The

British Medical Journal

THE JOURNAL OF THE BRITISH MEDICAL ASSOCIATION.



Including an Epitome of Current Medical Literature

WITH SUPPLEMENT.

No. 3516. SATURDAY, MAY 26, 1928. Price 2/6

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Parke, Davis & Co. are definitely committed to a perpetuation of this long-established policy of scientific research, which may logically be expected to lead to equally important developments in the future.

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PULMONARY ASBESTOSIS IN SOUTH AFRICA.

(With Special Plate.)

BY

F. W. SIMSON, M.B., CH.B.ED.,

PATHOLOGIST AT THE SOUTH AFRICAN INSTITUTE FOR MEDICAL RESEARCH, JOHANNESBURG.

It has been known for some time that workers exposed to the dusty atmosphere arising from some processes involved in the preparation of asbestos materials suffer from pulmonary disability. The mining of the mineral itself is probably not a source of danger, as asbestos is mined mostly in open quarries. After sorting, there remains waste rock which still contains fibre in payable quantity. Crushing of this rock causes a considerable degree of dust exposure, and exposure to the dusty atmosphere is still more exaggerated in the carding and spinning of asbestos in the mills.

Very little concerning the pathological changes in the lungs of persons working with asbestos has been found in the literature, and it was thought that a record of the following cases might be of interest.

On September 2nd, 1926, the medical officer of an asbestos mine in Southern Rhodesia forwarded to the South African Institute for Medical Research three small specimens of lung from a *post-mortem* case for histological examination.

CASE I (No. 9026).

The subject was a male adult native, who had worked for twelve months in the asbestos mill, and, except for a short period before his death, had had a good record of health. For nine weeks before death he suffered from acute tuberculosis, and the *post-mortem* findings showed miliary tuberculosis involving the lungs, liver, spleen, and pericardium. The object of the histological examination was to ascertain if there was any evidence of fibrosis in the lungs which might be directly ascribed to the nature of his employment, since workers in the mill are exposed to a very dusty atmosphere.

Apart from the tuberculosis and associated fibrosis, sections of the lungs showed a certain amount of connective tissue change which had no obvious connexion with the tuberculous process. It was also found that curious golden yellow segmented structures, with rounded or club-shaped ends (Fig. 1), were embedded in this fibrous tissue, together with very minute, doubly refractile particles, the latter presumably silica. Although the curious segmented bodies were remarked upon, no further investigation was carried out at the time, and the new-formed fibrous tissue was attributed to the presence of silica.

CASE II (No. 11016).

It was not until September 29th, 1927, when a portion of lung from a second case was sent by the medical officer from the same mill, that the foreign bodies and fibrosis were more fully investigated. This piece of lung was from a male adult native who had been employed in the mill for a period of two years. About September, 1926, he was admitted to hospital suffering from pneumonia, and had a long illness. He was discharged, and later (September 19th, 1927) readmitted in a dying condition. He was very emaciated, and had the physical signs of pulmonary tuberculosis with fibrosis. At autopsy the lungs were firmly bound down by adhesions, the root glands enlarged and hard, and the lungs on section hard and fibrous with an almost leather-like consistence. The mesenteric glands were also considerably enlarged.

Histological sections showed a generalized but moderate degree of fibrous thickening of the pleura, trabeculae, and alveolar walls. In addition, there was a much more marked fibrosis arranged in irregular-shaped nodules, chiefly related to the blood vascular system and bronchi. This fibrous tissue was cellular, the elements arranged in an irregular manner, and included some small lymphocytic accumulations (Fig. 2). There was no resemblance to the orderly, whorled arrangement and sharp definition of the silicotic nodule (Fig. 3). The bronchi were the seat of slight catarrhal changes, and many of the alveoli contained "dust cells" filled with phagocyted particles. There was no evidence of tuberculosis or acute pneumonic consolidation. Embedded in the fibrous tissues, lying free in alveoli (Fig. 4), and contained in phagocytic cells, there were numerous golden yellow segmented bodies (Figs. 5 and 6), a few large angular black bodies, and very minute doubly refracting particles. Phagocytosis was a very striking feature. Large numbers of the bodies were contained within ordinary mononuclear cells and irregular-shaped multinucleated giant cells (Fig. 7). Phagocytosis was not confined to the smaller particles, but even large rods were seen completely enclosed and often bent in order to allow them to occupy the space within the cells (Fig. 7). It was thought that these foreign bodies, together with the crystalline matter, may have been the cause of the fibrosis, as the connective tissue, both in distribution and formation, was very suggestive of changes resulting from a dust occupation of the lungs. At the same time the history of pneumonia and protracted recovery must be taken into consideration, since an unresolved pneumonia with subsequent fibrosis is not an uncommon occurrence amongst natives working on the mines in South Africa.

CASES III AND IV (Nos. 6419 and 6731).

Consultation of the records and previous histological sections of material from the same mine has revealed two additional cases, both of which showed lobar pneumonia. There was very little connective tissue increase, but the unusual structures (Fig. 8) and refractile crystalline particles were present. No history of length of service in the mill was obtained with either of these cases.

Further study of the golden yellow bodies showed a variety of shapes, but the most common forms had rounded or club-shaped ends and a segmented body tapering to a finely pointed tail. They were non-refractile to polarized light, soluble in strong acids, and, on raising to a red heat, turned black and tended to lose their outline. In sections treated with hot dilute hydrochloric acid and potassium ferrocyanide they gave a well-marked Prussian blue reaction. No pigment except these structures giving the iron reaction could be detected in the sections examined. Strong hydrochloric acid, having been tested for the presence of iron and found negative, was used to dissolve out iron from fresh sections. After treating the sections the hydrochloric acid gave a very distinct red-pink colour with potassium thiocyanate, and the red-pink colour disappeared on the addition of a solution of mercuric chloride. The sections were re-examined and showed that the majority of the golden yellow bodies had been dissolved out. From these tests it was concluded that the structures contained a large percentage of iron.

As controls, sections of lungs from a large number of miners on the Rand who had died from silicosis and tuberculosis were examined. Bodies such as have been described above were found in none of these, nor was the Prussian blue reaction or other test for iron positive except in those cases where the pigment was obviously of haematogenous origin. A single case of a miner was also investigated; he had worked for twenty-eight years in the haematite mines in the North of England, and subsequently for seven and a quarter years in the gold mines of the Rand, South Africa. The cause of death was carcinoma of the gall-bladder. Macroscopically the pulmonary root glands were enlarged, pigmented, and fibrosed. The pigment was dark rust-coloured and gave a marked Prussian blue reaction with dilute hydrochloric acid and potassium ferrocyanide. Occasional rust-coloured subpleural islets were visible. On section the lungs showed a slight diffuse fibrosis and a few large areas of fibrosis. The whole lung gave a marked iron reaction. Histological sections of the large areas showed moderately well defined, but irregularly shaped, masses of well-formed acellular fibrous tissue (Fig. 9). The alveolar walls were slightly thickened, and there was a moderate degree of connective tissue increase round the blood vessels and bronchi. A large quantity of pigment of a reddish-brown colour was contained in phagocytic cells and lying free in alveoli, alveolar walls, and between the fibres of the newly formed fibrous tissue. The greater part of this pigment gave the iron reaction. In addition, there was another variety of pigment, in much smaller quantity, in the form of crystalline refractile particles. The latter was intimately mixed with the iron-containing dust. This lung was especially examined to determine, if possible, whether the same peculiar bodies were being formed from a deposit of ferric iron dust as in the case of an asbestos dust which contained both ferrous and ferric iron. A careful and thorough search was made, but no particles with a similar appearance were detected (Fig. 10). At the time of the patient's death this case of ironstone phthisis was complicated by underground work in the gold mines on the Rand, but in 1919 it simulated, by *x*-ray photography and physical examination, an early case of silicosis,

F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
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and confirms the findings of Sir Kenneth Goadby[1] and Dr. Cronin.[2]

In addition to the human lungs showing asbestosis, Dr. Mavrogordato of the South African Institute for Medical Research has supplied me with the lungs of a guinea-pig which died in December, 1927, from causes other than asbestosis. This animal was exposed to an asbestos dust atmosphere experimentally. The length of exposure was two hours a day on each of fifty days. The first exposure took place on February 4th, 1925, and the last on April 1st of the same year. The asbestiform compound used for the experiments was a chrysotile[3] obtained from the mine in Southern Rhodesia. Histological sections showed a slight generalized fibrosis and an increase in pigment, but the interesting feature was the presence of the golden yellow bodies (Fig. 11), similar to those seen in the lungs of human pulmonary asbestosis.

A comparison between the human cases and the experimental animal showed that the fibrosis was more rapid and extensive in the human cases than in the experimental animal. This is readily explained by the difficulty in reducing the tough asbestos fibre to a uniformly fine powder, and to the presence of a comparatively small proportion of the rock dust which is usually associated with asbestiform compounds. For "dusting" animals a limited amount of dust is available, and of this only a small proportion contains particles of sufficiently small dimensions to permit of their reaching the lung alveoli. In silicosis[4] the size of the majority of the particles[5] which reach the alveoli is between 1μ and 3μ; in the haematite lung, mentioned above, the particles appear larger, but even here are much smaller than the greater number of those prepared from asbestos for "dusting" experiments. In the working mill the conditions are very different from an asbestos dust atmosphere produced experimentally. Fine dust is continuously reaching the atmosphere, and only the very fine particles remain suspended for any length of time. These gradually increase in numbers until a maximum concentration is reached, then remain more or less constant during working hours. Thus it will be seen that, in order to produce changes in experimental animals showing the same degree of fibrosis in the same length of time, an atmosphere approximating that of the working mill will have to be obtained.

The amount of fibrosis in two of the human cases (Cases I and II) was quite definite, and, if due to the presence of asbestos dust, the initial rate of production was rapid when compared with present-day non-infective silicosis on the Rand. It is difficult to state a definite time for the production of an appreciable degree of fibrosis in pure non-infective silicosis, but modern observation tends to show that it is in the neighbourhood of ten years. In Case I a moderately marked fibrosis had taken place after one year of work in the mill, but this was complicated by tuberculosis. It is known that the rate of fibrous tissue production is very much greater in dust diseases complicated by infections, but even allowing for this the connective tissue increase in Case I was rapid. In Case II there was a still more definite fibrosis after two years of work in the mill with no evidence of tuberculosis.

Before this work was completed Drs. Cooke,[6] Stuart McDonald, and Oliver[7] published their papers dealing with pulmonary asbestosis, and previous to that a short article on the same subject appeared in the *Lancet*. The similarity between the case described and ours was suspected when the first article appeared, and our work goes far to confirm the findings. As in those recorded here, the asbestos dust responsible for the changes in the lungs in their case was a chrysotile. Whether other asbestiform compounds are capable of producing these changes it is impossible to say, as there appears to be no record of any such cases in the literature.

In the Union of South Africa[8] and Rhodesia there are many asbestos mines, from some of which chrysotile is obtained, but two other interesting varieties are found—namely, crocidolite and amosite. Amosite is a comparatively recent discovery, the chemistry of which has not been completely worked out, but it appears to be somewhat similar to crocidolite in composition. Both these compounds contain a large percentage of ferrous iron. Analysis of four samples of amosite[9] showed between 32 and 44 per cent. of FeO, and eight samples of crocidolite[9] between 16.5 and 40.5 per cent. Up to the present there has been no examination of *post-mortem* material from cases of death among those working in mills where these minerals are treated. No such material has been made available.

Chrysotile or serpentine asbestos usually contains 2 to 3 per cent. of FeO isomorphously replacing magnesia. The analysis of Dr. Cooke's case showed 3 per cent. of FeO, and the Rhodesian mineral, according to Mr. A. L. Hall,[3] 2.44 per cent. Dr. McCrae of the Government Chemical Laboratory, Johannesburg, analysed the FeO content of the asbestos used by Dr. Mavrogordato in his animal experiments, and found a much lower percentage—namely, 0.45. Apparently even with very small percentages of FeO the golden yellow bodies are formed in the lungs.

With regard to the unusual structure and chemical nature of the golden-yellow bodies found in the lungs in pulmonary asbestosis, until many more cases have been examined and more experimental work has been done very little can be stated. There is no doubt that they are in some way associated with the asbestos, or, probably, more particularly with the FeO content, either of the asbestos itself or of the dust of the mill. This dust contains a much higher percentage of iron, which may be derived partly from the lode from which the asbestos is mined.

Three possibilities regarding the formation of the golden yellow bodies are worthy of mention:

(1) In the form of a gel, as suggested by Dr. Stuart McDonald.

(2) As particles of ferruginous quartz formed in the lungs under conditions similar to weathering, or ferruginous quartz changed in composition as a result of combination with constituents of the body fluids. In support of this it may be mentioned that crocidolite, which is an alkali silicate with ferrous iron, is especially liable to decomposition when exposed to weathering. Sodium is removed, the iron oxidized and hydrated to form limonite, and silica set free; there then results a ferruginous quartz which possesses the finely fibrous structure of the original mineral. It is extremely hard, and coloured a rich golden yellow. It is possible that a change such as this occurs with the small quantity of ferrous iron associated with chrysotile, and the colour of the bodies in the lungs is very suggestive.

(3) Phagocytosis of these structures is a very prominent feature in the lungs, and it was thought that the action of these cells may have been responsible, first, for some change in chemical composition, then a building up and moulding into the various shapes seen.

The fibrous tissue change in the lungs of the above-mentioned cases of workers in asbestos mills is probably the result of a reaction on the parts of the tissues to both the golden yellow bodies and a small quantity of silica.

Sufficient cases of pulmonary asbestosis have not been recorded to base an opinion upon the liability to secondary infection by specific inflammatory processes such as tuberculosis, but it is very suggestive that two of those now recorded, which have been examined histologically, have shown tuberculosis complicating the changes produced by an asbestos dust occupation of the lungs.

Besides these cases there is still further evidence in favour of tuberculosis being a complicating factor.

Dr. H. M. Murray reported a fatal case in the *Charing Cross Hospital Gazette* in 1900; and in the United States of America, from one source,[7] during the period 1907 to 1914 there were 13 deaths, 3 of which were from tuberculosis.

In 1910 Dr. Collis[10] reported on the relationship of asbestos dust to pulmonary tuberculosis, and found that 5 deaths from phthisis had occurred in five years amongst a staff of less than forty workers employed at a factory where asbestos is woven.

In conclusion, I wish to record my thanks to Dr. Mavrogordato for data and material from an experimental animal; to Dr. Irvine, chairman of the Miners' Phthisis Medical Bureau, Johannesburg, for material from silicosis cases and from the lungs of a haematite miner; to Dr. McCrae for his analysis of the FeO content of a sample of asbestos; and to Mr. P. Longmore for his valuable assistance in preparing the microphotographs.

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FIG. 1.—Pulmonary asbestosis (Case 1). Golden yellow bodies lying in the centre of a nodule of young fibrous tissue. (× 850.)



FIG. 2.—Pulmonary asbestosis (Case II). Irregular fibrotic nodule showing a moderate degree of cellularity. The bodies embedded in this tissue are just visible. (× 250.)

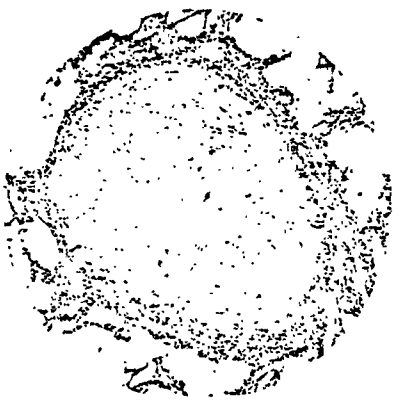


FIG. 3.—Silicosis. Nodule showing orderly whorled arrangement and sharp definition characteristic of this type of fibrosis. (× 250.)



FIG. 4.—Pulmonary asbestosis (Case II). Small phagocytes containing granular dust and golden yellow bodies. One large body is lying free in the alveolus. (× 850.)

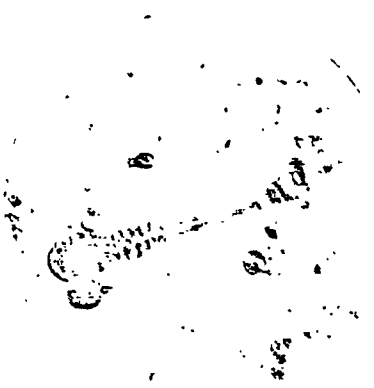


FIG. 5.—Pulmonary asbestosis (Case II). Large golden yellow structures with globular ends and segmented body tapering towards one end. (× 850.)

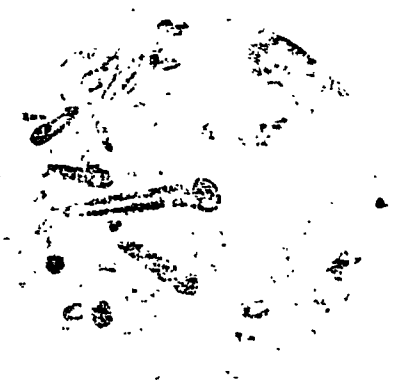


FIG. 6. Pulmonary asbestosis (Case II). Large golden yellow structures with globular ends and segmented body tapering towards one end. (× 850.)

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FIG. 7.—Pulmonary asbestosis (Case II). Alveolus showing several large multinucleated giant cells containing golden yellow bodies. (× 850.)



FIG. 8.—Pulmonary asbestosis (Case III). This lung showed acute pneumonic consolidation. Golden yellow bodies in phagocytic cells and lying free in an alveolus. (× 850.)



FIG. 9.—Haematite miner's lung. Showing well-formed acellular fibrosis and large masses of granular pigment. The greater part of this pigment gave the iron reaction. (× 425.)

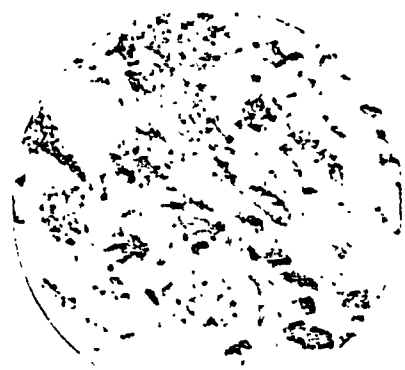


FIG. 10.—Haematite miner's lung. Showing appearance of ironstone dust and absence of golden yellow bodies. (× 850.)



FIG. 11.—Lung of experimental animal. Showing golden yellow body and small phagocytes containing granular dust. (× 850.)

GENERAL COUNCIL
ON
MEDICAL EDUCATION AND REGISTRATION.

SUMMER SESSION, 1928.

THE one hundred and twenty-seventh session of the General Medical Council was opened on Tuesday, May 22nd, at the Council's offices at Hallam Street, under the presidency of Sir DONALD MACALISTER, Bt., K.C.B.

New Members.

The following new members were introduced and took their seats: Alfred William Sheen, C.B.E., M.S., F.R.C.S., as representative of the University of Wales for one year from December 12th, 1927; John Kay Jamieson, M.B., as representative of the University of Leeds for three years from January 1st, 1928; Sir William Taylor, K.B.E., C.B., M.D., F.R.C.S.I., as representative of the Royal College of Surgeons in Ireland for one year from February 1st, 1928; Sir Robert Alfred Bolam, O.B.E., M.D., as representative of the University of Durham for five years from March 6th, 1928; and George Henry Edington, M.D., as representative of the Royal Faculty of Physicians and Surgeons of Glasgow, from May 7th, 1928, to April 6th, 1930.

PRESIDENT'S ADDRESS.

Sir DONALD MACALISTER then delivered the following address from the chair:

GENTLEMEN,—We have to record with regret the loss of no fewer than six members of the Council since our last session in November. Dr. James Alexander Macdonald of Taunton died on April 23rd. He was first elected a direct representative of English practitioners in 1911, and again and again re-elected. His energetic character and his skill in practical affairs won him a high place in the regard of his brethren, and enabled him to attain to leadership in their counsels. His lamented death creates a vacancy on the Council, which must be filled by an election to be held "as soon as conveniently may be" during the summer. Sir Arthur Chance has for twelve years been a conspicuous figure among us; his keen intellect and knowledge of professional conditions gave value to his frequent contributions to our discussions and to our administrative work. I am sorry to say that it is not to waning interest but to ill health that his retirement is due. Our cordial good wishes for his recovery go with him. The Royal College of Surgeons in Ireland have honoured us by sending in his room Sir William Taylor, K.B.E., C.B., Regius Professor of Surgery in the University of Dublin, and Past-President of the College. Dr. James Alexander Adams, for eight years our esteemed colleague from the Royal Faculty of Glasgow, has also been constrained by impaired health to withdraw from our fellowship. We shall miss his sturdy good sense and his hearty goodwill. I am happy to learn that rest and care are already effecting an improvement in his strength. To Dr. Adams's seat the Royal Faculty have elected my Glasgow colleague Colonel George Henry Edington, M.D., D.Sc., Honorary Physician to His Majesty the King, and President of the Faculty, to whom in your name and my own I offer a cordial welcome. Three other members have retired from office at the expiration of their respective terms—Dr. Thomas Wardrop Griffith, C.M.G., University of Leeds, Dr. David Hepburn, C.M.G., University of Wales, and Dr. Robert Howden, University of Durham. For a series of years these have been our familiar friends and fellow members in this Council, and we cannot let them leave us without acknowledging gratefully their loyal helpfulness in our common tasks. The University of Leeds has chosen to represent it Professor James Kay Jamieson, Dean of its Medical Faculty; Wales has appointed Professor Alfred William Sheen, C.B.E., director of the Surgical Unit in the Welsh National School of Medicine at Cardiff; and Durham has presented us an old friend in a new guise by returning Sir Robert Bolam, O.B.E., to bear for a time a double burden of representation. By experience in his case, by reputation in the case of his professional colleagues, we are well assured that their co-operation in the work of the Council will be as serviceable as it is welcome.

Of members *emeriti* three in the fullness of years have passed in honour from our veterans' roll. These are Sir William Selby Church, Bt., K.C.B., from 1889 to 1899 member for Oxford, and until his death trustee for the English Branch Council; Sir Dyce Duckworth, Bt., who at the end of last century represented the Royal College of Physicians of London, and acted as our treasurer for fifteen years; and Dr. Henry William Langley Browne, from 1906 to 1919 elected and re-elected by the suffrages of his fellow practitioners in England and Wales. As one of the few members of the Council who was privileged to serve with and to learn from all of these, I offer my memorial tribute to the worthy examples they furnished to their successors.

On November 23rd, 1858, nearly seventy years ago, the Council met for the first time pursuant to a summons by the Secretary of State. During threescore years and ten many wise and good members of our profession have been inscribed upon its roll of members *emeriti*. From them we have received a heritage which we are proud to cherish and emulous to maintain. For more than half of its lifetime I have been privileged to take part in the Council's fellowship, and, recalling memories of nearly forty years, I am convinced that at no previous period was it more conscious than it now is of its responsibilities or more zealous to fulfil them for the public good. Our inheritance from the "fathers and brethren" of past generations has not been dissipated, it has been enhanced.

Twenty-four years ago the Council adventurously entrusted me, then one of its junior members, with the onerous task of upholding the dignity of the President's chair. My term of office expires a week hence; but as May 27th may fall outside the limits of the present session, I propose to consult your convenience in making a fresh election of a President by resigning my trust into your hands this afternoon, so soon as certain necessary business is completed. No President, let me say, has ever received a fuller measure of loyal support and encouragement than has fallen to me. For that, and for the opportunity you have thus given me of rendering service to the public, and to the profession as its ministers, I shall ever be proud and grateful.

The Lord President of the Council, with whose office we stand in special relation, has informed us that on March 22nd His Majesty in Council revoked the Order in Council of 1908, by which the privilege of practising in this country was originally afforded to the practitioners of Quebec. That Province, by formal legislation, had already withdrawn the reciprocal privilege of practice within its territory hitherto accorded to the registered practitioners of the United Kingdom.

The British Pharmacopoeia.

In June, 1926, the Council, on the recommendation of the Pharmacopoeia Committee, requested the Lord President "to take steps for the appointment of a suitable committee, including members of the Council, empowered to make inquiries, to collect information, to receive evidence, and to make recommendations on the question whether it is desirable to make any, and if so what, alterations in the existing law or practice relating to the preparation or publication of the *British Pharmacopoeia* and to its adaptation to the requirements of the British Empire." The Lord President was pleased to grant the Council's request, and a subcommittee of the Committee of Civil Research was duly appointed in July, 1926, the terms of reference being those suggested by the Pharmacopoeia Committee. The Right Hon. H. P. Macmillan, K.C., was appointed chairman, and your President and Dr. Dale were members. The report of the subcommittee, which is unanimous, has now been submitted for the Council's consideration, and will be brought before you by the Pharmacopoeia Committee at this session. Its conclusions were reached, as I can testify, after very careful and judicial consideration of the problems that have to be solved in the altered circumstances of the times; and I shall have no hesitation in commending to you, as worthy of adoption, the proposals for the readjustment of our practice which have been wrought out in

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harmonious deliberation, by the subcommittee. I record here with special satisfaction the first conclusion—"that it is not necessary or desirable to make any alterations in the existing law relating to the preparation or publication of the *British Pharmacopœia*." For if that view is accepted, it will rest with the Council, without waiting for legislation, to take immediate action for such alterations in our practice as may be found necessary or desirable in view of the current revision of the *British Pharmacopœia 1914*. I am but giving expression to the sentiments of my fellow members when I say that we are all deeply and gratefully sensible of the singular ability and wisdom of our chairman, Mr. Macmillan, and of the eminent service which, through him, the Lord President has rendered to the Council and to British pharmacopœial science and practice. [The report is summarized at p. 915 of this week's *Journal*.]

Medical Education in India.

By your instructions the important reports on medical education in India furnished by Sir Norman Walker and Colonel Needham, with the conclusions of the Executive Committee thereon, have been communicated to the Secretary of State for India, and through him to the Government of India and to the Indian universities. We have been officially assured that in the course of this year the question of the central control of standards of medical qualification in India will be dealt with in connexion with the pending inquiry on Indian government generally; and further, that proposals are now before the Central Legislature for the establishment of an All-India Medical Council, with which this Council will be able to discuss and settle questions of reciprocal recognition of professional qualifications more conveniently and more satisfactorily than is possible in present conditions.

The University of Calcutta, which has meantime applied for the recognition of its degrees, has brought into early operation its new regulations, revised so as to bring them into better accordance with the statutory requirements for practice in this country, and desired that its final examinations held under the amended regulations should be inspected and reported on by an inspector approved by the Council. The Indian Government, notified of this application, has deputed Lieut.-Colonel J. W. D. Megaw, I.M.S., to perform this service, in the absence of Colonel Needham on leave. His appointment has been duly approved, and the Executive Committee will probably have to meet in July to receive his report and others relating to India.

The General Council's Income Tax.

Two recent decisions, in the Court of Appeal and in the High Court, directly affect the Council and call for mention. The first has reference to an application for exemption from income tax payments on dividends received from investments of surplus income by the General Council and its Branch Councils. The Court appears to have decided that, though the Council is concerned by statute with medical education and registration, its functions are not so exclusively "educational" as to make it legally a "charity" within the meaning of the law. Our Legal Assessor has kindly prepared an opinion bearing on the purport of the decision which will be at our disposal for guidance.

Proceedings for Misdemeanour.

The second decision, obtained at the instance of the Dental Board, may be held to dispose finally of the objection sometimes raised to the Council's proceedings in cases of conviction in England or Ireland for "misdemeanour" under Section 29 of the Medical Act, 1858. It has been asserted by counsel for the defence that in that section "misdemeanour" must be read as if the words were "indictable misdemeanour." The objection has, under legal advice, been again and again overruled from the chair. That ruling is now sustained by the judgement of the High Court.

The Act for ratifying the Agreement on Medical Registration, made on behalf of Great Britain, Northern Ireland, and the Irish Free State, has been passed into law, and the Agreement is now in force.

Registration of Opticians Bill.

The Departmental Committee appointed to consider the Registration of Opticians Bill, before which Mr. Eason and I gave evidence on your behalf, have reported against the Bill, and it will no doubt now be dropped.

I regret to say that the greater part of your time this session must be occupied by judicial inquiries into allegations of misconduct or of conviction against registered practitioners. Some of them offer features of difficulty which will probably call for prolonged deliberations. All of them will certainly receive your close and considerate attention. It may well be that to do justice to all the evidence brought before you the session may be prolonged beyond the end of the present week, and so encroach upon the Whit Monday holiday. Much will depend on the progress we make in the first two or three days of the session.

The Medical Register.

The publication in February of the *Medical Register* and of the *Students' Register* shows that the annual numbers of registered practitioners and of registered medical students continues to fall steadily from those of the post-war inflation period. In 1927, 1,341 new practitioners were enrolled, as compared with an average number of 2,167 for the preceding seven years. The number of medical students entered in the *Register* was 1,214, as compared with the seven years' average of 1,487 per annum. The decrease in both figures is likely to continue for two or three years, more particularly as regards practitioners, for the effects of the drop in the number of students, which took place in 1923 and 1924 under the influence of the new regulations, are not yet exhausted.

Though the decrease in annual registration is reflected in our financial statement, I am glad to say that, owing to prudent anticipation on the part of the Finance Committee, it has been discounted in advance. Our surplus for the past year is less than it has been, but it still reaches the substantial amount of £3,031; while the assets of the General and Branch Councils have been increased by £2,557. Our financial position is, in fact, sound and satisfactory.

RE-ELECTION OF PRESIDENT.

A vote of thanks was accorded to the President on the motion of Professor LEATHES, seconded by Sir NORMAN WALKER.

Sir Donald MacAlister then retired from the chair, which was occupied temporarily by Sir Holburt Waring.

Sir NORMAN WALKER proposed the re-election of Sir Donald MacAlister for a period of five years. Sir John MOORE seconded, and this was carried unanimously.

Sir DONALD MACALISTER, on again taking the chair, was heartily applauded. He said: "I am getting rather old for service, but if you think there is anything I can do for you still, my services are heartily at your disposal."

National Insurance.

WARWICKSHIRE PANEL AND LOCAL MEDICAL COMMITTEE.

Case of Excessive Cost of Prescribing.

A MEETING of the Warwickshire Panel and Local Medical Committee was held at Coventry on May 10th, when Dr. HERBERT MALINS presided over a very full attendance. A considerable part of the proceedings was taken up with the hearing of a representation made by the Minister of Health that excess cost had been imposed on the Drug Fund by the nature of a certain practitioner's prescribing. The case of the Ministry was laid before the Panel Committee by one of the Ministry's medical officials, and the practitioner concerned attended in person. It was subsequently decided by the Panel Committee that excess cost had been imposed on the Drug Fund by reason of the large quantities of proprietary articles ordered; a charge of undue frequency not being satisfactorily established. The sum of £10 was assessed as the amount of the excess in the three months reviewed.

The Warwickshire Insurance Committee asked the Panel Committee to meet in conference with the Pharmaceutical Committee with a view to advising how the prescribing of substances regarded as foods could be avoided. The Panel Committee decided that this was an administrative matter, as they had already expressed opinions upon several doubtful cases and were prepared to give further decisions as requested.

Proposed Joint Post-Graduate Scheme.

The question arose of combining with the Oxfordshire and Northamptonshire areas for a joint scheme providing facilities of post-graduate study for doctors in rural areas. The suggestion

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emanated from the Ministry of Health consequent upon the Panel Committee's previous application for a local scheme financed from the Special Mileage Fund. It was intimated that the Ministry were prepared to sanction a joint scheme for doctors in rural areas, the circumstances of whose practices are such that it would be necessary to employ locumtenents if they proposed to absent themselves for purposes of post-graduate study and could not afford other expenses incidental to a course of study. The chairman was authorized to represent the Panel Committee in further negotiations and arrangements.

The chairman reported that in accordance with the discretion given to him he had authorised realisation of the Panel Committee's assets accumulated as the result of voluntary levies, and had paid over to the National Insurance Defence Trust the sum of £869, which was the quota ascertained to be due. The question of further methods of raising the Panel Committee's administrative income was deferred.

Dr. C. R. Lunn reported in detail with regard to the recent meeting of the Midland Conjoint Group, and it was decided to take advantage of the offer to give publicity to reports of the Panel Committee's meetings made by the *Birmingham Medical Review*.

Correspondence.

Contract Rate for Juvenile Oddfellows.

SIR,—At a meeting of the Kingston-upon-Hull Panel and Local Medical Committee held on May 10th, the recommendation of the Council of the British Medical Association that the contract rate for attendance upon juveniles should be 3s. 8d. per annum (in some cases less), including medicine, was considered; and I was instructed to send to you for publication in the *Supplement* the following resolution, which was passed unanimously:

"That this Committee strongly disapproves of the proposal put forward by the Medico-Political Committee, endorsed by the Insurance Acts Committee and approved by the Council, recommending the acceptance of a fee of 3s. 8d. per annum for attendance upon juvenile members of clubs or societies;

"That it is especially disappointed at the apparent attitude of the Insurance Acts Committee, inasmuch as it holds—as the Insurance Acts Committee has hitherto held—that any such lowering of the fee for any form of contract practice will prejudicially affect the capitation fee under the National Health Insurance Acts.

"And that it urges all Local Medical Committees to see that the matter is brought forward before the Local Divisions of the British Medical Association in order that representatives may be instructed to oppose and vote against the recommendation of Council when it comes before the Annual Representative Meeting in July."

—I am, etc.,
Hull, May 12th. JOS. NELSON,
Honorary Secretary.

*** This matter is of primary interest and importance to those practitioners who have hitherto been rendering services of the character indicated at a rate, at the highest, of 6s. 6d. per annum. There is no suggestion, of course, that there is any obligation at all to develop this class of work in areas where other methods prevail or are preferred. The general effect of such raising of the contract rate on that adopted for insurance work or other classes of contract work has been carefully considered by the Medico-Political Committee, the Insurance Acts Committee, and the Council, who are of opinion that a favourable rather than an unfavourable effect on the other capitation fees may be expected. In these circumstances it appears desirable that practitioners and areas not primarily concerned with contract attendance on juvenile Oddfellows should not commit themselves to a final decision before discussion at the Representative Meeting in July.

Naval and Military Appointments.

ROYAL NAVAL MEDICAL SERVICE.

Surgeon Commanders C. M. R. Thatcher to the *Greenwich* in continuation and as Naval Health Officer and Medical Transport; F. C. Hunot to the *Victory* X 1 for R.N. Hospital, Portland; G. D. Fergusson to the *Maine*; J. S. Orwin to the *Royal Sovereign*; G. E. D. Ellis, O.B.E., to the *Victory* X 1 for Portland Dockyard.

Surgeon Lieutenant Commanders A. B. Grant to the *Cambrian*; J. E. Clark to the *President*, additional for three months' post-graduate course; A. De B. Joyce to the *Triad*.

Surgeon Lieutenants A. M. McDonnell to the *President* for three months' post-graduate course; C. B. Nicholson to the *Dolphin*; P. J. A. The O'Rourke to the *Yarmouth*; J. A. Cusack to the *Royal Sovereign*; E. C. Davis to the *Tamar* for R.N. Hospital, Hong-Kong; P. B. Jackson to the *Mantis*.

Surgeon Lieutenant (short service) E. J. K. Weeks has transferred to the permanent list, seniority of September 9th, 1924.

To be Surgeon Lieutenants A. R. Ewart and M. Clifford.

ROYAL NAVAL VOLUNTEER RESERVE.

Surgeon Lieutenant D. R. F. Bertram to the *Victory* for R.N. Hospital, Haslar, for training.

Surgeon Lieutenant J. L. Cox to the *Emperor of India* for training.

ROYAL ARMY MEDICAL CORPS.

Major (temporary Lieut.-Colonel) B. Biggar, from the seconded list, is restored to the establishment, and relinquishes the temporary rank of Lieutenant-Colonel, March 2nd, 1927 (substituted for notification in the *London Gazette* of March 11th, 1927).

Captains to be Majors: D. H. Costa, G. T. Carraway, and P. G. Russell.

A. MacMillan to be Lieutenant on probation.

ROYAL AIR FORCE MEDICAL SERVICE.

Flight Lieutenant C. S. Strachan to No. 28 Squadron, India, instead of to Headquarters, India, as previously notified.

Flight Lieutenant T. Sheehan relinquishes his temporary commission on completion of service and is permitted to retain his rank, April 29th, 1928 (substituted for notification in the *London Gazette* of May 8th, 1928).

The following are granted permanent commissions in the ranks stated: Flight Lieutenant F. B. C. L. B. Crawford and Flight Lieutenant R. C. Freeman.

REGULAR ARMY RESERVE OF OFFICERS.

ROYAL ARMY MEDICAL CORPS.

Lieut.-Colonel R. McK. Skinner, having attained the age-limit of liability to recall, ceases to belong to the Reserve of Officers.

SUPPLEMENTARY RESERVE OF OFFICERS: ROYAL ARMY MEDICAL CORPS.

Lieutenant G. Marshall to be Captain.

R. R. Crowley to be Lieutenant.

INDIAN MEDICAL SERVICE.

Colonel H. M. Cruddas, C.M.G., O.B.E., has retired from the service.

Lieut.-Colonel W. V. Coppinger, Professor of Ophthalmic Surgery, Medical College, Calcutta, and Ophthalmic Surgeon of the College Hospital, is appointed to officiate as Surgeon-General, Bengal, during the absence of Major-General Tate on leave.

The services of Major M. G. Bhandari are placed at the disposal of the Government of the Punjab for employment as Superintendant of the Borstal Institute, Lahore.

Lieutenants to be Captains: K. M. Bharucha and J. D. O'Neill.

VACANCIES.

BELFAST: ULSTER HOSPITAL FOR CHILDREN AND WOMEN.—(1) Honorary Physician. (2) Honorary Assistant Physician.

BETHNAL GREEN HOSPITAL, E.2.—Assistant Medical Officer. Salary £400 per annum.

BIRMINGHAM AND MIDLAND HOMŒOPATHIC HOSPITAL AND DISPENSARY.—Resident House-Surgeon. Salary £150.

BIRMINGHAM EDUCATION COMMITTEE.—Assistant School Medical Officer (male). Salary £600 per annum.

BRIDGE OF WEIR: SANATORIA OF SCOTLAND.—Resident House-Physician (Protestant, male, unmarried). Salary £200 per annum.

BURNLEY COUNTY BOROUGH.—Assistant Medical Officer of Health (lady). Salary at the rate of £475 per annum.

CAMBRIDGE UNIVERSITY: PATHOLOGICAL LABORATORY.—John Lucas Walker Studentship. Annual value £100.

CANCER HOSPITAL (FREE), Fulham Road, S.W.3.—House-Surgeon. Salary at the rate of £100 per annum.

CHELMSFORD: ADMINISTRATIVE COUNTY OF ESSEX.—Three Assistant County Medical Officers of Health. Salary £600 per annum each.

CHESTER UNION.—Resident Assistant Medical Officer at the Institution. Salary £200 per annum.

CITY OF LONDON HOSPITAL FOR DISEASES OF THE HEART AND LUNGS, Victoria Park, E.2.—House-Physicians (male). Salary at the rate of £100 per annum.

CORSHAM MEMORIAL HOSPITAL, Kingswood, Bristol.—House-Surgeon (male). Salary £150 per annum.

DERBY: BOROUGH MENTAL HOSPITAL, Rowditch.—Second Assistant Medical Officer. Salary £150 per annum.

DOWN COUNTY REGIONAL EDUCATION COMMITTEE.—School Medical Officer (male). Salary at the rate of £750 per annum.

EASTBOURNE: PRINCESS ALICE MEMORIAL HOSPITAL.—Junior House-Surgeon (male, unmarried), rising to Senior after three months. Salary at the rate of £100 per annum as Junior, and £125 per annum as Senior.

EAST LONDON HOSPITAL FOR CHILDREN, Shadwell, E.1.—House-Physician (male). Salary at the rate of £125 per annum.

HARTLEPOOLS HOSPITAL.—House-Surgeon. Salary £150 per annum, rising to £200 after six months.

HASTINGS: ROYAL EAST SUSSEX HOSPITAL.—Honorary Assistant Surgeon.

HOSPITAL FOR SICK CHILDREN, Great Ormond Street, W.C.1.—(1) House-Physician. (2) House-Surgeon. (Males, single.) Salary £50 for six months. (3) Medical Registrar (male) in Out-patient Department; salary £250 per annum.

KENSINGTON BOARD OF GUARDIANS.—Assistant Medical Officer (woman) at St. Mary Abbott's Hospital. Salary £250 per annum.

KENT COUNTY COUNCIL.—Locumtenent Assistant Medical Officer at the County Sanatorium, Lenham. Salary £8 8s. a week.

LEICESTER ROYAL INFIRMARY.—Locumtenent House-Surgeon. Four guineas weekly.

LONDON UNIVERSITY.—(1) Professor of Pathology (Sir William Dunn): salary approximately £1,330 a year. (2) University (part-time) Chair of Dietetics, tenable at St. Thomas's Hospital Medical School; salary £1,000 a year.

MANCHESTER: ANCOATS HOSPITAL.—House-Surgeon (Orthopædic). Salary £100 per annum.

MANCHESTER NORTHERN HOSPITAL FOR WOMEN AND CHILDREN.—Senior and Junior House-Surgeons. Salary £120 and £100 per annum respectively.

NEWPORT, MON.: ROYAL GWENT HOSPITAL.—(1) Honorary Surgeon. (2) Two Honorary Assistant Surgeons. (3) Honorary Assistant Ophthalmic Surgeon.

NOTTINGHAM: CITY MENTAL HOSPITAL.—Deputy Medical Superintendent. Salary £650 per annum, rising to £700. In addition £50 per annum for D.P.M. and £10 for M.P.C.

POPLAR HOSPITAL FOR ACCIDENTS, East India Dock Road, E.14.—Second Resident Officer. Salary at the rate of £175 per annum.

QUEEN'S HOSPITAL FOR CHILDREN, Hackney Road, E.2.—(1) Casualty Officer. (2) House-Surgeon (male). (3) Physician in charge of the Skin Department. Salary for (1) and (2) £100 a year each.

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ROYAL COLLEGE OF PHYSICIANS OF LONDON.—Charles Murchison Scholar in Clinical Medicine.

ROYAL FREE HOSPITAL, Gray's Inn Road, W.C.1.—House-Physicians, House-Surgeons, Casualty Officer (female), and Obstetric District Assistant.

ROYAL NORTHERN HOSPITAL, Holloway Road, N.7.—Clinical Assistant in the Medical Out-patient Department.

ST. MARY'S HOSPITAL, W.2.—Surgical Registrar. Salary £200 per annum.

SALFORD ROYAL HOSPITAL.—Casualty House-Surgeon (male). Salary at the rate of £125 per annum.

STAFFORDSHIRE GENERAL INFIRMARY.—House-Physician (male). Salary at the rate of £150 per annum.

STOCKPORT INFIRMARY.—Visiting Anæsthetist.

SURREY COUNTY COUNCIL.—Medical Superintendent at the Sanatorium, Milford, Surrey. Salary £900 per annum.

SWANSEA HOSPITAL.—House-Surgeon (male, unmarried). Salary £150 per annum.

TONBRIDGE UNION.—Resident Assistant Medical Officer (male) at the Institution. Salary £275 per annum, rising to £350.

WARRINGTON INFIRMARY AND DISPENSARY.—Junior House-Surgeon (male, unmarried). Salary £175 per annum.

WEIR HOSPITAL, Grove Road, Balham, S.W.12.—Junior Resident Medical Officer (male, unmarried). Salary £150 per annum.

WEST LONDON HOSPITAL, Hammersmith Road, W.6.—(1) House-Physician. (2) House-Surgeon. (3) Resident Assistant Casualty Officer and Aural and Ophthalmic House-Surgeon. (Males.) Salary at the rate of £100 per annum.

WREXHAM AND EAST DENBIGHSHIRE WAR MEMORIAL HOSPITAL.—Two Resident House-Surgeons (male). Salary at the rate of £100 per annum.

WOOLWICH UNION.—First Assistant Medical Officer at the Plumstead and District Hospital. Salary £400 per annum, rising to £500.

CERTIFYING FACTORY SURGEON.—The appointment at Salford and Stretford (Lancashire) is vacant. Applications to the Chief Inspector of Factories, Home Office, Whitehall, S.W.1.

This list of vacancies is compiled from our advertisement columns, where full particulars will be found. To ensure notice in this column advertisements must be received not later than the first post on Tuesday morning.

APPOINTMENTS.

BOLINGBROKE HOSPITAL, Wandsworth Common, S.W.—*Honorary Physician:* W. Ernest Lloyd, M.D., M.R.C.P. *Out-Patients' Officer, Ophthalmic Department:* Alexander Lumsden, M.B., Ch.B.

LEVY, S. L., F.R.C.S., Assistant Surgeon to the London Jewish Hospital, Stepney Green.

CERTIFYING FACTORY SURGEONS.—T. E. Skinner, M.R.C.S., L.R.C.P., for the Wivenhoe District (Essex), and S. Jackson, M.D.Ed., at Penarth (Glamorgan).

DIARY OF SOCIETIES AND LECTURES.

ROYAL SOCIETY OF MEDICINE.

Sections of Laryngology and Otology.—Summer Meeting. Thurs., 10 a.m. to 12.30 p.m. (Laryngological)—Mr. Rake: Achalasia and Degeneration of Auerbach's Plexus; Mr. A. J. Wright: Silent Tracheotomy, its Significance; Dr. Lowndes Yates: Methods of Estimating the Liability to Post-operative Haemorrhage from Unsutured Wounds; Mr. W. M. Mollison: Dysphagia due to Pharyngeal Paralysis. 2.30 to 4.30 p.m. (Laryngological)—Dr. Jobson Horne: Cancer of the Vocal Cords; Dr. Watson-Williams: Familial Infectivity of Chronic Sinusitis; Sir StClair Thomson: Intrinsic Cancer of the Larynx operated through a Laryngo-fissure (lantern demonstration). Fri., 10.30 a.m. to 12.30 p.m. (Otological)—Professor Dr. Otto Mayer (Vienna): The Pathology of Otosclerosis; Dr. A. Lowndes Yates: A Working Hypothesis for Research in Otosclerosis; Mr. Harold Kisch: Temporal Muscle Grafts in the Radical Mastoid Operation; Mr. Douglas Guthrie: Fat Grafting in Mastoid Surgery. 4 to 6.30 p.m. (Laryngological)—Cases and Specimens. Dinner at the Hotel Victoria at 7.45 p.m., followed by a dance. Sat., Otological Session—9.30 a.m., Cases. 10.30 a.m., Professor G. Portmann (Bordeaux): Vasomotor Affections of the Internal Ear; Mr. William S. Sharpe: The Influenza Ear. Cases and Specimens. There will be a display of instruments and apparatus during the Meeting.

ROYAL SOCIETY OF TROPICAL MEDICINE AND HYGIENE, London School of Hygiene and Tropical Medicine, Endsleigh Gardens, W.C.1.—Wed., 5.15 p.m., Dr. Joaquin J. Vallerino, Roentgenologist to the Herrick Clinic, Panama, Lantern Demonstration: The Value of *X*-Ray in Intestinal Amœbiasis.

POST-GRADUATE COURSES AND LECTURES.

FELLOWSHIP OF MEDICINE AND POST-GRADUATE MEDICAL ASSOCIATION, 1, Wimpole Street, London, W.1.—*St. Peter's Hospital*, Henrietta Street, W.C.: Wed., 2 p.m., Clinical Urological Demonstration; no fee. *Royal Northern Hospital*, Holloway Road, N.7: Thurs., 4.30 to 5.30 p.m., Clinical Demonstration; no fee. *St. John's Hospital*, Leicester Square, W.C.2: Post-graduate Course in Dermatology, every afternoon. *National Hospital*, Queen Square, W.C.1: Course in Neurology for two months; particulars and tickets from the Fellowship of Medicine. Copies of syllabuses on application to the Secretary.

LONDON SCHOOL OF DERMATOLOGY, St. John's Hospital, Leicester Square, W.C.2.—Thurs., 5 p.m., Skin Diseases of Animals Transmissible to Man. Fri., 5 p.m., Bullous Eruptions.

NORTH-EAST LONDON POST-GRADUATE COLLEGE, Prince of Wales's General Hospital, Tottenham, N.15.—Mon., 2.30 to 5 p.m., Medical, Surgical, and Gynæcological Clinics: Operations. Tues., 2.30 to 5 p.m., Medical, Surgical, Throat, Nose, and Ear Clinics; Operations. Wed., 2.30 to 5 p.m., Medical, Skin, and Eye Clinics: Operations. Thurs., 11.30 a.m., Dental Clinics; 2.30 to 5 p.m., Medical, Surgical, and Ear, Nose, and Throat Clinics; Operations. Fri., 10.30 a.m., Throat, Nose, and Ear Clinics; 2.30 to 5 p.m., Surgical, Medical, and Children's Diseases Clinics: Operations.

WEST LONDON HOSPITAL POST-GRADUATE COLLEGE, Hammersmith, W.—Mon., 10 a.m. to 1 p.m., Genito-urinary Operations, Surgical Wards, Skin Department; 2 p.m. to 5 p.m., Eye and Gynæcological Departments. Tues., 10 a.m. to 1 p.m., Medical Wards, Demonstration of Venereal Diseases, Electrical and Dental Departments; 2 p.m. to 5 p.m., Gynæcological Operations, Throat, Nose, and Ear Department. Wed., 10 a.m. to 1 p.m., Children's Medical Department, Medical Wards, Pathological Demonstration; 2 p.m. to 5 p.m., Eye Department, Surgical Wards. Thurs., 10 a.m. to 1 p.m., Neurological and Massage Departments; 2 p.m. to 5 p.m., Eye and Genito-urinary Departments. Fri., 10 a.m. to 1 p.m., Skin, Dental, and Electrical Departments, Medical Wards, Clinical Demonstration; 2 p.m. to 5 p.m., Throat, Nose, and Ear Department. Sat., 9 a.m. to 1 p.m., Medical Wards, Throat, Nose, and Ear Operations, Medical Children's Department, Rectarial Therapy Department. Daily at 2 p.m., Operations, Medical and Surgical Out-patient Departments.

SHEFFIELD UNIVERSITY POST-GRADUATE CLINICS.—At Royal Hospital: Fri., 3.30 p.m., Strabismus.

GLASGOW POST-GRADUATE MEDICAL ASSOCIATION.—At Eye Infirmary: Wed., 4.15 p.m., Eye Cases.

British Medical Association.

OFFICES, BRITISH MEDICAL ASSOCIATION HOUSE, TAVISTOCK SQUARE, W.C.1.

Departments.

SUBSCRIPTIONS AND ADVERTISEMENTS (Financial Secretary and Business Manager. Telegrams: Articulate Westcent, London; [illegible]

MEDICAL SECRETARY (Telegrams: Mediscera Westcent, London).

EDITOR, *British Medical Journal* (Telegrams: Aitiology, Westcent, London).

Telephone numbers of British Medical Association and British Medical Journal, Museum 9261, 9262, 9263, and 9264 (internal exchange, four lines).

SCOTTISH MEDICAL SECRETARY: 6, Drumsheugh Gardens, Edinburgh. (Telegrams: Associate, Edinburgh. Tel.: 24361 Edinburgh.)

IRISH MEDICAL SECRETARY: 15, South Frederick Street, Dublin. (Telegrams: Bacillus, Dublin. Tel.: 4737 Dublin.)

Diary of the Association.

MAY.

25 Fri. London: Dominions Committee, 2.30 p.m.
Bromley Division: Town Hall, Anerley. Mr. Philip Turner on Modern Methods in Surgical Diagnosis, 8.30 p.m.
Lincoln Division: Annual Meeting, Lincoln General Dispensary, 3 p.m.
Shropshire and Mid-Wales Branch: Royal Salop Infirmary, 3.30 p.m.

28 Tues. Dartford Division: Livingstone Hospital, 3 p.m.
South Carnarvon and Merioneth Division: War Memorial Hospital, Towyn, 2.15 p.m.

30 Wed. London: Journal Committee, 2 p.m.
London: Finance Committee, 3 p.m.
Glasgow and West of Scotland Branch: Annual Meeting, Royal Infirmary, Glasgow, 2.30 p.m. Clinical Demonstrations after Meeting.
North Middlesex Division: Annual Meeting, Southgate Council Offices, Palmers Green, 3.30 p.m.

31 Thurs. London: Private Practice Committee, 12 noon.
Bromley Division: Annual Meeting, White Hart Hotel, Bromley, 8.30 p.m.
Gloucester Branch: Annual Meeting, General Hospital, Stroud. Dr. J. R. Charles on Manganese Toxæmia, 6 p.m.
Trowbridge Division: Norton Hill Colliery, Midsomer Norton, 3 p.m.

JUNE.

5. Tues. London: Ophthalmic Subcommittee, 3.30 p.m.
City Division: Annual Meeting, Metropolitan Hospital, Kingsland Road, E.

6 Wed. London: Conference of Representatives of Medical Staffs of Hospitals, 2 p.m.
Lambeth and Southwark Division: Annual Meeting, B.M.A. House, Tavistock Square, W.C.1, 4.15 p.m.
Lanarkshire Division: Stonehouse Hospital, 3.30 p.m.

8. Fri. City Division: Clinical Meeting, Metropolitan Hospital, Kingsland Road, E., 4.30 p.m.
Southern Branch: Annual Meeting, Queen's Hotel, Southsea. Colonel Macarthur on Some Medical References to Pepys, preceded by Supper, 9 p.m.

12 Tues. Hastings Division: Hastings Infirmary, Frederick Road, 3.15 p.m.
St. Pancras Division: B.M.A. House, Tavistock Square, W.C.1. Dr. W. Langdon Brown on Endocrinology and the Futures, 9 p.m.

13 Wed. London: Council, 10 a.m.

14 Thurs. Hampstead Division: Annual Meeting, Hampstead General Hospital, 8.30 p.m.
Hyde Division: Annual Meeting, Hyde Town Hall, 8.30 p.m.
Kent Branch: Annual Meeting, Acacia Hall, Dartford, 2 p.m. Luncheon, 1 p.m.

15 Fri. Border Counties Branch: County Buildings, Dumfries, 3 p.m.

19 Tues. Lewisham Division: Town Hall, Catford. Mr. J. M. Redding on *X*-ray Examination of the Alimentary Tract, 8.45 p.m.
Metropolitan Counties Branch: Annual Meeting, B.M.A. House, Tavistock Square, W.C.1, 4 p.m.

BIRTHS, MARRIAGES, AND DEATHS.

The charge for inserting announcement of Births, Marriages, and Deaths is 2s., which sum should be forwarded with the notice not later than the first post on Tuesday morning, in order to ensure insertion in the current issue.

BIRTHS.

BULMAN.—At Hillside, Hereford, on May 18th, to Dr. J. R. and Mrs. Bulman, a son.

GRIAN.—On April 5th, at Nairobi, to Dr. and Mrs. E. U. Gillan (Geraldine Sikes, M.B., Ch.B.), Scots Mission, Tumu-Tumu, Kenya Colony, a daughter.

NEWHAM.—To W. B. Turner Newham, A.R.I.B.A., and Marjorie Newham, M.R.C.S., L.R.C.P. (*née* Auden), a son, on April 17th, at Windy Ridge, Waterkloof, Pretoria, South Africa.

PANTON.—On May 17th, 1928, at 35, Hoghton Street, Southport, to Dr. and Mrs. J. Allison Panton (*née* Kathleen Heath), a daughter.

DEATH.

WALLER.—On May 15th, at "The Drachenfels," Nuneaton, Dr. Harry Mortlock Waller in his 57th year.

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F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
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PULMONARY ASBESTOSIS IN SOUTH AFRICA.

(With Special Plate.)

BY

F. W. SIMSON, M.B., CH.B.EDIN.,

PATHOLOGIST AT THE SOUTH AFRICAN INSTITUTE FOR MEDICAL RESEARCH, JOHANNESBURG.

It has been known for some time that workers exposed to the dusty atmosphere arising from some processes involved in the preparation of asbestos materials suffer from pulmonary disability. The mining of the mineral itself is probably not a source of danger, as asbestos is mined mostly in open quarries. After sorting, there remains waste rock which still contains fibre in payable quantity. Crushing of this rock causes a considerable degree of dust exposure, and exposure to the dusty atmosphere is still more exaggerated in the carding and spinning of asbestos in the mills.

Very little concerning the pathological changes in the lungs of persons working with asbestos has been found in the literature, and it was thought that a record of the following cases might be of interest.

On September 2nd, 1926, the medical officer of an asbestos mine in Southern Rhodesia forwarded to the South African Institute for Medical Research three small specimens of lung from a *post-mortem* case for histological examination.

CASE I (No. 9026).

The subject was a male adult native, who had worked for twelve months in the asbestos mill, and, except for a short period before his death, had had a good record of health. For nine weeks before death he suffered from acute tuberculosis, and the *post-mortem* findings showed miliary tuberculosis involving the lungs, liver, spleen, and pericardium. The object of the histological examination was to ascertain if there was any evidence of fibrosis in the lungs which might be directly ascribed to the nature of his employment, since workers in the mill are exposed to a very dusty atmosphere.

Apart from the tuberculosis and associated fibrosis, sections of the lungs showed a certain amount of connective tissue change which had no obvious connexion with the tuberculous process. It was also found that curious golden yellow segmented structures, with rounded or club-shaped ends (Fig. 1), were embedded in this fibrous tissue, together with very minute, doubly refractile particles, the latter presumably silica. Although the curious segmented bodies were remarked upon, no further investigation was carried out at the time, and the new-formed fibrous tissue was attributed to the presence of silica.

CASE II (No. 11016).

It was not until September 29th, 1927, when a portion of lung from a second case was sent by the medical officer from the same mill, that the foreign bodies and fibrosis were more fully investigated. This piece of lung was from a male adult native who had been employed in the mill for a period of two years. About September, 1926, he was admitted to hospital suffering from pneumonia, and had a long illness. He was discharged, and later (September 19th, 1927) readmitted in a dying condition. He was very emaciated, and had the physical signs of pulmonary tuberculosis with fibrosis. At autopsy the lungs were firmly bound down by adhesions, the root glands enlarged and hard, and the lungs on section hard and fibrous with an almost leather-like consistence. The mesenteric glands were also considerably enlarged.

Histological sections showed a generalized but moderate degree of fibrous thickening of the pleura, trabeculae, and alveolar walls. In addition, there was a much more marked fibrosis arranged in irregular-shaped nodules, chiefly related to the blood vascular system and bronchi. This fibrous tissue was cellular, the elements arranged in an irregular manner, and included some small lymphocytic accumulations (Fig. 2). There was no resemblance to the orderly, whorled arrangement and sharp definition of the silicotic nodule (Fig. 3). The bronchi were the seat of slight catarrhal changes, and many of the alveoli contained "dust cells" filled with phagocyted particles. There was no evidence of tuberculosis or acute pneumonic consolidation. Embedded in the fibrous tissues, lying free in alveoli (Fig. 4), and contained in phagocytic cells, there were numerous golden yellow segmented bodies (Figs. 5 and 6), a few large angular black bodies, and very minute doubly refracting particles. Phagocytosis was a very striking feature. Large numbers of the bodies were contained within ordinary mononuclear cells and irregular-shaped multinucleated giant cells (Fig. 7). Phagocytosis was not confined to the smaller particles, but even large rods were seen completely enclosed and often bent in order to allow them to occupy the space within the cells (Fig. 7). It was thought that these foreign bodies, together with the crystalline matter, may have been the cause of the fibrosis, as the connective tissue, both in distribution and formation, was very suggestive of changes resulting from a dust occupation of the lungs. At the same time the history of pneumonia and protracted recovery must be taken into consideration, since an unresolved pneumonia with subsequent fibrosis is not an uncommon occurrence amongst natives working on the mines in South Africa.

CASES III AND IV (Nos. 6419 and 6731).

Consultation of the records and previous histological sections of material from the same mine has revealed two additional cases, both of which showed lobar pneumonia. There was very little connective tissue increase, but the unusual structures (Fig. 8) and refractile crystalline particles were present. No history of length of service in the mill was obtained with either of these cases.

Further study of the golden yellow bodies showed a variety of shapes, but the most common forms had rounded or club-shaped ends and a segmented body tapering to a finely pointed tail. They were non-refractile to polarized light, soluble in strong acids, and, on raising to a red heat, turned black and tended to lose their outline. In sections treated with hot dilute hydrochloric acid and potassium ferrocyanide they gave a well-marked Prussian blue reaction. No pigment except these structures giving the iron reaction could be detected in the sections examined. Strong hydrochloric acid, having been tested for the presence of iron and found negative, was used to dissolve out iron from fresh sections. After treating the sections the hydrochloric acid gave a very distinct red-pink colour with potassium thiocyanate, and the red-pink colour disappeared on the addition of a solution of mercuric chloride. The sections were re-examined and showed that the majority of the golden yellow bodies had been dissolved out. From these tests it was concluded that the structures contained a large percentage of iron.

As controls, sections of lungs from a large number of miners on the Rand who had died from silicosis and tuberculosis were examined. Bodies such as have been described above were found in none of these, nor was the Prussian blue reaction or other test for iron positive except in those cases where the pigment was obviously of haematogenous origin. A single case of a miner was also investigated; he had worked for twenty-eight years in the haematite mines in the North of England, and subsequently for seven and a quarter years in the gold mines of the Rand, South Africa. The cause of death was carcinoma of the gall-bladder. Macroscopically the pulmonary root glands were enlarged, pigmented, and fibrosed. The pigment was dark rust-coloured and gave a marked Prussian blue reaction with dilute hydrochloric acid and potassium ferrocyanide. Occasional rust-coloured subpleural islets were visible. On section the lungs showed a slight diffuse fibrosis and a few large areas of fibrosis. The whole lung gave a marked iron reaction. Histological sections of the large areas showed moderately well defined, but irregularly shaped, masses of well-formed acellular fibrous tissue (Fig. 9). The alveolar walls were slightly thickened, and there was a moderate degree of connective tissue increase round the blood vessels and bronchi. A large quantity of pigment of a reddish-brown colour was contained in phagocytic cells and lying free in alveoli, alveolar walls, and between the fibres of the newly formed fibrous tissue. The greater part of this pigment gave the iron reaction. In addition, there was another variety of pigment, in much smaller quantity, in the form of crystalline refractile particles. The latter was intimately mixed with the iron-containing dust. This lung was especially examined to determine, if possible, whether the same peculiar bodies were being formed from a deposit of ferric iron dust as in the case of an asbestos dust which contained both ferrous and ferric iron. A careful and thorough search was made, but no particles with a similar appearance were detected (Fig. 10). At the time of the patient's death this case of ironstone phthisis was complicated by underground work in the gold mines on the Rand, but in 1919 it simulated, by x-ray photography and physical examination, an early case of silicosis,

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and confirms the findings of Sir Kenneth Goadby[1] and Dr. Cronin.[2]

In addition to the human lungs showing asbestosis, Dr. Mavrogordato of the South African Institute for Medical Research has supplied me with the lungs of a guinea-pig which died in December, 1927, from causes other than asbestosis. This animal was exposed to an asbestos dust atmosphere experimentally. The length of exposure was two hours a day on each of fifty days. The first exposure took place on February 4th, 1925, and the last on April 1st of the same year. The asbestiform compound used for the experiments was a chrysotile[3] obtained from the mine in Southern Rhodesia. Histological sections showed a slight generalized fibrosis and an increase in pigment, but the interesting feature was the presence of the golden yellow bodies (Fig. 11), similar to those seen in the lungs of human pulmonary asbestosis.

A comparison between the human cases and the experimental animal showed that the fibrosis was more rapid and extensive in the human cases than in the experimental animal. This is readily explained by the difficulty in reducing the tough asbestos fibre to a uniformly fine powder, and to the presence of a comparatively small proportion of the rock dust which is usually associated with asbestiform compounds. For "dusting" animals a limited amount of dust is available, and of this only a small proportion contains particles of sufficiently small dimensions to permit of their reaching the lung alveoli. In silicosis[4] the size of the majority of the particles[5] which reach the alveoli is between 1μ and 3μ; in the haematite lung, mentioned above, the particles appear larger, but even here are much smaller than the greater number of those prepared from asbestos for "dusting" experiments. In the working mill the conditions are very different from an asbestos dust atmosphere produced experimentally. Fine dust is continuously reaching the atmosphere, and only the very fine particles remain suspended for any length of time. These gradually increase in numbers until a maximum concentration is reached, then remain more or less constant during working hours. Thus it will be seen that, in order to produce changes in experimental animals showing the same degree of fibrosis in the same length of time, an atmosphere approximating that of the working mill will have to be obtained.

The amount of fibrosis in two of the human cases (Cases I and II) was quite definite, and, if due to the presence of asbestos dust, the initial rate of production was rapid when compared with present-day non-infective silicosis on the Rand. It is difficult to state a definite time for the production of an appreciable degree of fibrosis in pure non-infective silicosis, but modern observation tends to show that it is in the neighbourhood of ten years. In Case I a moderately marked fibrosis had taken place after one year of work in the mill, but this was complicated by tuberculosis. It is known that the rate of fibrous tissue production is very much greater in dust diseases complicated by infections, but even allowing for this the connective tissue increase in Case I was rapid. In Case II there was a still more definite fibrosis after two years of work in the mill with no evidence of tuberculosis.

Before this work was completed Drs. Cooke,[6] Stuart McDonald, and Oliver[7] published their papers dealing with pulmonary asbestosis, and previous to that a short article on the same subject appeared in the *Lancet*. The similarity between the case described and ours was suspected when the first article appeared, and our work goes far to confirm the findings. As in those recorded here, the asbestos dust responsible for the changes in the lungs in their case was a chrysotile. Whether other asbestiform compounds are capable of producing these changes it is impossible to say, as there appears to be no record of any such cases in the literature.

In the Union of South Africa[8] and Rhodesia there are many asbestos mines, from some of which chrysotile is obtained, but two other interesting varieties are found—namely, crocidolite and amosite. Amosite is a comparatively recent discovery, the chemistry of which has not been completely worked out, but it appears to be somewhat similar to crocidolite in composition. Both these compounds contain a large percentage of ferrous iron. Analysis of four samples of amosite[8] showed between 32 and 44 per cent. of FeO, and eight samples of crocidolite[8] between 16.5 and 40.5 per cent. Up to the present there has been no examination of *post-mortem* material from cases of death among those working in mills where these minerals are treated. No such material has been made available.

Chrysotile or serpentine asbestos usually contains 2 to 3 per cent. of FeO isomorphously replacing magnesia. The analysis of Dr. Cooke's case showed 3 per cent. of FeO, and the Rhodesian mineral, according to Mr. A. L. Hall,[3] 2.44 per cent. Dr. McCrae of the Government Chemical Laboratory, Johannesburg, analysed the FeO content of the asbestos used by Dr. Mavrogordato in his animal experiments, and found a much lower percentage—namely, 0.45. Apparently even with very small percentages of FeO the golden yellow bodies are formed in the lungs.

With regard to the unusual structure and chemical nature of the golden yellow bodies found in the lungs in pulmonary asbestosis, until many more cases have been examined and more experimental work has been done very little can be stated. There is no doubt that they are in some way associated with the asbestos, or, probably, more particularly with the FeO content, either of the asbestos itself or of the dust of the mill. This dust contains a much higher percentage of iron, which may be derived partly from the lode from which the asbestos is mined.

Three possibilities regarding the formation of the golden yellow bodies are worthy of mention:

(1) In the form of a gel, as suggested by Dr. Stuart McDonald.

(2) As particles of ferruginous quartz formed in the lungs under conditions similar to weathering, or ferruginous quartz changed in composition as a result of combination with constituents of the body fluids. In support of this it may be mentioned that crocidolite, which is an alkali silicate with ferrous iron, is especially liable to decomposition when exposed to weathering. Sodium is removed, the iron oxidized and hydrated to form limonite, and silica set free; there then results a ferruginous quartz which possesses the finely fibrous structure of the original mineral. It is extremely hard, and coloured a rich golden yellow. It is possible that a change such as this occurs with the small quantity of ferrous iron associated with chrysotile, and the colour of the bodies in the lungs is very suggestive.

(3) Phagocytosis of these structures is a very prominent feature in the lungs, and it was thought that the action of these cells may have been responsible, first, for some change in chemical composition, then a building up and moulding into the various shapes seen.

The fibrous tissue change in the lungs of the above-mentioned cases of workers in asbestos mills is probably the result of a reaction on the parts of the tissues to both the golden yellow bodies and a small quantity of silica.

Sufficient cases of pulmonary asbestosis have not been recorded to base an opinion upon the liability to secondary infection by specific inflammatory processes such as tuberculosis, but it is very suggestive that two of those now recorded, which have been examined histologically, have shown tuberculosis complicating the changes produced by an asbestos dust occupation of the lungs.

Besides these cases there is still further evidence in favour of tuberculosis being a complicating factor.

Dr. H. M. Murray reported a fatal case in the *Charing Cross Hospital Gazette* in 1900; and in the United States of America, from one source,[9] during the period 1907 to 1914 there were 13 deaths, 3 of which were from tuberculosis.

In 1910 Dr. Collis[10] reported on the relationship of asbestos dust to pulmonary tuberculosis, and found that 5 deaths from phthisis had occurred in five years amongst a staff of less than forty workers employed at a factory where asbestos is woven.

In conclusion, I wish to record my thanks to Dr. Mavrogordato for data and material from an experimental animal; to Dr. Irvine, chairman of the Miners' Phthisis Medical Bureau, Johannesburg, for material from silicotic cases and from the lungs of a haematite miner; to Dr. McCrae for his analysis of the FeO content of a sample of asbestos; and to Mr. P. Longmore for his valuable assistance in preparing the microphotographs.

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FIG. 1.—Pulmonary asbestosis (Case I). Golden yellow bodies lying in the centre of a nodule of young fibrous tissue. (× 850.)

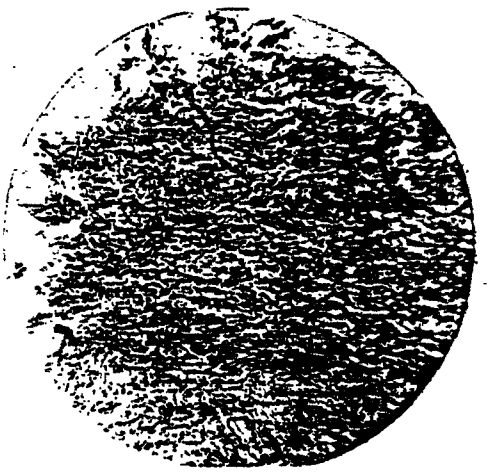


FIG. 2.—Pulmonary asbestosis (Case II). Irregular fibrotic nodule showing a moderate degree of cellularity. The bodies embedded in this tissue are just visible. (× 250.)

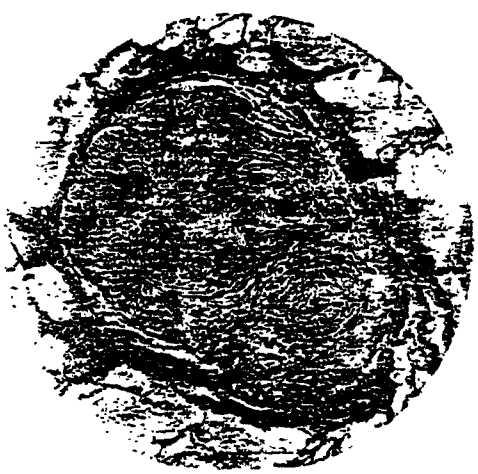


FIG. 3.—Silicosis. Nodule showing orderly whorled arrangement and sharp definition characteristic of this type of fibrosis. (× 250.)

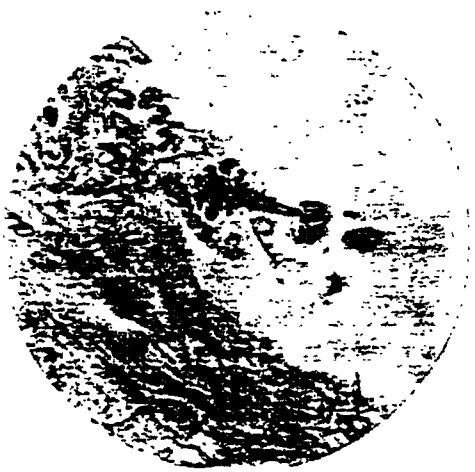


FIG. 4.—Pulmonary asbestosis (Case II). Small phagocytes containing granular dust and golden yellow bodies. One large body is lying free in the alveolus. (× 850.)



FIG. 5.—Pulmonary asbestosis (Case II). Large golden yellow structures with globular ends and segmented body tapering towards one end. (× 850.)

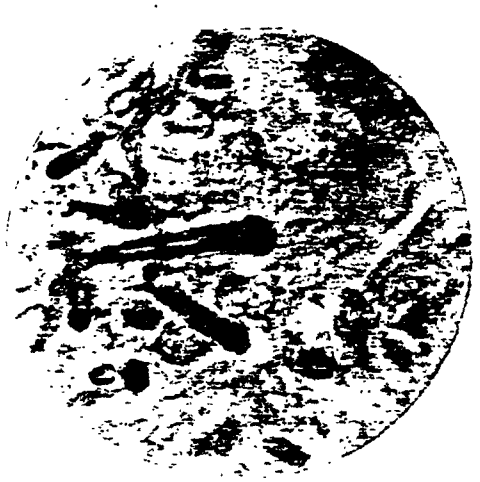


FIG. 6.—Pulmonary asbestosis (Case II). Large golden yellow structures with globular ends and segmented body tapering towards one end. (× 850.)

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FIG. 7.—Pulmonary asbestosis (Case II). Alveolus showing several large multinucleated giant cells containing golden yellow bodies. (× 850.)



FIG. 8.—Pulmonary asbestosis (Case III). This lung showed acute pneumonic consolidation. Golden yellow bodies in phagocytic cells and lying free in an alveolus. (× 850.)



FIG. 9.—Haematite miner's lung. Showing well-formed acellular fibrosis and large masses of granular pigment. The greater part of this pigment gave the iron reaction. (× 425.)

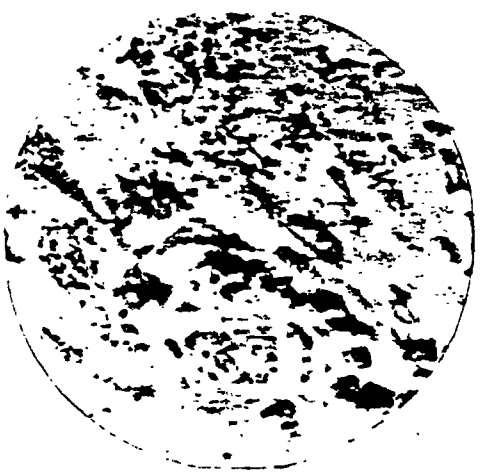


FIG. 10.—Haematite miner's lung. Showing appearance of ironstone dust and absence of golden yellow bodies. (× 850.)



FIG. 11.—Lung of experimental animal. Showing golden yellow body and small phagocytes containing granular dust. (× 850.)

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ABDOMINAL PAIN AS EXEMPLIFIED IN ACUTE APPENDICITIS:

A CLINICAL AND BIOLOGICAL CONSIDERATION.*

BY

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THE EVOLUTION OF OUR KNOWLEDGE OF ABDOMINAL PAIN.†

ALMOST the first considerable contribution to our knowledge of the mechanism of abdominal pain was made by J. Ross of Manchester[1] in 1887. Ross held that there were two kinds of pain in visceral disease—true splanchnic pain, felt in the affected organ; and associated somatic pain, referred to the cerebro-spinal nerves of the body wall. Lennander[2] established the insensibility of the exposed gastro-intestinal tract to the ordinary painful stimuli, and attributed all abdominal pain to stimulation of nerves in the sensitive parietal peritoneum. Mackenzie, whose views form the orthodox teaching of the current textbooks, accepted Ross's views on somatic pain, but rejected splanchnic pain as non-existent. He believed that painful stimuli passed from the viscera through the afferent splanchnic nerves to the spinal cord, but were only appreciated by the brain as arising from the sensory nerves of the parietes. Mackenzie's theories of a viscero-sensory and viscero-motor reflex have been widely accepted, and will be discussed later. Hurst[3] in 1911 published observations which have restored our belief in true splanchnic pain; he proved that this type of pain is produced by a single adequate stimulus—namely, increased tension in the muscular wall of the viscus concerned. Yet Hurst does not reject Mackenzie's views on the viscero-sensory and viscero-motor reflex mechanism.

My purpose in this paper is to discuss the light which a study of acute appendicitis throws on the mechanism of abdominal pain; and since Mackenzie's theories were based very largely on his observations in cases of appendicitis, this disease may reasonably be used to test those theories.

THE TWO PAINS IN APPENDICITIS.

The conventional teaching on the pain in acute appendicitis is that the attack is ushered in by pain referred to the region of the umbilicus or a little above it, and that after a few hours the pain becomes localized in the right iliac fossa or moves down into that region.

The Initial or Central Pain.

The first point that I wish to emphasize is that the initial pain is entirely different in character and in its mode of origin from the pain which appears in the right iliac fossa a few hours later. The initial pain is felt in the centre of the abdomen, and though the patient may refer it to the mid-line at or above the umbilicus, he often describes it as "all across," sweeping his hand evenly across the central region of the abdomen. It is, in short, very imperfectly localized. The pain is often described by the patient as "like an ordinary bellyache, but more severe." It is frequently griping in character and varies in intensity; the more severe spasms usually occur at more or less regular intervals, and last for a few seconds, during which the patient moans and writhes restlessly in bed. This early pain is entirely unassociated with any tenderness on palpation, and the patient may rub or press on his abdomen in a vain attempt to secure relief—a thing that he never does when the second pain has appeared.

This initial pain in appendicitis is, I believe, a true splanchnic pain, and, like all true splanchnic pain, is due to increased tension on the muscular wall of the viscus concerned. Some degree of obstruction to the lumen of the appendix, causing retention of inflammatory exudate distal to the obstruction, is an essential factor in its production. Sometimes—in fact, it is almost the rule in the most fulminating cases—we find a hard, laminated faecal concretion engaged in the relatively narrow base of the appendix, while distal to it a collection of foul pus under great tension rams the concretion home into the base. In this condition, so well described by Wilkie[4] as acute appendicular obstruction, the central pain in the umbilical region continues until general gangrene or localized perforation of the appendix relieves the tension within it and the pain disappears. In other cases a stricture at the base, the result of some former ulceration, gives rise to the same sequence of events. In others a kinking at the base combines with inflammatory swelling of the mucosa to occlude the outlet into the caecum. In yet rarer instances a foreign body is the occluding agent. A critical examination of the specimens removed in a large number of cases of early appendicitis has convinced me that wherever this splanchnic pain is present some degree of obstruction to the lumen, with retention of inflammatory exudate under tension beyond it, will be found. It is possible that the inflamed condition of the appendix lowers the threshold of painful stimulation and allows a relatively slight distension to cause pain; but without increased tension visceral pain is impossible.

Under certain conditions recurrent attacks of appendicitis may occur in which this splanchnic central pain is the only evidence of the disease, and great difficulty in diagnosis results. A striking instance of this difficulty was afforded by a man, aged 21, who gave a history of four severe attacks of epigastric pain, each lasting for a few hours, during the course of four months. There had been neither tenderness nor muscular rigidity during the attacks. Exploration a week after the last attack showed that the only viscus affected was the appendix, which was swollen and congested in its distal portion. There was a narrow stricture at the base, and, distal to this, a collection of thick yellow pus. In the ten months that have passed since the operation there have been no more attacks.

It is evident that this patient was suffering from recurrent attacks of acute obstructive appendicitis of too mild a type to cause perforation, and that his pain was of the pure splanchnic appendicular type. The reason for the entire absence of local pain and rigidity I shall discuss later, when dealing with the second pain. The brief intermittent colicky attacks of central abdominal pain so common in children, and described by physicians as "umbilical colic," are very commonly due to spasmodic efforts to expel a concretion or a nest of threadworms from the appendix, and form another example of pure splanchnic pain.

Although the splanchnic pain in acute appendicitis is felt in the umbilical or lower epigastric region, and not in the region of the appendix, it should not be described as a referred or reflected pain, as no radiation of pain or reflex process is involved. The appendix is developmentally a part of the mid-gut loop. The brain can only appreciate painful stimuli arising from any portion of the mid-gut as vaguely situated in the centre of the abdomen, and stimuli of appendicular origin are no exception to the rule. It is characteristic of this splanchnic pain that it is dull and aching in character—as patients express it, "like an ordinary bellyache"—and vaguely localized; in other words, it is a form of Head's protopathic pain.

*A post-graduate lecture delivered at the Manchester Royal Infirmary.
† For reasons of space this introductory section has been abridged.

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The Second or Localised Pain.

A few hours after the onset of the acute attack the second pain makes its appearance in the right iliac fossa. The initial splanchnic pain is usually still present, but it tends, either gradually or suddenly, to sink into insignificance. The new pain is entirely different in character from its forerunner. It is localized, severely at first, to the right side. It has a sharp or stabbing character. Any movement of the abdominal muscles, as in deep breathing, vomiting, or coughing, accentuates the pain, and the right iliac fossa becomes exquisitely tender on palpation. The patient no longer writhes in pain, but lies still in bed, resenting any movement and even complaining of the pressure of the bedclothes. The respiratory excursions of the lower abdominal wall are now increasingly limited.

Since the cutaneous and muscular phenomena interpreted by Mackenzie as the viscero-sensory and viscero-motor reflex have received such general attention, we must now consider them in detail.

CUTANEOUS HYPERALGESIA IN ACUTE APPENDICITIS.

Mackenzie's theory of a viscero-sensory reflex was based on his observation that in certain abdominal diseases areas could be mapped out in which the skin of the abdominal

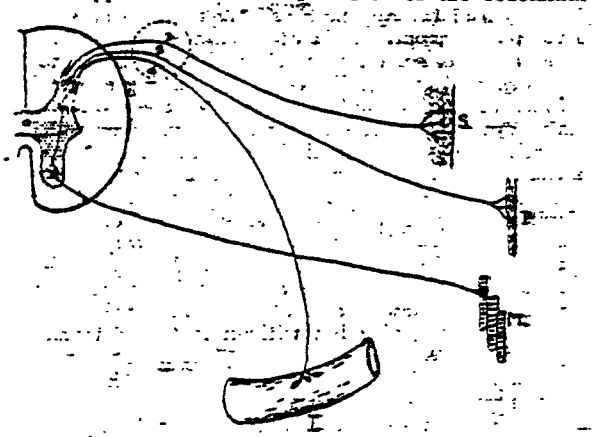


FIG. 1.—To illustrate Mackenzie's theory of a viscero-sensory and viscero-motor reflex. S=Skin. M=Abdominal muscles. P=Parietal peritoneum. I=Intestinal tract.

wall could not be lightly pinched up and drawn away from the underlying muscles without evoking pain. Impressed by the similarity between these areas and the skin areas mapped out by Head in cases of herpes zoster Mackenzie made the assumption that afferent stimulation through the splanchnic nerves from the inflamed viscus caused an irritable focus in its own centre of grey matter in the cord, as a result of which the sensory nerves from the skin supplied by the same spinal segment became excessively irritable. (Fig. 1.) Stimuli, such as a light pinch of the skin, which normally cause no pain, in the presence of visceral inflammation, so Mackenzie taught, become painful. Then, regarding his viscero-sensory hypothesis as proved, he next argued that from these hyperalgesic areas we could, by comparison with Head's diagrams, deduce the segmental innervation of the affected viscera. He also laid great stress on the value of these areas of hyperalgesia in the diagnosis of acute abdominal catastrophes.

Sherren[3] attempted to systematize the matter by investigating the hyperalgesia present in a series of 124 cases of acute appendicitis. He found cutaneous hyperalgesia in 40 of these, and described a cutaneous triangle of hyperalgesia over the right iliac fossa in a majority of the positive cases. Sherren's views as to the mechanism of this reflex clearly conform closely with those of Mackenzie, for he believes that hyperalgesia is never present where the appendix is gangrenous or perforated, and goes so far as to teach that disappearance of the hyperalgesia may constitute an important indication for immediate operation. He also states that cutaneous tenderness does not vary with the position of the appendix.

It appears to me necessary to consider two points in connexion with hyperalgesia in acute appendicitis—namely, its value in diagnosis, and the mechanism of its production.

The Value of Hyperalgesia in Diagnosis.

There is a marked discrepancy between the statements of different observers as to the frequency of hyperalgesia in acute appendicitis. Sherren, in 124 cases, found hyperalgesia in 40, or 32 per cent. Robinson,[4] in 123 cases, found hyperalgesia in 26, or 21 per cent. Zachary Cope[5] found hyperaesthesia (not amounting to pain) in 110 of 185 cases, or 59 per cent. Further, both Robinson and Cope differ from Sherren in finding that hyperalgesia and hyperaesthesia occur quite frequently with a gangrenous or ruptured appendix, and with this opinion my own observations are in full agreement.

A phenomenon that can be detected by different observers with a frequency that varies from 21 to 59 per cent. would appear to be of but little help in diagnosis. Unless, given certain pathological conditions in the appendix, hyperalgesia can be detected as a constant phenomenon, I hold that it is merely of academic interest.

A further consideration which invalidates hyperalgesia as an aid to diagnosis is the extreme frequency with which it can be elicited over the appendix in the neurotic abdomen, or those cases simulating chronic appendicitis, where on exploration no evidence of organic disease in the appendix or any adjacent organ can be found.

The Mechanism of Production of Hyperalgesia.

All observers are agreed that when hyperalgesia is present in acute appendicitis it is found, in the vast majority of cases, in some part of the right iliac fossa only. If we accept Mackenzie's hypothesis that it is due to stimuli arising in the appendix and travelling by way of the splanchnics to the spinal cord, we should expect it, however, to be bilaterally symmetrical. The appendix is a portion of the embryonic mid-gut loop. It becomes fixed in the right iliac fossa relatively late in the development of the embryo, and long after it has received its splanchnic innervation. As a developmentally median organ its nervous connexions are presumably with both sides of the spinal cord, and consequently Mackenzie's hypothesis as to the origin of the hyperalgesia would appear to be at variance with anatomical evidence. Zachary Cope, in the article quoted previously, suggests that irritation of the sensitive parietal peritoneum may in many cases determine the presence of right-sided hyperaesthesia, yet he goes on to argue that some evidence is furnished by his cases to show that the appendix is supplied mainly by the tenth dorsal segment; thus he tacitly accepts Mackenzie's viscero-sensory reflex.

My own conclusions are that the hyperalgesia is a phenomenon in which the splanchnic afferent nerves take no part. I believe that the nerves of the exquisitely sensitive parietal peritoneum affect their cutaneous branches by radiation, and that the process is precisely analogous

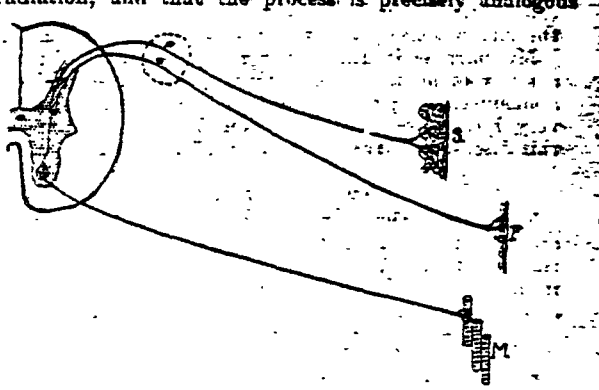


FIG. 2.—To illustrate the mechanism of peritoneo-cutaneous radiation, and the peritoneo-muscular reflex. S=Skin. M=Abdominal muscles. P=Parietal peritoneum.

with the cutaneous hyperalgesia along branches of the fifth cranial nerve so often present in toothache. (Fig. 2.) The communication or synapsis rendering this radiation possible probably takes place in the posterior root ganglia of the nerves concerned. On account of its inconstancy, however, the practical value of hyperalgesia in clinical medicine has been greatly overestimated.

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Muscular Rigidity in Acute Appendicitis.

We have, however, in connexion with the localized pain of acute appendicitis an objective phenomenon of prime importance because of its constancy under certain well-defined conditions. This is the deep tenderness on gentle palpation with the flat of the hand over the appendix, associated with reflex and involuntary muscular rigidity. In order to appreciate the extent and degree of this muscular rigidity it is necessary to have the patient lying at ease on his back, with the head well supported on a pillow. Gentle pressure with a warm hand on the unaffected left iliac fossa through a full respiratory cycle gives a standard of comparison. The hand is then transferred to the area of pain in the right iliac fossa, and again exerts gentle pressure through one or more respiratory cycles. The hard, unyielding contraction of the affected area of the flat muscles, the corresponding immobility of the muscle in full expiration, and the marked tenderness on pressure over the contracted muscle can then be readily appreciated and the extent of the rigidity determined. The area of muscular rigidity and tenderness corresponds accurately with the area to which the patient points when asked to indicate the position and extent of his pain.

The Value of Muscular Rigidity and Tenderness in Diagnosis.

By noting the exact position and extent of the muscular rigidity and tenderness in an early case of appendicitis, at a stage when the initial splanchnic pain has given place to the sharper pain in the right iliac fossa, but before perforation and spreading peritonitis have confused the picture, it is possible to predict with the greatest accuracy the position in which the inflamed appendix will be found. When the appendix is curled up on the outer side of the caecum the maximum rigidity is found close to the anterior superior iliac spine; when the appendix is pointing upwards towards the spleen the maximum rigidity is nearer to the umbilicus than the conventional McBurney's point. In the rare undescended caecum the maximum rigidity is higher than usual, and corresponds with a point just below the lower margin of the right lobe of the liver. Where the appendix hangs over the brim of the pelvis the rigidity is in the lower part of the rectus muscle, well below and internal to a line joining the anterior superior spine and the umbilicus. With a prolapsed caecum which has dropped low into the pelvis there may be no rigidity or tenderness on palpating the abdominal wall, but in such a case rectal examination will usually reveal marked tenderness on pressure by the finger from within towards the right side of the rectum. In this early stage the accuracy with which the inflamed appendix can be located is remarkable. One striking instance will suffice.

A woman, aged 50, became ill with pain in the umbilical region and vomiting. When seen fifteen hours after the onset there was no abdominal rigidity or tenderness, but on rectal examination pressure towards the right wall of the pelvis caused intense pain. I diagnosed an inflamed pelvic appendix. For domestic reasons some delay ensued, and I saw her again twelve hours later. She had now typical tenderness and rigidity in the right iliac fossa, while the tenderness per rectum had almost disappeared. I remarked before operating that she must have a very mobile caecum, which had moved up out of the pelvis between my two visits, dragging the appendix with it. Operation disclosed precisely that condition. The caecum was so loosely attached that it could be lifted through the wound six inches above the abdominal wall, and the appendix, which was long and free from effective adhesions, was acutely inflamed and covered with flakes of plastic lymph. The appendix and caecum were found lying in the iliac fossa well above the brim of the true pelvis. From the condition found I have no doubt that the change in position that I had predicted had actually taken place.

The Mechanism of Reflex Muscular Rigidity and Associated Deep Tenderness.

The arguments that I have advanced against Mackenzie's hypothesis of a viscero-sensory reflex apply with an even greater cogency to the theory of a viscero-motor reflex by which he attempted to explain the phenomenon of protective rigidity in appendicitis. The almost invariably unilateral position of the rigidity makes the agency of the splanchnic nerves improbable, because, as I have argued above, the appendix is developmentally not a right-sided but a median organ; and the far greater constancy of muscular rigidity than of cutaneous hyperalgesia in acute appendicitis lends greater strength to this argument. Mackenzie himself appreciated the difficulty, as he admits in his work on *Symptoms and their Interpretation*, where he says (p. 175, fourth edition): "I cannot satisfactorily account for the predominant symptoms from the appendix being so distinctly one-sided, seeing that it is developmentally a portion of the digestive tube." But even if we could accept the tacit assumption underlying Mackenzie's theory that there is a specially intimate connexion through the splanchnic nerves between the appendix and the right side of the spinal cord, how are we to reconcile it with the fact—which I have so many times verified—that the area of muscular rigidity and deep tenderness corresponds exactly with the position of the appendix? If the viscero-motor reflex were a fact, the muscular rigidity produced by it would be constant in position, since it would be determined by the segmental innervation of the appendix, and would be entirely unaffected by the position in which the appendix happened to be lying in relation to the abdominal wall.

I find, then, that the clinical investigation of the distribution of muscular rigidity in appendicitis reveals facts that are entirely inconsistent with Mackenzie's viscero-motor reflex theory. Nor am I aware of any physiological experiments which make it probable that such a reflex exists, nor of any anatomical evidence of a communication in the cord between splanchnic afferents and somatic efferent nerve fibres. The whole theory appears to me to be an unsound extension of Ross's theory of somatic referred pain, based upon a mistaken interpretation of clinical and operative findings. Mackenzie did not appear to appreciate the exquisite sensitiveness of the parietal peritoneum to even slight degrees of inflammation. Had he done so I believe that so acute a mind as his would have perceived that in a peritoneo-muscular reflex lies the explanation of this protective muscular rigidity, and that the splanchnic afferent nerves have nothing to do with the reflex rigidity in appendicitis.

The cumulative effect of correlating pre-operative symptoms with operative findings in acute appendicitis has convinced me that the second or localized pain in the disease is entirely dependent on stimulation of the sensitive parietal peritoneum. (Fig. 2.) In cases such as the first one quoted above, where recurrent attacks of obstructive appendicitis gave rise to the epigastric splanchnic pain alone, the parietal peritoneum was shielded from the appendix by a fairly thick omentum; and as the degree of inflammation was too mild to penetrate through the thick walls of the appendix and the omentum the parietal peritoneum was not affected. This explains the complete absence of localizing pain or rigidity, and the difficulty in diagnosis. An appendix wrapped round by omentum and coils of small intestine as a result of some former attack will, in fat patients, often give rise to no characteristic right-sided pain or rigidity until it has perforated. This absence of rigidity is particularly liable to occur if the caecum and appendix are lying low in the true pelvis. But a degree of inflammation so slight as to cause but a little congestion of the outer serous coat of the appendix and a trifling fibrinous deposit will, provided it lies within reach of the parietal peritoneum, cause the most accurately localized tenderness and rigidity. Should perforation occur the rigidity and tenderness extend *pari passu* with the inflammation of the parietal peritoneum, while from the moment of perforation all the initial splanchnic pain disappears.

The Peritoneo-Muscular Reflex and Peritoneo-Cutaneous Radiation.

Since the parietal peritoneum is supplied by the same cerebro-spinal nerves as the overlying muscles and skin, the accuracy with which an inflammatory stimulus from within the abdomen is localized can be easily understood. It is necessary, however, to insist that a true nervous reflex mechanism through the governing centre in the spinal cord is involved. The tonic contraction of the affected area of muscles, recognized on palpation as a hardness that never relaxes during the whole respiratory cycle, makes it impossible for us to believe that we are pressing on the inflamed parietal peritoneum itself. The pressure required to appreciate the muscular rigidity is too light to have any

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influence of that kind, and even on inspection alone the tonic muscular contraction may readily be appreciated, if we observe the limitation of respiratory movements in the lower rectus muscle.

The peritoneo-cutaneous radiation is best appreciated by a consideration of the shoulder-tip pain resulting from stimulation of the parietal peritoneum lining the under-surface of the diaphragm. In some observations on this shoulder-tip pain[6] I have drawn attention to the fact that whenever the sensory terminations of the phrenic nerve under the diaphragm are stimulated, either mechanically or by inflammatory exudate, a pain is felt over the corresponding shoulder in the area supplied by the third and fourth cervical nerves. This shoulder-tip pain is of special interest as proving a peritoneo-cutaneous reflection or radiation of the painful stimulus. By the descent of the diaphragm in the embryo this area of parietal peritoneum becomes widely separated from its corresponding skin area, and thus an embryological event, dependent on the development of the lungs, enables us to observe the working of the pain-producing mechanism. While I have proved the invariability of shoulder-tip pain where the diaphragm is stimulated, I have not found the same constancy of cutaneous hyperalgesia as tested by light pinching over the acromion process. In some cases the patients describe the pain as akin to rheumatism in the shoulder, and deny any tenderness on light pinching or deep pressure. In some instances tenderness is felt, but only on deep pressure on to the acromion process, while in others definite hyperalgesia is felt on light pinching.

It cannot be doubted that a similar radiation or spreading of painful stimuli from the parietal peritoneum to the skin overlying it via the spinal cord occurs in the anterior abdominal wall, though the proximity of skin to peritoneum has prevented its recognition. When the under-surface of the diaphragm in a patient under spinal anaesthesia is stimulated by the insertion of a gauze swab between the liver and the diaphragm, the patient complains of pain in the shoulder-tip area, but feels no pain locally. So, when the parietal peritoneum is stimulated I believe that the pain is felt in the skin and subcutaneous tissue alone. The exact position in the nervous system of the synapses necessary to produce this radiation is uncertain. The teaching of Mackenzie and Ross would lead us to expect to find it in the grey matter of the posterior horn of the cord, but there would appear to be a greater probability that it lies in the posterior root ganglia. (Fig. 2.)

If I have succeeded in proving my contention that the muscular rigidity in acute appendicitis is a reflex result of peritoneal stimulation alone, the diagnosis of acute appendicitis becomes a far simpler clinical problem. Mackenzie himself, obsessed by his theory of a viscero-motor reflex, taught that it was impossible to separate the symptoms produced by the inflamed appendix from those produced by the inflamed parietal peritoneum. From my experience in teaching students I am sure that the wide-spread acceptance of Mackenzie's doctrine has introduced an unnecessary difficulty into the diagnosis of abdominal lesions. The student, picturing muscular rigidity as a reflex from the inflamed organ through the splanchnic afferent nerves, and conscious that peritonitis produces a similar effect, finds a hopeless impossibility in the task of distinguishing between the two processes, and is apt to regard abdominal diagnosis as very largely guesswork. But if he can be taught that true reflex involuntary rigidity is the result of stimulation of the parietal peritoneum, and of that alone, and that the only true pain felt in the gastro-intestinal tract is a splanchnic pain due to increased tension and exaggerated peristalsis, the investigation of a case of acute abdominal disease becomes relatively straightforward.

A Biological Consideration of Abdominal Pain.

I will finally sketch in briefest outline what I conceive to be the biological or evolutionary aspect of abdominal pain. With the development of the alimentary tract and the peritoneal cavity a great responsibility for the protection of the abdominal viscera was laid upon the parietal peritoneum. To guard against bacterial invasion of the peritoneal cavity from without by penetrating wounds, or from within by perforation of a hollow viscus, the parietal peritoneum was endowed with nerves of exquisite sensitiveness to mechanical or chemical insult. Stimulation of this layer produced reflex guarding of the overlying muscles, with pain felt in the skin and on the surface of those muscles. At the same time another reflex—not dealt with in this paper, but also originating in the parietal peritoneum, the splanchnic inhibitory reflex—was provided to secure rest to the intestinal tract and so to avoid the diffusion of septic material by peristalsis.

Against the danger of intestinal obstruction another mechanism had to be elaborated. Violent peristaltic efforts of myogenic origin attempted to overcome the obstructing force, and their occurrence was registered by painful afferent stimuli through the splanchnic nerves, appreciated by the brain as spasmodic in character, and vaguely localized in the centre of the abdomen. This splanchnic pain would seem to be the more primitive in order of evolution. It is akin to protopathic pain in its dull character and in the absence of precise localisation. Moreover, a considerable stimulus is needed before consciousness of pain is produced.

Summary.

1. The evolution of our knowledge of the mechanism of abdominal pain is summarized.
2. The initial central pain in acute appendicitis is a true splanchnic pain, due to increased intra-appendicular tension.
3. The localized right-sided pain is due to irritation of the parietal peritoneum.
4. Cutaneous hyperalgesia is too variable in its incidence to be of value in the diagnosis of acute appendicitis.
5. The mode of production of cutaneous hyperalgesia is discussed. Mackenzie's viscero-sensory reflex theory is criticized.
6. The mechanism of reflex muscular rigidity and the associated deep tenderness is discussed. Mackenzie's viscero-motor reflex theory is criticized, and the role of the parietal peritoneum emphasized, protective muscular rigidity being ascribed to a peritoneo-muscular reflex.

I am indebted to Professor J. S. B. Stopford, M.D., F.R.S., for his kindness in drawing the diagrams illustrating this paper.

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AN OPERATION FOR THE CURE OF PROLAPSE OF THE RECTUM IN THE FEMALE*

BY

FREDERICK J. McCANN, M.D., F.R.C.S.

THE aim of the operation herein described is to restore the muscular retentive mechanism which prevents the bowel prolapsing after each act of defaecation.

In July, 1913, a single woman, aged 51, came to see me; she had undergone an operation for rectal prolapse four years previously, the prolapsed portion of the bowel being excised. The operation was, unfortunately, a failure. The bowel still prolapsed for nearly two inches and the anal orifice surrounded by scar tissue admitted three fingers. She had complete incontinence of faeces, and was unable to earn her living as a nurse. Her condition was deplorable, and her nervous system had suffered considerably in consequence. She was reluctant to undergo another operation, but ultimately yielded to persuasion.

The bowel was returned and the patient was placed in the elevated lithotomy position; an incision was then made around the anal orifice anteriorly and laterally for three-fourths of its circumference. The perineum was incised in the middle line from the fourchette to the anal orifice; this incision was further prolonged anteriorly into the labium of each side for about an inch and a half. The lower end of the rectum was freed by dissection anteriorly and laterally, exposing the levator ani on either side, whilst the lower portion of the posterior vaginal wall was dissected upwards for about two inches. A V-shaped piece was then cut out

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of the anterior rectal wall and the anterior margin of the anal orifice. The cut edges were united by catgut sutures, after tying the bleeding vessels. The scar tissue surrounding the anus was dissected out, and the anal orifice reconstructed to the requisite size by a series of catgut sutures passed so as to take a grip of the sphincter ani and to avoid the mucosa of the bowel. A V-shaped piece was next removed from the posterior vaginal wall, followed by the suture of the levatores ani muscles in front of the lower end of the rectum. The cut edges of the posterior vaginal wall were then sutured together by catgut sutures, which were passed through the united levatores ani muscles, and when tied brought the latter in close apposition with the posterior vaginal wall. Silkworm-gut sutures were passed through the perineal tissues to coapt the divided perineal body, and further to coapt the already sutured levatores ani muscles. The skin edges were finally united with catgut, whilst a special silkworm-gut suture was inserted to prevent the anal orifice falling backwards.

The patient made a smooth recovery and regained complete control of her anal sphincter. She has, moreover, remained well up to the present date, and has expressed herself as being completely cured. She has been enabled to discharge her duties as a nurse and to lead a life of unusual activity. The result of this operation satisfies the time test, for the patient has remained perfectly well up to the present date—that is, for thirteen years.

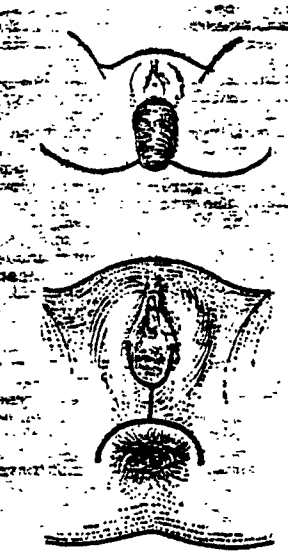


FIG. 1.—The smaller diagram shows the prolapse of the rectum. The larger diagram shows the line of the incision after the prolapse has been returned.

On thinking over this operation I concluded that it was unnecessary to excise a portion of the rectal wall and anal margin (as that procedure only led to scar formation) instead of building up and strengthening the anal sphincter, which could be done much better without removing any portion of the bowel; and although the functional result had been so good, yet I believed that avoiding a scar would be even better. I was able to put my ideas into practice when this patient brought her sister to me in October, 1924, and the operation I performed on her appears to be suitable for the majority of cases. This woman was 65 years of age, the mother of three children, and had her last confinement twenty-nine years previously. She had had slight rectal prolapse and loss of control ever since her last child was born. When she presented herself for examination the rectum protruded for four inches, and she informed me that the amount of rectal prolapse had been gradually increasing. There was no evidence of ulceration.

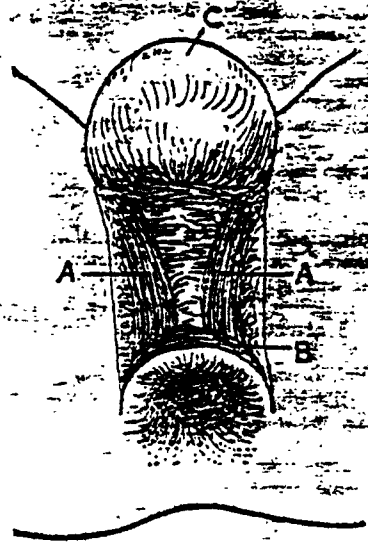


FIG. 2.—Levatores ani exposed together with the sphincter ani. The vaginal flap has been reflected upwards. A, Levator ani. B, Sphincter ani. C, Vaginal flap.

It is essential that such patients should have a preliminary period of rest in bed, not only for purposes of local cleansing, but because congestion is diminished in those who have struggled to be about. The prolapsed bowel should be returned, and if possible retained, which still further diminishes local congestion.

During the operation the elevated lithotomy position is employed in order to diminish the tendency to protrusion of the rectum. An incision is made around the dilated anal orifice anteriorly and laterally for three-quarters of its circumference. A mesial incision is then made from the anal orifice to the fourchette, which, when deepened, splits the perineal body (Fig. 1). This incision is prolonged at its anterior extremity outwards and forwards into each labium. The anal sphincter and the lower end of the rectum are exposed by dissecting away the superjacent tissues, and the posterior vaginal wall is dissected upwards for about two inches (Fig. 2). Catgut sutures are now introduced grasping the sphincter ani, being passed on one side from within outwards under the sphincter muscle and avoiding the mucosa, and in the reverse order on the opposite side, and are then tied. A sufficient number of these sutures are introduced to restore the anal orifice to the normal size, and when a good grip of the sphincter muscle is taken by the sutures this muscle is strengthened and tightened, and a normal anal aperture is constructed. Sutures of catgut are further used to tighten the stretched or torn fascia over the lower end of the rectum and to reinforce any weak spots.

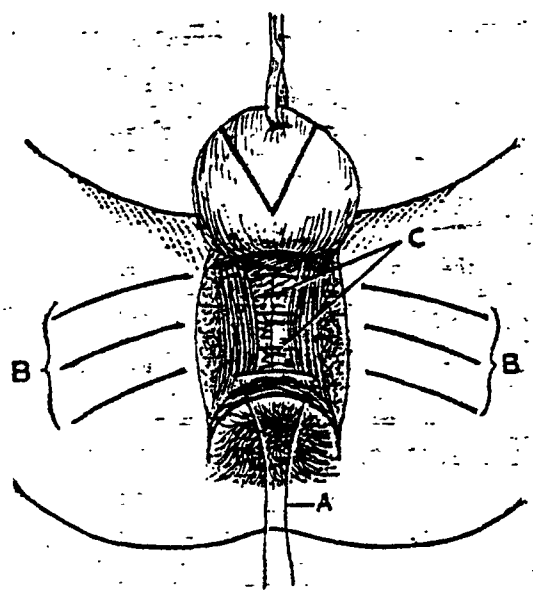


FIG. 3.—Sutures in position, V-shaped piece excised from vaginal flap. A, First of a series of catgut sutures to reconstruct anal orifice. B, Silkworm-gut sutures passed deeply through the levator ani and skin on each side. C, Fascial sutures of catgut. The levatores ani are further united with catgut.

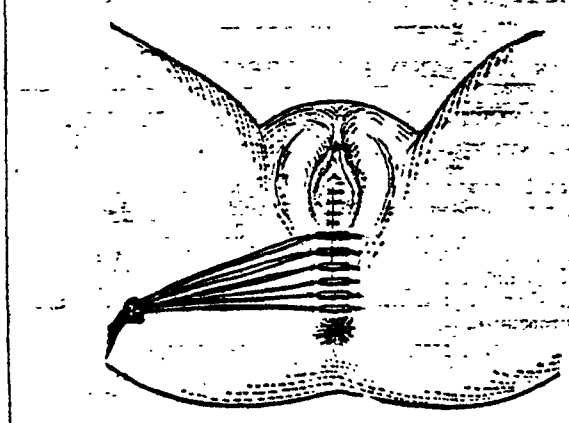


FIG. 4.—Operation completed. Silkworm-gut sutures tied through small pieces of india-rubber tubing.

A sufficient number of silkworm-gut sutures are next inserted; these pass inwards through the skin and levator ani muscle on one side and outwards through muscle and skin on the opposite side. The levatores ani muscles are then united by catgut sutures. A V-shaped piece is excised from the posterior vaginal wall, and the edges united by catgut sutures, which, when passed, also take a grip of

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the levatores ani muscles, in order to bring these muscles and the posterior vaginal wall into close apposition (Fig. 3). The skin edges are next united with interrupted catgut sutures and the silkworm-gut sutures tied through small pieces of india-rubber tubing, thus completing the operation (Fig. 4). The last or most posterior silkworm-gut suture is passed so as to prevent the anal orifice falling backwards, which is not infrequent after operations for complete rupture of the perineum. Catgut may also be employed for this suture.

A "sacral anus" is a complication which should not be encountered where the necessary precautions have been taken during the operation to restore the anal canal. After this operation I believe it is best to refrain from administering purgatives at least for some days in order that healing may remain undisturbed. Should the patient be uncomfortable in consequence of the bowel not acting, warm olive oil should be run into the rectum through a small india-rubber tube, and a dose of castor oil given by the mouth. The bowels should afterwards be kept acting by a gentle laxative.

The result of the operation described was completely satisfactory, the wounds healed well, and there was complete sphincteric control. The patient has been enabled to be about and lead an active life, whereas formerly she was more or less of an invalid, spending most of her time either in bed or on a couch, and being forced to give up her business in consequence of her physical suffering.

When writing this paper I received unexpectedly a letter from this patient, in which she states:

"I am writing to tell you the operation has proved a perfect success. It was some time before the bowels acted naturally, but now I am like another woman. I was a long time making up my mind to the operation, but I am glad I did, and I am very grateful to you for your care and skill. I only wish other sufferers knew the benefit."

Although this type of operation remedies the anatomical defects which seem to accompany this variety of prolapse, yet congenital predisposition is an etiological factor which cannot be overlooked, for these two women were sisters, and I am informed that another sister and two cousins suffer from rectal prolapse. Exercises to cause contraction of the levatores ani muscles and sphincter ani should be practised after this operation, and such exercises are still more necessary in the presence of congenital muscular weakness. Finally, this operation offers a prospect of cure, not merely to the surgical derelicts cast adrift because of the failure of other methods, but to those who bear their suffering not knowing that anything can be done for their relief, as well as to those who from knowledge of failures have lost faith in modern surgery.

SPIRIT AND BIPP TREATMENT.

BY

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BARRY.

Professor Rutherford Morison's bipp treatment is not, I think, always clearly understood, and if employed haphazardly and without attention to detail may be disappointing. The following case, which recalls that of Dr. Monica Bell and Professor Morison (December 10th, 1927, p. 1077), shows a remarkable result obtained by the use of this procedure.

On December 7th, 1927, a feeble old lady of 77 was knocked down by a motor lorry and sustained a severe compound comminuted fracture of the lower end of the right tibia and fibula, involving the ankle-joint. She was brought into the Barry Surgical Hospital suffering from shock and haemorrhage. Although a rough tourniquet had been tied round the leg the wound was still bleeding, and there was evidence from the saturation of her clothes that the haemorrhage had been profuse. A large dose of morphine and atropine was administered, and a more efficient tourniquet applied. At the end of about one hour she was sufficiently recovered from the initial shock to justify operation.

Under gas and oxygen the wound was freely opened up and the bleeding points secured. The bone was found to be badly comminuted, and many completely detached loose pieces were removed; other fragments showing a reasonable attachment to the periosteum were left. Attention was now directed to the rest of the wound. The skin edges were excised, and badly lacerated portions of muscle and fascia were removed. Fortunately it was possible to save the anterior tibial nerve; this had been completely stripped by the violence of the injury, but remained in continuity. The wound was now freely swabbed out with methylated spirit, after which it was carefully dried, one or two additional bleeding points being secured at the same time. (There is always a fair amount of bleeding after the application of spirit.) The wound was temporarily packed with dry gauze during the changing of the gloves and towels. On resuming, a small quantity of bipp was introduced into the cavity, and thoroughly rubbed into every available nook and cranny. Lengths of thick linen thread were carefully bipped, and by their means the skin edges were roughly approximated; owing to the loss of tissue accurate apposition without tension was not possible or desirable. The dressing consisted of long pads of gauze freely soaked in spirit, each pad being liberally sprinkled with boric powder. The pads were laid along the wound and did not encircle the limb. A top dressing of wool was temporarily held in position by a bandage.

The plasters were applied as follows. The first plaster extended from above the wound to above the knee—the knee being slightly flexed during the application. The plaster was reinforced with thin laths of wood. The second plaster encircled the foot below the wound. Traction was now made on the foot by means of a weight and pulley, and when alignment of the foot was perfect the intervening space was rapidly filled in with the third plaster. Before the plasters were firmly set a large window was cut out over the wound, and the whole case was divided longitudinally from top to bottom. This division was continued through the wool and bandages until the skin was exposed. This step was an important one in view of the possibility of subsequent swelling, and the very real danger of gangrene in a patient of this age.

The patient stood the operation well, and returned to bed in a fair condition. Before leaving the theatre 500 units of anti-tetanic serum were injected. I would now also employ anti-gas gangrene serum, but I did not have a stock in readiness at the time.

Prognosis.—The prognosis given to the relations was a bad one. Apart from the immediate dangers of shock and haemorrhage, there remained the possibility of gangrene, and later of severe sepsis with osteomyelitis. At best only healing by granulation could be hoped for, and a very poor functional result.

Progress.—The old lady remained very feeble and debilitated, but no special pain was felt in the foot, and the temperature caused no alarm. There was some trouble with the bladder and bowels. On the seventh day—more from curiosity than necessity—I removed the dressing. The wound was quite dry. The skin was healthy right up to the cut edges, between which lay a hard dry mass of congealed blood. I took out the stitches and dressed the wound with spirit gauze and powder. A week later a similar dressing was applied. From start to finish not a bead of pus or even serous oozing occurred. At the end of a month the splint was removed daily for massage, and a fortnight later discarded altogether. At the present time she can bend her knee to a right angle, and can voluntarily move the foot through 30 degrees. The wound is healed and the fracture firmly united.

Comments.

The technique used in this case was almost identical with that instituted by Professor Morison at the Northumberland War Hospital. Points to notice are:

1. The full excision of the wound.
2. The liberal use of spirit.
3. The small quantity of bipp required. This must be well rubbed into the exposed surfaces and no excess left.
4. The use of bipped sutures; this prevents infection of the needle holes and the spread of sepsis from the skin to the deeper structures.
5. The dressing with spirit and boric powder.
6. The absence of any encircling bands round the limb.
7. The infrequent dressing of the wound.

The last requires courage, but is most essential if secondary infections are to be avoided.

AN ATYPICAL CASE OF HYPERGLYCAEMIA IN GENERAL ANAESTHESIA.*

BY

R. L. MACKAY, *M.C.*, B.Sc., M.D.Glas.

(From the Wolverhampton and Staffordshire General Hospital.)

The unusual extent of the increase in the blood sugar during general anaesthesia in the following case, combined with the absence of glycosuria or of any untoward symptoms, make it worthy of record.

A woman, aged 50 years, was the subject of a major operation on account of gastric ulcer, hour-glass stomach, and chronic appendicitis. She was prepared for operation in the normal manner, having no food on the morning of operation, and receiving 1/4 grain morphine and 1/100 grain atropine about an hour previous to the administration of the anaesthetic.

* This case is one of a series in a research towards the expenses of which a grant has been made by the British Medical Association.

F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
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Urinary tests before operation showed no abnormality as regards the presence of albumin or of sugar. Induction of anaesthesia was by chloroform-ether mixture, and then ether was employed to maintain the anaesthesia. Blood samples were taken from the finger before, and at intervals during and after, operation, and the blood sugar content estimated by MacLean's method. At the end of operation, which consisted of partial gastrectomy, gastro-enterostomy, and removal of the appendix, since shock was present, she received a rectal saline injection, containing 5 per cent. glucose. The first two urines passed by the patient after the anaesthetic were collected and tested for glucose by the fermentation test and by Fehling's test (Bertrand's modification). The result with each test was negative. Albumin, acetone, and diacetic acid were similarly found to be absent. The patient made an excellent recovery from the operation, and was discharged later from hospital in a reasonable state of health.

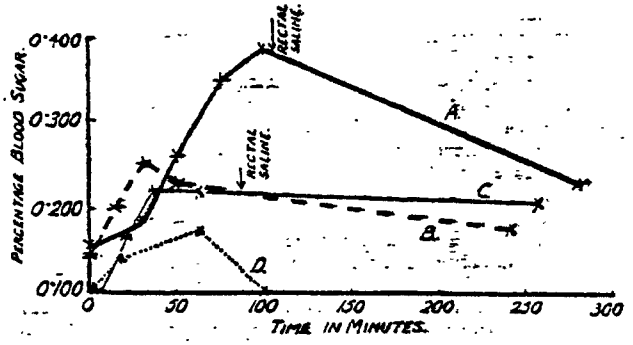
The time record for this case is as follows:

Time in minutes.			
0	...	...	First blood sample taken—0.150 per cent. Induction of anaesthesia begun with CE mixture.
10	...	...	Change over to closed ether.
30	...	...	Second blood sample—0.181 per cent.
50	...	...	Third blood sample—0.260 "
75	...	...	Fourth blood sample—0.350 "
85	...	...	Anaesthetic stopped.
100	...	...	Fifth blood sample—0.386 per cent.
105	...	...	Rectal saline with 5 per cent. glucose.
280	...	...	Sixth blood sample—0.229 per cent.

Commentary.

This case, which forms one of a series in an investigation into the blood sugar changes in general anaesthesia, is interesting for the following reasons.

First, it is an example of the fact that general anaesthesia, whether by chloroform, ether, or CE mixture, is accompanied in practically every case by an increase in the concentration of the sugar in the blood, manifest within a very few minutes of induction, and continuing, within limits, throughout the period of anaesthesia.



A. Blood sugar curve of case as here described. Anaesthesia lasted for eighty-five minutes. Sugar absent from urine, both before and after anaesthesia. This curve, which is unusually high, may be compared with the two following curves, which are more typical of those found in the longer anaesthesias.

B. Blood sugar curve in a case of gastro-enterostomy, on a man aged 60, for malignant stenosis of the pylorus. Anaesthesia lasted for fifty-five minutes, and a rectal saline was given as in Case A. Urine did not ferment with yeast after operation.

C. Blood sugar curve in a case of hydatid disease of the liver in a man aged 38. Anaesthesia lasted for seventy minutes, and there was no glycosuria before or after operation.

For purposes of comparison there has been superimposed upon the above curves and on the same scale that of curve D, which shows the course of the blood sugar after a 50 grams glucose meal, as carried out by MacLean (1925).

Secondly, this case demonstrates that the extent of the increase may be far above that caused by the giving of a 50 grams glucose test meal, as carried out by MacLean. This is well seen by comparison with MacLean's curve (curve "D" on the accompanying figure) and the curves of two other cases (curves "B" and "C"), in which anaesthesia lasted for about an hour. These latter curves are quite typical of the usual anaesthetic hyperglycaemia, and differ only from the case here described in the degree of hyperglycaemia recorded.

Thirdly, in this case the unusual amount of hyperglycaemia to 0.386 per cent. would lead one to expect some subsequent degree of glycosuria, if the doctrine of a renal threshold for sugar of about 0.180 per cent. is to be accepted in its entirety. But such glycosuria was proved absent in this case by the two chief tests for sugar. Likewise, in the two other cases the curves of which are shown here, although the renal threshold was exceeded for some considerable time there was no subsequent glycosuria. As urinary secretion is not usually suppressed in anaesthesia, curves such as these lead one to doubt the validity of the renal threshold value, or to postulate for the anaesthetized state the existence of some other factor as yet unexplained.

Summary.

A case of anaesthetic hyperglycaemia of great extent, and unaccompanied by glycosuria, is described.

I wish to thank Mr. Deansley, F.R.C.S., honorary surgeon to the Wolverhampton and Staffordshire General Hospital, for permission to record the details of this case.

MacLean (1925): *Diagnosis and Treatment of Glycosuria and Diabetes.* Baltimore.

RUPTURE OF UTERUS EARLY IN THE FIRST STAGE OF LABOUR.

BY

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THE following case is reported because it is of interest from several points of view. In the first place, rupture of the uterus apparently occurred early in the first stage of labour before rupture of the membranes, and without any of the usual causes, such as malpresentation or disproportion between the size of the child and the mother's pelvis. Secondly, the patient had had two normal labours previously; all were of short duration and free from complications. Lastly, she survived the rupture, though hysterectomy was not performed until twenty-four hours had elapsed from the presumed time of its occurrence.

The patient, a European woman, aged 36, was admitted to hospital at 12.30 a.m. on October 6th, 1927, for labour at full term accompanied by severe abdominal pain. She stated that two days previously she had not been feeling well, so took castor oil, which resulted in four motions, and at 6 p.m. slight labour pains commenced. At midnight the pains were more definite, but were not severe enough to require medical aid of any sort. At 2 a.m. on October 5th, after two or three sharp pains, she suddenly felt an acute pain of a different sort; after this the child seemed to alter its position to the upper part of the abdomen, and within two or three hours its movements ceased. At the same time bleeding began from the vagina, and pain was felt on taking each breath. A doctor was called in the morning, and after an injection she slept; the bleeding became less, but on waking she felt no better. She vomited several times during the day, and from 3 p.m. the vomit was dark brown. The bowels did not act that day. As her condition was becoming so much worse she was brought to hospital at midnight.

The past history was that she had had two children, the last one two and a half years previously. All the labours were quite normal and quick. She had never needed instruments. The last menstruation had occurred in February, 1927.

She was of medium height and nutrition, and was evidently in great pain on admission, especially in the upper part of the abdomen, which caused her to cry out all the time. The pulse rate was 110, and the tension was fairly good. The temperature was 100.4° F. and the respirations 30. The abdomen was markedly distended, especially above the umbilicus, where the outline of the dilated stomach was clearly seen; there was great tenderness all over it. The child was lying transversely across the middle of the abdomen, and was felt just under the abdominal wall; it could be moved about easily, but much pain was caused. No foetal heart sounds were heard. There was a small quantity of bright blood coming from the vagina.

The patient was so restless that a little chloroform was given for satisfactory vaginal examination. The cervix was found dilated, and the placenta lying above it was almost completely detached. The otherwise empty uterus lay on the right. On the left the membranes led out through a large tear in the lower part of the uterus and cervix, and the child could be felt lying in the unruptured bag of membranes among the intestines. Fresh bleeding was caused by the examination. A catheter was passed, and two ounces of slightly blood-stained urine were drawn off.

It was decided to open the abdomen, and the patient was prepared at once. By that time her pulse had risen to 132 and was decidedly weaker. She had vomited coffee-ground material once. Saline injections were commenced, and a 6-inch incision was made in the middle line, two-thirds being below and one-third above the umbilicus. The child, a full-term female of normal size, was

F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
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found lying free among the intestines in its bag of membranes, with the placenta still partly attached to the lower half of the uterus. There was a large rent extending from the middle of the vagina on the left side up through the cervix to about the junction of the middle and lower third of the body of the uterus; the left broad ligament had been split from far out on the lateral pelvic wall to close up against the bladder. There were only a few small clots in the abdominal cavity.

After removing the child with the placenta and membranes intact subtotal hysterectomy was performed, leaving the appendages, since they were healthy. The tear in the cervix and vagina was closed with a continuous catgut suture, and the stump of the cervix was sewn over in the same way. The abdominal wall was closed in four layers without drainage. The patient stood the operation fairly well. On her return to bed the stomach was washed out, as it had been found very distended. Within an hour after the completion of the operation, however, her condition became grave. She was restless, and her pulse had risen to 160, but by 8 a.m. she was improving, and by midday was decidedly better. By 2 p.m. the pulse rate had dropped to 130. The temperature was 98.8° F. and the respirations 30.

After this the patient made steady progress. There was a slight degree of fever for the first six days, up to 100°, and once to 100.5° F.; then the temperature became normal for three days, rose slightly on the two following days, and after that returned to normal. Her pulse was 100 to 120 for the first few days.

At the end of the first week slight thickening was felt in the upper part of the broad ligaments on either side, but there was very little tenderness. The patient took her food well from the first. The wound healed by first intention, and she was discharged well on October 29th.

The patient was seen a month later, and, except for moderate anaemia, was doing well. On vaginal examination the pelvic contents appeared quite normal, and there was no sign of cellulitis. The cervix was patulous on the left side on the site of the old tear.

The specimen was sent to the gynaecological museum of the Calcutta Medical College Hospital.

THE PROMOTION OF CALCIUM RETENTION.

BY

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THE success of calcium therapy is so dependent upon the degree of retention it achieves that satisfactory results can only be expected when the principles underlying calcium retention receive at least as much attention as its administration. Even in the discussions on the therapeutic uses of calcium salts at the Annual Meeting of the British Medical Association last July, this close connexion does not appear to have been sufficiently emphasized.

Unless the principles of calcium retention are given the consideration their importance deserves, failures and incorrect conclusions as to the value of calcium therapy are the inevitable results. In some cases there would be no retention of calcium, but, on the contrary, an increased loss, since it favours acidosis. When the dose of calcium chloride is as heavy as 10 grams a day—and as much has been given by one physician—it is not surprising that the results are so entirely disappointing as to bring calcium therapy into disrepute.

Acidosis is readily recognizable by the increased acidity of the urine, and the higher the degree of acidity the more lime the urine has withdrawn from the blood, as was shown by Schetelig in 1880 and confirmed more recently; the weaker also must have been the alkaline reaction of the blood from which the urine was excreted. It is therefore a logical inference that the losses of calcium are smaller (or the calcium *retention* is greater) when the degree of blood alkalinity is high. This degree corresponds under normal conditions with 0.3 per cent. of sodium carbonate (or bicarbonate in the venous blood). In other words, as the blood alkalinity decreases the calcium loss in the urine rises above the normal, which is 0.2 gram in twenty-four hours.

This leads to consideration of the question as to how the blood alkalinity is created and maintained in man and herbivorous animals. Carnivorous animals obtain their sodium carbonate from the intaraction of ammonium carbonate and sodium chloride; in man and omnivorous animals this occurs completely only under such conditions as prolonged hunger. The most common factor in alkalinization in man and the herbivora is the oxidation of the alkaline salts of organic acids; potassium and sodium salts, especially of citric and malic acids, are contained in leaves, roots, tubers, and fleshy fruits. The potassium citrate and malate in such vegetables are converted into sodium salts by the sodium chloride contained in the meals. These salts, however, are lacking in meat and all kinds of seeds, which indicates the importance of a well-balanced diet. It is a very important and significant fact that milk contains sodium citrate; otherwise a baby would suffer from acidosis from the first day of its life.

Proteins, however, which form such an important part of present-day diet, favour a state of acidosis. Their sulphur contents appear in the urine as sulphuric acid and ester-sulphuric acid, and their phosphorus contents as acid phosphates. Therefore the physiological laws of a correct diet are observed by the usual practice of supplementing a dish of meat with potatoes, or cabbage and fleshy fruits. When, however, the meals consist of an excess of meat, beans, and bread, without any green vegetables or fruits, there would be no calcium retention, and ailments, such as gout, might gradually arise. It would definitely be a mistake to employ calcium chloride in such a case.

With animals, such as cattle and horses, which feed chiefly on hay, the use of calcium chloride produces excellent results by favouring growth, fecundity, and health. The normal dose of calcium chloride has been inferred from physiological laws, and fixed at 0.04 gram of the crystallized salt to 1 kilo of body weight, or 0.02 gram of the anhydrous salt. Hay contains alkaline salts of citric, malic, and other organic acids, which provide for calcium retention and counteract the acidosis produced by calcium chloride.[1] Therefore, when due consideration is given to the usual diet of man, calcium lactate is preferable to calcium chloride, since it does not favour acidosis, and far superior still to calcium lactate is the double salt of calcium and sodium lactate (Wulfing), since it favours calcium retention by being oxidized into carbonate. Many physicians have used it with most excellent results.

Is the calcium content of the blood a reliable index?

There is still considerable adherence to the view that a deficiency of lime in the system can be recognized by determining the amount of calcium in the blood. It has, however, been proved by various workers that this is decidedly unreliable, and Stewart[2] was right in calling that index unsatisfactory. Indeed, it has been commonly observed that, in various diseases which readily respond to calcium therapy, the blood-calcium was normal, or higher than normal, and not lower, as one would expect. In other cases, again, the calcium index of the blood was below the normal. In short, the evaluation of the calcium content of the blood is not a sure guide for the application of calcium therapy. Such an examination of the blood calcium is, moreover, unnecessary, even if there is a developing disease which cannot be definitely diagnosed, since calcium can do no harm in any case, and frequently acts as a prophylactic.

The fact that a lack of lime in certain organs is sometimes coincident with a rise of blood calcium is accounted for when we remember that the calcium stored in the bones can be utilized to fill up deficiencies in other and more vital parts of the body. Since this transfer of calcium takes place through the blood, an increase of blood calcium may be observed in spite of a deficiency of calcium in certain other organs. Sometimes when there is not enough calcium in the food bone calcium will supply the material needed for calcification of tuberculous foci in the lungs, or it may serve to calcify weak arteries and thus increase their power of resistance against a rise of blood pressure. Even the teeth may be called upon to give up part of their calcium in certain cases; hence the suggestion by many women that the birth of each child costs the mother a tooth.

How unreliable an index is the evaluation of the blood calcium has recently been again demonstrated in cases of urticaria undergoing hospital treatment. Because the

blood calcium was found to be normal it was doubted whether calcium therapy would be of any use, and this in spite of the work of Wright and Bettman and the observations of numerous other authorities. Herzfeld and Lubowski[2] observed hypercalcaemia in 100 patients who suffered from neuralgia, chorea, tabes dorsalis, and chronic enteritis, yet calcium therapy has furnished splendid results in cases of neuralgia. Vergliano, Looft,[4] and Tschiember[5] have observed hypercalcaemia in a series of cases of tuberculosis; Loeper and Bechamp[6] in cases of nephritis, asthma, and pneumonia; Longo[7] in rickets, and Blum[8] in a case of osteomalacia. In all these cases, however, calcium therapy would have produced entirely satisfactory results, in spite of the contrary inference from the state of hypercalcaemia.

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[1] Cf. Oscar Loew: *Der Kalkbedarf von Mensch und Tier*, fourth edition, O. Gmelin, Munich. [2] *British Medical Journal*, October 29th, 1927, Report of Discussion on Therapeutic Uses of Calcium Salts, p. 737 et seq. [3] *Deut. med. Woch.*, 1923, p. 603. [4] *C. R. Soc. de Biologie*, 1924. [5] Ibid. [6] Ibid., vol. 89. [7] *Il Policlinico*, 1910, p. 498. [8] *Presse Médicale*, 1922, p. 225.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

PNEUMOCOCCAL PERITONITIS DURING THE PUERPERIUM: RECOVERY.

THE rarity of the occurrence of pneumococcal infections of the peritoneum would seem to justify publication of a case, especially since recovery ensued.

A woman, aged 24, was delivered of her first child on May 16th, 1927. The labour was conducted by Dr. C. Fraser, who simply eased the head over the perineum with forceps, under light chloroform anaesthesia. The labour was otherwise normal, and the placenta was expelled half an hour after delivery.

On May 23rd, seven days after delivery, the temperature rose to 103.2° F., and the pulse rate was 140. On the following day I was called to see her by Dr. Fraser, and gently brushed over the interior of the uterus with a gauze swab on a holder, but found no retained chorion; the uterus had scarcely involuted at all. I injected an ounce of sterile glycerin through a catheter into the uterine cavity, after the manner of Remington Hobbs. The patient was also given 5 grains of quinine bihydrochloride intramuscularly, and 60 c.cm. of polyvalent antistreptococcal serum, since the case looked like a streptococcal infection; but the report by Dr. H. M. Galt on the swab which I took from the cervix was that the film showed Gram-positive diplococci, while from culture were recovered diphtheroids, *Staphylococcus albus*, and a few coliform bacilli.

On May 25th the temperature had fallen to 99.4° F. and the pulse rate to 100, the patient being very comfortable. I contented myself by giving a further 5 grains of quinine and injecting another ounce of glycerin into the uterine cavity. On May 26th in the morning the temperature again rose to 103° F., and the patient complained of severe pains in the lower abdomen. Towards evening the abdomen had become rigid; vomiting had set in, and the pulse was uncountable.

It was obvious that the patient had general peritonitis, and the case looked hopeless. She was given an anaesthetic, and I opened the abdomen, and found the coils of intestine, as also the uterus, tubes, and ovaries, coated with a greenish covering of fibrinous exudate. I let out about two pints of turbid fluid. Three drainage tubes were inserted through the laparotomy wound, one to the right, another to the left, and a third down into the pelvis.

On May 27th her condition was better, although she vomited from time to time. Her pulse rate was 130 and her temperature 101° F. She was pouring out copious fluid through the drainage tubes. Dr. Galt's report of the turbid fluid taken from the abdomen was that the film showed large numbers of pneumococci, while on a trypsgar medium an abundant and pure growth of pneumococci was obtained. On receipt of this report the patient was given 10 c.cm. of Pané's antipneumococcal serum.

On May 28th her condition had further improved; she ceased vomiting, her bowels acted, and she began to take nourishment. She was given another 10 c.cm. of Pané's antipneumococcal serum. On May 29th a further dose of the serum was injected; pus was coming freely through the drainage tubes.

From this point her recovery was uninterrupted, although her temperature did not become normal until the end of June. An abscess in the right forearm, which also proved to be pneumococcal, was opened on June 16th. She is now in good health.

I have ventured to report this case since pneumococcal peritonitis during the puerperium is rare. In making a search through the literature I have so far found only one case, although there must have been others, no doubt, where a bacteriological examination was not made. This case is reported by Professor C. Monckeberg[1] of Santiago du Chili. His case was fatal, and differs from mine in that pneumococci were found in the swab taken from the cervix; pneumococci were also found in the mouth of the "sage-femme" who attended the woman in her labour, which may or may not have been the cause of infection. No laparotomy was performed in this case, but the necropsy revealed purulent endometritis, pneumonia, and peritonitis. The pneumococcus was found abundantly in the ascitic fluid, as in my case.

[1] *Gynécologie et Obstétrique*, Tome vi, 1922, No. 1.

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HAEMORRHAGE FROM THE DEEP EPIGASTRIC ARTERY INTO THE RECTUS ABDOMINIS.

THE following case is of special interest in view of the diagnostic difficulty experienced.

A man, aged 55, was admitted to the Kettering General Hospital with a provisional diagnosis of acute intestinal obstruction. He had continued his work until the morning of the day of his admission to hospital, when he had a sudden attack of pain in the umbilical region; the pain was definitely localized, increasing in severity with each respiration. On palpating the abdomen the left rectus was found to be markedly rigid, and there was also a certain amount of general abdominal rigidity; a definite painful area on pressure was present about the middle of the left rectus. The bowels had acted in the morning before the onset of pain; the abdomen was not distended, and the flanks were resonant. There were repeated attacks of feeling sick, but he was unable to bring anything up. The tongue was furred and the breath foul. The temperature was 98° F., and the pulse 108 (8 p.m.). An enema was given with good results. Operation was postponed, and the patient was kept under close observation. At 2 o'clock the next morning the temperature was 100.4° F., and the pulse 78; pain and rigidity still persisted. At 10 a.m. the temperature was 99° F., and the pulse 80. As the pain and tenderness persisted it was decided to operate. The abdomen was opened in the middle line above the umbilicus, and the middle third of the left rectus was found to be the seat of haemorrhagic effusion with apparently no other pathological lesion. The patient became worse under the anaesthetic, and, although the operation was short, stimulants had to be resorted to twice before he left the table. Death occurred on the fourth day after operation.

At the necropsy the haemorrhage into the rectus was found to have increased. The heart valves were apparently normal, but the myocardium was extremely friable; throughout the arterial system there was what appeared to be an advanced stage of general arterio-sclerosis.

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TINEA INTERDIGITALIS PEDIS.

IN his recent address on ringworm and its treatment Dr. J. M. H. MacLeod mentions (*British Medical Journal*, April 21st, p. 656), among other varieties of ringworm affection, a type of "eczematoid ringworm of the extremities"—otherwise tinea interdigitalis pedis. Without discussing the question of which particular variety of epidermophyton is responsible for this most discomforting and intractable affection, I desire to question the wisdom of part of the treatment recommended for it by the lecturer—namely, the advice to soften the skin by soaking in salt water or wading in sea water; and perhaps also the choice of medicament.

This affection manifests eczematous characters, and always appears to be readily curable in cold climatic conditions, but recurs somewhat unaccountably in the summer time, or more particularly under tropical conditions of living, when it is then most intractable. Any such conditions which result in undue moisture of the skin between the toes induce a fresh outbreak of symptoms, initiated by intense irritation and followed by vesication, painful fissures, and the appearance of white sodden patches of thickened epidermis between and beneath the toes. Moisture and warmth are the two factors necessary to promote development of this fungoid affection, which seems able to remain unnoticed in the epidermis for months before reappearing. Salt-water bathing is harmful, because it usually leads to moisture remaining between the toes despite careful drying, and sea wading especially so, because in addition it means spreading of the toes, with consequent causation of fissures made needlessly worse than they otherwise might have been. I would certainly dissuade any sufferer from sea wading or walking barefoot on a sandy beach if previous experience had not already made him wise. It has been demonstrated to me that a week's indulgence of sea bathing in the summer can precipitate the reappearance of this affection after

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having been entirely absent for many months during the winter, and in spite of the fact that a mildly antiseptic ointment—namely, 2 per cent. yellow oxide of mercury in vaseline—was used between the toes after careful drying, and the socks were sterilized by soaking in lysol solution. I have found that (*a*) dusting powders used with the idea of drying the skin between the toes are useless to prevent reappearance of this affection, whilst antiseptic powders continually used on sensitive skin lead to irritation, which it is most desirable to avoid; (*b*) any spirituous preparation, including salicylic acid in spirits, is unnecessarily severe, and, furthermore, aggravates cracking and shedding of epidermis; (*c*) salicylic acid ointments tend to a similar result.

After an exhaustive trial of many preparations I have found that the most satisfactory medicament is an ointment of 2 to 3 per cent. chrysarobin in mvaseline, applied sparingly but often, after careful washing and drying of the toes. It is at the same time essential to excise the top from all vesicles, remove all loose epidermis and clean up the edges of ulcers. This ointment soothes and softens the irritated skin, maintains its elasticity, precludes the penetration of undue moisture, induces healing without any aggravating effect, and the drug appears satisfactorily to penetrate the epidermis and kill the fungus proliferating in its substance. Moreover, its continued use renders soft and pliable the tough horny skin of the sole of the foot adjacent to the base of the toes, which is very necessary to promote the healing of ulcers so prone to occur in this area; it seems probable that here also is the source from which there develops a reappearance of the affection months after its apparent cure has been effected.

Liverpool. HUGH H. SIDDON, M.B., Ch.M. Sydney.

British Medical Association

CLINICAL AND SCIENTIFIC PROCEEDINGS.

LEICESTER AND RUTLAND DIVISION.

NEW DEVELOPMENTS IN PHARMACOLOGY.

In a lecture given to the Leicester and Rutland Division on May 1st, with Dr. E. LE LLLER in the chair, Professor W. E. DIXON discussed the trend of thought in the art of therapeutics. He deplored the lack of pharmacological initiative and research in this country, as a result of which for many years there had been dependence for new drugs and treatments on Germany, France, and America. He then gave a detailed description of two drugs which had recently come into prominence.

A New Type of General Anaesthetic.

The first, a tribrom-ethyl alcohol, was a new general anaesthetic known by the trade name of "avertin," the action of which had been determined precisely by Straub. It was a solid substance which at body temperature dissolved only to about 3 per cent. in water, but if more concentrated solutions were required it could be employed in a suspended form. To produce general anaesthesia in a patient weighing 12 st. about 10 grams of this substance was administered per rectum; this was rapidly absorbed—indeed, considerably more rapidly than water or saline solution—and the patient was anaesthetized and ready for the surgeon within ten minutes. With this anaesthetic operations had been performed lasting two hours or more without pain or any subsequent discomfort to the patient, and a considerable clinical literature was already available. At first, accidents happened after using it, but since the mechanism of its action had been better understood these had entirely disappeared. The drug after absorption acted on the central nervous system like the commoner anaesthetics, but within a few hours it was completely broken up in the body, the bromine being converted to sodium bromide. With an anaesthetic dose of 10 grams about 11 grams of sodium bromide was produced, and such an amount led to sleep lasting perhaps for thirty-six hours after the operation had been completed. The proportion of bromide excreted depended upon the amount of sodium chloride in the blood, and varied with it; it was well known that under normal conditions when the chloride was constant the excretion of bromide was very slow and after a single dose could be detected in the urine for several days. It was a simple matter, however, to get rid of this excess. In the case under consideration, if after the operation had been completed the excess of bromide should be eliminated by increasing the excretion of chlorides, this was effectively achieved by injecting from 5 to 10 grams of common salt, suitably diluted, into the rectum. One objectionable feature of this form of anaesthesia, as indeed of other forms of anaesthesia, was the production of some degree of acidosis. To combat this it was advisable to dose the patient before operation with sodium bicarbonate. The great advantages of this method of producing anaesthesia were obvious—the ease and certainty of producing the desired effect in a short time and for a long period, the absence of discomfort during administration, and the general comfort of the patient for several hours after the operation was completed were some of them.

Specific Therapy in Septicaemia.

In discussing specific therapy Professor DIXON paid considerable attention to mercurochrome, the sodium salt of mercury dibrom-fluorescein. It contained about 26 per cent. of mercury and 21 per cent. of bromine, and had a molecular weight of 750, which was a molecule so large as to be approximating to the colloidal state in solution. The samples obtainable on the open market varied considerably in their toxicity; many experiments showed that rabbits succumbed to an intravenous injection of 10 mg. per kilo of body weight, but Professor EYRE had stated that he had a preparation which, while possessing therapeutic efficiency, did not kill rabbits in doses of 25 mg. per kilo. The lack of uniformity in many of the experiments with this compound might not be unconnected with this variability. Mercurochrome was non-astringent and non-irritant. Its antiseptic action in the test tube was high; thus *B. coli* and *Staphylococcus aureus* in urine were killed by concentrations of 1 in 1,000 within a minute. This fact had led to the prevalent view that it acted as a cure by directly destroying micro-organisms; this might be true in the case of local infections. Thus it might account for the cure of bladder troubles used in a strength of 1 in 1,000, or for posterior urethral injections (1 in 400) employing a catheter, or for local applications to the vagina in gonorrhoea where sometimes as strong a solution as 1 in 25 was required. Mercurochrome was given, however, mainly by intravenous injection to effect a cure of general infections, and remarkable clinical reports had been published by many different clinicians. Why so large a number of patients were cured after such injections was not understood. It had been suggested that the beneficial results were due to colloidal shock reaction, and in favour of this was the fact that the compound was rapidly excreted by the bile, and that no bactericidal properties were shown by the blood, the bile, or the joint fluids in those cases in which arthritis was a symptom of the infective process. Moreover, occasionally the injection was followed by a sudden rise in temperature, succeeded by a rapid fall and associated with other symptoms of mild shock, as in the gold treatment of tuberculosis. Clearly, then, the element of shock might not be without its significance. The lecturer, however, regarded the bacteriological findings of little importance in appraising its therapeutic value when compared with the findings of the physician. Several substances which produced a cure of specific disease had apparently little direct action on the causal agent. This was true, to mention only one example, for the complex dye substance prepared by the Bayer Laboratory and by Fourneau, which effected a cure of certain forms of trypanosomiasis. Ehrlich at first discarded atoxyl as useless in syphilis because its direct action on protozoa was negligible, though when its curative properties came to be recognized it formed the starting point from which salvarsan was ultimately evolved. Experiments made on animals inoculated with the pneumococcus or anthrax bacillus had shown that mercurochrome produced a considerable percentage of cures—50 per cent. or more—but even these results were not yet conclusive, since, although they had been confirmed, they had also been denied. Clinical reports were more definite and impressive. They

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showed that in a large proportion of cases of septicaemia in which a pure culture of streptococci could be obtained from the blood injections of mercurochrome were followed by a cure. Young had reported the clinical results in 173 cases of septicaemia treated with mercurochrome, with a cure in 63 per cent. The papers by Dr. Young and his colleagues showed so many remarkable cures that the use of this remedy deserved a more extensive trial in this country. In septicaemia mercurochrome was given intravenously as a 1 per cent. solution in doses beginning with 2 or 3 mg. per kilo; from one to five doses at intervals of four to five days might be required to effect a cure. In desperate cases of septicaemia or other infections where the patient might die in a day or two 5 mg. per kilo, or even more, might be given. The objectionable results which might occur were stomatitis and, with large doses, transient albuminuria, though the latter effect was rare. The weak point about mercurochrome therapy at the present time was its variability in toxicity, and, therefore, possibly in its therapeutic efficiency; for this reason the maker should guarantee the molecular weight and the percentages of bromine and mercury, and should state its toxicity. Nevertheless, mercurochrome was not a dangerous drug to use, and its many users in other countries were convinced of its merit.

GUILDFORD DIVISION.

CLINICAL PATHOLOGY AND GENERAL PRACTICE.

At a meeting of the Guildford Division on May 3rd, with Mr. H. B. BUTLER in the chair, Dr. R. C. MATSON gave an address on some aspects of clinical pathology as an aid to the practitioner.

Dr. Matson first emphasised the great importance of the total white count in addition to the differential count in determining whether a morbid condition was septic or chronic. Both results should be combined to avoid wrong conclusions. Thus a differential count of 44 per cent. lymphocytes might indicate a slight condition of no importance, but if the total white cell count was 15,000 to 20,000 per c.mm., the probability was that an early lymphatic leukaemia existed; thus by omitting the total count an important diagnosis might be overlooked. It was necessary to remember that a physiological leucocytosis occurred after food; if a series of counts was required, the determinations should always be made at the same hour each time. An inquiry whether the patient was on a full diet or not was important. In the anaemias a complete white count was as necessary as a complete red count, since a leukaemia might easily be missed if the examination was limited to the total number of red cells, the haemoglobin, and the colour index. This was especially true of the acute leukaemias, as the process was often so rapid and the physical signs were practically absent, though the patient might be dead in a week. Passing to Widal tests, the lecturer warned against paying too much attention to the leucopenia in typhoid infections, since a leucocytosis might often follow. Widal tests should not be performed before the tenth day, since the agglutinins were not in evidence previously. For an earlier diagnosis than this a blood culture was required, and in the third week of the disease the urine and faeces should be examined. Patients vaccinated with T.A.B. might retain the agglutinins in their blood for so long as thirty years, and a period of seven years was quite common. In those who had suffered from typhoid and paratyphoid infections the blood might retain its agglutination power for the rest of life. It was probably always necessary to inquire whether the patient had suffered from these infections or had been vaccinated with T.A.B. They showed, as a rule, an agglutination of low titre, which should arouse suspicion. If the leucocytosis accompanied a positive Widal reaction, a secondary infection superimposed on the original typhoid one should be suspected, or a developing typhoid cholecystitis, or perhaps periostitis. It had been found that patients with endocarditis might give a positive reaction in low dilutions, and it had been asserted that miliary tuberculosis might act similarly. Controls should always be employed. Dealing with van den Bergh's reaction, Dr. Matson explained its uses in determining the cause of jaundice due to hepatogenous conditions such as stone in the common bile duct, or neoplasm, and in toxic and haemolytic jaundice, where there might be a direct reaction, or a bi-phasic reaction where an obstructive and a toxic process were combined. He added that the test was very valuable in latent jaundice, and in some cases of pernicious anaemia. In blood grouping for transfusion it was very important to match the recipient's serum against the donor's red cells after the grouping process had been performed. The blood calcium estimation was becoming increasingly popular, especially in thyroid deficiency diseases. The value was low as a rule in skin diseases, and might be very low in cases of colitis; it was probably very high in arthritis deformans. The blood urea test was of great value to the surgeon as indicating the condition of the kidneys, and whether there was much impairment of renal function, especially in cases of enlargement of the prostate. Blood sugar tests were of little value if taken without reference to the time of day and to previous estimations. A glucose tolerance curve should always be constructed, commencing with the result obtained during a fasting period. Glucose should then be given, and the dose be repeated half an hour and one hour afterwards. In this way the patient's tolerance might be determined at once and the necessary dieting prescribed.

Reports of Societies.

INTRAVENOUS TREATMENT OF VARICOSE ULCERS.

At a combined meeting of the Sections of Dermatology and Surgery of the Royal Society of Medicine, on May 16th, with Mr. R. DAVIES-COLLEY in the chair, a discussion was held on the treatment of varicose ulcers by obliteration of varicose veins by injection.

The CHAIRMAN, introducing Professor Sicard, who initiated the method in 1916, mentioned that obliteration of veins had been attempted fifty years ago by the injection of ferric chloride, but the method had been given up because it had proved unsafe. He added that Professor Sicard and his colleagues had now removed the danger from this intravenous injection method, and had rendered it of great practical value.

Professor SICARD reviewed the factors concerned in the production of ulceration in the lower limb. The influence of varix, age, heredity, and derangements of the endocrine system were discussed, and the analogy between the action of pituitary extract on the veins and adrenaline on the arterioles was mentioned. These various factors caused weakness of the walls of the veins and of the supporting perivascular tissues, with incompetence of the valves of the veins. Syphilis alone or associated with any of these other factors was a fairly common cause of ulceration. Local factors, such as trauma, intrapelvic pressure, phlebitis, infection, and prolonged standing, played an important part. Professor Sicard classified ulcers in the lower extremity in four therapeutic groups: (1) Post-phlebitic ulcers with oedema of the limb. This type was certainly not suitable for injection, the only lines of treatment being rest, massage, and support. (2) Dirty serpiginous ulcers of long standing, with marked local dystrophy, were also unsuitable for injection, and could only be treated by rest, disinfection, vaccines, light, and surgery. (3) Ulcers with moderate or mild local disturbance, usually preceded by local dermatitis, were very much improved by sclerosing injections of the veins combined with local applications. (4) Mixed syphilitic and varicose ulcers, which were cured by antisyphilitic treatment combined with local obliterative injections. With the aid of microscopic drawings the pathology of chemical renitis and thrombosis was described, and the firm adherence of the clot to the endothelium was demonstrated. Professor Sicard said that with his colleagues Drs. Forestier and Gougier he had demonstrated the passage of fluids from the superficial to the deep veins of the limb on slight muscular contraction, by means of the injection of opaque solutions such as lipiodol or sodium iodide into the superficial veins, followed by stereoscopic

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x-ray photographs. These photographs were shown, and they illustrated clearly the passage of the lipiodol into the deep veins on slight muscular movement. He therefore always performed the injection in the supine position, instructing the patient to keep the limb absolutely still and flaccid. In this way the injected fluid remained in the superficial vessels and produced a much better thrombosis. Numerous lantern slides were shown of patients before and after treatment, to indicate the marked improvement in the appearance of the limbs and the healing of the ulcers. Examples of venectasia, extending to the pubis and upper abdomen, were also shown. Professor Sicard pointed out that these cases were not suitable for injection, since there was often obstruction to the deep veins, and also because they were difficult to sclerose owing to the rapid stream of blood through them. It was in these cases that accidents were liable to happen. A 20 to 60 per cent. solution of sodium salicylate in water was the most satisfactory; he gave 2 to 3 c.cm. in one dose, and he injected all the veins immediately proximal to the ulcerated area. The number and frequency of the injections had to be adapted to the individual case. Other solutions, containing quinine and urethane, sodium citrate, glucose, as well as hypertonic saline, had been used with less success. In conclusion, Professor Sicard said that the improvement was most marked in the early cases; when eczema was a predominant feature it rapidly improved. No complications had been encountered, and relapse was rare; when this did occur a second course of injections was invariably successful.

Mr. TWISTINGTON HIGGINS based his observations on 200 completed cases of varicose veins, in thirty-five of which there was active ulceration. He had used sodium salicylate, quinine and urethane, and 50 per cent. glucose, and found that sodium salicylate and the quinine solution were equally satisfactory. Discussing the parts played by trophic disturbances, trauma, and infection in the pathology of varicose ulceration, he said that the best results were obtained by the injection method, in cases in which the trophic element predominated, and the poorest results in these cases presenting a great deal of infection. The speaker considered it most important to disinfect and clean the ulcer before commencing treatment, because any risk of embolism was increased in the presence of a septic focus. He commenced injection well above the ulcer, and noticed that, owing to the great dilatation of the vessels usually present, many injections were necessary to produce sclerosis, and that there was a greater risk of local necrosis since the vessels were usually very thin-walled and near the skin. He had not met with a case of embolism, but from the investigations of Professor Sicard and his own observations on histological examination of a vein after injection, he thought that the risk was very small, because the clot of irritative endovenitis was very adherent. He mentioned that Professor Sicard had treated 2,960 cases without the occurrence of embolism. To remove any possible risk of this complication he emphasized the importance of preliminary treatment of septic foci and the avoiding of excessive muscular movements for about three weeks after an injection. Mr. Higgins felt strongly that the greatest use of sclerosing injections lay in the preventive treatment of varicose ulceration. Patients were much more ready to submit themselves to the injection treatment at an early stage than they were to undergo an operation. The out-patient department of hospitals bore testimony to this procrastination, patients often only seeking treatment when a large and foul serpiginous ulcer was present. The pre-ulcerative stage was easily recognizable and the injection of the veins was of the utmost value in aborting the atrophic changes and re-establishing the nourishment of the tissues. The speaker, referring to perivenitis, necrosis, and cases with marked local reactions, said that these sequels were often due to faulty technique, though they sometimes occurred when the solution was injected correctly into the vein. Such complications occurred most often in severe cases, in elderly patients, in thin-walled veins, and in veins over bony prominences, such as the tibia and internal condyle of the femur. He thought that possibly the best treatment for these complications was excision. General toxic symptoms were rarely encountered; complaints of a little giddiness after sodium salicylate were sometimes received, and patients often tasted the quinine soon after its injection. Mr. Higgins had one case of vicarious menstruation after the injection of quinine and urethane. Complete failure, in his experience, was uncommon, and a successful obliteration of the vein could be promised in every case after repeated injections. Secondary dilatations did occur and under dosage produced thickening of the veins without occlusion.

Sir SIDNEY ALEXANDER said that he had used 40 per cent. sodium salicylate solution, quinine and urethane solution, and sodium chloride solution, but that he had obtained the best results with sodium salicylate. This solution produced a very marked immediate effect, and the thrombophlebitis occurred quickly. Patients, however, often had cramp soon after the injection. Quinine and urethane gave rise to little or no immediate discomfort, but about two or three days afterwards patients complained of pain in the legs, even worse than that occurring immediately after sodium salicylate injection. The speaker objected to the massive doses of glucose necessary to produce effective thrombosis. He used the horizontal position, but placed the patient with the leg hanging downwards for injection of the smaller veins. To prevent leakage, he immediately applied an isinglass plaster to compress the site of injection. Rest and local treatment of the ulcer were also necessary, and a word of warning was given concerning the use of quinine solutions during pregnancy.

Mr. DAVID LEVI reported the results of treatment of 60 cases. Of these 57 were cured, but 3 failed to respond to injections of 66 per cent. glucose. He had had one case of embolus following three injections of 66 per cent. glucose, and another patient had transient pain in the side. Mr. Levi showed microphotographs of the venitis following glucose injection, and pointed out the looseness of the clot. He therefore concluded that quinine solution was better. He had failed to produce experimental obliterative venitis in a rabbit's ear, even after obstructing the blood flow, and he therefore thought it was probable that the thrombosing effect of the injections only occurred in diseased veins.

Dr. GOLDSMITH pointed out that it was important to determine the direction of the blood flow in the veins in the upright position. A backward (centrifugal) flow produced oedema and stretching of the skin, with consequent ulceration. He thought that it was rational to expect that obliteration of such veins would aid the healing of the ulcer. He said that the advantages of the injection method over surgery were that injections could be given in cases of infected ulcer, and that the movement of the limb, allowed during the sclerosing process, played a very important part in the relief of the aching and the oedema. If the veins showed an upward flow they should not be injected, since they were not helping in the production of oedema of the skin. A history of phlebitis was also a contraindication to injection. The speaker only gave one injection at a time, since the height to which the thrombosis extended varied very considerably. He preferred glucose solution, since it was painless, non-toxic, and did not produce local necrosis. Glucose could be sterilized by boiling for half an hour without the production of toxic substances. He used a tourniquet in the erect position to demonstrate the vein, removing it after he had inserted the needle with the patient in the horizontal position.

Mr. R. T. PAYNE said he had treated thirty cases of varicose ulcer with sclerosing injections of quinine and urethane solution. All the ulcers were also treated with calamine lotion, and the patients were allowed to walk about during the course of treatment; all but one case showed signs of healing. He also used a tourniquet and compressed the site of injection for two minutes after withdrawal of the needle, and then applied strapping. The speaker thought that all the cases of local necrosis and perivenitis he had met with were due to this leakage of the solution after injection. He said that not only was there a distal flow in the veins, but that the capillaries shared in this back flow. It was the re-establishment of the capillary circulation which was of importance in the healing of an ulcer, and this could be attained by surgical extirpation of the veins and by firm bandaging, or by obliteration of the veins by injection.

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Dr. BRICKETT-OVERY said he had performed 500 injections with sodium salicylate. He usually produced six to eight inches of thrombosis, and had very little reaction. Dr. GREY mentioned that toxaemia was the chief factor in the production of varicose veins, since they made their appearance during pregnancy before the uterus was large enough to obstruct the blood return. He also referred to Boyd's comparison between the characters of the clot in thrombosis and blood clot after bleeding.

Dr. FORESTIER, replying for his colleagues Professor Sicard and Dr. Gaugier, said that the ulcers suitable for treatment by injection were those with moderate dystrophic changes, and these due to syphilis as well as trophic disturbances. Post-phlebitic ulcers and the large dirty serpiginous ulcers were not suitable for treatment. Venectasia of the pubis and abdomen was also unsuitable. He agreed with Mr. Twistington Higgins that the greatest use of the method was in prevention of ulceration. He never used a tourniquet, and had never failed to inject a vein. There was a marked difference between the pathological histology of chemical venitis and infective phlebitis. He thought that at present it was an open question whether there was any difference between the thrombus produced by glucose and that produced by the other solutions, but he added that the only fatal cases reported in the literature followed the use of glucose. Necrosis of the skin had not occurred since sodium bicarbonate had been discarded. In conclusion, he emphasized the importance of a thorough examination of the patient before treatment, paying special attention to the blood pressure and to the examination of the urine for albumin.

SKELETAL METASTASES IN CARCINOMA.

AT a meeting of the Section of Surgery of the Royal Academy of Medicine in Ireland on May 4th, with Dr. M. R. J. HAYES in the chair, Mr. F. J. HENRY reported a case of extensive carcinomatosis of the skeleton in a woman, aged 49, who had first noticed a lump in the left breast about a year previously.

Mr. Henry said that six months later this lump began to ulcerate through the skin, and the patient began to suffer from severe rheumatic pains in the back and about the shoulders. She was in an extremely miserable condition, being very cachectic and scarcely able to move. A large fungating mass was present in the upper part of the left breast, and enlarged glands could be felt in the left axillary and supraclavicular regions. X-ray examination showed multiple areas of rarefaction and erosion in the spine, ribs, and pelvic bones. There was pronounced angular deformity in the lumbar region, due to collapse of the bodies of the eleventh and twelfth dorsal, and possibly of the first lumbar vertebrae. The general appearances of the vertebral column were very unusual; they were attributed to decalcification and in some cases to condensation, probably brought about by compression. Secondary deposits were also demonstrated in the humeri, scapulae, and femora. A blood examination was made, but revealed none of the abnormalities described by Piney as occurring in diffuse carcinosis of the bone marrow.

Dr. M. R. J. HAYES said that he had never seen such extensive metastases as in this case. He discussed the probable path of infection, and suggested that it might be a secondary infection through the blood stream. He referred to the care taken in America to perform a complete examination before an operation in cases of carcinoma of the breast. The condition in which he had found secondary deposits most common, and occurring at a very early date, was carcinoma of the prostate.

Mr. WALTER C. STEVENSON thought that one reason why surgery and radiation treatment succeeded in cancerous cases was that when the growth was removed the power of the patient to resist cancer was strengthened.

Surgical Uses of Radium.

Mr. WALTER STEVENSON, in a paper on some surgical uses of radium, briefly summarized 247 cases treated during the year 1927. Of these, 127 patients suffered from malignant disease and 120 from non-malignant conditions; his communication dealt chiefly with the latter. He suggested that after cancerous cases had been treated the effect of radium treatment of cases met with in ordinary surgical or medical practice might well be investigated. He had found that prolonged radiation with small amounts of radio-active material appeared to have a pronounced effect in promoting the absorption of inflammatory products, curtailing the period of sepsis, and relieving pain. He instanced the case of a large swelling in the neck which disappeared with mild radiation, the amount of pus formation being minimal. A case of chronic otorrhoea of four years' standing following a mastoid operation cleared up within three or four weeks of radiation treatment for seven hours. Immediate relief of the intense pain and rapid healing followed mild radiation for five days of an ulcer of the leg of about fifteen months' duration following a compound fracture. The consolidation of a united fracture of the femur in a rickety child appeared to be greatly hastened by radiation. He stated that with some of his colleagues radiation appeared to be the routine method of treating tuberculous peritonitis; certain of these cases had been treated after exploratory laparotomy when very extensive disease had been found. Mr. Stevenson thought it probable that similar results would be obtained by x rays, but he added that the control of the dosage of radium was much better than in the case of x rays, and he instanced a case of recovery from tuberculous lung trouble which had radiated without intermission for seven months.

Dr. M. R. J. HAYES believed that in cases of tuberculous peritonitis laparotomy was the best treatment; he was always chary of applying radiation to acute inflammatory conditions. In cases of cervical adenitis, if any of the glands contained pus, the patients should not be treated by radiation until an operation had been performed and the pus let out.

Dr. R. STUMPF said that the indications for the use of radium treatment and treatment by x rays were not sufficiently known. It was possible by x-ray treatment in most cases to get as good results as were given by radium. In cases of keloid he preferred to use radium, and in cases of malignant disease of the mouth and oesophagus he employed combined treatment by radium and x rays. He had treated cases of tuberculosis of the larynx, boils, erysipelas, and actinomycosis successfully by x rays.

MANCHESTER PATHOLOGICAL SOCIETY.

AT the annual meeting of the Manchester Pathological Society on May 9th, with Dr. T. A. GOODFELLOW, the incoming president, in the chair, Professor J. S. DUNCAN gave a demonstration of venomous and non-venomous snakes. The mechanism of erection of the fangs and the action of the temporalis muscle in emptying the poison-secreting gland in venomous snakes were explained. The speaker added that the ordinary teeth were prehensile only, the victim being swallowed whole. The muzzle of the prey was swallowed first, since ingestion was easier in this way than in any other. Owing to the absence of mastication the opening of the trachea was placed far forward in the mouth, choking of the snake during deglutition being thus prevented. The venom contained a neurotoxin, as well as a proteolytic enzyme and a haemolytic body; the poisons were, to a large extent, specific. Mr. F. H. WESTMACOTT showed specimens and photographs from a case of chronic hypertrophic pulmonary osteo-arthropathy, one of the first examples of this condition to be reported. Mr. R. D. MOTHERSOLE showed a specimen of a congenital buccal cyst, about the size of an orange; it was found lying on the mother's perineum after delivery, with which it had caused some interference. The pedicle had been attached between the lower lip and the jaw of the child, who was alive and well. Professor SHAW DUNN showed specimens of ulcers of the oesophagus, among them two examples of decubitus ulcers of the pharynx, caused by the pressure of the cricoid cartilage against the vertebral column. In one case this pressure had been due to a marked anterior curvature, the result of spondylitis. Dr. C. POWELL WHITE demonstrated a number of microphotographs illustrating various points in the histology of tumours, including an adenoma and an adenocarcinoma of the rectum from the same patient, and also an adenocarcinoma arising in the centre of an adenoma.

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Reviews.

CLAUDE BERNARD'S "INTRODUCTION."

MR. H. COPLEY GREENE'S translation of CLAUDE BERNARD'S *Introduction to the Study of Experimental Medicine*[1] will help to make English readers acquainted with a work that should be in the hands of everyone who is engaged in medical research. The translation is excellent, and is preceded by an appreciative account of Claude Bernard by Professor Lawrence Henderson of Harvard and Paul Bert's article written at the time of Bernard's death. Although the *Introduction* made its first appearance in 1865 its value has not diminished in the lapse of years; indeed, it is difficult to believe that it will ever be out of date, because it expounds in a masterly way the fundamental principles of experimental research that hold for all time. It is, moreover, no mere philosophical dissertation, but a thoroughly practical guide to the research worker, explaining how discoveries have been and are to be made. Claude Bernard is insistent on the practical aspect; he sets aside theoretical questions of deduction and induction as unprofitable, and notes that although the Baconian induction has been made the foundation of all scientific philosophy, Bacon himself did not understand the experimental method; the hapless attempts that he made sufficiently prove it. Great experimenters appeared before all precepts of experimentation, as great orators preceded all treatises on rhetoric; Galileo and Toricelli admirably practised the experimental method which Bacon could never use, and it is the practice of experiment that Bernard explains in his book.

The need for a work of this kind at the present time is referred to by Professor Henderson. He points out that in the composition of modern scientific literature it is the custom to adopt a formal, rigid, and impersonal style which affords no insight into the personality and behaviour of the writer behind the printed page. The same is true of lectures; they are formal, logical, and impersonal. Yet what the novice in experimental research requires is an understanding of the working of the mind of the great investigator, and this is at the present time practically shut out from him; he has to initiate himself into mysteries which no one will explain to him. Of the real disadvantages resulting from this defect Claude Bernard has no doubt; he considered that the genius of inventiveness might be seriously diminished, or even smothered, by a poor experimental method. An inventive spirit and aptness of mind cannot be imparted by any means, but a good method enables such faculties as we possess to be turned to good account.

In Claude Bernard's *Introduction to the Study of Experimental Medicine* we are shown what are the essentials of a good method, and we have a vivid picture of himself at work by one of the most intelligent of modern scientists—a man of genius and a great physiologist. The numerous examples that he gives of his own experimental physiological investigations form an extremely instructive chapter, in which the working of his mind is portrayed in every detail and stage of the process—from the first inception in some, often chance or trivial, observation or hypothesis, and along lines often singularly circuitous and unexpected, up to the final goal of some important discovery.

The book is unique; there is no other like it, and apart from its scientific value it has literary merits which, at the time of its appearance, gained the applause of the French Academy.

FUNCTIONAL REPRODUCTIVE DISORDERS IN WOMEN.

THE book on the functional disturbances of the female reproductive system[2] by Professor GASTON COTTE is designed to show what can be done in restoration of function, and does not concern itself with those conditions, such as cancer, that call for radical treatment resulting in destruction of function.

Operations such as salpingectomy are not discussed, but those such as salpingostomy, which have for their object the restoration of function in a tube sealed by inflammation, are included. Similarly hysterectomy as a method of treatment for non-malignant conditions does not come within the author's theme, save in so far as he is concerned to advocate in women before the menopause the subtotal operation, with conservation of at least one ovary, when it is impossible to preserve the integrity of the reproductive tract. He has a very clear impression that the after-effects of this method are much less troublesome than those of the more radical operation.

The first, and much the longest, chapter is devoted to menstruation and its disorders, opening with a section on the sex cycle in the mammalia, which, taken as the biological foundation of the menstrual cycle in women, is considered in detail. In view of the author's purpose a full account of the physiological aspects and meaning of this function is given before going on to its disorders. These latter are confined to absence and deficiency, excess and irregularity of menstruation, dysmenorrhœa being considered under disorders of innervation. Treatment by medical means, especially organotherapy, and by physical and surgical procedures is discussed. He decries the excessive use of the curette, and in this plea will find much support. When, however, he proceeds to advocate various interventions on the ovaries largely based upon theories which are as yet incompletely established, he is on much more contentious ground. Resections of portions of ovarian tissue are advised, and it is suggested that if one ovary is found to contain atretic follicles and no corpora lutea, homoplastic grafting from the other should be practised. Many will hesitate to follow him in adopting speculative procedures of this kind, even if, as he points out, an application of radium may be tried in the event of a recurrence of symptoms. The next chapter covers disordered sexual relations—dyspareunia, vaginismus, and frigidity—and is followed by another on sterility and disturbance of embedding of the fertilized ovum, leaving aside the other disorders of reproduction during pregnancy, parturition, and the puerperium as being more particularly the concern of the obstetrician. Chapter iv is concerned with leucorrhœa and disordered secretion; chapter v with vascular disturbance; chapter vi with disturbances of innervation. The final chapter treats of ovarian insufficiency and the disorders consequent on castration. We doubt, however, if the method of treatment of dysmenorrhœa and "pelvic neuralgias" by division of the anterior hypogastric nerve of the sympathetic plexus after a deep dissection will meet with acceptance.

Our criticism of the book is that, though the author has set out with an excellent purpose, he has allowed his enthusiasm for avoiding mutilation and needless destruction of function to lead him to advance procedures which are unsupported by adequate experience of results.

THE PNEUMOTHORAX AND SURGICAL TREATMENT OF PHTHISIS.

THE pneumothorax treatment of pulmonary tuberculosis is so important, and still so new and therefore subject to revisions and improvements, that everyone interested in it must be grateful for a second edition[3] of a book which has already become the standard authority on pneumothorax treatment in this country. In his preface Dr. CLIVE RIVIERE points out that the original fourteen chapters have grown into nineteen by the addition of separate chapters on such subjects as the reduction of adherent pleura, pleural contraction and its effects, the duration of treatment and its termination. In addition, such subjects as the division of pleural adhesions, small-volume pneumothorax, selective collapse, oleothorax, and pneumothorax in childhood have received separate and special attention. But what distinguishes the second from the first edition most prominently is the addition of a second part dealing

[1] *An Introduction to the Study of Experimental Medicine.* By Claude Bernard. Translated by Henry Copley Greene, A.M. New York and London: Macmillan and Co., Ltd. 1927. (Med. 8vo. pp. xix + 226.)

[2] *Les Troubles Fonctionnels de l'Appareil Génital de la Femme.* Par Gaston Cotte. Paris: Masson et Cie. 1928. (Sup. roy. 8vo, pp. 570; 116 figures. 60 fr. sans majoration.)

[3] *The Pneumothorax and Surgical Treatment of Pulmonary Tuberculosis.* By Clive Riviere, M.D.Lond., F.R.C.P. Second edition. Oxford Medical Publications. London: Milford, Oxford University Press. 1927. (Cr. 8vo, pp. xxii + 311; 15 plates. 10s. 6d. net.)

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with the surgical treatment of pulmonary tuberculosis. The author has, of course, avoided those technical and operative details which must inevitably belong to the sphere of the surgeon, and he has confined himself to giving a general survey of the subject for the benefit of the practitioner who, in the interests of the patient, ought to know the indications and chances of success of operative intervention. It is interesting in this connexion to read that "in the estimation of the Matsons and Bisaillon, one-third of the 'no free space' cases, and one-third of the cases of ineffective partial collapse, are suitable for thoracoplasty, and should have this chance offered to them."

PULMONARY TUBERCULOSIS.

DR. G. T. HEBERT'S little book *Pulmonary Tuberculosis*[4] is intended for the senior student, the post-graduate, and the general practitioner. The first thing that strikes one about it is the peculiar arrangement of the subject matter. The first chapter is headed "Diagnosis"; then come the usual chapters on pathology, symptoms, physical signs, and x-ray examination. Instead of these being followed by a chapter on diagnosis, the author has inserted special chapters on pleural effusion and fibrosis; and when diagnosis is considered, the two chapters devoted to it, headed "Evaluation of evidence" and "Differential diagnosis," are separated by a special chapter on tuberculosis in children. It is to be hoped that in a future edition a more logical order will be arrived at. Apart from this fault of structure, the book is remarkably good; it is clear, direct, and dogmatic, as a popular textbook should be; and is illustrated by some very useful diagrams. We note the inclusion of the old error, copied from one textbook to another for the last forty years, that the smegma bacillus is decolorized by alcohol. It is really time that this was given up; it is quite impossible to distinguish the saprophytic acid-fast from the tubercle bacilli by morphological and staining methods, and this should be taught authoritatively.

RARE DISEASES OF VERTEBRAE.

DR. ANDRÉ LÉRI'S volume on affections of the vertebral column[5] may be taken as a sequel or second part of his book, *Études sur les affections des os et des articulations (colonne vertébrale exceptée)*, which also appeared in 1926, and was noticed in our issue of June 18th, 1927 (p. 1106). These "études," like those which formed the other volume, are all reprints from French journals, in many of which other authors have collaborated, some of whom are highly distinguished, such as Dr. Pierre Marie. The book is divided into five parts, the titles of which will give a clue to its subject matter. These are: I, Anomalies and "troubles" (that is, disorders) of development; II, Traumatic affections; III, Ankylosing disorders of the spine; IV, Localized vertebral rheumatism and its consequences; V, Miscellaneous affections. Of these, the first occupies more than one-third of the book, and includes interesting and often rare cases of maldevelopment, such as sacralization of vertebrae, lumbalization of sacrum, spina bifida, and various conditions which radiography has brought to the front of late years. Parts III and IV, on ankylosing diseases and rheumatic affections, occupy most of the rest of the book. Pott's disease is only referred to in a few pages in Part V on "Pottic" infantilism, in which will be found some interesting observations of cases of severe kyphosis, in which, as is familiar to many of us, there is some degree of arrest of sexual and general development.

Such a volume as this, and its fellow, is valuable as a work of reference, in which the practitioner who has come upon an unusual case may find a record of others of a similar kind, and some hints on their pathology and treatment. In general, however, Dr. Léri lays much more stress on pathology than therapeutics, for no descriptions of operations or apparatus will be found in this work. Dr. Pierre Marie, who has written the preface, welcomes this book, indeed, as an attempt made by a physician to annex a new territory in a domain which hitherto has almost entirely belonged to surgery. Those who annex, or try to annex, their neighbours' possessions are apt to get into trouble, and Dr. Léri must not be surprised if surgeons fail to admit his claims, since he has not made them good by cures without the help of surgeons. Indeed, in the case of spina bifida with incontinence of urine, Dr. Marie has to admit that the collaboration of a surgeon has been needed to achieve good results.

AYURVEDIST MATERIA MEDICA.

MR. K. M. NADKARNI, the author of a well-known work on Indian plants and drugs, has issued what appears to be a very complete *Indian Materia Medica*[6]—that is to say, a materia medica on Ayurvedist lines. The book will be of use to those who take an interest in native Indian matters, since it gives an insight into one of the more favourable and practical aspects of Ayurvedist medicine. Being restricted to Indian drugs its scope is necessarily limited in some slight degree, there being, for example, no mention of digitalis and strophanthus. The author, however, does not intend that his book shall replace the British materia medica, but that it may be used side by side with the latter. He hopes that his work may encourage the employment of the drugs prepared in the native bazaars, which are vastly less expensive than imported drugs, and employment of which would do something to meet the grinding poverty of the people. The book is, as we have said, frankly Ayurvedist, and the author expresses a wish, in his preface, that the Ayurvedist system were more closely and sympathetically studied. An article on the indigenous systems was published in this *Journal* in 1923 (vol. ii, p. 477), and was written after an impartial study of the subject, based solely on material furnished by a number of distinguished Ayurvedists. The conclusion reached was that Ayurvedism represents a stage in the development of medical science that is centuries behind the present level of knowledge. This conclusion implies no disparagement, for Ayurvedism is admittedly a subject of very great historical interest. Western medicine has passed through a similar stage, and it must be obvious to Ayurvedists that their science cannot remain stationary if it is to survive. It would be unreasonable to suppose that their ideas can be transformed in a day; the change is bound to be gradual, but of its importance for the welfare of the people of India there can be no doubt. It is possible that the main obstacle to further advance are the ideas that science rests on authority rather than on observation and experiment, and a failure to recognize that the *ipse dixit* of an authority, however venerable, is almost certain to contain an admixture of error, and is not unlikely to be a mere legend or play of the imagination.

NOTES ON BOOKS.

IN *Rebuilding the Child: A Study in Malnutrition*,[7] Dr. FRANK HOWARD RICHARDSON of Brooklyn, New York, the author of *Parenthood and the Newer Psychology* and of *Simplifying Motherhood*, addresses parents, teachers, nurses, and doctors, but the simple, somewhat elementary, style is perhaps better fitted for the parents. Malnutrition, according to the editorial foreword, which tells the reader that this book appeared as a series of articles in the *Trained Nurse and Hospital Review*, is the great disease of the American school child, and is shown by underweight for age and height, the latter being the more important: in fact, Dr. EMERSON, who contributes the introduction, neglects the age factor altogether. The child has a pasty face with a tired, don't-care expression, the chest is flattened, the angles of the scapulae stick out like rudimentary wings, and the abdomen sags and is prominent from want of tone. Malnutrition is not ascribed to deficiency of food, but to five classes of causes—faulty health habits,

[4] *Pulmonary Tuberculosis*. By G. T. Hebert, M.A., M.D.Oxon., M.R.C.P.Lond. London: E. Arnold. 1927. (Cr. 8vo, pp. 212; 5 figures. 7s. 6d. net.)

[5] *Études sur les affections de la colonne vertébrale*. Par André Léri. Paris: Masson et Cie. (6 × 8¾, pp. viii + 526; 115 figures. 75. 6d. net.)

[6] *The Indian Materia Medica*. Edited and published by K. M. Nadkarni. Bombay: K. M. Nadkarni. 1927. (Cr. 8vo, pp. xviii + 1142 + lxxxviii. 18s. net.)

[7] *Rebuilding the Child: A Study in Malnutrition*. By Frank Howard Richardson, M.D., F.A.C.P. With an introduction by W. R. P. Emerson, M.D. London and New York: G. P. Putnam's Sons, Ltd. 1927. (Cr. 8vo, pp. xxvi + 319; 44 figures. 7s. 6d. net.)

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faulty food habits, family strain, school strain, and physical defects—which are discussed in separate chapters. The subheading of the chapter on faulty health habits is "Americanitis." Among the directions given to parents in connexion with faulty food habits much stress is laid on the elimination from the diet of "added sweets," on stopping cream, and reducing the quantity of butter to scanty proportions. The method of treatment advised is inculcated by the system of the nutrition class, which Dr. Richardson had conducted for some years.

Problems in Psychopathology,[8] by Dr. T. W. MITCHELL, is based upon a course of lectures delivered to an audience drawn from members of the British Institute of Philosophical Studies. Following a chapter on the earlier development of psychopathology, the remainder of the book is devoted to an exposition and discussion of the theories of Freud. The writer, who is evidently now an adherent of the psycho-analytical school, writes with the clarity which characterizes his other contributions to psychopathology—and it is assuredly not an easy task to make the more recent views of Freud in respect to the development of the ego and the nature of the instincts comprehensible to the uninitiated reader. In concluding his book Dr. Mitchell states that the fundamental conceptions of psycho-analysis are those of conflict and repression, the unconscious, infantile sexuality, and transference; and he then proceeds to show how the post-analytical schools of Rivers, Jung, and Adler have arisen, and in what respects their tenets differ from those propounded by Freud.

A fifth and enlarged edition of Dr. W. D. Rose's book on *Physical Diagnosis*[9] has now been published. This has been completely revised both as regards text and illustrations. Important changes appear in the section on the heart, where the clinical aspect of early heart failure has been especially emphasized, and the section on endocarditis also has undergone a good deal of careful alteration. Recent advances in the various methods of diagnosis have been incorporated in the text.

The favourable reception accorded to the first edition of the work by Dr. LEROUX-ROBERT on high frequency in oto-rhino-laryngology[10] has justified the preparation of a new issue. This does not differ in essentials from the first edition, but the author has taken the opportunity of calling attention to improvements in the elaborate instrumentation necessary. The surgical aspect is well described; this has established itself more firmly in England than the medical, which has perhaps been neglected unduly. The author again insists on the necessity of exact measurements in dosage. A work of this kind is necessary to those who employ high frequency in a scientific manner. To those who are content to work by rule of thumb it will not appeal so strongly.

Lectures on the Biologic Aspects of Colloid and Physiologic Chemistry[11] is a volume of half a dozen lectures given by different authors at the Mayo Foundation and the Universities of Minnesota, Iowa, Washington (St. Louis), and the Desmoines Academy of Medicine from 1925 to 1926. Their general theme is indicated by the title. The lecturers have all made original contributions to knowledge in various departments of colloid chemistry or physics, and their remarks carry with them that freshness of tone and presentation which is almost inevitably lacking in a mere review of the work of others, however painstaking and thorough. Clearly, the appeal of the lectures to individual readers will depend to some extent on personal tastes and interests. Professor Chambers's remarkably clear discussion of the properties of boundary membranes cannot fail to interest the cytologist; Professor Barton's discussion of the ultramicroscope will appeal rather to the colloidal chemist and the bacteriologist. To the general reader, perhaps, the most instructive lectures are the first, by Professor Millikan, on "The principles underlying colloid chemistry," and Professor Bovie's discussion on "The biological effects of light."

The former occupant of the office of bursar and lecturer at King's College for Women, Household and Social Branch, Miss F. E. FINDLAY SHIRRAS, has written an excellent little book, *Aids to Catering*,[12] with special reference to institutions. Her chief object is to show that a large and attractive range of food can be provided at the common table, and at no greater cost or trouble to the kitchen staff than the more monotonous stodginesses that are too often found in schools and institutions. There are chapters that will be of help to the buyer, and information is given about meat, side dishes, stock, preserves and pickles, bread, and pastry of various kinds. There follow a calendar of seasonable food for each month of the year, hints on how to serve up the meat and fish, and finally the bills of fare of meals actually provided at the college for one whole year, day by day. An uncommonly attractive dietary is presented, good in balance, without hint of crankiness; and if the serving of it proved to be as good as the thought expended on the arrangement, then the girls in that college must have been a well-fed and contented group. The book is a good example of catering mixed with brains.

The number of medical men whose hobby is fishing must be very large; it is an excellent antidote to the cares of practice. The humorous novelist WILLIAM CAINE was a fisherman too, and his widow has collected into a book, *Fish, Fishing and Fishermen*,[13] sundry articles of his which first appeared in the *Field*, *Punch*, and other periodicals. Mr. Caine was a dry-fly fisher for trout—he preferred to call them trouts—and he regarded other forms of fishing as fit only for the baser sort of men. Even "daping" with the dry fly inspired him to an essay. As a fisherman he was justly indignant at the pollution of streams by the manufacturer, and the fish-killing propensities of the beet-sugar enthusiast would have aroused his wrath. In an article on bad form in fishing there is a comic diatribe against the man in the smoking-room who ventures to doubt the impressive statements of "fact" made by fishermen. Such a man is described as being at heart a "gudgeon-killer," who exchanges glances of the basest significance with his companion, "a doctor who dubs for eels by night with a ball of worms and worsted."

[8] *Problems in Psychopathology*. By T. W. Mitchell, M.D. The International Library of Psychology, Philosophy, and Scientific Method. London: Kegan Paul, Trench, Trubner and Co., Ltd. 1927. (Demy 8vo, pp. v + 150. 9s. net.)

[9] *Physical Diagnosis*. By W. D. Rose, M.D. Fifth edition, revised and enlarged. London: H. Kimpton. 1928. (6 × 9¼, pp. 819; 310 figures, 2 plates. 42s. net.)

[10] *La Haute Frequence en Oto-Rhino-Laryngologie*. Par Dr. Leroux-Robert. Deuxième edition, revue et augmentée. Médecine et Chirurgie Pratiques. Paris: Masson et Cie. 1927. (5¾ × 7¾, pp. xv + 216; 115 figures. 25 fr. sans majoration.)

[11] *Lectures on the Biologic Aspects of Colloid and Physiologic Chemistry*. Philadelphia and London: W. B. Saunders Company. 1928. (Post 8vo, pp. 214; 85 figures. 12s. net.)

[12] *Aids to Catering*. By F. E. Findlay Shirras. Introduction by Walter Rapman, M.A. London: J. M. Dent and Sons, Ltd. 1927. (Cr. 8vo, pp. ix + 115. 5s. net.)

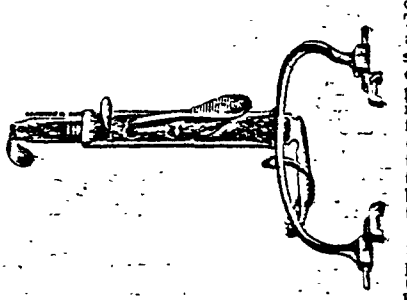
[13] *Fish, Fishing and Fishermen*. By William Caine. London: F. Allan and Co., Ltd. 1927. (Demy 8vo, pp. xii + 253; 1 portrait. 10s. 6d. net.)

PREPARATIONS AND APPLIANCES.

A Mouth Gag.

MR. NORMAN M. EADIE, Royal Hospital for Sick Children, Edinburgh, has designed a gag for tonsillectomy and other operations in the mouth which has given great satisfaction. It embodies the following advantages.

The teeth plates, with soft metal bearing surfaces, exert pressure on the molar teeth, which are not liable to injury, as is the case with the incisors. The pressure being applied equally to both sides by means of easily adjustable tooth-plates, the instrument is rigid and cannot rock from side to side; for edentulous patients this is a great advantage. The pressure being applied equally to both sides allows the tongue plate to remain accurately placed upon the tongue, which does not bulge out from beneath it. The outer surfaces of the tooth plates act as effective cheek retractors. With the moulded tongue plate sufficient depression of the tongue is obtained without undue tension upon the faucial pillars.



An anæsthetic tube is provided, while the three sizes of tongue depressor give it an almost universal range.

The gag is made by Messrs. J. Gardner and Son, Edinburgh.

An Aseptic Clinical Thermometer.

We have received from Messrs. Coates and Cooper (41, Great Tower Street, London, E.C.3) a specimen of their "Simplex" aseptic clinical thermometer, manufactured in this country. The thermometer has a small screw-top holder which fits into a metal case. Into the lower end of the case is inserted a moulded glass container, which will hold enough antiseptic solution (such as 2 per cent. carbolic) to bathe the lower end of the thermometer. There are slits in the outer case through which the presence of enough fluid in the container can be ascertained, and this is made easy if the solution is coloured. The whole appliance is no larger than a cigar, and has a clip for the waistcoat pocket. The thermometer can be unscrewed in a moment and withdrawn without removing the case from the pocket, and the antiseptic fluid can be replenished almost as readily. Leakage is prevented when the thermometer is in use by means of a rubber valve. A broken thermometer can be replaced by heating the composition in the screw-top holder. The price to the medical and nursing professions is 8s. 6d. complete.

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THE NEW PSYCHIATRY.

MAUDSLEY LECTURE BY SIR JOHN MACPHERSON.

THE Maudsley Lecture, under the auspices of the Royal Medico-Psychological Association, was delivered at the British Medical Association House, Tavistock Square, on May 16th, by Sir John Macpherson, formerly Commissioner in Lunacy for Scotland and Professor of Psychiatry in the University of Sydney.

Sir John Macpherson defined psychiatry in its literal sense as the medical treatment of mental disorders, which necessarily implied scientific investigation of their nature and causes. The commencement of the twentieth century was marked by the advent of psychopathology, though its significance did not at first attract much attention. For many years previously the medical world had been interested in Charcot's studies of hysteria, but it was reserved for one of his pupils, Janet, to demonstrate that hysteria was a mental disorder, and that its varied phenomena could be interpreted in psychological terms. Janet's contribution to psychiatry was the concept of dissociation. In some respects his definition of hysterical dissociation was not entirely satisfactory, because it implied a splitting up of consciousness and personality. It was highly improbable that there could be such a splitting up, for the cortical mechanism integrated as a single system. The vital process called consciousness was one thing; the outward expression of that process, which was called behaviour, was quite another. Behaviour might give the appearance of split consciousness because of changes in the integration of cortical processes; in the same way double personality depended upon different integrations within the cortical mechanism at different times.

Dissociation was a comparatively new term, though fifty years ago a similar condition was described by Hughlings Jackson, who taught that all morbid nervous phenomena were due to two factors—a negative factor consisting of loss of function at a higher level, and a positive factor consisting of over-function at a lower. The causes of dissociation resolved themselves into two co-operating groups, termed by the lecturer the *causa causans* group, including the whole familiar series of psychical and physical agencies, and the *causa sine qua non* group, which in the present state of knowledge could only be referred to generally as the inherent instability of the cerebral mechanism.

Freud and Orthodox Psychiatry.

It was in connexion with the cause of dissociation that Freud joined issue, maintaining that functional dissociation was caused by conflict of opposing psychological forces, and that the resulting symptoms were due to attempts on the part of the organism to adapt itself to altered conditions. Superficially such a statement appeared incompatible with contemporary views, but Freud proceeded to erect upon it a system of psychology which in a remarkably short time had captured, if not the assent, at any rate the attention, of the civilized world.

The Freudian theory and method were more firmly established than some people appeared to believe, for they were unassailable by direct argument or dialectic attack. To say that the Freudian hypothesis was embarrassing to psychiatry was no more than the truth; to say that it was supplanting the other was to exaggerate. The present position might be more correctly described as an *imperium in imperio*. The field of psychiatry was infinitely wider than that covered by Freudian doctrines; and its relations with the medical and cognate sciences were too close to allow the possibility of the new psychology superseding it.

The Foundations of Objective Psychology.

After some discussion of the vital functions of the cortex the lecturer went on to consider the foundations of objective psychology. From Pavlov's recent researches it was learned that cortical inhibition (physiologically a state of rest) had a tendency to irradiate from its point of initiation, and by a process of induction to cause excitation in neighbouring areas, which excitation arrested the spread of inhibition. Thus the cortex might be visualized as a mosaic of inhibitory and excitatory areas within which the dynamic activities of irradiation and induction acted and reacted in endless variety. Certain changes in cortical equilibrium resulted in sleep, in a kind of hypnosis, or in actual mental perturbation. That the depressed and exalted phases of the manic-depressive syndrome depended upon states of cortical inhibition and excitation had long been believed, but a more definite knowledge of the mechanism of these conditions was due to the researches of Pavlov. Once the cortical equilibrium was profoundly upset the effect did not pass away immediately, but might last for weeks and months, as was known from experience, and also again from the work of Pavlov on dogs.

There was no single symptom in the whole range of mental disorders which was not represented in the mental processes of normal people. We were dissociated from our surroundings when we were engaged in any absorbing occupation, when we forgot, and when we fell asleep. "When we dream, we are insane." As we were neither omniscient nor able to see into the future we were credulous, superstitious, and suspicious, and we developed many harmless delusions, the mechanism of which was the same as that of the delusions of the insane. We were only saved from insanity because our more or less efficient cortical mechanisms were able to correct our mental reflections and to inhibit our tendencies to abnormal behaviour.

The Question of Certification.

It was abnormal behaviour, the outward expression of cortical dissociation, that determined the necessity or otherwise of certification. The person who certified ought to be able to do so, not on the ground of abnormal behaviour alone, but also on the nature and cause of the cortical dissociation. Therefore medical education and experience were required for certification; the statutory appointment of a layman to revise the opinion of the medical certifier could be regarded only as a device to allay public suspicion. If proof was needed as to the prevalence of public suspicion it could be found in the provisions of the Lunacy Act, 1890, which showed less concern for the welfare of the insane than for the protection of the sane.

In any human system of the dimensions of lunacy administration it would be foolish to assert that mistakes and abuses could not occur; but the lecturer thought they must be extremely few in number. In his own experience he had never come across a single instance of abuse of certification or detention, but he had had cause to deplore the hardship imposed upon patients and their relatives by the reluctance of the medical man to certify. The same prejudices which influenced the framers of the Act of 1890 could be discerned in recent cases in the courts, not so much in the motives actuating the litigants as in the atmosphere of vindictiveness involving the proceedings. He had happened to be in a distant part of the Empire when newspaper reports of these cases were forthcoming; there they were received with amused surprise—amusement that courts of justice should deliberate for weeks over issues which appeared to present no great problems to the man in the street, and surprise that the Mother of Parliaments should not have devised less clamorous methods for the adjustment of disputes involving such pathetic and morbid details. He praised, by contrast, the simple and elastic administration of lunacy law in New South Wales, where it had recently been arranged that every large general hospital should make provision for the treatment of patients suffering from mental and nervous disorders. This was accomplished without legislative enactment.

The aims of the scientific spirit behind psychiatry, concluded Sir John Macpherson, could best be achieved by the admission of all cases of mental disorder to public hospitals without certification or judicial intervention. The great majority of patients and their relatives would welcome such an opportunity. There was sufficient legal machinery to deal with the small recalcitrant minority who would refuse to enter a hospital or remain in it. In addition to the existing mental hospitals advantage should be taken of every opportunity of utilizing the many scientific facilities of general hospitals by providing accommodation for the treatment of mental disorders in their vicinity. Such a provision, on an enlarged scale, was specially desirable in every centre of medical education. If mental patients had the opportunity of such informal access to treatment as was accorded to patients suffering from other diseases,

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mental disorders would be robbed of some of the terror and opprobrium attaching to them; psychiatry also would be brought into closer relations with general medicine, whereby its scientific spirit would be widened and its therapeutic efficiency improved.

CHRONIC ARTHRITIS.

THE publication of Dr. J. A. Glover's report[1] on chronic arthritis, with special reference to the provision of treatment, was mentioned in the *Journal* of May 12th, but in view of the recent conference on rheumatic diseases[2] at Bath, in which Dr. Glover took part, we now give a more detailed summary of this official document issued by the Ministry of Health.

This report, which is the third to deal with aspects of the problems of rheumatism, has been written in fulfilment of a promise given by the Minister of Health to a deputation from various approved societies, and the Chief Medical Officer, Sir George Newman, in a prefatory note, stresses the need for the organization of an adequate treatment in efficient centres if the very heavy claims on the funds of these societies are to be effectively reduced. Dr. Glover begins his report with a short section on the history of chronic arthritis, and then enters upon the difficulties of classification. The scheme used here is the same as in the previous report on the incidence of rheumatic diseases, and comprises rheumatoid arthritis (including infective polyarthritis), osteo-arthritis, gout, and a fourth group of "chronic joint changes unclassifiable." This scheme is amplified and discussed, and a table sets out the main points in differential diagnosis. The present report is mainly concerned with treatment, but a summary of some previous work on incidence is included, dealing particularly with insurance statistics, both British and foreign.

Etiology.

In the second section the more important problems in the etiology of chronic arthritis are discussed. Dr. Glover does not dogmatize on the question of heredity and diathesis, but quotes authorities supporting the various views. The prevalent idea is summed up in the statement that "the study of the family history of parents [? patients] will incline most people to the opinion that probably some hereditary influence does play a part in the production of chronic arthritis." The rather curious sex incidence of the various forms of the disease is next discussed, followed by some comments on the age of onset. There appear to be certain factors which play a part as predisposing causes in the production of chronic arthritis, and of these occupation, chill, dampness of houses or of localities, water supply, antecedent diseases, pregnancy, menopause, and mental stress are mentioned. The theory of focal sepsis is well reasoned. Here Dr. Glover observes: "We must regard chronic arthritis as an end-result, which may be caused by the results of the action of many different bacteria." After discussing the views of Timbrell Fisher, Hare, and other workers, he concludes that "the role of focal sepsis in the production of joint disease is not clearly known," but "the value of [the] theory of focal sepsis must, however, be interpreted chiefly in the light of clinical results." Disorders of metabolism are also held by authorities to play a part in a group of cases in which some inborn error or some acquired fault of metabolism is the primary cause. The results of various biochemical investigations in this field are summarized under the headings of basal metabolism, urinary analysis, and blood analysis, while the occurrence of achlorhydria and endocrine disturbances is also mentioned.

Treatment.

Coming to the main part of this report, Dr. Glover emphasizes from the start the importance of early diagnosis.

> "When a patient presents himself or herself with any symptom or sign suggestive of chronic arthritis the practitioner has two clear and urgent duties, the first to attempt to differentiate the variety of arthritis present and the stage to which the disease has progressed, and the second, even more important, himself to begin that determined search for an infective focus, in which later he may probably have to invoke specialist aid."

The next steps consist of a specialized search for focal sepsis and the measures to be undertaken for removal. In an analysis of some 545 cases it was found that demonstrable foci were present in 70 per cent. In this large group dental sepsis was the predominating form, and the whole question of the teeth in chronic arthritic conditions is next dealt with in a thorough manner. The need for expert dentists and good dental radiograms is stressed and the dangers of wholesale extraction are not overlooked. On this point Dr. Glover wisely remarks:

> "... whilst it has been necessary to sound a note of caution about wholesale or numerous extractions, it must be remembered that dentists are on the whole conservative, and that one tooth with hidden root sepsis left in the jaw may be quite sufficient to keep up a chronic arthritis."

Tonsillar sepsis, nasal sinusitis, and intestinal infections are next dealt with, and also urinary infection, especially in regard to the analogy of gonococcal arthritis. The septic focus having been dealt with, the question of vaccine-therapy next receives attention under the headings of autogenous vaccines, stock vaccines, and non-specific protein therapy. The last, especially when carried out with T.A.B. vaccine, is urged by authorities for the early case, and certainly the results here set out appear to warrant its more frequent use. Dietetic measures, in some instances "feeding-up" and in others cutting down the diet, are described, and the theory of vitamin deficiencies is mentioned. Drug treatment is summed up in half a page, and the absence of any comment on this is itself of significance. Next comes a long section on physiotherapeutic measures in chronic arthritis, whereby heat and "other insults" may be applied to the skin and joints. The principles of hydrotherapy and balneotherapy are set out, and details of the chief methods employed are given with illustrations. The internal administration of mineral waters is very fairly dealt with, and despite the unproved doctrine of the specific action of mineral waters in the treatment of chronic arthritis, it is concluded "that spa treatment may and should play a very important part in the treatment of chronic arthritis." Surgical measures required in chronic arthritis are also discussed, and the difficulties of assessing the results of the treatment of chronic arthritis by any means are explained.

The Provision of Treatment.

It becomes obvious as the methods of treatment are set out that the provision of a team of workers is necessary from the outset, and that appropriate treatment, even if it can be obtained, is a matter of very considerable expense. The existing provision of treatment in the general hospitals, in the Poor Law infirmaries, and in the spa hospitals is discussed, and the urgent need for further facilities is manifest. The work already done by the general practitioner in the past receives appreciative notice, and for the future Dr. Glover writes:

> "... the general practitioner will often have the opportunity of seeing such cases in the early stages when discovery and removal of the infecting focus and other appropriate treatment affords a greater chance than at the later stages of effecting a speedy and permanent cure. If the general practitioner is not content merely to relieve immediate symptoms, if he recognizes the necessity of searching for the cause, and if he exercises the tact, patience, and energy necessary to persuade the patient to submit to the necessary treatment, whether given by the practitioner himself or by others, invaluable time may be saved."

The need for physical treatment centres, as outlined in the annual report for 1925 of the Chief Medical Officer of the Ministry of Health, is insisted upon, and the possible provision of "arthritis units" to fulfil the purpose of research and observation as well as treatment is mentioned. Increased use of the existing spa hospitals for early cases is also urged. The out-patient clinics to be established, if funds permit, by the British Red Cross Society and the British Committee on Rheumatism are looked upon as the beginning of the provision of such clinics throughout the country, and the need for educating the public in preventive measures, especially with regard to dental sepsis, is emphasized.

In an appendix Dr. Fortescue Fox and Miss Margarethe Mautner describe the treatment of rheumatic diseases by physical methods in Germany.

[1] Reports on Public Health and Medical Subjects: No. 52. London: H.M. Stationery Office. 1928. Price 1s. 6d.
[2] *British Medical Journal*, May 19th, 1928, pp. 852-59.

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British Medical Journal.

SATURDAY, MAY 26TH, 1928.

THE EARLY DIAGNOSIS OF CANCER OF THE RECTUM

THE medical man whose patients can persuade him to give them offhand "something for piles" sounds the death knell of many an early case of cancer of the rectum; for it seems certain that, of all the types of cancer with which the surgeon has to deal, those occurring in the rectum and colon which are dealt with by excision at an early stage give better ultimate results than those arising in almost any other part of the body. The importance, therefore, of early diagnosis cannot be over-estimated or too often reiterated. The Subsection of Proctology of the Royal Society of Medicine recently held an interesting discussion on this subject (of which a report appeared in our last issue at page 846), and if there was one point above all others made most abundantly clear it was the imperative need for a routine digital examination in every case presenting rectal symptoms, no matter how trivial or unimportant they may appear to be. Everyone knows that this precaution is frequently neglected—the patient may resent it, the time or the surroundings may be inappropriate, the doctor may be hurried and overworked—and only too often the golden opportunity of recognizing a really early and curable case of cancer has slipped away. It is but too true that in far too many instances the patient does not consult a doctor at all until the growth has extended beyond all prospect of any curative treatment in our present state of knowledge; although it is satisfactory to learn that there is some evidence indicating not only that patients are coming to their doctors at an earlier stage of the disease, but that the medical profession as a whole is more alive to the necessity for earlier diagnosis and the value of early treatment.

Whereas the great majority of malignant growths of the rectum and recto-sigmoid are within reach of digital examination, and may therefore be classed as accessible or external cancers in the same sense as growths of the cervix uteri or buccal cavity, yet there is a proportion just beyond the reach of ordinary examination, and the detection of the growth calls for a little more care and skill. It is in just these cases that the proctoscope has proved of such great value; well named "an elongated finger with a human eye," it is so simple in use, so easy and cheap to maintain, and so convincing in its demonstration of those dangerous three or four inches of the lower bowel just beyond reach of the finger, that it is matter for surprise that it has not yet fully taken its place in the practitioner's armamentarium beside the otoscope, the laryngoscope, and the ophthalmoscope. It is certainly as easy to use as any of them, and there is further the comforting reflection that the differential diagnosis of diseases of the recto-sigmoid is simple, for all the published figures indicate that if any chronic ulceration is detected this is very much more likely to be cancer than anything else.

If a growth develops in a portion of the bowel beyond the reach of the finger or the simple proctoscope, its demonstration and its differential diagnosis present a more complicated problem, for the long sigmoidoscope will be necessary, and its introduction may require an anæsthetic. Moreover, even when the growth has been thereby visualized it may still be necessary to establish its exact nature by microscopic examination, and its precise extent by means of the barium enema and x rays. The microscopy of small portions of growth, obtained by passing special punch forceps up the sigmoidoscope, has now been reduced to so fine an art that the pathologist skilled in this work can not only give a very confident opinion as to the innocence or malignancy of the piece of tissue removed, but can also in cancer cases form a full idea as to the relative degree of the malignancy to be expected. Dr. Dukes showed many specimens to the meeting which well demonstrated the help he had been able to afford to his surgical colleagues at St. Mark's.

But what of those regions of the bowel in which digital or ocular demonstration of the presence of a lesion is impossible? What of those extensive areas of the colon beyond the reach of the longest sigmoidoscope—the cæcum, ascending and transverse colons, the splenic flexture, and the descending colon? Here one must to a large extent depend upon the careful weighing up of evidence less direct in character, and in doing so must not neglect the history to be obtained from the patient. As Sir William Wheeler emphasized in the paper with which he opened the discussion, the information to be obtained by careful cross-examination of the patient may be invaluable, and the evidence upon which he laid most stress was the history of a gradual change from normal bowel action to something abnormal. Persistence of such a symptom in spite of treatment should arouse suspicion and point to the need for further detailed investigation. Examination of the abdomen may give no help, for it is only in the later stages, when obstruction is established, that visible peristalsis, "ladder pattern" of the intestine, or a palpable tumour becomes manifest. Naked-eye examination of the faeces may also be quite negative, for it is only in extensive growths or those low down in the bowel that obvious blood or mucus is to be expected. Chemical examination of the faeces is, however, a different matter, for most authorities concur in the belief that occult blood, especially if found repeatedly, is very strong evidence indeed of at any rate some kind of ulcerative lesion of the gastric intestinal tract; on the other hand, its absence proves nothing.

What is the next step? The doctor is faced with a patient whose symptoms present nothing more striking than the recent onset of some slight trouble with the bowels of rather indeterminate character; occult blood has been detected in the stools, and physical examination is negative. Is he to wait and watch events, or is some further action necessary? Indubitably the latter; and equally without doubt it should consist in careful x-ray investigation by means of the barium enema, and not the barium meal. It seems necessary to be most emphatic about this, for the value of the opaque enema as compared with the opaque meal is not yet sufficiently appreciated by many of those who send patients to the radiologist. A barium meal administered to a patient with vague abdominal symptoms, and a report that "nothing abnormal is to be seen," may induce a wholly unwarranted feeling of security, for, as every radiologist knows, the passage of a meal may be hardly if at all delayed by a growth in the large bowel, which is revealed at once in a barium enema by its typical irregular filling defect, found constantly in all plates and at successive examinations. There are, of course, fallacies, both positive and negative: the positive

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induced by faecal matter, spasm, or extrinsic tumours which mimic the appearance of carcinoma and must be guarded against by careful preparation of the patient and repetition of the photographs. The negative fallacies are largely dependent upon imperfect technique, insufficiency of the enema, or lack of appreciation of the fact that the ordinary photograph shows only one plane of structures like the colon and sigmoid, which have no fixed anatomy. It is obvious that a filling defect in a portion of bowel whose axis is parallel to the path of the x rays might show nothing abnormal on the plate. Dr. Graham Hodgson described how he had successfully overcome this particular difficulty by an ingenious method of taking oblique views.

The trend of the discussion on May 9th made it quite clear that the more general use of the proctoscope and the sigmoidoscope, together with the development of the barium enema, have put the diagnosis of cancer of the rectum and colon on a much more scientific basis. The combined work of the surgeon, radiologist, and pathologist has effected much, and will reach its fruition when the general public can be persuaded that not all rectal symptoms indicate "only piles."

THE HARVEY TERCENTENARY.

THE celebrations of Harvey's publication three hundred years ago of the immortal *Exercitatio Anatomica de Motu Cordis et Sanguinis in Animalibus* have well illustrated the delectable doctrine that science knows no national or geographical boundaries. In March last the College of Physicians of Philadelphia, which rejoices in a wealth of Harveian treasures, paid its tribute, and was followed by Baltimore and Boston. Last week the Royal College of Physicians of London, as our columns have shown, organized a wonderfully successful celebration attended by delegates from twenty-one countries; and during the present week the Académie de Médecine of Paris, with that talent for graceful acknowledgement of pioneers in science which has in recent years been so much in evidence in generous recognition of British leaders such as Sydenham and Lister, has joined with her allies in commemorating the three hundredth birthday of Harvey's great achievement, which corresponds with the three hundred and fiftieth anniversary of his own birth. It may be recalled that the tercentenary of Harvey's birth was marked by a memorial fund to erect a statue at Folkestone, where he was born, and by a dinner in the College of Physicians' Library, when T. H. Huxley delivered a eulogy on Harvey's service to science and medicine.

The organization of this month's British commemoration was very appropriately in the hands of the Royal College of Physicians of London, whose chief glory is William Harvey, and it is specially fortunate that the President, Sir John Rose Bradford, whose early physiological work won him the Fellowship of the Royal Society, was able to correlate the activities of the College with those of the physiologists. Harvey's publication of his discovery of the circulation was even more important as inaugurating the modern method of experimental research, and the willing recognition by physiologists of this epoch-making event was a foregone conclusion. That the Fellows of the College are still obedient to the exhortation "to search and study out the secrets of Nature by way of experiment" was graphically shown by the convincing cinematograph films of Harvey's original physiological experiments as repeated by Sir Thomas Lewis and Dr. H. H. Dale, and exhibited to enthusiastic audiences at University College on May 15th and 16th. These demonstrations of the work which constituted "the new birth of physiology" were supplemented by other demonstrations bearing upon some more modern work on the circulation, both at University College, London, and at the meeting of the Physiological Society at Cambridge on May 19th with which a memorable week so fittingly concluded. It was a happy thought to include in the proceedings a luncheon party for the delegates at St. Bartholomew's Hospital (where Sir Wilmot Herringham gave a strikingly eloquent and comprehensive address on Harvey as a hospital physician), and visits to the two ancient English universities which also claimed Harvey at different periods of his active life. The success of the Harvey celebrations and the smoothness with which everything went were the result of much thought and attention to detail. The fact that this was a labour of love must not allow our debt to the Royal College of Physicians of London, its President, and Officers—and especially the Registrar, Dr. Raymond Crawfurd, fit representative of the scholar-physicians—to pass quietly into oblivion without an expression of gratitude.

The historical aspect of the three hundredth anniversary of Harvey's book has been admirably brought to the front by the publication of a facsimile of its first edition, presented to each of the delegates by the College of Physicians, and by the appearance of two further works—one old, a reproduction of the first English translation in 1653 of the *De Motu Cordis* (Nonesuch Press), and one new, *A Bibliography of the Writings of William Harvey, M.D.* (Cambridge University Press)—both due to the scholarly energy of a member of our profession, Mr. Geoffrey Keynes, the bibliographical authority on Sir Thomas Browne, Blake, and Donne.

RESEARCH BY OBSERVATION.

"WHEN we are reduced to observation, science crawls," said Lord Moulton twenty years ago. "When and in proportion as you can use experiment, the science advances rapidly. . . ." In the early pages of this issue we publish an account of an inquiry by Mr. John Morley into abdominal pain as exemplified in acute appendicitis.[1] Though the physiologists have taught us very much, yet for lack of adequate opportunity for experiment "pain" still escapes complete elucidation. Here, then, should be a legitimate field for research by observation, and we have to-day a restatement of a particular case which was set forth by Sir Henry Head in our columns some years ago. "In the early stages," he said, "before perforation has taken place, widespread pains may be present in the abdomen, corresponding to the afferent supply of the upper parts of the digestive tract. Such pains are due to abnormal movements of the stomach and intestine, and express the reaction of normal parts to a lesion situated in some allied physiological system. But when the appendix becomes perforated and inflammation of the peritoneum ensues, these referred pains are replaced by local manifestations, accompanied by deep tenderness over inflamed parts." Mr. Morley would confine the source of the initial pain to tension in the muscular wall of the appendix itself, and in his arguments in favour of local peritonitis as the exclusive source of the later rigidity and local pain he omits one provided by Head, who noted that the absence of tenderness in the loin, both to superficial stimulation and to deep pressure, is proof that its origin is not segmental reference from the viscus. The second part of the thesis is an attempt, so far as the evidence from appen-

[1] *British Medical Journal*, 1922, vol. i, p. 1.

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dicitis goes, to disprove the existence of any viscero-sensory or viscero-motor reflexes. Localized tenderness and rigidity and localized pain, since in appendicitis another explanation is forthcoming, are not in his view the expression of such visceral reflexes. Mackenzie, he says, "did not appear to appreciate the exquisite sensitiveness of the parietal peritoneum to even slight degrees of inflammation," and accordingly failed to perceive the part played by a peritoneo-muscular reflex in protective muscular rigidity. But on turning up *Symptoms and their Interpretation* we find, a few pages later than the paragraph he quotes, this statement: "... appendicitis may give rise to symptoms which are entirely confined to the reflex group, until the inflammation extends to the abdominal wall, when another series of symptoms may arise which are produced by a different mechanism." Both Head and Mackenzie were alive, it seems, to the observations upon which Mr. Morley relies, but they were less prone to generalize, and readier to admit exceptions to the general rules established by clinical observations. Most surgeons, we think, will agree upon the great frequency of correspondence between their own similar observations and operative findings, but few perhaps will not have met disconcerting exceptions, even in appendicitis. Granting, however, that in general terms all Mr. Morley says is true, there are other observations to be considered. Is muscular rigidity, familiar as a clinical sign of gastric and duodenal ulceration, dependent on stimulation of the peritoneum? Surely not. Is there no muscular rigidity associated with tonic spasm of the ureteral muscle, though the peritoneum in contact with the ureter is not inflamed, and indeed belongs to what Cope calls the "non-demonstrative" area? What of the viscero-sensory reflexes associated with cardiac disease, with bladder and prostatic lesions? What of the tenderness in the scalp related with visceral stimuli in the whole vagus field? If we call in aid, to support Mr. Morley, the deep tenderness over an area of pleuritic inflammation, there is still the difficulty that with the outpouring of fluid this deep tenderness disappears, and disappears, it may be, only up to the level of that fluid. A point of weight is scored by Mr. Morley in his insistence on the fact that muscular rigidity and hyperalgesia are purely right-sided, whereas, if visceral in origin, they should be bilateral, seeing that the intestine is developmentally median. It is curious, however, that laterality is, sometimes at least, recognizable in the case of ulcers of the stomach and duodenum; that we are able to differentiate colic in the ascending from that in the descending colon; that the areas of hyperalgesia of cardiac disorder show clear evidence of segmental distribution, with developmental sequence, and yet are often unilateral. It is a case, then, but not a conclusive case, that Mr. Morley presents against these reflexes. There will be a great measure of agreement with one deduction from these observations—namely, that hyperalgesia is not a trustworthy diagnostic sign; and there will be a considerable measure of sympathy with his expressed desire to simplify diagnosis for the student by the elimination of any reflexes that darken counsel.

THE INTERNATIONAL CONTROL OF DRUGS OF ADDICTION.

No great satisfaction can be derived from the discussions which took place during the sessions of the League of Nations Advisory Committee on the Traffic in Dangerous Drugs, held last month at Geneva. The Convention of 1925 remains unratified by a sufficient number of the requisite Powers to bring it into operation. The Control Board for which it provided, and upon which the Geneva conferences which drafted that Convention set so much store, has accordingly not been set up. Hence the machinery which the chairman of the second Geneva conference, M. Zahle, declared three years ago would initiate a "movement which will accelerate from day to day and from month to month," still remains inoperative. The Hague Opium Convention of 1912, which the Geneva Convention of 1925 was to "greatly strengthen," is accordingly the only international instrument available for control of traffic in opium, cocaine, and similar habit-forming drugs.[1] Indeed, it was contended by the American delegates that the later Convention derogated from the spirit, if not the letter, of the earlier pact of 1912 in the matter of limiting the production of opium and in the suppression of opium smoking. The Advisory Committee is reported to have been staggered and appalled at the extent and the extension of the illicit traffic in the crude and the manufactured drugs. The chaotic state of the central government of China has been accompanied by the reversion of that country to the position of being one of the chief producers of opium. The Government of the Straits Settlements, it was alleged, was responsible for an increased consumption of smoking opium from 43,000 kilograms in 1925 to 55,000 kilograms in 1926; and the only justification vouchsafed appears to have been that if the Malay Government had not supplied the drug smugglers would not have failed to do so. Then, again, it was asserted that hundreds of kilograms of morphine were being exported from France, ostensibly to Germany. The German delegate, on the other hand, maintained that such imports had not been received, and it was suggested that the consignment had passed through Copenhagen to Russia for illicit use. The records of imports and manufactures of cocaine in Japan likewise attracted attention, and were said to amount to a total four times greater than the world average. The Japanese delegate somewhat irrelevantly replied that Europe had tried eighty years ago to convert Japan to opium smoking. As regards the world production of opium, this had been recently estimated at more than 8,000 tons per annum, whereas the most liberal estimate of the "legitimate" need is less than one-tenth of that amount. Another disquieting feature was the extensive manufacture of codeine. During the first Hague Conference on Opium in 1911-12 a good deal of discussion took place as to whether codeine, like heroin, should be included as a dangerous drug. The British delegates urged its inclusion; the German delegates opposed, and maintained that there was no evidence to show that codeine was a drug of addiction. One of the British delegates promptly cited a case of "codeinismus" from the columns of the *Klinische Wochenschrift*; but finally, to secure agreement, codeine was omitted from the Convention. Signor Cavazzoni, the Italian delegate, again reiterated his distrust of the "Board of Control," proposed by the Geneva Convention of 1925, as being too aloof from the organization of the League of Nations to be effective and trustworthy. He also again pressed for governmental supervision or ownership of all manufactories of dangerous drugs. An alternative proposal by the German delegate, Dr. Anselmino, was the creation of a great international drug syndicate or trust, with which the League of Nations should enter into organic relationship by way of representation. All these proposals, coupled with the admitted fact that the situation as regards the international control of dangerous drugs and the suppression of illicit traffic therein is getting worse rather than better, seem to point to the principle which has been consistently advocated in these columns, which has been supported persistently in America, and which is implied by British legislation—namely: (1) that the use of opium, cocaine, their products, and similar drugs for other than medicinal purpose is an abuse and not legitimate; and (2) that to prevent such abuse it is necessary to control production at the source, so that there will be no surplus for non-medicinal or illegitimate purposes.

[1] The agreement made between Powers having possessions in the Far East, signed at Geneva in February, 1925, and published in a White Paper (Cmd. 3096), relates exclusively to "prepared" or smoking opium.

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THE CASSEL HOSPITAL.

In the report of the Cassel Hospital for Functional Nervous Disorders for the year 1927 the medical director, Dr. T. A. Ross, continues his policy of discussing only patients who have been at least twelve months away from the hospital. As an attempt is made, with considerable success, to keep in touch with former patients by getting them to report progress once a year, the results described are well tried, and have among hospital reports a peculiar value. This year's report, brief as it is, is full of interesting facts and suggestions. It furnishes, as in previous years, a striking justification of the methods of treatment employed at the hospital. In the group of patients for whom this institution is specially intended—the psychoneurotic group, of hysterias and anxiety states—the record is impressive, whether for percentage of improvement, consistency of results from year to year, or permanence, and this in spite of the fact that the claims of recovery or improvement are made with great caution, and the results are tested at length by the only criterion that is of nearly unassailable value—the test of the return to everyday life. In the present instance, of 102 psychoneurotic patients treated in 1926, 91 have so far replied to an inquiry about their health, and of those 70 reported themselves as well or much improved. This represents 77 per cent. of those replying, and contrasts with a percentage of 75 in 1925, 74 in 1924, 77 in 1923, and 68 in 1922, which was the first year to be so reported. These are remarkably consistent and well-sustained results, and in evaluating them it should be remembered that they have been brought up to date, and so give evidence of durability. They would be still more impressive if some indication were given of the duration of the illness before treatment was instituted. It has to be borne in mind that in some respects the Cassel Hospital population is a selected one—selected chiefly for its difficulty—for it is composed largely of patients who have been ailing for years, many of them for the greater part of their lives, and who have had many treatments with fleeting success. This may very well account for the pessimism of the report in regard to a small group—the obsessional group—of which there have been only twelve in the hospital since it opened. Experience in private and out-patient practice gives a more favourable impression of this type of illness, especially when it occurs in children and adolescents, than Dr. Ross has received from the Cassel Hospital material, which is mainly adult. From the figures quoted the therapeutic results in the chronic psychoneuroses, which are usually regarded so pessimistically, contrast very favourably with the results of treatment of other forms of chronic disability. In this connexion we note with interest that it is found to be a useful policy to have some former patients back for a brief second period of residence. Of 24 patients who returned under these conditions, 17 are now much better or well, so that the experiment seems fully justified. Such patients return usually to discuss the effect of putting into practice in ordinary life what they had learned in the Cassel Hospital, and to adjust any points in which they have failed to apply it satisfactorily. The idea of diagnosing dementia praecox in the early cases sent there has been abandoned; this is in accord with the most modern psychiatric teaching. It is not only unkind, but unscientific, to label patients "dementia praecox" merely because they present certain symptoms; the designation should be reserved for certain states of terminal dementia. For all earlier cases of this type the term "schizophrenic" is wisely preferred at the Cassel Hospital. It is of considerable interest that of the eight schizophrenics mentioned four are now well, and that most of them (Dr. Ross states) had to be discharged before recovery because they did not fit socially with the rest of the population, which is, of course, mainly psychoneurotic. He deplores the fact that it was impossible to provide special nurses to enable them to prolong their stay sufficiently. Such patients undoubtedly feel themselves to be different from the psychoneurotic population, and the latter also are quick to recognize the difference. It would add still more to what is to be learned from these very informative and constructive reports if more statistics could be given, such as the duration of the illness, the number of hours of treatment, the length of the hospital residence, and the age of the patients. Some indication of the relative permanence of the results with each type of psychotherapy selected would further enhance their value.

THE LIFE-HISTORY OF EPIDEMIC ENCEPHALITIS IN THE CHILD.

Finding that the prognosis in epidemic encephalitis in children has been insufficiently studied, Dr. Mary D. Stevenson records in the April issue of the *Archives of Disease in Childhood*[1] the results of her investigations in eighty-three cases, observed at intervals from 1918 to 1927. Twelve children had died, eight cases could not be traced, and sixty-three had been re-examined recently by the author. It was noted that 70 per cent. were boys, and the onset had occurred at ages varying from birth to 13 years. The disease began in most cases suddenly; after the acute illness there was a period of quiescence, followed later by the appearance of new symptoms. Mental alteration, nocturnal excitement, conduct changes, respiratory disturbances, the Parkinsonian syndrome, loss of accommodation, choreiform restlessness, myoclonic movements, and obesity occurred in that order of frequency. Fever was present at the commencement in most cases, and lethargy was a pronounced symptom in the majority. Of the motor disturbances described the most important were convulsions, seen in the acute stage; choreiform restlessness, occurring both early and late; myoclonus, which appeared in both early and late stages and had persisted for years; and the Parkinsonian syndrome, occurring in the late stages only. The prognosis of Parkinsonism is extremely bad, the majority of cases being steadily progressive. The ocular symptoms included diplopia, strabismus, ptosis, nystagmus, loss of the reflex on accommodation, inequality of the pupils, and disc changes. Among the paralyses that of the seventh cranial nerve was the most frequent, and in six cases there were transient paralyses of the limbs. The reflexes varied, and in twenty-three cases pain of a severe neuralgic character was present during the early stages of the disease. Examination of the cerebro-spinal fluid showed it to be under slightly increased pressure, but clear. During the acute stage there was an increase of the cells for two or three months. The colloidal gold test of Lange was usually positive during the acute stage, although in the first week it was occasionally negative. During the chronic stage it was again negative. Nocturnal excitement with inversion of the sleep rhythm assumed a very prominent position in the sequels seen in this series; it lasted from one month to five years, the average duration being eighteen months. Derangements of respiration took the form of (1) attacks of rapid and noisy breathing, (2) continuous rapid breathing with occasional attacks of noisy respiration, and (3) apnoea. Respiratory tics, such as frequent clearing of the throat, nose-blowing, and sniffing, were also present. The onset of these respiratory troubles usually occurred between three months and three years after the start of the disease, and was a late manifestation. There is a tendency for these disturbances to disappear. Mental alteration was found in the majority of the cases, and tended to increase, in contrast with Shrubsall's findings. Changes in conduct were seen in forty-six patients; in most cases improvement has occurred.

[1] Vol. 3, No. 14. Issued by the British Medical Association. London: B.M.A. House, Tavistock Square, W.C.1. Yearly subscription (6 numbers), 25s. Single number, 4s. 6d.

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Regarding the prognosis as to life, out of the author's series four children died during the acute stage and eight at varying periods after the acute illness. Only three of the whole series are normal; many are seriously crippled and need institutional treatment, thus demonstrating the seriousness of the outlook in epidemic encephalitis.

ARTIFICIAL PRODUCTION OF A FOWL TUMOUR.

Ever since Gye and Barnard put forward their theory of the cancer "virus," a great deal of attention has been directed to the study of the Rous sarcoma of fowls, on which their argument wholly depended, and especially to the nature of the filterable extract of these tumours. Gye claimed to have demonstrated that the extract contained two factors—the "virus" and the "accessory chemical factor"—neither of which was efficacious without the other; but the weight of scientific opinion has been unfavourable to this claim. It has even been doubted if the active principle of the fowl-tumour extract is of the nature of a virus, and Carrel has asserted that he has been able to produce tumours indistinguishable from the Rous sarcoma by injecting into fowls the pulp of chick embryos mixed with very weak solutions of arsenious acid or of indol. Carrel's claims in turn have been disputed by others, but Brebner[1] states that he has successfully repeated these experiments. But he has gone further. Impressed by the discovery of Warburg that tumours, placentae, and embryonic tissues have, in contradistinction to most other tissues, a greater glycolytic than respiratory property, he was impelled to try if the combination of placental extract and chick embryo pulp would have a similar effect to the Rous sarcoma extract. To this end he removed two placentae from a rabbit at or about full term, minced them finely, and mixed with them 10 c.cm. of saline. The mixture, after standing for thirty minutes, was centrifugalized, and the supernatant fluid added to the minced pulp of three eight-day-old chick embryos. This emulsion was injected into the pectoral muscles of two fowls. One of these fowls had developed a nodule by the twentieth day, and by the end of the forty-sixth day, when the bird died, it had a large nodule on the left side and a smaller one on the right. On dissection it was found that the tumours—grey-white in colour, firm in consistency, not very vascular—were actively invading the muscle substances. They showed no trace of embryonic tissue, such as cartilage, bone, or epithelial structures, as one would expect to obtain from the growth of the material injected. There were numerous metastases, especially in the lungs. The microscopic appearances were those of a sarcoma in which large cells predominated, with abundant cytoplasm and somewhat pale-staining reticulated nuclei—cells which were probably of mesoblastic origin—but the picture was by no means uniform, for dense cellular areas existed side by side with myxomatous areas, and there were a few giant cells and lymphocytes to be found. The metastatic deposits showed the same characters. The tumour was successfully transplanted into other fowls of the same breed, and had reached its fourth generation when the paper was written. The tumours were always progressive, had the histological characters of the original, gave rise to metastases, and proved fatal to the fowls in thirty-five days. Brebner further states that he repeated the experiments, using extract of guinea-pigs' instead of rabbits' placentae, and has produced similar tumours in six cases. So far he has not succeeded in propagating these tumours by filtrates or by desiccated material as in the case of the Rous sarcoma, but otherwise these fowl tumours are of a similar nature. No doubt this new observation will be thoroughly investigated by others; if it comes successfully through the test it will throw some light on the nature of the agent causing these peculiar chicken tumours, and, incidentally, it will remove the foundation on which Gye's theory was constructed.

[1] *Canadian Med. Assoc. Journ.*, April, 1928.

B.C.G. AND NON-TUBERCULOUS INFANTS.

At a recent session of the Academy of Medicine in Paris Professor J. Lignières, while speaking in high terms of Dr. Calmette's B.C.G., deprecated its use for pre-immunizing infants who were not exposed to infective surroundings. Although he was convinced that B.C.G. was a powerful help in the struggle against tuberculosis, and ought always to be employed when contagion was to be feared, he thought that the introduction of a living organism into the tissues led to an infection which, though never producing the lesions of tuberculosis, might still be harmful. He pointed out that there was a large mortality in rabbits used for experiments with B.C.G., that no trustworthy statistics were yet available on the vaccination of infants who were not exposed to tuberculous infection, and that, in any case, pre-immunization led to a prolonged infection of the lymphatic system by the B.C.G. Dr. Calmette reserved his reply to Professor Lignières until the session of the Academy on May 8th. Apparently he failed to recognize that Professor Lignières did not allege that the B.C.G. might produce tuberculous lesions in the vaccinated, and his answer was based mainly on this misunderstanding. He asserted, however, that experiments had shown that the mortality in rabbits was not due to injections of B.C.G., and he made the remarkable statement that in vaccinated infants the mortality from all causes was less than in the non-vaccinated. Professor Lignières again declared his admiration for the great discovery of Drs. Calmette and Guérin; he continued, however, to uphold his view that the use of B.C.G. should be avoided with healthy subjects brought up in non-tuberculous surroundings.

Dr. W. M. Willoughby, who has been medical officer of health for the Port of London during the past twelve years, was elected on May 17th by the Corporation of London to the post of medical officer of health for the City, in succession to Dr. W. J. Howarth, who retired recently owing to ill health.

The first award of the Dalby Memorial Prize, for the best original work in otology during the previous five years, has been made to Dr. Otto Mayer of Vienna. The award is in the hands of the Council of the Royal Society of Medicine, acting on the recommendation of the president and vice-presidents of the Section of Otology.

The annual general meeting of the Research Defence Society will be held at 11, Chandos Street, Cavendish Square, W.1, at 3 p.m. on Tuesday, June 19th. The Stephen Paget Memorial Lecture will be delivered by Sir Bernard Spilsbury, his subject being the work and responsibilities of a pathologist.

Professor Hideyo Noguchi, of the Rockefeller Institute for Medical Research, died at Accra, on May 21st, from yellow fever. Professor Noguchi went to Accra last November to investigate this disease, and contracted the infection in the course of laboratory work.

Sir StClair Thomson has been elected a corresponding member of the Société de Laryngologie des Hôpitaux de Paris, of the American Stomatological Association, and of the Philadelphia Laryngological Society.

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The Harvey Tercentenary.

BANQUET AT LONDON GUILDHALL.

THE Harveian celebrations in London concluded with a banquet given by the Royal College of Physicians at the Guildhall on Wednesday evening, May 16th. The reception by the President of the College, Sir John Rose Bradford, took place in the art gallery, and the company of nearly 500 Fellows and guests proceeded to tables in the great hall.

The President had beside him the German Ambassador and on his left the French Ambassador; other members of the Diplomatic Corps present were the Italian and Belgian Ambassadors, and the Austrian, Greek, and Finnish Ministers. The Government was represented by the Minister of Health and the Under Secretary for Scotland; the religious life of the nation by the Archbishop of York, the Archbishop of Wales, the Dean of Westminster, the Dean of St. Paul's, Cardinal Bourne, and the Chief Rabbi; law by the Lord Chancellor (Lord Hailsham), Viscount Sumner, Lord Wrenbury, Lord Blanesborough, Mr. Justice Rowlatt, Mr. Justice Maugham, Sir Ernest Wild, and Sir Thomas R. Hughes; industry and industrial science by Sir Alfred Mond, Sir Robert Hadfield, and Sir Charles Parsons; and the arts by Sir Frank Dicksee, Sir Reginald Bloomfield, and Sir Johnston Forbes-Robertson. The University of London was represented by Sir William Beveridge (the Vice-Chancellor) and Sir Gregory Foster; Edinburgh, by Sir Edward Sharpey-Schafer; Oxford, by Sir Farquhar Buzzard; and Cambridge, by Sir Humphry Rolleston. The three new Honorary Fellows who were able to be present (Sir Ernest Rutherford, Professor Pavlov, and Professor Wenckebach) were grouped near the President. Others at the principal table were Viscount Knutsford, Lord Somerleyton, the Earl of Crawford and Balcarres, Viscount Chelmsford, Lord Stanmore, Lord Riddell, and the High Commissioner for New Zealand. The great majority of the others present were medical men, including Lord Dawson of Penn; Sir Berkeley Moynihan, President of the Royal College of Surgeons of England; Sir James Berry, President of the Royal Society of Medicine; Mr. H. W. Carson, President of the Medical Society of London; Sir Robert Philip, President, Sir Ewen Maclean, President-Elect, and Dr. C. O. Hawthorne, Chairman of the Representative Body of the British Medical Association; Sir George Newman, Chief Medical Officer of the Ministry of Health; Sir Thomas Barlow, Sir Francis Champneys, Sir Anthony Bowlby, Sir John Bland-Sutton, Sir Wilmot Herringham, Sir James Fowler, Sir William Hale-White, Sir Thomas Horder, Sir Maurice Craig, Sir James Purves-Stewart, Sir Robert Armstrong-Jones, Sir William Willcox, Sir Holburt Waring, Dr. Graham Little, M.P., and Dr. F. E. Fremantle, M.P.

"*The Memory of William Harvey.*"

After the loyal toasts had been honoured, the PRESIDENT, in few words, called upon those present to drink to "The Memory of William Harvey," and the toast was honoured in silence.

"*The Delegates.*"

The MINISTER OF HEALTH, proposing the toast of "The Delegates," said that all would agree as to the greatness of the occasion which brought together so distinguished a body of men, including representatives from the universities and the learned societies of this country, of the British Dominions beyond the seas, and of numerous foreign nations. Many bore names which were held in honour throughout the whole of the scientific world. He noticed with particular pleasure the presence of Professor Castiglioni, representative of that University of Padua in which Harvey took his medical degree in 1602. Surely there could be no greater tribute to the influence of that wonderful treatise by Harvey than the fact that 300 years after its publication men of science should come together from all parts of the world to do him honour and acknowledge the debt they owed to him. Harvey's work was more than a discovery, it was a demonstration. So clearly did he state his problems, so skilfully did he marshal the evidence against the theories then current, so aptly did he illustrate by the results of his experiments the new theory which he put forward, that at one single blow he carried conviction to all his readers. Like another great scientist, Charles Darwin, he changed the whole current of men's thoughts. The present company had during the last two days listened to many appreciations of the work of Harvey from different aspects. The speaker was present that evening as the Minister for the time being responsible for the Department of Public Health, whose duty it was to prevent and avoid disease. Looking at Harvey's work from that point of view, it seemed to him that the whole system of preventive medicine was based and founded upon his discovery. For what was preventive medicine? Was it not the science and art of providing for the population the food, warmth, exercise, and recreation that were necessary to maintain a normal healthy circulation, and on the other hand to remove and avoid those factors which favoured the onset of disease and impaired the resisting power of the body, which was itself dependant upon the same circulation? Harvey's pre-eminent place in medicine was given to him because he was the founder of modern physiology, and all the services which were carried on in the name of public health in this country, through the local authorities, medical officers, sanitary inspectors, health visitors, maternity and child welfare centres, clinics and hospitals, the health insurance system, even the housing programmes, were just various methods of securing and safeguarding the physiological balance of the life of man. Mr. Chamberlain concluded by saying that of the various factors which were working to-day for the peace of the world there was none which was more potent than the brotherhood of the healing art. Diseases knew no frontiers, took no account of nationalities, and those who were fighting in this great warfare knew full well that if they were to win the battle they had to pool their resources and to regard medical men and sanitarians of all nationalities as their comrades in arms. It was in this spirit that he welcomed the delegates.

Professor A. CASTIGLIONI said that the period during which, as a young man, Harvey listened with so much earnestness to the teaching of the greatest anatomist of the time, Fabrizio d'Acquapendente, was the greatest and most glorious in the history of the University. Galileo Galilei had laid the foundations of experimental science with his immortal words. Through the intelligence and foresight of the Venetian Republic the entire University, enjoying complete freedom in matters of education, was influenced by the spirit of this earliest and greatest of experimental philosophers. At the same university Andreas Vesalius, student and afterwards Professor, had established modern anatomy, and for more than forty years Padua was the centre of anatomical research in Europe. It was into this environment that William Harvey brought his high intelligence and profound powers of observation, and here he came to know of the discoveries of Realdo Colombo and Andrea Cesalpino. Italy could with pride testify that while England had the glory of being the country of William Harvey's birth, it was the ancient University of Padua which afforded this famous man his course of instruction in physiological thinking which prepared him for his great discoveries. The glorious Italy of the Renaissance, which in letters and arts carried high the torch of beauty and truth to illuminate mankind, remembered to-day with pride the work of William Harvey as that of a beloved pupil. The speaker said that he was giving voice also to the feeling of all Italians who were tied to England in a bond of long-standing friendship. They did not forget the opportune assistance rendered to their land at all times by a country which they loved and admired. In commemorating the work of William Harvey of immortal fame he took the opportunity to emphasize those ties of friendship and unity of purpose, and to recall all those brilliant men, at one time students at Padua, who had held prominent positions in the Royal College of Physicians of London. He also brought greetings and good wishes from this ancient school, which followed with pride and affection the successes of its sons in another land, and in the name of the University of Padua, and also in the name of all those Italians who followed with such interest the progress and glory of British science, he greeted the President and members of the Royal College with the words "*Vivat, crescat, floreat!*"

Professor W. H. WELCH of Johns Hopkins University also responded to the toast, saying that it was difficult for him to follow the eloquent address of Professor Castiglioni, who represented something very significant in the life of Harvey. He himself could put forward no such claim, but he did desire to express what he felt to be the good fortune of the delegates and guests in being allowed to participate in that commemora-

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tion. There was something stirring in the thought that they assembled at the invitation and under the auspices of the Royal College of Physicians to celebrate an event unexampled in the history of human thought. The celebration had been in every way worthy of the event which it celebrated. The delegates had been received by the King, they had participated in some highly impressive and interesting ceremonies, they had visited not only the Royal College of Physicians, but Harvey's old hospital, St. Bartholomew's, and on the following days they were going to Cambridge and to Oxford. But he thought he was voicing probably the sentiments of very many of the delegates when he said that on the previous day, during the demonstrations at University College, they had felt themselves most vividly in the presence of the living Harvey. It was one thing to read about the fact that Harvey made this direct appeal to nature, that he really introduced independent scientific inquiry into the biological sciences, that he stood for biology in the same position as Galileo stood for the physical sciences, but to have this brought before the eye by demonstration was a singularly impressive experience. He thought that the prolonged applause with which the delegates endorsed the tribute paid by the President to Sir Thomas Lewis and Dr. Dale was more than ordinarily significant; they felt that they were applauding really the *persona propria*, as if Harvey had been before them and had conducted the demonstration. The delegates had also enjoyed the delightfully plain and simple and yet eloquent talk at Harvey's hospital by Sir Wilmot Herringham about Harvey the man. They realized what a man he was, a gentleman in every sense of the word, one who did not love to overthrow the spell of ancient authority, who did his work in a somewhat reluctant, slightly regretful way, one who was not altogether free himself from the trammels of mediæval thought, one who was not engaged in vituperation and did not light-heartedly abandon the old authorities. The speaker desired only to add how grateful he and his fellow delegates were to the Royal College of Physicians for having provided in so adequate a way this presentation of Harvey the investigator and Harvey the man. This visit would be one of the great experiences of their lives and an inspiration to them in future work.

"The Honorary Fellows."

The PRESIDENT next proposed the health of the newly installed Honorary Fellows, and repeated in substance the statement he had made at the reception at the College two days previously, which was reported in the *Journal* last week (page 867); explaining that the College had never had a roll of Honorary Fellows, though in history there were one or two who might by a stretch of language have been said to bear that title. Four most appropriate names had now been chosen for this honour: the Earl of Balfour, who in many directions had given great encouragement to medicine, Sir Ernest Rutherford, the distinguished physicist, Professor Pavlov, the doyen of physiology, and Professor Wenckebach, a man distinguished for the kind of work peculiarly associated with the genius of Harvey.

Professor WENCKEBACH addressed a few remarks in reply, modestly disclaiming any ability to speak for his great colleague Pavlov, but saying that Professor Pavlov's presence at that gathering was sufficient without any words. For his own part Professor Wenckebach felt himself singled out merely as one of a great army of practitioners in whose ranks he had served, and that the honour done him was really intended for them all. He was one of the hundreds of thousands of physicians who stood indebted to William Harvey, and not to William Harvey alone, but to the profession of medicine in Britain past and present.

Sir ERNEST RUTHERFORD also acknowledged the toast in graceful terms, saying that it was an idiosyncrasy of human nature that it appreciated most those marks of distinction which were least deserved. He felt, however, that his admission to the Fellowship of the College was attended by certain drawbacks, one being that he could no longer express his opinion of the merits of the medical profession with the same candour as heretofore. Harvey, he went on, was the first man to apply physics to medicine. It was true, as others had said, that all the essential facts on which Harvey based his great discovery were known before him. It was known that the blood flowed outwards in one direction, and inwards in another; but what he did, like Newton and others of whom the same was true, was to make a great generalization. All honour to the man who had the vision to do that! Harvey visualized the application of dynamics to the circulatory system. Sir Ernest Rutherford ended by asking his hearers what new scientific achievement they would most desire to see in their lifetime. A former generation would have made varied replies, but now, with so many conquests made—flight, and wireless accomplished, and television on the way—what remained but the achievement of the health of the community, and who could doubt that the disciples of Harvey would gain this also?

"The Royal College of Physicians."

The ARCHBISHOP OF YORK, in proposing the last toast, that of "The Royal College of Physicians," declared himself on that occasion to be a layman of laymen, who had had probably less to do with doctors professionally than anybody else in that hall. Yet, after all, he might on that occasion represent the highest and most altruistic ideal to which the medical profession could possibly rise—that of a humanity so healthy that the occupation of the Royal College of Physicians would have gone. He had one link with the Royal College which he greatly valued. The principal founder and first President of the College, Thomas Linacre, became 440 years ago what he was happy to say he (the speaker) still was, a Fellow of All Souls' College, Oxford, and he hoped he might without presumption be regarded as standing in the relation of founder's kin. That first President was indeed the precursor of the great man whose name was in all their hearts. It was but one hundred years before William Harvey began the experimental method of which he was the greatest illustrator, and Linacre as well as Harvey had the honour of graduating in medicine in the University of Padua, which had been represented with so much eloquence that evening. Linacre represented the union of medical science with letters and scholarship. He was the friend of Erasmus, Colet, and Thomas More. It was to be hoped that the connexion between the physician and scholarship and letters might be maintained. The study of humanities did give a unique distinction; he trusted that that old association between medicine and letters, that old succession of medical humanists who had done so much to give distinction to English life, would not be broken. Linacre also reminded him of the union between medical science and the Church, for he was during the last fifteen years of his life a clerk in holy orders. Then, as now and always, Theology was the queen of the sciences, and, like other queens, was apt to be somewhat jealous and dictatorial; for a considerable time she held Medicine under a somewhat painful constraint. But those days were passed; Medicine was now free, though he hoped that as there had been no divorce there would not even be any separation between the Church and Medicine, but a new comradeship based on freedom. They ought to be working together as fellow students in the spirit of science, with minds furnished as

Royal College of Physicians of London



Fellow 1607–1657
Censor 1613–1625–1629
Treasurer 1628–1629
Lumleian Lecturer 1615–1656

Banquet at the Guildhall
Wednesday 16th May 1928

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became disciples of truth, and he could wish that the Royal College of Physicians would take the lead in a new scientific and independent inquiry on the subject of spiritual healing. He did not think there was any profession in the world where the connexion between science and humanity was more close than in the great profession of which the College was the head. There research, teaching, and practice were all fused together in one common enthusiasm, and he liked to think that at that very moment there might be, under the College auspices, some man, having the spirit of Harvey, on the very brink of some great new discovery. No sooner would any such discovery be made than it would be taken up by the great body of practitioners and applied in every cottage throughout the length and breadth of the land.

The PRESIDENT contented himself with but a few words in reply. He thought that those who had witnessed the demonstrations arranged at the College during that commemorative week would agree that this ancient foundation was not proving unworthy of the trust which evidently Harvey in his time reposed in her; the Fellowship of the College included many men on whom the mantle of Harvey obviously had descended.

[Our illustration is reproduced from the cover of the dinner programme, designed and executed by Mr. Emery Walker. This bust of Harvey overlooks the main staircase of the College.]

DELEGATES' VISIT TO OXFORD.

A large number of the delegates visited the University of Oxford on Thursday, May 17th, and were entertained at luncheon in Harvey's college by the Warden and Fellows of Merton. The party reached Oxford by train and were met at the station by the Regius Professor of Medicine (Sir Farquhar Buzzard), the Dean of the Faculty (Dr. Ainley Walker), and a number of other members of the University. They were conducted in cars to different centres, and the morning was spent in visiting the Bodleian Library, the Old Ashmolean Museum, the Lewis Evans collection, Magdalen College (hall, chapel, cloisters, and gardens), and Christ Church (hall, library, kitchens, and quadrangles). At the Old Ashmolean Museum Mr. R. T. Gunther, curator of the Lewis Evans collection, spoke of Harvey's work with Bathurst at Trinity College, where they studied the development of chicks in incubated eggs. At 1.15 p.m. the different parties re-united at Merton College, where they were met by the Professors in the Faculty of Medicine, and were received by the Warden and Fellows of the College. Luncheon was served in the College Hall to about one hundred guests. On a small table in the centre of the Hall were displayed some of the College books relating to the period of Harvey's wardenship, and a bursarial account showing his signature was exhibited. After the loyal toast had been honoured the Warden (Mr. Thomas Bowman) expressed in felicitous terms the pleasure felt by the College in welcoming and entertaining the delegates. Sir John Rose Bradford (President of the Royal College of Physicians) replied on behalf of the guests, emphasizing the important part played by Oxford and Oxford men in the early history of scientific and medical investigation in England. Subsequently the visitors had the opportunity of seeing the College library and gardens, and proceeded in small parties to spend the afternoon in seeing some of the other colleges and University institutions. A short account of Harvey's connexion with Merton, drawn up by Professor H. W. Garrod, Fellow of the College, was presented to each of the guests at luncheon. This recalled that Harvey went to Oxford with the King after the battle of Edgehill, and was incorporated M.D. in the University on December 7th, 1642. He was appointed Warden of Merton on April 7th, 1645, but in the following June, when Oxford surrendered to Fairfax, Harvey ceased to be Warden. Merton possesses very few records of Harvey's wardenship beyond two autographs, but the College Register contains a fairly full account of his appointment as Warden and of the circumstances leading to it, together with a copy of the letter of appointment. Four days after his appointment Harvey called the Fellows together in the Hall and delivered a speech, exhorting them to friendship and goodwill. He is believed to have spent most of his time at Oxford studying the incubation of fowls.

On Saturday, May 19th, by the invitation of Bodley's Librarian, the members of the Oxford Bibliographical Society viewed a collection of books exhibited to commemorate the tercentenary, at the Radcliffe (Science) Library, University Museum, and were addressed by Sir Farquhar Buzzard on Harvey's discovery of the circulation of the blood.

DELEGATES' VISIT TO CAMBRIDGE.

The last event of the week was a visit of the delegates to Cambridge on Friday, May 18th, where they were entertained at luncheon by the Master and Fellows in the Hall of Gonville and Caius College, of which Harvey was a member, graduating B.A. in 1597. The guests were received by the Master, Sir Hugh Anderson, M.D., F.R.S., who welcomed them in the name of the College, and recalled that its second founder, John Caius, was President of the Royal College of Physicians of London in 1555–61, 1562–64, and again in 1571–72. The thanks of the delegates and other visitors were conveyed to the Master and Fellows by John Caius's successor in the presidency, Sir John Rose Bradford. Some of those who travelled to Cambridge by motor car turned off by way of Saffron Walden to Hempstead, Essex, in order to visit Harvey's sarcophagus and memorial in the parish church, of which an account appeared in our issue of May 12th (p. 816), from the pen of the late Sir Dawson Williams. On the Saturday the Physiological Society met in Cambridge and held a luncheon party in the Hall of Downing College, in commemoration of the Harvey Tercentenary. Many of the delegates attended, and afterwards took part in the scientific proceedings held in the large Botanical Theatre and adjoining laboratories. Professor Joseph Barcroft presided at the luncheon with Professor O. Frank of the University of Munich on his right, Sir John Rose Bradford on his left, and Professor Ivan Parlov facing him. The large company present included also Sir Humphry Rolleston, Regius Professor of Physic, Sir Archibald Garrod, Sir Charles Sherrington, Sir F. Gowland Hopkins, Professor H. R. Dean, Dr. W. E. Dixon, and Mr. J. H. Widdicombe, Senior Tutor of Downing. Professor Barcroft reminded the visitors that the Physiological Society was an informal and friendly body, whose members met chiefly to discuss work not yet ripe for publication. On this happy occasion, to celebrate the memory of the founder of modern physiology, the members welcomed their distinguished colleagues from abroad, and were delighted to have an opportunity of saying how much their writings and discoveries were appreciated in this country. After Professor A. V. Hill had given an account of the arrangements proposed for the Physiological Congress at Boston in August, 1929, the serious business of the afternoon began.

THE ROYAL SOCIETY CONVERSAZIONE.

The rooms of the Royal Society at Burlington House were filled with some interesting scientific exhibits for the usual spring conversazione on May 17th, when Sir Ernest Rutherford, O.M., Hon. F.R.C.P., President of the Society, received the guests, among whom were many of the delegates to the Harvey tercentenary celebration. Although there were many novelties to be seen, the repetition of some old experiments also drew interested groups; for example, there were some experiments in stereoscopic vision which were described in Dr. Robert Smith's *Opticks* in 1738, and again Faraday's studies of the crispations formed on liquids lying on vibrating surfaces were repeated by Sir William Bragg. The Royal Botanic Gardens at Kew sent for exhibition specimens of the plants yielding chaulmoogra oil, which is used in the treatment of leprosy. This oil is obtained from the seed of species of *Taraktogenos* and *Hydnocarpus*, tall trees occurring in the dense forests of India, Burma, and Siam. The British Mosquito Control Institute demonstrated the life-histories of various species of British mosquitos and the methods employed for controlling them. The Rothamsted Experimental Station

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ABDOMINAL PAIN AS EXEMPLIFIED IN ACUTE APPENDICITIS:

A CLINICAL AND BIOLOGICAL CONSIDERATION.*

BY

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THE EVOLUTION OF OUR KNOWLEDGE OF ABDOMINAL PAIN.†

ALMOST the first considerable contribution to our knowledge of the mechanism of abdominal pain was made by J. Ross of Manchester[1] in 1887. Ross held that there were two kinds of pain in visceral disease—true splanchnic pain, felt in the affected organ; and associated somatic pain, referred to the cerebro-spinal nerves of the body wall. Lennander[2] established the insensibility of the exposed gastro-intestinal tract to the ordinary painful stimuli, and attributed all abdominal pain to stimulation of nerves in the sensitive parietal peritoneum. Mackenzie, whose views form the orthodox teaching of the current textbooks, accepted Ross's views on somatic pain, but rejected splanchnic pain as non-existent. He believed that painful stimuli passed from the viscera through the afferent splanchnic nerves to the spinal cord, but were only appreciated by the brain as arising from the sensory nerves of the parietes. Mackenzie's theories of a viscero-sensory and viscero-motor reflex have been widely accepted, and will be discussed later. Hurst[3] in 1911 published observations which have restored our belief in true splanchnic pain; he proved that this type of pain is produced by a single adequate stimulus—namely, increased tension in the muscular wall of the viscus concerned. Yet Hurst does not reject Mackenzie's views on the viscero-sensory and viscero-motor reflex mechanism.

My purpose in this paper is to discuss the light which a study of acute appendicitis throws on the mechanism of abdominal pain; and since Mackenzie's theories were based very largely on his observations in cases of appendicitis, this disease may reasonably be used to test those theories.

THE TWO PAINS IN APPENDICITIS.

The conventional teaching on the pain in acute appendicitis is that the attack is ushered in by pain referred to the region of the umbilicus or a little above it, and that after a few hours the pain becomes localized in the right iliac fossa or moves down into that region.

The Initial or Central Pain.

The first point that I wish to emphasize is that the initial pain is entirely different in character and in its mode of origin from the pain which appears in the right iliac fossa a few hours later. The initial pain is felt in the centre of the abdomen, and though the patient may refer it to the mid-line at or above the umbilicus, he often describes it as "all across," sweeping his hand evenly across the central region of the abdomen. It is, in short, very imperfectly localized. The pain is often described by the patient as "like an ordinary bellyache, but more severe." It is frequently griping in character and varies in intensity; the more severe spasms usually occur at more or less regular intervals, and last for a few seconds, during which the patient moans and writhes restlessly in bed. This early pain is entirely unassociated with any tenderness on palpation, and the patient may rub or press on his abdomen in a vain attempt to secure relief—a thing that he never does when the second pain has appeared.

This initial pain in appendicitis is, I believe, a true splanchnic pain, and, like all true splanchnic pain, is due to increased tension on the muscular wall of the viscus concerned. Some degree of obstruction to the lumen of the appendix, causing retention of inflammatory exudate distal to the obstruction, is an essential factor in its production. Sometimes—in fact, it is almost the rule in the most fulminating cases—we find a hard, laminated faecal concretion engaged in the relatively narrow base of the appendix, while distal to it a collection of foul pus under great tension rams the concretion home into the base. In this condition, so well described by Wilkie[4] as acute appendicular obstruction, the central pain in the umbilical region continues until general gangrene or localized perforation of the appendix relieves the tension within it and the pain disappears. In other cases a stricture at the base, the result of some former ulceration, gives rise to the same sequence of events. In others a kinking at the base combines with inflammatory swelling of the mucosa to occlude the outlet into the caecum. In yet rarer instances a foreign body is the occluding agent. A critical examination of the specimens removed in a large number of cases of early appendicitis has convinced me that wherever this splanchnic pain is present some degree of obstruction to the lumen, with retention of inflammatory exudate under tension beyond it, will be found. It is possible that the inflamed condition of the appendix lowers the threshold of painful stimulation and allows a relatively slight distension to cause pain; but without increased tension visceral pain is impossible.

Under certain conditions recurrent attacks of appendicitis may occur in which this splanchnic central pain is the only evidence of the disease, and great difficulty in diagnosis results. A striking instance of this difficulty was afforded by a man, aged 21, who gave a history of four severe attacks of epigastric pain, each lasting for a few hours, during the course of four months. There had been neither tenderness nor muscular rigidity during the attacks. Exploration a week after the last attack showed that the only viscus affected was the appendix, which was swollen and congested in its distal portion. There was a narrow stricture at the base, and, distal to this, a collection of thick yellow pus. In the ten months that have passed since the operation there have been no more attacks.

It is evident that this patient was suffering from recurrent attacks of acute obstructive appendicitis of too mild a type to cause perforation, and that his pain was of the pure splanchnic appendicular type. The reason for the entire absence of local pain and rigidity I shall discuss later, when dealing with the second pain. The brief intermittent colicky attacks of central abdominal pain so common in children, and described by physicians as "umbilical colic," are very commonly due to spasmodic efforts to expel a concretion or a nest of threadworms from the appendix, and form another example of pure splanchnic pain.

Although the splanchnic pain in acute appendicitis is felt in the umbilical or lower epigastric region, and not in the region of the appendix, it should not be described as a referred or reflected pain, as no radiation of pain or reflex process is involved. The appendix is developmentally a part of the mid-gut loop. The brain can only appreciate painful stimuli arising from any portion of the mid-gut as vaguely situated in the centre of the abdomen, and stimuli of appendicular origin are no exception to the rule. It is characteristic of this splanchnic pain that it is dull and aching in character—as patients express it, "like an ordinary bellyache"—and vaguely localized; in other words, it is a form of Head's protopathic pain.

*A post-graduate lecture delivered at the Manchester Royal Infirmary.
† For reasons of space this introductory section has been abridged.

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illustrated the biological control of insect pests and noxious plants. Something was shown of the attempt now being made to control the European earwig in New Zealand by the introduction in that country of its European parasitic foes, and the destruction of noxious plants by insects which attack them. Another exhibit of interest consisted of marine animals and bottom deposits obtained by the *Discovery* expedition. These were a collection of squids, crustaceans, and fish illustrating the development of luminous organs in pelagic animals, also the cores of deep-sea oozes, obtained with a new form of bottom-sampling apparatus, and preserved in the tubes in which they were collected. The Marine Biological Association showed a submarine photometer apparatus which has been used on its trawler to a depth of 70 metres. The Department of Zoology of the British Museum contributed some very interesting natural history exhibits. One of these showed a portion of the intestinal wall of a whale heavily infected with acanthocephalan worms. It was mentioned that of a school of killer whales recently stranded in Scotland, every individual was found to be infected with this parasite, but even when the intestine was almost blocked by the worms the whales appeared to be in good condition. Other specimens were the giant shipworm (*Kuphus arenarius*), which was obtained in the Solomon Islands, and anatomical preparations of the ostrich and allied birds to illustrate the structure of the feathers and the arrangement of bones and muscles of the wing, and to show that this family of birds are derived from ancestors that had not acquired the power of flight. Lord Rayleigh demonstrated how the peacock's feather fades if exposed to ultra-violet light, the green changing to blue, and the colour disappearing altogether with long-continued exposure, and Dr. L. J. Spencer showed the brilliant fluorescence of fluorspar and certain other minerals when exposed to this radiation. Dr. R. J. Ludford brought from the laboratories of the Imperial Cancer Research Fund a number of microscope exhibits to illustrate cell structure and intra-vitam staining in tumour-bearing animals. He stated that mice given 1 c.cm. injections subcutaneously of 1 per cent. trypan blue at intervals of a few days could be kept alive for several weeks. Within some of the cells, such as those of the kidney and liver, the dye collected in the form of droplets in that part of the cytoplasm which coincided with the position of the Golgi apparatus. Areas of necrosis in transplanted tumours stained readily. There was a slight accumulation of dye in living sarcoma cells, but not in living carcinoma cells. Finally, there was a remarkable exhibit from the School of Pharmacy of the Pharmaceutical Society of Great Britain, consisting of specimens of the animal materia medica of the seventeenth century. At that time entire animals, as well as parts and excretions of animals, were largely used medicinally. In the *London Pharmacopoeia* of 1627 the bloods of fourteen animals, including that of man, were included. The Pharmaceutical Society recently came into possession of a number of these specimens, and some of the rarest and most interesting were shown. These included powdered mummy, which was supposed to resist gangrene; human skin, probably employed as a ligature; powdered shark's teeth, used for scorpion bites; the ends of tails of scorpions, given as a diuretic; callosities on the knees of horses, used for epilepsy; human blood, given as a sudorific and diaphoretic; calculi from the human bladder, given for stomach trouble; and human skull, powdered, considered good for epilepsy. During the evening Dr. Stanley Kemp gave an account of whaling in the Antarctic, with lantern illustrations of the methods used and of the scenery in the dependencies of the Falkland Islands.

A BIBLIOGRAPHY OF HARVEY.

THE tercentenary of the publication of Harvey's *Exercitatio Anatomica de Motu Cordis et Sanguinis in Animalibus* has been piously commemorated under the auspices of the Royal College of Physicians of London, of which, to quote from Munk's *Roll*, he was "the brightest ornament"; but bearing in mind the proverb "*litera scripta manet*," there is every reason to welcome the three volumes which have most appropriately appeared to render the celebrations complete, and especially Mr. Geoffrey Keynes's beautifully printed "*A Bibliography of the Writings of William Harvey, M.D., Discoverer of the Circulation of the Blood.*"[1] This fine product of the Cambridge University Press by a Cambridge graduate is so extraordinarily complete that some might like to imagine some inspiration from the late Sir William Osler, in whose study the first entry in the *Bibliography* was made on February 12th, 1927. There are five sections, giving detailed accounts of the Harveian writings, with interesting information about the actual resting places of the rare editions. As is only natural and right, nearly half the volume is occupied with the *De Motu Cordis*; then the *De Circulatione Sanguinis* (1649), or the two letters to John Riolan the younger, and the *De Generatione Animalium* (1651) are similarly described. The fourth section, Omnia Opera, deals with publications of his collected works, and the fifth section, Miscellanea, contains notices of the necropsy on the famous Thomas Parr, reputed to be 153 years old, Sir George Paget's publication of a letter from Harvey to Samuel Ward, the Master of Sidney College, Cambridge, letters subsequently made public by Dr. J. H. Aveling and Dr. S. Weir Mitchell, and the well-known *Prolectiones*, or notes for his Lumleian Lectures of 1616, brought out as an autotype reproduction by the College of Physicians in 1886. There is, in addition, an index of the recorded copies, the British Museum with 35 entries, leading the College of Physicians of Philadelphia, which has 31.

Each section is introduced by a bibliographical preface full of scholarly lore—for example, the details of the cancelled title-page of the *De Circulatione Sanguinis*—and there are a number of well-executed illustrations and reproductions of title-pages. The *De Motu* and the *De Generatione Animalium* were both translated into English for the first time in 1653, but the responsible hand is unknown, and the suggestion that it was that of Dr. Martin Llewelyn, whose dedicatory poem to Harvey appears at the beginning of the latter translation, has not any evidence in its favour. The first English translation of the *De Motu Cordis* has just been edited by Mr. Keynes and issued by the Nonesuch Press. Of the first edition of the *De Motu* 17 copies have been tracked down; its Latin text has been printed twenty times, the last occasion in ordinary type being in 1824; but the College of Physicians has now had 250 copies of a photographic facsimile of the original edition prepared to commemorate the tercentenary.

ROYAL MEDICAL BENEVOLENT FUND.

AT a recent meeting of the committee forty-nine cases were considered and £659 voted to forty-one applicants. Since the beginning of the year £2,362 has been made in grants to urgent cases of distress. The demands for help increase; subscriptions are very urgently needed, and should be sent to the Honorary Treasurer, Sir Charters Symonds, 11, Chandos Street, Cavendish Square, W.1. The following are notes on a few of the cases relieved at the last meeting.

M.D.Durh., at the age of 76, with his wife blind and suffering from cancer, and without a penny saved, suddenly found himself out of employment. No provision had been made for old age, as since 1912 he had not been able to earn more than £200 a year. Before then he had educated two sons for the medical profession; one died during the war, and the other is delicate and is himself struggling to keep going. There were also two daughters to be educated. He will apply for the old age pension. The Fund voted £40.

Widow, aged 69, of L.R.C.P. and S.Ed. The applicant's husband died of cancer, leaving her penniless. He had been a salaried assistant, and on his decease the widow received only £25, the salary due to his death. The sale of furniture and a small gift of £20 has brought her total capital up to £150. The applicant is now living with a niece, the wife of a clergyman, who has only his stipend and is unable to support her. Voted £25.

Widow, aged 77, of M.R.C.S. Since her husband's death in 1884 the applicant has maintained herself as companion-housekeeper, but at 77 she is unfit for work, and her only income is the old age pension of £25 a year. Voted £36.

The Royal Medical Benevolent Fund Guild still receives many applications for clothing, especially for coats and skirts for ladies and girls holding secretarial posts, and suits for working boys. The Guild appeals for second-hand clothes and household articles. The gifts should be sent to the Secretary of the Guild, 58, Great Marlborough Street, W.1.

[1] "*A Bibliography of the Writings of William Harvey, M.D., Discoverer of the Circulation of the Blood, 1628–1928.* By Geoffrey Keynes, M.A., M.D., F.R.C.S. London: Cambridge University Press. 1928. (8 × 10¾ pp. xii + 67; 8 illustrations and 12 reproductions of title-pages. 21s. net.)

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THE LESSONS OF RARE MALADIES.

ANNUAL ORATION BEFORE THE MEDICAL SOCIETY OF LONDON BY SIR ARCHIBALD GARROD.

THE Annual Oration before the Medical Society of London was delivered on May 21st by Sir ARCHIBALD GARROD, K.C.M.G., D.M., F.R.S., whose subject was the lessons of rare maladies. Mr. HERBERT W. CARSON, President, was in the chair.

Sir ARCHIBALD GARROD said that in rare diseases were to be found the keys to not a few dark places in physiology and pathology. At the time of the First Empire, when the French universities were in the melting-pot, there were established in some of the medical schools professorships for the exposition of rare cases and diseases; and in the *Dictionnaire des Sciences Médicales* (1813) there was an article by Fournier on rare cases which extended to 120 pages. In British medical journals and transactions the speaker had found only two addresses on this subject—a series of Bradshaw Lectures by Sir James Paget in 1882, and a previous oration to the Medical Society by Sir Jonathan Hutchinson in 1889. Paget observed: "We ought not to set them [rare cases] aside with idle thoughts or idle words about 'curiosities' or 'chances.' Not one of them is without meaning; not one that might not become the beginning of excellent knowledge, if only we could answer the question—Why is this rare? or, being rare, why did it in this instance occur?" The study of what might be styled Nature's experiments was of special value, and many lessons which rare maladies taught could hardly be learnt in other ways.

There were two preliminary questions at the outset: Was it needful to draw a dividing line between rare cases and rare diseases? and What was meant by a rare disease? The answer to the first question was in the negative. Any example of a rare disease was a rare case, and a rare syndrome might be due to a lesion of a common kind in an uncommon situation. With regard to the second question, he did not propose to include in the category maladies which were common in hotter countries, but rare or absent from our own, nor infective diseases of lower animals rarely met with in human subjects, nor maladies the common occurrence or rarity of which depended upon the prevalence or absence of dietary defects. The truly rare maladies touched upon in this oration were such as were seldom seen in men living on any part of the globe or under any conditions of life. As to the criterion of rarity, he took it that between those common illnesses which went far to fill the hospitals and those so uncommon that the recorded examples could be counted upon the fingers every degree of rarity was represented; yet it seemed to him that the bulk of diseases fell into one or other of the more extreme categories, and that comparatively few were "somewhat rare."

Departures from Type.

One of the chief reasons why rare maladies could teach so much was because they called attention to the ordinary things otherwise accepted as a matter of course. We took for granted our own asymmetry—regarded it as natural that the liver should lie to the right and the spleen to the left. A case of transposition of viscera set us thinking, pondering as to the underlying cause of the more usual arrangement. Many rare maladies had as their underlying causes more or less abrupt departures from type such as were usually spoken of as mutations, which were transmitted to offspring, either as dominant or recessive characters. Such departures often threw light upon problems of heredity, on the development of the body, or of the living processes of which the body was the seat, and on the liabilities of individuals to special forms of disease. Some unfavourable mutations were anomalies of structure, manifesting themselves as malformations, such as claw-hand or excess of digits; others were functional mutations, and these, like interferences with a delicate and complicated machine, might bring about results which, however undesirable, threw valuable light on normal working. Thus from the study of some rare maladies much knowledge was gained of diathesis, the constitutional factor in the causation of disease. Idiosyncrasies also—those special sensitivities to certain protein substances, to pollens, foods, and drugs—had a share in the causation of some rare syndromes.

Addison's Researches.

The orator took as his first example the least rare of rare maladies, Addison's disease, specially to call attention to Addison's pamphlet (1855), which was a model of scientific clinical medicine, controlled by morbid anatomy. In the preface to that epoch-making monograph in which he set forth his researches Addison described it as "a first and feeble step towards inquiry into the functions and influence of the adrenals, suggested by pathology"; for it was clear to him that it was the seat and not the nature of the lesions which determined the symptoms. From that "first and feeble step" had grown up our knowledge not only of the functions of the adrenals, but also of the other endocrine glands, and of the hormones which they secreted. As more had been learned about them they had been recognized as the regulators of the metabolism of the tissues, also of height and weight, temperature, and blood pressure. It had become increasingly evident that the several ductless glands, acting, some as mutual opponents and others as allies, formed a balanced mechanism, which set limits to the various functions, and by readjustments of which the phenomena of puberty and of the climacteric were brought about. The most recent advances in endocrine studies; the isolation and synthesis, first of adrenaline itself, and lately of thyroxine; the study of their physiological actions, and the utilization of insulin, might rank among the greatest achievements of medical science, and all might be traced back, directly or indirectly, to Addison's researches.

Passing to inborn errors of metabolism, the orator mentioned alcaptonuria, a rare anomaly, which behaved as a characteristic Mendelian recessive character, and was wont to occur in several brothers and sisters, whose parents were usually normal but were in a large proportion of cases first cousins. By the study of this malady from the standpoint of chemistry, and by the administration to its subjects of a variety of aromatic compounds, much light had been thrown upon the katabolism of proteins; it had also shown how a metabolic product might have the power of staining certain living tissues in a selective manner, and, further, that a trifling deviation from the normal in metabolism and the presence in the tissues of small quantities of an intermediate product, normally destroyed, might so lower the resistance of tissues that, after the lapse of many years, there was developed, under the stress and strain of daily life, a characteristic form of osteo-arthritis. Another still rarer malady was congenital porphyrinuria, or haematoporphyria, which stained the bones a deep brown colour, and had taught us much regarding the action of light upon the living organism.

Tissue Anomalies.

The orator's next example was taken from that group of tissue anomalies which included the familio-hereditary affections of the nervous and muscular systems to which Gowers gave the name of "abiotrophies." These illustrated a point upon which Hutchinson laid much, perhaps too much, stress—namely, the affinities between morbid states and their tendency to merge into each other. Thus in a particular family tissue anomalies might crop up in different members, in one some form of muscular atrophy, in another myotonia atrophica. The muscular dystrophy and myotonia had in the observed cases been limited to the collaterals of one generation of a family, seldom developing before the age of 25; but cataract, which was associated with the syndrome, had been traced back through four or five generations. Some recent investigators held that the underlying factor in the disease under discussion was a widespread defect of the endocrine glands, and that what was here discovered was a pluriglandular syndrome. It

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might well be that other affections of this group, the abiotrophies, would prove to be local manifestations of much wider maladies, and that the link between the calcareous deposits and the digital anomalies in myositis ossificans might be found in a generalized defect of the mesenchymatous tissues, of which these were merely the most conspicuous signs.

He next touched upon the very rare and curious disease first described by Gaucher in 1882; and known by his name—a form of enlargement of the spleen, met with in a child, and characterized by the presence in the splenic tissue of numbers of large hyaline cells which stained but feebly. Before long it was realized that this was no form of malignant growth, and that the changes were by no means limited to the spleen, the liver becoming greatly enlarged and the haemopoietic tissue generally being involved. In recent years it had been shown that the peculiar Gaucher cells, found in all the affected parts, owed their swollen and hyaline appearance to the presence in them of a chemical substance, kerasin, a member of the class of galacto-lipins. One of the latest theories was that here one had a perversion of the metabolic process, and that kerasin was a product of abnormal metabolism. The subjects of such maladies as the abiotrophies and Gaucher's disease furnished striking examples of constitutional liabilities. It was because they were uncommon individuals that they were predestined to suffer—in other words, the patient rather than the malady was rare.

Maladies Still Obscure

In conclusion, the orator spoke of some rare maladies the lessons of which had been learnt only in part or not at all. The syndrome known as intermittent hydrarthrosis had features which might be described as uncanny. Effusion into the knee-joint here recurred with a regularity comparable to that of some forms of malaria, and was clearly not connected with the life-history of any parasite. An exactly similar periodic hydrarthrosis was sometimes met with in cases of arthritis of various kinds. There was undoubtedly a connexion between the cutaneous lesions of the erythema group and affections of the joints—witness the familiar serum sickness. Again, periodicity was met with in other maladies of the anaphylactic group, in erythemata occasionally, in asthma often, and in Henoch's purpura almost always; but in none of these conditions was there any such accurate periodicity as in hydrarthrosis. The most likely explanation was that each attack desensitized the patient for a time, at the expiration of which the trouble recurred.

Another very uncommon syndrome was sulphaemoglobinaemia, clearly an acquired malady, with no indication of family or hereditary occurrence. Its chief problems still awaited solution. Chloroma was another rare malady which presented important unsolved problems. Another of the most obscure of rare diseases was that malady involving the bone marrow, of which the copious excretion of the Bence Jones protein was the diagnostic sign. That weird mixture of infantilism and premature senility which Hastings Giffard described under the name of "progeria," and the developmental anomalies of bony structures, of which achondroplasia, oxycephaly, and hypertelorism might be cited as examples, had not yet revealed their secrets, but would repay investigation. Of all these it might be said that they tended to prove the truth of Harvey's dictum that "Nature is nowhere accustomed more openly to display her secret mysteries than in cases where she shows tracings of her workings apart from the beaten path." The orator hoped that there would always be some who would seek to guess the riddles and to learn the lessons of the rarer maladies.

At the annual meeting of the Medical Society of London, which preceded the oration, Dr. John Walter Carr was elected president for 1928–29, Dr. J. E. H. Roberts a new vice-president, and Dr. Anthony Feiling and Mr. R. Davies-Colley honorary secretaries. It was stated that the society now numbered 626 Fellows, including 15 honorary Fellows. The vote of thanks to Sir Archibald Garrod for his oration was proposed and seconded by Sir James Berry and Dr. J. W. Carr respectively.

THE BRITISH PHARMACOPOEIA

PROPOSALS FOR A STANDING COMMISSION

THE report of the subcommittee on the *British Pharmacopoeia*, appointed by the Committee of Civil Research at the instance of the General Medical Council, was published on May 17th.[1] In its fifty-seven pages it gives a brief account of the evolution and present position of this official publication, records the criticisms directed against the existing machinery for its production and revision, and submits a series of proposals for its future conduct and constitution. The subcommittee, which came into being on July 19th, 1926, was directed in its terms of reference

> To make inquiries, to collect information, to receive evidence, and to make recommendations on the question whether it is desirable to make any, and if so, what, alterations in the existing law or practice relating to the preparation or publication of the *British Pharmacopoeia* and to its adaptation to the requirements of the British Empire.

The members of the subcommittee were as follows:

> The Right Hon. H. P. Macmillan, K.C. (Chairman).
> The Right Hon. Lord Dawson of Penn, G.C.V.O., M.D.
> Sir Donald MacAlister, Bt., M.D., President of the General Medical Council.
> Dr. H. H. Dale, F.R.S., Director of Department of Biochemistry and Pharmacology, Medical Research Council.
> Mr. Edmund White, Past-President of the Pharmaceutical Society of Great Britain.
> Dr. H. G. Dain, Chairman, Conference of Representatives of Local Medical and Panel Committees; British Medical Association, 1919–24.

The subcommittee's task fell naturally into two main branches—consideration of the legal position of the *Pharmacopoeia* and consideration of the machinery for its compilation and revision in the light of current difficulties. So far as the first question is concerned, it concludes that no change involving legislation is necessary, and the bulk of the proposals put forward therefore relate to the method by which it is considered the *Pharmacopoeia* should be produced, and the considerations which should govern its composition. In view of the fact that no change in the law is suggested, the subcommittee states: "We recognize that . . . the carrying into effect of our recommendations will depend on their acceptance by the General Medical Council, but we are hopeful that the scheme which we propose will commend itself to the Council." The scheme referred to provides for the appointment by the General Medical Council of a selection committee consisting of persons nominated by the Council itself, by the three pharmaceutical societies, and by the Medical Research Council. This selection committee will nominate a Pharmacopoeia Commission, a permanent body, which will be charged, under the general direction of the General Medical Council, with the actual work of preparing future issues of the *British Pharmacopoeia*. Provision is made to secure the co-operation, where it is desired, of representative bodies in the Dominions and in India.

Difficulties in Securing Co-operation

At this point we may recall the chain of events which led to the institution of the inquiry now completed. At the autumn meeting of the General Medical Council in 1925 it was announced that preparations had been made to proceed with a revision of the *British Pharmacopoeia*, 1914. Communications had been addressed to the various Governmental authorities interested, at home and in the Dominions, and to universities and medical corporations in this country, inviting relevant suggestions, while the Pharmaceutical Society of Great Britain had been asked to co-operate by nominating members of a pharmaceutical advisory committee and a committee of reference in pharmacy. The Council, therefore, proposed to proceed on the lines which had governed the earlier revisions. Difficulty was experienced, however, in securing assurances of the requisite expert assistance, and it became clear that pharmacists generally objected to the perpetuation of a system which involved the performance by them of a large part of the work required, while the responsibility for editing the *Pharmacopoeia* was retained by a committee of the General Medical Council. An interesting account of

[1] Cmd. 3101. London: H.M. Stationery Office or through any bookseller. 1928. 1s. net.

F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
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the position by Professor A. J. Clark of Edinburgh University (he then held the chair of pharmacology at University College, London)—was published in the *British Medical Journal* on January 2nd, 1926 (p. 30). In it he gave a critical analysis of the methods employed in the preparation of the *British Pharmacopoeia* and of the *United States Pharmacopoeia*, the tenth revision of which had just been completed. As a result of the criticisms directed against its procedure, the General Medical Council convened a conference between the members of its Pharmacopoeia Committee and representatives of various medical, scientific, and pharmaceutical bodies, and at a meeting on February 23rd, 1926, a free discussion took place. The outcome of these proceedings was the appointment of the subcommittee whose report is now under review.

Defects in the Present System.

This document surveys the evolution of the *British Pharmacopoeia* from the earliest times, giving particular attention, of course, to the part played by the General Medical Council in the execution of its responsibility for the production of this work under the Medical Acts of 1858 and 1862. A review is given of the methods of preparation adopted for each successive edition from 1864 to 1914, in the course of which period the system now in the melting-pot was gradually built up. Reference is then made to certain developments which have taken place since 1914, such as the passing of the Therapeutic Substances Act, 1925, and the subcommittee proceeds to comment on the machinery of the General Medical Council in this period, stating that:

"The functions of the Pharmacopoeia Conference and the committees of reference set up to assist in the preparation of the fifth *British Pharmacopoeia* came to an end on its publication. The Pharmacopoeia Committee of the General Council continued to meet at intervals, and presented half-yearly reports dealing with matters referred to above (e.g., the Therapeutic Substances Act), and any other topics arising which affected the *British Pharmacopoeia*. But no systematic or continuous work was undertaken with a view to the next revisal, and no digests of material were compiled. . . . In 1921 the Pharmacopoeia Committee received an offer of co-operation in matters of common pharmaceutical interest from the Chairman of the Committee of Revision of the *United States Pharmacopoeia*, which was cordially accepted, and this was followed by the transmission of advance copies of material compiled by the United States Committee dealing with proposed omissions and additions, drafts of new monographs and the like."

After giving a survey of the more recent events mentioned above the subcommittee submits a detailed study of the legal status of the *Pharmacopoeia* throughout the British Empire, and goes on to review the criticisms of the existing regime placed before it by interested parties. This criticism, the report states, was directed against both "the method of production and the resulting product." With regard to the criticism of what may be termed the non-expert status of the Council the subcommittee remarks:

"It was pointed out that the General Medical Council has a number of most important public duties, judicial and administrative, to perform, and that its members are selected not with a view to their fitness or capacity to take part in the production of the *British Pharmacopoeia*, which is only one of their functions among others, but rather because of their general ability and professional standing."

The subcommittee found that one of the main objections to the existing system came from those who had assisted in the production in the past, and who were dissatisfied with the status accorded them in relation to their work. This was not confined to the pharmaceutical societies: the complaint was general that the experts in the various branches of science whose collaboration was essential did not enjoy a responsible status such as they claimed their services merited.

The report proceeds to consider the nature of the *Pharmacopoeia*, introducing its discussion with the note:

"In early times pharmacopoeias were little more than descriptive lists of medicines in use by the profession, and their compilation was generally the work of medical men. But a modern pharmacopoeia must be much more than this. It must contain not only a carefully scrutinized list of current drugs of repute, but also authoritative standards whereby the purity and efficacy of these drugs may be tested."

The definition suggested by the British Medical Association* is quoted:

"The *Pharmacopoeia* should contain so far as practicable all those drugs and preparations which experience shows to be in common use by medical practitioners and which in the interest of the public require a standard method of preparation, or a standard of strength, or a standard of purity, provided that such drugs and preparations have a therapeutics or diagnostic value, or are pharmaceutically necessary."

The members of the subcommittee came to the conclusion that it was unnecessary for them to discuss in detail the sphere of the *Pharmacopoeia*; as this was a matter for those charged with the preparation of future editions, and they therefore concentrated their attention on the question of securing that this work should be undertaken by those best fitted for it. The result of their deliberations on this matter has already been indicated, and is given in greater detail in the summary printed below. With regard to the period of publication, it is suggested that the revisions should be so arranged that the successive issues of the *British Pharmacopoeia* should appear in the middle of the intervals of the issues of the *United States Pharmacopoeia*, which is already published every ten years. Considerable weight is attached to the establishment of an adequate secretariat with suitable staff and equipment, in view of the importance of co-operation with other parts of the Empire and with the United States and the growing international aspect of pharmaceutical enterprise. The report indicates that the subcommittee has been assured that the important work of research, often of a voluntary nature, which has so frequently been provided in the past by experts with laboratory facilities at their disposal, will be given to the proposed Pharmaceutical Commission increasingly, if it is established.

In making investigation into the question of the adaptation of the *Pharmacopoeia* to the needs of the Empire communications were addressed to a number of the Dominions and Dependencies, and for the most part their answers indicated that they were either satisfied with the existing system or were prepared to accept a revised *Pharmacopoeia* without representation on the body responsible for its production. Various Canadian interests, however, held that Canada should have a voice in revision, but the Canadian Government, although twice approached, did not find it possible to appoint an authoritative representative to discuss with the subcommittee the best means of adapting the *British Pharmacopoeia* to Canadian requirements. General suggestions for adapting the *Pharmacopoeia* to regional needs are given in the report.

Conclusions and Recommendations.

The report gives the following summary of the principal conclusions and recommendations of the subcommittee:

(i) That it is not necessary or desirable to make any alterations in the existing law relating to the preparation or publication of the *British Pharmacopoeia*.

(ii) That the General Medical Council set up forthwith a Selection Committee to be charged with the duty of selecting persons to form a new body to be designated "The Pharmacopoeia Commission."

(iii) That the composition and functions of the Selection Committee be as follows: (*a*) The Selection Committee should consist of four persons nominated by the General Medical Council, three persons nominated jointly by the Council of the Pharmaceutical Society of Great Britain, the Council of the Pharmaceutical Society of Ireland, and the Council of the Pharmaceutical Society of Northern Ireland, and two persons nominated by the Medical Research Council; the representatives in each case to be chosen by the nominating body either from among or from outside its membership. (*b*) The chairman of the Selection Committee should be appointed by the General Medical Council from among their four representatives. (*c*) The Selection Committee so appointed should select persons representative of the various appropriate departments of knowledge and experience to form the Pharmacopoeia Commission. (*d*) The number of persons selected to form the Pharmacopoeia Commission should not be prescribed, but should be left to the discretion of the Selection Committee, who should have power from time to time to select additional persons for permanent or temporary membership, including representatives

*A "watching" committee was appointed by the British Medical Association in July, 1926; a memorandum was prepared for presentation to the subcommittee, and evidence on behalf of the Association was given by Dr. J. W. Bone and Dr. G. C. Anderson, Deputy Medical Secretary.

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of India or the Dominions. (c) The Selection Committee should submit to the General Medical Council for approval the name of one of the selected persons to be chairman of the Commission.

(iv) That the manner of appointment, composition, and functions of the Pharmacopoeia Commission should be as follows: (a) The Pharmacopoeia Commission should be appointed by the General Medical Council, its members being persons whose names are submitted to the Council by the Selection Committee. (b) The Pharmacopoeia Commission should be a permanent body with an office and suitable secretariat, and the work of collecting and collating material, preparing reports, and conducting correspondence with a view to the preparation of future issues of the *Pharmacopoeia* should be carried on continuously. (c) The actual work of preparing future issues of the *British Pharmacopoeia* should be undertaken by the Pharmacopoeia Commission under the general direction of the General Medical Council; on each revision the completed volume should be submitted by the Commission to the General Medical Council for approval; and when approved it should be issued as heretofore with the authority of the General Medical Council. (d) The Pharmacopoeia Commission should have power to appoint subcommittees, and to include among the members of such subcommittees experts in any particular branch, whose assistance may be desired, although they may not be members of the Commission.

(v) That in future the *British Pharmacopoeia* should: (a) Be revised and reissued at stated intervals of ten years, supplements being issued between the successive editions as required. (b) Contain only standard drugs in general use throughout the Empire.

(vi) That where it is desired in any part of the Empire to sanction the use of particular local drugs, or alternative preparations not included in the *British Pharmacopoeia*, this should be left to be effected by the Governments concerned by the issue of local supplements or addenda.

(vii) That the Governments of the Dominions and of India be requested by the General Medical Council, through the appropriate channels, to set up or cause to be set up responsible and representative committees to co-operate with the Pharmacopoeia Commission in the revision of the *British Pharmacopoeia*, if they desire and are willing to take part in the work.

(viii) That, at any rate until the results of the publication of the next revision are seen, the funds necessary for carrying on the work of the Pharmacopoeia Commission be provided by the General Medical Council, who should receive the proceeds of all sales of the *Pharmacopoeia*, a separate account being kept.

Scotland.

William Mackenzie Memorial Medal.

THE first award of the recently instituted William Mackenzie Memorial Medal, "In recognition of valuable contributions to ophthalmology," will be made to Dr. A. Maitland Ramsay, honorary director, James Mackenzie Institute for Clinical Research, St. Andrews; consulting ophthalmic surgeon, late surgeon, Glasgow Royal Infirmary and Ophthalmic Institution. The presentation will take place in Glasgow in the autumn, on a date to be arranged, and on that occasion Dr. Ramsay will deliver an address.

Chair of Genetics at Edinburgh.

Dr. F. A. E. Crew has been appointed by the University Court of Edinburgh University to be professor of animal genetics and director of the University Department of Research in Animal Breeding under an ordinance founding this chair, which received the approval of His Majesty on May 7th. The chair was founded by a donation from Lord Woolavington, supplemented by a grant from the International Education Board, New York. Professor Crew is a graduate of Edinburgh University, where he took the degree of M.B. in 1912. During the war he served with the R.A.M.C. in India and France, and on demobilization took up a post as assistant in the Natural History Department of the University. In 1920 he was appointed director of the newly formed Animal Breeding Research Department, then housed in High School Yards. He has organized much research and contributed many papers to the literature on this subject. In 1926 Dr. Crew was William Withering lecturer at the University of Birmingham, and in 1928 Milroy lecturer at the Royal College of Physicians, London. Among the works which he has published have been volumes under the titles of *Animal Genetics*, *Organic Inheritance in Man*, and *Heredity*.

Conference of Health Visitors.

The Scottish Association of Health Visitors, Women Sanitary Inspectors, and School Nurses held the 9th annual conference in the City Chambers, Edinburgh, on May 12th, when Lady Leslie Mackenzie presided. Dr. William Robertson, medical officer of health for Edinburgh, who welcomed the delegates on behalf of the Town Council, said that within the last twenty years the task of the visitor had become less depressing than it used to be because social conditions were gradually improving and the people were taking a much greater interest in themselves and in their families, and housing conditions were being remedied. The work did not now consist merely in visiting slums, but it was still the duty of health visitors to reduce the number of apathetic and indolent people who paid no heed to the simple things that mattered in regard to health. In the next thirty years most of the efforts made by health visitors would be preventive rather than remedial. Dr. Ernest H. Connell opened a discussion on psychology and nursing, and claimed that they lived in a psychological age. Dr. David M'Kail (Glasgow) said that in some quarters of Glasgow the attitude of the people was to do nothing in the presence of illness, and to take up the bad mental attitude of saying, "It is in the family." The health visitor had a big work in front of her in helping to educate such people. Councillor Mrs. MiHar (Edinburgh) said that the juvenile delinquency committee had found that in practically no family where a health visitor was attending was a juvenile delinquent found. The delegates in the afternoon visited several of the hospitals of the city. On the previous evening they had attended a reception in the City Chambers, given by the Corporation, where they had been received by Bailie Hay in the absence of the Lord Provost.

Teeth of the Working Classes.

At the annual meeting of the Edinburgh Dental Hospital and School Professor P. S. Lelean moved the adoption of the directors' report. He said that national decadence was shown in no way more decisively than in the condition of the teeth. From 95 to 97 per cent. of school children in Britain suffered from dental caries. Referring to 60,000 recruits for the army seen annually, the official report declared that on an average six teeth were decayed, of which two needed immediate extraction and four required treatment to make the recruit dentally fit. This was the condition of the mouth in the young, relatively vigorous recruit; what, then, must be the condition of a debilitated, ill-nourished mother of the slums? The Edinburgh Dental Hospital had made a magnificent attempt to stem this tide of decay and to put right the appalling condition of the teeth of the working classes. Last year in the hospital 12,000 teeth had been conserved, 1,600 dentures had been fitted, and 22,000 treatments had been given by the 132 students attending the school. The speaker considered that it was pathetic that the total contributions of the public in Edinburgh would only suffice to maintain the institution for one week in the year, and that £8,000 was still required to pay for the additions to the hospital which had been opened last year.

England and Wales.

Training and Employment of Midwives.

THE Minister of Health has appointed a departmental committee whose terms of reference are: "To consider the working of the Midwives Acts, 1902 to 1926, with particular reference to the training of midwives (including its relation to the education of medical students in midwifery), and the conditions under which midwives are employed." The committee is appointed with the concurrence of the Central Midwives Board, and its appointment forms part of the measures for dealing with the problem of maternal mortality and morbidity which were referred to by the Minister when introducing the Estimates of the Ministry of Health in the House of Commons on May 15th. The members of the committee are as follows: Sir Robert-

F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
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Bolam, M.D. (chairman), Dr. J. W. Bone, Dame Janet M. Campbell, M.D., Lady Cynthia Colville, Dr. W. A. Daley, Dr. J. S. Fairbairn, Dr. T. Eustace Hill, Miss Alice Gregory, Mr. A. B. Maclachlan, Dr. F. N. Kay Menzies, Mrs. Bruce Richmond, and Miss Katherine J. Stephenson. The secretary will be Mr. W. H. Howes of the Ministry of Health, to whom all communications relating to the work of the committee should be addressed.

King Edward's Hospital Fund for London.

The Prince of Wales presided at the annual meeting of the King Edward's Hospital Fund for London, held at St. James's Palace on May 15th, to which a brief reference was made in our last issue (p. 883). After reading a message from the King, in which His Majesty expressed his gratification at the results achieved by the special distribution of £255,000 received from the estates of the late Mr. and Mrs. John Wells, which had helped the hospitals of London to provide 1,600 additional beds and to meet other urgent requirements, the Prince of Wales stated that the accounts showed a better result than had been anticipated in November, when the League of Mercy announced that it would give the Fund £17,000 instead of £15,000, so that the ordinary distribution could be increased to £247,000. This year they had already had a gift of £10,000 for general purposes from an anonymous donor, and their capital had been increased by a donation of £10,000 from Mr. J. J. Crosfield. Referring to the statistical report on the hospitals of London His Royal Highness said the total voluntary contributions to the 140 hospitals amounted to something like £1,800,000 a year. In the report, for the purpose of helping hospitals to control their expenditure by providing comparative figures of cost, quantities consumed were now given as well as money spent. The inquiry by the Pay Beds Committee into the question of hospital accommodation for the middle and professional classes was nearly finished, and the conclusions would be based on a study of pay beds as they now existed in London. Grants from the Wells legacies, which began in 1924, had for four years enabled the Distribution Committee to take each urgent scheme as it came along, at any time of the year, and give it a grant. In addition to other work, three new hospitals had been built and four had been rebuilt on new sites. In conclusion, the Prince referred to the loss the Fund had suffered by the deaths of Lord Cave, Sir William Church —who was a member of the council for twenty-seven years— and Sir John Craggs. Lord Revelstoke, honorary treasurer, presented the accounts, saying they had been able to carry forward £2,700 as a balance to next year, and gave an interesting account of the origin of the Wells legacies. The report of the general council submitted by the Earl of Donoughmore, chairman of the Management Committee, after referring to several matters already mentioned, stated that the total sum distributed during the last ten years, including all special payments, was £3,360,688. The British Charities Association again gave £15,000 last year, while an anonymous donation of £8,000 was received. Special consideration has been given to various aspects of the accidents problem, arising out of increased road traffic, and particular attention has been directed to the burden thrown upon hospitals provided to meet local needs by cases arising from this cause. The Fund is engaged in inquiries with a view to preparing practicable proposals to lay before a conference of the various parties concerned. A report on the new edition of the Fund's statistical report was approved. This edition is the first to be based on the new regulations under the revised uniform system of hospital accounts, and contains much valuable data relating to income, expenditure, and working costs in 139 institutions. The proceedings terminated with the moving of a vote of thanks to the Prince of Wales for presiding and for his continued interest in the Fund.

The Hospital for Sick Children and the Foundling Hospital Site.

The need for the reconstruction of the Hospital for Sick Children, Great Ormond Street, London, has been recognized for some time past, and consideration is being given to the question of securing a new site. Early this year the board of the hospital was approached by the Foundling Estate Protection Association with the proposal that the Foundling Hospital site should be purchased jointly, the forecourt to be preserved as an open space for the public and the Children's Hospital to be rebuilt where the "Foundling" buildings now stand. Mr. Stanley Hall, F.R.I.B.A., has reported that to rebuild the Sick Children's Hospital on its present site would be attended with grave disadvantages as regards air, light, and health conditions generally, and at a general court of governors on May 16th it was stated that the Council of King Edward's Hospital Fund, in view of the architect's report, would raise no objection to efforts being made to secure a new site, provided that the board was satisfied with the prospect of securing adequate funds. A committee has been formed from the board of management and from the Foundling Estate Protection Association, which is in negotiation with the owners of the property, and if the result of these negotiations is satisfactory an appeal on a large scale will, no doubt, be launched. Almost the only critics of the scheme were described as those who advocate other plans for the exploitation of the Foundling Estate.

Prevention of Tuberculosis in Childhood.

In a memorandum of the tuberculosis group of the Society of Medical Officers of Health reference is made to a useful form of preventive work which has been adopted in Shropshire. Infective tuberculous women who are pregnant are admitted to a sanatorium until just before labour, when they are transferred to a special open-air ward at a maternity hospital. After her confinement the patient returns to the sanatorium, and the infant is sent for one year to the County Home for Ailing Babies, where four beds are reserved for these cases. Attempts are made at the end of the year to board out the babies for a further period with relatives of the patient. Emphasis is laid also in the report on the importance of tracing sources of infection, it being borne in mind that the notified case is often not the chief danger. Removal of potential patients from a source of infection is advocated, either, as in France, by the Grancher system, or by making use of a residential open-air school. Attention is called to the valuable work which the general practitioner can render as regards steps being taken for the prevention of infection, and also for the education of the lay public. A closer degree of co-operation is advocated between the tuberculosis department, the school medical department, and maternity and child welfare centres. The opinion is expressed that the prevention of tuberculosis would be facilitated by extending Insurance Act benefits to the dependants of the insured.

Ireland.

Appointment of Dispensary Medical Officers in the Free State.

Under the Local Authorities (Officers and Employees) Act, 1926, a dispute has arisen between the Department of Local Government and Public Health and the South Cork County Board of Public Assistance with regard to the appointment by the latter body of a dispensary medical officer who was not one of its officials, and served under another health authority. In connexion with the matter the Local Government Department, in a letter to the local body, pointed out that as none of the existing medical officers in the employment of the Board was desirous of accepting the office, the vacancy should be reported to the Local Appointments Commissioners. In reference to the minute of the Board requesting the Minister to sanction the appointment of Dr. Nyhan, the Minister desires to state that he is unable to meet the wishes of the Board. If it were possible for the Board to nominate a particular officer from outside their area, a condition of affairs would arise that practitioners generally would be denied opportunity for preferment on grounds of their experience or attainments. After most careful consideration, the Minister has decided, in the general interests, that, where an appointment is not proposed from existing officers of a local authority, the making of the

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appointment should be placed in the hands of the Local Appointments Commissioners, who have suitable machinery for assessing the relative merits and qualifications of eligible candidates.

Medical Benefits (Northern Ireland).

In the Northern House of Commons when a money resolution in connexion with the National Health Insurance Bill was proposed, Labour and Nationalist members urged the inclusion of medical benefits under the Act. Mr. Kyle (Labour) said that unless they got an assurance that such benefits would be included, he thought every measure of this kind should be opposed to the utmost. There was nothing impossible about the proposal, he said, and the Local Government Commission were within an ace of reporting in favour of it when they were stampeded by members opposite in favour of the dispensary system. He declared that under the present system there was an inducement to doctors to certify people who were not incapable of work. Mr. J. Devlin and Mr. Healy supported the proposal. Mr. J. M. Andrews, Minister of Labour, said that at the present moment it would be inadvisable to adopt the suggestion. There were special difficulties in connexion with the matter, and it would be very foolish, in the interests of the poorest of their people, to make any drastic decision. He did not think that the dispensary system was unpopular, and they must be careful that in doing away with that system they did not do the people an injury instead of a benefit. The resolution was agreed to, and the Bill was carried through its remaining stages and passed.

Return of Empty Medicine Bottles and Cases.

At Cavan Circuit Court, Messrs. Evans Sons Lescher and Webb, Ltd., Liverpool, sought to recover £26 9s. 9d., value of unreturned empties in connexion with the supply of medicines, the defendants being the Cavan Board of Health. A sum of £15 was lodged in court to meet the claim. Eighteen dispensary districts were involved, and sixteen doctors were in court. Dr. O'Rourke, Ballyconnell, said that dispensary doctors should not be asked to return empties. It was not in the terms of their appointment. There should be something in the nature of a clearing house. A decree was given for £24 7s. 9d., with £5 expenses.

Correspondence.

THE PATHOGENESIS OF ACUTE PRIMARY GLAUCOMA.

SIR,—In a paper on the relation between capillary pressure and secretion, published in the *Proceedings* of the Royal Society, May 29th, 1912, M. Flack and I stated that

"the increased tension in glaucoma is due to increased imbibition and secretion of fluid, resulting from an altered metabolism of the ocular tissues, leading to compression of the veins, and to a rise in the capillary-venous pressure, and therefore intraocular pressure. . . . . Acute glaucoma resembles an inflammatory condition in any other part of the body."

Dr. Maitland Ramsay, in his address published in the *British Medical Journal* of May 12th (p. 789), ascribes the disease to a toxin producing congestive changes—a similar view. He assumes that there is normally, both in the eye and in the glomeruli of the kidney, an excess of pressure sufficient to overcome the osmotic pressure of the plasma proteins and produce filtration. This is a view combated by me and my co-workers, M. Flack and J. McQueen. Duke-Elder, by his recent ingenious observations on the retinal venous and arterial pressures, has not, in my opinion, secured any evidence which proves his assumption of the existence of a capillary pressure much above that of the intraocular fluid.

Tamura, in Japan, recently has confirmed our view concerning the glomerular capillary pressure. The excess of this over that of the fluid in the Malpighian capsule does not suffice to produce filtration. The whole question of capillary pressure and filtration is dealt with in a paper now ready for publication by James McQueen and myself. This will appear in the *British Journal of Experimental Pathology*.

By secretion of fluid we mean the control of the amount and nature of the fluid by the living cells and endothelial membranes. It is these which are altered by metabolic changes and toxins. It is not the push of a capillary pressure, but the penetrability of the endothelial membranes and the pull of the tissue cells, which is of first importance.—I am, etc.,

London, W.W., May 17th. LEONARD HILL.

SIR,—The interesting lecture by Dr. Maitland Ramsay on the pathogenesis of acute primary glaucoma raises of necessity the problem of the genesis of the intraocular fluids. Let me quote:

"It is generally agreed that the tissue fluids come from the blood plasma by dialysis through the walls of the capillaries, and Duke-Elder has demonstrated that the intraocular fluids obey the same physico-chemical laws. He believes, therefore, that the aqueous humour is a dialysate, and has brought forward evidence to prove that it is neither a secretion nor a filtrate. His work has put the physiology of the intraocular circulation into line with the circulation in the body as a whole."

This seems to me to be going somewhat fast. I am afraid there are some hedges and ditches in the course, but I am ready to be instructed how to take them. Let me state the problems.

As regards the filtration theory, it rests on the belief that the pressure in the capillaries of the eyeball is a filtering pressure—that is, above 48 to 55 mm. of Hg. It is generally agreed that the intraocular pressure is somewhat lower, by 1 or 2 mm. of Hg, than the pressure in the retinal veins. Taking the intraocular pressure at 25 mm. of Hg, on the filtration theory there would be a loss of pressure (pressure gradient) between capillaries and veins of more than 22 to 28 mm. of Hg. Elsewhere in the body the loss of pressure between capillaries and veins is 1 to 2 mm. of Hg. Loss of pressure in the arteries is due to change of arterial lumen—its narrowing—and the main loss of arterial pressure in the body is in the arterioles. There is no evidence of any peculiarity in the lumen of the capillaries of the eyeball to make this enormous reduction of pressure between capillaries and veins. It seems more probable that the capillary pressure in the eyeball is 1 to 2 mm. of Hg above the vein pressure, as elsewhere in the body. Consequently no filtration pressure exists in the capillaries of the eyeball.

The secretory theory denied the existence of a filtration pressure. The mechanism of secretion remained more or less a mystery. Now we have the dialysis theory. A very notable experiment in dialysis was carried out by Abel, who passed the blood from an artery through collodion tubes to a vein, the collodion tubes being placed in a bath of saline. The saline solution is later analysed for the substances that have entered it from the blood by diffusion—amino-acids, etc. It will be noted that what enters the saline solution are the crystalloids it does not contain originally or contains in less concentration. Were the bath distilled water, all the various salts, etc., of the blood would pass through the collodion membrane.

It is attractive to think of the tissue fluid as an Abel's bath, and similarly with the aqueous humour of the eye. But the bath in the case of the eyeball must be renewed. Six cubic millimetres of aqueous fluid per minute is estimated to be made in the eyeball. Consequently six cubic millimetres of salt- or crystalloid-deficient water has to be made per minute in the eyeball from somewhere to allow of dialysis occurring; and perhaps more, because the six cubic millimetres estimate does not include what passes out through the canal of Schlemm and what may be absorbed into the capillaries of the eyeball, because if there is no filtration pressure in the capillaries of the eyeball, and the pressure gradient between capillaries and veins is 1 to 2 mm. of Hg, then the osmotic pressure of the blood in the capillaries is unbalanced practically, and water will pass into the capillaries of the eyeball from the aqueous humour.

I do not wish to undervalue the evidence gained by

experiments on haemorrhage. There the tissue cells mobilize water deficient in salts which passes into the capillaries to restore blood volume. But if in the case of the eyeball the ciliary processes, for example, produce a salt-deficient water, they might, it seems to me, just as easily produce a normal intraocular fluid; and now we are back again at a secretory theory. The most important hedge to be taken in the course is an accurate direct measurement of capillary pressure in the eyeball. But it is a pleasure to know there are workers in the saddle.—I am, etc.,

Halewowen, May 12th. JAMES M. MCQUEEN.

IMMUNITY FOLLOWING HERPES.

SIR,—Dr. Parkes Weber, for whose encyclopaedic knowledge of the literature of disease I have the highest regard, expresses in your issue of May 19th (p. 875) doubt as to the possibility of second attacks of true herpes. I think everyone will agree that in the vast majority of cases one attack of herpes does confer immunity. Yet I have seen at least three cases of recurrence of true herpes. The first was a surgeon whom I saw many years ago with an attack of herpes frontalis on the left side. There was distinct scarring. Twenty years later I saw the same surgeon suffering from an attack of frontal herpes on the right side, and, on my expressing surprise, he told me that some years before this attack, and after his previous attack of left frontal herpes, he had had an attack of herpes in the deltoid region, and he showed me the scarring which had resulted.

The second case was that of a lady whom I saw in consultation with the late Dr. Lewis, a case of severe herpes in the distribution of the right fifth nerve. A year before, Dr. Lewis told me, she had had an attack of herpes zoster, the scarring from which was still very marked.

The third case was a hospital patient who had an extensive eruption of herpes zoster. When I told him it was "shingles" he said that ten years before he had had an attack of shingles in the neck, and on examining his neck I found marked scarring of the nature of which I could have no doubt.

I may mention, incidentally, with reference to the third attack experienced by the surgeon that his daughter, a fortnight after the attack developed, became ill with chicken-pox.—I am, etc.,

London, W.1, May 21st. JAMES TAYLOR.

VACCINES IN THE TREATMENT OF GONORRHOEA.

SIR,—Dr. McCrea's article on the above subject in the *Journal* for May 5th (p. 755) deserves the careful attention of the venereologist, and for a variety of reasons, all of which have a very direct bearing upon the successful treatment of male gonorrhoea in the clinics working under the Ministry of Health scheme.

From my own experience when in charge of the venereal diseases clinic at Warrington, and in private practice, I can thoroughly endorse Dr. McCrea's general conclusion that the routine administration of vaccines in acute male anterior gonorrhoea not only reduces the number of complications, but materially shortens the time the patient is under treatment.

At the Warrington clinic from 1921 to 1924 vaccines were given as a routine, and during that period there was not a single in-patient admitted suffering from gonorrhoea or any of its complications. During this time the vaccines used were those of the residual type, prepared by Dr. C. E. Jenkins, the pathologist to Salford Royal Hospital. In the year 1924, when vaccines were not given as a routine, there were 119 in-patient days on account of gonorrhoeal complications.

Dr. McCrea's figures show, however, a surprisingly high incidence of posterior extension of the disease, both in the vaccine and the non-vaccine series—81 per cent. in the former and 88.5 per cent. in the latter. Under the routine treatment hereafter described the proportion of such cases approximates 25 per cent., and on investigation these are found to have committed some indiscretion in treatment, exercise, or drink. A proportion of 30 per cent. is certainly not unusual where reliance is placed upon the patient treating himself with a syringe, and no vaccine is sufficiently potent to counteract the damage wrought by that most dangerous of all urological instruments.

The routine treatment I adopt for a case of acute anterior urethritis (duration two to seven days) is as follows:

(1) Alkaline diuretic mixture.
(2) Wearing of a proper suspensory bandage of the type made and provided at the City of Salford Municipal Clinic.
(3) Vaccines every seventh day for nine weeks.
(4) *Daily irrigations into the bladder from the commencement*, with the lowest pressure sufficient to overcome the resistance of the sphincter muscle. For the first three weeks the irrigations are of potassium permanganate, increasing in strength from 1 to 3 grains to the pint twice or thrice daily. In the next three weeks the solution used is oxycyanide of mercury in similar strengths, given twice daily. In the seventh, eighth, and ninth weeks picric acid is used, increasing in strength from 1 to 3 grains to the pint, and administered once a day. In the tenth week silver nitrate, 1 in 10,000, is used on alternate days, and during this week the urine and the prostatic secretion are examined. From the commencement of treatment, upon every occasion the patient attends, smears are taken if available, and the urine is examined at each visit. During the eleventh and twelfth weeks treatment is entirely suspended, the patient merely attending for urine examinations daily. In the thirteenth week there is given a provocative injection of vaccine or of aolan, and specimens are taken for examination in twenty-four and forty-eight hours.

Criteria of cure are: no discharge, no pus in morning urine, no gonococci recoverable from urethra or prostate, no abnormal prostatic smear, urethra normal on urethroscopic examination. Permission to marry is not given till the patient has been negative for six months after the cessation of treatment.

I have found that under this regime approximately 75 per cent. of acute gonorrhoeas remain anterior in site and are free from all clinical and bacteriological signs of the disease by the tenth week. In no such case has a relapse been observed in the six months succeeding the cessation of treatment. This is to be attributed to the following factors: (1) routine vaccines; (2) bladder irrigation from the beginning; (3) change of solution every week as to strength and every third week as to kind; (4) absolutely forbidding the patient to use a syringe; (5) irrigation at least once daily for the first four weeks; (6) if the patient is unable to attend at least once daily he is provided with a correctly designed home irrigator, in the use of which he is thoroughly and practically instructed.

In patients who appear with a discharge of two days' duration or less, a more intensive line of treatment is adopted. This consists of:

(1) Routine vaccines; (2) during the first week posterior irrigations with potassium permanganate (1 grain to the pint) thrice daily; (3) after each irrigation the patient lies on the couch and 20 minims of warm iodargol are injected into the anterior urethra, the penis clamped, and the iodargol gently massaged along the canal. This is retained for at least fifteen minutes. In 50 per cent. of such early cases there are no clinical or bacteriological signs of the disease at the end of five weeks. The iodargol is discontinued at the end of seven days and the ordinary routine is carried out for the remainder of the time, except that from the fourth week onward the patient only irrigates once on alternate days.

I am convinced that the syringe is the main cause of posterior involvement, and that in clinic treatment it should, as is the case in the Salford Municipal Clinic, be relegated to the museum. Treatment is available in this clinic for males and females every day from 8.30 a.m. to 8.30 p.m., and for four hours each on Saturday and Sunday. It would seem only possible to give the man with gonorrhoea adequate modern treatment in an establishment which is open twelve hours daily, and where the treatment is carried out by a whole-time staff of highly trained orderlies. Vaccines are decidedly worth while, but of much greater moment is the discarding of the syringe in favour of copious posterior irrigations from the beginning.

The method adopted in this clinic for the examination of pus in the second urine after prostatic massage is that described by Dr. Cuthbert Dukes in the *British Medical Journal* of March 10th (p. 391), any count over 100 being regarded as abnormal.—I am, etc.,

E. TYTLER BURKE,
Venereal Diseases Medical Officer for the City of Salford.

May 7th.

F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
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THE ORIGIN OF ISCHAEMIC CONTRACTURE.

SIR,—Ischaemic contracture only occurs where tight bands have been applied round the injured part, never where the fragments have been merely replaced and kept at rest. In my view it is these tight bands which cause the trouble, and I never use them. To reduce the displacement and then fix "the arm up in full flexion by passing adhesive plaster round the doubled-up limb," as was done in the case described, is a thoroughly bad method, though Professor Hey Groves, in his article published in the *Journal* of May 12th (p. 807), characterizes it as "universally approved." It is this "universally approved" method which causes all the trouble. It should be entirely given up. Instead, after the displacement is reduced, either by manipulation or open operation, the wrist should be tied to the neck in Thomas's knotted sling, leaving the arm, elbow, and forearm free.—I am, etc.,

PAUL BERNARD ROTH,
Orthopaedic Surgeon, and with Charge of Fractures, Miller General Hospital.

London, W.1, May 14th.

THE INTRAVENOUS INJECTION OF INDIGO-CARMINE.

SIR,—In the *British Medical Journal* of December 10th, 1927 (p. 1087), Mr. W. W. Galbraith is reported as employing, in the investigation of patients suffering from renal tumours, "an intravenous injection of 5 c.cm. of a 4 per cent. solution of indigo-carmine."

Surely 4 per cent. is a mis-report for 0.4 per cent., since a 4 per cent. solution of indigo-carmine involves a contradiction in terms, indigo-carmine being soluble only up to 0.8 per cent. The mistake should not be allowed to pass without remark, for others might be tempted to adopt the stated technique; and, as this would have grave risks, I hope that I may be allowed to quote from a recent short article in the *Clinical Journal* (April 11th, 1928), in which I reported the only case which I have witnessed of the intravenous injection of 4 per cent. indigo-carmine:

The patient, "a woman of 41, who was being cystoscoped under general anaesthesia, suddenly became of green-yellow colour shortly after the intravenous injection of 2 c.c. of 4% indigo-carmine, and became collapsed." Various restorative measures were employed, and the patient slowly improved.

"On coming round from the anaesthetic she complained that she could not see, but this disquieting phenomenon fortunately disappeared within 24 hours.

"20 c.c., or less, of 4% indigo-carmine may be used for *intramuscular* injection in testing renal function, or in order to find the ureteric orifices, during cystoscopy; but the dye is more commonly and conveniently given intravenously as a 0.4% solution. It should not be intravenously administered in a preparation of much greater strength than this, as it is soluble only up to 0.8%. In greater concentration the dye is no longer in solution, but in suspension, and, although then suitable for intramuscular injection (since the muscular tissues filter off the particles), is unsuitable for direct injection into the blood-stream, as embolism may occur.

"Macalpine, speaking of indigo-carmine, says that 'shock, dizziness and pallor have been recorded as resulting from its use at too great strengths,' and cites two cases in which 'a 4% solution was used by mistake. In addition to some slight vomiting, the skin—especially around the eyes and over the scrotum—became a bright indigo blue. One of the patients also suffered from transitory convulsions, due doubtless to minute emboli of undissolved dye lodging in the cerebral capillaries.'

"Although, as in the instance above quoted, recovery ensued, such cases emphasize the importance of noting the exact position of the decimal point before administering intravenous injections."

—I am, etc.,

ALEX. E. ROCHE, M.D., M.Ch., F.R.C.S.

London, W.1, May 10th.

*** The report was printed in the form in which it came to us from the Royal Medico-Chirurgical Society of Glasgow.

MEDICINE, LAW, AND THE PUBLIC.

SIR,—Some time ago a judge of the High Court upbraided and lectured a medical witness who asked for his fee before he was sworn. The learned judge must have known that the witness was within his rights. The witness presumably thought himself justified in asking to be paid before giving evidence.

Quite recently a jury has gratuitously expressed the opinion that a defendant doctor should have called in another doctor to hear the plaintiff refuse the treatment advised. Surely this is impertinence in every sense of the word.

Now we have a coroner and his jury criticizing the methods of one of our greatest hospitals in that a resident medical officer, on his own responsibility, sanctioned the transfer of a patient to another institution. The coroner would pass, without criticism, similar action on the part of a practitioner outside the hospital, but in the case of the hospital he recommends that such a transfer be authorized by two resident officers acting in consultation and then sharing the responsibility.

These three incidents call for reflection. What is the meaning of it? It is true that many learned judges of to-day treat the medical profession as one to be respected and deserving of consideration. On the other hand, there are some highly placed members of the legal profession who resent the rise and progress of our profession. For centuries the law has had high places, large emoluments, and good social status among its attractions, while the profession of medicine has been in a lowly state. The progress of medicine has altered the relationship, and it is possible that the profession of law resents the change. Can it be what novelists and psychologists call the "inferiority complex"?

With regard to juries, we have to remember that they are composed of members of the public. The public, when in good health, are not in sympathy with doctors. Their conversation in railway carriages and other places is largely about ailments. Remedies are freely suggested, mostly unorthodox. Osteopaths, chiropractors, herbalists, Continental charlatans are all recommended as being so much better than our doctors at home. All classes drink patent medicines, advised by their friends or the chemist, for the cure of ailments that have not been diagnosed. These advisers would hesitate to recommend a particular motor car, on the ground that they did not understand enough about it. But the much more complicated mechanism of the human body does not daunt them. So many of the public have learnt to read and so few to think. There is the risk of an ignorant valetudinarian public expressing unjustified opinions from the jury box.

What is to be done about it? Very little can be done in court, and nothing can be done with the public. But the members of both professions who meet in friendly fashion to discuss matters of medico-legal interest might consider the matter. If a good example were set by the leaders of the legal profession it might permeate through all the courts, possibly even to the coroner's.—I am, etc.,

May 8th. F.R.C.P.

MEDICAL RESPONSIBILITY FOR LUNACY CERTIFICATION.

SIR,—There has been not a little anxiety lately in the minds of the medical profession regarding the risk of liability for the certification of alleged lunatics.

This risk would be avoided if the procedure were so altered that the doctor was not obliged to take upon himself the invidious position of being the agent to declare that so-and-so is a fit and proper person to be shut up in an asylum and deprived thereby of all civil and personal rights. The doctor's true function is not to imprison people, but to give advice as to the treatment most conducive to recovery.

As matters now stand, the doctor, when called in, has in most instances to depend on hearsay evidence from those in touch with the individual who is said to be affected. He has often but little opportunity of discovering for himself what amount of truth there is in the assertions made. Not being himself a witness of what has occurred, he may have extreme difficulty in drawing up a certificate based on personal observation.

In the memorandum presented by the British Medical Association to the Royal Commission on Lunacy all cases of mental instability are divided into two classes: (1) those for whom detention is a necessity; and (2) those for whom

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it is not: the criterion for certification being that the individual can be *proved to have so conducted himself as to render detention a necessity.*

It is evident that the parties who can themselves give first-hand proof as to the conduct they have witnessed are the proper people to appear before the magistrate, and to state what they know. The magistrate can then weigh the evidence, thus carrying out the true function of a judicial authority, while the doctor is at the same time secured from liability.

The individual concerned should, in fairness, be represented by a friend; but there need be no publicity in the matter.—I am, etc.,

London, May 12th. S. E. WHITE, M.B., B.Sc.

THE HARVEY CHAPEL AT HEMPSTEAD.

SIR,—May I add a note to my late friend Sir Dawson Williams's article on William Harvey? He stated that lapping in lead seemed to be peculiar to the Harvey family. It was common to all the better class from Henry VII to about 1675. Henry VII, his wife, and James I are all in shaped lead coffins in the vault in Westminster Abbey; Sir Henry Vane is in a very much more elaborate one in Shipbourne Church, near Tonbridge. I have seen one for a child so shaped that it would stand on its feet. The case was made by casting in two halves. After having been bandaged and sometimes embalmed, the corpse was laid in the lower half, and the body-shaped top was then soldered to this, and as a rule, a lead or silver inscription plate was soldered to the breast. The inscription on Harvey should read:

DOCTER
WILLIAM + HARVEY
DECESED + THE + 3
OF + IUNE + 1657
AGED 79 YEARS.

The bound volume of the 1767 edition of his works was encased in lead, and the hermetically sealed bottle containing the engrossed parchment account of the day's proceedings in another lead case. Both were placed at the foot of Harvey's coffin in the sarcophagus. These details are from the privately printed account (1883) of this second funeral of Harvey by the late Dr. William Munk, librarian to the Royal College of Physicians.—I am, etc.,

F. WILLIAM COCK, M.D., F.S.A.

Ashford, Kent, May 15th.

PHARYNGO-OESOPHAGEAL SPHINCTER.

SIR,—I have often deplored the fact that British discoveries frequently remain unrecognized and unappreciated until they are re-imported under a foreign name. Mr. Negus's letter (p. 879) seems to me to add one more to the list.

Although the discovery of this muscle has been attributed to Killian, Jackson, and others, it is, I believe, the fact that it was first described long years ago by Sir Everard Home, one of John Hunter's illustrious successors, and his beautiful dissection of it can still, I think, be seen in the Royal College of Surgeons Museum.

It is true to say that with the advent of oesophagoscopy its clinical importance has been pointed out by Chevalier Jackson, but although I yield to none in my admiration for Dr. Jackson and his work, I think that the credit for its actual discovery must remain with Sir Everard Home.—I am, etc.,

London, W.1, May 18th. WALTER HOWARTH.

CAUSES OF THE DECLINE IN TUBERCULOSIS MORTALITY.

SIR,—Often in the last seventeen years the *British Medical Journal* has published for me views in direct conflict with what Sir Robert Philip enounced at Bath on April 20th.[1] I have urged that as against phthisis (bovine tuberculosis is another question) the statesman's supreme weapon is the enhancement of the standard of living of the poor—in two words, of real wages. Sir Robert so far appears to agree; where we part company is that I argue that history here and elsewhere teaches that the best, perhaps the only, way of raising real wages is by the policy known as *laissez faire*. There are gaps in Sir Robert's argument that seem wholly to invalidate it. May I hope that he will resolve my doubts?

1. He begins from 1871; why not from 1841? There is nothing in history to equal (though there are a score of instances of minor degree corroborative) the fall of the phthisis mortality which followed Peel's daring reform of the tariff from 1842 onwards. As Koch has said, that fall was greater before the cause was known or anything public done than since. By 1871 the mortality had fallen by more than 50 per cent.; if the decrease had really been accelerated the disease would have been extinct by now. Sir Robert thus omits to quote the most brilliant success known, and that due to a distinctively *laissez faire* policy in its proper, as well as its vulgar, sense.

2. He omits to mention the slackening of the rate of decline this century. The rate had become practically stationary when Professor Karl Pearson was able to prophesy a rise in 1915. So, in 1912, did I. Professor Pearson tells me that the interruption of the war was fatal to his data; to mine it was an immense reinforcement. The crude death rate in 1917 was nearly double—in 1918 more than double—that of 1905.

3. He pointedly leaves out the war figures. I submit that you can find in them the solution of the problem. The tables of all countries which keep records show that an economic change—that is, of real wage rate—registers itself on the phthisis curve in the third year. Thus the long, slow fall of real wages from 1896 to 1910 shows itself in the gradual slackening of the decline of mortality; the rapid fall from 1912 to 1914 in the rise from 1915 to 1917. If the theory were correct, a fall should begin in 1918. It did, as the Registrar-General points out. As if to clinch the point, the rate for the year was raised above 1917 by the influenza outbreak of 1918; but the excess was due to deaths in asylums, and the disease had picked out people uninfluenced by wage fluctuations, as small-pox picks out the unvaccinated in a school. The quinquennium is the only one in our records which fails to show a decrease on its predecessor: the increase is the biggest we have known, and follows as the prophesied effect, or at least—*sequitur fallor*—the sequel of the biggest effort the State has made.

4. He bases the triumph of State activity on the rates of 1919-23 and does not explain why the great and sudden improvement had taken place. But the State was no more active in 1919 than in 1913, perhaps less so. In wages, however, there had been a startling difference ever since 1915.

We who advocate a drastic curtailment of State activities do so because we know from history that State gifts to the poor are always at the expense of real wages and always tend to demoralize. If this needed proving, the course of events this century should have made us wary. Only the other day the House of Commons took it for granted that the Insurance Act had resulted in widespread demoralization—the only difference of opinion was as to whether it was among doctors or patients—in the year of lowest mortality with the highest morbidity.

I submit that, when all the factors are considered, the question is whether State intervention, so far from diminishing phthisis, has not retarded the efforts of greatly advanced science and the results of a vast improvement in social habits and conventions, which together might by now, of themselves, have extinguished the disease.—I am, etc.,

Bath, May 2nd. B. G. M. BASKETT.

[1] See *British Medical Journal*, April 28th, p. 701.

Medico-Legal

MISDEMEANOURS AND PROFESSIONAL DISCIPLINE.

THE appeal of Pickup *v.* The Dental Board, which was dismissed by a court consisting of the Lord Chief Justice, Mr. Justice Avory, and Mr. Justice Shearman on May 10th, has an interest for the medical as well as the dental profession. Again and again, in cases before the General Medical Council, it has been argued on behalf of the respondent that the Council has no power to erase his name on account of conviction for a misdemeanour, when such misdemeanour is not of the class which is triable on indictment, but the Council has consistently overruled such objections, being advised that the word "misdemeanour" in the Medical Act is used in the widest sense. The case recently decided was an appeal against the order of the General Medical Council, on the recommendation of the Dental Board, that the name of one James Pickup should be erased from the *Dentists Register* on the ground that he had been convicted of misdemeanours within the meaning of Section 13 of the Dentists Act, 1878. The case was reported when it came before the General Medical Council in the *Supplement* to our issue of December 10th, 1927 (p. 227). In

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dismissing the appeal the Lord Chief Justice said that the contention of the appellant that the expression "misdemeanour" in Section 13 meant misdemeanour triable on indictment could not be supported. This was clear from the words of the section. There was a proviso to the section stating that when the offences were of a trivial nature they might not be held to disqualify a person from practising dentistry. Thus it seemed to be contemplated that the misdemeanours in the section were not confined to indictable misdemeanours, but would include others, even those which, by their trivial nature, made the application of the proviso proper. The other justices concurred.

In his address from the chair of the Dental Board on May 8th, before this case had been decided, the Right Hon. Sir Francis Dyke Acland referred to this impending judgement, and said that he trusted a judgement would be obtained as to the offences which might properly be termed misdemeanours and which would be of service to the General Medical Council as well as to the Board.

FORGERY OF A DEATH CERTIFICATE

At the Old Bailey, on May 18th, Charles Forbes, who was alleged to have posed as a registered medical practitioner in the West Central district of London for seven years, pleaded guilty to forging and uttering a death certificate, and was sentenced to nine months' imprisonment, without hard labour. It was stated that the certificate was issued in respect of an old woman who had been under the care of the accused. The defence alleged that Forbes had qualified as a medical practitioner, but that his name had been removed from the *Medical Register* thirty years ago after he had been convicted of fraud. According to a statement made in the course of the earlier police court proceedings, Forbes described himself to the registrar of births and deaths as a graduate of Aberdeen University; the registrar, after supplying the accused with a book of certificates, came into possession of a letter which aroused his suspicion and communicated with the General Medical Council.

Medical Notes in Parliament.

[FROM OUR PARLIAMENTARY CORRESPONDENT.]

THE Currency and Bank Notes Bill was read a third time in the House of Commons on May 22nd, on which day the House of Lords read the Equal Franchise Bill a second time after a division. The report and the third reading of the National Health Insurance Bill were set down for May 23rd. On May 24th the House of Commons rose for the Whitsun recess till June 5th, when the Finance Bill will come up for second reading.

The Parliamentary Medical Committee met at the House of Commons on May 22nd and considered questions to be raised on the report stage of the National Health Insurance Bill. It was reported that on the third reading of that bill Mr. Chamberlain might indicate that he hoped at a future date to propose the provision of medical and midwife's attendance in childbed as a statutory benefit under the national health insurance scheme.

Ministry of Health Estimates.

In the House of Commons, on May 15th, a vote to complete the sum of £20,774,000 for the Ministry of Health was considered. Mr. CHAMBERLAIN explained that the Estimate showed an increase of nearly £1,000,000 over last year. Practically half of the gross estimate of £21,700,000 was needed for the housing branch of the Ministry. With regard to slums, the most urgent feature was overcrowding. He saw, however, ground for hope in the fact that although only 14,000 houses were affected in the schemes submitted for slum clearance since the war, every year over 500,000 houses were reconditioned. The estimates showed a small increase under each of the headings in connexion with which the Ministry of Health distributed Exchequer grants to local authorities for certain services. There were four of these services: treatment of tuberculous disease, maternity and child welfare work, venereal disease, and welfare of the blind. Generally it might be said that the increases were due to the normal development of the services. But this did not exhaust the functions of the Ministry of Health. He had always regarded the Ministry as a sort of general headquarters staff, whose duty it was to collect information regarding the fight against disease and make it available to all concerned in the campaign. A great deal of research had been carried on in regard to cancer, which was perhaps the largest single cause of mortality. That research had dealt with the causes and treatment of cancer both in this country and abroad. They had not yet been able to put their fingers upon any fact or series of facts which would allow them to say that they had solved the problem of cancer—very far from it—but all the time they were encroaching upon the field of the unknown; all the time they were advancing their knowledge. The Ministry of Health had mapped out a sort of scientific survey of what could be done to-day in the effective treatment of cancer, and they had followed that up with a careful and exhaustive inquiry into a large number of cases of cancer. They had also done something to bring into prominence certain methods of treatment which they had ascertained, from information derived from this country and abroad, had proved particularly effective in the treatment of cancer. These were methods of radiology—the use of radium itself and so-called x-ray therapy. These methods were costly, and were not easily adopted by all authorities, but they believed that by proper organization more effective use could be made of the equipment which they actually possessed. They were keeping in the closest touch with a great number of other agencies—the British Empire Cancer Campaign, the public health authorities throughout the country, and the local cancer committees working in some of the great provincial centres. While they could not say that they were even in sight of a cure or of a method of prevention of cancer, nevertheless they were on the right path, and one day—no one could say when—they might actually turn the corner and find themselves in the presence of the goal which they sought.

Encephalitis lethargica was a disease in regard to which central action was particularly necessary if they were to make progress, because this disease was fortunately not sufficiently common yet for any hospitals or any private practitioners to have seen very many cases of it. During the past two years there had been about 1,500 cases a year in this country. The Ministry had instituted an exhaustive inquiry into about 3,000 cases of sleepy sickness. It had been carried out by Dr. Pasmore, one of the officers of the Ministry of Health, and the results of the inquiry showed that only about 25 per cent. of the cases registered about 33 per cent. died, and the remaining 40 per cent. were more or less disabled mentally or physically. The valuable part of this inquiry was that for the first time they knew what were the proportions of the persons attacked by this disease who recovered, died, or were permanently injured. They knew the different forms of injury which sufferers from encephalitis lethargica might sustain; they knew how those things proceeded, and they had got for the first time some inkling of what were the best ways of treating the disease. The inquiry came very opportunely after the passing of the Mental Deficiency Act, because in the light of the inquiry they might hope that that Act might be put to more effective use. The inquiry disclosed a considerable variety of cases, and it must be understood that the treatment which might be effective and desirable for one case might be quite wrong for another. The Mental Deficiency Act would enable them to classify cases and treat them in the best manner. He thought that the popular impression that encephalitis lethargica was tending to decrease was correct, but, of course, sufficient remained to make it a very serious problem, because the effects of the disease were frequently permanent, and a person once affected remained a charge upon the community perhaps for the rest of his life.

There were really two distinct groups of diseases which came under the heading of rheumatism—acute rheumatic fever, which so often attacked children and which was frequently associated with heart disease, and chronic rheumatism of the joints and muscles, which frequently disabled industrial workers. Last year approved societies spent on sickness benefit and medical benefit for rheumatic insured persons £5,000,000, and in the same year 5,250,000 weeks' work were lost owing to the incidence of rheumatism among insured persons. They calculated that rheumatism accounted for one-sixth of the whole industrial invalidity of the country. With regard to rheumatism he was told that the treatment which afforded the best hope was one of prolonged rest in institutions, and the Ministry of Health during the past two or three years had tried to encourage the provision of hospital accommodation set apart specially for this purpose. To-day, for the first time, we had actually got from 400 to 500 beds specially earmarked for the treatment of acute rheumatism. As regarded chronic rheumatism, the first thing required was advice, because the causes of this rheumatism were many and various, and it might, and very frequently did, spring from some local centre of infection. It might be the teeth that were wrong, or the tonsils, or the intestinal tract. In the absence of advice, people accepted rheumatism as though it were a sort of act of God, which could not be prevented, and for which nothing could be done. Yet, under the advice of the specialist, it might be traced to some quite easily removable cause, and the suffering might be almost instantaneously relieved. A great deal was being done for that. In the case of the children there was the school dental service, which employed something like 900 dentists, and was treating about 1,000,000 children a year. In the case of the elder insured persons there was the dental benefit, to which approved societies were now devoting some £3,000,000 a year, with a result which he hoped would show itself in a lessened demand upon the funds in the future from rheumatism, and the consequent incapacity to work. At present approved societies were paying about £250,000 a year to two hospitals for the treatment of their patients, and another £200,000 a year was being devoted to convalescent homes in connexion with which, in some cases, there was now being developed spa treatment. But they felt that something more than this was required, and that there were forms of treatment, especially those connected with radiant heat and light, which had shown very promising results experimentally, and which the Ministry desired to see extended for the benefit of a larger part of the population. The Red Cross Society was now trying to organize the setting up of an experimental clinic of this kind in London, and as soon as that was ready he proposed, by regulation, to authorize approved societies to make a contribution to that clinic and to obtain treatment for their members there. The committee would realize that the full development of a preventive and curative system in connexion with rheumatism must mean the expenditure of very large sums of money. It might be that in the present financial state of the country it was not possible to carry on that development as rapidly as we should wish, but we were at last beginning to realize the nature of the disease with which we had

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to cope, and the extent to which it was crippling our people, and, as that knowledge became more widespread, he thought that we should see a willingness to devote to the improvement of those conditions whatever money might be found necessary.

The Ministry of Health had now been established for nine years, and as far as one could measure the progress of the public health by the general vital statistics the record of the Ministry was not unsatisfactory. The general death rate in those years had gone down from 14 per 1,000 to 12.3, and the infant mortality rate had dropped from 89 to 70 per 1,000. But there was one figure which showed no improvement, although it concerned a very vital subject. That was the figure of maternal mortality. It was a terrible thing to think that to-day, out of every 250 mothers, one died in childbirth. That was not really the full measure of the injury that was being done. One must not only remember what happened to the family when the mother was taken away, but one must think of those other mothers who might not die, but who emerged from their confinement permanently injured in their health and unable really to fulfil the full duties of motherhood. He felt that the time had come when a great new effort ought to be made to bring down those figures of maternal mortality and to improve the health of these mothers. There were many things we did not know yet about the causes of maternal mortality, but we did know something. We knew that these figures persisted steadily throughout the country, but, nevertheless, they were not universal. There were places where we could find much lower figures. They would be found in those cases where there was the most careful ante-natal and post-natal supervision, and where the people themselves had the greatest opportunities of learning what was necessary for them to preserve their health and the lives of their infants. The Ministry of Health was taking up this question very seriously. He was now endeavouring to institute a new inquiry into the causes of maternal mortality. He was trying to enlist in that service the general practitioners throughout the country, as well as the local authorities; and the British Medical Association had assured him that it was deeply interested in the question, and would use all its influence to get its members to give every assistance possible to his inquiry. Under this scheme a local medical officer of health would make inquiry into every case of maternal mortality which occurred, wherever it might be, throughout the country. They would make this inquiry on a plan which would be laid down by a committee at the Ministry of Health on the lines of the Cancer Committee. Their returns would come in quarterly to that committee, the information would be classified, and the committee would draw what conclusions it was possible to draw from the information obtained. All that information would then go back again to the local authorities, and would be made known to those responsible for the conduct of the infant welfare centres and the maternity hospitals. He was also setting up a committee to inquire into the whole position of midwives—into their status, training, and remuneration. After all, the success or failure of any efforts made to improve the conditions of childbirth in the country must largely depend on the midwives, on whom a great responsibility rested. Midwifery was a hard and arduous profession; it was not a well-paid profession; and if we were to get the right class of women to enter that profession we must make the conditions such that this class of people would be attracted. If we could indicate with any confidence to the people of this country what were the precautions necessary to take if we were to remove this menace from our midst, he could not believe that the national conscience would allow the lives of the mothers to be sacrificed merely for the sake of a few extra thousands of pounds.

In the ensuing debate Dr. FREMANTLE said that while he admitted that there was still a great lack of houses, he thought the accounts given were exaggerated. Taking the census of 1911 as a basis—and it was the only sure one—our housing shortage to-day was only about 40,000 houses. He did not think that the position was getting worse in regard to overcrowding; speaking generally, it would be found that the position was very slowly improving.

Dr. WATTS congratulated the Minister of Health, and remarked that ever since Mr Neville Chamberlain had been at the head of the Ministry he had shown not only a knowledge of administration, but of medicine, and a mastery of scientific fact quite unusual in a layman. He felt that the Ministry was becoming unwieldy, and suggested that certain services should be transferred to another department, perhaps the Home Office. The medical service in connexion with the Factories Act might be removed from the Home Office to the Ministry of Health. Thus they would co-ordinate, under the Ministry of Health, the entire health services of the country. With regard to tuberculosis, we were still spending some millions of pounds a year on the upkeep of sanatoriums. However useful they might be from a preventive point of view, or for the segregation of tuberculous people, they were, from a curative point of view, of little use. Some portion of the money available might usefully be devoted to investigating other methods which, in the opinion of several medical members, offered a much better prospect of cure.

Mr. SCRYMGEOUR asked if Dr. Watts found, from actual evidence, that sanatorium work was not producing results commensurate with the expenditure on it.

Dr. WATTS: From the curative point of view, most decidedly. The sanatorium method, he said, could only show 14 per cent. of cures, which was very low, whereas other methods showed 70 or 80 per cent. of cures. He also wished to call attention to the serious increase of small-pox, and the question of vaccination. For some time past a great number of people had not only not had their children vaccinated, but had not taken the trouble to make the necessary declaration of a conscientious objection. The result was that the law in this respect was practically a dead letter. He hoped that something would be done in this matter, because those of them who knew small-pox, and were acquainted with its history, realized that previous epidemics had always been preceded by sporadic outbreaks of a mild character, which had suddenly burst forth into a virulent epidemic, which had carried away thousands of people and crippled thousands of others. That was a very real danger which he anticipated if vaccination was not going to be more general in this country. This was the only country in the civilized world where vaccination was not carried out. He had had an example of the way in which other countries dealt with this question when, last autumn, he went to Brazil with a delegation from the Commercial Committee of the House of Commons. They were freed from all troubles in regard to passport and customs examinations, but the Brazilian Ambassador said to them: "There is one obligation from which I cannot free you, and that is the obligation to be vaccinated." All the delegation had to be revaccinated before leaving this country.

Dr. VERNON DAVIES said that the greater part of the debate had been taken up with housing and slums, but very little had been said on the question of health, yet that was fundamentally the duty of the Minister of Health. The Minister spoke about cancer and the progress that had been made in its treatment, referring particularly to radium treatment. He seemed to create the impression that the Ministry of Health was anxious to help the radiologists to deal with cancer, and that it was very hopeful as to the results. He (Dr. Davies) wished to impress upon the House and upon the country that the only safe treatment for cancer was early and complete operation. In late and inoperable cases radium treatment might prolong the life of the patient, or perhaps give him a little more ease. Whatever they did, they they should not get into their heads the idea that radium would cure cancer. It could not do it at the present time. It was only a help, and he was afraid that the rather hopeful tone of the Minister of Health might create a wrong impression in the country, and thus prevent some of these poor people from seeking medical advice in the early stages when something could be done.

He was glad that the Minister dealt with rheumatism. This question had come to the fore lately, and all who read the address of the Chief Medical Officer of the Ministry of Health were very much impressed. It proved that the Minister had in his department a full knowledge of rheumatism and of its bad economic, social, and physical effect. The Minister said that there were 400 to 500 beds in the country earmarked for the treatment of rheumatism in children. That number was almost ludicrous when they knew that with young children the huge majority of those who got rheumatic fever or acute rheumatism developed heart disease, and that it was essential that they should be given absolute rest for a long time. It seemed pitiable that, in the whole of this great country, with the thousands of free beds in our Poor Law institutions, something could not be done to see that these poor children could be taken to hospital and kept there until they were fit for a more or less useful life.

The question of maternity always roused the sympathy of the House, and he was certain that the Minister was fully alive to the importance of this subject, but he was not sure that they were using the material they had at hand to the best advantage. They heard of a shortage of midwives, but it must be borne in mind that the midwife's life was a very difficult one—a very hard life and poorly paid. Yet he had known of many cases where midwives were thoroughly trained and yet could not get a sufficient amount of work for the reason that the better-class patients now went to nursing homes and the poorer-class patients went to Poor Law hospitals. He knew more than one midwife who was seriously concerned as to how she was going to carry on her livelihood on account of these claims at both ends taking away the patients which she previously had. That was a point which the Minister would have to bear in mind, especially if he was going to increase the number of midwives. Another question which he wished to bring before the House was that of milk. A great campaign was going on in the country by which everybody was advised to drink more milk, and everything was being done to show people the advantages of milk, and, of course, the Ministry were doing all in their power in conjunction with the Ministry of Agriculture to impress these plans on the public. They had got to know recently that milk was a perfect food, that it was rich in vitamins, and that it was the only suitable nourishment for young children or suckling children. It was also a very useful food for adults, and they were doing all they could to see that this country produced good pure milk at a cheap price. At present there was a great deal of milk adulteration going on. The adulteration was of a lower standard in the towns than in the counties, and the only conclusion he could come to was that in the counties the administration of the Sale of Food and Drugs Act was usually carried out by the police authorities, who acted by a rule-of-thumb method. They administered the Act rather from the point of view of saving the purchaser's pocket and seeing that he got full value than from the point of view of health. That was a grave mistake. The function of the Ministry of Health should be not to save the pockets of the people, but to look after their health. When one considered that, with the records in their department of the enormous adulteration that had gone on, they had apparently done nothing, that fact must be weighed in the balance against the many acknowledged excellencies of the department. He suggested that the administration of the Sale of Food and Drugs Act in regard to foodstuffs, and milk in particular, should be taken out of the hands of the police and put in the hands of the local health authority.

Sir BASIL PETO said attempted abortion was a material contribution to maternal mortality. Septic peritonitis almost always supervened upon attempted abortion. He suspected that the prevalence of venereal disease was also closely associated with it. He asked that the restrictive regulations for welfare centres and ante-natal centres should be relaxed and that medical officers in charge should have unfettered discretion to give or withhold

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information on birth control. He was told that, though there was some diminution in syphilis, gonorrhœa was on the increase. Yet the official system of the Ministry refused to allow the civil population access to preventive measures from which in the army and navy admirable results had followed. Could the Minister now declare, as he had done in 1925, that the prevalence of venereal disease was diminishing?

Mr. PETHICK LAWRENCE asked what the Government had done to classify the maternal death rate. Had they figures to show what deaths resulted from carelessness of doctor, midwife, or nurse; from poverty or malnutrition, or from the fact that some women ought never to have had a child at all? When it was certain that, if a woman had a child, that child would be diseased or defective, or if that woman's life was going to be imperilled by bringing a child into the world, doctors in clinics supported out of public money should have the right to give information. Women in all classes were determined to have this information, and if it could not be given them scientifically by appointed officers of the State, they would get it in ways less correct, and possibly more injurious. Undesirable forms of information, when disseminated among women, were difficult to eradicate, and some doctors now had a grave problem in trying to alter what had been passed from one to another among the poorer women of the country.

Mr. BRUNDELL dissented, contending there was no evidence to show that the failure of maternal mortality to diminish was due to the failure of ante-natal clinics to give information about birth control.

Mr. SCRYMGEOUR asked whether there was to be an outcome from the report of the Royal Commission on Lunacy. The practice of relegating people suffering from mental depression to an institution where there were others more seriously affected was deleterious. Parliament was dealing with venereal disease in too timid a fashion.

Sir KINGSLEY WOOD said that until the House of Commons came to a contrary decision the Minister of Health and the department intended to maintain the present formula that maternity and infant welfare centres should only deal with expectant or nursing mothers, that it was not the function of an ante-natal centre to give information on birth control, and that exceptional cases where avoidance of pregnancy seemed desirable on medical grounds should be referred to a private practitioner or to a hospital. It would be a great pity if over 2,000 centres attended by about a third of the women who gave birth to children were involved in this controversy. Sir Kingsley spent most of his speech in answering the criticisms of the Government's housing policy. He also dealt with allegations concerning the death of a child at Chester-le-Street which had been alleged to be hastened by malnutrition. He contended that inquiry had not confirmed this allegation.

The vote for the Ministry of Health was carried by 209 to 99.

Treatment of Mentally Deficient Prisoners.

The House of Commons, on May 21st, considered, in Committee of Supply, the vote for £473,969 for the expenses of prisons in England and Wales. Mr. RHYS DAVIES moved a reduction of the vote by £100, and asked how many cases of encephalitis lethargica there were at the moment in the gaols. One of the biggest tragedies in this country was that there was no appropriate institution to which to send cases of that kind.

Sir VIVIAN HENDERSON (Under Secretary to the Home Office), replying to various questions raised in the debate, said that every effort would be made to improve the accommodation at the prisons, and to improve the recreation and workshop facilities. With regard to sleepy sickness, it was stated, in the medical part of the 1926 report of the Prison Commissioners, that during the period under review no case of the onset of encephalitis lethargica occurred during detention in prison or in any Borstal institution. It showed that the whole question was being carefully watched by the medical officers concerned. Where any question of mental defect was considered by the medical officer of the prison to exist, steps were now being taken to transfer those persons to a prison which was specially adapted or where special treatment was given. Birmingham was one of those prisons. The Prison Commissioners were following up this question and trying to eliminate prisoners apparently suffering from any mental defect. Such prisoners were dealt with very much more leniently and received a different type of treatment from that given to the ordinary prisoner. Whether they were dealt with in the same way as if they were sent to a mental institution he could not say offhand. He had not been able, personally, to look into the matter, but it had not been overlooked, and was being dealt with to a certain extent. The Mental Deficiency Act, passed last year, also covered a certain amount of the recommendations of the Young Offenders Committee in regard to this question. In the prisons every step was taken to see that where clothing was handed over from one man to another it was thoroughly and properly disinfected, and that in no case was it in a condition where it could give any disease to anybody. In the last two years there had been a very considerable improvement in the diet, particularly in variety. He did not honestly think that there was any reasonable ground for complaint on that score. At a later stage in the debate Sir V. Henderson said that special steps were now taken, where a man was committed to prison and the prison doctor thought he was of a low state of mental efficiency without actually being certifiable, to transfer that man to a special prison. That was a new departure which was being carefully watched, and, if successful, would be further developed.

The amendment was negatived and the debate adjourned.

Recommendations of the Royal Commission on Lunacy.—Answering, on May 17th, questions by Mr. Snell and Sir Nicholas Grattan-Doyle, Mr. CHAMBERLAIN said he appreciated that early legislation was desirable in pursuance of some, if not all, of the recommendations of the Royal Commission on Lunacy and Mental Disorders, but owing to the other commitments of the Government he could not say when it would be practicable to introduce a bill.

Certification of Mentally Deranged Persons.—On May 21st Sir KINGSLEY WOOD replied to Sir F. Hall, who asked if his attention had been called to cases which had occurred from time to time in recent years in which mentally deranged people who would ordinarily be under restraint had, owing to the liberty allowed them, committed suicide, whether he was aware that in some of these cases doctors and magistrates had refused to sign certificates owing to their fear of possible legal proceedings, and whether he would appoint a departmental committee to consider and advise whether any amendment of the law relating to the certification of lunatics was desirable. Sir Kingsley said that the answer to the first part of the question was in the affirmative. The Minister of Health saw no necessity for the appointment of a departmental committee to consider the matter, as the Royal Commission on Lunacy reported upon difficulties of this kind and made recommendations for an amendment of the law.

Report of the Voluntary Hospitals Commission.—Replying, on May 17th, to a question by Mr. Lunn, Mr. CHAMBERLAIN said the final report of the Voluntary Hospitals Commission, of which Lord Onslow was chairman, was in the printer's hands, and the work of the Commission would be concluded with the issue of the report. Excluding contributions towards specific grant-aided services, the total Exchequer grants in aid of the general expenses of voluntary hospitals since 1918 amounted to £500,000; and the distribution of this sum by the Commission was completed on March 31st, 1924. There had always been cases of voluntary hospitals in financial difficulties, but a great improvement had happened in the last few years, and in the absence of a further contribution from the Exchequer it would be no use to keep the Commission in being. Colonel ACLAND-TROYTE suggested that the voluntary hospitals should be relieved of all rates. No answer was returned.

Motor Accidents and the Voluntary Hospitals.—Sir KINGSLEY WOOD told Mr. Lunn, on May 22nd, that the Minister of Health hoped that the report of the Voluntary Hospitals Commission would be issued this month. The Minister of Health must receive and consider the report of the Commission before deciding whether, in view of the great increase in cases caused by motor accidents which had to be dealt with by the hospitals, he would call a conference between representatives of the voluntary hospitals, insurance companies, and other organizations concerned, for the purpose of drafting a scheme to cover the expenses of the treatment of cases caused by motor accidents. Mr. LUNN asked if Sir KINGSLEY knew that last year there were more than 100,000 motor accidents, which cost voluntary hospitals more than £500,000, and that thousands of people awaited treatment for whom these hospitals were created, but who could not be treated because of motor cases which were going into the hospitals and paying nothing for their treatment. Sir KINGSLEY WOOD said that these facts might be true, and when the Ministry of Health received the final report of the Commission he hoped it would be able to give this matter further consideration.

Fees of Doctors Summoned to Urgent Cases.—Answering a question on May 16th, Sir KINGSLEY WOOD said he had not seen the evidence given at an inquest at Shoreditch on Ernest Murch, of Rochford, Essex, at which an allegation had been made that a doctor, summoned to attend this man, refused to do so because his fee could not be paid by the person summoning him. It appeared from a press report that the coroner was not satisfied that the facts were as alleged, and the Minister of Health did not consider it desirable to introduce legislation making it compulsory for doctors to attend urgent cases and for their fees to be paid from public funds. Sir Kingsley added that he did not think the Shoreditch case was anything more than an exceptional one.

Pensions Hospitals.—On May 22nd Lieut.-Colonel G. F. STANLEY told Mr. Robinson that the staff employed in area war pension offices outside London numbered 1,471, and that employed in Ministry hospitals and clinics in the provinces, in Scotland, and Northern Ireland numbered 1,647. Arrangements had had to be made to vacate two hospitals—Craigleith, Edinburgh, and Castle Leazes, Newcastle-on-Tyne, which were too large for their requirements—provision being made for the patients in substituted institutions of the Ministry at Edenhall and Dunston Hill. Apart from these cases, it was not possible to say what local offices, clinics, or hospitals it might be found necessary to close during the present financial year.

Prevalence of Venereal Disease.—Sir KINGSLEY WOOD, replying to Sir B. Peto on May 22nd, said that syphilis and gonorrhœa were not compulsorily notifiable, and the only information available as to their prevalence in the civilian population was that obtained from the treatment centres provided by local authorities. The returns received from these centres showed that since 1920 there had been a considerable reduction in the number of persons treated at the centres, although the figures for the last two years showed a small increase over those for 1925, which was probably due to recent improvements in the facilities provided at some of the centres and to continued propaganda as to the dangers of these diseases. He was not aware that the present policy in dealing with these diseases involved any denial of access to preventives through chemists. The restrictions imposed by the Venereal Diseases Act,

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1917, applied only to written or printed notices or instructions in regard to the use of preventives. Sir B. PIRO asked whether the diminution and recent increase, to which Sir Kingsley had referred, applied equally to both diseases or only to one. Sir KINGSLEY said that there was a slight difference between the two diseases, but he did not think the increase was a very large one.

Small-pox.—On May 21st Sir KINGSLEY WOOD, replying to Mr. Groves, who asked the Minister of Health whether, seeing that when small-pox contacts were isolated the inspector filled in a printed form giving information on various points, including when the contact was last vaccinated, and that such forms came into the possession of the medical officer of health, he would say why they were not used for the compilation of information as to the vaccinal condition of small-pox contacts who subsequently developed small-pox, said that the Minister was advised that it was not the usual practice to isolate small-pox contacts. Mr. Groves's question therefore did not arise.

Expenditure on Cancer Research.—Mr. CHAMBERLAIN, replying to a question on May 22nd, said that the provisional number of deaths registered during 1927 as caused by cancer was 54,079. The expenditure borne on the vote of his department during the five years ending March 31st last which was directly assignable to cancer research was £8,343. In addition the Exchequer grant administered by the Medical Research Council was applied to the promotion of research into this and other diseases.

Compensation for Insanitary Premises.—On May 22nd Mr. CHAMBERLAIN told Sir R. Gower that compensation on the basis of site value applied only to premises which were included in a scheme as confirmed on account of the sanitary condition of the houses, or because those premises were dangerous or prejudicial to health. He was of opinion that the provisions of Section 48 of the Housing Act, 1925, were, in some respects, unsatisfactory, and he had under consideration proposals for amending them.

Water Supply of Schools.—Answering Dr. Vernon Davies, on May 17th, Lord EUSTACE PERCY said he was in constant communication with the Minister of Health about schools which had no water supply. Lord Eustace also told Mr. March that he had no particulars showing how many of the fifty-two schools in Herefordshire which were without water in 1925 were still unprovided, nor how many public elementary schools in England and Wales had no sanitary accommodation but privy middens.

Notes in Brief.

On March 31st, 1928, there were 5,944 physically defective children on the rolls of special schools in London, compared with 5,347 on March 31st, 1924. In Birmingham the corresponding figures were 1,165 and 1,101.

The Minister of Health is not prepared to postpone the operation of the regulation prohibiting the use of preservatives in cream.

The number of cases of overcrowding and other insanitary defects in workshops notified to local authorities by factory inspectors were 3,334 in 1925, 3,061 in 1926, and 2,775 in 1927. The reports of the medical officers of health showed that twenty-five workshop occupiers were prosecuted for sanitary offences in 1925 and 1926.

The Services.

DEATHS IN THE SERVICES.

Major-General Sir Samuel Hickson, K.B.E., C.B., Army Medical Service (ret.), died at Bournemouth on March 22nd, aged 68. He was born on November 12th, 1859, the fourth son of the late Captain R. M. Hickson of Dingle, Kerry, and educated at Trinity College, Dublin, where he graduated B.A., M.B., and B.Ch. in 1884. Entering the R.A.M.C. as surgeon on May 30th, 1885, he became brevet lieutenant-colonel on August 22nd, 1902, lieutenant-colonel substantive on May 30th, 1905, brevet colonel on January 2nd, 1913, and colonel on July 7th, 1914, retiring on December 26th, 1917. He served in the Mashonaland campaign in South Africa in 1896–97, and he was mentioned in dispatches in the *London Gazette* of February 18th, 1898, and received the medal with a clasp; in the South African war in 1899–1901, in operations in the Orange Free State and in Cape Colony, was mentioned in dispatches in the *London Gazette* of July 29th, 1902, and gained the Queen's medal and King's medal, with two clasps to each, and a brevet lieutenant-colonelcy; and in the recent war of 1914–18, when he was thrice mentioned in dispatches, in the *London Gazette* of October 19th, 1914, December 24th, 1917, and December 30th, 1918, and received the C.B. and K.B.E. He was appointed honorary surgeon to the King in 1913, received the C.B. in 1915, and the K.B.E. on January 1st, 1919; also the honorary rank of major-general on May 8th, 1919. He married, in 1903, Elizabeth Constance, widow of R. Fry, and younger daughter of the late Rev. Canon Belsher of Cork.

Dr. George Dougal McReddie died at Greenhithe, Kent, on May 10th, at the great age of 91. After taking the M.R.C.S. and the M.D.Brux. in 1877, he entered the uncovenanted medical service in India, and served for thirty years in the North-West Provinces, now the United Provinces of Agra and Oudh. As he retired over thirty years ago there can be none left on the active list, and not very many on the retired list, who served with and remembered him.

Obituary.

ARTHUR MANKNELL, M.B., B.S.

Past-President, Yorkshire Branch, British Medical Association.

It was with a distinct feeling of a personal loss that the medical profession in Bradford heard of Dr. Manknell's death, which took place on May 13th. He had been working within a week of the end, and its suddenness increased the profundity of the blow.

Arthur Manknell was born at Leeds in 1866. He received his early education there, and then proceeded to the Yorkshire College, whence he graduated M.B.Lond. in 1891 and B.S. in 1893. He also obtained the M.R.C.S. and L.R.C.P. diplomas in 1891. When the Yorkshire College became the University of Leeds Manknell received the M.B., Ch.B. *ad eundem* of the new institution. After graduating he held the appointments of senior house-surgeon and ophthalmic and aural house-surgeon at the General Infirmary in Leeds, and then went to Bradford as assistant to the late Dr. David Goyder of that town. On the death of the late Dr. S. C. Hirst of Craisterdyke, near Bradford, Manknell took over the latter's extensive practice, and carried it on with ability and success till his untimely decease. He was an excellent general practitioner, careful, conscientious, and considerate, with the welfare of his patients ever at heart, and was held in high esteem by them. In religion he was a sound Churchman, and took an active part in the affairs of his own parish, wherein he had held office as churchwarden, and also of the diocese, wherein he served on various committees. He took nothing for granted, but worked *de rien*, and thus his utterances were always authoritative.

Among his professional brethren Manknell was held in great and deserved regard. Nothing was too much trouble for him; he worked early and late, often at considerable sacrifice, in promoting the interests of the profession, and his presence was always looked for and desired at meetings. Perfectly definite in utterance, he gave his views on any subject clearly: ambiguity was foreign to him. His advice was much sought after in various matters, being sound, weighty, well matured, and to the point, and he was as a tower of strength to a younger man who had a difficulty to solve. But it is for his great and loyal devotion to medical politics that Manknell will be chiefly remembered. Always an active member of the Bradford Division of the British Medical Association, he was till the day of his death one of its chief pillars. He had been its chairman, and he had also held the office of president of the Yorkshire Branch. He was representative of the Bradford Division from 1912 to 1914, and again from 1921 to 1927. He had also served on a number of central committees and subcommittees of the Association, including the Public Health and the Medico-Political and Parliamentary Committees, and for the past nine years had been a member of the Council. In committee and Council meetings his quiet common sense and close attention to business were highly appreciated by all. Manknell was also one of those instrumental in the success of the Annual Meeting held at Bradford in 1924, on which occasion he held office as president of the Section of Medical Sociology. He took a prominent part in the meetings which preceded the inauguration of the National Health Insurance Act, but when that measure became law Manknell accepted office as chairman of the Local Medical and Panel Committee, and was still chairman at the time of his death. He will be difficult to replace, as the experience he had garnered conduced much to the smooth working of the panel system in Bradford. He had also been president of the Bradford Medico-Chirurgical Society, and served on its council.

The funeral service, which took place at the Bradford Cathedral prior to the interment at Nab Wood cemetery on May 16th, was attended by a large concourse of his medical colleagues, the general public, and the representatives of institutions with which he had been connected. The Bishop of Bradford, in the course of his address, testified very feelingly to the loss which the Church, the medical profession, and the public had sustained. Dr. Manknell is survived by his widow, his son, and his daughter. The gap which he has left among us in Bradford will be hard to fill. *Vulde deflendus est.*

J. B. D.

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Dr. ANDREW GILMOUR, whose death occurred suddenly at Wimbledon, on May 13th, in his fifty-second year, was a native of Edinburgh, and was educated at George Watson's College and the University in that city, graduating M.B., Ch.B. in 1898. He proceeded M.D. in 1902, and in the same year obtained the diploma in public health. In 1912 he was admitted M.R.C.P.Ed. He devoted the greater part of his career to work in the public health service after serving as a medical officer throughout the South African war. He spent some ten years in Paisley, being appointed assistant medical officer for that burgh in 1909, and later school medical officer. On the reorganization of the Scottish educational system in 1919 the county became the administrative unit, for this purpose he was appointed senior school medical officer to the Renfrewshire Education Authority. Soon afterwards he accepted office under the Hindley Urban District Council, where he remained till 1922, when he was appointed medical officer of health for the borough of Wimbledon, holding also the posts of school medical officer, medical superintendent of the isolation hospital, and borough bacteriologist and analyst. During the late war he held a commission in the R.A.M.C., serving in Gallipoli, Salonika, France, and Belgium. He was a Fellow of the Royal Institute of Public Health, and of the Society of Medical Officers of Health, and a member of the British Medical Association. His funeral service was attended by the Mayor and many members of the Corporation of Wimbledon, and of the various civic departments and institutions with which he was associated. Among the mourners was his brother, who is also a medical practitioner. Dr. Gilmour is survived by his widow and a young son. A colleague writes: He was one of the few who, though advancing in age, do not lose any of their enthusiasm for their work. Public health work was his hobby throughout his life, and much of his spare time was occupied in formulating schemes and reports for the improvement of the efficiency of his department. Such keenness often brings with it extremism, but there was no suggestion of this in him, and all his public health judgements were shrewd and well thought out. At the borough isolation hospital he did some of his best work, for fevers was a branch of medicine in which he was most interested. He was among the earliest to take up the use of anti-scarlet fever serum, and was keeping careful records of its efficacy. Quite recently he equipped and started working the borough bacteriological laboratory, in which he spent much time and took considerable interest. To the general practitioner he was always ready to give freely his best help and advice, and his loyalty to his colleagues and to his profession as a whole will long be remembered. As a man he was rather sensitive, and for this reason was occasionally misunderstood. But those who had the privilege of being admitted to his friendship found a charming personality and a heart of gold, always kind and ready to help to his utmost those in trouble or difficulty.

Dr. ARTHUR STAFF DUTTON, who died in London on March 25th, had been an invalid for some years before his death, which occurred at the age of 63. He received his medical education at St. Thomas's Hospital, obtaining the diplomas L.R.C.P. and M.R.C.S. in 1892. A considerable part of his professional life was spent in Oxford, although in his later years he resided mainly in London. He contributed to the proceedings of several professional societies, and was a frequent correspondent to medical journals; he was the author of a book, published in 1908, entitled *The National Physique*. He was keenly interested in research work, and even in his last illness maintained his contact with professional affairs. He is survived by his widow.

Dr. THOMAS DRYDEN NICHOLSON died on April 29th, after a short illness, at his residence at Brampton, Cumberland; he had spent the greater part of his professional life in the Shap district in the neighbouring county of Westmorland. He was born at Greystoke Gill in 1864, and obtained his medical education at Edinburgh, graduating M.B., C.M. in 1890. He subsequently commenced practice at Bolton-on-Dearne in Yorkshire, and held the post of honorary surgeon to the Montague Cottage Hospital, Mexborough. In 1899, however, he removed to Shap, where he carried on a practice covering a very extensive and thinly populated area under arduous conditions for over twenty years, holding during this period a number of public and other medical appointments. About eight years ago he moved to the milder climate of Brampton, where the conditions of medical practice were less exacting. He was appointed honorary surgeon to the Brampton and District War Memorial Cottage Hospital. Dr. Nicholson served on the council of the Border Counties Branch from 1923 to 1926, and on the Executive and Ethical Committee of the English Division of that Branch from 1925 to 1927. He took a keen interest in public affairs, and was for long a prominent member of the North Westmorland Conservative Association. He was a member at one time of the Shap Urban District Council, and in 1912 was appointed a Justice of the Peace for Westmorland. One of his favourite recreations was boxing. He is survived by his widow, two sons, and two daughters.

Dr. REGINALD SPENCER PEARSON, who died suddenly at his residence in Lambeth on May 1st, was a native of Cumberland, where he was born in 1866, being the son of a clergyman. He received his medical education at Owens College, Manchester, obtaining the diplomas M.R.C.S.Eng. and L.R.C.P.Lond. in 1890, and subsequently, in 1898, the D.P.H. After a period of service as medical officer of health to the Wigan rural district, he commenced practice in North London, where he remained for about ten years. For family reasons he then moved to Leighton Buzzard for a time, being medical officer to the Linslade rural district, and on his return to London he settled down in the Clapham district, where he built up an extensive practice. He served also as medical officer to Spurgeon's Orphanage, to the Church of England Home for Waifs and Strays, and to St. Joseph's Catholic Home, Clapham. He was a Fellow of the Medical Society of London and a member of the British Medical Association, in which he served on the executive committee of the Lambeth and Southwark Division. On the London Panel Committee he represented the insurance practitioners of Lambeth. During the past few years Dr. Pearson took an active interest in municipal affairs, and ten years ago he secured a seat in the borough council of Lambeth, in which he held the office of mayor for a period which ended only last November. He was among the most popular and most conscientious of municipal workers, and devoted himself particularly to public health affairs, being notably active recently in connexion with child welfare. An earnest churchman, he had been for several years one of the churchwardens of Lambeth Parish Church. He was also a keen Freemason, and took a considerable interest in sport. At the funeral service, held at the Lambeth Old Parish Church, there were present many representatives of the borough of Lambeth, of the church, and of the medical profession. Dr. Pearson is survived by his widow, three sons, and a married daughter.

Dr. ELIZABETH PARK YOUNG PATERSON died in a Glasgow nursing home after a brief illness on May 2nd, at the age of 33. She was a native of Clydebank, and received her medical education at the University of Glasgow, graduating M.B., Ch.B. in 1918, and obtaining the D.P.H. in 1925. After a succession of resident posts in Glasgow—in the Royal Infirmary, the Sick Children's Hospital, the Maternity Hospital, and the Eye Infirmary—she held an appointment under the Ayrshire Education Authority, and subsequently spent about two years in ante-natal work in Leeds. She then returned to Clydebank, where she commenced practice, and was appointed medical officer to the old Kilpatrick Parish Council. Two years ago she was appointed an assistant medical officer for maternity and child welfare work on the staff of the Glasgow public health department. She was a member of the British Medical Association. A colleague writes: Dr. Elizabeth Paterson was deeply interested in child welfare work, and brought to it an appreciation of practical difficulties gained by experience in varied branches of practice. She had a kind heart and sympathetic manner, but to this was added a

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shrewdness and firmness born of knowledge of human nature. Of the esteem in which she was held by her friends and colleagues it is unnecessary to write. This was well demonstrated by the large attendance at the funeral service held in Radnor Park United Free Church, Clydebank, of which Dr. Paterson was an active member. The profession was well represented, and there were present members of both the medical and nursing staffs of the Glasgow public health department.

Dr. HARRY MORTLOCK WALLER, who died suddenly at Nuneaton on May 17th, in his fifty-seventh year, entered the profession late in life, and received his medical education at St. Bartholomew's Hospital, obtaining the diploma L.M.S.S.A. in 1918. He subsequently held a medical appointment under the Ministry of Munitions, and spent several years in the Far East, where he was at one time medical officer to H.H. the late Rajah of Sarawak and to the Sarawak Government, and served for a period as principal medical officer of that territory. On returning to England he practised in various districts—notably in Cheshire, Carnarvon, Nottingham, and Cardiff—and for the last three years had been resident at Nuneaton. He had served as a medical referee under the Ministry of Pensions, and acted for a period as honorary surgeon to the Griff division of the St. John Ambulance Association. A short time ago he decided to retire, and had just completed the disposal of his practice when he had a seizure which proved fatal. Dr. Waller, who was a member of the British Medical Association, is survived by his widow and two daughters.

Universities and Colleges.

UNIVERSITY OF LONDON.

THE title of Professor of Experimental Pathology in the University has been conferred on Dr. Archibald Leitch in respect of the post held by him as Director of the Research Institute at the Cancer Hospital, London.

The title of Reader in Pathological Chemistry in the University has been conferred on Dr. C. R. Harington in respect of the post held by him as Lecturer in Pathological Chemistry at University College Hospital Medical School.

Dr. Geoffrey Hadfield has been appointed as from May 1st, 1928, to the University Chair of Pathology, tenable at the London School of Medicine for Women. Since 1919 he has been pathologist, bacteriologist, and clinical pathologist to the Bristol General Hospital.

Dr. Percival Hartley has been appointed as from August 1st, 1929, to the University Chair of Biochemistry, tenable at the London School of Hygiene and Tropical Medicine. Since 1922 he has been on the staff of the National Institute for Medical Research, Hampstead.

Dr. F. D. Turner has been appointed a Governor of the Royal Grammar School, Colchester, and Dr. M. E. Delafield as representative (in respect of University College) at the International Convention of Cancer, to be held in July next.

The Dunn Exhibitions in Anatomy and Physiology for 1928 have been awarded to Mr. J. D. H. Bird of King's College.

Dr. Robert Knox has been recognized as a teacher of radiology at the Cancer Hospital. Probationary recognition has been granted to Mr. G. P. Crowden as a teacher of physiology at University College for a period of two years from March, 1928.

It has been resolved to institute, in accordance with the regulations on University titles, a Readership in Morbid Anatomy and Histology, tenable at the Middlesex Hospital Medical School, and a Readership in Bacteriology, tenable at University College Hospital Medical School.

Dr. W. W. Jameson has been admitted to the Faculty of Science as from January 1st, 1929.

The regulations in the Faculty of Medicine for internal students have been amended by the addition at the end of the first paragraph, under the heading "Second Examination for Medical Degrees, Part II," on page 251 of the Red Book, 1927-28, of the following: "either as an internal or as an external student."

The regulations for the First Examination for Medical Degrees have been amended by the addition of the following paragraph at the end of the section headed "General Biology," on page 243 of the Red Book, 1927-28, and page 218 of the Blue Book, September, 1927:

Candidates will be required to bring to the practical examination note-books containing a record of their previous practical work for inspection by the examiners if desired. These note-books must be certified by the teachers of the candidates as being the actual working notes made by them in the laboratory.

Dr. John Fawcett has been elected chairman of the Committee of the Medical Members of the Senate for the remainder of the year 1927-28; Sir John Rose Bradford, F.R.C.P., has been appointed vice-chairman of University College Committee for the year 1928-29.

NATIONAL UNIVERSITY OF IRELAND.

THE following degrees and diplomas in the Faculty of Medicine were conferred at University College, Dublin, on May 12th:

M.D.—G. E. Breen, W. H. B. Magauran.
M.B., B.Ch., B.A.O.—S. J. Savage, G. A. O'Reilly, D. P. Toomey, P. J. Aird, L. Brennan, Fras Carroll, W. E. Chinneide, J. D. Grant, J. A. Henry, M. J. Kenny, W. P. Lapoin, J. J. McCarthy, T. S. McDevitt, F. A. MacDonald, J. F. S. Mafanghlin, M. T. O'Reilly, Maude F. Timony, M. G. Walsh.
D.P.H.—M. J. Sheehy, Kate A. Moran, V. L. Coghlan, Hanora Casey, Josephine Conway, W. R. Casson, Margaret M. Purcell.

ROYAL COLLEGE OF SURGEONS OF EDINBURGH.

THE following 25 successful candidates, out of 34 entered, having passed the requisite examinations between January 2nd and 7th, have been admitted Fellows:

Elsie V. Crowe, A. Cumming, F. W. Duthie, P. Garson, B. Glaser, C. D. Gossage, C. Grantham-Hill, G. A. Hardwicke, A. Hobson, L. W. Houghton, C. W. Isaac, J. B. Learmonth, F. L. Lewis, E. O. Lloyd, Beatrice H. Lunn, C. R. McCash, B. L. McFarland, S. McMahon, E. C. Meikle, R. G. Phillips-Turner, F. E. Stayner, S. M. Vassallo, G. L. Wilson, C. L. Walker, J. E. Zohrab.

Bathgate Memorial Prize.

The Bathgate Memorial Prize, consisting of bronze medal and set of books, has, after a competitive examination in materia medica, been awarded to J. L. Meikle.

ROYAL COLLEGES OF PHYSICIANS AND SURGEONS OF IRELAND.

AT the spring examinations, held under the conjoint scheme, the following have passed in the examinations noted:

FINAL QUALIFYING EXAMINATION IN MEDICINE, SURGERY, AND MIDWIFERY.—G. F. A. Condon, P. Daly, E. P. Mahood, F. L. G. Malone, M. J. McCloskey, J. F. Power, P. B. Walsh.
D.P.H.—F. J. Ryan.
D.P.M.—G. N. W. Thomas.

ROYAL COLLEGE OF SURGEONS IN IRELAND.

THE following candidates have been approved at the examinations indicated:

PRIMARY FELLOWSHIP.—R. L. Forsyth, M. B. Lavery, T. B. Lundy.
FINAL FELLOWSHIP.—D. V. O'Connor.

Medical News.

THE Samuel Augustine Courtauld Institute of Biochemistry of the Middlesex Hospital will be opened on Thursday, June 14th, at 3.30 p.m., when Sir Archibald Garrod will deliver an address.

THE Macalister Lecture before the London Clinical Society will be delivered at the London Temperance Hospital, Hampstead Road, N.W.1, on Thursday, June 7th, at 8.45 p.m., by Sir Berkeley Moynihan, P.R.C.S., on medicine in art. All medical practitioners are invited to attend with friends. Those intending to be present are asked to notify Mr. H. P. Winsbury White, honorary secretary, 51, Harley Street, W.1.

THE next Chadwick Lecture will be given at the Chelsea Physic Garden at 5 p.m. on Thursday, June 7th, by Professor W. E. Dixon on narcotic plants. Sir William Collins will preside. Admission is free. Further information about Chadwick public lectures may be had from the secretary, Mrs. Aubrey Richardson, at the offices of the Chadwick Trust, 204, Abbey House, Westminster.

AN evening reception will be held at the house of the Royal Society of Medicine (1, Wimpole Street, W.1) on Monday, June 4th. The guests will be received by the President and Lady Berry at 8.30 o'clock, and at 9.15 Mr. C. Leonard Woolley will give an illustrated address on recent excavations at Ur of the Chaldees. Objects of interest will be shown in the library, and there will be music and light refreshments.

AT the meeting of the Society for the Study of Inebriety to be held in the rooms of the Medical Society of London (11, Chandos Street, Cavendish Square, London, W.) at 4 p.m. on Tuesday, July 10th, Dr. H. M. Vernon will open a discussion on the scientific control of alcoholism.

THE annual meeting of the Sheffield Branch of the Medical Women's Federation will be held in the Medical Library, The University, Sheffield, on Saturday, June 30th, at 3.30 p.m., when a lecture will be given by Dr. Letitia Fairfield on child guidance, or American methods of dealing with maladjusted children. Non-members of the Federation will be cordially welcomed.

THE fifth annual congress of the Incorporated Association of Hospital Officers will be held at the Royal Horticultural Hall, Westminster, on June 1st and 2nd, with Sir Arthur Stanley in the chair. The subjects to be discussed are wireless in the hospitals, including its effect upon patients and the broadcast appeals, and hospitals as centres of education. The annual dinner of the association will be held at the

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Hotel Cecil on the evening of June 1st. From May 29th to June 1st, in the Royal Horticultural Hall, there will be a hospitals and institutions exhibition.

THE Fellowship of Medicine and Post-Graduate Medical Association announces that on Wednesday, May 30th, Mr. Ogier Ward will give a clinical demonstration in urology at St. Peter's Hospital, at 2 p.m., and that on Thursday, May 31st, at 4.30 p.m., Dr. H. C. Semon will give a clinical demonstration at the Royal Northern Hospital. Special courses will be given in June as follows: at the Children's Clinic and other hospitals a course in diseases of children, June 4th to June 16th; at the City of London Hospital for Diseases of the Heart and Lungs, Victoria Park, a course in diseases of the chest, and at the Chelsea Hospital for Women a course in gynaecology, both from June 18th to 30th; at the West End Hospital for Nervous Diseases, a course in neurology from June 25th to July 21st; a practitioner's course in medicine, surgery, and the specialities at the London Temperance Hospital from June 18th to 30th, in the late afternoon. It may be recalled that the general course of work continues throughout the year and may be begun at any time. Special arrangements are made for part-time study. Full particulars may be had from the Fellowship of Medicine, 1, Wimpole Street, W.1.

A POST-GRADUATE course in genito-urinary diseases, consisting of weekly lectures on special subjects, will be given in June and July at St. Paul's Hospital, Endell Street, W.C.2, whence details may be obtained. No fee will be charged and the lectures are open to any medical practitioners and students who may care to attend. The first lecture will be given on Thursday, June 7th, at 4.30 p.m., and subsequent lectures at the same hour on either Wednesdays or Thursdays until July 26th.

THE annual meeting of the Society for the Relief of Widows and Orphans of Medical Men was held on May 16th, when the annual report and financial statement were presented and the officers were elected for the ensuing year. The annual report showed that during 1927 four members were elected, three died, and one resigned. The society had a total membership of 303, with invested funds amounting to £139,400. The sum of £4,782 was distributed in grants among the fifty-one members and seven orphans, and on December 31st fifty widows and one orphan were in receipt of grants. A subcommittee has been formed to consider the question of membership of the society with a view to its expansion. Membership is open to any registered medical practitioner who at the time of his election is resident within twenty-one miles of Charing Cross. Should he remove outside the radius he nevertheless remains a member of the society, provided he conforms to the by-laws. Further particulars and application forms for membership can be obtained from the secretary of the society, 11, Chandos Street, Cavendish Square, W.1.

AT the annual meeting of the Infants Hospital, Vincent Square, Westminster, on May 21st, it was announced that a big extension scheme, involving an expenditure of £250,000, is to be undertaken. Ground has been acquired adjoining the present site, and it is hoped to commence reconstruction soon. The scheme provides for more than doubling the number of cots available, for creating a new maternity block, for enlarging and modernizing the surgical section, for greatly increasing the out-patient accommodation, and for making new quarters for the nursing staff. Sir Gomer Berry, chairman of the committee of management, who presided, intimated that as a memorial to his wife he proposed to make a gift to the hospital of £50,000, payable over the next seven years, to cover the entire cost of a new maternity block.

THE opening of the extension of the Mildmay Mission Hospital in Austin Street, Bethnal Green, took place on May 19th. Lord Radstock, who presided, recalled the origin of the hospital, saying that more than sixty years ago, when London was visited by a terrible plague of cholera, the Rev. W. Pennefather and a staff of trained deaconesses set on foot in Bethnal Green a work for the benefit of the suffering. The mission then inaugurated was now known as the Mildmay Mission Hospital. It was unique among hospitals in that it had sent out at least 75 doctors and 120 nurses into the foreign mission field, and 350 women had received at the hospital a measure of practical training to fit them for tending the sick at home or abroad. The extension was then dedicated by the Rev. Colin C. Kerr, rector of Spitalfields, and formally opened by Lady Cooper. The x-ray department, which was the gift of Sir H. Percy Shepherd, was opened by him. Mr. Herbert S. Shipton, chairman of council of the hospital, said that nobody, except himself, knew how very much was owing to Dr. Henry White, the medical superintendent, and Miss Woodhouse, the matron. The sum which it was necessary to raise for this scheme was £22,764, and up to the previous evening the amount received had been £19,051.

THE report of the National Baby Week Council for 1927 records the various measures employed, with considerable success, by this body in the advancement of the ideals for which it stands. Many of its efforts have been duly noted from time to time as they occurred. The number of baby weeks, health and baby weeks, baby competitions, and other local propaganda activities assisted during the year was 564; an experiment in propaganda work in rural districts, conducted by the Cambridgeshire Federation of Women's Institutes, yielded satisfactory results in spite of the difficulties attending such efforts in thinly populated areas. Film displays, the use of which has been considerably extended, have also proved valuable in bringing home to those interested the need for instructed motherhood. The council's 1928 campaign again provides for the celebration of National Baby Week during the first seven days of July, in the course of which the usual programme of conferences and competitions has been arranged. As in former years, while regarding all aspects of maternity and child welfare as important, the council urges that attention should be given especially to three selected problems. These are: (a) immunization as a means of protecting young children against disease; (b) prevention of maternal mortality, with special reference to antenatal care and to the provision of maternity homes and hospitals; and (c) new developments in maternity and child welfare work.

THE committee appointed by the Royal Medico-Psychological Association has received very encouraging promises of support for the memorial volume to the late Sir Frederick Mott, and it is hoped that the book may be ready in the early autumn. The title suggested is "Contributions to Psychiatry, Neurology, and Sociology. Dedicated to Sir Frederick Mott by his Colleagues, Friends, and former Pupils." The publication has been entrusted to Messrs. H. K. Lewis and Co., Ltd.

APPLICATIONS are invited by the University of Glasgow before April 1st, 1929, for the Harry Stewart Hutchison Prize of about £50, which is offered for the best original research in a branch of medical science relating to children. The prize is open to medical graduates of not more than ten years' standing, of all British and colonial universities. Further information with regard to this prize will be found in last week's advertisement columns.

THE Board of Education has published in pamphlet form a list of certified special schools, recognized institutions for the training of the blind and other defective children, and nursery schools in England and Wales. The schools are grouped according to type and arranged in counties, details being given of the accommodation available and the average attendance in 1926–27 in each case. Copies of the list may be obtained from H.M. Stationery Office, price 1s.

THE Cambridge University Press announces for early publication Part II of Professor Joseph Barcroft's work on *The Respiratory Function of the Blood* and a revised edition of Dr. F. D. Drewitt's *Romance of the Apothecaries' Garden*.

INFORMATION regarding the special study tour for medical practitioners to the spas and health resorts of Italy, to which reference was made on May 5th (p. 787), may be obtained from the Italian Travel Bureau, 16, Waterloo Place, Regent Street, S.W.1, where bookings may be effected and all arrangements completed. The tour will extend from September 5th to September 21st, covering a number of places of interest in Lombardy and Piedmont, including the Italian Riviera and the Italian lakes.

THE eighth international congress of dermatology and syphiligraphy, which was to have taken place in 1915, three years after the congress held in Rome in 1912, will meet at Copenhagen from August 5th to 8th, 1930. Further information can be obtained from the general secretary, Dr. S. Lomholt, Raadhuispiads 45, Copenhagen.

THE French league against the venereal peril will hold a congress at Nancy from May 29th to 31st, when the following subjects will be discussed: the history of syphilis, the education of the public, the antisyphilitic dispensary, and organization of means for combating inherited syphilis. Further information can be obtained from Dr. Spillmann, Faculté de Médecine, Rue Lionnois, Nancy.

DR. TAILLENS, professor of diseases of children at Lausanne University, has been nominated Chevalier of the Legion of Honour. Professor Manuel Quintela, formerly dean of the faculty of medicine of Montevideo, has been nominated officer of the Legion.

THE 125th anniversary of the birth of the chemist Justus Liebig, who was born at Darmstadt on May 12th, 1828, is to be celebrated by rebuilding with the original material the house in which he was born, and the addition to it of a museum.

TRACHOMA is prevalent in Tokyo, where there are now over 330,000 cases in a population of about two millions.

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Letters, Notes, and Answers.

All communications in regard to editorial business should be addressed to ***The EDITOR, British Medical Journal, British Medical Association House, Tavistock Square, W.C.1.***

ORIGINAL ARTICLES and LETTERS forwarded for publication are understood to be offered to the BRITISH MEDICAL JOURNAL alone unless the contrary be stated. Correspondents who wish notice to be taken of their communications should authenticate them with their names, not necessarily for publication.

Authors desiring REPRINTS of their articles published in the BRITISH MEDICAL JOURNAL must communicate with the Financial Secretary and Business Manager, British Medical Association House, Tavistock Square, W.C.1, on receipt of proofs.

All communications with reference to ADVERTISEMENTS, as well as orders for copies of the JOURNAL, should be addressed to the Financial Secretary and Business Manager.

The ***TELEPHONE NUMBERS*** of the British Medical Association and the BRITISH MEDICAL JOURNAL are *MUSEUM 9861, 9862, 9863,* and *9864* (internal exchange, four lines).

The ***TELEGRAPHIC ADDRESSES*** are:
EDITOR of the BRITISH MEDICAL JOURNAL, *Aitiology Westcent, London.*
FINANCIAL SECRETARY AND BUSINESS MANAGER (Advertisements, etc.), *Articulate Westcent, London.*
MEDICAL SECRETARY, *Mediocre Westcent, London.*

The address of the Irish Office of the British Medical Association is 16, South Frederick Street, Dublin (telegrams: *Bacillus, Dublin*; telephone: 62550 Dublin), and of the Scottish Office, 6, Drumsheugh Gardens, Edinburgh (telegrams: *Associate, Edinburgh*; telephone 24361 Edinburgh).

QUERIES AND ANSWERS.

CRAMP AFTER SCIATICA.

DR. S. A. EWING (Melbourne, Australia) writes: In reply to the query of "K." in your issue of March 10th (p. 430) for suggestions as to the relief of cramp following sciatica, for such or any form of cramp complete relief will often follow the wearing of woollen socks into which the pyjamas are tucked at bedtime. Those wearing stockings may find it advisable to carry them well above the knees. Undue exercise should be avoided, though with the above method immunity may result even after moderate fatigue.

MEDICAL FACILITIES ON MOHAMMEDAN PILGRIM SHIPS.

"PORT SAID," who is returning home from the East after a voyage as ship's surgeon, is desirous of having the experience of any member of the profession who has acted as surgeon on board a Mohammedan pilgrim ship to Jedda. He would like to know the sickness and death rate, if any, and what sick comforts were allowed and given on board; also if the sick pilgrims were treated with kindness by the ship's officers. His own experience of a single voyage has been wretched, and he wonders what the case has been with others.

TREATMENT OF CHRONIC NASOPHARYNGEAL CATARRH.

"C. C." invites suggestions for the treatment of chronic nasopharyngeal catarrh in a patient suffering from chronic phthisis. Various douches and sprays have been tried without benefit. Nasal surgeons whom he has consulted do not advise surgical treatment.

A HOSPITAL STERILIZER.

DR. R. H. S. MARSHALL (Oswestry) asks for information as to the best "sterilizer" which would take clothes and bedding and be suitable for an isolation hospital of twenty-four beds, chiefly used for scarlet fever and diphtheria. Central heating is already installed, and gas is laid on, but not electricity. He would like to know type, approximate cost, and where it can be obtained.

RADIOGRAPHY OF VISCERA.

DR. FF. ROBERTS (Cambridge) writes: "Cowal" (May 19th, p. 884) will find the information he requires on orthodiagraphy of the heart in a small book by Vaquez and Bordet, *The Heart and Aorta: Studies in Clinical Radiology.* The English translation is published by Messrs. Humphrey Milford, Oxford University Press. There are, of course, a number of works on radioscopy of the chest and abdomen. A standard work, and the best which I have seen, is Assmann, *Klinische Roentgendiagnostik der inneren Erkrankungen.* Unfortunately there is no English translation. A good account of the alimentary canal is also given in *The Roentgen Diagnosis of Diseases of the Alimentary Canal*, by Carman (published by Messrs. Saunders).

INCOME TAX.

"P. H." inquires what will be the position of a man who retires on a pension of £320 per annum, having an income of £200 from dividends, taxed before receipt, and entitled to an allowance for one child and a dependent relative.

*** If the wife be living the total allowances due for 1928–29 are: Personal £225, earned relief £53, child £60, dependant £25 total £363. There will therefore be no tax due on the £320 pension, and repayment of tax can be claimed against the dividends to the extent of (£363—£320=) £43 at 4s. and (£200—£43=) £157 at 2s.—that is, £24 6s. in all.

Repayment of Loan.

"X. Y. Z." is paying about £400 a year out of his earnings by repayment of a loan obtained for the purchase of a share in a partnership. He asks: "Am I liable to be assessed on this sum of £400?"

*** "X. Y. Z." is, of course, assessable on his earnings—that is, on income, not on outgoings; the real question is, Can he deduct the £400 in reckoning the amount of his earnings? The answer is that he cannot. That payment is an application of his income, and not an expense incurred in earning it. The amount represents a payment of capital, and cannot be deducted by him or be assessed to tax as income of his partner.

LETTERS, NOTES, ETC.

SEA-SICKNESS.

DR. F. GREENE KELLY writes: As a ship's surgeon of some years' experience I quite agree that so far we have no remedy for *mal de mer*, though the patient can greatly assist matters by taking calomel at night, followed by a saline next morning. Whether anything is gained by remaining on deck in the open air or being confined to the cabin largely depends on individual idiosyncrasy. I have had patients who, as long as they were confined to their cabin, showed no improvement until they were brought on deck: exactly the reverse occurred in those cases which tried the "fresh air treatment." The same applies to the drugs applied as remedies; sodium bicarbonate, bromides, atropine, and tincture of iodine have been employed with very varying degrees of success.

INFECTION AMONG CHILDREN IN CASUALTY DEPARTMENTS.

DR. THOMAS BLEZARD (Mansfield) writes: The correspondence on the possible spread of small-pox by "casuals" brings to my mind a state of affairs which existed—and very likely still exists—at a large general hospital where I once did "locum" as house-physician. As at most general hospitals, the casualty department was always crowded with mothers bringing children suffering from almost any complaint. While waiting to be seen the mothers naturally mingled generally, and the children did likewise. Later, a very obvious scarlet fever rash might be noticed on a child; it was then isolated and was soon on its way to an isolation hospital. But did this action negative any possible—and in my opinion probable—chance of infection to the other children in the waiting room? In my short stay I came across scarlet fever, measles, and, I think, diphtheria. It is possible that the residents found other types of infectious disease. Whether small-pox has been met with in this way I cannot say, but it is a possibility not to be ignored. Probably similar conditions prevail in many general hospitals where poor people take their sick children to the casualty department before calling in a doctor. Some method should be adopted whereby children with rashes or sore throats would be isolated on entering the hospital and would not mingle with other patients. The casualty officer should be notified at once of such cases.

MEDICAL GOLF.

AT the annual meeting of the Manchester and District Medical Golfers' Association, on May 16th, the challenge cup was won by Dr. J. S. Brown of Wigan. The Walter Gold Medal for the best scratch score was won by Dr. T. D. Burt of Gorton, who had a gross of 78. Dr. C. R. J. Boland of Ancoats Hospital, Manchester, secured the Walter Silver Medal for the best gross score by players with handicaps of 10 and upwards.

TREATMENT OF INJURIES ROUND THE ELBOW-JOINT—A CORRECTION.

IN the report received by us of Mr. J. F. H. Stallman's clinical demonstration to the Gloucestershire Branch, which was published in our columns on May 12th (p. 902), there appears to have been an error. Mr. Stallman was quoted as saying that, in his opinion, all injuries round the elbow-joint should be treated by prolonged immobilization in plaster. We are asked to explain that his statement with regard to prolonged immobilization in plaster applied only to myositis ossificans, and that his reference to injuries round the elbow-joint was to the effect that, no matter how trivial, they should be treated with proper respect.

VACANCIES.

NOTIFICATIONS of offices vacant in universities, medical colleges, and of vacant resident and other appointments at hospitals, will be found at pages 47, 48, 49, 52, and 53 of our advertisement columns, and advertisements as to partnerships, assistantships, and locumtenencies at pages 50 and 51.

A short summary of vacant posts notified in the advertisement columns appears in the *Supplement* at page 227.

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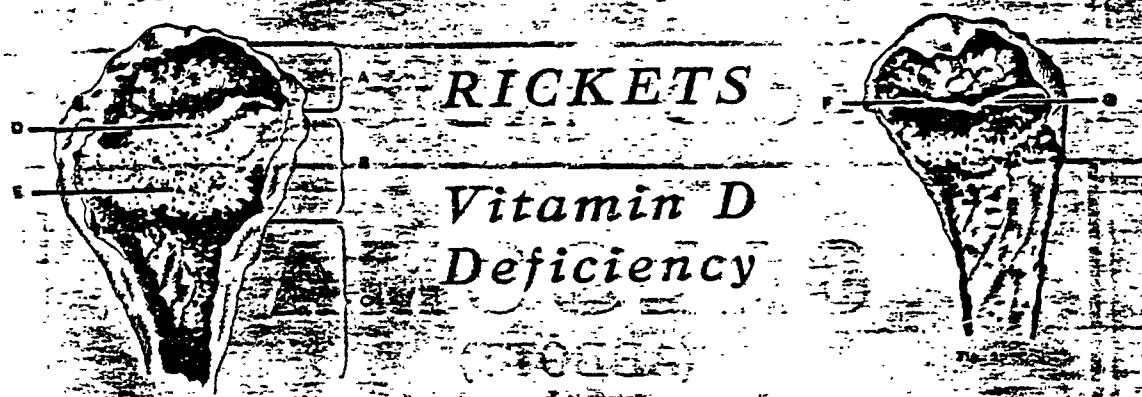
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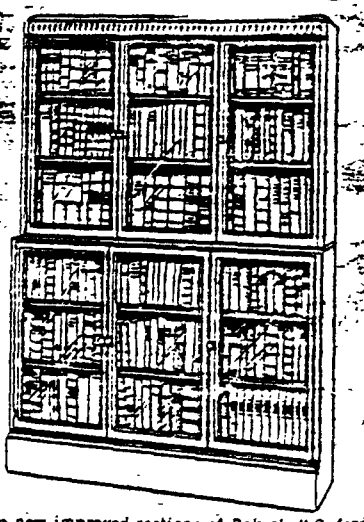
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F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
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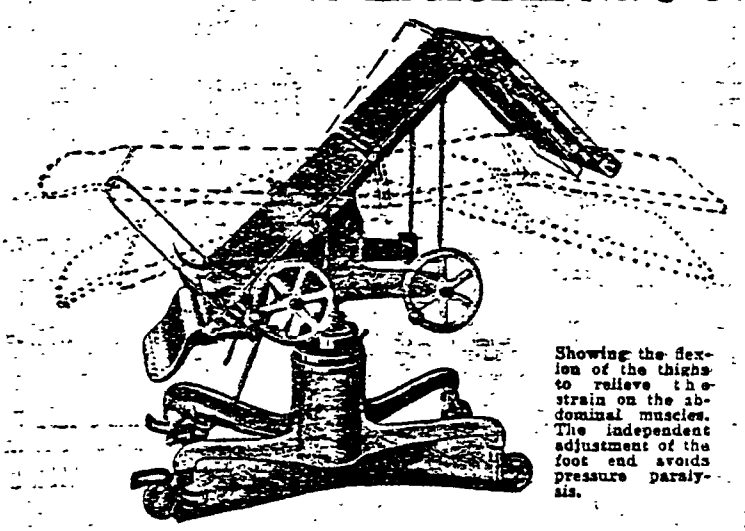
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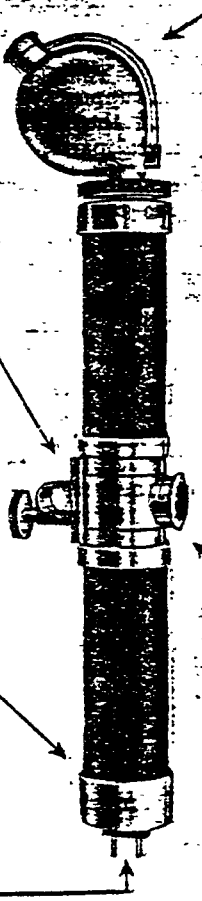
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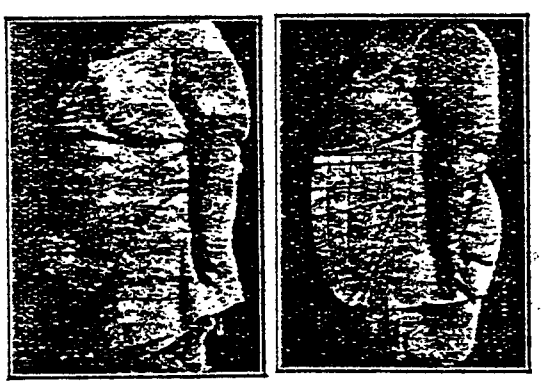
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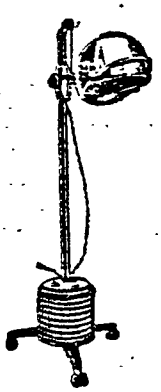
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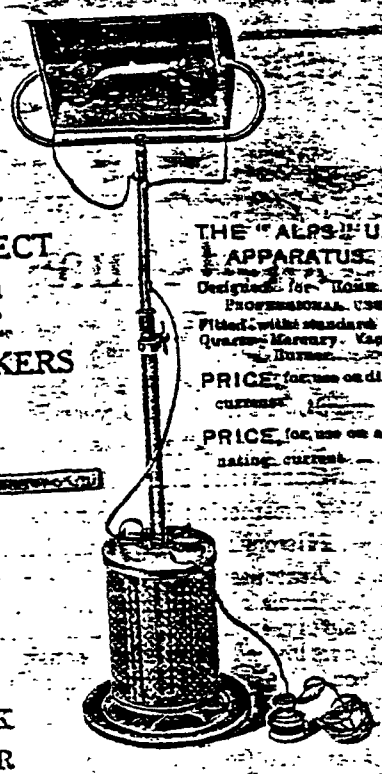


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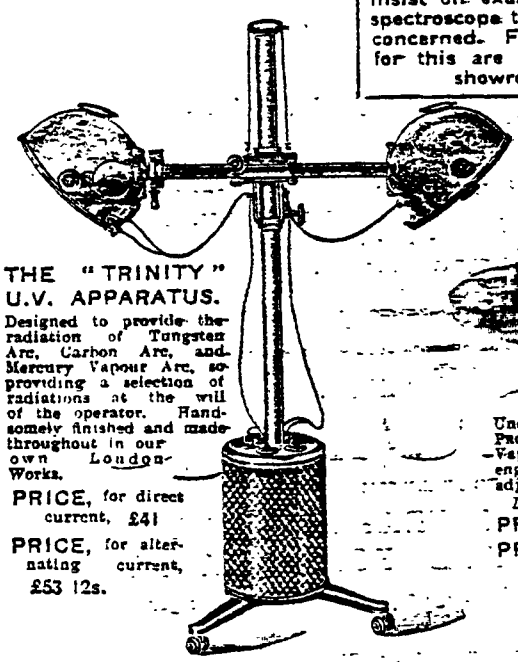
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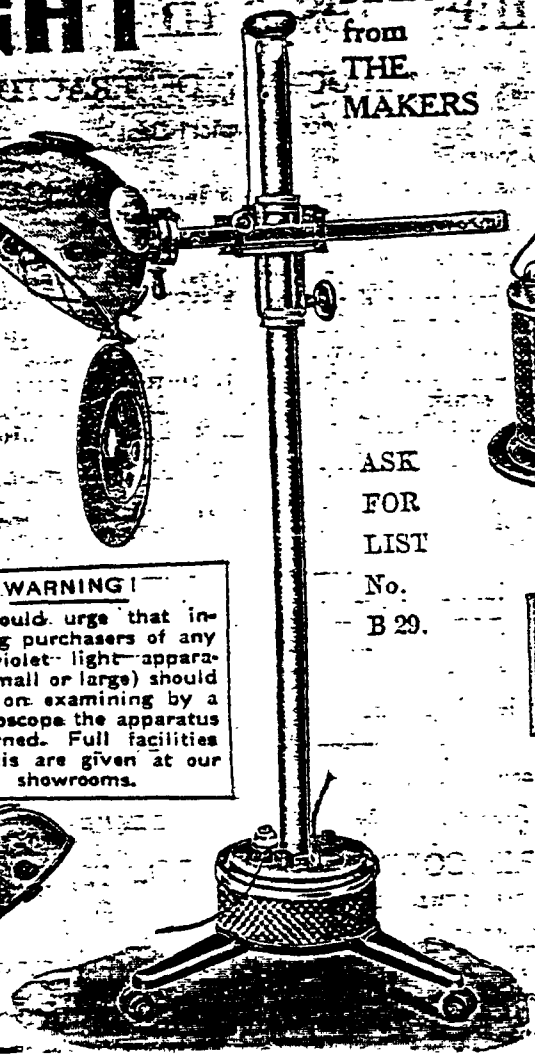


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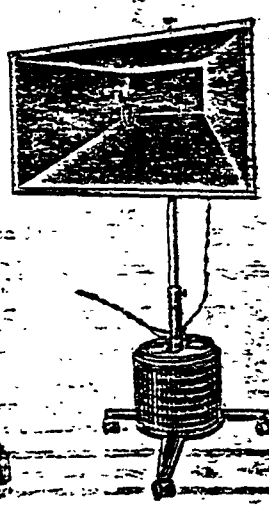
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containing the equivalent of one teaspoonful and one tablespoonful of Cod-liver Oil, U.S.P. Standard, and in this form the product is kept free from oxidation and light influence by the hermetically sealed non-actinic jujube covering.

Clinical sample on request.

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Manufacturers of "ROBOLEINE," the Food that Builds the Body, the Reconstructive Food which has been consistently prescribed for over 20 years, and used with the happiest results by Hospitals, Sanatoria, and Welfare Centres.

INSULIN 'A.B.'

TRADE A B MARK Brand

INSULIN 'A.B.' Brand is prepared only in the form of sterile solution which is immediately ready for injection.

Its use ensures: 1. Ready adjustability and accuracy of dose;
2. Full activity and stability;
3. Absence of reaction and pain on injection.

'A.B.' Brand Insulin maintains a world-standard of purity and excellence; its activity is guaranteed by the most complete physiological tests and standardisation on the basis of the accepted unit. Before issue, each batch is passed under the authority of the Medical Research Council.

Supplied in Two Strengths:

20 units per c.c. Packed in bottles containing:
5 c.c. (100 units or 10 doses) 2/8 each
10 c.c. (200 „ 20 „) 5/4 „
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Full particulars and the latest literature will be sent post free to Members of the Medical Profession:

Joint Licensees and Manufacturers:

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Graham Street, City Road, London, N.1

Allen & Hanburys Ltd.
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Cholumbrin (BOOTS)

SODIUM TETRA-IODO-PHENOLPHTHALEIN

SPECIALLY treated capsules containing 0·50 gram overcome the difficulties previously experienced in obtaining a product which will liberate the drug in the correct situation.

"Cholumbrin-Boots" is satisfactorily absorbed and does not produce vomiting. It is issued in special stearic acid coated capsules, and a very high percentage of positive results is obtained by the oral route when this special capsule is employed.

Packed in boxes of 20 capsules 7/-.

Obtainable through all branches of Boots

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BOOTS PURE DRUG CO. LTD.,
Manufacturing Chemists and Makers of Fine Chemicals
NOTTINGHAM ENGLAND
Telephone: Nottingham 45501. *Telegrams:* "Drug Nottingham." C.B.2

F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
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ACL Doc 13301 · Page 82 of 129
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Kaylene

FOR

TOXAEMIAS of INTESTINAL ORIGIN

The medley of harmful substances absorbed from the bowel has well been termed the master toxin, because it not only lowers the general level of health, but dominates the reactive processes of the body, and so prepares the way for invasion by infective bacteria of all kinds.

KAYLENE IS A POWERFUL DETOXICANT and is much prescribed for acute bacterial infections of the intestines.

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KAYLENE-OL & PHENOLPHTHALEIN
are convenient preparations for the successful treatment of CONDITIONS ARISING FROM TOXAEMIA

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HOVIS

Most nourishing Bread

After all the discussions as to the relative values of white, wholemeal, and various brown breads, it is satisfactory to have conclusive evidence at last.

Following many experiments by various research workers it is shown that no bread contains so large a percentage of Vitamin B as HOVIS, or is such an active agent for healthy growth when forming the basis of the diet.

As is now well known, even a partial deficiency in Vitamin B in the diet, if lasting for any length of time, impairs health, and, with children, prevents perfect development.

HOVIS, even in small quantities, provides sufficient vitamin in a digestive form as no other bread does, and it is liked by all.

Richest in Vitamin B

HOVIS Bread consists of White Flour with the wheat germ incorporated. It is this which gives it its special value, since the germ is the part richest in the Vitamin.

The "brownness" of bread is not a measure of its vitamin content. HOVIS does not contain bran and is easily digestible.

Note the following figures showing the Vitamin B content of milling products and yeast in 100 g. dried bread:

White Bread	200
Wholemeal Bread	1,450
HOVIS Bread	2,600

The evidence is conclusive. For providing the maximum of nourishment economically no bread equals HOVIS.

HŌVIS

(Trade Mark.)

Best Bakers Bake it

HOVIS LTD. LONDON & MACCLESFIELD

"In all infectious diseases, in all chronic anæmic and asthenic conditions, the mineral content of the Organism becomes impaired."
(Prof. ALBERT ROBIN of PARIS)

COMPOUND SYRUP
of the Hypophosphites (Fellows')

"The Standard Mineralizing Tonic"

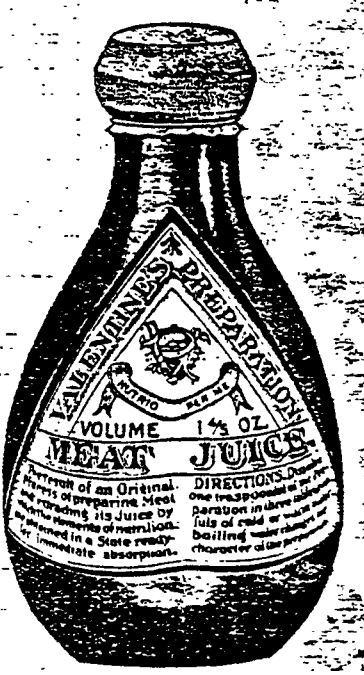
—combines the nutritive action of the Chemical Foods Calcium, Sodium, Potassium, Iron, Manganese, and Phosphorus, with the dynamic properties of Quinine and Strychnine

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Valentine's Meat-Juice

For **Quieting** the **Irritable Stomach** and **Aiding** the **Tired Digestive Organs**, for **Refreshing** the **Fever Patient** and for **Restoring** and **Strengthening** when Other Food Fails, **Valentine's Meat-Juice** is used in **Hospitals** and prescribed by many leading Physicians and Surgeons.



Physicians are invited to send for Clinical Reports from Hospitals and General Practitioners in all parts of the world.

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VALENTINE'S MEAT-JUICE COMPANY,
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JB 94

BOOTS PRODUCTS

Liver Extract (BOOTS)

A highly concentrated extract of FRESH LIVER specially prepared for the treatment of

PERNICIOUS ANÆMIA

Made by a process tested and found efficient by the Medical Research Council

(See B.M.J. and LANCET, March 10, 1928.)

Supplied in vials each equivalent to ½-lb. Fresh Liver

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Special Discounts to the Medical Profession and to Hospitals

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Recurrent Asthma and Hay Fever

The researches of Chen and others on the use of Ephedrine (the alkaloid of the Chinese plant Ma Huang) in the treatment of recurrent asthma and hay fever have established the superiority of Ephedrine therapy over all other forms of treatment.

Ephedrine possesses many advantages. It may be administered orally; it is prolonged in its effect; and, when in a pure state with all traces of pseudo-ephedrine removed, it is perfectly harmless to patients of any age.

To ensure the administration of the true alkaloid absolutely free from pseudo-ephedrine, it is advisable to prescribe

EPHEDRINE HYDROCHLORIDE B.D.H.

Ephedrine Hydrochloride B.D.H. is issued in tablets for oral use, also in solution and in tablets for hypodermic use.

There are also available:

1 A solution in liquid paraffin for use as a nasal spray,
2 An aqueous solution for use as a throat spray.

Literature on request

THE BRITISH DRUG HOUSES LIMITED

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Al. (3a)

McCOY'S
COD-LIVER EXTRACT TABLETS

With reference to the recent prosecution at Salford when a fine was inflicted upon Messrs. Boots the Chemists as a result of the sale of our tablets, we, McCoy's Laboratories, Ltd., wish to make clear the following facts:

1. We have reimbursed Messrs. Boots in the amount of the fine, costs, and expenses to which they were subjected as retailers, and we further state that all responsibility is accepted by us.

2. These tablets are our own proprietary line, and we alone are responsible for the formula, ingredients, packing, and advertising.

3. Messrs. Boots the Chemists have no control over or shareholding in our Company whatsoever, but sold our tablets simply as retailers in common with other chemists.

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WHAT A RECENT TEST OF BABY FOODS REVEALS

PHOTOGRAPHIC EVIDENCE

A test carried out by an Eminent Authority

THIS test records a striking fact which will prove of widespread interest to the medical profession. It reveals a factor of the utmost importance, viz., the effect of acidity on various milk foods in a baby's stomach. It serves to demonstrate conclusively how Humanised Trufood alone can stand comparison with an infant's natural diet.



Cows' Milk [Grade "A"] and 3 well-known Infant Foods



Breast Milk and Humanised Trufood
VIRTUALLY IDENTICAL

NOTE THESE FEATURES:

1. The perfect and uniform flocculation of Breast Milk and Humanised Trufood.
This precludes any possibility of a strain being placed on the digestive organs of the infant.

2. The heavy curdled condition of the other foods.
Foods which act like this are much less easy to digest, with the consequent danger of imposing a strain on the digestive system.
It is clearly indicated that only Breast Milk and Humanised Trufood are in the correct condition for natural digestion.

The finest testimony to HUMANISED TRUFOOD

INVESTIGATION HAS REVEALED

This test reproduces the action which takes place in an infant's stomach

IN a milk preparation for infant feeding, the effect of the action of acid on the constituents is of very great importance. Salivary digestion may be taken to be entirely lacking and an acid precipitation of the caseinogen is the first change which takes place in the stomach. It is important that the digestion of the precipitated casein be facilitated to the utmost extent in order to allow of not only quick and effective action of the digestive ferments but also of rapid passage from the stomach to the intestine, so suppressing stagnation and bacterial decomposition. Both these effects are largely determined by the nature of the acid precipitation. If the precipitate is finely flocculent as in Breast Milk and Humanised Trufood, both effects are at a maximum, but if it be coarse and lumpy, both are retarded as the attack by the digestive ferment on the lumpy curd is slow and the whole digestive process tends to become uneven. In the case of Breast Milk and Humanised Trufood, however, digestion is uniform and rapid.

In the test glasses shewn here, acid in sufficient quantity to precipitate the caseinogen has been added to Cows' Milk, Human Milk, Humanised Trufood and various reconstituted milk preparations, at bloodheat temperature. It will be noted that—

(*A*) In cows' milk and in most reconstituted milk preparations in which no precautions have been taken to "protect" the caseinogen, heavy and usually agglutinous curds are formed.

(*B*) In Human Milk and in Humanised Trufood (in which a similar "colloidal protection" is assured) the precipitation of the caseinogen is of the finest character or imperceptible. It follows therefore that—

In (*A*) Digestion will be slow, uneven, as the curd is not penetrated by the gastric juice and on account of the delay, time is given for bacterial decomposition and often gas formation.

In (*B*) digestion would be rapid and even. The uniform distribution and penetration of the gastric juice suppresses undesirable bacterial decomposition and the production of gas, and the stomach is emptied normally and quickly.

Photographic prints of this test and details of how to carry it our will be sent upon receipt of professional card.

INDEPENDENT ENDORSEMENT

The tests referred to in this announcement have also been carried out in the laboratories of
THE CLINICAL RESEARCH ASSOCIATION, LTD.
and the findings completely confirmed.

HUMANISED TRUFOOD

The Scientific Alternative to Breast Feeding

TRUFOOD LTD., THE CREAMERIES, WRENBURY. Nr. NANTWICH. CHESHIRE

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Note for the Medical Profession

Sepsis

UNTIL recently, no antiseptic has been available for the treatment of sepsis which not only possesses adequate germicidal power, but can be applied in effective dilutions without damage to tissues.

Monsol has a germicidal action on the Streptococcus Pyogenes more than ten times greater than that of pure phenol or lysol, and can be applied in dilutions stronger than those found capable of killing this organism, even to mucous membranes.

The following are some of the conditions in which this property can be utilised:

THROAT INFECTIONS
As a gargle in streptococcal tonsillitis; for the treatment of streptococcus carriers in scarlet fever outbreaks.

SKIN CONDITIONS
As an ointment or lotion in impetigo and other forms of dermatitis; for boils and carbuncles.

WOUNDS AND ABRASIONS
As an immediate prophylactic application, or as a dressing for injuries already septic.

OBSTETRICAL PRACTICE
As a vaginal or intra-uterine douche.

DENTAL SEPSIS
As a mouth-wash after extractions.

Many hundreds of letters have been received from medical men testifying to the value of Monsol in the treatment of septic conditions.

Monsol
Liquid for dressings, douches, packs, and all sick-room purposes

Monsol Ointment

MONSOL BRAND

Monsol Capsules
Keratin-coated for intestinal disinfection

Monsol Throat Pastilles

GERMICIDE AND DISINFECTANT

U.K. Distributors: Thomas Christy & Company, 4-12 Old Swan Lane, Upper Thames Street, London, E.C.
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MORE LETTERS FROM PRACTITIONERS WHO HAVE TRIED BEMAX

"(Took it) myself . . . . age 64 years . . . . Felt almost immediate benefit and am feeling stronger. Am troubled with stricture of œsophagus and sac, so don't know exactly how much enters the stomach . . . . . Am recommending to patients."
(N.S.D. 20) L.R.C.P., L.R.C.S.

"(Taken by) myself and family . . . . Within a few hours, feelings of satisfaction and well being."
(N.S.D. 4) M.R.C.S.

". . . . . Am of opinion that it increases resisting power to infection."
(N.S.D. 102) M.R.C.S., L.R.C.P.

The originals of these reports may be seen at our office by any registered medical practitioner.

Literature describing the results of our experiments and the research work we are doing in connection with Bemax, may also be obtained from the address given below.

Bemax

THE DETOXICATED EMBRYO OF CEREALS

THE BEMAX LABORATORIES VITAMINS [1928] LTD 38 DANEMERE STREET LONDON SW15

UNDER NEW PROPRIETORSHIP.

JOHN BELL & CROYDEN

wish to emphasize to the Medical Profession the character of their

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"IODOLYSIN"

Trade Mark.

A Powerful Fibrolytic Agent

Strikingly Successful in Chronic Arthropathies



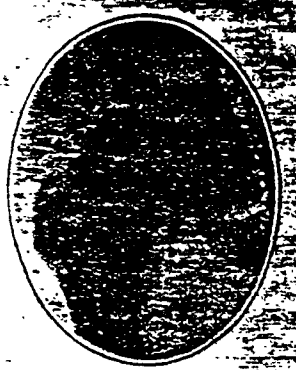
Radiograph of Knee-joint in Rheumatoid Arthritis.

A fibrolytic agent which gives really satisfactory results in a large percentage of cases must appeal to the general practitioner who has constantly to deal with difficult and intractable cases of chronic rheumatism and allied conditions. This can be justly claimed for 'Iodolysin' which has a striking effect in Rheumatoid Arthritis; and it is also employed with advantage for the removal of all forms of pathological fibrous tissue.

'Iodolysin' is a chemical combination of Iodine and Thiosinamin with these special advantages:

Ready Solubility in water. Well tolerated. Absence of local reaction on injection

'Iodolysin' is supplied in ampoules for hypodermic injection; in capsules for oral administration, or as an ointment or paint for local application.



Radiograph of Hip-joint in Rheumatoid Arthritis.

Free Clinical Sample and Literature on request

CANADA: 66 Gerrard Street East, Toronto

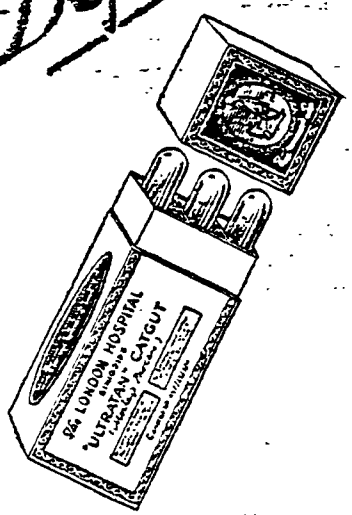
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Dependability

"ULTRATAN" LONDON HOSPITAL BINIODIDE CATGUT

(Morley's Process)



1 It is prepared at the London Hospital under strict antiseptic conditions
2 Sterilization of the gut starts before decomposition begins after the death of the animal
3 "Ultratan" Catgut is prepared for 10, 20, 30 and 40 days absorption
4 A feature of Biniodide Catgut is its great tensile strength
5 It is in continuous use, with unfailing success, in seventeen operating theatres in the London Hospital

Members of the profession are invited to visit the department at the London Hospital, Whitechapel, to inspect the process of manufacture throughout.

A Sample and Descriptive Booklet sent post free on application to

ALLEN & HANBURYS LTD., 48 Wigmore Street, London, W. 1

The London Hospital Catgut may be obtained from all the leading Surgical Equipment Houses.



GASTRONOMICS

A.D. 70

"Touching the paunch or belly," says Pliny, according to his English translator, Dr. Holland, "much ado there is with it; and although most men care for nothing else in this life but to content and please the belly, yet of all parts it putteth them to the most trouble. For one while it is costive, so that it will give no passage to the meat, another while so slipperie as it will keep none of it; one time you will have it so peevish as that it can receive no food, and another time so weak and feeble that it is able to make no concoction of it."

A.D. 1928

Pliny's observations on gastro-intestinal disorders do not differ greatly from those of medical men practising to-day, except in the quaintness of the old English translation; but the knowledge of the causes of fermentation and putrefaction gives the twentieth century an advantage in treatment not possessed by any preceding one. To limit the violence of chemical changes produced by harmful bacteria is the aim of every therapeutic measure for the benefit of alimentary disabilities, and in the bactericide Dimol the medical profession has recognised this great new assistance at their disposal.

THE EFFICIENCY of Dimol in the treatment of *all intestinal disabilities of bacterial origin* is conclusively told in the interesting clinical reports which, together with a brochure dealing with the pathological significance of the intestinal toxaemias, will be sent to any medical man on application to the

Dimol Laboratories Limited, 40, Ludgate Hill, London, E.C.4

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TRADE A B MARK

ALFRED BISHOP
Limited

Continental Spa Treatment at Home.

FOR those physicians who wish to prescribe for their patients a course of one or other of the Continental Medicinal Spring Waters, but whose patients cannot spare the time or incur the expense of a visit to the actual Springs themselves —

BISHOP'S MINERAL WATER VARALETTES

will now enable anyone to take the prescribed treatment at home. These Varalettes contain the chemical constituents of the Natural Waters themselves in the form of soluble effervescent tablets, known throughout the world as Varalettes. By dissolving two of these Varalettes in half-a-tumbler of water, it is now possible to obtain practically the equivalent of half-a-tumbler of the Natural Spring Water itself in a pleasant and convenient form and at a comparatively small cost. Among the Waters which can now be taken in this form are the following :—

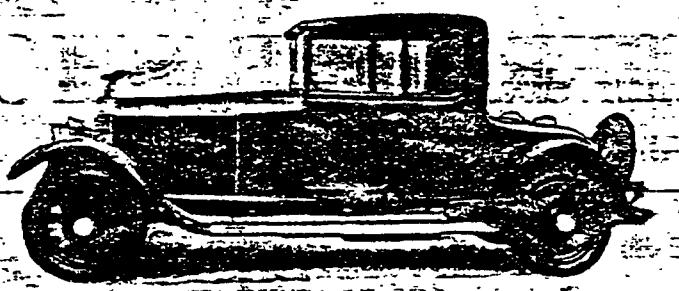
Lithia.	Homburg.
Vichy.	Royat.
Kissingen.	Saint Galmier.
Carlsbad.	Wiesbaden
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A sample bottle of any of the Medicinal Spring Varalettes will be sent free to any medical man on request, to show what the Varalettes are and how they act.

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JULY 23rd to JULY 27th, 1928, inclusive.

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Monday,	July 23rd.	2 p.m. to 6 p.m.
Tuesday,	,, 24th.	9 a.m. to 6 p.m.
Wednesday,	,, 25th.	9 a.m. to 6 p.m.
Thursday,	,, 26th.	9 a.m. to 6 p.m.
Friday,	,, 27th.	9 a.m. to 6 p.m.

FORMAL OPENING BY PRESIDENT-ELECT

The Exhibition will be formally opened by the President-Elect, accompanied by other Officers of the Association and the Members of the Representative Body, on Tuesday, July 24th, at 9.30 a.m.

RECEPTION ROOM.

The Reception Room will also be in the DRILL HALL in the centre of the Exhibition, and the Registration and Ticket Counters, etc., will be so arranged as to allow uninterrupted access to all gangways for convenient inspection of exhibits.

Plan of Exhibition, with full particulars, now available.

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Ten years ago this claim was made for the Armstrong Siddeley six. To-day it still holds good.

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In each class, for value, performance and appearance, you cannot buy a better car than the Armstrong Siddeley.

30 h.p. 6 cylinder from £1,150.
20 h.p. 6 cylinder from £735.
15 h.p. 6 cylinder from £590.
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ALL BRITISH. Prices ex Works. Dunlop Tyres.

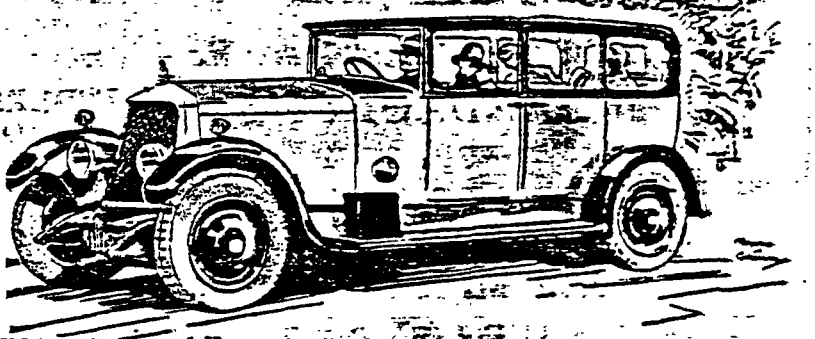
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THE DISC WHEEL

As an example of designing skill take the Armstrong Siddeley disc wheel. Enormously strong and simple in the fewness of its parts, yet light, neat and easy to clean. Introduced nearly ten years ago, this wheel foreshadowed the development of front wheel brakes.

Armstrong Siddeley disc wheels and brakes form the best and safest equipment. Freedom from wear, remarkable stopping power, and ease of adjustment are characteristics of them.



BUY BRITISH AND KEEP YOUR COUNTRYMEN EMPLOYED.

THE CRITERION HOUSE FOR LIVERIES



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We are now making an interesting display of the well favoured and NEW SEASON STYLES in LIVERIES FOR THE CHAUFFEUR—elegance, distinctiveness, and practicability are the three outstanding features. A prompt visit to our Holborn Showrooms will repay you; if this is impossible order by post or telephone Hol. 8484.

Perfect satisfaction guaranteed.

THE BROOKLANDS

The Gamage Brooklands is one of good taste where motor liveries are concerned. This suit comprises a Double Breasted Jacket and Trousers made from perfect all-wool Blue Serge, and executed by leading craftsmen. Fittings from stock at

84/- 95/- 115/6

CHAUFFEURS' GABARDINE COATS

made from shower proofed wool-unions Gabardine, lined with a proofed check lining, or mercerised Black Italian. Essentially the coat for you, because it will not detract from the general appearance of distinctiveness. 75/-

The Gamage Light Weight Blue Gabardine Coat—*unlined* 55/-

A complete range of sizes enables us to fit from stock.

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BANDAGES AND BINDERS

Made of High-class Artificial Silk Wool and Cotton.

For Sprains, Varicose Veins, Passive Swellings, Head Bandages, etc.

LAKE'S "Crêpsyl" (WOVEN CRÊPE)

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Both materials in all widths of Cream or Flesh Colour at same prices.

BANDAGES—

Widths: 2" 2½" 3" 4"

Prices: 2/- 2/6 3/- 4/- each.

Free samples will be sent to any Doctor, Surgeon, Matron, or Nurse upon application to the Makers for Wholesale and Export:

BINDERS FOR CHILDREN AND OBSTETRIC CASES

Widths: 4" 5" 6" 8"

Prices: 4/- 5/- 6/- 8/- each.

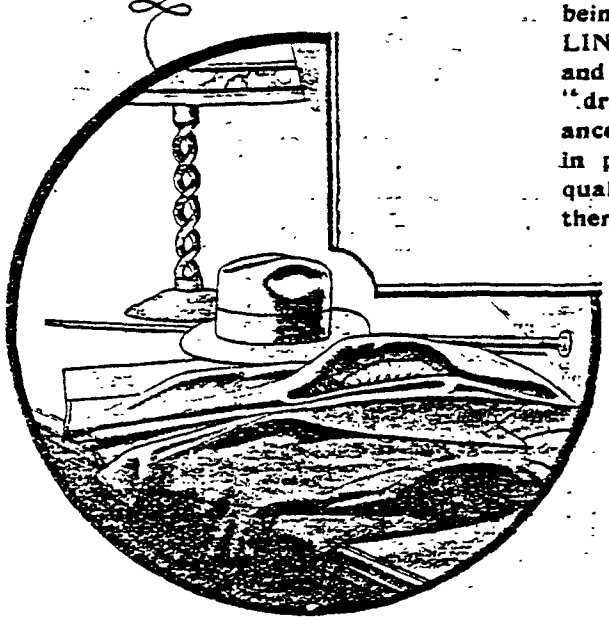
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Prices: 10/- 12/6 15/- each.

All Binders are reinforced to prevent sagging in the middle

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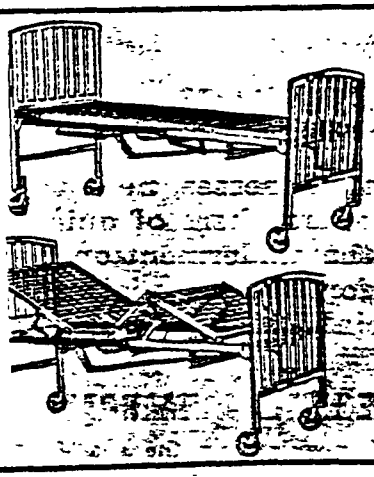
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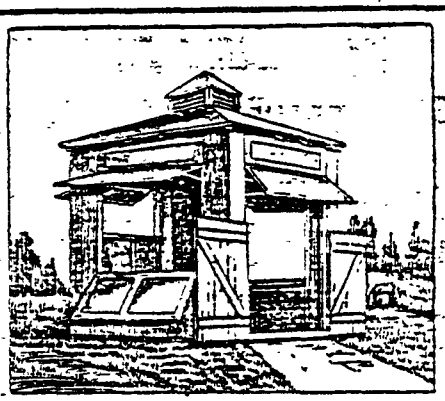
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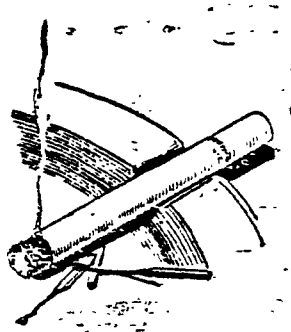
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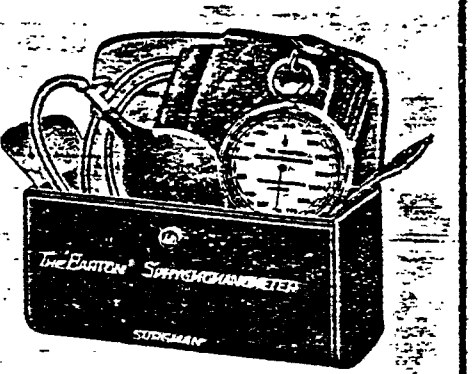
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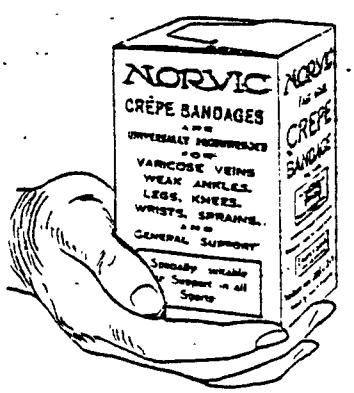
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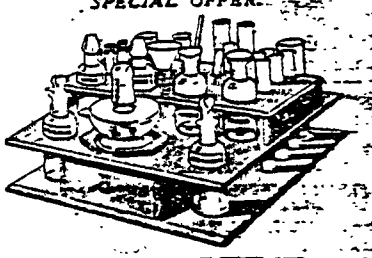
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F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
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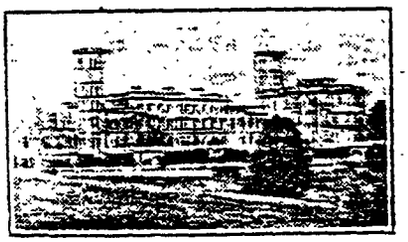
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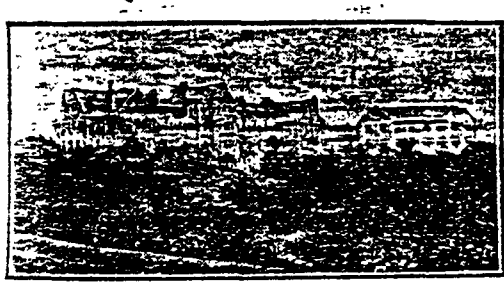
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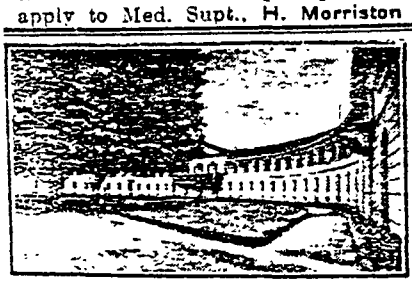
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A Course of Lectures on PATHOLOGICAL RESEARCH IN ITS RELATION TO MEDICINE has been arranged for the SUMMER SESSION. These Lectures will be given in the Lecture Room of the Bacteriological Department of the Institute on Thursday afternoons at 5 p.m.

The last Three Lectures of the series are as follows:

	SUBJECT.
MAY 31st. G. V. ANREP, M.A., M.D., F.R.S. (Lecturer in Physiology, Univ. of Cambridge).	"Pathology of Conditioned Reflexes."
JUNE 7th. Sir OLIVER JOSEPH LODGE, Kt., D.Sc., F.R.S.	"The Uses We Make of the Ether of Space."
JUNE 14th. PAUL FILDES, M.B., B.Ch. (Assistant Bacteriologist, London Hospital).	"Principles of the Treatment of Tetanus with Antitoxin."

These Lectures are open to all Members of the Medical Profession and to all Students in Medical Schools without fee.

MEDICAL CORRESPONDENCE COLLEGE

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"How to Pass the F.R.C.S.," free on application to the Secretary.

Royal College of Physicians of London.

CHARLES MURCHISON SCHOLARSHIP IN CLINICAL MEDICINE.

The next Examination for this Scholarship will be held at the Royal College of Physicians of London, on Tuesday, June 26th, and following days.

The Examination is open to any Student of Medicine who, subsequently to the date of his passing his professional Examination in Anatomy and Physiology for a Medical qualification, has studied for a period of not less than two and a half, and not more than five, years at a Medical School in London, recognized by the Royal College of Physicians, or at the University of Edinburgh, including Medical Classes recognized by the Medical Faculty of the University, whether holding a Medical qualification or not.

The Scholarship is of the value of Twenty Guineas, and is tenable for one year.

Intending candidates are required to send their names to the Registrar of the Royal College of Physicians, Pall Mall East, London, not later than June 9th, with evidence of the duration of their Medical Studies from the Deans of their respective Schools, and evidence of the date at which they passed their Examination in Anatomy and Physiology.

RAYMOND CRAWFURD, M.D.,
Pall Mall East, S.W.1. Registrar.

M. D. THESIS

(Camb., Edin., Glasg., Durh., &c.)

SKILLED COACHING, GUIDANCE, and ADVICE from Specialist Tutors, in conformity with the Regulations of the various Universities. Apply for particulars and free booklet, "Hints on Writing a Thesis for the M.D. Degree," to the SECRETARY, Medical Correspondence College, 19, Welbeck Street, London, W.1.

F.R.C.S. (Edin.).

A TUTORIAL CLASS for the next Examination commences shortly.

Particulars from Charles Whittaker, F.R.C.S., Anatomical Dept., Surgeons' Hall, Edinburgh.

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F.R.C.S. (Eng.),	*Primary*	145
(1906-27).	*Final*	122
M.R.C.P. (Lond.),	1914-27	143
D.P.H.	(Various) 1906-27 (Completed Exam.)	267
F.R.C.S. (Edin.),	1918-27	33
M.R.C.S., L.R.C.P.	*Final* 1910-27 (Completed Exam.)	376
M.D. (Dur.)	(Practitioners) 1906-27	35
M.D.	Various. By Thesis. Numerous successes.	

Preparation for Medical Preliminary, and Chemistry, Physics, Anatomy, Physiology, and final subjects for the Conjoint Board; M.B. (Cantab., etc.); also D.P.M., D.O.M.S., D.T.M. & H., D.L.O., L.M.S.S.A., etc. Numerous successes.

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Medical Prospectus gratis along with list of Tutors, etc., on application to the Principal, Mr. E. S. WEYMOUTH, M.A., 17, Red Lion Sq., London, W.C.1. (Telephone: HOLBORN 6313.)

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PRINCE OF WALES'S GENERAL HOSPITAL, N.15.

The Practice of the Hospital is limited to Medical Practitioners. Particulars from T. H. C. BENIANS, F.R.C.S., Dean.

F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
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UNIVERSITY of CAMBRIDGE.

Diplomas in (a) PUBLIC HEALTH, (b) HYGIENE (for foreign graduates), (c) TROPICAL MEDICINE AND HYGIENE.

Courses of Instruction in the Subjects of the Examinations commence October 10th, 1928. Full particulars to be obtained from MR. J. E. PURVIS, Public Health Chemical Laboratory, Medical School, Cambridge.

University of Cambridge.

PATHOLOGICAL LABORATORY.

THE JOHN LUCAS WALKER STUDENTSHIP.

Applications for this Studentship, the holder of which shall devote himself (or herself) to original research in Pathology, are invited, and should be sent, accompanied by copies of papers containing published work, testimonials, and references, before June 30th, to Professor H. R. DEAN, Pathological Laboratory, Medical School, Cambridge, to whom also applications for further information regarding the Studentship may be addressed. The Studentship is of the annual value of £300, and is tenable for three years.

May 15th, 1928.

University of London.

A Course of Three Lectures, with lantern illustrations, on "*Graves's Disease*" will be given by Dr. JOHN EASON, M.D., F.R.C.P.Ed. (of the Royal Infirmary, Edinburgh), at the MIDDLESEX HOSPITAL MEDICAL SCHOOL (Cleveland Street, W.1), on TUESDAY, WEDNESDAY, and THURSDAY, MAY 29th, 30th, and 31st, at 5.30 p.m. At the first lecture the chair will be taken by Dr. R. A. YOUNG, C.B.E., M.D., F.R.C.P. (Senior Physician to the Middlesex Hospital).

Admission free, without Ticket.

EDWIN DELLER, Academic Registrar.

University of London.

The Senate invite applications for the Sir William Dunn Chair of Pathology, tenable at Guy's Hospital Medical School. Salary approximately £1,330 a year. Applications (12 copies) must be received not later than first post on June 15th, by the Academic Registrar, University of London, South Kensington, London, S.W.7, from whom further particulars may be obtained.

University of London.

The Senate invite applications for the UNIVERSITY (part-time) CHAIR OF DIETETICS, tenable at St. Thomas's Hospital Medical School. Salary £1,000 a year. Applications (12 copies) must be received not later than first post on June 22nd, by the Academic Registrar, University of London, South Kensington, London, S.W.7, from whom further particulars may be obtained.

Dickinson Research Travelling SCHOLARSHIP IN MEDICINE.

The Trustees invite applications for the Dickinson Research Travelling Scholarship in Medicine.

The Scholarship is of the value of £300, tenable for one year. Candidates must be University Graduates who have taken out the full course of Clinical Instruction required by their examining bodies in the Manchester Royal Infirmary and the University of Manchester, and have earned distinction in so doing. They may apply for the Scholarship within any period of years after qualification as may be approved by the Trustees.

A copy of the Regulations governing the Scholarship can be obtained from the undersigned, to whom six copies of application should be sent not later than Thursday, June 14th.

Manchester Royal Infirmary. FRANK G. HAZELL, Secretary to the Trustees.

Liverpool School of Tropical MEDICINE.

UNIVERSITY OF LIVERPOOL.

COURSES OF INSTRUCTION (lasting about three months) for the Diploma in Tropical Medicine, commence on October 1st and January 7th, and for the Diploma in Tropical Hygiene on January 12th and April 26th. (Candidates for the D.T.H. must possess the D.T.M.).

For particulars apply to the Hon. Dean, Liverpool School of Tropical Medicine, Pembroke Place, Liverpool

General Lying-in Hospital York Road, Lambeth, S.E.1.

RESIDENT MEDICAL OFFICER required for July 1st next. Appointment for three months; £100 per annum, with board. Applications, with three testimonials, to be sent to the Secretary not later than June 4th.

Woolwich Union.

FIRST ASSISTANT MEDICAL OFFICER.

A First Assistant Medical Officer (resident, male) is required at the Plumstead and District Hospital, Plumstead High Street, S.E.18.

The Hospital accommodation is 320 beds, divided into Medical, Surgical, Gynæcological, and Obstetrical, etc., sections. There are X-ray, Electro-therapeutic, Massage, and Sunlight Departments, and the Hospital has a Consulting Staff.

The person appointed must have experience in surgery and undertake casualty work; and will be required to carry out such other duties as may be assigned to him by the Medical Superintendent, and should occasion arise, to assist at any of the other Institutions under the control of the Guardians.

Experience in the management and routine work of a hospital is desirable.

Salary £400, rising £25 annually to £500 per annum, with residence and rations, subject to deductions under the Poor Law Officers Superannuation Act.

Further particulars of the appointment may be obtained by personal application to the Medical Superintendent between the hours of 10 a.m. and 1 p.m., or by letter.

Applications, upon forms to be obtained on my office, as under, upon receipt of a stamped addressed foolscap envelope, or by personal application, must be returned to me not later than June 7th.

By Order,
ARTHUR HOLDER,
Clerk to the Guardians.

Union Offices,
Plumstead High Street,
S.E.18.

Down County Regional EDUCATION COMMITTEE.

SCHOOL MEDICAL OFFICER.

The above-named Committee invite applications for the position of School Medical Officer at a salary at the rate of £750 per annum, together with £50 per annum for travelling and maintenance expenses.

The person appointed must be a fully-qualified male medical practitioner of not less than 30 years of age on June 1st, 1927, and must have a Diploma in Sanitary Science, Public Health, or State Medicine, or shall have such qualifications as the Ministry of Home Affairs, Northern Ireland, may approve. Previous experience in School Medical work is desirable. Particulars as to duties, etc., may be obtained from the undersigned, at 27, Great Victoria Street, Belfast, with whom applications on official application forms must be lodged not later than Monday, June 11th.

DAVID C. QUAIL,
Director of Education.

May 14th, 1928.

County Borough of Burnley.

APPOINTMENT OF ASSISTANT MEDICAL OFFICER OF HEALTH AND ASSISTANT SCHOOL MEDICAL OFFICER.

Applications are invited from registered medical practitioners for the post of Lady Assistant Medical Officer of Health.

The successful candidate will be required to act as Resident Medical Officer at the Council's Maternity and Children's Hospital (44 beds), and, in addition, to perform such other duties as may be required of her from time to time by the Medical Officer of Health.

The salary will be at the rate of £475 per annum, plus board, lodging, and laundry, the estimated value of which is £125 per annum.

Application forms, together with conditions of service and a list of duties, may be obtained from the Medical Officer of Health, Public Health Department, St. James' Street, Burnley, to whom applications, accompanied by copies of three recent testimonials, should be forwarded not later than Saturday, June 2nd.

Canvassing, either directly or indirectly, will be a disqualification.

COLIN CAMPBELL,
Town Clerk.

Town Hall,
Burnley.
May 8th, 1928.

Central London Throat, Nose, AND EAR HOSPITAL, Gray's Inn Road, W.C.1.

OUT-PATIENT STATISTICAL REGISTRAR.

There will be a vacancy on July 1st for the above-named Officer, who must have had experience in the Specialty.

The duties are mainly statistical, but the Registrar is also required to assist the Surgeons in seeing patients when required, and to undertake elementary post-graduate teaching in conjunction with the In-patient Registrar.

There are small honoraria attached to the post, which is tenable for one year, subject to re-election for a period of not more than five years in all.

Applications, accompanied by copies of not more than three recent testimonials, should be sent to the undersigned before June 2nd next.

JOHN H. YOUNG, Secretary.

Surrey County Council.

SURREY COUNTY SANATORIUM.

APPOINTMENT OF MEDICAL SUPERINTENDENT.

Applications are invited for the appointment of Medical Superintendent at the Surrey County Sanatorium, Milford, Surrey (the erection of which is now almost complete). The Sanatorium will contain 300 beds for patients (male and female) suffering from pulmonary tuberculosis. Salary £900 per annum, with house (free from rent, rates, and taxes), and water supply. The appointment will be subject to the provisions of the Local Government and Other Officers Superannuation Act, 1922, and to the Standing Orders of the Council, which provide (inter alia) that the appointment may be determined at any time by three months' notice.

Applications, accompanied by copies of three recent testimonials, should be made on the prescribed form and sent to the County Medical Officer of Health (3, Grove Crescent, Kingston-upon-Thames), from whom copies of the application form may be obtained and to whom any inquiries relating to the appointment should be addressed. Last day for receipt of applications, Monday, June 4th.

Canvassing, directly or indirectly, will disqualify.

DUDLEY AUKLAND,
Clerk of the County Council.

County Hall,
Kingston-upon-Thames.
May 11th, 1928.

Administrative County of Essex.

APPOINTMENT OF THREE ASSISTANT COUNTY MEDICAL OFFICERS OF HEALTH.

The County Council of the Administrative County of Essex invite applications for the above posts from registered medical practitioners specially qualified in the treatment of Tuberculosis, School Medical Inspection, and Maternity and Child Welfare; holding a Diploma of Public Health, and not over 45 years of age.

Preference will be given to candidates who have had at least three years' experience in Public Health work, subsequent to their medical qualification. The salary attached to each appointment will be £600 per annum and travelling expenses. The persons appointed will be required to devote their whole time to the service of the Council, and to perform such duties and to furnish such advice and assistance appertaining to their offices as may be required, and to reside in such districts of the County as the Council may decide. The appointments will be subject to three months' notice on either side.

Applications, on the prescribed forms, obtainable from the undersigned, and accompanied by copies of not more than three testimonials, which will not be returned, should be addressed to me and delivered at the Shire Hall, Chelmsford, not later than Wednesday, May 30th.

JOHN H. COOLD,
Clerk of the County Council.

Shire Hall,
Chelmsford.
May, 1928.

Chester Union.

RESIDENT ASSISTANT MEDICAL OFFICER.

The Guardians of the above Union invite applications for the appointment of a duly qualified Resident Assistant Medical Officer at their Institution, St. James's Hospital, Hoole Lane, Chester.

Salary £200 per annum, together with furnished apartments, attendance, rations, and laundry.

The candidate appointed will be required to act generally under the direction of the (part-time) Senior Medical Officer and to report to, and consult with him; as and when required, to administer anæsthetics, etc.; to do the Hospital dispensing (drugs, etc., will be provided), and to give Lectures to Probationer Nurses. The Hospital is recognised by the General Nursing Council as an Associated Training School in affiliation with the Birkenhead and West Derby Union Infirmaries.

Applications, stating age, qualifications, and experience, accompanied by testimonials, must be sent to the undersigned on or before June 6th.

G. S. N. HULL,
Clerk to the Guardians.

St. Martin's House,
Chester.

Papworth Village Settlement (Under Royal Patronage).

Applications are invited for the post of SECOND ASSISTANT MEDICAL OFFICER at the Papworth Village Settlement for the treatment of tuberculosis. The Institution consists of a Hospital and Sanatoriums of 260 beds for men and women.

Commencing salary £250 per annum, with board, lodging, and laundry. Applicants, who must be male and single, should apply, giving age and qualifications, and enclosing copies of recent references, to the Medical Director, Papworth Village Settlement, Papworth Hall, Cambridge.

F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
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City of Manchester.

The Public Health Committee of the Corporation require the services of a fully qualified Whole-time Woman MEDICAL OFFICER, experienced in Midwifery and Children's Diseases, to hold (under the direction of the Medical Officer of Health) Consultations and Infant Clinics at the Maternity and Child Welfare Centres of the Manchester Corporation, and (under the like direction) to perform such other duties as appertain to the office.

The salary will be £600 per annum.

A statement of the duties and conditions of office may be had on application, in writing, to the Medical Officer of Health, Civic Buildings, 1, Mount Street, Manchester.

Applications, stating age and experience, and endorsed on the envelope "Medical Officer Child Welfare," must be addressed to the Deputy Town Clerk only, and not to members of the Committee or Council, not later than Saturday, June 9th, and be accompanied by not more than three recent testimonials.

The successful candidate will be required to contribute to the Corporation Superannuation Fund, and to execute their deed of service.

Canvassing in any form, oral or written, direct or indirect, is prohibited.

Town Hall, Manchester. H. DUNKS, Deputy Town Clerk.

May 22nd, 1928.

County of London.

The London County Council invite applications for appointment as EIGHTH ASSISTANT MEDICAL OFFICER (male) in the Mental Hospitals service. Candidates must be under 35 years of age, and be registered to practise both in medicine and surgery in England. Salary, £300 a year, rising by annual increments of £25 to £400 a year, without emoluments, with (at present) fluctuating temporary additions making the total commencing remuneration about £423 a year. Charges made for board, lodging, etc. (at present £2 9s. weekly), if required to be resident. Candidates appointed will be pensionable under the Asylums Officers Superannuation Act, 1909. Full particulars and conditions of appointment on form of application (on which alone application can be made) obtainable from the Acting Chief Officer, Mental Hospitals Department, The County Hall, Westminster Bridge, S.E.1. Canvassing disqualifies. Completed applications must be received by Thursday, June 7th.

MONTAGU H. COX, Clerk of the London County Council.

Warrington Infirmary and Dispensary.

The Board of Management invite applications for the post of JUNIOR HOUSE SURGEON (male), unmarried.

Applicants must be duly qualified medical practitioners. Salary £173 per annum, with board, apartments, and laundry. Applications, stating age and qualifications, with copies of three recent testimonials, should be sent in to the undersigned not later than June 5th. The post will become vacant about July 1st.

By Order.
HENRY L. BOOT, Supt. & Secretary.

May 19th, 1928.

Wrexham & East Denbighshire War Memorial Hospital.

(105 Beds.)

TWO RESIDENT HOUSE SURGEONS (male) required at above Hospital—one to commence on July 1st, and the other on August 1st. Appointments are for a period of not less than six months. Salaries £100 per annum respectively, with board and laundry.

Applications, stating when they can commence duties, age, nationality, experience, and qualifications, accompanied by three recent testimonials, to be sent to the undersigned not later than Friday morning, June 8th.

LESLIE SPENCER, Secretary.

May 16th, 1928.

The Hartlepools Hospital.

(100 Beds.)

Applications are invited for the post of HOUSE SURGEON at the above Hospital from July 1st.

Salary £150 per annum, rising to £200 after six months. Board, residence, and laundry provided. Appointment for one year. Previous Hospital experience desirable.

Applications (accompanied by copies of not more than three recent testimonials) to be sent to the undersigned not later than June 8th.

There will be a vacancy for a Junior House-Surgeon in September.

F. NEVILLE HART, Secretary.

All Saints' Hospital (for Genito-Urinary Diseases).

Out-patients' Dept. and Secretary's Office: 49/57, Vauxhall Bridge Road, S.W.1.
In-patients' Dept.: 91, Finchley Road, N.W.8.

RESIDENT SENIOR HOUSE-SURGEON (male) required on July 1st, for a period of three months. Salary at the rate of £200 per annum, with board, lodging, and laundry.

HOUSE SURGEON (male) required for period of six months from July 1st, the first three months to be as Non-resident House Surgeon, salary at the rate of £150 per annum, and the second three months as Resident House Surgeon, salary at the rate of £200 per annum, with board, lodging, and laundry. The duties as Non-resident House Surgeon consist of attendance at the Out-patient Department every afternoon and three evenings weekly.

Applications, stating age, experience, qualifications, and enclosing copies of testimonials, should reach me not later than June 12th.

D. H. EADE, Secretary.

Burnley Union.

RESIDENT MEDICAL OFFICER.

The Guardians of the Burnley Union invite applications for the appointment of Resident Male Medical Officer at Primrose Bank Institution, Burnley.

The gentleman appointed will be required to co-operate with the Visiting Physician in regard to the treatment of the sick.

The salary is £300 per annum, together with furnished apartments, rations, washing, and attendance valued for purposes of Superannuation at £120 per annum. The appointment will carry fees estimated at £33 per annum for certifying mental cases.

Form of application which may be obtained from the undersigned must be returned not later than June 9th.

H. E. PURTON, Clerk to the Guardians.

Union Offices, Burnley.

May 22nd, 1928.

St. Mary's Hospital, W.2.

SURGICAL REGISTRAR.

The Board of Management invite applications for the above post. Candidates for the appointment must be registered medical practitioners and Fellows or Members of the Royal College of Surgeons of England or a Graduate in Surgery of a University in the British Empire.

The salary is £200 per annum, with luncheon and tea.

Copies of the Regulations for the Surgical Registrar may be obtained on application to the Secretary's Office.

Applications, with copies of testimonials, not exceeding three in number, should reach the undersigned on or before Wednesday, May 30th.

W. PARKES, Secretary.

City Mental Hospital, Nottingham.

DEPUTY MEDICAL SUPERINTENDENT required at the above Hospital. Salary £650 per annum, rising by £10 per annum to £700, together with unfurnished house, rates and taxes free, valued for Asylums Officers Superannuation purposes at £95. No other emoluments. In addition, £50 per annum for D.P.M., and £10 per annum for M.P.C.

Applications, with fullest particulars, to be sent to the Medical Superintendent.

City of London Hospital for Diseases of the Heart and Lungs, Victoria Park, E.2.

(Bus, tram, and rail, Cambridge Heath, L. & N.E.R.)

Applications for two posts of HOUSE PHYSICIAN (male), with copies of recent testimonials, are invited to be sent to the undersigned by Monday, June 11th.

The appointments will be for six months from June 28th and July 1st respectively. Salary at the rate of £100 per annum, with board, residence, and laundry provided.

GEORGE WATTS, Secretary.

Kent County Council.

Wanted, LOCUM TENENS, with hospital experience, for eight weeks commencing July 14th, to act as Assistant Medical Officer at the County Sanatorium, Lenham, 155 beds.

Salary 8 guineas per week, in addition to board, lodging, and washing.

Apply, stating age and experience—
ALFRED GREENWOOD, M.D., County Medical Officer.
Sessions House, Maidstone.

Queen Mary's Hospital for the East End, E.15.

Telephone: Maryland 2616.

Applications are invited from fully qualified and registered men for the following posts:—
1 HOUSE PHYSICIAN.
2 HOUSE SURGEONS.
1 OBSTETRIC HOUSE SURGEON.
1 HOUSE PHYSICIAN AND CASUALTY OFFICER.

The Hospital contains 208 beds, including 46 Maternity, and other special departments.

Candidates, who should have previously held a Hospital appointment, must send copies of testimonials to the undersigned, not later than Tuesday, June 5th.

RAPHAEL JACKSON (Major), Secretary.

Derbyshire County Council.

LOCUM FOR SANATORIUM.

Applications are invited for the post of Woman Locum Resident Assistant Medical Officer at the Walton Sanatorium, near Chesterfield (130 beds), for a period of eight weeks commencing June 11th. Salary at the rate of £350 per annum, with board, lodging, etc. Experience in artificial pneumothorax desirable.

Applications, together with copies of two recent testimonials, to be sent to the undersigned on or before May 31st.

W. M. ASH, County Medical Officer.

New County Offices, St. Mary's Gate, Derby.

May 22nd, 1928.

Royal East Sussex Hospital, Hastings.

Applications are invited for the post of HONORARY ASSISTANT SURGEON to the above Hospital. Candidates must be under 45 years of age, and be either a Fellow or Member of the Royal College of Surgeons of England, or a Fellow or a Licentiate of the Royal College of Surgeons of Edinburgh or Northern Ireland, or a Graduate in Surgery of one of the Universities of the United Kingdom, and also be duly registered under the Medical Acts.

Applications, accompanied by copies of three recent testimonials, should reach the Secretary not later than 12 noon on Saturday, June 16th.

WILFRID G. KEMSLEY, Secretary.

Salford Royal Hospital.

(265 Beds.)

Applications are invited for the appointment of CASUALTY HOUSE SURGEON (male). Salary at the rate of £125 per annum.

The appointment is for a period from June 1st to December 31st next, with board and residence.

Candidates must be registered under the Medical Acts.

Forms of application, which may be obtained from the undersigned, must be delivered without delay.

By Order of the Board.
GEORGE RUDDLE, Gen. Supt. & Secretary.
Salford Royal Hospital, Manchester.

May 21st, 1928.

Stockport Infirmary.

VISITING ANÆSTHETIST.

Applications are invited from duly qualified medical practitioners of either sex for this appointment.

Particulars can be obtained on application to the undersigned.

Applications, with copies of testimonials, to be delivered not later than Wednesday, May 30th.

EDWIN J. PEARCE, Secretary-Supt.
The Infirmary, Stockport.

May 17th, 1928.

The Anglo-American Summer Clinic.

Les Fontaines de Mourraille, Le Ray, Nice, A.M.

APPOINTMENT OF MATRON.

Applications are invited for the position of Matron. The salary will be at the rate of £150 per annum, together with board, residence, laundry, and railway fare (2nd class) to and from Nice, and the term will be for six months. The appointment is renewable.

Applications, stating age and experience (including knowledge of languages), together with copies of not more than four recent testimonials, to be sent to the Secretary, A.A.S.C., Les Fontaines de Mourraille, Le Ray, Nice, France.

F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
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APPOINTMENTS—Important Notice.

Medical Practitioners are requested not to apply for any appointment referred to in the following table without having first communicated with the Medical Secretary of the British Medical Association, B.M.A. House, Tavistock Square, W.C.1.

(a) British Islands.

CONTRACT PRACTICE.

WALES.

EBBW VALE, MON.
(*Workmen's Medical Society.*)

GILFACH GOCH, GLAMORGAN.
(*Workmen's Medical Scheme.*)

LLWYNYPIA, CLYDACH VALE, PENYGRAIG, GLAMORGAN.
(*Workmen's Medical Scheme.*)

MARDY, GLAMORGAN.
(*Workmen's Medical Scheme.*)

NEATH AND DISTRICT.
(*Medical Aid Association.*)

OAKDALE, MON.
(*Medical Officer for Medical Aid Association.*)

CONTRACT PRACTICE (*continued*).

WALES (*continued*).

OGMORE VALLEY, GLAMORGAN.
(*Wyndham Colliery Medical Aid Society.*)
(*Workmen's Medical Scheme.*)

PUBLIC HEALTH.

FIFE EDUCATION AUTHORITY.
(*Male Assistant School Medical Officer.*)

GLASGOW EDUCATION AUTHORITY.
(*Male Assistant Medical Officer.*)

CORPORATION OF GREENOCK.
(*Assistant Medical Officer of Health.*)

BOROUGH OF JARROW.
(*Assistant Medical Officer.*)

PUBLIC HEALTH (*continued*).

LEEDS EDUCATION COMMITTEE.
(*Assistant School Medical Officer.*)

NOTTINGHAMSHIRE COUNTY COUNCIL.
RANSOM SANATORIUM.
(*Assistant Resident Medical Officer.*)

SURREY ADMINISTRATIVE COUNTY.
(*County Medical Officer of Health.*)

YORKSHIRE NORTH RIDING COUNTY COUNCIL EDUCATION COMMITTEE.
(*Assistant School Medical Officer.*)

YORKSHIRE WEST RIDING COUNTY COUNCIL.
(*School Medical Inspector.*)

(b) Colonial Medical Service.

WINDWARD ISLANDS MEDICAL SERVICE.
(Grenada with Carriacou, St. Vincent and St. Lucia.)

(c) Overseas Appointments.

Medical Practitioners are requested not to apply for any appointment referred to in the following table without having first communicated with the Honorary Secretary of the Division or Branch named in the second column or with the Medical Secretary of the British Medical Association, B.M.A. House, Tavistock Square, W.C.1.

Town or District.	Hon. Sec. of Division or Branch.	Town or District.	Hon. Sec. of Division or Branch.	Town or District.	Hon. Sec. of Division or Branch.
NEW SOUTH WALES. (*All Friendly Society Appointments.*)	Dr. R. H. TODD (Hon. Sec., New South Wales Branch), B.M.A. Building, 30-34 Elizabeth St., Sydney, N.S.W.	VICTORIA. (*All Institute or Medical Dispensaries.*)	Dr. FRANK DAVIES (Hon. Sec., Victorian Branch), British Medical Association, Medical Society Hall, East Melbourne, Victoria.	WESTERN AUSTRALIA. (*Contract and Lodge Practice.*)	Hon. Sec. Western Australian Branch, British Medical Association, No. 6, Bank of N.S.W. Chambers, St. George's Terr., Perth, Western Australia.
QUEENSLAND. (*Brisbane Associated Friendly Societies' Institute.*)	Dr. E. S. MEYERS (Hon. Sec., Queensland Branch), British Medical Association, Adelaide St., Brisbane.	WELLINGTON, NEW ZEALAND. (*Contract Practice Appointments.*)	Dr. D. E. FENWICK, O.B.E., Hon. Sec., New Zealand Branch, British Medical Association, P.O. Box 156, Wellington, New Zealand.		

Address: B.M.A. House, Tavistock Square, W.C.1. By Order of the Council of the British Medical Association.
May 23rd, 1928. ALFRED COX, Medical Secretary.

West London Hospital,
Hammersmith Road, W.6. (226 Beds.)

Required, ONE HOUSE PHYSICIAN, ONE HOUSE SURGEON, and ONE RESIDENT ASSISTANT CASUALTY OFFICER, and AURAL and OPHTHALMIC HOUSE SURGEON (males). These three appointments are tenable for six months from July 1st next, subject to one month's notice on either side. Salary at the rate of £100 per annum, with board, lodging, and washing allowance. Candidates must be registered under the Medical Act. Applications (which must be made on printed forms obtained from me), must reach me not later than first post on Friday, June 8th. Selected candidates will be required to call upon such members of the Medical Staff as directed, to be in attendance at a Meeting of the Medical Council on Friday, 22nd June at 4 p.m., and the House Committee Meeting at 4.45 p.m. the same day, when the appointments will be made.

H. A. MADGE, Secretary.

Manchester Northern Hospital
FOR WOMEN AND CHILDREN,
Park Place, Cheetham Hill Road, Manchester.

The Committee of Management require the services of a SENIOR HOUSE SURGEON and JUNIOR HOUSE SURGEON, both duly qualified, who are to commence duties on July 1st. Senior House Surgeon, salary £130 per annum, with board and residence; Junior House Surgeon, salary £100 per annum, with board only.

Applications, stating age and experience, with copies of recent testimonials, to be sent to the Secretary, Mr. JAMES C. DANIELS, 38, Barton Arcade, Manchester, not later than June 1st.

Queen's Hospital for Children,
Hackney Road, London, E.2.

CASUALTY OFFICER required on July 1st. Six months' appointment. Salary £100 a year, with board, residence, and washing. Preference given to candidates who have previously held resident appointments. Applications must be made on forms to be obtained from the Secretary, and must be sent in with not more than four testimonials, on or before June 4th.

T. GLENTON-KERR, Secretary.

May 14th, 1928.

Queen's Hospital for Children,
Hackney Road, London, E.2.

HOUSE SURGEON (male) required on July 1st. Six months appointment. Salary £100 a year, with board, residence, and washing. Applications must be made on forms to be obtained from the Secretary, and must be sent in with not more than four testimonials, on or before June 4th.

T. GLENTON-KERR, Secretary.

May 14th, 1928.

Ancoats Hospital, Manchester.

HOUSE SURGEON (Orthopædic) required to commence duty immediately. Salary £100 per annum, with board, residence, and laundry, etc. Applications, stating age, qualifications, experience, etc., to be forwarded to the undersigned on or before May 29th, together with copies of three recent testimonials.

By Order of the Board,
HERBERT J. DAFFORNE,
General Supt. & Secretary.

Borough Mental Hospital,
ROWDITCH, DERBY.

SECOND ASSISTANT MEDICAL OFFICER wanted. Commencing salary £350 per annum, with board, apartments, attendance, and laundry. One interested in laboratory work preferred. Candidates must be unmarried, and registered under the Medical Act. The appointment is subject to three per cent. deduction on salary and emoluments under the Asylum Officers Superannuation Act, 1909. Apply, stating age and full particulars, to the Medical Superintendent.

Poplar Hospital for Accidents.
East India Dock Road, Poplar, E.14.

The Committee invite applications for the appointment of SECOND RESIDENT OFFICER at a salary at the rate of £175 per annum, all found. Candidates must have held an appointment as House Surgeon at a Hospital. Applications must be accompanied by a statement of the candidate's qualifications, and be forwarded to the Secretary, with three recent testimonials, not later than Wednesday, May 30th.

Birmingham and Midland Eye
HOSPITAL, Church St., BIRMINGHAM.

There will be a vacancy for a HOUSE SURGEON at the above Hospital of 115 beds early in July. Salary £110 per annum. The appointment will be made on June 14th next. Applications should be sent to the undersigned not later than Saturday, June 9th, with copies of not more than three testimonials. Some previous Ophthalmic experience desirable.

C. A. MASON, General Supt.

May 15th, 1928.

F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
Published by AsbestosClaims.Law
ACL Doc 13301 · Page 112 of 129
asbestosclaims.law/library/13301/112

British Medical Journal,
BRITISH MEDICAL ASSOCIATION HOUSE,
TAVISTOCK SQ., LONDON, W.C.1.
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ASSISTANCIES.

Wanted, — Outdoor Assistant (male), view early partnership, in Industrial Practice near Manchester. Salary £400 to £500 according to experience. Must drive car. State full particulars.—BRITISH MEDICAL BUREAU, 24, London Rd., Manchester.

Wanted. — Assistant, English, male, indoor. Willing to motor-cycle. Mixed country practice. Usual bond. Photo and essential particulars.—Address, No. 2928, B.M.A. House, Tavistock Square, W.C.1.

Wanted, for August 1st.— Indoor ASSISTANT, for Industrial Practice, Manchester district. Salary £300. Recently qualified man preferred. Photo and references.—Address, No. 2812, B.M.A. House, Tavistock Square, W.C.1.

Wanted. — Young Protestant ASSISTANT for mixed Practice N. of England. Able to motor-cycle, and live out if required.—Write, stating age, nationality, and all essential particulars. Usual bond required. —No. 2887, B.M.A. House, Tavistock Sq., W.C.1.

Wanted.—Assistant (to live in). Car and £250 p.a. Must have held house appointments and had surgical experience. — Address, No. 2903, B.M.A. House, Tavistock Square, W.C.1.

Wanted. — Indoor Assistant, male, for general practice near Durham. Salary £300 to £350. Young Scottish graduate with some experience preferred.—Address, No. 2932, B.M.A. House, Tavistock Sq., W.C.1.

Wanted. — Indoor Assistant (male), for Industrial Practice, Manchester. Newly-qualified Aberdeen Graduate preferred. Salary £250 p.a.—BRITISH MEDICAL BUREAU, 24, London Road, Manchester.

Wanted, an indoor Assistant in a Colliery Practice in Glamorgan. Salary £275 per annum.—Write, stating age, references, etc., to No. 3002, B.M.A. House, Tavistock Square, W.C.1.

Wanted.—Indoor lady Assistant in Country PRACTICE.—Address, No. 2930, B.M.A. House, Tavistock Square, W.C.1.

Wanted.—Indoor male Assistant in general Practice, London. Work light. R.C. preferred. Usual bond. State essential particulars, and enclose photo.—Address No. 2907, B.M.A. House, Tavistock Square, W.C.1.

Wanted, by M.B., Ch.B., ASSISTANTSHIP or LOCUM. 4 years' experience private and panel. Excellent refs., keen, energetic; well received. Drive car. Free beginning of June.—Address, No. 2916, B.M.A. House, Tavistock Square, W.C.1.

Wanted. — Part-time Assistant for three evenings a week; London. 6.30 p.m. to 9 p.m.—Wednesday, Thursday, and Friday.—Address, No. 3007, B.M.A. House, Tavistock Square, W.C.1.

Wanted. — Assistantship with view to early succession, by M.B., Ch.B. (1924); ex H.P., H.S., ear, nose, and throat, mids., and gynæcology; all teaching hospitals; some G.P. Keen, well received.—Address, No. 2909, B.M.A. House, Tavistock Square, W.C.1.

Wanted. — Assistantship, with view, by M.B., B.S.Lond., male, aged 26; 1½ yrs.' exper. G.P.; 1½ yrs.' resident appointments, London Hospital.—Home County or London suburb preferred. — Address, No. 3012, B.M.A. House, Tavistock Square, W.C.1.

Assistant (man or woman), indoor, wanted. Country town, Midlands. Public Health, panel, private. State age, religion, and full particulars. Only letters replied to where essential particulars are stated. —No. 2705, B.M.A. House, Tavistock Sq., W.C.1.

Assistant, male, single, under 30, British, £300 p.a. (outdoor); with rooms. —Address, No. 3006, B.M.A. House, Tavistock Square, W.C.1.

Assistantship — wanted by L.R.C.P. & S.I., L.M., aged 30, married, no children. Experienced panel and private. Well received. Used to sole charge. Available for interview, London. — Address, No. 2926, B.M.A. House, Tavistock Square, W.C.1.

Indoor Assistant, motor-cyclist, abstainer preferred. Work light. Colliery practice. State religion, height, experience. Photo desirable. — Address, No. 2915, B.M.A. House, Tavistock Square, W.C.1.

M.B., doing post-graduate work, desires part-time indoor ASSISTANTSHIP in London. Young, energetic, and keen. Abstainer.—Address, No. 2921, B.M.A. House, Tavistock Square, W.C.1.

M.B., Ch.B., D.P.H., Scot, æt. 30, wishes ASSISTANTSHIP or PARTNERSHIP, view to early succession. About £1,200. Capital. — Address, No. 2920. Tavistock Square, W.C.1.

M.B., Ch.B., 33 years, single; tall, good appearance; 2 yrs.' H.S., 4 yrs.' G.P., sound, reliable, wants ASSISTANTSHIP, any locality. Small salary if time for reading. Motorist.—Address, No. 2923, B.M.A. House, Tavistock Square, W.C.1.

Ophthalmic Practice.—Wanted, an ASSISTANT in a Practice in a Northern Town, able to take up Eye work chiefly, but willing to help in General Practice. Great scope for the right man. Good salary and prospects. — Apply, to Mr. PERCIVAL TURNER, 4, Adam Street, Strand, W.C.2.

Required, Assistantship or long LOCUMSHIP by Parn Doctor; well experienced in private and panel practice. Conscientious; total abstainer. Can drive car.—Address, No. 3004, B.M.A. House, Tavistock Square, W.C.1.

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Wanted.—A Medical Woman for research on certain diseases of pregnancy in India, under the Indian Research Fund Association. Passage paid. Salary according to experience of research.—Apply, to Dr. M. I. BALFOUR, 14, Norfolk Sq., London, W.2.

Wanted. — Post as Doctor's Secretary; Typing and Book-keeping.— D. BATSON (Nurse), 214, Kew Road, Richmond.

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Doctor recommends lady as SECRETARY; commercial trained, shorthand, typewriting, card-index, filing, accounts; C.M.B.—Write, M. N. H., 34, Hanbury Road, Acton, London W.3.

Secretarial.—Gentleman, aged 40 (retired), open for secretarial and book-keeping duties to Hospital, Sanatorium, or Medical Profession. Moderate salary. Highest references. Can drive car.—Address, No. 2918, B.M.A. House, Tavistock Square, W.C.1.

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As Locum. — An exper. Doctor (middle-aged), had own practice, and now doing some 10 locums annually, desires further ENGAGEMENTS. Free June 3rd. Terms from 6 gns. p.w. Well recom.—'Medicus,' c/o Dr. Roberts, 51, Dalston Lane, London, E.8.

As Locum Tenens.—Wanted by experienced M.B., B.Ch., B.A.O., D.P.H., LOCUM in Hospital at Hospital rates. Now free. — Address, No. 3014, B.M.A. House, Tavistock Square, W.C.1.

Locum wanted, Manchester.— Small Practice, no midwifery, about three weeks. Time at present uncertain. State age, where qualified, experience, terms, and when available. — Address, No. 2902, B.M.A. House, Tavistock Square, W.C.1.

Locum wanted; 3 to 4 weeks, August early September. South-West Town. Work very light; no midwifery. Hospitality to wife possible. Should bring own car. State terms.—Address, No. 3015, B.M.A. House, Tavistock Square, W.C.1.

Locum work or small panel and private practice required by Oxford Graduate; London conjoint; late House Physician of a big London Hospital.—Address, No. 2919, B.M.A. House, Tavistock Sq., W.C.1.

Locum wanted for two weeks commencing July 1st. Write, stating experience and all essential particulars, to Dr. M. MICKLER, 3, North Terrace, Stockton-on-Tees.

F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
Published by AsbestosClaims.Law
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PARTNERSHIPS.

Wanted.—Partnership or Practice, North or Central Scotland, yielding £800 to £1,000 p.a., by M.B., Ch.B(Ed.); æt. 28; 4 yrs.' exp. priv. and panel. Ex. refs. Capital avail. Own car. Free middle of June.—No. 2925, B.M.A. House, Tavistock Sq., W.C.1.

Wanted, by M.B., Ch.B.Ed. (1923); Scot., æt. 28, single; ex H.S., ex H.P., exp. G.P.; PARTNERSHIP worth £600 to £700; small hospital town pref.—Add., No. 2915, B.M.A. House, Tavistock Sq., W.C.1.

M.B., B.S.London, aged 28; 4 years' resident hospital posts, 12 months' C.P., desires share worth £1,000 p.a. in good middle-class Practice, London or near. Own car. £1,000 down, balance by arrangement. Preliminary assistantship.—Address, No. 3016, B.M.A. House, Tavistock Square, W.C.1.

Near Sheffield.—Partnership in old-estab. mixed-class Practice. Cash receipts last year—£3,489. Panel 2,900. Good house available, containing 4 bedrooms. Rent £40 p.a. Premium, one-half share, £3,000 (including valuable book debts); part deferred.—BRITISH MEDICAL BUREAU, 24, London Road, Manchester.

Partner wanted, unopposed country Practice, aged 50 or under; half share. Good house and garden, with modern conveniences, rent or sell.—Address, No. 2912, B.M.A. House, Tavistock Square, W.C.1.

Partnership. — Nottingham. — Half share, two years' purchase. Good general practice, panel trifling.—Address, No. 2904, B.M.A. House, Tavistock Square, W.C.1.

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Wanted.—Mixed general Practice, doing £2,500 or more, with panel, London or South of England. Advertisers (experienced men) are now free, and will pay cash. No agents.—Address, No. 2917, B.M.A. House, Tavistock Square, W.C.1.

Wanted.—Middle and working-class PRACTICE, in pleasant surroundings (no collieries). Panel 1,500 up. Good house, with garden essential. Country practice entertained. £2,000 cash available. No agents.—No. 3015, B.M.A. House, Tavistock Sq., W.C.1.

Wanted.—Practice, with panel, Midlands, North, or Scotland preferred. House to rent essential. Can pay £800 down, remainder by instalments.—Address, No. 2931, B.M.A. House, Tavistock Square, W.C.1.

Wanted shortly, good-class PRACTICE of £2,000 to £3,000 per annum. Preferably in Spa or Health Resort. Panel and contract practices will not be entertained. — Address, No. 2711, B.M.A. House, Tavistock Square, W.C.1.

Wanted. — Practice (income £1,200 to £1,800). Scope for surgery. Midlands, Potteries district, or North preferred.—Address, No. 1501, B.M.A. House, Tavistock Square, W.C.1.

Wanted, by M.B., B.S., aged 32, a nice-class PRACTICE of £2,000 in the South of England or London.—"W.," c/o MITCHELL & Co., 22, Craven Street, Strand, W.C.1.

Wanted, in one of the Northern Counties, a good-class Country or Country Town PRACTICE of about £1,000 p.a. with nice house and garden to rent essential.—Address, No. 2908, B.M.A. House, Tavistock Square, W.C.1.

Wanted, to buy, Practice, with panel of at least 1,000, and capable of extension. House to rent.—Address, No. 2910, B.M.A. House, Tavistock Square, W.C.1.

Doctor's Branch Surgery and NUCLEUS for sale, main road position on new housing estate, 15 mins. from Victoria. No competition, no rent, immense scope. £300 for quick sale, inclusive of drugs, furniture, fittings, etc.—Address, No. 2927, B.M.A. House, Tavistock Square, W.C.1.

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For Sale.—A Practice in East Midland Town. Death vacancy. Panel 900, and private practice. House, with garage, to sell or let on lease. — Address, No. 2905, B.M.A. House, Tavistock Square, W.C.1.

For Sale. — Woman's Practice, NUCLEUS, London, S.E. Low premium. —Address, No. 3005, B.M.A. House, Tavistock Square, W.C.1.

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North Wales. — Safe country PRACTICE, worth £1,500 p.a. (panel £600), for sale. No resident opposition. Expenses low. House, rent £100. Partnership intro. if desir. Prem. £1,300 cash or £2,000 by instal. —No. 2923, B.M.A. House, Tavistock Sq., W.C.1.

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For Sale.—Beautiful House in best part of good-class residential seaside town on Lancashire Coast. Eminently suitable for resident patients or high-class nursing home. Excellent prospect of attaining good-class practice. 8 or 9 bedrooms, and 3 reception rooms. Very low price to immediate purchaser. Parties.—No. 2901, B.M.A. House, Tavistock Sq., W.C.1.

For Sale, at St. Annes-on-Sea, large Detached HOUSE, suitable for a Nursing Home or Convalescent Home. Splendid position on the promenade.—Apply, Box 125, ASHCROFTERS Ltd., Waterloo Buildings, Piccadilly, Manchester.

For Sale, Nature Cure Home, freehold, Herts, 40 minutes from London; fully equipped. Owner retiring. Splendid opportunity.—Apply, WISE, Solicitor, High Welwyn, Herts.

Highbury.—Good opening for Doctor in select neighbourhood. Corner RESIDENCE for sale (re-decorated). 10 large rooms, scullery, bath, etc. Side entrance. Good gardens. Ample space for garage. 61 years' lease; g.r. 10 gns. Vacant. Price £1,500. View by appt.—OWNER, 74, Aberdeen Road.

Sunderland.—For Sale.—"Lyndhurst," Woodside, splendidly built HOUSE, containing 14 large rooms, boxroom, 3 lavs., laundry, stable, usual outhouses, grounds. Best residential growing district facing main road. Suitable for Practice or Nature Cure Home. Offers to—E. M. FEATHERSTONE, 12, Woodside, Sunderland, Durham.

Surrey.—Good opening for doctor in rapidly growing good-class district. Splendid position on main road. Freehold house, 3 reception, 3 bedrooms, good garden (3/4 acre), double garage, electric light, and gas.—Particulars of GURNEY & ANDREW, Solicitors, Bude.

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HOSPITAL VACANCIES.

The Weir Hospital, Grove Road, Balham, S.W.12.
JUNIOR RESIDENT MEDICAL OFFICER (male, unmarried) required.
Candidates must be fully qualified and duly registered. Salary £130 per annum, with board, residence, and laundry.
Applications, with copies of testimonials, to be sent to the Secretary, from whom further information may be obtained.

Sanatoria of Scotland, BRIDGE OF WEIR, Near Glasgow.
Applications are invited for the post of RESIDENT HOUSE PHYSICIAN (male, Protestant, unmarried). Salary £200 per annum, with board, laundry, and residence, in the Sanatoria. Duties to commence on June 12th or sooner. State qualifications and previous experience, and enclose three testimonials, to Medical Superintendent, Sanatoria of Scotland, Bridge of Weir, Renfrewshire.

The Staffordshire General INFIRMARY, STAFFORD.
Applications are invited for the post of HOUSE PHYSICIAN (male). Salary at the rate of £150 per annum, with board, lodgings, etc. The appointment to be taken up as early as possible, and to be for at least six months. Candidates must be duly qualified and registered under the Medical Acts. Applications, stating age, accompanied by copies of three recent testimonials, must reach me by Thursday, May 30th.
Stafford, May 21st, 1928. A. E. COLLINS, Secretary.

Ulster Hospital for Children and WOMEN, BELFAST.
Applications are invited for the positions of (1) HONORARY PHYSICIAN and (2) HONORARY ASSISTANT PHYSICIAN to the Hospital. Particulars as to the qualifications required may be obtained from, and applications, with copies of testimonials, should be addressed to, the Honorary Secretary to the Board of Management, on or before June 16th.
Ulster Hospital for Children and Women, Belfast. J. M. SINCLAIR, Hon. Secretary.

Warneford General Hospital, LEAMINGTON SPA.
RESIDENT HOUSE PHYSICIAN required on June 2nd. Salary at the rate of £165 per annum, with board and laundry.
Applicants, who must be qualified and registered and single men, should apply at once to the undersigned, and send copies of at least three testimonials (which will not be returned unless postage is enclosed).
W. RUSSELL RUDALL, House Governor & Secretary.

East Suffolk & Ipswich Hospital.
VACANCY ON HONORARY STAFF.
The Board of Management invites applications for the post of ASSISTANT OPHTHALMIC SURGEON.
Applications, on forms to be supplied, accompanied by copies of three recent testimonials, to reach me on or before Monday, June 25th.
The Hospital, Ipswich. ARTHUR GRIFFITHS, Secretary.
May 26th, 1928.

Cumberland Infirmary, Carlisle.
JUNIOR HOUSE SURGEON required July 9th, three or six months' appointment. Salary at the rate of £135 per annum, board, residence, etc. Previous Hospital experience desirable. Applications, stating age, with copies of not more than four testimonials, must be received by the first post on Wednesday, June 6th.
J. G. HOWITT, Secretary.

Dorset Mental Hospital, HERRISON, DORCHESTER.
JUNIOR ASSISTANT MEDICAL OFFICER required. Candidates must be duly qualified, registered, and unmarried. Commencing salary £300 per annum, rising by two yearly increments of £25 to £350, with board, apartments, laundry, and attendance. The appointment is subject to the provisions of the Asylums Officers Superannuation Act, 1909. Applications, stating age and qualifications, with copies of recent testimonials, should be sent to the Medical Superintendent.

F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
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Tonbridge Union.

RESIDENT ASSISTANT MEDICAL OFFICER.

The Guardians of the above Union invite applications for the appointment of a duly qualified Assistant Medical Officer (male), at their Institution at Pembury, near Tunbridge Wells, who will act also as Assistant Medical Officer of the Horsmonden, Pembury, Tonbridge, and Tunbridge Wells Four Law Districts.

Salary £275, rising by annual increments of £25 to £350 per annum, together with furnished apartments, attendance, rations, and laundry.

The candidate appointed will be required to act generally under the direction of the (part-time) Senior Medical Officer, and report to, and consult him, as and when necessary. He will be required to do all visiting work, administration of anæsthetics, etc. He will also be required to perform such operations as the Senior Medical Officer may decide. He will receive lunacy and extra medical fees, except in respect of the Tonbridge District, and will be appointed Public Vaccinator. The total fees are estimated at £75 per annum. He will be required to provide himself with means of locomotion to the satisfaction of the Guardians.

The Infirmary is recognised by the General Nursing Council as a Training School in affiliation with the Lambeth Hospital.

The Assistant Medical Officer will be required to give lectures to the Probationer Nurses.

Applicants must be single and not over 32 years of age, and preference will be given to those who have held House appointments in a recognised Hospital.

The appointment will be subject to two months' notice on either side.

Applications on forms to be obtained from the undersigned, together with copies of not more than three recent testimonials, must reach me not later than Wednesday, June 6th.

By Order,
JOHN MOSS,
Clerk to the Guardians.

130, High Street, Tonbridge.
May 19th, 1923.

City of Birmingham Education COMMITTEE.

ASSISTANT SCHOOL MEDICAL OFFICER (Male).

Applications are invited for the appointment of Male Assistant School Medical Officer, to begin duty on September 3rd. Remuneration at a candidate with suitable experience and qualifications, £600 per annum, Inclusive; £10 per annum travelling expenses.

Forms of application should be returned not later than Thursday, June 7th. Further information may be obtained from the undersigned. Communications should be endorsed "Assistant School Medical Officer."

Canvassing will disqualify.

P. D. INNES,
Chief Education Officer.

Education Office,
Council House,
Margaret Street,
Birmingham.
May 19th, 1923.

Kensington Board of Guardians.

ASSISTANT MEDICAL OFFICER (Woman).

The Guardians invite applications from registered medical practitioners under 35 years of age for the post of Assistant Medical Officer at St. Mary Abbot's Hospital. The salary attached to the office is £250 per annum, with apartments, board, and washing, and the lady appointed will be required to devote her whole time to the duties of the office.

Forms of application, which must be returned not later than 10 a.m. on Friday, June 1st, may be obtained by sending a stamped addressed foolscap envelope to the Clerk to the Board, Guardians' Offices, Marloes Road, W.8.

East London Hospital for CHILDREN AND DISPENSARY FOR WOMEN, Shadwell, E.1.

Applications are invited for the post of HOUSE PHYSICIAN (male) vacant on June 9th.

The appointment is for six months. Salary at the rate of £125 per annum, with board, residence, and laundry provided.

Applications, together with testimonials, should be sent to the undersigned not later than Saturday, June 2nd

W. M. WILCOX, Secretary.

Cossham Memorial Hospital, KINGSWOOD, BRISTOL.

Applications are invited for the post of HOUSE SURGEON (male). Salary £150 p.a., with board, residence, and laundry.

Candidates must be unmarried, and duly qualified and registered.

Applications, stating nationality, accompanied by copies of three recent testimonials, must be received by June 9th.

E. J. HAWKINS, Secretary.

Bethnal Green Hospital, London, E.2.

ASSISTANT MEDICAL OFFICER.

Applications are invited for the appointment of an Assistant Medical Officer at the above Hospital, at an inclusive salary of £400 per annum, with furnished apartments, board, and washing.

The Hospital is a recognized Training School for Nurses, has accommodation for 650 patients, and possesses X-ray apparatus and a fully-equipped laboratory. The Medical Staff consists of eight medical men, a visiting Dental Surgeon, a Consulting General Surgeon, and Consulting Specialists for certain diseases.

Candidates must possess both medical and surgical qualifications, be duly registered, and have held previous hospital appointments. The candidate appointed will be required to devote the whole of his time to the duties of the office, as assigned by the Medical Superintendent, which duties include such outdoor medical work as may be necessary.

Applications must be made upon forms which are obtainable from the undersigned, and which must be completed and returned not later than Saturday, June 9th.

C. FAULKNER JONES,
Clerk to the Board.

Administrative Offices,
Bishop's Road,
Bethnal Green, E.2.
May 19th, 1923.

Royal Gwent Hospital, NEWPORT, MON.

(Newport and Monmouthshire Hospital).

HONORARY ASSISTANT SURGEONS.

There are vacancies for two Honorary Assistant Surgeons, and applications are invited for these positions.

Applicants must be Graduates of a University or Fellows of a Royal College of Surgeons.

The successful candidates will be required to hold office subject to the Rules and Regulations of the Hospital.

It is expected that there will be applications from members as present on the Honorary Staff.

Further particulars may be obtained from the undersigned, to whom applications, with copies of testimonials, should be sent on or before June 4th.

J. K. MILLWARD,
Secretary-Supt.

May 18th, 1923.

Royal Gwent Hospital, NEWPORT, MON.

(Newport and Monmouthshire Hospital).

HONORARY ASSISTANT OPHTHALMIC SURGEON.

The Directors require an Honorary Assistant Ophthalmic Surgeon, and applications are invited for the position.

Applicants must be Graduates of a University or Fellows of a Royal College of Surgeons, and should have had some special experience in Ophthalmic work.

The successful candidate will be required to hold the office subject to the Rules and Regulations of the Hospital.

Further particulars may be obtained from the undersigned, to whom applications, with copies of testimonials, should be sent on or before June 4th.

J. K. MILLWARD,
Secretary-Supt.

May 18th, 1923.

Royal Gwent Hospital, NEWPORT, MON.

(Newport and Monmouthshire Hospital).

HONORARY SURGEON.

There is a vacancy for an Honorary Surgeon, and applications are invited for this position.

Applicants, other than those now members of the Honorary Staff, must be Graduates of a University or Fellows of a Royal College of Surgeons.

The successful candidate will be required to hold the office subject to the Rules and Regulations of the Hospital.

It is expected that there will be applications from members at present on the Honorary Staff.

Further particulars may be obtained from the undersigned, to whom applications, with copies of testimonials, should be sent on or before June 4th.

J. K. MILLWARD,
Secretary-Supt.

May 18th, 1923.

Swansea Hospital. (316 Beds.)

HOUSE SURGEON wanted. Gentleman, single. Salary £150, with board, residence, and laundry. Appointment for 12 months. Duties to commence on or about June 11th.

Applications, stating age, nationality, and experience, with copies of three recent testimonials, to be delivered to the undersigned by June 2nd.

O. C. HOWELLS, Secretary-Supt.

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London, E.—Death Vacancy.—About £1,200 p.a. Visits 3/6 to 5/-. Panel nearly 1,200. Good house and garden.—Apply, No. 8328.

London, S.E.—1/2 share of £1,800 to £2,000 p.a. Visits 4/- to 10/6. Appointments £50 p.a. No panel. Choice of houses.—Apply, No. 8327.

Home County.—£500 p.a. Visits 3/6 to 10/6. Panel 200. Good house and garden to rent.—Apply, No. 8323.

South County.—£5,000 p.a. 1/4, 1/3, or 1/2 share. Good-class non-panel. Fees 5/6 to 21/-. Mids. 3 gns. Good house to rent.—Apply, No. 8269.

Glasgow.—Urgent Sale.—Over £830 p.a. Panel 589. Fees 3/6 up. Good house and separate surgery.—No. 8324.

Death Vacancy.—S. Wales.—About £500 p.a. Panel 150. Small appts. Good fees. Good house, 6 bed., etc.—Apply, No. 8323.

Eastern County.—1/3 or 3/8 share of £3,400. Panel and appts. over £1,400. Fees 3/6 to 21/-. Georgian house and nearly acre of grounds.—Apply, No. 8321.

Lancs Coast.—Average £2,200 p.a. 1/3, 1/2, or 2/3 for disposal, early succession. Panel about 700. Fees 3/6 to 7/6. Surgery scope. House, 6 bed., etc.—Apply, No. 8318.

London, S.E.—Over £500 p.a. Cash and panel. Panel over 600. Fees 2/6 to 5/-. Separate surgeries.—No. 8316.

City Practice.—Av. over £930 p.a. Fees 3/6 to 21/-. Appts. over £300. Panel 306. Lock-up premises.—No. 8315.

London, S.E.—£8—£10 p.w.—NUCLEUS (lady doctor). Fees 2/6 to 10/6. Small panel. Flat accommodation. Premium £450.—Apply, No. 8312.

Hampshire.—About £2,400 p.a. 2/5 share for sale. Visits 5/- up. Mids. 2 gns. up. Large panel. Appts. and clubs. House, 6 beds., etc.—Apply, No. 8307.

S. E. Suburb.—About £1,100 p.a. 1/2 share with early succession. Middle-class. Visits 3/6 to 15/-. Panel 850. Appts. £75 p.a.—Apply, No. 8305.

Lancs. — About £1,400 p.a. Appts. about £115 p.a. Panel 1,400. Mids. as 2 gns. Visits 3/6 to 5/-. House, 3 beds., to rent.—Apply, No. 8285.

Bucks. — Average £730 p.a. Mids. 3 gns. up. Panel about 550. Visits 3/6 to 10/6. Good house and garden. Tennis.—Apply, No. 8294.

Lancs Coast.—About £1,700 p.a. Non-panel. Fees 7/- to 2 gns. Little mids. House, 7 beds., etc., to let.—No. 8284.

Bucks. — Death Vacancy. — 1/2 share of £1,200 p.a. Appts. about £500 p.a. Panel 700. Visits 3/6 up. House, 8 beds., etc. Premium 1½ years.—Apply, No. 8296.

London, N.—About £6,000 p.a. One-third share for sale. Select panel. Visits 3/6 up. Not much mids. House, 5 beds., etc.—Apply, No. 8215.

N. Wales Coast. — £1,800 p.a. Appts. £230 p.a. Panel 2605 p.a. Visits 3/6 to 15/-. House, 8 beds., etc., low rent.—Apply, No. 8279.

London, W.—About £800 p.a. Appts. about £100 p.a. Small panel. Visits 7/6 up. Little mids. Large house to rent.—Apply, No. 8278.

Country Town 50 miles of London. — Share of £3,600 p.a. prov. assy. Panel and appts. over £700. Visits 4/- up. Mids. 3 gns. up. Choice of houses.—No. 8267.

Sussex.—£1,250 p.a. 2/5 share with view to succession. Panel and appts. £800 p.a. Visits 7/6 to 10/6.—No. 8251.

Essex.—Over £1,200 p.a. and increasing. Panel, appts., clubs, etc., about £500 p.a. Mids. 2½ to 3 gns. Visits 5/-. House, 5 bed., good garden, with tennis.—Apply, No. 8230.

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SCOTLAND.—Good-class non-dispensing G.P. situated in best locality in one of the chief cities. Excellent houses. Receipts over £1,500 p.a. Several appointments. Scope for surgery. Premium £2,200. House for sale.

LONDON, S.W.6.—Lock-up surgery in busy working-class locality. Receipts £1,460 p.a. Panel 910 approximately. Fees 2/6 upwards. Rent 25/- per week. Premium 1½ years' pur.

HOME COUNTIES (just over 20 miles from London).—Situated in charming locality. Excellent 10-roomed house with tennis court, garden, etc. Receipts approximately £700. Panel over 500. Fees 2/6 upwards. Prem. for prac. 1½ years' pur. House £3,500 or near offers.

SCOTLAND.—DEATH VACANCY. Receipts over £1,500 p.a. Panel 750. Appointments about £1,000 p.a. Small lock-up surgery to rent. Locum in charge. Premium £1,000.

ESSEX.—Small country PRACTICE. Receipts approximately £500 p.a. (Apart from electrical work). Medium-sized house with garden, garage, etc., to rent. Premium £800. Drugs, fittings, etc., at valuation.

SUSSEX.—Old-established country G.P. Receipts £900 p.a. Panel about 700. Fees 2/6 up. Excellent scope for energetic man used to country life. House to rent. Premium £1,350.

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HOME COUNTIES.—Within easy reach of town. PARTNERSHIP. Well-established country G.P. Receipts over £3,000 p.a. Panel 2,000. Suitable house available. Premium for quarter share with view to larger share, 2 years' purchase.

LONDON, S.E.—Lock-up surgery. Working-class locality. Plenty of scope. Receipts over £800 p.a. Panel about 650. Premium £1,200 or reasonable offer. Suitable flat available if desired.

MANCHESTER.—Near. Old-established G.P. Receipts £1,900. Panel about 1,300 increasing. Excellent detached house may be rented or purchased. Premium for PRACTICE and book debts, £2,900.

LONDON, N.—NUCLEUS lady doctor's practice. Increasing panel of 88. Receipts £200. Ground floor flat to let. Premium £250.

SCOTLAND.—Aberdeenshire. Non-dispensing G.P. Receipts £700 p.a. Panel 350. Detached house to rent. Two appointments. Premium £1,050. Half down, balance within 2 years.

LONDON, S.W.—Lock-up surgery. Busy main thoroughfare. Rent £83 p.a. Receipts approximately £220. Panel about 200, increasing. Premium £375 for practice and lease of house, or near offer.

RELIABLE LOCUMS AND ASSISTANTS SUPPLIED AT SHORT NOTICE.

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The Hospital for Sick Children,
Gt. Ormond Street, London, W.C.1.

A MEDICAL REGISTRAR is required (for Mornings only) in the Out-patients' Department on June 11th.

Gentlemen are invited to send in their applications, addressed to the Secretary, with copies of not more than three testimonials written specially for the purpose, before 12 o'clock, on Monday, June 4th.

The appointment is made for one year, but may be held, subject to re-election, for three years.

Salary £230 per annum, with luncheon when on duty, and an allowance of nine guineas for the purpose of providing a substitute during annual leave.

Candidates must be registered medical men, and must have held a responsible Hospital appointment, and be prepared to take up the duties on June 11th.

All candidates must be in attendance at the Hospital, to appear before the Joint Committee, if required, on Wednesday, June 6th, at 5 p.m.

Forms of application and copies of the rules for, and details of the duties of the appointment will be supplied on application to the Secretary.

By Order of the Board of Management.
JAMES McKAY,
May, 1928. Secretary.

The Hospital for Sick Children,
Gt. Ormond Street, London, W.C.1.

The following appointments will be vacant shortly:

HOUSE PHYSICIAN; HOUSE SURGEON; on July 1st.

Gentlemen are invited to send in their applications, addressed to the Secretary, before 12 o'clock, on Monday, June 4th, with copies of not more than three testimonials given specially for the purpose, and also evidence of their having held a responsible hospital appointment.

Each appointment is made for six months. Salary £50, laundry allowance £5, and board and residence in the Hospital.

Candidates must be unmarried and possess a legal qualification to practise.

All candidates must be in attendance on Wednesday, June 6th, at 5 p.m. precisely, to appear before the Joint Committee, if required.

Forms of application and copies of the rules may be obtained from the Secretary.

By Order of the Board of Management.
JAMES McKAY,
May, 1928. Secretary.

Princess Alice Memorial Hospital
EASTBOURNE. (96 Beds.)

Applications are invited for the post of JUNIOR HOUSE SURGEON, male (rising to Senior after three months, subject to satisfactory performance of duties). Candidates must be unmarried, fully qualified, and registered. The appointment is for six months, commencing July 1st. Salary at the rate of £100 p.a. as Junior, and £125 p.a. as Senior, together with board, lodging, and laundry.

Applications, stating age and qualifications, and accompanied by copies of not more than three recent testimonials, should be sent to the Secretary not later than June 1st.

Royal Free Hospital,
Gray's Inn Road, W.C.1.

Applications are invited for the following appointments:

1. HOUSE SURGEON to the Senior Surgeon and to the Surgeon in charge of the Throat, Nose, and Ear beds; SECOND HOUSE SURGEON; THIRD HOUSE SURGEON; FIRST HOUSE PHYSICIAN; HOUSE PHYSICIAN to the Children's Department; GYNÆCOLOGICAL HOUSE SURGEON; OBSTETRIC HOUSE SURGEON.

Duties of the above to commence July 1st.

2. SECOND HOUSE PHYSICIAN; CASUALTY OFFICER (Female); OBSTETRIC DISTRICT ASSISTANT.

Duties to commence August 1st.

Of these posts, one House Surgeon appointment and one House Physician appointment are open to male candidates. The other appointments are reserved for former Students of the London (Royal Free Hospital) School of Medicine for Women.

Candidates must be duly qualified and registered medical practitioners, and must submit applications, stating age, and accompanied by copies of three testimonials, to the undersigned on or before June 2nd.

REGINALD R. GARRATT, Secretary.

The Cancer Hospital (Free)
(Incorporated under Royal Charter),
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The Committee are prepared to receive applications for the post of HOUSE SURGEON. Salary at the rate of £100 per annum. The appointment is for six months and subject to rules, a copy of which may be obtained from the Secretary. Previous experience as a House Surgeon is indispensable.

Applications, with three (copies only) testimonials, to be sent to the undersigned not later than the first post on Wednesday, May 30th.

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GILBERT G. PANTER, Secretary.

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7. WEST OF ENGLAND. — Mixed general country town PRACTICE. Receipts £777. Panel about 370. Good house, garden, and garage.
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F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928) Published by AsbestosClaims.Law

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2. SOUTH WALES.—FAVOURITE SEASIDE RESORT.—Sound and increasing PRACTICE, producing about £1,300 p.a., including panel of 600. Fees 3/6 to 21/-. Well-situated house, with 6 bedrooms, and good professional accommodation. Garden. Garage. Price for freehold £1,500. Good schools, and sport of all kinds. Knowledge of Welsh not necessary. Premium £2,000.
3. LONDON, S.W.—Rapidly increasing outlying suburb.—Old-established mixed general PRACTICE. Income for the immediate past year £1,500, including panel of 1,100, and offering large scope. Fees 2/6 to 5/-. Visits 3/6 to 7/6. No midwifery. Good house, with large garden, tennis court, etc. Valued at £3,000. Price £2,500. Premium 1½ years' purchase.
4. LINCS.—COUNTRY PRACTICE, NEAR COAST.—Old-established unopposed PRACTICE. Income for last twelve months about £1,000, including panel of 1,237, and Union £50. Good house, with ample accommodation, garden, tennis court, and paddock. Garage for two cars, and chauffeur's cottage. Rent £30 p.a. Premium 1½ years' purchase.
5. LANCS.—SUBURB OF LARGE TOWN.—Old-established PRACTICE, held by Vendor 30 years. Income for the immediate past year over £2,000; including panel of nearly 1,500. Fees 2/6 to 10/-. Very good house, in its own grounds; garage. Price for leasehold (with 929 years to run) £2,550, of which £1,550 could remain on mortgage. Premium 1½ years' purchase; payable half cash and balance over 3 or 4 years.
6. SURREY.—Growing residential town within 20 miles. Very old-established mixed-class PRACTICE, worth last year over £1,300, including panel of about 1,250. Visits 5/- to 10/6. Mids. 2 to 7 gns. (about 15 cases p.a.). Pretty residence, with ample surgery accommodation (separate entrance), 3 reception, 7 bedrooms, bathroom, etc. Good garden, with tennis court. Garage. Vendor's (freehold. Price £3,000. Premium £1,300. Social and excellent educational facilities. Cottage Hospital. Satisfactory reasons for selling.
7. SOUTH COAST.—FAVOURITE HOLIDAY RESORT.—Well-established non-dispensing PRACTICE. Average income about £1,100, including panel of 1,200. Consultations 2/6 to 10/6, visits 5/6 to 21/-. Practically no midwifery. Very good house, in best position on sea-front. Price for leasehold (with 20 years to run at a ground rent of £4 p.a., and renewable) £2,250. Premium £1,800.
8. NOTTS.—COUNTRY TOWN.—Old-established mixed general PRACTICE in hunting country. Average income about £1,200 and increasing, including appointments of £200, and panel of 850. Advice and medicine 2/6, visits 5/- to 10/-. Good house, with garden and tennis lawn. Price for freehold £2,200, or a similar house could be obtained on lease at a rental of about £50 p.a. Premium 1½ years' purchase.
9. DEVONSHIRE.—Very old-established unopposed country PRACTICE, in up-to-date village, offering exceptional facilities and amenities, in pretty district within few miles of large town. Receipts for past 3 years average about £1,450 p.a., including Union and Vaccination £66, and panel of 530. Visits 3/6 to 21/-. Mids. discouraged. Charming residence in own grounds of about 2 acres, with ample accommodation. Electric light. Rent £50. Premium 1½ years' purchase. Good society and sport.
10. SOUTH WALES.—COAST TOWN.—PARTNERSHIP.—A half share in an old-established general Practice. Average income about £2,500, with panel of 600. Fees 3/6 to 7/6 and a few at 21/-. Large well-situated house on 66 years' lease (ground rent £7 10s.). Price £2,000. Premium £2,000.
11. LONDON, N.W.—Old-established non-panel (ample scope for this) PRACTICE, averaging nearly £700 p.a. Visits 3/6 to 5/-. Midwifery 3 to 5 gns. (9 to 10 cases yearly). Car not kept. Large semi-detached non-basement residence with good garden. Part is let off and this arrangement could be continued, leaving a net rental of £22 p.a., plus rates and taxes. Premium £800.
12. CORNWALL.—HOSPITAL TOWN, NEAR SEA.—A 3/32 share to commence with, is for disposal in a sound mixed better and middle-class Practice. Average income for the last 2 years about £3,100, including panel of 3,700. Surgery fees 2/6 to 10/6. Visits 3/6 to 15/-, with medicine extra. Small convenient house, with garden and garage. Can be rented on lease at £85 p.a., or would be sold for £1,500. Premium 2 years' purchase.
13. ESSEX.—GOOD HOSPITAL TOWN.—PARTNERSHIP.—A one-third share in an old-established mixed general Practice. Steady average income of about £1,800. Panel of over 1,500. Fees from 2/6, main 3/6 and 5/-. Visits 5/- upwards. Little midwifery. Excellent accommodation for a bachelor. Good sport. Large scope. Premium 2 years' purchase. Ingoing partner should be keen on medicine, as Vendor does surgery.
14. NORTHERN CATHEDRAL CITY. — Old-established mixed general PRACTICE. Income for last year £920, including panel of 640. Fees 7/6. Car optional. Commodious well-situated house, with small garden. Price for freehold £2,000. Large mortgage if desired. Excellent sport and schools, also social advantages. Premium £1,500.
15. WESTMORLAND. — COUNTRY TOWN. — Old-established PRACTICE, held by Vendor many years. Steady average income of £1,450. Visits 3/6, 5/-, and upwards, mileage extra. Beautiful scenery and good roads. Panel of 300, could be increased. Semi-detached house, with 3 bedrooms, small garden. Garage. Electric light. Price £1,300. Premium 1½ years' purchase.
16. SUSSEX.—Within ten miles of Seaside Resort.—Old-established mixed-class PRACTICE, situated in small very attractive country town (pop. nearly 5,000; with large surrounding district)—amidst beautiful scenery. Receipts for past 3 years average £2,792 p.a., including panel of over 2,000, and Union and Vaccination appointments. Good house, with surgery, waiting room, and dispensary; 3 receptions, 7 bedrooms, etc. Garden and garage. Electric light. Price £3,000, £2,000 on mortgage at 6 per cent. Premium £4,500.
17. WESTERN COUNTY.—Good residential town, with very attractive surrounding district. Old-established mixed-class PRACTICE, producing nearly £1,500 p.a., including panel of about 600. Fees 3/6 to 21/-. Mids. 3 to 8 gns., about 20 cases yearly. Very good detached corner house, with ample accommodation and large garden, tennis lawn, etc. Price for freehold £2,000. Premium 1½ yrs.' pur.
18. LARGE PROVINCIAL UNIVERSITY CITY (WEST).—Good-class old-established non-dispensing PRACTICE, averaging nearly £1,600 p.a. (last year £1,785), including select panel of 480. Visits up to 21/-. Very little midwifery. Good house in best part of City, overlooking Park, and containing ample accommodation. Price freehold £2,250. Premium £2,350. Educational facilities excellent. Golf, tennis, etc.
19. WEST INDIES. — Very old-established PRACTICE averaging over £3,200 p.a. for past 3 years, including transferable appointments worth £600, and situated in a town offering social attractions. Patients mostly upper class. Visits 12/- to 30/-. Mids. about £10 (8 to 10 cases p.a.). Rent of Consulting Rooms £100 p.a. Furnished or unfurnished houses available, or successor could reside in an Hotel. Purchase of residence (suitable ones always offering) is advisable eventually. Price about £2,000. Premium £2,000, £1,000 down and balance by instalments. Climate is excellent and well suited to children. Golf, tennis, etc. Knowledge of surgery or some speciality advantageous, but not essential.
20. NORTH-WEST OF ENGLAND.—LARGE TOWN, near Coast. Very old-established mixed general PRACTICE, held by Vendor for nine years. Income for last year over £2,700, and increasing. Panel of about 840. No appointments. Fees 3/6 to 10/6. Very little midwifery from 3 gns. Exceptionally good well-situated house will be let on lease. Considerable scope for electro-therapeutic, and ear, nose, and throat work, and some surgery. Premium 1½ years' purchase, part by arrangement.
21. ESSEX COAST. — FAVOURITE RESORT. — PARTNERSHIP. — A one-third share, to commence with, in an old-established middle-class Practice. Average income of about £2,800. Panel of 600. Visits 4/6 to 21/-. Little midwifery. Suitable accommodation can be obtained. Premium 2 years' purchase.
22. HOME COUNTIES.—PARTNERSHIP.—A one-fourth share, to commence with, in a very old-established mixed-class Practice, comprising many good families. Income for the past twelve months at the rate of over £2,000. Fees 2/6 to 21/-. Suitable house available on rental. Price about £1,600. Sport of all kinds and plenty of schools. Premium £1,600, £1,000 down and balance by instalments. Oxon or Cantab graduate preferred.
23. CAPE PROVINCE.—PARTNERSHIP in well-established unopposed Practice, situated in very attractive district in centre of wealthy farming country, within 50 miles of Coast Town on main line of rail. Receipts for past 3 years average £3,282 p.a. (last year £3,594). Remaining partner (37 years of age) has been in practice 5 years. Bungalow residence, with 3 reception, 4 bedrooms, bathroom, etc. Large lawns, fruit, and flower garden. Garage. Servants' quarters separate from house. Price £1,200, £600 cash and balance on mortgage at 6 per cent. Premium for half share £1,200, half down and remainder by two yearly instalments of £300.
24. TASMANIA.—In a very beautiful and thriving agricultural district (climate excellent and bracing), an old-established unopposed PRACTICE in a small town (pop. about 1,000, with further 4,000 in district), averaging £1,283 p.a. (last year £1,380), including M.O.H. appointment £25 and Lodges £205. Held over 30 years. Visits 10/-, mileage extra. Mids. 4 gns., under 20 cases. Large brick-built house with bathroom, etc., in 11 acres of ground, tennis court, etc. Gas and water laid on. Electric light installed shortly. Vendors' freehold price £1,900, £1,000 on mortgage at 6 per cent. Premium £950.
25. NEW ZEALAND (North Island).—Increasing Town (pop. 2,500, with further 6,000 in district) amidst beautiful surroundings 70 miles from large city, on main line, well-established PRACTICE, producing £1,150 for last financial year, including £100 from Lodges. Consultations 10/6. Midwiferies 5 gns. Two opponents. Very good Bungalow residence, with ample accommodation and ½-acre of garden. Garage. Rented on lease or can be bought. Premium £1,000. Purchaser should have fair knowledge of surgery.
26. NEW ZEALAND (North Island).—Well-established PRACTICE, with small private Hospital for surgical, medical, and maternity cases, in Township (pop. of district 3,500) with beautiful surrounding district. Income £2,500 p.a., including transferable appts. £350. Held 14 years. Opposition (one) negligible. Premium for practice £1,150. Price of private Hospital £3,000, and bungalow residence £1,000. Of total amount £2,000 down, £1,550 by five yearly instalments of £310, plus interest, £1,600 on mortgage. Opportunities for major surgery. Personally recommended.

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EPITOME OF CURRENT MEDICAL LITERATURE.

Medicine.

505. Pulmonary Ventilation in Phthisis.

R. WILLIAMSON (*Quart. Journ. Med.*, April, 1928, p. 371) has made observations on the pulmonary ventilation, oxygen consumption, and respiratory quotient of patients suffering from pulmonary tuberculosis and of normal individuals. Experiments were performed in three groups: in the first, a series of observations were made on the same patient, who had been fasting and at rest for fourteen hours; in the second group the records were made three times during the day on the same patient, the initial readings being taken under the basal conditions present in the first group; in the third series determinations were made on healthy subjects at varying times during the day. The results of these investigations showed that the pulmonary ventilation and consumption of oxygen varied from time to time in the same patient under the same basal conditions of rest and fasting; by plotting these values against each other it was found that each was directly proportional to the other. The same direct ratio was found to hold in the second group of experiments, where the variables fluctuated with the taking of exercise or food. In the normal subject the correspondence between ventilation and oxygen consumption was less marked owing to the variability of the respiratory quotient. The author considers that for practical purposes the pulmonary ventilation is a measure of oxygen utilization, and therefore of metabolic rate, and he suggests that determination of pulmonary ventilation made under constant conditions may be a useful means of estimating the progress of a patient. With a given oxygen consumption the tuberculous patient is found to have a greater ventilation than a normal subject, and this observation is adduced to explain the fact that dyspnœa is more readily produced by work in the tuberculous than in the healthy individual.

506. Anginoid Attacks Due to Tobacco.

E. MOSCHCOWITZ (*Journ. Amer. Med. Assoc.*, March 10th, 1928, p. 733) records four illustrative cases, in persons aged from 35 to 62, in whom tobacco smoking caused anginoid pains, which ceased when they no longer smoked. One of the four was a woman. They had all smoked for many years previous to the seizures. Two smoked only Turkish cigarettes, and two strong Havana cigars with occasional pipes, so that the variety of tobacco used apparently made no difference. The pain of tobacco heart differs from that of coronary or aortic disease in being more intense, of longer duration, and usually accompanied by little or no disturbance of heart function. A prominent feature is the apparent sensitization which occurs. In some cases more or less pain was caused by merely puffing a cigarette or sitting in an atmosphere of tobacco smoke. Moschcowitz describes two varieties of tobacco heart: (1) those in which evidence of cardiac injury is not present, and (2) those in which the signs are suggestive of the intraventricular conduction disturbance associated with coronary or aortic disease. In the latter tobacco is probably the exciting cause of the anginoid pain. Treatment consists in complete withdrawal of tobacco, as mere limitation of its use is not enough. The pains do not cease immediately after withdrawal, but they continue for many weeks or even months. Although the mechanism of tobacco angina is not definitely known, the most probable explanation is that it is due to the constrictive action of tobacco on the blood vessels.

507. Encephalitis in Measles.

THE rarity of nervous complications in the course of measles (Bonheim in 5,940 cases only noted their presence in 0·4 per cent.) induces D. BLASI (*La Pediatria*, April 1st, 1928, p. 362) to record a case in a child aged 3. Four days after the appearance of a typical measles rash generalized convulsions developed; they were rather more marked on the left side, and between the attacks the child was in a stuporose state, with occasional cephalic cry. She refused food for two days, but had no vomiting, and there were no pulmonary or cardiac changes. There was slight strabismus and neck rigidity. The knee-jerks were exaggerated. Kernig's sign was absent, and lumbar puncture gave no evidence of meningitis. The symptoms lasted about six days and then slowly disappeared; after a few weeks the child completely recovered. The author believes the encephalitis in this case was probably due to the measles toxin.

508. Capillary Dilatation in Deep-seated Inflammation.

A. PARAVICINI (*Rend. dell' Instituto Medico "Sacco,"* January–February, 1928, p. 49) has observed that many patients with deep-seated inflammatory processes present filiform subepidermic striæ of a bright red colour and of a permanent character; localized on the skin of the trunk, especially that of the supraspinous fossæ at the site corresponding to the pulmonary apices, the extent of this striation varying with the severity of the subjacent lesion. The striæ may also be found on distinct parts of the shoulder and breast, corresponding with lesions in the mediastinum, pericardium, or pleura. They resemble those met with on the nostrils of alcoholic subjects, but differ from them in their greater delicacy. In all the cases in which the author observed the sign it was constantly associated with deep-seated lesions, usually of a tuberculous nature. The condition is thought to be a dilatation of the superficial cutaneous capillaries, which is at first transient and subsequently becomes permanent. The only other changes in the skin observed are dryness, slight increase of thickness, occasional branny desquamation, and adhesions. Most of the author's observations were made in mining centres, where the sign was frequently met with, especially among subjects of pneumonoconiosis and dry pleurisy.

509. Diagnosis of Glandular Fever.

L. D. CADY (*Amer. Journ. Med. Sci.*, April, 1928, p. 527) discusses the diagnosis of sporadic infectious mononucleosis (glandular fever), and reports nine cases. He concludes that the diagnosis from such conditions as syphilis, tuberculosis, and Hodgkin's disease can only be established by careful study of the differential white cell count in association with the clinical features. The clinical symptoms may persist for a few months, but the abnormal blood picture continues for months or years after the initial attack. Patients may be affected in the fourth or fifth decades, as well as during childhood and early adult life.

510. Treatment of Laryngeal Diphtheria.

E. S. PLATOU and C. A. STEWART (*Minnesota Med.*, March, 1928, p. 170) have found two measures of value in the treatment of laryngeal diphtheria. The first of these is laryngeal suction for removing laryngeal membrane. Through a laryngoscope a plain semi-soft or metal catheter is introduced, the distal part of which is attached to a suction machine. Over a two-year period the incidence of intubation was reduced approximately one-half by this method, which is comparatively simple after practice with the laryngoscope. The second measure is intraperitoneal injection of antitoxin. Tests showed that this method was second only to the intravenous, and that sufficient antitoxin was present in the blood one hour after intraperitoneal injection to neutralize all the circulating toxin in the very worst case of diphtheria.

Surgery.

511. Embolectomy.

U. BANI (*Il Policlinico*, Sez. Chir., March 15th, 1928, p. 117) reports the case of a woman, aged 39, admitted into hospital with a history of sudden pain in the right leg, followed by coldness and deadness of the limb, and gangrene, evidently due to an embolus in the femoral artery. The leg was amputated in the middle third of the thigh. A week later the patient was seized with a similar sudden attack of pain in the left leg, and there was evidence of an embolus in the left femoral artery. The leg was cold and insensible, the reflexes were absent, and no pulse could be felt below Scarpa's triangle. In spite of her grave general condition the clot in the femoral artery was removed about six hours after the onset of the symptoms. Local anæsthesia was used and an embolus about 4 cm. long was extracted from the artery. The arterial wound was sewn up with catgut without involving the intima; silk threads were left on the artery and were brought out of the external wound in case secondary hæmorrhage should occur. The immediate result of the operation was excellent, the leg became warm, sensation returned, and pulsation could be felt in the arteries. The leg continued to do well for the next seventeen days, when, after sudden emotion, the heart, which was affected with advanced mitral stenosis and fibrillation, failed, and death occurred from embolism. No necropsy was allowed.

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512. Treatment of Suppurative Osteomyelitis.

M. SAIDMAN (*Zentralbl. f. Chir.*, April 7th, 1928, p. 844) recommends irrigation of the medullary canal in all cases of acute or subacute osteomyelitis of long bones. After opening the medullary canal with a small trephine, within a short distance of the upper and lower epiphyses, he removes the marrow through these openings by means of a curette or spoon. The medullary cavity is then irrigated with dilute methylene blue solution or other antiseptic by means of a syringe and cannula, the latter having a lateral orifice. In the case of very long bones, such as the femur, tibia, and humerus, it is sometimes advisable to trephine the diaphysis at three or even four equidistant points; it may also be necessary to introduce a curved sound through the trephine openings before the medullary canal can be irrigated thoroughly. Saidman describes the case of a man, aged 53, who had a typical attack of subacute osteomyelitis in the upper half of the left tibia. The operation was performed under local anaesthesia. Two small incisions were made at the upper and lower borders of the painful area. Through these the medullary canal was opened by means of a small trephine, the outlet being made larger than the inlet, and the marrow in the vicinity of the trephine openings was removed with a spoon. Pus flowed from both orifices. The wounds were lightly plugged and the limb was fixed in a Volkmann's splint in the position of rest. The temperature rose at first and then fell slightly, otherwise there was but little change in the clinical condition. Two days later the medullary canal was irrigated with a weak antiseptic solution under very low pressure. From the exit orifice a mixture of the solution, pus, and masses of marrow containing large drops of fat escaped, and the irrigation was continued until the solution was clear. The procedure was performed six times; only after the first treatment was there a rise of temperature and increased pain in the inflamed area, which necessitated the administration of a hypodermic injection of morphine. On the next day the patient was free from pain and slept soundly. The rapid improvement that followed the first irrigation was evidently due to the treatment. Saidman claims that this treatment is scientific, and so simple that it can be performed under local anaesthesia.

513. Surgery of the Sympathetic Nervous System.

G. PIERI (*Arch. Ital. di Chir.*, February, 1928, p. 487) publishes a series of cases illustrating the effect of section of the rami communicantes in conditions where pain is the predominant symptom, and where after abdominal section no sufficient cause is found to explain the symptoms. He reports three cases of gastralgia which could not be explained by the ordinary suppositions, where ramisection caused complete cessation of the pain. Three cases of persistent pain in the right iliac fossa not apparently due to the appendix or caecum were also relieved by ramisection. In these cases he also removes the appendix as a prophylactic measure. The next three cases refer to biliary pseudo-lithiasis, occurring in young subjects suffering from pain in the right hypochondrium especially over the gall-bladder, and radiating to the back without fever or jaundice. One case of doubtful slight pancreatitis was relieved of pain by ramisection. The author also reports cases of renal, vesical, testicular, or pelvic pain treated similarly with success. He only resorts to this symptomatic treatment after excluding any removable cause. As to the duration of the cure, none of the cases are very old—the oldest goes back only two years—but in every case the relief has been maintained to date. Pieri adds that when operating on the dorsal roots care must be taken to avoid injuring the pleura, and in every case the nerve trunks must be disturbed as little as possible. Altogether the author has performed thirty-one ramisections, with one death from broncho-pneumonia.

514. Prevention of Post-operative Bleeding in Haemorrhoids.

J. A. WESSLER (*Med. Journ. and Record*, March 21st, 1928, p. 310) considers quinine, urea hydrochloride, and coagulen to be an ideal combination for the prevention of post-operative haemorrhage in haemorrhoidectomy. He prefers local to general anaesthesia, using a 1 per cent. solution of quinine and urea hydrochloride with the addition of 3 per cent. coagulen, a combination which afforded a nearly bloodless field during operation in fifty cases without any post-operative bleeding. After dilatation of the sphincters under a 1 per cent. solution of novocain the most dependent haemorrhoid is injected with the solution from base to apex to the point of distension and blanching. After it has been drawn down the skin and pile tissue are divided at the mucocutaneous junction and a No. 30 linen thread is passed round the pedicle, the entire haemorrhoid being tied and cut off, leaving sufficient stump to prevent slipping of the ligature. Each individual haemorrhoid is similarly treated. The advantages claimed are that the quinine and urea hydrochloride produce a prolonged anaesthetic effect, while the coagulen prevents secondary haemorrhage and provides a nearly bloodless field. Wessler advocates coagulen as being a solution of thrombokinase isolated from blood platelets; it is free from protein and there is no danger of anaphylactic shock. It is a stable preparation which remains uniform in potency; if necessary, the ampoules can be sterilized by boiling, without affecting the coagulating qualities.

Therapeutics.

515. Treatment of Syphilis Associated with Tuberculosis.

R. MARCLAND (*Bull. et Mém. Soc. Méd. Hop. de Paris*, March 29th, 1928, p. 548) illustrates the harmful influence of novarsenobenzol on tuberculous syphilitic patients by describing two cases in which the first few injections were followed by uncontrollable activity in previously quiescent lesions. Arsenical compounds as a whole have, during the last fifteen years or so, fallen into disuse in pulmonary tuberculosis on account of the risk of aggravation of the disease. Such activation is brought about by the pulmonary congestion which follows the administration of arsenic, and this drug is therefore specially contraindicated when there is fever; haemoptysis, or progressive loss of weight. Considerable elevations of temperature in febrile tuberculous patients have been shown to follow five or six injections of cacodylate of soda. Marcland remarks that syphilis and tuberculosis are such common diseases that they must frequently coexist, and it is therefore important to make a thorough search for a tuberculous lesion whenever a febrile reaction or a loss of weight occurs during treatment with novarsenobenzol. Patients suffering from both diseases should not be treated with this drug unless the temperature and physical signs are carefully watched so that the administration may be immediately stopped should signs of tuberculous activity appear. If withdrawal of arsenic becomes necessary treatment should be continued with bismuth and mercury. These drugs are well tolerated by tuberculous patients, and although cure of the syphilitic condition may be delayed, it may ultimately be effected. On the other hand, it may be difficult or even impossible to arrest a pulmonary tuberculous lesion which has been lit up by the ill-advised and uncontrolled use of novarsenobenzol.

516. The Treatment of Bronchiectasis.

ACCORDING to R. STRISOWER (*Wien. klin. Woch.*, April 5th, 1928, p. 495) the three most important indications to prevent the extension of bronchiectasis are to decrease the expectoration, to assist in its expulsion, and to prevent gangrene. One of the most important measures in diminishing the expectoration is to decrease the amount of fluid imbibed. It should amount to about 500 c.cm. per diem for three days, and on the fourth day, which may be called a "drink" day, the ordinary amount is taken. To avoid thirst a slice of orange or lemon may be given and the mouth may be washed out with soda-water. The following remedies can also be employed: atropine, turpentine, eucalyptus, menthol, quinine and camphor in solution, and eucalyptus and menthol dissolved in oil. To assist in its expulsion the expectoration should be made thinner by alkaline waters and potassium iodide. The most important means for getting rid of the expectoration is the adoption of Quincke's position and respiratory gymnastics. Adoption of the following position is often efficacious—the patient should be in the dorsal position with the pelvis raised, and should then take deep breaths. He should then bend the hips and knees and press them firmly into the abdomen. Salicylates and diathermy have also proved useful. If there are signs of gangrene neosalvarsan injections should be given; should there be no result after six or eight they must be abandoned. An operation is indicated if the sputum is excessive and putrid, or if the disease progresses in spite of treatment.

517. Ephedrine in Asthma and Hay Fever.

R. GREEN (*Malayan Med. Journ.*, March, 1928, p. 10) records his observations upon the symptomatic treatment of asthma and hay fever with ephedrine. The hydrochloride was given orally in doses varying from 1/2 to 1½ grains in ten asthma cases, while in two cases of hay fever a 3 per cent. ephedrine sulphate solution was applied locally to the nasal mucous membrane. Each asthma patient was kept under observation for from two to six hours, and in some cases the blood pressure was recorded every half-hour. Complete relief was obtained in six of the ten cases, while five developed toxic symptoms, including mental confusion, urticaria, palpitation, tremor, sweating, tachycardia, or collapse. Green thinks

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that ephedrine is of much the same value in asthmatic attacks as adrenaline, but has the advantage of being given by mouth instead of by injection. In view of the toxic symptoms sometimes arising small doses should be employed until tolerance is established. When the drug was used during an attack the blood-pressure was unaffected or lowered, but when given during a quiescent period the blood pressure was temporarily raised, so that it would appear to have the same contraindications as other blood-pressure-raising drugs in diseases of the cardio-vascular system. In the two cases of hay fever treated by local applications of ephedrine sulphate to the swollen nasal mucous membrane marked temporary relief for three hours was obtained; 1 grain of ephedrine hydrochloride had no effect upon the symptoms, but produced a toxic effect of faintness, palpitation, and sweating similar to that noticed in some of the asthma cases.

518. Treatment of Pulmonary Tuberculosis by Sanocrysin.

V. BIE and M. S. ANDERSEN (*Acta Tuberculosea Scandinavica*, 1927, vol. 3, Fasc. 2, p. 61) publish details of a series of 36 cases of pulmonary tuberculosis treated by sanocrysin. Injections were made intravenously as a rule, occasionally intramuscularly, of a 5 per cent. solution, and in general the dosage was regulated according to Moeligaard's directions. Two series of injections were given, sometimes three. In the early stages of the investigation an antituberculosis serum was given during the first series of injections, but later this practice was discontinued. Most of the patients after treatment with sanocrysin were dispatched to a sanatorium. Of 12 acute cases with tubercle bacilli in their sputum 6 patients died, 4 were apparently cured (1 relapsed later), 1 remained stationary, and 1 was improved. Of 12 acute cases, and 2 chronic cases with acute exacerbations, without tubercle bacilli in their sputum, 1 patient died, 9 were apparently cured (but 2 relapsed later), 3 were probably cured (but were not examined later), and 1 was improved. Of 8 chronic cases with tubercle bacilli in their sputum 3 patients died, 1 was apparently cured, 2 were improved, and 2 remained stationary. Two patients with chronic disease but without tubercle bacilli in their sputum were apparently cured. Against these may be set 19 cases that were not treated by sanocrysin. Seventeen of these were acute cases, or chronic cases with acute exacerbations, with tubercle bacilli in the sputum; of these, 9 patients died, 4 were improved, and 4 were worse. Of 2 acute cases without tubercle bacilli 1 patient died, the other was improved. The authors consider that these figures demonstrate the value of sanocrysin treatment.

Ophthalmology.

519. Transmission of Arsenic to the Aqueous Humour.

A. M. YUDKIN, A. C. KRAUSE, and D. G. MORTON (*Arch. of Ophthalmol.*, March, 1928, p. 147) describe four experiments on dogs with regard to the transmission of arsenic to the aqueous humour. They found that, whereas after intravenous infection of large doses of arsenical compounds practically no arsenic could be found in the aqueous, yet if paracentesis of the anterior chamber was performed shortly before or after the intravenous injection arsenic was found in the aqueous fluid, and, further, that this presence of arsenic in the aqueous could be increased by further paracentesis. The arsenic present in the aqueous fluid after these procedures leaves the anterior chamber in a few hours. The instillation of pilocarpine and eserine helps to increase the quantity of arsenic in the aqueous. In view of their experiments the authors suggest that in cases of syphilitic affections of the eye, and in particular in cases of interstitial keratitis, paracentesis of the anterior chamber should be performed near the time of the intravenous injection of an arsenical compound, and that the paracentesis might with advantage be repeated again within a few hours, and that concurrently pilocarpine or eserine drops should be instilled into the eye.

520. Keratitis Due to an Infection of Trachoma.

DURING the course of annual autumnal epidemics of acute conjunctivitis in Athens, due often to the bacillus of Weeks; B. ADAMANTIADIS (*Ann. d'Oculist.*, February, 1928, p. 119) has noticed that in certain patients, particularly infants, a latent trachoma becomes apparent during the decline of an acute conjunctivitis; the course of this acute condition was much longer in trachomatous subjects, and favoured complications of the cornea or aggravated existing ones. This ulcerative keratitis, caused by a superinfection of the trachoma by Koch's bacilli, differs from other forms of keratitis in the following characteristics. The ulceration, always due to this bacillus, occurs in debilitated cases, and is limited to the middle of the cornea on the horizontal meridian. It is in the form of a narrow, very deep in the centre and less so on the two sides; perforation always occurring in the centre. The edges appear polished, shiny, and without any greyish infiltration. The ulceration is uncomplicated by suppuration and has a very rapid course. Two or three days after the onset of the ophthalmia the cornea is affected and speedily becomes eroded in its depth. Abundant lacrymation and intense periorbital pains accompany the corneal involvement. The prognosis is very grave, though with continuous and systematic treatment it is not hopeless. The author recommends daily cauterizations with a 1 per cent. solution of silver nitrate after careful eversion of the lid, instillations of pilocarpine or argyrol, and compress dressings. At first, owing to the lacrymation, these dressings should be changed four or five times daily, the instillations being then made, and an antiseptic ointment applied. In obstinate cases subconjunctival injections of mercury cyanide may be given combined with parenteral injections of milk.

521. Ramsay Hunt's Zoster.

E. ROLLET (*Journ. de Méd. de Lyon*, March 20th, 1928, p. 149), who records an illustrative case in a woman aged 70, states that in addition to the ordinary ophthalmic herpes characterized by pain, eruption, and various disturbances of the anterior segment of the eye, such as keratitis or iritis, there is a form of ophthalmic zoster in which the posterior segment is involved owing to affection of the optic nerve. The inflammation of the nerve appears to be secondary to herpetic meningitis, the existence of which is proved by lumbar puncture, which shows a distinct lymphocytosis. Whereas optic atrophy occurring in general diseases and intracranial affections is symmetrical, unilateral atrophy will often be found to be due to a previous attack of ophthalmic zoster.

522. Mikulicz's Disease Treated by X Rays.

R. E. WRIGHT (*Amer. Journ. of Ophthalmol.*, December, 1927, p. 903) describes a case of this disease in which the lacrymal and submaxillary glands were involved. The swelling of the lacrymal glands was so great that corneal ulceration ensued and the lids had to be sutured. X-ray applications were given over a period of six weeks, two being given to the left eye, which was the one least involved, and six to the right eye. At the end of the six weeks the swelling of the lacrymal glands had disappeared.

Obstetrics and Gynaecology.

523. Surgical Intervention in Extrauterine Pregnancy.

H. P. BROWN, Jun. (*Annals of Surgery*, April, 1928, p. 581) records the experiences gathered from 109 cases of ectopic gestation treated at the Pennsylvania Hospital. Regarding the etiology and pathology of this condition, Robinson has stated that it is due rather to a functional disturbance of the tube than to an inflammatory and mechanical condition of the tube itself, and numerous authors have shown that the cause of rupture and haemorrhage, conditions chiefly responsible for the symptoms, are dependent not only on the distension of the tube by the growing embryo, but also on the degree of penetration of its walls and blood vessels by the foetal elements. In the present series a combination of vaginal bleeding and abdominal pain was the most frequently seen—namely, in 55 per cent. of the cases—while lower abdominal pain without haemorrhage occurred in 35 per cent. Salpingitis was noted as having been present in only 10 per cent., while a high leucocyte count was not observed frequently enough to be of diagnostic value. In no instance was the temperature on admission above 101° F. The onset of the symptoms was found to be often insidious, depending largely on the degree and rapidity of rupture of the tube or embryonic sac. The differential diagnosis between ectopic pregnancy and conditions simulating it, especially salpingitis and appendicitis, is frequently difficult. In the present cases the right side was involved in 53 per cent. and the left in 38 per cent., while on operation the tube alone was removed in 81 per cent. and both tube and ovary in 15 per cent. In two cases both tubes were excised, and in one ovarian pregnancy only the ovary. The mortality was 6.3 per cent. Brown concludes that diagnosis is difficult in atypical cases, and that much reliance cannot be placed in the menstrual history or the absence of previous pregnancies. In doubtful cases where an acute surgical emergency is not present reasonable delay is permissible in order to arrive at a correct diagnosis, but in those presenting symptoms of active bleeding immediate operation is necessary without waiting for a reaction from shock, since there is always a chance of recovery despite extensive intra-abdominal haemorrhage or shock. Where indicated an autotransfusion may be beneficial.

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524. Treatment of Ovarian Cysts during Pregnancy.

M. BROUHA (*Bruxelles-Medical*, April 15th, 1928, p. 803) states that, while the systematic operative treatment of ovarian cysts during the first months of pregnancy is generally approved, opinions differ as to its advisability during the latter months. Despite the dangers of torsion, rupture, and suppuration of the cyst, surgical intervention, practised by certain authorities, is not recommended by Brouha owing to the risk of causing a premature accouchement and eventration due to rupture of the abdominal cicatrix; a case of this nature is cited. When the cyst lies in the abdominal cavity spontaneous natural delivery is possible, and the cyst can be treated at the end of the puerperal period. Pelvic cysts cause a mechanical obstruction, and other measures are necessary. Manipulation of the cyst into the abdomen is tedious and risky; puncture, formerly much practised, and vaginal incision of the tumour have been abandoned. Ovariotomy is the method of choice, and Brouha advocates the combining of this operation with natural delivery. When dilatation of the os is almost complete, and not before, he opens the abdomen, removes the cyst, temporarily closes the abdomen, and terminates labour per vaginum by forceps or version. Two cases treated with complete success in this manner are reported. This method is not applicable when the cyst lies intraligamentally, or when strong adhesions are present. There is also risk in cases where the foetal vitality has already suffered, as the exteriorization and luxation of the uterus may cause disturbances of the placental circulation capable of producing foetal asphyxia. These are said to be the two only contraindications, and the method possesses the immense advantage of conserving the uterine integrity, which is so advisable for future pregnancies and labours. Brouha recommends a definite closing of the abdomen only at the end of the accouchement, as then the reduced size of the uterus renders suturing much easier. Moreover, it is thus possible to verify a haemostasis of the pedicle, which is liable to be interfered with during delivery.

525. Antistreptococcal Serum in Treatment of Puerperal Septicaemia.

C. BERNARD (*Gynécol. et Obstét.*, March, 1928, p. 216) reviews the results given by treatment by antistreptococcal serum in puerperal septicaemia. Thirty-five cases were treated: in all the diagnosis was confirmed by blood culture, bacteriological examination of pus from metastatic abscesses, or necropsy. Streptococci were found in the blood in eighteen cases. The proportion of cures was 37.1 per cent.; if the cases are deducted in which death occurred within a few hours of the serum being injected, as well as those in which the pathological agent was other than a streptococcus, the cures numbered 47.3 per cent. The doses advocated are high: from 80 to 100 c.cm. in two injections during the first day and on succeeding days from 60 to 80 c.cm. Two or three days are required in which to judge of the efficacy of the treatment. The conclusion is drawn that the serum may act (1) in about 20 per cent. of cases, rapidly and perhaps specifically, the temperature falling and the general condition improving as from introduction of antibodies is appropriate to the infecting agent; (2) more slowly and indirectly, its efficacy being non-specific and equal or inferior to that of colloidal metallic preparations given intravenously.

Pathology.

526. The Action of Ergotamine on the Autonomic System.

M. GOLDMAN (*Arch. des Mal. du Cœur*, April, 1928, p. 204) has observed the effect of ergotamine, the principal active constituent of ergot, on normal individuals and on those suffering from various diseases. This substance was injected into and under the skin and intravenously in doses of 0.25 mg. upwards of the tartrate. A diminution of pulse rate varying between 6 and 60 beats a minute was found; this was due either to excitation of the cardio-inhibitory mechanism or to predominance of the latter as a result of paralysis of the sympathetic terminations. When atropine had been previously administered the reduction of the pulse rate was even more marked. In relation to adrenaline it was found that this drug would abolish the ergotamine effect, whereas ergotamine did not influence the effect of adrenaline. The fact that ergotamine has a variable effect depending upon the bodily state at the time of administration was shown by the accelerating influence on the pulse rate in a patient suffering from hyperthyroidism. The effect of this substance on the blood pressure was always to increase the diastolic pressure. Generally the pulse pressure rose, but in a few cases there was a fall, so that the systolic pressure dropped below the original level. This alteration of diastolic pressure by ergotamine is comparable with the effect of adrenaline, but the change is more prolonged. It is concluded from these investigations that ergotamine excites the sympathetic innervation of the muscles of the peripheral vessels, while in the heart it activates the parasympathetic and perhaps paralyses the sympathetic. The sympathetic supply to the stomach is stimulated so that secretion and motility are diminished. The therapeutic indications for ergotamine are the following: circulatory disorders with a tendency to tachycardia, whether paroxysmal, toxic, or glandular; cases of transient or permanent hypotension, especially in circulatory failure; and digestive troubles associated with excessive secretion and motility.

527. Infectious Necrotic Hepatitis in Australian Sheep.

A. W. TURNER (*Ann. de l'Inst. Pasteur*, February, 1928, p. 211) has previously submitted evidence to show that the black disease (infectious necrotic hepatitis) of Australian sheep is essentially a localized infection of the liver due to *Cl. oedematiens*. He now gives an account of the experimental reproduction of the disease in animals, and the preparation of a protective vaccine. By cultivating the organism for several generations in a glucose nitrate agar medium he obtained a type which was highly virulent but only slightly toxic to guinea-pigs. Injected in a dose of 0.25 c.cm. it gave rise to local oedema, and to a pleural and peritoneal effusion; but instead of the organisms being confined to the local lesion they were found in the serous effusions, in the viscera, and in the blood. In one out of ten guinea-pigs injected with this dose necrotic areas were found in the liver containing large Gram-positive bacilli which proved to be *Cl. oedematiens*. Similar areas of necrosis in the liver were found in a sheep injected with the bacillus. Experiments seem to indicate, however, that the appearance of these necrotic areas, both in guinea-pigs and in sheep, is the exception rather than the rule. Vaccination experiments were attempted in both animals, but with rather ambiguous results. A formolized whole culture of *Cl. oedematiens* injected on one, two, or three occasions into guinea-pigs gave rise to no definite immunity. In sheep the results appeared to be more hopeful, but unfortunately so few animals were available for use as controls that the interpretation of the experiments was difficult. The author thinks, however, that animals can be protected with a suitable vaccine, but that an experiment in the field on a large scale is necessary before the value of prophylactic vaccination can be ascertained.

528. The Mesenteric Glands and Fat Absorption.

C. CASSANO (*Il Policlinico*, Sez. Med., February 1st, 1928, p. 93) reports a histological investigation of the function of the mesenteric glands in dogs during the digestion of fats. The stains used for the microscopic sections were Sudan III and haemotoxylin, and the method of Ciaccio for lipoids. Cassano found that the fatty substances in the mesenteric glands did not exist only as neutral fats, but also as soaps and fatty acids. Two hours after the ingestion of a fat-containing meal the glands showed conspicuous activity in building up the large fat molecules at the expense of the soaps and other lipoids. After twelve hours' digestion the neutral fats prevailed in greater quantity than the soaps. At this period also he noted deposits of neutral fats inside the blood-vessels. It thus appeared that there was a gradual passage of these fats into the blood circulation, this being contrary to the opinion formerly held that the fats pass wholly by the receptaculum chyli into the thoracic duct. From twenty-four to forty-eight hours after the last meal there was always to be seen a large quantity of fat in the glands, indicating that they acted as a storehouse to economize the fats. During protracted fasting (seven to fifteen days) the mesenteric glands still conserved part of the deposited fats, and at the same time it was noted that a certain amount of separation had occurred, liberating the fatty acids and augmenting the soaps.

529. Bacteriological Examination of Rheumatic Nodes.

B. LE BOURDELLÈS (*C. R. Soc. de Biologie*, March 9th, 1928, p. 691) examined bacteriologically two small subcutaneous nodes removed during life from the scalp of a young man suffering from cardiac rheumatism. The nodes, which were taken out under strict aseptic precautions, were dropped, the one into glucose peptone broth, the other into a modified Noguchi medium. On the fourth day a streptococcus developed in the glucose broth, and on the tenth day in the Noguchi medium. Subcultures made from these primary cultures remained sterile. The organism did not haemolyse the patient's blood. The author considers this finding of a streptococcus as of interest in relation to the etiology of acute rheumatism.

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SUPPLEMENT
TO THE
BRITISH MEDICAL JOURNAL.
LONDON: SATURDAY, MAY 26TH, 1928.

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British Medical Association.

CURRENT NOTES.

Access to the B.M.A. House.

The private roadway and pavements leading into the British Medical Association House from Tavistock Square are now entirely closed for traffic while excavations are in progress, and the Association can take no responsibility for accidents occurring to persons who may pass over the site of the work now proceeding. A covered wooden passage has been constructed to form an entrance to the building for foot passengers from Tavistock Square. Members and others who do not wish to use this covered way, or who wish to bring motor cars or other vehicles into the Association's premises, must proceed southwards down Tavistock Square, turning left at the bottom of the Square into Tavistock Place, turning left again into Marchmont Street, and again left round Cartwright Gardens, thus entering the courtyard of the B.M.A. House through the archway under the Great Hall.

Some Work at Headquarters.

On Wednesday the Hospitals Committee completed its arrangements for the conference of medical staffs of voluntary hospitals to be held at the British Medical Association House on Wednesday, June 6th. As indicated in a Current Note in last week's *Supplement*, if a sufficient number of representatives notify their intention to be present it will be possible to arrange for reduced railway fares at the rate of a single fare and a third for the return journey. The committee directed the preparation of a model contributory scheme to be submitted for discussion at its next meeting. The Association is constantly hearing of schemes in one part of the country or another which fail to conform to the requirements laid down from time to time by the Hospitals Committee, and it is thought that if a model contributory scheme is formulated it may serve as a useful guide, especially for members of hospital staffs in any area where a new scheme may be brought into existence. The committee also directed the preparation of a memorandum dealing with cottage hospitals in their relation to the hospital policy of the Association. On May 24th the National Formulary Subcommittee, to which the Retail Pharmacists' Union and the Ministry of Health were asked to send representatives, met to discuss the projected national formulary. It will be remembered that the subcommittee was set up to carry out the instruction of the Panel Conference that the Insurance Acts Committee should expedite the production of such a formulary. The subcommittee hopes to finish its work in time to report to the next conference.

By-laws under the Nursing Homes Registration Act, 1927.

The Ministry of Health is just about to issue draft model by-laws under the Nursing Homes Registration Act, 1927. By the courtesy of the Ministry the British Medical Association was given an opportunity of seeing the draft by-laws and making suggestions for their amendment. Particulars of these suggestions will be found in the Annual Report of Council published in the *Supplement* to our issue of April 28th (p. 152), under the heading "Registration of Nursing Homes." It is important that Divisions should take an early opportunity of approaching their local authorities in order to secure that no amendments are made locally to which exception is taken. Clause 5 (1) of the Act lays down that there shall be no inspection of medical records. In order that this provision shall not be lost sight of the Ministry of Health has consented, at the suggestion of the Association, to recommend local authorities to print this section at the end of their by-laws, and it is very important that Divisions should see that this is done. The Ministry has already circularized local authorities (Circular 862 of March, 1928) calling their attention to the obligations imposed by the Act and the desirability of advertising its requirements to all concerned, and issuing the necessary forms of application for registration at the earliest possible date.

Examination of Vagrants for Small-pox.

The Medical Secretary has received a number of requests for information as to what remuneration doctors should ask from the guardians for the duty of examining vagrants under Order No. 859 of the Ministry of Health to determine if they show any sign of being affected by small-pox. This Order places on Poor Law medical officers the duty of the daily inspection of vagrants for signs of small-pox before they are discharged, and states that "in view of the extra work and responsibility which may be involved the Minister will be prepared to consider any application which may be made by a board of guardians for his sanction to the payment of reasonable additional remuneration to the medical officer." The Public Health Committee has given careful consideration to the matter, and has also been in consultation with the Secretary of the Poor Law Medical Officers' Association, and has decided that the remuneration asked for should be 1s. a head, with a minimum of 10s. for each attendance.

Scholarships and Grants in Aid of Scientific Work.

Scholarships.

The Council of the British Medical Association is prepared to receive applications for Research Scholarships as follows: An Ernest Hart Memorial Scholarship, of the value of £200 per annum, and three Research Scholarships, each of the value of £150 per annum. These Scholarships

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are given to candidates whom the Science Committee of the Association recommends as qualified to undertake research in any subject (including State-Medicine) relating to the causation, prevention, or treatment of disease. Each Scholarship is tenable for one year, commencing on October 1st, 1928. A Scholar may be reappointed for not more than two additional terms. A Scholar is not necessarily required to devote the whole of his or her time to the work of research, but may hold a junior appointment at a university, medical school, or hospital, provided the duties of such appointment do not interfere with his work as a Scholar.

Grants.

The Council of the British Medical Association is also prepared to receive applications for Grants for the assistance of research into the causation, treatment, or prevention of disease. Preference will be given, other things being equal, to members of the medical profession and to applicants who propose as subjects of investigation problems directly related to practical medicine.

Conditions of Award: Applications.

Applications for Scholarships and Grants must be made not later than Saturday, June 2nd, 1928, on the prescribed form, a copy of which will be supplied on application to the Medical Secretary of the Association, B.M.A. House, Tavistock Square, London, W.C.1.

Applicants are required to furnish the names of three referees who are competent to speak as to their capacity for the research contemplated, to whom reference may be made.

NOTICES OF MOTION BY DIVISIONS FOR THE ANNUAL REPRESENTATIVE MEETING, CARDIFF, 1928.

Treatment by Radiation and Electricity.

By BIRMINGHAM CENTRAL: That subpara. (3) of the recommendation contained in para. 81 of the Annual Report of Council be amended by the deletion of the words "except on the responsibility and under the general supervision of a registered medical practitioner" and the substitution therefor of the words "except on the recommendation by and under the direction of a registered medical practitioner."

Paying Centres for Infant Hygiene.

By BIRMINGHAM CENTRAL: That (with reference to Recommendation A contained in para. 95 of the Annual Report of Council), as it is a matter of experience that instructional centres frequently lead to subsequent treatment, the Representative Body considers it undesirable that paying centres for infant hygiene should be instituted.

Contract Rate for Juvenile Oddfellows.

By BIRMINGHAM CENTRAL: That the recommendation contained in para. 104 of the Annual Report of Council be amended to read as follows:

> That in view of the fact that the whole cost of medical attendance on the juvenile falls on the parent, who is often in poor circumstances, the Representative Body approve of a standard rate in urban areas of 8s. 8d. per head per year, including drugs, for the remuneration of medical practitioners for medical attendance and medicine for juvenile members of the Manchester Unity of the Independent Order of Oddfellows; that the Council be authorized to approve a slightly lower rate than 8s. 8d. per head per year, for a time to be definitely stated, for application in any area in which it is satisfied that owing to economic conditions the standard rate of payment is not feasible; and that it be an essential part of this arrangement that there must be free choice of doctor by patient and of patient by doctor.

By CLEVELAND: That the recommendation contained in para. 104 of the Annual Report of Council be amended by the deletion of the words "that the Council be authorized to approve a slightly lower rate than 8s. 8d. per head per year, for a time to be definitely stated, for application in any area in which it is satisfied that owing to economic conditions the standard rate of payment is not feasible."

By WIGAN: That (with reference to the recommendation contained in para. 104 of the Annual Report of Council) the Representative Body deprecates the acceptance by medical practitioners of any contract to provide medical attendance and treatment for uninsured women and juveniles except through the ægis of the State.

Membership and Acceptance of Post which is subject of "Important Notice."

By STRATFORD: That (with reference to the Motion by North Middlesex—see p. 213 of *British Medical Journal Supplement*, May 19th) any registered medical practitioner who has obtained a position to which he was appointed whilst it was the subject of an "Important Notice" in the *British Medical Journal* shall not be eligible for membership of the British Medical Association until the propriety of his membership has been considered and recommended by the Central Ethical Committee.

Association Notices.

TABLE OF DATES.

June 2, Sat.	Publication in BRITISH MEDICAL JOURNAL SUPPLEMENT of result of election of members of Council by grouped Branches, and of result of election of members of Council and Representatives in Representative Body by Public Health Service members.
	Nomination papers available (on application at Head Office) for election of 12 members of Council by grouped Representatives (British Isles).
June 7, Thurs.	Names of Representatives and Deputy Representatives must be received at Head Office by this date.
June 13, Wed.	*Council.*
June 21, Thurs.	Meetings of Constituencies must be held between this date and July 30th to instruct Representatives.
June 30, Sat.	Supplementary Report of Council appears in BRITISH MEDICAL JOURNAL SUPPLEMENT.
July 4, Wed.	Amendments and riders for inclusion in A.R.M. agenda must be received at Head Office by this date.
July 20, Fri.	*Annual Representative Meeting*, Cardiff, 10 a.m.
	Nominations for election of 12 members of Council by grouped Representatives must be received (at A.R.M., Cardiff) by this date, 2 p.m.
July 21, Sat.	*Annual Representative Meeting*, Cardiff.
July 23, Mon.	*Council*, Cardiff.
	Annual Representative Meeting, Cardiff.
July 24, Tues.	*Annual Representative Meeting*, Cardiff. Annual General Meeting; Cardiff, President's Address.
July 25, Wed.	*Council*, Cardiff. Conference of Honorary Secretaries, Cardiff.
	Meetings of Sections, etc., Cardiff.
July 26, Thurs.	*Meetings of Sections*, etc., Cardiff.
July 27, Fri.	*Meetings of Sections*, etc., Cardiff.

ALFRED COX, *Medical Secretary.*

BRANCH AND DIVISION MEETINGS TO BE HELD.

BORDER COUNTIES BRANCH.—The annual general meeting of the Border Counties Branch will be held at the County Buildings, Dumfries, on Friday, June 15th, at 3 p.m. Agenda: Branch Council's report and financial statement; report of the election of office-bearers for 1928–29; Dr. John Ritchie will give his presidential address entitled "Some primitive conceptions of disease and their bearing on public health."

GLASGOW AND WEST OF SCOTLAND BRANCH.—The annual meeting of the Glasgow and West of Scotland Branch will be held in the Pathological Department, Royal Infirmary, Glasgow, on Wednesday, May 30th, at 2.30 p.m. After the annual meeting there will be a clinical demonstration given by the members of the staff.

GLASGOW AND WEST OF SCOTLAND BRANCH: LANARKSHIRE DIVISION.—A meeting of the Lanarkshire Division will be held at the Stonehouse Hospital on Wednesday, June 6th, at 3.30 p.m.

GLOUCESTER BRANCH.—The annual general meeting of the Gloucester Branch will be held at the General Hospital, Stroud, on Thursday, May 31st, at 6 p.m. Agenda: Election of officers; annual report of the Branch Council; to make new rules, or alter or repeal existing rules; address by Dr. J. R. Charles, physician to Bristol Royal Infirmary, on manganese toxæmia.

KENT BRANCH.—The annual meeting of the Kent Branch will be held at Acacia Hall, Dartford, on Thursday, June 14th, at 2 p.m. The presidential address will be delivered by Dr. M. W. Renton on the increasing influence of hospital practice and clinics on private practice, both general and special. Dr. M. W. Renton invites all members and their wives to a luncheon at 1 p.m. in the gymnasium, Acacia Hall. Messrs. Burroughs Wellcome and Co. have arranged an exhibition of micrographs of the commoner parasites and pathogenic organisms with reference to the sero- and vaccino-therapy associated with their presence, and will entertain members and their wives at a garden party in the grounds of Acacia Hall. The Tennyson Smith golf challenge cup competition will be held on the same day.

KENT BRANCH: BROMLEY DIVISION.—A meeting of the Bromley Division will be held to-day (Friday, May 25th), at 8.30 p.m., at the Town Hall, Anerley (adjoining Anerley Station), when Mr. Philip Turner will give a paper on modern methods in surgical diagnosis. The annual meeting of the Division will be held on Thursday, May 31st, at the White Hart Hotel, Bromley, at 8.30 p.m. Agenda: Report of executive; election of officers; Annual Report of Council.

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KENT BRANCH: DARTFORD DIVISION.—A general meeting of the Dartford Division will be held at Livingstone Hospital on Tuesday, May 29th, at 3 p.m. Agenda: Annual Report of Council; instruct representative in Representative Body; elect chairman, 1928–29.

LANCASHIRE AND CHESHIRE BRANCH: HYDE DIVISION.—The annual general meeting of the Hyde Division will be held in the Hyde Town Hall on Thursday, June 14th, at 8.30 p.m.

METROPOLITAN COUNTIES BRANCH.—The annual general meeting of the Metropolitan Counties Branch will be held at the British Medical Association House, Tavistock Square, W.C.1, on Tuesday, June 19th, at 4 p.m. Business: (1) Report of scrutineers on election of officers; (2) Annual Report of Council; (3) report of representatives of the Branch on the Central Council; (4) presidential address by Dr. Christine Murrell entitled "Our changing times."

METROPOLITAN COUNTIES BRANCH: CITY DIVISION.—The annual general meeting of the City Division will be held at the Metropolitan Hospital, Kingsland Road, E., on Tuesday, June 5th. The next clinical meeting of the Division will be at the Metropolitan Hospital on Friday, June 8th, at 4.30 p.m.; tea at 4 o'clock.

METROPOLITAN COUNTIES BRANCH: HENDON DIVISION.—A meeting of the Hendon Division will be held at the Hendon Cottage Hospital on Friday, June 29th, at 8.30 p.m., when members are invited to show cases. The meeting will subsequently discuss the Supplementary Report.

METROPOLITAN COUNTIES BRANCH: HAMPSTEAD DIVISION.—The annual meeting of the Hampstead Division will be held at the Hampstead General Hospital on Thursday, June 14th, at 8.30 p.m., for the election of officers and Executive Committee.

METROPOLITAN COUNTIES BRANCH: LAMBETH AND SOUTHWARK DIVISION.—The annual meeting of the Lambeth and Southwark Division will be held at the British Medical Association House, Tavistock Square, W.C.1, on Wednesday, June 6th. Tea at 4.15 p.m.

METROPOLITAN COUNTIES BRANCH: LEWISHAM DIVISION.—A meeting of the Lewisham Division will be held at the Town Hall, Catford, on Tuesday, June 19th, at 8.45 p.m. Mr. J. M. Redding will read a paper on some points in the *x*-ray examination of the alimentary tract.

METROPOLITAN COUNTIES BRANCH: NORTH MIDDLESEX DIVISION.—The annual general meeting of the North Middlesex Division will be held on Wednesday, May 30th, at 3.30 p.m., in the Southgate Council Offices, Palmer's Green. Agenda: Financial statement for 1927; election of Divisional officers; Annual Report of Council; instruction of representatives in Representative Body.

MIDLAND BRANCH: LINCOLN DIVISION.—The annual meeting of the Lincoln Division will be held at the Lincoln General Dispensary to-day (Friday, May 25th), at 3 p.m. Agenda: Election of officers; arrangement of a meeting to be addressed by a representative from headquarters.

METROPOLITAN COUNTIES BRANCH: ST. PANCRAS DIVISION.—A meeting of the St. Pancras Division will be held at the British Medical Association House, Tavistock Square, W.C.1, on Tuesday, June 12th, at 9 p.m. Dr. W. Langdon Brown will read a paper on endocrinology and the future.

METROPOLITAN COUNTIES BRANCH: WILLESDEN DIVISION.—A meeting of the Willesden Division will be held at the Willesden Hospital, Harlesden Road, N.W., on Wednesday, June 20th. Dr. Margaret Emslie will discuss the care of the infant.

NORTHERN COUNTIES OF SCOTLAND BRANCH.—The annual meeting of the Northern Counties of Scotland Branch is to be held at Kyle of Lochalsh on June 30th. This will be the first meeting of the Branch which has been held in the area of the Islands Division.

NORTH WALES BRANCH: SOUTH CARNARVON AND MERIONETH DIVISION.—The next meeting of the South Carnarvon and Merioneth Division will be held at the War Memorial Hospital, Towyn, on Tuesday, May 29th, at 2.15 p.m. Agenda: Minutes and correspondence; report of Executive Committee (members are asked to bring with them the SUPPLEMENTS of April 28th, May 5th, and May 19th); demonstrations of *x* ray and artificial sunlight by Dr. J. A. Davies; cases will be shown by Dr. J. A. Davies and Dr. F. S. Jackson.

SHROPSHIRE AND MID-WALES BRANCH.—The fifty-third annual spring meeting of the Shropshire and Mid-Wales Branch will be held at the Royal Salop Infirmary to-day (Friday, May 25th), at 3.30 p.m. Agenda: Election of president for 1928–29; consideration of Annual Report of Council.

SOUTHERN BRANCH.—The annual meeting of the Southern Branch will be held at Queen's Hotel, Southsea, on Friday, June 8th. Supper will be served at 9 p.m., and there will then follow an address by Colonel Macarthur entitled "Some medical reference to Pepys," which will be illustrated by lantern slides.

SOUTHERN BRANCH: JERSEY DIVISION.—A meeting of the Jersey Division will be held at the General Hospital on Thursday, June 21st, at 3.30 p.m. Dr. A. H. Jacob will read a paper on tuberculosis from the point of view of the tuberculosis officer.

SUSSEX BRANCH: HASTINGS DIVISION.—The next meeting of the Hastings Division will be held at the Hastings Infirmary, Frederick Road, on Tuesday, June 12th, at 3.15 p.m. Dr. Bower will conduct members over the infirmary, and after tea clinical cases will be shown.

WILTSHIRE BRANCH: TROWBRIDGE DIVISION.—A social meeting of the Trowbridge Division will be held at the Norton Hill Colliery, Midsomer Norton, on May 31st, at 3 p.m., open to members and friends. After inspection of the colliery tea will be provided at the Commercial Hotel by the chairman, Dr. Spence.

Meetings of Branches and Divisions.

BIRMINGHAM BRANCH: BIRMINGHAM CENTRAL DIVISION.

THE annual meeting of the Birmingham Central Division was held on May 8th, with Dr. BEARDS in the chair. The annual report of the Executive Committee was received and approved. The following officers were elected to serve during the ensuing year:

Chairman, Dr. MARRIS. *Vice-Chairman*, Dr. BEARDS. *Honorary Secretaries*, Drs. Garbutt and L. A. N. Line. *Representatives in Representative Body*, Mr. W. Stirk Adams, Mr. A. W. Nuttall, Dr. C. A. Brown, Dr. G. Dain, and W. A. Marris. *Deputy Representatives in Representative Body*, Dr. L. A. N. Line.

A letter was read from the medical officer of health about the provision of electrical and medicated baths in connection with a public bath in Birmingham. It was decided to reply that there seemed to be ample provision at most of the hospitals, and that the probable demand would not justify the expense. It was decided that expenses, such as for stationery, incurred by the secretaries of the Medical Charities Fund should be met by the Central Division. The meeting was subsequently adjourned until May 18th, for further consideration of the report.

DORSET AND WEST HANTS BRANCH.

THE Dorset and West Hants Branch held its summer meeting at the Yeatman Hospital, Sherborne, on May 9th. The following officers were elected for 1927–28:

President, Mr. A. Basil Rooke. *Vice-Presidents*, Drs. Whitaker-McCall. *Honorary Secretary*, Dr. McCall. *Honorary Treasurer*, Dr. Grey-Edwards.

The reports from the Bournemouth and West Dorset Divisions were approved. Mr. A. B. ROOKE read a paper on some recent advances in medicine and surgery. The Sherborne members entertained the visiting members to lunch and tea.

METROPOLITAN COUNTIES BRANCH: MARYLEBONE DIVISION.

THE annual meeting of the Marylebone Division was held on May 9th, when the chairman, Dr. JOSSON HORNE, presided. Dr. PERCY SPURGIN and Sir WILLIAM WILLCOX were elected chairman and vice-chairman respectively for 1928–29. The Annual Report of Council was considered.

Mr. MCADAM ECCLES opened a discussion on the general practitioner and paying beds in hospitals. He described in detail the various proposals that were under discussion in this connexion, and laid emphasis on the points that were likely to come before the Annual Representative Meeting for consideration and decision. Mr. BISHOP HARMAN, Dr. HAWTHORNE, Mr. WALTER SPENCER, Dr. ROXBURGH, Dr. GOULLET, and other members took part in the discussion, and accounts were given of the various schemes already in operation in London.

METROPOLITAN COUNTIES BRANCH: STRATFORD DIVISION.

THE members of the Stratford Division, at the invitation of their chairman, Dr. GARLAND COLLINS, visited the West Ham Council's sanatorium for adult cases of tuberculosis at Dagenham on May 9th, and were shown over the institution. From Dagenham they proceeded to the council's convalescent home at Harold Wood, where, after inspecting the wards and grounds, tea was provided, and the visitors were welcomed by the chairman of the hospitals committee of the council, who emphasized its desire to elicit the co-operation and goodwill of the local medical practitioners. Dr. CHALLANS, chairman of the West Ham Insurance Committee, responding for the visitors, congratulated the council on its efficient and up-to-date institutions. On behalf of the Stratford Division he reciprocated the desire of the council in respect to co-operation, and referred to the fact that the chairman of the Division was the medical officer of health for the borough.

NEW SOUTH WALES BRANCH.

A Year's Work.

THE annual report of the Council of the New South Wales Branch for the year ending March 29th, 1928, has now been issued to the members. During the period under review the membership of the Branch rose from 1,593 to 1,661. Ten ordinary meetings, three extraordinary, and seven clinical meetings of the Branch were held, the average attendance being fifty-one. The ordinary meetings were arranged in conjunction with meetings of clinical sections, a system which has been found to work very satisfactorily. The special clinical meetings were held at various hospitals, and the extraordinary meetings were concerned with the passing of the revised articles and by-laws. In connexion with the holding of the third session of the Australasian Medical Congress (British Medical Association) in Sydney in the spring of 1929, Sir Alexander MacCormick has been appointed president by the Federal Committee, and the organization of the Congress is proceeding satisfactorily. Additional land has been acquired for the Association's new premises in Macquarie Street, Sydney, and the desired frontage of 60 feet has now been secured; competitive designs for a building have been invited from architects throughout the Commonwealth. During the year seven British Medical Association Lectures were delivered at meetings of local associations outside the metropolitan area, and post-graduate courses were held in diseases of children and in obstetrics.

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NORTH OF ENGLAND BRANCH: TYNESIDE DIVISION.

At a meeting of the Tyneside Division on May 8th the Report of Council was discussed generally; its detailed consideration was postponed to the next meeting. A letter was received from the Whitley Bay Council approving the suggestion of health lectures and promising support. The suggestion of the Council of the Durham University College of Medicine for a united endeavour of the northern counties to engage in the cancer campaign was favourably received, and Dr. Adams was appointed to represent the Division at the proposed preliminary meeting. The thanks of the Division were accorded to the Blyth Division for their recent invitation to a clinical evening, at which Dr. Dickinson of Newcastle gave a most entertaining and instructive exposition of the newer methods of diagnosis of pulmonary tuberculosis. Dr. Noel R. Rawson was elected deputy representative to the Annual Representative Meeting. After the meeting Mr. KNAPTON of Kodak Ltd. demonstrated films of medical, surgical, and general subjects to a gathering of about thirty, including visitors from Newcastle, Ashington, Blyth, and South Shields.

SOUTH MIDLAND BRANCH: BUCKINGHAMSHIRE DIVISION.

A MEETING of the Buckinghamshire Division was held on April 27th. Dr. ROSS reported that he had issued the British Medical Association circular letter with reference to the varicose veins investigation, and had received replies from thirty members who were willing to assist. Dr. BRADSHOOK brought forward the question of motor accidents on the high roads; a considerable discussion ensued. The HONORARY SECRETARY read several circular letters regarding medical charities, and suggested that a small sub-committee should be formed to work with the Local Medical and Panel Committee. Several members present considered that the time was not yet opportune, and it was agreed that the papers should lie on the table. It was agreed to hold the annual Branch meeting in June, and that Dr. Harwood-Yarred should be asked to make arrangements for a speaker. The honorary secretary then read correspondence with regard to health lectures, stating what was already being done in the county. After considerable discussion it was agreed that health lectures in country districts were not so desirable as in thickly populated centres, and that they should be given by the public health authority and by approved special lecturers. The circular letter on reports to coroners was considered, and it was agreed that a copy should be sent to the Buckinghamshire County Council. A discussion followed on the rates of payment for juvenile Oddfellows; it was generally agreed that 3s. 3d. was as good as could be expected, and it was hoped that all rates in Buckinghamshire would be brought up to that level. Dr. Ross then gave a summary of the annual report of the inspection of midwives for 1927.

It was decided that Sir James Berry should be invited to address a future meeting.

SOUTH WALES AND MONMOUTHSHIRE BRANCH: SOUTH-WEST WALES DIVISION.

A MEETING of the South-West Wales Division was held on May 5th at Carmarthen, with Dr. D. H. PENNANT in the chair. Dr. T. R. Davies (Llanelly) was appointed representative for the Division at the Annual Representative Meeting at Cardiff, and Dr. Oscar Williams (Llanelly) deputy representative. In view of the fact that the Division had already communicated some months previously with the coroners of Carmarthenshire County Council about the fees for reports to coroners where no necropsy or inquest was held, it was decided to appoint Drs. C. P. Parry, W. A. T. Lloyd, and A. H. S. Buitt to wait on the appropriate committee of the county council.

The recommendation of the Council with reference to contract rates for juvenile members of the Independent Order of Oddfellows was discussed thoroughly. As a result the representative was instructed not to support the Council as the recommendation now stands, unless it be amended so as to provide adequate mileage grants. The Division was of the opinion that the rate was barely reasonable for an industrial area, and that it was absolutely inadequate for a rural area. Motions for the Annual Representative Meeting at Cardiff were adopted.

SOUTH-WESTERN BRANCH: TORQUAY DIVISION.

A MEETING of the Torquay Division was held in the Torbay Hospital on April 4th, with Mr. E. WARD in the chair; Dr. E. I. SPRIGGS of Ruthin Castle gave a British Medical Association Lecture entitled "The clinic and the family doctor." The speaker first emphasized the importance to the patient of the conduct of his case by his own family doctor, and, secondly, the importance to the doctor of establishing an accurate diagnosis as early as possible in difficult and troublesome cases. He commented on the frequency with which curable organic lesions could be found in cases classed under the vague headings of neurasthenia, visceroptosis, and auto-intoxication, when the patients were thoroughly investigated by "team work." He next drew attention to the great value of having a patient under continued trained observation, and illustrated this point by special reference to the investigation of obscure pains—as, for example, by x rays—at the time when the pain was acute. Dr. Spriggs explained that diagnosis was the chief function of such clinics as he referred to, and that it was desirable that the family doctor should conduct the treatment when possible. In certain cases, however, a short preliminary course of more elaborate treatment was often helpful, and in some types of case considerable benefit was obtained from the controlled life and ordered routine of such an institution.

At the close of his paper the lecturer referred to the increasing importance being given, especially in America, to the value of routine medical examinations of healthy people for the early symptoms of disease, and he urged general practitioners to bring this to the notice of their patients and explain its value to them. Drs. CARVER, DISTIN, GRIFFITHS, and HAYDON took part in the subsequent discussion of the paper, and after the lecturer had replied to their comments a very hearty vote of thanks to Dr. Spriggs was moved from the chair, and was carried by acclamation.

The annual meeting of the Torquay Division was held on May 9th. After the minutes of the previous annual meeting had been read, certain matters arising from them were discussed, especially the proposed contributory scheme for the Torbay Hospital. The office-bearers for the ensuing year were then elected as follows:—

Chairman, Dr. R. G. Riddell. *Vice-Chairman*, Dr. J. M. Jarvis. *Honorary Secretary*, Dr. W. G. Davidson. *Honorary Auditor*, Dr. E. A. McCallum. *Representative in Representative Body*, Dr. R. Ward. *Deputy Representatives in Representative Body*, Dr. W. G. Davidson and Dr. J. MacLennan.

The HONORARY SECRETARY then presented the annual report of the Executive Committee, which showed that a gratifying amount of useful work had been done by the Division during the past year. A letter from the Public Medical Service for London regarding contract rates for attendance upon juvenile Oddfellows was then read, and the points raised by it were very fully discussed. Some points in the Annual Report of Council were then considered, but a fuller discussion of this was postponed until the next meeting on June 22nd.

SURREY BRANCH: GUILDFORD DIVISION.

AN extra meeting of the Guildford Division was held on April 26th at the King George V Sanatorium, Godalming, a unit of the Metropolitan Asylums Board, by invitation of Dr. James Watt. On arrival the members were escorted round the grounds in groups by the superintendent and his assistants. The patients were seen at work—gardening, attending to the livestock, and learning leather work and fine carpentry. Visits were paid to the hospital block, containing the more serious cases, the x-ray room, the pavilions or open-air wards, the kitchen with its up-to-date labour-saving apparatus, and the disinfecting plant. Tea was served in the great hall, after which Dr. WATT gave a short address on the treatment of the patients, illustrated by numerous skiagraphs and some cases. He stated that great interest had been displayed in the graduated labour and vocational training, but he wished to emphasize that the most important, and, in fact, the essential, factor was rest, which must be very prolonged in the early stage. A patient was kept in bed for, sometimes, three or more months, until his condition was absolutely afebrile, for pyrexia showed that the condition was still toxic. Then walking exercise was started and gradually increased to five miles a day; this was followed by very light and then increasingly heavy work, until return was possible to the normal occupation, with precautions against the infection of others. He did not consider that antitoxin vaccine prepared from the patients was a really valuable form of treatment, and he had discontinued it. The artificial pneumothorax treatment was described, and the numerous skiagraphs illustrating this part of his address aroused keen interest. A vote of thanks was proposed by the vice-chairman, Dr. FLEMING, and seconded by Dr. C. C. SCOTT; Dr. WATT replied.

SUSSEX BRANCH: BRIGHTON DIVISION.

A SPECIAL meeting of the Brighton Division was held on Friday, May 4th, at Steine House, Brighton, when Messrs. Kodak Ltd. gave a cinematograph display of medical subjects. The first film illustrated intestinal peristalsis in animals anaesthetized with urethane, and showed extremely well the various movements of the gut, including the pendulum variety, segmentation, peristaltic rushes, and normal colonic antiperistalsis. The next subject was obstetric, and the methods displayed excited comment among the thirty or more members present. Following these two films of general interest to all members came two depicting operations—namely, thoracoplasty under local anaesthesia at the Mayo Clinic, and a decompression operation at the London Hospital by Mr. Souttar. The latter film illustrated very clearly the mechanics of Mr. Souttar's ingenious instrument. The lighter part of the programme included a Japanese travel film.

SUSSEX BRANCH: CHICHESTER AND WORTHING AND HORSHAM DIVISIONS.

THE clinical meeting of the Chichester and Worthing Division was held on May 9th, with Dr. FRANK HINDS in the chair. The following were elected to office for the coming year:

Chairman, Dr. F. H. Alexander. *Vice-Chairman*, Dr. H. J. M. Milbank-Smith. *Honorary Secretary*, Dr. Duncan D. Mackintosh.

A combined meeting of the Chichester and Worthing and the Horsham Divisions was then held for the purpose of electing a representative to the Annual Representative Meeting at Cardiff in July. Dr. H. J. M. Milbank-Smith was elected representative and Dr. M. H. H. Vernon deputy representative. Mr. F. E. FELDEN (Hove) read a most interesting paper on some observations on renal tuberculosis, which was illustrated by lantern slides. In the discussion which followed the CHAIRMAN, Drs. GIBSON, GARRATT, GRIFFITHS, TEMPLETON, and HEYWOOD-WADDINGTON spoke. Dinner followed in the Burlington Hotel. The health of the chairman was proposed by Dr. LEDGER and seconded by Dr. PERRY; both referred to the esteem in which Dr. Hinds was held, and wished him happiness in his approaching retirement from practice.

F. W. Simson, Pulmonary Asbestosis in South Africa, British Medical Journal (1928)
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