to adopt a more active policy of aggression and retaliation in the protection of the individual.

THE ADVANTAGES OF THE ABDOMINAL ROUTE IN OPERATION FOR UTERINE CANCER.*

By MARY A. D. SCHARLIEB, M.D., M.S.LOND.,
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London, &c.

ONE of the most pressing duties and one of the most exacting aims of our lives is the reduction of the mortality caused by uterine cancer. We are all seeking some remedy or some operation which may prove of general service, but up to the present time we have come to no definite conclusion, as is proved by the number of operations practised and the variety of medical and other forms of treatment. It is only within the last thirty years that any sustained attempt has been made to cure cancer of the uterus.

The great surgeons of earlier times were not able to

diagnose the disease sufficiently early to justify operation—hæmorrhage and irregular discharges were thought to be the normal accompaniments of the menopause, and local examination was not usually made until these symptoms had long been present and were associated with the characteristic odour and well-marked cachexia of the later stages of the disease. By that time, needless to say, all possibility of successful operation was passed.

In the *Lancet* for November 26th, 1881, not quite twenty-five years ago, there is a report of the first excision per abdomen of the cancerous gravid uterus. It was performed by Sir Spencer Wells and the patient recovered. In a report of the discussion on this case at the meeting of the Medico-Chirurgical Society, the opinions of many distinguished men are recorded.

Dr. Graily Hewitt congratulated the operator on his boldness and skill, he approved of the separation of the cervix from the surrounding tissues "by a process of tearing rather than cutting," and wisely thought this method conducive to the safety of the ureters.

Dr. Playfair drew attention to the bearing of the case on those of cancer of the cervix, of non-gravid uterus, and thought they should be dealt with "without running the risk of abdominal section, not by simply shaving off the growth by the écarteur, but by Marion Sims' excision of the whole of the diseased part; and the application of chloride of zinc."

He said further that "in the more common form of medullary cancer affecting the upper part and not the cervix, abdominal section had not been adopted; but in such cases diagnosis was most difficult. No one," he added, "would venture to excise a uterus because it was thought to be affected, and the element of fixation, which is so important in diagnosis, is just the element which would prevent its removal."

Dr. Matthews Duncan admired and wondered. He said "the operation had settled the possibility of successfully dealing with cancer of the uterus in advanced pregnancy, but it was one thing to determine what is possible and another what is advisable. . . . But," he said, "the commonest cases are those of the vaginal portion, and here the operation is unfavourable because of the early involvement of the parametric tissues. It was just in these cases that a thorough radical operation like this was to be desired."

Since those days the surgery of the uterus has made rapid advance and the microscope has proved a most efficient ally. The old trouble that still remains is the lamentable delusion still existing, that hæmorrhage abnormal in time or amount and hæmorrhage recurring after a prolonged period of amenorrhœa is to be regarded as the normal condition during the menopause.

We still have to deplore that a large percentage of women suffering from cancer uteri came to us too late; that many practitioners will not examine such cases, and that a still larger number are satisfied when the vaginal portion of the cervix appears to be healthy. The profession, the nurses, and the public still need converting to the belief that (1) all uterine hæmorrhage, abnormal in time or quantity, calls for examination; and (2) that all hæmorrhage, no matter how slight, which occurs in a woman after the menopause is a danger signal; and is, in the majority of instances, due to malignant disease.

Operations for cancer of the uterus may be classified as (1) supravaginal amputation; (2) vaginal hysterectomy; (3) para-vaginal hysterectomy; (4) abdominal hysterectomy.

Each method has its advantages and its disadvantages, and each operator is liable to continue to employ the method which has yielded fair results and to the performance of which he brings a certain dexterity.

If the operator is equally happy in operating per vaginam and per abdomen post-operative shock is less by the former route, but that is probably its one superiority; operation through the abdomen secures—

I. A more fully exposed and convenient field of operation.

* Paper read at the British Gynecological Society, on Thursday May 10th, 1906.

2. A better opportunity for breaking down adhesions without injury to the bladder or the intestines.

3. More adequate examination and removal of pelvic glands, especially of those lying along the course of the iliac vessels, and about the bifurcation of the aorta.

4. Less danger to the ureters, which may generally be examined and preserved uninjured while the cellular tissue is dissected away and the uterine vessels are tied to their outer side.

5. More reliable hæmostasis; the vessels being easily ligatured; a great improvement in the use of clamps, which are always liable to bruise the tissues and have been known to cause necrosis and secondary hæmorrhage.

6. The bladder and rectum are more easily separated, and are less likely to be injured.

7. The vagina can be divided lower down—a great gain in cases in which the disease has spread to the walls of this tube.

8. In bad cases less time is consumed in operating by the abdominal route; and, certainly, cases that were inoperable by the vaginal route may be successfully completed per abdomen. Especially is this the case where the vagina is long, narrow, and rigid as in elderly virgins and nulliparæ.

It is not to be expected that all these advantages will be conceded by those surgeons who have practised vaginal hysterectomy for the last twenty years, and whose operative skill and technique are in this operation very near perfection. There is, however, not one of us who does not deplore the appalling percentage of inoperable cases, the awful prospect of early recurrence. There is not one of us who would not thankfully exchange a percentage of 15 per cent. for 60 per cent., and whose patients would not gladly share in the long immunity from recurrence demonstrated by the statistics of Wertheim, Mackenrodt, and others.

When the time has come for a definite advance and the pioneer work of many workers has made it possible, the great discovery is apt to be made by several people at the same time, and places as far apart as Vienna and Baltimore ring with the fame of similar achievements.

In comparing results of operations it is not fair to compare the results of an operation reserved for the most advanced cases with the results of the one done in the least advanced. Not only must the immediate results be less favourable, but the expectation of recurrence is necessarily greater. Even if a surgeon determines to do all operations for cancer uteri in the same manner, comparison of results remains difficult; for at one time a pessimistic opinion in the out-patient department will lead to the admission to the ward of none but early cases, while at another time an optimistic colleague may send in cases which are so far advanced as to make operation doubtfully justifiable. Still, it is worth while to look at the published statistics of several well-known surgeons.

Döderling (*Hegar's Beiträge, Band ix. Heft 2*) quoted in the *Journal of the British Gynæcological Society* for 1905 publishes the following figures:—48·3 per cent. operated on per vaginam; 16·4 per cent. operate mortality; 40·6 per cent. recoveries (so-called cures); 15·8 per cent. of all cases seen by him.

Jacobs, whose excellent paper was read here in April, 1905, gave the following statistics. High amputation of cervix uteri:—13 cases, 12 recurred during first year and one after fifteen months. A most melancholy record. From 1891 to 1897 he performed vaginal hysterectomy 81 times—80 cases recovered, 1 died, 10 cases lost sight of; of the 70 remaining there was recurrence in—first year, 70 per cent.; second year, 13 per cent.; third year, 17 per cent.; and fourth year, 1·4 per cent. Not one woman was alive five years after the operation.

He performed abdominal section on 95 carefully selected cases in which the malignant disease was apparently limited to the cervix uteri, and in whom the general health was good, with the following results: Operation, 95; deaths 6=6·3 per cent.; 6 lost sight of.

Recurrence—first year, 50 per cent.; second year, 21 per cent.; third year, 4·2 per cent.; fourth year, 2·1 per cent.; fifth year, 2·1 per cent.; sixth year, 1·05 per cent. Two patients were alive at the time of reading his paper.

Mr. Jessett stated that of 180 vaginal hysterectomies for cancer, 10 died, about 5·4 per cent.; lost sight of 20. Recurrence, first year, 35 per cent.; second to fourth years, 23 per cent.; fifth to thirteenth years, 8 per cent.

Mackenrodt compares three operations each preferred by a special operator:

	Para Vag. Hyst. Schuchardt. per cent.	Vaginal Hyst. Olshausen. per cent.	Ab. Hyst. Mackenrodt. per cent.
Operability	62	50	90
Mortality	12	7	20
Recoveries	24	38	69
Recurrence	64	54	11

If these figures are to be taken at their face value, and no doubt they deserve to be so taken, abdominal hysterectomy for cancer of the cervix yielded splendid results in his hands. To find an operability of 90 per cent. and a recurrence within five years of 11 per cent. only, is a strong recommendation even when it has to be weighed against so heavy a mortality as 20 per cent.

Professor Wertheim at Leicester, in 1905, told us that of 290 cases of cancer of the cervix he had 60 to 70 per cent. free of recurrence after four or five years, and that the range of operability had increased in his practice from 15 per cent. to 50 per cent.

Bland Sutton, at Oxford, in 1904 thought that 5 per cent. only of hospital cases were operable. He preferred the vaginal route in cancer of the cervix because it occurs most frequently in parous women, but would operate per abdomen for cancer of the body, as it is commonest in nulliparæ. Authorities might be multiplied, but those quoted appear to prove the point that removal of the cancerous uterus per abdomen offers the widest range of operability and the longest period of immunity in the largest percentage of cases.

Mayo Robson in the Bradshaw Lecture on the "Treatment of Cancer," in December, 1904, gives us the following statistics: 12 total hysterectomies, no death. 1 patient alive and well after 8½ years, 1 after 7 years, 1 after 6 years, 2 after 5 years, 2 after 3 years, 1 after 1½ years, and four lost sight of.

Fourteen cases of very free supravaginal amputations of the cervix—1 patient alive and well after 11½ years 1 after 10½ years, 1 after 10 years, 1 after 9 years, 1 after 6 years, 2 lost sight of, 1 recurred after 4 years, and 5 recurred after 1 year or less.

Dr. Cuthbert Lockyer found 20 per cent. of his cases operable, and out of 13 cases had no operative mortality. He had one patient free from recurrence 4 years after operation. All these were vaginal hysterectomies, and in all the disease was cervical.

Miss Aldrich Blake's table of cases presented at the Leicester meeting of the British Medical Association is particularly valuable, because she has admitted no case in which the disease was not cervical in origin and because she has given a careful pathological report of each case. The table includes 16 cases without a death from operation, and in at least three cases there was no recurrence up to three years after operation.

The earliest of the reported operations was in May, 1902, so that the five-year limit has not yet been attained, but of all the sixteen cases two only are known to have had recurrence.

My own table of 23 cases is of far less value because it comprises all my cases of abdominal hysterectomy for malignant disease, whether of cervix or of body, whether carcinoma or sarcoma. All recovered but the first case.

Great stress was laid by Wertheim on the fact that he preferred the abdominal route because he could thus remove much parametric tissue with the organ, not primarily because he obtained readier access to the glands. He found a direct extension of the disease in

the parametric tissues in 22 per cent, of all cases, and involvement of glands in 28 per cent.

It is not a little remarkable that Wertheim, Kelly and others find that the pelvic glands are not infected by cancer in about two thirds of the cases, and that the tissue which most of all needs removal is the cellular tissue around the uterus. That this tissue is more readily removed through the abdomen than through the vagina is evident. The uterus removed per vaginam being often as it were shelled out from surrounding tissues, while the fear of wounding the ureters often prevents the surgeon from cutting as wide of the diseased organ as is necessary. Per abdomen, if the peritoneum is incised across the anterior surface of the uterus it can usually be stripped down without much difficulty, and carries the bladder and the vesical ends of the ureters into safety. Still more if Kelly's plan of splitting the broad ligaments early in the operation is carried out it becomes comparatively easy to tie the main trunk of the uterine artery near the pelvic wall, and to gradually work in towards the uterus so as to approach ureters from the outer side, and to isolate them without injury or too much difficulty. As a rule, the bladder is easily preserved, but a clean cut into it is not a fatal accident. Its walls are so vascular that it heals rapidly if not infected, and if drained by a stationary catheter for a few days. Wounds of the ureters are much more regrettable and ought to be avoided; but much care must be taken not to bruise these small and delicate tubes, and beyond all things not to injure their tiny vessels.

In the following table I have recorded 21 consecutive cases, the *bona fides* being guaranteed by the fact that the first patient died on the day of the operation. In these 21 cases there were:—

	Cases.
Sarcoma	4
Squamous-celled carcinoma	3
Glandular carcinoma	10
Endothelioma	2
Chorio-epithelioma	1
Doubtful	1
	—
	21
Death on day of operation	1
Recovered	20
	—
	21
Disease of cervix—	
Squamous	3
Glandular	4
Disease of body—	
Sarcoma	4
Carcinoma	7
Endothelioma	1
Perithelioma	1
Chorio epithelioma	1
	—
	21
Recurrence—	
Free after 6 years	1
Free after 5 years	
4'5	1
4	
3'5	1
3	1
2'5	2
2	1
1'5	
Less than 1	1
Not known	6
Died of cerebral hæmorrhage..	2
Died same day	1
Died soon after	2
Died after one year	2
	—
	21

To these may be added two cases operated on since Christmas, both of whom survived the operation.

It has not seemed possible in a short paper to repro-

duce all the statistics that are available, and yet it ought to be done and published—the literature is growing fast and in a few years will be unmanageable.

The progress made in the education of the profession and of the public has been wonderful, but it is still very imperfect and very partial. Sometimes a wave of pessimism sweeps over us and we are ready to echo the despairing opinion of a great northern surgeon, and say the benefits of operation are out-weighed by the risks. That this is a mistaken opinion all the available figures prove. The percentage of operability and of freedom from recurrence rises steadily while the operative mortality is constantly shrinking, and much is to be hoped for from the improved technique, the earlier recognition and the more constant appeal to the microscope. So let us be strong and of a good courage, the battle is to be won and victory even now hovers over our banners.

THE OUT-PATIENTS' ROOM.

FRENCH HOSPITAL AND DISPENSARY.

A Case of Cerebral Abscess with its Post-mortem Appearances.

By HENRI DARDENNE, M.D. EDIN., M.R.C.P. LON.

AMONG the out-patients at the French Hospital on April 20th, 1906, was a cellarman, æt. 48, who complained of a slight loss of power in his left arm, and inability to talk properly.

The history he gave was that on April 17th, his left hand and arm were suddenly, and without any apparent cause, affected with jerking movements over which he had no control. When these had ceased, after about an hour, he noticed that his mouth was drawn to the right. His left arm remained weak, and also his right leg, but to a lesser extent. He also stated that he had had a sharp attack of rheumatic fever about five years ago, otherwise, his health as far as he could remember, had always been good. He never suffered from headache, vomiting or giddiness, and denied having ever had syphilis or any other venereal disease. His sight had always been excellent, and also his hearing.

On examination it was noticed that he had facial paralysis of a cerebral origin, for the upper branches of the facial nerve were not involved. The movements of the orbicularis, palpebrarum and frontalis muscles were intact and the voluntary movements on that side were more impaired than the emotional ones. There was no reaction of degeneration.

His speech was laboured and indistinct, and the angle of his mouth was slightly drawn to the right side. The tongue could not be easily protruded. It presented no real deviation when its position was taken from the lower incisors.

His left arm was in a paretic state, but there was no actual paralysis. His leg was also weak and he walked with a slight limp, otherwise his gait was normal. His lungs were healthy and nothing peculiar was noticed in his ears or nose. His pupils were normal, and reacted both to light and accommodation. His temperature was normal. His pulse about 75 per minute, and regular. There was no tension and his blood vessels appeared healthy. His heart was slightly enlarged. The apex beat was in the mammary line, and in the sixth intercostal space. There was a distinct double systolic murmur to be heard at the apex, and the second pulmonary sound was accentuated.

Though he denied having ever had syphilis and though unable to find any indications to the contrary, a mixture containing 15 grains of bromide and 20 grains of iodide of potassium three times a day was prescribed, and as he refused to be admitted he was advised to go to bed at once. In the afternoon on the same day, Dr. Dardenne received an urgent call to go and see him as he was very ill. Dr. Dardenne said that on arrival he found the patient was suffering from a very severe attack of Jacksonian epilepsy. His whole left arm was affected with clonic spasms, and this at the rate of about 30 per minute. His pupils appeared

normal. His face was still paralysed, and his left leg could be moved only with considerable effort on his part. He was conscious. His tongue could hardly be protruded and his speech was most indistinct. His temperature was 103° F.; and he was perspiring very freely, and a glowing heat arose from his couch and pillow.

Immediate removal to the French Hospital was advised, and he was admitted the same afternoon.

This attack gradually passed off, and on the 23rd he had improved slightly and his speech was clearer. On the 24th he was worse, and at times comatose. The left leg was now quite paralysed, and anæsthetic. Both knee-jerks were absent and the left external rectus was paralysed. He became more and more comatose and died on the 26th. During all the time he was in the hospital his temperature remained normal, and at no time did he complain of headache; neither did he suffer from vomiting.

Only a partial *post mortem* could be obtained. On removing the skull cap, the meninges on the right motor area were found to be covered with a purulent fluid, and an abscess about the size of a small walnut was situated in the middle third of the ascending frontal and parietal convolutions on the right side. It had ruptured and its cavity presented a ragged aspect, and the adjacent convolutions were more or less torn and shreddy. It contained no definite capsule. The cavity encroached by its two extremities into the upper and lower thirds of the ascending frontal and parietal convolutions. The abscess was distinctly of an acute nature, and of recent origin. The meninges were not thickened anywhere, and the brain presented a normal aspect, except in the immediate vicinity of the abscess cavity, where it was deeply congested, and somewhat œdematous.

Remarks:—This case of cerebral abscess presented none of the ordinary characteristic symptoms such as fever, delirium, vomiting, and rigors, and as to its etiological factors, there was never any history of trauma. The patient's lungs were sound, and so were his auditory organs. He never suffered from any of the specific fevers or from influenza, and there were no bone or liver affections present. Most likely the cause of the abscess was a septic embolus, which got detached from his diseased mitral valves, he had had a sharp attack of rheumatic fever five years ago. It was certainly one of those cerebral cases which, had it been possible to form a definite diagnosis, would have had a great chance of being cured by proper surgical interference, the localising symptoms being most typical.

OPERATING THEATRES.

ST. PETER'S HOSPITAL.

ENUCLEATION OF THE PROSTATE.—Mr. SWINFORD EDWARDS operated on a man, æt. 73, who had had difficulty in micturition for the past two years, during the last year of which he had to rely entirely on his catheter. There had been some slight hæmorrhage on one or two occasions, probably due to some damage during catheterism. Per rectum, the prostate was markedly though not much enlarged, elastic, and fairly movable. Mr. Edwards found cystoscopy on the present occasion impossible, owing to the contracted condition of the deep urethra; he therefore proceeded at once to do a suprapubic enucleation. On opening the bladder the finger only found a small nipple-like projection from the posterior part of the vesical orifice. Mr. Edwards did not consider that relief would be obtained by simply removing this projecting part of the prostate; he looked upon the obstruction to micturition as being due rather to the

elongation and compression of the prostatic urethra by the hypertrophied prostate. The enucleation was carried out in the manner usual at St. Peter's Hospital, that is to say, by scratching through the mucous membrane over the projecting portion of the prostate, this gland having been pushed well up towards the suprapubic wound by two fingers in the rectum, and steadied there, then sweeping the finger or fingers (whichever may be the more convenient) completely around the gland, working in a plane between the capsule of the prostate and the inner layer of the prostatic sheath. In this case the prostate was removed whole, and was lying free in the bladder within three minutes from the commencement of the enucleation. The operator found that the point or points at which the freeing process was most difficult was at about the level of the entrance of the common ejaculatory ducts; this, he said, was the usual spot where the surgeon may encounter the most difficulty in the enucleation of the prostate. Another place where surgeons may expect a little difficulty is in tearing through the junction of the prostatic and membranous urethra. In some cases, a large portion of the prostatic urethra remains behind, the prostate, being, as it were, pulled off it as a strawberry is pulled off its stalk; in other cases quite a considerable quantity of the membranous urethra is torn away; but Mr. Edwards did not look on this as advisable if it could be avoided, for in one such case in his own practice a stricture resulted for which an internal urethrotomy had to be performed, thereby increasing the length of time of convalescence and necessitating the regular passage of a steel bougie. This was the only case of stricture Mr. Edwards had had following this operation. The prostate was now removed from the bladder with a pair of forceps; the two fingers of the right hand were again introduced into the bladder, whilst two fingers of the left hand were inserted into the rectum, the left hand being as before covered with a rubber glove. The walls of the prostatic cavity were next well pressed together by the opposing fingers. This reduced the size of the cavity and tended to prevent hæmorrhage. In this particular case the absence of hæmorrhage was remarkable. A one-inch diameter rubber drain was now inserted into the bladder through the suprapubic wound and fixed by a suture to the integument. A small gauze drain was left in the pre-vesical space and three silkworm gut sutures brought the edges of the external wound into apposition, leaving room for the drains. It was not found necessary to insert any deep sutures. The prostate was passed round, and Mr. Edwards pointed out the fact that it was removed whole, and that bands of non-stripped muscular fibre were well marked, running across it, this showing that the gland had been removed with its capsule; for, had the adenomatous masses been taken away from within the capsule, such muscular fibres would not have been present. In this case, he said, the prostate could not have weighed more than an ounce, showing that the size of the gland was no measure to the obstruction caused to micturition. With regard to the sheath of the prostate, he pointed out that it was derived from the recto-vesical fascia and embraced the prostate by two chief layers; the innermost lies between the prostatic capsule and the surrounding plexus of veins, whilst the outer one passes over the veins and encloses them. It would thus be seen that if the enucleation was carried out in the proper plane severe hæmorrhage was avoided, and the operation itself was not so liable to be fraught with disastrous results, as the pelvic fascia is not opened up.

TRANSACTIONS OF SOCIETIES.

THE BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD MAY 10TH, 1906.

MR. BOWREMAN JESSETT, President, in the CHAIR.

Mrs. SCHARLIEB read a paper entitled: "The Advantages of the Abdominal Route in Operations for Cancer of the Uterus," which will be found on page 551 *ante*.

Mr. MAYO ROBSON thought the first thing to be recognised both by the profession and the public was, that cancer, wherever situated, was a local disease. If only the attention of the public could be drawn to that fact and lead them to seek advice at an early stage, whether in regard to cancer of the stomach or cancer of the breast, or cancer of the intestine, surgeons could promise them that in 30-50 per cent. of cases a cure would be effected. He would not limit the term cure to merely the absence of recurrence within three years, but for longer periods than that. In his Bradshaw lecture, to which Mrs. Scharlieb had been good enough to refer, he tried his best to present statistics from many authorities in regard to operations for cancer in various organs, both as to the immediate risks and the ultimate results. Those statistics, whatever might be thought of their value, were at all events honestly given. And many of them were very remarkable. For instance, Dr. Halstead's operations on the breast—and he referred to the breast although he believed in that case it applied to the uterus as well, because in the breast one was able to take away not only the tumour itself, but also to follow that up by removing the glands, and that was of importance in relation to the abdominal route in uterine surgery. In those cases he believed Halstead had had 42·8 per cent. of cases in which there had been no recurrence in from three to four years after the operation. In the early days of his work supra-vaginal amputation of the cervix certainly did really effect a cure, and in many of them he knew the patients were living years and years afterwards in absolute and perfect health. As soon as the disease had extended into the uterus from the cervix, he was clearly convinced it was infinitely better practice to do the operation by the abdominal route. When doing the vaginal operation the surgeon knew he was simply removing the local disease, and there was no possible opportunity of removing the glands or the cellular tissue of the broad ligaments. But by the abdominal route, with the patient in the Trendelenberg position, everything could be seen most beautifully, the broad ligaments could be widely removed, and complete hæmorrhage could be brought about. That operation did not cause a moment's anxiety, for the uterine and ovarian arteries could be ligatured, and having removed the uterus one could lay open the peritoneum along the crest of the ileum and pick out the glands carefully, without hurry and without danger. In that way one was able to do just as complete an operation in cancer of the uterus as in cancer of the breast. Not only so, but it could be done with very little shock as there was such slight exposure of viscera. He could not understand the paper which was given by an eminent specialist in the North, who gave such a gloomy picture of the results after hysterectomy for cancer. It was his own opinion that cancer of the uterus is a curable affection if seen early and removed widely. It was a more satisfactory operation if done by the abdominal route. He thought the chief lessons which had to be learnt were, that operation should be undertaken early, and that efforts should be made to educate the public, so that if after the menopause abnormal hæmorrhages were seen they ought immediately to

seek advice. A determined effort was being made in Germany to promulgate that knowledge, but in England it did not seem to be possible, owing to the probable imputations either of charlatanism or self-advertisement.

Mrs. STANLEY BOYD said that if operators succeeded in getting the cases as early as they wished, any good operation would succeed. Supra-vaginal amputation succeeded in the early days, no doubt, because cases were carefully selected, and those operated on were all in an early stage. Mrs. Scharlieb, in previous papers, had given excellent results by the vaginal method, and if cases were taken sufficiently early, possibly equally good results would follow. But the fact was that many cases came which were not in such an early stage of the disease as one wished, and therefore it was incumbent upon surgeons to seek a method which would give the operator the means of dealing in more advanced cases with some hope of success, as did the abdominal method where the disease had passed the limits of the organ in which it originated. She began to operate by the abdominal route in July, 1901, because she was unhappy over the results obtained by the vaginal route. She was not more satisfied with her results by the abdominal route, but that was partly because in her early cases the technique was not as good as it might have been, and also because some cases were rather far advanced. Since July, 1901, she had had nineteen cases of malignant disease of the body and the cervix, eight being malignant disease of the body, and eleven of the cervix, those of the body including one case of sarcoma. In two of the cases of cancer of the cervix the operation was practically the combined operation, that is to say, begun as vaginal hysterectomy and finished by the abdominal method on account of the difficulty of bringing down the uterus from adhesions. Out of the whole number she had two deaths, one of which was purely from sepsis. Two of those nineteen cases were complicated by pregnancy. In another case of five months' pregnancy the uterus was removed with cancer of the cervix, and she remained well. Three out of the whole number of the cases of cancer of the body were complicated by fibroids. Out of the eight cases of cancer of the body, four remained well. One was well after five and a half years—and that was a case of sarcoma. One was well after four and a half years, one after two years, and the last was only recent, having been operated on only five months ago, and therefore of very little value. As already mentioned, one died of suppuration of the abdominal wound. Two showed metastasis within the first year, and one was thought to have died within two years of operation, and therefore probably from recurrence of the disease. There were eleven cases of cancer of the cervix, and of those, one which she had already mentioned died at the end of operation. In three the disease recurred locally, all of them within two years, and one died within a year. Therefore it might be said that four recurred locally. Of three she could not trace the after-history. But as they were fairly recent, she was still hoping she might get news of them. Two were at present in hospital. It had been said that the operation for cancerous cervix was a very dangerous one because of bringing the cancer of the cervix through the abdomen. In her cases the abdominal wound suppurated in three, and one of them proved fatal. One case suppurated but healed very well, but one at present in hospital was complicated with extensive pelvic cellulitis, and most troublesome cystitis. Another case showed a vesico-vaginal fistula at the end of the first week, apparently from necrosis of a piece of the bladder.

She had found enlarged glands in three of the nineteen cases mentioned. Of those three, microscopical

examination showed cancerous deposit in only one. Stripping down the peritoneum would not carry down the ureters, they needed careful dissection anteriorly, and that was the most troublesome part of the operation. Stripping the peritoneum could not clear the ureters, because anteriorly they were not in contact with peritoneum but were embedded in connective tissue. She had seen the ureters literally dissected out of a cancerous bed, leaving a distinct and deep groove in the connective tissue removed which could be well seen. She believed surgeons would very much extend the field of operation by adopting the abdominal route.

Dr. MANSSELL MOULLIN would have liked to have heard a little more definitely the arguments in favour of the abdominal route as compared with the vaginal. In his opinion such cases as those under discussion must largely depend upon two elements: first, on the nature of the case, and secondly, on the bias of the operator. Anyone who had special experience in operating by the vaginal route would no doubt be able to do very much more by that route than one who had not such experience. He thought the abdominal route offered certain advantages. It enabled the operator to see what he was about and to ascertain more exactly the extent of the disease, whether the bowel had been involved or the glands affected. If the bowel and lymphatic glands were infected, it was better not to proceed to eradicate the disease if it was fairly clear it could not be done successfully.

Dr. PURCELL said it was twenty years since he began the operation by the vaginal route, with a mortality of 20 per cent., which was afterwards reduced to 17, 15 and 12 per cent. His cases were not selected, they came seriatim, and he operated upon them. Latterly the mortality of the operation was 5 per cent. or 6 per cent. In cases seen sufficiently early, the uterus could be removed by the vagina in about 20 minutes. In more difficult cases the operation will occupy about an hour or even one hour and a half. But it must be always remembered that the longer the operation lasted the greater was the risk to the patient, and that if one hour were exceeded in performing the operation the patient would most probably die. One of the chief dangers with regard to the operation per vaginam was that of injury to the ureters, and that had to be considered by those who selected that route. That risk would be avoided by choosing the abdominal route, and the uterine and ovarian arteries could both be tied. In some cases, where the parts were fixed, the uterus could be curetted and plugged with chloride of zinc paste. He had exhibited to the society casts of the entire uterus, showing the whole of the internal surface sloughed away. Those cases which were past operation did well under the chloride of zinc paste. All gynaecologists would say that if the body of the uterus was the part affected, either by carcinoma or sarcoma, the abdominal route was the one that should be selected and panhysterectomy should be the operation.

Miss ALDRICH BLAKE said she proposed to speak of a single operation which was carried out entirely through the abdomen. She did not do any part of the removal through the vagina, though of course one cut across the vagina to remove it, and that was done from above. She fully agreed with former speakers as to the importance of early diagnosis but the want of it was by no means always due to the neglect of patients to seek advice. Numbers of patients came and said that they had consulted their usual medical adviser, who had told them what they themselves and their neighbours believed—that the symptoms complained of were due to their time of life. She had practised the abdominal route four years because it seemed to her, from the experience in removing fibroids from the abdomen, that it secured freer and easier removal than appeared possible from the vagina. The vagina itself was more easy to remove freely when beginning from the abdomen than from below. With the Trendelenberg position, she thought one could get as far as possible from the disease

in the cervix, sparing nothing but the ureters and the bladder and the rectum. She had never removed any part of the rectum with the uterus, because it seemed to her that in none of the cases which were otherwise suitable was it implicated. Of her 34 cases six were of the body and none died. Twenty-eight were in the cervix and vagina, and two of them died. So that in cancer altogether the percentage on the whole 34 cases would be just over 5.9 per cent., or taking the cancer of the cervix alone, about which she thought there might be more doubt as to the advisability of the abdominal route, the mortality of her own cases had been 7.1 per cent., and of course she hoped it might grow less rather than more.

Dr. HEYWOOD SMITH said much of the responsibility with regard to delay before seeing an operator rested with the medical man. The practitioner so frequently fell in with the patient's own suggestion as to her diagnosis, and thought it was due to the menopause; and instead of recognising the menopause as the cessation of hæmorrhage and not the increase of it, she was told that it was some weakness. It used to be the object of surgeons to remove the tumour through the smallest abdominal incision possible. But a few inches more or less in the length of the incision did not increase the shock perceptibly nor lessen the patient's likelihood of recovery. Moreover, by the freer incision it was possible to thoroughly explore the pelvis, and with the patient in the Trendelenberg position, there was no doubt a greater likelihood of thoroughly removing the disease by the abdominal route. He thought the Society might well undertake the production of a pamphlet addressed to general practitioners and also to the public, especially to the women of our country, pointing out certain prominent symptoms which might arise, and urging them on the appearance of such to get proper medical advice.

Mr. RYALL said the abdominal operation appeared the more scientific of the two. By the vaginal route it was necessary to deal with the broad ligaments and tie them *en masse*, whereas by the abdominal route one could deal with them in a more surgical manner. Also, by the abdominal route one could remove glands which could not be got away by the vaginal method. He had been very interested to hear what Miss Blake said about the gland which she mentioned on the uterine artery where it was crossed by the ureter. He had noticed that occurring sometimes. In his last case it was considerably enlarged, and yet when examined microscopically there was no evidence in it of malignant infection. Shock in abdominal operations was due to the amount of handling which the viscera underwent and to their exposure. But pelvic operations were borne remarkably well, and with the intestines out of the way the amount of shock might be said to be reduced to the minimum. The abdominal operation certainly occupied a longer time if the surgeon conscientiously and properly closed the wound. On the other hand, if he chose the vaginal operation there was very little closing up of that kind to be done, the operator hid the results of his work by a plug of gauze, and left the rest to Nature. He scarcely agreed with the remark that if the glands were found at the operation to be enlarged the operation should be abandoned. That should not be regarded as a sufficient reason for giving up the operation, especially as it would be very often found to be merely a hyperplasia in which there were no cancerous elements. The disease tended to spread along the vagina and recurrence occurred in the vaginal walls and followed the course of the uterine and internal iliac veins. The advantage of the abdominal route was in being able to remove the seat of origin of the disease. But when invasion of the broad ligaments took place the operator would be sure to damage by the vaginal route the ureters or leave some of the disease behind, whereas by the abdominal route it was easy to dissect up the ureters and free them.

Dr. R. T. SMITH said there was one consideration which he had found in his experience, and which

might be added to the reasons given for operating by the abdominal route. It was that that route enabled one to be aware of any previously existing peritonitis which might have caused adhesions. He remembered one case in which he removed a fairly large portion of the cervix by the vaginal method, and afterwards he was obliged to remove the whole uterus. The patient died three or four days afterwards from intestinal adhesions, and it was found post mortem that that had been caused by some previous peritonitis. In that case, if it had been done by the abdomen there was no doubt the adhesion would have been detected during life, and the patient's life might have been saved. He also emphasised the importance of recognising and treating eroded and lacerated cervixes as a prophylactic against cancer.

Dr. SMALLWOOD SAVAGE remarked that the time occupied by the operation was an important matter, and he would like to hear whether Mrs. Scharlieb cleansed the vagina previously to giving the anaesthetic.

The PRESIDENT said the subject was the most important in gynaecology. It had to be remembered that twenty years ago those poor sufferers had nothing done for them, they were left to die of their disease, whereas now perhaps 15 per cent. to 20 per cent. who came to the operator soon enough could be cured. Surely that was a great triumph for gynaecology, and he thought the Society could justifiably feel somewhat proud of having been instrumental in bringing about that desirable change. Of course, the great point was early diagnosis. But he did not think sufficient stress had been laid on the importance of the situation of the growth in the uterus. If there were growth of the os, recognised at an early stage, it seemed unnecessary to choose the abdominal operation and submit the patient to an operation which was more severe than the circumstances called for. In the last two or three weeks he saw six patients who were operated upon by him twelve or fourteen years ago by supra-vaginal hysterectomy. He gave up that operation because four out of six cases upon which he operated before the menopause had atresia of the canal, and in several cases a further operation was necessary for that condition. They were done before the occurrence of the menopause, but they were alive and well now, ten or twelve years afterwards. One poor woman turned up at the hospital the other day whom he had lost sight of for years and had forgotten. As she reminded him of the operation, he looked up his notes and found that twelve years ago he removed a cancer of the uterus. His idea was that the pendulum was now swinging too much in the direction of very radical operations. If a patient came after the menopause with cancer of the os or cervix, and was debilitated she could be operated upon quite well and successfully by supra-vaginal hysterectomy, and with a fair chance of freedom from recurrence, whereas if the more severe abdominal operation were chosen it might be the cause of her death. He did not advocate removal by the abdominal route in all cases of cancer in any part of the uterus. He took exception to that so far as cancer of the body of the uterus was concerned, because in that condition so limited he was sure the glands were not infected, and in the majority of cases which he had seen he was sure that pelvic glands were not affected, certainly not nearly as many cases as were supposed to have been involved. With regard to shock, there was no doubt that the shock following the abdominal operation was considerably greater than that after the vaginal, especially if the woman had been suffering from severe hæmorrhages. It was possible to remove the whole of the adnexa by the vagina without difficulty, when the uterus was mobile. He did not intend to try that method. Dr. Purcell referred to the combined operation, and he thought there was something to be said for it. He had seen several cases with extensive disease, and saw Dr. Purcell operate on one where there was a large uterus, with a sloughing mass coming through the vagina. He separated the

vagina all round, and pushed the bladder out of the way, opening up the abdomen and removing the whole lot through the abdominal wall. With regard to the chloride of zinc treatment referred to, he showed a large number of cases before the Society, ten or twelve, and it was astonishing how much disease could be removed by means of chloride of zinc. He had shown casts of the whole uterus apparently. One very interesting point was that in the first two or three cases in which he applied it he went down the next day to the hospital expecting to see the patients in agony, but found that they were in no pain whatever, and in ten days time the uterus all came out when it was taken hold of. But the after effects from the use of the substance were not encouraging, there was considerable contraction afterwards when the cicatrix closed up, and the patients suffered much pain, and very often the uteri were found to be implicated, and therefore he felt that he must give up the treatment. He agreed that when the larger part of the uterus was involved the operation should be carried out through the abdominal route, provided that the disease had not extended into the tissues beyond the vault of the vagina. If the disease extended from the cervix into the cellular tissue round the neck of the uterus, he did not think that if one got more of the vagina away there would be much of the disease left behind. To sum up, he would say that the vaginal method should be used where the disease was in the lower part and in the os, but where it implicated the cervix and beyond, the abdominal route was the right one.

Mrs. SCHARLIEB, in reply, said that the extent to which those who took part in the discussion had agreed with her made it almost unnecessary to advance further arguments in favour of the abdominal route. No one would think of removing a cancerous uterus with a fungating mass protruding through the os by the abdomen without having first cauterised or otherwise destroyed that mass. With regard to shock, the elements in the production of shock, other things being equal, were the exposure of the intestines and the unnecessary injury if they were exposed. The moral of that was to put the patient in a good Trendelenberg position and pack the intestines off. With regard to time occupied by the two operations, the longer the time taken the greater the degree of shock. And she thought it must depend on the nature of the case and the experience of the operator how much time would be expended in each case. It was true that in the case of a lax vagina in a woman who was a multipara, the uterus could be got down through the vulva, and it should be possible to remove it in twenty minutes, but she had sometimes spent from one to one and a half hours over it. That was longer than by the abdomen, because when the patient was in the Trendelenberg position with a good exposure, one was able to get the uterus out within an hour. Chloride of zinc, she admitted, made beautiful sloughs, but she was afraid of having sloughs from the bladder and rectum. She had used it in inoperable cases, but not otherwise. She had read a paper some time ago before some medical men, and urged very strongly that women who had hæmorrhage of unusual amount or irregular in time should be examined. And the medical men present got up one after another and said they would not dare to do it, that if they proposed examination of such patients they would soon be left without any patients at all. It was a lamentable fact that it should be so, and therefore the only course open was to educate both the profession and the public, including nurses.

At the invitation of Dr. W. Jones Greer, F.R.C.S.I., president of the Newport Medical Society, Sir Thomas Moyle, ex-president of the Royal College of Surgeons, Dublin, gave an address on "The Value of the X-rays to the General Practitioner" last week at the Newport Infirmary.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.

MEETING HELD MAY 4TH, 1906.

Devoted to the exhibition of Pathological Specimens.

MR. G. PERNET in the Chair.

DR. E. HOBHOUSE (Brighton) showed a specimen of congenital pyloric stenosis from an infant of 6 weeks. The child died the night before it was intended to operate.

DR. E. C. MACKAY exhibited a specimen of cerebrum with a tumour situated in the anterior half of the right side, which is probably glioma.

DR. CAUTLEY exhibited (1) a larynx with congenital laryngeal stenosis from a child of 5 months, the epiglottis is folded on itself longitudinally so that the superior aperture is much narrowed; (2) a specimen of abnormal sutures of both parietal.

DR. SUTHERLAND exhibited a skull with congenital syphilis and hydrocephalus; it shows well-marked craniotabes, also the results of intra-cranial drainage for hydrocephalus. The skull has contracted until the bones are over-riding.

DR. A. LEATHEM exhibited (1) a specimen of stomach showing ulceration round the pylorus, covered with diphtheritic membrane. (2) A microscopic section of a piece of membrane from the pylorus, showing diphtheria bacilli.

DR. J. G. EMANUEL (Birmingham) showed three specimens of congenital deformity of the heart. In the first (lent by Dr. G. W. Powell) the aorta and pulmonary artery arose from a single ventricle, probably the right. All the valves were normal. In the second (lent by Dr. O. J. Kauffmann) the aorta arose from the right ventricle, and the pulmonary artery from the left, and the foramen ovale was widely open, this specimen was from a boy, *æt.* 11. In the third (lent by Dr. Stacey T. Wilson) the membranous part of the inter-ventricular septum was absent and the aorta arose as much from the right as from the left ventricle.

DR. F. LANGMEAD exhibited (1) a specimen of primary sarcoma of lung removed from a girl, *æt.* 5. The signs during life were those of pleural effusion. Post-mortem the left side of the thorax was occupied by a large mass of new growth; it was situated within the lung, and was strictly limited by visceral pleura, except in the upper and outer part of the thorax. No growth was found elsewhere. (2) A specimen of brain showing meningeal hæmorrhages due to whooping-cough; the coughing had not been especially severe before the onset of the nervous symptoms. (3) A skull and lower jaw from a child who died of meningitis. The skull showed several areas of tuberculous osteitis, the bone, with the exception of the inner table, was replaced by caseous material, a similar condition was found in the lower jaw and malar bones. (4) A microscopical section from a girl, *æt.* 8 months, showing many tubercle bacilli from the base of a gastric ulcer; a second specimen from a boy, *æt.* 1 year and 11 months, also showing tubercle bacilli.

MR. GEORGE PERNET exhibited (1) microscopical sections of *nævi cystepitheliomatosi disseminati* (lymphangioma tuberosum multiplex). This is a very rare disease, consisting of numerous small tumours situated about the upper part of the front of the chest mainly, but also on the back and face. The specimen is from a woman, *æt.* 25, in whom the growths are said to have appeared at 16. The histological appearances are small cysts with colloidal contents and strands and aggregations of cells, which Mr. Pernet considered were of epithelial origin. (2) A drawing and photograph of racial pigmentation on the buttocks of a Siamese baby, received from Dr. Gimlette, of Kelantan, Siam.

DR. G. CARPENTER exhibited (1) a specimen of congenital morbus cordis. (2) Interstitial nephritis and cirrhosis of the suprarenal capsule. (3) Tuberculous

kidney removed by operation, from a girl of 10 years. (4) Lung, with multiple abscesses, from a child of 3 years, with pyo-pneumothorax.

MR. H. S. CLOGG exhibited (1) a specimen of fibro-sarcoma from the parotid gland; (2) An angio-sarcoma from the parotid gland. (3) A sac from a right inguinal hernia, studded on its inner surface with miliary tubercles.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT LEEDS, ON MAY 18TH, 1906.

MR. R. FARRELL, President (Sheffield), in the Chair.

FATAL CASE OF VARICOSE VEINS IN THE VULVA.

DR. J. B. HELLIER (Leeds) showed the uterus with the undisturbed placenta and membranes of a woman who died undelivered of hæmorrhage entirely from varicose veins in the vulva. The bleeding occurred in the street, and the patient was brought into hospital dying. Dr. E. O. Croft had recently seen a case of serious post partum hæmorrhage in which the blood came from a lacerated varicose vein just inside the vaginal orifice.

DR. HELLIER also showed two blighted ova which had been retained for several months in utero, together with a living twin, which perished during an eclamptic seizure near term.

DR. W. K. WALLS (Manchester) described a case of early cancer of the cervix in which, during vaginal hysterectomy it was found that the posterior uterine wall was firmly attached to the anterior rectal wall by a mass of tissue which subsequent investigation proved to be a new growth of epithelial origin. The tissue between the cervical cancer and the mass in the posterior uterine wall was perfectly healthy.

THE PRESIDENT mentioned the case of a patient, *æt.* 28, who miscarried at the sixth month of her second pregnancy, and was then found to have a large fibroid in the posterior wall of the uterus and cystic disease of both ovaries. Bleeding was so severe as to indicate hysterectomy, which was done six weeks after the miscarriage. The fibroid was a typical example of the change known as red degeneration.

DR. W. WALTER (Manchester) showed

FIBROMYOMA REMOVED BY ABDOMINAL PAN-HYSTERECTOMY,

from a patient, *æt.* 60, on account of hæmorrhage which began ten years after the menopause. Microscopic sections of the fibroid showed that angiomatous changes were in process. The patient had undergone a previous abdominal section, and the uterus was adherent to a portion of the abdominal wall, otherwise the size of the tumour would not have prevented its removal by the vagina, which, though senile, could have been enlarged by paravaginal section.

DR. LLOYD ROBERTS (Manchester) described the case of a woman whose symptoms were dysmenorrhœa, pelvic pain and ovarian tenderness. She was better after being curetted, but was later readmitted to hospital with pain in the left leg and loin, and with pus and blood in the urine. The left kidney was enlarged and incision was followed by the evacuation of a quantity of pus and mucus. The kidney was finally removed, and ten days later the patient died with complete suppression of urine. The right kidney was then found to contain a large mass of calculi which had destroyed its function.

LAMINARIA TENTS.

SIR W. J. SINCLAIR (Manchester) showed plants of sea-tangle (*laminaria*) from the coast of Iona, and tents manufactured from this material by the crofters of the island. The *laminaria*, after drying, was soaked in a solution of mercuric chloride until swelled to its full size. The tents were then fashioned roughly, and after being again completely dried, were trimmed and polished. These tents were therefore not only sterile, but were actually antiseptic. Tangle tents were first described by Dr. Sloan, of Ayr, in the *Glasgow Medical Journal* in 1862. Sir J. Y. Simpson popu-

larised their use. In 1870 they were already condemned in the *Edinburgh Medical Journal*, and readers on the subject would see that the evil reputation which tents acquired was solely due to the fact that they were introduced in days when not only were antiseptic precautions unknown, but when ordinary cleanliness was ignored in surgical work, Simpson himself remarking that it was economical to hang up a tent to dry after use in order that it might serve a second time. Tents reached Germany at a later date, when antiseptics were coming into use, and thus escaped obloquy in that country, where they were still largely used and where alone they were manufactured. Laminaria had a much greater co-efficient of dilatation than turgella wood, the root of *nyssa aquatica*, and laminaria tents should be freely used now that it was realised that they could not be a source of infection unless improperly used. They were much better and safer than any rapid mechanical dilators. The small tents shown were for dilatation of the unimpregnated uterus; but, from the size of the plants shown, it was clear that tents could be made (for use during pregnancy) large enough to secure dilatation admitting two fingers and permitting version. Long rods of laminaria could also be used for the induction of premature labour instead of the ordinary bougie, as their expansion would have its effect in stimulating uterine contractions, and would produce cervical dilatation at the same time. A further point was the desirability of supporting British industry by using tents made by the crofters of the western islands close to the source of the raw material, instead of buying tents imported from Germany.

HARVELIAN SOCIETY OF LONDON.

"Clinical Meeting" held May 10th, 1906, at the Paddington Infirmary.

Dr. MAURICE SQUIRE showed the following cases:—

1.—*Hæmorrhage into right crus cerebri*.—Woman, æt. 57, fell down on getting out of bed, and remembered nothing more till the next day. On admission to the infirmary, there was complete paralysis of muscles supplied by right third nerve, paresis of left face, arm and leg, with deviation of tongue to the left. Condition improved so that she could partially open right eye, but now movements of left eye are impaired so that she cannot move it beyond middle line in either direction. Discs normal.

2.—*Periostitis of humerus in child* of 3.—Twin brother has similar affection in one arm. The case was discussed by Dr. Willcox and Dr. Hall.

3.—*Infantile paralysis* in child, æt. 2, affecting anterior tibial muscles of right leg.

4.—*Case of sprue* in man, æt. 30. Patient was a soldier who had been 8 years in India, where he had "continued fever." Present illness started six months after return home in 1904, with vomiting and diarrhoea, which has persisted on and off since. On admission April, 1905, emaciated, denudation of epithelium of tongue, copious offensive light-coloured stools. The case was discussed by Dr. Willcox, who had found a milk diet beneficial in a similar case.

5.—*Case of scleroderma* in man, æt. 43. The disease had commenced at the age of 14. There were patches of scleroderma on shins, feet, thighs and arms.

6.—*Carcinoma of pylorus*, with secondary growth in liver in man, æt. 45.

7.—*Case of myopathic dystrophy*.—Patient was man, æt. 45, who first noticed weakness of muscles of upper arms in 1905, which has steadily increased. No history of any similar affection in other members of family. On admission, March, 1906, marked wasting of sternomastoid, trapezius, latissimus dorsi, pectoralis major deltoid, biceps and triceps, some wasting of scapular muscles and thumb muscles in both arms. No anaesthesia, no fibrillary tremors. Muscles react to Faradism and galvanism. Patient has improved considerably by treatment and gained power in many

of the affected muscles, which have increased in size. He has gained 18 lb. in weight.

8.—*Dislocation of sternal end of left clavicle* in man, æt. 70, who was knocked down by a van, the wheel passing over his chest and fracturing second and third ribs on left side as well.

Dr. WILLCOX showed a case of

RHEUMATOID ARTHRITIS IN BOY, ÆT. TEN.

Two years ago he complained of pain in hands and feet, and gradual thickening of joints took place. There is now marked thickening on inter-phalangeal joints in both hands with limitation of movement, and also thickening of inter-phalangeal joints of toes. Hands and feet always cold and turn blue in cold weather. Frequently suffers from chilblains.

The case was discussed by Dr. Winslow Hall and Dr. Macevoy.

Dr. WILLCOX also showed a case of a man, æt. 31, with ataxic gait, marked nystagmus, and total deafness. Two years ago he had syphilis. One year ago became ataxic, and hearing failed, being completely lost in six weeks. Knee-jerks lively, plantar reflexes, flexor response, no sphincter troubles; no facial or ocular palsy. Discs normal. No tremors, no anaesthesia. Has suffered from headache but no vomiting. The deafness was attributed to intralabyrinthine syphilis, and the other symptoms to pachymeningitis round the cerebellum.

ULSTER MEDICAL SOCIETY.

THE Eighth Meeting of the Session was held in the Medical Institute, Belfast, on THURSDAY, May 17th, Dr. CALWELL, President, in the Chair.

On the recommendation of the Council, the following resolution was proposed by Professor Lindsay, seconded by Dr. Morrow, and passed unanimously:—That we, the Fellows and Members of the Ulster Medical Society are strongly of opinion that, in the interests of the citizens of Belfast, and with the object of insuring the confidence of the medical profession, and of bringing the health department of the city into line with what is being done in other cities of similar size and importance, it is absolutely essential—(1) That the new medical officer of health should be possessed of high skill, scientific knowledge, and thorough practical training and experience in public health—a subject which has now become a pure speciality. (2) That the present remuneration, which is inadequate to attract suitable candidates, should be increased. (3) That in any rearrangement of duties the new medical officer of health should be sole head of a department in charge of the health of the city in all its branches, and should alone be responsible to the Health Committee and City Council for the proper administration of all matters pertaining to the health of the city. It was decided to send copies of this resolution to the Lord Mayor, City Clerk, the members of the City Council, and to the Local Government Board, and that a deputation should wait on the Health Committee and on the next meeting of the City Council.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, May 20th, 1906.

FOREIGN BODIES IN THE ŒSOPHAGUS.

THE most common of all foreign bodies of the œsophagus, especially in children, is that of pieces of money.

Called to a child who swallowed a piece of money, the practitioner, says M. Caubet, will have to satisfy himself on two questions: Is the piece arrested in the œsophagus, and at what point?

By what means can it be extracted?

The answer to the first question is to-day furnished by the radioscope; by placing the child before a screen, it will always be easy to see the shadow of the foreign

body, and to fix its situation, which is generally at the upper orifice of the thorax.

As to the mode of extraction, many opinions prevail. Some recommend extraction by the natural outlet (Kirmisson, Broca, Jalaguier), others, with M. Sébillan, condemn this method in favour of external œsophagotomy, while still others only advise œsophagotomy where the first attempt at extraction by the natural way has failed.

At the last meeting of the Société de Chirurgie, a member related a case of a set of false teeth impacted in the œsophagus and removed by external œsophagotomy after repeated attempts at extraction by the mouth. A large number of speakers (Sébillan, Pozzi, Tuffier, Kirmisson, &c.) declared that when the foreign body had pointed angles no attempt should be made to extract it by the pharynx; that œsophagotomy should be performed as soon as the position was made known by the radioscope.

The instruments used by the partisans of the first method are the basket of Græfe, and the hook of Kirmisson.

The former is the best-known, and the most employed in spite of its disadvantages, which are constant; it is too large and consequently liable to wound the œsophagus of a child. The basket is hinged on to the rod, and when it passes between the piece of money and the posterior wall of the œsophagus the operator draws on it. By this movement the basket expands and receives the piece; but in this position the object is caught in the inferior border of the cricoid cartilage, and extraction becomes impossible, and if the operator is not prudent he will tear through the gullet, an accident that has frequently taken place in the hands of inexperienced operators.

According to M. Caubet, the Kirmisson hook is much more preferable; it is less in size and its edges are blunt and smooth, so that there is no risk of wounding.

The mode of operation is somewhat similar to that of tubage for croup. A sheet is rolled round the child to guarantee immobility. An assistant, seated on a chair, holds him firmly between his knees, while another, standing behind the chair, fixes the head. The mouth is kept open by a large cork placed between the molars. The operator introduces his left finger into the mouth of the patient and guides the hook on it to the posterior wall of the pharynx. The instrument is then introduced, with the hook in front and pushed down. The hook has evidently passed below the object, but the operator must not expect to feel a shock or something abnormal; generally, nothing is felt. The instrument is then drawn up very gently, using little traction movements if necessary, and finally the piece is removed.

This method frequently succeeds, and is exempt from danger when proper precaution is taken.

To resume. Called to a child who swallows a piece of money, the first thing to be done is to bring him under the influence of the radioscope so as to be assured that the body is really in the œsophagus, and at what point. If not more than fifteen days have elapsed since the accident, extraction by the Kirmisson hook is indicated. External œsophagotomy should be reserved for pieces of money impacted for a long time in the œsophagus, and other objects provided with projections.

GERMANY.

Berlin, May 20th, 1906.

At the meeting of the Medical Society, Hr. Orth showed preparations of four cases of

PULMONARY PHTHISIS IN GUINEA-PIGS experimentally produced. They had been infected with human tubercle bacilli, and on examination *post mortem* showed typical appearances of human pulmonary phthisis—nodules, caseation and cavities. The usual form of experimental tuberculosis in animals was on the contrary the miliary. Now, it might be

looked upon as proved that there was an artificially produced pulmonary phthisis, and that one might be set up by the exclusive injection of tubercle bacilli with a mixed form of infection absolutely excluded. The injections were made exclusively subcutaneously or intravenously; the lungs were therefore infected by means of the blood current. Each guinea-pig had its separate cage, so there could have been no infection from one to another. Of the four animals dying from pulmonary consumption, three lingered rather a long time, 150 days, the fourth died on the 53rd day, whilst of animals dying of miliary tuberculosis, some had survived a very long time. The assumption, therefore, that the phthisical changes were the result of long standing disease and only occurred in the course of such lengthened illness was not tenable.

The explanation why this hitherto unobserved form of lung disease appeared in these animals must lie in the individual peculiarities of the animals themselves, and it was notable that all four animals were previously treated for "cold blood" tuberculosis. The idea that in this way the soil was prepared for the development of pulmonary phthisis was not to be rejected without further information.

Hr. Eckstein spoke on

PARAFFIN INJECTIONS AND IMPLANTATIONS IN NOSE AND CHEEK DEFECTS.

He added to his earlier demonstrations on this subject, since the introduction of which the cases had considerably been added to. As before, he still used hard paraffin with a melting point of about 50°C. In this way the occurrence of fatty embolism was excluded, and also the possibility that the injection causes a disturbing pressure; on the other hand, the plastic results obtained had been considerably better. The paraffin was not absorbed, at least in any period that came into practical consideration, unless that once exceptionally it was not deposited in a solid mass, but in fine needles and particles. More recently he had performed implantation of hard paraffin in which all unforeseen accidents were excluded. (A large number of patients and photograms were shown).

Hr. Silberstein recalled a case of amaurosis as a result of the injection of paraffin. He did not believe such an occurrence was excluded by the use of hard paraffin.

Hr. Kirschner had made microscopical examinations in quite a number of cases, and had always found the same condition, viz.: that granulation tissue grew around spicules and needles of paraffin, and these were therefore in process of absorption.

Hr. Joseph would warn them on the ground of his own experiences against too much optimism as regards paraffin injections. He was of opinion that they should only be made use of in cases where the disfigurement was so great that it could not be made greater.

Hr. M. David had observed that both soft and hard paraffin were liable to be absorbed, the latter, however, rather more slowly than the former.

At the Society for Surgery, Hr. Stubenrauch spoke on

PLASTIC OPERATIONS ON THE BILIARY SYSTEM.

and related the following case:—A patient, æt. 46, suddenly took ill in 1904 with rigors, pain and vomiting, and later, jaundice came on; the symptoms then gradually disappeared. On April 27th, 1905, the violent pain returned and an operation was performed on May 1st. There was stenosis of the bile duct, resulting from pancreatitis, on July 27th, a plastic operation was performed for closing the fistula that remained.

Hr. v. Wreden, St. Petersburg, made some observations on

TECHNIQUE.

He said patients often came in an extremely reduced condition. With these he injected 0.015 of morphia, and then performed gastro-enterostomy under cocaine, and used Murphy's button. There was no difficulty. In this way he had operated on 28 cases successfully.

Hr. Heidenhain, Worms, drew attention to the frequent combination of gastric ulcer and apical catarrh—this gave the indication for operation. He had seen some relapses after gastroenterostomy. The patient's freedom from all symptoms was no certain proof of the healing of the ulcers; these might go on in a latent condition. He therefore recommended that the stools should be examined for blood after operation. Only when there was no blood in the stools after coarse feeding without flesh meat, could one say for certain that the ulcer had healed.

Hr. Secfisch, Berlin, contended that gastrolisis rarely attained its object, especially in the case of surface adhesions. Even in the case of banded adhesions the end was rarely attained. In one such case a relapse occurred. He had also often seen relapses after pyloroplasty. In gastroenterostomy he used the suture; if one wished to use Murphy's button, retrocolic gastroenterostomy should be performed, then the button did not drop into the stomach.

Hr. Kuhn, Cassel, remarked emphatically that the extent of the incision in gastroenterostomy was of importance. The opening should not be made too large, as at the time of operation the organ was in a state of contraction. The consequences of too large openings was after-operations, a very small opening was sufficient. He had never seen a *circulus viciosus* after anterior gastroenterostomy.

AUSTRIA.

Vienna, May 20th, 1906.

LOCAL ANÆSTHESIA.

FOR minor operations a safe local anæsthesia has not yet been found. Neumann is now practising in his Oto-Chirurgical operations with a mixture of cocaine and supra-renal extract. He injects this into the bony meatus of the ear below the periosteum, which produces perfect local anæsthesia. Cocaine alone has proved to be a dangerous agent, but whether its safety is assured by the combination with the supra-renal extract is yet a matter of speculation. Both of these agents are proved to be dangerous and how their combination will be safe is a puzzle. Both of them produce emboli, while the extract leaves the walls of the vessel in an atheromatous condition.

TETANUS.

Hochwart gave the Gesellschaft a further explanation of his monograph on 160 cases of tetanus. Since the writing of the monograph he had followed up 55 of the cases in order to obtain a correct record of the subsequent history. Eleven of these cases have since died. No real cause can be attributed for the early demise, as many of the other cases were performing the same duties, of equally good appearance, and possessed similar advantages. It is possible that tetanus has the effect of weakening the constitution, and exposing the system to an easy invasion by the infectious diseases.

Of the remaining 44 we have only a written correspondence to show for eleven of these cases, but the other 37 were personally investigated and examined. Fourteen of these were in perfect health, four were yet doubtful, and the remaining seventeen still suffered from tetanoid attacks, several of them suffering from a chronic form of sickness resembling myxœdema.

Seven of them had the tetanic attacks only in the winter months; others had it in a less degree, which might be designated as latent tetanus, as the characteristic paræsthesia and contractions were present with Chrostek's and Erb's symptoms, the former being a hyperæsthesia of the facial nerve. If the pes anserina be pressed with the finger the facial muscles are thrown into convulsions. Several of these cases have developed large thyroid glands, while one gave birth to a child in this state which had tetanus also after it was born.

Hochwart concluded that these tetanic epidemics in

Vienna are of recent date, as Skóda only records one coming under his personal notice. The incidence of the disease seems to expend itself in one place, then gradually disappear to commence in another place.

Another fact may be learned from these cases, that the prognosis is not so favourable in these cases as formerly asserted. The mortality is heavy, while the chronicity of the disease becomes a serious danger to the patient.

Schrötter thinks that tetanus has previously been confounded with "Shoemakers Cramp" and thus has appeared more frequently than Hochwart believes. For the last 25 years he had devoted considerable time to the examination of protocols engrossed in the records of the hospital and found that Skoda has many similar cases on record. His object in this search was to discover the relation between tabes and syphilis, which were inseparably bound up together. He also found all the symptoms of tetanus mixed up with these cases, which we may infer were genuine tetanus.

Sternberg thought the insurance offices might give some information on the subject from their invalid list, but owing to the decentralising of the "Kranken Kassen" no reliable statistics can be obtained.

Hochwart acknowledged the truth of Schrotter's suggestion, and believed that these cases must have been more frequent than recorded.

HEPATIC PULSATION.

Jagic showed a patient, female, æt. 30, engaged as a saleswoman, with cardiac stenosis of the auriculo-ventricular opening. The patient had suffered from articular rheumatism at one time.

On close examination an almost negative venous pulse was observed in the neck. The liver, however, was enlarged and pulsated; no impulse of the heart could be found to act on the liver; after the apex beat or systole the liver collapsed, and extended over the greater part of the diastole. The pulsation of the liver was synchronous with the small venous pulse in the neck. From these symptoms he diagnosed mitral stenosis with an open foramen ovale. With Volland's double manometer he was able to clearly demonstrate the hepatic pulse.

FROM OUR SPECIAL CORRESPONDENTS AT HOME.

BELFAST.

The sole topic of interest in medical circles in Belfast is the coming appointment of a medical officer of health, and the prospects of the contemplated job for the appointment of an ex-member of the city council being defeated. The Ulster Medical Society has taken a clear and strong line in the matter, and in the resolution published in the report of their meeting last week, which appears in another column, they speak with no uncertain voice. The newspaper correspondence on the subject of the health of the city still rages, and the air is thick with statistics. The chairman of the Public Health Committee Dr. King-Kerr, marshals whole battalions of figures every second or third day, designed to prove that all is well under his loving care, but week after week the registrar-general rudely repeats that Belfast has one of the highest death-rates of any large city in the United Kingdom, and it will take a lot of writing to convince the man in the street that all is well in the face of that fact. Dr. King-Kerr resented greatly some remarks of Dr. Caldwell, the president of the Ulster Medical Society, and in one of his letters to the press made some reference to King Charles's head. Dr. Caldwell neatly retorted that nowadays members of public bodies who obstinately oppose all reform do not lose their heads, but if they are not careful they may possibly lose their seats. It was a very palpable hit, and the one hope is that the city councillors may realise that the electors are in earnest in this matter, and that we may at last see our city with a man able and willing to carry out sweeping reforms in health matters.

LETTERS TO THE EDITOR.

THE MIDWIVES ACT AND THE MEDICAL PROFESSION.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—The unfairness of the Midwives Act to the medical profession in its present form is becoming more evident every day. During the last few weeks the Central Midwives' Board has received information respecting the local administration of the Act from almost every area, and an analysis of these returns indicates that thirty-three of the county councils have not yet appointed a medical executive officer. In twenty-eight county borough councils the Medical Officer of Health has been selected to assist the local supervising authority.

The Act contains no provision to secure payment for professional services. Liverpool and Cardiff are the only centres where the councils have made any arrangement for the payment of medical men. As the law stands, practitioners are everywhere responsible for the safety of the poor parturient women during the attendance of midwives practising under legal supervision, and yet out of three hundred and sixty-nine local supervising authorities only two have engaged to secure payment for professional services. Medical men are now summoned to assist in emergencies throughout the country, and many practitioners have to travel miles to aid midwives in cases of danger and difficulty.—I am, Sir, yours truly,

J. WARD COUSINS,
Representative of the Royal College of
Surgeons of England on the Central
Southsea, May 21st, 1906. Midwives Board.

THE TAXATION OF PROFESSIONAL INCOMES.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—I have perused your article headed "The Taxation of Professional Incomes." It is indeed well that the select Committee of the House of Commons is going to consider the question of differentiation and the advisability of taxing the recipient of an earned income at a lower rate than the person who receives his income spontaneously.

May I, however, be permitted to sound a note of warning to the profession? In 1861 a Committee considered this question and in my belief the result adverse to differentiation was brought about in a large part by the competitive evidence of professional witnesses, medical witnesses among others. Now if differentiation is to come, it is necessary that fine distinctions should not be introduced and that there should be one cleavage between earned and unearned incomes, and one cleavage only. If strong evidence is given in favour of preferring the recipient of a professional income to the recipient of a commercial income; the recipient of an income from brain to him who receives from the joint action of brain and capital; of preferring the person whose professional education has been expensive to him whose education has ceased with his school days, then I take it differentiation will be again shelved.

I believe that the Committee will propose the adoption of a system of differentiation, always providing that these cross distinctions are not introduced to complicate the system and make it, as they undoubtedly would, absolutely impracticable. If the profession will be satisfied that the earned incomes of its members be taxed at a rate considerably lower than the unearned incomes of its members and of other persons, then it is certainly possible to produce a scheme which will confer this benefit, and the benefit should be sufficiently marked to satisfy the workers.

I am, Sir, yours truly,

T. HALLETT FRY.

ROLLESTON ON MITRAL STENOSIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I have read Dr. Rolleston's "Clinical Lecture" on this subject, in your issue of April 18th, with very

great interest, as we get a good many cases of the kind out here. What perhaps interested me most was his clear definition of the physical signs and murmurs by which to distinguish between Mitral Stenosis, Mitral Regurgitation, and Aortic Regurgitation. In this lecture the author tells us that the patient came into hospital with acute articular rheumatism, which rapidly yielded to treatment by the salicylates and carbonate of soda; but I was disappointed not to find any reference or suggestion as to the treatment of mitral stenosis, especially in its earlier stages. Could he favour your readers with suggestions under this head doubtless others would be grateful beside,—

Yours very truly,

A COLONIAL PRACTITIONER.

Capetown.

Coronation Fund for Nurses in Ireland.

THE annual general meeting in connection with King Edward VII.'s National Coronation Fund for Nurses in Ireland was held on May 14th. Her Excellency the Countess of Aberdeen, patroness of the Society, presided.

The annual report stated that the number of nurses and probationer nurses now registered as members is 177. The number of new members who joined since last meeting is 17. It is to be regretted that as yet but few nurses seem to appreciate the useful work that the Society is doing. During the last year (ending May, 1906) three members applied to the Society for help and each received a grant. The balance sheet shows that the Society is very economically managed. The Council entertain the strong hope that this institution which is the only one of the kind in Ireland, will grow in usefulness every year, and be beneficial to the body of the nurses of the sick working at their profession in Ireland.

Sir A. Chance proposed, and Sir W. Smyly seconded the adoption of the report. After the Council for the coming year had been elected, Sir Andrew Reed proposed, and Sir William Thomson seconded, a vote of thanks to Her Excellency, which was carried amid applause.

Her Excellency, in reply, said it gave her great pleasure to be there and identify herself with the work of the Society. She thought that nurses should show their belief in the Society by joining it. Her Excellency suggested to the Council to appeal to nurses not alone to join for the sake of themselves, but also for the sake of their sister nurses. She trusted that next year there would be a large increase in the membership.

The proceedings then terminated.

Royal College of Surgeons of Edinburgh.

At a meeting of the College held on the 16th inst., the following gentlemen, having passed the requisite examinations, were admitted ordinary Fellows:—Hirjee Nowroji Anklesaria, L.M. and S., Bombay; Charles Mackie Begg, M.D., M.R.C.P.E., Dunedin; Reginald Bryson, L.R.C.P. and S.E., Captain I.S.; John Burdon-Cooper, M.D., Bournemouth; Robert Sturgeon Cocke, M.R.C.S.Eng., London, W.; James Mathieson Kirkness, M.B., Ch.B., Edinburgh; Siavax Byramji Mehta, L.M. and S., Bombay; Victor Edgar Sorapure, M.B., Ch.B., Liverpool.

At the same meeting Dr. Robert McKenzie Johnston, 2, Drumshugh Gardens, Edinburgh, was appointed Secretary and Treasurer, and Dr. James William Beeman Hodsdon, 6, Chester Street, Edinburgh, was appointed representative of the College on the General Medical Council for five years from June 21st next.

The Medal and set of books presented to the College by Colonel William Lorimer Bathgate, in memory of his late father, William McPhune Bathgate, F.R.C.S.Ed., Lecturer on Materia Medica in the Extra Academical School was awarded after the usual competitive written examination in Materia Medica, etc., to Mr. James Hay Johnston, 18, Plewlands Terrace, Edinburgh.

MEDICAL NEWS IN BRIEF.

The Medical Society of London.

A LARGE number of Fellows and visitors attended the *Conversazione* of the Medical Society of London on Monday, May 21st, when, after a reception by the President, Sir Lauder Brunton, F.R.S., a very interesting oration was given by Professor Kocher of Berne, under the title of "Some Contributions to the Pathology of the Thyroid Gland." The Professor, amongst other remarks, stated that he preferred the term "heart goitre" to that of "exophthalmic goitre," as tachycardia comes on before the exophthalmic symptoms. He exhibited a table of 165 cases on which he had operated; these he divided into three series. The first series, comprising ten cases, he called *struma vasculosa* and beginning Basedow's disease with mostly local symptoms; all of the ten were absolutely cured by the operation. The second series of sixty cases he designated *struma basedo-coificata*, a milder form of Basedow's disease developed on a pre-existing goitre; of these two were greatly ameliorated, and forty-nine cured. The third series comprising 106 cases he described as *struma Basedowi*, or typical Basedow's disease; of these sixty-two were cured, nine greatly ameliorated, seventeen ameliorated, and nine he obtained no further news of, and nine died. Therefore, in summing up, the total mortality was 5 per cent., immediate healing 95 per cent., no later news 10 per cent., died later 2 per cent., improved 10 per cent., greatly improved 7 per cent., cured 8 per cent.

Sir Victor Horsley proposed a vote of thanks to Professor Kocher in a few graceful words, in which he alluded to King, of Guys, who a century ago had done so much to advance this branch of surgery.

Sir Felix Semon seconded, and the vote of thanks was carried by acclamation. A *conversazione* followed, a pleasant feature of which was the music of the Blue Viennese Orchestra.

Banquet of the Royal College of Surgeons of England.

THE President (Mr. John Tweedy) the Vice-Presidents Mr. H. T. Butlin and Mr. Edmund Owen) and the Council of the Royal College of Surgeons entertained at dinner on Friday last the Norwegian Minister, Dr. Nansen; Baron Takaki, F.R.C.S., Field-Marshal Sir George White, Sir Edward Fry, Lord Justice Cozens-Hardy, Sir Joseph Dimsdale, Sir R. Douglas Powell, Sir George Young, Vice-Admiral W. H. Henderson, the Hon. John Collier, the Master of the Temple, Sir Alexander Binnie, Sir Thomas Smith, Sir Frederick Treves, Sir Richard H. Charles, the Masters of the Mercers, Grocers, Drapers, Clothworkers, Apothecaries, Armourers and Brasiers, Leathersellers and Saddlers Companies, Capt. de Courcy Hamilton, R.N., Mr. Almeric Fitzroy, Mr. Jonathan Hutchinson, Mr. Thomas Bryant, Professor Percy Frankland, Professor Sims Woodhead, Mr. Giraud Browning, Mr. Sidney Lee, Mr. H. M. Ellis, Surg.-General Keogh, Surg.-Gen. Branfoot, and the Rev. J. L. Evans. The members of the Council present on the occasion were Mr. Langton, Professor Howard Marsh, Mr. Morris, Mr. Mayo Robson, Mr. Godlee, Mr. Watson Cheyne, Mr. Page, Mr. Ward Cousins, Mr. Pearce Gould, Mr. Morgan, Mr. Clutton, Mr. Moullin, Mr. Dent, Mr. Makins, Mr. Eve, Mr. Bowlby, Mr. Golding-Bird, Mr. Cripps, with Professor Stewart (Conservator), and Mr. Cowell (Secretary). After the dinner the President presented the honorary gold medal of the College to Lieut.-Col. Sir Richard Havelock Charles, I.M.S., K.C.V.O.

Medical Scholarships in Trinity College, Dublin.

THE Board of Trinity College, Dublin, applied during the past week to the Court of Chancery in Ireland to obtain the sanction of the Court to certain changes which they desired to make in the regulations governing studentship in medicine awarded by them under the will of Jane Begley, who left the sum of some £5,000 for the purpose of awarding such studentships. The

original provisions of the will contained clauses based to a large extent on the fact that the medical curriculum at that time covered a period of four years, and it has now been found that the adoption of the five years system rendered the strict carrying out of these clauses prejudicial to the satisfactory administration of the trust. The Board accordingly applied to have the necessary alterations made and suggested a scheme whereby the studentships should be open to all students who had passed the senior freshman's final examination either before or after the date on which they enter the school of physic, a preference to be given in the discretion of the Provost and Senior Fellows to students of longer standing in their Arts course. Judge Barton said the scheme was an excellent one, and he referred it to Chambers to have same settled.

Drug Contracts in England and in Ireland.

IN the House of Commons on Wednesday last, Mr. Chas. Devlin asked the President of the Local Government Board whether he was aware that several English Boards of Guardians had refused to consider tenders of Irish chemical and drug companies for medicine supplies and had informed such Irish companies that the contracts for such goods are invariably given to local firms; and whether, in view of the fact that the Local Government Board of Ireland insist that Irish Boards of Guardians must consider English as well as Irish tenders in such matters, he would take such steps as would place Irish firms on the same footing as English firms. Mr. Burns replied that he believed that some Boards of Guardians in England and Wales only considered tenders from local firms, but he was not aware of any case in which a distinction had been made between tenders from Irish firms and tenders from other persons not belonging to the locality. It did not appear to him to be desirable that a Board of Guardians should only consider local tenders, but at present it did not seem to him to be necessary to alter the existing regulations on the subject. Will the Irish Local Government please note this? "What's yours is mine, what's mine is my own" is not a very satisfactory answer in such cases.

Hall v. Fenton and Another.

IN this case in the King's Bench Division, before Mr. Justice Phillimore and a special jury, the plaintiff, Mrs. R. J. Hall, sued the defendants, Dr. W. H. Fenton, senior physician at the Chelsea Hospital for Women, and Dr. S. J. Cameron, formerly house surgeon at the same hospital, to recover damages for injuries sustained by her owing to the alleged negligence of the defendants. The defendants denied liability. It appeared that in June 10th, 1903, the plaintiff was admitted into the Chelsea Hospital for operation. She was placed under anæsthetics, and the operation was successfully performed by Dr. Fenton. The negligence alleged by the plaintiff was that she was not informed that an instrument inserted when she was unconscious would require to be removed in two months' time, and that she was not told to return to the hospital for that purpose. As a result, according to the plaintiff's case, the instrument was not discovered until some 18 months afterwards, and had done her serious injury. On behalf of the defendants evidence was given to the effect that the plaintiff was instructed to present herself as an out-patient two months after the operation, and that by the hospital routine it was impossible that she could have been allowed to leave without receiving such a direction. The jury returned a verdict for the defendants, adding a rider to the effect that they thought it was desirable that in cases such as the present written instructions should be given to the patients by the hospital authorities if they were required to return.—His Lordship said he thought the suggestion was a very wise one, among other reasons for the protection of the hospital authorities in case of questions arising as in the present instance.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially Compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT MEDICAL LITERATURE.

Microscopic Stagnation as Sign of Cancer.—Zeigler (*Zeit. f. Klin. Med.*, Berlin, 1906) announces that the first and sometimes the only symptom of cancer in the lesser curvature of the stomach is the discovery of minute remnants of food at a time when the stomach should be empty. This retention of microscopic relics of the stomach contents is characteristic of cancer when, after evacuation of the stomach of the macroscopic remains of the food, microscopic relics persist to the next ingestion of food, not merely for an hour afterwards. This daily finding persisted for months in certain patients. The retention is to be distinguished from the old conception of stagnation of stomach contents not only quantitatively but qualitatively as well. As a rule, it is not even the precursor of the other. In the limited and persistent form to which Zeigler refers, it occurs only under certain conditions, that is, when part of the stomach wall in the lesser curvature or in its vicinity has become rigid by induration and has lost its power of peristalsis. This is always the case in malignant disease. The presence of lactic acid bacilli is an early sign of retention, even of these microscopic amounts, and their resistance to lavage is an important point in the indirect diagnosis of cancer. In patients whose stomachs were apparently free from food at latest two and a half hours after a test breakfast without milk, and seven hours after a test meal, he examined the stomach an hour or so later and again the next morning fasting. The little mass of mucus found in the opening in the tip of the sound was then examined and found to contain evidences of the microscopic stagnation. They are examined for bacilli, starch grains, meat fibres and fat droplets. Leucocytes are also liable to be present, and suggest the point where the stagnation of the microscopic relics takes place. These findings can be encountered for weeks and months without other symptoms, if the cancer does not happen to develop where characteristic symptoms must follow. In his typical cases of this isolated microscopic retention there were no traces of blood, no tumefaction, cachexia, ascites, nor glandular swelling. At most, only a family tendency, anæmia and the peculiar pain in the back were observed. The microscopic stagnation persisted unmodified, even after rinsing the stomach with an infusion of tea or hops or a solution of silver nitrate. In non-cancer cases there is none of this microscopic retention; the stagnation is either macroscopic or entirely absent. The lactic acid bacilli are also readily banished by one or two rinsings of the stomach. Their resistance to rinsings is characteristic of a malignant process. D.

Serum Treatment of Typhoid Fever.—Brunon and Josias (*Bull. de l'Acad. de Med.*, Paris, 1906) report the results of the use of antityphoid serum in 100 children, æt. from 3 to 16. The typhoid mortality in their service with other methods of treatment was 17 per cent., but under serotherapy it dropped to 3 per cent. In the fatal cases the serotherapy had not been applied until the 15th, 16th, and 38th days respectively. It has an unmistakable action on the disease, modifying and attenuating it as a whole, shortening its duration, reducing the chances for complications, and the mortality. They are convinced that the outlook for a typhoid patient is very much better when the serum is injected as an adjuvant to the usual measures. It is absolutely harmless. D.

Mercurial Inunctions and their Action on Urinary Organs.—Kleineberger (*Zeit. f. Klin. Med.*, Berlin, 1906) describes the findings in thirty-seven cases after mercurial inunctions. They prove that this method of treatment is not so harmless as generally supposed.

Changes in the urine develop almost constantly and are due to the action of the mercury on the secreting parenchyma of the kidneys. As this effect occurs early and after small doses, when manifest albuminuria develops the kidneys are already severely affected and general mercurial intoxication installed. As mercury is such an efficient remedy, we can not dispense with it, he adds, but we should not give it for a long time and without sufficient grounds in chronic nephritis, and even in that case it should be suspended if indications of serious albuminuria develop and casts are found in the urine. D.

Chronic Latent Appendicitis.—Reclus calls attention (*Gaz. des Hôpitaux*, 1905, No. 119) to an important clinical form of appendicitis of a chronic nature, which is characterised by thickening of the cæcum, tympany, pain on compression of the appendix, and increase in size of the appendix which can often be made out by careful palpation of the right iliac fossa. Constipation accompanies, and is perhaps the cause of the inflammatory condition, and entero-colitis or membranous colitis may also co-exist. He advises a systematic examination of the appendix in all cases of chronic dyspepsia, in all cases of chronic diarrhœa, and in children who suffer from vomiting or who complain of nausea after taking meat or fatty foods, as all the above symptoms may be the result of a chronic appendicitis. Further symptoms are nervousness, irritability, fatigue after slight exertion, insomnia and general neurasthenic signs. Nutrition also suffers, and there may even be occasional fever resulting from toxic absorption. The only treatment is complete extirpation of the appendix, and this is usually followed by most favourable results, the entero-colitis improving and all the symptoms becoming ameliorated. M.

Acute Rheumatic Arteritis.—Barié reports a case (*Presse Méd.*, 1905, No. 24) of severe pain and increased pulsation in the brachial artery occurring in a case of acute joint rheumatism, and discusses generally the cases of acute arteritis occurring in this disease, and which, according to French writers, are a frequent complication of it. They find it not only in the aorta, but also in the arteries of the limbs and in the coronary vessels. The first symptom complained of is pain, which is situated along the entire length of the inflamed vessel, and is often of great severity; then one finds a greatly increased pulsation over the painful area, which is apparently produced by a general dilatation of the vessel; and, lastly, various abnormal sensory disturbances appear, and there is pain on pressure along the course of the vessel. In those varieties in which complete obliteration does not occur, and where there is only a limited inflammation of the vessel wall, healing rapidly takes place. Should obliteration occur all the signs of local anæmia become manifest, and may even be succeeded by local gangrene. M.

Atypical Leukæmia with Osteo-Sclerosis.—Rauwoerck and Moritz record a case of a woman, æt. 37, who was admitted to hospital complaining of an enlargement of the abdomen, which she had first noticed six years previously. She was found to have a large splenic tumour, slightly enlarged lymph glands, 6 per cent. hæmoglobin, 3½ million red blood corpuscles, 7,000 white corpuscles, poikilo cytosis, and numerous nucleated red cells. A differential count of the white cells showed about 18 per cent. lymphocytes, 65 per cent. leucocytes, 2 to 4 per cent. myelocytes, 6 to 13 per cent. eosinophiles, and 5 per cent. large mononuclear cells. The patient died of sepsis after extirpation of the spleen; the autopsy showed sclerosis of most of

the bones, myeloid hyperplasia of the marrow and of the spleen, and giant cell development in lymph glands, liver, and kidneys. The case belongs, therefore, to the very rare group described by Pappenheim as myeloid pseudo-leukæmia. With regard to the osteo sclerosis, cases have been described by von Henck, von Jacksh, and others, all of which agreed in showing bone marrow alterations, and some increases in the number of myelocytes and transitional cells in the blood. Occasionally the osteo-sclerosis itself has only been very slightly marked.

M.

Pathology of Raynaud's Disease.—Strauss (*Archiv. Psych.*, Bd. 39, I.), records a case of Raynaud's disease with necropsy report. The patient was a woman, æt. 26, who for six years had suffered from various, symptoms of disseminated sclerosis, and in whom four fingers of the left hand and two of the right, along with several toes, presented a cyanotic appearance. Finally the fingers of the left hand became gangrenous. The *post mortem* showed the presence of multiple sclerosis. Besides numerous foci in the medulla, the superior olive was found to be especially involved, though the axis cylinders and ganglion cells were uninjured. In the capillaries above the gangrenous fingers hyaline thrombi were present. An inflammatory condition in the controlling vasomotor centre in the medulla pointed to the disease being an angio-spastic gangrene. The ischæmia or cyanosis produced by the spasm is followed as a later consequence by gangrene from deficient nutritive supply to the part. Strauss, therefore, asserts that Raynaud's disease is not a trophoneurosis, but an angioneurosis which may develop either as an independent disease or may be engrafted on other disease of the nervous system.

M.

Tachycardia Associated with Simple Goitre.—Zeska (*Centralbl. f. die Med. Wissensch.*, 1906, No. XI.) draws attention to the fact that various cardiac disturbances may be met with in association with thyroid diseases, which are in no way identical with Graves' disease, and which up to this have attracted very little attention. He says that goitrous patients, especially young persons, have as a rule a rapid action of the heart, which in certain cases may become true tachycardia. This is especially the case in deep-lying goitres. Such patients frequently also complain of palpitation, a symptom which is often regarded as merely a part of the general anæmia from which they are also suffering. Cure of the anæmia, however, leaves the cardiac symptoms unabated, while on the other hand excision of the goitre usually leads to rapid relief. The relation of the goitre to these symptoms is easily understood, when it is remembered that other neck tumours can produce similar effects by pressure upon the vagus or sympathetic. In fact, the symptoms are in no way specifically connected with the functions of the thyroid, but are to be regarded as pressure effects. "Strumous tachycardia," as the condition may be named, he regards as a definite indication for operation.

M.

The Treatment of Diabetes Mellitus.—Williamson (*The Med. Chronicle*, May, 1906) relates three cases illustrating the value of aspirin in the treatment of this disease. The first case was that of a woman, æt. 52, who on admission to hospital was passing 54 ozs. of urine per diem with 22 gr. of sugar to the ounce. For the first ten days the patient was kept on ordinary hospital diet which included 11 oz. of white bread daily; no drugs were given except a little peppermint water three times a day. During the next three weeks experiments were made with various articles of diet, but five weeks after admission to hospital the condition of the patient was practically unchanged. The treatment with aspirin was then begun and 15 grs. of the drug were given three times a day, the former diet being maintained unchanged. In four days the total quantity of sugar excreted per diem had fallen from 910 grs. to 106 grs. Twenty days later the total quantity of sugar excreted in twenty-four hours was

116 grs. Five of the 11 ozs. of white bread allowed daily were then replaced by 5 ozs. of gluten bread, and the next day the sugar excretion was reduced to 49 grs. Three days later there was no reaction for sugar with Fehling's solution. In the second case treatment by aspirin was followed by a reduction in the daily sugar excretion from 1,564 to 402 grains, and when the aspirin was discontinued the daily excretion of sugar increased again to 1,586 grs. In the last case, that of a patient who was passing 688 grs. of sugar daily on admission to hospital, after treatment for three weeks with aspirin the sugar had completely disappeared from the urine. Dr. Williamson says: "In all these cases the disease was of a mild form. In severe forms of diabetes aspirin has often little influence. It is important that alkaline water or milk should not be taken just after the aspirin. One drop of lemon juice in a little water should be taken with each dose of the aspirin."

K.

Lumbar Puncture—Kopetzky (*Amer. Journ. Med. Sciences*, April, 1906) discusses this procedure as an aid to diagnosis, as a therapeutic measure, and for the production of anæsthesia. For diagnostic purposes the essential points to be considered in the examination of cerebral fluid are: The pressure under which the liquid is obtained; its colouration; its bacteriology; its cytology; its chemical examination; its cryoscopic examination. Of these various methods of examination by far the most important are the bacteriological and cytological examination. The diagnostic importance of pressure is on the whole a limited and secondary one, while so much variability in the colouration of the fluid has been observed that little faith can be placed on the data obtained by this method. Neither the chemical nor cryoscopic examination of the fluid has as yet yielded much which is of practical value for the purposes of diagnosis. The bacteriological and cytological examination is often of great value as an aid to diagnosis. It must be remembered, however, that in this, as in other cases, negative results are of nothing like so great importance as are positive results. The data obtained must always be considered with the clinical evidence of the disease, for it is only in some cases where the bacteriological findings have been positive, such as in cerebro-spinal meningitis, that a certain diagnosis can be made by the method alone. As a therapeutic measure the method may be used either for the introduction of medicaments into the spinal canal or for the relieving of pressure by the withdrawal of excessive amounts of fluid. Some success has attended the introduction of antitetanic serum into the spinal canal, but even in this case the results are by no means universally favourable, and in the use of other drugs the method has been very disappointing. As regards the second therapeutic principle the idea of producing a favourable therapeutic result by the withdrawal of the spinal fluid, there is a wide divergence of opinion, though on the whole it would appear to be favourable. On this point judgment must still be reserved for fuller knowledge. As a procedure for the production of anæsthesia it suffices to say "that the enthusiastic endorsement accorded to it at its introduction into this country some few years ago is on the wane. It is still a valuable procedure in selected cases, but many operators both here and abroad have abandoned it and condemned it."

K.

NOTE.—A summary will appear each week in the following sequence:—

- (1) "Recent Medical Literature."
- (2) "Recent Surgical Literature."
- (3) "Recent Gynæcological and Obstetrical Literature."
- (4) "The Recent Literature of Physiology and Pathology."

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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 reforwarding from office to office. When sending subscriptions the same rule applies as to office; these should be addressed to the Publisher.

MIDWIVES AS WITNESSES.

A CORRESPONDENT writes us from York as follows:—"Dear Sir,—I have been asked if a registered midwife, when called to an inquest on a child three months old, is entitled to a fee as a witness. The said midwife had delivered the mother of the infant in question, and put in the usual post-partum attendance, but had not seen the infant for six weeks before its sudden death, and then only in a casual way. The courtesy of your reply will oblige.—D.M.T."—[The midwife would be entitled to attend, in our opinion, as an ordinary witness, if required to do so by the coroner. It is obvious, however, that she could offer evidence only in general terms as to the nature of the confinement and the healthy condition or otherwise of the child. The only expert opinion of any value regarding the cause of death, under the circumstances described, would be that of a qualified medical witness.—ED., M.P. and C.]

DERMATOLOGIST (Brighton).—There are specially named instruments sold for the purpose, but you will find ordinary forceps and scalpels quite sufficient. Norman Walker's book is sound and practical.

THE EMPLOYERS LIABILITY BILL AND MEDICAL PRACTITIONERS.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR.—Now that the above Bill is before Parliament I would suggest, that the different divisions and branches of the B.M.A., and other medical societies take immediate action, so that all medical practitioners shall be included in the above Bill. Almost all the illnesses and accidents which attack us come through our dangerous occupation; while each year finds the majority less able financially to provide against sickness, accident, infirmity, and old age. I would suggest immediate action.

Liverpool, May 15th, 1906.

ROBERT R. RENTOUL.

IS CARDIFF OVER-DOCTORED?

Is Cardiff over-doctored? Mr. James Matthews, the Newport librarian, replies, "Emphatically, yes!" "Cardiff," he says, "has 128 doctors, and Newport has only 33. If Cardiff has three times the population of Newport, then Cardiff has, pro rate, too many doctors by 27. This testifies to the fact that the people of Newport do not take quite so much physic as the good people of Cardiff, and that Newport must be a very healthy place to live in." There is a fatal flaw in Mr. Matthews's argument. Pro rata, Newport has twice as many undertakers as Cardiff!—*Western Mail*.

VERONICA (Bolton).—Write to the matron of one of the large London hospitals. If you like we can give you particulars as to paying probationers.

KING'S COLLEGE, LONDON.

The enterprise of modern hospital managers is boundless. King's College, London, seems about to emerge into a magnificent maturity from its former comparative chrysalis-like obscurity. Seven acres of ground have been presented by Mr. W. F. D. Smith, M.P., for the site of the new hospital. The number of beds will be raised from 224 to 600. This week a great Elizabethan fair and fête is being held, on behalf of the building fund, in Lincoln's Inn.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MAY 23rd.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. J. Berry: Clinique. (Surgical). 5.15 p.m. Lecture:—Dr. A. Mackenzie: The Treatment of Acute Pneumonia.

THURSDAY, MAY 24th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m. Lecture:—Dr. P. Stewart: Tropic Nervous Diseases.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Dr. Arthur Giles: Lecture on Obstructed Labour.

FRIDAY, MAY 25th.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m. Papers.—Dr. F. Hawkins: Case of Thrombosis of the Abdominal Aorta.—Dr. C. R. Box: A Series of Cases in which Pulmonary Embolism was Due to Displacement of Pulmonary Thrombosis.—Dr. F. P. Weber: Acute Dilatation (Atony) of the Stomach and Intestines connected with Pneumonia and Pericarditis.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Dr. St. Clair Thompson: Clinique. (Throat).

TUESDAY, MAY 22nd.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 p.m. Lecture.—Mr. Walter Edmunds: New Growths of the Intestinal Tract with their Treatment.

Vacancies.

Huddersfield Infirmary.—Senior Male House Surgeon. Salary £20 per annum, with board, residence, and washing. Applications to Mr. J. Bate, Secretary, Infirmary, Huddersfield.

London County Asylum, Horton, Epsom, Surrey.—Junior Assistant Medical Officer. Salary £150 per annum, with board, furnished apartments, and washing. Applications to H. F. Keene, Clerk of the Asylums Committee, Asylums Committee Office, 6 Watertown Place, E.W.

Parish of Paddington.—District Medical Officer. Salary £100 per annum. Applications to Henry F. Aveling, Clerk to the Guardians, Guardians' Offices, 313-319 Harrow Road, W.

Hull Royal Infirmary.—House Physician. Salary £100 per annum, with board and furnished apartments. Applications to the Chairman of the House Committee.

Cornwall County Asylum, Bodmin.—Third Assistant Medical Officer. Salary £135 per annum, with board, furnished apartments, washing, &c. Applications to the Medical Superintendent.

Radcliffe Infirmary and County Hospital, Oxford.—Secretary Superintendent. Salary £150 a year. Applications to the Treasurer at the Radcliffe Infirmary.

Perth District Asylum, Murthly.—Assistant Physician. Salary £120 per annum, with board and residence. Applications to Dr. Bruce, Phys. Supt., Murthly, Perthshire.

Appointments.

ARMOUR, DONALD, M.B. Toronto, M.R.C.P. Lond., F.R.C.S. Eng., Assistant Surgeon to the National Hospital for the Paralysed and Epileptic.

BARNARD, ANNIE T., M.B., B.S. Lond., Refractionist to the Royal Eye Hospital, Southwark, S.E.

BLAKENY, JOHN HENRY, L.R.C.P. Lond., M.R.C.S., Public Vaccinator for the No. 1 District by the Cheltenham Board of Guardians.

DONALD, DAVID, L.R.C.P. and S. Edin., L.F.P.A. Glasg., Honorary Medical Officer to the Aldershot Hospital.

FENTON, W. J., M.B. Camb., M.R.C.P. Lond., Assistant Physician to Charing Cross Hospital.

GILES, A. E., F.R.C.S. Edin., M.D. Vict., Surgeon to In-patients at the Chelsea Hospital for Women.

MCHOU, JAMES, M.B., Ch.B. Glasg., House Surgeon at the Royal Eye Hospital, Southwark, S.E.

REYS, OWEN LEWELLYN, M.B., Ch.B. Edin., Clinical Assistant to the Electrical Department at Cardiff Infirmary.

ROB, WILLIAM FRANCIS, L.R.C.P. and S. Edin., Clinical Assistant to the Royal Hospital for Diseases of the Chest, City Road.

STEWART, PURVIS, M.D., F.R.C.P. Lond., Physician to the Italian Hospital, London, W.C.

Births.

CAMPBELL.—On May 19th, the wife of P. E. Campbell, M.B., C.M., Medical Superintendent, Caterham Asylum, of a daughter.

SMITH.—On May 17th, at High Down, Hindhead, the wife of Gilbert Smith, M.D., F.R.C.S., of a son.

SMITH.—On May 7th, at Mossel Bay, S. Africa, to Alste and Douglas Wilberforce Smith, M.B., B.S. Lond., a daughter.

STOKES.—On May 15th, at 43 Clapham Road, London, the wife of Ronald M. Stokes, L.R.C.P. and S. Edin., &c., of a son.

UNITT.—On May 13th, at Quorn, Leicestershire, the wife of James A. Unitt, M.R.C.S., of a daughter.

WIGGINS.—On May 15th, at Worthing, the wife of Henry Wiggins, M.R.C.S. Eng., L.R.C.P. Lond., of a daughter.

Marriages.

CONWAY—LEGGE-NEWCORNER.—James Conway, L.R.C.P., L.R.C.S.I., late Captain R.A.M.C., son of Captain Conway, Lahore, India, to Georgina, widow of the late Alfred John Legge-Newcombe, of Devonport.

Deaths.

GREGORY SMITH.—On May 17th, at 24, Lingsfield Road, Wimbledon, Harriet, widow of John Gregory Smith, F.R.C.S. Eng., aged 87.

RANSOME.—On May 14th, at "Sunnyhurst," Bournemouth, Lucy Elizabeth, wife of Arthur Ransome, M.D., F.R.S.

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THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, MAY 30, 1906.

No. 22.

NOTES AND COMMENTS.

A Coroner on Hospitals.

THE good folk of Birmingham have been for some weeks past thrown into a quandary as to the management of their general hospital. The father of a child that died from severe burns made some extraordinary statements at an inquest. He said that the little patient was not seen for forty minutes after going to the hospital, and not dressed for forty minutes later again. Mr. Coroner Bradley, who heard the case, appears to have accepted the implied censure of the medical staff off-hand, and to have assumed gross negligence on their part. His proper course, in view of the seriousness of the allegations, would have been to adjourn the inquiry so as to permit of an explanation from the other side. The latter has since been made, and puts the affair in quite another light. It throws, indeed, the whole of the blame upon the distraught father, who refused to leave his child in the hospital wards, although warned of the critical nature of the child's condition. All this pertinent evidence, however, should have been placed before the jury before they arrived at their verdict. We presume Mr. Bradley is a lawyer, which makes this bandying with *ex-parte* evidence the more inexplicable. Meanwhile, his action in the matter has done a great injury to a worthy public charity.

His View of Hospital Aid.

THE most extraordinary feature of Mr. Bradley's now notorious inquest was his remark to the mother of the deceased child to the effect: "If you were not satisfied with the attention you got from a charity, you could have gone elsewhere." This crystallises the position, so far as the relations of that section of the public which supplies the patients to the hospitals is concerned. They have long ceased to regard the relief afforded by medical charities as a favour, and look upon it as a right. The result is not a little misleading. The poorer classes, the newspapers and the public have come to look upon the system of medical charities as one which must be maintained at a high and often, according to our view, an impossible standard. From this point of view there is something to be said for the view of Mr. Bradley, although at first sight it seems to be inexcusably cynical. If the "elsewhere" of his dictum were interpreted on ordinary principles of justice, it would often mean that the hospital patient

should be employing and paying for the services of a private medical practitioner. To that extent we are with Mr. Bradley.

A Breach of Bar Etiquette.

THE Bar of England is governed, as everyone knows, by unwritten laws that are no less stringent than those which regulate, more or less, the medical profession. With barristers, for instance, direct advertising is anathema, constituting an ethical offence of an extremely gross nature. The Inns of Court have recently been considerably fluttered by the action of a member of the Middle Temple, who is said to have issued to some of the metropolitan mayors a circular letter marked "confidential," intimating that he had commenced practice at the Bar in connection with work of a parliamentary, municipal and public health nature, and requesting those addressed to communicate that fact to town clerks. This matter having come before the benchers of the Middle Temple, they ordered that the offender should be severely censured, and be excluded for a year from hall, library and garden of his Inn. The resolution, to the outside world, will sound somewhat like the terrible sentence framed by the Abbot upon the jackdaw of Rheims. For all that, it is one of the most serious catastrophies that could mar a barrister's professional career. The wonder is that in so closely-guarded a precinct any member should have had the temerity to send out a circular letter of the kind alluded to.

Professor W. R. Smith on the Subject.

THERE is a sequel to the Middle Temple affair. A week ago, at the meeting of the Holborn Council, a member said he wished to draw attention to a matter closely touching the honour of the Mayor and of the Council. The Mayor of the body in question is Professor W. R. Smith, a medical man, who holds a Chair at King's College and is a member of the Middle Temple. He ruled out of order the councillor who drew attention to the legal censure, and intimated his opinion that an explanation would be forthcoming. He suggested that the proper course would be to refer the whole thing to the Holborn Parliamentary Committee. The councillor thereupon gave notice of his intention at the next meeting of the Council to move: "That a small committee be formed to consider the circular sent by the Mayor to the metropolitan

mayors; and the action of the Benchers of the Middle Temple, as reported in the public press, and the circumstances connected therewith, and to report whether the action of the Mayor in the matter calls for the censure of the Council." The affair, which rests here for the present, appears to call for consideration on ethical grounds in medical as well as in legal circles. King's College, for instance, may have something to say in the matter.

LEADING ARTICLE.

THE GENERAL MEDICAL COUNCIL.

THE eighty-third session of the General Council of Medical Education and Registration was last week introduced by the presidential address of Dr. Donald MacAlister. Needless to say, his speech was lucid, able and comprehensive, and save, perhaps, from the progressive point of view, left little to be desired. A brief analysis of its chief points, however, emphasises the narrowness of the sphere of action covered by the Council and the comparatively small results attained by a machinery of such vast potential power as that undoubtedly possessed by our governing body. If we venture to offer any criticisms, we do so in all friendliness and in the sincere hope that one day the General Medical Council may enter into the fulness of its kingdom. At present the Oxford Street Parliament appears to be going through a phase of imperialism somewhat resembling that which recently swayed the national mind, with results that are still draining the pockets of the taxpayer. The first half of Dr. MacAlister's address was devoted to international reciprocity as regards medical registration. He announced that Nova Scotia had applied to be admitted to share such reciprocal privileges, and that Japan had been actually thus admitted. At the same time he described his reception on a recent occasion at Rome, and dwelt upon the fact that Italy alone of European nations had entered into an agreement of reciprocity with us in respect of medical education. All this is doubtless to the good as an imperial asset, but there are other things nearer home that stand in urgent need of legislative reform. There is, for instance, the enormous mass of quack practice conducted at the expense of the public even more than that of the medical profession. To organise a strict supervision of the education, the qualification, and the ethical life of the legitimate medical practitioner while charlatans are allowed to defraud and swindle the public by the sale of nostrums, and to injure qualified practitioners by the illegitimate practice of surgery and medicine, is to achieve a great feat of topsy-turvy legislation. It is true that the General Medical Council are considering

a petition for incorporation addressed to the Privy Council by the British Optical Association and a Bill now before the Lords entitled "The Sight-Testing Opticians Bill." Both documents, as the President pointed out, propose that powers and privileges shall be conferred on certain persons, who are not qualified medical practitioners, in relation to the diagnosis and treatment of ocular defects. Dr. MacAlister anticipated careful scrutiny of this matter at the hands of the Council on the grounds that the proposals in question touch closely the practice of ophthalmic medicine and surgery. In point of fact, they trench on the legitimate work of one of the best-organised and most powerful of special branches of medical work. The ophthalmic surgeons have taken up the matter vigorously, and have thereby shown a worthy example to the rest of their medical brethren. If the General Medical Council were to adhere to the excellent maxim that they should carefully consider all matters "closely touching" medical and surgical practice, they would at once find their hands full and their proceedings the centre of interest not only of medical men, but of the enormous interests involved in the thousand-and-one fraudulent medical ventures that invade every town, village and remote dwelling of the United Kingdom. Sooner or later drastic registration must follow the rising standard of popular enlightenment. Should the General Medical Council wish to assume any position of real weight in the medical world it will lose no opportunity in advancing such legislation, and especially in increasing its own scope of action and in broadening its own constitution upon democratic and representative lines. There are many ways in which the Council might carry out vigorous repressive measures even on its present basis. To mention one or two such methods: Why should not the Council urge the Government to prohibit the postage of obviously fraudulent quack advertisements? Why not urge the public prosecution of newspapers for conspiracy with fraudulent quacks by inserting their advertisements. Quackery is rendered possible only by advertisement, and the two chief agencies are the daily journals and the post office. It is somewhat reassuring to learn that the Council are introducing two Bills to prevent medical practice by companies. In the process of time we may hope for better things from the new and more progressive policy adopted by the present distinguished President.

Fee for Self-Vaccination.

At a recent meeting of the Guardians of Haslingden Union, Mr. Tomlinson, the Chairman, reported on the conference held in London which had for its object the reduction of the cost of vaccination to Poor-Law unions. It appeared that the cost of vaccination through the whole country had gone up 500 per cent. in ten years. A member asked if a statement that in the conference it was reported that one medical man had charged for vaccinating himself was true. He could scarcely believe it. The Chairman: The statement was made in the conference and the name was given.

NOTES ON CURRENT TOPICS. I

Feeding of School Children.

Now that the Select Committee of the House of Commons appointed to consider the Education (Provision of Meals) Bill has finished taking evidence, it is interesting to review the general feeling that was found to exist among those witnesses who were in position to form an authoritative opinion. The case for the feeding of half-starved children has always been clear to those who value the national physique and the cause of education, but the difficulties of securing that this should be done with the greatest advantage to the child and to the country and the least damage to parental responsibility and to the purse of the ratepayer have been very great. The evidence given before the Select Committee certainly showed one thing, namely, that to embark by Act of Parliament on a large scheme of feeding such children would be to embark on a dangerous experiment, however much it may be restricted and guarded. The necessity for inquiry was abundantly obvious, but we trust that the Committee will not urge the Government into any rash adventure now that the facts are clearly before them. While doubtless in the big towns a certain number of children are underfed these numbers seem to have been exaggerated, for in Glasgow, for example, only about one per cent. of the children appeared not to have been sufficiently fed at home, and, on the other hand, these children are nearly always found to belong to idle, drunken, and careless parents. There was a considerable feeling that the present voluntary agencies could by wise economy of effort cope with the really necessitous cases, and that action should be directed towards making the parents feel the extent of their neglect. We shall be glad to see what the Committee recommend when their report is issued, for though no child should be allowed to starve or be insufficiently fed, the parent when guilty should become the object of the reformers' effort.

Industrial Mortality.

Now that the voice of labour is so powerful in Parliament, the question of dangerous occupations is likely to be regarded as one of ever-increasing importance. The principle of compensation of workmen for injuries sustained by reason of their occupation is nowhere more apparent and more obviously entitled to redress than in the case of diseases contracted in factories and workshops. During the month of April last the total number of cases of poisoning and of anthrax officially reported to the Home Office was fifty-two, consisting of forty-four cases of lead poisoning, one of mercurial poisoning, and seven of anthrax. Out of this list the small proportion of three deaths was recorded, one being due to lead poisoning and two to anthrax. With regard to plumbism, it appears from the returns that the greater number are attributable to trade processes involving fumes. It may be stated broadly that in dusty

lead trades poisoning may be avoided by suitable precautions. There can be little reasonable doubt that a properly qualified scientific investigation would reveal methods whereby the bulk of lead poisoning cases amongst workpeople might be materially reduced, either by improved workshop environment or by the substitution of other materials in place of lead.

London Port Health Work.

IF the system of retaining special privileges for ancient bodies is capable of justification, it is only on grounds of good work thoroughly kept up to the requirements of modern science. It is something of an anomaly that the City of London should still be the health authority for the Port of London; but those who read the annual report of the medical officer of health will be satisfied that he and his staff carry out their unostentatious but vitally important duties with admirable skill and assiduity. According to the last report just issued over 10,000 vessels entered the port during 1905, and over 3,000 of these had to be visited by medical officers because of sickness on board. Three cases of suspected plague were found and detained at the isolation hospital, but in all of them the bacteriological findings were negative. Last autumn, owing to the presence of cholera in Russia and Germany, detailed inspection of ships from ports in those countries had to be made, and it is satisfactory to know that the precautions adopted were sufficient to prevent the entrance of the disease into Great Britain. A rat-destroying campaign has been going on, and the warfare has resulted in the destruction of 60,000 of these unseemly rodents infesting ships and warehouses. Dr. Williams is evidently thoroughly alive to the responsibilities of his post, and is to be congratulated on the success that has attended his efforts.

Post-mortem Signalling.

ONE of the minor drawbacks to living in a community of civilised beings is the difficulty of being original; any idea that is put forward as new by anybody seems to have been anticipated by someone else. We hesitate, therefore, to characterise as original a suggestion which has just been made by a Miss Lind-af-Hageby, to prevent premature burial, but at all events we may claim it as striking. This lady would have all dead bodies removed to a mortuary where they would be under the supervision of a corps of "death verifiers" till these experts were satisfied that life was extinct. Then the bodies would be placed in their graves, but, lest the death verifiers should have been in error, to each grave should be attached a signalling apparatus whereby the dear departed might, if they felt symptoms of reviving consciousness, communicate with their friends above ground. It is said that an experimental cemetery was constructed on these principles in America, and that out of 1,200 bodies there buried no less than six telegraphed to their sorrowing relatives. We hardly think that English people are yet sufficiently Americanised to

believe in the bogey of premature burial and to arrange codes of telegraphic signals with their dying relatives, but in case there be any such timid persons we should recommend a simpler plan than burying them first and seeing if they signalled afterwards. We confess the six signallers in the American cemetery rather "startled us" till we remembered certain "facts" of an equally sensational nature which were associated with a Miss Lind-af-Hageby, and which evaporated into unsubstantialities when presented to a hard-headed British jury.

Conscientious Objectors.

WE have often wondered which is the more puzzling person to diagnose—the *bond-fide* traveller or the conscientious objector. Certain characteristics of each one knows; the *bond-fide* traveller generally has a red nose, and the conscientious objector usually has a loud voice; but neither of these symptoms is pathognomonic. There is one feature, at any rate, they each share in common, namely, the right to be taken on trust by those with whom they are brought into contact. Nobody may question the veracity of a *bond-fide* traveller, and nobody may presume to doubt the disinterestedness of a conscientious objector. A recent circular issued by the Home Secretary to the magistrates throughout the country, to inform them as to their duties with regard to a conscientious objector, is a marvel of circumlocution. "The question for the magistrates," it runs, "is not whether the applicant's belief is well or ill-founded, but solely whether they are satisfied that he conscientiously believes. . . . The Act does not require that the belief should be reasonably founded. It is not necessary to the proof of conscientious objection that a certificate should be produced, or even that evidence should be given, of any particular state of health of the child. Any ignorance on medical or sanitary or statistical questions is no ground for refusal of a certificate." That Mr. Gladstone interprets the Act according to its wording cannot be gainsaid, but what does it all amount to? The Act is hopelessly illogical, and as the Minister for Education has written in his literary past, "An illogical opinion only requires rope enough to hang itself." The "conscientious objector" clause and the Home Secretary's elaborate instruction might be boiled down into the homely saying, "If a man likes to be an ass, let him be as big an ass as he pleases."

Conference on Infantile Mortality.

WE are glad to hear that the National Conference on Infantile Mortality, which is to be held in London next month, promises to be a success. The moving spirits in its inauguration and promotion are Alderman Broadbent, Mayor of Huddersfield, and Bailie Anderson, Convener of the Public Health Committee of Glasgow, both of whom are well-known for their zeal in the cause. It is good news that Mr. John Burns is to be President of the Conference, for it deals with a subject

that needs not only the support of the Government of the day, but also that of a strenuous member of it. In such a position Mr. Burns is likely to be seen at his best. It seems a pity that only two days are to be devoted to the proceedings, as the question is a vast and complicated one, and it will be impossible for its various aspects to be more than touched upon in the time at disposal. Infant mortality, like the tuberculosis death-rate, is one of the test measures of the health of a town, and of the intelligence of its inhabitants, so that it may be said to be the expression of the degree of civilisation reached by a particular community. No one remedy, however important in itself, can be relied upon to put down the excess of infant deaths, for improper feeding, overcrowding, maternal ignorance, and poverty all take a share with the prevalent atmospheric conditions in causing them. If the Conference, by calling attention to the whole question, gains sympathy and support for the efforts of its promoters in quarters where the extent of the evil is unknown, it will do well. We hardly think it can accomplish much more.

A Chronic Cure.

AN interesting sidelight on quack methods was thrown from the dock at the Clerkenwell Sessions last week when one, Ernest Miller, was charged with stealing a watch and chain. The prisoner was a cripple and had what is described as a "withered" left arm; moreover he pretended to be deaf. Although his occupation was given as that of a tailor, Ernest Miller confessed in evidence that he had enjoyed a less onerous and more lucrative position than that of following the goose. His infirmities were his assets, and he had "worked" for Dr. Bodie, a gentleman whose proceedings have been commented on in THE MEDICAL PRESS AND CIRCULAR from time to time. The Chairman asked the detective in charge of the case who Dr. Bodie was, and received a reply to the effect that the gentleman went on the music-hall stage and pretended to cure crippled people. The prisoner was employed to pose as a patient, and used to be carried on to the stage night after night to receive Dr. Bodie's ministrations, which resulted each night in a "cure." Apparently Miller improved in the mimetic art, for as time went on he seemed to be worse when carried on and better when he hopped off. We are thankful to say that for eighteen months he will not have the opportunity of conniving at similar deceptions, as his time will be fully occupied at hard work—an experience we should judge to be as unusual as it will doubtless prove salutary.

Discipline in Teaching Hospitals.

THE medical student is still an attractive interest to the man-in-the-street as one of the few romantic spirits left in these days of grey competition and drab decorousness. The authorities of the medical schools wisely keep a blind side to pranks that are for the most part but harmless outward signs of boisterous animal spirits. To

keep too tight a rein on students of any class is to court disaster. It is to be hoped that these axioms may be carefully considered by the managers of the Edinburgh Royal Infirmary. Some half-dozen students recently met within the walls of that institution to celebrate the departure of one of their number to India. They kept up the gathering beyond the official hour, and appear to have committed some other trivial offences against a complicated and multitudinous set of rules. As a result, their hospital tickets were suspended and they were forbidden to enter the hospital for six months, while their names and sentences were "posted" at the gates. If the facts be as stated—and they have not been officially contradicted—the disparity of the punishment to the offence appears to be of a Gilbertian order. The managers would be wiser in future to consult their medical staff before issuing orders of this Spartan nature.

Mr. Bernard Shaw in Cap and Bells.

MR. BERNARD SHAW has so long posed as jester to the community, and he takes such keen delight in fooling his readers and listeners, that it is just possible he occasionally does not see through his own fooling. We have all heard of the unfortunate gentleman who played the part of the cat in the pantomime with such zest and thoroughness that he came to believe himself a cat, and insisted afterwards on going about on all fours. We confess on reading Mr. Shaw's address to the British Union for the Abolition of Vivisection we are in some doubt as to whether he appeared on all fours or in his proper person. This befogging and puzzling of the public is, of course, part of Mr. Shaw's humour, but it has certain drawbacks. There is just a chance that there are people so matter of fact as to regard his utterances as serious, though we confess his extravagances are so "shavian" (we believe that is the correct word) as to give them warning. Thus it is possible that there are people who will believe that the opposition of medical men to fads such as "anti-vivisection" is, as Mr. Shaw states, only assumed in order to give an excuse for writing signed letters to *The Times*, and thereby attracting fees to the pocket. Advertisement, however, it should be remembered, is just as essential to a writer of plays as to a medical man. It would be too absurd to take Mr. Shaw's vagaries seriously, but really he should be a little more careful to safeguard himself against such a misunderstanding.

A Standard of Puerperal Morbidity.

THERE is no doubt that the progress of medical science is much hindered by the lack of proper statistics on which to base inquiry. Medical men are not, and cannot be, trained statisticians, and under present circumstances every man does what is right in his own eyes. There are no uniform standards, and, consequently, there is the greatest difficulty in collating the experience of different observers. It is this fact which renders the

numerical results of large institutions such as Johns Hopkins University so valuable, merely in lieu of results gathered over a larger area. In the matter of puerperal morbidity, it is some satisfaction that a representative Committee, appointed by the British Medical Association at the suggestion of the Master of the Rotunda Hospital, has recommended a standard which we hope will be accepted as authoritative both by the maternity hospitals and by the practising obstetricians throughout the Kingdom. The standard—a temperature of 100° F. occurring more than once at any time during the first eight days, and all cases of puerperal mortality—is not as exact as all might wish, but it presents the estimable feature of great simplicity. Moreover, the decision of what the standard should be is by no means as important as the fact that a standard has been recommended with authority. We trust that even those who see its imperfections will loyally adopt it.

PERSONAL.

WE understand that Professor Bergmann has been summoned from Berlin to Constantinople to the Sultan's daughter, who is suffering from appendicitis.

A PENSION of over £900 per annum, being two-thirds of the salary and emoluments, amounting to £1,350 a year, has been granted by the Hampshire County Council, to Dr. Thomas Blair Worthington, who, after over 21 years' service, has retired from the post of medical superintendent of the County Asylum at Knowle.

At the Mansion House, London, Lord Rothschild presided at a meeting of the British Red Cross Society, which is an amalgamation of the British National Society for Aid to the Sick and Wounded in War and the Central British Red Cross Council.

A DINNER was given last week by a number of local practitioners to Dr. Irby Webster, ex-medical officer of the Willesden Infirmary, on his leaving Harlesden.

SURGEON-GENERAL SIR THOMAS JOSEPH GALLWEY, K.C.M.G., who has done much useful work in several arduous campaigns, has been chosen to succeed Surgeon-General W. H. M'Namara, C.B., as principal medical officer at Aldershot.

ON the 23rd instant Mr. Whitelaw Reid, the American Ambassador, presided at a festival dinner in aid of the Charing Cross Hospital. Subscriptions were announced amounting to £12,257.

THE annual dinner of the officers of the Indian Medical Service will take place at the New Gaiety Restaurant, London, on Thursday, June 14th, at 7.45 p.m. Particulars can be obtained from Dr. P. J. Freyer, 27, Harley Street, London, W.

SIR DONALD CURRIE, G.C.M.G., through whose munificent gift of upwards of £100,000 the buildings are being erected, will lay the Foundation Stone of the School of Advanced Medical Studies, Nurses' Home, and Maternity Students' House in connection with University College Hospital, London, on Monday, June 11th, at 4 p.m.

MR. PERCY W. G. SARGENT, F.R.C.S., has been appointed Assistant Surgeon to the National Hospital for the Paralysed and Epileptic, London. Mr. Sargent is the eldest son of Mr. E. G. Sargent, of Clifton, and is an Old Cliftonian.

A CLINICAL LECTURE

ON

PERSISTENT DUCTUS ARTERIOSUS.*

By G. A. GIBSON, M.D., Sc.D., LL.D.,

Physician to the Royal Infirmary, Edinburgh; Examiner in Medicine, Oxford University Examiner in Clinical Medicine, Edinburgh University.

AN interesting chapter might be written upon the difficulty often expressed in obtaining a hearing for new facts. It is, indeed, a curious circumstance that obstinate preconceptions frequently prevent the reception of obvious truths. Common rumour tells us that no one above the age of forty accepted the teaching of Harvey; we may well believe it. Perhaps the reluctance exhibited by the learned men of the 17th century to adopt his views should reconcile us to the difficulty we have in securing the reception even of facts which can be stated as definitely, and proved as certainly, as a mathematical problem. These remarks naturally arise as the result of considering the very interesting case now before us. As the various clinical features unfold themselves, you will find that the patient furnishes an excellent illustration of a cardiac affection to which much attention has been given by myself, but of which the diagnosis is not yet generally recognised. On two occasions the subject has been fully explained by me, yet my position is still like that of "the pelican in the wilderness," "the owl in the desert," or "the sparrow alone upon the housetop," to which the Hebrew singer pathetically likened himself. Before dwelling at greater length upon this somewhat depressing aspect of the subject, let me state the facts of the case.

The patient is a strong and muscular man, aged twenty-four, who has been trained as a mason. He has always lived in the country, and enjoyed, as far as he knows, perfect health. As a trooper in the Yeomanry he was always in the van when it came to skirmishing on foot, or any other part of military duty demanding strenuous physical exertion. The patient, if indeed, he may be called so, was sent to me by Dr. Harvey Littlejohn. The reason for his appearing in the Infirmary is that he applied for admission to the Edinburgh Police Force, and on routine examination he was discovered to have some cardiac lesion.

His father died recently of influenza followed by chest complications. His mother and his brothers and sisters are perfectly healthy. He himself cannot remember ever being ill, except when he passed through an attack of measles in youth. He has never suffered from breathlessness or palpitation. There has never been a trace of cyanosis or of chilliness. In short, there have been no symptoms connected with the circulation. On inspection there is no trace of any abnormality either in form or colour; there is no preternatural pulsation in the vessels of the neck; but on producing redness of the forehead there is a slight capillary pulsation. The apex beat is seen in the fifth intercostal space just inside the mammary line; the arteries are perfectly healthy; the pulse is of moderate pressure, and the rate varies from 70 to 80. The character of the pulsation shows a slight

increase in celerity, but it can scarcely be called a good example of Corrigan's pulse. On applying the hand over the præcordia the apex beat is found to have its maximum intensity in the fifth intercostal space half-an-inch inside of the mammilla, and shows no departure from normal strength and rhythm. Palpation, however, reveals one interesting abnormality. In the third left intercostal space, close to the sternum, there is a beautiful thrill, and the rhythm of this thrill is most characteristic. It begins distinctly after the apex beat, as is appreciated on placing a finger over it for comparison, while another finger rests over the third left intercostal space, and it continues for a considerable time after the cessation of the apex beat. On closer analysis it is found that the thrill is continued almost until the following apex beat, and there can be felt most distinctly the recoil of blood upon the semilunar cusps producing the second sound just about the middle of the thrill. This thrill in itself is, as we shall see, absolutely diagnostic. The upper border of cardiac dulness is at the middle of the third left costal cartilage, and transversely it extends 1½ inches to the right, and ¾ inches to the left of midsternum. From the examination, therefore, so far, we may conclude that there is little, if any, hypertrophy. The phenomena observed on auscultation are, at the first blush, slightly confusing, as there is apparently one long continuous murmur occupying both systole and diastole, with a reinforcement of intensity during each of these phases. On more careful analysis, however, the rhythm and distribution of three distinct murmurs become quite clear. At the inner end of the first right intercostal space there is a short, systolic murmur, which is conducted upwards into the vessels of the neck. In the midsternum, opposite the attachment of the fourth costal cartilages, there is a soft, short diastolic murmur which is propagated for a short distance towards the ensiform cartilage. Taken in connection with the other phenomena, which have been described, there can be no doubt that these two murmurs are produced by aortic obstruction and regurgitation. In the third left intercostal space, an inch and a half from the edge of the sternum, there is another murmur perfectly distinct in character from the two just mentioned. It begins quite obviously after the commencement of the first sound. It is continued during the latter part of that sound and the whole of the short pause. It persists throughout the second sound, and dies away gradually during the long pause. The murmur is distinctly rough and thrilling in its character. It begins, however, somewhat softly, and increases in intensity so as to reach its acme just about, or immediately after, the incidence of the second sound, and from that point gradually wanes till its termination. The second sound can be heard to be loud and clanging, and when carefully analysed it is the

* A Clinical Lecture delivered in the Royal Infirmary, Edinburgh.

pulmonary part of that sound which is accentuated. The blood shows a slight increase in its normal constituents. The erythrocytes reach 5,300,000, and the leucocytes 10,000 per c.mm.; the hæmoglobin amount to 90 per cent. There is, therefore, a slight tendency towards the condition of blood found in cyanosis. There is no trace of any departure from normal conditions in any other system of the body.

In this case we have phenomena which are not merely characteristic, but are absolutely pathognomonic. Although the arterial pulse is not a very good example of that which is so often found in aortic incompetence, yet it has a certain amount of resemblance to the features described by Corrigan and in association with the capillary pulse it is suggestive, the position and conduction of the systolic and diastolic murmurs are characteristic, and there can be no room for doubt as to the existence of a moderate degree of aortic obstruction and incompetence. We may dismiss this part of the case without further comment except to remark that the aortic lesions have produced but little interference with the circulation, seeing that there is practically no alteration in the size of the heart.

The most interesting features of the case, and those which have led me to bring the patient before you to-day, centre in the thrill which is felt in the second intercostal space, and also in the murmur which accompanies it, the maximum intensity of which you will remember is in the third left intercostal space. It is unnecessary to tell you that the rhythm of the thrill and murmur at once negative the possibility of their being produced in the heart itself. There is absolutely no possibility of the production of a murmur in the heart surviving two phases of cardiac activity. In this case the thrill and murmur begin about the middle of the first sound, when the great venous valves are closed and the arterial valves are open. They continue during the short pause, and accompany the second sound, when the auriculo-ventricular valves are opening and the arterial valves are closing, and they die away about the middle of the long pause. No cardiac valvular lesion could produce such phenomena. No lesion of the inter-auricular or inter-ventricular septa could produce such effects. The only possible cause for it must be a lesion connected with one of the great arteries in which there is high pressure existing from shortly after the ventricular contraction until shortly before the next ventricular systole. With the situation of the thrill and murmur as they are in this case, it must be obvious that the aorta or the pulmonary artery must be the origin of the appearances. As there is no indication of any disturbance connected with the chest, apart from the facts which have been brought before you, it is perfectly obvious from the anatomical position of the thrill and murmur that they must be caused by a stream passing from the aorta to the pulmonary artery. It is possible to conceive of a communication between the two vessels produced by a small aortic aneurysm opening into the pulmonary artery and producing physical signs somewhat resembling those which have been placed before you. Roberts, (1) Wade, (2) and Walshe (3) have described such cases, and several similar instances have recently been described by Gairdner (4), who has summarised the observations of the

authors just mentioned. Two points negative an explanation of this kind: Firstly, there is very little alteration in the condition of the arterial walls; secondly, the thrill and murmur do not begin at the commencement of the first sound, as does an ordinary systolic murmur in aneurysm of the first part of the aorta, but they follow the commencement of the first sound by an appreciable interval. It is, therefore, absolutely beyond the possibility of doubt that we have in this case a persistent ductus arteriosus. Several cases presenting perfectly identical symptoms and signs have been under my care during the last few years. In describing systematically the pathological features and clinical results of persistent patency of the arterial duct, two of these cases were detailed by me, and the rhythm of the thrill and murmur was diagrammatically figured in order to illustrate the semblance of rational symptoms and physical signs produced by the affection. (5) Two years afterwards a most beautiful example of the affection, absolutely free from all complication by the presence of any other lesion, was under my care in the Royal Infirmary. The features of the case were demonstrated in the wards and in the theatre, and the diagnosis of a perfectly uncomplicated ductus arteriosus was made. The patient was in my ward on account of anæmia, and, after making an excellent recovery, she went out. A few weeks later she was readmitted on account of lobar pneumonia, of which she died, and at the *post mortem* examination we found that there was absolutely no trace of any cardiac lesion, but that the ductus arteriosus was patent. These facts formed the subject of a Clinical Lecture, afterwards published, (6) and furnished an absolute proof of the possibility of diagnosing the lesion under consideration. And yet, in spite of this absolute demonstration of the correctness of my contention as proved by the pathological results, the diagnosis of this lesion appears to be still a subject of scepticism. In the latest edition of one of the best works on "Physical Diagnosis," that of my friend Dr. R. C. Cabot, the following sentence occurs:—"It is been claimed that a murmur occurring through systole and into diastole is diagnostic of an open arterial duct, but this supposition is not borne out by *post-mortem* evidence." (7) The clinical lecture to which reference has been made must have escaped his observation.

To sum up the essential facts upon which the diagnosis of persistent arterial duct may be confidently founded, let me mention that there may be no dyspnoea, cyanosis, œdema, or other evidence of disturbance of the general circulation, the recognition of the lesion depending entirely on the presence of two physical signs. Inspection may fail to reveal any facts of importance; palpation yields the valuable sign of a long thrill following the apical impulse, and continuing beyond the recoil of the blood on the semi-lunar cusps, the shock of which may be felt during the thrill; percussion may negative the suspicion of any increase of cardiac dulness—in fact, it usually does so in uncomplicated cases; auscultation gives the second and the most invariable evidence of the lesion in the presence of a murmur which is pathognomonic. Beginning distinctly after the first sound, it accompanies the latter part of that sound, occupies the first pause, accompanies the second sound, which may be accentuated in the

pulmonary area or may be doubled, and finally dies away during the long pause.

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1. Roberts: *Brit. Med. Journ.*, Vol. I., 1868, p. 421.
2. Wade: *Med. Chir. Trans.*, Vol. XLV., p. 211.
3. Walshe: "Diseases of the Heart and Great Vessels," 4th Edit., London, 1873, p. 529.
4. Gairdner: *Glasg. Hosp. Rep.*, Vol. II., 1899, p. 1.
5. Gibson: "Diseases of the Heart and Aorta," Edin. and Lond. 1898, pp. 161, 303, and 310.
6. Gibson: *Edin. Med. Journ.*, New Series, Vol. VIII., 1900, p. 1.
7. Cabot: "Physical Diagnosis," London, 1906, p. 266.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The Lecture in next week's number will be by Arthur P. Beddard, M.D. Cantab., F.R.C.P. Lond., Assistant Physician to Guy's Hospital, Physician to the West London Hospital, &c., "On Cough" (delivered at Guy's Hospital).

ORIGINAL PAPERS.

A NOTE ON
ACUTE HERPETIFORM STOMATITIS
AND OTHER FORMS OF
ULCERATIVE STOMATITIS IN
ADULTS.

By F. PARKES WEBER, M.D.,

AND

KARL FURTH, M.D.,

Physicians to the German Hospital, London.

THE clinical group of cases which may be placed under the heading acute herpetic stomatitis, though doubtless recognised in practice by many, is not much considered in the ordinary text-books. Hall and Tilley (1) say: "Occasionally an eruption of vesicles resembling those seen on the skin in cases of herpes is observed on the pharynx. Accompanying the eruption there are shiverings and feverish symptoms. The patients complain of sore throat, and on inspection small vesicles are seen on the palate and fauces; these speedily burst and form round ulcers." J. E. Garretson (2) speaks of "herpetic tonsillitis" and "herpes of the pharynx." F. Kraus (3), in Nothnagel's "System," enters into the subject at rather greater length, and, under the heading "Pseudo-Herpes Buccalis" or "Stomatopharyngitis herpeticiformis," writes: "Acute catarrhal sore throat is rarely (though occasionally in several cases simultaneously) associated with 'herpes of the pharynx' ('angina herpeticus')." Such cases are characterised by the development of crops of vesicles on the tonsils and their neighbourhood. The vesicles last only a short time, being succeeded by pseudo-membranes of small or medium size. The herpetic eruption may likewise appear on the lips and the buccal mucous membrane. Of this affection there is an acute form, a (rare) protracted form, and a recurrent form." Kraus goes on to say that in the acute form the active stage lasts four or five days, and is accompanied by fever, up to about 103° F. The rare protracted form is characterised by repeated relapses accompanied by the appearance of fresh crops of vesicles. In the recurrent form the patient is repeatedly affected at longer or shorter intervals. Thus, he says, some women suffer from a slight herpetic sore throat (angina herpeticus) with nearly every menstrual period.

The following case observed by one of us is a typical example of the acute form:—

E.O., a young German, æt. 17, was spending the Easter holidays in the Isle of Wight, when on April 17th he complained of pain in swallowing and some general malaise. He came up to London and was first examined on the morning of the 19th. He then had a temperature of 103.2° F., and the pulse was 108;

the tongue was very much coated, the gums were red and swollen, the mucous membrane of the pharynx was very red, the left tonsil was considerably swollen and the submaxillary lymphatic glands on the left side were enlarged and very tender on pressure. The patient complained of considerable pain in his throat and mouth, and was quite unable to bite solid food. He was given aspirin, and was treated locally by gargles of chlorate of potassium, peroxide of hydrogen, and borax and glycerine; a wet compress was applied to the neck. On the following day a number of small ulcers could be seen on the underlip, the tonsil, and the soft palate. The ulcers were about the size of a linseed, or a little larger, and had a yellowish white surface with a deep red margin. Small vesicles could be detected at two or three parts of the soft palate. These, however, did not remain long, but in the course of a day presented the same appearance as the above described ulcers. During the next two days some fresh ulcers developed, especially on both edges and the under surface of the tongue, which were extremely painful. The swelling of the gums increased, the mucous membrane presented a whitish grey appearance, and at many places, especially on the projections between the teeth, there were small ulcers, but not surrounded by a red border like those on the lips and palate. There were also some distinct ulcers on the left tonsil. The right tonsil was not affected. The tongue itself was not much swollen. There was constant salivation, at least two pints of saliva being secreted in the 24 hours. On April 21st both lips were much swollen, and the underlip was covered with vesicles which soon broke and began to suppurate. No lymphatic glands except the submaxillary on the left side were enlarged. The temperature kept to about 101° to 102° F., but it should be mentioned that the patient was being treated with aspirin. The whole condition was so painful that he was only just able to swallow milk by the help of a glass tube. After April 23rd there was no fresh eruption, and the condition soon improved. The temperature was normal on April 25th, and after the affected parts were touched several times with a solution of nitrate of silver rapid improvement took place.

The following is another case observed by us:—W.T., a healthy man, æt. 36, began to suffer about December 2nd from sore mouth, enlargement of lymphatic glands under the jaw, and fever (102° to 103° F.). He could not eat, and there was constipation. When he was seen on December 7th there were minute sore spots on the tongue and lips, fœtor *ex ore*, and tender enlarged lymphatic glands under the jaw. The temperature then was 102.2° F. On the evening of December 8th the temperature was only 99.2° F. (the patient had been given some antipyrin), but the sore spots in the mouth were still present. Chlorate of potassium was used in this case. The patient rapidly improved. In this affection the gums seem to recover later than the rest of the mouth.

There appears to be no definite connection with influenza, but some years ago a house-physician at the German Hospital suffered from probably the same form of stomatitis when there was influenza about. As far as we know, no proper bacteriological investigations have yet been carried out. In June, 1898, two brothers came to the Out-patient department at the German Hospital both suffering from herpetic stomatitis. The younger one, æt. 19, had only been affected five days and had enlarged lymphatic glands under the jaw, whilst no glands could be felt in the elder one, æt. 20, in whom the stomatitis had commenced eleven days ago. These two brothers worked as clerks in a building where drainage alterations had recently been carried out. Small epidemics of "ulcerative stomatitis," probably of the same nature, have been described. (4)

Typical cases of acute herpetic stomatitis do not last much longer than a week, and protracted cases, such as those of the second class mentioned by Kraus, must be very rare.

Goodhart (5), speaking of ulcerative stomatitis in the adult, which, he remarks, some would call "herpes of the mouth," says the attacks are recurrent at intervals in certain individuals. Apparently these recurrent cases referred to by Goodhart are similar to those of the third group to which Kraus refers when he says that some women suffer from a slight "angina herpetica" with every menstrual period.

In regard to diagnosis, acute herpetic stomatitis is not likely to be confused with true herpes zoster (unilateral), when the latter (as it only very rarely does) affects the tongue or other parts of the interior of the mouth. True "foot and mouth disease" is probably so rare, if it occurs in man at all in England, that it hardly comes into the question. Squamous pemphigus may occasionally, however, affect the mouth, pharynx, or larynx, whilst the skin is free, or practically free, from eruption. This is usually a very severe affection and its chronicity alone distinguishes it from the cases which we group under the heading "acute herpetic stomatitis."

It is possible, however, as has been suggested, we believe, by Dr. Pringle, that some of the protracted and "recurrent" cases of herpetic stomatitis, and some of the cases classed as "dyspeptic" or "neurotic" ulcers of the mouth may in reality be minor forms of chronic and recurrent pemphigus of the mouth.

In 1903 one of us in an Out-patient department saw a delicate-looking woman, æt. about 43, with probably tuberculous signs at the apex of one lung. She said she was subject to ulcers of the mouth and tongue which were painful when any salt from her food irritated them. She had a small ulcer, smaller than the size of a silver threepence on the inner surface of one lip, which had lasted about 14 days; such ulcers, she said, seldom lasted more than two weeks; sometimes she had two or three in the mouth at the same time. She seemed to think that the ulcers in the mouth bore no definite relation to digestive disturbances, constipation, or the menstrual periods. In May, 1903, one of us had a woman, æt. 29, under his care as a hospital in-patient, who had spat a little blood, probably from the mouth. The history was that in October, 1902, little ulcers began to appear on the buccal mucous membrane and under the tongue. In the hospital, in 1903, the ulcers had a whitish appearance, and some of them were found to commence as blebs and then break. There were generally three or four present in the mouth at the same time, and probably no single one lasted many days; fresh ulcers appeared as the old ones disappeared. Their onset was accompanied by pain and there was occasionally slight evening fever (to about 100° F.). The condition seemed not to be much affected by treatment. There was no suspicion of artificial production.

A. Jacobi (6), of New York, and W. K. Sibley (7) have written interesting articles on "Neurotic Ulcers of the Mouth" ("stomatitis neurotica chronica") and Jacobi in his account collected all the cases he could find recorded. Two of his patients were men (8). Sibley's three patients were all women. Sibley speaks of the persistence of the affection through many years, and considers that the ulcers are the result of a distinct trophoneurosis, mental trouble appearing to be the underlying cause. In his cases no medicinal treatment appeared to give very obvious result, and he regarded removal from home and its accompanying worries as the only curative treatment.

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- (1) *Diseases of the Nose and Throat*. Second Edition, London, 1901; p. 367.
- (2) *A System of Oral Surgery*. Fifth Edition. Philadelphia, 1890, p. 722 and p. 804.
- (3) *Die Erkrankungen der Mundhöhle und der Speiseröhre*, Wien, 1897, Heft 1., S. 164.
- (4) Stanley Melville (West London Med. Chir. Soc., May 3rd, 1901) spoke of 16 cases occurring in his practice accompanied by fever and swelling of sub-max-

illary glands and followed by weakness during convalescence.

(5) *Lancet*, November 25th, 1896.

(6) *Transactions of the Association of American Physicians*, 1894, Vol. 9.

(7) *British Medical Journal*, April 15th, 1899. See also letter by A. Court on a similar case, *British Medical Journal*, May 20th, 1899.

(8) A query in the *British Medical Journal*, May 5th, 1906, referred to a man, æt. about 45, who for about the last two years had suffered from crops of small ulcers on the mucous membrane of the mouth, varying in size from the head of a pin to a splint pea and not found further back than the anterior half of the tongue.

TRAUMATIC INFLAMMATIONS OF THE KNEE-JOINT.

BY ALBERT HOFFA, M.D.,

Geh. Medizinalrat, Professor Extraordinary of Orthopædic Surgery and Director of the Poliklinik für Orthopædies, University of Berlin.

SPECIALLY REPORTED BY OUR BERLIN CORRESPONDENT.

LAST year I drew attention to a very frequent disease of the knee-joint which has a high practical interest. I named the disease from an anatomical standpoint, Fibro hyperplasia of the fatty bodies lying in the plicæ alares below the patella. From the anatomical examination made by my assistant, Dr. Becher, on the material then at hand, I have further described the process that takes place in the sub-patellar fatty bodies and which consists first in cellular infiltration of the sub-intimal tissues, in the formation of young connective tissue cells in perivascular cell collection around the deeply running vessels; and with this villous increase, hyperæmia of the vessels and hæmorrhage into the tissues.

The affection progresses, there is especially increased vascularity, and it becomes visible as the residuum of hæmorrhage that has taken place into the connective tissue enveloping the foreign bodies. I have attributed the process to traumatic causes.

As regards the clinical symptoms of the affection now described, they consist in typical phenomena of incarceration, in attacks of pain and in disturbance of the function of the joint.

As objective symptoms there is, along with a more or less considerable atrophy of the quadriceps muscle, a characteristic swelling on both sides of the ligamentum patellæ, in the tissue lying between this and the patella. This swelling is of firm consistence, shows pseudo-fluctuation, and readily "creaks" on palpation.

Finally I pointed to the good results that had been obtained in such troubles by extirpation of this sub-patellar fatty body.

My work quickly met with confirmation from Lejars, of Paris, and from Gangele, who removed similar fatty bodies from the foot in case of flat foot. Flint also met with similar bodies.

In the course of time our experiences on this question have increased; I have now a considerable series of cases (43) in which I have extirpated the fatty bodies at times along with partial arthrectomies. Regarding the anatomical examination of the material removed, for which I am indebted to my first assistant, Dr. Wollenberg, we shall report more in detail later on, along with our other pathological joint material. Here I will only give a general account of traumatic arthritis, with which are associated the typical feature of connective tissue hyperplasia of the sub-patellar fatty bodies over the course of the disease, its pathological anatomy, its diagnosis and treatment.

Traumatic arthritis arises through subcutaneous injury to the joint; in the slighter cases it does not arise from a single grosser knock, but from a series of smaller ones, of which the patient can have been scarcely conscious. The disease described by me, that has its seat in the sub-patellar fatty bodies, is frequently due to the milder chronic traumata of that

kind, and yet the action of these lesser individual traumatisms mounts up, inasmuch as more swelling or hæmorrhage is left every time, so that every fresh injury makes it worse, through causing increase of tissue.

That form known as distortion, sprain, is to be considered a severer form of traumatic joint disease; here there is a more severe dragging or incarceration of the soft parts of the joint, but without grosser lacerations.

The severest form of trauma is that which leads to laceration of the capsule and ligaments, and, further, to injury to the bony constituents themselves.

All these injuries have this in common, that the affected joint first of all reacts with exudative symptoms; these in slight cases may be insignificant or even not noticeable. In the cases designated as distortions, in which there is not much hæmorrhage, there is in a few days a good deal of severe effusion, and through this, swelling and functional disturbance of the joint. The pains present at the moment of the injury generally disappear quickly, but usually return with the increased swelling.

The severest form of traumatic articular disease, causes rapid and highly marked symptoms, the effusion of blood reaches its maximum in a few hours and the pain is great.

Whilst in the latter cases surgical aid is procured at once, in the slighter ones the patients take care of themselves and even then only a short time. They frequently, however, attempt self-ordered "functional treatment," but in vain, for they add fresh irritations to the diseased joints. Then when the joint gets worse rather than better, all possible methods of treatment are naturally attempted, and then we frequently meet these cases in our consulting room, months or even years after the receipt of the injury.

We will at present devote especial attention to this group, as it forms a large contingent of our joint disease cases, and as even in its advanced stages is accessible to treatment.

We will first describe the anatomical processes in the diseased joints. The effusion that usually disappears rapidly under suitable treatment shows a disposition to return when the joint is used too much. With the least injury a fresh effusion takes place, with all its troublesome symptoms. If such a joint is cut into we find in it a greater or lesser quantity of fluid, poor in mucin, serous in character and yellowish in colour. The synovia is reddened and swollen, especially whenever there are naturally folds in it, therefore especially in the lateral folds, in the folds around the patella and those of the upper recess, particularly also in the villi of the subpatellar and subpatellar fatty tissue.

If we examine the synovial membrane microscopically we find in the recent cases a vascular new growth, especially in the narrow connective tissue zone directly below the intima of the membrane as well as in the newly-formed villi. We find that the normal villi show processes of growth, also where the synovia lies flat, or only slightly wavy we find villous formation. These villous growths are naturally most luxuriant, where the villi are normally most frequent—that is, in the above-mentioned folds of the synovial membrane. The intima is in parts covered by a thin layer of organised fibrine, rich in connective tissue elements, which in later stages takes on a pale violet tinge with Weigert's staining.

We find further in recent cases young connective tissue cells with large white nuclei which, starting in the adventitia of the vessels and following the course of the vessels, complete the substitution of the fat tissue by connective tissue.

The subintimal connective tissue, as well as the synovia itself, is diffusely studded with more or less numerous, mostly mononuclear leucocytes, with small nuclei that stain deeply with nuclear colouring material. Along with these diffuse infiltrations, we find here and there perivascular lymphoma-like

accumulations of these leucocytes, but not nearly so numerous and bulky as we see them in certain forms of "infectious articular inflammations." We have never found fresh hæmorrhages in the last of the preparations examined, but frequently pigment which lay partly intracellularly and partly extracellularly in the inter-spaces of the connective tissue. But we have never seen such copious pigment in these forms of disease as in cases of gonorrhœal arthritis, arthritis deformans, and "rheumatism." If the process advances we find an even more abundant connective tissue mass that has taken the place of the sub-synovial fat. The older this connective tissue becomes the poorer it becomes in nuclei. Its basic substance becomes closer, more homogeneous, more shiny, and shows frequent degenerations (especially mucous and hyaline degenerations). The fatty tissue also has at last participated in the process of proliferation, inasmuch, as in certain groups of cells it has grown into the newly-formed connective tissue; thus it can fill up quite newly-formed (originally) connective tissue villi, whereby they become broader and flatter.

The changes here described are met with, as our latest investigations showed, in the cases that present the appearances of simple fibrous hyperplasia of the sub-patellar fatty tissue, generally not only in these fatty bodies but the whole synovia shows similar changes with only slight differences corresponding to the anatomical differences in the structure of the synovia in the different parts of the cavity of the joint. Our investigations show us, as I remarked in my first publication on the subject, that "the injury may proceed from the interior of the joint, in so far as the fatty tissue (or the synovia) can be drawn into sympathy by a condition of chronic irritation." We find, therefore, exactly similar changes of the synovia in arthritis deformans with free bodies, in internal derangement, &c. In the latter cases, we must look upon the changes of the synovia as secondary and traumatic.

After the anatomical details I now proceed shortly to diagnosis:—

The history of the clinical conditions described places us in a position to fix the diagnosis with tolerable certainty. That mistakes may occur is proved to us by three very interesting cases in which we found tuberculosis of the synovial membrane, one of which was scarcely capable of diagnosis, inasmuch as the anatomical examination brought into evidence that recent miliary tuberculosis had developed on an old chronic arthritis which had led to excessive hyperplasia of the connective tissue. The tubercle nodules were nowhere confluent, and had nowhere become caseous.

Quite recently we have acquired a beautiful means of making our diagnosis more certain in Robinson and Werndorff's Röntgenography, after preliminary insufflation of oxygen into the joint. This process allows a differentiation of the soft parts of the joint never before known. We carry out the insufflation by means of an apparatus devised by Dr. Wollenberg. It is simple and does its work well.

Finally, as regards treatment, I need not go into that of the recent traumatic affections, as with neglected cases of which we are speaking principally their surgical treatment with certain limitations is more rapid and most certain. The procedure made use of by us is a partial arthrectomy. I proceed from the thought that the chief pain and troubles are caused by the rubbing the folds of the synovial membrane with their villi against each other at every movement, and by incarceration of the fatty tissue masses caused by their growth. Our aim is, therefore, mainly to remove these projecting folds and villi. We usually make a longitudinal incision on the inner side of the patella for the reason that the greatest changes in the joint are usually on the median side. We only add an external incision when there are growths outside the patella that cannot be reached from the internal incision. We now extirpate the hypertrophic fatty bodies as well as the villi and folds, paying special

attention to the re-duplication folds of the upper recess, and the folds around the patella, and also to the synovial covering of the condyles of the femur.

The main suture includes the fascia; sometimes when the hæmorrhage is free we place a strip of gauze in the lower angle of the wound, otherwise we close the wound at once. The leg remains from two to four days on a splint. After eight to ten days the sutures are removed and we commence with the after treatment, which consists of massage and passive movement. After twelve to fourteen days the patient gets up. The whole course of treatment generally lasts from six to eight weeks.

When I first spoke of a limitation of the indications, I had in mind chiefly the physical condition of the patient. Strong, energetic people, who wish to get well, may be promised a speedy recovery, but it is different with weakly individuals without energy, and with those whose minds are under the influence of adverse circumstances.

In such cases we first try a lengthened course, with the usual mechanical curative means. This is principally in the direction of strengthening the power of the quadriceps muscle. It is only when these measures fail that operation comes into question.

Operation removes the troubles with almost absolute certainty, and may be unconditionally described as the simplest and safest method. Out of my forty-three cases operated on, in only one, and that a highly nervous woman, did any loss of power of movement remain, and in a second in which complete ankylosis of the joint had taken place. The result in the latter case is due to faulty operation. To be safe, I allowed myself to be led astray into dusting the joint with iodoform powder after a perfectly aseptic operation, easily performed. Excessive swelling with great pain came on at once, which prevented mobilisation of the joint. Later on, outward *brisement* was done, but without result. This is the only case in which any wound complication has arisen, and it was certainly due to the insufflation of the iodoform into the joint. All the other cases went on smoothly, and the patients got rid of their troubles.

OPERATING THEATRES.

NORTH WEST LONDON HOSPITAL.

ANEURYSM OF THE INTERNAL SAPHENOUS VEIN.—MR. MAYO COLLIER operated on a young woman, æt. 20, who had been admitted into hospital suffering from a swelling on the inner side of the right knee joint. The patient was a strong, healthy girl, who up to this time had enjoyed the best of health. Her occupation was that of a housemaid, and her duties as such had not been particularly arduous. There was no history of injury. The present swelling on the inner aspect of the knee joint had existed some time, but until recently had not caused any pain or discomfort. The skin over the swelling was quite normal and was not adherent. On pressure the tumour could be made to disappear, only to return immediately the fingers were withdrawn. A distinct thrill could be heard with the stethoscope, but pressure below the swelling would annul this sound. It was evident that the tumour was connected with the internal saphenous vein and was not a hernial protrusion from the joint. Mr. Collier made a longitudinal incision over the site of the tumour, and a fair thickness of superficial fascia having been divided a large aneurysm-like swelling was found attached to the outer aspect of the internal saphenous vein. The swelling was about the size and shape of a bantam's egg; the vein above and below was not particularly thickened but appeared larger in calibre than would have been expected. The dilatation itself was not thin walled, and it appeared of much the same thickness and consistence as the vessel. It was easily dissected out

from its surroundings, it was not adherent to the skin or to the capsule of the joint. A ligature was passed round the vein above and below and the tumour removed. Mr. Collier said this would have been a most perfect example of an aneurysm had it occurred in an artery, and he was not aware that a similar dilatation of all the coats of a vein had been recorded. He could offer no satisfactory explanation of the condition found. It should, he said, be noted that the dilatation differed entirely from the ordinary bulgings found on varicose veins, in so far as the tumour was attached to one side only of the saphenous vein and did not involve the whole circumference of the vessel.

WESTERN OPHTHALMIC HOSPITAL.

EXCISION OF LACHRYMAL SAC.—MR. G. W. THOMPSON operated on a woman, æt. 45, who had been admitted for long-standing obstruction of the nasal duct with dilatation of the lachrymal sac. After all aseptic precautions had been taken, Mr. Thompson, before beginning, said this operation was best done in adults without a general anæsthetic, by a subcutaneous injection of a mixture of 4 per cent. cocaine with adrenaline chloride, 1 in 4,000, equal parts, one injection generally sufficing. A vertical incision was made over the sac, cutting through the muscular fibres of the orbicularis, the muscles not being atrophied; a Müller's speculum, was then introduced in order to keep open the skin wound. (In the absence of this instrument, Mr. Thompson stated that a skin suture on either side, weighted, would serve the same purpose). Then a slight vertical incision was carried along the junction of the lachrymal and nasal bones through the connective tissue, so as to separate the sac from the lachrymal bone; a kind of dissector was now employed to separate the inner wall of the sac from the lachrymal bone, the separation reaching the commencement of the nasal duct downwards and upwards as far as possible. The next procedure was to separate the outer wall of the sac from the surrounding tissues with the same instrument, the separation being continued until it met the division on the inner side, thus completing the circle. A tenotomy hook was used to further complete the separation downwards and upwards. There was always considerable difficulty experienced, Mr. Thompson said, in dislodging the upper part or head of the sac from its connections with the lachrymal bone and the internal tarsal ligament, but a little careful manipulation with the curette and dissector (which should always occupy a few minutes, lest a portion of the sac be torn through or left behind) was generally sufficient (there was no need to divide the internal tarsal ligament). The next step was to seize the sac with a pair of dissecting forceps, pull it downwards and forwards, and proceed to cut, by means of a pair of straight narrow scissors, its connection with the membranous portion of the nasal duct. The aim in snipping it, Mr. Thompson pointed out, was to get a long way down the bony nasal canal in order to get rid of as much of the diseased tissue as possible. This manœuvre, being over the wound was sewn up and a firm bandage, with elastic pressure to be kept on for a couple of days, was applied; this was to prevent exudation into the space left by the removal of the sac. Mr. Thompson thought in adults local anæsthesia was advisable in preference to general because there was less bleeding, and free access was possible as no mask was over the patient's face; besides, all possible disadvantages of a general anæsthetic were obviated. He said it was a long way preferable not to open the sac, nor was it necessary to introduce a probe into the canaliculus to serve as a director. The operation, he said,

was quickly done, and saved the patient the risk of a serious affection of the eye at any time of his or her life. Again, syringing and repeated probings were thus spared, and that meant a great deal of time saved to the patient, besides the possibility of the latter not succeeding in curing the condition. With regard

to the question of tears, they continued to overflow for three to six months and then they usually stopped permanently, but in about 1 in 15 cases of excision of the sac the overflow of tears down the cheek continued; under such circumstances it would become necessary to excise a portion of the lachrymal gland itself.

TRANSACTIONS OF SOCIETIES.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, MAY 25TH, 1906.

The President, Mr. CLUTTON, in the Chair.

AFTER the general business of the annual meeting had been concluded,

Dr. FRANCIS HAWKINS (Reading) read an account of a case of

THROMBOSIS OF THE ABDOMINAL AORTA, in a female, *æt.* 56. She was first seen in 1900, when she complained of pains in the head, giddiness with a feeling of pitching forward, and reeling when walking. She was not seen again till May, 1904. Four months previously (Jan. 1904) while standing at work she suddenly felt cramp-like pains in her right leg, and subsequently similar pains in her left leg. Later she found her legs gradually become weaker. When seen, she complained of a numb feeling in her legs, which were extremely sensitive to touch; deep pressure produced great pain, especially so in the calf of the leg. Knee jerks were present. The skin of legs was of normal colour. On June 4th, quite suddenly, the legs became very numb, cold, and white. The lips became blue, hands cold, and pulse at wrist very feeble. No femoral pulse could be felt. An hour later there was severe abdominal pain with vomiting and subsequently great abdominal distension, and the patient died. At the autopsy mitral stenosis was found. The femoral and iliac arteries were quite occluded with blood clot, and a blood clot was found in the abdominal aorta, extending up above the superior mesenteric artery. At the bifurcation of the aorta on the posterior wall a calcareous plate was seen. There was an old infarct in the right kidney and several recent ones in both kidneys. Dr. Hawkins commented upon the causation of the condition.

Dr. FAWCETT showed three specimens of thrombosis of the aorta.

Mr. WARRINGTON HAWARD referred to the rarity of thrombosis of the aorta compared with atheroma there, and suggested that there was in this case some blood alteration.

Mr. A. E. BAKER narrated the case of a woman with heart disease who woke up with great pain in the legs. Pulsation was absent in both femorals, but returned on the right side forty-eight hours later, when gangrene began in the left foot. The left leg was amputated and the vessels found normal. From the suddenness of the onset he concluded that embolism had occurred.

Dr. A. E. GARROD remembered a charwoman being admitted into St. Bartholomew's with numbness of the feet. There was no abdominal pain, as in Dr. Hawkins' case. After death, the clot was found to extend only an inch above the bifurcation.

Dr. CHARLES R. BOX communicated a series of cases in which Pulmonary Embolism was due to the Displacement of a Thrombus in the main trunk of the pulmonary artery. In each instance there was reason to believe that pulmonary thrombosis had first occurred, and was later followed by displacement of the clot with the development of the symptoms of pulmonary embolism. The series included cases of cellulitis of the leg, severe burns, typhoid fever, diabetes mellitus, malignant disease of abdomen and operations for the radical cure

of hernia. Stress was laid upon the importance of recognising the premonitory signs of the condition, which were the development of a murmur at the base of the heart, acceleration of the pulse and moderate cyanosis with dyspnoea. It was pointed out that death might be practically instantaneous, with pallor, or delayed, with cyanosis and asphyxia. Infarction of the lung was exceptional. The prophylaxis and treatment of the condition was briefly summarised, and the possible danger of artificial respiration in further dislodging the clot was mentioned.

Mr. W. C. SPENCER did not think that absence of clot in the peripheral proved that the clot had formed in the pulmonary vessels.

Dr. H. H. TOOTH mentioned several cases in which a coiled up clot had been found. In one case it appeared to be a cast of the inferior vena cava.

Dr. A. E. RUSSELL asked for suggestions as regards treatment.

Surg.-Gen. LONGHURST suggested the use of ammonia.

Mr. CLUTTON and Mr. MAKINS both related cases in which the clot had come from veins.

Dr. C. R. BOX, in reply, said that the presence of a mould of the pulmonary valves on the clot seemed to prove that it had formed at that situation.

Dr. F. PARKES WEBER read a short paper on a case of ACUTE DILATATION (ACUTE ATONY) OF THE STOMACH AND INTESTINES CONNECTED WITH PNEUMONIA AND PLEURO-PERICARDITIS.

Patient was a debilitated and delicate-looking young woman, *æt.* 21. She was admitted to the hospital on about the third day of an attack of pleuro pneumonia. Since the illness (diphtheria?) six weeks previously she had developed a tendency to belch up wind. Just before admission she had been able to eat nothing, but after admission she took a good deal of food and at the same time lost the power of bringing up wind; this probably marked the commencement of the gastrointestinal muscular atony and the acute distension followed. Great relief resulted from lavage of the stomach, but the meteorism did not immediately subside, showing that the intestines as well as the stomach were involved. Afterwards for some time there was pericardial friction to be heard, but the progress of the case was ultimately satisfactory. Three out of the forty-four cases of acute dilatation of the stomach collected by Campbell Thomson were connected with pleurisy and pneumonia. The present cases ought perhaps rather to be termed "acute tonic gastro-intestinal tympanites." Dr. Weber alluded to the analogy between "acute dilatation of the stomach," "ballooning of the rectum," "paralysis of the non-gravid uterus," and "acute atony of the urinary bladder during operations," all of these conditions being temporary states of atony in hollow muscular viscera. Exact studies on the innervation have already helped to elucidate some of them.

Dr. FAWCETT considered that "paralytic" was a better term in this connection than "atonic."

Dr. C. R. BOX suggested that acute dilatation might possibly be due to obstruction, say in the duodenum.

Dr. NORMAN DALTON mentioned a case in which influenza was followed first by gastrectasis and later by enterectasis. He thought the condition was toxæmic and not obstructive.

ROYAL ACADEMY OF MEDICINE IN IRELAND

SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, MAY 4TH, 1906.

The President, JOSEPH O'CARROLL, M.D., F.R.C.P.I.,
in the Chair.

EXHIBITS.

Dr. F. C. PURSER exhibited organs from a case of cancer of head of pancreas. He said the patient, a man, *æt.* 57, complained of pain in the abdomen, especially in the region of the umbilicus. He gave a history of syphilis, jaundice, and great emaciation. The clinical notes revealed that the heart was normal as regarded the position of the apex beat. No murmur was heard. Patient developed sensory aphasia and hemiplegia of the right side, due to an embolus lodged in the cortical branches of the middle cerebral artery, and died on April 2nd. A large thrombus was found in the left ventricle, and well-marked vegetations on the aortic valves. Cocci were discernible in sections of the thrombi under the microscope. Thrombi formation in the heart was well known in cases of cancer; and it was not yet settled whether such a condition was due to organisms or to slow circulation. A hæmorrhagic infarct was found in the spleen and secondary growths in the liver.

Dr. O'CARROLL said fat necrosis was a common occurrence in pancreatic disease.

Prof. MCWEENEY inquired were there any thrombi on the right side of the heart.

Dr. PURSER, in reply, said that no thrombi were found on the right side of the heart. In preparations of the thrombi from the left ventricle he saw what looked like staphylococci.

UNUSUAL DEGENERATION OF THE LIVER.

Prof. O'SULLIVAN said the patient from whom the liver was taken was a middle-aged man who had had two attacks of jaundice. He was under the care of Dr. Walter Smith and Sir Charles Ball. The latter operated and found the common bile duct and gall-bladder perfectly empty. There was no evidence of obstruction or of bile to be seen anywhere. The liver weighed 4 lbs. 5 ozs., was larger than normal, of a greenish-yellow colour, and the capsule was smooth. On section it showed greenish-yellow areas, separated by lines of red material. Microscopic examination showed that the centre of the lobule was degenerated, and a zone of comparatively healthy liver cells was to be seen towards the periphery. The degenerated cells in the centre showed an almost entire absence of protoplasm, and their nuclei were shrunken and deformed. A great many cells were filled with granules of bile pigment, and the bile capillaries were filled with plugs of inspissated bile. There was no inflammation of the smaller bile ducts, and no sign of increased connective tissue formation. The cells were separated from each other and had lost their columnar arrangement. No bacteria were found. In ordinary fatty liver the fatty change was at the periphery of the lobules. It seemed possible, in cases where the bile capillaries were plugged, that the degeneration of the liver cells might be due to poisoning by the bile acids produced by the cells themselves.

Prof. MCWEENEY said the outer cells of the lobules also looked degenerate. They did not give a very good nuclear stain. He would like to have seen the appearance of the lobules in preparations stained for fibrin and fat.

Dr. FINNY said he saw this man in consultation the day before he died. There was no evidence of phosphorus poisoning.

Prof. WHITE said he saw a case three or four years ago which, in a certain manner, resembled the one under discussion. The patient died of sub-acute yellow atrophy. The liver showed red and yellow patches. In the red patches there was no formed connective tissue, but a small amount of granulation tissue. He

did not see why this liver should not be classed with "yellow atrophy"—a condition which, in less severe forms, he thought was more common than was generally supposed. The absence of a large amount of fat in sections stained with osmic acid or Soudan iii. would not prove that the liver cells had not undergone complete fatty degeneration, as the fatty products are quickly enough removed.

Dr. O'CARROLL spoke of the tendency to consider the liver at fault when anything went wrong, and no other organ could be made out to be affected.

Prof. O'SULLIVAN, in reply, said the osmic acid sections which he had made had partly failed owing to imperfect penetration of the osmic acid; but even in the imperfect sections obtained the presence of fat was quite discernible. The experiments of Rosenfeld seemed to show that even in toxic degenerations the fat found in the liver cells was mainly deposited from the blood.

ASPERGILLUS FUMIGATUS IN EYE.

Dr. H. C. MOONEY exhibited specimen with culture of *aspergillus fumigatus* in the eye, caused by an oak husk sticking on cornea of an agricultural labourer. After cautery was applied, the patient got well. Only sixteen or seventeen cases of the kind have been recorded, two of which occurred in the United Kingdom.

Prof. MCWEENEY said he had seen *aspergillus fumigatus* occurring in the auditory meatus.

Dr. H. C. MOONEY exhibited and showed sections of non-pigmented flat sarcoma of the chorioid.

PRIESTLEY SMITH'S NEW METHOD OF PRESERVING EYES FOR MUSEUM PURPOSES.

Dr. H. C. MOONEY described the method and demonstrated its advantage over the older gelatine and gelatine and formalin methods.

BACTERIAL ASSOCIATION IN A CASE OF SPREADING EMPHYSEMATOUS GANGRENE.

Prof. MCWEENEY stated that the patient was a youth, *æt.* 18, admitted under the care of Mr. McArdle to St. Vincent's Hospital, suffering from compound fracture of the right humerus, the result of a hunting accident. He was unconscious, and within four hours of the accident the temperature rose to 108°, evidently from shock to the medulla. Despite careful cleansing and replacement of the bones the arm became swollen and glazed after twenty-four hours, sero-sanguineous discharge came on, which became fetid, the limb became dark and brawny, and emphysema occurred round the shoulder-joint. Owing to the brain condition, amputation was out of the question. Free opening of the cellular spaces of the arm gave issue to the fluid, which was examined. The side of the chest and neck became emphysematous, and death occurred in four days after receipt of the injury. Bacteriological examination by anaerobic agar-plates in a Bulloch's apparatus yielded three organisms. One was a streptococcus, one a bacillus resembling *B. coli*, and the third was *Bacillus aragenes capsulatus* of Welch and Nuttall. This proved to be a large, anthrax-like, motionless rod with rounded ends, staining well with Gram; spore-formation not observed though it must have been present on the bacilli Gram from portion of exudate that had been heated to 80° C. for ten minutes. They formed flocculent whitish colonies in gelatine and agar. The former crustations were not liquefied but only softened. Much gas formation. A rabbit injected intravenously with 1 cc. of the broth culture and then killed, and the body kept warm overnight, showed enormous distension of the solid viscera with gas bubbles ("foaming" organs). He now showed some of these organs [demonstration]. Curiously, he had failed to induce the bacillus to grow on Löffler's serum or in blood outside the body. The gas had a slight odour of rancid butter. The coli-like bacillus could not ferment any sugar, and was an alkali-former—in fact, the only feature in which it resembled *B. coli* was its colonies on gelatine. It was a very short non-motile rod, often resembling an oval diplococcus. If intra-peritoneally inoculated it produced purulent peritonitis in a rabbit, which, however,

recovered. The streptococcus grew abundantly on gelatine, made broth diffusely turbid, and was non-pathogenic for rabbits by itself, but injected along with the coli-like bacillus it killed them. Cultures and microscopic preparations of all three organisms were demonstrated.

Prof. McWEENEY exhibited two brain tumours—one being an angio-sarcoma (perithelioma) of the right *centrum ovale*, the other an encapsuled sarcoma of the pons.

Prof. McWEENEY showed blood films of leukæmia due to large mononuclear leucocytes.

CENTRAL MIDWIVES BOARD.

MEETING HELD MAY 24TH.

The President, Dr. CHAMPNEYS, in the Chair.

MIDWIVES AND THE DUBLIN MATERNITY HOSPITALS

At the beginning of the meeting a letter was read from the Clerk of the Council enclosing copy of a resolution passed by the Board of the National Maternity Hospital, Dublin, in favour of Examinations in Dublin, and one to the same effect from the Rotunda Hospital.

The CHAIRMAN remarked that this had been sprung upon them rather suddenly, and as he did not want to be too abrupt and say they could not do it, he thought it would be better to return an answer that the resolution passed on May 10th would be put into effect as soon as Ireland was within the Act, and a small committee would be called on to consult on the matter.

Sir WM. SINCLAIR said they would be giving Ireland all the advantages and none of the drawbacks. He thought a careful answer should be drawn up and presented to the Lord President, and this resolution was passed unanimously.

The SECRETARY then stated that the Whitechape Guardians had inquired as to the requirements of the Board in order to render the Maternity Ward fit for a training college, to which answer was returned to Sir Shirley Murphy asking if Dr. Wankley could see his way to suggesting the necessary structural alterations and to report thereon to the Board. A letter was read from Dr. Wheatley, County Medical Officer for Shropshire, asking whether midwives who have notified the Local Supervising Authority that they intend only to practise as monthly nurses are subject to obligations imposed by the Rules. Answer was returned that they would no longer be under inspection, have to keep a register, or carry appliances.

MIDWIVES ACTING UNDER DOCTORS.

The question next under discussion referred to the necessity for a midwife acting under a doctor to report a case.

Miss PAGET thought the doctor was responsible.

Dr. PARKER YOUNG said that when women were treating cases on their own responsibility they were responsible until a doctor was called in, when the responsibility devolved on him.

Mr. WARD COUSINS considered the midwife responsible in her double functions of midwife and nurse.

Dr. PARKER YOUNG and Dr. DAKIN said they would not care to employ a woman who had to report all details of the case to the Local Supervising Authority, and it was ultimately agreed that the nurse's public responsibility ceased when the doctor was called in.

With regard to the matter of journey expenses for Examiners, raised at a previous meeting, the following extra fees were fixed:—

Cardiff to Bristol and back	£2 2
Birmingham " " " "	4 4
Liverpool to Manchester and back ..	2 2
Leeds to Newcastle and back	5 5

APPLICATIONS FROM POOR LAW INSTITUTIONS.

After the reading of the memorandum concerning Poor Law Institutions and their efficiency as training schools,

Sir WM. SINCLAIR said he objected to every clause in it. It was not true that an Institution, if allowed

to train, obtained a better class of probationers. He had had 25 years' experience and found the workhouse midwife inhumane and rough; moreover the teachers were often inexperienced, and there was no reason why women should not come up to the larger schools. A slur also had been cast on local inspectors. He had always found them faithful, and they certainly could have no object in stating an untruth.

Miss PAGET (also speaking from experience) replied she had found workhouse midwives quite equal to others, and at the Queen Victoria they were preferred, being most kind and capable.

Miss WILSON agreed, saying there were 800 workhouses and infirmaries, whose nurses had been a great boon to the community.

Sir WM. SINCLAIR answered that he had no doubt they were respectable, but if questioned it was a very different story, as they showed great ignorance.

Miss PAGET added that the women could not come to London to be taught as there were not sufficient schools; and this the Chairman confirmed, remarking that the London took a few, but not many, and those in the other hospitals were chiefly for the benefit of students.

The meeting then considered the report of the Penal Committee, and the PRESIDENT announced that new offices had been taken in Caxton House, Westminster.

GENERAL MEDICAL COUNCIL.

FIRST DAY.—TUESDAY, MAY 22nd, 1906.

DR. MACALISTER, President, in the Chair.

THE official notification of the election of Leonard Kidd, Esq., M.D., as Direct Representative for Ireland reported to the President as returning officer on February 16th, 1906, was read.

Dr. Kidd was introduced by Dr. Little.

The PRESIDENT delivered the following address:—

GENTLEMEN,—One change only has occurred in our membership since the last session, though I understand that other changes are imminent. Sir William Thomson, who for ten years had filled an honoured place in the Council as a Direct Representative for Ireland, ceased to hold office on February 28th. An election was accordingly held, in pursuance of the Medical Act, 1886, and under the regulations made by the Privy Council, during the month of January. The candidates nominated were Sir William Thomson and Dr. Leonard Kidd, of Enniskillen. As the result of the first scrutiny of the votes, the Branch Council for Ireland found that the number of voting papers whose validity was regarded as doubtful exceeded the difference between the numbers of apparently valid votes recorded for the two candidates respectively. The Branch Council was thus unable, without further inquiry, to certify to me as returning officer the result of the election. In the circumstances, I thought it proper to suggest that a recount should be made, with the aid, if necessary, of a legal assessor. The suggestion was adopted, and in the end Dr. Leonard Kidd was certified to be duly elected. In your name I bid him welcome to the Council, as the representative of the registered Medical Practitioners of Ireland. But we cannot part with Sir William Thomson without expressing our appreciation of the valuable service which since 1896 he has rendered to the Council, to the profession, and to the State. His courtesy, his independence of view, his impressive speech, and his zeal for the interests of his professional brethren in Ireland will long be remembered by all with whom he was here associated. I am glad to have his assurance that he has recovered from the illness which disabled him during the election, and that his experience of the fortunes of war, acquired in other and sterner fields, now stands him in good stead. In November I called your attention to the probability that some of the Canadian Provinces might, in pursuance of the amending Medical Act of 1905, make application for the extension to them of the privileges

of medical reciprocity with the United Kingdom. The first to seek admission is the Province of Nova Scotia. His Majesty the King has been satisfied that the provincial laws afford an equitable basis for the grant of reciprocal privileges, and accordingly on May 11th an Order in Council was made applying Part II. of the Medical Act, 1886, to that part of the Dominion of Canada. I have already forwarded a request, through the Secretary of State for the Colonies, for particulars of the conditions, as to study and examinations, under which medical diplomas are granted in Nova Scotia. These particulars will in due course be laid before you, in order that you may satisfy yourselves regarding the sufficiency of the qualifications and give directions for their registration in the Colonial List. In my own opinion it is highly desirable, in the interest of the Dominion itself, no less than in that of the Empire at large, that closer professional relations should be established between the mother-country and her daughter-states beyond the seas. From recent minutes of the Executive Committee it will be seen that legislation for the better control of medical practice, and for the effective recognition of our own registrable qualifications, is making constant advances in the several Crown Colonies of the Empire. It will, I am sure, be welcome to the Council should the rest of the Canadian Provinces see fit to follow the example of Nova Scotia, and so enable us to unite all the self-governing Colonies with ourselves in one bond of mutual recognition and mutual privilege. I have accepted an official invitation to visit Canada during the summer, and I hope to have the opportunity of conferring on the question of medical reciprocity with some of the authorities there who desire further explanations of its scope and purport. It will be gratifying if the result is to accelerate the movement which, by the action of the maritime Province, has now auspiciously begun. By an Order of His Majesty in Council, dated December 11th, the Medical Act of 1886 was applied to the Empire of Japan. Full details respecting the prolonged course of preparatory and professional study and examinations required for the medical degrees of the Imperial University have now been obtained through the Foreign Office. I have prepared for the use of the Executive Committee and of the Council a memorandum on the subject, in which these details are set forth. You will probably be of opinion that the conditions for University graduation in Japan are amply sufficient to guarantee the efficiency of its bachelors and doctors of medicine. Complete information regarding the other avenues to medical qualification in that country is not yet to hand; but so far as our information goes, it shows that our Japanese Allies have provided wisely and fully for the education of their practitioners in the science and art of Western medicine. Let me add that it also does much to explain the unparalleled efficiency and success of their military medical service in the recent war. It is not too much to say that the surgeons and sanitary officers of the Japanese forces have proved themselves capable of teaching many wholesome practical lessons to the nations of the West.

You will permit me to mention, before leaving the subject of international relations, a recent personal experience of my own. Last month I was invited, as your President, and as deputy for the Vice-Chancellor of the University of Cambridge, to be present in Rome at the ceremonial opening of the magnificent group of clinical schools and laboratories known as the *Polichinico* and at the festival then held in honour of Professor Guido Baccelli, its founder and director. Having been also accredited by the Lord President of the Privy Council, I was received as the representative of this country, and with other foreign delegates had the honour of delivering in the Capitol, before his Majesty King Victor Emmanuel and his Ministers, an address of congratulation to Professor Baccelli and to the University of Rome. As the Council is aware, Italy alone of European nations has entered into an agreement of reciprocity with us, in respect of medical registration. His Majesty was pleased to note the fact with satisfaction

and graciously offered me a special welcome on that account. During the subsequent proceedings, the close professional relations between Italy and the United Kingdom were frequently referred to, and always with cordial expressions of goodwill. It was impossible to resist the impression that the council, by recognising for registration the medical degrees of the Italian Universities, had made an important contribution to the traditional comity existing between the two nations. In September next the University of Aberdeen celebrates its four-hundredth anniversary, and I have been favoured, as President of the Council, with an invitation to take part in the ceremonies. On the occasion of the four-hundred-and-fiftieth anniversary of the University of Glasgow, the Council forwarded its congratulations and good wishes to that University (Minutes, 1901, p. 210). Should this precedent be followed, I shall be glad to receive your instructions for the preparation and presentation of a suitable address to the ancient University of Aberdeen. The Lord President has forwarded for our consideration a petition for a charter of incorporation, submitted to the Privy Council by the British Optical Association, and a copy of a Bill, entitled "The Sight-Testing Opticians Bill," now before the House of Lords. Both documents propose that powers and privileges shall be conferred on certain persons, who are not qualified medical practitioners, in relation to the diagnosis and treatment of ocular defects. As the proposals touch closely the practice of ophthalmic medicine and surgery they will doubtless receive your careful scrutiny. At my request, a confidential memorandum has been prepared on the subject as an aid to your consideration; you will probably find it a useful summary of the facts which have to be kept in mind. The Privy Council has also sent to the Council, for this purpose represented by the English branch, a draft of the revised Rules framed by the Midwives Board. Many important modifications have been made in the Rules, as the result of the experience gained by the Board since 1903. Under the Midwives Act 1902, the branch council is entitled to make representations on the revised text, and these must be considered by the Privy Council before the rules are approved as valid. A draft of the Supplemental Charter which is being sought from His Majesty in Council by the University of Wales was before the Executive Committee in February. The Charter, if granted, will empower that University to establish a Faculty of Medicine and Surgery, and to grant degrees and diplomas in the faculty. I have ascertained that the intention of the University authorities is to require that candidates for medical degrees shall have studied in one of the colleges of the University as matriculated students for not less than three years of the whole medical course, and that they shall have graduated in arts or science before graduating in medicine or surgery. The Executive Committee were of opinion that no objection should be raised to the grant of the Charter, but pointed out that the degrees conferred in virtue of its powers would not be registrable qualifications, in the absence of an Act of Parliament amending the Medical Acts in that sense. If precedents are followed such an Act will contain a clause empowering the University of Wales to appoint an additional member of this Council. The addition will bring our number up to thirty-five. As the Council chamber is even now inconveniently crowded its extension becomes an urgent necessity. The office site committee, acting on the powers entrusted to it, has completed an arrangement whereby the council may at once resume possession of the reserved portion of our Hanover Square site. In view of the commencement of building operations there the committee has thought it opportune to obtain plans and estimates for the enlargement during the summer of our present chamber. These the committee will submit to you during the session. We may therefore hope that in November we shall be able to meet in greater comfort and convenience than is now possible. Fortunately the expense of the improvement, which I think is inevitable, will fall upon us at a time when we

can bear it without difficulty. The accounts of the past year are already in your possession, and I am happy to say that for the first time since 1895 they show a surplus of income over expenditure. The amount of the surplus is £907; it is due partly to an increase of income, but in greater part to a decrease of expenditure due to the expedition with which the Council carried through the business of its two sessions in 1905. Owing to the election of direct representatives in the current year an exceptional charge of considerable amount will have to be met by the branch councils, and it is therefore incumbent on us to persevere in our course of economy in so far as it is compatible with the full and efficient discharge of our statutory duties. One method by which our sittings may be kept within convenient limits has been in active operation during the present year. I refer to the careful preliminary consideration by the standing and special committees of important subjects remitted to them. Digests, memoranda, and draft reports have been prepared and circulated in good time to members, who have thus had the opportunity of coming to a conclusion on the questions raised, and of offering reasoned recommendations to the Council concerning them. To the Chairmen of committees and to the Council's officials our grateful acknowledgments are due for much preparatory work of this kind. Reports by the education and examination committees, and by the practical midwifery committees have been drawn up on this plan and will be submitted to you at the present meeting. It would, in my opinion, conduce to the value of our discussions in full Council were they in most cases confined to question of principle, on which, of course, the decision of the Council must be clear and authoritative; questions of detail might then be left to the Committees to work out at leisure. Power to deal with details has already been given to the Pharmacopœia, Education, and Students' Registration Committees, and in view of the great increase in the size of the Council within recent years, it is worth considering whether the practice might not with advantage be extended. It would also facilitate the arrangements of the Committee meetings if, so far as is practicable, the membership of each standing committee were independent of the others. I commend the suggestion to the Branch councils, with whom rests the duty of nominating standing committees. The Executive Committee also will present reports on certain points affecting your standing orders. Regarding the practice and constitution of the Penal Cases Committee, Dr. Finlay has given notice of an important motion. If I am in order in alluding to the subject from the Chair, I would say that in my opinion the full committee of nine, with the solicitor and legal assessor, who are always present, is unnecessarily large for the purpose in view. As a matter of practical experience the statutory dental committee of five, with the same legal assistance, is found to be sufficient and efficient, though it has to act not only as a committee of advice with reference to penal cases, but also as a court of first instance for ascertaining the facts. I see no disadvantage, and some substantial advantage, in reducing the Penal Cases Committee to five members, two from England, one from Scotland, and one from Ireland, with the President. If this were done the objection felt by your legal advisers and by the Executive Committee to the mere rescission of Chapter IX., 5 (ii.) of the Standing Orders would be removed; and our practice under the Medical Acts would be assimilated to our practice under the Dentists Act. Under instructions from the Companies Bill Committee I have had prepared two drafts, one of a "Prohibition of Medical Practice by Companies Bill," the other of a "Dental Companies (Restriction of Practice) Bill." In their preparation I have had the active co-operation of your legal advisers, and the friendly help of Mr. Muir Mackenzie. Sir John Batty Tuke and other members of Parliament, in both Houses, have also afforded me the advantage of their practical experience and counsel as to the best method of presenting the Bills to Parliament. It will be enough here to say that the Bills are now ready, and that there is reason

to hope that they may be introduced during the present Session. Some of the disciplinary cases with which you will have to deal, and which present certain features of novelty in detail, will serve to bring home to the members of the Council the gravity of the situation arising from the unrestricted exercise of the skilled professions by joint-stock companies. The Council, within the sphere of its jurisdiction, can do something, the ordinary law of conspiracy or of fraud can do something more to place obstacles in the way of flagrant abuse of the Companies Acts. But, as our experience accumulates, it becomes ever plainer that a change in the law is the only means whereby the public interest can be effectively safeguarded against the ingenious evasions that are possible under the existing law of corporate irresponsibility.

Moved by Dr. LITTLE, seconded by Dr. NORMAN MOORE and carried by acclamation: That the President be thanked for his address and requested to let it be printed in the Minutes.

Moved by Dr. NORMAN MOORE, seconded by Dr. BRUCE, and agreed to: That the Council do adjourn at 4 p.m. to enable certain committees to meet for the completion of their Reports.

Moved by Dr. NORMAN MOORE, seconded by Sir PATRICK HERON WATSON, and agreed to: That eight yearly tables showing the results of professional examinations for 1905 be received and entered on the Minutes.

Moved by Sir PATRICK HERON WATSON, seconded by Dr. McVAIL and agreed to: That the thanks of the Council be conveyed to the Director-General of the Medical Department of the Royal Navy, the Director-General of the Army Medical Service, and the Under Secretary of State for India respectively for the returns which they have again furnished to the Council, with the request that these returns may in the future continue to be furnished to the General Medical Council.

Moved by Dr. NORMAN MOORE, seconded by Mr. THOMSON, and agreed to: That the Report from the Executive Committee on the Dental business transacted since the last meeting of the Council be received and entered on the Minutes. The report referred to—

1. The names of the following persons, the prescribed conditions having been duly fulfilled in each case, are restored to the Dentists' Register—G. M. Brown, Samuel Halliday, George F. Hare, William Lait, William Taylor, Vivian E. Turner.

2. The intention of Sir John Batty Tuke to reintroduce in the House of Commons the two Bills relating to the practice of Medicine and Dentistry by limited liability companies.

3. Copy of a despatch from the Governor of Hong-Kong enclosing the draft of an ordinance to regulate the qualifications and to provide for the registration of Dentists in the Colony.

Moved by Dr. NORMAN MOORE, seconded by Dr. BRUCE and agreed to: The Report of the Executive Committee: That in virtue of the authority conferred on the Executive Committee of the G.M.C. the Committee now instruct the Registrars to accept for registration as an additional qualification the degree of B.Sc. in public health of the University of Glasgow.

Moved by Dr. NORMAN MOORE, seconded by Sir THOMAS MYLES, and agreed to: That the Report received from the Council's solicitor with reference to the Standing Orders with regard to the summoning of the Penal Cases Committee, be received, entered on the minutes and approved. The opinion negated any alteration being made in the summoning of the Penal Cases Committee.

Moved by Dr. FINLAY, seconded by Sir V. HORSLEY and agreed to:—

1. That the Clause in Standing Orders—"The President shall be empowered not to summon the Scottish or the Irish members of the Committee, as the case may be, unless any complaint forwarded from Scotland or from Ireland has been presented for consideration be rescinded."

2. That the number of the members of the Penal Cases Committee be reduced from 8 to 4.

3. That the Penal Cases Committee consist of two members from England, one from Scotland, and one for Ireland.

Moved by Dr. NORMAN MOORE, seconded by Dr. Finlay and agreed to: That it be remitted to the Executive Committee to amend the Standing Orders in accordance with the foregoing resolutions.

Moved by Sir JOHN WILLIAM MOORE, seconded by Sir V. HORSLEY, and agreed to: That the quorum of the Penal Cases Committee be three.

Moved by Dr. NORMAN MOORE, seconded by Mr. Thomson and agreed to that the Report of the Executive Committee with regard to the present position of the question of the application of Part II. of the Medical Acts, 1886, to the Empire of Japan be received and entered on the Minutes—The degrees of Bachelor (Igakushi) and Doctor (Igaku Hakushi) of medicine of the Imperial University of Japan be recognised by the Council as entitling to Registration in the foreign list of the Medical Register, the applicant to produce (1) satisfactory evidence of identity; (2) satisfactory evidence of good character; (3) satisfactory evidence that he is by the law of Japan entitled to practise medicine, surgery, and midwifery in that country; (4) the diploma of Bachelor or Doctor of Medicine of the Japanese Imperial University; (5) satisfactory evidence in relation to the circumstances 1, 2, 3, set forth in Section 12 of the Medical Act 1886; (6) officially attested translations of such Japanese documents as are produced under any of the foregoing heads.

On motion from the Chair, it was resolved unanimously that the report be adopted.

The Council then sat *in camera*, and subsequently adjourned.

SECOND DAY.—WEDNESDAY, MAY 23RD, 1906.

Dr. MACALISTER, President in the Chair.

The Minutes of the last meeting having been read and confirmed, the Council considered *in camera* a report of the Executive Committee in regard to an application for the restoration of a name after erasure under section 29 of the Medical Act, 1858. On ceasing to sit *in camera* the Council proceeded to the consideration adjourned from November 29th, 1905, of the facts proved against William Harding Crowther, registered as of 15, Bloomfield Road, Ealing, London, L.S.A. Lond., 1876, L.F.P.&S.Glas., 1880, who had been summoned to appear before the Council to answer the following charge as formulated by the Council's Solicitor:—

"That you have systematically sought to attract patients by means of a series of advertisements in the *People* newspaper of an Institution for Stricture, &c., at 8A, Guilford Street, Gray's Inn Road, of which you are the surgeon, and which is carried on for your private gain."

At the conclusion of the deliberation of the Council on the case on November 29th, 1905, the President announced the decision of the Council as follows:—

"The Council have carefully considered the facts alleged against Mr. William Harding Crowther in the Notice of Inquiry, and have found that they have been proved to their satisfaction; but they have adjourned the further consideration of the case until the next session in order that Mr. Crowther may have an opportunity of appearing before the Council and giving an account of his conduct in the interval. Meanwhile Mr. Crowther will be required to furnish at once a medical certificate in regard to his state of health."

This certificate was supplied as required.

Mr. Crowther did not attend in answer to his notice, but was represented by Mrs. Crowther, who attended to answer any questions which the Council might desire put to her.

Dr. Woods attended on behalf of the London and Counties Medical Protection Society, the Complainants.

The solicitor having read the notice to attend, Dr. Woods stated, in answer to a question put from the chair, that he had no new facts to adduce.

The Solicitor having read a letter from Mr. Crowther, together with a certificate from Dr. H. H. Tooth, of 34, Harley Street, W., and a testimonial from the

Rev. W. Theodorice Vale, of Kissingbury Rectory, Northampton.

Mrs. Crowther made a statement on behalf of Mr. Crowther, and answered questions put to her from the Chair, and by a member of the Council through the Chair.

Strangers having, by direction of the Council, withdrawn, the Council deliberated on the case *in camera*.

Dr. Woods, Mrs. Crowther, and strangers having been re-admitted, the PRESIDENT announced the decision of the Council as follows:—

"Mrs. Crowther, I have to inform you that the Council have given careful consideration to this case, and that they have decided *not* to direct the Registrar to erase from the Medical Register the name of Mr. William Harding Crowther."

4. The Council proceeded to the consideration, adjourned from November 30th, 1905, of the fact proved against Hamlet Lloyd Davies, registered as of 2, Crofton Street, Great Western Street, Rusholme, Manchester, M.B., Mast. Surg. 1874, Univ. Edin., who had been summoned to appear before the Council to answer the following charge as formulated by the Council's Solicitor:

"That you have accepted and continued to hold the appointment of paid Medical Officer to the Rusholme and District Provident Dispensary, an Association which systematically practises canvassing for the purpose of procuring patients."

At the conclusion of the deliberation of the Council on the case on November 30th, 1905, the PRESIDENT addressed Mr. Davies as follows:—

"Mr. Davies, the Council have deliberated very carefully on your case, and they have come to the conclusion that the facts alleged against you in the notice of inquiry have been proved to the satisfaction of the Council. The Council feel it their duty to express their sense of the gravity of the facts which have been proved against you; but, in order to give you an opportunity seriously to reconsider your position in relation to the Rusholme and District Provident Dispensary, they have adjourned the further consideration of the charge until the next Session, when you will have to appear and satisfy the Council as to your conduct in the interval."

Mr. Davies did not answer to his notice, and Dr. Bateman, on behalf of the Medical Defence Union, the Complainants, did not appear. The Solicitor read the notice to attend and Mr. Davies' answer to the notice. Strangers having, by direction of the Council withdrawn, the Council deliberated on the case *in camera*. The case was adjourned for consideration to Saturday, May 26th.

Strangers having been re-admitted, the Council proceeded to the consideration of the case of John Bate Bowden, registered as of Mountain View, Blaenavon, Mon., M.B., Mast. Surg. 1884, M.D., 1886, Univ. Edin., who had been summoned to appear before the Council to answer the following charge, as formulated by the Council's Solicitor:—

"That you accepted and held until after you had received notice of the present complaint, the appointment of paid medical officer of the Blaenavon Tradespeople's Doctor's Fund, an Association which systematically practises canvassing for the purpose of procuring patients."

Dr. Bawden attended in answer to his notice. Mr. Charles Parnham Skrimshire and Mr. Arthur Blair Avarne attended in support of their complaint.

The Solicitor having read the notice to attend, Mr. Skrimshire opened the case for the complainants. He read a statement of the facts which he had prepared, and tendered certain letter-cards which he alleged had been left by Dr. Bawden with persons canvassed after the Blaenavon Tradespeople's Doctor's Fund had ceased to exist. Mr. Avarne also read a statement which he had prepared in support of the complaint. He then tendered himself as a witness as to the accuracy of his statutory declaration, which he read. He also identified a letter-card which had been sent to a patient by Dr. Bawden after the termination of the fund.

Mr. Avarne answered a question put to him by Mr. Skrimshire. He was cross-examined by Dr. Bawden.

Mr. Skrimshire then tendered himself as a witness in support of the accuracy of his declaration. Dr. Bawden did not desire to cross-examine him. Mr. Skrimshire identified a letter-card which had been sent out by Dr. Bawden, and answered questions put to him, through the Chair, by members of the Council.

Mr. Skrimshire put in statutory declarations which had been made by Mr. John Jones, of 24, Broad Street, Blaenavon; Mr. William Merriman, of Park Street, Blaenavon; Mrs. Rosetta Minchin, of the Ivor Castle Hotel, Blaenavon; two declarations by Mr. Henry Jeffrey Jones, of Woodbine Cottage, Blaenavon; another Declaration by Mr. John Jones, of 24, Broad Street, Blaenavon. Dr. Bawden, in answer to questions put from the Chair, stated that he did not challenge these declarations.

Dr. Bawden then addressed the Council on his own behalf, and read letters which he had written to the Registrar before the complaint was made against him, and in answer to the Registrar's request for an explanation. Dr. Bawden then tendered himself as a witness and answered questions put to him by Mr. Avarne. Mr. Skrimshire did not desire to put any questions to Dr. Bawden. Dr. Bawden then answered questions put to him, through the Chair, by members of the Council. This closed Dr. Bawden's case. Dr. Bawden answered questions put to him by the Legal Assessor.

Mr. Skrimshire then addressed the Council in reply. Mr. Avarne did not desire to make any observations. Strangers then, by direction of the Council, withdrew in order that the Council might deliberate on the case *in camera*.

Dr. Bawden and strangers having been re-admitted, the PRESIDENT announced the decision of the Council as follows:—

"Dr. Bawden: It is my duty to inform you that the Council, after careful consideration, have come to the following decision:—That the facts alleged against you in the Notice of Inquiry have been proved to the satisfaction of the Council; that the Council judges you to have been guilty of infamous conduct in a professional respect, and directs the Registrar to erase from the Register the name of John Bate Bawden."

Strangers then, by direction of the Council, withdrew in order that the Council might deliberate on certain items of business *in camera*.

The Council subsequently adjourned.

THIRD DAY—MAY 24TH, 1906.

Dr. MACALISTER, President, in the Chair.

The Minutes of the last meeting were read and, as amended, confirmed.

The Council then proceeded to the consideration adjourned from December 1st, 1905, of the facts proved against John Jones Atwood, Thomas Rose Smart, Walter Bennett, Montague Alex Levason and Daniel Shea whose names all appear on the Dentists' Register as "in practice before July 22nd, 1878," and who were connected with the Company of Guy White and Co., Ltd. The Dental Committee on May 18th, 1906, after having heard evidence tendered by Messrs. Atwood, Levason, and Shea, and considered letters from Messrs. Levason, Shea, Smart, and Bennett, found that the following facts were thereby established: The said J. J. Atwood, T. R. Smart, W. Bennett, M. A. Levason, and D. Shea have all severed their connection with G. Guy White and Co., Ltd., the company their association with which was the subject matter of the complaint, and none of them has since had any connection with this or with any similar company. Resolutions for the winding up of the company have been passed and registered at Somerset House. All these gentlemen attended in answer to their notice excepting Mr. Smart. Mr. Shea in addressing the Council stated that he had nothing to add to his former explanations to which he adhered; the other accused practitioners did not desire to make

any statements. Mr. R. W. Turner, Counsel of the British Dental Association, said that his inquiries substantiated the statements of the accused practitioners as to their conduct in the interval. After the Council had deliberated *in camera*, the PRESIDENT, when strangers had been re-admitted, announced the judgment of the Council as follows: "The Council having further considered the charge proved against J. J. Atwood, J. R. Smart, W. Bennett, M. A. Levason, and D. Shea and the Reports of the Dental Committee thereon, does not judge you guilty of infamous or disgraceful conduct in a professional respect."

The Council next proceeded to the consideration of the Report of the Dental Committee on the charge against George Charles Smith. The Committee held the inquiry on May 18th, 1906, to ascertain the facts. The accused practitioner, who is on the Dentists' Register as in practice before July 22nd, 1878, and whose address on the Register is 153, High Street, Lewisham, London, S.E., did not attend and was not represented. He has been in practice in Lewisham for the last twenty-one years, and claims to have the largest practice in South London. Mr. Smith recently entered into an arrangement with a Mr. Farkasch for the purpose of extending his practice by a system of canvassing by paid canvassers organised and superintended by Mr. Farkasch. The canvassers distributed documents from house to house containing order forms for signature, addressed to Mr. Smith, with schedule of charges for dental operations and for supplying artificial teeth, and subsequently called to solicit signatures to these order forms and to receive deposits in respect thereof. The canvassers on these visits examined the mouths of persons who permitted them and advised them as to their requirements and gave estimates of cost. From twelve to twenty persons were employed to canvass for Mr. Smith's dental practice. Mr. Farkasch is not a qualified dentist, but he carries on a dental practice under the name of the "Hygienic Institute" at Glasgow and elsewhere by a similar system of canvassing, and carries on the practice by unqualified assistants. For the purpose of organising the system of canvassing on behalf of Mr. Smith, Mr. Farkasch opened an office at 142, High Street, Lewisham, opposite Mr. Smith's surgery, and Mr. Smith's name appears on this door as well as on Mr. Smith's surgery. Mr. Smith employs unqualified assistants at 153, High Street aforesaid, who are in the habit of conducting dental operations on patients at Mr. Smith's surgery, and extract teeth at the private residences of patients who have signed orders in the form above mentioned. Mr. Smith states that he does not wish to defend his right to remain on the Register. The evidence before the Committee consisted of (1) Statutory declarations by the following persons:—(a) Mr. Frederick Powell, (b) Mr. Frederick Joseph Gardner. (2) A letter from Mr. Smith to the Registrar, dated April 30th, 1906. (3) A further letter from Mr. Smith, dated May 16th 1906. (4) A letter from Mr. Farkasch to the Dental Committee, dated May 17th, 1906.

Mr. R. W. Turner, Counsel, instructed by Messrs. Bowman and Curtis-Hayward, Solicitors, addressed the Council on behalf of the British Dental Association and the Council having deliberated *in camera*, the PRESIDENT, on strangers being re-admitted, announced the decision of the Council to Mr. Smith, who was now present, as follows: "Mr. George Charles Smith—On the facts found in the Report of the Dental Committee it has been proved that you have been guilty of conduct which is infamous and disgraceful in a professional respect, and the Council directs the Registrar to erase from the Dentists' Register the name of George Charles Smith."

The Council proceeded to the consideration of the Report on the charge against William MacGregor Veitch, L.D.S.R.C.S.Eng., 112, Prince's Road, Liverpool, and Thomas Wafer Byrne, L.D.S., R.C.S.Eng., L.D.S., F.P.S.Glas, 2, Prince's Road, Liverpool. The inquiry by the Dental Committee took place on May 18th, 1906. The accused

practitioners appeared and were represented by counsel and solicitors. The report was as follows :

The Committee find that the following facts were established by the evidence :—

(1) The Practitioners complained of are on the Dental Register with the qualifications above set forth—Mr. Veitch at 112, Prince's Road, Liverpool, and Mr. Byrne at 2, Prince's Road, Liverpool.

(2) Mr. Veitch and Mr. Byrne respectively carried on practice as Dentists in their own names at their registered addresses, but they also carried on a dentist's practice under the name of Entwistle Bros., Ltd., at 218A, London Road, Liverpool, and also at Seacombe. They were the only two Directors and Mr. Veitch was the Secretary of the Company, and, with nominal exceptions, they held the whole of the shares.

(3) Mr. Veitch and Mr. Byrne purchased the goodwill of this business from the representatives of deceased dentists of that name, who had carried on a dental practice for many years previously. The Company employed an expert advertiser of the name of Kelly, who had complete control of the advertising department. The company issued advertisements and circulars of an objectionable character, and containing claims of superiority over other practitioners.

(4) The Company employed an unregistered assistant named James Kermod Goldsmith, who attended patients and performed dental operations at 218A, London Road, aforesaid. Mr. Goldsmith was registered as a Dental Student in July, 1894, and had passed all his examinations except the final examination, and had gone through a course of practical dentistry at the dental hospital. Mr. Veitch or Mr. Byrne attended daily at the premises in London Road, with which they were in telephonic communication, and they superintended or performed the more serious operations. Their instructions to Mr. Goldsmith were to do the mechanical work of an unqualified assistant, but Mr. Goldsmith did not, as he admitted, in practice follow these instructions, but performed dental operations under gas administered by himself on his own responsibility.

(5) Both Mr. Veitch and Mr. Byrne retired from the directorship, and parted with their shares in the Company on April 2nd, 1906. The complaint against them was made on April 27th, and they were asked by the Registrar for an explanation on April 30th. In reply to the complaint and when under examination they expressed their unqualified regret for their mistaken conduct, and contended that the advertisements were directed against unqualified competitors.

The evidence before the Committee consisted of the following :—(1) The oral evidence of the following persons—(a) Mr. Charles Bowen, (b) Mr. Veitch, (c) Mr. Byrne, (d) Mr. Goldsmith. (2) Five statutory declarations. (3) Four documents. (4) A letter from Herbert J. Davis, the solicitor for the accused practitioners. (5) Copy of the annual return of the company made up to May 11th, 1906, and filed.

Both Mr. Veitch and Mr. Byrne addressed the Council and Mr. B. W. Turner replied on behalf of the British Dental Association. The Council having deliberated *in camera*, the PRESIDENT, on strangers being re-admitted announced the finding of the Council as follows : " Mr. W. Macgregor Veitch, and also Mr. Thos. Wafer Byrne—The Council have given long and careful consideration to your case and, on the facts found in the Report of the Dental Committee, it has been found that you have been guilty of conduct which is infamous or disgraceful in a professional respect, and the Council direct the Registrar to erase from the Dentists' Register the name of William MacGregor Veitch and the name of Thomas Wafer Byrne."

The Council next considered the Report of the Dental Committee on the inquiry held on May 19th, 1906, with regard to Isidore Clifford, Ruby Edmond Clifford, Walter Clifford and Stanley Clifford, all on the Dentists' Register as at 20, Grosvenor Street, London, W., and as in practice before July 22nd, 1878. The Committee

find that the following facts were established by the evidence :—

All the accused practitioners joined in forming and are the principal shareholders and the only directors of a limited company named " The American Dental Institute, Ltd.," incorporated under the Companies Acts for the purpose (*inter alia*) of promoting the adoption of advanced American and other scientific methods of dental surgery, which company carries on dental practice at divers addresses in London, Manchester, and Liverpool. That in such practice the company employs unregistered assistants (namely, Mr. Skrimshire, Mr. Robertson, Mr. McCormick, Mr. Kennedy, Mr. McDermid, and Mr. Storey, all using the title of doctor) to attend patients and perform dental operations upon them. That the company systematically advertises extensively by pamphlets of an objectionable character and containing claims of superiority over other practitioners and depreciation of them. The accused practitioners by their Counsel also did not dispute the accuracy of an article in the *Review of Reviews* which set out at great length within quotation marks an interview with one of the directors of the company, containing scandalous and highly objectionable remarks with regard to English dentists and dentistry. The accused practitioners by their Counsel undertook that the company (of which they are practically the whole of the shareholders) should be dissolved; that neither they nor the company would employ any persons contrary to the resolution of Council of November 24th, 1892, and further that they and the Company would discontinue all advertisements of every kind. The evidence before the Committee consisted of the following :—

(1) The oral evidence of the following persons :—(a) Mr. Charles Bowen, (b) Miss A. F. Foley, (c) Mr. W. Knight.

(2) The following depositions and statements :—(a) Statement submitted by the Hon. Sec. of the British Dental Association, with office copy of the memorandum of Association of the American Dental Institute, Limited, and of the annual returns of that Company, dated October 11th, 1905, and with three pamphlets circulated by that company, and a copy of the *Review of Reviews*, dated November 15th, 1901, containing an account of an interview with one of the directors of that company. (b) Two statutory declarations by Mr. Charles Bowen, dated respectively April 26th and May 4th, both in 1906, the latter exhibiting a pamphlet circulated by the American Dental Institute, Limited. (c) A statutory declaration by Miss A. F. Foley, dated April 27th, 1906, exhibiting a card of the American Dental Institute, Limited. (d) A statutory declaration by Mr. W. Knight, dated April 17th, 1906. (e) A statutory declaration by Mr. W. F. T. Brown, dated April 28th, 1906. (f) A statutory declaration by Mr. Arthur Cecil Curtis-Hayward, dated May 4th, 1906. (g) A letter from the American Dental Institute, Limited, to Mr. W. Knight, dated April 28th, 1906, with two appointment cards. (h) An account for professional attendance by the American Dental Institute, Limited, addressed to Mr. W. Knight, dated May 17th, 1906. (i) A letter from the Solicitor of the accused practitioners to the Registrar, dated May 4th, 1906.

All the accused practitioners were present in answer to their notices, together with Mr. C. M. Warrington, K.C., with him Mr. T. L. Wilkinson, their Counsel instructed by Messrs. Frank Richardson and Sadlers, Solicitors.

The British Dental Association, the Complainants, were represented by Mr. R. W. Turner, Counsel, instructed by Messrs. Bowman and Curtis-Hayward, Solicitors.

Mr. Warrington and Mr. Turner briefly addressed the Council. The Council having deliberated *in camera*, the PRESIDENT, on strangers being re-admitted, announced the decision of the Council as follows :— " Isidore Clifford, Ruby Edmond Clifford, Walter Clifford and Stanley Clifford—The Council have deliberated carefully on your case, and on the facts found in

the report of the Dental Committee, it has been proved that you have been guilty of conduct which is infamous and disgraceful in a professional respect, and the Council directs the Registrar to erase from the Dentists' Register the names of Isidore Clifford, Ruby Edmond Clifford, Walter Clifford and Stanley Clifford."

Moved by Dr. NORMAN MOORE, seconded by Sir VICTOR HORSLEY and carried unanimously: That the recommendation of the Executive Committee with reference to the British Optical Association and in regard to the Sight-testing Opticians Bill be adopted as follows: "That the Lord President of the Privy Council be informed that the Council have carefully considered the petition and the Bill submitted to them, and are of opinion that it would be dangerous in the public interest to confer the privileges and powers contemplated therein on persons other than those duly qualified in medicine and surgery; and that the Council trust that the sanction of Parliament and of the Privy Council will be withheld from these proposals."

Moved by Dr. PUE SMITH, seconded by Mr. MORRIS and agreed to: That the accompanying memorandum, subject to such amendments as may be approved, be transmitted to the Lord President of the Privy Council as setting forth the grounds on which the objections of the Council are based.

Moved by Dr. NORMAN MOORE, seconded by Sir THOMAS MYLES, and agreed to: That the following letter from the President of the Pharmaceutical Society be received and entered in the Minutes:—

" 26, Brechin Place, South Kensington.
May 22nd, 1906.

"Dear Dr. MacAlister,—I am writing as President of the Pharmaceutical Society of Great Britain, to draw the attention of the General Medical Council to the amendment which was recently carried in the House of Lords on the Poisons and Pharmacy Bill, to the effect that a company or body corporate, composed of unqualified persons, may use the title of chemist provided they employ a person who is qualified under the Pharmacy Acts.

"This decision, if allowed to become law, may have far-reaching results, not only to chemists, but also to dentists, medical men, and others where a personal qualification is required by law.

"I hope the General Medical Council may see fit to exert their great influence to protest against such a new departure, and I have the honour to invite that Council to take such steps as they deem necessary to impress upon the Government and the Houses of Parliament the danger to the public, and the injustice to qualified persons, of such proposed legislation.

"I am, yours very faithfully,

"R. A. ROBINSON,

"President of the Pharmaceutical Society of Great Britain.

"Dr. MacAlister, President,
"General Medical Council."

Moved by Mr. TOMES, seconded by Sir John William MOORE, and agreed to: That the President be requested to inform the Lord President of the Privy Council that, in the opinion of this Council, the principle involved in the Poisons and Pharmacy Bill, as amended in the House of Lords, whereby corporate bodies are permitted to assume professional titles, which titles no member or director of such company need be personally qualified by training, examination, and registration to assume, is fraught with obvious and extreme danger to the public."

Moved by Sir HUGH BEEVOR, seconded by Mr. MORRIS, and agreed to: That Mr. Edward Percy Paton, F.R.C.S. Eng., M.D. Univ. Lond., be appointed Assistant Examiner in Surgery to the Apothecaries' Society of London for a period of four years, vice Mr. Steward, who retires by rotation."

Moved by Dr. ADYER-CURRAN, seconded by Sir THOMAS MYLES: That in consideration of the heavy expense entailed on the Apothecaries Hall, Dublin, by the appointment of the Surgical Examiners from London and Edinburgh respectively, the Council resolve that at the next vacancy these examiners be

appointed from amongst the profession practising in Dublin.

After a short discussion Dr. ADYER-CURRAN, with the consent of his seconder and of the Council, subsequently withdrew his motion.

Moved by Sir PATRICK HERON WATSON, seconded by Dr. NORMAN MOORE, and agreed to: That the Report from the Examination-Committee on the returns as to examinations for entrance to the Navy, Army, and Indian Medical Services received by the General Council on May 22nd, 1906, be received and entered in the Minutes.

Moved by Mr. BROWN, seconded by Dr. BRUCE: That a copy of this Report be sent to each licensing body.

The motion was lost.

Moved by Sir THOMAS FRASER, seconded by Sir PATRICK HERON WATSON, and agreed to: That the President and Treasurers of the Council be requested to arrange for the preparation and transmission of a suitable address of congratulation to the University of Aberdeen on the celebration in September next of its four-hundredth anniversary."

By direction from the Chair, strangers then withdrew, in order that a certain matter might be considered.

The Council subsequently adjourned.

FOURTH DAY—FRIDAY, MAY 25TH, 1906.

Dr. MACALISTER, President, in the Chair.

The Minutes of the last meeting were read, and as amended, confirmed.

The Council in camera then considered a preliminary matter before proceeding with the programme of business.

On the re-admission of strangers the Council considered the case of Alexander Lane, registered as of Saville Chambers, Newcastle-on-Tyne, M.R.C.S. Eng. 1880, L.S.A. Lond. 1880, F.R.C.S.I. 1893, M.D. Dur. 1899, who had been summoned to appear before the Council to answer the following charge as formulated by the Council's solicitor: "That you sold to Mr. Ellis Pearson a medical practice at Bideford which was not a genuine *bona-fide* goodwill and practice, but was a practice fraudulently built up by you for the purpose of sale.

Dr. Lane attended in answer to his notice together with Mr. F. W. Hill, of 134, Fenchurch Street, E.C., his solicitor.

Dr. Bateman appeared on behalf of the Medical Defence Union, the complainants, together with Mr. Ellis Pearson.

The solicitor of the Council having read the notice, Dr. Bateman asked a preliminary question as to the manner in which the Council desired him to conduct the case, as he was prepared either to go into all the facts of the case, or to commence with the verdict of the jury in the action for damages. Mr. Hill also expressed his readiness to adopt either course, and stated that he was willing to take up the case without entering into it *ab initio*, provided that he might deal with the Judge's summing-up to the jury. On the advice of Mr. Lushington this was agreed to, and Dr. Bateman opened his case. He called Mr. Pearson as a witness and examined him as to the accuracy of his declaration and of the exhibits thereto. Mr. Pearson was then cross-examined by Mr. Hill, and re-examined by Dr. Bateman. This closed Dr. Bateman's case.

Mr. Hill then opened the case for Dr. Lane by tendering him as a witness for cross-examination by Dr. Bateman, and to answer any questions which the Council might desire to ask. He did not himself propose to ask any questions at this stage. Dr. Bateman accordingly cross-examined Dr. Lane. He was re-examined by Mr. Hill as to an offer of a composition which he had made to Mr. Pearson, and as to an application to a judge in Chambers about a month after the trial for a stay of execution, which had been refused on the ground that it was made too late.

Dr. Lane answered questions put to him by the legal assessor as to the steps which had been taken

by him or on his behalf to apply for a new trial and a stay of execution.

Mr. Hill tendered an official transcript of the shorthand writers' notes of the summing-up by Mr. Justice Lawrance at the trial of the action which he read a copy of the taxed bill of the plaintiff's costs to show the date when the application for a stay of execution had been refused; the Report by the Official Receiver; and the decision of the County Court Judge, which he put in and read.

Dr. Bateman did not take exception to any of these documents.

Mr. Hill also read the claim of the plaintiff in the action, and the judgment of Mr. Justice Bigham and Mr. Justice A. G. Lawrance on the appeal against the decision of the County Court Judge.

Mr. Hill then in a clever speech addressed the Council on behalf of Dr. Lane. Dr. Bateman addressed the Council in reply.

The Council deliberated on the case *in camera*. Strangers having been re-admitted, the President announced the decision of the Council as follows: "Dr. Alexander Lane.—The Council have deliberated on your case and have passed the following resolution: That the facts alleged against you in the Notice of Inquiry have not been proved to the satisfaction of the Council."

The Council proceeded to the consideration of the case of James Brander, registered as of 44, Leadside, Northfield, Aberdeen, M.B., Mast. Surg. 1876, Univ. Aberd., who had been summoned to appear before the Council on the following charge:—"That you were on the 15th day of February, 1906, convicted of the following crime or offence at Aberdeen Police Court namely, of drunkenness and riotous behaviour." Mr. Brander did not answer to his notice. The solicitor of the Council read the notice to attend, the answer by the accused practitioner, the certificate on conviction and notes of previous convictions which had been obtained from the Aberdeen police authorities. The Council deliberated *in camera* and, strangers having been re-admitted the President announced the decision of the Council as follows: "That James Brander having been proved to have been convicted of a crime or offence the Registrar be directed to erase his name from the Medical Register."

The Council then adjourned.

FIFTH DAY.—SATURDAY, MAY 26TH, 1906.

Dr. MACALISTER, President, in the Chair.

In answer to a question by Mr. Tomes (notice of which had been given) with regard to the communication to the Lord President of the Privy Council, on the Poisons and Pharmacy Bill, the President read the letter which he (the President) had sent which was entered on the minutes.

The Council then considered the case against Hamlet Lloyd Davies adjourned from November 30th, 1905. Mr. Davies appeared before the Council and stated that he had resigned the appointment to the Rusholme and District Provident Dispensary and said he was now assisting in a cash private practice. The solicitor of the Council read a letter from Dr. Bateman who had represented the complainants, the Medical Defence Union, in which he informed the Council that there was no further complaint.

The Council, having deliberated *in camera*, the President, on the re-admission of strangers, informed Mr. Davies that his name would not be erased from the Register.

The President announced that the name of William Patrick Kirwan would be restored to the Register.

The Council next received a report from the Examination Committee on the whole cycle of Visitations and Inspections. The report as proposed by Sir P. Heron Watson, seconded by Dr. Caton, was accepted to be placed on the minutes, after each clause had been separately discussed (proposer and seconder being the same). (Clauses 1, 2, 3, 4, 5 were carried after a little discussion; Clause 6 was carried after some discussion as to the position the subject of pathology should

occupy in the examinations, 7, 8, 9 were agreed to; 10 was carried—19 for, 12 against, 1 absent—after considerable discussion with regard to special subjects at examinations, and the advisability or not of the examiner in these subjects being an expert in them, several amendments being proposed and lost; 11, 12, 13, 14 were carried; an amendment of Sir Victor Horsley, seconded by Dr. Bruce, to the effect that the second paragraph should be omitted in Clause 15 was carried; 16 was approved, as also 17 with the addition of: "It is the opinion of the Examination Committee that no Candidate who has failed in Clinical Medicine or Clinical Surgery can pass his final examinations"; the other clauses of the Report were approved.

A motion was next brought forward by Dr. Bruce, seconded by Sir T. McC. Anderson and agreed to: That it be remitted to the Education Com. to consider how far Recommendation V. of the General Medical Council—viz., 'That the fifth year should 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 of this year six months 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'—is at present being given effect to, and if the Committee sees fit to recommend to the Council such changes in the said resolution as would be likely more effectually to secure the object aimed at by the Council in 1890." Dr. Bruce made a speech in support of his motion. Dr. Mackay, on the part of the Education committee, said that the Committee would be very glad to consider the question raised by the motion, but he thought it best that they should not be unduly hurried.

The Chairman of Business (Dr. Norman Moore) then moved that the nominations of the Branch Council for the following Committees be adopted—Examination Education, Public Health and also the names of members for the following Committees (nearly in every case the names being those of the present members). Pharmacopœia, Finance, Dental. These motions were each seconded and carried.

The Council then adjourned.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, May 27th, 1906.

MEDICAL TREATMENT OF CANCER.

OF all the maladies which afflict humanity, cancer in its causes and treatment is perhaps the least understood, and the number of inoperable cases are legion. It is for this reason that any medical treatment promising the least success is always welcome. The general treatment of cancer is that which applies to all cachectic affections, while the local treatment is considerably varied in its applications. But any or all of the therapeutic agents employed give but little satisfaction both to the medical attendant and the patient. Dr. Le Toux, however, recommends strongly the injections of one or other of the usual serums around the malignant growth, and affirms that they retard considerably the progress of the tumour and raise the moral condition of the patient.

He employs indifferently anti-diphtheritic and anti-tetanic serum for no other reason than that they are easily obtainable. He injects around the cancer every eight days ten cubic centimetres (two drachms and a half) of serum. The needle is introduced into the healthy skin, the point directed towards the tumour which it touches, when the liquid is injected, the needle is withdrawn and another injection made farther on, so that finally the periphery of the tumour is thus bathed in serum. The usual effect of these injections is a decrease in the volume and a flattening of the

tumour; the fungosities assume a healthy aspect and the general condition of the patient is improved. In certain cases, like the following, both patient and attendant cherished for a time the illusion that an effective cure without operation had been obtained.

A woman, æt. 60, entered the hospital at Vannes in January, 1904, for an ulcerating tumour of the right breast. The patient, robust and mother of a large family, stated that two years previously she received a violent blow on the right breast, and suffered from it for about a month. Some time afterwards, she noticed a hard lump in the gland, but said nothing about it until the skin began to ulcerate.

When she entered the hospital her general condition was perfect, but the right mammary gland was very voluminous and largely ulcerated. An operation was proposed and accepted, and M. Le Toux removed the breast and all the glands he could find in the axilla. A month after, the patient left the hospital the wound being almost completely healed. Towards the end of the same year the patient returned to the hospital, but this time she presented a striking contrast to her condition some months before. She was emaciated, cachectic, and so weak that she almost fainted when being examined. When the breast was uncovered a large ulcerated and bleeding morbid growth was found seated on the cicatrix of the previous operation surrounded with violet coloured skin. An operation was impossible.

Injections of anti-diphtheritic serum were made every week for five weeks, as above described. After the first injections the hæmorrhage ceased and the tumour commenced to flatten. In the third week the decrease in the growth was remarkable, while the fungoid ulcerations changed aspect, resembling healthy granulations, and the patient was so surprised at the change that she went about telling everyone of her wonderful cure.

However, the progress was not maintained; the fifth series of injections remained without effect, on the contrary the tumour seemed to have a tendency to increase in size. A change in the serum was made, but the anti-tetanic serum was no better, and it was evident that it was useless to proceed any further with that treatment. As the condition of the patient had, however, greatly improved, Dr. Le Toux suggested a second operation which was now possible, but the patient feeling herself so much better refused absolutely all interference, and some months afterwards she succumbed.

Other cases observed and treated by the head-surgeon of the Vannes hospital warranted him to state that in the employ of these serums we have one of the best methods of treating inoperable cancers, and which may be prescribed concurrently with other means.

The treatment is easy and is worth a trial; it improves the local and general conditions of the patient and raises her hopes, to the moral and material benefit of the treating physicians.

GERMANY.

Berlin, May 27th, 1906.

At the German Surgical Society, Hr. Kraster, Freiburg i. B., spoke on

FURTHER DEVELOPMENT OF OPERATION FOR HIGH-SEATED CANCER OF THE RECTUM.

He would confine himself to the combined method as the only one that was in a position to improve results. The sacral operation was inadequate, as the lymph glands could not be extirpated by it. The idea of the combined method was not new, but it had only more recently become practicable. Laparotomy was added to the sacral incision, when one was placed in a difficult situation; it was an act of desperation during an operation. Such operations had been several times performed, but the results had been unfavourable.

That was not to be wondered at when laparotomy was a last resource and performed after lengthened futile attempts to get at the disease by the sacral opening. Later, however, the combined operation was decided on from the beginning, and then not only was the operation made easier, but other advantages were gained. The operation became more cleanly, it was easier to find out the extent of the disease, to recognise the glands implicated and to ascertain whether a successful operation was possible. In case it was not, the sacral opening would not be made and one would content oneself with making an artificial anus. The abdominal incision must be made in such a way as to allow thorough inspection of the pelvis. The Trendelenberg position was the best, the incision was that for artificial anus, or the median incision might be selected, or the two might be combined. In France an iliac anus was now made, and all was then extirpated through the sphincter. This method had not met with approval in Germany, and rightly so. The speaker was opposed to it, as continence and retention of the function of the bowel were better retained by the combined than by the sacral method, and for this reason resection of the rectum was thought better. This was specially recommended by Trendelenberg. The diseased part was made movable through the abdomen, brought up, and amputated. Unfortunately this could not often be done, the size of the tumour with the gland making it frequently impossible. In such cases therefore, the sacral incision must be brought into play. The speaker had first done this in 1899, and had frequently repeated it. The operation was done more easily when after opening the abdomen the bowel was cut through above with the thermocautery; the upper end was in charge of an assistant; the lower was invaginated and sutured. The tumour was now easily separated from the sacral side. The hæmorrhoidal vessels were ligatured, so that the operation was bloodless. Both hypogastric vessels might be ligatured at the same time, if necessary. After mobilisation of the tumour, the patient was placed on the side and the sacral opening was made. The extirpation of the tumour was now made from the abdomen. The operation was easier in women than in men. After resection the sacral wound was closed by suture, and the dressings applied.

What now was gained by the combined method? Was recovery more permanent? One could not say at present. Even the immediate results could not be estimated as no one surgeon had done it many times. We had, therefore, to collect the result of the different operators. Schloffer had done this: He had collected 65 cases, of which 33 were fatal. The speaker had performed the operation ten times with four deaths. The mortality was not very encouraging, but the operation might be much more perfect and in such cases where the patients were near to death already the results were not quite so "unerfreulich" The causes of death were of importance—2 patients died of collapse after tedious operation, and practice would remedy this. Most of the speaker's deaths were among his earlier cases. Shortening the period of narcosis would help, and perhaps we could do without general anaesthesia. One patient died from obstruction of the bowel from displacement of the omentum and torsion of the colon. A death from such a cause would not occur again, as he now fixed the omentum and prevented its slipping back. The operation was much less dangerous in females. Among the ten cases were three women, all these recovered. According to Schloffer of 13 men 8 died, but of 10 women only one succumbed. The reason for this lay in the greater resisting power of women, and also in their more roomy pelvis. He advised that we should not be so reluctant to employ the combined method, nor to use it only for the worst cases and as a last resource. We should then make use of its advantages; we should certainly obtain better permanent results, and by further improving the technique of the operation and by practice we should reduce the rate of mortality.

AUSTRIA.

Vienna, May 27, 1906.

PROTRACTED PRIAPISM.

At the Gesellschaft der Aerzte, Blum showed the members a young man, æt. 20, who, six days previously had been suddenly attacked during the night with a very painful erection which had existed ever since.

According to his own story, he fell from a ladder six months ago and alighted on the buttocks, injuring the perineum which was followed by inflammation in the neighbouring tissue. There are no signs or symptoms of sexual abuse or organic poisons. The penis was 21 cms. in length=8 inches, with a hard bony resistance which was confined to the corpus cavernosa penis leaving the corpus cavernosum urethrae quite free and flaccid at the base, the glans penis white, reaching to the umbilicus.

The cutaneous surface of the organ was quite unchanged; no testimony of self pollution or sexual excitement and no evidence of any nervine defect beyond the white pale face of the patient, who was evidently suffering from a severe condition of leucæmia linealis.

The patient had an enormously enlarged spleen, with great enlarged glands in the inguinal and axilla glands. The proportion of white to red corpuscles was 1.5 or 565,000 white corpuscles to 3,235,000 red.

Blum found other ten cases of this character recorded in the literature on the subject, which made it of some interest to the Society. There was one symptom in this case worthy of note, which does not appear in any of the other cases—viz., pain! In all the other cases this is specially noted; in the present case none is present to any extent—rather a discomfort.

Now as to the direct cause several suppositions have been offered. Among those given are thrombi, disturbance of the circulation in the corpora cavernosa, irritation of the nervi erigentes, swollen glands pressing on the nerves of the plexus pudendus, and the altered constituents of the leukæmic blood. In the case before us a slight thrombus may be present, as Kast found at the abduction on his case, when we remember the fall some time before.

The prognosis is dubious when we interpretate the dangers to which the patient is exposed during the morbid transitions. Purulent changes in the swollen member are prone to produce pyæmia. To avert this danger heroic surgical interference would be the best in the present case, but as we are uncertain of the real cause the Röntgen Rays have been adopted in the hope of producing resolution without the risk of pyæmia.

THE RONTGEN RAYS IN THE GRAVID STATE.

Fellner and Neumann next recorded the results of their experiments with 15 dogs. In three cases the rays were applied to the one ovary only; the other 12 both ovaries. The dogs were bound, narcotised with ether, and the rays applied at a focal distance of 12 cms. or 4.7 inches, giving six to seven Holzknechts units each. The first case had both ovaries acted on from the middle line, the later ones were acted on from the flanks whereby the uterus could be uncovered. Laparotomy was usually performed about the beginning of the third week and one of the ovaries removed. With only one exception none of the animals aborted. The oviducts about this time were observed to be degenerated while the primordial follicles were very few and also degenerated. The corpora lutea contained granular cells, which coloured feebly or not at all, and were void of a nucleus. They also contained a colloid mass, which did not lie in the centre, but was easily distinguished from the other part of the cell. The later oviducts were covered with a sort of granular epithelium and blood surrounded by a thickened fibrous tissue. The degeneration in these cells was more marked and indicated a more active secretion as in myoma approaching the climatic period. These results point to greater difficulty in proving criminal interference. In the discussion Latzo said he had often applied the rays in the gravid condition, but never produced abortion.

FROM OUR SPECIAL
CORRESPONDENTS AT HOME.
SCOTLAND.

THE KINEMATOGRAPH AS A MEANS OF CLINICAL TEACHING.—A demonstration of the value of the kinematograph for teaching purposes was given before the Edinburgh Medico-Chirurgical Society, on May 16th, by Dr. W. Chase, of Boston, who has devoted much time and trouble to securing living pictures of eclamptic seizures, morbid gaits, spasms, chorea, and other disturbances of motion. Before exhibiting his films, the lecturer spoke of the educational value of the pictures, in enabling such phenomena as epileptic seizures to be studied at leisure. Many students, and even some practitioners, had never had an opportunity of seeing a typical major attack of epilepsy from start to finish, but when once satisfactory kinematographic films had been secured these could be multiplied and supplied to any teaching institution. The kinematograms exhibited by Dr. Chase were of great interest. He showed representations of patients in the *status epilepticus*, in which the various phases of the seizure were very clearly depicted. One of the points which came out especially clearly was the precise way in which (in some patients) each seizure recapitulated the movements of the one which preceded it. Again, the deep abdominal respiration characteristic of the later stages of the seizure, and the priapism which accompanies the tonic phase were well brought out. Various morbid gaits—ataxia, hemiplegia, festinating, spastic, &c.—were likewise well demonstrated. Of special interest were the pictures of idiots, showing the rhythmical salaam movements, gestures of the hands, &c., which are so common in some forms of mental defect. Athetosis forms the subject of another series of pictures, while cases of chorea, of habit spasm, of Jacksonian epilepsy were also shown. Dr. Chase repeated the demonstration on the succeeding day in the University for the benefit of the students, who attended to the number of nearly 600.

DISCIPLINE IN THE ROYAL INFIRMARY.—We have forbore to mention a matter affecting the relations of the resident physicians and surgeons of the Royal Infirmary to the governing body of that institution until a final decision was arrived at by the latter, and as the incident which became public property through the lay and professional press, is now at an end we need not refer to it at length. Some weeks ago a good deal of surprise was occasioned by the posting up at the gates of the Infirmary of a notice suspending the hospital tickets of five gentlemen who had formerly acted as resident physicians and surgeons. It was felt that although doubtless the managers might be justified in precluding, for disciplinary reasons, the holders of hospital tickets from entering the Infirmary, to pillory them by placing their names in what is practically a public place, was, to say the least, harsh. And additional doubt was cast on the justice of the action by the fact that several of the offenders were well known as excellent students and had a record which rendered rowdyism, or anything approaching thereto, improbable. It seems that these five gentlemen had been in the residency after the hours permitted by the rules, and that they were reported for this, and also for having made a noise in the corridors. While all admitted, and expressed regret for, their action in staying in the house after hours, those who were guiltless of the noise disclaimed blame therefor, while the guilty admitted their fault. Yet in spite of this the managers dealt with all on the same footing and punished them in the same way. The matter came up at several subsequent Board meetings and finally was disposed of by the managers, in consideration of a further apology and expression of regret, rescinding their sentence on all. The incident having terminated thus satisfactorily may well be forgotten.

EDINBURGH HARVEIAN FESTIVAL.—Sir John Halliday Croom delivered the oration at the 124th Harveian Festival held on May 18th. He selected as his topic

"The Times of Harvey." The oration was followed by the annual dinner, over which the orator presided, and at which the toast of "The immortal memory" was duly honoured. Dr. Edwin Bramwell proposed "The Guests," which was responded to by Dr. Chase, Boston.

CARSWELL-GILCHRIST FUND.—The fund which is being raised to assist in defraying the expense to which Drs. Carswell and Gilchrist were put in defending an action brought against them by a patient whom they had certified as insane will close on June 12th. Dr. W. G. Dun, 15, Royal Crescent, Glasgow, will receive subscriptions up to that date. The action was brought last December, and was commented on in this column at the time.

BELFAST.

THE HEALTH OF THE CITY.—Following up the campaign for the appointment of a thoroughly trained health officer for the city, a deputation of medical men from the Ulster Medical Society waited on the Public Health Committee of the Corporation last week, and laid their views on the situation clearly before them. The deputation consisted of Dr. Calwell (President of the Ulster Medical Society), Professors Lindsay and Byers, and Drs. Dempsey, Morrow, and Storey. Professors Lindsay and Byers spoke, pointing out the necessity of having a specially trained man as Medical Officer of Health, owing to the great advances recently made in that branch of medical work, and the impossibility of a general practitioner keeping abreast of them. They also pointed out that the great problems needing solution in Belfast were not peculiar to our city, but were found in most large cities, and a man trained in one of these was fitted to deal with the questions arising here. The Chairman of the Committee, Dr. King-Kerr, who has for weeks been carrying on a newspaper war with all reformers, tried to "corner" the members of the deputation by raising various difficulties concerning details, but they wisely answered that they were not there to settle details, but to urge certain broad general principles, and eventually the chairman was closed by some of his own committee, who gave a very sympathetic hearing to the deputation. It is reported that the Committee have agreed to recommend to the City Council that the salary offered to the new Medical Officer shall be £800 per annum to begin with, which is one of the main points contended for, as this will be sufficient to attract a properly qualified man. The other chief point is not yet settled, but there seems some chance of its being carried, and that is that an automatic rise of salary shall be arranged, so that the Health Officer will not be afraid to do his duty for fear of offending property owners who command the purse strings in the Council. At first sight it seems unlikely that the City fathers would abandon any of their jealously-guarded powers and prerogatives, but it seems that the canvassing and wire-pulling for rises of salary have in the past been such a nuisance that many of them would be glad to be rid of it by making all rises of salary automatic.

LETTERS TO THE EDITOR.

THE CHRISTIAN SCIENCE QUACK.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—At the present moment the public mind is being edified (no joke meant) by the prosecution of a medical man, or an ex-medical man, for healing a patient by the series of fantastic negations known as Christian Science. As that case is in the courts I have nothing to say as to its possible merits or demerits. I may however, draw attention to one extraordinary fact with regard to this form of irregular medical practice—namely, that the only attempt at punishment is concentrated upon one particular man, simply because he happens to have held—or to be still holding—a legal medical qualification. Surely if it be an offence for such a man to substitute deadly buffoonery in place of legitimate scientific method, it must be a far worse

offence for another person—with no pretence to any medical training whatever to tend the sick in the same way. Yet in our legislative wisdom we provide for the punishment of the qualified man and let the unqualified go scot free. Surely the protection of the community demands the control of all irregular medical practice, whether conducted by legally qualified or by ignorant and untrained charlatans. Where is the General Medical Council all this while? Why should their energies end at advising Parliament not to grant facilities for irregular medical practice to opticians and trading companies? Why should not the General Medical Council bring all its influence to bear upon the Government to pass a measure to control quacks and quackery? Such a measure is urgently needed for the safety of our fellow countrymen. Or why should not the General Medical Council stir up the police to take action? In many cases a police prosecution would put a stop to practices that are a standing disgrace to our boasted civilisation. It would take the boisterous satire of a Rabelais to do justice to the farce of a nation that rules the qualified medical man with a rod of iron, but lets the ignorant quack spread his nets for the unwary in the broad light of day. Meanwhile the pirate piles up hoards of ill-gotten pelf, while the highly qualified practitioner is often doomed to starve in silence.

I am, Sir, yours truly,

THE DENIZEN OF A BACK STREET.

THE ROYAL INSTITUTE OF PUBLIC HEALTH: THE HARBEN LECTURES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I shall be obliged if you will allow me to say that, owing to the great interest which has been evinced in the forthcoming Harben lectures, which are this year being delivered by Professor Elie Metchnikoff, of the Pasteur Institute, Paris, it has been found desirable to make arrangements for these lectures to be given in a larger lecture theatre than that of the institute.

Through the kindness of the Council of King's College the large lecture theatre of that college has been placed at the disposal of the institute, where the lectures will, therefore, be given on Friday, May 25th, Monday, May 28th, and Wednesday, May 30th, at 5 p.m.

A reception was held at the Royal Institute of Public Health, 37, Russell Square, on Friday, May 25th, at 3.30 p.m., at which Professor Metchnikoff was present, and to this, as well as to the lectures, all those interested were cordially invited.—I am, Sir, yours truly,

JAMES CANTLIE, M.A., M.B.Aberd.

London. W.

Honorary Secretary.

Trinity College Dublin—Post Graduate Classes.

We have received a copy of the prospectus of the post-graduate course of instruction in the School of Physic, Trinity College, Dublin. The classes begin on June 11th, and the course lasts three weeks. From the time-table we observe that work begins as a rule at 8.30 a.m., and the classes succeed one another at short intervals till 5 p.m. The scheme is a practical one and embraces hospital demonstrations, operations on the cadaver, laboratory work, and lectures on special subjects. A feature which, so far as we know, is peculiar to the postgraduate course in Trinity College, is that a limited number of the members of the class may reside in College rooms and dine on commons for a very moderate sum. As the number of available rooms is small, early application should be made by any qualified man who intends taking over the course and wishes to reside in college. The honorary secretary, 27, Lower Fitzwilliam Street, Dublin, will afford any further information that may be desired.

DR. TARNOWSKY, OF ST. PETERSBURG.

THE death is announced of Dr. Benjamin Tarnowsky, Honorary Professor of the Academy of Medicine, St. Petersburg, Member of the Council of Medicine of the Russian Empire. Deceased was well known to many members of the profession in this country.

MEDICAL NEWS IN BRIEF.

General Medical Council—Close of the Session.

THE last meeting of the present session took place on Monday, May 28th, 1906, Dr. MacAlister, President, in the chair.

Some very important medical business was dealt with, including among others a motion by Sir Hugh Beavor, with reference to an Act to vary the diploma or title of Licentiates of the Society of Apothecaries of London; an adjourned consideration postponed from December 1st, 1905, relating to the Visitation and Inspection of Qualifying Examinations; a motion by Sir V. Horsley, dealing with the voting in the election of Direct Representatives; and a motion by Mr. Brown for the increase in the number of Direct Representatives to the maximum number permitted by the Medical Act of 1880. A full report of this meeting will appear in our next issue.

The International Congress of Medicine.

A MEETING of the National Committee was held at the rooms of the Medical Society of London on Thursday last, May 24th. There were present, among others, Dr. Pavy, F.R.S., Sir Dyce Duckworth, Deputy Inspector General Johnston, R.N., Dr. Boyd Joll, Mr. George Jackson, Mr. Jessop, and the honorary secretaries (Mr. Clive Riviere and Mr. D'Arcy Power). A report upon the Lisbon Congress was read and adopted. It stated that about seventy-five members (British) had attended the Congress and that communications had been made to the Section by Dr. Pavy, Prof. Hubert Boyce, Prof. R. J. Anderson, Dr. Gustav Mann, Dr. Rashford, Sir Dyce Duckworth, Dr. Boyd, Joll, Dr. Mott, Dr. Ferrier, Dr. Radcliffe Crocker, Dr. Stanley P. Atkinson, Mr. D'Arcy Power and Mr. Kenneth Goadby. Attention was also drawn to the fact that by the appointment of Sir Dyce Duckworth by His Majesty's Honourable Privy Council, the British Government had been for the first time represented by a delegate. Votes of thanks were ordered to be given to Prof. Bombarda, the Secretary General of the Lisbon Congress, for the admirable manner in which he had organised the meeting, and to the British colony at Oporto for the hospitality which they had extended to the British members of the Congress who had visited that city. The proceedings closed with a vote of thanks to the Medical Society for the use of the room.

The Coleman Case. Meeting of the Medical Profession.

A NOTICE signed by the Presidents of the Royal Colleges of Physicians and Surgeons of Ireland has been sent to a large body of the medical profession in Ireland, asking them to attend a meeting which will be held at the Royal College of Physicians at 5 o'clock p.m., on Wednesday, June 6th. At this meeting the following resolution will be submitted:—"That we, the professional brethren of Dr. James Byrne Coleman, hereby congratulate him on the successful manner in which he has recently refuted the unfounded charges brought against him, and express our sympathy with him in the trouble through which he has passed 'without blemish on his character or honour.'" If this is carried, as there is no doubt it will be, it will be further proposed that a copy of it be sent to every member of the profession in Ireland for their approval, and that a special copy with the names of those approving of it be subsequently publicly presented to Dr. Coleman.

Royal College of Surgeons in Ireland.

FELLOWSHIP EXAMINATION.—The following candidates having passed the necessary examination have been admitted Fellows of the College:—C. M. Benson, B.Ch., &c., Univ. Dub.; P. J. Byrne, L.R.C.S., &c., Edin.; A. N. Crawford, L.R.C.S.I., &c.; P. L. Crossbie, L.R.C.S.I., &c., Surgeon Royal Navy; W. L. Murphy, L.R.C.S.I., &c.; W. J. Niblock, B.Ch., &c.; Royal Univ. Irel., Captain I.M.S.; G. Sheppard, L.R.C.S.I., R. A. Stoney, B.Ch., &c., Univ. Dub.

The following candidates have passed the primary part of the Fellowship Examinations: A. Greene, B.Ch., Univ. Dub.; R. V. Khedkar, L.R.C.S., &c., Edin.; J. W. Killen, B.Ch., &c., Royal Univ. Irel.; O. St. J. Gogarty, Student Univ. Dub.; J. P. Grainger, Student R.C.P. and S.I.; C. Greer, Student R.C.P. and S.I. (Victoria, Australia); W. E. Hopkins, Student Univ. Dub.; S. W. Hudson, Student R.C.P. and S.I.; H. B. Sherlock, Student R.C.P. and S.I.; G. J. W. Tierney, Student Royal Univ. Irel.; P. J. Timoney Student, R.C.P. and S.I.

Testimonial to Dr. Anthony Roche.

AN interesting ceremony took place recently at the Royal College of Science in Dublin, when Professor Anthony Roche was presented by upwards of 150 students, on the conclusion of his course of lectures on sanitary science, with a piece of plate. Mr. William Field, M.P., occupied the chair. The efforts which Professor Roche has made in the cause of popularising the study of sanitary science are well known.

London Hospital Medical College.

As Emeritus Professor of Clinical Surgery, Mr. Jonathan Hutchinson, F.R.S., will deliver a Course of four lectures on Tuesdays, June 12th, 19th, and 26th, and July 3rd, at 3 o'clock, in the Clinical Theatre at the Hospital, on the following subjects:—(1) June 12th—On the Transmission of Syphilis to the Third Generation. (2) June 19th—On Syphilis and Tuberculosis. (3) June 26th—On Tuberculosis and Diseases of the Skin. (4) July 3rd—On Diseases of the Skin caused by Insects. Members of the Profession will be admitted on presentation of their address cards.

Large Legacies by a Medical Man.

DR. THOMAS CORBETT, of Droitwich, formerly in practice as a surgeon at Kingston-on-Thames, has left property valued at £388,729 gross, including £48,314 in net personalty. In addition to his legacy of £10,000 to Worcester for pensions for the blind poor previously announced, he has bequeathed £5,000 each to the following London hospitals:—Guy's Hospital, St. George's Hospital, Middlesex Hospital, St. Thomas's Hospital, University College Hospital, Great Ormond Street Hospital for Sick Children, and the East London Hospital for Children. There are numerous other bequests to charities mentioned in the will, amounting altogether to over £96,000.

London School of Tropical Medicine.

AN "at home" at the Royal Albert Dock Branch of the Seamen's Hospital Society on Saturday, May 19th was attended by about 200 executive officers of all the London and many provincial hospitals. The occasion was the completion by Mr. P. Michelli, Secretary of the Seamen's Hospital Society, of his year of office as president of the Hospital Officers' Association, and among those present were:—Sir Francis Lovell, Sir Frederick Young, Captain Tunnard, Mr. Keith D. Young, the Society's architect, Mr. W. R. Pite (architect to the new King's College Hospital), Dr. Harford (of Livingstone College), Dr. C. C. Choyce (Medical Superintendent of the "Dreadnought" Hospital), Capt. Worlidge, Mr. Walter Alvey (honorary secretary Hospital Officers' Association), and Mr. Charles T. Walrond (consulting engineer St. George's Hospital and the Children's Hospital, Great Ormond Street), and many others. The Hospital and London School of Tropical Medicine in connection therewith were open to inspection, details of the building being given by Mr. Keith D. Young. A lantern demonstration was given in the theatre of the school and a demonstration of microscopic specimens of the parasites of malaria, sleeping sickness, &c., was given by Dr. Stanton in the laboratories. Speeches were delivered by Sir Fredk. Young and others, and opportunities were afforded for visiting vessels of the P. and O. and Ocean lines.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially Compiled for THE MEDICAL PRESS AND CIRCULAR.

RECENT SURGICAL LITERATURE.

The Diagnosis and Surgical Treatment of Gall-Stones.

—G. A. Syme (*Intercolonial Med. Journ.*, March 20), first calls attention to the diagnosis of gall-stones, the classical symptoms are usually given as severe pain, or colic, with vomiting, often rigors and fever, jaundice, and the passage of the stone in the motions. It is also stated that gall-stones may exist for a long time, without giving rise to symptoms of any sort; the results of operative treatment have, however, shown very clearly that gall-stones produce symptoms, though not the typical ones above mentioned, and hence are often overlooked. Among a large series of cases submitted to operation, half had never had biliary colic, and in half of those who had suffered from pain, it had been called gastralgia. Only 25 per cent. had been jaundiced, while the passage of a stone had hardly occurred in any of the cases. On the other hand, 80 per cent. complained of digestive disturbances, and in almost every case the earlier treatment had been for gastritis. It can be said with truth that the most common symptom of gall-stones is indigestion. The indigestion has, as its natural and expected sequence, an attack of nausea and vomiting, indeed gall-stones may give rise to all the symptoms of pyloric obstruction. Too great stress cannot be laid on the importance of early diagnosis of the presence of concretions in the gall bladder or ducts, also the error of regarding them as harmless because they do not produce any serious symptoms at the time, and the necessity for early operation as soon as their presence is suspected. G.

Metastases in Gonorrhœa.—W. Schwetz (*Revue Med. de la Suisse Romande, Jan.*), calls attention to the metastases which occur in addition to the local complication of gonorrhœa. The metastases may be divided into those in which the gonococcus may be demonstrated, and lesions of the skin and nervous system, the specific nature of which is clinically inferred. Of the first class, arthritis, bursitis, and teno-synovitis are the most common. Gonorrhœal endocarditis has often been observed, but nearly always in cases in which joints are already affected. Cases of pericarditis, pleurisy, phlebitis, and cerebro-spinal meningitis depending on the presence of the gonococcus, have been recorded. Gonorrhœal peritonitis should be classed rather as an extension of the infection than as a metastasis; less frequently the gonococcus can give rise to suppuration in the subcutaneous, or inter-muscular connective tissue. The coccus in all these cases is transported by the blood stream, and not as is sometimes supposed, by the lymphatics, the knee being so frequently infected is explained by the frequency with which this joint sustains slight injuries, which act as predisposing causes to the infection. As to the infections which are regarded on clinical grounds as complications of gonorrhœa, it is difficult to exclude the possibility of coincidence, or the presence of other causes. The eruptions are usually seen in cases with severe joint lesions, and may assume the form of erythema, purpura, or keratosis. While erythema may be attributed to the administration of copaiba, its occurrence when the drug is not taken, seems to imply a causal connection. Neuralgia in the form of sciatica, and peripheral neuritis may occur, optic neuritis is a very rare complication. In some cases atrophy of groups of muscles have been observed, without any implication of the corresponding joint. The cutaneous and nervous manifestations of gonorrhœa are due probably to toxins, which act in a manner analogous to those of diphtheria. G.

Scopolamine-Morphine — Chloroform Anæsthesia — H. J. Whitacre (*New York Med. Jour.*, March 31) gives

his views on this form of anæsthesia, the results were somewhat irregular, the application of the drug sometimes difficult, but in the great majority of the cases the patients enjoyed a freedom from the pre-operative and post-operative discomforts which was most gratifying. If the anæsthetic is safe there is abundant reason for its use in surgery, if the use of this drug is attended with danger, this should be made clear. With this object in view the author undertook a number of experiments on animals, combined with an extensive research of the literature on this subject; from this work he draws the following conclusions: (1) Scopolamine-morphine narcosis is not devoid of danger; (2) The use of scopolamine and morphine alone for surgical narcosis is not justifiable, and in his experience is not practicable; (3) a single dose two hours before operation, lessens the discomforts attendant upon the operative procedure to a high degree, and may obtain a definite place in surgical practice; (4) four deaths have occurred in a series of 2,400 cases, which have been so definitely related to the use of this method of narcosis, that they may be called scopolamine deaths. This, however, in the absence of autopsy demonstration; (5) these deaths have been reported as occurring with a type picture of alkaloid poisoning, and heart failure has been given as a direct cause of death; (6) a fatty degeneration of the liver and kidneys has been produced by repeated doses of scopolamine alone, and of scopolamine with morphine, in animals; (7) this method of producing or assisting narcosis cannot yet be recommended for use in general practice in spite of the great advantage it seems to offer; (8) scopolamine has a tendency to rapidly lose its power after it is placed in solution. A solution more than three days old should never be used. G.

Operation for the Radical Removal of Penile Carcinoma.—Nicoll (*Glasgow Medical Journal, May, 1906*), describes the method of operation he has employed for the last eleven years on epithelioma originating in the anterior part of the penis. In these cases the lymphatics pass almost wholly to the dorsum of the penis, the main vessels passing back on either side of the dorsal vein to the glands in the groin in the first instance, secondarily to the deep inguinal glands. The corpora cavernosa, the posterior parts of the corpus spongiosum, and the intra-pelvic glands are only affected secondarily and late in the process of the disease. A "Y" incision is employed. The "O" loop obliquely encircles the penis, and is merely skin deep. The "leg" of the Y extends along the dorsum of the penis. Through it the dorsal lymphatic glands are dissected out *en masse* with the dorsal bloodvessels, and all surrounding areolar fascia. The "arms" of the Y extend along the folds of the groins. They constitute deep wounds through which are removed all the superficial inguinal glands, and surrounding fat, and through which are also removed any deep inguinal glands found on exploration of the retro-peritoneal fat round the iliac vessels on the brim of the pelvis. The corpora cavernosa are divided transversely by transfixion, at the line of the skin incision round the penis. The corpus spongiosum is divided in a line somewhat anterior to the above and obliquely leaving the inferior lip of the divided urethra longer than the superior. When the wound is closed this ensures a meatal orifice with a "spout-like" inferior lip. Drainage is necessary, as one effect of the wholesale removal of fat and lymphatics from the groin is a lymphorrhœa from the groin wound. No catheter is

tied in, but regular catheterisation is practised for three or four days. The immediate results in the nine cases operated on by the author have all been satisfactory. Recurrence has not taken place in four patients (whose history was followed) after eight, six, five, and four years respectively. One early case died within eighteen months of extensive carcinomatous involvement of the deep inguinal glands. The seventh case died after three years with symptoms of hepatic cancer. The last two cases were operated on within the past year.

Extra-peritoneal Transplantation of the Ureters into the Rectum in Extroversion of the Bladder.

—London (*Brit. Med. Journ.*, April 28th, 1906) describes his method of operative treatment in extroversion of the bladder. The operation is commenced by completely dividing the artificial front wall of the bladder (if plastic operations have already been done) in order to expose the trigone. A director is passed up each ureter to serve as a guide. A button or rosette of mucous membrane, about the size of a sixpenny piece, is cut around the ureteral orifice, so as to save any valvular or sphincteric action which that opening might possess. By means of the director the termination of the ureter can be easily defined in the thickness of the bladder wall, followed and stripped up from the sub-peritoneal tissue. On passing the finger into the rectum, nothing more than its coats are found to intervene between it and another finger in the sub-peritoneal tissue. A pair of Lister's forceps are guided along the finger in the bowel and thrust through its walls; its blades are opened widely enough to seize the end of the ureter, which is then drawn through into the rectum, and kept there in position with an ordinary pair of clip forceps. The same manoeuvre is repeated on the opposite side, and the operation thus completed. The handles of the forceps dangle outside the anus. In the case of the operation particularly described the forceps attached to the right ureter were accidentally removed, and whilst the left ureter remained permanently transplanted, the right worked out of the rectum very soon. About a month later the right ureter was fixed into the sigmoid flexure, by a modification of Maydl's trans-peritoneal operation. The operation which was performed in 1899 is a complete success. The fears that used to be entertained as to the rectum being unable to tolerate the presence of urine are quite unfounded, as the patient who is now seventeen years old, can go all night without trouble. A modification of technique used by the author in subsequent operations consists in first inserting a rubber catheter with its point removed, into the ureter, and stitching it to the mucous membrane. This facilitates the drawing of the ureter into the rectum without so much bruising of the orifice.

Intubation of the Larynx in Cases of Diphtheritic Dyspnoea.—McCaul (*Dub. Journ. of Med. Science*) describes the technique of intubation of the larynx by O'Dwyer's tube, and discusses its advantages as compared with tracheotomy in hospital practice. His figures are taken from the cases treated in the Bristol Royal Infirmary during the last nine years. Out of the total of 300 serious cases on 36 tracheotomy alone was performed. Of these 25 or 69.4 per cent. died. In 85 equally severe cases intubation was followed by 15 deaths, or a mortality of 17.6 per cent. In addition, there were 40 cases in which it was necessary to do both tracheotomy and intubation. Of these 27, or 67.5 per cent. died. In 32 of these latter cases tracheotomy was necessary after intubation, owing to obstruction below the tube by membrane in the trachea. Blocking of the tube by membrane pushed down during introduction occurred in two cases, both of which were saved by prompt tracheotomy. In the author's opinion the advantages of intubation are—
1) Great diminution of mortality as compared with tracheotomy, especially in the first three years of life. (2) The absence of wound in the neck. (3) Celerity, the time usually required being 5—10 secs.,

after the gag has been inserted. (4) There is much less danger of subsequent pneumonia. (5) Intubation is easier to perform than tracheotomy. (6) In hospital practice intubation throws less work on the hospital staff.

Transient Blindness due to Spasms of the Retinal Artery.—R. A. Lundie (*Ophthal. Rev.*, May, 1906) records a case of transient blindness which he was able to watch with the ophthalmoscope. There was a short constriction of the vessel supplying the blind part of the retina which gave Lundie the impression of its being pinched between the thumb and forefinger. After administering a stimulant there was partial relaxation of the spasm. The patient recovered his sight within an hour from the onset. In discussing the subject the author says that spasm is the only explanation of the symptoms and appearances which seems feasible, since embolism or thrombus could hardly pass away as quickly as the symptoms do in many of these cases. Besides, the attacks are very liable to recur, and too often become permanent. Lundie is unable to explain the cause of the spasm. Many cases recorded as retinal embolism have been preceded by prodromal attacks of temporary loss of sight which may have been caused by spasm; the final attack differing from the others in its permanency. Spasm of the retinal arteries has an interest not confined to ophthalmology. If we have spasm occurring in arteries which are open to inspection is it not probable that we may have it elsewhere giving rise to symptoms not easily accounted for. In some of these cases of retinal spasm there is also found diplopia which can hardly be explained, except by an extension of the spasm beyond the retinal arteries to those of some part of the extra-ocular neuro-muscular apparatus. To arterial spasm may be credited, perhaps, some of the transient disturbances of the brain and other parts. While recording a condition which, although not a rarity, is seldom observed in operation, Dr. Lundy seems to avail himself of the opportunity of driving a nail into the coffin of retinal embolism.

Toxic Amblyopia.—Wray (*Trans. Ophthal. Society*, Vol. XXV., 1905), gives his views on this subject. Tachycardia may be found accompanied or unaccompanied by amblyopia in excessive smokers. In the cases of tachycardia from tobacco poisoning, there is no "toxic breath" as is always the case in amblyopia from the same poison. Pipe smokers and particularly those whose teeth are carious, furnish most of the cases of amblyopia. Cigarettes hardly ever cause this form of amblyopia. The giving up of tobacco does not always insure a complete cure, a positive scotoma in some cases persisting throughout life. The treatment Wray advises consists of abstinence from tobacco, drinking large quantities of water during the day—five pints—with moderate exercise and open-air life. In some cases he gives pot. iod. as a diuretic to avoid diarrhoea setting in. In 14 to 16 days he has seen vision improved from $\frac{1}{8}$ to $\frac{3}{8}$ in some cases.

Collargol Frictions in Panophthalmitis.—Baudoin (*La Clinique Ophthal.* 25 Juillet, 1905), relates having cured, or perhaps, aborted a case of panophthalmitis. At the first dressing after operation the wound was noticed to be badly infected. The treatment consisted of rubbing 20 per cent. collargol ointment for eight minutes into the skin of the inside of the arm which had first been thoroughly scrubbed to redness. The eye was treated with instillations of methylene blue and scopolamine and a dressing of 5 per cent. hermophenyl compress. Frictions were continued until the fifth day when the eye was out of danger. In a second case the infection was brought to a stand in eight days by this treatment.

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

NOTICES TO CORRESPONDENTS, &c.

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

ACCEPTED LECTURES AND ORIGINAL PAPERS.

The following have been received and are hereby acknowledged:—
Clinical Lecture "On Cough," by Arthur P. Beddard, M.D. Cantab., F.R.C.P. Lond., delivered at Guy's Hospital.

Clinical Lecture on "Inflammation of the Conjunctiva," by A. Maitland Ramsay, M.D., Professor of Ophthalmology at St. Mungo's College, Glasgow, delivered at the Glasgow Ophthalmic Institution.

Clinical Lecture on "The Clinical Examination of the Blood," by Arthur Whiting, M.D., M.R.C.P. Lond., delivered at the North London Post-Graduate College.

Clinical Lecture on "The Hæmoptysis of Tuberculous Subjects," by Professor G. Lemoine, M.D., of the Paris Faculty of Medicine.

Paper on "The Diagnosis of Some Acute Abdominal Diseases," by A. S. Barling, M.R.C.S., M.R.C.P. Lond., Surgeon to the Royal Lancaster Infirmary.

Paper on "The Treatment of Appendicitis," with cases (illustrated), by Dennis Kennedy, F.R.C.S., Surgeon to Jervis Street Hospital and to the Children's Hospital, Dublin.

Paper on "The Fulminating Form of Appendicitis and its Treatment," by H. J. Robson, M.R.C.S., M.R.C.P. Lond.

R. A. M. (Worcester).—The late Dr. Thos. Corbett, who has recently bequeathed the large legacies to hospitals, is not the gentleman of the same name familiarly known as "The Salt King." The latter died some years ago, leaving also a large fortune. Both were connected with Drogheda, and it is probable were related, but of this we have no knowledge.

NORTHUMBERLAND.—The terms offered do not appear to us to be adequate. On principle, therefore, our correspondent should decline to accept them.

MEDICAL EDUCATION.—Our correspondent's letter on this subject is unavoidably crowded out.

EXPERTS CREDO.—The preparation is no longer included in the "British Pharmacopœia."

STUDENT.—There is no objection, if it is a convenience, to paying the fees by instalments.

L.R.C.P. LOND.—The notice desiring the practitioner to cease attendance was quite in order, seeing that it was courteously expressed.

A HIGHLAND PRACTITIONER.—The relationship stated does not preclude a fee from being charged for services rendered.

G. E. S. (Manchester).—The next examination for commissions in the Indian Medical Service will be held in London on July 24th and four following days. Forms of application must be applied for previously at the India Office.

THE SEATING ACCOMMODATION AT THE ROYAL MEDICO-CHIRURGICAL SOCIETY.

We have received two letters from correspondents complaining of the hard wooden seats on which members are compelled to sit when attending any of the various Society meetings held within the Hanover Square building. One correspondent puts his protest in rhyme, the burden of which is summed up in the concluding lines:—

"It's no wonder at all the attendance is small,
For you might as well sit on the top of a wall."

After this lament we would suggest to the Council of the Society that members be induced to attend meetings in greater numbers by the promise of comfortable armchairs.

DR. JOHN DOCTOR YOUNG.

One of the witnesses in a case at the Blackpool County Court last week was Dr. Young, a local practitioner, and when he informed Judge Hamilton that his full name was John Doctor Young, his Honour remarked, with a smile, "That's curious. So you are Dr. John Doctor Young?"

Meetings of the Societies, Lectures, &c.

WEDNESDAY, MAY 30th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. J. Pardee: Clinique. (Surgical). 5.15 p.m. Lecture.—Dr. H. Tilley: Hoarseness—its Clinical Significance, Diagnosis, and Treatment.

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

THURSDAY, MAY 31st.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m. Lecture.—Mr. J. Sherren: Some Points in the Surgery of the Peripheral Nerves.

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

FRIDAY, JUNE 1st.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. L. Paton: Clinique. (Eye).

ASYLUM WORKERS' ASSOCIATION (11 Chandos Street, Cavendish Square, W.).—4 p.m. Annual General Meeting. Sir John Batty Tukey M.D., M.P., F.R.S.E., President of the Association, in the Chair.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m. Operations. Dr. R. Bradford: Medicine.

3.15 p.m. Mr. McGavin: Surgery. Out-patient Demonstrations:—10 a.m. Surgical and Medical. 12 noon. Skin.

SATURDAY, JUNE 2nd.

LONDON SCHOOL OF CLINICAL MEDICINE (Dreadnought Hospital, Greenwich).—2.30 p.m. Operations. Out-patient Demonstration:—0 a.m. Surgical and Medical. 11 a.m. Eye.

Vacancies.

Cornwall County Asylum, Bodmin.—Third Assistant Medical Officer. Salary £135 per annum, with board, furnished apartments, washing, &c. Applications to the Medical Superintendent.

Huddersfield Infirmary.—Senior Male House Surgeon. Salary £80 per annum, with board, residence, and washing. Applications to Mr. J. Bate, Secretary, Infirmary, Huddersfield.

Bristol Royal Hospital for Sick Children and Women.—House Surgeon. Salary £80 per annum, with board, rooms, and attendance. Applications to the Secretary.

Devon County Asylum.—Assistant Medical Officer. Salary £125 per annum. All found. Applications to Medical Supt., County Asylum, Exminster.

North-Eastern Hospital for Children, Hackney Road, Bethnal Green, E.—Resident Medical Officer. Salary £100 per annum, with board, residence, and washing. Applications to the Secretary.

Northumberland House Private Asylum, Finsbury Park, N.—Assistant Medical Officer. Salary £120 per annum. Applications to the Medical Superintendent.

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

Bethlem Hospital.—Two Resident House Physicians. Honorarium £25 each per quarter will be paid. Applications to the Treasurer, Bridewell Hospital, New Bridge Street, E.C. (See advt.)

Parish of Birmingham.—Workhouse Infirmary.—Assistant Resident Medical Officer.—Salary £104 per annum, with furnished apartments, rations, coal, gas, laundry, and attendance. Applications to Charles Fletcher, Clerk to the Guardians, Parish Offices, Edmund Street.

Appointments.

COOMBE, CAREY, M.D., B.S. Lond., Demonstrator of Pathology to University College, Bristol.

FRESHWATER, J. D. H., M.B. Cantab., House Physician at the Essex and Colchester Hospital.

GARDINER, PETER, M.D., C.M. Glasg., D.P.H. Lond., District Medical Officer by the Redruth (Cornwall) Board of Guardians.

HALL, ARTHUR, M.D. Cantab., Visiting Physician to the Sheffield Union Hospital.

HAYES, T. CRAWFORD, M.D. Dub., F.R.C.P. Lond., Professor Emeritus of King's College and Consulting Physician to the Hospital.

LYNCH, D. M.D., M.Ch. R.U.I., Certifying Surgeon under the Factory and Workshop Act for the Slieveveagh District of the county of Cork.

MARSHALL, J. A., M.D. Durh., House Surgeon at the Swanses Hospital.

STEEN, ROBERT HUNTER, M.D. Lond., Demonstrator in Psychological Medicine at King's College.

STRATFORD, HOWARD M., M.R.C.S., L.R.C.P. Lond., Surgeon at the Essex and Colchester Hospital.

TURLE, G. DE B., M.D., B.S. Durh., M.R.C.S. Eng., L.R.C.P. Lond., Obstetric Registrar and Tutor to King's College Hospital.

WILKINSON, GEORGE, M.B. Cantab., Visiting Surgeon to the Sheffield Union Hospital.

Births.

BEVAN.—On May 25th, at Kensington Garden Terrace, the wife of Arthur Bevan, M.D., of a daughter.

CROWE.—On May 22nd, at Homeleigh, Yelverton, the wife of H. Warren Crowe, M.D., of a daughter.

EMPSON.—On May 22nd, at Milborne Port, Somerset, the wife of John Empson, M.D., C.M., L.R.C.P.I., L.R.C.S.I., L.M., of a son.

FIELDING-GOULD.—On May 23rd, at 94 Mount Street, Grosvenor Square, London, the wife of R. Fielding-Gould, M.A., M.D., M.R.C.P., of a daughter.

MACNAMARA.—On May 17th, at Bankyle, Corodun, the wife of Dr. Geo. U. Macnamara, of a son.

PURDY.—On March 27th, at Port Said, J. S. Purdy, M.D., F.R.C.S., Surgeon-Captain New Zealand Militia, of a son.

WADDELOW.—On May 22nd, at the Chantry, Whiteley, the wife of John J. Waddelow, J.P., F.R.C.S. Eng., of a daughter.

Marriages.

CHRISTISON—FLOWER.—On May 24th, at St. Jude's, South Kensington, Fred Hamilton Christison, son of the late James Christison, M.D., of Preston, to Kathleen, daughter of the late Major Lamrock Flower, of Saltford, Somerset.

GRAY—FRAMPTON.—On May 23rd, at St. Alban's, Teddington, Ronald Evelyn Gordon Gray, M.A., M.B., B.C. Cantab., M.R.C.S., younger son of the late Archdeacon Gray, M.A., D.D. Cantab., and of Mrs. Gray, of Kensington, to Ethel, younger daughter of Algernon Frampton, of Teddington.

Deaths.

ASHMEAD.—On May 11th, at 850 West Twenty-third Street, New York, of tubercular meningitis, Sarah, wife of Albert S. Ashmead, M.D.

JACOB.—On May 25th, at Reigate, Edward Long Jacob, M.R.C.S., M.R.C.P., eldest son of the late Rev. George Andrew Jacob, D.D., aged 72.

MACCORMACK.—On May 24th, at 13 Malone Avenue, Belfast, John son of the late Henry MacCormack, M.D.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

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WEDNESDAY, JUNE 6, 1906.

No. 23.

NOTES AND COMMENTS.

Stamp-Lickers' Tongue.

SOME years ago we pointed out the dangers that lurk in the licked postage stamp, and coined the phrase "stamp-lickers' tongue" to describe an evil resulting therefrom. Since then much has happened—especially in the education of the Post-Office authorities, who now supply the public with "moisteners" at most of the large offices. Now it seems clear enough that any danger such as that pointed out must arise from the gummed side of the stamp. We stated that the risk was due to bacteria either native to or acquired by the sticky medium, which was in some instances stated to be made of horse-serum. We notice that our esteemed contemporary, the *Lancet*, has gone one better by detecting poison in the yellow threepenny stamp. It is not easy to understand how that section of the public which still adheres to the reckless practise of stamp-licking can be affected by the pigment used by the printer, unless, indeed, he takes to the expensive luxury of eating stamps. Poison, however, is a subtle thing, so it is perhaps well that the whole matter is being officially investigated. The poison in the case of the yellow stamp is said to be chromate of lead, and thereby hangs a tale of danger that is not phantom.

Lead in Pepper.

THE real and deadly peril to which we allude is not relegated to the picture side of a postage stamp, but is placed on our breakfast and dinner tables, and actually swallowed. There is strong reason to believe that chromate of lead is systematically used for the adulteration of yellow and red pepper. Several years ago a partner in some large lead works told the present writer of an extensive order for chromate of lead which was openly purchased for the purpose of adulterating pepper. Clearly, there could hardly be a more insidious or more deadly way of slowly poisoning that part of the community which seasons its food with the condiments of Cayenne or of Nepaul. For various reasons the examination of specimens of those two peppers by public health authorities is a rare occurrence, but the facts as stated are perfectly well known to every public analyst of experience. Both the peppers in question are so highly priced that adulteration becomes a game yielding large profits. Here is a simple lead adulteration that would reward official investigation with more sensational and useful "copy" than the consider-

ation of poisons that may or may not enter fractionally into the printers' ink of coloured stamps.

The L.S.A. (London) Diploma.

The General Medical Council has approved the principle of the proposed Act to vary the diploma laid before them by the London Society of Apothecaries. The draft Bill provides that the holder of the diploma shall be entitled to registration as a "Licentiate in Medicine and Surgery of the Society of Apothecaries, London." The letters to indicate so cumbersome a title will be multiple indeed, and it seems a great pity should the Apothecaries be unable to hit upon a terse description connecting the possession of both medical and surgical qualifications by its licentiates. The change in the description of the licentiateship has been inevitable ever since the Apothecaries took to medical and surgical practice. For generations the dispute as to the precise definition of the L.S.A. has been carried on with more or less acute remissions. Should the qualification become really popular under its new guise, it will prove a formidable rival to the Scotch and Irish Colleges. After all, it is only natural that Englishmen should prefer to have a London qualification, provided it can be obtained on equal terms and carries a status equal to that of minor provincial qualifying bodies.

Teaching of Midwifery.

The report of the special committee of the General Medical Council appointed to inquire into the operation of the rules regarding the midwifery practice of candidates for medical qualifications came under the consideration of the Council at its last meeting. It is a document of far-reaching importance, and, if acted upon, would, we believe, lead to a complete and long needed reform in midwifery teaching. The main trend of the committee's recommendations are in the direction of ensuring that students shall conduct twenty cases of labour in the intern or extern maternity department of a hospital after, and not until after, he has received sufficient preliminary instruction to enable him to profit by his bed-side experiences. Everyone who has any knowledge of the manner in which students are allowed to attend their cases in many institutions will understand at once how important such a change will be. It means two things, first, that the student will receive his instruction from persons competent to instruct him, and, secondly, that he

will receive it at a time when he is capable of mentally benefitting by it.

The Royal Commission on Trinity College, Dublin.

The eagerly awaited list of the members of the Royal Commission on Trinity College, Dublin, and the terms of reference have at last been published, and on the whole will, we believe, be found to give satisfaction both inside and outside the walls of that ancient seat of learning. In order that the Commission may get with as little delay as possible to the essential part of its labours, the report of the previous Commission on Higher Education in Ireland which sat in 1901 will be taken as read, and the labours of that Commission be considered as introductory to those of the present Commission. It is hoped that by this means a considerable amount of time will be saved.

Small-pox and Notification.

Under the familiar heading "How Disease is Spread," an account is published in a Manchester evening newspaper of a singularly gross and callous offence against the Notification Acts. In the police court it was stated that a Town Council official visited defendant's house and found that the whole of the family had suffered from small-pox. The mother and one of the boys were actually suffering from the malady at the time of his visit, but the boy continued at work. A girl attended school all the time. It was shown in evidence that the mother went to a public house to purchase beer, and that a man next door contracted the disease. The defence was that a month before a medical man said one of the children had chicken pox and the parents thought the rest were similarly affected. In a case of this kind it is clearly impossible to ascertain the extent of the resulting mischief. For weeks past an epidemic of small-pox has swept through the district, a fact that the existence of a single undetected and circulating focus of infection such as that of the family in question would quite account for. The loss in sickness and death arising therefrom would most likely reach in the aggregate a very large sum. The magistrates inflicted a fine of 5s. 6d. upon the parents for each of the two children exposed.

LEADING ARTICLE.

HOSPITAL ISOLATION AND SCARLET FEVER.

IN the autumn of 1904 we published a series of papers by different writers on the subject of scarlet fever and its preventive treatment by means of isolation hospitals. All these writers took the view, in which we ourselves concurred, that scarlet fever had shown itself refractory to hospital treatment, and that there were other objections to the method which were sufficiently grave to call for a full and authoritative inquiry. At that time, our voice was as one crying in the wilderness, but since then we have noted signs that the demand has had the sympathy not only of our contemporaries, but also of many prominent sanitarians, lay and medical. No doubt it needs a little boldness on the part of those who have advocated the erection of hospitals for scarlet

fever, to admit now that the system has proved far less successful than was anticipated, and, indeed, promised, but if as has been shown there are many serious drawbacks to the hospital system, it is wise and necessary that the whole question should be considered *de novo*. It cannot be contended that isolation hospitals are not in many ways a convenience to the medical officer of health and to the poor, but there are also specific dangers in them, and after all they were established not for the purposes of charitable relief but for the prevention of the spread of scarlet fever. It is now not in doubt that the hospitals have conspicuously failed to fulfil their primary object, and one can hardly wonder if grumbles and rumours of grumbles are heard in various quarters as to this result. Several medical officers of health have been led to make inquiries in their own districts as to the effect that has been produced in them by the establishment of hospitals, and though some of these investigations have furnished some evidence more or less favourable to the system, none of it has been really definite or conclusive. On the other hand, others have been equally astonished to find how little preventive work their hospitals have done. Dr. Thresh, Medical Officer of Health for Essex, speaking at a meeting of the Chelmsford Rural District Council the other day, said that his faith in the utility of infectious hospitals had been shaken in 1902, and from his own inquiries and reports received from other districts he had been bound to modify his views. In his annual report he stated that as a result of his study of the scarlet fever cases in his district, that where patients were removed from houses in which there were susceptible inmates practically as many secondary cases occurred in these houses as in those from which the patients were not removed. The cause of the failure of hospitals, he said, was so patent that one could only wonder it had not been recognised before, namely, there were so many patients suffering from mild attacks of scarlet fever and diphtheria, and so many healthy persons with the organism of these diseases in their throats, that spread took place far and wide from these unrecognised sources. This being so, it was obvious that no improvement in hospital administration or methods of treatment could have any effect in controlling the dissemination of these diseases. Dr. Thresh further made the significant statement that from his experience he could say that the majority of cases, if they could have reasonable care and attention, did better at home than in hospitals, where mild and severe cases, and acute and convalescent ones, were mixed indiscriminately in wards. He held that the provision of hospital facilities was a question for every district, and should be decided on the special circumstances presented by each district. We need hardly point out that words to this effect coming from so high an authority as Dr. Thresh, are worthy of peculiar respect and attention, and thus confirms amply the contentions raised in THE MEDICAL PRESS AND CIRCULAR nearly two

years ago. Moreover, other medical officers of experience, notably Dr. Arnold Evans, of Bradford, have written and spoken in a similar strain. Indeed, there are signs that the arguments used have at last filtered through to the medical department of the Local Government Board, for we hear that that Board are thinking of appointing a Commission to inquire into the working of the hospital system. We hope this is so, and we also hope that the Commission will be composed of members perfectly independent of Government influences, for it must be remembered that the Local Government Board itself has for twenty years been deeply committed to the system and has urged the indiscriminate provision of isolation hospitals on local authorities all through the country. The Commission should be free to express whatever views it forms precisely from the evidence tendered to it, that is, if its conclusions are to command general respect.

NOTES ON CURRENT TOPICS.

Clairvoyance and the Studio Murder.

It is hardly possible to imagine the daily press as a whole taking a less dignified attitude than that it has adopted towards what is called the "studio" murder. A sordid tragedy which must have caused ineffable pain to the relatives of the dead artist, and which might have well been left in the hands of the detective department, has been boomed for "copy" by many of the most popular journals as though it were a horse race or a cricket match. The psychological condition of a public which demands such detail in its horrors and of a press which retails them with ill-concealed gusto cannot but be a cause for anxiety to those who care for the sanity of their generation. By way of introducing an extra sensation into its columns the *Tribune* lately published a "dramatic statement" by a clairvoyante, in which this anonymous person sought to give a connected story of the crime. The clairvoyante is said to have been led to the work by a physician for whom and with whom she works, and this physician gave his time without "any pecuniary return or recompense of any nature." We think he might have been better employed. The whole of the visions seen by the clairvoyante are palpably reproductions of an early theory of the crime, backed up by some equivocal detail which can be made to mean anything or nothing. The only value attached to the statement is that it pins the clairvoyante to certain definite facts, which are now known almost certainly to be untrue, and in the event of an arrest being made they will be shown to be so. We would like to call attention to this "dramatic statement" merely for the purpose of fixing beforehand a tissue of "facts" which are already becoming attenuate as fresh evidence accumulates, and are likely to fade altogether when the full light of day is turned on. We fancy that this column of sensations will demonstrate pretty well what clairvoyance is worth.

The London & Counties Protection Society. THE recently issued annual report of the London & Counties Medical Protection Society is an interest-

ing document. It registers the combined progress of an excellent movement, and shows once again that medical men are by nature fitted for organisation. During the year 1905 no less than 446 new members were elected, and the total membership at the end of the year reached the encouraging figure of 3,552. At the same time the total income amounted to £2,069, 18s. as compared with £1,669 2s. 11d. in the previous year. But perhaps the most important financial fact in connection with this Society is that the reserve fund stands at £2,164 18s. 9d., and the total cash assets at £2,467 4s. 3d. Turning to the body of the report we find numberless instances in which members have been defended and aided in time of difficulty. The Society has also taken up the question of coroner's inquests in general, and Mr. Troutbeck's attitude in particular. While the Society must be congratulated upon their prosperity, it still remains a matter of unceasing regret that they cannot join forces with other organisations of a similar nature. It is the clear and bounden duty of every practitioner to join a body of this kind.

Bar v. Medicine.

A PLEASANT little function took place the other day at Northwood, in the shape of a golf-match between a team of barristers selected from the Bar Golfing Society and a team of doctors led by Dr. Girdlestone. Dr. Girdlestone beat his opponent Mr. Beveridge by the handsome margin of 5 up and 4 to play, and Dr. Simson, Dr. Howarth, and Dr. Dane gained almost equally easy victories over Mr. Simpson, Mr. Hoare, and Mr. Marshall Hall. Two of the matches were halved, and in one only—namely, that between Mr. F. S. Jackson and Dr. Webb, was the barrister successful, and then only on the home green. In a foursome which followed the doctors, represented by Dr. Girdlestone and Dr. Hawkins, did not do so well. They were actually 5 down at the eighth hole, but playing pluckily drew up level at the fifteenth; they lost the next two, however, and Mr. Beveridge and Mr. Bonner, their opponents, thus won by 2 up and 1 to play. We are glad to be able to congratulate the doctors on the prowess they exhibited and the success that attended their efforts, especially as the team consisted of working members who cannot find much time to improve their game. Social contests such as these conducted in a sportsmanlike spirit can do much good in helping medical men and barristers, whose professional interests are so widely separated in many ways, to understand and appreciate each other, and we hope to see many more of them organised and kept up.

French "Maybrick" Case.

FRANCE, that home of wonderful trials, has just emerged from a sensation that vividly recalls our own Maybrick case. A Mdme. Canaby was tried at Bordeaux for having attempted to poison her husband in order to be free to marry a friend who had known her for years, M. Rabot by name. On the facts that were proved there can be no

doubt that M. Canaby was taken ill at his house with arsenic poisoning and that he did not get better of it till he was removed to a nursing home and placed under skilled care. Also that the arsenic was obtained by Mdme. Canaby by means of prescriptions which she forged herself, and that she was in the habit of receiving money from M. Rabot. The extraordinary feature of the case was that M. Canaby declared that he believed in his wife's innocence and declined to take legal proceedings on his initiative. As is usual with female prisoners in France, Mdme. Canaby exhibited a series of neurotic phenomena in the dock and excited the greatest commiseration in the breasts of the public. The jury found her "not guilty" on the charge of attempted murder, but "guilty" of using forged documents, for which latter offence she was sentenced to fifteen months imprisonment. As, however, she had been nearly that time awaiting trial her sentence expires almost immediately. In the absence of full details we do not presume to express our own opinion on the facts, but surely this case, with the evidence so black against the prisoner and a verdict of "Not guilty," will find its way into the text-books of forensic medicine to show either the untrustworthiness of circumstantial evidence or the susceptibilities of French juries.]

Embalmed Beef.

FRESH meat the housewife can form some idea of; tinned meat can be guessed at; but sausages must be taken on trust. The energetic action which President Roosevelt is taking in passing a stringent bill for meat inspection through the American Parliament cannot but give rise to uneasy feelings in this country as to the trustworthiness of the preserved meats that come to us from the States. A novel written by Mr. Upton Sinclair called "The Jungle" caused a great deal of feeling in America. It dwelt in lurid terms on the ingenuity with which unsound meat and the flesh of diseased animals was so prepared for canning, hampickling, and sausage-making that the consumer could not recognise the defects. For ourselves we are inclined to think the book over-reaches itself, as it paints the horrors too thickly and with too warm a brush, but even if a tithe of the tricks adopted by the packers, and winked at by Government inspectors, are founded on fact, it would be well to draw on other sources for our supplies here. President Roosevelt's action, though it will doubtless tend to establish confidence in the trade eventually, is certainly disconcerting to the British consumer at the moment, and the trade would certainly do well in their own interest to take some steps to let the public over here know the full truth about these matters from their own point of view.

Geneva Convention.

JUST as one can kill a cat with a hatchet or by choking it with cream, so can war, that ghastly anachronism which civilised countries still tolerate, be killed either by emphasising its brutalities till people's consciences rebel or else by softening its

rigours till it becomes a farce. The first step in the latter direction was taken in 1864 by the holding of the first Geneva Conference, which it is well to remember was brought about largely through the efforts of a medical man, Dr. Dumant. The second Convention, held four years later, still farther defined the usages which should exist between civilised combatants in warfare; and now the Swiss Government are seeking to extend the principles on which the former Conventions were founded by a further gathering of international representatives. Most of the points for consideration are unfortunately minor ones of convenience, such as the provision of identification plates for soldiers, the prevention of robbery of the wounded, the interchange of casualty lists between combatants, the guarding of the wounded as prisoners of war, and the drawing up of fresh regulations for the hospital corps. Important doubtless as these points are, and much as all humanely disposed people will wish to have them settled, what would be really useful would be if they could be made the basis of a definite policy having for its object the reduction of war to absurdity. It is so illogical already that a soldier should be allowed to bayonet his opponent once, but not to repeat the act if the first blow takes effect, that a very little common-sense is needed to make the whole business of war a byword.

American Preserved Meats.

THE horrors of the American meat trade recently unearthed by that most masterful of men, Mr. Roosevelt, will affect many countries outside the U.S.A. The United Kingdom, for instance, is one of its big customers, but the trade will now most certainly show a rapid fall. There is nothing that impresses the imagination of the man in the street instantaneously and more deeply than anything to do with the purity and the cleanliness of his food. It will take many a day to forget that American potted meats, including game and chicken, are made of worthless odds and ends, often putrid, sometimes rejected and returned from a foreign port, fouled with the excreta of rats, stored in dark and noisome vaults, and ground up incontinently with poisoned rats. As table delicacies of the potted meat variety are not cooked, it seems tolerably certain that many disease organisms must in that way be conveyed to consumers. It is a revolting idea that Englishmen should be riddled with disease due to the cynical filthiness of American meat magnates. As heat destroys microbes some degree of safety may be induced by the thorough cooking of American preserved meats. There is much to be done, none the less, in setting the British house in order. The environment of many bakeries, hotels, and restaurant kitchens, private slaughter houses, sausage factories and other places where food is prepared and stored, is unspeakably unclean on our own side of [the Atlantic. "Preserve us from all preserved meats," would appear the safest maxim under present conditions.

Cotton Wool and Swallowed Foreign Bodies.

THE introduction of radiography has given the surgeon a fresh impetus in the treatment of foreign bodies in the alimentary canal. The use of œsophageal bougies before a screen examination would be nowadays bad surgery except in remote places or in cases of extreme urgency. A recently reported instance of disaster following the attempted instrumental dislodgment of a fragment of mutton-bone in the gullet recalls the cotton wool treatment of such cases introduced about a year ago by Bell, of Liverpool. His plan was simple. He gave the patient a small handful of absorbent cotton wool to eat mixed in gruel or in jam sandwiches. In several cases thus treated the foreign body was passed within twenty-four hours; enveloped in the cotton. The simplicity and safety of this plan should render it a valuable "stand-by" in general practice.

The Humanity of Surgery.

THE most popular view of the surgeon to the vulgar mind is that of a man callous to all the gentler feelings of mankind. Knife in hand he is ready to lay bare the innermost recesses of his fellow creatures, bodies at a moment's notice. Yet in truth his proceedings are all prompted by the highest motives that can animate the human heart—and as a matter of simple statement an immense amount of the good he effects is brought about without the use of a knife. The supreme guiding aim of the good surgeon is to safeguard the welfare of his patient, so far as may be possible to his art. To that end he subordinates all minor considerations, conscious of the fact that his surgery is founded on a real humanity that does not shrink from performing operations for want of resolution. If the body of a lower animal is needed to test some operative procedure or help his patient he exercises his power over that animal in the interests of the human being whose welfare is the paramount consideration. Yet there are shoals of sentimental folk ready to shriek at him as a heartless vivisector, whereas they would willingly sacrifice scores of fish, fowl, and higher mammals simply to feed their sick friend. But the surgeon goes his own way in spite of sentimentalities.

Income-Tax for Medical Men.

THERE are many arguments in favour of exempting incomes earned by professional men from taxation. If the principle is to be applied at all, it would be hard to imagine any single profession entitled to such exemption more than that of medicine. Its members have to work early and late and no large income is attainable without years of arduous application. The greater the success, again, the greater the need of individual exertion, and the fee remains a purely personal honorarium for services rendered until the last day of life. This standpoint is perhaps not sufficiently recognised by all authorities on political economy. Mr. Chiozza Money, for instance, recently remarked that professional incomes are often derived from

services which are of no value to the community. "The existence of a large leisured class," he goes on, "creates an army of attendants who draw big fees, but who most certainly do not earn them. Take the case of a fashionable barrister, who draws hundreds of pounds in connection with a society libel case, or that of a fashionable surgeon, who wastes his time dancing attendance upon well-to-do vermiform appendices, or that of a journalist hot-foot after a scandal." The barristers and journalists may safely be left to defend themselves. With regard to the "fashionable" disease, appendicitis, it may be pointed out that the malady like daylight falls on rich and poor without distinction. Even a great statistician, were he seized by this fatal bowel inflammation, might well expend a hundred pounds or so to secure the attendance, dancing or driving, or even deviling, of a skilled surgeon, otherwise the science of political economy and the House of Commons would probably lose a distinguished ornament. We take it that Mr. Money, like many economists, has sharp limitations in his knowledge of many social conditions, and that the medical world falls in one of the gaps. Under the circumstances, we may congratulate ourselves that the taxation or otherwise of professional incomes will not be settled by Mr. Chiozza Money.

PERSONAL.

LORD AMPHILL will preside at the annual meeting of the Colonial Nursing Association on June 13th, at 3.30 p.m., at the Colonial Office.

MR. WILLIAM EDWIN WILLIAMS, F.R.C.S.Ed., M.R.C.S.Eng., has been elected Chairman of the Bedwelty Division of Monmouthshire, in place of the late Mr. J. D. James, M.R.C.S.Eng.

MR. WILLIAM E. COLLINS, M.D.Lond., it is reported, will shortly be called to the Upper House in the New Zealand Legislature.

THE will of Mr. W. R. H. Stewart, F.R.C.S., late of 42, Devonshire Street, Portland Place, W., and of Wilbet Crofton, Orpington, Kent, a leading authority on diseases of the throat, nose and ear, has been proved at £12,347.

THE will of Dr. John Hamilton Buchanan, M.D., late of Sowerby, Thirsk, Yorks, fellow, ex-president of the Yorkshire branch of the Incorporated Society of Medical Officers of Health, J.P. for the North Riding of Yorks, medical officer of health to the Thirsk Union, has been proved at £12,832.

PROF. METCHNIKOFF, of Paris, who has been delivering the Harben lectures at King's College, is to be awarded the Harben gold medal by the Institute of Public Health, in recognition of his distinguished services to science.

ON Tuesday evening last a large party presented Dr. Anderson, of Ardsheal, with a handsome silver salver on the occasion of his leaving the district, in recognition of his many valuable services in his private and public capacity.

ON June 11th, Sir Donald Currie will lay the foundation stone of the new block of buildings, which is to be added to University College Hospital, London. The extension will include a school for advanced medical studies, a nurses' home, and a maternity students' home.

A CLINICAL LECTURE ON COUGH.

By ARTHUR F. BEDDARD, M.D. Cantab., F.R.C.P.Lond.,

Physician to West London Hospital; Assistant-Physician to Guy's Hospital, London.

GENTLEMEN,—I am going to say a few words about cough. It is a mistake to conclude that some affection of the respiratory tract is the only common cause of cough. That is, doubtless, a common cause, but by no means the only common cause. One difficulty often met with is this—that in many cases of slight bronchitis, on examining the chest, you hear nothing abnormal whatever. In other words, in order to make a diagnosis of slight bronchitis, which in these cases is the cause of cough, you have certainly got to exclude some other things. It is just the same with some people you meet with in the out-patient department who are wearing a plaster over their lower ribs. They have had pain on respiration, you have not heard any rub, but these patients are said to be suffering from pleurisy, this view being founded on the assumption that the commonest pain in the lower part of the ribs is that of pleurisy, instead of being, as it is, that of indigestion. The fact is, there are a large number of symptoms complained of by patients, and the only way in which you can diagnose their cause is by going for what is the commonest thing, and that is a question of experience to find out.

The commonest causes of cough are certain conditions of the pharynx, and then bronchitis, and until you have excluded certain conditions of the pharynx, it is impossible to say to a patient, "You are certainly suffering from bronchitis." Any affection of the respiratory tract may produce cough. You may have cough in pleurisy, or in enlarged glands of the neck, or as the result of things in the external auditory meatus, or in heart disease, or in œdema of the lungs, but nearly all these rarer conditions are early diagnosable by physical signs, and by things obviously existing in each respective case.

What are the conditions in the pharynx that you look for, in order to account for these frequent coughs? The commonest condition certainly is this: When you look down these people's throats you see an extremely red, rather purple, and œdematous-looking pharynx, and a great, long uvula. In many cases you see large venules all over the wall of the pharynx, on the flap of the palate, and also on the uvula itself. The commonest cause of this condition is certainly chronic indigestion, and, in saying that, I am giving you my own personal experience. Some people have the idea that stomach coughs are due to irritation of the vagus in the stomach. I do not believe it, because lots of people have plenty of gastric irritation, but they do not cough, as a rule, unless they have got this condition of their pharynx that I have described. Cough, associated with the external auditory meatus, is said to be due to irritation and consequent stimulation of the vagus nerve there. That may, or may not be true.

In other cases, when you look at the throats of people troubled with coughs, you see something different, especially on the back wall of their pharynx. This is covered by a red, granular, or chronic pharyngitic secretion, which is mucous or muco-purulent in character. That is also common in chronic indigestion, and extremely common in people who smoke too much.

Another condition that leads to cough is elongation of the uvula, due to cold which has relaxed the muscles of the pharynx. In other cases where you get cough, you see large tonsils, or you believe that the patient is suffering from adenoids. Both of these conditions may give rise to cough. As to adenoids, when you look down the throat of a child suffering from adenoids, you may see absolutely nothing; its tonsils may be

normal, and the adenoid tissue is entirely invisible. Adenoids usually block up the posterior nares, but you may have a lot of adenoid tissue present in the pharynx which does not obstruct the posterior nares in the slightest degree. I am trying to point out that lots of children have an abnormal condition of adenoids, which even may be suppurating and causing glands in the neck, and yet have nothing visible in their pharynx, and no obstruction of their posterior nares. The only way to determine whether adenoids are present is to stand behind the child, push its cheeks between its teeth, so that it cannot bite you, for it would have to bite itself first, and then put your finger up the back of its nose. That is perfectly easy to do.

The question is, what would make you think that a person's cough was almost certainly of pharyngeal origin, apart from what you see? It is quite easy to determine, from the sound that people make when they cough, whether they are coughing up stuff from the lungs or whether the cough is simply of pharyngeal origin. One thing that should raise your strong suspicion about a cough which is not bronchial, and has nothing to do with the respiratory track, is this—that the cough practically occurs only night and morning. The reason why some people cough when lying down has, as a rule, something to do with their uvula; why others cough when they rise up in the morning I cannot explain. But people whose cough is entirely pharyngeal cough almost entirely night and morning. It is extremely violent, as a rule, and they bring up a little sticky, dirty mucus, but not much purulent secretion. Then, again, people with pharyngeal cough undoubtedly complain to you of hæmoptysis. It is very common to have patients who are said to be suffering from early phthisis, merely because they have blood-stained expectoration. But everybody who has blood-stained expectoration has not got phthisis. That is a most important thing to impress upon students, because nowadays, if it is suggested that a person has got early phthisis, he is sent to a sanatorium for six months, and that is a serious matter, unless it is absolutely essential. Nor should a diagnosis of early consumption be made in too light-hearted a way, because of the consequences upon your patient of telling him that such is the fact. The hæmoptysis that people bring up from their pharynx is a glairy sort of mucus, with long streaks of blood, very often; whereas, in consumption, people, as a rule, cough up small quantities of pure blood, or blood practically unmingled with anything.

As to the treatment of this condition of the pharynx, I would say, first, do not give your patient gargles. If you want to get between the anterior pillars of the fauces, or to the back wall of the pharynx, it is not the slightest use giving gargles; the stuff will never reach the parts affected. Painting is one certain way by which you can get at the parts affected, but most patients probably paint everything excepting those parts; they paint the tip of their tongue, the soft palate, the hard palate, but never get the stuff into their pharynx, which is the part that they should try to get at. Another way of reaching the pharynx efficiently is by a spray. That means, of course, that the patients must get the necessary instruments, but, unfortunately, out-patients, as a rule, cannot afford to purchase them. Sprays, however, are a most effectual way of getting the fluid on to the whole of the back wall of the pharynx and all the adjacent parts.

I have already said something about mistaking these

people for cases of early phthisis. When I took over the out-patients here, I had, as one of my legacies, a perfectly healthy and strong-looking girl who had been regularly up to the hospital for four years with a diagnosis of early phthisis. It was put down on the letter that "there were no physical signs." A person, of course, who has had consumption for four years without physical signs, is either perfectly well or else she has not had consumption at all. This girl told me that every morning she had blood-stained saliva in her mouth, and there was sometimes some on the pillow. I examined the inside of her mouth and found that she had got a large polypus at the front of her back teeth. That was taken out. I want to emphasise the fact that it does not follow, because a person has got hæmoptysis, that he has also got phthisis. It is most important, therefore, to examine the person's pharynx and mouth carefully, in order to ascertain that there is not some perfectly obvious cause for the hæmoptysis. As a matter of fact, from the character of the hæmoptysis, and the time of day that it usually occurs, you may be able to come to the conclusion that the case is not one of tubercle of the lung at all.

With regard to bronchitis, which is the other, on the whole, most common cause of cough, you can often, by ascertaining the symptoms, get a fair idea as to whether these people's cough is due to bronchitis or not. Persons with bronchitis have very little expectoration, and, as a rule, they experience a sense of tightness of their chest, which is not present in pharyngeal cough. This tightness of the chest indicates that the respiratory mucous membrane is inflamed, and so it is that patients thus affected will tell you they feel "cold air" going down their chest.

As to the use of expectorants in bronchitis: The mechanism for getting fluid out of the bronchial tubes is twofold. You can only empty your large bronchial tubes by coughing. Then, secondly, in order to get the fluid from the small into the large bronchial tubes, there must be shedding of ciliated epithelium, to a large extent. If all the ciliated epithelium in the smaller tubes has been shed, the patient will not be able to get rid of the fluid by coughing. But so long as you can get these people to expectorate, then you may hope that the case will go on satisfactorily.

Now what is your object in giving an expectorant for bronchitis? According to your object you will prescribe your drug; though, let me tell you, I do not believe that any expectorant ever cured bronchitis. But why do I give an expectorant, how long do I give it, and when do I stop giving it? Take a patient who has got a really severe attack of bronchitis. He feels frightfully tight in the chest, and this sensation is a very material discomfort indeed, and you have got to relieve it by treatment, you have got to give an expectorant.

There is one other reason for which I give an expectorant in bronchitis. In the early stage of the disease the patient has in his tubes a thick, viscid fluid, and it requires an enormous effort on his part to cough this stuff up. This effort may be very considerably lightened if you render the secretion more liquid by giving an expectorant. As soon as you have changed the patient's rhonchi into a large rale it means a more liquid state of the sputum, and if you then go on giving your patient expectorants in the same degree as before you may do him a deal of harm. In a rather bad case of bronchitis you may hear rhonchi in the upper part of the chest and rales at the base of the tubes, which means that the patient's expectoration is trickling down the tubes and not coming up. It is, therefore, quite clear that a fairly liquid secretion is a secretion which the patient has not the power to expectorate. You do not now trouble, therefore, to make the secretion more liquid by giving an expectorant, else the patient will be unable to cough it up.

There are conditions, then, in which you must hold your hand in the giving of expectorants. Whenever you see cases of capillary bronchitis, whether in an adult or in a child, but especially in a child, let nothing persuade you to give these people expectorants. By

capillary bronchitis you mean bronchitis of the small bronchial tubes, and you recognise it by hearing all over the lung what are not much louder than crepitation sounds in a case of pneumonia. When you hear these crepitations, and whenever the patients are a bit cyanosed, do not give them expectorants. They are already cyanosed because they cannot get the stuff up. The same is true with regard to broncho-pneumonia, with bronchitis in children. In children there are two kinds of broncho-pneumonia, and these you can distinguish by the physical signs. On examination you may hear in one child's chest, with broncho-pneumonia, the ordinary physical signs of lobar-pneumonia and general bronchitis. In another child you hear patches of bronchial breathing dotted about the chest, and all over the chest there is general bronchitis as well. The first is a pneumococcal primary disease of the alveoli; the second is very often a streptococcal bronchitis which has spread to the alveoli and produced broncho-pneumonia. You may give the first child expectorants if you like, and you may benefit it thereby. But do not give the second child expectorants, because its bronchitis has affected its small tubes to such an extent that the alveoli are diseased, and if you go on pouring ipecacuanha into a child like that, you will certainly help to drown it. That is what generally kills those children.

Another condition in which you should not give expectorants is that of œdema of the lungs, due to heart disease or other causes. In cases of œdema of the lungs you hear fine crepitations, not much louder than pneumonic crepitations, dotted about the lower lobes. Even if these people cough a little, and perhaps bring up blood-stained sputum, do not give them expectorants; you can do them no real good by giving these, and you may do them a great deal of harm, because the trouble is for them to get the stuff out of their bronchial tubes.

There is one other condition in which you should not give people expectorants, and that is when they have acute lung disease and when, instead of coughing, they do not cough at all. That is a most serious condition of lung disease because when their respiratory centre has reached a stage of either circulatory failure or general narcosis, when, as a fact, it ought to be producing dyspnoea and cough, they are then certainly within measurable distance of death. To give these people expectorants is most ridiculous, because they cannot bring up the stuff that they are making, much less the stuff that you are going to persuade them to make. I would also say do not give them opium, because opium does not stimulate the respiratory centre. What you have got to do with these people is to wake up their respiratory centre so as to bring on cough and dyspnoea. The best way to effect this is by giving them oxygen until they are pink, not *slightly* pink merely, and to get them pink it may be necessary to keep them twenty-four hours under oxygen.

There is other treatment that you may adopt in these cases. You may give these people such drugs as will tend to stimulate their respiratory centre, such drugs as strychnine, or strophanthine. Or, in the case of adults, but never in children, you may rub them with block ice. If you want to stir up a person's circulation, or raise his blood pressure, the way to do it is to stimulate the sensory nerves in his skin, and this can be very effectually brought about by wrapping the patient in a sheet and rubbing him with block ice. That will wake up his respiratory centre, if anything will. You cannot do that with children, or even with adults who have already reached a condition of sub-normal temperature; it is only possible to do it in adults, and only in adults, who have considerable pyrexia. You know that the surface of a child's body, as compared with its bulk, is very different to that of an adult, and you cannot afford, in children, to extract enormous quantities of heat out of their bodies with such things as ice. If you do use ice, you must use it with profound care.

In the case of children, the old-fashioned treatment was to give them emetics when they had ceased to

cough, in order that by forcible contractions of their diaphragm they would not only vomit the contents of their stomach, but also empty their bronchial tubes. It is perfectly true that occasionally this can be done. But emetics are powerful depressants, and if a person is already in a rather bad condition it is quite obvious that you should not try to make him sick by an emetic, unless you think it is the lesser evil of the two. Then, again, by the time that his respiratory centre has got so dulled that he won't cough his vomiting centre is in much the same condition, and therefore it is extremely difficult to make him sick by ordinary emetics. Apomorphia is not the class of emetic that should be used, simply because it is so tremendous a depressant to the whole circulation and to the body generally. In the early stage you certainly can make children sick, but I want to point out that when they have got too far you cannot even do that. I have even tickled their throats with feathers to try to make them sick, or cough, but their throats have been absolutely insensitive to tickling. Another means that may be adopted is to try and make them sneeze by giving irritating snuffs, so that in sneezing they may empty the base of their lungs. The moral of all this is: If you can prevent it, never let a person get into this condition; immediately he shows any sign of it give him a powerful emetic and so endeavour to stave it off.

Another subject that I want to say a word about is that of cough in heart disease. Supposing that you get a person who is in bed with cardiac disease, and coughing until he is blue in the face, what is happening to his circulation? He is getting up a positive pressure in his thorax, and thereby making the return of venous blood into his thorax so much the more difficult. That does not improve the circulation in a person with heart disease, because what is wanted in such a case is to get the blood out of the veins into the arteries, and not to dam it back by keeping it in the veins. As a result of this positive pressure in the person's thorax the pressure in his pulmonary artery is raised enormously, and also, of course, that in his right heart, and if you allow that condition to continue without interference in anyone suffering from cardiac disease you are not showing a very profound knowledge of the circulation. I want to point out that coughing, in heart disease, from whatever cause the coughing may ensue, is a very serious thing.

Another condition in which coughing becomes serious is in people who have either already got, or had, a cerebral hæmorrhage, or in people who have got bad cerebral arteries. If you ask any clinician what are the predisposing causes of cerebral hæmorrhage, he will tell you "such things as straining at stool," whereby you get up positive pressure in your thorax. And Hill showed, years ago, that pressure in the cerebral arterioles is influenced much more from the venous side than from the arterial side of the circulation; and as the act of coughing sets up positive pressure in the latter area it is obviously a most serious thing, especially if violent, in a person who has got soft or bad cerebral arteries.

The last thing I am going to say a word about is cough in phthisis. One of the commonest ways in which tubercle is spread about in the lung is by aspiration of the tuberculous material into the healthy bronchial tubes. When you breathe in you suck this material into the healthy bronchial tubes, and so spread the disease. It is perfectly clear then that a person with tubercle should cough in order to bring this stuff up. Your object in treating people with phthisis is not to stop the cough altogether. In most cases the right attitude to take is to give these persons a dose of something that will secure to them so many hours' freedom from cough at night, in order that they may get refreshing sleep, and then leave them alone during the rest of the day unless their cough is violent. To give these patients doses of morphia, or opium, four or five times a day, as is often done by the ignorant, is to my mind ridiculous, because it does not effectually stop their cough. Moreover, there is no drug which so

thoroughly upsets a person's vitality and digestion as opium in any form whatever, and, as you know, his digestion, his appetite, is the principal thing about his prognosis. There is no doubt that hyaline is an effectual drug for stopping the cough, and is certainly much less calculated to upset the digestion and appetite than such preparations as morphia or opium.

There are conditions in phthisis when you must stop the cough at all risks. The most common one is hæmoptysis, and the way to stop the bleeding is certainly to give the patients, as a start, an injection of morphia. In cases where hæmoptysis occurs in phthisis they get for a considerable time afterwards a rise of temperature and further physical signs in the chest, such as an outbreak of miliary tubercle; these things being the result of the aspirating of the blood, mixed with tubercle bacilli, about the healthy chest.

In phthisis there is hæmoptysis and hæmoptysis. In those cases where there is very little bleeding you are dealing more with a pneumonic condition than with cavitation, and it does not matter when they have hæmoptysis. But in a case of phthisis where there is cavitation and much hæmoptysis you are dealing with a large number of blood-vessels, and if you allow those persons to go on coughing, and coughing violently, they may die from the hæmoptysis.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The Lecture in next week's number will be by A. Matiland Ramsay, M.D., Professor of Ophthalmology, at St. Mungo's College, and Lecturer on Eye Diseases, at Queen Margaret College, University of Glasgow, on "Inflammation of the Conjunctiva."

ORIGINAL PAPERS.

MODIFIED DRIED MILK FEEDING OF INFANTS AND YOUNG CHILDREN.

By D. SOMMERVILLE, M.D., M.R.C.P. LOND.,
Lecturer on Public Health at King's College, London.

AND

FRANCES M. HARPER, M.B., D.P.H. CAMB.

IN 1905 one of us determined the compositions, and digestibilities (by laboratory experiments), of a number of desiccated milks; and a brief account of a variety that presented constant composition, and behaved uniformly under gastric and pancreatic digestions, was published in the October number of *Public Health* of that year. It was then claimed that in respect of its reaction to rennin, to peptic digestion, to pancreatic digestion, and in respect of the digestibility of its fat, when properly reconstituted, this milk approached more nearly to human milk than does raw cow's milk. Subsequent investigation has shown that the product is sterile, and that when packets are opened the contents are much less liable to invasion by bacteria than bottled or tinned milk in the liquid or semi-liquid state. A two-pound tin, for example, may be left open for six months, and when the superficial half-inch of powder is removed the remainder is sterile. The importance of this fact in connection with the distribution of milk, more especially amongst the poor, is obvious.

In order to test the product as a food for infants and young children, we selected a district in East Central London, where we supplied babies of all ages, from four weeks to nine months, with a milk powder, modified by the addition of lactose, &c. A scale of quantities was constructed for

the different ages, and amounts for individual meals were weighed, packed in clean willow boxes, and given to the mothers, with instructions for the proper reconstitution of the milk and times of feeding.

Records have been kept of each child, including date of birth, date of commencing the diet, general physical condition, character of stools, nature of previous feeding (breast, cow's milk, condensed milk, &c.), health conditions of the mother, and weekly increase in weight. Since November 1st, 1905, we have studied the effects of the food on fifty-five babies. More than 60 per cent. of the mothers had no breast milk, and the remainder had a very deficient supply which in many cases disagreed with the child. Twenty-seven children have lived wholly on the product for three months, and in all definite improvement has taken place. Where nausea and vomiting existed in babies fed on cow's milk and barley water, change to the dried preparation was generally successful in cutting short these symptoms in twenty-four hours. The characters of the stools improved rapidly in all cases, and this is an important feature in the effects of this food. The change for the better was greater in cases previously fed on condensed milks. The swollen and tense abdomen found in 75 per cent. of these cases became small and soft, and screaming and whining ceased. Where wasting had occurred on breast milk, the improvement was equally great and rapid.

Increase in weight of five ounces weekly has been recorded in several cases; in a less number six ounces weekly; and the average for the whole number is over four ounces.

When it is considered that more than one-third of these children suffered from congenital syphilis or rickets, and that several were at first so wasted that they must have inevitably died in a limited period, we think that the results will be deemed satisfactory.

It would therefore seem that there is a place for this dried milk food amongst the poor, where breast feeding is impossible, where clean and modified cow's milk is not to be had, or where it disagrees, and in all cases where condensed milks are used it is advisable to administer occasionally orange juice, raw egg albumin, or raw meat-juice.

Its sterility and the absence of dense clot in the infant's stomach under the action of rennin bespeak an important position for the product in time of epidemic diarrhoea.

THE DIAGNOSIS OF SOME ACUTE ABDOMINAL DISEASES.*

By A. S. BARLING,
Surgeon to the Royal Lancaster Infirmary.

MR. CHAIRMAN, GENTLEMEN,—It gives me very real pleasure to come among you once more and I value very highly the privilege that you have conferred in allowing me to talk over with you the diagnosis of some acute abdominal diseases. If I can arouse your interest, and thereby incite some of you to relate your experiences and express your opinions—often of wider range and of much greater value than my own—our object will have been attained and our time will not be ill-spent.

The cardinal symptoms presented by these cases are :

—(1) pain; (2) shock; (3) vomiting; and (4) though this is not always present, obstruction and consequent meteorism.

I think you will agree when I say that no more difficult problem ever confronts the medical man than that of forming a diagnosis, and indeed it is not infrequently impossible to do so. When the beginning is sudden and dramatic, and the patient in great suffering, the friends are alarmed and the medical attendant on the alert; but when it is more insidious it is sometimes difficult to convince them of the gravity of the condition until it is too late.

It is of the utmost importance to decide at the earliest possible moment, whether the case is one which calls for surgical interference or whether it is likely to be amenable to medical treatment. Certain cases always require operation, others never do so, but unfortunately the majority fall into a class midway between the two and are a source of much perplexity and anxiety to all of us.

The first thing to be done when confronted with one of these is to obtain from the friends, corroborated, if possible, by the patient, a full and detailed account of the time and manner of the onset, not forgetting to ask for any exciting cause, such as a fall or a strain. Having elicited this, inquiries should be made into the previous history. Possibly we may hear of a former attack of appendicitis, or of gall-stones, or renal colic accompanied by hæmaturia, or there may have been progressive constipation with wasting or melæna, pointing to malignant disease, or symptoms of ulcer of the stomach, or enteric fever.

In a woman the menstrual function should receive careful attention having in mind a possible extra-uterine gestation. Kelly even quotes a case in which the appendix was removed and it was discovered at the *post mortem* that the condition was due to a criminal attempt at abortion.

And now as to the aspect of the patient. You will generally find him lying on his back with his knees drawn up and his hands above his head. His face is that of one suffering from serious illness. At first there may be merely an anxious drawn expression, and the face may be flushed. Later it becomes pale or blue and pinched, and there is a gradual change until the appearance described by Hippocrates is presented. Doubtless you all remember it, but we may perhaps with advantage recall it.

"A sharp nose, hollow eyes, fallen temples, cold, contracted ears with the lobes inverted, the skin about the forehead hard, streaked, and dry; the colour of the whole face pale, or black or livid, or like lead," and he goes on to say, "If the countenance appears thus at the beginning of the disease it ought to be inquired whether the patient has been watchful, or had a violent purging, or been oppressed with hunger. For, if any of these are owned, the danger is to be esteemed so much the less, and the crisis happens in 24 hours where the countenance is changed by these causes. But if none of these are in the case, nor a reinstatement happens within the time now mentioned, it is a certain sign that death is near at hand."

If the *alæ* of the nose are working it is a bad sign, as showing great interference with respiration due to limitation of the movements of the diaphragm.

Restlessness is a grave symptom, as is also its antithesis, apathy.

The pulse is quick and small; if its rate is 100 and this persists for some hours, operation is imminent. If it is also intermittent, this is an additional reason for haste.

The temperature is often very misleading. It ought to fall, in a favourable case, on the second day. A low temperature, accompanied by a fast pulse, is very ominous.

Vomiting is almost universal at the beginning of any acute abdominal attack, but if the course tends towards recovery it soon ceases. If it persists or recurs, it is a notable danger signal.

The quiet, ceaseless pumping up of large

*An Address delivered before the Furness Division of the British Medical Association.

quantities of thin bile-stained fluid is a sign of the most serious import.

*The tongue very early becomes coated, and in the later stages is dry and cracked.

And now let us dwell for a few moments on the symptom which most appeals to the patient. I refer, of course, to pain.

At first this is often general or confined to the umbilicus, but after a few hours it almost always becomes localised and its position offers a very fair guide to the seat of the mischief.

If the pain is *Epigastric*, we think of—

- 1.—Rupture of ulcer of stomach.
- 2.—Acute dilatation of the stomach.
- 3.—Rupture of ulcer of duodenum.
- 4.—Diaphragmatic pleurisy.
- 5.—Pneumonia.
- 6.—Acute pancreatitis.
- 7.—Gall-stones.

If *Umbilical*—

1.—The various forms of obstruction of the bowels (more especially affecting the small intestine).

If *Hypogastric*—

- 1.—Pelvic appendicitis.
- 2.—Various conditions of the female generative organs.

If *Iliac*—

- 1.—Appendicitis.
- 2.—Ruptured tubal pregnancy.
- 3.—Pyo- or hæmato-salpinx.
- 4.—Twisted ovarian pedicle.

If *Lumbar*—

- 1.—Stone in the kidney.
- 2.—Torsion in movable kidney.
- 3.—Stercoral typhlitis.

Hypogastric pain, accompanied by rigidity in both recti is almost diagnostic of pelvic appendicitis—at least in the male.

There is a curious reflected superficial pain over the right iliac region in appendicitis.

In obstruction the pain is of three kinds, according to the stage. There is first a stabbing pain due to the actual injury to the peritoneum, this is followed by a colicky pain caused by the efforts of the bowel to expel its contents, and, lastly, there is the constant pain increased by pressure due to peritonitis.

The pain caused by rupture of any organ is said to be very sudden, and often agonising in its intensity. I have, however, seen cases in which the rupture of an appendix has been followed by marked temporary relief. This, I take it, being due to the lessened tension.

And now let us come to the examination of the abdomen. The patient should lie perfectly flat in a good light which falls equally on both sides.

On inspection we shall notice whether the abdomen is distended or no, and if so, if the distension is symmetrical.

Then we shall note the amount of movement during respiration and if it is general or only occurs in the upper part. It may even be unilateral. An excellent example of this occurred in a case that was brought down to me by Dr. Martin, of Kirkby Lonsdale, a week ago this evening. A boy, æt. 9, was in the morning suddenly seized with severe abdominal pain, accompanied by vomiting. The pain, at first general, had become localised at a point above and to the left of the umbilicus, the respiratory movements on that side were decidedly less marked than on the others. On opening the abdomen, it was found that a portion of the small intestine had slipped between an omental adhesion and the parietes at the point indicated by the pain.

If the movements are free, the presence of serious mischief is not likely.

There may be local distension as in appendicitis, or sub-diaphragmatic abscess.

Coils of distended intestine may be seen. Having learnt all that is possible from inspection, we now try what palpation will reveal. I need not enter into

the manner in which this ought to be carried out, you all know it; but let me remind you to do it systematically, each organ being examined and thought about separately. Never allow your thoughts to be lured away from the particular part that is under investigation. (It is as bad as thinking of the bunker when you are playing an approach shot, and we all know what is likely to happen in that case).

The things to be sought for are:—

- 1.—Tenderness.
- 2.—Rigidity.
- 3.—The presence of fluid in the peritoneal cavity.
- 4.—Any local enlargement. In this connection let us never forget to examine most carefully all the points at which hernia may occur. It is not at all difficult to overlook a Richter's hernia.

We now proceed to employ percussion.

Personally, I do not attach great value to it, and although I have a good ear for music, I have never been able to tell with any degree of certainty whether a given note was the resonance of the stomach or of a distended colon.

There is one condition, however, in which it is of the greatest value. I refer to a suspected perforation. If the liver dulness is gone, the abdomen not being greatly distended, we may be tolerably certain of free gas in the peritoneal cavity. Auscultation may be of use in determining whether the obstruction is due to mechanical interference or to paralysis of the gut. Rectal and vaginal examinations should never be omitted. In the majority of cases they do not help us, but occasionally very valuable information is obtained. The apex of an intussusception or an inflamed mass in the pelvis, or even an appendix may sometimes be felt, especially in children. Never omit a careful examination of the chest and urine.

Having completed our examination, it may be well to clear the ground by eliminating a few of the commoner conditions which respond to the services of the physician.

The first that occurs to me—perhaps from my four years' residence in the Potteries—is lead colic. The patient is usually not in bed, the pain is paroxysmal, confined to the umbilical region, and the abdomen is flat. An examination of the gums and a look out for any signs of peripheral neuritis or anæmia or albuminuria are generally sufficient to establish the diagnosis. The use of lead as an abortifacient may be remembered.

The gastric crises of locomotor ataxia are sometimes alarming, but they need not detain us; a glance at the eyes and a tap on the patellar tendon suffice. Nearly allied to these are the gastric crises which occur in morphia takers, and which I fancy are not so well known. They usually appear when the patient is diminishing the dose of his drug. There is first a feeling of indigestion, with fulness about the pit of the stomach. This may last for some hours, but sooner or later is followed by a dull constant aching pain in the epigastrium; this rapidly grows worse, and may become so bad as to prostrate the patient completely. Vomiting and alarming collapse follow. I have mistaken it for a ruptured gastric ulcer. The treatment does not concern us to-day.

Another class of case occurs to me in which we see all the signs of acute abdominal mischief, but which are secondary to some thoracic disease. This emphasises the importance of a routine examination of the chest in all cases. The abdominal symptoms are of little importance and soon give way to calomel and magnesium sulphate. I have recently seen two very interesting examples of this; one last summer with Dr. Troughton, of Bentham. A boy with patches of catarrhal pneumonia in both lungs had also abdominal pain and distension. It was a question whether he had appendicitis, but the whole thing cleared up and he got well. The other case a month or two ago, with Dr. Penny, of Greenodd, occurred in a young woman. She had pain at the epigastrium, distension of the abdomen, vomiting and constipation.

There was also consolidation at the base of the left lung. The abdominal symptoms disappeared under aperients, but unfortunately the lung became gangrenous and the patient died some weeks afterwards. I know of one case which was operated on under the impression that it was one of acute obstruction. Nothing was found, and at the *post mortem* the cause of the symptoms was revealed in a lung consolidated by pneumonia.

The order of things is sometimes reversed, and empyema is a recognised sequel of appendicular abscess. It is not very common. I only recall two cases in my own practice.

Acute dilatation of the stomach is worthy of mention and may closely simulate rupture. I well remember a case in which I operated for my colleague, Dr. Rayne, last year. The patient, a young woman, had been in the Royal Infirmary for some weeks suffering from undoubted gastric ulcer of some years' standing. During that time she had had several attacks of hæmatemesis. Suddenly one day she was seized with agonising pain at the pit of the stomach, and vomited partly digested blood. When I saw her some hours afterwards she was in a state of collapse, pulse hardly perceptible. The abdomen was moderately distended, the liver dulness obliterated. She was put under ether and the abdomen opened. There was no perforation, but the stomach was greatly distended, reaching down to a point midway between the umbilicus and the pubes.

It was washed out through an œsophageal tube and several pints of altered blood removed. A gastro-jejunostomy was then performed. Unfortunately the patient only survived for a few days.

Another condition in which epigastric pain is a leading characteristic is pancreatitis. We all remember that after the King's illness it became fashionable to suffer from appendicitis. Society, however, discovered that not only kings, but even quite common people were afflicted by it. Gall-stones then for a short time became all the vogue, but this year I am told that nobody can hope to be received in the best circles unless he has pancreatitis. Not a great deal is known of it as yet. The conditions with which it is most likely to be confounded are intestinal obstruction, and perforation. Fitz describes the symptoms as follows:—

"Acute pancreatitis is to be suspected when a previously healthy person, or a sufferer from occasional attacks of indigestion, is suddenly seized with a violent pain in the epigastrium followed by vomiting and collapse, and in the course of 24 hours by a circumscribed epigastric swelling, tympanitic or resistant, with slight elevation of temperature. Circumscribed tenderness in the course of the pancreas and tender spots throughout the abdomen are valuable diagnostic signs."

"There is prostration, often extreme, frequent collapse, and a feeble pulse. Obstinate constipation for several days is the rule, but diarrhœa sometimes occurs. If the case does not end fatally in the course of a few days recovery is possible, or a recurrence of the symptoms in a milder form takes place and the characteristics of a sub-acute peritonitis are developed."

The recurrent shock seems to me to be the most valuable diagnostic sign.

If the abdomen is opened and no obstruction found, a look out should be kept for fat necrosis. This mostly occurs in the omentum, mesentery, and pancreas, where it forms the well-known islands of Langerhans.

A case that I saw last summer at the County Asylum in consultation with Dr. Cowen is interesting as bearing on this point.

The patient, a fat, middle-aged woman, had some hours previously been struck violently in the epigastrium by the knee of another inmate. She collapsed and shortly afterwards vomited. When I saw her she was recovering from the shock, but the abdomen was becoming distended. As the liver dulness was unaffected, and as the symptoms seemed, if anything, to be abating, we decided to wait and treat symptoms. She had obstruction for 24 hours, which then gave way to turpentine enemata. The following day she again collapsed, and again on the day after, but then

made a good recovery. We made the diagnosis of a hæmorrhage into the pancreas. I ought to have mentioned that she seemed to have great epigastric pain and tenderness, but owing to her mental state it is difficult to speak definitely. There was some swelling on the second day, but no definite tumour could be felt, nor any abnormal want of resonance.

Having now considered, and if possible eliminated, the cases which recover under medical treatment, we come to the great mass of those which exhibit peritonism and which require surgical skill for their cure.

They may be broadly divided into—

1.—Acute strangulation.

2.—Peritonitis.

These may, of course, be due to a very large number of conditions which time will not allow us to discuss. The relative frequency of the two states does not help us much as the following table, taken from Battle and Corner's book on the Appendix, will show. They tabulate 456 cases of acute abdominal affection which were treated at St. Thomas's Hospital. Of these 37 per cent. were due to appendicitis and its complications, 40 per cent. to obstruction, and 11 per cent. to perforation. We see that 48 per cent. were due to peritonitis, and 40 per cent. to obstruction. It may be useful to consider for a few moments the signs and symptoms pertaining to each of these two great groups and endeavour to distinguish between them.

As regards the *onset*, it is abrupt in obstruction but in peritonitis may be preceded by local pain.

In obstruction there is never a *rigor*. In peritonitis it is often present. The *temperature* in obstruction is sub-normal, at first rising as inflammation sets in; in peritonitis it is generally high at first, falling later from exhaustion or toxæmia.

Pain is severe in both classes, but in the former is most often referred to the umbilicus, whilst in the latter the right iliac region is often affected.

Tenderness is absent at the beginning of obstruction, whilst it is a marked sign even in the early stages of peritonitis.

Vomiting comes on early in obstruction and soon becomes fecal; in peritonitis it is less urgent and rarely fecal, except towards the end.

Rigidity is absent in obstruction but marked even in the early stages of peritonitis. Sometimes a peritoneal rub can be heard by means of the stethoscope.

A leucocyte count is of great value if taken early. If the leucocytosis is high—over 20,000 to the cubic millimetre—and is rising it is a sign of inflammatory mischief.

Even with the greatest care it is impossible in the majority of cases to make a minute diagnosis before opening the abdomen, and indeed this must be so from the very nature of things, but it is well to form some rough working theory, if only to guide us in the choice of the site of an incision.

It would be useless to attempt to enter into the minutæ of the differential diagnosis of the hundred or one causes of acute symptoms, but taken as a general rule the seat of pain and tenderness will be a trustworthy indication as to whether the incision should be made in the mid-line above or below the umbilicus, over the gall-bladder, in the iliac region or even in the loin.

I recall a case sent to me by Dr. Shaw, of Bowness, which presented the appearance of obstruction, but in which the symptoms were due to a twisted floating kidney. A nephrorrhaphy cured the patient.

The best imitation of an appendix case that has come under my care was that of a middle-aged woman sent to me from Wennington by Dr. Bradley some eighteen months ago. She had every sign of appendicitis, even down to the presence of a fluid tumour—immovable—in the cæcal region. I had the doubtful satisfaction of removing through a lateral incision an ovarian cyst about the size of a large orange which was becoming gangrenous from torsion of its pedicle.

I had intended to tell you of three suppurating hydratids, one of which burst into the duodenum, which

simulated everything except what they really were; of a few gall-bladders which showed abnormal symptoms, one being opened opposite to the iliac spine; of an appendix in which I counselled delay because of a cessation of vomiting and a falling pulse and temperature, but which subsequently revealed a huge post colic abscess; of a case of impeded fæces; of one that I took to be entero-spasm, and of two ruptured tubal pregnancies, but the plaguey old man with the scythe and sand glass is menacing me, so I must submit.

In conclusion, then, let us again recall those things which weigh most when we are balancing the great question, operation or not?

If, some hours after the onset, the general appearance of the patient does not indicate improvement, the pulse is 100 or over, the vomiting not abated and the bowels not relieved by enemata, there ought to be no further delay.

Many a time and oft have I regretted holding my hand, but never have I been sorry for operating. It is better to interfere unnecessarily in fifty cases than to allow one to die without a chance being given to him. If done early a mere opening of the abdomen—primarily for diagnostic purposes—is not a matter of great danger.

Finally, if you have any reasonable doubt as to the course to adopt, I say operate, and again operate.

TREATMENT OF DIPHTHERIA.

By RICHARD WOOD, M.D. ST. AND.,
Llanbedr, North Wales.

WHEN we are called to a case of diphtheria there is at once a feeling of anxiety and doubt in our own mind as to the result; few diseases more severely tax our resources than this one. We have to think of so many details, of hygiene, diet, and medicine. With regard to medicine, up to the present time, none has been discovered upon which any reliance can be placed; and as to the so-called specifics which are recommended by some authorities, they are sure to fail when put to the test.

In the year 1891 this hopelessness and despair of successful treatment became changed for one full of promise and hope when Professor Behring introduced the antitoxin treatment, which, if applied early enough and the serum used in sufficient quantity, appeared destined to take the first rank in saving life. But even in this hope there was much disappointment. There was always delay in obtaining the antitoxin serum, and when obtained the parents did not always sanction its use, or the medical man in attendance had his doubts about the dose to subcutaneously inject. And even now, if you ask various authorities as to the quantity, one will tell you, for a child of 10 years, to inject 400 units every three hours for a couple of days. Another tells you, you must not give less than 600; and you may give 1,000 units. And yet a third, that it is perfectly useless to give anything less than 1,500 units to 2,000. And still another, that he gives in very severe cases, to a child 6,000 units, and to an adult 12,000. When you find such a difference of opinion it is not surprising you feel in doubt as to what the dose really is, and you finish by coming to the conclusion that you may give any dose and hope for good results. If some men give 600 units with good results, why give more? and how are you to decide, in one instance to give 600 and in another to give 1,000? or again—when are you to give it every three hours, and when only once in the 24 hours? And besides this difficulty others arise, as to the mode of giving it. Some men prefer to give it by the mouth and others by the rectum.

Not very long ago I treated a case following measles, and after three or four injections hypodermically the little patient died. An action was entered against me for causing the death of the child by the injection of the serum. I was very much disconcerted by this, and my ardour in applying the serum cooled considerably. The ingratitude of the public is monstrous. We

expose our lives to all kinds of infection, and there are people ready to prosecute us at every turn if they think they have a chance. In my case the action was withdrawn at the last moment, but my legal expenses had to be paid.

Before the antitoxin serum came into use I had occasionally applied hydrochloric acid to the throat, and now and then recovery took place. But there was much difficulty in the application; and hoping that some other form of chlorine might answer, I applied chlorine in the form of gargle, which answered with adults but not with children. I then adopted the spray, and gave directions for its application every half hour, night and day. Many mothers and nurses begged of me not to enforce it during the night; but I found if an hour or two passed without using it there was more difficulty in getting rid of the patches of membrane. In most of my cases where I could depend on the mother using the spray every half-hour, the patches sometimes disappeared in two days or three days. After disappearing, the half-hour was prolonged to two or three hours with directions to come back to the half-hour if any patches reappeared; and the attendants became quite keen and expert in looking after them. Of course, in addition to the frequent application of the spray it was essential to devise means and measures to support life by the administration of slightly alcoholic stimulants and easily assimilated food, like milk and beef tea—discarding altogether all those artificial extracts and various vaunted preparations. Medicines which have a depressing effect were zealously avoided. The abstraction of blood was never had recourse to on any account.

It seemed always to be a question as to whether your patient should be allowed to get up or to be kept in bed. Some authorities will insist on the little patient (speaking of children) being put to bed with bottles of hot water to retain the heat of the body, and they will keep the room at a temperature of 60°. But why? What reason can they have for it? Moreover, they insist on the patient being screened from every current of air, and yet the poor patient is suffocating from want of it; they order a screen carefully arranged so as to surround the child's cot, and a jet of steam to be directed towards the little patient; and by this means the child's strength is as much reduced as by the disease. A word of advice here would be to do unto others as you would be done by. I actually saw a poor child treated like this until drops of perspiration were running down the face, which was twitching and partly cyanosed.

I have treated a great number of children and some adults, but I have never deprived them of air. I have relied entirely on the chlorine spray, and I prefer it to the antitoxin treatment, which fails to show a greater percentage of recoveries than 17 per cent. The antitoxin serum may not be altogether at fault, as it is very much the habit of medical practitioners to give the serum without fully relying upon it, and so combine a kind of mongrel treatment, so that if the patient dies the serum is condemned—if the patient lives his recovery is due to their skill, and not to the serum. If reliance were placed on the effect of the serum, why order the patient drugs, and on no account to be removed from the bed, or to be raised from the recumbent position—even the bowels to be evacuated in the recumbent position, when there is no sign of heart complication? And again, if reliance is placed on the serum, why order brandy for children in quantities like 5 ounces to 10 ounces daily? which has been strongly recommended by some physicians.

With our present knowledge and experience of the serum I am not satisfied. It promised great things. I believe it is capable of better results than we can at present show, but we must wait for more exact knowledge as to the dose and mode of administration. And as there are many men in the profession who do not advocate the treatment, let them use the chlorine; but how are they to use it? I have had partners and assistants and locums—most men now consider it a

virtue to ignore the compounding of medicines, and when lately I tried to explain the method of producing the chlorine to a friend he turned upon me and exclaimed, "Surely, man, I am not a pharmaceutical chemist!" This method is as follows: Put in a dry bottle half a drachm of potassic chlorate; on the top of it twenty minims of strong hydrochloric acid, and cork it lightly. After ten minutes the contents of the bottle will look green. Add to it an ounce of water and shake briskly. Add another ounce and shake; and so on gradually until five ounces and a half have been added. Put in half an ounce of syrup to sweeten. This forms the spray. By way of medicine, which I give more to satisfy the friends than as a means of cure, I give some glycerine boracic with solution of borax in small doses every three or four hours, or a solution of chlorine in small doses of a teaspoonful every four hours.

From time to time I come across children of so refractory a disposition that they will not submit to the application of spray. I have had recourse in such cases to the following process. I have generated the gas in their immediate proximity, by placing a bottle close to the head of the bed, with a drachm or a drachm and a half of chlorate of potash in powder and a drachm of pure strong hydrochloric acid poured upon it, and the bottle left uncorked. In a few minutes the gas begins to pervade the room and the child cannot help inhaling it. I have done this four or five times a day with the happiest results. A fresh bottle must be used every time and care must be taken that it is perfectly dry.

In making the spray great latitude may be exercised as to the quantity of potash chlorate. A whole drachm or two drachms may be used, provided the acid be limited, of which I seldom use more than half a drachm.

In cases of membranous croup I apply the same treatment. I do not make a point of keeping patients in bed, nor excluding the air. I prefer opening the windows, night and day, although the room may be kept warm with fires. This mode of treatment is simple and the greatest reliance may be placed in it if carried out thoroughly, and by means of trustworthy nurses.

Before ending this paper I should like once more to call the attention of my readers to the importance of the mode of preparing the solution of chlorine, for to-day on referring to a very valuable little work on *materia medica*, by Hale White, he describes its preparation as follows (page 232):—Strong hydrochloric acid, *min. v.*; potassium chlorate, *gr. 9*; water one ounce; by which he would certainly obtain a solution of potassic chlorate and hydrochloric acid, but no chlorine. I daresay he takes for granted that any man of sense would know that in the first place the acid and potash must be mixed together and left in the bottle for some minutes until the production of gas makes itself evident by a green colour. But he does not say so. It is very necessary the acid should not become diluted by a few drops of water that might be in the bottle as chemical action will be lessened by the dilution. That was my reason for laying such stress on the bottle being quite dry.

If those who are going to give this treatment a trial fail to produce a green solution of chlorine, they had better not attempt it, for its trial will be a dead failure. Even to go on using the solution after it has lost its colour is no longer effective; and the best way of retaining the colour for a few days is by keeping the solution in a drawer in complete darkness.

THE OUT-PATIENTS' ROOM.

WESTMINSTER HOSPITAL.

Case of Latent Infective Meningitis.

By PURVES STEWART, M.D., F.R.C.P.

A YOUNG man, *æt.* 21, came to the Out-Patient Department on May 21st, complaining of headache,

diffusely distributed all over the cranium, of two weeks' duration, almost constant, and keeping him awake at nights; also nausea and vomiting after food, but no spontaneous vomiting. On further inquiries, it was found that for twelve months the patient had suffered from left side otorrhœa; this suddenly stopped a fortnight ago. Since then the headache had occurred. The patient was examined by Mr. de Santi, who found a dry perforation of the left membrana tympani without evidence of any mastoid or sinus trouble. Mr. de Santi therefore sent the man to Dr. Stewart for an opinion as to the cause of the headache. The patient was obviously ill; he had severe diffuse headache but no local tenderness over the mastoid, or anywhere else on the cranium; the pulse was 90, the skin cool, and the temperature normal. The left pupil was larger than the right, but reacted normally. Ophthalmoscopic examination showed a doubtful fullness of the veins at the inner side of both optic discs; the cranial nerves were otherwise normal, the sensory, motor and reflex functions were also normal. The history of the case was, Dr. Stewart thought, highly suggestive; the sudden stoppage of the chronic otorrhœa when followed by head symptoms was, he said, always suspicious, and therefore, notwithstanding the absence of abnormal signs on examination by an expert aurist, one felt disposed to suspect some intra-cranial infective process. Dr. Stewart pointed out that it was now clearly established that every form of meningitis was associated with an excess of cells in the cerebro-spinal fluid; in the acute infective varieties of meningitis the cells were of the polynuclear type, whilst in the tuberculous and syphilitic varieties mono-nucleated cells were found. If no excess of cells were present, meningitis could be excluded. Accordingly, Dr. Stewart performed lumbar puncture: the fluid withdrawn was turbid; this in itself, he remarked, was pathological and showed the presence of meningitis. Microscopical examination of the fluid demonstrated an enormous leucocytosis, the cells being of the poly-nuclear type. The diagnosis of an infective meningitis being therefore clearly established the patient was admitted to the hospital for immediate operation. This was performed by Mr. W. G. Spencer, who on exploring the middle ear found it full of cholesteatomatous debris. A complete Stacke's operation was carried out and the middle ear was left free to drain externally. The patient's symptoms at once improved, his headache ceased, and it became evident that the leakage of infective material from the ear into the cerebro-spinal fluid had been arrested. Up to then the patient continued to improve. No further examination of the cerebro-spinal fluid had yet been made, but that would probably be carried out at regular intervals.

Dr. Stewart said that this case recalled a rather similar one of an officer who had been the subject for many months of chronic left-sided otitis media; he somewhat rapidly developed mental dulness and slight aphasia with some fever. In this case also the cerebro-spinal fluid was turbid, and showed an enormous excess of poly-morpho-nuclear leucocytes numbering no fewer than 371 in a field of 400 diameters. Operation was at once undertaken by Mr. Ballance, an infected area of brain cortex was exposed in the left temporoparietal lobe; no abscess was found. The symptoms rapidly subsided, and the patient made a complete recovery.

OPERATING THEATRES.

GREAT NORTHERN HOSPITAL.

NECROSIS OF THE LOWER END OF THE FEMUR.—MR. PEYTON BEALE operated on a boy, *æt.* about 10, who had been admitted with a sinus in the popliteal space. A probe on being inserted came upon bare bone, which from its position appeared to be about one inch below the bifurcation of the linea aspera. As regards

the previous history the patient had noticed a swelling in his popliteal space some two months previously; this had rapidly got larger, was very painful and burst through the skin in a few days, discharging about two ounces of pus. The case was considered to be one of necrosis at the back of the lower end of the femur, a not very uncommon condition, but one the pathology of which appeared to be very obscure. A vertical incision about six inches long was made in the middle of the posterior aspect of the thigh, its lower limit being midway between the two condyles. The popliteal vessels were pulled towards the inner side of the incision by a spatula; it was then found that the periosteum covering the triangular portion of bone at the back of the femur was bulging and on this being incised some thin pus escaped; several small flat sequestra also came away, these were necrosed portions of the compact tissue. About half an inch below the epiphyseal line was an opening about a quarter of an inch in diameter which led directly into the cancellous tissue of the bone. A sharp spoon was introduced through the opening and the whole of that which would correspond to the cancellous tissue was found quite soft, fatty, greyish yellow in colour, and when it was scooped out there was practically nothing left but a shell of compact tissue. The opening into this space was enlarged to about the diameter of one inch and packed loosely with iodoform gauze; the wound was plugged all round with cyanide gauze, the edges of the upper end being brought together by two or three stitches. Mr. Beale said that this case was one of a kind with which he was quite familiar, but which he admitted he did not at all understand. As regards previous history, there was as a rule nothing of any importance although there was occasionally a history of some injury to the duct. The first symptoms were those of an acute abscess deep in the popliteal space, which burst through the skin within two or three days; there were never symptoms such as were seen with acute periostitis or osteomyelitis; what generally happened to these cases was as follows: The surgeon would probe the sinus and detect bare bone, he then would enlarge the sinus and scrape the surface of the bone with a sharp spoon, then stuff the wound; this was never successful; the procedures in some cases would have to be repeated many times; afterwards the patient would be found suddenly to have an abscess within the knee-joint, the joint becoming completely disorganised and an amputation through the middle of the femur having to be performed. When such a specimen was examined the conditions of the lower end of the femur was found to be such as described in the case on which he had just operated, but an aperture would be found leading into the knee-joint through the inter-condylar notch. He stated that a similar case under his care had been described in *Operating Theatres* on August 2nd, 1899; this case was complicated by rupture of the popliteal vessels, the latter having become quite rotten by the continual passage of pus close to them; since then he had come across seven or eight cases of the same kind, and he was quite certain that the right treatment was a vertical incision down the centre of the popliteal space, removing the compact bone tissue at the back of the lower end of the femur, and scraping out the remains of the cancellous tissue. The disease, he pointed out, certainly did not start at the epiphyseal line and all the evidence went to show that it originated in the cancellous tissue at the lower end of the femur; there was no evidence that the affection was a tuberculous one and in each case he had treated in the manner above described the wound had completely healed up, though of course the process of healing was a slow one occupying some months.

VICTORIA HOSPITAL FOR CHILDREN.

HAIRPIN IN THE BLADDER WITH SECONDARY CALCULUS.—Mr. J. CUNNING operated on a female child, æt. 5, who had been admitted suffering from frequency of, and pain on, micturition. These symptoms were known to have existed six weeks. On admission, she was examined bimanually, and also with the sound, and a stone was discovered in the bladder. It was decided, therefore, to perform the operation of lithotripsy, but the patient was prepared also for the supra-pubic operation in the event of lithotripsy proving to be impossible. The bladder was washed out with boracic lotion, but it was impossible to introduce more than an ounce and a quarter of fluid as the viscous would not retain more; it was then thought that there was something abnormal about the case. When the lithotrite was introduced, some difficulty was experienced in grasping the stone, and when this was effected it was felt that the calculus did not move freely; for this reason it was thought unsafe to proceed with crushing, so the bladder was opened supra-pubically. On the finger being introduced a large stone was discovered, which was felt to be fixed in the bladder like an ordinary encysted calculus. To get this calculus out it was found necessary to place a finger of left hand in the rectum, in order to push the stone up, so that it might be enucleated. As Mr. Cunning got the stone loose he was astonished to find a three and a half inch hairpin imbedded in it; the hairpin was lying transversely in the bladder, but was easily extracted. The calculus, which measured one inch and a quarter by three quarters of an inch, was phosphatic. The bladder was washed out and a drainage tube left in the supra-pubic opening. Mr. Cunning said that it was remarkable that a child of such tender years should have a foreign body in the bladder; there was no history as to how it had been introduced. The child herself knew nothing about it and her parents were both dead. It was possible and most likely that the child had experienced irritation about the genitals and had been scratching with a hairpin, which had suddenly disappeared. This had in all likelihood happened, he thought, at least six months before he had seen the case. It was interesting to note, he considered, how easily a stone could be felt in a child's bladder by bimanual examination, of course, in both sexes, a finger being in the rectum. He pointed out that if any difficulty was experienced in the free rotation of a stone when caught by the lithotrite (especially in such a small bladder as that of a child) it was wise to perform at once a supra-pubic operation. He would invariably, he asserted, try lithotripsy first in any child, providing the stone were small and not a hard oxalic calculus, because in three or four days after that operation the patient was able to get about, and felt no effects from the manipulations, whilst after supra-pubic lithotomy the child would be confined to bed for at least a fortnight, with, in addition, the discomforts of supra-pubic drainage. He drew attention to the high reflection of the peritoneum on the bladder of a child, therefore the surgeon in operating did not in most cases even see the peritoneum. The extraction of the stone was much facilitated, he remarked, by the introduction of a finger into the rectum, whereby the calculus was pushed up; in doing that it was of great importance to wear a glove on the hand, which by that means, when the covering was removed, was perfectly aseptic to go on with the remainder of the operation.

It was satisfactory to note that the child was up in ten days; the wound was healed, and she was able to hold her water for between three and four hours at a time.

TRANSACTIONS OF SOCIETIES.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF SURGERY.

MEETING HELD FRIDAY, MAY 11TH, 1906.
The PRESIDENT, Sir Arthur Chance, P.R.C.S.I., in the Chair.

ENUCLEATION OF THE PROSTATE.

SIR WILLIAM THOMSON read a paper on a further series of the above. He described the more important of eighteen cases, and discussed various points of interest which had been noticed. One of the specimens shown weighed six and a quarter ounces, and one ten ounces, less a few grains. He described the after treatment of the cases and management of various complications, and discussed continuous severe hæmorrhage from the prostate. For that he had carried out enucleation with success. He believed that was the first time that the operation had been reported as undertaken for hæmorrhage only, and he maintained that it was the proper treatment where all other means failed.

SIR THORNLEY STOKER expressed himself in doubt as to the accuracy of statistics concerning the mortality resulting from operation for prostatic enlargement. The time required for prostatic enucleation, in his experience, varied. He had enucleated a large prostatic growth in two minutes, but in another case in which the growth was small the enucleation took half an hour. He recommended benzoate of sodium as a useful drug for promoting acidity of the urine. He considered the Trendelenberg position attended by danger in the case of aged patients.

SIR ARTHUR CHANCE favoured operative measures directed towards the relief of patients suffering from the effects of senile prostatic enlargement. He had found large prostates easy to deal with, and he had frequently noticed that small prostates gave the most intra-thoracic complications. He regarded the Trendelenberg position of great assistance, and he had not found it attended by any obvious risk.

SIR WILLIAM THOMSON, in replying, stated that there was no direct relationship between the degree of prostatic enlargement and the intensity of the symptoms. He alluded to cases of death following suddenly after operation, and which were due evidently to embolism. With regard to washing out the bladder, he usually did so through the urethra forty-eight hours after the enucleation.

MR. L. A. GUNN read a note on Bladder Tumours, and illustrated his remarks with the aid of a series of lantern slides.

BRITISH LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL ASSOCIATION.

GENERAL MEETING HELD (Rooms of the Medical Society of London) ON FRIDAY, MAY 11TH, 1906.
The President, Dr. Woods, in the Chair.

MR. STUART-LOW exhibited a case of
CLEFT PALATE,

in which adenoids diminished the dyslalia. He remarked that, as so much that was harmful had been attributed to the presence of adenoids, it would sound almost paradoxical to speak of any advantages to be gained by their existence. This case illustrated the fact well, however, that but for the adenoids the defects of speech would have been more pronounced. With such a large palatal deficiency it was very remarkable that articulation was not more imperfect. The practical point he wished to emphasise was that in

cases of defective palate adenoids should not be removed, as the result would be to render the dyslalia more marked. Therefore in operative cases the adenoids should not be removed until the palate operation was completed.

DR. DUNDAS GRANT agreed with Mr. Stuart-Low that the adenoids should remain until after the palate operation.

MR. MAYO COLLIER expressed surprise that the palate had not already been operated on.

The PRESIDENT was in favour of leaving the adenoids until after the palate had been repaired. He was also of the opinion that the operation for cleft palate should remain with the specialist and not be handed over to the general surgeon.

DR. ANDREW WYLIE showed a case of

LYMPHANGITIS OF THE UPPER LIP

in a female patient, æt. 22, who had come to his clinic at the Central London Throat, Nose and Ear Hospital. She complained that the lip had been swollen for the last five and a half years, sometimes being so large as to touch the tip of the nose. Three years ago interstitial keratitis gradually appeared in both eyes. He brought forward this case because, while acute lymphangitis of the lip, due to some local irritation, is common, congenital lymphangitis of lip, called macrocheilia, is not uncommon; chronic hypertrophy lasting 5½ years is rare.

MR. DENNIS VINRACE wondered if vaccination three years ago had modified the course of the disease.

MR. H. BARWELL did not consider that vaccination had anything to do with it.

MR. MAYO COLLIER showed a case of nævus of cheek.

DR. KELSON showed a case of laryngeal disease in a school-mistress, æt. 36, who had suffered from loss of voice for four months. The ventricular bands were swollen, the vocal cords thickened, and the intratonsils swollen.

DR. DUNDAS GRANT considered the case to be more likely inflammatory than tuberculous.

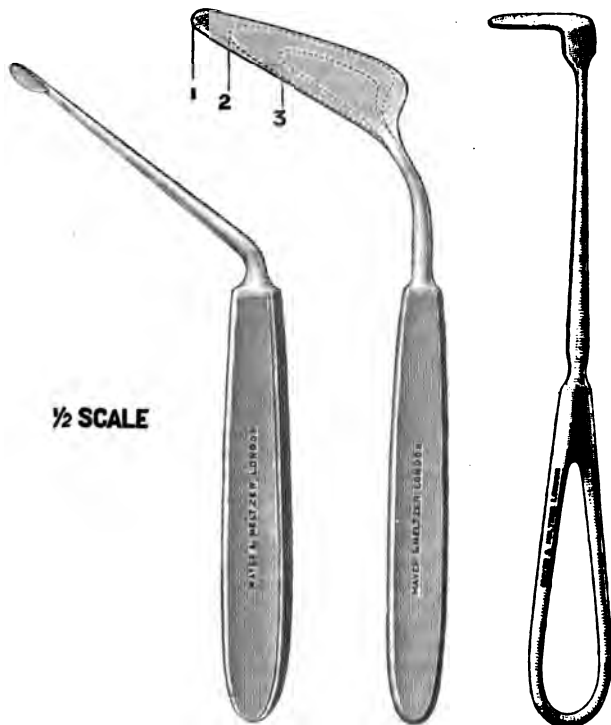
MR. HAROLD BARWELL considered the case to be one of chronic laryngitis due to nasal obstruction and over-strain of the voice in a dusty atmosphere.

The PRESIDENT thought examination of the sputum would help the diagnosis.

NASAL GUARDS FOR RESECTION OPERATION.

DR. WYLIE exhibited some nasal guards for resection operations which he had designed. For deviations of the septum causing obstruction, the simple removal of the obstruction and leaving a large perforation of the septum was nearly obsolete except in exceptional cases. Many operations, as Asch's Meursissette, have been devised, but he considered the submucous resection operation introduced by Killian was the most successful. From an experience of a considerable number of cases he was of opinion that this operation could be more easily performed without the speculum, the chief difficulty being to use instruments through the speculum. Freer and others had dispensed with the use of the speculum but introduced nothing to preserve the mucous membrane from injury during the operation. The guard exhibited was inserted between the cartilage of the septum and the mucous membrane on the concave side where one blade of the septum was usually inserted. The surgeon held the guard in position himself; his assistant retracting the nares, etc., also the mucous membrane on the convex side, by means of a retractor similar to Freer's, but made of copper to be easily bent. With the guard on the concave side and the nares well opened by the retractor, the surgeon could dispense with the speculum, and with comfort cut away the deflected cartilage by means of modified Killian knives (one for each side); or, if the septum was thin, by means of Killian's plough or Ballenger's ingenious swivel knife. The guard if held properly protected the mucous membrane. If the deviation extended to the vomer, strong

forceps, as Jansen-Middleton's, and also Killian's gauge could be more easily manipulated in that way. The



guards were made in three sizes by Mayer and Metzler, 71, Great Portland Street, London. The blades or nasal ends were made of copper, so that they could be easily bent to suit any deviation; the handles were firm and solid.

LARYNGOLOGICAL SOCIETY OF LONDON.

At the last meeting of this Society Mr. Charters Symonds, F.R.C.S., President, occupied the chair.

THE ORAL INFECTION OF SYPHILIS.

Dr. H. J. Davis exhibited three patients, members of one family, who were all the subjects of syphilis, communicated by oral infection from one to the other. The first to develop syphilis was a child, æt. 11 (there was no evidence of genital infection), first seen on account of a dusky, macular eruption on the arms, the legs and the body, tonsillitis, severe adenitis, with enlarged glands in neck and groin; there was no appearance of a primary sore. The child's grandmother æt. 60, a widow for fourteen years, nursed and slept with the child during her illness. She became ill with tonsillitis, adenitis, and a typical rash and early iritis. There was no evidence in her case of any primary sore. The third member of the family was the child's aunt, who was inhabiting the same flat as the child and her grandmother, and developed a chancre inside the right nostril. When exhibited the patient presented mucous patches on the tonsils, early roseola, and the primary sore could be seen at the junction of the skin and mucous membrane of the right nostril.

Dr. D. R. PATERSON exhibited a fish-hook removed from the œsophagus and also a tooth-plate, which had been swallowed during sleep and had become lodged opposite the supra-sternal notch. Dr. Paterson also showed a skiagram of the neck in a case where a piece of meat was impacted in a stricture of the gullet. The cases illustrated how such foreign bodies could be removed with instruments of precision, and also the necessity for discouraging the indiscriminate use of coin-catchers and probangs. Dr. Paterson also exhibited

a case of left-recurrent paralysis and paralysis of the soft palate, associated with middle ear disease and facial palsy on the same side.

Dr. H. PEGLER exhibited a patient with bilateral ulceration of the posterior segments of the vocal cords. The opinions expressed were in favour of it being a case of pachydermia laryngis.

Dr. HERBERT TILLEY exhibited four cases of chronic frontal empyæmata operated on by a simplified Killian operation.

Mr. CLAYTON FOX showed a case of tuberculosis of the soft palate, the pharynx and the epiglottis.

Cases were also shown by Mr. Charles Parker and Dr. Dundas Grant.

GENERAL MEDICAL COUNCIL.

SIXTH DAY.—MONDAY, MAY 28TH, 1906.

Dr. MACALISTER, President, in the Chair.

A MOTION by Dr. FINLAY: "That the Council sit to-day till the business in the Programme has been concluded" was lost.

A question (notice of which had been given) was asked by Mr. Brown: "To call attention to the scheme adopted by the British Medical Association in regard to the nomination and election of Direct Representatives to the Council, and to ask the President whether the pledge exacted by the Association is not calculated to encroach on the privileges of the Council."

A notice was next brought forward by Mr. Brown, seconded by Mr. Jackson: "That the following notice of motion be referred to the Education Committee for consideration, and report to the Council: 'That a period of pupillage of not less than twelve months with a registered medical practitioner officially recognised for the purpose by one of the Licensing Bodies should be regarded as equivalent to a period of six months of the ordinary medical curriculum.'" The motion was lost.

The Council elected an Executive Committee and a Penal Cases Committee. The Council then received the following communication referred to the Council by the Executive Committee in regard to a Draft Bill promoted by the Society of Apothecaries of London.

(a).

"17, Wimpole Street,
"Cavendish Square, W.
"March 30th, 1906.

"Dear Sir,—The Society of Apothecaries desire to bring the draft of a Bill for amending the title of L.S.A. to the notice of the Medical Council, and for the expression of their opinion should such be their desire.

"I am, yours truly,

"To the Registrar. HUGH R. BEEVOR."

(b).

"An Act to vary the diploma or title of Licentiates of the Society of Apothecaries of London.—Whereas since the 30th day of June, 1887, every person applying to the Society of Apothecaries of London for its licence to practise as an apothecary has been required to pass a qualifying examination in medicine, surgery, and midwifery duly held by the said Society of Apothecaries with the assistance of examiners appointed by the General Council of Medical Education and Registration of the United Kingdom (hereinafter referred to as the General Council) in accordance with the provisions of the Medical Act, 1886, which came into operation on the date aforesaid. And whereas the diploma or title of 'Licentiate of the Society of Apothecaries, London,' has heretofore been inserted in the Register kept under the Medical Acts (hereinafter referred to as the Medical Register) as the qualification of a registered medical practitioner holding the said licence of the said Society of Apothecaries. And whereas it is desirable that the terms of the diploma or title granted by the said Society of Apothecaries to its Licentiates who have passed such qualifying

examination as aforesaid shall clearly indicate that it is a qualification in both medicine and surgery. Be it therefore enacted, &c. :—This Act may be cited as the 'Apothecaries Act, 1906.' It shall be lawful for the said Society of Apothecaries to grant to every person who has since the 30th day of June, 1887, passed or shall hereafter pass a qualifying examination in medicine, surgery, and midwifery duly held by the said Society of Apothecaries in combination with another medical corporation or a university or with the assistance of examiners appointed by the General Council, in accordance with the requirements of the Medical Act, 1886, the diploma or title of 'Licentiate in Medicine and Surgery of the Society of Apothecaries, London.' The said diploma or title of 'Licentiate in Medicine and Surgery of the Society of Apothecaries, London,' shall be deemed to be added to the qualifications in Schedule (A) to the Medical Act, 1858, and every person possessed of such diploma or title shall be entitled to have the same entered in the Medical Register as his or her qualification or additional qualification for registration under the Medical Acts."

Proposed by Sir HUGH BEEVOR, seconded by Sir THOMAS MYLES, and agreed to, that the communication be entered on the Minutes.

A motion by Sir HUGH BEEVOR, seconded by Sir THOMAS MYLES: "That this Council has no objection to the statutory definition (*i.e.*, in an Act of Parliament) of the registrable title L.S.A. whereby 'surgery' as well as 'medicine' shall be connoted," was carried.

The Council proceeded with the adjourned consideration, postponed from December 1st, 1905, of the proposed Standing Orders relating to the Visitation and Inspection of Qualifying Examinations.

The Standing Orders as revised by the Executive Committee and submitted to the Council on December 1st, 1905, were as follow:—

VISITATION AND INSPECTION OF QUALIFYING EXAMINATIONS.

(1) The qualifying examinations of the several licensing bodies in the three divisions of the Kingdom shall be visited and inspected on behalf of the Council from time to time as the Council shall direct.

(2) The visitations shall be conducted by one or more members of the Council deputed as visitors for that purpose; the inspections by one or more Inspectors appointed by the Council, but not members thereof.

(3) The cycle of visitations and inspections shall ordinarily extend over three years. Within each of the three years the universities of one division of the kingdom and the Licensing Corporations of another division of the kingdom shall be visited and inspected.

(4) The visitor or visitors shall be appointed by the Council at the May Session in each year for the ensuing calendar year; and visitors belonging to one division of the kingdom shall be deputed to visit examinations held in another division. Should a visitor so appointed be unable to act, or should no appointment have been made in time for a particular examination, the Executive Committee, or in case of emergency the President, shall appoint a visitor for that turn. All appointments so made shall be reported to the Council at the Session next following.

(5) One or more inspectors shall be appointed for the cycle of inspections and for all three divisions of the kingdom. An inspector shall not, during his tenure of office, act as examiner in any qualifying examination.

(6) A visitor shall receive no remuneration, but shall be paid his travelling and hotel expenses.

(7) The remuneration of an inspector shall be at the rate of two hundred pounds per annum, in addition to his travelling and hotel expenses.

(8) A list of the examinations to be visited and inspected in the ensuing year, with their respective dates, shall be drawn up and circulated among members of the Council before or during the May Session, with a request that members will intimate to the President which examination or examinations they are willing to visit.

(9) The President shall give to each visitor and inspector a formal commission in writing under the seal of the Council.

(10) It shall be the duty of inspectors to report to the Council their opinion as to the sufficiency or insufficiency of each examination attended by them. Their reports shall set forth in order all necessary particulars as to the questions proposed in the written, oral, and practical parts of the examination, the cases and the appliances provided for clinical examinations, the arrangements made for invigilation, the method and scale of marking, the standard of knowledge shown by successful candidates, and generally all such details as may be required for adjudicating on the scope and character of the examination.

It shall be the duty of visitors to report, separately from the inspectors, on each examination visited by them, and they shall include in their report such particulars and observations thereon as they deem important for the information of the Council.

(11) Visitors and inspectors shall include in their reports, in the form of a brief diary, a statement of the days and hours at which they were respectively present during the course of the examination, and of the parts or divisions of the examination in progress on each day.

(12) Visitors and inspectors shall be made acquainted with such previous reports on the examinations attended as the Executive Committee or the President may direct, together with the remarks and observations of the licensing bodies and the reports of the Examination Committee thereupon. They shall also be provided with copies of the recommendations of the Council in regard to professional examination, and shall include in their reports a statement of the extent to which these recommendations have been carried out in the case of each examination attended.

(13) The reports of visitors and inspectors when prepared shall be forwarded to the President, who shall cause them to be printed. The final proof copies of the reports, as corrected, shall be signed in writing by the visitors or inspectors, as the case may be, and shall be preserved by the General Registrar as the authoritative copies.

(14) Previous to the meeting of the Council at which the reports of visitors or inspectors are to be considered, confidential copies, not exceeding 50 in number, of each report shall be forwarded for consideration to the Licensing Body to which such report refers, with a request that the body will make such remarks and observations thereon as may be thought necessary, and will forward the same with as little delay as possible to the General Registrar.

(15) A confidential copy of each report of the visitors or inspectors, together with the remarks and observations made thereon by the Licensing Body concerned, shall be supplied, when ready, to each member of the Council.

(6) The Examination Committee shall consider and report to the Council on each report of the visitors and inspectors, and shall also, at the end of the cycle of visitations and inspections, present to the Council a general report on the results and conclusions arrived at.

[A motion by Dr. McVAIL, seconded by Dr. Bruce, to have the discussion on his amendments *in camera* was lost.]

In the discussion which followed Dr. McVail's amendments, the principal points referred to were: Complete separation between visitation and inspection. Inspections not to be intermittent. The inspectors should not be underpaid. They should be paid according to the work done. Should the reports be confidential, that is to say, only for the General Medical Council and the Privy Council? Is visitation merely the right of access to examinations by any member of the General Medical Council, or are visitors commissioned by the General Medical Council?—

The following proposed Standing Orders relating to

inspections and visitations of qualifying examinations were submitted by Dr. McVail:—

(1) The Medical Council shall, as required by sub-section (2) and Section 3 of the Medical Act, 1886, appoint inspectors to attend at all or any of the qualifying examinations held by the bodies which, under the divisions (a), (b), or (c) in Sub-section (1) of Section 1 of the Medical Act, are entitled to hold such examinations (the subjects of examinations were defined in a resolution of the General Medical Council of June 6th, 1890).

(2) Generally the inspectors shall be instructed by the President to give special attention to (ix), (x), and (xi) of the Council's enumeration of the subjects of professional examination, and "to report to the General Council their opinion as to the sufficiency or insufficiency of every examination which they attend, and any other matters in relation to such examination which the General Council may require them to report."

(3) It shall be the duty of the Examination Committee of the Medical Council to advise the Council as to where and when inspections should take place, and as to the subjects other than (ix), (x), and (xi), which may at any time require special inspection.

(4) The Examination Committee shall also advise the Council as to where and when Visitation of Examinations by members of the Council or other persons appointed by the Council under Section XVIII. of the Medical Act of 1858 should take place, and as to the subjects of these examinations to which visitors should give particular attention. The visitors shall report in writing to the Medical Council.

(5) The remuneration of an inspector shall be according to the work done by him on a scale of payment to be determined by the Medical Council with the sanction of the Privy Council as required by Sub-section (4) of Section 3 of the Medical Act, 1886, and visitors who are not members of the Council shall be paid on this scale.

(6) Members of Council acting as visitors shall receive only travelling and hotel expenses.

(7) The Medical Council, on receiving a report from the inspectors on a qualifying examination, shall forward a copy of such report "to the Body or to each of the Bodies which held the examination in respect of which the said report was made, and shall also forward a copy of such report, together with any observations thereon made by the said body or bodies to the Privy Council," as required by Sub-section (3) of Section 3 of the Medical Act, 1886.

(8) The reports of the inspectors and the remarks by the bodies inspected shall be regarded as confidential documents for the information of the General Medical Council and the Privy Council, and shall not be published by the Council in the public Minutes.

The following amendments on the Standing Orders as submitted by the Executive Committee were proposed by Dr. FINLAY, and seconded by Sir V. HORSLEY (notice having been given):—

I.—"That all references to visitations and visitors be struck out of Chap. XXIII. of the Standing Orders, as revised, in order that these matters may be dealt with separately by the Council."

II.—On Standing Order (5) "That instead of the words 'one or more inspectors' the following be substituted: 'Three Inspectors, one for medicine, one for surgery, and one for midwifery.'"

III.—On Standing Order (7) "That instead of the words 'two (hundred)' the word 'one' be substituted. No. I. was carried.

Nos. II. and III. were referred to the Examination Committee.

The following motion was then brought forward by Sir V. HORSLEY, seconded by Dr. BRUCE, "That the Executive Committee be instructed to approach the Privy Council and to secure such alteration in the Regulations 8 and 10 of the Schedule of Instructions to Voters under Section 8 of the Medical Act, 1886, as will provide for the adoption of the principles of

voting by ballot in lieu of the existing system of election of Direct Representatives."—After a discussion this was carried.

Sir JOHN WILLIAMS, seconded by Mr. JACKSON, presented a report from the Students' Practical Midwifery Committee. This was received, approved and entered on the Minutes.—On the proposition of Sir JOHN WILLIAMS, seconded by Dr. NORMAN MOORE, it was resolved that this report be sent to the Licensing Bodies.

The report of the Education Committee, proposed by Dr. MACKAY, and seconded by Dr. NORMAN MOORE, was received, approved, and entered on the Minutes.

The Public Health Committee reported that as no business had come before them they had no report to make to the Council.

The report of the Finance Committee brought forward by Dr. Pye-Smith, seconded by Mr. TOMES, was received, adopted, and entered on the Minutes.

The report of the Students' Registration Committee brought forward by Sir Hugh Beavor, seconded by Sir J. BATTY TUKE, was received, approved and entered on the Minutes.

A motion was brought forward by Mr. BROWN, seconded by Sir VICTOR HORSLEY, "That representations be made to the Privy Council that the time has arrived when the number of Direct Representatives for England, Scotland, and Ireland should be increased to the maximum number permitted by the Medical Act of 1886." This motion met with but little support from the Representatives of Corporations and Universities. Sir JOHN BATTY TUKE, however, said he was in support of the motion, for he did not object to an increase of *Direct* Representatives, though he thought that Representatives elected under a scheme such as that of the B.M.A. would be indirect and not direct, Representatives.

An amendment proposed by Dr. SAUNDBY, seconded by Sir THOMAS MYLES: "That the increase should only be of one member for England" was lost. 14 against, 7 for, 9 did not vote, 4 absent, and the original motion on being put was lost—15 against, 6 for, 8 did not vote, 5 absent.

A Dental Registration and Examination Committee and a Students' Registration Committee were elected.

Mr. Allen was re-elected Registrar.

A vote of thanks to the President was proposed by Dr. NORMAN MOORE, seconded by Dr. LINDSAY STEVEN, and carried by acclamation.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

FRANCE.

Paris, June 3rd, 1906.

HOT WATER IN SURGERY.

PROF. RECLUS makes an extensive application of hot water in his surgical practice and numerous are the cases which benefit from its employment. Its efficacy and the reasons of its almost universal action, he says, are explained by the fact that morbid phenomena have frequently at their basis inflammation of the tissues and it is against this element common to so many local affections that heat exercises its influence. It actuates the circulation, facilitates the cellular exchanges, removes waste and infiltration from the organs and favours diapedesis and phagocytosis.

By hot water he means water at the temperature of 122° to 131° F. Less than 122° the effect is not so energetic, while more than 137° would be ill-supported by many patients, especially in such regions as the hand, face and genital organs. A thermometer should be always used to graduate the temperature. Of the many uses M. Reclus finds for hot water may be mentioned the disinfection of wounds caused by accidents. It possesses the triple advantage of being slightly antiseptic, of being an excellent hemostatic, and of warming the patient rendered cold and rigid by the traumatic shock.

A strong jet should be directed on the tissues, so

as to penetrate all portions of the wound and thoroughly clean out all blood clots, foreign bodies, &c.

In the treatment of sprain, hot water is of the utmost value. The affected point is plunged not into cold water as was recommended in the middle of last century, but into hot water twice a day for ten or fifteen minutes; after which massage is applied for a similar period of time, and finally an elastic bandage surrounds the parts, producing gentle pressure.

Certain visceral inflammations, such as perimetrosalpingitis in woman and inflammation of the prostate in man, are greatly benefited by the use of hot water as enemas. In the former cases the patients frequently affirm that they have been in the habit of using injections of hot water for a long time without success. But, as Reclus remarks, it is generally found that the temperature of the water does not exceed 104° , which is entirely insufficient, and in any case it should be given as enema and not as injection.

To pretend to influence the uterus and its neighbouring organs by vaginal injections is what he calls an anatomical error. By vaginal injections, the hot water only attains the os and beyond the question of cleanliness its action is nil. By enemas on the contrary, the liquid is only separated from the uterus, ligaments and ovaries by the thickness of the cul de sac of Douglas.

The enema should be administered every morning half an hour before rising, if, naturally, the condition of the patient did not require to rest in bed. The water should be allowed to enter slowly into the rectum so as to avoid any premature muscular contraction. Some patients find it painful, and difficult to retain the enema as the temperature of 122° or 131° seems to them to be unbearable. In any case they should be encouraged, in view of the excellent results obtained, to endure a little suffering if need be. M. Reclus published recently a series of cases of salpingitis where extirpation was judged indispensable by some of the best gynaecologists, and which by simple rest and enemas of water at 122° to 130° got completely well.

The best treatment for inflamed prostate is enemas of hot water, renewed three or four times a day. The effect is most surprising, the swelling, pain, dysuria and retention of urine, disappear with extraordinary rapidity.

The same may be said in the treatment of chronic cystitis from hypertrophy of the prostate. The congestion of the organs diminishes and the morbid phenomena are relieved or disappear.

These enemas are also recommended against hæmorrhoids, which they relieve and when an operation is not accepted (dilatation or excision) they frequently cure, if only temporarily.

In superficial inflammations, as boils, anthrax, erysipelas, whitlows, &c., hot water is an excellent application. A compress folded several times is immersed in water at the desired temperature and applied to the inflamed part. At the end of a few seconds it has got cold and has to be renewed, and so on for ten or fifteen minutes several times a day.

It is not only acute inflammation that is benefited by applications of hot water, it influences also the chronic form and modifies the surface of sores of no tendency to heal. For a long time back Prof. Reclus used hot water in treatment of ulcers; it stimulated the sore and in a short time signs of healthy granulation was observed. In Switzerland this method is largely used.

GERMANY.

Berlin, June 3rd, 1906.

At the Congress for Innere Medizin, Hr. Kraus, Berlin, spoke on

THE PATHOLOGY OF THE THYROID GLAND.

He said a secretion within the gland had been proved. Blum's theory of intoxication by intra-glandular iodization was still hypothetical. The thyroid gland of the adult animal must have a specific power of selection

and to it must be ascribed a chief *role* in the dissemination of iodine in the fluid masses. It was remarkable that iodine first appeared during extra-uterine life, and then slowly entered the infantile organism. The quantity of iodine in the thyroid was subject to certain oscillation both under normal and abnormal conditions. An explanation of the function of the gland based exclusively on its iodine constituents was not possible. The disease of thyreoaplusia that never exhibited localised or general convulsions or pareses rendered possible a preliminary separation of the functions of the thyroid and the parathyroid glands. The question of relation between tetania strumipriva and human epithelial granules was, from the experience of operators, probable. As effects of the whole, thyroid fluid had proved injurious to the heart, and lowered blood pressure as well as a marked acceleration of the pulse, at least in certain animals—the dog, for instance—might be taken for granted. Many facts were in favour of the assumption of a regulatory power over the heart. He could not accept the assumption that the goitre heart was simply to be looked upon as a form of Basedow's disease. The Basedow problem could not be cleared up by a prolonged discussion of the relations of the syndrom to the thyroid on one certain point alone. All the clinical symptoms fitted much better than formerly into the nosological system that was based on hypofunction of the thyroid gland. The therapeutics of thyroid gland diseases remained very hopeful.

Hr. Kocher, Bern, said that treatment with thyroid gland preparations, only had an effect so long as they were being used; the symptoms returned when they were left off. The causes of tetany and cachexia must be different. In Basedow's disease we have to do with a hyperthyreosis. His conclusions were we could accurately distinguish two groups of disease dependent on changes in the thyroid apparatus and separate them sharply from each other in the thyreoprive and the thyreotoxic diseases. The thyreoprive diseases were consequences of total or partial loss of function of the thyroid gland. A distinction must be drawn between loss of the thyroid proper with its special train of symptoms and the loss of the parathyroid in its acute or chronic form in the shape of intoxication appearing as tetania parathyreopriva. Together they formed the large group of hypothyreoses of which myxœdema and cretinism were examples. But much more were the thyreoprive equivalent to be considered in which individual symptoms stood in the foreground, such as thyreoprive disturbances of growth, the thyreoprive disturbances of the sexual function, thyreoprive psychoses and neuroses. In all grades and forms of this group the thyroid preparations, and within certain limits iodothyrene, were a sovereign remedy, in so far as all symptoms that could improve did so, so long as proper doses were made use of; their action was, however, purely palliative. The radical remedy was the implantation of healthy thyroid gland. The thyreotoxic diseases were consequences of increased activity of the changed thyroid gland. They ran on acute or a chronic course, the first under the form of an intoxication, the latter more approaching to disease of tissue change. Further investigation must decide how far these groups must be classed under the title hyperthyreoses, how far a dysthyreosis is mixed up with them. Here also treatment was certain when the physician had recognised the commencing stages, the milder form and the hyperthyreotic equivalents amongst which the "Kraus" heart and certain psychoses stood in the foreground. The remedy here was anything that limited the activity of the thyroid gland. Before all ranked the exclusion of all physiological irritations by bodily and mental rest. Connected with this was the nutrition in which a substitute for exaggerated decomposition of albumen must be allowed for, but avoiding all that excited the thyroid gland. Here milk was in place and perhaps especially thyreoprive goats' milk and milk powder, and above all phosphates. The radical treatment was operation by

ligature and excision according to the degree of the hyperplasia.

Hr. Neusser, Vienna, said there must be a very close relationship that was not yet explained between the activity of the thyroid gland and that of the liver.

Hr. F. Müller pointed out how easily tired patients suffering from Basedow's disease were. There was a pseudochlorosis with normal blood, cardiac symptoms with changes in the thyroid, a relationship between Basedow's disease and diabetes. The differentiation of Basedow struma from other strumas was possible.

Hr. Hœnnicke, Greifswald, could produce exophthalmus in animals. He looked upon granulative changes in the secretion as the cause of Basedow's disease.

Hr. Erdheim reported some fatal cases of tetanus.

H. Pfaundle in obduction in cases of congenital myxœdema had met with complete absence of the thyroid gland and also of the parathyroid; this was evidence against the news of Kraus and Kocher.

H. F. Schultze would keep up medicinal treatment for a year and then operate.

Hr. Blum, Frankfurt, adopted the standpoint that the thyroid gland was not a secreting organ, but that it seized upon poisons circulating in the body and rendered them non-poisonous, that it was a protecting organ, principally of the nervous system. There was a special iodine splitting power and property in the thyroid gland. In Basedow's disease he advised a diet free from fleshmeat, and bromini-albumen, 2 to 3 grammes daily.

Hr. Gilmer had had good results in treating Basedow's disease with X-rays.

AUSTRIA.

Vienna, June 3rd, 1906.

BASEDOWI OR SCLERODERMA.

SINGER presented a peculiar case of Basedowii which he considered to be more closely allied in its clinical and histological characters to scleroderma.

For twelve years past the patient had observed a swelling on the neck gradually increasing up to the eyes and down over the breast. The object that brought the patient to hospital was the swelling on the neck itself, which appears to have increased more rapidly within the last year and a half, and was now interfering with the freedom of breathing which was now resembling stridor. The intumescence certainly depended upon a swelling or enlargement of the right side of the thyroid gland. In addition to this hypertrophy there were also tracheal stenosis, slight exophthalmia, Stellwag's symptoms, insufficient convergence, slight tremor in hands, alimentary glycosuria and pulse acceleration. This testimony is strong proof of morbus Basedowii, but the cutaneous thickening on the breast and face is indicative of a primary change which seems to have preceded the glandular hypertrophy. The patient affirms that the commencement of her trouble was preceded by a large, soft swelling, which subsequently became as hard as stone, brown on the surface which involved the whole of the right mamma and the greater part of the left. It also extended over the trunk, and particularly to the space between the shoulder behind, where it had a livid hue with hard plaques at the margin of the morbid and healthy skin. Half a year ago a large, soft doughy swelling commenced on the left arm resulting in the same changes.

Singer thought this was an uncommon form of scleroderma involving the upper part of the trunk.

In the discussion that followed several of the members concurred in the opinion that the affection was one of carcinoma—primary in the mamma, and by metastasis was carried to the second breast, thyroid, axillary lymphatics, and finally to the skin by closing the lymphatic ducts and producing œdema.

RESECTION AND PROTHESIS OF LOWER JAW.

Pichler next exhibited two cases on whom he had operated for cancer of lower jaw. The first was æt. 64, who had an epithelium in floor of the mouth which

destroyed a large area of the lower jaw. The tumour was removed in January with the submaxillary glands. The jaw was sawn behind the second molar on the left side and behind the incisor on the right. The intervening portion of jaw was entirely removed and a tin model inserted with lead bindings to the remaining jaw, at both ends of the fitting to admit of the model being removed at any time to examine the wound. This immediate prosthesis was only temporary to hold the parts in place till the healing process was complete. Four weeks after this a complete model was inserted with an alveola for the insertion of teeth fitted with a hard gummy connection to the gum, and fixed with gold clamps in which are enclosed india-rubber connections to prevent movement or jar in the fitting. The teeth can finally be fitted into the alveola by the assistance of screws, which enable the patient to masticate his food as hitherto. This prosthesis has the great advantage of retaining the natural form and outline of the face.

The second case was a female, æt. 28, who had been similarly operated on for a giant-celled sarcoma of lower jaw.

NEOPLASM IN BOWEL.

Lorenz recorded the case of a female, æt. 48, on whom he had operated for carcinoma of the bowel at the coccum, around which were small metastatic tumours binding the whole mass together. It was found that 290 centimetres of the small intestine with a portion of the large intestine must be removed to prolong life. After a few complications, the recovery was complete. Fourteen days after leaving her bed, she was dismissed with a voracious appetite. After returning home to the country, she rapidly increased in weight and now looks strong and robust. The stools are of a semi-fluid or soft consistence.

HUNGARY.

Budapest June 3rd, 1906.

At the last meeting of the Budapest Inter-Hospital Association, Dr. Rottenbiller read a dissertation on

THE PROTECTIVE ROLE OF THE OMENTUM, of which the following is an epitome:—

It is only within the last few years that the importance of the omentum has come to be recognised. Its function has, however, never been thoroughly investigated. The animal experiments of two German physicians, Drs. Renzi and Boeri, were the first of this kind. The author, too, investigated the function of the omentum with especial reference to other abdominal organs, particularly the spleen. If the main stem of the splenic artery or vein in a dog be tied off, the spleen, after one to two months, still retains its integrity and the circulation is almost undisturbed. It is probable that the omentum sustains the circulation, at least in part, for it is often found lying on the spleen, its vascularity is increased, and in separating the adhesions considerable bleeding is caused. This activity of the omentum in restoring the inhibited circulation affords encouragement for such operations as that of Talma's for a disturbed portal circulation. If the blood supply to the spleen is entirely cut off, the organ becomes necrotic. But, even after several days, the omentum is observed to have surrounded the organ, and in ten days it has formed a dense network around the spleen, in the centre of which lies the organ, encapsulated, diminished in volume, and in a state of disintegration. After twenty days it is no larger than a nut, and enclosed in a fibrous capsule with walls about 2 to 3 mm. thick. In one to two months there is scarcely any trace of the spleen left except a small fibrous nodule, almost complete absorption having evidently taken place. The animals gave no symptoms of this process going on in their interior. If the circulation is entirely cut off and the omentum excised as much as possible, encapsulation does not take place, the spleen becomes necrotic but no absorption follows, and the animal dies within twenty-four to forty-eight hours. If this operation is done in two stages, the vessels being tied off about eight to ten days

after the omentum has been extirpated, death does not come on until three to ten days later. Neither one of these operations alone is fatal, but death is caused when both are done together, and is due, the author believes, to the extraordinary toxic qualities of the disintegration products of the splenic tissue. The absorption of these is more or less hindered by the encapsulation produced by the omentum. It was also determined that the same thing took place when a kidney was tied off, encapsulation by the omentum being followed by slow degeneration and subsequent absorption. Foreign bodies introduced into the peritoneal cavity were likewise surrounded by the omentum, and apparently remained without causing any further trouble. The author believes that these observations not only clear up the question as to what becomes of certain internal organs which may become cut off from their circulatory supply, but also serves to indicate certain therapeutic applications which are rendered possible by what is known of the functions of the omentum from these experiments.

FROM OUR SPECIAL CORRESPONDENTS AT HOME. SCOTLAND.

MEETING OF THE PHYSIOLOGICAL SOCIETY.—A conjoined meeting of the Physiological Society and Edinburgh Pathological Club took place in Edinburgh on June 2nd. A large number of members of the former Society resident in all parts of the country were present. No less than 31 communications were down on the billet, and thanks to excellent organisation and commendable brevity on the part of the speakers it was found possible to carry through all the business within the time allotted. One of the leading features of the meeting was a series of microscopic demonstrations by Dr. Chalmers Watson and a number of co-workers on the effect of an excessive proteid diet on the animal economy, the changes in nutrition, in the thyroid gland, in the kidneys, in the osseous and reproductive systems, and in the teeth being most striking. The animals used in the observations were rats. Papers on pharmacological subjects—the action of Tutin, a toxic glucoside obtained from the footgrass of New Zealand, which is so poisonous to stock, and on the relation between chemical constitution and physiological action—were contributed by Dr. Marshall. Professor Schaefer (in whose laboratories the meeting took place) gave a demonstration of the action of pituitary extract, showing that it raised the blood pressure and had a powerful specific action on the kidneys, causing swelling of the organs and free diuresis—a fact not without interest when considered in connection with the clinical observation that polyuria is not very rare in acromegaly. Dr. Harris read a note on the true relations of Relter's tetanus and other purely physiological papers. An interesting microscopic demonstration was that by Dr. Goodall, showing the stages of hæmatogenesis in the foetal sheep. Papers on Physiological Chemistry were also given by Drs. Noel Paton, Cramer, and Cathcart. Dr. Paton's communication had reference to the carbohydrate metabolism of the foetus. He has demonstrated the presence in foetal tissues and fluids of a levulose, the origin of which is in all probability the maternal placenta. Altogether the meeting was one of great interest, and after the scientific part of the proceedings had been overtaken the members went by train to North Berwick, where a golf match had been arranged, while, through the hospitality of Mrs. Schaefer, those who did not take part in the royal and ancient game were enabled to visit Tantallon Castle and the Bass. In the evening the usual dinner took place. The charming summer weather, so great a contrast to what we have experienced lately, did much to contribute to the success of the gathering.

RETIREMENT OF PROFESSOR MCKENDRICK, Glasgow.—We learn that Prof. McKendrick, who has occupied the chair of Physiology in Glasgow since the year

1876, intends to retire at the close of the ensuing summer session. He will carry with him the good wishes of hundreds of his old students, and the hope of all that he may long enjoy the ease and leisure which 30 years of strenuous work have so well earned. A number of names have been mentioned as prospective applicants for the chair, which is in the gift of the Crown, but until the vacancy is officially announced nobody, of course, can come definitely into the field.

THE INEBRIATES ACTS.—A deputation from the municipalities of the principal Scottish towns waited on the Secretary for Scotland on the 29th ult. to urge the Government to take up a Bill which has been drafted to amend the Inebriates Acts, 1879 to 1900. Mr. Myles, Town Clerk of Glasgow, was the principal speaker. The main contention of the deputation was that the existing acts were in many respects unworkable. The clauses proposed had for their chief objects simplification of procedure; for example, the detention in an inebriate reformatory of an habitual drunkard who has been thrice convicted may be ordered by a Sheriff without a jury, instead of the present cumbersome procedure being required. Clauses containing quite new provisions for dealing with persons who were squandering their means, and bringing their families to destitution through drink, but who had succeeded in keeping out of the hands of the police, and also for getting hold of habitual pauper drunkards and loafers—the class of persons familiarly known to parochial authorities as “ins and outs”—were also proposed. The Secretary for Scotland gave a sympathetic reply to the deputation but pointed out the Parliamentary difficulties in the way of passing their measure. The Lord Advocate, while agreeing with the principle of the Bill, feared that it would be necessary to overhaul all the statutes and pass something in the nature of a consolidating act. It seems thus, as though the proposals have little immediate prospect of receiving legislative sanction, but it is satisfactory to have official assurances that the matter will come under the purview of the Ministry.

BELFAST.

COUNTY DOWN ASYLUM.—The annual report of this institution, just issued by the resident medical superintendent, Dr. Nolan, shows a daily average of 715 patients at an average cost of £23 16s. 5d. This is calculated on the gross expenditure, less repayment of loans. Deducting receipts from paying patients, and other miscellaneous receipts, the net average cost was £22 2s. 4d., as against £22 13s. 5d. in the previous financial year, a saving of 11s. 1d. per head. Reduced by the capitation and Imperial grants the actual cost to the rates was £7 10s. 1d., which shows a net reduction of £1 12s. 2d. per head in two years. The substitution of cocoa for tea at supper saves £150 a year, and the farm has been highly remunerative.

THE HEALTH OF THE CITY.—At the monthly meeting of the Corporation, held last Friday, three deputations appeared with reference to the appointment of a Medical Superintendent Officer of Health. The first was from the Ulster Medical Society, and the same speakers were requested by the society to appear as had already spoken at the Public Health Committee a few days before, Professors Lindsay and Byers. The former said that in the death rate from tuberculosis Belfast stood about fifty years behind the great towns of England, and showed how other cities had dealt with the matter. Professor Byers emphasised the necessity of a skilled and trained man for the post. The other deputations, which were from the Citizens' Association and from the Trades Council, both took the same line as the medical deputation. After the withdrawal of the deputations the Chairman of the Public Health Committee, Dr. King Kerr, made a lengthy reply to their various criticisms, quoting a series of carefully prepared statistics to prove that all is for the best under the best of all possible committees. His child-like satisfaction with his own committee is most touching, but will not do much to restore public confidence in it, when the city is week by week declared by the Registrar

General to have one of the highest death-rates in the United Kingdom. In the end the proposal that a salary of £800 a year should be offered to the new Medical Officer was referred back to the Council in Committee.

LETTERS TO THE EDITOR.

MEDICAL EDUCATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR.—At the present time complaints of the apathy of Irish medical men to their collective interest are loudly expressed. An attitude, however, of indifference even though assumed, is better than one of futile opposition to internal vested interests and undignified dissension in presence of them. Until there is union on the basis of a definite policy it is just as well to let things slide.

In the issue of your journal of May 16th "Criticus" comments on an article I contributed (May 9th) to it, and what he says may be thought to require some notice. Whether that article was discursive in the sense Kant, or in that "Criticus" uses, the term may be allowed to pass if only what I say now is not taken as discursive in either sense. Simple propositions are not discursive, but may or may not become matter for discursive treatment in the mind of those entertaining them. "Criticus" gives certain propositions which, no doubt, one may proceed to entertain discursively if allowed as premises, but then they can be allowed as such only after examination. Want of space—not want of courtesy—compels me to meet them, not discursively, but by their simple contradictories.

The immediate occasion on my article was a comment in a preceding article on the Archbishop of Dublin's criticism on the Trinity College Medical School. The Archbishop, like everyone else, has a perfect right to criticise that or any other educational institution, but, as the comment was put, I inferred that his Grace did so with the spirit and purpose of an ecclesiastic, and not of a critic pure and simple. My proposition in reference to this was that Huxley had the task imposed on him of saving the freedom of science from, in particular, the "Oxford Movement" and its far-reaching influence. My critic states that in doing so I am renewing the dead hostilities of an obsolete controversy. The contradictory is that the conflict between ecclesiasticism and science is as much alive as ever it was, and promises, indeed to become more acute than it ever was. So far from the Darwinian side of the controversy as representing science being closed, it is in reality only opening. An issue, for instance, is looming up between physiological and conventional morality before which all that has gone hitherto will be child's play. Professional ecclesiasticism has learned some discretion, but great masses of the people are steeped in the ecclesiasticism represented by the Christian scientist and Dr. Dowie. In America there are ample materials for a man with the genius for the thing to play the part of a Mahomet in the teeth of both science and traditional ecclesiasticism. It is a trick with the professional ecclesiastic to ascribe movements altogether within the ecclesiastical sphere and giving the historical character of that sphere to a development of scientific ideas, although it is clear that these ideas have not as yet reached the masses. Now, and at no time, is science responsible for ecclesiasticism as it escapes the hand of its professed trainers.

"Criticus" says that the dissociation of medical education from the Universities which I suggest would narrow such education. But my suggestion is that the seven-eighths of us now free from the influence of ecclesiastically-controlled Universities should resist association with such institutions and exactly on the grounds that the association would narrow medical education. Education in such places is, and always has been, the education of prisoners in jails; they have given us centuries of Cathay in the past, and would still, except for outside pressure on them. My

position is that these Universities instead of promoting union and free association among medical men, would sunder them on narrow class, political, and sectarian grounds.

As the social advantages of the Universities do not exist for, and are not desired by, Irish medical men in general, I pass over them; those who have had most experience of them would probably set least value on them.

I set out with the proposition that Irish medical men are apathetic and indifferent to their own interests because utterly powerless as regards their own affairs. Why should they take any interest in Universities over which, as licensing and teaching bodies, they have no control whatever? The only real question that can exist for them now is how they can obtain the control, supposing they venture to think that they ought to have it instead of ecclesiastics and outsiders. There is, I believe, only one way whereby the profession may control licensing power directly, and medical education indirectly. It is, in the first place, by aiming at making the Medical Council the representative body of the profession, and, in the next place, by enlarging its powers when elected by the profession. At present the Council merely inspects examinations; that power should be made real and effective by its appointing examining boards in each of the three kingdoms having the sole right to grant licences. It should further have the duty of licensing schools and hospitals on proof of their possessing adequate provision for medical education. This would leave the schools as teaching bodies as they are, competing to turn out competent men, but not competing in licensing practitioners. The Universities might be left to give M.D. as they do LL.D. and D.C.L. degrees, but the Medical Council would give the right to practice, call to the Bar. The key to this is that the teaching bodies should not license, but be themselves, in respect of their function, subject to test by the licensing body.

What Irish medical men want is an objective, a practical policy which shall unite them. My proposition, I submit, is worth exercising their discursive faculty on. If, however, they can unite on no policy, I would recommend them to adhere to their attitude of silent and dignified reserve and allow their affairs to be regulated as hitherto over their heads. If through fear of their missing the meaning of the term education, they leave their education and its test to ecclesiastics who have no misgivings as to their own view of the term in all its longitude and latitude, they are right to leave the thing to the man who has a mind of his own.

My article in the issue of the 9th was headed, "University Education in Ireland," though I wrote more particularly in relation to medical education. I believe the transfer of the Divinity School from Trinity College to the representative body of the Irish Church to be imminent simply because Irish Churchmen will not, like Irish medical men, allow outsiders to control the education of their profession. It will, however, remain open to the divinity student to take an Arts degree in Trinity College, it is to be hoped, to prevent divinity from narrowing his education. I do not think that medical interests require the separation of the medical school from Trinity College; it is enough to take away from the College its power of licensing clerical, legal, and medical professional men. Law and medicine can, indeed, concede far greater liberty of teaching than divinity, and therefore the law and medical schools might remain in connection with the University. It would, however, simplify the University question to make them altogether independent.

I am, sir, yours truly,

▲ May 19th, 1906.

"YOUR CORRESPONDENT."

DR. DENIS J. COFFEY, Professor of Physiology in the Catholic University School of Medicine has been appointed a member of the Royal Commission to inquire into the affairs of Trinity College, Dublin, and the University of Dublin.

MEDICAL NEWS IN BRIEF.

The Chemical and Physical Society.

A REPRESENTATIVE gathering of members of the Chemical and Physical Society of London paid a visit to the Wellcome Chemical Works and Laboratories at Dartford on the 22nd ult., and were conducted through the various departments. The visitors seemed much interested in the scientific methods and elaborate apparatus employed, and were impressed with the extreme cleanliness everywhere apparent. It was at once recognised that the high standard of accuracy and finish could be maintained only by the exercise of technical skill of a high order, combined with the adoption of methodical systems and perfect organisation. The party then proceeded to the Wellcome Club and Institute, and were shown over the Staff Club House, the Gymnasium, the Library, and the Club House for lady employées, &c. After a walk round the extensive sports fields and other grounds devoted to recreative purposes the visitors were entertained at tea on the lawn.

Birmingham Medical Benevolent Society.

The annual meeting of this Society was held at the Grand Hotel, Birmingham, last week, Dr. A. S. Underhill (retiring president) in the chair. The report of the directors, presented by Mr. W. F. Haslam (hon. secretary), stated that the invested funds now amounted to £15,940, and there was a balance at the bank of £74. Twenty-three annuitants were on the books at the commencement of the year, of whom two died, and one new annuitant was added to the list. The annual value of the grants ranged from £18 to £36, and the sum expended in this way was £704. The Chairman, in moving the adoption of the report, pointed out that there were now 417 benefit members, the same number as at the beginning of the year. Sir James Sawyer, seconding, remarked that in the district covered by the Society, within 50 miles of Birmingham, there were 4,000 medical men, and he thought the number of members might be increased if its beneficent operations were more widely known.

Prizes in the School of Physic, Dublin.

We were able to announce some time ago that the subscribers to the Bennett Fund in Dublin had decided on the form their memorial should take. It is to be a medal presented biennially to the winner of the Surgical Travelling Prize, and a money prize to the second in the examination for the same prize. We understand that Sir John Banks, until a few years ago Regius Professor of Physic, has made an offer to the Board of Trinity College to provide similar awards in connection with the competition for the Medical Travelling Prize. His generous offer has been accepted, the only stipulation made by the Board being that the medal provided by Sir John Banks shall bear his effigy. It will be gratifying to students winning the blue ribbon of the School of Physic in future that they will be furnished with a memento of one or other of two of Trinity's most distinguished sons.

The Middlesex Hospital.

At the annual meeting on Thursday last of Governors of Middlesex Hospital, Prince Francis of Teck in the chair, it was stated that they had received a promise from Mr. H. L. Bischoffsheim to contribute the sum of £5,000 to the hospital to repay advances from the bankers and to meet other immediate expenses. They had also received a donation of £1,050 from Mrs. le F. Greenhill. During the quarter ended March 8th, 1,184 medical, surgical, and obstetrical patients received treatment as in-patients, and 10,853 patients were treated in the out-patients' department. Mr. Andrew Clark, the consulting surgeon, in seconding the adoption of the report, advocated, if possible the extension of the convalescent home, and praised the amount of work which was done in the cancer wards. The secretary announced that the total subscriptions, etc., received

for the quarter amounted to £1,745, an increase of £147 over the corresponding period of last year.

Trinity College, Dublin, Forthcoming Royal Commission.

THE Commission appointed to inquire into Trinity College, Dublin, and the University of Dublin will consist of the following: The Right Honourable Sir Edward Fry, late Lord Justice of Appeal (Chairman); the Right Honourable Christopher Palles, Chief Baron, Ireland; Sir T. Raleigh, K.C.S.I., D.C.L., Fellow of All Souls' College, Oxford; Sir A. W. Rucker, LL.D., F.R.S., Principal of the University of London, late Secretary of the Royal Society; H. Jackson, Esq., D.Litt., Regius Professor of Greek in the University of Cambridge; S. H. Butcher, Esq., D.Litt., late Professor of Greek in the University of Edinburgh; Douglas Hyde, Esq., LL.D., of Trinity College, Dublin; D. J. Coffey, Esq., M.A., Fellow of the Royal University of Ireland, Professor of Physiology in the Catholic University School of Medicine; S. B. Kelleher, Esq., Fellow of Trinity College, Dublin. The terms of reference are as follow:—To inquire into and report upon the present state of Trinity College, Dublin, and of the University of Dublin, including the revenues of the College and of any of its officers and their application, the method of government of the University and of the College, the system of instruction in the College and the teachers by whom it is conducted, the system of University examinations, and the provision made for post graduate study and the encouragement of research; and also to inquire and report upon the place which Trinity College, Dublin, and the University of Dublin now hold as organs of the higher education in Ireland, and the steps proper to be taken to increase their usefulness to the country.

Royal College of Surgeons, Ireland.

THE following candidate having passed the necessary examination, has been admitted a Licentiate in Dental Surgery of the College:—N. Y. Stewart. The following candidates have passed the primary part of the dental examination:—P. M. Black, R. F. Cooper, R. G. Fitchie, H. J. Hedley, S. Miller, T. J. Ollivere, D. M'C. Smith.

OBITUARY.

SIR WILLOUGHBY F. WADE, M.D. DUB.,
F.R.C.P. LOND.

SIR WILLOUGHBY F. WADE, M.D. DUB., F.R.C.P. LOND., who for many years occupied a prominent position in Birmingham, died in Rome last week, where for several years past he had wintered. Deceased took his B.A. Dub. fifty-seven years ago, and was elected to the Fellowship of the London College of Physicians in 1871. He was a Justice of the Peace for Warwickshire, Physician to the Birmingham General Hospital, Senior Physician to the Queen's Hospital, and Professor of the Practice of Physic and Clinical Medicine in Queen's College. A few years since he retired from practice in England and had resided in Florence and in Rome; in both cities he had a considerable following of wealthy patients, by whom he will be missed.

PROFESSOR WILLIAM STIRLING, now Dean of the Medical School of the University of Manchester, is a candidate for the Chair of Physiology in the University of Glasgow, vacant by the resignation of Professor McKendrick.

Mr. H. R. SWANZY, Surgeon to the Royal Victoria Eye and Ear Hospital, Dublin, and Mr. John Lentaigne, Surgeon to the Mater Misericordiae Hospital, have been respectively nominated as President and Vice-president of the Royal College of Surgeons in Ireland for the forthcoming year.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS.

ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR,

RECENT GYNÆCOLOGICAL AND OBSTETRICAL LITERATURE.

Ventrofixation Followed by Normal Delivery.—A. Laphorn Smith (*Amer. Journ. of Obstetrics*, May, 1905). After having performed over six hundred operations of various kinds for displacements of the uterus, the writer sees no reason to change an opinion already formed—namely, that when the uterus was normal in size and absolutely free from adhesions, and when there was no indication for opening the abdomen, the Alexander operation for shortening the round ligaments was the ideal one. But when there were adhesions, or when the abdomen had to be opened for some other reason, the operation of ventrofixation gave the greatest satisfaction. About five years ago Smith collected a large number of cases of pregnancy after ventrofixation, nine of which were operated on by himself. He was informed by the doctors who had sent these women that one had a miscarriage at the third month, and that all the others went on to full time and normal delivery, the only symptom referable to their operation being some pain and dragging on the artificial adhesions during the last month. But as far as the labour was concerned, there was absolutely nothing to indicate that ventrofixation had been performed. In conclusion, he states his present attitude as follows:—

1. In all cases in which the retroversion is the only lesion and where certain there are no adhesions he does an Alexander;
2. The only modification made in the technique of the Alexander operation, is to cross one ligament under the skin, tying the two ligaments with a reef knot opposite the right external inguinal ring, which knot is secured from slipping by a few fine catgut stitches.
3. In doing ventrofixation he scarifies a space an inch in diameter on the anterior surface of the fundus, doing same to corresponding abdominal peritoneum and anchors the uterus by two chromicized catgut stitches passed through peritoneum muscles and fascia on both sides, and deep into uterine wall. These stitches must last a month.
4. In both Alexander and ventrofixation operations it is important to amputate the cervix if it is too long—so as to leave the uterus only two and a half inches deep.

Radium Therapy in Pediatrics and Gynecology.—Freeman Abbé (*Amer. Journ. of Obstetrics*, May, 1905). A point which elicits many queries from those who have not done any work with radiotherapy is the method of applying the radium. The salt itself is not consumed in the applications. Only the radiations which are constantly being given off are used. Of these radiations the alpha rays, which are in the greatest quantity, have but slight penetration; the beta rays smaller in quantity, have much greater penetration, while the gamma rays have tremendous penetration, but are very few in number. If the radium be kept in a glass tube, all the gamma, most of the beta, perhaps some of the alpha rays will penetrate the glass and be accessible for use. If kept in an aluminium container all the beta and more alpha rays become available for use. And with a mica disc for a cover a still larger proportion of the alpha rays become available. The writer uses an aluminium container for stricture work, applications to the cervix, &c., and the flat mica covered box for surface work. The glass container is satisfactory even when containing weak radium for analgesic work. Two of the effects of radium, that have not yet been applied therapeutically, may be of interest. It has been shown by experimentation on animals that radium, like the x-ray, produces sterility in both the male and female. In the male the spermatozoa are no longer produced and in the female the Graffian follicles no longer ripen, this sterility has been but temporary lasting a few months; whether longer

exposures would produce a complete and permanent sterility has not yet been demonstrated. To come to the application of radium in pathological conditions. It gives the most satisfactory results in the treatment of birthmarks, lupus, and keloids. It is helpful in late cases of cancer of the uterus to palliate some of the symptoms, and may probably be curative in the very early stages. It is the most desirable treatment of inoperable strictures of the rectum and œsophagus, where it gives more comfort to the patient than colostomy or gastrostomy. F.

Angiomatous Fibroma of the Uterus.—W. Blair Bell and H. H. Clarke (*Journ. of Obstetrics and Gynecology*, May, 1905) report a case operated on for a pedunculated fibroid of the fundus uteri in which they found that the uterus to the right and posteriorly consisted of a large, soft, cystic feeling mass, not unlike an early pregnancy—the surface having the normal smooth uterine appearance. The broad ligaments contained very large tortuous veins. Supra-vaginal hysterectomy was performed, both ovaries and tubes being removed at the same time owing to the doubtful nature of the growth. On cutting into the mass on posterior wall of uterus after removal—a grey-blue semigelatinous mass, in which hard white nodules were interspersed, extruded itself through the incision in the uterine covering which formed the cyst wall, as it were. The cavity of the uterus appeared normal and both ovaries were sclerotic, microscopic. The great bulk of the tumour consists of unstriated muscle fibres. In parts it is very vascular, the vessels having thick walls which have undergone hyaline degeneration. There is also in some places myomatous tissue. It is unusual to see so many vessels in a myoma and the degeneration of the walls is also unusual. Virchow describes a somewhat similar tumour under the name of "complex telangiectatic myoma." It is the writer's opinion, and the opinion of several competent authorities who have seen this specimen, that it is a new growth rather than a degeneration, but so far they have not been able to trace the record of any similar case. The woman was unmarried, 41 years of age, and complained of profuse menstrual periods, considerable pre-menstrual pain, and attacks of severe abdominal pain accompanied by vomiting, in the intermenstrual periods. F.

Amenorrhœa Associated with Serious Eye Symptoms.—J. Gemmill (*Journ. Obstet. and Gyn., Br. Emp.*) cites a case of a girl, æt. 16., whose menstrual periods were normal up to the time she went to a boarding school, when they ceased. In about one month she suddenly became blind in one eye. At the end of three months she was practically blind in both. This blindness was caused by hæmorrhages into the vitreous. Treatment to bring on her periods has brought back the sight of one eye. The prognosis as regards the eye in this condition is not favourable, but if the menstrual period is not re-established it becomes still more grave, as repeated hæmorrhages may cause permanent damage. F.

Spontaneous Inversion of Uterus.—McKay, Wetherby (*Lancet*, April 28th, 1906) reports a case of spontaneous inversion of the uterus. He attended a primipara, the first two stages of whose labour were normal. About fifteen minutes after the birth of the child the patient with a strain expelled the placenta, which was attached to a tumour, which proved to be the fundus of the inverted uterus. Abdominal palpation revealed the absence of the fundus, and instead a hollow. The hæmorrhage was profuse, but after detaching the placenta reduction proved easy. The cavity was

washed with an antiseptic lotion. Beyond feeling faint the patient complained of little, until two hours after the reinversion, when she became very pallid and lost consciousness. Two like attacks followed during the day, but recovery though slow was apyretic and good. H.

Ossification of the Fontanelles and Closure of Sutures at Birth.—A Cause of difficult delivery.—Leahy-Lynch (*Lancet*, May 19th, 1906)—A primipara, æt. 33, completed the first stage of labour normally. The membranes were ruptured artificially, and the head lying in the first position was left to mould. After some time in the second stage, the patient was delivered under an anæsthetic by means of forceps. It was noted that the handles of the forceps were separated when the instrument was locked. Delivery was difficult and took longer than had been anticipated. On examining the child's head—a healthy male child weighing 8½ lbs., and measuring 21 ins.—ossification was found to be complete in the fontanelles and sutures, and such a state was responsible evidently for delay. There was no hydrocephaly. The blades marked the child slightly over the left mastoid region. Various clinical and anatomical authorities are referred to, and a wish expressed to know whether such cases are often met with, and the best means of forming a diagnosis. H.

How Far Shall the Child's Right to Live be Considered During Parturition.—Krönig, Freiburg (*Monatsf. Geb. in Gyn.*, March, 1906) repudiates the old view that the life of the child during parturition is of less importance than that of the mother, and brings forward important statistics in support of his arguments. He advises the immediate delivery of the child in cases of eclampsia by means of the vaginal Cæsarean section. The infantile mortality is thus reduced very considerably. Again, in cases of placenta prævia, the author, with Bumm, prefers the vaginal Cæsarean section to the usually performed version (Braxton Hicks). He also performs this operation in cases of prolapse of the cord, here naturally for the sake of the child alone. With regard to contracted pelvis, he holds that with good technique and proper asepsis, when the woman comes under treatment with an aseptic genital tract, the prognosis, after symphysiotomy and Cæsarean section in relation to the maternal mortality, is not in the least more unfavourable than after craniotomy. Consequently he does not favour the induction of premature labour, owing to the difficulty in rearing the child, and would like it to be completely rejected in cases of contracted pelvis. Since it is practically impossible to know positively when induction of premature labour or prophylactic version are indicated, they are very often performed on patients who, if they had not been interfered with, would have delivered themselves spontaneously. On the other hand, he does not advise symphysiotomy, hebotomie, or Cæsarean section out of relative indications, on women in whom there is any suspicion of septic infection, or who are already infected. In such cases the author would only perform Cæsarean section for primiparae near the menopause, in whom another pregnancy is scarcely to be hoped for, and there is a great desire for a child. Also in patients with inoperable carcinoma uteri, in whom an early death, under any circumstances, is to be expected with certainty. In these cases, however, only the Porro-Cæsarean section with extra-peritoneal treatment of the stump should be considered. G.

The Mortality Connected with Contracted Pelves Formerly and Now.—Baisch, Tübingen (*Monatsf. Geb und Gyn.*, March, 1906) divides the years from 1840 to the present day into three periods, according to the changes which the art of midwifery has undergone in relation to contracted pelves. The first period which is represented by Michaelis, Litzmann, Schwartz, and Spiegelberg may be described as a period of carefully observed expectant midwifery, which, full of trust in Nature, made very little use of high forceps, prophylactic version, and induction of premature labour.

Cæsarean section was reserved for absolute contraction in other cases craniotomy being performed. The next period, with the help of antiseptics, saw the prophylactic operations for the sake of the child systematically performed. The last period dates from the day when Sänger perfected the Cæsarean section and Zweifel the symphysiotomy. These two operations spare us the perforation of the living child and the induction of premature labour with its uncertain results. Statistics regarding the maternal mortality show that the prophylactic operations for the sake of the child without improving its chances, endanger the mother, much more than the expectant treatment with the more frequent performance of Cæsarean section, hebotomie and symphysiotomy. In conclusion, the author points out that owing to the unfavourable prognosis in pelvic compared with vertex presentations, podalic version in transverse presentations should be more frequently replaced by cephalic version. The expectant treatment is in too protracted labour to be shortened by operative measures. The prejudice against the use of forceps in easy cases, where the delay is injuring the child, goes perhaps too far, but in long continued high position of the head both forceps and version are contra-indicated, and hebotomie should be performed to favour the entrance of the head into the pelvis. G.

Lactation and Menstruation.—Heil, Darmstadt (*Monatsf. Geb. u. Gyn.*, March, 1906), comes to the following conclusions as the result of his observations. He agrees with the statements of Mayer, Remfry, and Essen-Möller, that about 50 per cent. of all nursing women menstruate. The onset of menstruation during lactation is not a ground for removal of the child from the breast. On the contrary, menstruating nursing women are not exposed to the danger of uterine atrophy due to lactation. The number of menstruating mothers increases when the suckling is prolonged over the fourth month. This finds a plausible explanation in the theory of Thorn and Fränkel that the uterine atrophy due to the lactation has healed. An explanation regarding the cause of the onset or absence of menstruation during lactation in individual cases cannot be given, for if one were to consider every amenorrhœa as due to lactation atrophy, the cause of the latter is not to be found in some cases. A considerable proportion of nursing women menstruate during one lactation and not during another. It is probable that the menstruating nursing women and not the non-menstruating represent the healthy type. G.

A Case of Severe Uterine Tetany and Spasm of the Internal Os, is recorded by Rühl (*Monatsf. Geb. u. Gyn.*, March, 1906). The patient, æt. 29, a two-para, had a normal labour on first child. On examination forty-eight hours after the onset of pains, the cervix admitted two fingers. The child was lying transversely. Version being impossible owing to uterine tetany, it was decided to wait for full dilatation of the cervix, which, at the end of another three days, had not occurred. As fever arose on the sixth day, decapitation was attempted, but without success. The author was now called in. He found the uterus contracted firmly down on the child, the internal os admitted three fingers, manual dilatation of it was impossible. The spasm of the internal os and the tetany of the uterus did not even disappear under the deepest narcosis. Having failed to decapitate, he eviscerated broke up the body of the child and so extracted it. The placenta was easily expressed immediately after. Puerperium normal. Author advises the *morcellement* of the child rather than Cæsarean section when possible in such cases. G.

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

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

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.

A FORMER VIENNA STUDENT.—We believe the sanitary condition of the city to be as well advanced as any on the Continent; the death-rate, however, is a good deal higher than that of London, chiefly arising from diarrhoeal diseases and infant mortality.

FOURTH YEAR.—The book answering your requirements is the *Manual of Medicine*, by Prof. Monro, of Glasgow, of which a new edition is now before us. It is the one of all others free of "padding," and contains everything you will require at the examinations, expressed in the briefest and most practical manner.

W. F. (Portsmouth).—The most confirmed caviller could hardly find fault with the publication in the local newspaper of the facts connected with a presentation to a medical man of the district, whether in reference to their proposal or realisation.

"A MOVIN' MEDSIN."

A coloured woman threw the odds and ends of medicine left after her husband's death into the fire. The explosion that followed carried the stove through one of the windows. "Mos' pow'ful movin' medsin I eveh saw'd," said she. "No wondah the ole man gone dead.—*American Exchange*.

M. B. (Marlborough Road, W.).—The situation is clearly one of some delicacy. The tale of your patient is probably given in perfect good faith, and the refusal of the wife to see you professionally renders the caution still more necessary. Iritis of specific origin is sometimes treated as an ordinary trititis, without any apparent suspicion as to its real nature. In any case, we imagine, it is your duty to warn the husband as to the nature of his malady.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JUNE 6th.

OBSTETRICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Mr. H. T. Hicks, Dr. R. H. Bell, and Mr. D. Drew (introduced by Dr. Tate). Short communication:—Dr. W. H. B. Brook: Three Cases of Glycosuria of Pregnancy. Paper:—Dr. G. E. Herman: A Case showing (a) Uterine Contraction without Retraction, (b) Prolonged High Temperature of Nervous Origin.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Mr. P. Paton: Clinique. (Surgical), 5.15 p.m. Lecture:—Dr. B. Abrahams: The Rest Cure.

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

THURSDAY, JUNE 7th.

NORTH-EAST LONDON CLINICAL SOCIETY (Tottenham Hospital, N.).—4 p.m. Clinical Cases. Dr. T. Hicks, Dr. R. H. Bell, and Mr. D. Drew: (introduced by Dr. Tate). Short communication:—Dr. W. H. B. Brook: Surgical Diseases of Children.

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

FRIDAY, JUNE 8th.

WEST LONDON MEDICO-SURGICAL SOCIETY (Kensington Town Hall).—8.30 p.m. Cavendish Lecture:—Sir William MacEwen. Followed by Conversations and Exhibition.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chenies Street, W.C.).—4 p.m. Dr. L. Lack: Clinique. (Throat).

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

SATURDAY, JUNE 9th.

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

Vacancies.

Littlemore Pauper Lunatic Asylum, near Oxford.—Second Assistant Medical Officer. Salary £120 per annum, with furnished rooms in the Asylum and board. Applications to Thomas M. Davenport, Clerk of the Visiting Committee, County Hall, Oxford.

Hants County Asylum.—Third Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, washing and attendance. Applications to the Visiting Committee, Hants County Asylum, Fareham.

Sheffield Union Hospital.—Resident Medical Officer. Salary £100 per annum, with apartments and rations. Applications to Albert

Edwd. Brooker, Clerk to the Guardians, Union Offices, Westbar Sheffield.

North-Eastern Hospital for Children, Hackney Road, Bethnal Green, E.—Resident Medical Officer. Salary £100 per annum, with board, residence, and washing. Applications to T. Glenton-Kerr, Secretary.

Barnsley Hall Asylum, Bromsgrove, Worcestershire.—Medical Superintendent. Salary £800 per annum, with an unfurnished house, with fuel, electric light, washing, and garden produce. Applications to Robert J. Oliver, Clerk of the Visiting Committee, Shirehall, Worcester.

Perth District Asylum, Murthly.—Assistant Physician. Salary £120 per annum, with board and residence. Applications to Dr. Bruce, Phys.-Supt., Murthly, Perthshire.

Princes Christian Hospital, Sierra Leone, West Africa.—Salary £250 and rooms. Applications to Rev. Arthur Sinker, St. Anne's Vicarage, Hermondsey, S.E.

Saint Andrew's Hospital for Mental Diseases, Northampton.—Junior Assistant Medical Officer. Salary £200 per annum, with board, lodging, and washing. Applications to the Medical Superintendent.

Brecknock County and Borough Infirmary.—Resident House Surgeon. Salary £100 per annum, with furnished apartments, board, and attendance, fire, and gas. Applications to W. Powell Price, Secretary, 6, The Bulwark, Breton, South Wales.

Bristol Royal Hospital for Sick Children and Women.—House Surgeon. Salary £80 per annum, with board, rooms, and attendance. Applications to H. Lawford Jones, F.C.L.S., Secretary.

Salford Royal Hospital.—Junior House Surgeon. Salary £90 per annum, with board and residence. Applications to George Ruddle, Secretary and Superintendent.

Appointments.

ATKINSON-FAIRBANK, J. G., M.B., L.R.C.P., M.R.C.S., L.D.S. Eng.—Demonstrator to the Royal Dental Hospital of London.

BALL, L. C., L.D.S., Eng.—Demonstrator to the Royal Dental Hospital of London.

CAMERON, ISABELLA D., M.B., B.S. Edin., appointed by the Carnegie Dunfermline Trustees as Assistant to Dr. R. V. C. Ash in connection with the medical inspection of school children in Dunfermline and also as Lecturer in the College of Hygiene and Physical Training.

GILLES, ARTHUR, M.D., M.R.C.P. and R.C.S., Surgeon to In-patients at the Chelsea Hospital for Women.

HAYES, T. CRAWFORD, M.D. Dub., F.R.C.P. Lond., Professor Emeritus of King's College and Consulting Physician to King's College Hospital.

MCDOWALL, COLIN F. F., M.B., B.S. Durh., Second Assistant Medical Officer to the Newcastle-upon-Tyne City Asylum.

MCKAY, ROBERT, I.R.C.P. Lond., M.R.C.S., L.D.S. Eng., Assistant Dental Surgeon to the Royal Dental Hospital of London.

PATON, E. PERCY, M.D. Lond., F.R.C.S. Eng., Examiner in Surgery to the Society of Apothecaries.

RICHARDS, OWEN, M.D. Oxon., F.R.C.S. Eng., Surgeon to Kasr-el-Ainy Hospital and Professor of Clinical Surgery in the Egyptian Government School of Medicine.

RITCHIE, A. L., M.B., B.S. Aberd., Certifying Surgeon under the Factory and Workshop Act for the Cavendish District of the county of Suffolk.

SARGENT, PERCY W. G., M.B., B.C. Cantab., F.R.C.S. Eng., Assistant Surgeon to the National Hospital for the Paralysed and Epileptic, Queen Square.

Births.

BATEMAN.—On June 1st, at Heath End, Blackheath, the wife of F. J. Harvey Bateman, M.A., M.D., of a son.

DOWNES.—On June 2nd, at 106 Elm Park Gardens, London, the wife of Arthur Downes, M.D., of a daughter.

LAMPLOUGH.—On May 31st, at Kirkstall, Alverstoke, Hants, the wife of Charles Lamplough, M.D., of a son.

Marriages.

CHAMBERS—BELL-NEALE.—On June 2nd, at St. Dominic's Priory Haverstock Hill, London, Major Alexander Jasper Chambers, Royal Army Medical Corps, Netley, elder son of Charles Chambers, 35 Manor Road, Folkestone, to Helen Louise, second daughter of the late John Bell, of Southsea.

METCALFE—TURNBY.—On June 2nd, at All Saints', Mettingham, Kenneth Metcalfe, of Blantyre, British Central Africa, youngest son of Robert Ives, Metcalfe, Esq., M.D., of Beccles, to Winifred Lake, second daughter of the late Henry Turney, Esq., of Stourbridge, and of Mrs. Turney, of Mettingham House, near Bungay, Suffolk.

PAGE—SYMES-THOMPSON.—On May 29th, at St. George's, Hanover Square, Arthur Page, of New Court, Temple, son of N. Page, Esq., J.P., of Woodlands, Croydon, to Margaret Watkins, younger daughter of E. Symes-Thompson, M.D., F.R.C.P., of 33 Cavendish Square, and Finmere House, near Buckingham.

ROTHERHAM—BOILEAU.—On June 1st, at St. Michael and All Angels', Monkton Combe, Bath, Frank Herbert Rotherham, M.B. Lond., second son of the late Geo. S. Rotherham, of Corentry, to Hazel Durie, second daughter of Major L. M. Boileau, I.S.C., retd., of Combe Down, Bath.

Deaths.

HICKS.—On May 28th, in London, George Augustus Hicks, M.R.C.S., L.R.C.P., of Bournemouth East, son of the late Thomas Hicks, Esq., of Torquay, in his 70th year.

WADE.—On May 28th, at Rome, Sir Willoughby Wade, M.D., late of Birmingham.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, JUNE 13, 1906.

No. 24

NOTES AND COMMENTS.

The London Hospital as Popular Educator. THE management of the London Hospital certainly understand the art of keeping before the public. The light cure for lupus has been constantly paraded by them in the lay press, often in connection with names of the medical staff. Needless to say, the merits of that particular method are by no means scientifically established. The process is tedious, uncertain, costly, and the malady is apt to recur. In a word, it compares unfavourably with other surgical and medical measures practised for the relief and cure of lupus. That view, however, is not accepted by the lay board of the London Hospital, who advocate the light treatment with whole-hearted enthusiasm in season and out of season. Whatever doubts may pervade the professorial mind, none find even a momentary existence in the brain of the lay members of the London Hospital Committee. They advocate Finsen light treatment as the best possible method of treatment in lupus, and that is enough. Some of them go so far as to denounce "scraping," and other barbarous surgical measures. Well may the medical profession ask What is the basis of this new pseudo-scientific authority that has sprung up in our midst!

Where are our Medical Men? WHY should not a highly technical matter of medical research be announced to the world through the usual channels? What is there peculiar to the committee of the London Hospital that it should take upon itself to inform our countrymen upon the value of the light treatment in lupus? Not only that, but this enterprising committee of laymen have added to that essay a manifesto upon the opsonic index. If the Finsen treatment be from a scientific point of view in the clouds, the opsonic index is a hundred times more so—inasmuch as in its present form it is practically out of reach of ninety-nine hundredths of all medical practice, and, at the best, its precise and overwhelming value has not been demonstrated. These facts, however, do not hinder these enterprising laymen from advertising their faith, and, incidentally, the claims of their hospital upon the public purse, in the two ultra-scientific methods in question. That abstruse and tentative medical science should filter to the world through the medium of a lay hospital committee is farcical,

impertinent and altogether derogatory to the dignity that should govern and control the policy of a great and noble charity.

General Medical Council - Arrogance. THE contemptuous refusal of the General Medical Council to increase the number of direct representatives to the maximum permitted by the Medical Act of 1886 will not readily be forgotten. By fifteen votes to six the proposal was rejected. Eight members did not vote, though why a man should efface his representative position in so vital a matter is somewhat of a mystery. As a specimen of class arrogance the attitude of the Council with regard to the medical profession is unique in its intolerance. The only thing at all resembling its jealous protection of privilege is to be found in the House of Lords. However, the day is gone by for such an anomaly as that of a great profession like that of medicine being misrepresented and misgoverned by a handful of representatives, more or less fossilised corporations without a grain of sympathy for the outside medical practitioners. We trust our direct representatives will continue their efforts year after year to remove an abuse worthier of repressed Russia than of a free and enlightened United Kingdom.

Mr. Chiozza Money on Big Fees. WE recently commented on an extraordinary reference by Mr. Chiozza Money in the *Daily News* to the "fashionable surgeon, who wastes his time dancing attendance upon well-to-do vermiform appendices." Mr. Money, as an owner of that fateful anatomical survival, may one day welcome the attendance of a skilful surgeon at any price. Surely it cannot have escaped the notice of so eminent an economic authority that the services of the highly-qualified surgeon may be had free, gratis and for nothing in hospital if the sufferer cannot afford high fees. The *Daily News*, however, has treated our remonstrances with lofty contempt. The same journal, moreover, has mutilated the critical letter of a correspondent, whose original communication—departing from our usual custom—we reproduce in full in another part of the present issue. This course we consider justifiable in view of the slanderous nature of Mr. Money's allusion to the work of the surgeon.

LEADING ARTICLES.

INFANTILE MORTALITY AND THE | POPULATION QUESTION.

THE question of the excessive infantile mortality is one with which the medical profession is in every respect tolerably familiar; they need little, if any, enlightenment as to its causation or prevention. The question, however, calls for recognition by the mass of the people, who are to a vast extent entirely ignorant upon it; and its importance needs proper appreciation by statesmen, legislators, philanthropists, and publicists, upon whom the promotion of improvement so largely depends. It is satisfactory to learn that a conference on the subject, called together by the President of the Local Government Board, is to be held in London on June 13th and 14th. Besides representatives of public health authorities and medical associations, delegates from parish councils and school-boards are to be invited. The programme is a wide one; and the conference cannot fail to help in diffusion of knowledge in those directions where it is most urgently required. A great part of the present infantile mortality is preventable. The causation is complex, but the main factors are improper food and feeding, bad housing, foul air, filth, and overcrowding, together with neglect and ill-usage due to dense ignorance or wilful cruelty on the part of parents. The waste of life would be less deplorable if it did not form a measure of injury to the national physique by which it is accompanied. For every infant dead a number survive with damaged constitutions owing to the ordeal of mal-nutrition and acute disease through which they have struggled. The birth-rate at the same time is rapidly falling—the last returns are the lowest on record—and it is more than ever important for the national welfare that our increase, if small in quantity, should be of the best in quality. We wonder how many of our leading statesmen are giving attention to the population question in its widest aspect. How many of them have pondered the significance of the figures in the lately published census of the Empire. The census shows that in these islands, our colonies, and India, the white population altogether numbers only 55,000,000, whilst the coloured races form a total of some 400,000,000. None of our colonies suitable for a population of European blood contain more than an insignificant fraction of the millions they are capable of being made gradually fit to sustain. In some of them the birth-rate is falling at a pace which, as at home, will before many years, if continued, result in a stagnation of population as complete as that which has been brought about and maintained for thirty-five years among our neighbours the French. In the meantime, the population of the German Empire at home, increasing at the rate of 1,000,000 a year, now stands at 61,000,000, a significant fact for statesmen to reflect upon. Whatever role the mighty Teutonic people is destined to take in the evolution of the races, there

can be no doubt that nations in decay are at this present epoch as surely doomed to be gradually conquered or supplanted by more virile stocks as they were in the old days when the barbarian came down upon Rome. If we do not become prepared to colonise our magnificent over-sea possessions, where there is room for our natural increase for the next five hundred or perhaps thousand years, these eligible lands will in due course be over-run by races white or yellow who have not been affected by the vices of civilisation which already threaten to destroy some of the nations of Western Europe. The dream of a mighty British Empire, invulnerable by reason of the vast number of its properly organised populace—an Empire where peace, law, and liberty, the progress of humanity, shall be assured—the realisation of this dream depends upon the proper solution of the population question. This problem cannot be solved without sacrifice. A people whose motto is, "Let us eat, drink, and be merry, for to-morrow we die," who ask with the French cynic, "What has posterity done for us that we should sacrifice for posterity?"—a people pervaded by the spirit of anti-social egoism which subordinates every consideration to the desire for a life of ease and luxury, is surely doomed to destruction. Science is able to demonstrate with sufficient clearness that the pursuit of such an ideal can never lead to true happiness; and as the representative of science, the medical man may here co-operate with the religious teacher in the attempt to save modern society from the perils by which it is evidently becoming more and more encompassed. Viewed in these lights the question of infantile mortality is seen in its true size and shape—a much bigger thing than can ever be suspected, revealed, or explained by any merely superficial examination.

THE TIMES AS CENSOR MORUM.

A CORRESPONDENT, whose letter will be found in another column, has drawn our attention to a leading article in *The Times*, Friday, June 1st, on the meat scandal in Chicago. The article thus referred to is in every way a first-rate specimen of editorial writing, whether as regards its literary quality, its argument, or the lesson it inculcates. It ends with a severe indictment of democratic institutions and of the society which tolerates the abuses possible beneath them. It is at bottom all due to "a brutal system carried out by brutal agents, a system by which, in a land supposed to be free and democratic, the plutocrat grinds the souls of men and women as ruthlessly as his machines disintegrate his tuberculous cattle, his cholera-smitten hogs, and his putrid hams. Universal suffrage, universal education, omnipresent free libraries, all the panoply of modern panaceas for the abuses supposed to be inseparable from older regimes, result in a tyranny more body and soul destroying than any exercised by autocrats or feudal oppressors." These revelations have brought forward an "appeal for Socialism to redress the evils of individualism run mad. But who shall guarantee that men such as have captured the industrial machine will not also capture the State machine of the Socialist Utopia? Had we not better—and in this country, perhaps, as

well as in the United States—hark back a little to the ideas of an older morality, and try to restore in the community something of the notions of duty, and of simple living which are now unhappily much out of fashion?" Readers of THE MEDICAL PRESS and all those acquainted with the present day business methods of *The Times* will be disposed to ask why the Editor of the leading journal does not look at home, why does he not appeal to his employers, the proprietors of the paper, to set an example in the practice of the morality the ideas of which we are losing? Why do not the proprietors of *The Times* begin by refusing to augment their income by abetting a traffic denounced frequently in their own columns. Why does *The Times* now freely admit the advertisements of quacks and quack medicine vendors described not so long ago in their editorial pages as "some of the most complete and finished of the many impostors who are parasitic upon modern civilisation"? Why does not *The Times* endeavour to put a stop to a system which it described as "undermining the health of so many victims"? If the proprietors are not aware of the character of the trade which their editors a few years ago frequently exposed, why do not they make inquiry, and in the meantime if their income should be diminished they might set an example in "duty and simple living which are now, unhappily, so much out of fashion."

NOTES ON CURRENT TOPICS.

The Council Election at the Royal College of Surgeons, England.

THE annual election of members of the Council of the Royal College of Surgeons, England, takes place on July 5th, at which three vacancies will be competed for, under the rule of compulsory retirement. The retiring councillors are Mr. John Langton, Mr. Richardson Cross, and Mr. Henry Morris. Mr. Langton will not seek re-election, while Mr. Morris and Mr. Cross have decided again to seek the suffrages of the Fellows. In addition to these two candidates, we hear that Mr. George Arthur Wright, B.A., M.B.Oxon., F.R.C.S., Professor of Surgery at the Victoria University, and Surgeon to the Royal Infirmary, Manchester, will come forward, as well as Mr. Charters Symonds, F.R.C.S., Surgeon to Guy's Hospital. Thus far, then, there are two metropolitan surgeons, and two provincial surgeons who will compete for the three vacancies. The re-election, we may anticipate, of Mr. Henry Morris is a foregone conclusion, owing, apart from his high surgical position, to the claims which he has upon the Fellows for the valuable work which he has done for the College during his past term of office. On the other hand, the fact that two provincial surgeons should have decided to go to the poll introduces a difficulty, since it is doubtful whether the provincial Fellows will be prepared to run both candidates. Possibly, therefore, the Fellows in the provinces will cast their votes for one or other of their representatives and not for two,

and distribute their support in other directions. It would be entirely unprecedented were two provincial Fellows to be successful at the poll at one election. Under the circumstances, then, it will be of interest to see how the votes will be cast in this regard. Meanwhile, no doubt college politics being dead so far as the Fellows are concerned, vigorous canvassing will take place among the personal friends of the candidates to ensure the success of their respective nominees. Just as we go to press we learn of another candidate, namely, Mr. Bruce Clarke, surgeon to and lecturer on surgery at St. Bartholomew's Hospital. Mr. Clarke is also a member of the Court of Examiners, and it will be remembered that last year he magnanimously withdrew his candidature in favour of his senior colleague, Mr. Harrison Cripps, who was successful. Mr. Bruce Clarke, who is possessed of sound business qualities, would in many ways be a useful and excellent addition to the Council of the College under its present antiquated constitution.

The "Medical Register."

UNDER existing circumstances one of the most valuable functions of the General Medical Council is the correct keeping of the *Medical Register*. Needless to say, the work involved in their duty is arduous and exacting, and to be carried out successfully demands the co-operation of members of the medical profession. In view of the approaching elections of Direct Representatives, it is specially desirable that all practitioners should assure themselves that their correct addresses are inserted; otherwise they will not only be disfranchised, as the Council will be debarred from sending voting-papers, but they will also incur the risk of having their names erased from the *Register*. In the present year the usual circulars of inquiry have not been issued, inasmuch as the mere sending out of voting-papers will in itself furnish a means of correction. It is a self-evident duty, indeed, for medical men to verify the correctness or otherwise of their reference in the *Register*. We may perhaps venture to urge upon every practitioner in the United Kingdom that he should this year take that obvious precaution before leaving for his summer or autumn holiday. Specific questions will always find a ready answer from Mr. James E. Allen, the courteous Registrar of the General Medical Council, Oxford Street, London.

The Sight-Testing Bill.

WE are glad to see that the General Medical Council has expressed strong views with regard to the Bill promoted by the British Optical Association in regard to sight-testing opticians. The occasion is one of unusual interest, since it is, we believe, the first time that the Government has invited the General Medical Council to express an opinion on a Bill before Parliament which is thought to affect the medical profession. In return, the Council has declared "that it would be dangerous in the public interest to confer the privileges and powers contemplated therein (*i.e.*,

in the Bill) on persons other than those duly qualified in medicine and surgery." Obvious as this is to all instructed persons, the Council is well advised in supporting its opinion by a memorandum detailing the grounds on which it is based, as otherwise its opposition would doubtless be regarded by some as sprung from mere jealousy. It can never be too strongly impressed on the public that our opposition to quack practice is based not on our own interests, but on the safety of the public. It is to be hoped that the Government may be moved by the advice they have received to stop the Bill from further progress. It is to be hoped, too, that the precedent established in this case may be followed, and that the General Medical Council may take its proper place as the adviser of the Government on all matters affecting the profession.

The Army Medical Service.

WE are glad to note that Mr. Brodrick, by his letter to *The Times* last week, has directed public attention to the present position of the Army Medical Service. The medical papers have never ceased to urge that for the safety of the Army it is necessary that the Director-General should have immediate access to the Secretary of State, and should be present at the meetings of the Army Council. As Mr. Brodrick points out, "a large proportion of the questions which come before the Army Council necessarily involve medical opinion." We may add that in future this proportion is likely to grow larger. It seems almost impossible to impress on the older combatant officers that only the smallest part of an Army surgeon's duty is to treat wounds. Under present conditions his principal occupation both in peace and war is the treatment of disease, but this is not as it should be. The most important duty of an Army Medical Service—and we hope that this will soon be universally recognised—should be to prevent disease. That other nations have not been slow to profit by our own disastrous failures in this respect is shown by the extremely low rate of disease in both the Japanese and Russian armies in the late war. The present position of the Director-General as a subordinate to the Adjutant-General, through whom alone he is in communication with the Secretary of State and the Army Council, is not such as to give his views the prominence they deserve in the discussion of matters affecting the health of the Army.

An American in Harley Street.

THE stress of sheer quack competition falls with disastrous effect upon the legitimate medical practitioners of the United Kingdom. It will indeed be an evil day when that injury is supplemented by the invasion of legally-qualified men from other countries who conduct their practice on the lines adopted by pushful tradesmen. Recently "an American gentleman," Mr. Le Grand N. Denslow, of Harley Street and Dorset Square, London, has been run to earth by the Medical

Defence Union. Some time since advertisements appeared in the daily newspapers from a person who stated he had been cured of locomotor ataxy, and offering to inform sufferers where they could get similar relief. Upon application, the address of Denslow was obtained by a clerk, who persuaded the great specialist to accept for a friend a fee of one hundred guineas, fifty pounds to be paid at once, and the balance by agreement. The prosecution charged Denslow for falsely pretending to be, and using the titles of, a doctor and a physician, thereby implying that he was registered under the Medical Acts of 1858 and 1886. The fine imposed for this impudent defiance of British law and professional tradition was £30, with £10 10s. costs, a mere flea-bite compared with the fees that appear to have been extorted from patients. However, it is to be hoped that the exposure will cause others holding foreign qualifications to hesitate before invading the United Kingdom. The result of the prosecution places another feather in the cap of the Medical Defence Union.

Premature Burial.

THE Society for the Prevention of Premature Burial rests upon a somewhat shaky foundation. It assumes that unfortunate human beings are systematically buried alive, and seeks to prove that position by cases in which persons have not been buried alive and of alleged live burials that will not stand the test of critical examination. The only serious scientific investigation of the matter hitherto written was that contained in a small volume published some years ago by Messrs. Bailliere and Cox, under the title, "Premature Burial: Fact or Fiction?" One of the axioms of the author is that it would be impossible for the signs of life to elude careful and competent medical examination. At the same time, he insists that no single undoubted case of live burial has been conclusively proved in the whole of the vast literature of the subject. The term "conclusive" he defines as proved by evidence that would satisfy a court of law. In other words, the position of those who form a society to meet a danger that has not been shown to exist is ludicrous. Yet so absurd and unscientific a proceeding is supported by several medical men, whose presence in that galley can be accounted for only by the fact that medicine has not yet attained the position of an exact science, and that medical men are perforce largely empirical in their intellectual methods.

Direct Representatives on the General Medical Council.

AT the recent session of the General Medical Council the question of the increase of the direct representation of the profession on the Council was discussed on the motion moved by Mr. George Brown suggesting that request should be made to the Privy Council to raise the number of direct representatives to the maximum allowed by the Medical Act of 1886. Now, though the Council is

beginning to awake to a sense of its duties, it is doing so by slow and uneasy stages, and one cannot therefore be surprised at the views expressed by the representatives of the interested corporations which hold so unfair a proportion of the seats. Dr. Little went so far as to say that the great duty of the Council was to enable the public to distinguish between qualified and unqualified practitioners, and that it was only a secondary part of its functions to look after the interests and honour of the profession. It is precisely on account of such views being held that the present constitution of the Council calls for radical change if any real advance is to be made in the status and well-being of the profession. It is as absurd as it is unjust that the government of the profession should be in the hands of the nominees of the Universities and Medical Colleges, whose first object is to promote the continuance and extension of their own privileges, and the fact that the motion was lost by a two to one majority shows that the profession must not cease to make its voice heard if it is to obtain justice in this matter. It is a pity that the question should be complicated by the intention of the British Medical Association to run its own candidates for the seats of the direct representatives, as this action has been raised as an excuse for objecting to an increase. Not much is likely to be gained by making the direct representatives the nominees of the Association, responsible to carry out its policy and no other.

Diocesan Congress and Faith-Healing.

THE London Diocesan Congress in the course of its annual May meeting discussed *inter alia* the subject of faith-healing. They hold that Christian Science, improperly so-called, has obtained among church people has caused some heart burning among ecclesiastics, and of late they have been giving some attention to the matter. The crude absurdities of "Eddyism" do not commend themselves to modern Churchmen in responsible positions, but the power of faith in healing is a weapon which they think has been neglected. Archdeacon Sinclair, who opened the discussion spoke strongly against certain of the doctrines of Christian Science as purveyed by Mrs. Eddy, showing that they were absolutely at variance with Church teaching and common-sense, but although he advocated a larger use of prayer and faith in the promotion of the cure of the sick he laid great stress on the fact that such means should be supplementary to the employment of medical and surgical aid. Lord Halifax as an advanced Ritualist, was in favour of reviving the practice of anointing the sick and it is interesting to learn from the Bishop of London that his colleagues in lawn are already giving the question their earnest consideration. It is a curious commentary on the difference existing between the ecclesiastical and the scientific habit of mind that the Bishop considered the propriety of the laying on of hands and of anointing the sick was a matter for historical research to determine

rather than one whose utility should be demonstrated by experiment before adoption. But it certainly is something gained that the Church as a whole has remained unimpregnated by the silly chatter of hysterical American women.

PERSONAL.

H.M. KING EDWARD, accompanied by the QUEEN, will to-day (Wednesday) formally open the Midhurst Sanatorium for Consumption at 4.30 p.m.

SIR CHARLES TUPPER, the veteran Canadian pioneer and statesman, now in this country, is nearing his eighty-fifth birthday, and sixty-three years ago took his degree of M.D. at Edinburgh.

DR. E. A. G. DOYLE, Resident Surgeon of the Colonial Hospital, Port-of-Spain, Trinidad, has been made District Medical Officer of South Naparima, and is succeeded at the Colonial Hospital by Dr. E. N. Darwent, of the San Fernando Hospital.

It is announced that Sir Frederick Treves will deliver a lay sermon on Hospital Sunday, June 17th, at 11 a.m. in Union Chapel, Islington.

MR. F. H. MORISON, M.D., has been appointed to the Commission of the Peace for the borough of West Hartlepool.

DR. ROBERT KOCH has resigned his position on the presidential board of the Berlin Medical Society, on the ground of his engagements in Africa, in connection with the investigation of sleeping-sickness. Professor Koch expects to be absent two years.

THE Fellows of the Royal College of Surgeons of England will, on Thursday, July 5th, proceed to the election of three members of Council, those who retire by rotation being Mr. John Langton, Mr. Henry Morris, and Mr. F. Richardson Cross. Mr. Langton was first elected in 1890, and has served for two terms of eight years. Mr. Henry Morris was first appointed in 1893. Mr. John Tweedy's term of office would also have come to an end, but having been re-elected president last July, he remains a member of the Council.

DR. A. DOUGLAS HEATH, M.D., M.R.C.P., M.P.C.S., has been appointed dermatologist for the new department of skin diseases of the Birmingham General Hospital. In the same Institution, Dr. A. Stanley Barnes, M.D., B.Sc., M.R.C.P., M.R.C.S., M.B., Ch.B., has been appointed assistant physician in place of Dr. G. H. Perry, resigned.

DR. W. M. HAMILTON, at one time Mayor of Eccles, was last week invested by the Earl of Lathom as Provincial Grand Registrar of West Lancashire to the great satisfaction of a large number of the Brethren in the Borough of Eccles.

MR. M'ARDLE, F.R.C.S.I., Surgeon to St. Vincent's Hospital, has been elected President of the Irish Medical Association for the ensuing year. Professor Byers had been elected President of the Belfast Branch of the Association.

MR. J. NIELD COOK has had an extension of eighteen months in the tenure of his office of Medical Officer of Health for Calcutta.

DR. ALEXANDER PEDDIE, the oldest medical practitioner in Scotland, has completed his ninety-sixth year. Some years ago he gave an interesting Harveian Lecture, which dealt largely with the life of Dr. Brown, the author of "Rab and His Friends."

A CLINICAL LECTURE ON INFLAMMATION OF THE CONJUNCTIVA,

Delivered at the Glasgow Ophthalmic Institution.

By A. MAITLAND RAMSAY, M.D.,

Professor of Ophthalmology at St. Mungo's College; and Lecturer on Eye Diseases at Queen Margaret College, University of Glasgow.

INFLAMMATION of the conjunctiva is so common that you will, at the dispensary, in a very short time, see a considerable number of cases; nor will you be long in private practice till you are called upon to treat a patient suffering from conjunctivitis. That this should be so is clearly due to the exposed position of the eyes on the face. The inflammatory changes which occur will be best understood if I first say a few words regarding the normal anatomy of the parts concerned.

The conjunctiva is a mucous membrane which lines the inner surface of the eyelids and is reflected to cover the whole of the anterior surface of the eyeball. When, therefore, the lids are closed the membrane forms a sac with a slit in the anterior wall corresponding to the palpebral fissure. Up to a certain stage of fetal life, indeed, the sac is complete, for the eyelids are firmly united till the growth of the eyelashes brings about separation along the anterior portion of the union, and thereafter degeneration of the epithelial cells leads to separation of the posterior and central portions. Some animals—cats and dogs, for example—are even born with the lids sealed, and this state of matters persists for several days after birth.

For convenience of description, the membrane may be divided into three portions—that lining the lids (*conjunctiva palpebrarum*); that covering the globe (*conjunctiva bulbi*); and the fold of transition (*conjunctiva fornicis*). The palpebral portion is firmly united to the tarsus, over which it is so tensely stretched that it is impossible to dissect it from the underlying structures in order to obtain flaps for the repair of a breach of surface. In this it presents a marked contrast to the bulbar portion, which is loose and freely movable as far as the limbus. From that point, however, where it becomes the epithelial layer of the cornea, it is firmly bound down. At the retrotarsal fold the membrane is loose, and is arranged in a series of ridges which stretch readily so as to accommodate the conjunctiva to the movements of the eyeball. In the whole of the conjunctival epithelium, but especially in that covering the globe and in the retrotarsal fold, there are normally present goblet cells which, owing to their contents consisting largely of mucin, have been called "unicellular mucous glands." According to Greef this latter name indicates their true function, which is to moisten and protect the conjunctiva and cornea; so that even extirpation of the lachrymal gland is innocuous; while, on the other hand, xerosis of the conjunctiva, involving their destruction, leads to desiccation in spite of a copious flow of tears. On no other part of the human skin, as has been pointed out by Harman, does this primitive glandular secretion of mucin persist, and its purpose here is evidently to provide the eyeball with a smooth frictionless surface to facilitate ease of movement.

When the conjunctiva is healthy, it is perfectly transparent, for the blood vessels and lymphatics with which it is abundantly supplied are so minute that, with one or two exceptions, they are invisible and in no way modify the whiteness of the underlying sclerotic. In general venous congestion, however, there is usually injection of the larger conjunctival vessels, and the appearance of the membrane is often characteristic of peculiar constitutional states.

Notwithstanding that the conjunctiva is the most accessible of all the mucous membranes, its pathology is far from being thoroughly understood. It has been studied too much from the standpoint of the specialist, and too little from that of the general pathologist,

which is the proper point of view. If it is to be properly understood it must be regarded as a mucous membrane, similar to, and governed by, the same physiological and pathological laws which control every other mucous membrane in the body. Its diseases must, therefore, be studied in their whole pathology, and looked at in this way it is capable of affording a large amount of information of great value both in diagnosis and in treatment. Abnormal paleness for example is always associated with anæmia, and a peculiar yellowness is one of the earliest as well as one of the most constant signs of jaundice.

Whenever any irritant—physical, chemical, or microbic—gains entrance to the conjunctival sac, the mucous membrane becomes at once congested, and in proportion to the amount of the hyperæmia the white of the eye is concealed by an intricate meshwork of injected blood-vessels. The resulting redness is one of the earliest as well as one of the most characteristic signs of conjunctival inflammation. Every eye that is red is not, however, to be regarded as suffering from conjunctivitis, and careful examination will readily distinguish injection of the superficial or conjunctival vessels from hyperæmia of those that are more deeply placed. In the former condition, which denotes inflammation of the conjunctiva, the tint is brick-red, most intense in the region of the retrotarsal fold; the congested vessels are comparatively large and tortuous, and are arranged in the form of a network freely movable with the ocular conjunctiva; pressure will momentarily drive the blood away and expose the sclerotic; there will be lachrymation and intolerance of light; and the pain is similar to that experienced when a foreign body is lodged between the lids and the ball.

Hyperæmia of the deep-seated vessels denotes implication of the cornea or iris, and then the colour is rose-pink and the congested portion forms a zone round the cornea; the distended vessels are minute and hair-like and lie in the episcleral tissue under cover of the conjunctiva; pressure does not materially diminish the amount of vascularity; the pupil does not react promptly to the stimulus of light; and the pain complained of has a characteristic throb, is markedly nocturnal, and is usually circumorbital. Should the injection be localised, the fascicle of blood-vessels running towards the cornea invariably terminates in a phlycten or an ulcer; and should the vessels, more especially the veins, be large and varicose there is probably deep-seated mischief in the choroid, and the more livid the congestion the more serious the inflammation. Where, as is very often the case, superficial injection and deep injection co-exist, it is, as a rule, easy to determine by careful inspection which of the two predominates.

Not only is inflammation of the conjunctiva very common, as has been already said, but it shows itself in many forms; and according to Harman it occurs most frequently in the early years of life, in the female sex, in the months of April, May, and June, and among the poor, the dirty, and the overcrowded. That there should be many varieties is just what we would expect when we consider how the epithelium lining the different portions of the conjunctiva varies. Over the lids it is cylindrical with the characteristics of a mucous membrane, while over the globe it is of a stratified pavement form allied in structure to the skin. Clinically this is important because in all inflammations primarily affecting the palpebral conjunctiva hyperæmia with secretion is the most important objective

sign; while those of the bulbar conjunctiva are distinguished by the occurrence of phlyctens or papules similar to those found in cutaneous eruptions. Immediately beneath the epithelium is a very thin layer of adenoid tissue which in the retrotarsal folds forms small clumps—a peculiar arrangement that explains the occurrence of the lymphatic follicles forming the principal clinical feature of inflammations originating in this region.

The discharge which occurs in all cases where the palpebral conjunctiva is primarily affected is highly infective, and is virulent in direct proportion to its profuseness and yellowness. It varies in its nature, but each variety reproduces its like by direct contagion, a result probably always due to the presence of some particular micro-organism; and while it is not at present possible to classify all forms of conjunctivitis on this basis alone, yet certain specific organisms have been found to be invariably associated with certain inflammations.

In the healthy conjunctival sac all the ordinary bacteria have been found present, but only a few of them have been proved to be pathogenic. That their presence is not more harmful is probably due in part to the bactericidal action of the tears which, when normal (that is, slightly alkaline in reaction), seem capable of neutralising the virulence of many micro-organisms. When, however, the reaction of the tears is acid, the conjunctiva is much more readily attacked by microbes. Micro-organisms have the power of producing certain poisonous substances, infinitesimal quantities of which can cause inflammation and disease in general; and it is these toxins, and not the bacteria themselves, that penetrate deeply into the tissues of the body. As the specific action must therefore be looked on as chemical, a suitable medium is essential for the development of the microbe and the full exercise of its pathogenic powers; and so the condition of the conjunctiva at the time of infection is, to a great extent, the dominant factor in determining which micro-organism shall become the agent of mischief.

While histological peculiarities of structure, therefore, undoubtedly modify the results of infection, it is also clearly demonstrated by clinical observation that diathesis plays a most important part not only in influencing the course of the inflammation, but also in determining the particular form it may assume. For example, conjunctivitis occurring in a strumous patient is usually characterised by the presence of pustules or phlyctens on the bulbar conjunctiva, whereas in a gouty subject the deeper structures are involved and there is active hyperæmia which is transient and recurrent, and at times markedly periodic. Predisposition must, therefore, always be taken into consideration, and in every case of conjunctivitis full weight must be given to each of the three important factors: (a) the pathogenic micro-organisms, (b) the part of the conjunctiva primarily affected—the anatomical site, and (c) the constitution of the patient.

Active hyperæmia, which is the starting point of all conjunctival inflammations, is seen in its simplest form in the irritation produced by a foreign body—e.g., a particle of dust. The eye is red and waters, especially when exposed to the light, and winking causes a sharp pain; but there is no discharge, and the symptoms speedily disappear after the exciting cause has been removed. Should the irritant, however, remain, the conjunctivitis passes the stage of simple hyperæmia, the particular form the inflammation will assume depending largely on the behaviour of the discharge and other inflammatory products that are now developed. All the forms may, according to Meyer, be classed under one or other of the four following groups:—

"1. Simple hyperæmia of the conjunctiva, or hyperæmia accompanied by a mucous catarrhal, puromucous, or entirely purulent secretion. (Catarrhal, blenorrhœal, and purulent conjunctivitis.)

"2. The conjunctivitis in which the morbid secretion shows a tendency to become plastic, forming solid deposits either on the surface or in the thickness of the

conjunctival tissue—(pseudo-membranous and diphtheritic conjunctivitis).

"3. The conjunctivitis in which the secretion only takes place at certain places and elevates the epithelial layer in the form of pustules (phlyctenular conjunctivitis).

"4. Conjunctivitis in which the products of the disease take a special form, granulations, the anatomical nature of which is still a matter of discussion (granular conjunctivitis, trachoma)."

This classification, though now old, is the best of those of older date. The new classification is, as has been already said, largely according to micro-organisms, but, as the action of these is modified by anatomical site, and by the constitution of the patient, these factors require to be taken into account in determining the final grouping.

For clinical purposes we may, broadly speaking, divide cases into acute and chronic.

All acute inflammations are characterised by the presence of secretion which may be catarrhal, purulent, or plastic, but, however greatly the cases resemble one another clinically, bacteriological examination shows that the exciting micro-organisms may vary greatly. Catarrhal conjunctivitis, for example, is always associated with the bacillus of Weeks, subacute catarrhal conjunctivitis with the diplo-bacillus of Morax-Axenfeld, and purulent conjunctivitis with the gonococcus of Neisser.

In another group the inflammation is caused by the microbes, which are found in greater or less number in the conjunctival sac in its normal condition, and which do harm only under special conditions—the pneumococcus, the staphylococcus, and the streptococcus, the first two being specially prominent in epidemics among children, particularly after measles or any other of the exanthemata. Such forms of conjunctivitis are greatly influenced by the constitution of the patient, and if the child be scrofulous, or of scrofulous tendency, there is an efflorescence of papules on the bulbar conjunctiva. This, which is known as phlyctenular conjunctivitis, is neither more nor less than the expression of a diathesis, or, as Wright would put it, the indication of a low tuberculo-opsonic index—negative phase.

In still a third group—of which the most striking example is the plastic conjunctivitis associated with the Klebs-Loeffler bacillus, the staphylococcus, and the streptococcus—the special micro-organism acts only after the conjunctiva has become inflamed through the agency of the toxins manufactured by other microbes. Wherever, therefore, the clinical diagnosis is doubtful, a differential diagnosis can be made only through the recognition of specific microbes, and thus bacteriological examination comes to be a necessary complement to clinical study, and proves valuable alike in diagnosis, prognosis, and treatment.

In any variety of acute conjunctivitis the discharge is apt to become plastic and to form a false membrane, and, speaking generally, the appearance of a false membrane always indicates that the prognosis has become more unfavourable. It must, however, always be remembered that discharge may be rendered plastic and become adherent to the conjunctiva through the over-use of certain remedies—more especially alum and nitrate of silver—and that the membrane disappears at once when the use of the drugs is discontinued.

Care must also be taken not to confound membranous conjunctivitis with diphtheria of the conjunctiva, which is a disease that may not only destroy the eyeball but may even prove fatal. As it is not likely that I shall be able to show you a case I shall give a brief account of the symptoms. In diphtheria of the eyelids coagulation takes place within the tissues, thereby causing necrosis of the conjunctiva; while in the membranous or croupous form the exudation coagulates merely on the surface. The disease is seldom primary, usually reaching the eye by spreading along the tear-passages from the nasopharynx. It most frequently attacks children between the second and the eighth

year, and the prognosis is always most serious. In very severe cases, in which the staphylococcus and the streptococcus are found in addition to the Klebs-Loeffer bacillus, the eyelids are swollen, infiltrated, and brawny; they cannot be everted; and it is often hardly possible to open the palpebral fissure wide enough to see the cornea. A false membrane of ashy grey colour covers more or less completely the congested livid-red conjunctiva, and is so incorporated with the lids that it is separated from them only with difficulty, leaving the surface raw and bleeding. The membrane forms again with extraordinary rapidity. It spreads from the lids to the globe, and, in malignant cases, the destruction of the cornea is almost inevitable, and in addition, as a result of cicatricial contraction, the lids adhere to the eyeball and give rise to symblepharon, complicated by trichiasis and entropion. It is of the utmost importance, therefore, that the disease should be recognised at the earliest possible moment, and that, whenever an accurate diagnosis has been arrived at, antitoxin should be injected. The lids themselves must be kept clean by the free use of a warm solution of permanganate of potassium or of sulphate of quinine, but nitrate of silver, so potent for good in purulent conjunctivitis due to the gonococcus, ought not to be employed, even in weak solution, until the false membrane has separated; and its use must be discontinued at once if the exudation threatens again to become plastic.

Diphtheria of the conjunctiva is the only form of conjunctivitis against which we at present possess a reliable antitoxin, but the bacteriology of conjunctival affections teaches us that effective treatment must be largely antiseptic in character. The older ophthalmologists had arrived at the same conclusion empirically, for the remedies most frequently employed by them were nitrate of silver, sulphate of zinc, and perchloride of mercury. Our present fuller knowledge serves not only to corroborate the opinions arrived at by our forefathers, but also explains to us how it is that these drugs act so beneficially. Perchloride of mercury is inimical to all forms of microbic life, and, although the conjunctiva will not tolerate solutions of sufficient strength to kill the microbes, yet the drug undoubtedly moderates their activity, probably by altering the protoplasm so that, their food supply being seriously diminished, they speedily degenerate and die. We now know also that the bacillus of Weeks and the gonococcus of Neisser are speedily killed whenever they are brought into contact with solutions of the salts of silver, while the diplo-bacillus of Morax-Axenfeld is at once destroyed by a weak solution of sulphate of zinc. In addition to the use of those specific remedies, non-irritating sterile solutions must be freely used to sweep from the conjunctival sac all the micro-organisms which it contains; and this mechanical cleansing is perhaps of even more importance than the application of any special antiseptic.

Most forms of acute conjunctivitis if left to themselves, or if unskilfully treated, are apt to become chronic, and to persist for an indefinite time; and so the clinical distinction between the acute and the chronic forms may be said to be that in the latter the symptoms are much less intense and the progress is much more protracted. Take, for example, the most sensitive part of the conjunctiva, the palpebral portion. This is very apt to become chronically inflamed and thickened in those whose occupations expose them to the action of dust or of any chemical irritant, and the process will, if left unchecked, go on till a condition of ectropion is developed. The eversion of the lid causes displacement of the inferior punctum, and so the tears are not carried away by the proper excretory channels, but overflow on to the cheek. The epiphora thus induced serves to perpetuate the inflammation and to render its treatment all the more difficult.

The characteristic objective feature of all forms of chronic conjunctivitis is hypertrophy of the layer of adenoid tissue which is always present more or less abundantly in the normal conjunctiva. When the inflammation confines itself chiefly to the retroarsal

folds this adenoid tissue becomes collected into heaps called follicles. These, which are round, pinkish, translucent bodies, about the size of a pin-head, projecting from the surface of the conjunctiva, and arranged in rows parallel to the border of the lid, occur mostly in the lower retroarsal fold where they are rarely visible till the lower lid is everted. If, as sometimes happens, the inflammation extends to the palpebral conjunctiva, they will be accompanied by catarrhal discharge. In the most typical form of follicular conjunctivitis, however, there is but little redness of the eye, and the chief symptoms are sensations of itching and heat, and difficulty in seeing to read or sew by artificial light. The disease occurs for the most part in children at school and usually both eyes are affected. It arises most frequently and may even become epidemic through overcrowding and bad ventilation; but an acute attack may be excited by the long-continued use of either atropine or eserine. It always runs a prolonged course, is very liable to relapse, and undoubtedly predisposes to attacks of other forms of conjunctivitis.

Another form of follicular inflammation is spring catarrh, but this I must be content to illustrate by lantern slides, as, owing to the rare occurrence of the disease in this country, it is very unlikely that I shall be able to show you a case. Though spring catarrh was first mentioned by Arlt in 1846, and was several times afterwards referred to by other observers, it was not till 1876 that Reymond gave the first anatomical description of it. Occurring during hot weather, not contagious, and never epidemic, it assumes two forms—(a) bulbar, to which any cases recorded in the United Kingdom have belonged; and (b) tarsal, which is the type most common in Italy. In the former variety there is usually a reddish or yellowish tumour at the limbus on either the nasal or temporal side of the cornea. This growth is hard, movable, painless, and of uneven surface; and it may become confluent and surround the cornea with a cartilaginous collar. The tarsal variety affects only the upper lid, the conjunctival surface of which is closely studded with irregular prominences, bluish white in colour as if the epithelium had been brushed over with milk. There is little discharge, and as a rule the cornea remains transparent. The disease affects both eyes, runs a chronic course, and, though it subsides or even wholly disappears in autumn, almost invariably recurs on the return of hot weather.

Trachoma (which sometimes appears in an acute form, though it is oftener chronic) is a form of conjunctivitis which presents microscopic characters similar to those of follicular conjunctivitis, but is quite different from it in both anatomical site and clinical history. The conjunctiva, at first studded with granulations which later on pass into connective tissue, is ultimately converted into cicatricial tissue, which during the process of contraction, implicates the deeper structures of the lids, and thus produces deformity of the tarsal cartilage with inversion of the eyelashes. The corneal conjunctiva becomes affected by pannus, and severe cases end in complete conjunctival atrophy, so that the covering of the eyeball is dry, shrivelled, and cuticular, a condition described as *xerosis conjunctivæ* or xerophthalmia.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The lecture in next week's number will be by Henry Jellet, M.D., Du'., B.Ch., F.R.C.P., Gynaecologist and Obstetrical Physician, Steeven's Hospital, Dublin, Examiner in Midwifery in the Royal University, and the Royal College of Physicians; Ireland, on "Pelvic Tuberculosis."

Royal College of Surgeons, Ireland.

At a meeting of the President, Vice-President, and Council, held on May 22nd, the following examiners were elected:—Physiology and Histology (Courts A. and B.)—Messrs. D. J. Coffey and E. L. Ledwich. Engineering and Architecture (Court A.)—Mr. C. J. Powell. Dutch (Court A.)—Mr. J. A. L. Hahn.

ORIGINAL PAPERS.

THE EARLY OPERATIVE TREATMENT OF APPENDICITIS.*

By DENIS KENNEDY, F.R.C.S.I.,

Surgeon, Jervis Street Hospital, Dublin; Surgeon Children's Hospital, Dublin.

It is quite usual to read in surgical text books, and in medical journals elaborate accounts of the indications for operation in appendicitis. The condition of the pulse, the temperature, and the tongue, the position of the legs and numerous other signs and symptoms are all enumerated to show when we should operate; and usually, as a final touch to the picture, the writer gives us a couple of special signs which when present always make him recommend operative procedure. And all this forgetful of the fact that no two cases run on exactly parallel lines. In consequence we cannot wonder that the ordinary practitioner is confused as to the course he should adopt in these cases, and that there is a fixed idea in the minds of the general profession that operation in appendicitis should only be carried out when the patient is on the brink of the precipice, that it is exceptionally dangerous, and that every effort should be made to bring the patient to convalescence without it. I am of opinion that the subject ought to be viewed from quite a different standpoint; and that once the disease is diagnosed, that in itself ought to be quite sufficient to have operation carried out. I refer, of course to true acute appendicitis and only to the acute condition, throughout my communication. I do not say that every case of appendicitis must be operated on to save the patient's life, but I do say that the results of early operative treatment are much better than those at present obtained by what is called the expectant treatment. This is the opinion held by the large majority of the best surgeons in America, and by many Continental surgeons of the highest repute.

Instead, therefore, of giving a long list of symptoms that call for operation, I would give two or three conditions that are opposed to it. First, when a patient cannot be operated on under favourable circumstances, and by someone that knows how. Secondly, when the patient is practically moribund; and thirdly, when some visceral lesion is present, such as bad heart disease, which would contraindicate any operation whatever.

I can imagine some ten or fifteen years ago men laying down the law as to when operation should be carried out for intestinal obstruction or for strangulated hernia. I am old enough to have been taught that in the latter condition taxis was first to be tried, then a hot bath until the patient nearly fainted, then taxis, then an anæsthetic, and finally taxis while the patient was under the influence of the anæsthetic. If the hernia were not then reduced, and the patient happened to be alive, the question of operation should be discussed. No wonder the mortality was high, either with or without operation. Pretty much the same idea at present prevails with regard to the treatment of appendicitis. When the circumscribed inflammation becomes diffuse, when the localised abscess bursts into the general peritoneal cavity, when the appendix is sloughing; in short, when the patient is in the worst possible condition for operation, and when the difficulties to the operator are almost insurmountable, then and not till then are we to attempt to get rid of the offending organ. Consequently the duration of this most painful illness is anything from three weeks to as many months, and the mortality is said to be from 20 to 25 per cent. With early operation the duration of the illness will be exactly eight days, and the mortality nil. Besides, we do not expose our patient to any unnecessary procedure. We are all, I think, agreed that once a person gets an attack of appendicitis, if not operated on

during the attack, and should he survive, he must be operated on afterwards to prevent a recurrence.

There is a widespread notion in the profession, even among operating surgeons that opening the abdomen during an attack of appendicitis is particularly dangerous. This I believe to be a complete fallacy. During the last two years I have operated on 43 cases of acute appendicitis. The illness previous to operation varied from eight hours to about three weeks; the pathological conditions found were anything from simple appendicitis to gangrene of the appendix with diffuse peritonitis; the ages of the patients ranged from three to seventy-one years, and I have not had a single death. If operation is carried out before complications have arisen, appendectomy during an attack is just as safe as during the quiescent period, and when complications have arisen, such as peri-appendicular suppuration, operation is no longer a matter of choice, but a matter of necessity.

Most of us are usually able to diagnose appendicitis when it occurs. None of us can tell what pathological conditions may be present or ensue during the attack. Diffuse peritonitis, formation of secondary abscess, sloughing of the appendix, intestinal obstruction, any or all may ensue from what was originally a mild attack, and we may have very little proof of their occurrence till it is too late for our patient. To show the futility of expecting some cases to get well without operation, and to illustrate the dangers to our patient there may be in delay, with your permission I will give a brief history of some of the cases I have operated on.

CASE 1.—Master E. F., *at.* 10, I saw on Monday, December 17th, 1905. He was ill from the previous Friday, had persistent vomiting, and continuous pain diffuse over the abdomen, but worse over the right iliac fossa. No motion of his bowels had occurred for three days, in spite of large quantities of purgatives, and an enema that had been administered, and only one ounce of urine had been secreted during the previous 24 hours. His abdomen generally was distended and the muscles over the right half were very rigid. The temperature was 101, and his pulse rate 110. I diagnosed appendicitis with ensuing ileus, and recommended immediate operation. Both the diagnosis and the treatment recommended were agreed to by my colleague, Dr. Savage, whom I asked to see the patient with me in consultation. The boy was sent to a nursing home, and I operated that evening, Mr. Tobin kindly assisting me. I found the inflamed appendix twisted like the letter *v* behind the cæcum, and so firmly fixed by adhesions that the lower end of the cæcum was bent backwards and upwards almost at right angles. The ileum was distended. On removing the appendix the cæcum resumed its normal position, and flatus at once began to gurgle through. There was some pus, and a good deal of serous and plastic peritonitis in the neighbourhood, especially over the small intestine. I wiped away the pus, provided for drainage, and the boy made a rapid and complete recovery.

CASE 2.—Frances B., *at.* 5. I was called to see on August 2nd, 1905. She was suffering from a typical attack of appendicitis. Two days subsequently Dr. Savage saw the case with me in consultation. The question of operation was discussed, but the child's mother strongly objected. As the disease seemed to be running a normal course, and as there were no urgent symptoms, we consented to wait, and adopt the treatment of masterly inactivity. Nothing of consequence happened until the night of August 5th, when the child suddenly collapsed, her temperature suddenly falling from 102 to 96. When I saw her in the early hours of Sunday morning her condition was one of extreme collapse, with its associated symptoms. There was no longer any question of postponing operation if the child was to get the least chance of recovery. Dr. Savage again saw the case in consultation, and agreed as to its urgency. On account of the patient's condition she could not be removed to a private hospital, and consequently I had preparations made as

* Paper read at the meeting of the Surgical Section of the Royal Academy of Medicine, February, 1906.

quickly as possible for operation in her own home. On opening the abdomen by an incision over McBurney's point, I had the greatest difficulty in finding the appendix. I prolonged the incision upwards in front of the kidney, as a mass was to be felt in that region. I found a gangrenous appendix, lying in a quantity of faecal pus, along the posterior wall of the caecum. On removing the debris, which included some faecal pellets, the outer coat of the posterior wall of the caecum ruptured spontaneously, to the extent of about an inch. I attempted to suture both the appendiceal opening and the rent, but no suture would hold. I greatly feared sloughing of the caecum would ensue. I had to content myself with wiping away the pus and debris as well as possible, and packing the parts with iodoform gauze. I made a counter opening in the loin and provided for drainage both through the loin and anteriorly. Nutrient enema kept the child alive during the next 24 hours, then she began to take nourishment by the mouth. No motion of the bowels was allowed for the first five days on account of the bad condition of the caecum. The child made a perfect recovery, and has not even a ventral hernia, as sequelae I was much indebted to the able assistance of Dr. Savage, during and subsequent to the operation, in bringing this case to a successful issue.

CASE 3.—Miss M., æt. 28, I sent to Jervis Street Hospital in June, 1904. She suffered from a well marked attack of appendicitis, and had been ill for 24 hours. I kept her under observation for a couple of days, carrying out the usual expectant treatment. She did not improve, and on the evening of the third day of her stay in hospital her temperature reached 105 after a pronounced rigor. I operated on the following morning, after a consultation with my colleague, Dr. Thompson. The appendix was greatly inflamed and distended, and there was well marked evidence of general serous peritonitis throughout the whole abdomen without a trace of any adhesion whatever. In a few hours more I have no doubt the abdomen would have been filled with pus. I removed the appendix, flushed out the abdomen with normal saline solution, and provided for free drainage. The patient made a complete recovery. Through my delay in operating, which was due to the prevalent practice, I nearly sacrificed my patient's life.

CASE 4.—Mrs. B., æt. 71, was sent to me to Jervis Street Hospital by my colleague, Dr. Savage. Six years previously she had an attack of appendicitis, from which she recovered, but a swelling about the size of an orange remained in the right iliac fossa. It did not cause her any trouble, and consequently she refused operation. On a Tuesday morning as she was getting out of bed, she felt something give way in her abdomen, and pain and vomiting quickly ensued. She developed intestinal obstruction, with peritonitis, and although urged to operation by Dr. Savage, she refused until the following Saturday morning, five days after her attack beginning. When I saw her in hospital she was in a semi-comatose condition, with all the appearance of approaching death. I carried out operation at once, making a long incision over the appendiceal region. The abdomen was filled with pus and there was no attempt at any limiting adhesion. I quickly removed the appendix and provided for free drainage. I neither douched, or in any way attended to the toilet of the peritoneum, for the simple reason that any delay would cause the patient's death on the operating table. For 48 hours the dressings were constantly saturated with pus. Her bowels acted the day after operation, and she made a slow but good recovery, leaving hospital eight weeks after operation, with no sequela, only a fistula from the peritoneal cavity.

CASE 5.—A young girl, æt. 22, was admitted to Jervis Street Hospital, April, 1905. Twenty-four hours previously she attended the out-patient department complaining of some abdominal pain; she refused to be examined and consequently was not prescribed for. She returned to her home; pain continued through the

day and night, associated with vomiting. The following morning she collapsed and was brought to hospital in the ambulance. I saw her, in consultation with my colleague, Mr. Byrne. We diagnosed perforating appendicitis, and carried out immediate operation. The whole region around the appendix, and the pelvis, was filled with faecal pus without any limiting adhesions. The appendix was intensely inflamed, and perforation had occurred through the caecum, half an inch from the base of the appendix. I sutured the perforation, removed the appendix, wiped out the pus and debris with gauze sponges wet with hot saline solution, and provided for free drainage. I used no douche whatever. She made a good recovery.

CASE 6.—Mr. S., æt. 56, I saw in consultation with Drs. Savage and O'Carrol in August, 1905. Patient was six days suffering from appendicitis, and a large swelling was present in the right half of the lower part of the abdomen. He had been a liberal drinker, and suffered from fatty degeneration of the heart with congestion of the lungs, liver and kidneys. Albumin was present in the urine in quantity. We were unanimous as to the gravity of the case, but the difficulty was to find a solution. The condition of the patient's abdomen demanded operation, his general condition was totally opposed to it. On the advice of Dr. O'Carrol we decided to wait for 24 hours in the hope of improvement supervening. That night the patient had rigors, and his condition next day was decidedly worse. Consequently I carried out operation, being assisted by Mr. Tobin and by Mr. Keegan, who gave the anæsthetic. I incised over the appendiceal region, and evacuated a large abscess from between coils of small intestine, and from behind the caecum. The suppuration was limited by marked adhesions, I could only have removed the appendix with great difficulty, and a prolonged operation; I therefore contented myself with wiping out the pus, and providing for free drainage. The patient made a good but protracted recovery under the care of his physician Dr. Savage, in spite of the fact that three weeks after his operation, he got an attack of profuse hæmoptysis, which was probably due to hæmorrhagic infarction of his lung. He is again to be seen vigorously prosecuting his business as a bookmaker at all the race meetings in Ireland.

CASE 7.—Mr. M., æt. 30, I was called to see at Camden Street, about 3.30 a.m. on the morning of November 23rd, 1905. The patient had gone to bed quite well on the previous night and awoke about 12 o'clock with violent pain in his abdomen. This



Showing appendix with constriction near the caecal end and a small perforation at the distal end, removed from Case 7.

was followed by vomiting. When I saw him he was quite collapsed, pain was severe, his legs were drawn up, and there was great tenderness and rigidity of the

muscles of the abdomen on the right side, particularly over the iliac region. His temperature was 102 and his pulse rate 115. I diagnosed fulminating appendicitis, and sent him at once to Jervis Street Hospital in the ambulance. I operated a few hours subsequently. On opening the abdomen by an incision crossing McBurney's point, pus was present everywhere without a trace of any limiting adhesion. I found the appendix enormously distended with a perforation half an inch from its tip, and through this perforation pus was flowing freely into the abdominal and pelvic cavities. I removed the appendix, wiped out the pus with gauze sponges, wet with hot saline, and provided for drainage. I used no douche. The patient made a rapid and complete recovery. This case is specially interesting from the fact that six months previously the patient had an attack of enteric fever which so closely resembled appendicitis, that a positive diagnosis could only be made with the Widal reaction. He also suffered from well marked mitral regurgitation.

With regard to the diagnosis of the disease it does not as a rule present any great difficulty, particularly in adults. Murphy of Chicago, lays special stress on the order of the occurrence of the symptoms. He says, "there is first abdominal pain, sudden and severe, followed by nausea and vomiting, general abdominal sensitiveness, elevation of temperature, beginning from two to twenty-four hours after the onset of the pain. These symptoms occur almost without exception in the above order, and when that order varies I always question the diagnosis." He also says "that temperature in acute appendicitis must always be present, and that it never precedes pain." I think this summing up of the symptoms is as near as we can get to a good guide for the early diagnosis of the normal illness in adults. Two symptoms that are often relied on for a diagnosis are very fallacious. First the right leg alone I have never seen drawn up even when an abscess was present. Both legs may be drawn up when diffuse peritonitis exists. Second, the most tender spot is not always McBurney's point, but varies according to the position of the tip of the appendix. The rectum, and in females the vagina, should always be examined, to determine whether pelvic suppuration is present or not; and no examination of a child is satisfactory without an anæsthetic. In children the diagnosis sometimes presents great difficulty as is illustrated by the following case:—

Baby K., æt. 3, suffered for five days from violent spasms of abdominal pain; there was no vomiting, no temperature, and only very slight constipation. During the intervals of the attacks of pain the child seemed well. On careful examination I found a thickening over the region of the appendix, and there was considerable tenderness present. The spasms of pain gradually diminished, the child's general condition improved, but the swelling and tenderness in the right iliac fossa seemed to get more pronounced. Consequently I recommended operation, which I carried out in the private hospital, 20, Mountjoy Square, assisted by Dr. Savage and Dr. Lewis Farrell. On incision over the appendiceal region, I found a large mass adhering to the anterior abdominal wall. To get into the abdomen I prolonged my incision upwards and was then enabled to separate the mass from the anterior parieties. I found the mass to consist of a very long thick appendix, with the distal half entirely enveloped by the omentum. I amputated the appendix, excised the part of omentum involved, and removed the whole mass together.

Professor McWeeney examined the specimen, and reported that it showed undoubted signs of having been the seat of repeated attacks of inflammation, while the part of the appendix and omentum matter together were on the point of breaking down into an abscess. The child made a rapid and complete recovery.

The incision I make for appendicectomy in acute cases is the one that crosses McBurney's point. I

avoid the muscle splitting operation, as I believe that its advantages are outweighed by its disadvantages. If the appendix is at all in an abnormal position, it may be difficult or impossible to find with such an incision, and if the incision has to be enlarged it takes considerable time.



Showing appendix enveloped by omentum removed from child, Baby K., æt. 3.

Our aim in operating ought to be two-fold. First remove the offending organ if possible. Second where peri-appendicular suppuration or exudation exists, free drainage should be provided for.

In some cases it is not possible to remove the appendix, however desirable if may be, without endangering our patient's life, especially where abscess exists. The manipulations necessary to free the appendix may cause serious injury to an inflamed bowel in the neighbourhood, or may carry infection to a wider area than was previously involved; or the condition of the patient may be such as not to be able to bear a prolonged operation. Fortunately its removal is not always necessary to save our patient's life. But convalescence will be more prolonged, suppuration will be more persistent, and consequently there will be much more risk of a ventral hernia ensuing. Besides, a focus of infection is left in the abdomen, which may give rise to trouble again either in the near or remote future. What is, however, absolutely essential is that where pus is present, whether localised to the neighbourhood of the appendix or not, free drainage must be provided for. I think on this largely depends the success of the operation as a life-saving means. I employ for drainage, a slit rubber tube with a gauze wick. I change the gauze as soon as it becomes saturated, as I believe once that occurs it acts as a plug, not as a drain. We must remember that pus may be present in quantity from appendicitis, either in the pelvis or in the retro-cæcal region, and no signs of it appear when we open the abdomen. Consequently, if we have to search for a suspected abscess these are two most likely regions in which we may find it. Further, if pus is present free around the appendix, it will most likely have made its way to the pelvis. The question of drainage through the rectum or vagina must then be considered. I have met with retro-cæcal appendicitis and abscess in four cases. The condition may be suspected if in connection with appendicitis there is a fulness and tenderness in front of the right renal region. In one of my cases, in a child already mentioned, the appendix was completely gangrenous and lay well up in front of the kidney. The points to be remembered in operating in those cases are:—First, we must

prolong our incision upwards, and secondly, to reach the trouble we must draw the cæcum and ascending colon towards the mid line. We can thus remove the appendix, get rid of pus, and establish free drainage through the loin or anteriorly without the least danger of the general peritoneal cavity becoming infected.

I am no believer in the extensive procedures that are sometimes carried out in cases where suppuration exists in connection with appendicitis. These consist in removing the appendix at any cost, in free manipulation of the intestine in excising every portion of the omentum that comes near the pus, in breaking down adhesions freely, and in douching, swabbing, and paying elaborate attention to the toilet of the peritoneum. I am thoroughly convinced that whether suppuration is localised or diffuse, the peritoneum is well able to look after itself, if it gets a fair chance by free exit being given to the pent up inflammatory exudate; and that where diffuse suppurative peritonitis exists, the quicker the operation is finished and the less manipulation there is of the intestines the better. Douching, if used at all, should only be employed when the fluid used can escape by a counter opening, as freely as it enters the abdomen, and when a large part of the abdominal cavity is infected. Under those conditions, it is certainly harmless except for the time it takes, but its benefit is a very doubtful quantity. Rough sponging injures the delicate endothelial lining of the peritoneum, and thereby tends to destroy its inherent power of resisting infection. I content myself with gently wiping away any pus that I find, with a gauze sponge wet with normal saline solution. I have practically given up the use of the douche altogether in these cases. I may say that although I originally adopted this line of treatment on account of the bad condition of a couple of patients, I find that I by no means am alone in recommending it. Senn long since has given up douching the peritoneum in peritonitis, and I may again be permitted to quote Murphy, of Chicago. He says: "I am convinced that the great mortality which has been reported of operations in the second stage (of appendicitis) have been due in a measure to excessive manipulation, sponging, flushing, &c. I am a strong opponent of lavage of the peritoneum."

In conclusion I may say—

(1). The dangers of operating during an acute attack of appendicitis have been greatly exaggerated, and with proper care are mostly imaginary.

(2). When suppuration is diagnosed, operation should not be delayed in the hope of adhesions being formed, and the pus becoming circumscribed.

(3). Children who get the disease usually have to be operated on for recovery.

(4). Our motto in treating the disease should be: "Leave nothing to chance." Consequently have the appendix removed as early as possible.

I owe an apology to the members of this Section for bringing such a well-discussed subject before them, and for my inability to treat it in a communication such as this in anything like an exhaustive manner.

THE SOURCES OF FAT IN MILK.

By E. F. WILLOUGHBY, M.D., D.P.H.

THE commercial value of milk for the manufacture of butter and cheese depending almost exclusively on the percentage of the fat, and its dietetic value, especially in the rearing of infants, being equally affected by the relative proportions subsisting between the other constituents and this, which is the most uncertain and variable of all, it is obviously to be desired that we should seize every opportunity of learning something of the sources whence the fat is derived and the means, if any, by which its production may be maintained or increased. Dr. Engel (*Arch. f. Kinderheilkunde*, B. XLIII, H, 1-4, 1906), assistant to Dr. Schlossmann, of the Dresdner Säuglings-

heim, with this view undertook a course of experimental feeding of nursing mothers. Proceeding on the assumption that not only the ancient notions of the derivation of the milk fat from the breaking up of the gland cells and of body fat from the metabolism of carbohydrates, but also the Munich doctrine that fat was produced by a "splitting" of the molecule of albumen, the carbohydrates acting indirectly are "sparmittel," and, as more convenient fuel were untenable, he looked to a simple transfer of the body fat from its subcutaneous deposit, or to the fat contained in the food. To verify the latter source, he employed a fat which should betray its presence in the milk by its high iodine number, oil of sesame presenting the greatest advantages, and gave it in daily doses larger or smaller for about a month to nursing women, some of whom were abundant and others scanty milkers. The effect of the oil on the milk fat in the raising of its iodine number was noted every three or four hours, instead of on the mixed milk of the whole day, as by previous observers, enabling him thus to follow it till the complete elimination of the foreign fats. It rose in every instance from a normal of 40 or 45 until the curve reached its highest point in a few hours, when it slowly sank. Women with an abundant secretion could, he found, completely eliminate every trace of 100 grams within twenty-four hours, whereas those with less active breasts required a proportionately longer time—thirty-six to forty-eight hours, or smaller doses, the smallest quantity given being 15 grams, but even this showed itself in a similar curve, though not rising so high and subsiding sooner. The influence of these meals of fat on the actual percentage of fat in the milk could not be made out, but it was certainly in no way detrimental to the quality of the milk or the health of mother or child. With a view to determining the influence of the fat in the food on the secretion of the breast, he put several women—good milkers—on a diet specially poor in fats, in fact, that prescribed by Rosenfeld for the cure of obesity, consisting of potatoes, green vegetables and fruit, lean meat, poor cheese and indifferent beverages given freely. After fourteen days, though the women had lost weight more or less, their health was good, the yield of milk was unaffected, and the percentage of fat not appreciably so, so that their infants thrived as before. Within two days, however, of the commencement of the new diet the iodine figure rose and remained constantly high until the resumption of the normal diet, showing the different source of the fat, viz., the tissues in place of the food, remaining, however, as sensitive as ever to changes in the diet in the form of an occasional meal with oil of sesame. From these observations one may safely conclude that the milk fat is derived from two sources—the body fat and the food fat; that the latter is the more easily utilised, but that when it is withheld or reduced, recourse is had to the former, and that the increase of the milk fat by a liberal allowance of fat in the food is practicable within narrow limits only, though within these limits it is not only prompt but lasting. It would be well to examine the relation and behaviour of the unsaturated fatty acids in connection with the green and mucous stools which Gregor associates with a low percentage of fat in the mother's milk, and also the importance of fat as a vehicle for bodies capable of solution in or combination with the fats, as iodine

and bromine, and probably many more. Some of these might be used therapeutically, but the nitrogenous dye, "Sudan III," having been known to be so abundantly excreted as to stain the cream a deep rose, it is very probable that many of the gastro-intestinal derangements of infants might be traced to the excretion of organic poisons ingested by or secreted in the maternal organism. Auto-intoxication is a recognised cause of disease, and no doubt it may be carried a step farther in the poisoning of the infant through its mother's milk.

THE OUT-PATIENTS' ROOM.

MERCY HOSPITAL, CORK.

Case of Congenital Cardiac Disease.

UNDER THE CARE OF D. J. O'CONNOR, M.A., M.D.,
M.R.C.P.I.

The patient was a male child, *æt.* 2. The appearance of the patient at once suggested the nature of the case. For while the child did not appear to be suffering from any acute disease, and looked bright and cheerful, the cheeks, lips, tip of the nose, and ears, were deeply cyanosed. The nails were of an even deeper livid hue, and the terminal phalanges of the fingers and toes were clubbed to a greater extent than I have ever noticed in any other disease. The rest of the body was normal in colour.

The mother stated that the child was "very blue" when born, and that this lividity had persisted in the parts referred to. It was increased by any exertion, but was especially marked when the child coughed or cried. The child also seemed to be very short of breath when it underwent any exertion, such as even walking a few steps. In other respects, however, it enjoyed good health, and had never been really ill in the ordinary sense of the word.

On examining the chest the area of cardiac dulness was found to be increased on the right side to a slight extent, the percussion note over the lower end of the sternum being dull. The apex beat was normal in position. Over the base of the heart a loud systolic murmur could be detected, this being better heard over the pulmonary than over the aortic area. A similar murmur could be heard over the apex, but this was evidently transmitted from the base, as its gradual diminution in intensity could be traced from base to apex. No thrill could be detected over any portion of the cardiac region. An examination of the blood revealed a moderate degree of polycythæmia, the red blood corpuscles numbering 5,600,000 per cm. A film preparation of the blood showed no abnormalities. The white blood corpuscles showed no change in quantity or quality. After examining the patient on two or three separate occasions, I formed the opinion that the case was one of congenital stenosis of the pulmonary orifice. It must be admitted, however, that the differential diagnosis of the various forms of congenital heart disease is a matter of exceeding difficulty. Their rarity makes it impossible for one to become familiar with their physical signs, and the errors of the wards have to be corrected in the *post-mortem* room. As, however, these various lesions do not differ materially in their symptoms or in their course, their recognition during life is a matter rather of pathological than of clinical interest.

OPERATING THEATRES.

ST. THOMAS'S HOSPITAL.

CASE OF APPENDICITIS AND OVARIAN CYST.—MR. EDRED CORNER operated on a girl, *æt.* 16, operated on in November, 1903, for a large appendix abscess on the right side of the abdomen. A fortnight after the

first operation another large abscess was opened on the left side and a faecal concretion removed from the track of the former abscess. Four days after the opening of the left abscess, she got a faecal fistula, which closed in a few days; in all probability, Mr. Corner thought, it was connected with the small intestine. The case, he said, was one of considerable interest at the time, and was recorded in his Erasmus Wilson Lectures. Since this illness she has got thinner, more easily tired, and her general health has been depreciated in many ways. Moreover, she had had at least three definite, one being severe, attacks of appendicitis. Examination showed both scars sound, no hernia; also tenderness in the right iliac fossa and in the pelvis *per rectum*. As he knew full well that the occurrence of suppuration in appendicitis by no means necessarily destroys the appendix, he advised the removal of the appendix. This was done in May, 1906, through an incision displacing the rectus inwards. The cæcum was adherent to the abdominal wall. The remains of the appendix, the distal half was merely a fibrous cord, were found internal to the cæcum. As is his rule in female cases, the internal appendages were examined, with the result that an adherent, blood-containing cyst was found on the left side. This was removed with some difficulty. Its wall showed signs of considerable inflammation and of some necrotic change. The abdomen was closed in the ordinary way. Mr. Corner said that before operation the case presented two problems of interest: (1) The condition of the appendix after two large abscesses had formed, and a large concretion had escaped from it. (2) What had happened to the adhesions round these abscesses. The operation he considered answered these: (1) The distal half of the appendix had been absolutely destroyed and the remaining part was very doubtfully responsible for her three "subsequent" attacks. (2) The adhesions had, to a great extent, gone, particularly in the pelvis, but to a lesser extent in either iliac fossa. In other words, they had disappeared from the more movable viscera, the small intestine, and remained around the less mobile, the large. But, he remarked, the case presented a further feature of great clinical interest. The solution of the clinical problem of her case was found in the pelvic viscera. He had pointed out over and over again the importance in every female case of appendicitis of examining these structures. Previously stress was laid on an examination of the *right* uterine appendages. In this case it was the *left* which were wrong. It was very possible that the development of the left ovarian cyst had something to do with the abscess on the left side opened in 1903. An abscess had formed in the pelvis, then tracked up by the rectum to the left iliac fossa. It must, he thought, have affected the left ovary on its way.

ROYAL SOUTHERN HOSPITAL, LIVERPOOL.

ACUTE PERFORATIVE APPENDICITIS.—MR. NEWBOLT operated upon a man, *æt.* 20, who on May 4th, 1906, was seized with pain in the appendicular region accompanied by vomiting, this being his first attack. Next day he was able to work, but at twelve noon on May 6th the pain became agonising. He was seen by Dr. Medwin later on, when his pulse was 120, his temperature 102°, and he was evidently very ill. The lesion was recognised, $\frac{1}{2}$ gr. of morphia given, and he was sent into hospital. On admission at 4 a.m. on May 7th, his pulse was 130, his temperature 100.2°, and his respirations were 36. His abdomen was slightly distended and was resistant to palpation all over. There was an indurated mass in the right iliac fossa. The

abdomen was opened at 5 a.m., seventeen hours after his seizure by an incision low down near the anterior superior spine of the ilium. The gangrenous appendix perforated at its base came into view, and was removed together with some gangrenous omentum. A little foul blood-stained fluid escaped. On further examination it was found after breaking down some adhesions with the finger, that sero-pus escaped from the pelvis, and from the right flank. An attempt to get rid of the fluid by dry sponging was made, but it was evident that the whole abdominal cavity was infected, and so much free fluid escaped from different regions in the abdomen that it was thought better to wash out freely. Glass tubes were inserted in each flank and above the pubes into Douglas's pouch. The irrigator was applied through the abdominal incision and some gallons of saline solution at a temperature of 105° were washed through the abdomen until all ran clear. A large gauze pack was put in the wound and the glass tubes were lightly plugged with gauze. The patient left the table in a very collapsed condition, but rallied gradually under the influence of free stimulation, strychnine, and saline injections. Mr. Newbolt did not consider that cases in which the abdomen was full of sero-purulent fluid could be treated by any one plan. That is to say, there were cases in which dry swabbing was indicated, and others in which free lavage only could be of service. In this case it seemed hopeless to get the fluid swabbed out, and as the whole cavity was flooded with sero-pus, no fresh infection could arise from the method adopted.

In those cases in which the mischief was localised, Mr. Newbolt said he never used irrigation, but trusted to dry swabbing and a free drain. In a recent case of perforated gastric ulcer with escape of contents, the whole abdomen being soiled, free irrigation was carried out by placing one tube in the epigastric wound and another in the pouch of Douglas, saline solution was run through till all was clear, and cultivations of the fluid from the tubes proved sterile for the three days during which they were retained, the patient making a good recovery. Mr. Newbolt insisted upon the necessity of immediate operation in all cases in which patients with appendicitis complained of this acute agonising pain; he considered that it was nearly always due to perforation of the appendix, and the fact that this youth, when admitted at 4 a.m. was comparatively comfortable was due to the morphia which had been given, and would have been most misleading had not the practitioner in attendance warned the surgeon of the true nature of the case. In this instance nature had not been able to shut off the general cavity of the peritoneum above and below, though she had made a bold attempt by wrapping the omentum around, but this also was infected by the disease.

Vomiting was troublesome for two days; the glass tubes were removed from the loins in forty-eight hours, and from above the pubes on the third day, gauze only being substituted. Some discharge took place from the wound in the appendicular region. The patient eventually made an excellent recovery.

TRANSACTIONS OF SOCIETIES.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD JUNE 6TH, 1906.

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

Dr. W. T. RITCHIE showed (for Dr. Gibson) a case of "Symmetrical Trophic Lesions of Both Thumbs," without definite symptoms of syringomyelia.

Mr. DAVID WALLACE showed a patient after cholecystectomy for "Septic cholangitis." The history was that for a week previously she had suffered from acute abdominal symptoms, with fever, and that on examination there was tenderness and resistance over the right hypochondrium, where, on palpation, grating friction, indicative of perihepatitis, was felt. The diagnosis of cholangitis was made, and on opening the abdomen the greatly distended gall-bladder was exposed. It was punctured, and fluid with the odour characteristic of infection with *b. coli* was withdrawn. Thereafter the gall-bladder, containing a number of calculi, was excised. In these cases there was great danger of infecting the peritoneum, and special care had to be taken to shut off the cavity by packing round the gall-bladder with sponges before removal.

Mr. STILES showed two children after operation for HIRSCHSPRUNG'S DISEASE.

The condition, which was also known as congenital dilatation of the colon, was named after its describer, and the symptoms were obstinate constipation from birth associated with enormous distension of the abdomen. The superficial veins on the abdomen were dilated, the lower aperture of the thorax was greatly widened, and from time to time waves of peristaltic movement could be seen passing over the belly. The first case had come under observation four years ago, when the child was *æt.* 5, and was in all respects typical. Never since he was born had the boy had a natural

motion, enemata having always been required in order to keep the bowels open. The child was in extremely poor condition—emaciated, and with deep hollows under the eyes. On opening the abdomen in the left iliac region the colon presented; it had exactly the appearance of an adult stomach. As the state of the patient precluded any extensive operation, colostomy was performed, the mucous membrane of the gut being sutured to the skin so as to make a permanent artificial anus. Two years later the child was brought back to hospital for the purpose of having the artificial anus closed if possible. On opening the abdomen in the middle line the colon was found dilated to the size of a man's thigh. As nothing radical could be done, the wound was closed. The child now was in good health and well nourished; his bowels moved daily through the artificial anus, but the intestine between the artificial anus and the rectum was found to be loaded with impacted fæces. On the whole, the result was good, because these cases had almost invariably proved fatal. In the second case, operated on about three weeks ago, the typical symptoms and signs had also been present. The operation had consisted in anastomosing the ilium to the pelvic colon, so that fluid, instead of solid fæces, might enter the rectum. The disproportion between the size of the colon and the small intestine was so great as to make anastomosis difficult, and although prior to the operation every effort to wash out the colon had been made, it was found to be loaded with fluid and semi-solid fæces. After operation some anxiety was felt lest the distended bowel should press on the lumen of the anastomosed ilium and cause obstruction, and, in fact, there were some signs of this for several days. The patient had made a good recovery and now was running about quite well. In this case the hypertrophy and dilatation was limited to the descending and pelvic colon, and this was the condition usually met with. It was a

matter of dispute whether Hirschsprung's disease was a primary hypertrophy and dilatation, whether it was due to stricture, or whether it arose in consequence of some functional derangement of the neuro-muscular mechanism of the colon comparable to what has been supposed to be the case in congenital hypertrophy of the pylorus. Probably some cases of volvulus in adults, preceded by years of constipation, were of the same nature as the condition described.

Dr. G. A. GIBSON showed a series of tracings from cases of heart-block.

Mr. CAIRD showed four examples of intestinal carcinoma removed from the pelvic colon and rectum.

Mr. WALLACE showed Gall-bladder and Calculi from case of septic-cholecystitis.

Dr. AITCHISON ROBERTSON exhibited a new antidote and emergency case containing appliances for coping with cases of accidental or suicidal poisoning, &c.

Dr. DAVID WALLACE read a paper on "Tumours of the Bladder: Why Operative Treatment is so Frequently Unsuccessful in its Remote Curative Result. A Plea for Early Diagnosis," which we hope to publish in our next.

Mr. CAIRD, in discussing the paper, suggested that in future it might be possible to perform more radical operations on the bladder, now that it was known how tolerant the rectum was of implantation of the ureters. There was apparently no reason why the whole bladder should not be removed, and the ureters brought out to the skin or implanted into the colon. Possibly the cæcum might be employed to form a new bladder.

After some remarks by Mr. Miles, Mr. WALLACE, in replying, mentioned a case in which the bladder had been removed, the ureters led into the cæcum, and the appendix converted into a species of urethra. Whatever was the pathological explanation of the recurrence of apparently benign tumours, it was only common-sense to suppose that the likelihood of this would diminish with early removal.

Dr. A. H. H. SINCLAIR read a paper on THE EARLY DIAGNOSIS OF GLAUCOMA BY THE SCREEN TEST (BJERRUM'S METHOD).

In Bjerrum's method of testing the field of vision the principle of using a white object against a black background is employed as with the perimeter, but with important differences. In the perimeter the test object employed subtends an angle of $\frac{1}{2}$ a degree, and when the test is reduced below this size the field of vision becomes restricted accordingly. Bjerrum employs very much smaller test objects, with the intention of testing the state of vision *within* the full perimetric limit of the field. With the perimeter the defects found in the field are said to be absolute; with Bjerrum's test defects found are called relative, because when a larger test object is employed over the same area vision can be excited. In making Bjerrum's test the absolute limits of the field are first determined by the ordinary perimeter, and then the state of relative vision within this field is examined by a small white test object used at a distance of one or two metres against a large black screen. The distance at which the patient is placed has the two-fold effect of increasing the eye to which scotomata are projected and therefore making them more easy of delimitation, and, second, of reducing the visual angle of the test object. The apparatus consists of a large screen of black velvet, having marked out on it in black thread radiating lines and concentric circles. To obviate the need for so many threads, Dr. Sinclair employed a rod with a scale engraved on it for either one or two metre distance, which was placed along the radiating lines and thus marked out the position of the test object, without the concentric circles of thread being required. The various precautions necessary in working with the test were then described, and fields of normal eyes taken by the method were shown. In using the smaller test objects the effect of retinal fatigue must be remembered. The distinctive characteristic of the field in glaucoma, which has been referred to as Bjerrum's symptom, depends on the relationship of the area over

which vision is most fully presented to the area of relative deficit, and may be stated as follows:—The area of most acute vision, as also of relative defect, are in contact with the blind spot, or may be said to meet at the blind spot. When scotomata are present they frequently occupy a paracentral position forming an arc round the fixation-point, the concavity of the arc being towards the fixation-point. Such scotomata never reach beyond the blind spot towards the temporal side, but may extend to the periphery on the nasal side. The form of the field characteristic of glaucoma appears with remarkable regularity in all cases. It is quite distinctive from the field found in optic atrophy. It is the earliest, and often the only demonstrable evidence of the presence of the disease. The paper was illustrated by numerous perimetric tracings, and tracings made by Bjerrum's test from a score of cases of glaucoma.

Drs. GEORGE BERRY and T. V. PATERSON concurred with Dr. Sinclair in his estimate of the great value of Bjerrum's test as an early sign of glaucoma. It was, however, a test which required considerable experience on the part of the observer to give reliable information, and was of no value when carried out by a tyro.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

MEETING HELD FRIDAY, MAY 18TH, 1906.

Dr. JAMES CRAIG in the Chair.

SUDDEN HEMIPLEGIA IN A CHILD DUE TO TUBERCULOUS CEREBRAL TUMOUR.

Dr. TRAVERS SMITH read notes upon the case of a male child, æt. 2½, who, upon January 1st, 1906, whilst in apparently perfect health, suddenly lost voluntary power in the right arm and leg. A fortnight later great rigidity appeared in the affected arm and leg. The right leg, and to a less extent, the left one, were drawn up in the intra-uterine position. On March 1, the child showed signs of tuberculous meningitis, and died upon March 6th. *Post-mortem*, tuberculous meningitis was found, and a large tuberculous tumour, the size of a hen's egg, was found to occupy the region of the corpus striatum and internal capsule. No hæmorrhage was visible in or around the tumour. Dr. Travers Smith considered the case interesting from the following points of view: (a) The large size of the tumour; (b) its position; (c) the power of a tumour to produce sudden hemiplegia in a child apparently healthy.

ARTIFICIAL RESPIRATION.

Mr. ROBERT WOODS read a paper on this subject, in which he compared the relative advantages of Sylvester's method with the older one of direct insufflation. He showed that by direct insufflation more air was introduced, and, therefore, the stimulating effect on the vascular and respiratory mechanisms as well as the rapidity of elimination of a drug such as chloroform was greater, while the impurity of the air insufflated (the original reason for abandoning the method) was negligible.

Professor THOMPSON said he agreed that Mr. Woods' ideas on artificial respiration were an improvement on the methods at present used, his only objection being the repugnance of placing mouth to mouth.

THE NAUHEIM TREATMENT.

Dr. A. AINSLIE HUDSON read a paper on this subject. He described the composition of the effervescing baths, and detailed his methods of artificially preparing these in Ireland. He then gave an explanation of the physiology of the improvements which follow the baths, and the exercises which accompanied them. The immediate effect of the application of the water, rich in salines, is to produce a powerful stimulation of the muscular coats of the superficial blood-vessels, an effect greatly enhanced by the presence of the CO₂. Dr. Hudson also detailed the technique of the treatment, and described the nature of the exercises the

patients performed, and indicated the nature of the ailments and the symptoms which could be cured or alleviated by the treatment.

The Chairman and Dr. Finny discussed the treatment, which they agreed was often beneficial.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD.

GERMANY.

Berlin, June 10th, 1906.

At the Medical Society, Hr. S. Munter spoke on THE HYDRO-THERAPEUTIC TREATMENT OF FEBRILE INFECTIVE DISEASES.

He first gave an historical review of the subject, and said that since the time of Brandt, hydro-therapeutic measures had been successfully employed against fevers, and particularly typhoid. Extraction of heat, however, even if it did play a part, was not the only active factor.

We knew now that rise of temperature supported the efficacy of the natural protective material of the organism, that the alkalescence of the blood rose with the gradual rise of temperature, but not with sudden rises. But experience taught that a very high or continuous fever was a grave danger to the organism. From this was to be extracted the teaching that only excessive or long continuous fever should be made the object of treatment.

The objects of fever treatment should be the diminution of heat production on the one side, and an increased giving off of heat on the other. The latter was more easily practicable than the former, and it was best done by bath treatment. Cold water spongings served for minor reductions of temperature, but in cases of high fever baths were more useful; but it must be remembered that these increased the production of heat and were of grave importance in cases of high fever, and the organism must be got accustomed to bear them, so the bath must be gradually cooled from 28° C. to 20° C. Cool douches, whilst in the bath, followed by friction, were to be recommended. For patients who got chilled easily carbonic acid baths were suitable. All these measures acted favourably on the heart and blood vessels, on the nervous system, and on the digestive organs. The better circulation was expressed by the increase in diuresis after the bath. In spite of this, the excretion of urea and uric acid fell because the stasis in the organs was raised and through this the tissue change was diminished.

At the Verein f. Innere Medizin, Hr. Plehn reported a case of

BLACK WATER FEVER.

The patient had lived a year and a half in Togo, and although he had taken quinine in prophylactic doses whilst there, he had suffered several times from malaria, and at last he got black water fever. The quinine was now stopped entirely when he had another severe malarial relapse. Euquinine was now given in $\frac{1}{4}$ gram doses. After three such doses the temperature rose, and after five doses black water fever came on. The patient now returned to Germany; he had attacks of malaria on board ship, but took no more quinine; he came to Berlin and put himself under the speaker's treatment. Examination revealed considerable enlargement of the spleen and slight liver enlargement. The question what one should do in such a case was a difficult one. If no quinine were given the malaria relapses would return; if no quinine were given the patient would die of complicated malaria; if quinine were given he would get black water fever. Here the mortality was not so high, however; it was, if the patient was under medical control, about 12 per cent. If in latent malaria quinine was given at once, black water fever might come on, but frequently it did not. This was the state of affairs in the colonies. If the patients came back to Europe, the disposition to the disease disappeared; sometimes even without quinine, but not by any means in all cases. In any case,

quinine must be tried, if the patient remained under medical treatment; if he insisted on leaving he should be sent into the country, to the mountains, to recoup. In the present case, in which no parasites were seen in the blood, quinine was tried. At 11 o'clock in the morning $\frac{1}{4}$ gm. of euquinine was given; two hours later the patient had a rigor with jaundice and vomiting; in short, a black water attack. With this there was almost complete anuria, only 25 ccm. were passed the first day; it contained a quantity of albumin and was of a deep black colour. The patient felt fairly well, but the day following only 17 ccm. of urine were passed, and in the days following from 30 to 70 ccm. Otherwise the improvement continued. With such a degree of anuria he had never yet seen a recovery. Here the disease ran a more favourable course, after copious subcutaneous infusions of saline solution, free washing out of the stomach, and infusions into the rectum with the same kind of fluid, diuresis was restored. Up to two litres of urine per diem were excreted, notwithstanding the large amount of insensible perspiration due to the hot weather. It was remarkable that there was no trace of œdema. The patient might now be considered cured. No cylinders were to be found in the scanty urine; epithelial tubules first appeared when the diuresis came on. During the course of the disease there was no hæmaturia, only hæmoglobinuria.

Hr. A. Fraenkel asked if methylene blue had been tried in black water fever.

Hr. Plehn said Yes; it had proved absolutely useless. It was the same with salipyryne, phenocoll, antipyryne, and similar remedies; they could even set up black water fever in tropical malaria.

Hr. Hans Kohn asked what Plehn thought of doing further for his patient as he still had his malaria.

Hr. Plehn replied that that was not certain, as not infrequently the parasites were destroyed after black water fever. He had sent the patient to Thuringia to recoup, with instructions not to take quinine, but to return at once on any reappearance of malaria.

AUSTRIA.

Vienna, June 10th, 1906.

INTRA-MURAL TUMOUR OF BLADDER.

HABERER presented a case to the Gesellschaft from whom he had removed a fibroid from the inside of the bladder.

The patient was æt. 30, and came to him in March, 1902, with inguinal hernia of the right side, for which he operated. In November of the same year he was operated on for hernia of the left side. At no time before this had the patient complained of pain in urinating or any other cystic trouble.

Fourteen days after the second operation he began to complain of a constant pressure in the region of the bladder with a smarting, burning pain on urinating. The patient had no fever at any time, but commenced to lose appetite and weight.

There was no history of venereal disease; the urine was clear, but sometimes contained traces of blood.

Palpation revealed a tumour to the right, and slightly above the symphysis pubis; a small round tumour about the size of a child's fist; a smooth surface and hard consistence. It was movable and not painful. The cystoscope revealed a round tumour about the size of a walnut projecting from the internal wall of the bladder. Above this tumour were two necrotic patches of the mucous membrane, which when touched very lightly commenced to bleed. The prognosis was rather gloomy as the symptoms pointed to a malignant fibroid originating in the wall of the organ. From the tumour towards the umbilicus a broad, fibrous band extended, which led to the presumption of a tumour having originated in the urachus and subsequently protruded into the bladder.

Bier's anæsthetic was applied, i.e., anæsthetising the spinal cord, and performing the Sectio-Alta removed the inflammatory tumour, from which proceeded a fibrous band upwards and toward the middle line.

On opening the tumour it was found to contain necrotic tissue in the centre bathed in sterile pus which communicated with the pedicle and required to be scraped out and cleaned before closing. Free drainage was succeeded by perfect recovery.

The inflammation seems to have been partially para-vascular and intra-mural in the production of the tumour, escaping in the direction of the least resistance. The proximate cause, he concluded, was the result of the operation for hernia on the right side, which was performed according to Bassini's method, which is to separate the seminal duct from the cord and, laying it in a channel of its own, external and at a higher level.

AN ORGANISATION FOR NURSES.

The Gesellschaft was seriously moved by the subject of nurses brought forward by Moskovicz, who seems to be bold enough to venture a raid on the Church. He proposes that all nurses should be educated on secular lines and fitted properly for their duty at the bedside. It may seem strange to English ideas that secularism cannot be tolerated in the teaching of nurses, but it must be remembered that the same anomaly exists in our own education. Moskovicz pointed out that Austria at the present time had only 4,237 nurses, while Germany had 24,000 Roman Catholic nurses and 12,000 deaconesses.

Billroth hoped when he founded the "Rudolfshäuser" twenty-five years ago, to have a perfect supply of nurses in Austria, but the restrictions have been so great as to destroy all the good anticipated. Why? he asks, when Germany, France, England, and America have an abundance and to spare of trained nurses. If war took place at any time with Austria, the hospitals would have to be closed or beg from other countries. He desired a central institution for teaching nurses as a profession and not as an auxiliary to religion, which confined nurses too much and destroyed the health.

Escherich concurred with the preceding speaker that we required nurses better trained with their hands in the arts of medicine and surgery.

Teleky and Exner hoped to see the ethical and educational status of this class raised by the formation of a proper society which should not be subject to the cloister.

HUNGARY.

Budapest, June 10th, 1906.

At the recent meeting of the Royal Society of Physicians of Budapest, Dr. Egmont Baumgarten exhibited a case of an affection of the accessory sinus of the nose associated with

PARALYSIS OF OCULAR MUSCLES.

He pointed out that chronic diseases of the sphenoidal sinus are usually accompanied by severe symptoms, and on account of its proximity to the eye it might entail serious consequences to that organ. In the patient shown a year ago was a complaint of much headache. Soon after he became unable to open the eyelid. Two months ago diplopia developed. Diseases of the antrum of Highmore and of the frontal and ethmoidal sinuses having been excluded, the headache and other severe symptoms led him to seek for the seat of the disease in the sphenoidal sinus, and he therefore made an opening into the sinus through its anterior lower wall. Ptosis and the protrusion disappeared on the following day, and the patient could move his eye better. Two days later, after the removal of the anterior part of the middle turbinal, Baumgarten scraped out the granulations lodged in the sphenoidal sinus. The patient felt very faint under this treatment, otherwise was quite well. The eye now moves inwards to the middle line, upwards only a little, downwards tolerably well. The posterior wall of the eye was intact. The patient denied having had syphilis, nor had he previously had any infective disease. This made it very difficult to assign the real cause of the affection. That the eye-muscle paralysis is dependent upon the sphenoidal disease appears

likely, and this view is confirmed by anatomical considerations; it is confirmed, moreover, by the result obtained.

FAT CHANGES IN THE STOMACH.

Dr. Gerber related his experiments on dogs with fat. After twenty-four hours' fasting they were provided with a meal of fat. Six hours later they were killed, and a weighed quantity of the contents of the stomach taken for analysis for free fatty acids. In one of the cases there was a decided increase of the free fatty acid, while none was observed in the other. He next took part of the mucous membrane of the stomach, and determined its power of breaking up fat in a test tube. He placed neutral olive oil in a portion of the stomach, and suspended it in a water extract; another portion of the stomach was suspended in glycerine extract and gently shaken for half an hour at 40° C. As a control experiment another portion of the stomach was boiled, and the olive oil placed in it in the same manner as the fresh experiments. The digestive power of the mucous membrane was then analytically tested with "petrol aether" and the free acid determined. The results were that the conversion into neutral fats as *in vivo* were very slow. The glycerine extract was quite inert as well as the mucous membrane of the second cut, as no ferment was found.

A CASE OF BANTI'S DISEASE.

Dr. Brajer brought before the notice of the Society the case of a young woman, æt. 23, who up till two years ago was perfectly healthy, but after this period began to gradually enlarge over the abdomen. Neither malaria nor syphilis had ever been present. A year ago the enlargement was diagnosed as a splenic tumour, whereupon arsenic was freely administered for a few months without success. More recently she complained of extreme weakness and pain in the back associated with palpitation.

On her reception into hospital a hard splenic tumour was easily palpated over the symphysis pubis in the middle line. The liver was slightly enlarged but smooth, with slight œdema of abdomen. No glandular swelling; accidental systolic murmur; lungs normal. The blood had 58 per cent. of hæmoglobin, 2,800,000 red corpuscles, and 1,800 white ones, or a proportion of 1,600 to 1. Beyond this leucocytosis there was a slight relative lymphocytosis. In the urine was found a large amount of urobilin and gall-colouring matter. There were temporary attacks of icterus in hospital, but under arsenic treatment the colour improved, but the tumour remained the same, although the blood changed. Hæmoglobin, 72 per cent.; red corpuscles, 7,000,000; white, 1,270; or proportion of 3,100 to 1. The complex symptoms with successive leukæmia pointed to an advanced form of Banti's disease.

FROM OUR SPECIAL CORRESPONDENTS AT HOME. SCOTLAND.

THE GLASGOW CANCER HOSPITAL.—The directors of this institution have just issued an appeal for funds on behalf of the proposed extension, and the establishment and equipment of a research department. The hospital has been in existence for about 15 years; it began in a small way in an ordinary dwelling-house, where there was subsequently established, in addition to an indoor department, an out-patient department provided with trained nurses who visited and dressed patients at their own homes. Some years ago the size of the hospital was increased by the erection of a building at 132-138 Hill Street, where excellent work has been carried on, not only among Glasgow patients, but among patients drawn from all over Scotland. While the primary object of the hospital is to treat medically and surgically cases of cancer, a very important secondary object—the establishment of a research department has been kept steadily in view. To place this on a proper footing so that good and useful work may be done, means a staff of special workers who

would require to be paid suitable salaries. Probably £1,000 a year would be needed. This seems a large sum of money, but such research work is better not carried out at all than in an improper and unscientific manner. The directors think a beginning might be made by securing the annual support of a number of subscribers for from 3 to 5 years, so as to give the research undertaking a trial. The directors, however, wish it clearly to be understood that the treatment of cancer in the hospital will be on the same lines as in all other infirmaries elsewhere. Under these circumstances, the directors appeal for £20,000 for buildings, and an annual guarantee of £1,000 for research. We learn that nearly £4,000 has already been collected, and that one of the most pressing needs for extension is the provision of small wards for patients advanced in the disease. Dr. Beatson, whose name is so well known in connection with operations for cancer of the breast, is one of the surgeons to the hospital.

PHTHISIS AT THE EDINBURGH CITY HOSPITAL.—Some time ago we referred to the proposal to admit advanced cases of pulmonary tuberculosis, which were serving as foci of infection, to a special pavilion in the Edinburgh Fever Hospital. Since this ward was opened in April, 21 cases have been admitted, of whom 8 have died. The last admission was on May 26th, since when there has only been one application. As the weekly mortality from phthisis is 13 or 14, the small number of patients seems to imply either ignorance on the part of those who were expected to benefit or indifference to the public health aspects of the question on the part of medical men. The Public Health Committee have accordingly taken steps to make their scheme more widely known to secretaries of dispensaries and others. Probably one potent cause of the small number of admissions is the natural desire of those who know that their time is short to die in the homes and among the relations where their lives have been spent.

EDINBURGH ROYAL INFIRMARY OLD RESIDENTS' CLUB.—The 12th annual dinner will take place at the Caledonian Station Hotel, Edinburgh, on June 29th, at 7 o'clock. Sir Lauder Brunton will be in the chair, and a number of old residents from distant parts of the county are expected to be present. Those who wish to attend are asked to send their names to Dr. Edwin Eramwell, 23, Drumsleigh Gardens, Edinburgh, not later than June 25th.

LETTERS TO THE EDITOR.

ISOLATION HOSPITALS AND SCARLET FEVER CASES.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

DEAR SIR,—It appears to me that there is much to be said in favour of isolation hospitals, and I should like to cite a few cases which have recently come under my personal observation. I saw a child, æt. 6, about a month ago, who was suffering from scarlet fever. The father worked in some extensive works in the town, and the eldest son was a clerk in the same works. The house occupied by this family was small. There were eight children at home. The child was at once removed to the Isolation Hospital and no further case occurred. About the same time I saw the child of a carpenter, also suffering from scarlet fever. There were two other children at home. The parents refused to allow the infected child to be removed to hospital. The other children contracted the disease.

Again, if we take the case of a very mild case of scarlet fever, which is treated at home. Parents are apt to regard these cases as very unimportant, and among the poorer classes efficient isolation is practically impossible.

Let me cite another case—The child of a clerk contracted scarlet fever. The mother refused to allow her to be removed to the Isolation Hospital. There were two other children in the house. Judge of my annoyance when visiting the house two days after seeing

the first child, I found the other children playing with the infected child. "I thought that they were bound to get it," was the only reason given for this act of foolishness. It is not only the children who suffer, but often, doubtless, the disease is spread by the incaution of parents.

Then, again, in the event of an outbreak of scarlet fever among the poor, what a boon it is to the general practitioner who has also to attend midwifery cases, to be able to send these cases away, knowing they will be well cared for, instead of having to attend a number of them through a prolonged and tedious convalescence.

Finally, let us not forget the mortality. How poor are the chances of recovery in the case of the children of poor, ignorant and perhaps drunken parents in cases in which complications arise. How many more cases of nephritis would occur under such conditions, of otitis in cases in which the cleansing of the naso-pharynx was entrusted to incompetent or neglectful persons. I know that as a general practitioner. I have often blessed our isolation hospital when I have had several cases of scarlet fever occurring among my poorer patients at a time when I had an operation or confinement impending. Three weeks ago I saw a child with scarlet fever. The next door neighbour's child had scarlet fever, and had not been removed to the Isolation Hospital. My patient was removed at once, and although there were two other young children in the house no further case has occurred.

Isolation hospitals have certainly proved a boon to me and my patients, and doubtless other medical men have experienced the same advantages. Statistics are a vain thing to either condemn or uphold belief.

I am, Sir, yours truly,

Bedford, June 11th, 1906.

G. J. Ross.

THE TIMES AS CENSOR MORUM.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—In reference to your most praiseworthy attitude with regard to lay journals and quack advertisements, may I draw your attention to a leading article which appeared in *The Times* of Friday, June 1st? The writer lashes the Chicago meat packers with a whip of scorpions; and the question at once suggests itself—How can a newspaper consistently thus attack rogues in America whilst it supports no less heartless and injurious rascals at home. A considerable proportion of the advertisements and paid puffs in *The Times* emanate from men—medical quacks and quack medicine concoctors—who were formerly ranked by its editors among the criminal classes and denounced accordingly on every occasion.

If the proprietors of *The Times* will inquire, they will find that medical quackery in every form has now become the pursuit of a vast army of adventurers, who find in it a perfectly safe enterprise for the plunder of simple suffering humanity. They will find that quackery in many forms is used as a system of black mail, and that the lower class of advertising dentists and such impostors as obesity-curers and cosmetic quacks make their money by slightly veiled extortion from the foolish women for whom they especially lay themselves out. These men often merely pick the pockets of their victims; the more cruel and cynical scoundrels—such as cancer, rupture and venereal quacks—play a game involving questions of life and death. *The Times* managers can easily satisfy themselves that the statements of their editors to which I have referred with regard to the injury to the public health due to the quack medicine trade are more applicable at the present day than ever. Other quacks pursue their nefarious trade under the cloak of medical or electrical "institutes," and of drink-cure establishments, or under the mask of religion in the form of Christian science and esoteric Buddhism. *The Times* has it in its power to expose and to put an end to the whole hideous system. The vilest class of advertisements may not be discoverable in its columns, but so long as it admits the classes it now freely accepts.

it is impossible to expect inferior papers to draw a line. *The Times* does it, we cannot live without it; this is the reply of the small newspaper owner when appealed to. We have all been hitherto proud of *The Times*, and have regarded it almost as a magnificent national institution—a potent instrument in promotion of social progress and civilisation. It is truly deplorable to contemplate the destruction of the influence it might still continue to wield.

I am, Sir, yours truly,
HENRY SEWILL.

June 9th, 1906.

THE ALCOHOL QUESTION.

To the Editor of the MEDICAL PRESS AND CIRCULAR.
SIR,—At last these questions of Alcohol, Fermentation, Temperance, and the causes of intemperance are being dealt with on proper scientific principles, and it is only to be regretted that this was not done long ago.

Very little assistance has been given by the medical profession in this work, and it is right to draw attention to the fact that the MEDICAL PRESS AND CIRCULAR may claim to have some credit for the views expressed more than five years ago on the subject of Temperance and Legislation (Wed., Jan. 23rd, 1901).—I am, Sir, yours truly,

R. L.

THE CHRISTIAN SCIENCE QUACK.

SIR,—Your correspondent, "Denizen of a Back Street," plainly possesses the gift of generalising and of directness—two things that cannot fail to bring a man sooner or later into prominence. My only complaint about his letter is that he is far too moderate. Personally, I regard the state of our law as regards irregular medical practice as a screaming farce. We harry the qualified with minute and, in some cases, ridiculous codes, while we permit the unqualified to amass fortunes at the cost of the health and the lives of the community. In other words, the law protects the subject against the heterodox qualified medical practitioner, whilst it refuses to protect him against grossly ignorant persons who fleece the public with assumptions of medical and surgical knowledge.

Let us as a first step rouse the profession to the necessity of reform of the General Medical Council, so as to make it really representative of the medical profession, and not, as it now is, practically in possession of a number of ancient bodies with conflicting individual interests, but never a thought and never a care for the practitioners whose money supports the Council.

I am, Sir, yours truly,

A RETIRED HARLEY STREET PRACTITIONER.

MR. CHIOZZA MONEY AND THE "DANCING" SURGEON.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—I enclose herewith an extract from an article written by Mr. Chiozza Money, M.P., for the *Daily News*, and also my letter dealing with the paragraph. The *Daily News* has inserted my letter, but only in part. Hence this communication dealing with the matter, as owing to the mutilation of my letter it has not been adequately inserted in the columns of your contemporary.

I am, Sir, yours truly,

T. HALLETT FRY.

2, Cloisters, Temple, E.C., June 6th, 1906.

(Copy of letter sent to the Editor, *Daily News*.)

"SIR,—I have read Mr. Chiozza Money's article in your issue of 31st ult., and, despite the fact that he is an authority upon the distinction between earned and unearned incomes, I fail entirely to agree with him when he states 'the recipients [of big fees] certainly do not earn them.' He instances the cases of fashionable surgeons, fashionable barristers, and hot-footed journalists. With the latter I leave Mr. Money himself to deal, as he knows more of the utility to the

community of journalists than I do. However, when we consider the question of the fashionable doctors, the story is entirely different, as it is notorious that no doctor draws huge fees whose labours are not of great benefit to his patients. It is unnecessary to insist that no professional man can get to the top of his profession and draw his "hundreds of pounds" without the possession of very considerable skill, and this skill which is paid for in so many pounds of gold is cheaply bought at the price of life, limb, or health. The case of the fashionable barrister is very similar, and the very instance that Mr. Money gives, viz., the drawing of 'hundreds of pounds in connection with a society libel case,' shows that he has not appreciated at all the value of the services of the members of the profession of the Bar to the public. Is it not necessary to exterminate that objectionable class of calumniators who endeavour to spread ruin often in order to obtain some paltry benefit for themselves, or to self-redress their so-called wrongs in a manner which the law of the land does not permit? Perhaps I may be permitted to maintain that earned incomes include earned incomes of every species, and I should like to add that if such fine distinctions as those of Mr. Money are to be introduced, then it is absurd for any legislative body to endeavour to distinguish between earned and unearned incomes. As has so often been maintained, one strong dividing line is all that is necessary and is all that is possible, and such differentiation as Mr. Money now proposes must evidently defeat his own object of systematic graduation and differentiation between incomes earned and unearned.

"In conclusion I should like to call your attention to the paragraph, which read as follows:—'Persons so employed may be clever men, but their lives are useless to their fellows, and the fees they draw are a huge tax upon the useful labour of others,' and can only add that I consider this sentence to be wholly objectionable.

(Signed) T. HALLETT FRY.

2, Cloisters, Temple, E.C."

Extract from Mr. Money's Article.—"We ought not to conclude hastily that all incomes other than those from property are earned. Professional incomes are often derived from services which are of no value to the community. The existence of a large leisured class, possessing enormous wealth, creates an army of attendants who draw big fees, but who most certainly do not earn them. Take the case of a fashionable barrister, who draws hundreds of pounds in connection with a society libel case, or that of a fashionable surgeon, who wastes his time dancing attendance upon well-to-do vermiform appendices, or that of a journalist hot-foot after a scandal. Persons so employed may be clever men, but their lives are useless to their fellows, and the fees they draw are a huge tax upon the useful labour of others."

[In view of the gratuitous offensiveness of Mr. Chiozza Money's original observations, and the fact that neither apology nor withdrawal has followed, we print the above communication in full.—ED. M.P. & C.]

DIRECT REPRESENTATION ON THE GENERAL MEDICAL COUNCIL.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—Will you permit me to reply to several correspondents who wish to know my views on three points, which, being of general interest, may claim the wide publicity of your columns.

1. As to whether I have any suggestions concerning the education of the medical student before registration: My answer is that as the education of all classes in the country has advanced so rapidly during recent years and no proportionate demands have been made on students before registering, I am of opinion that we must demand that at the very least they shall possess a degree in arts or science. I give this option for the present in order that those who will eventually become members of the profession shall not have been trained in a too fixed and cast iron groove, and so that

both arts and science men may be attracted to its ranks. There are openings for both and it would serve to enrich the personnel of its membership and would help to stimulate a friendly rivalry between these two cultured classes. We should have the pure scientist who has taken the science degree, and he, of course, would be the man to go in more fully for his own department. On the other hand, the arts graduate would not be debarred, of course, from developing the scientific element, but would be more equipped to maintain the more general erudite element of the profession. By this means we should not only get a better class of men throughout the profession, but it would be a very effectual means of eliminating undesirable from its ranks. Those who have no real taste for learning and culture for its own sake would have to seek occupation elsewhere. The teachers at the schools of medicine would have better material to deal with and we might expect a more elevated tone throughout. Another advantage would be that there would be fewer students registered each year, but this would be no great drawback. Enough would join for many years to come until the supply was more on a par with the demand than is the case at present or has been for many years. Rather than adopting the one portal system just now I would endeavour by these means to improve the present one.

2. That in lieu of the benefits which students derived in former days from the apprenticeship system with respect to etiquette, medical students in each of their last two sessions should be compelled to attend at least three lectures on medical ethics.

3. As a nominated candidate for election to the General Medical Council, an expression of opinion has been asked for as to canvassing for public vaccination cases on the part of either medical officers or other Poor-law officers on their behalf. I hold strongly that it should be regarded by the Council as "infamous conduct in a professional respect," and would advocate as stringent punishment as upon those in humbler spheres of the profession.

Since writing the above I have been pleased to see that the University of Wales insists on either a degree in Arts or Science from medical students.

I am, Sir, yours truly,

G. H. BROADBENT.

8, Ardwick Green, Manchester, June 9th, 1906.

THE PRODUCTION OF ANIMAL EXTRACTS.

To the *Editor of THE MEDICAL PRESS AND CIRCULAR.*

SIR.—In view of the great interest being taken at the present time in regard to animal products, and the natural anxiety in the public mind, we wish to state with all the emphasis at our command that it is quite impossible for any of the medicinal products issuing from our laboratory to be contaminated with pathogenic organisms. The precautions taken in the way of inspection of the glands, &c., before they are made use of, the aseptic methods of preparation, and the bacteriological and microscopical, as well as the physiological and chemical tests employed, are such as to make it an absolute impossibility for any disease-bearing germs to be found in any of the active principles or extractives from animal sources made by us. We beg further to say that all our animal preparations are made in our own laboratories under the immediate supervision of those chemists and biologists to whose unremitting watchfulness and care has to be attributed the reputation which our firm enjoy throughout the civilised world, as regards the purity and quality of its medicinal products generally.

We are, Sir, yours truly,

London, June 9th, 1906. PARKE, DAVIS AND Co.

Navy Medical Service.

THE following surgeons have been officially gazetted for promotion to the rank of staff surgeon:—H. C. Whiteside, R. L. Dickinson, H. W. B. Shewell, M.B., M.A., J. Martin, C. B. Fairbank, H. J. Chater, R. St. G. S. Bond, M.B., F.R.C.S., F. C. B. Gitting, M.B., R. M. Richards and A. G. Eastment.

REVIEWS OF BOOKS.

ORTHOPÆDIC SURGERY. (a)

ONE of the most striking and valuable features of this treatise on orthopædic surgery is the number and excellence of the illustrations it contains. There are 592 engravings, most of which are reproductions from photographs of patients showing deformities, and the results obtained by treatment. A large number demonstrate treatment by apparatus and manipulation. Other figures again are intended to portray the attitudes assumed in different pathological conditions. For instance, a series of eight photographs showing the method of getting up from the ground in a patient affected by pseudo-hypertrophic muscular paralysis. Illustrations of this last nature are found throughout the book. They forcibly demonstrate the characteristic attitudes in various diseases, and efficiently take the place of a long verbal description in the text. There are also several good skiagrams.

The treatise is divided into chapters dealing briefly with the etiology and pathology of the subject under discussion, and more fully with the examination, estimation and treatment of the deformities usually considered as belonging to this branch of surgery.

The first five chapters are devoted to tuberculous disease of the spine, hip, knee, ankle and other joints. The chapters on Pott's caries and hip disease are most comprehensive. In the edition before us particular attention has been paid to those subjects in the study of which the greatest recent advances have been made. The most important changes from the second edition, published in 1899, will be found in the chapters treating of congenital dislocation of the hip, scoliosis, traumatic and non-traumatic coxa vara, and non-tubercular diseases of joints. The remaining chapters are taken up with the surgical aspect of rickets, paralysis, talipes, torticollis, and other deformities of the trunk and limbs. Chapter xxi. on "Practical Details of Apparatus" has been added in this edition, and gives the description and drawing of the splints, boots, braces, &c., usually employed in orthopædic work. The information contained in this section of the work will be found useful to the general practitioner, when ordering mechanical appliances in the process of treatment of congenital and acquired deformities.

In conclusion, this Treatise on Orthopædic Surgery is nicely got up, is written in an interesting and lucid style, and possesses the qualities which are likely to ensure its popularity with the profession.

THE PATHOLOGY OF INFLAMMATION. (b)

THIS is a remarkable work for one who has, we imagine, reached or perhaps passed the allotted span of human existence. It is a fine example of fertility of thought, industry, and enthusiasm rarely seen in physicians who have attained unto the venerable position of "consulting" medical advisers to their hospitals. In 1892, Dr. W. H. Ransom, at the Nottingham meeting of the British Medical Association, gave an address before the Section of Medicine on "Some Diseases of Plants Compared with those of Man." The present volume is in great measure an amplification and extension of this address. The author, educated in the forties of last century, was brought up in a school of pathology which viewed inflammation not as a part of general pathology, but as a group of phenomena, some of them objective only, and chiefly exhibited in man. Under the influence of the teaching of the evolutionist and the demonstrations of the experimentalist, the outlook has been widened, and

(a) "Treatise on Orthopædic Surgery." By Edward H. Bradford, M.D., Surgeon to Boston Children's Hospital; Professor of Orthopædic Surgery, Harvard Medical School; and Robert W. Lovett, M.D., Surgeon to the Infant's Hospital, and to the Peabody Home for Crippled Children; Assistant in Orthopædic Surgery, Harvard Medical School. Third Edition. London: Baillière, Tindall and Co. 1905. Royal 8vo. Pp. vi, and 670. Price 21s. net.

(b) "The Inflammation Idea in General Pathology." By W. H. Ransom, M.D., F.R.S., F.R.C.P., Consulting Physician to the General Hospital, Nottingham. Pp. vi., 354. London: Williams and Norgate, 1905.

through the self-imposed task of one to whom has been granted the advantages of an exceptionally long retrospect, this fuller view and deeper conception are in these pages faithfully and fully portrayed. Dr. Ransom here shows that the zoo-pathologists and thalo-pathologists must combine experiences, if clear biological ground is to be secured and true insight fully attained as to the nature of pathological processes. In unfolding views relating to the inflammatory idea, the author dwells at length on the result of the study of gall-growths and of cecidia, and in his efforts to present his thesis, he brings forward much of speculative interest and no little of pathological value. The work, however, is mainly critical and contentious, and conclusions are presented in a philosophic form, which at times is almost pedantic. Some of the sentences are of inordinate length, one extending for more than twenty-one lines. There is nothing like a complete reference to modern experiments and recent observations bearing on the subject, although the work of Bashford and Murray and some few other investigators receive almost undue consideration. We could have wished that the venerable author had seen fit to expound his views by reference to what must have been a peculiarly rich and extensive clinical experience. The work as it stands is mainly of academic interest, and we fear will do little to influence present-day opinions or modify current teaching in regard to the nature and mechanism of the reaction of living tissues, vegetable or animal, to the various forms of irritants. The work, however, is an achievement of which the author may well be proud, and we tender him our respectful congratulations, and trust he will be given strength to accomplish the publication of the second part, which he indicates is his full purpose. There is a good index, and the work is well printed, but we regret to say there are no illustrations.

THE NATIONAL DISPENSATORY. (a)

THE title of this great volume gives a good idea of the ground covered by its authors and editors, which include the best-known writers in America on therapeutics, chemistry, botany, and pharmacy. The book is designed to succeed the Dispensatory of Stelle and Maish, which is familiar to all students of materia medica. The sections on the action and use of drugs are edited by Professor Hare, whose writings on therapeutics are so widely read and appreciated, and the information is enhanced by an excellent therapeutical index, in which, under the name of each disease, will be found references to all the medicines employed in its treatment.

The effort to cover a field so immense has swollen the volume to a large size; it consists of 1860 pages, many of which are beautifully illustrated, and as it weighs nine pounds we cannot but regret that it was not bound in two volumes. Ponderous volumes are very inconvenient to handle, and deter the reader, although the cover may bear the respected name of Professor Amory Hare.

DISEASES OF THE RECTUM. (b)

THE object of this small work the author tells us in the preface "is to place before the student and practitioner a brief account of the symptoms, diagnosis, and treatment of the more ordinary diseases which affect the termination of the alimentary canal. It is not intended to contain a complete account of all the morbid changes which occur in this region. Reference to such conditions as congenital malformation, non-

malignant ulceration of the rectum, fibrous stricture of the rectum, and benign tumours has been omitted, partly because I am hopeful that I may have the opportunity of making good these deficiencies at some future time."

The book is up to date, easy to read, and we agree with most of the treatment advocated. We hope the author will soon render the book more complete, for in its present form it is unlikely to take the place of any of the existing books dealing with this region.

We would suggest that the introduction be omitted when the book appears again. For the following is surely unnecessary in a book intended, as the author states, for the student and practitioner:—

"In the history of our species, the ano-rectal region has always been regarded as a contemptible and degraded portion of the anatomy. One cannot be surprised that such should be the case, for it would be unnatural to our instincts to assign any but the meanest place to a member whose functions, however, necessary, are of such an objectionable nature. Personally, the author is unwilling to assent to this popular condemnation. He would submit that, instead of meriting the abuse and neglect to which it is subject, the organ deserves far more consideration and care than is usually bestowed upon it. For the preservation of our health it cannot be denied that the functions of the rectum are fully equal to those of the most honourable and important of our members. Who will deny the fact that these same functions are the most wilfully neglected, and therefore the most frequently disordered, of any of our physiological processes? Unfortunately for himself, mankind has his rectum partially under his own control, it was built to suit his own convenience, and in many cases he has tried to make it his slave rather than his helpmate. Our modern civilisation with its luxuriant and artificialised foods, our lack of exercise and sedentary habits, our false sense of modesty, and above all our unsystematic attempts at a daily routine, are responsible for giving us a monopoly in rectal disorders among all proctodæum-possessing animals," &c.

OBITUARY.

S. FINKELSTEIN, M.D.

MUCH regret has been caused among the Jewish community by the death of Dr. S. Finkelstein, of Manchester, at the age of 41. Before coming to this country, Dr. Finkelstein was assistant physician at one of the principal hospitals in Vienna. He was a member of the British Medical Association, medical officer for the Lancashire and other insurance companies, honorary physician of the Manchester Home for Aged and Needy Jews. He was author of "Extirpation des Schultergürtels nach einer neuen Methode." Being advised to reside in a warmer climate, he gave up his practice in Manchester and went to live in Egypt, death taking place at Alexandria.

WILLIAM GILL, L.F.P.S.GLASG., L.R.C.P.ED.

MR. WILLIAM GILL, the oldest practitioner in Radcliffe, Lancashire, and medical officer for the town, died suddenly at the council offices on the 5th inst. Deceased was educated at Glasgow, where he qualified in 1879. He held various medical appointments and was much respected in the district.

PROFESSOR VON BERGMANN, who recently visited Constantinople in consultation over the third daughter of the Sultan, decided that surgical treatment was unnecessary. Besides a fee of £75,000 his Majesty conferred upon the Professor the Grand Cordon of Osmanieh, with the star in brilliants, and has created him first honorary professor of the Imperial School of Medicine and of the Hamdieh Hospital.

THE annual dinner of the Royal College of Veterinary Surgeons was held at the Trocadero Restaurant on the 8th inst., Mr. Joseph Abson, the president, occupying the chair.

(a) "The National Standard Dispensatory, containing Natural History, Chemistry, Pharmacy, Actions and Uses of Medicines, including those recognised in the Pharmacopœias of the United States, Great Britain, and Germany, in Accordance with the Eighth Decennial Revision of the United States Pharmacopœia, 1905." By Hobart Amory Hare, B.Sc., M.D., Jefferson Medical College, Philadelphia; Charles Caspari, Jr., Ph.D.; and Henry H. Rusby, M.D. London: J. and A. Churchill. 1905.

(b) "Diseases of the Rectum." By F. Victor Milward, M.B., B.C.Cantab., F.R.C.S.Eng., Surgical Casualty Officer, General Hospital, Birmingham, Surgeon to Out-Patients, Children's Hospital, Birmingham. Pp. 193 and IX., 27 illustrations. Birmingham: Coralish Brothers Ltd. 1906.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons, England—Annual Council Election.

THE annual meeting of Fellows will take place on the first Thursday in July next for the election of three Fellows into the Council of the College. The Exhibition of additions to the Museum of the College will be on view on the same day, and a Fellows' Subscription Dinner will be held in the evening. The members of the Council to retire on this occasion as referred to in another column, are Mr. John Langton, of St. Bartholomew's Hospital, Mr. Henry Morris, of Middlesex Hospital, and Mr. Francis Richardson Cross of Bristol. Mr. Langton will not again offer himself for re-election. Both Mr. Morris and Mr. Cross are candidates for re-election. The other candidates who offer themselves for election to the Council are Mr. George Arthur Wright, of Manchester Royal Infirmary, Mr. William Bruce Clarke, of St. Bartholomew's Hospital, and Mr. Charters James Symonds, of Guy's Hospital. A voting paper will be sent to each Fellow, whose address in the United Kingdom is registered at the College, and Fellows will not be required to apply for voting papers.

With reference to the period of office of the present members of Council the following particulars may be of interest:—In 1907 Mr. F. S. Eve (elected as substitute, for the late Mr. T. R. Jessop, in 1904), Mr. H. W. Page and Mr. Mansell Moullin, retire. In 1908 Mr. Harrison Cripps (elected as substitute for Sir Alfred Cooper in 1905), Mr. Ward Cousins and Mr. Pearce Gould retire. In 1909 Mr. Mayo Robson, Mr. Watson Cheyne and Mr. Clement Lucas retire. In 1910 Mr. Howard Marsh, Mr. John Morgan and Mr. H. H. Clutton retire. In 1911 Mr. Henry Butlin, Mr. Clinton Dent, and Mr. G. H. Makins, retire. In 1912 Mr. Anthony Bowlby, Mr. Gilbert Barling and Mr. Edmund Owen retire. In 1913 Mr. Rickman Godlee and Mr. Golding-Bird retire. Mr. John Tweedy, if not re-elected as President in July next, retires next year.

Royal College of Surgeons, Ireland.

NEW president, Vice-president, and Council:—President—Henry R. Swanzy; Vice-president—John Lentaigne. Council—Edward H. Bennett, William Stoker, Sir Charles Cameron, John B. Story, Sir Charles B. Ball, Sir Thomas Myles, Sir Arthur Chance, Richard D. Purefoy, Sir Lambert H. Ormsby, Henry G. Sherlock, R. Bolton McCausland, John S. M'Arde, Robert H. Woods, Thomas Donnelly, William Taylor, Edward H. Taylor, G. Jameson Johnston, R. Charles B. Maunsell, William Ireland Wheeler.

Medical Prosecution.

AT Marylebone, on the 5th inst., Mr. Le Grand N. Denslow, an American gentleman, of 38, Harley Street, and 36, Dorset Square, was summoned for falsely pretending to be, and using the titles of, a doctor and a physician, thereby implying that he was registered under the Medical Acts of 1858 and 1886, and was recognised by law as such. Mr. Harold Morris, barrister, prosecuted for the Medical Defence Union; and Mr. Freke Palmer, solicitor, defended. Mr. Morris said that the defendant held himself out as a person who could cure locomotor ataxia, and he professed to have effected some wonderful cures. In February last, an advertisement appeared in a daily paper stating that a gentleman, after suffering severely from locomotor ataxia for fifteen years had been cured by a new method, and offering to inform sufferers where he obtained relief. A clerk from the office of the solicitors to the prosecution wrote to the advertiser, and thus obtained the address of the defendant. He then saw the defendant, who said he was Dr. Denslow. The clerk explained that he had a friend suffering from locomotor ataxia, and asked if he could cure him. He replied in the affirmative, and said that he was a specialist for that complaint and had performed some wonderful cures. He added that he was an American

doctor, and the English doctors were too slow in their methods and too old-fashioned. They tried at first to stop him, but without success, and then, in order that he might be in the midst of them, he took rooms in Harley Street. He said that his charge was 500 guineas to those who could afford it, but he should soon be charging 1,000 guineas, for, he added, the cure cost him 150 guineas a week. In the end, however, he agreed to charge a fee of 100 guineas, and to accept 50 guineas down and the balance by arrangement. Mr. Freke Palmer denied that the defendant had falsely pretended to be a doctor in London. He held numerous qualifications, including the M.D. of New York, and up to 1902 he had a large practice in that city and at Minnesota, since which time he had been largely engaged in the investigation of the terrible disease of locomotor ataxia. He entirely disapproved of the advertisement put into the paper by a grateful patient, and, as to his using the title of doctor, he thought he could do so, so long as he did not hold himself out as a London doctor. He was fined £30, with £10 10s. costs.

The Coleman Case—Meeting of the Medical Professions.

A VERY largely attended meeting of the medical profession in Dublin was held at the Royal College of Physicians on Wednesday last, the President (Sir William Smyly) in the chair. The following resolutions were proposed and carried unanimously:—

Proposed by the President of the Royal College of Surgeons (Sir Arthur Chance), seconded by Sir Arthur Macan—"That we, the professional brethren of Dr. James Byrne Coleman, hereby congratulate him on the successful manner in which he has recently refuted the unfounded charges brought against him, and express our sympathy with him in the trouble through which he has passed without blemish on his character or honour."

Proposed by Sir Francis Cruise, seconded by Dr. James Little—"That a copy of the foregoing resolution be sent to every member of the profession in Ireland for their approval."

Proposed by Sir Thornley Stoker, seconded by Sir William Thomson—"That a copy of the first resolution with the names of those approving of it, be publicly presented to Dr. Coleman."

Proposed by the President of the R.C.S. (Sir Arthur Chance) seconded by Mr. John Lentaigne, and carried unanimously—"That a committee consisting of the Presidents and past Presidents of both Royal Colleges be constituted for the purpose of carrying out the foregoing resolutions."

The Royal Medical Benevolent Fund of Ireland.

THE annual meeting of the supporters of this fund was held on Tuesday last in the Royal College of Surgeons. Mr. Henry Swanzy, vice-president of the College, occupied the chair.—Sir John W. Moore read the report of the Central Committee, from which it appeared that nine applications for grants from the relief fund were considered in anticipation of the regular annual distribution, three of these were from new applicants; one was postponed to the annual distribution, and one was refused being ineligible. The other seven cases were all pressing and grants amounting to £95 were made. The total amount of the grants recommended since last distribution is £1,085. The total number of applicants considered during the year was 81. Of these 72 were from the widows of medical men, 5 from, or on behalf of their orphans, and 4 from medical men themselves. Five cases were found on investigation to be ineligible. Only two hospitals have this year forwarded a list of subscriptions from the students attending them, viz, the Royal City of Dublin Hospital and the Meath Hospital. Deputy Surgeon-General Joynt read the treasurer's report, which stated that during the financial year 1905-

1906 '85 grants were awarded by the Central Committee amounting to £8,522 10s. The amount paid through the Central Treasurer was £196 6s. as compared with £216 9s. 6d. the preceding year. Subscriptions received from the branch treasurers amounted to £323 4s. 8d., as compared with £380 14s. 7d. in the preceding year. Since the accounts were closed on April 30th, £50 19s. from Central Branch, and £62 os. 6d. from County Branches have been received.—Sir Thornley Stoker moved the adoption of the report and Sir Lambert Ormsby seconded.—Dr. Kidd (Enniskillen) moved and Dr. W. Taylor seconded the adoption of a resolution thanking the Committee and officers of the parent Society, as well as those of the provincial branches, for their hearty zeal in the Society's beneficent work, and their student brethren, who had contributed tangible proof of their generous sympathy in the cause. Mr. M'Arde (President Irish Medical Association) moved the appointment of the Central Committee and officers, and the hon. secretaries and treasurers of branches for the ensuing year. From what he knew of the Association he felt justified in commending it to the profession.—Dr. Denham seconded the resolution, which was adopted. This concluded the business of the meeting.

West London Medico-Chirurgical Society.

A LARGE gathering of the members of this Society, together with a considerable number of their friends, assembled at the Kensington Town Hall under the presidency of L. A. Bidwell, Esq., F.R.C.S., to listen to the Cavendish Lecture delivered by Sir William Macewen, F.R.S., F.R.C.S., LL.D., on "Some Points on the Surgery of the Lung." Though lasting longer than the specified time, the lecture held the attention of the audience to the very end. Amongst other points, it touched upon the hilum pulmonis being a dangerous place for the surgeon in operations on the lung; on the importance of placing the patient on the affected side in opening the pleura; on the differentiation of pneumothorax and emphysema; on shock being specially caused in operations on the lung by the effect produced on the heart; on the fact that surgery may bring about not only alleviation, but also actual cure in tuberculous destruction of the lung. In support of this last a very interesting case was given.

The President having returned thanks to Sir William Macewen, a move was made to the large hall to inspect the various medical and surgical exhibits which occupied its entire area, some even overflowing on to the stage and into the ante-room, there being no less than forty-five exhibitors. The pleasant smoking conversation was further enlivened by the music of the London Concert Orchestra.

St. Thomas's Hospital.—House Appointments.

THE following gentlemen have been selected as House Officers:—*Casualty Officers*.—(Senior) F. R. E. Wright, M.B.Lond., M.R.C.S., L.R.C.P., D.P.H.; (Junior) L. E. C. Norbury, M.B., B.S., M.R.C.S., L.R.C.P. *Resident House Physicians*.—F. M. Bulley, M.R.C.S., L.R.C.P., M.A.Cantab. (extension); R. C. Jewesbury, M.A., M.B., B.Ch.Oxon., M.R.C.S., L.R.C.P. (extension); M. A. Cassidy, M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P.; H. S. Sington, M.R.C.S., L.R.C.P. *House Physicians to Out-Patients*.—H. C. Squires, M.A., M.B., B.Ch.Oxon., M.R.C.S., L.R.C.P.; A. N. Dickson, M.R.C.S., L.R.C.P.; N. R. Cunningham, M.R.C.S., L.R.C.P.; W. O. Sankey, M.R.C.S., L.R.C.P. *Resident House Surgeons*.—H. T. Gray, B.A., B.C., Cantab., M.R.C.S., L.R.C.P. (extension); A. W. Hooker, M.B., B.S.Lond., M.R.C.S., L.R.C.P. (extension); J. H. Drew, M.B., B.S.Lond., M.R.C.S., L.R.C.P. (extension); H. Falk, B.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P. (extension). *House Surgeons to Out-Patients*.—R. J. H. Cox, M.R.C.S., L.R.C.P. (extension); F. S. Hewett, B.A.Cantab., M.R.C.S., L.R.C.P. (extension); A. B. Howitt, B.A.Cantab., M.R.C.S., L.R.C.P. (extension); W. G. Howarth,

M.A., M.B., B.C.Cantab., M.R.C.S., L.R.C.P. (extension). *Obstetric House Physicians*.—(Senior) S. R. Gibbs, M.R.C.S., L.R.C.P.; (Junior) E. L. Atkinson, M.R.C.S., L.R.C.P. *Ophthalmic House Surgeons*.—(Senior) C. R. B. Eyre, M.R.C.S., L.R.C.P.; (Junior) H. E. Gotelee, M.R.C.S., L.R.C.P. *Throat*.—S. G. MacDonald, B.A.Cantab., M.R.C.S., L.R.C.P. (extension); H. B. Whitehouse, M.R.C.S., L.R.C.P. (extension). *Skin*.—J. Wallace, B.A.Oxon., M.R.C.S., L.R.C.P.; G. L. Webb, B.A., B.C.Cantab., M.R.C.S., L.R.C.P. *Ear*.—A. L. Loughborough, M.R.C.S., L.R.C.P. (extension); G. D. Alexander, B.A.Cantab., M.R.C.S., L.R.C.P. *Children's Surgical*.—C. M. Page, M.R.C.S., L.R.C.P. (extension); S. G. MacDonald, B.A.Cantab., M.R.C.S., L.R.C.P. (extension).

St. Bartholomew's Hospital and College.

DR. W. H. HURTLLEY, D.Sc.Lond., has been appointed to the lectureship on chemistry, and will begin in September next. The department of physics has recently been transferred to larger rooms, and the new laboratory has been thoroughly equipped at a cost of £450. The examination for the Shuter Scholarship, value £50, in anatomy and physiology will be held on July 2 and 3. It is open to graduates in arts of the University of Cambridge.

PASS LIST.

London University.

THE following candidates have passed the M.B., B.S. Examination:—

Honours.—George Cockcroft (*a, d, University Medal*), Guy's Hosp.; Archibald Thos. William Forrester (*c*), St. Bart's Hosp.; Paul Leon Giuseppe (*c, e*), St. Bart's Hosp.; Montague Leonard Hine (*a*), Middlesex Hosp.; Thomas Bramley Layton (*d*), Guy's Hosp.; George Percival Mills (*d*), Univ. of Birmingham; Charles Max Page (*b, d, e*), St. Thomas's Hosp.; John Heatly Spencer (*e*), Charing Cross Hosp.; Violet Ackroyd Turkhud (*b*), Lond. (R.F.H.) Sch. of Med. for Women; H. Francois Vandermin (*a*), Guy's Hosp.; Rawdon Augustus Veale (*a*), Univ. of Leeds; John Alexander Watt (*b, c*), Univ. College; and Arthur Stanley Woodwork (*a, d*), St. Bart's Hosp. (*a*) Distinguished in Medicine; (*b*) Distinguished in Pathology. (*c*) Distinguished in Forensic Medicine and Hygiene. (*d*) Distinguished in Surgery. (*e*) Distinguished in Midwifery and Diseases of Women.

M.B., B.S. (Pass) Examination.—Arnold Alcock, Frank Alcock, Harry R. Allingham, Arthur Beeley, Fitchard J. Bentley, James F. Blackett, Margaret L. A. Boileau, Alexander C. Bryson, Wilfrid E. Burrows, B.Sc., Thomas C. Clare, Geo. P. C. Claridge, Colin Clarke, Leonard Colebrook, Josephine Coupland, Reginald J. H. Cox, Edwin T. H. Davies, George De la Cour, K. R. Drinkwater, B.Sc., James E. Dunbar, Edward V. Dunkley, Hugh R. Evans, Cavendish Fletcher, Peter G. Foulkes, Thomas M. Hardy, Wm. C. F. Harland, Pantland Hick, Frederick W. Higgs, Bernard Higham, Edith B. Hollway, Richard Holtby, Walter L. Holyoak, Annie W. Hyatt, Percy C. P. Ingram, George F. Jones, Andrew M. Jukes, Cecil L. Lakin, George B. McKean, James E. Martin, Robert V. G. Monckton, Helen I. Moss, Alfred H. Parkinson, B.Sc., Theodore C. Pocock, Percy J. Probyn, Hamilton E. Quick, B.Sc., Max. B. Reichwald, Philip M. Roberts, Lillian T. Rowland, Sophia Seekings, Nora F. Smith, Charles A. Stidston, B. Tchaykovsky, B.Sc., Thomas Turner, Howard F. Warner, John B. V. Watts, Arthur G. Wells, Harold B. Whitehouse, and Lillian E. Wilson.

B.S. Examination (for students who graduated in medicine in or before May, 1904) Honours.—John G. French, St. Mary's Hosp.; Reginald A. Greeves, Guy's Hosp.; Harold E. Ridewood, M.D. (University Medal), London Hosp.

B.S. (Pass) Examination.—John James, King's Coll.; Chas. E. W. Lyth, Univ. of Sheffield; James A. Milne, London Hosp.; Charles M. Roberts, St. Thomas' Hosp.; and Gerald W. Russell, Guy's Hosp.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS. ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR,
THE RECENT LITERATURE OF PHYSIOLOGY AND PATHOLOGY.

Lymphocytosis in Whooping-Cough.—Churchill (*Journ. of the Amer. Med. Assoc.*, May 19th, 1906) describes the condition of the blood in whooping-cough, basing his results on 86 cases of his own, and 64 reported by others. He finds that a general leucocytosis is present in all cases of whooping-cough, and that a lymphocytosis is present in about 85 per cent. of the cases. This fact he believes to be of considerable diagnostic value, since in none of the diseases likely to be confused with whooping-cough—bronchitis, pharyngitis, laryngitis—is there a lymphocytosis. It is well to emphasise the author's caution to pay heed to the age of the patient in making the examination, since in young children the proportion of lymphocytes to other leucocytes is much higher than it becomes later in life. Thus, in an infant of one year the lymphocytes constitute about 50 per cent. of the total white corpuscles, but from that time forward their relative number gradually diminishes. R.

Agglutination by the Serum in Tuberculous Pleurisy.—Courmont (*Journ. of the Amer. Med. Assoc.*, May 19th, 1906) describes the relation existing between the agglutinative power of the serous effusion in tuberculous pleurisy, and the course of the illness. By a study of 115 cases of the disease he has found that of 67 cases where the effused fluid had a positive agglutinating action, 50 recovered, while of 48 cases where there was no agglutinating action, 35 died or suffered from serious exacerbations. It would follow from these figures that there is a mortality of about 25 per cent. in cases with a positive action, and a mortality about three times as great in cases with a negative action. Moreover, Courmont found reason to believe that the degree of the agglutinating action had a direct bearing on the gravity of the attack. Of 34 cases where there was a feeble sero-reaction, 65 per cent. terminated in recovery, and 35 per cent. fatally. These observations have an important bearing on prognosis. Where the agglutinating action is high, the prognosis is good; where low or absent, it is bad. Moreover, during the course of the illness the action changes. In cases progressing favourably, the power of agglutination continuously improves, while in those where death is imminent the power gradually diminishes, if, indeed, it has been present at any time. R.

The Organism of Syphilis.—Maclennan (*Brit. Med. Journ.*, May 12th, 1906) expands his communication published in that journal of February 3rd, of the present year, and noticed in our Summary of February 21st. In that he suggested a developmental relation between the *spirochæta pallida* and the *cytorrhycles luis* of Siegel, and in the present paper he gives further details in support of this view. In the first place he notices, what many observers have found, that *spirochæta pallida* is invariably found, even in undoubtedly syphilitic lesions, and that apes have been infected with material from which *spirochæta pallida* was apparently absent. Moreover, there are many organisms or bodies observed present with greater frequency than *spirochæta pallida*. In a film populated by every conceivable organism it is hardly logical to take one of the scarcest, though most striking organisms present, and declare it specific. Maclennan, therefore, sets himself to describe in detail the various forms observed by him in smears from syphilitic lesions, and he gives diagrams which seem to show that some at least are stages in the development of the *spirochæta pallida*. The most prevalent form is not unlike the *cytorrhycles luis*, though more closely resembling the Leishman-Donovan body. Such forms seem to have the power

of developing tails, or, at any rate, tailed bodies, very similar to them are found. On the other hand, many *spirochæta* were seen, attached either at the end or at the middle, to spherical or ring-like bodies. Between these two classes, Maclennan thinks he has seen intermediate forms. The main conclusion of the paper is that *spirochæta pallida* is only one stage in the history of a protozoon, of which *cytorrhycles luis* is probably another. Whether this be so or not, Maclennan has certainly added to our knowledge of the life-history of *spirochæta pallida*. R.

Protozoa in Syphilis.—De Korte (*Practitioner*, June, 1906) describes certain bodies he has observed present in syphilitic chancres, and condylomata, and in the blood during the secondary stage of syphilis. He thinks it a strong point against the *spirochæta pallida* that it is not commonly present in the blood during the infective period of syphilis. In searching for it, however, he has constantly met with the bodies he describes. The most common of these is a small, very dark, circular body, measuring from 2m. upwards, and closely resembling an air bubble. As figured, the body is indistinguishable from a deeply-stained lymphocyte. At a later stage, this body is described as extruding two polar bodies, and, later still, it becomes cystic, consisting of a hyaline ectocyst with a very dark endocyst. The effect of mercury on the blood is to cause rupture of the cyst, and, finally, complete disappearance of all the bodies. It will be noticed that the body observed most commonly by De Korté has some resemblance to one of the bodies described by Maclennan, though De Korté does not suggest any relation with the *spirochæta*. R.

The Influenza Bacillus.—Jorhmann (*Deutsch. Archiv. f. Klin. Med.*, Bd. 84, Heft. 5 and 6) found influenza bacilli relatively frequently in the broncho-pneumonic patches of measles and diphtheria cases, and less often in scarlatina without any difference existing in the clinical phenomena. He also found bacilli with characteristics similar to those of Pfeiffer's organism in the sputum of these cases, and also along with other bacteria in twelve cases of pulmonary phthisis. On the other hand, he only found them in twelve out of thirty-six cases which were diagnosed clinically as influenza. Jorhmann accordingly denies the etiological importance of so-called influenza bacilli in cases of true influenza, and thinks that other organisms must play a part in influenza epidemics. He considers, moreover, that the bacilli cannot be regarded as the causative agent in the catarrhal processes of children, but believes that they should rather be looked upon as parasitic bacilli. M.

Dysentery in England.—Saundby (*Brit. Med. Journ.*, June 9, 1906) publishes two cases of dysentery occurring in England. He very justly criticises the illogical distinction made by Hale White and others following him, between dysentery and what they term "ulcerative colitis." As Saundby points out, the disease known as "ulcerative colitis" has the morbid anatomy, symptoms, and treatment, of dysentery, but yet has been classed as distinct. In recent years bacteriological investigation has bridged across the supposed gap, and it is only in England that any attempt at a distinction still persists. In the later of Saundby's two cases, Hewetson succeeded in detecting and isolating the bacillus of Shiga, thereby establishing the identity of the disease with one of the most common forms of tropical dysentery. Saundby is perhaps right in stating that this is the first discovery of the Shiga bacillus in the dysentery of this country, but McWeeney

of Dublin isolated last year a very similar, if not identical, organism from a case of asylum dysentery (MEDICAL PRESS AND CIRCULAR, April 26, 1905).

R.

Pathology of Yellow Fever.—Marchaux and Simond (*Annales de l'Institut Pasteur*, March 25th, 1906) publish their fourth and last memoir detailing the results of their researches into yellow fever. The present contribution gives an account of the pathological anatomy of the disease, together with a general summary.

As regards the anatomy, the authors find no gross lesion other than the well-known points of the colour of the body, the colour and consistency of the liver, and the punctiform hæmorrhages of the brain and digestive tract. In regard to minute changes, they entirely bear out the statement of Sodre and Couto that the disease is a generalised steatosis. While all the organs undergo more or less fatty degeneration, this change is most marked in glandular epithelium. The glands of the skin, and of the intestine, however, as well as the intestinal epithelium, always escape. The changes in the liver are progressive, with, in protracted cases, distinct signs of regeneration. The anatomical conditions are illustrated by beautiful plates.

In summing up their general results, the authors state that there is no other means of infection than by the bite of the *Stegomyia fasciata*. The bites of all other mosquitoes, and the handling of blood, excreta, fomites, and the organs of dead subjects, are innocuous. Moreover, the *stegomyia* only bites at night, and it cannot become infected from any other source than the actual body of a patient suffering from yellow fever in the first three days of the disease. For an infected *stegomyia* to become infective, a period of twelve days must elapse. In certain conditions the female insect may transmit infection to her offspring, but never beyond the first generation.

As to the virus itself, the authors find that it can be experimentally conveyed by inoculation of the blood of a patient in the first four days of the disease. To have effect, however, the inoculation must be by injection of the blood or serum into the tissues; mere rubbing of the serum into a raw surface has no effect. The microbe is very small, as it traverses, in a diluted serum, the Chamberland B. filter. It is easily destroyed, warming for five minutes at 55° rendering infected serum innocuous. Blood exposed to the air at ordinary temperatures, loses its virulence in forty-eight hours.

The ordinary period of incubation is from four to six days, though in some cases it may be as long as thirteen days. The serum of a convalescent contains protective bodies to such an extent that it has curative properties. One attack confers immunity, usually permanent, but occasionally only temporary, second attacks, however, being benign. No race has any natural immunity to the disease. Although all ages are susceptible, the child rarely suffers severely.

It follows from these highly important observations, that on the side of prophylaxis it is necessary carefully to isolate all cases of yellow fever, not from men, but from mosquitoes. The larvæ of the *stegomyia* must be destroyed wherever practicable, and all inhabitants of infected regions should protect themselves from mosquito-bites, especially at night.

R.

Eosinophilia.—Staubli (*Deutsch. Archiv f. Klin. Med.*, Bd. 85, Heft 1 and 2), after meeting with several cases which presented an increase of eosinophiles up to from 24 to 30 per cent. of all leucocytes present, determined to study the condition experimentally. For this purpose, he fed guinea-pigs with flesh infected by *trichinæ*, and found that eosinophile cells began to increase in number about eight days later, about the time when the parasites began to pass into the general tissues from the intestinal wall. The number gradually rose to from 1500 to 5,000 per cm., and again fell, except in very severe infections. Incidentally, Staubli confirmed the view of Teslar and others that *trichinæ* embryos are developed within the intestinal wall and

are carried into the blood *via* the thoracic duct. He found no alteration in number of eosinophile cells in the bone marrow, nor in the intestinal walls or even within the muscles in the neighbourhood of the encapsulated parasites. The peculiar relation which eosinophile cells present to bacterial affections was also demonstrated. In the peritoneal fluid and in the mesenteric tissue of guinea-pigs, large numbers of these cells are found. Intraperitoneal injections of living or dead bacteria cause them to rapidly disappear, apparently owing to a negative chemotaxis. On the other hand, intravenous injections of bacteria have little effect.

M.

Aspergillus Niger in Pulmonary Affections.—Risel points out (*Deutsch. Archiv. f. Klin. Med.*, Bd. 85, Heft 3 and 4) that while *Aspergillus fumigatus* has long been known to have pathogenic properties, nothing certain has as yet been proved with reference to *Aspergillus Niger*. He then records a case in which the pathogenicity of this mould seems undoubted. It was a case of a tuberculous diabetic patient in the apex of whose lung a large vomica was found, the inner wall of which was covered over with a continuous layer of the *Aspergillus Niger*. The mould had also grown for some distance into the surrounding tissue. Cultures gave typical *Aspergillus Niger*, and experiment showed that injections into the lungs of rabbits produced a pseudo-tuberculous condition.

M.

Activation of Pancreatic Juice by Calcium Salts.—Delezenne refers to the fact (*Compt. Rend. de l'Acad. des Sciences*, T. 141, No. 20) that pancreas when thrown as fresh as possible into sodium fluoride solution and macerated, yields a fluid which is quite inactive, but which can be activated by the addition of intestinal juice. Also intestinal juice prepared in a similar way is inactive, while that from the intestinal glands is active. This observation led Delezenne to the conjecture that it might be calcium salts, which rendered possible the activity of pancreatic and intestinal juices, and this supposition was substantiated by finding that the addition of lime salts readily activated previously inactive pancreatic and intestinal juices. When the juices contained much sodium carbonate or phosphate, much lime had to be added to bring about the desired result. The discovery throws much light on the relation of lime salts to ferment action, and in particular on the action of entero-kinase.

M.

Fœtal Pneumonia.—Bochenski and Gröbel describe a case *Casopsis lekaru ceskych*, 1905, p. 1159) of a woman who got an attack of lobar pneumonia during the last month of pregnancy. Three days after the onset the child was born in a cyanosed condition, and over its lungs small liquid rales were audible, and a dull note was obtained on percussion. The child died eleven hours after birth, and the autopsy showed acute catarrhal bronchitis with confluent hæmorrhagic lobar pneumonia of both lungs. The cause of the inflammation was proved by histological examination and by culture methods to be the pneumococcus of Frankel. Portions of the lungs were in a condition of grey hepatisation, proving that the disease must have originated before birth. The authors isolated the pneumococcus from the mother's blood, and state their belief that it had passed thence *via* the placenta into the fœtal circulation. The reason why the other organs of the child escaped is difficult to assign, unless the lungs be regarded as a *locus resistentiæ minoris* to the attacks of the pneumococcus. No examination of the placenta was made.

M.

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

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

MODIFIED DRIED MILK FOR INFANT FEEDING.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

DEAR SIR,—I am sorry that I was out of town when the proof of the short article by Dr. Harper and me arrived, so that I could not get it returned in time.

In the last paragraph but one there are a couple of printers' errors which alter materially the meaning of that paragraph. The reading should be: "and in all cases where condensed milks are used. It is advisable to administer, &c." The omission of period and capital you will see completely alters the sense.

Might I trouble you to kindly correct in your next issue.

Very faithfully yours,

D. SOMMERVILLE, M.D.,
Lecturer on Public Health in
King's College, London.

London, June 8th.

A WARNING.

We reprint the following experience of a doctor in Johannesburg from the *Liverpool Daily Courier* in the hope that it may be useful to those who meditate emigrating to South Africa:—

To the Editor of the LIVERPOOL COURIER.

SIR,—I have been here three months, and as things are in a very bad way I am sorry I have left Kimberley. I have come out at a bad time, as the place is almost bankrupt, and the best people are leaving for home almost every day, because of the interference of the home Government with the Chinese. Owing to the uncertainty several of the mines are every week discharging hands, who swell the ranks of the unemployed, a number of whom are walking the streets half starved. There is a bitter feeling against the home Government, and it would take very little more to start a riot or revolution. It is dangerous to be out after dark. Band-bagging and robbery are of daily occurrence, so the sooner you turn out the present Government the better it will be for everybody.—Yours, &c.,
Johannesburg, May, 1906.

A CANARD.

We learn on most trustworthy authority that there is no truth whatever in the report (which has lately been going the round of medical circles) "That the Egyptian Government has summoned one of our leading surgeon-oculists to proceed to Egypt without delay and remove the cataracts from the Nile (so long an eyesore)."—A. D.

SHIP SURGEON.—For the most part gynecologists condemn all attempts at destruction of the foetal life in extra-uterine foetation. Many such methods, as by electrical current, tapping, and injection of various fluids have been devised, but they are uncertain and dangerous. The only scientific plan is the exploratory incision, with removal of foetus if present. Under such circumstances at sea, you would be justified in conducting the operation single handed in the absence of skilled assistance.

THE PROFIT ON PILLS.

The Australian Customs authorities have recently sued an importer of medicines liable to duty. The action arose over an importation of a quack medicine called "Dr. Morse's Indian Root Pills." The importer of these pills gave the value of the consignment as £154 and paid £23 2s. as duty. The selling value, on which the Customs established their right to levy duty, was £2,160 8s. Thus pills at £154 and duty at £23 2s. equals £177 2s., the selling price of which amounts to £2,160 8s.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JUNE 13th.

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

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. L. Cheate; Clinique. (Surgical). 5.15 p.m. Lecture:—Mr. J. Poland: The Use of Mechanical Appliances in Surgical Treatment.

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

THURSDAY, JUNE 14th.

BRITISH GYNECOLOGICAL SOCIETY (20 Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. Macnaughton-Jones. Paper:—Dr. R. Lyle: A Series of 50 Consecutive Abdominal Sections.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m. Lecture:—Mr. M. Fletcher: Certain Points in the Diagnosis and Treatment of Meningitis.

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

FRIDAY, JUNE 15th.

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

POST-GRADUATE COLLEGE (West London Hospital, Hammer-smith Road, W.).—10 a.m. Medical and Surgical Wards. Practical Anaesthetics. 11 a.m. Minor Operations. 2 p.m. Medical and Surgical Clinics. 2.30 p.m. Operations. 3 p.m. Mr. Bidwell: Intestinal Surgery. 6 p.m. Mr. Paget: Surgical Cases.

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

SATURDAY, JUNE 16th.

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

Vacancies.

Brecknock County and Borough Infirmary.—Resident House Surgeon. Salary £100 per annum, with furnished apartments, board, and attendance, fire, and gas. Applications to W. Powell Price, Secretary, 6, The Bulwark, Breton, South Wales.

Bolton Infirmary and Dispensary.—Junior House Surgeon. Salary £100 per annum, with furnished apartments, board and attendance. Applications to the Hon. Secretary, W. W. Cannon, Esq. 20 Mawdsley Street, Bolton.

West Derby Union.—Assistant Resident Medical Officer. Salary £125 per annum, with board. Applications to Harris P. Cleaver, Union Clerk, Union Offices, Brougham Terrace, Liverpool.

The Liverpool Hospital for Consumption and Diseases of the Chest.—Pathologist and Assistant to the Honorary Medical Staff. Salary £150 per annum. Applications to the Secretary, 77A, Lord Street, Liverpool.

North-Eastern Hospital for Children, Hackney Road, Bethnal Green, E.—Resident Medical Officer. Salary £100 per annum, with board, residence, and washing. Applications to the Secretary.

Barnsley Hall Asylum, Broomgrove, Worcestershire.—Medical Superintendent. Salary £300 per annum, with unfurnished house, fuel, electric light, washing, and garden produce. Applications to Robert J. Oliver, Clerk of the Visiting Committee, Shirehall, Worcester.

Hants County Asylum.—Third Assistant Medical Officer. Salary £150 per annum, with furnished apartments, board, washing and attendance. Applications to the Visiting Committee, Hants County Asylum, Fareham.

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

Sheffield Union Hospital.—Resident Medical Officer. Salary £100 per annum, with apartments, rations, &c. Applications to Albert Edwd. Booker, Clerk to the Guardians, Union Offices, Westbar, Sheffield.

Appointments.

LANDER, CHARLES LLEWELLYN, M.B., B.S., B.Sc.Lond., Assistant Surgeon to the Royal Albert Hospital, Devonport.

MAX, W. PAGE, M.D.Lond., F.R.C.P.Lond., Lecturer on the Physiology of the Nervous System at University College, London.

MCDONALD, J., M.B., M.S.Glasg., Certifying Surgeon under the Factory and Workshop Act for the Barking District of the county of Essex.

MCENTRY, JAMES JOSEPH, L.R.C.P. and S.Edin., L.F.P.S.Glasg., Medical Officer of Health for the Shire of Kerang, Victoria, Australia.

NAYLOR, RUPERT GEORGE, L.R.C.P.Edin., F.R.C.S.Edin., Medical Officer of Health for the Shires of Bulla and Melton, Victoria, Australia.

PORTER, A. E., M.D., D.P.H.Camb., Medical Officer of Health of the Borough and Rural District of Reigate.

SOOTT, ERIC NORMAN, L.R.C.P. and S.Edin., L.F.P.S.Glasg., Medical Officer of Health for Arwata, Korumburra, and Jumbunna Ridings, Victoria, Australia.

Births.

PATERSON.—On June 3rd, at Boaz Island, Bermuda, the wife of Major Ian Paterson, B.A.M.C., of a daughter.

Marriages.

MOWAT—BOWDEN.—On June 8th, at St. Andrew's Church, Nottingham, Harold Mowat, M.B., Ch.B., youngest son of Magnus Mowat, J.P., of Granville Park, Blackheath, to Winifred, second daughter of Frank Bowden, of Elmwood, Nottingham.

RAND—BOWRING.—On June 7th, at St. Mary's Church, Long Ditton, Arthur Harold Rand, youngest son of John Rand, F.R.C.S., of Lovelace Road, Surbiton, to Winifred Florine, elder daughter of Edward J. Bowring, of Westcroft, Long Ditton.

RENTON—WILSON.—On June 7th, Ralph Stuart Renton, M.B., B.I., of Blackhill, co. Durham, to Melene Dare, daughter of Mrs. Wilson, Rose Cottage, Shotley Bridge.

Deaths.

BREWIS.—On June 5th, at "Curriemyre," Willington, co. Durham, Lenna, the dearly-beloved wife of Edward J. Brewis, M.D.

CANN.—On June 5th, at the house of his son-in-law, the Rev. E. E. Peters, Bedworth, Warwickshire, Thomas Martyn Cann, M.R.C.S. of Newhaven, Sussex, aged 66.

HAYWARD.—On June 8th, at Haydock, Lancashire, Thomas Ernest Hayward, M.B.Lond., F.R.C.S.Eng.

OWEN.—On June 7th, at 2, Brandling Park, Newcastle-on-Tyne, within a few hours of birth, Ethel Elizabeth Holland, daughter of Sir Isambard Owen, M.A., M.D., &c., &c.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, JUNE 20, 1906.

No. 25

NOTES AND COMMENTS.

**A
Curious
Slander.**

A CASE presenting an unusual form of attack upon a medical man was tried at Kingston-on-Thames last week. It arose out of the energetic action of the

Medical Defence Union in defending the honour of a medical man, Dr. Albert Max Sully, who considered that he had been, or was likely to be, injured by the defendants. In evidence it appeared that a woman, Alice Wray, aged twenty-one, had caused Dr. Sully considerable personal annoyance in 1902, and that Dr. Sully had demanded and received an apology from the woman and her mother withdrawing certain allegations, and that since receiving their letter he had declined to attend them professionally. Last February the younger woman gave birth to a child, and she registered his birth in the name of "Arthur Albert Max Sully." Shortly afterwards the child died, and the elder defendant registered the death in the same name. These actions seemed to Dr. Sully and the Medical Defence Union as an attempt to create the impression in the locality that Dr. Sully was father to the child, especially as the mother gave the name of "Sully, formerly Wray," to the registrar. On the charge of giving false evidence when registering the birth, the Registrar-General brought the two women before the magistrates, and in Court they confessed that the woman was not actually married, but was going to be to a Mr. Sully. No evidence was forthcoming as to the presence of this second Mr. Sully in Claygate, the neighbourhood in question, and Alice Wray confessed she did not know where he was now. Yet it was because this mysterious Mr. Sully was father to the child that she gave him the name complained of! She stated that she did not accuse Dr. Sully of being the father, and of course no suspicion of any kind was attached to that gentleman by the Court.

**Dr.
Sully
Vindicated**

THE Medical Defence Union scored the success which we have now learnt to look for more or less as a matter of course. The view taken by the magistrates was that

the offence was an error of judgment rather than a deliberate crime, and the women were let off with a moderate fine. Dr. Sully has the satisfaction of clearing his name, but we consider the women remarkably lucky in getting off so lightly on the defence put forward. A more impudent and atrocious form of attack upon a member of an

honourable profession it would be hard to imagine. It is a matter of much significance to the medical profession that the Registrar-General has come forward as prosecutor in this case. If he would extend his energy in a more active defence of the legal veracity of certificates of births and deaths, he would confer a vast boon on the community by way of checking the operations of a host of quacks and charlatans.

**The London
Hospital
and Opsonins**

ANY medical practitioner who allows himself to be interviewed by a newspaper reporter with a view to publication rightly incurs the condemnation of his fellows.

It is not easy to say why that general rule should not apply to a medical man simply because he happens to be within the walls of a hospital. In the *Daily News* of June 8th is the account of an interview with "a pathological expert at the London Hospital," who discussed in learned fashion the experiments with opsonins, dating back, as he ingenuously admitted, no longer than the year 1903. Upon the strength of this mature experience, the London Hospital poses before the world as the apostle of a new era in therapeutics, which is announced to an admiring public by the honorary secretary, a layman, through the medium of the Board of Governors. Why should not experiments of a highly technical kind be carefully investigated and results communicated to the medical profession through the usual channels of the medical journals and the medical societies?

**Fleet Street
Science.**

The communication of the "pathological expert" is calculated to rouse the curiosity of the man in the street to fever-

pitch. It seems hardly credible that Fleet Street should favour its readers with the following abstruse scientific information, which we quote without comment: "Besides tubercle, we can apply the opsonic principle to boils, carbuncles, streptococcus, bacillus coli, pneumo-coccus, Malta fever, and many diseases. What is new, however, is that we are now enabled to watch the progress of our experiments and treat our patients according to their condition. This we do by means of the opsonic index. The *modus operandi* is briefly this: We gather the micro-organisms of the disease, which, after culture, we kill by submitting them to a heat of about 62° C. Then, by sub-cutaneous

injection we inoculate and in that way stimulate the patient to produce his own protective bodies; in other words, to increase his powers of resistance against the disease."

LEADING ARTICLE.

INFANT MORTALITY AND PATENT MEDICINES.

ONE of the least understood of sociological problems is that of the national conscience. It may slumber for centuries amid surroundings of an ethically immoral nature, and then wake up when least expected to an overwhelming sense of the necessity of reform. Viewed broadly, its general trend is certainly in the direction of progressive humanity, more especially as regards the inner life and government of communities. Of late years its attention has been riveted upon questions of public health affecting the nation as a whole, such as sewage disposal and the purity of food and water. One of its most remarkable developments, however, has been the increasing study of child-life. It may be claimed, indeed that the complex conditions of heredity and environment concerned in the upbringing of the child in health and in disease have never before been approached in a purely scientific spirit. Statistics point with unerring finger to the fact that hitherto our infant population has been ruthlessly sacrificed by ignorance of various elementary laws. The recent National Conference on Infantile Mortality held in London may be taken as an indication of the modern attitude of awakened interest. The Right Hon. John Burns, M.P., President of the Local Government Board, put the matter in a nutshell when he stated that, roughly speaking, 100,000 infant lives were being sacrificed every year to neglect, carelessness, thoughtlessness and ignorance. In the first year of life there were as many deaths as in all the other years taken together up to the age of eighteen. The average expectation of life in one particular class, engineers, had during the past half-century been raised by the very noteworthy addition of ten or twelve years. At the same time, the average ages of the wives had been extended by a similar period. But, in spite of that remarkable saving of adult life the infantile mortality in that particular class had been practically stationary. A fact of that kind could not fail to make a deep impression upon the mind of so shrewd an observer of social problems as Mr. John Burns. It brings us to the kernel of the matter, inasmuch as it contains the inevitable conclusion that the excessive infantile mortality is preventable just as the adult death-rate was preventable and has been prevented. We may not be able to share with Mr. Burns' roseate view that the result of the Congress over which he presided should be to bring down in the next five or

ten years the infantile mortality by 30 per cent. or more. Within the period mentioned a great deal can unquestionably be accomplished, but many obstacles must be surmounted ere the dreams of the philanthropist are likely to be fulfilled in this particular field. At the very outset we are faced by an imperfect medical knowledge of many of the physiological and pathological problems of child-life, but the subject is happily emerging rapidly into regions of scientific light. Then, again, the question of infantile mortality is inextricably wrapt up in that of the conditions of labour. The extent to which poverty is concerned may be shown by the fact that in the Royal, borough of Kensington the infantile death-rate in the poorer districts is sometimes ten to twenty times higher than in the richer localities of the same suburb. Then, again, the absence of mothers when engaged in work at factories entails disastrous results upon the little ones left at home. Improper feeding accounts for a vast number of deaths. Let us add to Mr. Burns' list the vast army of children sacrificed every year by patent medicines. Any coroner of experience could give a list of soothing syrups, cough drops, teething powders and other proprietary medicines for children which sacrifice life wholesale. These murderous nostrums are sold under the ægis of a Government stamp, and depend for their sale upon newspaper advertisement. So that we have here the grim irony of a Government and a public press that demand the reduction of our excessive infantile mortality on the one hand, while on the other they are doing their best to swell that mortality by encouraging the deadly traffic of the patent medicine man. We commend this view of the situation to Mr. John Burns and to the earnest band of workers who have taken up the great national question of infantile mortality.

British Medical Association—Toronto Meeting.

WE are asked by the Honorary Local Secretary to make the following announcement:—It is hoped that most of the European visitors to Toronto will avail themselves of the opportunity of crossing the Continent to the Pacific Coast, where they will see for themselves the vast extent of the Canadian "Wheat Fields," the magnificence of the scenery in the Rockies and the wonderful possibilities for mining and other enterprises. To enable the local committee to arrange for this trans-continental trip, it is desirable that those contemplating it should send their names to the *Honorary Local Secretaries, Medical Building, Toronto*, at an early date. The cost for the round trip from Toronto is \$67.75. (£13 11s.).

Because of the difficulty of transporting several hundred by a special train, it has been thought desirable, both by the Local Committee and the Local Authorities, that the various members be sent off in groups of from eighteen to twenty-five. That would mean giving them a special sleeping car to themselves; consequently, if the names of certain groups that would prefer to travel together could be sent in, it would be a still greater convenience; or even if groups of ten or twelve could be sent in, the Local Committee will make an endeavour to couple certain groups of British, Canadian and American visitors in the hope of increasing the mutual interest and enjoyment of the trip.

NOTES ON CURRENT TOPICS.

A Side-light on Medical Education.

THE usual misuse is being made of the returns of the examinations for the Medical Department of the Royal Navy, the Royal Army Medical Corps, and the Indian Medical Service. Year after year the General Medical Council solemnly receives these returns and refers them to the Examination Committee, and year after year the medical and lay papers solemnly lecture the corporations and the public on the conclusions they choose to deduce from them. As a matter of fact, in so far as the returns are supposed to cast, as the phrase is, "a side-light on medical education," as given by the various corporations in the three countries, they are quite valueless. Any comparison of the different licensing bodies would depend on two assumptions, neither of which is justified. The first is that candidates from the provinces and from Scotland and Ireland compete at the service examinations on the same terms as London candidates. This they do not, as the examiners are almost altogether members of the London school and any variation from medical London opinion is bound to be regarded as a fault. The second assumption is that the candidates from each school are representative of the standard of that school. This is unlikely to be true, since some schools have "service tradition" and their best men look to one or other of the services for a career, while in others there is no such tradition, and but a few men, who may be good, bad or mediocre, present themselves for competition. When the returns are considered in detail, the numbers are seen to be much too small and uneven to admit of the percentage comparisons which some of our contemporaries diligently compile. Thus, to take one example, 100 per cent. of the candidates from the English Conjoint Board, Edinburgh University and Aberdeen University, are said to have "qualified." This result, however, is based on 39 candidates from the Conjoint Board, 20 from Edinburgh, and 2 from Aberdeen. We fail to see any just conclusion likely to be drawn from these returns, and we fail to see any reason for the sanction they receive from the General Medical Council.

The French Medical Excursions.

SUPPORTERS of the *entente cordiale* among the medical profession, in one way or another, are afforded plenty of opportunities of international intercourse. The interesting series of trips organised within the last year or two by French medical men to various watering places have proved a great success. In issuing their invitation this year it has been found necessary to limit the number of invitations, as it was found almost impossible to provide for a party of 150 visitors suddenly invading a small town or village. In future it is announced that the total number will not exceed 100, and that invitations will be allotted to various counties. Under the new

scheme Great Britain receives a proportion of twenty. In order to secure a place, therefore, it will be necessary to make immediate application. The movement is clearly one of great value to the development of French health resorts, and might be followed with advantage by our own countrymen.

"Are Doctors Greedy?"

UNDER the catchpenny title, "Are Doctors greedy?" a newspaper discussion has been recently carried on in the *Sheffield Daily Telegraph*. Needless to say, the views advanced on either side are not of high intellectual calibre. The original proposition was that of a Mr. J. E. Bradwell, who read a paper on the subject before the Sheffield United Friendly Societies Council. As may be imagined, his remarks were mainly directed to the relations of the medical profession with friendly societies. The grievance arose when medical men declined any longer to regard two shillings per member per annum as adequate payment for their services. The demand for a higher scale evoked from Mr. Bradwell the view "they had expressed their demands in words which would be somewhat in place in the mouth of a highway robber, holding a pistol to the head of a defenceless traveller, but scarcely what should be expected from a body of cultured, refined, and tender-hearted gentlemen." Medical men clearly give solid services in return for a paltry payment, so that the analogy of the highwayman is no happier than the comparison of the defenceless traveller with the friendly societies. The latter evidently think that all the business part of the transaction should appertain to the societies, and that tender-hearted professional gentlemen should not soil their hands by interfering with such transactions.

U. C. H. School and Nursing Home.

UNIVERSITY COLLEGE HOSPITAL may indeed consider itself lucky, for it has found what every charitable institution is always looking for—a fairy godfather, or, in its own case, two fairy godfathers who have come along and cut the financial knot. In the first place the late Sir John Blundell Maple re-built the hospital and brought it up to the requirements of modern hygiene; and secondly, Sir Donald Currie presented it with £100,000 to build a new Medical School and Nurses' Home. The hospital itself has been completed for sometime, and on June 11th the foundation stones of the new School and Home were laid by the donor himself. It is gratifying to know that the whole of the princely donation will not be swallowed up in building expenses, but that according to estimate some £20,000 will be left over after the erection is complete for the purpose of forming the nucleus of an endowment fund. But pleasant as it is to be able to dwell on individual generosity, it cannot be regarded as satisfactory that a community which relieves its sick poor by charitable institutions depends on receiving large sums from a few wealthy persons rather than on subscriptions sent by all people according to their means. In

this matter London is notoriously behind the provincial towns, and its needs are proportionately greater as being the centre of a great district and a vast Empire. Mr. Carnegie, we believe, refuses to give donations in large amounts to hospitals, because he considers that there should be a charge which all should contribute to and be willing to bear without appeals to the specially wealthy.

Food Inspectors' Hypocrisy.

THE public are notoriously prone to be guided by the *dernier cri* and by that alone, so that one need not be surprised that at present they are giving vent by all the usual channels of expression to disgust and horror over the American meat scandals. That newspapers should be filled with inflammatory articles and that questions galore should be asked in Parliament is only to be expected, and we hope that whatever action may be taken as the result of the agitation will ensure a cleanly and healthy supply of good meat coming to us from America; but it savours not a little of hypocrisy that in England, where food inspection is of the flimsiest nature, as a rule, and where few authorities concern themselves to have inspectors who know the pathological appearances of the commonest diseases of animals, the outcry should be so loud and vehement. With few public abattoirs in the country it is impossible, even for the most highly qualified inspectors, to keep any supervision over the meat prepared for the public; and with regulations often conspicuous by their absence the milk-trade is conducted in a scandalous fashion and causes—it may be asserted without fear of contradiction—thousands of cases of disease and death annually. If the British people would examine the beams in their own eyes before plucking so vigorously at those in their neighbours they would cut a more dignified figure, and one that would command more general respect.

The Ameer and Lady Doctors.

MR. RUDYARD KIPLING has familiarised us with the deeds of native rulers that win recognition from the Indian Government. Among these the improvement of sanitation would seem to play an important part. The particular prince, of whom Mr. Kipling sings, calculated that a new sewer should be worth at least a C.S.I., and stopped all his beneficent operations in disgust when he found he was only to receive a C.I.E. What honour, we wonder, is regarded as an equivalent for engaging English women doctors to attend on the ladies of a ruler's harem? It appears that the Ameer of Afghanistan, whose father long had an English doctor for himself, lately came to the conclusion that the ladies who live under his protection should also receive the benefits of Occidental science, and qualified women doctors were appointed to the Court. Unfortunately this step did not commend itself in practice to Nasrullah Khan, his brother, who has been managing the affairs of the kingdom in the Ameer's absence,

and now that the potentate has returned to take up the government in person a conflict of opinion is going on at Court. What the result of it may be, we dare not venture to prognosticate, but Nasrullah is said to be backed by an influential coterie of nobles, whilst the Ameer is "on the side of the angels." Knowing the usual character of Eastern despots, to whom the Ameer appears to be no exception, we can only wish the ladies a happy issue out of their troubles without any of the Oriental amenities that generally accompany a monarch's displeasure.

Hospital Sunday in London.

ON the 17th instant the great annual festival of Hospital Sunday was celebrated in London. In spite of the attraction of rival metropolitan institutions, it is confidently believed that the donations will exceed those of any previous year. The State service at St. Paul's was attended by the Lord Mayor, who was supported by His Majesty's judges, and a number of City officials, who listened with deep interest to an eloquent sermon by the Bishop of Stepney. No less than 162 institutions and 80 dispensaries receive assistance from the Fund, and we are glad to see that several smaller hospitals are this year included in the list of grants. The persistent neglect of small institutions has always seemed to us a serious defect in the administration of this most excellent fund. Mr. George Herring has once again announced his intention of adding threepence to every shilling collected.

Livingstone College.

SPEAKING at the Commemoration Day Proceedings at Livingstone College on May 31st, Mr. Cantlie emphasised the very great importance of training in elementary medicine, surgery and hygiene to missionaries going to uncivilised lands. Many of them, as he pointed out, left their homes to die for Christianity; but he considered it a nobler aim to live for Christianity, and the College had been established for the purpose of teaching men how to live. He compared the course of training to the St. John's Ambulance course, and showed that whilst in England accidents were of frequent occurrence there were comparatively few mishaps of this kind in lands where there were no mines, manufactories, or wheeled vehicles. In tropical countries, however, disease struck down its victims with terrible suddenness, and it was necessary that ordinary missionaries should know how to deal with the most common diseases. People said that a little knowledge was a dangerous thing, but, like the teaching of the St. John's Ambulance, the course at Livingstone College was complete of its kind, and it gave to missionaries exactly the teaching which they required in medical subjects, and he considered that no missionary should go abroad without some such training. He regretted that the chief missionary

societies had not taken the matter up in the way that they should do, and he considered that many of them were trading on the religious fervour of their representatives through sending them out without proper equipment in the way of medical knowledge, and in so doing he considered that they were juggling with human lives.

Which is the Mother?

"It is a wise child that knows its own father," runs the proverb, but never hitherto has popular philosophy doubted the relationship of the child to the woman who bore it. It has been left for American surgery to help to bring into the world an infant whose maternity is, to say the least of it, debateable. The case is reported in the *New York Medical Record* of May 5th of this year. A married woman, who after a miscarriage developed signs of cirrhotic ovaritis, had her ovaries removed by Professor R. T. Morris so effectually as to assure the operator that no vestige of ovarian tissue remained behind, nor was the least particle allowed to contaminate the peritoneum. After this had been done, portions of the healthy ovary of another woman just removed during an operation for uterine prolapse were grafted into the broad ligaments. This was in 1902. The patient bore a healthy infant in March 1906! Professor Morris appears to regard his handiwork merely in the light of an interesting experiment, but obvious fallacies apart, and assuming that the facts are as he believes, the vista opened up is uncommonly extensive. Suppose it should prove possible, as he hints, to cure sterility thus, or to restore fertility to a woman past her climacteric. The dynasty tottering to extinction for want of an heir would take heart again. Collateral heirs would contest, even to the House of Lords, the entailed rights of the Isaac sprung from a heteroplastic graft. The new operation might even become as fashionable as appendicectomy, and no longer need the worn-out aristocracies of Europe seek to escape annihilation by admixture with the healthy blood of the actress and American heiress. But the matter has a serious side. If the discomforts, even dangers, accompanying an artificial menopause can be obviated by ovarian grafting, the benefit of the procedure is undeniable; but if a possible pregnancy, in which the woman conceives a child of whom, biologically, she is not the mother, no right thinking man would incur the risk of such a contingency without explaining to man and wife the descent of future offspring. Professor Morris (though he wonders "which parent" the child of his patient will most resemble) writes that "the mother who has borne the child is the real mother, as she furnished the nutriment for the development of the child," and perhaps the common law of England would regard such an offspring as the "heir of her body." But it took the wisdom of Solomon to settle one case of disputed maternity—and Solomons are rare in these days.

University of Dublin—Proposed Honorary Degrees for Medical Men.

At a meeting of the Senate of the University held on June 14th it was decided to confer the Honorary Degree of Doctor of Medicine on Sir Richard Gowers, K.C.B., M.D., F.R.S.; and of Doctor of Science on Colonel David Bruce, M.B., C.B., F.R.S., R.A.M.C., and on Dr. Almroth Edward Wright, M.D., F.R.S. These degrees will be conferred on the third of next month.

PERSONAL.

PRINCESS CHRISTIAN presided last week at the annual meeting of the Council for the Promotion of the Higher Training of Midwives.

DR. R. MURRAY LESLIE, Physician and Pathologist to the Royal Hospital for Diseases of the Chest, has, on the recommendation of M. Cambon, the French Ambassador in London, received the Order of "Officier d'Académie Française."

THE RIGHT HON. R. B. HALDANE, K.C., M.P., his Majesty's Secretary of State for War, has kindly consented to distribute the prizes at the London Hospital Medical College on Friday, July 13th.

THE prizes to the students of St. Thomas's Hospital will be presented on June 27th, at 3 p.m., by Professor William Osler, F.R.S.

DR. J. S. HALDANE, F.R.S., has been appointed by the King one of the Commissioners to report on certain questions relating to the health and safety of miners and the administration of the Miners' Acts.

MR. BURNETT MAY has been appointed honorary consulting surgeon to the Queen's Hospital, Birmingham, an institution to which he has rendered valuable services for many years.

STANLEY B. ATKINSON, M.B., of the Inner Temple, has been placed on the Commission of the Peace for the County of London.

DR. PERCY AUSTIN RODEN has been made a Justice of the Peace for the borough of Droitwich.

DR. HUMPHRY has been re-appointed Lecturer in Medicine of the University of Cambridge for five years.

PROFESSOR SIMS WOODHEAD has been appointed to represent the University at the dedication of the new buildings of the Harvard Medical School on September 25th and 26th, 1906.

SIR DONALD CURRIE on June 11th laid the foundation stone of the School of Advanced Medical Studies Nurses' Home and Maternity Students' House at London University College Hospital.

In the "Honours Tripos" Cambridge University list, published on Monday last, we are glad to see the name of Howard Simson Tindall, son of Mr. A. A. Tindall who has for forty years been connected with THE MEDICAL PRESS AND CIRCULAR.

THE Raymond Horton Smith prize for 1906 for the best thesis for the degree of doctor of medicine presented during the academical year at Cambridge has been awarded to Harold Theodore Thompson, M.A., M.B., B.C., the subject being: "On certain changes in sensation associated with gross lesions of the spinal cord."

DR. JOHN PHILLIPS was last week elected a consulting physician to the British Lying-in Hospital, on his retirement from the post of physician to in-patients, after a service of some twenty-five years.

A CLINICAL LECTURE ON PELVIC TUBERCULOSIS.

By HENRY JELLETT, M.D., F.R.C.P.I.,

Gynæcologist and Obstetrical Physician to Dr. Stevens Hospital, Dublin.

GENTLEMEN,—In my lecture of to-day I propose to discuss the subject of pelvic tuberculosis, and to illustrate my remarks by the clinical records of three patients whom I shall show you, and who were recently under my care in this hospital. Perhaps I should commence by saying that for my present purpose I propose to limit the meaning of the term "pelvic tuberculosis," to tuberculosis of the tubes, the ovaries, and the pelvic peritoneum, excluding all reference to tuberculosis of the uterus or bladder, though this condition should, strictly speaking, also be included under the heading.

There is no doubt that the Fallopian tube is by far the most common site of primary genital tuberculosis, and that the most common seat of secondary extension from the tube is the ovary. I think perhaps that I may even go a little further than this and say that in women between twenty and forty years of age the uterine appendages are the most common site of intra-abdominal tuberculosis. At the same time, the distinction which I have drawn between primary and secondary infection must be clearly noticed; for it is a curious fact that while the tube is one of the most common sites of primary infection in the female, the ovary is one of the rarest. A few cases have been recorded in which primary infection of the latter was noticed without an accompanying infection of any other part of the body, but they have been very few and they are always open to the criticism that the true primary site of infection has been overlooked.

The manner in which tubercle bacilli reach the tube, in the first instance, has for long been the subject of discussion. In some cases, where the tubal infection is secondary to a general peritoneal infection, the route is obvious and is one of direct extension. In other cases, and they perhaps constitute a majority, in which there is no primary focus from which direct extension can occur, the mode of infection is more difficult to explain. Such cases may be divided into two groups:—one group formed by those cases in which there are tuberculous lesions elsewhere in the body, but not in direct contact with the tubes; and a second group formed by those in which no such primary focus of infection exists.

In the first group, bacilli are doubtless often carried through the blood or lymph stream according to the primary site of infection, and they reach the Fallopian tubes by these routes as they reach other parts of the body. The answer to the question, "Why should the tubes be so frequently selected for the deposit of infection?" will, I think, be difficult to find. The fact that they are so frequently selected goes to prove that the resistance they offer is lower than that offered by the other tissues of the body. This is, however, but a shifting of one of the question, for to the further question, "Why is the resistance of the tube lower?" we have at present no answer.

There are, however, in addition to the blood and lymph streams, two other routes which can be followed by bacilli which have already gained entrance to the system. These routes were specified by Hegar, who distinguished them as "ascending" and "descending." These terms do not require explanation further than to say that in following the ascending route the bacilli ascend through the vagina and uterus into the tubes, and in following the descending route they descend from the peritoneal cavity into the tubes. In other words, the ascending route is that followed by

the spermatozoa, the descending route that followed by the ovum. The descending route is readily understood, since we know that microscopical particles deposited in the peritoneal cavity tend to find their way into the tubes, being helped along by a serous current. In this way, bacilli which have passed through the intestinal walls into the peritoneal cavity, or which come from peritoneal infections, may be carried downwards until they come to lodge in one of the numerous recesses between the folds of tubal mucous membrane.

The ascending route is more interesting, and is perhaps of more importance, from the fact that both primary and secondary infection can be carried by this route and also that prophylaxis may be of value in preventing infection from travelling along it. Primary infection by this route may occur if tubercle bacilli are carried into the vagina or uterus by the fingers or instruments of the gynæcologist, or if they are deposited there in the semen of a man suffering from tuberculosis of the genital tract. It is also possible that bacilli may find their own way into the vagina from without and be carried upwards by the ascending mucous currents, which, according to Mr. Bond, exist in the vagina and other mucous canals. These bacilli may come from an entirely heterogenetic source or may have been first brought into the region of the vulva from other tuberculous lesions, more especially in the intestine or urinary tract. It is interesting to ask ourselves why, if infection of the tubes really occurs by the ascending route, there are so few cases of tubercle of the endometrium? I think that, if not a reason, at any rate an explanation may be found in the anatomical structure of the tubal mucous membrane, which affords so perfect a nidus for an infecting organism, while, on the other hand, not only does the smooth surface of the uterus not afford the same recesses in which organisms can lodge and grow, but even the shelter which it does afford is swept away each month.

So much, then, for what we know of the origin of tubal tuberculosis. There is a great deal of fairly probable surmise, and very little certainty.

What are the symptoms of pelvic tuberculosis? I think that perhaps I can best lay before you those that are usual by discussing the histories of the three patients whom you see. I may preface what I have to say with the statement of my own opinion that there are no special symptoms or groups of symptoms which can be regarded as pathognomonic of tuberculosis of the appendages, or which will enable us to make a diagnosis prior to operation between this condition and tubal and ovarian infection of any other kind. This is an important matter to remember when we are considering the advisability of operating in any case of adnexal infection, and I shall return to it later.

The first patient, E. W., is æt. 34. She has been married for seven years and has never been pregnant. She came to seek my advice in the first instance because she had suffered for a considerable time from a pain in the lower part of the abdomen and the back, which pain was commencing to affect her general health. She had menstruated regularly in the past, but the amount lost at each period was excessive. On examination under an anæsthetic, I found that the uterus was normal in position, but softer than is usual; that the left ovary was enlarged to three times its normal size; and that the right ovary was apparently normal in size but fixed. There was also evidence of the existence of adhesions, and of tubal thickening.

There was not, however, and to this I again direct your attention, any evidence to suggest that the case was tubercular in origin.

Three days later I opened the abdomen, and then found that the left ovary was enlarged to the size of a hen's egg; that the fimbriated extremity of the corresponding tube was adherent to the rectum, and that the tube itself was thickened and was as large as a finger; that the right ovary contained a number of small cysts; and that the right tube was in a similar condition to the left tube, save that a number of "sago grains" were scattered over it and over the adjacent intestine. I then removed the left ovary and both tubes, and also incised the right ovary and resected the cysts it contained. Finally, I made sure that the stumps of the tubes left behind were patent by passing a probe through them, and then closed the abdomen. The patient's convalescence was afebrile, and I removed the sutures on the eighth day. As you can see, her condition is now excellent and she will leave the hospital to-morrow, that is, seventeen days after the operation. The pathologist, Dr. Rowlette, has examined the removed appendages and reports the case to be one of tuberculosis. I have little doubt that this woman's after-history will be satisfactory, and that there will be no return of the trouble. Owing to the early operation one ovary has been spared, and, consequently, she will be free from the unpleasant consequences of a premature menopause. Had the operation been postponed, under the belief that the local conditions could be relieved by other means, when the time for operation eventually arrived the operation necessary would have been very different from that I have described, and would certainly have left the patient *minus* both sets of appendages and probably *minus* her uterus also.

The second case to which I wish to direct your attention is one in which genital tuberculosis is associated with tuberculosis of one ureter. Which condition is the primary one it is hard to say, but I fancy that the genital tuberculosis is. I think I am right in saying that ureteral tuberculosis is usually secondary to renal tuberculosis, and in this case careful and direct palpation of the kidney has failed to reveal any evidence of this condition, nor does microscopic examination of the urine elicit any such evidence. The patient, M. F., unmarried, æt. 24, came to me complaining of pain in the left side and difficulty in passing water for the last six weeks. She menstruated normally, but somewhat too heavily, and she suffered pain during and after the occurrence of the discharge. On bi-manual examination, a small and firm swelling fixed to the left side of the bladder and apparently lying on the tract of the left ureter could easily be felt, and on examining Douglas' pouch, it was found to be occupied by a somewhat similar swelling, apparently formed by the appendages. The uterus was retroverted. The urine, which was slightly cloudy, was examined on several occasions, and at times was found to contain slight traces of albumin and pus, and at times was free from both. At no time were any tube casts seen. I made a cystoscopic examination of the bladder with Nitze's cystoscope, and found that while the right ureteral orifice and the greater part of the bladder wall was healthy, the region of the left orifice was markedly diseased. At this spot the mucous membrane appeared to be covered with numerous granulations, and the ureteral orifice suggested rather the opening of a sinus into the bladder than a ureter. In consequence of these appearances I diagnosed the case as one of tubal and ovarian inflammation, and considered that the swelling adherent to the bladder was formed by a pus sac which probably opened into the bladder.

On opening the abdomen the condition of the pelvic organs was found to be very much as I have described, save that the swelling beside the bladder was quite separate from the appendages and obviously was formed round the ureter. The swelling in Douglas' pouch was formed almost entirely by the left appendages, those on the right side being comparatively healthy. A loop of

the pelvic colon was prolapsed into Douglas' pouch, and had become densely adherent to the back of the enlarged appendages at three spots. As a result of the adhesions, the intestinal wall was drawn out into nipple-like projections, and the tops of these projections were caseating as a result of the extension of the tubal infection. In consequence, when separating the adhesions, the top of each projection was in turn torn off, and three openings into the pelvic colon resulted. As, however, the loop could easily be drawn into the wound, the openings were successively closed without difficulty, and never gave any trouble. Ventro-fixation by Kelly's method was then performed and the abdomen closed, the right appendages being allowed to remain.

Dr. Rowlette examined the removed ovary and tube, and reported that they showed typical tuberculous changes. The patient made an excellent recovery in spite of the formation of a small abscess in the abdominal wound. From this about three ounces of pus escaped, and though the abscess cavity itself quickly healed, the skin wound took some weeks before complete union resulted. Since the operation, I have examined the bladder twice with the cystoscope, and the granulations round the left ureter have almost completely disappeared, with the result that the ureteral orifice is now plainly visible. The ureteral swelling has also slightly diminished in size.

The third case is very different from the foregoing cases. M. C., æt. 22, has been married for the past three years, and has had two children. The second of these was born three months ago. Since then, she has complained of severe pain in the right iliac fossa, and of profuse discharge from the vagina. She has also been steadily losing flesh. On examination, the uterus was found to be directed backwards and to the right, while behind the uterus and filling Douglas' pouch there was a swelling corresponding in size and position to that usually formed by inflamed and pus-containing appendages. As the patient had a hectic temperature, I decided to try to drain the tubes through the vagina, with a view to their future removal, and, accordingly, I made an opening from the posterior vaginal fornix into Douglas' pouch. There was considerable difficulty in getting into the pouch, and on finally doing so, I found that it was occupied, so far as its lower part was concerned, by a mass of friable tissue. This tissue could be separated easily enough from the bottom of the pouch, but as I could not remove it completely I took away a small piece for examination and plugged the hole I had made, intending to complete the operation on another day by the abdomen. On examination of the removed tissue, it was reported to be tuberculous.

A week later I opened the abdomen and found the intestines and appendages matted together with every evidence of advanced pelvic tuberculosis, which was also commencing to extend upwards into the abdomen. With considerable difficulty the uterus and adnexa were removed. In the course of the operation, a sac containing very foul pus was opened and the pelvis infected by it. In separating an adhesion the rectal wall, which was softened and apparently infiltrated by tubercle, was perforated, and a fistula resulted. As was only to be expected from the nature of the case, the abdominal wound became infected and localised abscesses also formed in the region of the appendix and in Douglas' pouch. These abscesses were drained both through the vagina and through the abdominal incision.

As after two months there was no appreciable improvement in the patient's condition, and as her temperature still remained high and she was fast losing ground, I decided to re-open the abdomen with the object of trying to reach another collection of pus which I believed to be present. On doing so, however, I found the abdominal peritoneum extensively covered with nodules of tubercle, and the intestines to be universally adherent. In endeavouring to separate some of these adhesions my finger passed through the wall of a portion of small intestine which was as soft as a

piece of wet blotting-paper, owing to tuberculous infiltration. As it was impossible to draw the torn loop up to the abdominal incision to suture it, I had to make another opening over it and I then sutured the tear. The condition of the intestinal wall was, however, such that I did so without any hope of success.

The patient, who possessed a most marvellous vitality, rallied after this operation, and for a time seemed to improve. The fistulæ closed to a considerable extent, and she was able to go to a convalescent home. You now see her on her return from there. Her condition is very poor. The abdomen is markedly retracted, and she is very thin. The recto-vaginal fistula is practically closed, but the small intestine discharges through both abdominal wounds. There is no prospect of being able to make any attempt to close them in view of the condition that exists inside the peritoneal cavity, and, indeed, the evidence points to the spread of the tuberculous infection and to a fatal termination of the case in the near future.

Here, then, you see a direct contrast to the first case. It is probable that the patient herself was far less resistant to the infection than was E.W., and that the infection occurring immediately after child-birth had more favourable opportunities for its extension. This woman, however, had been under treatment for some weeks before I saw her, under the idea that the tubal condition was due to an ordinary puerperal infection, and would abate if given time. I cannot help thinking that if she had been operated upon immediately, both the operation itself would have been more simple and its after-results more satisfactory.

I think, Gentlemen, that these three cases which I have shown you to-day are sufficient for the purpose in view, namely, to show you the different clinical aspects which genital tuberculosis may assume. In the first case, you have seen one of uncomplicated genital tuberculosis in which early operation has been performed with the best results. In the second case, you have seen one of a complicated genital tuberculosis in which early operation has been performed with good immediate results, but with more problematic results as regards the future. In the third case, you have seen one of complicated genital tuberculosis in which operation was delayed. The results, as you have seen, have been most unsatisfactory, and any material improvement in the condition of the patient is unlikely.

Perhaps I might with advantage have mentioned one other patient on whom I recently operated for pelvic peritonitis, and in whom I found evidences of a pre-existing and slight infection limited to the tube. In her case, the "opsonins" developed in the body apparently had proved capable of overcoming the tubercular infection, with the result that the only trace that was left of it, if I overlook for the moment indirect traces such as pelvic adhesions, were several small calcareous masses which blocked the lumen of the tube and caused sterility.

Before concluding, I must add a few words on the treatment of these cases. I am afraid that we must start with the acceptance of the fact that there is no means of diagnosing the existence of genital tuberculosis prior to operation, save perhaps in those cases where the infection has extended so far as to invade the general peritoneal cavity and cause symptoms of tuberculous peritonitis. From the sole point of view of whether we are to operate or not, I do not know that this failure of diagnosis is of any very great importance, since, even if the enlargement of the appendages is caused by some other form of infection, operation will probably be required. It is, however, a misfortune that we cannot always definitely and at once tell the nature of the infection while we are operating, because if the infection is tuberculous it is often advisable to perform a more radical operation than would otherwise be the case. Occasionally, too, the opposite may happen, and we may be led to carry an operation for tubal infection further than is actually necessary, because we have mistakenly made a clinical

diagnosis of tuberculous infection. It is true that, in many cases, the nature of the case is made clear while we are operating by the presence of sago-grains on the peritoneum, but in their absence I freely confess that I have repeatedly, during operation, believed that the case was one of tuberculous infection when subsequent examination proved that it was not, and *vice versa*.

As a general rule in operating on salpingo-oöphoritis, I would lay down as a guiding principle to remove all diseased tissue and to spare all that is healthy or that is capable of recovery. This may seem an obvious truism, but it by no means follows that it is always acted upon. There is, I think, a tendency to regard as diseased an ovary held down by adhesions, or congested in consequence of tubal disease or uterine displacement, and to remove it *en masse* with the tube. My point is that much of the odium that has been attached to operations on the appendages is the result of indiscriminately removing the latter without pausing to separate the diseased from the healthy, or the organs which are necessary to the future well-being of the woman from those with which she can dispense without discomfort. The same remarks apply to the uterus. If it is diseased, remove it without hesitation, but do not remove it merely because someone has expressed the opinion that the removal of inflamed appendages is useless unless the uterus is also removed. I am quite prepared to grant that such operations are useless if the uterus is allowed to fall back after them into Douglas' pouch and to become adherent there. It is, however, a much easier matter to perform ventral fixation or suspension than to remove the uterus, and if to the relieved uterus is added the ovary or even portion of an ovary which has been spared, and perhaps the patent stumps of the Fallopian tubes, a woman is left with her genital functions perfect instead of being *minus* organs whose presence is necessary to her comfort.

These are the principles which I would recommend you to adopt in dealing with non-tuberculous salpingo-oöphoritis, and if you adopt them in such cases you will find that you will also adopt them in most tuberculous cases because you will be unable to make an exact diagnosis during operation. If you can make such a diagnosis, then the same principles will still govern you, save that the term "diseased tissue" may be extended to include any tissue in which there is evidence of tuberculous infection.

If there are small caseating patches in or on the ovaries, the latter must be removed and so also must the uterus if in a similar condition. If there is a collection of pus in the pelvis, it is also an indication for the removal of the uterus in order that free drainage into the vagina may be possible.

The questions should we drain in these cases, and, if so, by what route are interesting ones, but time forbids me from entering into them to-day. So far as my own practice is concerned, they may be answered in a few words. I never drain by any route unless there has been a considerable amount of pus in the pelvis, or unless there are necrotic and pyogenic areas which cannot be entirely removed. In such cases, I drain by the vagina either through an opening in Douglas' pouch or through the gap left by removing the uterus. I never drain through the abdominal wall.

Of course, if all that Professor Wright claims for opsonic treatment is true, there will be a tendency to abandon the operative treatment of tuberculous lesions in favour of serum treatment. I do not think, however, that such a tendency will establish a lasting principle, since even if the tuberculous infection is removed, how can it be expected that the serum will also remove all trace of the resultant lesions? If the serum does not do so, the gynaecologist will still be required to remove abscess formations and to bring about a radical cure of the uterine and ovarian malpositions which have been caused by the contraction and healing of the tuberculous areas.

NOTE.—A Clinical Lecture by a well-known teacher appears in each number of the journal. The Lecture is.

next week's issue will be by Arthur Whiting, M.D., M.R.C.P.Lond., Dean of the North-East London Post-Graduate College, Physician to the Tottenham Hospital, and to the Mount Vernon Hospital for Diseases of the Chest, on "The Clinical Examination of the Blood."

ORIGINAL PAPERS.

ON THE FULMINATING FORM OF APPEN- DICITIS

SIMULATING THE ONSET OF A SEVERE
ATTACK OF EPIDEMIC INFLUENZA OR
OF ACUTE PNEUMONIA, AND ITS suc-
CESSFUL TREATMENT BY IRON
ACETATE AND BELLADONNA.*

By HERBERT J. ROBSON, M.R.C.S., L.R.C.P.,
Leeds.

THE following symptoms typify the class of case referred to under the above heading: sudden abdominal pain which may or may not be referred to the right iliac fossa; rigor, a smart attack of fever, the temperature running up to about 103° F., or even 104.6° F., the pulse to 100, or considerably over 100, and the respirations to 20 or 22; severe headache and backache often contemporaneous with the abdominal pain. Nausea and vomiting may or may not be present, and tenderness upon pressure is usually if not always elicited over the appendix region. The patient looks ill and has often a pinched, peritoneal look. There is often albumin in the urine, and, as a rule, constipation exists.

But for the abdominal pain and tenderness and the pinched expression the case might be easily mistaken for a severe attack of epidemic influenza, or even for the onset of acute pneumonia; though, as proving that it is not the latter disease are the facts that the respiration-rate only registers twenty or thereabouts and there is an absence of cough, chest pains or chest signs.

Such are the cases that in my opinion, if not actively treated by iron acetate and belladonna and a carefully-considered dietary, rest, &c., will in all probability go on rapidly to suppuration and necessitate operation; and such are the cases that, if actively treated from the commencement by iron acetate and belladonna, a nourishing non-starvation diet, rest, &c., will, as a rule, clear up without operation. I am aware that this is rather a sweeping statement to make; but after having carefully watched and noted this class of case during the last twenty-five years, both in bed and on the operating-table, and particularly since about 1890, I feel justified in making it. I have seen such cases treated by the expectant and semi-starvation method, and I have seen them treated as though they were severe cases of epidemic influenza; but generally, I believe I may say always, with the same result, viz., suppuration.

On the other hand, if it is thought expedient to operate at any time after the commencement of the medical treatment, the patient will be in a better condition to bear operation if he has previously had the iron acetate and belladonna treatment here advocated than he would had only the expectant treatment and the semi-starvation diet been adopted.

I argue that these cases of fulminating appendicitis require as much distinction from catarrhal appendicitis as does a case of pneumonia from a case of bronchitis, or as does a case of suppurative tonsillitis (or quinsy) from a case of follicular tonsillitis, both as regards prognosis and treatment. This type of case, in fact, is a very different thing from the ordinary case of catarrhal appendicitis, where the symptoms are much less marked, where no albumin is present in the urine, and where there is often not the rigor and never the severe headache and backache; and as such I think it deserves distinctive note and treatment. Clinically it resembles, as previously stated, the onset of a severe attack of epidemic influenza or of acute pneumonia, and one might almost expect to find that the influenza bacillus or Fränkel's pneumococcus was the cause of the trouble. Judging by clinical experience alone, I would even go further and assert that there are two forms of this fulminating appendicitis, viz., an influenzal form and a pneumococcal form, and that the latter is the more severe; but that the treatment here advised is equally applicable to both. Furthermore, I believe that this pneumococcal appendicitis (if such I am justified in calling it) sometimes complicates pneumonia (particularly apical pneumonia) and causes the acute abdominal symptoms occasionally observed in these cases, and which may be mistaken for typhoid complications; though I have not yet been able to verify this by *post mortem* examination.

The treatment advocated for the disease is as follows:—First of all the patient, or the friend of the patient, is told what the case is, and he is given the option of immediate operation, and also the option of a consultation with an operating surgeon. If necessary, and if external local applications fail to ease, a dose of morphia is given in as small a quantity as possible to relieve pain; gr. ½ of extract of belladonna is given every three hours until physiological symptoms are produced, when it is administered less frequently, and the following mixture is given every three hours in water:—

R Liquor ferri perchlor., 15 m.;
Liquor ammonii acetatis, 2 drachms.;
Aq. chloroformi, ad. ½ oz.

Ft. mist.

To relieve the headache hot applications are used, and to ease the backache—if such be present—a hot rubber bottle is applied; but, if possible, the coal-tar derivatives are avoided, as I believe them to be positively harmful in this complaint. Warmth is applied to the abdomen over the region of the appendix, turpentine stupes being often used with advantage. I believe the topical application of cold often does harm in these cases, particularly if the appendicitis is of influenzal origin; though one could understand its doing good if the case were of pneumococcal origin. But the difficulties of diagnosing this point are great; therefore the safest application is warmth. A rectal soap enema is given to relieve constipation, half an ounce of turpentine, mixed with an egg, being added to this if tympantites be present. Purgatives are of course avoided. Strict rest in bed in the recumbent posture is enjoined. The temperature of the bedroom is kept at 60° F. night and day, and a light, fluid, nutritious diet, and one producing little residue is given.

* Read before the International Congress of Medicine at Lisbon.

In my earlier days of practice I used to see appendicitis treated by a semi-starvation diet, as it was then thought that the operating surgeon would have a better chance of a successful result if such a dietary course were followed out, and should the case ultimately require operation; but I have long since failed to see either the benefit or the wisdom of it in these cases of fulminating appendicitis, as I think that they in particular demand a highly nutritious though light and fluid diet, but at the same time one leaving as little residue as possible in the intestinal tract.

I could give notes of several cases, comparing those in which the above treatment was successfully adopted without operation, and those in which only the expectant treatment was followed out and which speedily suppurred, thus, of course, necessitating operation; but lack of spare time prevents me from doing this now. I therefore only submit the bare facts and general *résumé* of my experience in these cases; though I hope upon some future occasion to have the opportunity of publishing the cases in detail.

I look upon the administration of the belladonna as an important adjunct in the treatment, not only on account of its sedative action upon the intestines, but also because of its anti-suppurative action, as pointed out by Christopher Heath, Ringer and others.

TUMOURS OF THE BLADDER:

WHY OPERATIVE TREATMENT IS SO FREQUENTLY UNSUCCESSFUL IN ITS REMOTE CURATIVE RESULT—A PLEA FOR EARLY DIAGNOSIS.*

By DAVID WALLACE, C.M.G., M.B., C.M., F.R.C.S.ED.,

Assistant Surgeon, Edinburgh Royal Infirmary; Examiner in Clinical Surgery, Royal College of Surgeons, Edinburgh.

THAT vesical tumour is by no means a rare malady is shown by the large collections of reported cases made for statistical purposes. One surgeon has operated on nearly 400 cases, and I have myself had experience of more than fifty cases. The results of operation, as shown by statistics, are very disappointing, for it is rarely that patients survive for very long without recurrence, and it is towards this point—a plea for early diagnosis as a means of improving the prospect of removal—that my remarks will be chiefly directed. Vesical tumours are commonly classified as papillomata, carcinomata, sarcomata, adenomata, and as rarer forms, myomata and angiomata. Malignant growths are much more common than simple tumours, and carcinomata than sarcomata. In benign tumours the operative mortality is about 17.7; in malignant cases about 29 per cent. One of the explanations of the unsatisfactory results of operation is probably the site which they commonly occupy—the floor of the bladder, where free excision is difficult, and dangerous from the risk of wounding the ureters. An additional circumstance, favouring recurrence is the long duration of the symptoms in many patients before surgical aid is sought. He (the author) remarked that he wished to draw attention to the importance of employing cystoscopy at the earliest onset of bladder symptoms; the procedure was easy of performance, harmless,

and comparatively painless. By cystoscopy information of great value in giving a prognosis—such as the site of the tumour or tumours, the size of their attachment, and their nature, malignant or simple—could be gleaned. As to the general rule governing palliative operation, the following were some of the guiding principles. Delay operation as long as possible in unfavourable cases, operate in septic cases. Severe hæmorrhage indicates operation; suprapubic cystotomy relieves the symptoms, drains the bladder of septic material, and prevents hæmorrhage. Frequency of micturition is abolished, and the patient is enabled to go about in comfort wearing a suitable urinal.

Canceroidal Tumours are usually infiltrating and ulcerative. The early symptoms to which they give rise are those of cystitis—frequent and painful micturition, while hæmorrhage occurs later. They affect chiefly men in later life, fifty being the average age. On rectal examination the hard mass may be felt in the base of the bladder. Cystoscopic examination is often difficult on account of the infiltration of the bladder wall and the contracted state of the organ. Only palliative operation is possible, as the growths invade neighbouring organs. *Papillomata* are either fimbriated or warty, the former being frequently pedunculated, the latter usually sessile. The hæmorrhage to which they give rise is not always typical. Not infrequently the blood is uniformly mixed with the urine, and simulates the hæmaturia arising from renal disease. The diagnosis therefore depends on cystoscopic examination. Since these tumours are benign operative treatment ought to be curative, yet, as is known, recurrence is very frequent. It is a not uncommon experience to find that after one of these papillomata is removed the symptoms reappear, and on cystoscopic examination more than one villous tumour is found at the old site. The reasons why removal is so often followed by this unsatisfactory result are probably, first, the fact that cases are not operated on early enough; second, the site of the tumour, in the trigone, near the ureter, preventing free removal, and, third, failure completely to remove the mucous membrane round the base of the growth. By the use of a rectal bag, the employment of the Trendelenberg position, and by having a good light thrown into the bladder from a head lamp, the difficulties connected with the position of the papillomata can be largely overcome. The difficulties in prognosis are illustrated by two cases, in one of which a tumour was thoroughly removed with a large piece of adjacent mucous membrane right down to the muscular layer of the bladder wall. Pathologically it was pronounced benign, yet it recurred in the form of multiple growths on two successive occasions. On the other hand, a case had been operated on in which it was impossible, apparently, completely to extirpate the tumour; the growth was pronounced by the pathologist to be epitheliomatous, and yet no recurrence took place, though a number of years had elapsed.

The Medical Officers of Schools Association has issued (through Messrs. Churchill) a pamphlet containing reprints of two addresses delivered before it by Mr. T. C. Horsfall and Dr. Herringham. The subjects dealt with relate to physical training in schools, and these addresses will be read with profit by all who are interested in physical education.

* Abstract of Paper read before the Edinburgh Medico-Chirurgical Society, June 6th, 1906.

CLINICAL RECORDS.

TWO CASES OF ADDISON'S DISEASE AND THE EFFECT OF THE ADMINISTRATION OF SUPRARENAL EXTRACT.

By A. GORDON GULLAN, M.D.Lond., M.R.C.P., F.R.C.S.,

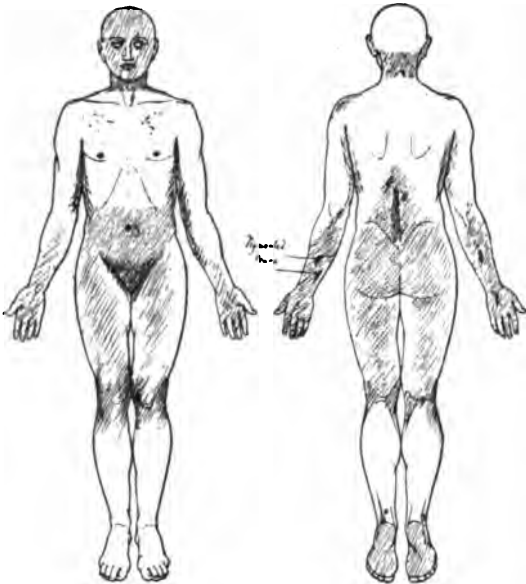
Lecturer on Clinical Medicine, University of Liverpool; Physician to the Liverpool Stanley Hospital.

As the value of suprarenal extract in the treatment of Addison's disease is still *sub judice*, I think that the results obtained by the administration of this medication in two cases of that disease which have recently been under my care will be of interest.

CASE I.—Joseph G., a young butcher, æt. 18, was admitted into the Stanley Hospital on September 7th, 1903, complaining of pains in the epigastrium, vomiting, and weakness. His face was sallow, and his pulse was extremely small.

There was no history of phthisis or tubercle in his family. The lad stated that he had always been healthy till the present illness, which began, according to him, two months prior to admission, when he was troubled with severe aching pains in the epigastrium following food, but this was relieved by vomiting after each meal. He said that he had lost flesh during his illness and become very weak; he also noticed that "his skin was yellow."

On admission.—Patient was a thin but well-developed youth; his face and hands were cold and livid; temperature subnormal, 97° to 98° F.



There was a large amount of pigmentation of the skin over the body, especially marked in certain regions (*vide chart*), namely:—

The exposed parts: Neck as far as the collar, where it ended abruptly, and the back of the forearms, where it gradually shaded off.

The normal sites: Deep pigmentation of the axillæ, nipples, penis, and scrotum.

The parts exposed to pressure: The lumbar region of back, specially the lumbar spines, about the knees, the soles of the feet, and also in two scars on the back of the left forearm.

The pigmentation was of a yellowish brown or copper tint, shading in some regions to a dark brown, and reaching a maximum in some small black pigmented spots scattered about the chin, lips, back, and ankles. There was also some copper-coloured mottling on the mucous membrane of the cheeks and gums.

There was tenderness in the epigastrium and left hypochondrium on deep pressure, and a distinctly tender spot was found over the eleventh and twelfth ribs posteriorly, on each side (3 ins. from the spine on the right and 2½ ins. on the left).

The pulse was 80 per minute, extremely small, very low tension, but regular. At no time could a sphygmographic tracing be obtained. The cardiac impulse was absent. There was no superficial dulness, and the deep dulness only extended 3 ins. to the left. The heart-sounds were clear at all areas, but distant. Liver dulness was 4 ins. in the nipple line. Splenic dulness normal. He had no cough, and the respirations were 20 per minute, otherwise normal. The urine was acid, scanty, high-coloured, contained urates on standing, and sometimes a trace of albumin. The quantity of urea was relatively greatly increased. The muscular system was flabby, but there was not much wasting.

After admission, our immediate object was to stop the persistent vomiting, so he was placed on a very light diet, and 10 grs. of bismuth carbonate were given just before food, with the desired effect for a time. On September 14th, extract of suprarenal in gr. 5 doses was given thrice daily, and this was increased to gr. 10 a few days later. On October 2nd the suprarenal extract was increased to gr. 15, and the patient had improved. He had no pain, and had not been sick for a week, and his pulse was a little stronger. This improvement was maintained till October 19th; but he was steadily losing weight—about 2 lbs. per week—and the pigmentation in the mouth was more marked. On that date the vomiting returned with all its severity; he complained of acute pain in the abdomen and in both lumbar regions, pressure under the last rib on each side causing him to jump and cry out. The pain was so intense on October 22nd that he lay curled up in bed groaning; he was very sick, and all medicines had to be stopped; hypodermic injections of morphine were given to relieve the pain, and some brandy. The muscular weakness was most pronounced at this time, and the deep cardiac dulness was found to have further diminished. He gradually became semi-conscious, and died on October 25th. The *post mortem* was made on the same day, and the report is briefly as follows:—Body extremely emaciated, marked pigmentation of the skin as noted during life. Lungs healthy, no evidence of tubercle, recent or old. Heart small, muscle substance atrophied, pale and friable, valves healthy. Stomach large and somewhat congested; bowels healthy. There was considerable matting of chronic inflammatory tissue in front of the aorta round the celiac axis and affecting the celiac plexus, the semilunar ganglia, the terminations of the greater and lesser splanchnic nerves, and extending outward to the suprarenal bodies. Both suprarenal glands were very much enlarged, nodular on the surface, and hard; on section both glands showed numerous caseous and fibrous nodules, varying in size from 5 to 15 mm. in diameter.

CASE II.—Mary R., a married woman, æt. 32.

Family History.—One brother died of phthisis. She has three children alive; one died of meningitis and another of diarrhoea. The present illness began two years ago, when she states that she was getting thin, low-spirited, and continually fainting; she also had great pain in both lumbar regions, particularly the left. As she had a severe attack of vomiting in January, 1904, she applied to the Stanley Hospital and was admitted. She was then noticed to have slight bronzing of the lower half of the face and neck. Her pulse was very small and easily compressible, and she had marked tenderness over both suprarenal bodies. There was general lassitude; her temperature was frequently subnormal, occasionally falling to 97° F. The tongue was coated, vomiting troublesome, and bowels rather constipated. She was placed on light diet, and calcium chloride and tincture of nux vomica prescribed. After three weeks she became an out-patient, and has remained so ever since, having been

readmitted, however, on two occasions (*i.e.*, in March and August, 1904). At the latter date her condition became worse, and the pigmentation was more marked on the face and neck, and also appeared on the backs of the forearms and on the hard palate, and she was also more subject to syncopal attacks. On August 5th she was ordered gr. 5 of suprarenal extract four times a day, and this was increased to 10 grs. and then 20 grs., thrice daily. This treatment was continued up to December 9th, with considerable benefit: she lost her lassitude to a great extent, had no fainting attack, her pulse was stronger, she vomited much less frequently, and the tenderness over the suprarenals was not so marked. She also gained in weight. On December 9th she was confined, and had a normal labour, the child being healthy.

She was then absent from the out-patient department for three weeks, and consequently the suprarenal extract was omitted for that time; and it is an interesting fact that the symptoms from which she had been free, *i.e.*, fainting, vomiting, and general lassitude, all gradually returned. On January 2nd of this year the suprarenal extract was recommenced, and the above symptoms steadily abated. She has been taking gr. 20 to gr. 30 of the extract regularly up to the present time, with great benefit. On another occasion, however, in April, she had a mild attack of bronchitis, when it was omitted for a short period while expectorants were given, and then her former symptoms returned and the pigmentation increased; these diminished when she took the extract again. She is now in fair health, has gained in weight, and only on occasions is troubled by vomiting or a syncopal attack. It is noticed that if she omits the suprarenal extract for only a few days, through not coming to the hospital, her pulse is always much weaker and her symptoms aggravated. This case, in the benefit she has derived from suprarenal extract given by the mouth, agrees with the two cases reported by Dr. G. Oliver (1) (though the bronzing has not improved to the extent which appears to have been apparent in his second case), and also with that recorded by Dr. Rolleston (2) in his admirable Gulstonian Lectures.

It also illustrates how the treatment must be continued, as laid down by Dr. Rolleston (3), and also that the suprarenal extract must be given in large doses. Dr. E. Lloyd-Jones records a case of Addison's disease (4) who was cured by taking twelve tablets per diem; my patient is taking eighteen tablets per diem.

The special points of interest in these cases are: (1) the severity and rapid progress of the disease in Case I., though the lesion was that of chronic tuberculosis of the suprarenal bodies plus secondary inflammation of the neighbouring sympathetic; and the little benefit derived from the extract; (2) the chronicity of the symptoms in Case II., and the considerable benefit derived from the suprarenal extract, so that she even easily stood the strain of pregnancy and parturition. These cases certainly lead me to support Dr. Byrom Bramwell's view (5), that those cases which improve on this form of treatment may be due to adrenal inadequacy alone, and the remainder are due to an additional lesion (I should like to word it, a secondary lesion) of the neighbouring sympathetic. This was the condition in Case I. But I cannot agree with Dr. Bramwell's suggestion that all those cases which improve have a non-tuberculous lesion (though some of them may have, as the one recorded by him); for it seems quite logical that, in the early stage of Addison's disease when of an undoubted tuberculous nature (and personally I have not yet seen a *post mortem* in which the condition was not of a chronic tuberculous nature), the disorder starts in the adrenal body and may lead to inadequacy of that body before the sympathetic plexuses are involved. At such a stage I believe treatment by suprarenal extract would be most beneficial, and if combined with good wholesome diet, fresh air, &c., the disease may be checked or cured; but then if, as a result, there

remains sclerosis of the adrenal bodies, the suprarenal extract would have to be continued to supply the internal secretion of the organ, probably for the rest of the patient's life. Hence the great importance of early diagnosis, and an early trial of this form of treatment in Addison's disease.

REFERENCES.

- (1) "Pulse Gauging," p. 89; *British Medical Journal*, 1895, vol. ii., p. 654.
- (2) *British Medical Journal*, 1895, vol. i., p. 748.
- (3) Allbutt's "System of Medicine," vol. iv., p. 566.
- (4) *British Medical Journal*, 1895, vol. ii., p. 483.
- (5) *British Medical Journal*, 1897, vol. i., p. 71.

OPERATING THEATRES.

ROYAL FREE HOSPITAL.

SENN'S GASTROSTOMY. — MR. WILLMOTT EVANS operated on a man, *æt.* 50, who had suffered for about four months from difficulty of swallowing. This difficulty was at first slight but had steadily increased until about three weeks before admission. It had become completely impossible for the patient to take any solid food, though liquids could be swallowed with comparative ease. During the time that the dysphagia had existed he had steadily emaciated until at the date of admission he was extremely thin. He placed the site of obstruction at a point in the neck corresponding to the lower border of the larynx, and a bougie introduced through the mouth was arrested at about this situation. On palpation some indefinite thickening was felt behind the commencement of trachea, but no definite tumour could be made out and no enlarged lymphatic glands were discoverable. The man complained also of a troublesome cough and expectorated some amount of mucus, which was never blood stained. The diagnosis was made of malignant disease at the commencement of the *œsophagus* and it was resolved to perform gastrostomy; the patient consented after the nature of the operation had been explained to him. The patient's mouth was very septic and several teeth were loose; an attempt was made to improve the condition of the mouth by means of a tooth brush and a lotion containing Sanitas. The patient was anaesthetised and a vertical incision was made two inches in length about midway between the middle line and the left linea semilunaris, the upper end of the incision reaching to within three-quarters of an inch of the costal margin. When the rectus was reached the fibres were separated to the extent of the skin incision and the posterior sheath of the muscle, and the peritoneum having been divided the abdomen was opened. The stomach presented in the wound and it was identified by the attachment of the great omentum to its lower border and by the thickness of its wall. The viscus was then drawn up into the wound, and a point chosen about three inches from the greater curvature; here an opening a little less than a quarter of an inch in length was made, penetrating all the coats of the stomach; a piece of rubber tubing was next taken about ten inches in length of a size sufficient to pass through the opening fairly tightly, and this was passed into the cavity of the stomach to the extent of two inches: it was then fixed by means of a catgut stitch, which passed through the tube and also through the stomach wall; a purse-string suture of silk was then passed through the serous and muscular coats of the stomach about a third of an inch from the tube and was gently tightened, the rubber tubing attached to the opening in the stomach

being pushed in at the same time. A second, a third and a fourth purse-string suture was inserted in the same manner, each about a third of an inch outside the preceding one, and as each was tightened the rubber-tubing was pushed inwards; thus a cone of stomach wall was made to project into the cavity of the viscus and from the apex of the cone the rubber tube projected into the cavity of the stomach. A silk suture was then inserted as follows—it was passed through the anterior layer of the rectus sheath on one side of the wound, and then through the posterior layer, then through the muscular coat of the stomach and through the posterior and anterior layers of the sheath on the other side of the wound; this stitch was intended to fix the stomach firmly against the anterior abdominal wall and a similar stitch was inserted below the rubber tubing. The skin was sutured with silk and the wound dressed with sterilised gauze. Mr. Evans said that at the present time the original operation of gastrostomy was entirely abandoned as the simple direct opening into the stomach almost invariably leaked to a distressing extent and the ingenuity of surgeons had been exercised to devise methods which would not allow of any such leaking. There was little doubt that in this country at least Franck's operation was far more frequently performed than any other method of gastrostomy, but Mr. Evans inclined to prefer the method devised by Senn which he had just employed. Kader's method, he said, was similar in principle to Senn's, but the mass projecting into the stomach was quadrilateral rather than conical. The reasons for why he preferred Senn's operation were these. In the first place it was extremely simple and occupied less time than either of the others; it was also probably less liable to cause leakage, and the third reason was perhaps the most important, and it was this: that it was possible to feed the patient at once, and if necessary a meal of milk or milk and egg could be introduced into the stomach on the operating table. A point of some importance in gastrostomy, he thought,

was the date at which it should be performed; undoubtedly in the earlier cases it was usually done too late, so that in many of these the patient died within a few days of the operation. During recent years, he pointed out, gastrostomy was usually performed at an earlier stage of the disease, and great differences of opinion existed among surgeons as to the best time to operate. Mr. Evans thought that a marked loss of weight was in itself quite sufficient to justify the operation, and therefore he advocated gastrostomy as soon as this loss of weight occurred, even though the patient might retain the power of still taking solid food to some extent. In an ordinary person the loss of a stone in weight was, he considered, amply sufficient to indicate operation, for this loss showed that the patient was unable to take food sufficient to keep him in health. As soon as the patient recovered from operation six ounces of milk were administered through the rubber tube, and the same quantity was given every four hours. The patient was encouraged to take food by the mouth and the teeth were kept as clean as possible; this was considered important, as tending to prevent the occurrence of sepsis in the mouth and parotid glands, for if no food was taken into the mouth the saliva was not secreted and micro-organisms readily passed up the ducts. When the patient takes solid food by the mouth he retains the pleasure of tasting and rejects what he is unable to swallow; fruit is especially useful and valuable, for though the pulp may be rejected some of the juice is certainly swallowed.

The patient soon improved in appearance and, as so often happens, his power of swallowing seemed to increase for a time. He left the hospital a fortnight after operation improved in health and spirits. The ultimate prognosis was necessarily bad, but his general condition was improved, his comfort was increased, and his death, when it occurs, will be less painful and distressing than if he had been left without surgical assistance.

TRANSACTIONS OF SOCIETIES.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.

MEETING HELD THURSDAY, JUNE 14TH, 1906.

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

MR. NETTLESHIP and MR. MENTEITH OGILVIE gave an account, with diagrams and drawings, of a family in which twenty persons in four generations had a peculiar variety of

PARTIAL CONGENITAL STATIONARY CATARACT in the form of a perfectly circular, well defined, homogeneous or finely granular layer, of no great density, situated between nucleus and posterior pole, about 4 mm. in size. At first sight it might be taken for a small lammellar cataract, but the invariable absence of any trace of a second layer and the certainty that the opacity lay behind the nucleus negatived that diagnosis, whilst there was equally good evidence that it lay in front of the posterior pole. Some of the cases were first seen by Dr. Doyne at Oxford several years ago. These were re-examined by Mr. Ogilvie and were found to be unaltered, and he has recently discovered a large number of new cases. The change caused but little loss of visual acuity, and only a slight

desire to shade the eyes against bright light; hence the number of cases could only be determined by ophthalmoscopic examination of every accessible member of the family. Mr. Ogilvie examined about fifty persons, whilst one group living at Edinburgh was examined for the writers by Mr. G. Mackay. All the cases occurred in one branch of the family tree.

MR. SIMON SNELL (Sheffield) read a paper on **STEEL ALLOYS WHICH ARE NOT MAGNETIC.** He mentioned that during recent years steel alloys had been used in certain industries, and that these alloys had altogether different magnetic properties to ordinary iron or steel. Manganese steel which contained 12 per cent. of manganese, 87 per cent. of iron, and 1 per cent. of carbon, formed a very hard steel which was difficult to machine, but the point of interest was that it was non-magnetic. Its toughness made it useful for many purposes. Nickel and iron was another alloy, and this was as susceptible to magnetism as pure iron, but the admixture of a small percentage of manganese and carbon completely altered the magnetic properties. Thus a mixture of carbon, 0.4 per cent., nickel, 20 per cent., and manganese, 9 per cent., with iron, was absolutely non-magnetic. Another point was that if this same alloy were drenched in liquid air it became magnetic. Another alloy was chromium steel. It was magnetic

but less so than ordinary steel. Specimens of these were exhibited, and their magnetic peculiarities were demonstrated. Mr. Snell remarked that, fortunately, the vast bulk of all steel splinters penetrating an eyeball came from steel which was magnetic, and, therefore, the use of the electric-magnet was unaffected. The possibility of steel being non-magnetic should be borne in mind, and inquiries made as to the particular kind of steel from which the fragment injuring the eye became detached. In conclusion, Mr. Snell referred to other alloys which were highly magnetic. He had not, however, yet found that they were more magnetic than the soft iron in use had been.

Messrs. L. V. CARGILL and S. MAYOU described a case of

MILIARY TUBERCULOSIS

in an adult in which there was tubercle of the choroid with implication of one optic disc. The patient was a man, *æt.* 21, who was admitted into King's College Hospital in December, 1905. Although previously healthy, he had been feeling unwell for six weeks, and was supposed to be suffering from influenza. He perspired a good deal, was feverish and was losing weight. There were no physical signs in the lungs, and no tubercle was found in the expectoration nor blood. Opsonic index to tubercle was 1. Two weeks later an irregular yellowish white patch was found in the right eye near the disc, it was only slightly elevated, and there was no pigment. In the left eye there were signs of optic neuritis. The irregular pyrexia continued and signs developed in the lungs. On February 17th, tubercle bacilli were first found in the sputum, and death occurred three days later. The *post mortem* showed that the meninges were studded with tubercle, so also were the lungs and most of the abdominal viscera. The sections of the eye showed a typical tuberculous mass situated at the edge of the choroid on the outer side of the optic nerve, this mass involved the nerve and spread backwards through the lamina cribrosa. The anterior part of the globe was normal except for a congenital anterior synechia.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, MAY 25TH, 1906.

Sir A. V. MACAN in the Chair.

DR. ALFRED SMITH exhibited a "Specimen of Unruptured Tubal Pregnancy Removed by Operation." He said the woman, *æt.* 40, was the mother of six children, the last of whom was born last August. In January, February, and March of this year her changes were up to time, and normal. On examination, he found a mass in the left broad ligament, which he diagnosed as an ovarian cyst. Advising operation, the patient came to hospital, and after forty-eight hours he performed laparotomy. The tube seemed perfectly normal, and a little foetus was found lying in a blood clot in the cavity of the cyst as shown in the specimen.

DR. H. TWEEDY thought the hæmorrhage in this case came from the foetus. He advocated the removal of tumours at the side of the uterus for this amongst other reasons, that an unruptured tubal pregnancy might easily be mistaken for a less actively harmful tumour.

DR. HENRY JELLETT exhibited "Fibromatous Tumours of both Ovaries, with Carcinomatous Nodules throughout them, associated with Fibromyoma of the Uterus." They had been removed from a patient, *æt.* 58, who was twenty years married, and had had no children. On examination of the patient a hard, irregular tumour, filling the pelvis and extending up to the umbilicus, was found. The uterus was fixed posteriorly. He made the usual middle incision, but as this did not afford sufficient room he made a second incision, running out to the left anterior superior spine and at right angles to the first. He was then able to

remove the two ovarian tumours, which were adherent and had no pedicle. After their removal he found a third tumour formed by the body of the uterus, and consequently performed supra-vaginal hysterectomy. This case differed from a former one which he had brought before the Academy at the beginning of the Session in that there was no pre-operative infection, and that, consequently, the abdominal wound escaped infection, and also that there was not so extensive an extension of the growth. The patient was operated on on May 4, and she is now about to leave hospital apparently well.

DR. E. HASTINGS TWEEDY showed a specimen of "Intussusception in an Infant." He said the child was born in the Rotunda, and on the second day had hæmorrhage from the bowel. It died on the third day. At the *post mortem*, intussusception was discovered. He did not think that such a condition could have occurred after death. Diagnosis was impossible during the life of the child.

DR. ROWLETTE considered that the blood clot must have taken place from the point of the intussusception, and was *ante mortem*.

DR. E. HASTINGS TWEEDY read "The Report of the Rotunda Hospital for 1904-1905."

DR. ALFRED SMITH criticised the methods of estimating the standard of morbidity adopted in the British Islands, and was delighted that Dr. Tweedy had initiated a movement towards uniformity. Without accepting in full the proposed method he thought it should be given a fair trial. Considering the general instruction in Dr. Tweedy's Report that "we do not take into account the irregularities of pulse, or temperature so frequently observed within twenty-four hours of the period following delivery," some explanation was necessary as to Table IX., which included fifteen cases of morbidity occurring on the first day. He hoped this did not indicate a weak spot in their method of standardisation.

DR. H. JELLETT said that the report showed better results than previous years. He thought its form, however, might be improved, and in this connection he had brought down the report of the Clinic Baudelocque in Paris, which report, as would be seen, was divided into five distinct headings as follows:—(1) Abortions. (2) Labours. (3) Operations. (4) Morbidity. (5) Mortality. He suggested this form of report should be adopted in future. He considered that if the term "eclampsia" was to be made as wide in its meaning as Dr. Tweedy wished, it would be also necessary to widen our ideas on treatment, and not to rest content in the belief that the morphia treatment was suitable for every form of convulsion occurring in pregnant or puerperal women. Dr. Tweedy's effort to formulate a proper standard of morbidity deserved the thanks of the Academy. As to the case of the patient who died of septic infection resulting from venereal sores, he did not consider that mere abstention from examination, &c., was sufficient. Active treatment should be also adopted, and in such cases he would advise to place the patient under an anæsthetic, and treat the sores with pure formalin.

DR. STRITCH stated the procedure adopted at the Lock Hospital with puerperal cases suffering from venereal sores.

Sir ARTHUR MACAN thought the increase in the number of cases treated in the Rotunda was due to an increase in the number of external cases, which he remembered at one time only amounted to 70 per annum. It was found that the poison inducing eclampsia was lactic acid, sulphuric acid, or some other such substance. The great treatment for eclampsia was to deliver the woman. As regarded manual or operative methods of emptying the uterus in abortion, the former was preferable where possible. But where the os was tight, it was better to use the curette than to dilate the cervix. In cases of acute sepsis, it was questionable whether operative treatment was of much avail. He was not certain of the brilliant results of ligaturing the pelvic veins.

Dr. HASTINGS TWEEDY said that he would indeed be difficult to please were he not more than gratified at the very excellent reception accorded to this year's maternity report, and it was all the more gratifying to note the keen manner in which the different portions of the report were dealt with and criticised. He found himself in accord with practically all Professor Smith had said. Dr. Henry Jellett had very properly called attention to the case of one of the six women who had died, and who had been allowed to deliver herself naturally without interference, though the vulva was covered with suppurating sores. As a matter of fact, the delivery took place shortly after admission, and before active measures could be adopted. He believed with Dr. Jellett that such cases should receive very active disinfection before the birth of the child. His view as to the eclamptic statistics were that they should, at all events, be made to include the so-called uræmic convulsions, otherwise it was easy to persuade oneself that some of our fatal cases should be ascribed to this condition rather than to eclampsia. He spoke of the great work Sir Arthur Macan had accomplished during his Mastership in improving the aseptic condition of the hospital, and this in spite of the greatest structural imperfections. It was a mistake to think that Continental authorities were unanimous in the basis they adopted for estimating morbidity. As a matter of fact no such unanimity exists, and, if the maternity hospitals in the British Empire can only be persuaded to adopt the index of morbidity laid down by the British Medical Association, he believed that the good which will follow could hardly be exaggerated.

NORTH-EAST LONDON CLINICAL SOCIETY.

A Clinical Meeting of this Society was held on THURSDAY, JUNE 7th, 1906, Dr. F. J. TRESILIAN (Enfield), Vice-President, in the Chair.

The following cases and specimens were exhibited:—
Dr. TRESILIAN showed an ex-policeman, the subject of Locomotor Ataxy, whose pupils were normal. Other signs of tabes were not wanting and the condition began about three years ago.

Dr. A. J. WHITING showed (1) a woman, æt. 63, with Raynaud's Disease, the chief manifestation of which was local asphyxia. There were no cardiac symptoms. (2) A case of angio-neurotic œdema in a middle-aged man. He had attended the out-patient department of the Tottenham Hospital for some time, and various remedies had been tried with more or less success. An unusual feature in the case was that the patient knew himself when the attacks were coming on, as they were preceded by a peculiar dryness of the tongue and lips with a metallic taste in the mouth. Dr. Whiting also showed a photograph of a female patient whom he had previously exhibited before the Society, illustrating the acute phase of the disease. (3) A man with Lead Neuritis.

Dr. R. MURRAY LESLIE showed a man, an in-patient of the hospital, with aortic disease. There was no rheumatic history.

Dr. ARTHUR E. GILES exhibited (1) the appendages from a case of Double Pyosalpinx which he had removed by operation, previous to which the diagnosis had been one of tubal pregnancy. In a typical case of either kind the diagnosis was generally easy, but clinically the two conditions were often very similar. No assistance was afforded by the state of the cervix, as the cases of extra-uterine gestation generally occurred too early. A unilateral swelling was, perhaps, rather against pyosalpinx. The safest way would be to watch, if possible, for some weeks during which a tubal gestation would alter materially while a pyosalpinx would not. He thought that the history was the best guide in distinguishing an appendicitis from a pyosalpinx, the former usually having the more acute onset. (2) An ovarian tumour, partly solid, which resembled clinically a uterine myoma. In this case, moreover,

the uterus was in a state of fibrosis. (3) A uterine fibroid removed by a complete panhysterectomy.

Dr. G. BASIL PRICE showed a specimen of thrombosis of the superior and inferior longitudinal sinuses from a child, æt. 14 months, who had been admitted into the Tottenham Hospital under the care of Dr. Leslie for double pneumonia.

Dr. Leslie related the course and progress of the case since it had been under his care. At first the aspect of the child suggested a tuberculous meningitis, as it was comatose and feverish. The cerebral symptoms cleared up and then signs of pneumonia appeared. The total duration of the illness was sixteen days.

Dr. G. P. CHAPPEL recalled a similar case of a child admitted under his care for meningitis. The temperature was high, but after six days it came down and an apical pneumonia was discovered.

Dr. TRESILIAN thought that he had come across several cases of pneumonia presenting features of spinal meningitis—i.e., with tenderness over the spine, and the presence of Kernig's sign.

ULSTER MEDICAL SOCIETY.

ANNUAL MEETING, THURSDAY EVENING, JUNE 14TH.

The President, Dr. WM. ÇALWELL, in the Chair.

THE Treasurer's, Secretary's, and Librarian's reports were read and adopted. The membership has decreased slightly during the year, from the resignation of country members who joined when the institute was opened but who find it impossible to take much advantage of the facilities it affords for professional and social intercourse. On the other hand, a number of new Fellows and Members have joined, and the Treasurer's report showed that the finances of the Society were in a satisfactory state.

The following office-bearers for 1906-7 were elected:—
President: Dr. D. P. GAUSSON (Dunmurry). Vice-Presidents: Dr. W. B. McQUITTY (Belfast) and Dr. F. HOWARD SINCLAIR (Rostrevor). Hon. Treasurer: Dr. V. G. FIELDEN. Hon. Secretary: Dr. HOWARD STEVENSON. Hon. Librarian: Dr. W. L. STOREY. Hon. Editorial Secretary: Dr. J. RANKIN. Council: Sir Wm. WHITLA, Dr. J. R. DAVISON, Dr. T. A. DAVIDSON, Mr. A. FULLERTON, Dr. THOS. HOUSTON, and Dr. MCKISACK, with the seven trustees of the Institute, who are ex-officio members of Council.

On the recommendation of Council, the rule that the President should be elected for two years was altered, so that in future he shall hold office for one year, but shall be eligible for re-election.

Dr. H. H. B. CUNNINGHAM was elected a Fellow, and Drs. W. J. WILSON and A. MERRICK were elected Members of the Society.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS
ABROAD.
FRANCE.

Paris, June 17th, 1906.

REQUISITORY AGAINST FALSE APPENDICITIS.

PROF. DIEULAFOY created a great sensation a fortnight ago at the "Académie de Médecine," by speaking against surgeons operating for appendicitis where the cases were simply those of muco-membranous typhlocolitis.

He said: "I have been struck by the number of people who have been operated on for appendicitis without sufficient reason, and unfortunately this number has not ceased to increase. I have myself been one of the most active partisans of surgical interference in the treatment of appendicitis, and the longer I live the more I am convinced that it is the only efficacious and rational treatment for removal of the infected organ before it can become mortal—a rule of simple common sense confirmed by daily experience. But when I witness the number of operations which are

performed for appendicitis when it really does not exist; when I see the number of people who by an error of diagnosis are condemned to laparotomy, I am troubled in my conscience and I consider that it is my duty to bring the question before this Academy where appendicitis has been so often the subject of loyal and courteous discussions.

Here are some facts:—

I. One day a patient came into my ward at the Hotel Dieu who had been operated on for supposed appendicitis, when in reality he was suffering from muco-membranous typhlo-colitis. The surgeon was courteous enough to send me both the patient and his appendix. The appendix was healthy. As to the patient, his malady continued its course after as before the operation.

II. I was called in consultation by a young man who had suffered for some time from muco-membranous typhlo-colitis. From time to time he experienced very painful attacks, with nausea, vomiting, and ejection of membranes and mucus. At the moment I examined the abdomen I perceived in the right iliac fossa a characteristic cicatrix. I immediately said to the patient: "You have been operated on for appendicitis?" "Yes," he replied; "for an appendicitis that I did not have; they opened the abdomen in mistake and I suffered afterwards as much as before."

III. A lady came to my consulting room at the end of last year. She described to me all the symptoms of muco-membranous typhlo-colitis, which had lasted for several years and re-occurs at intervals. I examined the patient and found in the right iliac fossa a cicatrix the nature of which I could not misunderstand. I said to this lady: "You have been operated on for appendicitis?" "Yes," said she; "I have, although I had no appendicitis and I feel just as bad as before the operation. I suffer in the same places of the abdomen and pass the same mucus and the same membranes as before. I examined the painful cæcum from which the appendix had been removed ten months before. I found the pain of typhlitis resembling that of a good number of cases of appendicitis in the right iliac fossa and I could understand the mistake of those who, neglecting the other elements of diagnosis, confounded typhlitis with appendicitis and opened the abdomen of their patient for an appendicitis which did not exist."

The following case, and one on which I particularly insist, is one of those which have contributed the most to confirm my conviction regarding the question I have brought before you. Here is the case:—

I was called in consultation to the bed-side of a young girl who had been tormented for the last two years with a muco-membranous typhlo-colitis. At times and without any appreciable reason extremely painful attacks came on, in the course of which were expelled abundant mucosities and membranes. In one of the last attacks the pain predominated in the right iliac fossa, and one of our confreres as well as a hospital surgeon pronounced the case to be one of appendicitis. In consequence an operation was proposed and readily accepted by the patient, who hoped to obtain from surgery a care that medical treatment had apparently not been able to give. In my turn I examined the patient, who had just had a violent attack. The abdomen was supple and the walls yielding. On pressure sharp pain was felt over the transverse colon and at the angle of the ascending colon, but tenderness was greater in the right iliac fossa. However, this latter fact did not appear to be sufficient to admit the case as one of appendicitis. I am not one of those who believe that appendicitis is a frequent consequence of entero-colitis, for long experience has proved to me that predominance of pain in the right iliac fossa in the course of an attack of typhlo-colitis might almost always be imputed to typhlitis and not to appendicitis. To make an appendicitis quite another clinical tableau, which did not exist in the patient I had just examined, is necessary. It is thus that in the case of this young

girl I pronounced the malady to be one of muco-membranous typhlo-colitis, with predominant typhlitis, and rejected the diagnosis of appendicitis and operation.

My confreres were of a quite opposite opinion; for them there was no doubt about the appendicitis and the operation was decided. The operator asked me very obligingly to send one of my house surgeons to bring to me the appendix after ablation. The operation was performed and the appendix brought to me at the Hotel Dieu, where I examined it carefully with the help of one of my assistants. The appendix was absolutely healthy, and histological examination proved that there was no lesion. Here also was a patient who had suffered two years from mucous membranous typhlo-colitis with predominance of typhlitis and like so many others she had been operated for an appendicitis which she did not have.

Similar mistakes have been made times without number, during these last years especially, since from different quarters the diagnosis of certain cases of *soi disant* appendicitis have been confined to an histological examination. To explain: You are called in by a patient who complains of violent pain in the abdomen; he is aware that he is suffering from muco-membranous entero-colitis, for he has had already several similar attacks; he knows also that his condition is in nowise grave, but he suffers considerably and wants relief. You examine the abdomen very carefully and methodically and find it particularly tender over the colons, and when you reach the right iliac fossa the patient cries out, for pressure in the region produces a sharper pain than anywhere else. Then if you are imbued with the regrettable doctrine that appendicitis is a frequent consequence of entero-colitis you will tell your patient that his malady is complicated with appendicitis; you will explain to him the danger, and suggest a consultation in view of an operation. Both patient and the family are in consternation. In the meanwhile the usual steps are being taken, and finally the operation is performed. But as soon as the abdomen is opened you discover your error; the appendix is healthy, the typhlitis was taken for an appendicitis, and your patient should not have been subjected to an operation, and the patient continues to suffer as before.

Such mistakes are ignored by the public, but the public begins to think that appendicitis must be an extraordinarily frequent malady judging by all the persons that are operated on. They do not know that a large number of these persons had no appendicitis; I hope that in future they will be less ignorant on the question.

As much as I am an absolute partisan of surgical interference in true appendicitis, so much am I against it in the immense majority of cases of typhlo-colitis, where appendicitis does not exist.

GERMANY.

Berlin, June 17th, 1906.

At the Medical Society, Hr. P. Kronthal read a paper on

IS HYSTERIA A NERVE DISEASE?

He was opposed to the general view that hysteria was a functional neurosis, *i.e.*, a nerve disease without a demonstrable pathologico-anatomical cause. In favour of the functional view, it had been stated that in hysteria we had to do with an abnormal reaction of cells, but neither that nor the peculiar psychological condition could be held to have any value in favour of the generally received view. The abnormal reaction must be rather looked upon as a disease of the cells than as a disease of the nervous system, and as the psyche was not to be considered simply a function of the brain, but as a sum of the reflexes, for an explanation of the psychological disturbance it was not necessary to pre-suppose a disease of the brain. The brain appeared diseased in hysteria, because the reaction of the cells was abnormal, not inversely.

Hysteria was characterised in that it was not tied

to the course of the nervous system. That was also a reason the more for the assumption that it was not a nerve disease.

Hysteria was an easily changing morbid reaction of the cells.

As regarded treatment, it followed that we must take care to strengthen the cells, and this had long been done. It was a surprising fact that we had long adopted a correct treatment empirically in spite of a false theory.

Hr. Rothmann remarked that the previous speaker could not prove his cell disease, any more than changes in the nervous system could be proved.

Hr. E. Holländer then spoke on

THE TREATMENT OF TUBERCULOSIS OF THE MUCOUS MEMBRANES.

He reported on his ten years' experience in the treatment of tuberculous diseases of the mucous surfaces. Through the knowledge of his hot air cauterisation an unusually large number of cases of tuberculosis of the upper air passages came to him. As opposed to the secondary tuberculosis after primary pulmonary phthisis, he placed before them the clinical features of primary tuberculosis for which the point of entrance had been the nose, or the mouth, and, passing over the palate, throat, and larynx passed through the lymph passages into the lungs. The disease came before us, either accompanied by lupus of the external skin or not. The pathological forms of both categories might be identical, so that with an identical etiology the distinction between lupus and tuberculosis of the mucous membranes would be lost. The speaker pointed out the, on the whole, strikingly favourable prognosis in the pronounced form of ascending tuberculosis.

Of all the therapeutical means tried the best results were obtained from the contactless action of heat. The speaker had also been successful with hot air cauterisation in a large number of other tuberculous diseases of the mucous surfaces (larynx, the eye, the rectum, joints, &c.).

As, however, surgical means were not always practicable nor always necessary, the speaker tried other chemical ones. The following he had found successful: A 5 per cent. solution of sodic iodide was given once or twice a day internally, and then calomel was applied to the diseased part. A curative action took place in ulcerative processes through an elective caustic action and the chemotatic saturation with iodine. Particularly good results were obtained in this way in tuberculosis of the bladder.

At the Surgical Society, Hr. Payr (Gratz) spoke on **IMPLANTATION OF THE THYROID GLAND INTO THE SPLEEN.**

He began his investigations three and a half years ago by experimentally implanting the thyroid into the spleen of dogs, cats, and guinea-pigs. At first only one lobe was implanted. Examination showed that the implanted lobe lived and thrived in the spleen. Four weeks later the second lobe was implanted. A number of the animals died in consequence of the second series of operations; but part survived and showed no signs of disease. Three months later splenectomy was performed on the animals. If the implanted thyroid were in active function, tetanus and cachexia must now make their appearance. As a matter of fact tetanus came on twelve hours afterwards. The hæmorrhage caused by making the pocket in the spleen, was arrested by the implantation itself, the spleen was then sutured and the omentum was fastened on over it, in order to obviate any possible hæmorrhage in the upper part of the spleen. The implanted thyroid attached itself to the splenic structure, then gradually melted away to an insignificant connective tissue structure. Thyroid in dogs diminished in size to one-seventh after the ingrafting of pieces of thyroid.

In an appropriate case he carried out the procedure in the human subject. The case was that of a child of six, with myxœdema that had been treated with

thyroid preparation for three and a half years, but with no effect. The mother gave a piece of her thyroid for the purpose, which was implanted into a pocket made in the spleen. The whole operation was finished in twelve minutes. There was no after trouble. The operation was performed on December 12th, 1905, in the Gratz Kinder Klinik. The success was great; the child began to walk, it took notice of what was going on around it, its features already displayed intelligence; it fed itself, whilst before it always had to be fed. Implantation of the thyroid into the spleen was a serious operation and one not free from danger, but in such a hopeless case it was justifiable, even if the further course of the case was not favourable.

Hr. Kocher, Berne, would not go so far as to implant the thyroid into the spleen; he had had good results from implanting it between the peritoneum and the abdominal wall, better than could be obtained by thyroid preparations. He mentioned Christiani's method, instead of implanting a large piece of thyroid, implanting smaller pieces in various parts under the skin at different times.

AUSTRIA.

Vienna, June 17th, 1906.

SCLERODERMA.

SCHULLER exhibited an interesting case of Scleroderma to the members of the Gesellschaft. The patient was a female, æt. 21, and had always been healthy up to January last year, when she got a severe chill from which she never properly recovered. Any change of temperature downwards caused the skin to become ivory white all over the body and limbs. A few months later pain commenced in the back and limbs, the skin becoming brown and hard. The body-weight began to decrease and the menses cease. In December last year she came to the Nothnagel Clinic and was treated with thyroid tabloids—five per diem. Bathing, massage and rubbing were added to the treatment, but very little progress was made.

Two months ago she was transferred to Nerve Clinic and was given two thyroid tablets per diem and ten intramuscular injections of fibrolysin. During the first period of this treatment she seemed to improve, but the hard infiltration of the skin on the face, shoulders and arms are the only parts that have yielded to the efforts bestowed on it. A freer movement of the spine, jaws, and limbs have also been observed with an increase of weight. Beyond these changes no real improvement can be affirmed.

The Röntgen rays revealed a peculiar state of the bony structure in the form of a diffuse atrophy in the spongy structure of the bone while the calcareous portion remained unchanged. It is worthy of note that Chvostek's phenomenon was prominently present in this case, *i.e.*, the motor stimuli of the facial nerve was accentuated. When the trunk of the facial nerve in front of the ear was struck the facial muscles of that side of the face were convulsed. This is a phenomenon that Chvostek found constantly present in tetany.

SPIROCHÆTA AND SYPHILIS.

Hitherto the Spirochæta pallida has been found in all the syphilitic products except the tertiary gumma and the primary lymphangitis. Ehrmann has been diligently searching for this microbe and professes to have discovered it in these organs also. Reines and Lipschutz avow that they have also found it. They all confess that a wide series of sections are necessary before the microbe can be discovered. From this testimony we infer that the germ is rare and not yet likely to convince us that this is the infecting matter in syphilis. All of these investigators, or, rather, discoverers admit that the spirochæta pallida which they have isolated is a degenerate product of the healthy spirochæta usually met with. Why this should be in the most active stage of the disease is not so easy of explanation.

TRAUMATIC ANEURYSM.

Frisch had a preparation from a patient whom he

exhibited at an earlier meeting, where the diagnosis was made and the opinion given that the aneurysm was due to arterio-sclerosis. The patient was æ t, 61, which gave credence to this opinion, but from a series of sections taken he demonstrated conclusively that arterio-sclerosis was not the cause but repeated or chronic injuries to the ulnar vessel.

ARSENIC AND IRON IN CHLOROSIS.

Winterberg has recently been dissatisfied with the pill of arsenic and iron and after several experiments in the "Krankenhaus," has come to the conclusion that the preparation called "Arsenferratose" is the most efficacious drug we possess for chlorosis. This is a modification of ferratin, agreeable in taste, causes no digestive disturbance and contains 0.3 per cent. of iron and 0.003 per cent. of arsenic. One tablespoonful can be taken daily, which is equal to 0.1 gramme of iron and 0.00135 of arsenic or 0.002 grams of arsenious acid.

In some cases the blood was at a standstill with every other form, but immediately arsenferratose was prescribed the hæmatic fluid was changed and the patient improved.

FROM OUR SPECIAL CORRESPONDENTS AT HOME. SCOTLAND.

ROYAL COMMISSION ON THE CARE AND CONTROL OF THE FEEBLE-MINDED.

This commission sat in Edinburgh on the 11th, 12th, and 13th June for the purpose of taking Scottish evidence in addition to that already tendered. After hearing various witnesses the commissioners are making a tour of inspection of various institutions in Scotland. In his evidence Dr. W. Leslie Mackenzie laid stress on the imperative necessity of systematic medical examination of elementary schools to prevent the waste of educational energy on hopeless material. In examining children in Edinburgh he found that so-called "defectives" formed one per cent. of the whole, but the scrutiny of teachers alone was insufficient to classify backward children, feeble-minded or defective, or children with undeveloped faculties. Special teaching was needed for the feeble-minded; and special classes, as well as special schools were of value, the former as a preliminary to the latter. By a fully correlated organisation of special school, industrial school, reformatory, poorhouse, and asylum, the poorhouse might be drained of some of its feeble-minded stock. In cross examination Dr. Mackenzie said that it was not enough to educate feeble-minded children and then turn them adrift. Industrial schools should be extended, and certain powers of detention were called for. He favoured special schools rather than special classes, and did not recommend that the former should be under the school board as this would clash with lunacy administration.

Mr. R. B. Barclay, General Superintendent of Poorhouses, said that at present many of the inmates of smaller poorhouses were weak-minded, and in cross-examination said that there ought to be some separation of the same from the mentally defective.

Mr. Alexander Henderson, Governor of Barnhill Poorhouse, Glasgow, gave evidence as to the class of cases admitted. Feeble-minded persons were occupied with light work, and were in many ways the most contented of the inmates.

Sir James Alexander Russell, member of the District Board of Lunacy, testified to the success of Scottish Lunacy administration, and said that any scheme for the creation of institutions for persons of unsound mind not under the supervision of the Board would be regarded by the people of the county with suspicion. Many persons who ought for their own sakes to be certified were excluded from the benefits of the lunacy laws (1) from the existence of a restricted idea as to the amount of mental unsoundness which justified certification; (2) from reluctance on the part of relatives to admit insanity; (3) and from the danger of actions

at law. In the last respect some protection should be given to those who acted in good faith.

Mr. John Gulland, M.P., said that he had been so impressed by the number of mentally defective children attending Board schools that he had introduced a Bill (now through the House of Commons) to encourage the education of Scottish epileptic and defective children by special grants, as was done in England. School boards should be responsible for the education of all children in their districts whether sound or unsound. In reply to questions Mr. Gulland advocated that special schools should be under the school board. Defective children should be placed in the same category as the blind or deaf. The duty of taking charge of them should not devolve on charity.

Dr. N. Gordon Cluckie, Greenock, said that his experience as a town and county councillor, and as an ophthalmic surgeon, convinced him that the care and control of the feeble-minded should be continued to the Lunacy Board and not intrusted to a popularly elected body.

Dr. W. W. Ireland, for many years superintendent of Larbert Institution, said that the number of imbeciles etc., in Scotland was ahead of what was generally believed. Such patients were to be educated only by special training; their health required special attention, hence institutional treatment was desirable. The great need of Scotland was a custodial asylum for adult imbeciles. Epileptics, of whom there were nearly 4,000 in Scotland, also needed help sorely. If the State were to interfere with inebriates, habitual and wasteful indulgence in alcohol should be made a criminal offence, punishable by detention until there was good prospect of reform.

Dr. Clouston's evidence was to the effect that heredity was the chief cause of feeble-mindedness; he gave the results of an investigation in regard to epilepsy and congenital mental defect in a small parish in Orkney where these diseases were more common than insanity. The brain defect was attributed to too close interbreeding over a thousand years, since the Scandinavian invasion. His suggestions for the proper meeting of the risks to society and to themselves of the existence of the feeble-minded in our population were the following:—(1) Parents should be instructed as to what the condition meant, what its risks were, and what precautions should be taken when it existed; (2) feeble-mindedness should be made notifiable; (3) the effects of such instruction and notification would be to enable parents and teachers to distinguish weak-mindedness from "laziness," "bad-temper," "vicious tendencies," &c.

Dr. John Thomson, Physician to the Sick Children's Hospital, gave evidence as to the great difficulty at present of relieving parents of the care of idiotic or imbecile children; it ought to be obligatory on parish authorities to remove suitable cases to an appropriate institution even when the parents could pay only a small amount. In the case of pauper lunatics the inspector had to answer to the lunacy commissioners if he did not have them looked after; in mentally defective cases no such obligation existed.

Dr. Urquhart, Physician to the Royal Asylum, Perth, also gave evidence that the feeble-minded and defective were not adequately provided for in Scotland, and advocated the union of Scottish districts into combination districts to provide accommodation for idiots and imbeciles. There should be one authority only—the Board of Lunacy, and the Board of Education should have nothing to do with schools for defectives.

Drs. Quin, Donald, and Cunningham gave evidence as to the need for compulsory powers in dealing with inebriates and narcomania.

Dr. J. F. Sutherland, Deputy Commissioner on Lunacy, was of opinion that the central supervision and control of all feeble-minded persons in imbecile boarding schools, poor-houses, labour colonies, etc., should be vested in the Board of Lunacy. School boards should have local supervision of feeble-minded

children of school age in attendance at special schools or classes. Feeble-minded children in reformatories, industrial schools, and training ships should be removed from those to imbecile boarding schools and later to labour colonies.

Evidence was also given by Dr. McNaughton Medical Officer of Perth Union; Sheriffs Guthrie and Fyfe, Mr. Allan, Chairman of the Glasgow School Board and Miss Montegale.

BELFAST.

PRESENTATION TO DR. DARNELL AT BANGOR.—The respect in which Dr. Darnell is held in Bangor, Co. Down, and the measure of sympathy evoked by the recent litigation in which he has been involved, were shown at a meeting held last week in the Dufferin Memorial Hall, in that town, under the presidency of Lord Clanmorris. The object of the meeting was to present to Dr. and Mrs. Darnell substantial tokens of goodwill and respect from his patients and neighbours, these taking the form of a handsome silver rose bowl, an illuminated address, and a purse of one hundred guineas. The presentations were made by the Dowager Marchioness of Dufferin and Ava, Lady Clanmorris, and Mrs. S. C. Davidson. In reply Dr. Darnell thanked his friends for their kindness and specially for the sympathy shown to him during the past two years.

It may be mentioned that the fund which is being raised by Dr. Darnell's professional brethren now amounts to about £230, with £50 more promised. It will soon be closed, and all subscriptions should be paid at an early date.

QUEEN'S COLLEGE, BELFAST.—At a meeting of the Executive Committee of the Better Equipment Fund held last week, a most satisfactory financial statement was presented. The chemical laboratories, now to be completed are to be known as the Donald Currie Laboratories. The Physiological Laboratories, for the enlargement and greatly improved fitting of which plans are ready, are to be the Jaffe Laboratories. The Pathological department is also to be better housed and equipped in the Musgrave Laboratories, while the physics professor will find a new home in the Harland Laboratories, now almost ready for occupation. The annual Parliamentary grant has never been increased since it was first voted for the upkeep of the college more than fifty years ago, so there is ample scope for the better equipment of all departments, but specially the scientific ones.

THE PRINCIPAL MEDICAL OFFICER FOR THE CITY.—The matter of the appointment of a successor to Dr. Whitaker is still much before the public and opinions are still divided as to whether the Corporation will carry out the plainly expressed wishes of the citizens, and obtain the services of a first-class man at an adequate salary, or perpetuate the job freely discussed for the past six months, when its possibility was first mentioned in our columns. The job in question is the proposed appointment of a local general practitioner, lately a member of the Corporation, but retired long enough before Dr. Whitaker's resignation to be eligible to succeed him. The public generally has not a word to say against the gentleman in question, a much esteemed practitioner, except that he has not been specially trained in public health work. It is recognised that every man has a right to do the best he can for himself, but feeling is very strong, especially so in the profession, as to the action of the chairman of the Public Health Committee, a medical man, in not giving the support to the reform party to which his medical brethren are practically unanimous in saying that party is entitled. Needless to say, if the chairman of the Public Health Committee were to say boldly that the health of the city is in a bad state, and that all the efforts of his committee have been only partially successful in improving matters, and that they must have a well qualified and thoroughly trained medical officer, the business would be settled, for no one would venture to block such a proposal coming from such a

source. But sad to admit, the chairman devotes his energies to personal remarks concerning the medical men who have appeared before the Corporation to urge the necessity for reform, and he produces elaborate statistics to prove that the health of the city is only under a temporary cloud, while week after week for months, Belfast is pilloried by the Registrar-General as having the highest, or one of the highest, death rates in the United Kingdom.

LETTERS TO THE EDITOR.

FOOD INSPECTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Just now when public attention is being directed to the question of the purity of food supplies, it will probably be of interest to your readers to know something of what is being done with regard to the inspection of food sold in this country.

Some seven years ago the Report of the Royal Commission on Tuberculosis made several suggestions with a view to securing the purity of the food supply, and recommended that in future no person be permitted to act as a Meat Inspector until he has passed a qualifying examination. These suggestions and recommendations were embodied in a circular issued by the Local Government Board to the local authorities throughout the country. Following on this report the Royal Sanitary Institute, in order to facilitate the carrying out of these suggestions, established special training and examinations directed to the qualification of public officers whose particular duty was the inspection of meat and food.

These Examinations for Inspectors of Meat and other Foods are held in the principal centres in England, and have by special request been extended to colonies where other examinations are held by the institute.

The syllabus for this examination was submitted to, and in general terms approved by, the Local Government Board of England, the Local Government Board of Scotland, and the Local Government Board of Ireland. The examination is made in every way as practical as possible, and the candidates are examined on actual specimens of meat, fish, canned, and preserved foods. During the period that this examination has been held, 280 candidates have come up for examination, and 193 certificates have been granted. Many of those who have obtained certificates are now holding appointments in the principal towns and ports of the country.

The President of the Local Government Board, in reply to a question in the House last week, called attention to the importance of efficient inspection of food supplies, and it is in order to make such inspection possible that the Institute are urging the necessity of local authorities having for this purpose the assistance of competent and qualified officers.

I am, Sir, yours faithfully,

J. LANE NOTTER.

Chairman of Council.

The Royal Sanitary Institute, London.

June 14th, 1906.

ARMY MEDICAL REFORM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It is not likely that Mr. Brodrick's incisive and startling letter which appeared in *The Times* last week will escape your editorial eye. This letter was followed shortly by a communication from Sir Frederick Treves which deserves equal attention. It is evident that if the Army Medical Department is to be reformed the best plan will be to copy in all main details the organisation of our Japanese allies. This is almost a shameful confession, but the position will become much more shameful if things be allowed to continue as they are, for we shall then in a short time have fallen so far behind the times that our model for the first steps will be the Chinese. They, as we know, are advancing by long and steady steps in the wake of

the Japanese. If Chinese be used as a scornful term to denote grotesque topsy-turvydom in a Government institution, nothing could be more Chinese than some of the arrangements in the present administration of our Army Medical Department. What could be more grotesque than the fact that the head of the department is the Adjutant-General—an officer probably absolutely ignorant of medical science in every respect. This officer is again under the control of a Secretary of State who may not only be ignorant of medical science, but may probably be one of the large class very common, even among leading statesmen, who scorn science in general, and distrust, or hate medical science in particular. If the cry for efficiency has any real meaning we ought speedily to see a medical man put at the head of the Army Medical Department and vested with such authority and responsibility as shall do away with the defects that led to such appalling losses from disease in the South African campaign—losses which, as Sir Frederick Treves suggests, should weigh heavily on the consciences of the people of this country. They were easily preventable and could have been prevented by medical science.

I am, Sir, yours truly,
A M.D.

June 8th, 1906.

MEDICAL EDUCATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am glad to see from his letter under above heading in your issue of the 6th inst. that "Your Correspondent" has receded from his previous position. In his article of May 9th he said, speaking of medical men: "The better their knowledge of the historical teaching universities is the clearer, probably, it will appear to them that control of medical education by the profession requires not association with, but complete dissociation from, these institutions." The universities to which he refers are, it is clear, Oxford, Cambridge, and Dublin. In his letter of June 6th, however, he remarks: "I do not think that medical interests require the separation of the medical school from Trinity College." In my letter of May 16th, I tried to suggest the value of university education for medical students. "Your Correspondent" admits the argument as far as Dublin University is concerned.

With much that is contained in his letter I agree. Of the rest there is little use in speaking, since he chooses to meet my propositions, "not discursively, but by their simple contradictions."

I am, Sir, yours truly,

CRITICUS.

WORK IN LATER LIFE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—After some years of hospital life in London we grow rather tired of it, and are glad of rest and change. We want some new fields for observation and research, where questions of interest may be assisted by those who can bring special knowledge and experience to bear upon them. During the last two years I have had opportunities of studying certain peculiar maladies or conditions which are common among those whose lives are spent in work in the slate quarries and setts in North Wales. The symptoms which come under the notice of doctors generally are rather peculiar. In a typical case the patient has been working for ten or fifteen years or more in one of the slate quarries. He complains of pain in the epigastric area, and in the back and abdomen. Sickness is sometimes troublesome. There is general debility and want of strength for work. There is apparently nothing very definite in the case, and the result is that the causes are thought to vary. Too much tea some think may be a cause, or too much whisky, though the latter is not often so. There is one symptom which is pretty constant, and that is a quick pulse, and some increase and irregularity of the action of the heart. A pulse varying from 96 to 120 is usual. Irregularity of the bowels and constipation is another symptom. Pains in the

lower dorsal region and down the thighs are usual. On inquiring carefully into the history of these cases, the conclusion we are forced to come to is that the peculiar work of quarry and sett men, for many hours a day, and for many years, then the strain from use of heavy hammers and the position of the body are also peculiar, causes cardiac dilatation and its consequences; and these cases are interesting, for we do not meet with them in our City hospital experience. It is impossible to avoid reflection on the lives of men who are fine samples of muscularity and health, but whose work is attended with consequences which are sad and distressing, and which should in some way be considered by us, as a question of fair and honest conduct.

I am, Sir, yours truly,

T.

ISOLATION HOSPITALS AND SCARLET FEVER CASES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I should be glad to add my testimony to that of Dr. Ross, who writes in THE MEDICAL PRESS AND CIRCULAR of June 13th. In the borough in which I reside, a semi-rural albeit "urban" district, there existed ten years ago no isolation accommodation of any kind for infectious diseases. The housing problem was chronic; much overcrowding existed permanently among the poor, and every year outbreaks of disease occurred even among the scattered and isolated village colonies comprised within the district where the natural surroundings are of the most favourable character. Scarlet fever attended by a considerable mortality was a frequent visitor; and the severe sequelæ mentioned by Dr. G. J. Ross, as so commonly following badly attended cases were noticeable in many instances. The sanitary administration of the whole district was in a backward condition; and with a view to improvement a ratepayers' association was formed—the Town Council, composed almost completely of small local tradesmen, showing no inclination to initiate reform. They were soon forced to open a temporary hospital for scarlet fever; and, later, to build and equip a complete isolation hospital in accordance with the requirements of the Local Government Board. The immediate result was practically to put an end to the deaths from scarlet fever, and to prevent the disease from occurring more than sporadically. During ten years there has been no wide-spread outbreak amounting to a small epidemic such as before used to occur frequently. Every one of the advantages named by Dr. Ross has been conspicuous. One advantage he does not refer to. A single scarlet fever case in a home very often means stoppage of work for every inmate engaged in wage-earning; it often means poverty and misery, or at least considerable money loss. All this is now put an end to by prompt removal of the cases and thorough disinfection of the house. The cost of the hospital and the charge on the rates for its upkeep are repaid over and over again in the benefits conferred upon the whole community.

I am, Sir, yours truly,

Reigate, June 13th, 1906.

A RESIDENT.

OBITUARY.

SIR HALLIDAY MACARTNEY, K.C.M.G., M.D.

SIR HALLIDAY MACARTNEY, for nearly thirty years British Secretary to the Chinese Legation in London, died on June 8th. He was born at Galloway in 1833, and studied medicine at the University of Edinburgh, where he took the M.D. in 1858. While a student he served with the medical staff of the Anglo-Turkish contingent in the Crimea. He was attached to the 99th Regiment, with which he went to India, and afterward to China, where he found his destiny. After the sack of the Summer Palace and the proclamation of peace, he obtained permission to enter the Chinese service. He took an active part in the Taiping rebellion. He founded an arsenal at Nanking and after

wards entered the Diplomatic Service. Later Macartney organised the diplomatic representation of China in Europe, remaining in London as Councillor to the Chinese Embassy. He was created K.C.M.G. in 1885. Sir Halliday Macartney first married a Chinese lady; in 1884 he married a French lady, and in 1902 was left a widower with three sons and one daughter.

JAMES MOWAT, M.B., C.M., Edin.

We regret to report the death, at Edinburgh, on May 25th, at the age of 43, of Dr. James Mowat. Dr. Mowat was educated medically in the University of Edinburgh where he graduated C.M. in 1887. He was Surgeon-Captain to the 9th Volunteer Brigade (Highland Brigade) Royal Scots, and Surgeon to the High Constables of Edinburgh.

SPECIAL ARTICLES.

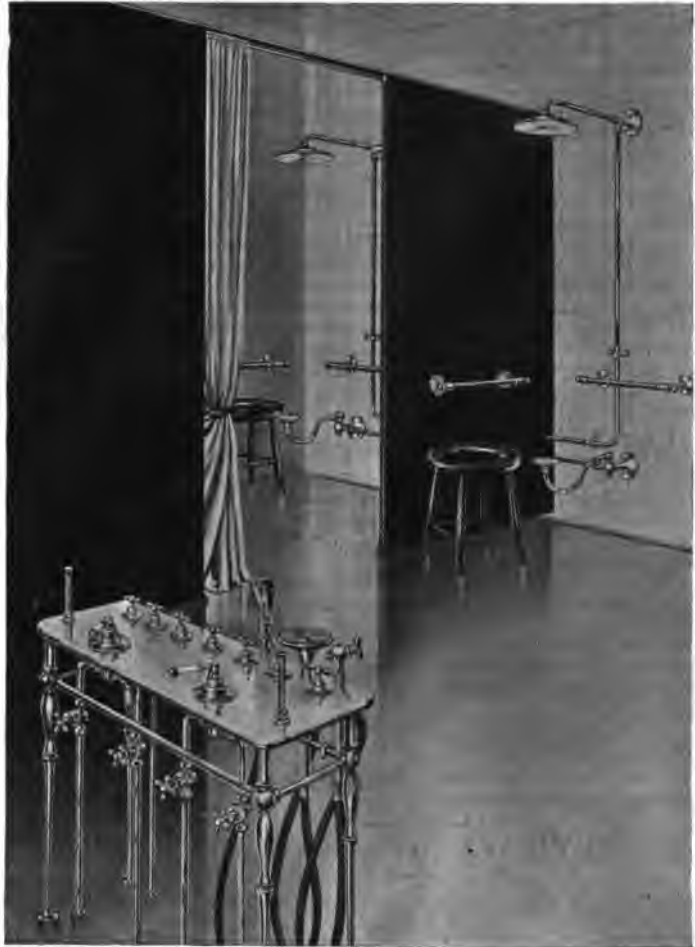
THE OPENING OF THE KING'S SANATORIUM AT MIDHURST.

THE opening of the great sanatorium for consumption at Midhurst, Sussex, forms a notable landmark of modern preventive medicine. Among all his solid claims to a lasting place in the pages of history, it may well be that His Majesty King Edward VII. will leave behind him none more lasting than that institution formally opened on June 13th. Accompanied by the Queen, His Majesty was received at Midhurst Station, which lies about seven miles from Haslemere, by the Lord Lieutenant of the County, the Duke of Norfolk, the Sheriff, and other officials and neighbouring notabilities, together with the Advisory Committee, including Sir William Broadbent, Sir Francis Laking, Sir Douglas Powell, Sir Felix Semon, Sir Frederick Treves, Sir Hermann Weber, Dr. Theodore Williams, and others. Dr. Arthur C. Latham and Dr. F. J. Wethered, who had gained respectively the first and second prizes for essays on the constitution of sanatoria, were presented to the King. The building stands some 500 feet above the sea level, in the midst of its own grounds covering upwards of 150 acres of land more or less surrounded by pine forest. The sanatorium is built almost on the centre of the site, and is divided into two portions, one for patients and the other for administrative purposes. The building is of red brick and white stone, and is distinguished by its red roof, its green shutters, and its broad balconies for patients. The interior is fitted up according to modern views, with washable and polished surfaces, good ventilators, and specially constructed furniture. The sanitary fittings by Messrs. Doulton are specially to be noted as representing the best and most advanced productions of modern sanitary science. The accompanying illustration shows a hydro-therapeutic room fitted up by that firm. There is accommodation in the King's Sanatorium for 100 patients, of whom 14 will pay eight guineas a week, and the remainder two guineas weekly, while accommodation is provided for 22 necessitous patients. The class for whom the Sanatorium is intended is the class just above the very poor, upon whom the stress of a chronic disabling disease such as tuberculosis falls with such disastrous weight. Medical men will learn a great deal by a visit to Midhurst Sanatorium.

TREATMENT OF VENEREAL DISEASE IN THE ARMY.

THE Advisory Board for Army Medical Services has issued a "Final Report" on the above subject. It will be remembered that three previous reports have been drawn up regarding the same subject, of which the first dealt with current medical literature, and with information in the possession of the Army Medical Department; the second contained the opinions of physicians and surgeons as experts; while the third was the account of a tour undertaken by Major Pollock, R.A.M.C., to collect information on the subject at various foreign centres. The intention of the present document is to present the principal conclusions to be drawn from the information previously collected, together with practical recommendations as to treatment. In this intention there is no doubt that it succeeds admirably; and while there is no new information to be found in its pages, it will be found a convenient and, within limits, a trustworthy guide for those who have to treat syphilis, particularly under the conditions of military life.

The subject of the prevention of venereal disease



does not enter into the terms of reference to the committee responsible for the Report, but, nevertheless, a section is devoted to establishing the proposition that "taking into consideration the present state of expert opinion abroad, and the opposition certain to be raised in this country should the re-enactment

(a) "The Treatment of Venereal Disease and Scabies in the Army." Final Report. London: Printed for His Majesty's Stationery Office by Eyre and Spottiswoode. Price 6d.

of a statute on the lines of the Contagious Diseases Acts be proposed, the Committee has come to the conclusion that in the United Kingdom, at any rate, an attempt to grapple with the problem of venereal disease by methods of compulsory isolation and treatment is neither practicable nor expedient."

As the question discussed was avowedly outside the immediate work of the Committee, it might have been better to refrain from any expression of opinion on the point.

There follows a full discussion of the mercurial treatment of syphilis, starting with the established fact that experience is unanimously in favour of the mercurial treatment. Considerable stress is laid on the supposed necessity of thoroughly establishing the diagnosis before starting treatment:—"It is agreed, by nearly all that the presence of syphilis must be absolutely ascertained before this drug is administered. The amount of evidence, however, required by different individuals in order to establish the diagnosis appears to vary within considerable limits." Some, in fact, believe they can distinguish syphilis by the primary sore, while others demand that secondary symptoms must have developed.

"It appears to the Committee that accuracy in diagnosis is essential to thorough treatment, and in such a matter the judgment of the medical adviser must be guided by his own experience, and by the special condition of the patient. It is, strongly felt, however, that in all cases of doubtful infection the patient should be kept under close and if necessary, prolonged observation, and that before mercury is administered, the presence of syphilis should be established without doubt. The risk incurred by delay in the administration of mercury is inconsiderable compared to the importance of a correct diagnosis."

It hardly seems to us quite established that in order to have perfectly trustworthy statistics, the health of individuals and, therefore, the efficiency of the Army as a whole is to be endangered. The first function of the medical department of the Army is to safeguard the health of the individual men, and not to compile accurate statistics, however great may be the scientific value of the latter.

The Report gives clear and thorough instructions regarding the administration of mercury, whether by the mouth, by the skin, or by injection. There is a distinct leaning toward the last method, which, as regards military practice, is certainly the most trustworthy. With ordinary aseptic precautions it appears free from risk.

Sound practical advice is given regarding the treatment of gonorrhoea, soft chancres, buboes, and scabies.

The question is discussed as to whether venereal diseases should be treated in special hospitals or not, and the opinion arrived at that the best method is to treat such diseases in specially arranged wards of general hospitals.

The Report will be found of great practical value to military and naval surgeons, and will well repay perusal by all who may have to treat venereal diseases in general practice.

REVIEWS OF BOOKS.

THREE NEW WORKS ON OPERATIVE TECHNIQUE.

DR. YELVERTON PEARSON (1) in the course of a most interesting work on Modern Surgical Technique, deals at some length with the principles and technical details required by modern surgery. The book is primarily intended for students, house-surgeons, and surgical assistants, but the author also hopes, and we

(1) "Modern Surgical Technique in Its Relation to Operations and Wound Treatment." By C. Yelverton Pearson, M.D., M.Ch., F.R.C.S., Professor of Surgery, Queen's College, Cork; Fellow and Examiner in Surgery, Royal University of Ireland; Surgeon to the North Cork Infirmary; c. &c. Pp. xix. and 392. With two coloured plates and 111 illustrations in the text. London: John Bale, Sons, and Danielsson. 1906.

think his hope will be realised, that it will be found of use to the operating surgeon and the general practitioner.

The book is divided into four parts. The first is entitled "Preliminary Considerations," and deals with such subjects as the principles of aseptic surgery, surgical bacteriology, infection, disinfection, and antiseptics. Part II. deals with prophylactic disinfection, and contains twelve chapters in which the disinfection of the hands, the use of gloves, the preparation of the patient's skin and mucous membrane, the sterilisation of instruments, and the preparation of sponges, suture materials, &c., are fully discussed. The chapter on the infection of the hands is particularly full, and in addition to containing a careful description of many of the different methods of sterilising the hands, contains an interesting account of actual bacteriological experiments on hands made by Professor Pearson and his assistants. The methods recommended certainly do not err on the side of laxity, and we confess that it is with a thankful spirit that we recognise what the ability to operate in gloves saves one. We do not mean to convey that Dr. Pearson fails to attach due importance to gloves, but we think that perhaps he needlessly emphasises the undoubted difficulties to which they at first give rise. No one can operate with comfort in gloves at the first attempt, nor at the second nor third, any more than one can at first walk with comfort in snow shoes. Constant practice however, breeds confidence in their use, and once the surgeon has got thoroughly accustomed to them he will find that it is in but few cases that he will be inclined to voluntarily discard them.

Part III. deals with wound technique—the nature and treatment of wounds, the prevention of hæmorrhage, needles, sutures, and drainage material and their uses. With regard to the all-important question of drainage, the author is inclined to the advice of Senn, "When in doubt, drain," particularly in the case of emergency operations. Part IV. deals with operative technique, post-operative treatment, operations in private houses, and asepsis in general practice. It is carefully written and contains much information of value.

Dr. Pearson puts what he has to say clearly and succinctly. His book is full of information, and is most valuable as a reference on small points, and its teaching is modern and surgically correct in all particulars. We are confident that in recommending the book to surgeons generally, our advice will be appreciated by those who take it.

MR. C. HERON WATSON (2) has accomplished a work of much value to those members of the medical profession who do not read German with facility by bringing forward a translation of Carl Haegler's work on the Cleansing, Disinfection, and Protection of the Hands. This most valuable monograph deals at considerable length with the subject of hand sterilisation and protection, and constitutes perhaps the most important work existing on the subject. Its general trend may be summed up in the author's words:—"We possess neither chemical nor mechanical means enabling us to rely with certainty on the practicability of always rendering the hands absolutely free from germs, either for the space of a moment or for a period of time requisite for the performance of an operation. In view of this, the expression "sterilisation of the hands," is meaningless. The logical outcome of such experience would seem to us to be the recommendation of the universal use of rubber gloves. Professor Haegler however, does not come to such a conclusion. Again, to quote him:—"As a rule, when operating, I wear sterile thread gloves, and these I subsequently change several times. I am well aware that these gloves are permeable; but, on the one hand, they prevent the

(2) "The Cleansing, Disinfection, and Protection of the Hands: an Experimental and Critical Study." By Dr. Carl B. Haegler. Translated by Charles Heron Watson, M.B., F.R.C.S.Ed., Assistant Surgeon to the Leith Hospital. Pp. xix. and 218. With nine full-page illustrations. Edinburgh and London: William Green and Sons. 1905

surface of the hands from coming in direct contact with the wound or the ligatures, and, on the other hand, they permit of smooth organs—such as loops of intestine—being handled with much greater certainty. Still, I do not shrink from introducing my bare hand into the abdominal cavity in prolonged investigation of its contents, or in other manipulations. In the case of all operations on inflamed tissues, I wear rubber gloves." We strongly recommend the perusal of this work to all those interested in the important subject of skin sterilisation.

DR. RUSSELL FOWLER'S (3) work on the "Operating Room and the Patient," contains about a quarter the amount of writing that Professor Hægler's work contains, but in true American fashion it is spread out so as to occupy a book of some twice the size and weight. The book is dedicated to nurses and and intern students and is in large measure intended for them. Had it been produced in a less pretentious form we should more willingly notice with favour its many good points, but when the material for a student's booklet or manual is laid before its readers as in this book, it must naturally expect to be subjected to a more severe criticism than its relative importance seems to justify. The spelling is very dreadful and is not even consistent. If we must spell "iodin" and "benzin" thus, why should "sterile" and "vaseline" be allowed to save their tails? We note that rubber gloves after disinfection are to be hung up to dry, and their surfaces kept from coming into contact by "blowing into the glove occasionally or by packing the fingers with strips of iodoform gauze." These, of course, are undoubtedly two ways of effecting the desired end, but "there are others." The last forty pages of the book are occupied by lists of instruments required for different operations. These lists will no doubt be useful to nurses, but we confess we do not see the necessity of devoting forty pages of superfine paper to them. They might equally well have been disposed of in ten pages. There are some twenty photographs of patients in different attitudes and in different degrees of undress, in addition to fifteen other illustrations.

THE DENTISTS' REGISTER, 1906. (a)

THE Dentists' Register for 1906 contains the usual information as to registration, fees upon registration, the Dental Act in full, and other important matters connected with the dental profession generally. The important notice to registered dentists which first appeared in the issue of 1904, again is prominently displayed on page 3, and it behoves all registered practitioners to see to it that their names are duly included in the list at the end of the book. It is interesting to note that the number of practitioners who were registered under the Act of 1878 as being before that date in *bona fide* practice of dentistry, is gradually though slowly shrinking, the percentage being 16 per cent., as against 18 per cent. in 1903 of the whole number of registered dentists.

THE DENTAL ANNUAL, 1906. (b)

THIS excellent work (now in its fourth year of issue) contains references, arranged with clearness and simplicity, to practically all the recent work and events connected with or touching on dental matters generally. The new educational regulations at home and in the colonies, recent professional organisations, proceedings of the General Medical Council, and many other important matters, are included in its pages. One of the features of the book is a "Directory of Dental

Practitioners," arranged topographically; while the long list of distinguished names of contributors on Pp. XX-XXI, is a guarantee of the catholicity of the special articles. It would be beyond the space at our disposal to enumerate all the many articles on novelties or improvements of the past year, but among those which we have noted specially may be mentioned those on Aluminium and its Uses in Dentistry, Anæsthetics (illustrated), and Obtundents, typical subjects which will interest all practitioners who wish to keep their knowledge of scientific progress abreast of the times. There can be no doubt that the "Dental Annual" is a reference work of the highest value, which no dentist can afford to be without.

BUCHANAN'S HANDBOOK OF SURGERY. (a)

WE have perused this very readable manual with very great pleasure and profit. It is a handbook in every sense of the word, and gives very concise and practical information on general surgery and should prove useful to those students who have learnt their surgery from many authors and teachers. To those who are about to present themselves for examination in surgery, this book ought to be of great assistance, as all subjects are carefully treated and brought well up-to-date. We have no hesitation in recommending its perusal to teachers in surgery, and advanced students preparing for examination. The subjects are divided into three sections running into twenty-three chapters, and the volume is not large, but convenient in size, and easily carried to class-room or medical school.

THE HEALTH OF OUR CHILDREN. (b)

THIS book is an attempt on the author's part to pass on some of her experiences gained in Africa and in India to mothers whose lot it may be to bear and rear their children in sub-tropical climates. The pages are full of useful and practical information regarding the ordinary ailments of infancy and childhood. After two valuable chapters on growth and development we have an account given of infant-feeding. Miss Robinson is clear and dogmatic on the question of breast-feeding, which she says must not be given up until strict investigations have been made of the case by a medical man. In speaking of the results of feeding babies on condensed milk, we notice she refers to an authority who, however, has been called by the name of Hutchenson! (Should this not be Hutchinson?) The following chapter on "Dentition," is from the pen of Mr. W. S. Marsh, and is not only short, but very much to the point. The most interesting chapter in the whole book, however, is that on "Mental Development and Early Training." The causes of backwardness are stated to be ill-health, chronic dyspepsia, rickets, and mental defects, and the management of such cases is very clearly pointed out. The section on the subject of nursing discipline is full of important hints which, if acted on, will do much to prevent children from growing up spoilt and unmanageable. The rest of the book is concerned with the diseases incident to children. A chapter on "Nursing Emergencies" is given, and includes within its purview the management of fits, burns, cuts, bites and stings, foreign bodies, earache and toothache. A number of useful formulæ are given as an appendix.

This is altogether a sensible volume, free from much of the semi-scientific language which, unfortunately, too often abounds in such popular handbooks. It is written for intelligent people by one who knows what she is talking about and who has her theme at heart.

(3) "The Operating Room and the Patient." By Russell S. Fowler, M.D., Surgeon to the German Hospital, New York. Pp. 172. Illustrated. Philadelphia and London: W. B. Saunders Company, 1906.

(a) "The Dentists' Register, 1906." Printed and published under the direction of the General Council of Medical Education and Registration of the United Kingdom.

(b) "The Dental Annual and Directory, 1906." London: Baillière, Tindall and Cox, 1906. Price 7s. 6d.

(a) "Handbook of Surgery." By George Burnside Buchanan, B.A. Cantab., M.B., C.M., F.F.P.S. Glasg., Assistant-Surgeon, Western Infirmary, Glasgow; Assistant-Surgeon, Cancer Hospital, Glasgow. Sections III., Chap. xiii., pp. 525. 6s. net. Edinburgh: John Currie, 1906.

(b) "The Health of our Children in the Colonies. A Book for Mothers." By Dr. Lilian Austin Robinson. London: Longmans, Green & Co., 1906. Price 2s. 6d. net.

The book may be recommended as a guide not only to mothers in the Colonies, but even to students and general practitioners at home who desire to have an elementary knowledge of children and their diseases. We note that there is no index, and this defect should be remedied should a second edition be called for.

NEW BOOKS AND NEW EDITIONS.

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

- BAILLIÈRE, TINDALL AND COX (London).**
A Manual of Medicine. By Thomas Kirkpatrick Monro, M.A., M.D. Second Edition. Illustrated. Pp. 1,023. Price 15s. net.
- The Nature and Treatment of Cancer (Some Methods of Hypodermic Medication in the Treatment of Inoperable Cancer).** By John A. Shaw-Mackenzie, M.D., Lond. Third Edition. Revised and Enlarged. Pp. 99. Price, 2s. 6d. net.
- Gastric Surgery: Being the Hunterian Lectures delivered before the Royal College of Surgeons of England, on Feb. 19, 21, and 23, 1906.** By Herbert J. Paterson, M.A., M.B., etc., etc. Illustrated. Pp. 181. Price 5s. net.
- Supplementary Essays on the Cause and Prevention of Dental Caries.** By J. Sim Wallace, M.D., D.Sc., L.D.S. Pp. 31. Price 2s. 6d. net.
- The Ship-Surgeon's Handbook.** By A. Vavasour Elder, M.R.C.S., L.R.C.P., Surgeon Orient Steam Navigation Company. Pp. 167. Price 3s. 6d. net.
- Manual of Anatomy, Systematic and Practical, including Embryology.** By A. M. Buchanan, M.A., M.D., etc., etc. Vol. I.: Osteology; upper limb; lower limb. With 268 illustrations, mostly original and in colours. Pp. 569. Price 12s. 6d. net.
- Phlebitis and Thrombosis: The Hunterian Lectures, 1906.** By Warrington Haward, F.R.C.S. (Eng.) Pp. 88. With eight plates. Price 6s.
- Lectures on Midwifery for Midwives.** By A. B. Calder, M.B., M.R.C.S., Lecturer on Midwifery to London County Council. Illustrated. Pp. 274. Price 6s. net.
- J. B. BAILLIÈRE ET FILS (Paris).**
Traité d'Hygiène. Vol. II. Le Sol et L'Eau, sous la direction de M.M. P. Brouardel and E. Mosny. Pp. 460.
- JOHN BALF, SONS, AND DANIELSON, LTD. (London).**
The Urethrotomy and Kidney Capsulotomy in Diseases and Injuries of the Urinary Organs. By Reginald Harrison, F.R.C.S. Pp. 96. Price 2s. 6d. net.
- CASSELL AND CO., LTD. (London).**
A Handbook for Midwives and Maternity Nurses. By Comyns Berkeley, B.A., M.B., B.C. Cantab., M.R.C.P. Lond., M.R.C.S. Eng. Pp. 283. Price 6s.
- J. and A. CHURCHILL (London).**
Preservatives in Food and Food Examination. By John C. Thresh, M.D. Vict., D.Sc. London., F.I.C., and Arthur E. Porter, M.D. M.A. Cantab. Pp. 484. Price 14s. net.
- JOHN CURRIE (Edinburgh).**
Handbook of Surgery. By George Burnside Buchanan, B.A. Cantab., M.B., etc., etc. Pp. 647. Price 9s. net.
- WM. GREEN AND SONS (Edinburgh and London).**
Green's Encyclopedia and Dictionary of Medicine and Surgery. Vol. I.: Aachen to Brain. Pp. 538.
- Notes on Local Anæsthesia in General Surgery.** By J. W. Struthers, M.B., F.R.C.S. Eng. Pp. 136. Price 2s. 6d. net.
- T. C. AND E. C. JACK (Edinburgh).**
The Edinburgh Stereoscopic Atlas of Anatomy. Edited by David Waterston, M.A., M.D., etc. Section 5: Containing 50 Stereographs. Price 25s. net.
- H. K. LEWIS (London).**
Catarrhal Fevers, commonly called Colds; Their Causes, Consequences, Control, and Cure. By R. Prosser White, M.D. Ed., M.R.C.S. Eng. Pp. 111. Price 4s.
- Clinical Bacteriology and Hæmatology for Practitioners.** By W. D'Este Emery, M.D., B.Sc. Lond. Being the second edition of "A Handbook of Bacteriological Diagnosis for Practitioners." Pp. 240. Price 7s. 6d. net.
- The Combined Treatment in Diseases of the Eye.** By G. Herbert Burnham, M.D. Tor., F.R.C.S. Edin., M.R.C.S. Eng. Pp. 82. Price 3s.
- The Public Health Acts and Other Sanitary Laws and Regulations.** Specially prepared for the Diploma of Public Health. By Martin Elliott, of the Middle Temple and Western Circuit, Barrister-at-Law; and Gilbert Elliott, M.R.C.S.E., L.R.C.P., D.P.H. Lond., D.T.M. Cam. Pp. 168. Price 5s. net.
- J. B. LIPPINCOTT CO. (London).**
International Clinics. Edited by A. O. J. Kelly, A.M., M.D. Vol. I. Sixteenth Series, 1906. Pp. 308. Price (4 vols.) 35s. net.
- LONGMANS, GREEN AND CO. (London).**
The Diseases of the Nose and Its Accessory Sinuses. By H. Lambert Lusk, M.D. Lond., F.R.C.S. Illustrated. Pp. 399. Price 25s.
- MACMILLAN AND CO., LTD. (London).**
Appendicitis: Its Pathology and Surgery. By C. B. Lockwood, F.R.C.S. Second Edition. Pp. 342. Price 10s. net.
- A System of Gynecology by Many Writers.** Edited by Thomas Clifford Allbutt, M.A., M.D., etc.; W. S. Playfair, M.D., LL.D., etc.; and Thomas Watts Eden, M.D. Edin., F.R.C.P. Lond. Illustrated. Pp. 949. Price 25s. net.
- The Obstetrical Society of London: Transactions of the Obstetrical Society of London.** Vol. XLVIII. for the year 1906. Part I. for January and February. Edited by Herbert R. Spencer, M.D., and Robert Boxall, M.D. Pp. 68. Price 4s.

- YOUNE J. FENTLAND (Edinburgh).**
Text-Book of Anatomy. Edited by D. J. Cunningham, F.R.S., M.D., etc. Second Edition. Revised and Illustrated. Pp. 1,388. Price 31s. 6d. net.
- W. B. SAUNDERS AND CO. (London).**
A Treatise on Surgery. By George Ryerson Fowler, M.D. Illustrated. Pp. 722. 2 vols. Price £3 3s. net.
- A Treatise on Diagnostic Methods of Examination.** By Prof. Dr. Hermann Sahli. Edited (with additions) by Francis P. Kinnicutt, M.D., and N. B. Potter, M.D. Illustrated. Pp. 1,008. Price 27s. 6d. net.
- Nursing in the Acute Infectious Fevers.** By George P. Paul, M.D. Illustrated. Pp. 200. Price 4s. net.
- Essentials of Genito-Urinary and Venereal Diseases.** By Staling S. Wilcox, M.D. Illustrated. Pp. 313. Price 4s. net.
- THE SCIENTIFIC PRESS, LTD. (London).**
The Consumptive Working Man: What Can Sanatoria do for Him? By Noel Dean Bardswell, M.D., M.R.C.P., F.R.S. Pp. 202. Price 10s. 6d. net.
- G. STEINBEIL (Paris).**
La Question Sexuelle Exposee aux Adultes cultives, par Auguste Forel. Pp. 604. Price 10fr.
- THE WALTER SCOTT PUBLISHING CO. (London).**
Meta-Christian Catechism: The Simpler Parts for Use with Children. By H. Croft Hillier. Second Edition. Pp. 75. Price 1s.
- SWAN, SONNENSCHNIG AND CO., LTD. (London).**
Fibroid Tumour: A New Treatment Without Operation. By John Shaw, M.D. Lond. Pp. 80. Price 2s. 6d. net.
- JOHN WRIGHT AND CO. (Bristol).**
Consumption: Treatment at Home and Rules for Living. By H. Warren Crowe, M.D. Pp. 32. Price 1s. net.
- Diabetes Mellitus: its Pathological Chemistry and Treatment; Being Part VII of several Clinical Treatises on the Pathology and Therapy of Disorders of Metabolism and Nutrition.** By Prof. Dr. Carl von Noorden. Pp. 211. Price 5s. net.

NEW PREPARATIONS.

TABLOIDS, MISTURA ALBA.

The latest form of tabloid issued by the well-known firm of Messrs. Burroughs and Wellcome is that of a compound magnesium laxative. The precise combination is 15 grains of magnesium sulphate, 2½ grains of magnesium carbonate, and 130 minim of oil of peppermint. The directions are to crush the tabloid and dissolve in water, varying the number of tabloids in proportion to the dose required. This certainly seems a practical pharmaceutical product likely to be of use to busy practitioners, and especially as the source of origin is an absolute guarantee of the purity of the drugs employed.

BOROFAX.

"BOROFAX" is an antiseptic soothing emollient, possessing sedative properties. It is said to be superior to ointment or glycerin of boric acid in therapeutic action, owing to its readiness of absorption, its pharmaceutical elegance, and its freedom from rancidity. It encourages healing of superficial lesions,



and, therefore, forms a good application for chaps, burns, scalds, and abrasions. "Borofax" may be used with advantage in the treatment of eczema and many other skin affections, and also in excoriation or disease of mucous surfaces, such as that of the nostrils. It is beneficial and soothing to the skin after driving, motoring, cycling or exposure to extremes of temperature, and is supplied in collapsible tubes of two sizes.

OPHTHALMIC CAPSULES (DUNCAN).

DUNCAN'S Ophthalmic Capsules are intended to meet the requirements of the ophthalmic surgeon, who frequently requires to prescribe a short treatment of an ointment. These capsules, after being filled with an ointment, are hermetically sealed. They have a long tapering neck, and in using them all that is necessary is to snip off the extreme end with scissors and to give a gentle pressure, when the ointment will at once exude. These capsules also keep the ointment in an aseptic condition, as no more than the quantity necessary for use becomes exposed to the air. The gelatine has no action upon the ointment. This is a great advantage over the use of the metallic collapsible tubes, which are very apt to deteriorate the ointment. These capsules may be filled with any ointment which may be required; they are kept in stock made with cocain, atropin, and yellow oxide of mercury.

MEDICAL NEWS IN BRIEF.

Royal College of Surgeons of England.

AN Ordinary Meeting of the Council was held at the College on Thursday last, Mr. John Tweedy, President, in the Chair. The following members of the College having passed the required examinations and conformed to the bye-laws were admitted Fellows of the College: Edward Victor Hugo, M.D.Lond., and St. Barts; William G. Mortimer, M.B.Lond.; William P. Noall M.B.Lond., Manch. and Lond.; George I. T. Stewart, M.B.Aberd. and St. Thomas'; Arthur F. Hayden, M.B.Lond., and St. Mary's; Harold E. Ridewood, M.D. Lond.; Ernest Ward, M.B.Camb. and Lond.; Alexander M. Webber, M.B.Lond., and Guy's; Percival P. Cole, L.R.C.P.Lond., Guy's; George R. Footner, M.B.Camb. and St. Thomas'; William M. Mollison, L.R.C.P.Lond., Guy's; William J. O. Malloch, M.B.Toronto and Lond.; James A. Coupland, M.B.Lond., and Leeds School; Vivian B. Bennett, M.B.Lond., St. Thomas' and St. Bart's; George G. Farquhar, M.B.Aberd.; Duncan C. L. FitzWilliams, M.D.Edin.

Diplomas in Dental Surgery were granted to the following candidates:—Oswald H. Anderson, James E. O. Brawn, Charles S. Brown, Hugh G. Clark, Horace G. Codner, George W. Collinson, Wilfrid J. P. Dicks, Sidney G. Elliott, Walter Elwood, Roland P. Fenn, William E. Freeman, Cecil C. Freer, Francis J. Gillett, Joseph C. Harris, Oliver W. Heald, John W. Hindle, Frank M. Holborn, William J. Jones, Charles G. Lewis, Hugh W. Mace, Horace E. Marsh, Joseph W. Meadows, George K. B. Neal, William C. Palk, John H. Parsonage, Edward S. Pierrepont, Arthur T. Pitts, Horatio L. Power, William H. Plowman, Walter Rose, Harold Simms, Frederick Smith, Albert Spray, Greenwood Stansfield, Thomas C. Stephen, Cyprian H. Taylor, Ernest Wright.

QUESTION OF ADMITTING WOMEN TO THE COLLEGE EXAMINATIONS.

A report was received from a Committee appointed to consider the question of admitting women to the examinations of the College. The committee referred to the following resolution adopted by the Council in 1895: "That the Council of the Royal College of Surgeons of England, although in favour of granting the petition of the officers and teachers of the London School of Medicine for Women, do not see their way to admit women to the conjoint examinations in face of the vote of the meeting of Fellows and Members of this college and the expressed opinion of the Royal College of Physicians." The committee expressed the opinion that the time had come for again affording the Fellows and Members an opportunity of expressing an opinion in the matter, and they recommended that the Fellows and Members be consulted as to the desirability of approaching the Royal College of Physicians on the subject. The Council adopted the recommendation of the Committee.

The following examiners were elected for the ensuing year:—Board of Examiners in Anatomy and Physiology for the Fellowship: Anatomy, Mr. L. A. Dunn, Dr. Arthur Keith, Dr. Christopher Addison, and Mr. W. McAdam Eccles; Physiology, Professor E. Waymouth Reid, F.R.S., Professor E. H. Starling, F.R.S., Professor Leonard Hill, F.R.S., and Professor de Burgh Birch, M.D. Conjoint Examining Board: Elementary Biology, Dr. T. G. Stevens and Dr. H. W. Marett Tims; Anatomy, Mr. H. J. Waring, Dr. Arthur Keith, Dr. Christopher Addison, and Mr. J. Ernest Lane; Physiology, Professor W. H. Thompson, M.D., Dr. T. G. Brodie, and Mr. J. B. Leathes. Midwifery, Dr. G. F. Blacker, Dr. Arthur H. N. Lewers, Dr. W. Rivers Pollock, and Dr. Walter W. H. Tate. Public Health: (Part I.), Dr. Harold Spitta; (Part II.), Dr. H. Timbrell Bulstrode.

A summary of the history of the college, prepared by the President and Secretary, was presented, and it was decided to publish it in future editions of the College calendar.

A letter was received from Mr. Henry Morris reporting the proceedings of the General Medical Council at their recent Session, and a vote of thanks was given to him for his services as the representative of the College in that Council.

Royal University of Ireland.

THE Royal Warrant appointing Lord Castletown, of Upper Ossory, to be Chancellor of the Royal University of Ireland in the room of the Earl of Meath, resigned, has been received at the University. Important alterations have been made both in the Arts and Medical curriculum for the coming year. In future, instead of exhibitions of £40 and £25 respectively being awarded to the first and second candidates at the final examination on the marks received by them in all subjects, three exhibitions of £25 each will be given in special branches. One of these will be given to the best candidate in medicine, one in surgery, and one in gynaecology and midwifery. This is a much needed reform and one which we believe will be received with approval by the Examining Board.

Distribution of Liege Exhibition Awards.

THE Awards of the British Section of the recent Liege Exhibition were distributed on June 13th. The proceedings took place at the Mansion House, and the Lord Mayor, Alderman W. Vaughan Morgan, occupied the chair. Mr. Imre Kiralfy, the British Commissioner-General, read a report upon the Exhibition, and the meeting was subsequently addressed by the Belgian Minister, Count de Lalaing, Sir Albert Rollit, M. Edouard Seve, Sir William Holland, and the Lord Mayor. The Diplomas were then presented by Count de Lalaing. A notable feature of the ceremony was the receipt by Burroughs, Wellcome and Co., of five awards of Grand Prix; three Diplomas of Honour, three Gold Medals, and one Silver Medal.

The American Meat Scandal.

THE effects of recent disclosures are seen on every side, letters and disclaimers reach us from various sources, and even the directors of the two great manufacturing companies, Liebig and Bovril, against whom no possible suspicion attached, are anxious to assure the medical profession and the public that their extracts are absolutely above suspicion. Last week, at the annual meeting of Liebig's Extract of Meat Company, reference was made by the Chairman to the Chicago scandal. He assured his audience that all their manufacturing departments in the River Plate were carried on under the strictest scientific control. Tuberculosis was almost unknown in the River Plate, where the company's cattle farms were situated. All the animals passed expert veterinary examination before entering the factory, and the carcasses were again inspected by a chemist after killing. The process of manufacture from beginning to end was controlled by expert chemists, while as an additional safeguard, every batch of Lemco and Oxo was analysed and tested both at the works and in Europe before it reached the trade. The company had the use of an unlimited supply of water, the river at Fray Bentos being about four miles wide, and during the whole time killing was in progress hoses played upon the tiled floors, while at the conclusion of each day's slaughter the whole place was thoroughly flushed down and left spotlessly clean.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS.

ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR,

RECENT MEDICAL LITERATURE.

Intra-peritoneal Feeding.—Schmidt and Meyer (*Deutsch. Archiv. f. Klin. Medizin*, Bd. 85, Heft 1 and 2) report that from their experiments they find that intra-peritoneal injections of normal saline solution are rapidly absorbed in animals, and that in men suffering from uræmia or from sepsis, quantities of from one to two litres are absorbed in a day or two and cause no pain. The injections are made through a blunt needle introduced through the abdominal wall, and no wounding of the intestine has up to this been produced. They have also investigated intra-peritoneal feeding, and find that 10 per cent. solutions of grape sugar can be absorbed and consumed by dogs and rabbits without harmful effect, while solutions of lactose, maltose, and dextrin are badly absorbed and cause inflammation. The human peritoneum is more easily irritated, for after the injection of 250 ccs. of 5 per cent. grape sugar solution in a moribund individual, marked vascular injection was found at the autopsy. Egg albumen solutions (10 per cent.) were also found harmful, so that the experimenters advise that in future only 1 to 2 per cent. solutions should be tried. On the other hand, fat could be administered without causing inflammation. Further investigations seemed to show that the injection of blood serum might increase the resistance of the peritoneum to infection, if given before laparotomies, and the authors also had good results from the injection of a litre of oxygen into the abdominal cavity of an individual who was suffering from extreme dyspnoea during the course of an attack of lobar pneumonia. They had previously ascertained that oxygen gas was readily absorbed in animals. Intra-abdominal medication was also tried in a case of diabetic coma, a litre of 2 per cent. sodium bicarbonate being given, but without good result. M.

Collargol Injections.—Wassmuth reports (*Deutsch. Med. Woch.*, 1905, No. 49) two cases of septicæmia with severe symptoms and with characteristic temperature curves treated by collargol injections. After the injection of 6 cubic centimetres of a 2 per cent. solution into the median vein of the arm, both cases showed rapid amelioration of the symptoms, and the temperature fell. All the constitutional phenomena rapidly disappeared, and the delirium which was present soon passed off. Both cases made a complete recovery, but one of them required a second injection owing to a slight recurrence which took place on getting up. The injection did not cause any remarkable change in the number of leucocytes present, with the exception of a slight leucocytosis unaccompanied, however, by any alteration in the relative number of the cells. M.

Courvoisier's Law.—Moynihan contributes to the May number of the *Edinburgh Medical Journal* an interesting paper on violations of Courvoisier's law. As is well known, this law states that "in cases of chronic jaundice due to obstruction of the common bile duct, a contraction of the gall-bladder signifies that the obstruction is due to stone, while a dilatation of the gall-bladder points to obstruction due to causes other than stone. The law, however, is not inviolable, and seven cases are quoted which illustrate the exceptions that may be met with. The conclusions arrived at from the series quoted and from other illustrative cases are as follows: (1) The law may be broken when there is a stone or stricture in the cystic duct causing hydrops or empyema, together with the acute impaction of a stone in the common duct. (2) It may be broken when there is a stone in the cystic duct pressing upon

the common duct, or when there is distension of the gall-bladder by an acute inflammatory process along with obstruction of the common duct by stone. (3) Another exception is found in these cases where there is chronic induration of the head of the pancreas with a stone in the common duct, and also where there is malignant disease of the common duct along with chronic sclerosing cholecystitis. M.

Some Clinical Aspects of Syphilis.—Wild (*Brit. Journ. of Dermatology*, May, 1906) in an interesting paper bases his remarks on 1,000 consecutive cases of syphilis treated during the last twelve years at the out-patient department of the Manchester and Salford Hospital for Skin Diseases. During this period 1,043 cases of syphilis representing 1,000 individual patients occurred among 20,265 hospital out-patients, giving a percentage of 5.17. In 2,000 consecutive cases seen in private practice he found 99 cases of syphilis giving a percentage of 4.95. These figures compare favourably with those of Crocker, who found 6.1 per cent. of syphilis in 10,000 cases seen in hospital out-patient practice in London. In cases of congenital syphilis a difficulty often arises of distinguishing between a bullous syphilide and the lesion of pemphigus neonatorum. Wild considers the latter disease as due to some form of septic poisoning and had several cases which occurred in the practice of one midwife; all the cases yielded readily to simple antiseptic treatment. Among the cases of congenital syphilis in six the symptoms appeared within three weeks of birth, but the great majority first developed symptoms between four and twelve weeks after birth. Among the 55 patients with primary syphilis treated, three were children under four years of age with genital primary chancres; in each case the mothers were attending the hospital with recently acquired syphilis in the secondary stage. Wild looks on the prevention of tertiary lesions as the most important point in the treatment of syphilis, and believes that for this purpose it is necessary that mercury should be given until the onset of physiological symptoms shows that all the tissues of the body have been subjected to its influence. In ordinary cases he prefers to give mercurials by the mouth, the variety of the preparation being of little importance. He treats the patients with intermittent courses of mercury, with intervals of not more than three months, and continues this in ordinary cases for two years. K.

Clinical Observations on Ulcer of the Stomach.—Schroeder (*Amer. Journ. Med. Sciences*, May, 1906,) describes a case in which he made the diagnosis of chronic ulcer of the stomach situated in the region of the pylorus and associated with hyperchlorhydria and pylorospasm. The patient was treated by nutrient enemata and washing out of the stomach with a weak solution of bi-carbonate of soda for seven days. After this a little peptonised milk was given by the mouth, but on the twelfth day the patient vomited a considerable quantity of blood. Four days later the hæmorrhage was repeated, and the patient's condition became so bad that recovery appeared almost impossible; he gradually rallied, however, and was able to leave hospital feeling quite well three weeks later. Schroeder discusses the value of surgical interference in these cases and comes to the conclusion that it is only useful where there is organic obstruction at the pylorus, or where there has been frequently repeated hæmorrhage. In cases where the obstruction is due to simple pylorospasm he considers that gastro-enterostomy does

not afford much prospect of establishing physiological rest and drainage of the stomach. K.

Double Hemiplegia.—Rhein (*Amer. Journ. Med. Sciences*, May, 1906) records four cases of double hemiplegia, all of which ended fatally. In each case the lesion was of syphilitic origin, in one syphilitic encephalitis, in the other three cerebro-spinal syphilis. From an examination of these cases, Rhein draws the following conclusions: (1) In brain syphilis small microscopic foci of softening may occur in the cortex, the result probably of cutting off of the blood supply, and giving rise to hemiplegic symptoms and mental disturbances. (2) Syphilitic inflammatory encephalitis, while described comparatively rarely, may occur, and is probably due to inflammation originating in the small vessels of the cortex by the syphilitic poison circulating in them. (3) The change in the blood vessels is not always uniform. Sometimes the adventitia is more intensely involved and sometimes the intima. (4) Double hemiplegia, if not uncommon, is certainly not frequently described. K.

The Treatment of Arthritis Deformans with the Roentgen Rays.—Anders, Judson, Daland, and Pfahler (*Journ. Am. Assoc.*, May 19th, 1906), in a preliminary report, record two cases of arthritis deformans treated by the X-rays. In both cases the patients suffered from pain, swelling, and stiffness in the joints for the past four or five years, with great restriction of movement, some of the joints being ankylosed. The radiographic examination showed decalcification of the bones, erosion of the joint surfaces, and in some an exudate into the joint spaces. In the first case, in order to rule out any constitutional effect, only the joints of the wrist, elbow, and shoulder of the left side were selected for treatment. The man was treated three times a week, with a medium tube, at a distance of fifteen inches, with one milliamperes of current. Each treatment lasted about fifteen minutes. After the third treatment there was distinctly less pain and stiffness. In three weeks radiographic examination showed a decided improvement, and in nine weeks the joints seemed almost quite cured. Similar results were obtained in the second case. The efficiency of the treatment was all the more pronounced, inasmuch as the untreated joints did not appreciably improve. D.

Dietetic Management of Diabetes.—Croftan (*The. Gazette*, Detroit, May, 1906) insists on four points of special practical value in the dietetic treatment of diabetes. The first of these points is the danger of too much meat. Meat actually leads to sugar excretion in diabetes and excessive meat feeding favours the development of acidosis. Withdrawal or reduction of meat appreciably increases the tolerance for carbohydrates, even in mild cases. The second point is the danger of too little carbohydrates, which results in acidosis and finally coma. It is important to determine the tolerance or the so-called boundary of assimilation for carbohydrates in each case of diabetes. Third, a diabetic should receive the largest amount of fat in his food that he can possibly stand. Not only does fat spare the tissue albumins, but its caloric value is so high that it aids most materially in maintaining nutritive equilibrium. Fourth the value of the rice, potato, milk, and oatmeal cures. Croftan's experience has been limited to the oatmeal cure. He claims that if the rule is observed to stop the oatmeal cure if good effects are not seen within three days, the number of bad results will be reduced to insignificant figures. The best results are obtained in juvenile diabetics, and he urges that no case of juvenile or adolescent diabetes should be deprived of the benefit of an oatmeal cure. D.

Simple Test for Impending Mercurial Intoxication.—Severino (*Semain, Medicate*, Paris, 1906), has found that existing or impending mercurial saturation can be revealed by touching one or more of the teeth with fresh tincture of iodine. As the patient then wets the teeth with saliva, they turn pink in case of intoler-

ance or saturation, while this does not occur when the mercurial treatment is being well tolerated. The mercury eliminated in the saliva combines with the iodine to form the red biniodide if the proportion in the saliva is excessive. The proportion eliminated in the saliva is minimal when the kidneys and other emunctories are working properly, and the test gives negative findings, but when the mercury is accumulating unduly in the system this is revealed by the pink stain of the teeth after they have been touched by the iodine. D.

Addison's Disease on Traumatic Basis.—Börrmann (*Deut. Arch. f. Klin. Med.*, Leipsic, 1906) reports a case which he had opportunity to observe for four years, with the *post mortem* findings. There was not a trace of anything to suggest either tuberculosis or syphilis. The patient, a man, had fallen on the edge of an open trunk, hitting the region of the right suprarenal. He never quite recovered from the accident, and in the course of a year developed symptoms of Addison's disease, to which he succumbed three years later. Both suprarenals were found transformed into large hard tumours with necrosis in the centre, and no trace of suprarenal substance could be discovered. The solar plexus was mostly included in the tough fibrous mass forming the tumours. It is the first case on record, he says, of true Addison's disease of unmistakable traumatic origin. D.

Cirrhosis of the Pancreas in Diabetes.—Herxheimer (*Virchow Arch.*, Berlin, 1906) has had the opportunity of examining the pancreas in thirty-six cases of diabetes and his conclusions are rather against the "island of Langerhans theory." He is inclined to accept changes in the parenchyma of the pancreas as the cause of diabetes. In five cases described in detail, the alterations in the parenchyma of the pancreas were very pronounced. They were accompanied also by the efforts at regeneration characteristic of cirrhosis of the pancreas. This indicates that not only anatomically, but also physiologically, the essential injury inducing the diabetes must be sought in the parenchyma rather than elsewhere in the pancreas. D.

Senile Epilepsy Treated with Potassium Iodide.—McDougall (*Med. Chronicle*, April, 1906) records the case of a man, *æt.* 65, who early in 1905 was first attacked with an epileptic seizure. After some months the attacks became of almost daily occurrence and the patient was admitted to the David Lewis Colony. He was a strong, well-built man with no sign of organic diseases. On admission to the Colony he was given work in the joiner's shop, and 30 grs. of bromide of potassium were administered nightly. This treatment was continued for about a month, and though the patient was brighter and felt happier the fits continued with undiminished frequency. The treatment was then changed and ten grains of the iodide of potassium were given three times a day. On the fourth day of this treatment the seizures ceased, and have not returned though the dose of the drug has been greatly reduced. K.

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

THE Army Medical Department Report for 1904 has been issued as a Parliamentary Paper [Cd. 2,700]. It states that the total admissions to hospital during the year, from a force of 224,425 warrant officers, non-commissioned officers, and men, was 159,644, and the total deaths 1,592, and the total number of men finally discharged from the service on account of disease and injuries was 4,778.

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

AN ALLEGED BREACH OF ETIQUETTE.

We understand that the reports published in the newspapers, and referred to in our issue for May 30th, regarding an alleged breach of professional etiquette by Professor W. R. Smith in sending a circular letter to sundry Metropolitan mayors, had very little foundation in fact. We are glad to learn that Dr. Smith entirely repudiates the allegation, and that the letter referred to was sent to the mayor of one district only as a private friend. Any of our comments, based on erroneous newspaper reports, we, of course, willingly withdraw. It appeared to us at the time hardly credible that such a step could have been taken by a gentleman occupying so prominent a position in the medical world.

QUARANS (Chichester).—The most recent available statistics of the Metropolitan Asylums Board on the point are those for May, 1906. They return five cases of small-pox under treatment as against ten and six at the end of the two preceding months. These figures would have been much more disquieting had not the amount of susceptible material in the metropolis been considerably reduced by the epidemics of the last few years.

E. L.—Your letter is unavoidably crowded out.

M.R.C.S. (Liverpool).—Quite a partisan statement. Take no notice of it under existing circumstances.

Dr. F. S. T. will find the subject fully referred to in our Editorial columns last week.

ROBUSTOR (Carna).—The best circulating medical library is Mr. H. K. Lewis', 136 Gower Street, London.

PRESCRIPTION WRITING.—LATIN v. ENGLISH.

APROPOS of recent correspondence concerning medical prescriptions, whether they should be written in Latin or plain English, our contemporary, *The Globe*, tells the story of a physician, who, prescribed syrup of buckthorn for an old lady, wrote it in the usual form, "Syr. Ram. Cat." When she called again, he asked her whether she had taken the medicine. "No," she replied, indignantly, "I ain't a goin' to take ram cats for anybody."

CLINICAL LECTURES.

We have Clinical Lectures in hand by the following, the receipt of which is hereby acknowledged:—

"**Hæmatemesis.**" By Geo. Pester Chappel, M.D.Cantab., M.Ch., Physician to Tottenham Hospital (lecture delivered at the North-East London Post-Graduate College).

"**The Hæmoptysis of Tuberculous Subjects.**" By Prof. G. Lemoine, M.D., of the Paris Faculty of Medicine.

"**Some Points regarding Empyemata.**" By Herbert S. French, M.D.Oxon., M.Ch., M.B.C.P.Lond., Medical Registrar of Guy's Hospital (lecture delivered at Guy's Hospital).

"**Carcinoma.**" By Chas. B. Lockwood, F.R.C.S.Eng., Surgeon to St. Bartholomew's Hospital (lecture delivered at St. Bartholomew's Hospital).

"**The Diagnosis and Treatment of Ringworm.**" By G. Norman Meschen, M.D.Lond., B.Ch., M.B.C.P.Lond., Physician for Diseases of the Skin to the Tottenham and the West London Hospitals (lecture delivered at the North-East London Post-Graduate College).

"**Fæces Abscess, its Nature and Treatment.**" By B. C. Yelverton Pearson, F.R.C.S., F.R.U.I., Professor of Surgery in Queen's College, Cork (lecture delivered in Queen's College).

"**The Value of Philipowicz and Bernard's Signs in the Diagnosis of Typhoid Fever.**" By Prof. Louis Regis, of the Paris Faculty of Medicine.

"**The Surgical Aspects of Tubercular Peritonitis.**" By Francis J. Steward, M.S., M.B.Lond., F.R.C.S., Assistant Surgeon to Guy's Hospital and to the Hospital for Sick Children (lecture delivered at Guy's Hospital).

"**The Clinical Examination of the Blood.**" By Arthur Whiting, M.D., M.B.C.P.Lond., Dean of the North-East London Post-Graduate College, Physician to the Tottenham Hospital and to the Mount Vernon Hospital for Diseases of the Chest (lecture delivered at the North-East London Post-Graduate College).

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JUNE 20th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chelms Street, W.C.).—4 p.m. Mr. P. J. Freyer: Clinique. (Surgical). 5.15 p.m. Lecture.—Mr. E. T. Collins: Cataract (with lantern slide demonstration).

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

THURSDAY, JUNE 21st.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chelms Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m. Lecture.—Sir J. McFadyean: Anthrax.

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

FRIDAY, JUNE 22nd.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chelms Street, W.C.).—4 p.m. Mr. A. Lawson: Clinique. (Eye).

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

SATURDAY, JUNE 23rd.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN (Radcliffe Infirmary, Oxford).—3 p.m. Country Meeting. Papers by Dr. G. Carpenter, Dr. B. Rogers, Dr. E. C. Williams, Dr. Collin, Dr. A. G. Gibson, and Dr. H. Croly. Exhibition of Clinical Cases, Pathological and Anatomical Specimens.

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

MONDAY, JUNE 25th.

ODONTOLOGICAL SOCIETY OF GREAT BRITAIN (20 Hanover Square). 8 p.m. President's Valedictory Address. Short Papers:—(I) Mr. J. F. Colyer, L.R.C.P., M.R.C.S., L.D.S.: On Some Odontomes in the Museum of the Society" (illustrated with lantern slides). (II) Mr. F. Lawson Dodd, L.R.C.P., M.R.C.S., D.P.H., L.D.S. Some Notes on Oral Conditions in Relation to Tuberculosis.

Vacancies.

City of Leeds.—Assistant Medical Officer of Health and Chief Inspector of Nuisances. Salary £300 per annum. Applications to Robert E. Fox, Town Clerk.

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

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

Poplar Hospital for Accidents, Poplar, E.—Senior House Surgeon. Salary £135 per annum, with board and residence. Applications to Percy Rogers, Secretary.

Cambridgehire, &c., Asylum.—Senior Assistant Medical Officer. Salary £150 per annum, with board, lodging, and attendance. Applications to T. Musgrave Francis, Clerk to the Visitors.

St. Bartholomew's Hospital and College.—Demonstrator of Chemistry. Salary £150 per annum. Applications to T. W. Shore, Dean.

St. Bartholomew's Hospital and College.—Demonstrator of Physics. Salary £150 per annum. Applications to T. W. Shore, Dean.

Devon County Asylum.—Third Assistant Medical Officer. Salary £140 per annum, with board, lodging, washing, and attendance. Applications to Medical Superintendent, County Asylum, Exminster.

Cardiff Asylum.—Medical Superintendent. Salary £850 a year, with unfurnished house, light, coal, vegetables, and washing. Applications J. L. Wheatley, Town Clerk.

Jadray 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.

BRENNER, C. [S., M.D.Édin., D.P.H.Camb., Medical Officer to the Education Authority, Widnes.

COLLISON, HAROLD, M.B., B.S.Lond., F.R.C.S.Eng., Surgical Registrar to the General Infirmary, Leeds.

KITCHEN, H. E., M.B.O.S., L.R.C.P., House Surgeon to the Tottenham Hospital, London, N.

LANGLEY, ALFRED FARDON, M.D., C.M.McGill, L.R.C.P., L.R.C.S., L.M.Édin., L.F.P.S.Glasg., District Medical Officer by the Bath Board of Guardians.

O'DONNELL, JOHN, Visiting Medical Officer to Kilmatham Prison.

RIDOUT, C. A. SCOTT, M.S.Lond., F.R.C.S.Eng., Surgeon to the Aural and Throat Department of the Portsmouth and South Hants Eye and Ear Infirmary.

WALKER, THOMAS WARBURTON, M.B., Ch.B.Vict., District Medical Officer by the Tebbury (Gloucestershire) Board of Guardians.

WATSON, GEORGE W., M.D.Lond., M.B.C.P., Medical Registrar to the General Infirmary, Leeds.

Births.

GASKELL.—On June 11th, at Briar's Hey, Stechford, Birmingham, the wife of Leonard S. Gaskell, M.A., M.B., B.C.Cantab., of a son.

SAW.—On June 15th, at 27 Junction Road, Southsea, the wife of Major F. A. Saw, R.A.M.C., of a daughter.

Marriages.

YEARSLEY-SECKENDORFF.—On June 14th, at St. Thomas's Church, Orchard Street, London, Percival Macleod Yearsley, F.R.C.S., Senior Surgeon to the Royal Ear Hospital, to Lavinia Rose, widow of the late Siegmund Seckendorff, Esq.

Deaths.

RINGER.—On June 12th, at 20, Lansdown Terrace, Cheltenham, Dep. Surgeon-General Theobald Ringer, M.B., Indian Medical Service, late 7th Bengal Cavalry.

SKRIMSHIRE.—On June 8th, at Bag Enderby Rectory, the Rev. Arthur James Skrimshire, M.D.Édin., J.P., Rector of Somersby and Bag Enderby, Lincolnshire.

TAYLOR.—On June 15th, at Derby, of heart failure, Charles Henry Taylor, M.B., F.R.C.S., aged 48.

TROTTER.—On June 14th, at 4, St. Peter's Terrace, York, Surgeon-Colonel J. W. Trotter, late Coldstream and Scots Guards, eldest son of the late J. Trotter, M.D., of Durham.

THE MEDICAL PRESS AND CIRCULAR.

"SALUS POPULI SUPREMA LEX."

VOL. CXXXII.

WEDNESDAY, JUNE 27, 1906.

No. 26.

NOTES AND COMMENTS.

The Blaenavon Case.

THE recent embroilment at Blaenavon, which ended in the erasure of Dr. Bawden's name from the Medical Register, has excited a good deal of public comment.

As most of our readers are aware, two local practitioners had refused appointments to a local Tradespeople's Doctors' Fund, on the ground that the committee had canvassed the district, and, without any authority, had announced them as medical officers. Dr. Bawden was then introduced into Blaenavon, and his name widely circulated by the Fund in a further canvass. After various warnings from official bodies, Dr. Bawden gave up the post, but proceeded to circularise some of the members personally and by letter. For this last offence he was struck off the *Register* by the General Medical Council. In certain quarters this sentence is stigmatised as one of tyrannical and malignant cruelty. Most medical men will think otherwise, and will congratulate themselves that the Council, albeit in a roundabout fashion, is able to do something for the good of general practitioners. Sometimes the action of the Council has seemed to savour somewhat of persecution, but in a case like that of Blaenavon their disciplinary powers afford the sole safeguard against practices that have always been condemned by an honourable profession.

For Fees within Only!

THE disciplinary powers of the General Medical Council are mainly domestic. It is to that disastrous condition of affairs that the present unhappy plight of the general

practitioner is attributable. The Council enforce a cast-iron discipline upon duly qualified men, but at that point their duty ends, at any rate, so far as the defence of the legally qualified is concerned. The result is that after a costly education the practitioner finds himself faced with a laborious life in which he is handicapped by the ceaseless competition of illegal medical practice of all kinds, such as bone-setting, electrolysis, electrical treatment, and often undisguised quack medical practice of various kinds. How long will the profession tolerate a Council that makes no attempt to defend them against this piracy? The answer is probably that the policy of the Council will never be altered materially until its constitution is radically changed, so that instead of representing the interests of a number of corporate bodies, it becomes the champion of the

whole profession. That consummation, however, does not appeal to the majority of the Council, as shown by their recent contemptuous refusal to increase the number of direct representatives. What is there to fear so much, we wonder, in members chosen by general practitioners?

Shoddy Learned Titles.

FOR years past there has been a growing tendency amongst persons not possessing the right to add recognised and legitimate letters after their name to secure others from the most curiously unexpected quarters. Thus photographic societies have their members and fellows, herbalist societies (a sort of quack medicine cult) follow the same practice, together with friendly societies, salvationists and all kinds of bodies, eclectic, learned, semi-learned, social, scientific, semi-scientific, and what not. As a rule, the vanity is transparent and may be dismissed with a passing smile. Now and then the assumption is fraudulent, as when a quack uses the letters M.S., implying he is a surgeon, and explaining it as student of medicine or of music or some equally misleading description. Certain ambulance students have recently been unwise enough to add the letters M.B., M.A. to their names. The serious nature of this offence against good taste has brought the matter under the official notice of the British Medical Association.

Value of Ambulance Work.

IN the case of the St. John's Ambulance Association it must be particularly vexatious to the leaders of the movement to note such un wisdom on the part of any of their flock. The success of their work has been conspicuous. It has supplied to the man in the street that practical knowledge of how to meet accidents and sudden illness which he may find of incalculable value at any moment. Such knowledge is indeed power, and its possession converts the helpless onlooker into a skilled assistant able to prevent suffering, and it may be to save life and limb. Of course, there is a tendency on the part of the Ambulance student to make too much of his half knowledge, but none the less he is a distinctive and valuable product of our latter-day humanity. It would be a thousand pities were a handful of foolish ambulance students to bring discredit on a great national organisation by their attempts to impose on the public by borrowed plumes. Nor is it likely that they will escape reprimand from headquarters.

LEADING ARTICLE.

THE NEWSPAPER PRESS AND QUACKERY.

WE have full warrant for the statement that the attitude taken up by us with regard to quackery and the newspaper press has the approval of the profession, and we propose to keep the question to the front, by devoting space to it if necessary every week, until we shall have done what lies in our power to abate or put an end to the scandals and evils we have already to some extent exposed. Whatever we may achieve in this direction must be very far more to the advantage of the public than the profession. It may, indeed, be worth while once more to point out, as we have on several occasions previously explained, that it is at least extremely doubtful whether from the sordid point of view quackery does any harm whatever to the legitimate practitioner, whilst on the other hand it is certain that it forms for him a constant source of profit. Quackery constitutes a potent factor in deterioration of the public health: It manufactures invalids; it converts simple into chronic diseases; it renders chronic cases incurable. The great majority of victims from the hands of quacks gravitate sooner or later into those of qualified men, and money which would not otherwise be earned is thus put into the pocket of the profession. So far, therefore, as motives are concerned, the profession and its organs in the press may go into the fight against quackery with a clear conscience. It is a fight in which no lover of humanity, knowing the facts and having the power, could refuse to take part. The medical profession has hitherto remained almost powerless. Without the help of the lay press it has been impossible to prove their unselfishness; impossible to keep the facts clearly, fully, and persistently before the public until they might become understood and accepted by all the classes who need enlightenment. Quackery is a gigantic evil; it is rapidly growing, and its growth to a very great extent is due to the fact that no matter how gross and palpable the fraud, or even if the fraud has been exposed and stigmatised in the Courts of Law, the advertisement finds unquestioned admission into almost every newspaper. No doubt the proprietors and managers are often not fully aware of the nefarious character of the traffic they are abetting; we hope before we have done to dissipate any doubts in this regard. Many of the smaller papers are ashamed of the use to which they allow their advertising columns to be put, but when challenged on the subject excuse themselves on the plea that similar announcements are admitted to all the principal papers, from the *Times* downwards. This plausible, if not valid excuse, has reached us in more than one instance, and the fact that it can be put forth renders it imperative that reform shall begin in the leading journals. We must convince these papers that quackery is a system of fraud more cynical and more cruel than any practised by the great army of malefactors who live and amass

wealth by preying upon the public by the various methods of chicanery, which, practised with sufficient cunning, leave them clear of the meshes of the law. Quackery in its least hurtful form, as exemplified in "hair restorers" and bogus cosmetic preparations of a similar kind, merely picks the pockets of its victims; but many purveyors of such articles, among whom must be included a certain class of quack dentist, make their money by extortion or even blackmail practised upon the foolish women for whom they lay themselves out. The simplicity of such women may be gauged by the fact that enormous sums, for which ample returns must be made, are spent on advertising such gross swindles as mechanical apparatus warranted to cure organic deformities of the features. Quackery in its more harmful forms is a cause of suffering, misery, and death, and these results are brought about not only by quack practice, but by the lying advertisements of absolutely worthless nostrums upon which the victims of serious disease are induced to rely. In attacking the newspapers for their conduct in regard to quackery we have first singled out the *Times*, for the reason that, whilst nearly all the other leading papers have always admitted quack advertisements, the *Times* has until lately remained as honourably distinguished in this matter as it has been superior in the tone and quality throughout of its editorial pages. Not only did the *Times* formerly, for many years, refuse advertisements of a kind which brought in enormous incomes to its contemporaries, but it also took every occasion to expose and condemn medical quackery in every form. From its leaders on the subject we have frequently quoted. The proprietors have only to refer to their files of former years to learn, if, as appears, they have forgotten the character of the traffic to which they are now giving countenance. To the other great London journals, the *Morning Post*, the *Daily Telegraph*, the *Daily Mail*, and the *Standard*, we shall in due course devote more direct attention. In the matter of quack advertisements, they are all offenders. The three first named are all owned by Peers of the Realm. Each of these noblemen has made his position and gained his wealth by means of the paper he owns. Here, surely, if anywhere, is a case of "*Noblesse oblige*"; these wealthy noblemen dare not for shame stoop knowingly to augment their incomes by abetting, however remotely, the cowardly wretches who live by the plunder of suffering humanity. They may be shocked to be told that any portion of their income is at present derived from such a source; they can easily verify the statement by inquiring into the character of quack advertisements to which they give publicity. They may easily learn further that the appearance of these fraudulent announcements in the columns of leading journals, especially when under such distinguished ownership, is taken by many of the simple public as a guarantee of the good faith of the advertisers, and many a victim who might otherwise not be caught is thus inveigled into hands where robbery and maltreatment await him.

NOTES ON CURRENT TOPICS.

Army Medical Reform.

Two eminent men, well-qualified to speak about Army and medical administration, have recently insisted upon the necessity for instructing officers and men of the land forces in sanitation and hygiene. They are Mr. St. John Brodrick and Sir Frederick Treves. The former recalled the fact that at Walcheren, in 1804, the British loss from wounds was sixteen per thousand, as against 34·7 from disease. In the Crimea the corresponding figures were 150 and 230, while recently in South Africa they were 42 and 69. The sickness-rate in the last-mentioned campaign, however, was enormous, as there were 746 per thousand admissions to hospital for disease, as against 34 for wounds. Since the war much has been done to increase the strength and efficiency of the R.A.M.C. The fatal trend in the present system, however, appears to be in the subordination in sanitary matters of the medical to the combatant arm. The only path of safety is that which hands over to a skilled scientific officer the supreme control of camps, water supplies and other sanitary matters. The more that officers and men learn to appreciate the value and necessity of hygiene the more ready will they be to obey medical orders. The Director-General, according to Mr. Brodrick, should have a seat on the Army Council, and be independent of the Adjutant-General. In our opinion the medical branch of the service is one of paramount importance to the general efficiency of the Army.

A Medium Exposed.

THE cult of spiritualism appears to be founded and maintained by a carefully organised system of fraud. At any rate, exposure of some gross roguery or other invariably follows anything like a skilled and resolute investigation of its alleged phenomena. Hence it is reasonable to suspect that trickery lurks behind other spiritualistic wonders, even where it is difficult or impossible to demonstrate its existence. For obvious reasons the greater number of spiritualistic professors—if that term may be used—escape detection. Now and then, however, they are enmeshed in the nets of the hunter, but the matter usually ends with a few humorous paragraphs in the daily newspapers. The exposure of one Craddock, however, last week in Edgware Police Court, had a more eventful ending in the shape of a fine of £10, and five guineas costs, or in default a month's imprisonment. The exposure was made by a stalwart Colonel, who was told that the spirit of a brother officer had come to him. A face, with a very fuzzy and much turned-up moustache appeared to him through the gloom of the darkened room. The gallant Colonel then seized the pair of shoulders corresponding to the ghostly face and held on, while another officer flashed a light on the scene, and revealed Craddock, the medium, playing the part of the visiting spirit. The Colonel and his comrade paid half a guinea each for admission to

the séance, but their fees are presumably paid by the *Daily Express*, which is the real prosecutor. It would be a great boon to the public were some of our energetic newspaper proprietors to attack the far more noxious trade in quackery and patent medicines, compared with which spiritualism is a lame affair. Fraudulent nostrum vendors wax rich and pay large sums for advertisement whereas spiritualists carry on operation—and advertise—on a small scale.

Marriage and Degeneracy.

PHILOSOPHERS since the dawn of history have from time to time endeavoured to frame laws with a view of raising the physical standards of their countrymen. The most logical attempt was perhaps that of Sparta, which in ancient times destroyed forthwith all infants who showed bodily defects. There are many arguments, however, against the discharge of such a function by the State. The mere fact that some of the best intellects are associated with defective frames is alone sufficient to condemn any scheme which aims at the exclusion of bodily degenerates. In short, the evolution of mankind must apparently be guided in the future mainly by such natural laws as sexual selection and the lessened chances of survival of degenerates in the struggle for existence. At the same time, a great deal might be effected by the growth of higher general morality especially as it affects marriage. Perhaps one of the most fertile sources of national degeneracy is the marriage of the unfit. What reasonable objection could there be to a law prohibiting the marriage of persons actually insane, consumptive, or syphilitic? Clearly there is much to be said in favour of a medical examination of all candidates for matrimony. A Roumanian professor, Dr. Torna Torneska, is evidently an enthusiastic supporter of that view. He has actually introduced into the Roumanian Senate a Bill prohibiting marriage to all persons affected with chest diseases, organic affections of the heart, general paralysis, or any infectious disease which might prove injurious to their offspring. Although there is not much chance of any such Bill becoming law, there is always an educational value attached to the airing of important abstract theories of the kind in legislative chambers.

School Boards and Medical Officers.

IT is no less interesting than encouraging to note the growing tendency on the part of the medical profession to organise for definite practical purposes. In Dundee, a representative meeting of medical men was recently held at the instance of the local branch of the British Medical Association. Their object was to discuss the proposed appointment of a medical officer to the School Board. The meeting was practically unanimous in resolving that it would be improper for any member of the profession to undertake the post in question under the proffered conditions. The chief objections were that the duty and responsibility of the family attendant would

be unduly interfered with, that the prescribed form of certificate involved a breach of professional confidence, and that emoluments and other conditions of employment were unworthy of acceptance. The situation, thus clearly defined, seems based upon perfectly fair and understandable grounds. Unfortunately, the usual candidate of "independent" views, who is content to accept the post on any conditions, has appeared upon the scene. If the contentions of the local association be correct, the Defence Societies and the General Medical Council may have some future say in the matter to this gentleman.

Academic Medical Costume.

THERE is much to be said in favour of the practice of wearing academic robes at public functions. Picturesqueness is a feature of social life the value of which no community, however sober and sedate its national character, can afford altogether to set aside. Even the Puritans of the Commonwealth, in their search after austere ideals, adopted a dress that to this day forms a favourite model for painters. So far as the medical profession is concerned, they have never been much given to wearing college robes on public occasions. It is one of the signs of the times, perhaps, that of late years the tendency to appear clad in distinctive costume on state occasions has seized more or less upon the professional imagination. The annual medical gathering at St. Paul's Cathedral has given a considerable impulse to the robe-makers' business. Indirectly it has led to the demand for distinctive robes from Colleges that had been hitherto content to exist—in some cases for hundreds of years—without any such outward and visible sign of learned confraternity. That the practice is growing in popularity may be gathered from the fact that academic costume is to be worn at this year's Prize Distribution at Guy's Hospital, when the presentations will be made by Sir W. Cameron Gull, Bart., and all visitors are expected to be duly robed.

Recognition of Urinary Deposits.

A SURE and rapid method of enabling a medical man to recognise all the elements in a urinary deposit under the microscope has long been wished for. The usual stains can be employed and give more or less help at different times and with different elements in the deposit, but unfortunately the stains diffusing through the fluid in which the deposit is suspended render the contrast weak, even if they succeed in fixing the elements themselves. Without stains the difference in refraction between the fluid containing the casts and the casts themselves is so little that it is difficult to distinguish outlines accurately. An ingenious way of overcoming these difficulties has been devised by Amann, who finds that if finely divided pigments are used instead of diffusible stains the fluid is coloured deeply and the elements themselves are unstained. Consequently they stand up sharply against a dark background and are readily distinguished. Amann suggests the use of

ordinary Indian ink, such as is used by black-and-white artists, or Prussian blue, for the purpose. A drop of the fluid to be examined is placed on a stick, a touch of the pigment added, and the whole placed under a cover glass, when a dark groundwork of colour is obtained against which the elements of the deposit appear in sharp contrast. This simple and ingenious plan is well worthy of trial.

The Sale of Poisons.

THE Council of the Pharmaceutical Society have issued to the chairmen and secretaries of County Councils throughout Ireland an important circular with reference to the proposed abolition of some of the restrictions on the sale of poisons. It points out that there is at present no practical inconvenience entailed on farmers by the restriction of the sale of sheep-dips and other such poisons to qualified persons, since there are about fifteen hundred people qualified to keep open shop for the sale of poisons, in addition to many apothecaries. As there are thirty-two counties in Ireland, it follows that there are about fifty registered druggists for each. As in the agitation on the subject special reference has been made to sheep-dips, the circular does well to mention that several of the best dips are non-poisonous, and that two of the three recommended by the Department of Agriculture are non-poisonous. It has to be impressed on the public that the restrictions on the sale of poisons are in the interest of the public, and not of any trade or craft. We hope that the Pharmaceutical Society will meet with success in this endeavour.

Enteric Fever in an Asylum.

ON Saturday, the 23rd inst., the Metropolitan Asylums Board was notified of a serious outbreak of enteric fever at one of the newest institutions, namely, Belmont Asylum. The report of the Asylums Committee showed that up to June 18th fifty-four patients had been attacked, as well as two attendants. There had been four deaths, in two of which, however, the primary cause was returned as tuberculous. It is not surprising to learn that this report gave rise to an animated discussion at the Board, where the explanatory remarks of the Chairman of the Asylums Sub-Committee were sharply criticised. As one member pointed out, here was "the first sanitary authority in the world," which had allowed an epidemic of that kind to drag on until the district authority had been compelled to ask the Local Government Board to look into the matter. From the chairman's statements it appears that there were no nurses in the Asylum, but that at the end of twenty-one days, when there were forty-five patients, two male nurses were engaged. Even at the time of the report, incredible as it may seem, the cause of the outbreak had not been ascertained. If these things be true, then it is indeed time the Metropolitan Asylums Board ceased to be a nominated body and came under popular control. Money has been always spent by the Metropolitan

Asylums Board like water. One of the complaints against its administration has hitherto been the over-staffing of its institutions. Yet, in the case of Belmont, if the official statements made on Saturday last are to be accepted, we find forty-five patients suffering from typhoid fever placed under the care of two nurses. If no better provision were made in the hurry and confusion of a great campaign it would arouse the public indignation. In a great metropolitan Board with unlimited resources, whose watchwords are up to date science and perfect organisation, the possibility of an occurrence of this kind simply illustrates to our mind the laxity that is bound to creep in where the administration is not subjected to the unceasing vigilance of popular control.

The Studio Murder

THE extraordinary crime which not long ago sent a great shudder of horror through the metropolis is fast fading away into the region of seven-day wonders. An attempt has been made in certain quarters to revive interest in the murder by sensational statements as to the hushing-up of the affair by the police. It may or may not be the case that the authorities have taken the very serious responsibility of sending the criminal out of the country, and of taking steps to stop inquiry into a wide-spread scandal involving many persons. In the interests of public morality there is much to be said in favour of such a course, assuming that the crime involved is of the nature hinted at. There appears to be little reasonable doubt that the murdered artist was the victim of a moral mania that led to sexual perversions of a well-recognised type. There is, further, little doubt that he met with his death after the commission of that particular offence, possibly by reason of a sudden homicidal impulse on the part of his confederate. A recently-published theory states that the murderer was first drugged into insensibility, and on his recovering consciousness was seized with a sudden fierce paroxysm of rage. To this we must demur. The whole occurrence occupied only comparatively a small period of time, and no drugs are known to medical science that, administered in a glass of wine, can rapidly rob a victim of consciousness for a few minutes. Such incidents occur only in the experience of novelists and of journalists, not of medical men.

PERSONAL.

IT is announced that the King, on the occasion of the opening of the Sanatorium at Midhurst, has made the following appointments:—To be Member of the Fourth Class, Grand Cross, Mr. C. T. Williams, M.D.; to be Member of the Fifth Class, Mr. P. H. S. Hartley, M.D. Honorary Secretary of the Executive Committee of the King Edward VII. Sanatorium.

MR. HALDANE, Secretary of State for War, on June 25th, formally opened the building which has been recently added to the National Physical Laboratory at Teddington. The new building is intended to accommodate the electro-technical and photometric

work at present carried on in the Physics Laboratory. The Chairman at the opening ceremony was Lord Rayleigh, the President of the Royal Society, and Chairman of the General Board of the Laboratory.

THE annual dinner of the Indian Medical Service was recently held in the New Gaiety Restaurant, London, under the presidency of Surgeon-General L. D. Spencer, C.B.

THE prize of £50 and the gold medal of the Alexander Memorial Fund for 1905 has been awarded to Major F. Smith, D.S.O., R.A.M.C., for his essay on "Syphilis in the Army: its Causes Treatment and Prevention."

DR. R. MURRAY LESLIE has, on the recommendation of M. Cambon, the French Ambassador, received the Order of Officier d'Academie Francaise.

The new public analyst for Portsmouth, who was chosen from 29 candidates for the post to succeed Mr. Edward Russell, is Mr. F. W. F. Arnaud, F.I.C., F.C.S. Mr. Arnaud has been assistant to Mr. C. H. Cribb, the public analyst for the Westminster and Fulham districts, for over eight years, and during this time has performed valuable research in several branches of chemical analysis.

DR. R. S. EARL, Commissioner and Medical Officer of the Virgin Islands, has left the Colony on leave, during which Dr. C. O. Wynne, District Medical Officer of St. Kitts, will carry on his combined duties.

DR. WILLIAM ROBERTSON, of Bellcairn, Dumbartonshire, who died on May 6th, has left personal estate in the United Kingdom valued at £61,057 2s. 4d., of which £33,332 1s. 5d. is in Scotland.

DR. HANDFORD, having resigned the office of hon. physician to the Nottingham General Hospital, members of the have in order to mark their high appreciation of the great services he has rendered to the institution, presented him last week with a silver bowl, and an illuminated address.

DR. W. T. PROUT, C.M.G., Principal Medical Officer of Sierra Leone, is retiring from the Public Service on pension. He became Assistant Poor Law Medical Officer in Mauritius in 1885, and three years later was transferred to the Gold Coast, where he also acted as a District Commissioner. He succeeded the late Sir D. Palmer Ross as Principal Medical Officer of Sierra Leone in 1895, and was a member of the Legislative Council of that Colony. Pending the appointment of a successor to Dr. W. T. Prout the duties of Principal Medical Officer of Sierra Leone will be performed by Dr. T. Hood, who has served in that Colony for the past nine years.

DR. A. W. SIKES, M.R.C.P., F.R.C.S., has been awarded the degree of D.Sc. in Physiology, by the University of Oxford, for four papers, entitled, (a) "On the Phosphorus of Human Milk," (b) "On the Estimation of Proteid in Human Milk," (c) "On the Calcium of Human Milk," (d) "On the Globulin of Albuminous Urine."

THE death of Herr Fritz Shaudinn, one of the discoverers of the *spirochete pallida*, the supposed organism of syphilis, is reported from Hambourg.

THE two English doctors who were maltreated by a mob at Tung-ngan, are stated to have recently arrived at Amoy. Dr. Horne was nearly disembowelled, and left for dead. He contrived, however, to crawl to the American Mission, where he had been previously staying.

A CLINICAL LECTURE ON THE CLINICAL EXAMINATION OF THE BLOOD.

Delivered at the North-East London Post-Graduate College on May 10th, 1906.

By ARTHUR WHITING, M.D., M.R.C.P.Lond.,

Assistant Physician to the Tottenham Hospital, N., and the Mount Vernon Hospital for Consumption and Diseases of the Chest, and Dean of the College.

THE diagnosis of diseases of the blood is usually made, in the first place, on the facial appearance of the patient, particularly the pallor of the conjunctival and buccal mucous membranes, together with such clinical signs as dyspnoea on exertion, blueness of the sclerotic, a venous hum in the neck, and basic systolic murmurs, and in the second place on an examination of the blood. It is with the second and somewhat more difficult matter—the clinical examination of the blood itself—that we are concerned this afternoon.

GENERAL CHARACTERS OF NORMAL BLOOD.

The blood, as you know, consists of cells floating in a fluid, the blood plasma or liquor sanguinis. The cellular elements consist of red blood corpuscles or erythrocytes, white blood corpuscles or leucocytes, and blood plates. The red blood corpuscles contain hæmoglobin which has the function of carrying oxygen from the lungs to the tissues, a deficit in which is the factor in anæmia that threatens life. The red cells themselves, you remember, are bi-concave non-nucleated discs, from 7 to 8 micro-millimetres in diameter, numbering in healthy men about 5,000,000 per cubic millimetre, and 4,500,000 in healthy women. The leucocytes are colourless nucleated cells of several different forms, numbering from 5,000 to 8,000 per cubic millimetre.

The blood plates, about which but little is known, are round colourless bodies varying in size from perhaps one-tenth to one-third of the size of a red blood corpuscle, and numbering, perhaps, 200,000 in the cubic millimetre. I do not intend to take up much time by discussing these elements to-day, beyond saying now that they are probably concerned largely with blood coagulation. If a specimen of fresh blood be freed from red cells, it will be found that the blood plates form the nodes of the fibrin network; it is probably from them that deposition of fibrin occurs. In making some experiments on artificial anæmia in dogs some years ago, I had to remove blood from the jugular vein through a cannula, which was, of course, done under an anæsthetic, and I several times noticed that the last portion of the blood to be removed clotted very much more rapidly than the earlier, and examination showed it to be much richer in blood plates than the normal. A corresponding fact is that in hæmophilia, where the coagulating power of the blood is very defective, blood plates are in very small numbers.

STEPS IN THE EXAMINATION OF THE BLOOD.

There are at least five important steps in the examination of the blood that can fairly be called clinical, and are sufficiently rapid as to be suitable for use in active medical practice. These are (1) the microscopic examination of plain fields of blood freshly drawn by needle prick from the body; (2) the estimation of the number of the red blood corpuscles; (3) the estimation of the number of the white blood corpuscles; (4) an estimation of the amount of hæmoglobin; and (5) the microscopical examination of dried and stained films of blood to show the presence or absence of abnormal cell elements in the blood and the relative proportion of the different varieties of leucocytes.

The specific gravity and other physical characters of the blood, its chemistry, and its spectroscopy on the one hand, and its vital serum reactions, its bacteriology, and its parasitology on the other, cannot now be taken into account.

EXAMINATION OF FRESH SPECIMENS.

Very much may be learned from merely looking

with the microscope at a thin layer of fresh blood. Such a preparation is easily made, and need not take more than a minute or two. The tip of the finger is probably the best place from which to obtain the blood, although the lobe of the ear is nearly as convenient. The skin may be rubbed with a damp towel and then dried; the prick is conveniently made with a clean needle, and little or no pressure should be exerted to make the blood flow. A clean cover glass is applied to the drop, and then placed flat on a slide, when the blood spreads itself between the two by capillarity. Such a preparation will show the following points: Whether or not the individual red cells are of a good yellow colour, indicating a sufficiency of hæmoglobin; whether they are of uniform size; if some are large, macrocytes, and others small, microcytes, some stress on blood formation is probably indicated; whether the shape be regular—in very grave anæmias the red cells may be pyriform, with several processes, or almost any shape derived from the disc, in which case poikilocytosis is said to be present; whether the corpuscles form rouleaux rapidly and perfectly as in health or not; whether the fibrin network is dense and regular or not (a good way of ascertaining this is after a fairly thick layer has clotted to put a drop of a weak solution of methylene blue on one edge of the cover and a piece of blotting paper at the other; the watery stain is drawn through the preparation dissolving the red cells and leaving the fibrin network apparent and stained); whether the leucocytes are in considerable excess or not, normally there is about 1 to 1,000 reds, but in leukæmia there may be 1 to 100, or 50, or 20, or even an equal number. It is sometimes difficult to recognise the leucocytes without staining them, but if the upper level of the preparation be focussed they give a silvery shimmer which reveals them, or if the cover be tapped the red cells move about, but the white, being adherent to the glass, remain stationary; ordinarily they are visible in the wide meshes formed by the rouleaux. Lastly, a rough idea may be gained after a little practice as to the number of blood plates as compared with the number of the red cells.

ESTIMATION OF THE AMOUNT OF HÆMOGLOBIN.

For ordinary purposes, and especially for determining at regular intervals the progress of an individual case, and particularly in view of the ease and rapidity with which the information is obtained, the next step should, I think, be the estimation of the amount of hæmoglobin present. For doing this there are several methods, but I shall ask you to consider two only. The easiest, quickest, and cheapest of all is the Tallquist method. A drop of blood is placed on white blotting paper and compared with a printed colour scale like that I now show you. The other method is that with Gowers's hæmoglobinometer, which I also show you. It consists of two small test tubes of identical calibre, one of which is filled with glycerine jelly tinted with picro-carmin to the colour normal blood would give with a certain dilution; the other is graduated to 100 divisions, so that when 20 cubic millimetres of healthy blood are diluted 100 times, the tint in the two tubes is the same. A few drops of water are put in this graduated tube, then 20 cm. of blood measured by the pipette provided are added, and the mixture is diluted with water until the colour in the two tubes is the same. A background of white paper is desirable in judging of the colours, or the tubes may be held at the level of the eye between it and the light. In

my experience, 100 per cent. of HbO is never given by healthy blood with these tubes, and as an absolute standard it is not reliable, but for consecutive observations by the same person it serves very well.

Perhaps the chief indication in diagnosis from observation on hæmoglobin is that in chlorosis, and in most secondary anæmias, as from nephritis, cancer, tubercle, syphilis, lead poisoning, &c., the amount is reduced more than the red cells, *i.e.*, each red cell is poor in hæmoglobin, while in pernicious anæmia the number of red cells is reduced more than the hæmoglobin, *i.e.*, each cell is rich in the pigment. Speaking generally and from the point of view of clinical work, it may be said that as the hæmoglobin rises in ordinary anæmias the red-cells increase in number, and so, bearing this in mind, the labour of a blood-count may sometimes be saved.

ENUMERATION OF THE CORPUSCLES.

The best apparatus for counting the corpuscles of the blood is the hæmocytometer of Thoma-Zeiss, the price of which is about 30s. It consists of a pipette for diluting the blood 100 times or 200 times, and a slide ruled in very small squares for counting the corpuscles with the microscope. The pipette consists of a capillary tube opening into a glass bulb. Blood is drawn up the tube to the level of a mark on its stem, then a diluting fluid (nothing more is necessary for the purpose than normal salt solution, which may be tinted with methyl violet) is sucked up into the bulb at the end of the tube to a mark on the tube above it and the blood and fluid are mixed by shaking a glass bead about in the bulb. A drop of the mixture diluted 100 times, or, if rich blood, 200 times, is now placed on the slide.

The slide consists of a central disc bearing the rulings which is surrounded by a rampart of glass at a little higher level (1-10th mm.) so that when the cover is applied a definite depth of fluid is obtained, and a definite area is marked out by the squares, each being 1-400th m.m. The squares are focussed, using a $\frac{1}{4}$ in. or $\frac{1}{8}$ in. objective, and the corpuscles will be seen lying on them as in this diagram, or under the microscope on the table. I do not think it necessary to trouble you with details of the technique. They are quite simple, and readily become automatic with a little practice.

The number of red cells in, say, 50 or 100 squares is counted, and the average taken. Then the following calculation is made: The space above each square is 1-4,000 c.m., and the blood has been diluted 100 times; so, supposing the average number of red cells in a square is 12, the 12 multiplied by 4,000 would give the number of corpuscles in a c.m. of diluted blood, *i.e.*, 48,000, and this, multiplied by 100 (the dilution), *viz.*, 4,800,000, the number in a c.m. of undiluted blood.

The same principle may be used for the white blood corpuscles, though, as they are so much less numerous, a wider bore pipette with a smaller bulb is often used to give a dilution of only 10 times (the necessary calculation being made at the end), but in that case some fluid must be used to dissolve the red cells (which would otherwise obscure the lines) and leave the white; such a fluid is a 0.3 per cent. solution of glacial acetic acid suitably tinted. As a rule, however, in clinical work, both red and white cells are counted with the aid of the red pipette, a dilution of 1 in 100—and a device is used of making a field of the microscope correspond, say, with 50 squares (this can be done by lengthening or shortening the draw tube), and then counting the leucocytes in groups of 50 squares at a time—so many in each field.

An excess of red blood corpuscles is met with in congenital heart disease, in certain cases with chronic cyanosis, rising to 8,000,000, 9,000,000, 10,000,000, or even 12,000,000, in persons living at high altitudes, and in the newly-born. A diminution in their number is met with in anæmias of all kinds, and in pernicious anæmia may fall to 500,000, or even 250,000, and 100,000 has been recorded. In chlorosis the number

of red cells is not much diminished—to 4,000,000, it may be; in leukæmia perhaps to 3,000,000; after infectious fevers, in late tuberculosis, in syphilis, perhaps to 2,500,000. The fall in post-hæmorrhagic anæmia depends, of course, on the amount of blood lost; but recovery is fairly rapid, as the accompanying tables will indicate.

The number of leucocytes may be increased normally as in the new born, during digestion, in pregnancy, and after muscular exercise; it may be increased in many pathological conditions, of which leukæmia is the most striking, but a definite increase is seen in most acute infectious diseases—in pneumonia, erysipelas, diphtheria, ulcerative endocarditis, but diminished in typhoid and influenza, among other diseases, and not altered in tuberculosis. There is a leucocytosis in appendicitis, especially if suppuration be present, thus differentiating it from typhoid. There is usually a leucocytosis in cancerous and other cachexias.

DRIED AND STAINED SPECIMENS OF BLOOD.

The method of staining thin layers of blood for microscopic examination is especially directed to the differentiation of the varieties of leucocytes—a differentiation which leads to important clinical conclusions—and this differentiation can only be satisfactorily made by examining their nuclei (which are only visible when stained) and the staining reactions of their protoplasm. This method is probably the most important of all in such blood examination as we are considering.

A small drop of blood is allowed to diffuse itself between two clean coverslips placed face to face; these are then slid apart, leaving a thin film on each. By waving them in the air, they are rapidly dried, and are then ready for fixing before staining.

The ordinary fixing agents are heat, either by means of a moderately heated oven, 110° C. for an hour, or 150° for five minutes, or passing the films rapidly through a flame five or six times; a mixture of absolute alcohol and ether in equal parts in which they are immersed for half an hour or longer; or immersion in a mixture of one part formalin with nine of absolute alcohol for half a minute, after which they must be thoroughly washed in water.

But the method of fixing I intend to recommend to you is accomplished at the same time that the films are stained by the staining-method I intend to advise you to adopt, the fixing is accomplished by the alcohol in the staining fluid.

There are many methods of staining blood films, but that which I have come to consider as the most reliable, rapid, simple, and efficient—in other words the most suitable for our purposes—is by Jenner's stain. It is an alcoholic solution of a compound of eosine with methylene blue. It is to be bought ready made, either from Grubler's stains, or preferably, I think, in Grubler's original bottles in the liquid form.

Blood stains are divisible into two kinds—acid (in which the acid radicle of its constituent salt is the staining part) such as picric acid or eosine, and basic (in which the basic radicle is the active part) such as methylene blue. Speaking generally, the acid stains (as eosine) stain the protoplasm especially, and the basic stains (as methylene blue) stain the nuclei especially.

So with Jenner's stain the red blood corpuscles are stained red with eosine, and the nuclei of the leucocytes blue with methylene blue. The method for using this stain is as follows:—The dried films are covered with the stain and left for five minutes or so. It is poured off, and they are washed in distilled water, dried, and mounted in cedar oil or balsam. I may say that at a pinch you may use some methyl blue from the stain available for tubercle bacilli, and the eosine from the nearest red ink.

VARIETIES OF LEUCOCYTES.

The main object of staining blood, as I have said, is to differentiate the leucocytes, and to recognise the presence of abnormal cells. What, then, are the varieties of leucocytes in normal blood? Speaking

roughly, they are two—lymphocytes, with hyaline protoplasm and a single nucleus, and granulocytes, with granular protoplasm and a multiform nucleus—called the polymorphonuclear leucocytes. But each of these is divisible into three varieties, hyaline cells into whether they are small or large lymphocytes or having a lobed nucleus—transitional leucocytes. The idea being that the latter form a transitional stage between the cells with a single round nucleus and the multiform nucleus of the granulocyte. The granular cells are divided into those whose granules stain with acid dyes—oxyphile or eosinophile leucocytes, those with basic dyes—basophile leucocytes or mast cells, and those that colour with both—neutrophile leucocytes.

The non-granular or hyaline leucocytes are, therefore, three—the lymphocytes proper—the small mononuclear leucocytes, the large mono-nuclear leucocytes, and the transitional leucocytes.

The lymphocytes are a little smaller than the red blood corpuscle; both nucleus, which is round and nearly fills the cell, and the mere rim of hyaline protoplasm stain blue with methylene blue, the protoplasm more deeply than the nucleus; the nucleus has a nucleolus and a fine intranuclear network. In healthy adults they vary between 20 and 30 per cent. of all the leucocytes.

The large mononuclear leucocyte is two or three times as large as the red cell, the protoplasm is relatively more abundant in proportion to the nucleus—otherwise their characters resemble those of the lymphocyte.

The transitional leucocyte resembles the large mononuclear leucocyte in every way except that its nucleus is lobed. It represents an older stage of this mononuclear hyaline cell, and was believed, probably erroneously, to develop into the polymorphonuclear leucocyte. These two latter forms taken together vary in normal blood between 4 and 8 per cent.

The polymorphonuclear leucocytes are a little smaller than the large mononuclear. They are readily recognised in films stained with nuclear stains

by the appearance of the nucleus. This consists of several masses scattered throughout the cell at first sight detached, but really connected with fine strands of nuclear substance, the whole like a sparse string of beads, being twisted on itself in the form of S or Z or Y or E. The protoplasm stains with acid dyes, *i.e.*, faintly pink with eosine, but the granules embedded in it vary in different cells in their colour reaction. In the first group they are fine, numerous, and stain a purplish pink with Jenner's stain; these are the neutrophile polymorphonuclear leucocytes. In the second group, the granules are larger, not so densely crowded, and stain a bright deep pink with eosine; these are the eosinophile polymorphonuclears. The third group have large and still fewer granules which stain blue with Jenner's stain, these are the basophile polymorphonuclears, or the mast cells of the Germans.








The neutrophiles are the phagocytes proper, and are actively amoeboid; they are the most numerous of all the leucocytes in normal blood, varying from 60 to 80 per cent. The eosinophiles occur in from 1 to 5 per cent., and the mast cells from about 0.5 to 2 per cent.

ABNORMAL CELLULAR ELEMENTS.






The abnormal cells which are important from a diagnostic point of view are two—first, a large mononuclear white cell—possibly the predecessor of the polynuclear leucocytes, normally found only in the bone marrow. These are called *myelocytes*. They are as large or a little larger than the polynuclear leucocytes have a large round faintly blue staining nucleus, and granules either neutrophilic, eosinophilic, or basophilic.

The second abnormal cell is a *nucleated red cell*, the predecessor of the red blood corpuscle. In foetal life, as in adult amphibia, birds, and reptiles, all the red cells are nucleated; but in healthy extra-uterine life they only occur in organs where blood formation is progressing, in the spleen in early extra-uterine life, and in the bone marrow in later life. But when stress of blood formation becomes great, the original nucleated forms escape in smaller or large numbers from the blood-forming organs into the general circulation. They are

NORMAL CELL ELEMENTS.

HYALINE CELLS.		Red blood corpuscle.
		Small Mononuclear Leucocyte (Lymphocyte). 20 to 30 per cent.
		Large Mononuclear Leucocyte. 4 to 8 per cent.
		Transitional Leucocyte.
GRANULAR CELLS (Granulocytes.)		Neutrophile Polymorphonuclear Leucocyte. 62 to 70 per cent.
		Eosinophile Polymorphonuclear Leucocyte. 0.5 to 5 per cent.
		Basophile Polymorphonuclear Leucocyte. 0.25 to 2 per cent.

ABNORMAL CELL ELEMENTS.

NUCLEATED RED CELLS.		Microblasts.
		Normoblasts.
		Megaloblasts.
MYELOCYTES.		{ Neutrophile. Eosinophile. Basophile.
		Poikilocytes.

of three sizes—smaller than the red cell microblasts, the size of a red corpuscle normoblasts; and others two or three times larger—megaloblasts. The protoplasm is hyaline, yellow from hæmoglobin, and stains red with eosine like the ordinary red cell. The nucleus is round, has a coarse intranuclear network of even mesh, and no nucleolus, thus helping to distinguish it from the lymphocyte. Sometimes in the older cells, the nucleus stains so deeply with methyl blue that the network is not visible.

CLINICAL SIGNIFICANCE OF CORPUSCULAR VARIATIONS.

These, then, are normal and abnormal cellular elements of the blood. What is the clinical significance of variation from the normal. A few words about each variety must suffice. To begin with the last first—nucleated red cells—when the call on blood formation, as in any severe anæmia, is great the normoblasts appear in the blood; they occur in pernicious anæmia and in larger numbers still in spleno-medullary leukaemia; if the stress is very great indeed, as in pernicious anæmia, megaloblasts appear, and hence they are considered to be of grave prognostic import.

Myelocytes occur in and form an important point in the diagnosis of spleno-medullary leukaemia. Mast cells are increased in chronic spleno-medullary leukaemia, and may be more numerous even than the largely increased eosinophiles.

Eosinophile leucocytes are increased not only in this variety of leukaemia but in the paroxysmal stage of asthma, in presence of intestinal parasites and trichinosis in various skin diseases, and in malignant disease; they are diminished in septic conditions and in acute infectious diseases.

Neutrophile polynuclear leucocytes form the leucocytosis, to which reference has already been made, of acute infectious diseases, in that of digestion, pregnancy, and in septic conditions. But they are unaffected or diminished in typhoid, measles, and influenza, and in tubercle, unless suppuration or complications have occurred.

Lymphocytosis is seen in a few conditions, such as whooping cough and the gastro-intestinal diseases of infancy; but the condition in which it is of the first diagnostic import is lymphatic leukaemia.

The usual method of making a *differential leucocyte count* is to place each leucocyte recognised in a film under its proper heading in a column, add each column up separately, and all the columns together, and express each sort as a percentage of the whole.

For rapid clinical work, I would, in conclusion, suggest the following routine: Examine a plain preparation, estimate the hæmoglobin by Tallquist or Gower's apparatus, make a blood count with the Thoma-Zeiss instrument, and make films, staining them with Jenner's stain. I would also suggest that the examination of the blood, both in physiological conditions and in pathological states of all kinds, is thoroughly suitable as a basis for original work even in active general practice.

NOTE.—A *Clinical Lecture* by a well-known teacher appears in each number of this journal. The lecture for next week's issue will be by Professor Louis Regis, M.D., of the Faculty of Medicine of Paris, on "The Value of Philipowicz," and Bernard's Signs in the Diagnosis of Typhoid Fever."

ORIGINAL PAPERS.

COCAINISATION OF THE SPINAL CORD.

By ROBERT JONES, F.R.C.S.E.

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SPINAL cocaineisation has been known among foreign surgeons as having distinct claims, yet 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. about 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 mal-united 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 readmitted him, and we underwent precisely the same experience 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 vertebrae, and in ten minutes all sensation left him to well above his 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, æt. nearly 60, 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 footstep 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. We 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. Moore 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 fetid 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 anæsthetic. In one case the patient would not take chloroform, in the other he couldn't. Cocaine in each instance answered admirably. Cases of this kind are common, and we have all met with many people who forego very necessary surgical procedures 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 Leldswitsch were pioneers on the Continent, and Tuffier of Paris, a most trustworthy surgeon, 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 consensus of opinions abroad is adverse to any attempt at substituting cocaine for ether and chloroform. About eleven deaths have occurred in about 3,000 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 300 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 practice, 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 fluid escapes through the needle. Causes of failure in reaching the canal are easily avoidable. They may arise from the needle impinging on the lamina, 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 should feel 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 attempts 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 an 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 8 to 86; many of the patients suffered from organic diseases of heart, kidneys, and lungs.

Of 553 cases, nausea was present in 65; vomiting, 53; headache, 37; involuntary evacuation, 9; post-operative chill, 6.

One other not unusual symptom I will refer to, and that 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. Guinard, 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 flowing 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 253 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—

1st. Patients not suited for general anæsthetics, such as in those suffering from advanced phthisis, and from respiratory affections like bronchitis and asthma.

2nd. Towards people who have a fatal objection to taking an anæsthetic, and on whom an operation is urgently needed.

3rd. 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 spinal cocainisation.

A SERIES OF FIFTY CONSECUTIVE ABDOMINAL SECTIONS.*

By R. P. RANKEN LYLE, M.D. DUR.,

Obstetric Physician to the Newcastle Lying-in Hospital, &c.

IN December, 1902, the Samaritan Hospital was instituted in Newcastle-upon-Tyne for the practice of gynecology. There are six beds, including one emergency bed, for patients and an out-patient department, which is open two days a week. All the operations are performed in an ordinary attic under the most restricted conditions, and it has not been specially fitted up in

* Paper read at the meeting of the British Gynecological Society June 14th, 1906.

any way. Since its opening I have performed a very large number of major and minor operations, and I now have the honour of placing before you the result of the first fifty abdominal sections, and of drawing certain conclusions therefrom.

The date during which this series of operations was performed extends from October 1st, 1903, to January 18th, 1906, and they were performed for the following conditions:—

Ovarian cystomata, including dermoids	18
Fibro-myomata of the uterus	11
Ectopic gestation	6
Broad ligament cyst	3
Adherent retroversion	3
Pyosalpinx	3
Tuberculous disease of the peritoneum	2
Malignant disease of the cervix uteri	2
General abdominal carcinosis	1
Parovarian cyst	1
	—
	50

The following is a list of the operations performed:—

Ovariectomy	17
Supra-vaginal hysterectomy	8
Salpingectomy	5
Salpingo-oophorectomy	4
Enucleation of cyst	4
Cœliotomy	4
Myomectomy	3
Ventro-fixation	3
Panhysterectomy	2

I have unfortunately to record one death. The case will be fully described. The technique adopted in all these operations was of the simplest nature, as I am of opinion that complicated technique or elaborate preparations are not only unnecessary but may be even a source of danger to the patient, inasmuch as minor essentials may be sometimes accidentally overlooked when the preparations are too elaborate.

Antisepsis was very carefully carried out, the hands and forearms were thoroughly washed in hot lysol solution with a nail brush, then turpentine and methylated spirit were used and the hands and forearms well washed in 1 in 1,000 corrosive solution. The instruments were boiled and placed in 1 in 40 carbolic solution. The sponges which were of gauze, were boiled for 20 minutes, and were then wrung out of hot saline. All buried ligatures were of catgut, which was prepared by ether, methylated spirit and corrosive sublimate solution. Silkworm gut was used for all superficial sutures. The abdomen was prepared the night previous by washing with soap and water, then sponged with turpentine and methylated spirit, and the application of a corrosive pad over night, and washed with 1 in 1,000 corrosive sublimate solution just previous to the operation. No vaginal antisepsis was carried out even in cases of panhysterectomy. The abdominal incision was restricted to the smallest dimensions consistent with the proper performance of the operation, and there was consequently a marked absence of shock following the operation, and a diminished risk of ventral hernia in later years. All cut surfaces of peritoneum were properly adjusted, such as suturing the anterior and posterior layers of the peritoneum after hysterectomy and the removal of broad ligament cysts, and suturing the peritoneum over the pedicle in cases of ovariectomy and salpingectomy.

The abdominal wall was carefully sewn up in three and sometimes four layers, care always being taken to properly adjust corresponding structures. A small strip of plain sterilised gauze, wrung out of hot saline and covered with plain absorbent wool, was used as a dressing to the wound. The dressing was kept in position by strapping and flannel bandages. Ether, with one or two exceptions, was the anæsthetic. In three cases of pyosalpinx in which a small amount of purulent material escaped during the operation, it was carefully mopped up and did not cause any further trouble. In those cases where a large raw surface of peritoneum occurred—e.g., ventral fixation for adherent

retroversion, as much saline solution as possible was left in the abdomen, to float the intestines from the wounded surface and so prevent adhesions.

After Treatment.—The patient was given a drink of hot water with a little bicarbonate of soda in it (which is often effectual in relieving bilious vomiting) about three hours after the operation. This was freely continued in addition to barley water until the following morning, when she was given a cup of tea, followed during the day by milk diluted with barley or soda water. Early on the second morning after operation, calomel was given in two doses of five and three grains respectively, at an interval of one hour, followed by a hot seidlitz drink, half an hour later. As soon as the bowels were moved the patient was put on a liberal diet. The sutures were removed on the tenth day.

OVARIAN CYSTOMATA.

There were eighteen cases as follows:—

	Cases.
Simple unilocular	6
Multilocular simple	4
Multilocular undergoing colloid degeneration ..	3
Multilocular suppurative	1
Multilocular malignant	1
Multilocular papillomatous	1
Dermoids	2

In addition to these a case of left tuberculous pyosalpinx was found complicated with a right ovarian cyst the size of a goose egg, and a case of cervical fibro-myoma had a cystoma of each ovary. The following cases were of special interest:—

CASE 7.—Suppurating multilocular ovarian cyst with purulent peritonitis. This patient was exceedingly ill, having had a temperature of 104° F. for two evenings before the operation. On opening the abdomen the peritoneum was very inflamed and œdematous and the omentum was adherent to the tumour, which was about the size of a seven months' gestation. On separating the omentum several ounces of encapsuled pus escaped, the tumour was removed, the posterior vaginal fornix was opened and a gauze drain was inserted through it into the pelvis. The temperature fell to 97° F. on the morning after the operation, but was 105° F. the following evening; after a great deal of fluctuation it gradually fell to normal six weeks later, when she was discharged. Some days after leaving the hospital she had a relapse, and unfortunately died a fortnight later.

CASE 26.—Ovarian dermoid with twisted pedicle. The twist occurred about one week before admission, when there were the usual symptoms of peritonitis. On opening the abdomen the tumour was found partly gangrenous. She made an uninterrupted recovery.

CASE 42.—Malignant ovarian cyst. The whole of the peritoneum and omentum was infiltrated with hard malignant masses, and the tumour was found adherent in all directions and commencing to disintegrate. It was not removed, but the abdominal cavity was filled with saline solution and then closed. Convalescence, as far as the operation was concerned, was uneventful.

CASE 44.—Enormous multilocular ovarian cyst undergoing colloid degeneration: This patient was confined nine weeks previously of a seven months' child, since that time the abdomen rapidly enlarged, and on admission was about three times the size of a full term gestation. She was very emaciated and very ill, pulse 120, very feeble and temperature 99° F. She had severe dyspnœa, and was unable to lie down during the whole night before operation. The patient had to lie on her left side on the operating table, as respiration ceased when she was turned on her back. The abdomen was opened with her on her left side, and about two gallons of ascitic fluid escaped. The tumour, which was about 1½ times the size of a pregnant uterus, was adherent to the under surface of the liver and diaphragm. The pedicle was clamped and divided and the tumour removed from below upwards. The other ovary was about the size of an ostrich's egg. It was also removed, and the abdomen filled with about 1½ gallons of normal saline. During the greater part of

the operation the patient was practically pulseless, and respiration temporarily ceased on two occasions, the anæsthetic (ether) was not pressed, and during the closing of the abdomen she was partly conscious. She got three injections of 1-20th of a grain of strychnine. When returned to bed the pulse was just perceptible at 180, shortly afterwards it fell to 160, and in the evening it was 140. She made a good recovery, and six months later was reported to be in good health.

CASE 45.—Right ovarian cyst: In addition this patient had a left ovarian abscess which contained four or five ounces of very fetid yellow pus, and a double hydrosalpinx. She made an uninterrupted recovery.

FIBRO-MYOMATA.

Eleven operations were performed for the removal of fibromyomata, and in every case the symptoms complained of by the patient were sufficient to render the operation one of necessity. Supravaginal amputation of the uterus was performed in eight cases, and myomectomy in three. Myomectomy was the operation of selection, but in those cases where it was not feasible, supravaginal hysterectomy was performed, care being always taken to leave the ovaries, in order to save the patient from the ordinary consequences of their removal prior to the menopause. An artificial menopause practically means that the patient will be an invalid for many months, and it is highly desirable that this, if possible, should be prevented. It was not possible, however, to leave the ovaries in Case 47, as there was a cystoma of each ovary. The following cases are of interest:—

CASE 3.—Myomatous uterus and large ventral hernia. Death: This patient was operated on eight years previously, the ovaries being removed in the hope of curing her. The result, however, was that she continued bleeding, making her a chronic invalid, besides the tumour increased in size and she developed a very large ventral hernia, which reached to her knees and totally incapacitated her from work. She was very corpulent and anæmic. The abdomen was opened by an elliptical incision extending from the umbilicus to the pubis and surrounding the hernial sac, which contained nearly all the intestines. They were entirely adherent to the hernial ring which was four inches long by three broad. The intestines were separated from the ring which was dissected out. On examining the pelvis everything was found adherent, a myomatous uterus the size of a large coconut was freed from its adhesions and lifted out of the pelvis, the broad ligaments ligatured and divided, and the tumour removed, the cervix being left. The peritoneum was sutured over the stump. With some difficulty the intestines were returned into the abdomen and the abdominal wall sutured in four layers with strong catgut. She developed a small fæcal fistula in the lower angle of the wound which practically ceased discharging on the seventh day. During the next two days her condition was very satisfactory, but on the morning of the tenth day at 2 a.m., she was suddenly awakened with severe pain in the region of her heart, and much difficulty in respiration. She was deeply cyanosed, pulse very rapid, irregular and feeble. She was given stimulants internally, with strychnine and digitaline hypodermically. Considerable improvement took place till 6 a.m., when she had a similar attack, and died in ten minutes, death being due to pulmonary embolism, probably fat embolism.

CASE 32.—Myomatous uterus, supravaginal hysterectomy. The tumour was the size of a foetal head and impacted in the pelvis, causing partial intestinal obstruction: Patient had purulent cystitis, and was seriously ill. On opening the abdomen the bowels and omentum were found adherent all over the front of the tumour. These were separated and both tubes were found distended with pus. While removing them they both burst and some pus escaped. This was carefully mopped up. The myomatous uterus was removed and the abdomen closed. The patient made an uninterrupted recovery.

CASE 43.—Subserous fibro-myoma—myomectomy:

This patient was five months pregnant, and suffered severe pain on the left side of the abdomen. The abdomen was opened at the left border of the rectus, and a pedunculated myoma the size of a large goose egg was found in the left iliac fossa, and was removed from the surface of the pregnant uterus. The uterus then rotated from left to right through a quarter of a circle, so that the point of attachment came to lie in the middle line anteriorly. The patient went on to full term and had a normal confinement.

ECTOPIC GESTATION.

There were six cases of ectopic gestation. Case 17 was admitted on August 2nd, 1904. Rupture took place at 4 p.m. the following afternoon as she was lying quietly in bed. The patient rapidly became collapsed, but fortunately before an hour was passed I was able to proceed with the operation, which was in no way difficult. The abdomen was full of recent blood-clot, this was not removed. All these six cases made uninterrupted recoveries.

BROAD LIGAMENT CYST.

There were three cases, none of them presented any difficulty. The cysts were opened, the capsules enucleated, and the wounds in the broad ligaments sutured with fine catgut. They all did well.

PYOSALPINX.

In addition to the case which was associated with a myomatous uterus, and which is already described, there were three cases. One of these, Case 34, was tuberculous. It was single and was associated with an ovarian cyst of the opposite side. The pyosalpinx was matted with some knuckles of intestine, which were involved in the disease, and during its removal, the bowel unfortunately got injured. This was carefully and with some difficulty sutured. A strip of plain sterilised gauze was inserted from the wound in the bowel to the lower end of the abdominal incision to determine the track of a fæcal fistula, should such occur. The following day the gauze was removed, and two days later a small amount of fæces came through the lower angle of the wound. This continued for six days, then ceased and the fistula completely closed. With this exception, convalescence was quite uneventful.

CASE 28.—Double pyosalpinx of old standing: On opening the abdomen the intestines were found matted, with old and dense adhesions, over the tumour. They were separated with much difficulty, and during the removal of the tumours, one of them burst and a quantity of pus escaped, this was very carefully mopped up, and the abdomen closed without the insertion of any gauze for drainage. Three days later some discharge which had a fæcal odour, came through the lower angle of the wound. This continued for five days when the fistula closed spontaneously leaving a hollow granulating surface about two inches square. Three silk-worm gut sutures were inserted, pulling the granulating surfaces together, the wound healed perfectly and the patient did well.

ADVANCED MALIGNANT DISEASE OF THE CERVIX.

Panhysterectomy was performed in two such cases, in order to relieve severe symptoms of hæmorrhage and pain. Both patients recovered, although one of them developed a temperature, which, on one occasion, was as high as 102.6° F. The temperature, however, remained perfectly normal for nine days before she was discharged from the hospital.

DRAINAGE.

Gauze was used in three of the earlier cases—Nos. 5, 7, and 12—for the supposed purpose of drainage, but the result was unsatisfactory. In Case 5, panhysterectomy for ulcerating malignant disease of the cervix, gauze was used from the pelvis into the vagina, and the result was a gradual rise of temperature to 102.6° F., whereas in a similar case (Case 46), no gauze was used, and the patient made an uninterrupted recovery. In the case of the suppurating multilocular ovarian cyst (Case 7), the posterior vaginal fornix was opened and the pelvis drained through the vagina. The result was a pelvic abscess which had to be douched

for many days afterwards, and to which I have little doubt her high temperature and unsatisfactory convalescence was partly, if not mainly, due.

In Case 12 gauze was also used for the supposed purpose of drainage, on account of general oozing, and although this patient had a normal convalescence four weeks after the operation, a fæcal fistula developed during the fifth week.

I have since then altogether abandoned the use of gauze for drainage purposes in abdominal and pelvic work, unless in cases of pelvic abscess, where the abscess wall cannot be removed, and have since followed the following rule. If a little pus accidentally escapes I carefully mop it up and in case a large amount escapes and soils the intestines, I wash the intestines and pelvic cavity thoroughly with normal saline and then close the abdomen, leaving a considerable quantity of saline behind. In cases of general oozing I first secure the more important points, and then fill the pelvis with saline.

I have followed this rule in several such cases on which I have operated since, and the result has been quite satisfactory in every case. I have now no doubt that the gauze in the earlier cases did not act as a drain, but merely as a superfluous and noxious foreign body, and a local irritant to any intestinal surface with which it came in contact.

TEMPERATURE.

	One occasion only.	Two occasions only.	More than two occasions.	Total.
Not exceeding 100° 4 F.	—	—	—	28
100° 5° F to 101° F.	9	3	1	13
101° 1° F to 102° F.	—	5	1	6
102° 1° F to 103° F.	1	1	—	2
Above 103° F.	—	—	1	1

A study of the temperature charts of this series is most interesting, considering the circumstances under which the operations were performed. There was not a single case of "sepsis from without" in the wholeseries. In no less than 41 cases the temperature did not exceed 101° F. even on a single occasion.

In five cases the temperature exceeded 101° F. on two occasions only, but did not exceed 102° F. These cases were—

17. Recent ruptured ectopic with severe internal hæmorrhage.

21. Ovariectomy for simple ovarian cyst.

33. Supravaginal hysterectomy for large myomatous uterus in a very corpulent subject.

44. Double ovariectomy. The abdomen was enormously distended and the patient was extremely ill on admission.

46. Panhysterectomy for ulcerating malignant disease of cervix.

In Case 3, which proved fatal, the temperature was marked between 101° F. and 102° F. on three occasions. Only in two cases was the temperature recorded above 102° F. and less than 103° F. These were:—

5. Panhysterectomy for ulcerating malignant disease of cervix.

48. Advanced malignant disease of the peritoneum. The temperature was due in this case to a somewhat mild attack of left-sided pneumonia at the end of the second week after the operation.

Only in one case was there any serious degree of temperature. This case was one of suppurating multilocular ovarian cyst with purulent peritonitis, but the temperature was 104° F. for two nights prior to the operation.

CONCLUSION.

That the observation of the following points is highly desirable in order to obtain good results.

1. A correct preliminary diagnosis.
2. Simplicity in operative technique.
3. The simplest antiseptic preparations combined with aseptis.
4. The use of few surgical instruments and appliances.
5. Limited abdominal incisions.
6. The correct adjustment of all cut peritoneal surfaces.

7. The complete closure of the abdominal cavity, without drainage of any kind.

8. The free use of normal saline solution in cases where purulent material gets accidentally spilled in the pelvis or abdomen during the performance of an operation.

CLINICAL RECORDS.

NOTE ON CASE OF LARGE PSEUDO-MUCINOUS CYSTOMA.*

By MACNAUGHTON JONES, M.D.

THE patient, æt. 42, has been married two years. Menstruation had ceased in December, 1905. Soon after this she was troubled with vomiting. No internal examination was made, as she objected. A monthly nurse was engaged, who insisted early in May that the patient should see a doctor. On examination it was discovered that she was not pregnant, but thirty-five tumblers of ascitic fluid were drawn off. The day following the patient made a long railway journey to London. When I saw her I found that there was still enormous distension of the abdomen. She was greatly emaciated, and had the extreme type of "facies ovariana." Her weakness was so great that I made no examination, but determined to operate the next morning. She was not in the most favourable condition when placed on the table, and I had some unpleasant doubts as to whether she would survive the operation. The incision reached to a few inches below the umbilicus. I drew from the abdomen a very large quantity of ascitic fluid, disclosing a large tumour which completely filled it. There were comparatively few adhesions. Evidently there had been some escape of the contents before operation into the peritoneal cavity. I tried to take the tumour out entire, and succeeded in doing so with the exception of a small rent posteriorly, made in extraction. The bowel was everywhere highly congested, and in a state of sub-acute inflammation, with adherent flakes of fibrin here and there. The abdomen was freely flushed out with saline solution, and afterwards carefully mopped out with weak formalin.

It is not necessary to refer to the post-operative symptoms. Her condition now is most favourable, and she is gaining flesh, and so far there has been no trouble. Since the operation I have found the spleen somewhat enlarged, and any pain she has had has been referred to this region.

At a recent meeting of the Gynæcological Society I showed a specimen of a semi-solid mucin cystoma associated with ascites, and referred to Professor Schroeder's recent paper on the prognosis of such cases, and the prospects of metastasis occurring and transplantation of the contents in the event of rupture of the cyst.

In the same Society's *Journal* for August, 1905, our editor, Dr. J. J. Macan, gives the most complete summary of the views of Pfannenstiel, Hoffmeir, and those who, like Martin and Olshausen, took part in the discussion at the Kiel Congress of the German Gynæcological Society in June, 1905. That review of this most important subject includes Pfannenstiel's definition of the terms, "malignancy" and "recurrence" as applied to these tumours. He points out that malignancy is not established by the recurrence of the tumour or implantation. Both may occur in the case of a benign tumour. Cystadenoma is the more serious form; sero-cystic tumours, fibroma and dermoids are not so. Between adenomata and carcinomata it is often most difficult to distinguish. Of the pseudo-adenomata the papillary form is the most malignant. Of the pseudo-mucinous tumours over 90 per cent. are permanently cured. In these there is no anatomical malignancy. There is no true metastasis. Cachexia, however, is the result of the growth of large tumours, and has to be considered as a cause of death.

Hoffmeir argues as to the non-malignancy of the

* Read before the British Gynæcological Society, June 14th 1906.

pseudo-mucinous cystadenoma—dermoid and fibroma. Papillary serous cyst adenoma is a less favourable form than the simple serous variety. In all suspicious cases the other ovary should be removed. As in my case, before the menopause the preservation of the second ovary is of importance. "No definite rule can be laid down as to the permanency of cure or the time needed for watching."

Pfannenstiel regards the removal of the second ovary in all cases of doubtful malignancy as *imperative*. We may draw certain conclusions from the general experience of such cases:—

1. The necessity for early interference in ovarian cystoma and the greater urgency for operation when ascites is present to any extent.
2. The removal of the tumour when possible in its entirety without rupture of the cyst wall. This may require an incision from ensiform cartilage to pubes.
3. As little disturbance, contusion, or injury to the peritoneum as possible.
4. In all cases in which there is any escape of the cyst or loose vegetations present, the free washing out of the abdominal cavity with saline solution, and the mopping out of the pelvic cavity, the careful cleansing of any contents of the tumour from the exposed peritoneal and bowel surfaces; for purposes of prognosis microscopic examination of the cyst wall and its contents.
5. In all doubtful cases the removal of the second ovary; its removal in all cases after the menopause.

THE OUT-PATIENTS' ROOM.

METROPOLITAN HOSPITAL.

A Question of Diagnosis.

By LEONARD WILLIAMS, M.D., M.R.C.P.

THIS man, whose age is 48, comes here complaining of pain in the chest of paroxysmal character. He gives a history of having had pleurisy some years ago from which, so far as he knows, he recovered perfectly. The pain in his chest he first noticed soon after the pleurisy, and he has been troubled with it at intervals ever since. Latterly it has become so frequent that he wishes to be examined.

On looking at his chest you see that there is retraction at the fifth and sixth interspaces, and if you put your hand over the heart's apex, you will feel that this retraction is systolic in time. The heart's apex is displaced outwards, but not much. It is displaced downwards to the seventh interspace. The percussion dulness shows no enlargement to the right, but there is pulsation in the epigastric notch. On auscultation there is a loud systolic murmur at the apex and a very decided see-saw murmur at the aortic base; that is, a murmur both of aortic stenosis and aortic regurgitation. He also has a waterhammer pulse. If you palpate the upper part of his chest, you will find a very definite thrill which is transmitted into the carotids. Now, the origin of this thrill presents rather an interesting problem. Thrill may arise from aortic aneurysm, from mitral stenosis, from mitral regurgitation and from aortic stenosis. There is nothing to support the diagnosis of aneurysm in this case. The thrill of mitral stenosis is pre-systolic in time. It is rough and runs into the first sound; it is best appreciated at the apex. This thrill, however, is systolic in time and is best appreciated at the base. It is probably, therefore, not due to mitral stenosis.

The thrill of mitral regurgitation need hardly be considered. It is best appreciated at the apex, and is not a common accompaniment of the condition. The thrill which we are here examining is certainly very much better appreciated at the base than at the apex, and as we have evidence that there is disease at the aortic valve, in that there is definite aortic regurgitation, we are, I think, justified in assuming that this thrill is caused at the aortic rather than at the mitral valve. We have, however, to consider two other causes of thrill. One is aortitis. In aortitis a thrill is often

produced by the passage of the blood over the roughened surface of the arch. It is accompanied by a muffled first sound at the apex and an accentuated second sound at the base, and it is generally attended by an increase in the dulness at the manubrium sterni. These conditions not being present, I think we may exclude aortitis.

The other unconsidered form of thrill is that which may be produced by pericardial adhesions. The thrill in this man's case is felt at the apex and is of a peculiarly superficial character. It is attended by systolic retraction and practically disappears when the patient is in a recumbent posture. Now, this disappearance in the recumbent posture is very suggestive. Murmurs, as you know, which disappear in the recumbent posture are generally regarded as being caused by some influence outside the heart—in the pericardium or elsewhere. And the fact that this thrill disappears, coupled with its very superficial character makes me incline to the belief that, in so far as its apical position is concerned, it is due to adhesions rather than to anything intracardial.

A thrill which is caused by contraction at the aortic valve may, as we know, be transmitted to the apex, or the thrill itself may originate at the apex. You will remember Dr. Gee's aphorism that if you diagnose disease at two valves, you are probably wrong. But the thrill which is to be felt at the apex is not synchronous with the thrill which is to be felt at the base, so that it is obvious that, in this case at any rate, the apical thrill is not transmitted from the aortic opening.

If you put one hand at the aortic cartilage and another over the apex, you will feel that there are in reality two distinct thrills, and I think the probable explanation of the situation is this: This patient has aortic stenosis and aortic regurgitation, the thrill at the base is due to aortic stenosis, and the thrill at the apex is due to some pericardial adhesions which were contracted when he had his pleurisy some years ago, the inflammation of the pleural cavity having extended to the pericardium.

OPERATING THEATRES.

NORTH WEST LONDON HOSPITAL.

NÆVUS OF CHEEK.—MR. MAYO COLLIER operated on a boy, æt. 8, who was the subject of a large nævus on the right cheek. The mother stated that soon after birth she noticed a small dark spot on the inner aspect of the right cheek, not far from the lips. This had slowly increased in size until it had attained its present dimensions: it extended from the right angle of the mouth backwards as far as the right pillar of the fauces—the whole thickness of the cheek was involved; a considerable swelling covered only by thin skin was apparent on the outside, whereas the whole of the mucous membrane on the inner aspect of the cheek was invaded by a dark blue mass of venous tissue. On compression the mass could be made to considerably diminish; on removal of the pressure the tumour resumed its original size. No thrill or pulsation was present, and no previous treatment of any kind had been resorted to. The patient's mother had not even applied for treatment, but the boy having been admitted for a scalp wound was detained by the house surgeon as a case which should be further treated with respect to the nævus. Mr. Collier said this case was one of considerable difficulty; it was a matter of anxiety to know what the best treatment would be to adopt. Running through one's mind the various treatments adopted for the cure of nævi, not one alone would be found efficient on this occasion. [Of electrolysis, excision, cautery, ligature or injection, none here could be resorted to. Electrolysis with a hospital

patient, especially of such tender age and with such an extent of tissue involved, meant a great number of sittings and a large amount of time. Excision was out of the question, as the mass was too extensive and the disfigurement resulting would be worse than the disease. The same objections to the electrolysis would, he said, apply to the cautery as involving too many sittings and too much expenditure of time, and not holding out a promise of a satisfactory result. Ligature as ordinarily applied to *nævi* so as to strangulate the growth was in this case out of the question from the fact that the *nævus* involved the whole thickness of the cheek, and its excision would risk a serious deformity. The possible results of injecting tissues in this position such as slough, thrombosis and abscess did not recommend this method. Mr. Collier said that from the fact that the *nævus* was more apparent on the inner aspect of the cheek and a large number of tortuous veins could here be observed, he thought it would be wiser to attack the growth by stages, and to combine multiple ligature with one of the other methods he had enumerated. Accordingly, the mouth being held well open, he proceeded to pass six ligatures from above downwards with curved needles through the inner aspect of the *nævus*, so as to involve not more than half its thickness. The

first ligature was placed with some difficulty half an inch in front of the anterior pillar of the fauces. The result of perforating the *nævus* in this position was a considerable hæmorrhage, which was only arrested by further ligatures in mucous membrane only. The blood that flowed from the needle punctures was bright red, and was ejected with considerable force, showing that an artery of some size must have communicated with the *nævus*. In order to facilitate the introduction of the other five ligatures contemplated, Mr. Collier, as a preliminary step, tied the facial artery as it passes over the lower jaw. This step rendered the introduction of the other ligatures less difficult, although each and every one was accompanied by considerable hæmorrhage, and stitches had to be placed at the points of entry and exit so as to take up the mucous membrane only. The result of the operation was in the end extremely gratifying. For the first week there was much swelling of the cheek, and slight pain; at the end of three weeks the mass had considerably diminished, was distinctly hard in consistence, and presented little deformity when compared with the other side. No further treatment was resorted to, and the case was exhibited at the British Laryngological Association some six weeks afterwards, when a complete cure had been established.

TRANSACTIONS OF SOCIETIES.

BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD THURSDAY, JUNE 14TH, 1906.
Mr. BOWREMAN JESSETT, President, in the Chair.

DR. MACNAUGHTON JONES showed a large multilocular dermoid cyst of the ovary, removed from a patient, *æt.* 47. She had been a sufferer for twenty years, was extremely feeble, suffering from attacks of tachycardia and syncope. At operation the tumour was found to have filled the entire abdomen, the upper third consisting of a mucin cyst containing five pints of thick gelatinous fluid. This was evacuated, and the remainder of the tumour removed entire. The interesting point connected with the tumour was that the wall was smooth and denuded of hair, but in its section showed degenerate gland tissue and stumps of hair which were being devoured by multinuclear giant cells. In this country attention was first drawn to these giant cells by Mr. Herbert Williamson at a meeting of the Obstetrical Society, in October, 1904, and his conclusions, and those of Pfannenstiel, as regards the differentiation between dermoid cysts of the ovary and those found elsewhere in the body are of interest (*Obs. Trans.*, 1904). The patient had done well.

DR. MACNAUGHTON JONES also showed a large pseudomucinous systema tumour of ovary weighing twelve pounds, which he had removed from a patient, *æt.* 42. Some thirty pints of ascitic fluid were removed, and the patient was reduced to a state of extreme emaciation. The tumour was taken out whole. The patient had made a good recovery, and was gradually regaining flesh and strength. His remarks will be found fully reported under "Clinical Records" in another part of the present issue (see page 687).

THE PRESIDENT remarked that the second specimen was important chiefly in regard to the question of malignancy. The late Mr. Lawson Tait laid it down as an axiom that where there was a large abdominal tumour with ascites the probability was the tumour was malignant. He agreed with this in the majority

of cases. He wished to know why the remaining ovary was not removed, as the patient was forty-two years of age.

DR. MACNAUGHTON JONES said he did not consider ascites to be always associated with malignancy, as he had drawn off ascitic fluid from a number of cases where there had been an ovarian cystoma, and the patient recovered.

DR. RANKEN LYLE read a paper on "A Series of Fifty Consecutive Abdominal Sections," which will be found fully reported on page 684 of present issue.

DR. HERMAN remarked that Dr. Lyle had obtained the best results in all the cases but one, the patient in that case having died from a disease which at present they could neither predict nor prevent. As to the question of aseptic precautions in cases of the kind, he (Dr. Herman) believed that the septic poison was neither inhaled nor swallowed, but was conveyed by contact alone, and that the particles which conveyed the poison were subject to the law of gravity and did not fly up to the operator's beard or hair. He believed that the only necessity was to make everything aseptic that touched the patient or the wound. As to the question of drainage, he thought that if there was an abscess cavity one should make some provision for the exit of the pus. In several cases of extra-uterine abscesses he had put gauze in the opening with the object of preventing union by first intention, and so provided for the escape of the fluid, and the results, as a rule had been satisfactory. One way by which Dr. Lyle secured aseptic conditions during operations on the abdomen was the fact that he allowed only those to assist him who had been trained under his own eyes. The results of Dr. Lyle's cases showed that he took all the effective and necessary precautions, those precautions at the same time being very simple in character.

DR. EDEN said he was very glad to hear the reader of the paper emphasise the importance of making a correct diagnosis before doing an abdominal operation. The art of diagnosis was being neglected now-a-days. A larger amount of time given to diagnosis would be an advantage to both the operator and the patient. As

to the use of gloves, he thought that rubber gloves were necessary to good work, especially in infective cases. Then, again, he always tried to manage his instruments himself, and even to thread his own needles, in order to reduce as far as possible the risks which must result from several persons handling them during operation. With regard to drainage, the more experience he had of abdominal sections the less reason he saw to drain. But he never found any harm arise from a gauze drain. He used a rubber tube through which he passed the gauze, and he always found this answer very well. He could not imagine how a piece of sterile gauze would cause abscess. He thought there was a risk of filling the peritoneal cavity with saline fluid, as the fluid might carry infective material into parts where the presence of organisms might lead to serious consequences.

Dr. ELDER considered the results unique, and were only possible after the work done by such men as Spencer Wells, Lawson Tait and others. In cases where sepsis followed operation, he thought it was owing to infective material which came from outside. As to the question of drainage, he thought very few of them would go as far as Dr. Lyle. Dr. Elder instanced a case of rupture of an ectopic gestation occurring at night in a collier's cottage, where the conditions were very unfavourable, and although he left the peritoneum full of blood without drainage the patient got perfectly well. He thought that gloves rather interfered with the delicacy of one's touch, but in cases of suppuration were necessary.

Dr. R. L. DICKINSON (New York) said he had been impressed by the great simplicity and the common-sense methods employed by Dr. Lyle. He thought that in America there was a danger in having too many assistants for the class of operations they were specially considering that night. They trained too many assistants; the training schools insisted on having as many nurses as possible in the operating room. But he preferred to do his own work himself, and to give assistants as little chance as possible for omissions in connection with antiseptic arrangements. Catgut was mostly used in America in cases of abdominal section. The use of gloves had become practically universal there. The percentage of cases of sepsis had slightly dropped, since the use of gloves. He thought that as they increased in surgical skill they made their incisions proportionally smaller. It was his practice to use the smallest possible incision. As to drainage, in America the custom was never to drain except for pus in the connective tissue.

Dr. MACNAUGHTON JONES, in congratulating Dr. Ranken Lyle on the result of his cases, said that the good of early operation was asepsis, thorough and complete. He was one of those who considered that no pains, no precautions, should be omitted to attain this end. He endorsed Dr. Lyle's practice of free flushing out of the abdomen with saline solution in all cases requiring it. The three most important post-operative signs were temperature, pulse, and bowel. He considered that the two former varied so much that it was more especially when taken into consideration with the correlated signs and symptoms that they came to be of great importance. Of the three, the bowel gave him the greatest anxiety. Sepsis occasionally occurred no matter what precautions were taken. Fritsch's *dictum* was aphoristically true—the patient did not die, because of sepsis, but became septic because he was dying.

Dr. RYALL said he could not understand how saline fluid poured into the abdomen could prevent adhesions. He believed adhesions could best be prevented by getting the bowels to open soon after an operation. He was a great believer in a tubular drain in preference to gauze. He was a believer in masks so that talking or spitting or whispering into a wound might be prevented. The shorter the operation the better for the patient.

The PRESIDENT said an incision should be made sufficiently large to admit of the removal of the tumour

without stretching and afford a good view of the pelvis. He always had the vagina thoroughly disinfected, as it might have to be opened during the course of the operation, but he did not think he could always tell exactly what the nature of any lump was that he might find in the abdomen without opening it. The great secret of success in all cases of abdominal section was covering the stump by peritoneum and the sutures should be catgut.

Dr. RANKEN LYLE, in reply, said he only employed two assistants at each operation, and not more than three or four other students could stand in the room at the time. He thought that the only cases which should be drained were cases of pelvic abscess. In other cases he thoroughly washed with saline fluid, flushed the abdominal cavity and closed the wound. The saline solution also stimulated circulation in the peritoneum, and secondly, enabled the phagocytes there to devour the micro-organisms more easily. He did not think that the use of gloves was necessary. During an operation possibly nobody talked more than he did, but he had never seen any ill effects. Occasionally caps and masks might be necessary. He did not think that disinfecting the vagina did much good, as in the large majority of cases the vagina was not septic. He always took great care to flush out the pelvis and wash away the pus.

CORRESPONDENCE.

FROM OUR SPECIAL CORRESPONDENTS ABROAD. FRANCE.

Paris, June 24th, 1906.

FORMIATE OF SODA.

ACCORDING to Dr. Rachon, formic acid enjoys very remarkable bactericidal properties as regards the pneumococci of pneumonia. To six patients, of whom three were children, he administered formiate of soda (6 to 10 grains for children, 30 to 40 for adults). Under the influence of this treatment the fever fell on the third or fourth day. At the same time he prescribed rum or brandy. He observed in each case a certain amount of diarrhoea and sweating. In the treatment of tonsillitis, due to pneumococci, he prescribed a gargle of formiate of soda (4-100) with equal success.

Subsequently he treated 65 cases of pneumonia by the same method with only one death, and that patient was a heavy drinker.

In infantile diarrhoea Dr. Rachon prescribes formiate of ethyl as follows:—

Formiate of ethyl	20 to 40 drops.
Syrup of catechu	1 oz.
Water	4 oz.

A tablespoonful every three hours.

In every case the diarrhoea ceased within two days.

But it was in acute enteritis and summer cholera that the most remarkable results were obtained. He prescribed the formiate of ethyl at the dose of 25 drops daily.

Formiate of ethyl	25 drops.
Syrup of catechu	2 drachms.
Water	1½ oz.

A teaspoonful every two hours.

It would appear from the above, says Dr. Huchard, that formic acid constitutes a remarkable antiseptic against the pneumococci, which are thereby arrested in their development *in vitro*.

VEGETATIONS OF THE GENITAL ORGANS.

Collodion	1 oz.
Resorcin	2 drachms.

Apply to the tumour after washing with Hoffmann's anodyne or ether. Two or three applications are sufficient.

It is reported that the invitation to be given to the British Medical Association to select Exeter for next year's meeting will be accepted. The only other place which is openly desirous of receiving this influential body is Bradford.

GERMANY.

Berlin, June 24th, 1906.

At the Society for Surgery, Hr. Fritz König, Altona, spoke on

TRAUMATIC OSTEOMATA.

He said that after an injury, sometimes after sharp pain and swelling of the soft parts, a tumour of the bone formed that gave the impression of a periosteal sarcoma. Several circumstances were, however, opposed to the assumption, as the form of the tumour, which was diffuse upwards, ended sharply below. Further the X-ray image was different and also the course of the affection. After some months the tumour ceased to grow, or even became smaller. The speaker saw this in a case last year. In another case, that of a woman, æt. 54, who had fallen through a window, and who had spinal paralysis as a result, death ultimately took place. In this case a swelling of the femur came on four weeks after the injury which at the autopsy proved to be a thickening of the periosteum with bony inclusions. The external covering of the bone was torn by the force of the injury, hæmorrhage took place and the growth of the periosteum had followed in consequence. Here as in other cases there was no proper traumatic osteoma, but a structureless callus, therefore a tissue process as in the recovery from a fracture. If such tumours were operated on early nothing was gained, on the contrary the condition was usually made worse and recurrences took place after the operation. One should decide to operate only when the symptoms were very severe, and only then when the development of the tumour had been watched three or four months. Then all the new growth should be removed.

Hr. V. Bramann, Halle, had seen a large number of such tumours. Frequently there was no connection with the bone, but in consequence of the injury a bony development had taken place in the muscles, or had developed from the bony pieces torn off. He had operated after six months to a year, after waiting to see if any retrogressive change would take place.

Hr. Staffel, Chemnitz, had seen such cases in brewers' draymen, who were in the habit of raising the barrels on to the thighs. These were cases of Wade's disease, that frequently led to operation, so that the employment could not be followed.

Hr. Höcker, Stettin, would make a strong distinction between the two processes described by König and v. Bramann. The latter-mentioned cases had long been known in the varieties of the "exercise" bones and "riding" bones; these always proceeded from the muscles.

Hr. Zeoge v. Manteuffel, Dorpat, remarked that hæmatomata might also ossify. This ossification in Virchow's opinion, proceeded from the cells of the periosteum that found their way into the hæmatoma.

At the Hufeland Society, Hr. Ewald showed a man æt. 57, of healthy parentage and who had never been seriously ill. In 1903 he had inflammation of the veins of the legs. Two years later he had extreme swelling of the tonsil and glands of the neck. Respiration and deglutition were impeded. The tonsils and adenoid growths were removed. A splenic tumour was felt. The sub-maxillary glands were the size of a hen's egg, glands could also be felt down to the clavicle. The inguinal and axillary region were free. The blood showed no morphological change, the hæmoglobin contents had fallen to 50 per cent. The white and red corpuscles were in normal proportion. He was treated by 120 sittings of X-rays and the condition improved, the hæmoglobin rising to 70 per cent. The improvement was only temporary, however. The end of March, 1906, he returned to the hospital. Since January he had difficulty in swallowing. He looked cachectic; in both axillæ were glands the size of walnuts, the right tonsil was enlarged, the laryngeal opening was surrounded by growths, and the sounds of stenosis were heard on inspiration. Lungs and heart normal, liver enlarged, spleen much hyper-

tropical. No albumen, no sugar. Hæmoglobin 50 per cent. Red blood corpuscles, 2,500,000, white 4,500. Poikilocytosis. Examination of the stomach showed no free hydrochloric acid. Liq. Fowleri 60, later on 70 drops daily for five weeks, after that 60 drops again. On April 20th, the difficulty of swallowing had disappeared, the tonsils were small, the growths no longer to be seen. On May 5th the patient felt so well that he left the hospital. When admitted he weighed 55½ kgm., he went up gradually to 57½ kgm, but fell away at the end of April to 56, and weighed only 54 when he left. It was a fact that this brilliant and striking improvement was due to the arsenical and Röntgen ray treatment, but it was to be feared that the present good condition was only a temporary one and that there could be no question of any absolute recovery.

AUSTRIA.

Vienna, June 24th, 1906.

TETANY AND STRUMIPRIVA.

At the "Gesellschaft für innere Medicin" Leischner showed an interesting case in connection with the thyroid gland. The patient is a male, æt. 40, who was operated on by Billroth, 1890, who removed both sides of the gland but left the isthmus.

Three days after the operation typical tetanic cramp commenced, recurring two or three times every week. Shortly after this the hair began to fall out, succeeded by a new growth; along with this the nails fell off, and have done this annually since the operation. Marital desire has fallen off, and he has an objection to all kinds of flesh meat.

In the course of time the isthmus or small portion of the gland that was left began to increase, with a corresponding diminution of the tetanic attacks; but recently the attacks have returned with more severity, as they are now accompanied with unconsciousness.

The treatment with thyroid gland gave no relief to the patient, but bathing and hydropathic management gave better results. Some time ago he suffered severely from pains in the legs followed by cataract in both eyes for which he was successfully operated on. It is evident from these phenomena that the epithelial bodies of the gland must either have been injured or removed in the operation.

HELMINTHIASIS.

Goldmann read a long article to the members on tænia in the alimentary canal. Helminthiasis he affirmed comprehended all the vermicular parasites of the alimentary canal which are of importance in practice from the injury they do the mucous membrane of the bowel and the convulsions produced in infancy. Trichocephalus Oxyuris, Ascaris, &c., not infrequently produce appendicitis. Trichocephalus and Ascaris have been frequently found in the gall ducts and peritoneal cavity with resulting abscesses.

Again, many of the Helminthiæ form toxins which sooner or later produce a hæmolytic condition with serious consequences, particularly trichocephalus, tænia, and ankylostomum, which are very fruitful in producing intractable anæmia.

The sovereign remedy has always been some form of Ext. Filicis maris, which itself is not without danger to the patient owing to the large doses necessary for the removal of the parasite. Six grammes has produced intoxication and even death in the more susceptible, while blindness is not at all an uncommon result. It may be stated at once that this drug is quite useless for the removal of ankylostoma, and to be of any use in other cases must be given in large doses up to ten grammes for an adult. Goldmann has now treated 1,200 for ankylostoma. In his early practice Ext. Filicis mar. was generally used for this, but failing so frequently made him try cortex, pumicæ, granulata, chloroform, santonin, and bitumen fagi, with varying results. In other directions he used ribes embelia myrsinacæ, etc., with better results as vermicides but these are not vermifuges and must be given in large doses of 40 grammes. Sebirol is one of these pepper drugs which is a good vermicide but no vermi-

fuge, but which combined with thymol and salicylate makes a formidable agent. This mixture may be given in oil or made into a pastille with chocolate. No hungering period is necessary; only a purgative the day before the drug is administered and light food the day following.

Schrotter said he had obtained good results from the use of cortex fibrillorum puniceæ granulatae, in an extract form. The bowel must be well emptied and a day's fasting before the drug is administered. Friedjung said he had got better results from extr. aspidii spinulosa.

Rick recommended the kernels of cucurbita maxima; 130 rubbed up with sugar and cacao in the case of children.

Goldmann said aspidium spinulosum had failed miserably in his hands, particularly in ankylostomiasis.

LETTERS TO THE EDITOR.

HYGIENIC MEASURES AGAINST SYPHILIS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Prof. Elie Metchnikoff, in his lecture on Wednesday, May 30th, at King's College, said:—

Since it has been shown to be possible to guard both our skin and our alimentary canal against the attacks of insects and entozoa containing the virus of disease, how then does it happen that man runs a greater risk of being infected by a virus existing in other men. Man is the principal source of contagion in tuberculosis, influenza, and many other diseases of the respiratory organs.

Man, again, carries about and communicates without intermediary the virus of venereal disease. Since, then, both the organ which furnishes and the one which receives the virus belong to the human race, and to beings provided with the power of sense and of reasoning, it might appear simple and easy to avoid all danger.

This is what I have always thought, ever since I discussed the question of the prevention of venereal diseases as the Secretary of the Harveian Society for the prevention of those maladies, which took place in 1867; and I have always felt astonished at the callous way in which all attempts to lessen the prevalence of these preventable pests have been hushed up by persons who know so little about the mortality caused thereby.

Prof. Metchnikoff truly remarked that "syphilis is one of the most important causes in shortening human life and in bringing about mortal diseases." To prove his point he cited an account given by Prof. Runberg, of Helsingfors, contained in the *Deutsch. Med. Woch.*, 1900, p. 297, concerning 734 deaths occurring in insured persons, 11 per cent. of whom had died of syphilitic disease of the heart, general paralysis, brain lesions, in all 84 deaths. He adds to these, cases of cerebral apoplexy in persons under the age of 50, and considers that syphilis caused about 15 per cent. of the deaths of all these insured lives. The lecturer opined that next to phthisis, syphilis is the most frequent cause of death.

I should think that, however true this may be for some European States, it cannot be true for the population of the United Kingdom, for here chronic alcoholism and phthisis are surely much more fatal causes of disease than syphilis, and I remarked at one of the Congresses on Venereal Diseases, held in Brussels, that Paris seemed to me very much more affected with syphilis than London, as far as I could judge by personal observation and by statistical accounts at my disposal.

I believe that the police system of Paris increases the spread of syphilis, because it tempts young people to run into danger, instead of suggesting early honest intimacies between the sexes. And, after thinking over the question for many years, I have come to the conclusion that we males should commence by inflicting some penalty upon our own enfranchised sex, instead of on unenfranchised women, when any of us communicates syphilis to another person.

Miss Harriet Martineau once truly said that if women obeyed any law, it was merely out of good nature, since they had no voice in the enactment of any law, and consequently it seems to me that to be just we should punish only men, and not women, when they infect their neighbours. Of course, as in the case of affiliation, the charge of contamination by the man would require to be clearly proved to the judge and jury.

Prof. Metchnikoff speaks slightly of early marriage as a preventive of syphilis; but any one who knows how free our native Indian soldiers are from this disease will understand that early marriage is certainly a very great preventive measure.

But, unfortunately, the early marriages of the Hindoos leads to starvation, and they therefore fall from Scylla to Charybdis. But early marriages in France, where families are so moderate in size (100 wives of Parisian medical men have only 150 children.—Dr. Luland), and even among our own West-end people early marriage might ward off syphilis and not entail poverty.

Prof. Metchnikoff has done great service in proposing injunction with calomel ointment in case of any suspected contagion occurring, and we all trust that this plan may be of great service.

I am, Sir, yours truly,

C. R. DRYSDALE, M.D.

London, June 24th, 1906.

OUR HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—There is no doubt but that our whole hospital system will have to be reformed. Years ago, when there was no provision for the working classes for proper medical and surgical treatment, hospitals were supported financially, as a matter of principle, by those who did not belong to the working classes. Just as the system of education in this country during the last sixty years or so has changed, so the care of the sick poor has passed into other hands.

Hospitals are no longer restricted to the poor, but very many who would not have gone to hospitals in those days resort to them now; for the simple reason that it is impossible for them to get in their own homes the treatment they require. The reform that must be made in our hospitals is evidently that they must let the patients supply the funds required for their support, and not let them be treated as simple recipients of charity. Many, very many, who used to subscribe to hospitals in the past, now consider that they do enough in paying the rates and taxes for the support of the fever hospitals, asylums, infirmaries, and this class of institutions; and it is only those that have more than they want who can afford to be generous.

There is not the least doubt but that very serious injury has been done to the great body of general practitioners throughout the country by the opening of hospitals to those patients who used to pay the practitioners; and it would be well if the profession took this matter into consideration and used its influence in reform. Possibly and probably the want of funds will do more than anything; and a change will come when the public generally understand this question better.

I am, Sir, yours truly,

R. L.

INFANT MORTALITY AND PATENT MEDICINES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—There cannot be the least doubt about the murderous powers of baby-soothing medicines, to which you refer in your leader of June 20th; they constitute the determining lethal factor in a great number of cases. The fact, to which you are rightly giving prominence, that the advertisements of these cruel frauds find a place in most of the leading papers is astounding; it is impossible to believe the owners of newspapers can be fully alive to the truth; you are at any rate taking away any excuse for the future, not only with regard to this, but to the whole system of

quackery, and you are earning the gratitude of the public accordingly. Simple mothers and nurses reading frequent articles deploring the excessive infantile mortality cannot believe that the advertisements in the same papers recommending some "baby-soothing" nostrum with an attractive name can be pure deception. These drugs, in most instances, are given to "quiet" the child when it cries in pain from indigestion. If they have any potency it is in virtue of the narcotics or anodynes they contain. The baby's pain is mitigated, it sleeps; and the same process being repeated time after time, it either dies in the end from inanition or survives as a rickety cripple. In any case, instead of treatment of the cause—improper food and feeding, to which any medical man could at once direct himself—the symptom, pain, is alone dealt with, and, if mitigated, often with disastrous result. Cases of this kind used to be frequent only among the poor; that they are becoming more and more common in the homes of the well-to-do and the wealthy is, to some extent at least, traceable to the facts which you have exposed with respect to the powers for deceit conferred upon the quack medicine dealer by leading newspapers, which assume the function of guardian of the welfare of the people, and are so regarded by their less ingenuous readers.

I am, Sir, yours truly,
AN OBSCURE PRACTITIONER.

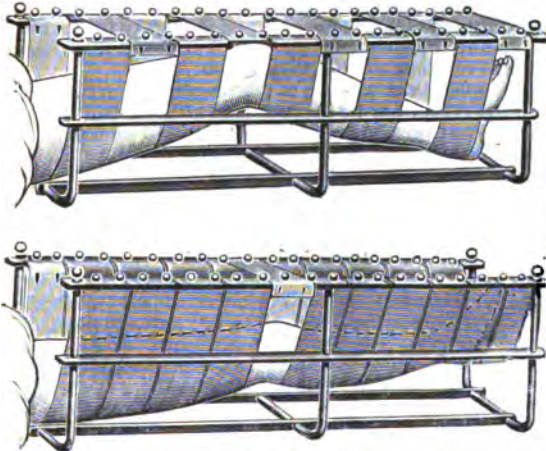
June 21st, 1906.

UNIVERSAL LEG SPLINT AND CRADLE COMBINED.

DR. CHEVERS of Manchester writes:—

This splint, as shown in sketch, consists of a white enamelled metal frame 32 inches in length, 7 inches in depth, and 9 inches wide. Along the top on each side is fixed a row of brass studs which serve to secure a series of 10 straps. These straps are each 3 inches wide and are button-holed or eyeletted so as to be adjustable to half an inch. They are made of pegamoid and may therefore be sterilised by boiling. The advantages claimed for the splint are as follow:—

It requires no padding, can be used for either leg, and is readily cleansed.



The swing arrangement of the straps when in position is more comfortable than a perfectly resistant surface.

By means of the adjustable straps it is adaptable to any size, shape, or length of limb, whether child or adult (even an amputation limb).

It is of the greatest convenience when heel pressure has to be relieved, which in case of either a short or long limb can be easily effected by removing the strap at the location of the heel, so that a space is left.

One of its greatest acquisitions is the elevation of the limb with steady graduated support to the whole under surface, which is attained by graduating the length of the straps on which the limb rests.

It is obvious also that by regulating the straps the splint can, if required, be used as a double inclined plane. One or more of the straps may be used over, instead of

under, the limb, so as to keep the limb or amputation stump fixed in case of a restless patient or child. If alternate straps are lowered nearly to the floor of the splint but not touching, so that the leg still swings, and the other ones buttoned perfectly tense across the top of the splint, the splint then acts as a perfect cradle, and all pressure of the bed clothes is removed. If any portion of the foot should project above the splint, an adjustable and detachable guard is provided to remove weight of clothes.

After the leg has been put up in fracture splints, it may then be placed in the universal splint and active motion thereby prevented.

When excessively wet dressings are required to be applied to the limb, such as evaporating lotions, they can be kept in place without the use of a bandage (which only absorbs the moisture and interferes with evaporation); and by the application instead of one or more of the non-porous pegamoid straps, and by placing a dressing tray within the splint under the suspended leg, it acts as a receptacle for the drippings from the moist dressings.

The placing of the straps over the limb very much facilitates the keeping of an ice bag in position, and they can be made use of for this purpose over any part of the limb, especially the knee in synovitis.

I have had frequent and various uses for the splint over a period of three years, and have found it of greatest service.

It is manufactured by Messrs. Jas. Woolley, Sons and Co., Ltd., surgical instrument makers, of Manchester.

THE NEW PRESIDENT OF THE ROYAL COLLEGE OF SURGEONS, IRELAND.



THE new President of the College of Surgeons is perhaps one of the most widely known of Irish surgeons on account of his world-wide reputation as an ophthalmologist. Mr. Swanzy received his medical qualifications from Trinity College, Dublin, in 1865, and in 1873 became a Fellow of the College of which he is now President. He holds the posts of Senior Surgeon to the Royal Victoria Eye and Ear Hospital, and of Ophthalmic Surgeon to the Adelaide Hospital.

He has also served as President of the Ophthalmological Society of the United Kingdom. His work on "Diseases of the Eye, and their Treatment" is universally known, and has passed into a ninth edition. Mr. Swanzy enters on his term of office as President of the Royal College with the complete respect and regard of his colleagues, and of the medical profession generally.

The new Vice-President of the College, Mr. John Lentaigne, F.R.C.S., is also a well-known surgeon, and holds the post of Surgeon to the Mater Misericordiae Hospital. Like his President, he is a graduate of Dublin University, and a most popular member of the medical profession.

THE NEW BENNETT MEDAL.

WE publish herewith pictures of the Bennett Medal which has been instituted by the old students of Prof. Bennett, of Dublin. The obverse is an excellent portrait of Mr. Bennett, while the reverse shows a representation of "Bennett's fracture." The designing is by Mr. Oliver Sheppard, R.H.A., and our readers are able to judge of its high artistic merits. We believe that subscribers can obtain replicas of the medal as mementoes at a moderate charge.



OBITUARY.

STANLEY MORSE, M.R.C.S., L.R.C.P.

WE much regret to notice the death by accident of Dr. Stanley Morse, second son of Mr. L. L. Morse, M.P. for South Wilts. He was educated at St. Bartholomew's Hospital, and qualified in 1905. Dr. Morse, who was 26 years of age, was senior house surgeon at the Metropolitan Hospital, Kingsland Road. A fortnight before his death he was conducting a *post-mortem* examination on a child who had died from some form of blood-poisoning, when he slightly pricked himself. Blood poisoning followed, and fatal complications developed. Dr. Morse had arranged to attend the wedding of his eldest sister at Swindon next week. This death adds another to the long list of medical men whose lives have been sacrificed at the altar of duty.

LIEUTENANT FORBES MANSON GRANT
TULLOCH, M.R.C.S., L.R.C.P.

LIEUTENANT FORBES MANSON GRANT TULLOCH, R.A.M.C., died on the 20th inst., at the Queen Alexandra Military Hospital, Millbank, aged 27. The youngest son of Surgeon-General Tulloch, of Eastbourne, he was born in 1879, and received his professional education at St. Mary's Hospital, whence he took the degree of Member of the Royal College of Surgeons, and Licentiate of the Royal College of Physicians, London, in 1901. He served in South Africa as a civil surgeon in 1902-3, and returning home was gazetted a lieutenant in the Royal Army Medical Corps from August 31, 1903. At the close of 1904 he was selected for special service in Uganda, and was sent out to Entebbe by the Colonial Office as a commissioner to inquire into the causes and prevention of sleeping sickness. In Uganda he unfortunately contracted the disease, and was invalided home, but the progress of the malady was very rapid, and on Wednesday it proved fatal.

Lunacy Administration in Ireland.

At the last meeting of the Medico-Psychological Association of Great Britain and Ireland, Dr. Dawson, Medical Superintendent of Farnham House Asylum, called attention to a matter of considerable importance to the resident medical officers of Irish asylums. He demonstrated to the Association how amongst other undesirable effects the newly-issued "Public Bodies Order" of the Local Government Board placed the medical officer in a subsidiary position to that of lay officers, and thereby interfered with the proper administration of the asylum. In consequence of Dr. Dawson's representation, the Association passed the following resolutions:—"That the Medico-Psychological Association of Great Britain and Ireland, having learned through reports in the public press of a movement in Ireland tending to lessen the authority of the resident medical officers of asylums, desires to express in the strongest manner its conviction that any such change would certainly result in injury to the patients, and would be in direct opposition to all progressive and enlightened treatment of the insane."

"That the resolution be delivered into the hands of the Right Hon. James Bryce, Chief Secretary to Ireland, the manner of such delivery being left to the discretion of the President of the Association."

We applaud the wisdom of the Association in ordering that the resolution be given "into the hands" of Mr. Bryce, as, if this course is followed, it will no longer be possible for him to plead in the House that "he has no knowledge of the circumstances."

Catholic University School of Medicine in Ireland.

THE following arrangements have been made in celebration of the fiftieth anniversary of the establishment of the above School of Medicine:—On Thursday, June 28th, there will be athletic sports at the newly acquired grounds, Croydon Park. On Friday, June 29th, there will be Solemn High Mass at the Catholic University Church, Stephen's Green, South, at 12 noon. His Grace Archbishop Walsh has expressed his intention of being present, and the Mass will be celebrated by the Very Rev. Mgr. Fitzpatrick. The sermon will be preached by the Rev. Dr. Cronin, F.R.U.I. The professors and students of the Medical School and of University College are expected to attend in academic costume, and will robe in University College at 11.30. At 8.30 p.m. on the same day, by kind permission of the Lord Mayor, a musical soiree and conversation will be held in the Mansion House. On Saturday, June 30, at 11.30 a.m., by kind invitation of the Very Rev. Dr. Mannix, President, there will be an excursion to Maynooth College, returning about 4.30 p.m. On the same evening (Saturday, 30th inst.), the anniversary banquet will take place at the Dolphin Hotel, at 7.30 p.m.

Past students are invited to participate in these celebrations, and as a considerable concourse is expected, applications for tickets (stating which functions it is proposed to attend) should be addressed to the Registrar, Prof. M'Loughlin, as soon as possible.

MEDICAL NEWS IN BRIEF.

Opening of the New Spa at Cheltenham.

TIME was when the mineral springs of Cheltenham were among the most renowned in Europe, attracting royalty and the aristocracy of Great Britain to the town with the strong backing of the leading physicians of the day. But the beautiful country surroundings got into the hands of financiers and speculative builders, who thought more of cutting up the land into building plots than of developing the attractions held out by the springs as a health resort. With the inauguration, however, of the new central spa last week, with its magnificent halls, pump room, etc., at a cost to the Corporation of £60,000, the foundation has been laid for a revival of the ancient popularity of Cheltenham, and we shall be greatly surprised if it does not shortly become a centre of attraction for the fashionable *habitués* of health resorts, and one to which the physician can again send such patients as would benefit by its waters, its health-giving and equable climate and the beauty of its surroundings. Nor has the social element been overlooked. As Dr. Armstrong, of Buxton, remarked at the opening ceremony, the new buildings would be dignified by the name of Kursaal by a less modest Corporation; and when we add that severe analytical tests prove the waters to be identical therapeutically to what they were "when George the Third was King," it will be understood that the new bid for public and professional consideration stands a very good chance of immediate recognition. We agree with Dr. Armstrong, who declared that if the Cheltenham springs were situated in Germany thousands of persons would be drinking them. Cheltenham certainly has a water unique in England, and it may be confidently predicted that if the local authorities of British spas bestir themselves the medical profession would frequently advise patients to take the cure at Cheltenham and other watering places at home, instead of journeying to foreign countries. Dr. Goodhart sounded the right note when he reminded those assembled at the opening that a very necessary adjunct to success was that hoteliers laid themselves out to act in conjunction with medical opinion as regards dietary.

Fatal Fall in a Hospital.

WE regret to record that Mr. Duke, one of the resident officers of University College Hospital, London, met with a terrible death last week. He went to the lift intending to descend to another part of the building. The lift was not at that floor at the time, and, through some mistake, he stepped into the shaft and fell into the basement, where he was discovered by an attendant dead.

Reassuring Tommy Atkins.

OUR contemporary, *The Scotsman*, reports an interview with Sir Frederick Treves, who remarked that he was not disposed to make any definite statement on the subject of the tinned meat scandals. He wished, however, most emphatically to state, with reference to certain assertions which have been published to the contrary, that the tinned meat supplied to the British Army by our military authorities is of the highest quality. "No man in the British Army should suffer from any tinned meat he has consumed," said Sir Frederick. "I am speaking in this matter from purely personal experience. I cannot say how much of the tinned meat consumed in the Army is derived from America, but it is really of little consequence. Whatever is eaten in the Army is so carefully supervised and tested by the authorities that the possibility of poisoned or deleterious materials being produced for consumption is practically nil."

The *Tribune* reports the results of an inspection by its own correspondent of the Armour Company's premises at Chicago, where the largest meat packing plant is in operation. So far as a superficial examination of the buildings and appliances could go, he says he found them in a remarkably clean condition. He

watched the processes of manufacture and the material used from the stage of living animal to the processes of canning and labelling for export. No deleterious substances are included, and the process is cleanly and inoffensive. There was no attempt to conceal any part of the process or any department.

Incorporated Medical Practitioners' Association.

THE annual meeting of the members of this Association was held in London at the Trocadero Restaurant, on the 14th inst., when Dr. A. Percy Allan, of Croydon, was elected President for the ensuing twelve months. After the meeting the members and friends dined together, Dr. Allan in the chair, who announced in reply to the toast, "Success to the Association," that the Council had resolved in regard to the forthcoming election of Direct Representatives to the General Medical Council to recommend the members to support the candidature of Mr. George Brown, one of the present representatives, and Mr. Joseph Smith, President of the Association of Members of the Royal College of Surgeons of England, who was a candidate at the last election. In the course of the evening, the retiring President, Dr. Rivers-Willson, presented a testimonial to Mr. G. Brown, consisting of an illuminated address and a cheque in recognition of his services to the Association as Hon. Secretary and Editor of the official journal. The address was as follows:—"This address is presented to Mr. Geo. Brown, M.R.C.S.Eng., L.S.A.Lond., Member of the General Medical Council of Medical Education and Registration, on his retirement from the post of Editor of the Official journal of the Association,

Fatal Inquisitiveness.

THE East Sussex Coroner inquired at Eastbourne, on the 18th inst., into the death of Richard Thomas Foard, æt. 16, a boy employed by Mr. Myers, a dentist. The boy was stated by his father to be of an inquiring disposition. His duty was to attend to the consulting room and to answer the door. Owing to his not returning home at the accustomed time a search was made and he was found dead, with the apparatus used for administering nitrous oxide gas affixed to his face. He was reclining on a couch, his head was buried in a cushion, and he was in such a position that it would be difficult for him to raise himself. Dr. W. Muir Smith stated that nitrous oxide was the most harmless of anaesthetics. Witness had no doubt that the boy died, not as the result of poisoning from the gas, but from asphyxiation, simply because he could not release his mouth in order to take fresh air. A verdict of accidental death was returned, and the jury added that no blame attached to Mr. Myers.

The Apothecaries' Hall, Ireland.

THE Freedom of the Worshipful Company of Apothecaries' Hall was conferred on Sir Christopher Nixon, M.D., and Professor D. J. Loffey, M.D., of the Medical Faculty of the Catholic University, at the Examination Room of the Apothecaries' Hall on Friday, June 22nd, at 4 o'clock. At the same time the degree of L.A.H. was granted *honoris causa* to these gentlemen. The Governor, Colonel Adyl Curran, M.D., J.P., F.R.C.S., presided, and gentlemen attending the function were expected to wear academic costumes.

Trinity College, Dublin.

THE following candidates have passed the Final Examination in Medicine:—Francis O'B. Ellison, Thomas J. Cobbe, Malcolm K. Acheson and Henry B. Leech, equal, Richard Connell and Langford V. Hunt, equal, John A. Hartley, Theodore C. Somerville, Michael P. Leahy, George S. Walton, William Hutcheson, Ernest C. Crawford, John du P. Langrishe, Ernest D. Caddell.

Diploma in Public Health.—The following have passed Part I.: Edward W. W. Cochrane, Charles H. Burtchaell, Henry Knaggs. The following have passed Part II.: Charles H. Burtchaell, Edward W. W. Cochrane.

WEEKLY SUMMARY OF THE MEDICAL JOURNALS.

ENGLISH AND FOREIGN.

Specially compiled for THE MEDICAL PRESS AND CIRCULAR.
RECENT SURGICAL LITERATURE.

Certain Injuries Commonly Associated with Displacement of the Head of the Humerus.—In the experience of R. Jones (*Brit. Med. Journ.*, June 16th, 1906) the commonest complication of fracture of the upper end of the humerus is dislocation of the shoulder. The order of frequency of fractures of the shoulder connected with dislocation is as follows:—(1) Fracture through the surgical neck. 2. Separation of the greater tuberosity. 3. Fracture through the anatomical neck embracing the tuberosities. 4. Fracture through the neck of the scapula embracing the coracoid. 5. Separation of the lesser tuberosity. 6. Fracture of the glenoid. 7. Separation of the glenoid, anatomical neck. 8. Separation of the anatomical neck of the humerus, not including the tuberosities. The etiology of the injury is not clear. Fracture may follow dislocation occasionally, but in the great majority of cases fracture and dislocation occur synchronously. The shoulder should be reduced at the earliest possible moment. Delay may seriously complicate the result, as an unreduced dislocation is often the forerunner of an ununited fracture. This combination is very serious. The head of the bone is so displaced and the ineffective callus so exuberant that the arm is not merely seriously restricted in movement, but painful pressure symptoms result. Immediate reduction may be very simple, very difficult, or quite impossible. The method which has proved most successful with the author is the forcible extension of the arm held vertically, with often very hard pushing upwards of the fragments. The surgeon should be urged to try any and every method to reduce the head rather than submit the patient to the very positive risk of operation. The only operative procedures to be recommended are excision of the head of the bone, and McBurney's operation for reduction by the open method. Having reduced the dislocation, the fracture of the humerus is of comparatively little moment. The patient is allowed to sit up as soon as possible, as this is the least harmful method of applying extension to the lower fragment. Perfect anatomical results are rarely obtained, but the practical results are usually good. The author strongly deprecates the wiring of fragments in fractures through the surgical neck. S.

Wound of Thoracic Duct; Ligature; Recovery.—Fullerton (*Brit. Med. Journ.*, June 16th, 1906) reports that while removing a large mass of tubercular glands from the left side of the neck, and extending down to the pleura, a sudden gush of opalescent fluid was seen to come from beneath the sterno-mastoid muscle. The fluid was found to issue from the open mouth of a vessel just in front of the scalenus anticus, about an inch above the inner end of the clavicle. The discharging vessel was ligatured with formalin catgut. The duct on the proximal side of the ligature immediately became distended, so as to form a flat, button-shaped swelling, tense and grey, about half an inch in diameter. This enlargement felt so tense that it seemed ready to burst, and great care was taken to prevent this. The distal end was found to be about an inch in length and extremely like a thin-walled vein. It divided near its termination into three smaller vessels, which opened separately at the junction of the internal jugular vein with the subclavian vein. No fluid issued from this end of the duct, but on passing a grooved director through it, and along one of the terminal branches into the innominate vein, blood flowed along the groove. On removing the director this bleeding ceased, showing the action of the valves of the duct. This end of the duct was also ligatured. The

skin wound was stitched and a glass drainage tube was inserted for forty-eight hours. On account of the risk of the rupture of the proximal end of the ligatured duct, the patient was kept on the lowest possible diet for a few days, and all unnecessary movements were interdicted. The patient made an uninterrupted recovery, without any swelling or sign of leakage from the duct. A blood-count eight days after operation showed very little deviation from the normal as regards the lymphocytes. S.

Very Early Conditions of Cancer of the Tongue.—Butlin (*Brit. Med. Journ.*, May 26th, 1906) describes seven cases in which he removed part of the tongue for what clinically appeared to be a precancerous condition. On microscopic examination (using a continuous series of sections) early cancer was found in each case. The author states: "Two years ago, before my eyes were opened by the work of the Imperial Cancer Research, I should have regarded five out of the seven as precancerous conditions, and I am now wondering whether there are really any conditions perceptible to human sight and feel which are precancerous in the sense in which I have been accustomed to employ the term." The forms under which the disease commenced in these seven cases are four in number, viz:—(1) A flat, very slightly raised, smooth, red, glazed plaque, feeling like a thin piece of gristle in the surface of the tongue, not thicker than a three-penny or sixpenny piece, and looking and feeling like a primary hard sore; (2) a white, warty growth, not ulcerated, and scarcely indurated at its base; (3) a slight thickening and hardening of an old leukoplakic area, rather distinguishable to feel than sight; (4) a nodular plaque, red, and commencing to ulcerate with drawing-in of the surrounding tissues. So far six of the seven patients remain well and free from recurrence of the disease. The glands were removed in five of the seven cases, and should be removed in every case. The author lost one patient from secondary affection of the glands, which did not make its appearance for more than three years after the successful removal of one of the smallest cancers of the border of the tongue he had ever seen. S.

The Etiology and Treatment of Oblique Inguinal Hernia.—Murray (*Brit. Med. Journ.*, June 16th, 1906) considers that all the evidence we possess is in favour of the view that the main factor in the causation of oblique inguinal hernia at all periods of life is the presence of a preformed sac, a patent funicular process, and that whether the bowel will or will not enter the funicular process depends primarily upon the size of the opening at the internal abdominal ring; and secondarily, upon the strength of muscles guarding it. As a general rule the only satisfactory way of treating a hernia is by means of operation, and other things being equal, the earlier in life the operation is performed the better. The essential point in the operation is to so completely obliterate the sac as to render the peritoneal surface at this level free from any dimpling or depression. In order to ensure this, the inguinal canal must be opened up and a ligature applied to the sac at the level of the internal abdominal ring. The divided aponeurosis of the external oblique is united by overlapping, for the inguinal canal is thus narrowed, lengthened, and its original obliquity restored. In elderly persons in whom the inguinal canal has for years been enormously stretched, recurrence after operation can only be prevented by the use of a truss or mechanical support of some kind. As patients of the labouring class are apt to discontinue wearing a truss owing to expense and inconvenience, the author has

adopted a plan which has so far been successful. A rubber pad 1 inch by 1½ inches in size, made of the best Para rubber, is used as an internal truss. The operation for the cure of hernia is conducted in the ordinary manner, the external oblique is divided and the neck of the sac is sewn as high up as possible. The pad is now placed in position. The cord and its vessels are threaded into the large hole by opening the slit extending from the upper part of the hole to the margin of the pad. The edges of the pad are then placed beneath the internal oblique and conjoined tendon on the one side, and Poupart's ligament on the other. It only remains to cover the pad and cord with the cremaster muscle and sew together by overlapping the divided fibres of the external oblique. The pad lies on the transversalis fascia, and is devised to fill a gap and afford additional support at a very weak spot in the abdominal wall. The author has used similarly a piece of gauze in femoral hernia to plug the femoral canal. S.

On Some of the Diseases and Injuries of the Eye Peculiar to Children.—S. Stephenson (*Brit. Journ. of Child. Diseases*, 1905), in the course of his lecture, referred to the following:—By application of forceps, clumsy digital examination or prolonged labour due to deformed or narrow pelvis, the infants are liable to *corneal injuries* of more or less serious nature. Drs. Thomson and Buchanan observed a considerable number of cases in Glasgow where deformed pelvises are fairly common. They noted two forms of corneal injury: (1) a diffuse temporary opacity, and (2) a permanent linear opacity, generally multiple. The first is the commoner, and is due to oedema. The second is due to a rupture of the posterior elastic lamina with subsequent formation of fibrous tissue. The majority of the cases have been observed where the forceps have been applied, but it is not to be concluded that the forceps is the direct cause of the injury, as cases have been observed where there was bilateral oedema of the cornea. It is important to recognise that the narrow pelvis and delay which necessitated application of the instruments may be just as likely to cause the condition. There is no doubt about the permanency of these injuries, for Stephenson had a case of his own under observation where the scar tissue produced considerable irregular astigmatism and consequent bad sight. *Retinal hæmorrhages* are also liable to occur. They have been estimated at 10 per cent. to 32 per cent. after normal labours. They are not to be seen, as a rule, by the ophthalmoscope, as they usually occur in the periphery of the fundus. It is supposed that the extravasations result from disturbance of the retinal circulation due to compression of the central blood vessels of the optic nerve by cerebro-spinal fluid under high pressure. Wehrli has suggested that in a majority of cases the exciting cause of glioma of the retina is to be found in retinal hæmorrhage sustained at birth. M.

Primary Malignant Disease of the Vermiform Appendix.—H. D. Rolleston (*Lancet*, June 2nd, 1906), has been able to collect 62 examples of primary malignant disease of the vermiform appendix. The diagnosis was confirmed by the microscope, in 42 cases; of these 37 proved to be carcinoma, three were endotheliomata, and two were sarcoma. The age at which the disease was found varied from 12 years to 81 years in only 12 per cent. of all the cases were secondary growths present. It is not possible to form a definite picture, typical of this disease from the clinical histories of these cases, some were operated on for other troubles, the condition only being discovered when the abdomen was opened—in the majority of the patients the symptoms were those of appendicitis, in one form or another, and may be separated into four groups—1, symptoms of the first acute attack; 2, chronic symptoms with an acute attack; 3, recurrent attacks; and 4, symptoms of chronic appendicitis. The results of operation on this condition, both immediate and remote have been surprisingly good, there were four deaths within two weeks of the operation, two within

a few months, while of the remainder, in only one case is any recurrence of the disease recorded, some of the patients being now free from the disease for years. G.

Carcinoma of the Penis.—Crette (*Deutsche Med. Woch.*, June) describes the case of a child aged two years, who was admitted to hospital with a history of persistent priapism of 8 days' duration. There was a penile tumour, which had previously given rise to no symptoms. The penis and corpora cavernosa were extirpated, it was then found that the latter were completely and uniformly filled with hard masses of tumour, of a whitish grey colour; in the perineal region the two corpora cavernosa and the corpus spongiosum were bound together by the tumour, and formed a solid mass the size of a walnut. The tumour proved to be a large celled carcinoma, the cells being arranged partly in tubes, and partly in wide, solid cords; its starting point could not be determined with certainty. G.

Tuberculosis of the Kidney.—Henry Morton in a paper (*New York Med. Journ.*, May 26th) discusses fully the pathology and diagnosis of this condition, he then considers the various means by which a diagnosis may be arrived at, as to the condition of each kidney, by means of cryoscopy, and the catheterisation of the ureters. The author has in such cases carried out the following treatment, with a large measure of success; when both kidneys are tuberculous or one is tuberculous and the other disorganised from Bright's, or an amyloid degeneration, the treatment can only be directed to the palliation of the symptoms, and consists in forced nutrition, irrigation of the bladder, urotropine with narcotics, to relieve the pain. In cases where pyonephrosis forms, and the patient suffers from severe pain and sepsis, a nephrotomy should be done, since if the kidney is not opened and drained, death will occur. If the other kidney is diseased complete extirpation is manifestly impossible, nephrotomy is undertaken merely as a palliative measure; the wound should be allowed to granulate up—usually a permanent fistula remains, but the patient's life will be prolonged. When one kidney alone is affected, it is better at once to remove completely the diseased organ; even a moderate bladder, or lung tuberculosis is not a contradiction for operation; the bladder heals, or at least improves, when the source from which the tuberculous material is poured into it, is removed. It has been the practice in past years to await a spontaneous healing of renal tuberculosis and while this sometimes takes place, it is so unusual that it cannot be depended upon, as in most cases that are left, the disease extends to the other kidney, and to other organs. Perinephritic abscess forming, as a result of tuberculosis of the kidney, calls for immediate surgical treatment, the pus evacuated by a free incision and the diseased organ removed, if the second kidney is healthy. G.

The Cause of Punctiform Hæmorrhages in the Appendix.—Prof. C. Bayer remarks on the comparative frequency, of this condition (*Centralblatt Chirurgie*, April 28th.) of punctiform hæmorrhages in the mucous membrane of the appendix, found in those cases, where the organ has been removed during the interval between attacks. He does not agree with the view of this condition, which is held by many surgeons, that these small hæmorrhages are due to the compression of the appendix by instruments, used during its removal. Recently Prof. Bayer in operating on a case of appendicitis, took great precautions that the organ should not be in any way injured, yet on opening it the punctiform hæmorrhages were present—he believes that they are due to the mesentery being ligatured, and so blocking the veins before all the arterial blood is cut off from the appendix, the rule being to ligature the mesentery first, and attack the appendix afterwards. G.

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

NOTICES TO CORRESPONDENTS, &c.

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

REPRINTS.—Reprints of articles appearing in this journal can be had at a reduced rate, providing authors give notice to the Publisher or Printer before the type has been distributed. This should be done when returning proofs.

A THOUGHT FOR THE BACTERIOLOGIST.

How often have I asked in vain
Can the microscopist explain?
How men who swallow pounds of dust
(As at their daily work they must)
Often appear the most robust!

Surely if all we're told were true
Be dust (so bad for me and you),
And if the dustmen only knew,
They then should number very few,
Instead of thousands as they do.

The only reason I can think
Is possibly what dustmen drink!
Which, acting as a germicide,
Keeps some alive, who should have died,
Or, making deadly microbes "tight,"
Assist the wandering Leucocyte!!!

—A. D.

ROYAL METEOROLOGICAL SOCIETY, PLEASE NOTE.

"Dr." BODIE, the "bloodless surgeon" of the music-halls, was recently fined £3 for an assault on a stage patient.

"Dr." Walford Bodie, the defendant, said he was a doctor of medicine and master in surgery in the United States.

His Honour.—What State?

Witness.—Chicago.

His Honour.—What does F.R.M.S. mean?

Witness.—Fellow of the Royal Meteorological Society.

ANTHRAX FROM HORSEHAIR.

Dr. Legge's report on the "Incidence of Anthrax in the Manipulation of Horsehair and Bristles" shows that in the seven years 1899-1905 there were 77 cases, with 18 deaths.

A WARNING.

THE attention of medical men may be drawn to the following announcement from the *South Wales Daily News*:—"In connection with the present dispute at Ammanford the workmen's committee, which consists of about twenty members, propose holding a mass meeting at an early date. A medical man from the Rhondda Valley is expected to attend.

PHYSICAL TEST FOR EMPLOYMENT.

THE importance of the following new departure to the medical profession is obvious:—One of the largest armour and gun manufacturing firms in the East-end of Sheffield has decided that all applicants for work will in future be required to submit to a medical examination by the company's doctor. The regulation is arousing strong opposition on the part of employees. The various unions fear they will have to support those rejected as physically unfit, and already a protest has been entered, backed up by fifteen of the most important branches of the engineering trade.

Meetings of the Societies, Lectures, &c.

WEDNESDAY, JUNE 27th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. H. L. Barnard: Clinique. (Surgical). 5.15 p.m. Lecture.—Mr. A. W. M. Robson: The Surgical Treatment of Cancer of the Stomach.

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

THURSDAY, JUNE 28th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Mr. Hutchinson: Clinique. (Surgical). 5.15 p.m. Lecture.—Dr. Langdon Brown: Purin Bodies and the Purinometer.

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

FRIDAY, JUNE 29th.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22 Chancery Street, W.C.).—4 p.m. Dr. J. Horne: Clinique. (Throat).

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

SATURDAY, JUNE 30th.

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

Vacancies.

County Borough of Belfast.—Purdysburn Fever Hospital.—Resident Medical Officer. Salary £150 per annum. Applications to Saml Black, Town Clerk, Town Hall, Belfast.

County Borough of Belfast.—Purdysburn Fever Hospital.—Hoos Physician. Salary £125 per annum. Applications to Saml Black, Town Clerk, Town Hall, Belfast.

County Borough of Belfast.—Purdysburn Fever Hospital.—Matron Superintendent. Salary £100 per annum, with residence, board, and laundry. Applications to Saml Black, Town Clerk, Town Hall, Belfast.

Cambridgeshire, &c., Asylum.—Senior Assistant Medical Officer. Salary £150 per annum, with board, lodging, and attendance. Applications to T. Musgrave Francis, Clerk to the Visitors.

Devon County Asylum.—Third Assistant Medical Officer. Salary £140 per annum, with board, lodging, washing, and attendance. Applications to Medical Superintendent, County Asylum, Exminster.

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

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

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

Ramsgate General Hospital and the Ramsgate and St. Lawrence Dispensary.—Resident Medical Officer. Salary £100 per annum, with furnished apartments, board, and attendance. Applications to H. W. Thornton, Secretary, Dispensary, Broad Street, Ramsgate.

St. Bartholomew's Hospital and College.—Demonstrator of Chemistry. Salary £150 per annum. Applications to T. W. Shore, Dean.

St. Bartholomew's Hospital and College.—Demonstrator of Physics. Salary £150 per annum. Applications to T. W. Shore, Dean.

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

Appointments.

BELL, R. H., M.R.C.S., L.R.C.P.Lond., Physician to the Out-patient Department at the British Lying-in Hospital.

BIET, T. D., L.R.C.P. and S.Edin., L.F.P.S.Glasg., Medical Officer of District B by the Thrapston Board of Guardians.

BROWLEE, ALEX., F.R.C.S.Edin., Honorary Anaesthetist to the Cardiff Infirmary.

GROSVENOR, E. L., F.R.C.P.Lond., M.R.C.S., Certifying Surgeon under the Factory and Workshop Act for the Chelsea District of the County of London.

HEATE, A. DOUGLAS, M.D.Lond., M.R.O.P.Lond., Dermatologist to the General Hospital, Birmingham.

LUCAS, GROFFREY, B.A.Cantab., L.S.A., Medical Officer of Health to the Ringwood Rural District Council.

PHILLIPS, HUBERT C., M.R.C.S.Eng., M. and L.S.A., Medical Officer to the South District of Paddington.

PHILLIPS, JOHN, M.D.Cantab., F.R.C.P.Lond., Consulting Physician to the British Lying-in Hospital.

PRATT, JOHN W., L.R.C.P.Edin., M.R.C.S., Deputy Medical Officer for the Badstock District by the Clutton (Somerset) Board of Guardians.

SHAW, W. VERNON, M.B., B.S.Oxon., Medical Officer to the Malton Workhouse, York.

SPENCER, A. F., M.B., B.S.Edin., Certifying Surgeon under the Factory and Workshop Act for the Kinghorn District of the county of Fife.

THOMPSON, R., M.D.Durb., M.R.C.S., L.R.C.P.Lond., Assistant Surgeon to the Eye, Ear, and Throat Department of the Brisbane Hospital, Queensland, Australia.

Births.

BARKER.—On June 20th, at Edendale, Finchley, the wife of Chesman Barker, M.B.Lond., M.R.C.S., L.R.C.P., of a daughter.

FURNIVAL.—On June 15th, at Wykeham, Shas Road, Acton, the wife of Captain C. Hilton Furnival, R.A.M.C., of a son.

SERPELL.—On June 18th, at 2, Cross Park, Plymouth, the wife of H. Hamilton Serpell, L.R.C.P., M.R.C.S., of Polyphant, Lewannick, Launceston, Cornwall, of a son.

Marriages.

BAILLIE-WETHERALL.—On June 14th, at the Parish Church, Warborough, Oxon., Robert Alexander Baillie, M.R.O.S., L.R.C.P., of Kent House, Lordship Lane, London, youngest son of the late Robert Baillie, M.Inst.C.E., of Blackheath, to Mary Maltravers, youngest daughter of the late Rev. Thomas Manle Wetherall, M.A., T.O.D., Stoken-Felham, Herts.

HUNT-DUTTON.—On June 20th, at Hensfield Parish Church, Ernest Rivax Hunt, M.A., M.D., Cantab., of 19 Dyke Road, Hove, Sussex, to Margery Mary, second daughter of the Revd. W. T. Dutton, Vicar of Sidesham, Sussex.

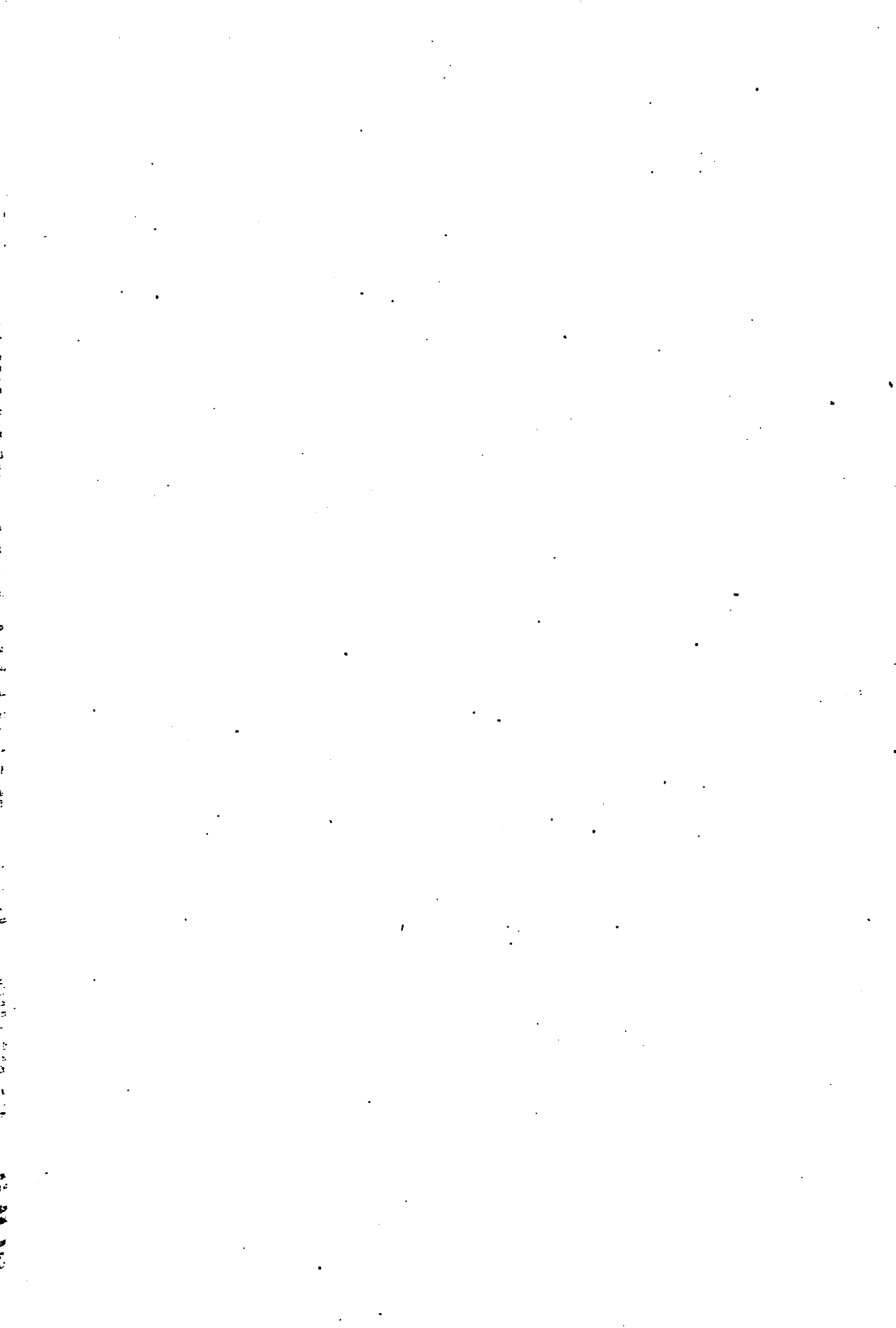
PARTRIDGE-FORBES.—On June 20th, at the Parish Church, Mickleham, Surrey, Lionel Strowd Partridge, B.A., M.B.C.S., L.R.C.P., of Warminster, to E. M. (Lily), only daughter of Wm. Forbes, of Cass, Giglio, Alassio, and formerly of Smyrna.

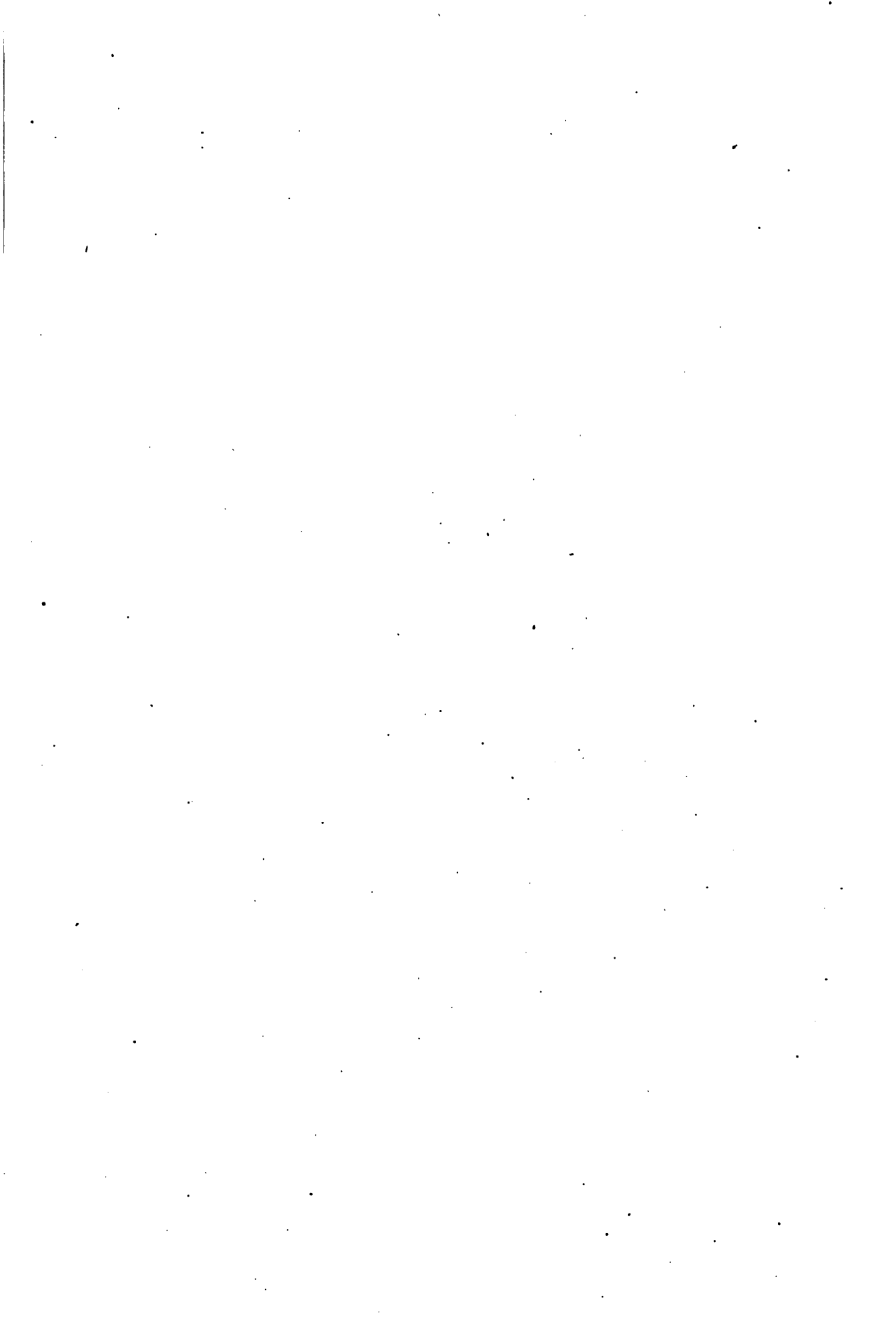
Deaths.

DUKES.—On June 19th, at University College Hospital, London, by accident, Lawrence Duke, M.A., M.B., B.Ch., Cantab., third son of Clement Dukes, of Rugby, aged 25.

KELAART.—On June 20th, at Esher, Elizabeth, widow of Edward Frederick Kelaart, M.D.Edin., F.L.S., F.G.S., Army Medical Staff, in her 82nd year.

TULLOCH.—On June 20th, at the Queen Alexandra Military Hospital, Millbank, Forbes Manson Grant Tulloch, R.A.M.C., aged 27, youngest son of the late Surgeon-General Tulloch, of Balmoon, Eastbourne.









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