The

British Medical Journal

THE JOURNAL OF THE BRITISH MEDICAL ASSOCIATION.



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❖ ❖

The following tables are extracted from an article published in the *Schweizerische Medizinische Wochenschrift*, by Drs. Uhlmann and Burow:

MEAT DIET (WITH PURINS)

In 24 hours	Without Treatment	Atoquinol	Phenylcinchoninic Acid
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Uric Acid	2.03 grm.	3.01 grm.	2.63 grm.

VEGETARIAN DIET (WITHOUT PURINS)

In 24 hours	Without Treatment	Atoquinol	Phenylcinchoninic Acid
Urine	3350 c.c.	3515 c.c.	3515 c.c.
Uric Acid	0.91 grm.	2.20 grm.	1.28 grm.

COMPARATIVE TESTS

Daily Uric Acid Elimination	Atoquinol (oral)	Atoquinol (cutaneous)	Phenylcinchoninic acid (oral)	Piperazine (oral)
	11.92 grm.	10.08 grm.	10.92 grm.	7.68 grm.

It will be seen from the above tables that the daily elimination of uric acid is greater when Atoquinol is used than with the phenylcinchoninic acid. Also in the third table it will be noticed that the cutaneous administration of Atoquinol by means of the ointment is most effective in causing an active elimination of uric acid

❖ ❖

In an article in *The Lancet*, May 12th, 1928, on "The Treatment of Toxic Peri-Arthritis," the author refers particularly to the value of Atoquinol in fairly large doses (six tablets per diem) for a long period in such cases. It was given in periods of three days on and three days off with large draughts of water. The author states that in the course of four years in 87 cases treated he has never seen Atoquinol give rise to any untoward symptoms.

❖ ❖

In the *British Medical Journal*, January 7th, 1928, a correspondent states that he has never found any trouble or discomfort to occur after the taking of allyl ester of phenylcinchoninic acid.

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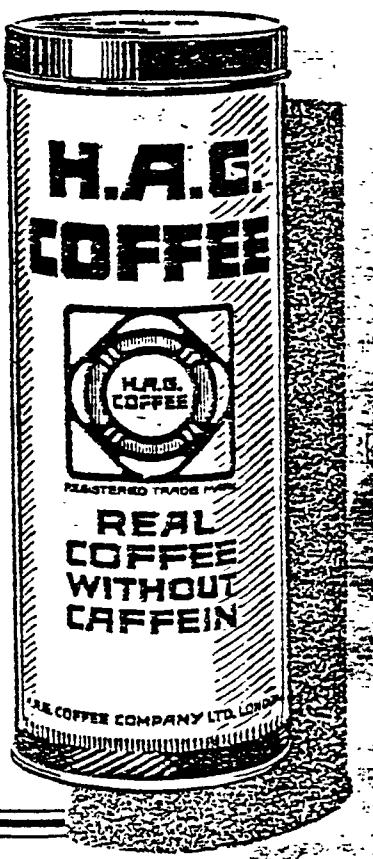
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General Medical Council: President's Address.

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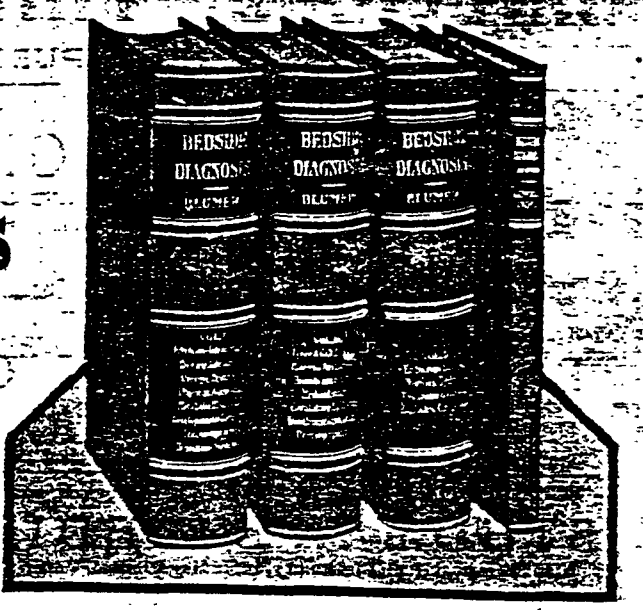
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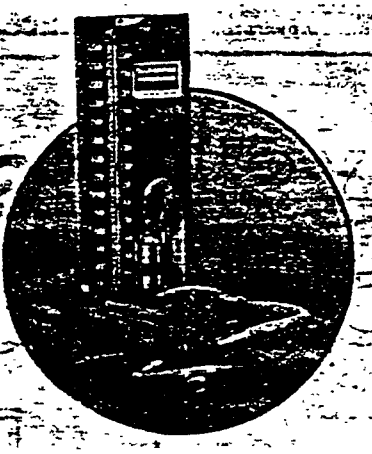
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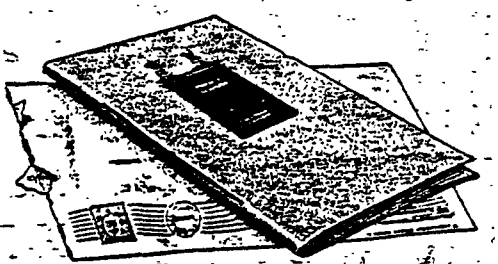
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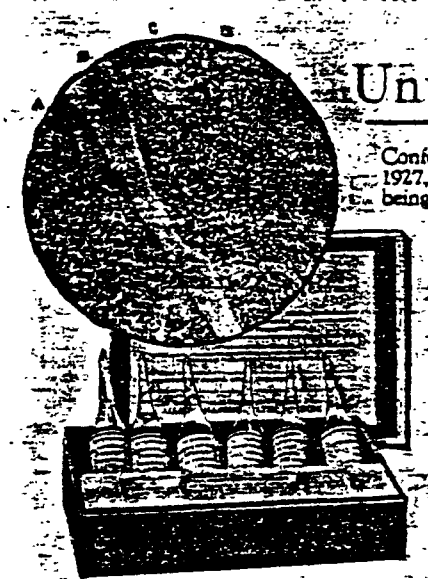
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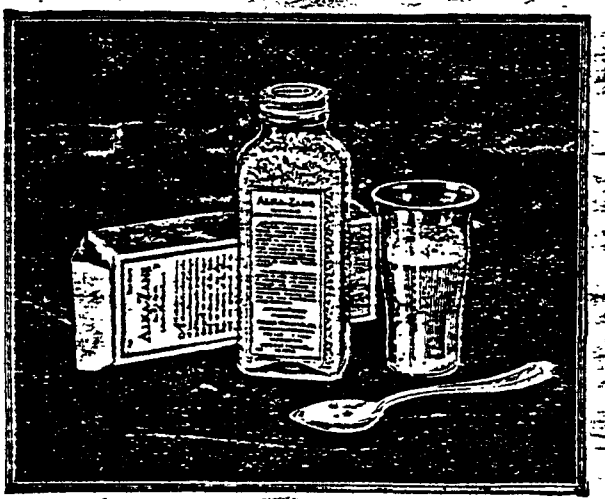
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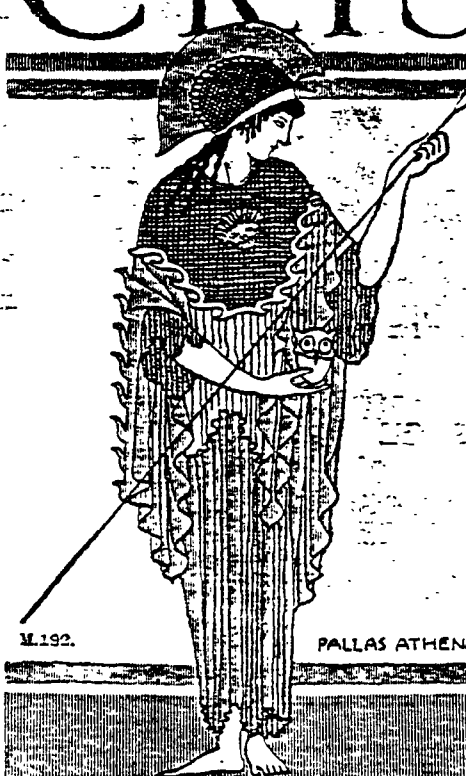
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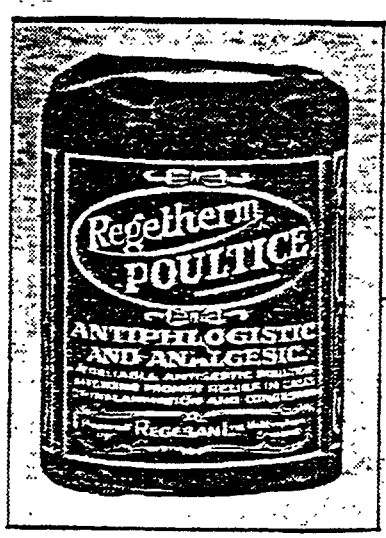
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Over forty years ago the foundation of the firm of BENGER'S FOOD, LTD., was laid by the late F. B. BENGER, a member of an old English family whose records in Wiltshire go back many generations, and whose association with that neighbourhood has been traced to the year 1517. The name Sutton-Benger, a Wiltshire village, is evidence of the family's long association with the County.

Like many businesses, it began in a small way, and as a branch of a more than century old pharmacy. It was established to produce highly scientific products in a highly scientific way; preparations which were the direct outcome of the original and classical researches in the realm of dietetics and digestion by the late Sir W. ROBERTS, M.D., F.R.S., who was assisted by Mr. BENGER in their production for practical application by physicians.

To-day, the firm of BENGER'S FOOD, LTD. is known to, and esteemed by, the medical faculty throughout the world. It is in touch with practising physicians, hospitals, nursing institutions, etc., co-operating in the elucidation of problems relating to dietetics.

The "Lancet" describes Benger's Food as :

"Mr. Benger's admirable preparation."

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M.214

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Benger's is a unique Self-Digestive Food for use with fresh milk. It has proved invaluable to physicians in their practice, especially by reason of the fact that its self-digestion can be regulated to suit the condition of the patient.

"The Medical Profession realises better than others how large a proportion of the population owe their lives to Benger's Food."

The "Practitioner," December, 1927.

Benger's Food has gained its great reputation, not by extravagant or sensational advertising, but by the constant recommendation of medical men who know its great merit. It has been valued by doctors and nurses for over 40 years.

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Liquor Pancreaticus. Pancreatin Pills. Essence of Rennet.
Liquor Pepticus. Peptonised Beef Jelly. Liquor Thyroidin.
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BENGER'S Food

Back of Every Pain..

IS a disturbance in the physical or mental equilibrium, an interruption of some vital function, a deviation from the normal. Injuries, inflammations, excessive muscular strain, disturbances of the circulation, all are productive of pain. And be it trivial or severe, prolonged or ephemeral, uppermost in the mind of the patient is the prompt suppression of that pain.

To the patient racked by the painful pneumonic process, nothing is more grateful or comforting than an Antiphlogistine jacket applied over the thoracic walls. Physicians conversant with this simple procedure generally concede that this plastic anodyne dressing increases the superficial circulation by the induction of artificial hyperemia setting up a highly decongesting process in the deeper seated tissues and thereby relieving the dyspnea and the stress on the right heart.

Doctors the world over are more and more coming to recognize the unique properties of



Antiphlogistine

as an invaluable auxiliary in the management of the pneumonias or wherever *pain* is a prominent factor.

THE DENVER CHEMICAL MFG. CO.,
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PETROLAGAR by force of its own merit has come into favour as a standard treatment for spastic and atonic constipation.

This product contains 65% pure paraffin emulsified with agar-agar by a process that splits the oil into such finely divided particles that they mix intimately with the intestinal contents. This produces a soft, well formed, easily passed faecal mass without the use of drugs.

Petrolagar is most economical as it may be given in decreasing doses as benefit occurs.

Write to Deshell Laboratories Ltd., Braydon Road, N.16, for literature and specimens.



Doctors will be convinced of the value of Petrolagar by prescribing it for a number of selected cases of constipation and carefully noting the results.

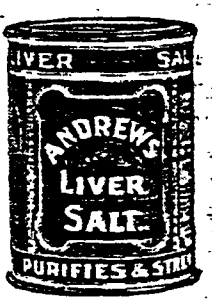
Petrolagar

'Petrolagar' is the trade mark distinguishing the fine emulsion of mineral oil and agar-agar, issued in four varieties: Plain, with Phenolphthalein, Alkaline and Unsweetened, manufactured only by Deshell Laboratories, Ltd., London, N.16.

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In those rheumatoid and fibrositic conditions consequent upon septic absorption, especially where the bowel has become infected, a large teaspoonful of Andrews Liver Salt taken in a tumbler of either warm or cold water each night at bedtime, will be found a most excellent adjuvant to vaccine treatment.

In such conditions it is absolutely essential to prevent faecal stagnation, and it is imperative that the contents of the bowel should be removed at least daily.



Dose: One-half to three teaspoonfuls, according to requirements, in a glass of water.

An 8-oz. Tin sent free on request.

Andrews Liver Salt

SCOTT & TURNER LIMITED, Works and Laboratories at Newcastle-on-Tyne





What Cod Liver Oil Does

It stimulates normal growth which has ceased or become stunted owing to lack of sunshine or proper food.

It prevents and cures rickets in children.

It gives increased protection against epidemics and against wasting diseases, such as consumption.

It maintains the strength during illness and assists recovery.

It builds up the system after illness and restores health, vitality and strength.

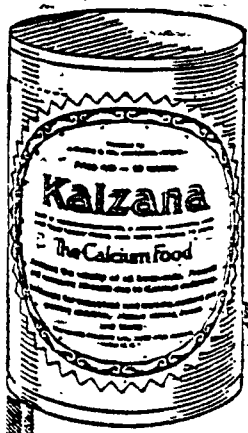
There is no proved efficient substitute for Cod Liver Oil as a natural source of the essential Vitamins A and D.

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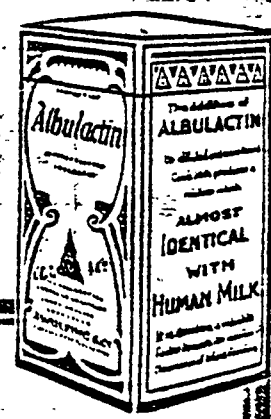


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The Practitioner says:

"Kalzana acts efficiently in promoting the growth of strong bones and healthy teeth; in protecting the expectant and nursing mother against a dangerous loss of calcium . . . . particularly because Kalzana promotes calcium retention."

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The aim, in artificial feeding, is to produce as near as possible the equivalent of human milk, and therefore the most important constituent is the lactalbumin, because, apart from its protein value, it is responsible for breaking down the casein curd into minute, digestible particles. Albulactin is pure, soluble lactalbumin — the vital proteid of human milk — and when added to properly modified cow's milk it produces a milk mixture closely allied to human milk in composition and physiological effect. With Albulactin it is easy to meet every phase of infant feeding between the premature weakling and the normal robust infant.

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Supplies for your own dispensing, and for Hospitals, Sanatoria, etc., are available on special terms.

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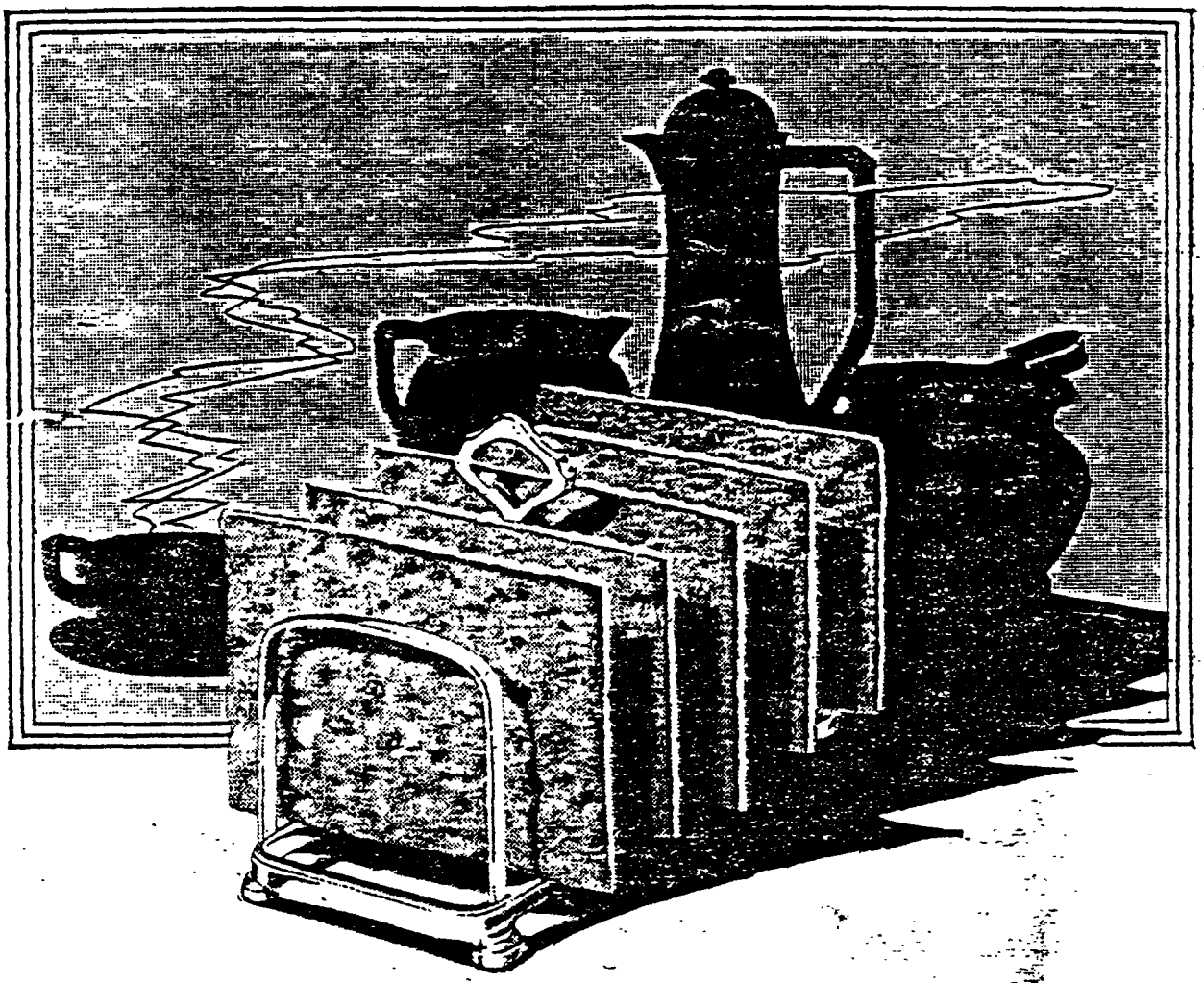
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Sold by all good grocers and stores at 1/6 per (40-50 slice) 1-lb. carton; ½-lb. 10d.

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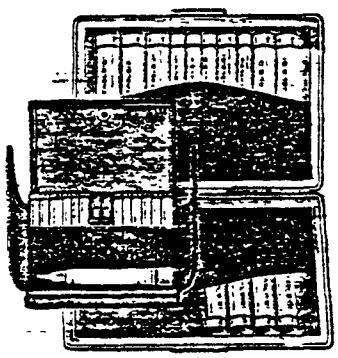


Gifts

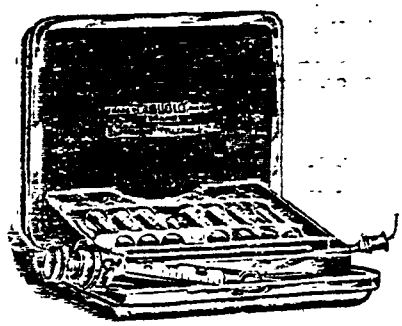
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No. 126
'Tabloid' Medicine Pocket-Case
Measurements: 5½ × 4 × 1½ in.



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Measurements: 3½ × 3⅜ × ⅞ in.

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CONCENTRATED SCARLET FEVER ANTITOXIN-GLOBULINS

12/6 *per phial of* 10 *c.c.*

Means are now available whereby an epidemic of this disease may be retarded, if not entirely prevented. The use of the Dick Test in epidemics reveals the susceptible, who may then be rendered immune by the injection of prophylactic.

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'Wellcome' Schultz-Charlton Test Solution

1 *c.c. Rubber-stoppered bottles* 2/0 *each*

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SCARLET FEVER PROPHYLACTIC

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1 *c.c. Rubber-stoppered bottles* ...	1/6 *each*	1 *c.c. Rubber-stoppered bottles* ...	2/0 *each*
10 *c.c.* „ „ „	9/0 *each*	10 *c.c.* „ „ „	18/0 *each*
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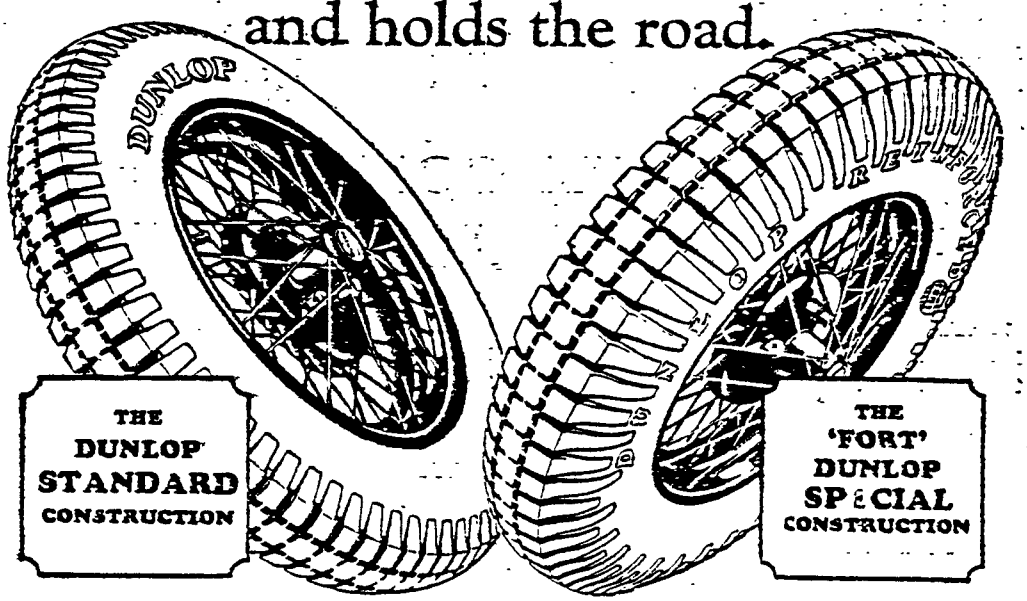
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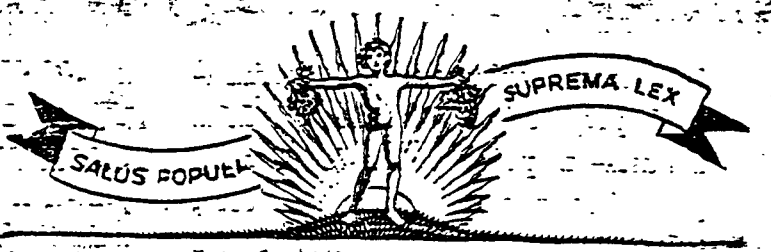
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'NEBOLINE'

COMPOUND No. 21

Atropine gr. 1/3; Eucaine Hydrochloride gr. 2; a solution of Hyponitrous Acid gas to saturation, with balsamic extracts, ad 1 oz.

is indicated

'Neboline' No. 21 is practically a specific for asthma, and where vapour treatment is advisable, this preparation is applied by means of the 'Vaporiser,' a remarkable instrument which reduces the solution to an almost invisible vapour which penetrates to the most remote positions of the respiratory tract.

"The Treatment of Pulmonary & Bronchial Affections" posted free on request.

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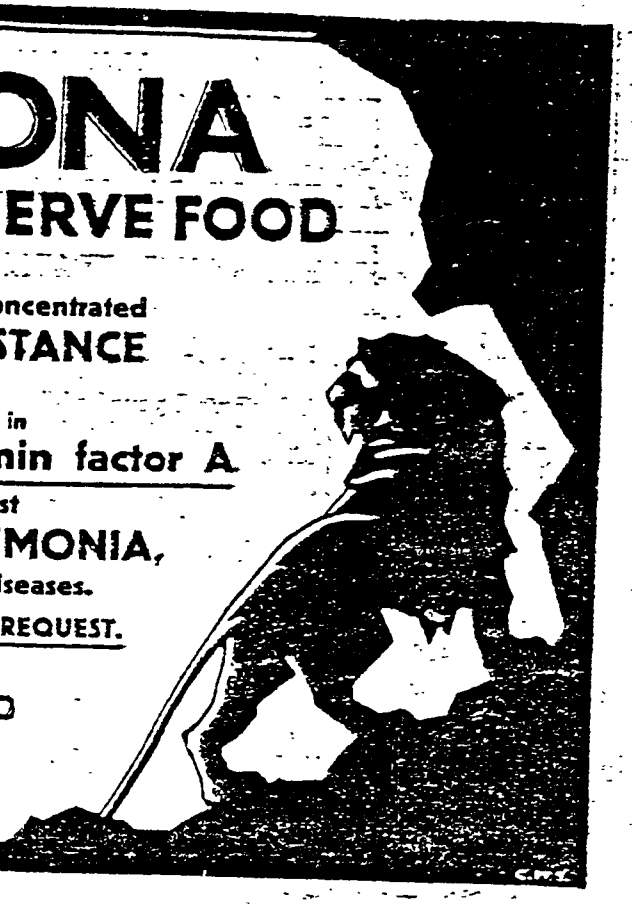
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Local Anæsthesia in Surgical Practice

FRACTURE OF THE RIGHT FEMUR.

Typical Case.

Mrs. S. E. B., aged seventy-one years.

Diagnosis: Supracondyloid T-fracture of the right femur.

Operation: Incision, reduction, and application of screws.

Anæsthesia: Transverse infiltration block.

Technique of Anæsthesia: Infiltration block. Novocain-Adrenaline 180 c.c. The patient was given no preliminary hypodermic medication. She was placed on the extension apparatus, great care being taken to make her as comfortable as possible. She was held in position by applying the extension screws, and the skin was prepared by painting with iodine. The line of incision—25 cm. in length—was infiltrated, each excursion of the needle bringing its point in contact with the femur. An especially large deposit of solution was made just posterior to the bone in the region of the fracture. The bone was exposed and the fragments gently separated by the use of a scalpel and chisel. In the meantime the traction screws were brought into play, and the lower fragments were gradually brought down to the proper level. One long screw and a stove bolt were introduced, after drilling the bones in order to prevent a recurrence of the displacement after operation, the fractured surface being rather oblique. This patient left the table with a pulse of 80; there was no hæmorrhage, no shock, no pain, and she presented no post-operative complications.

—Extract from "PRACTICAL LOCAL ANÆSTHESIA" (Farr.).

Full technique of this and one hundred other operations under local anæsthesia will be found in the above work published by Henry Kimpton, 263, High Holborn, London, W.C.1.

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Also employed with success in hay fever, associated skin affections, angio-neurotic œdema, cyclic vomiting, periodic diarrhœa, and the migraine-epilepsy syndrome; in short, to such conditions as exhibit an anaphylactic character or sensitisation.

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H. E. Seiler, A Case of Pneumoconiosis, British Medical Journal (1928)
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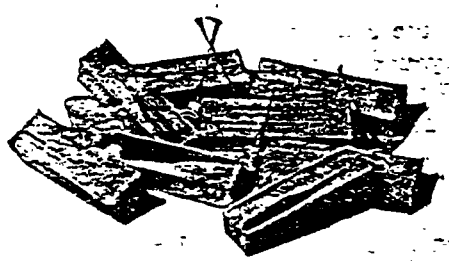
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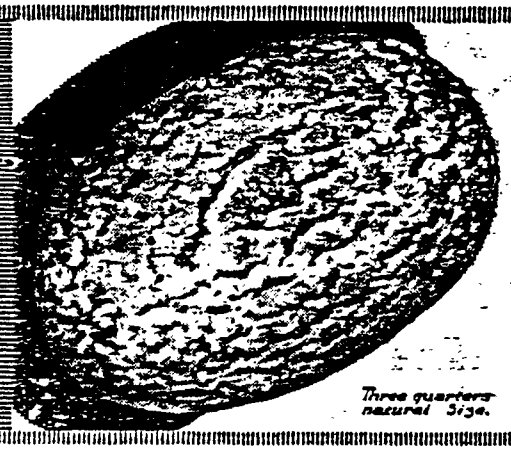
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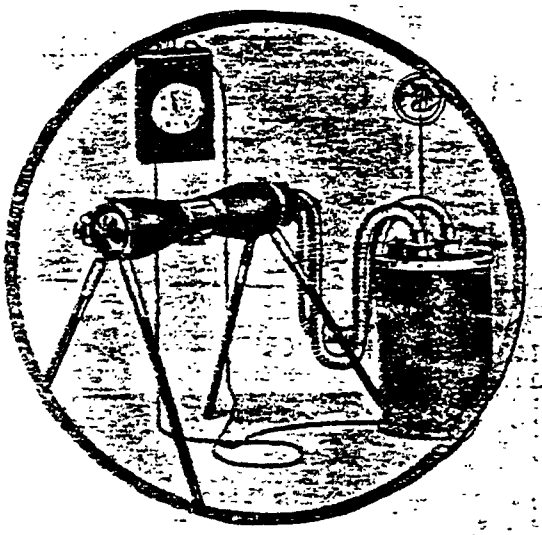
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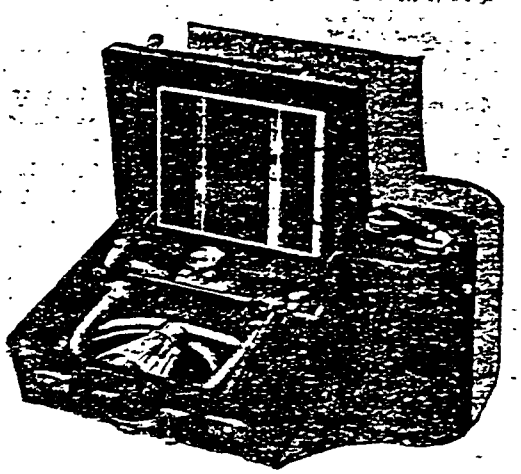
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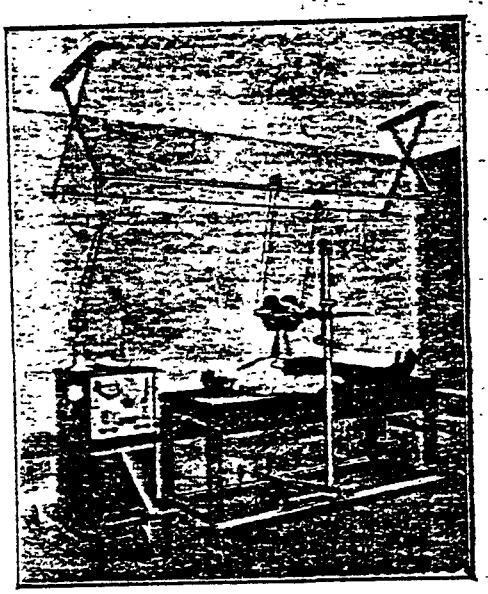


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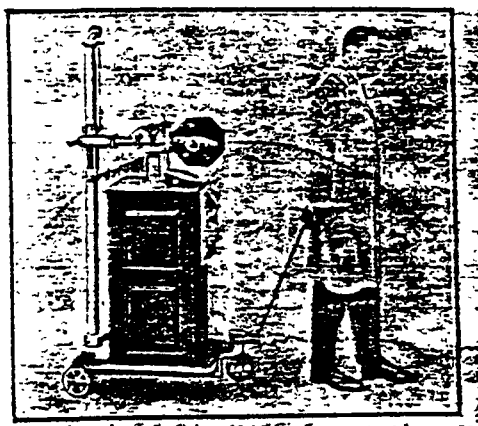
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H. E. Seiler, A Case of Pneumoconiosis, British Medical Journal (1928)
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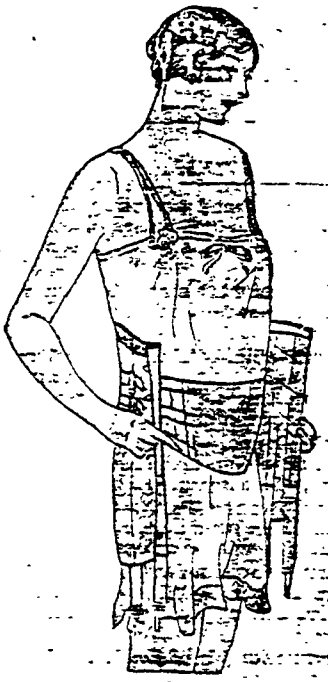
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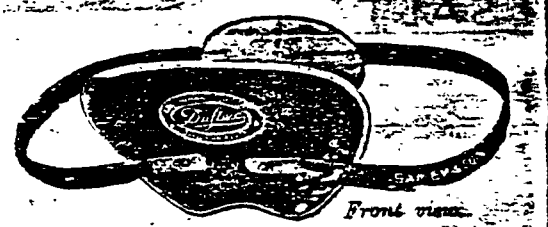
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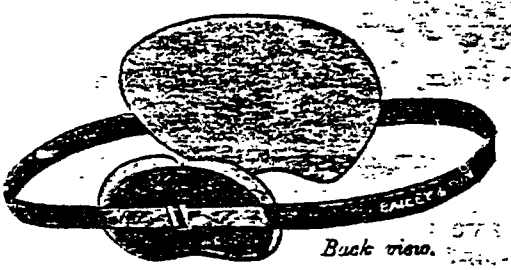
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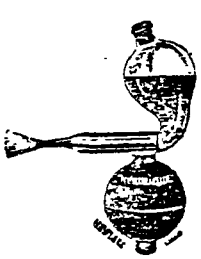
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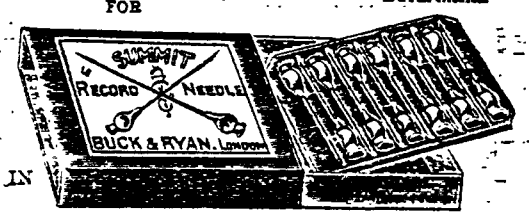
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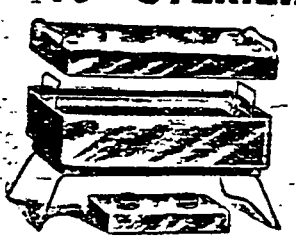


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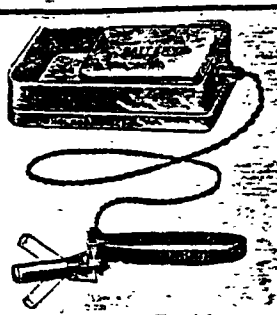
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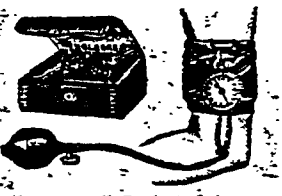
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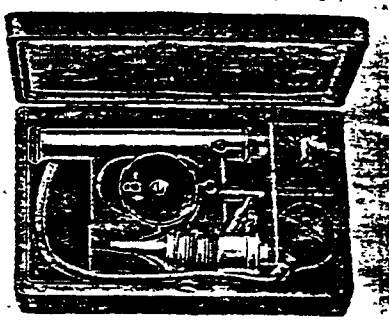
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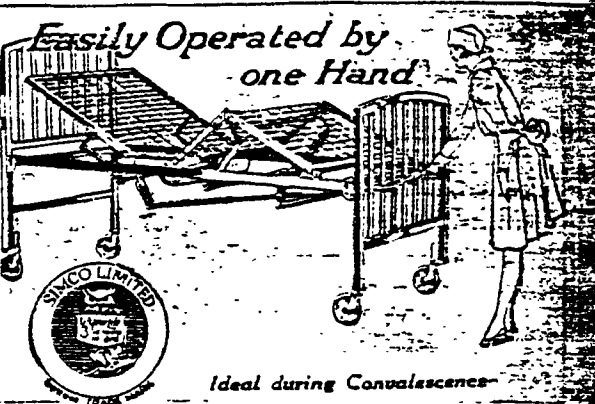
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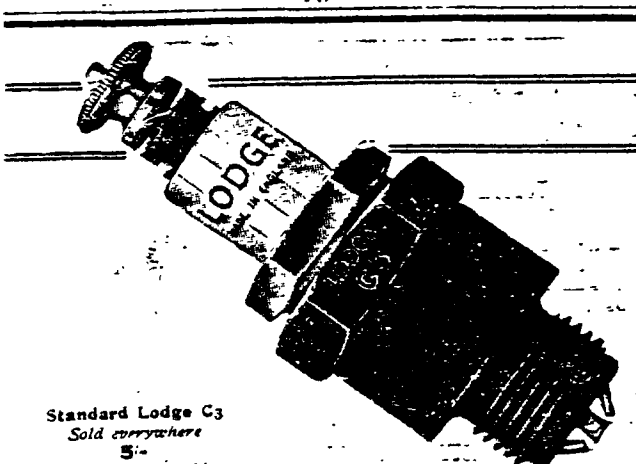
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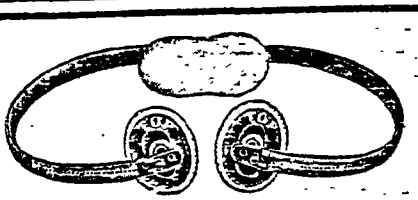
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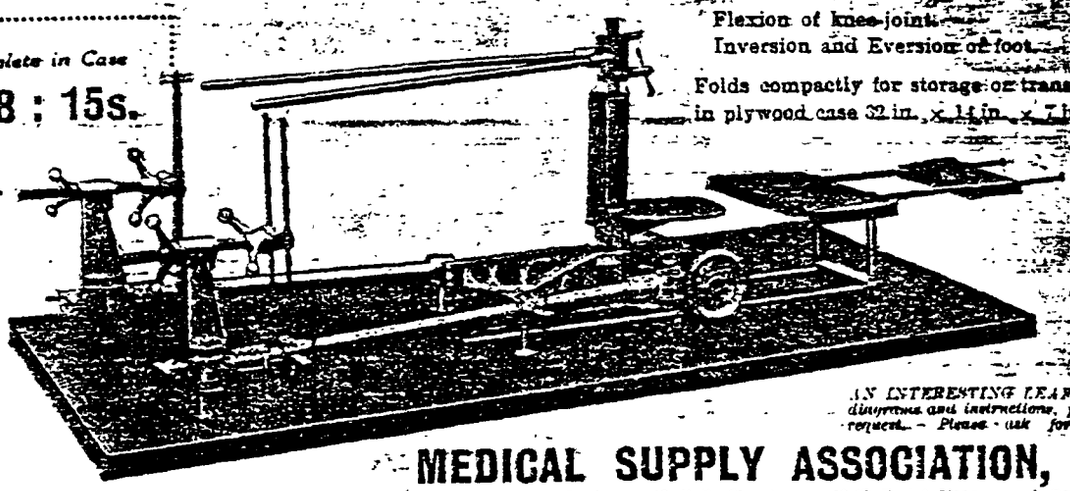
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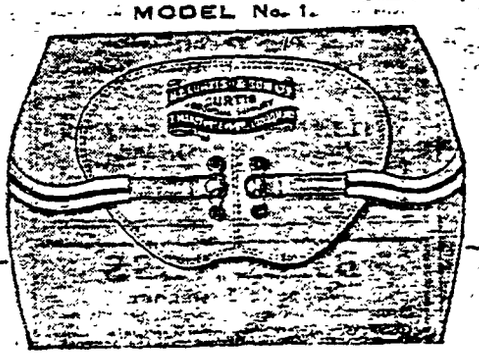
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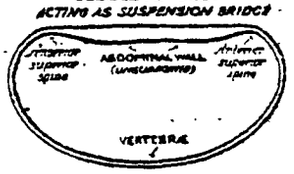
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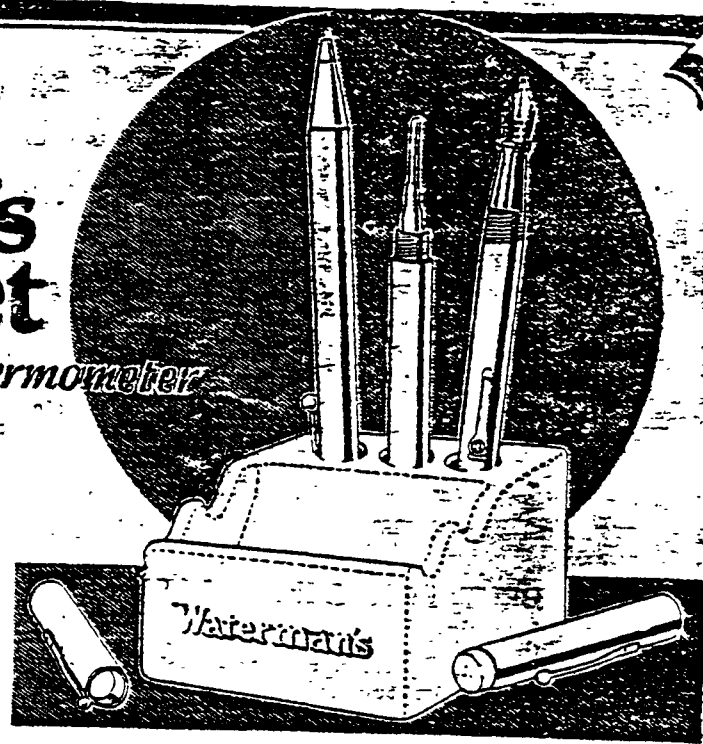
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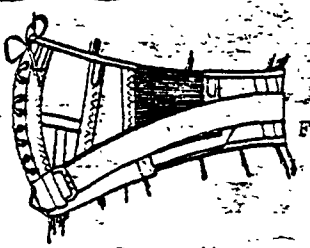
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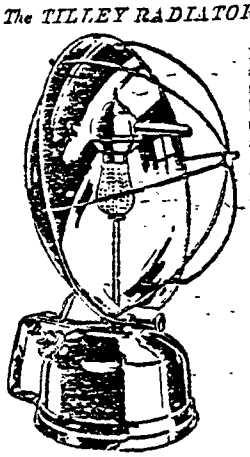
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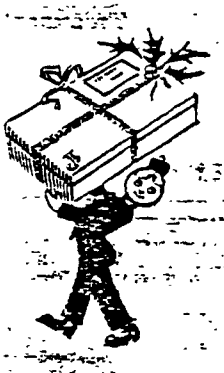


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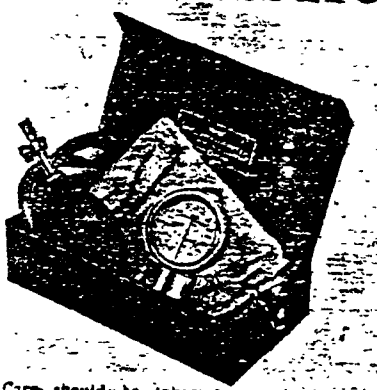
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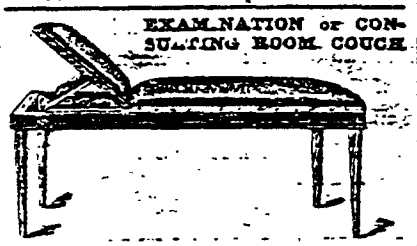
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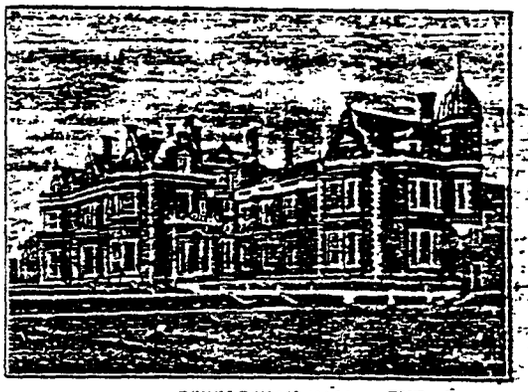
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FOR MENTAL DISORDERS,
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FOR THE UPPER AND MIDDLE CLASSES ONLY.

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Medical Superintendent: DANIEL F. RAMBAUT, M.A., M.D.

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This is a Reception Hospital in detached grounds, with a separate entrance, to which patients and voluntary boarders can be admitted. It is equipped with all the apparatus for the most modern treatment of Mental and Nervous Disorders. It contains special departments for hydrotherapy by various methods, including Turkish and Russian baths; the prolonged immersion bath, Vichy Douche, Scotch Douche, Electrical baths, Piomabières treatment, etc. There is an Operating Theatre, a Dental Surgery, an X-ray Room, an Ultra-violet Apparatus, and a Department for Diathermy and High-Frequency treatment. It also contains Laboratories for biochemical, bacteriological, and pathological research.

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Two miles from the Main Hospital there are several branch establishments and villas situated in a park and farm of 650 acres. Milk, meat, fruit, and vegetables are supplied to the Hospital from the farm, gardens, and orchards of Moulton Park. Occupation therapy is a feature of this branch, and patients are given every facility for occupying themselves in farming, gardening, and fruit-growing.

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The Seaside house of St. Andrew's Hospital is beautifully situated in a Park of 330 acres, at Llanfairfechan, amidst the finest scenery in North Wales. On the North-West side of the Estate a mile of sea coast forms the boundary. Voluntary Boarders or Patients may visit this branch for a short seaside change or for longer periods. The Hospital has its own private bathing house on the seashore. There is trout-fishing in the park.

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For terms and further particulars apply to the Medical Superintendent (Telephone: No. 56 Northampton) who can be seen in London by appointment.

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Telephone and Telegrams: Winterbourne 18.

This beautiful mansion in fifty acres of secluded grounds was built specially for the TREATMENT OF MENTAL ILLNESS. Voluntary boarders and certified patients of both sexes. Thorough clinical, bacteriological, and pathological examinations. *Separate bedrooms.* Private suites. Indoor and outdoor amusements. Wireless and other concerts. Occupational therapy. Physical drill. Garden and dairy produce from farm on the estate. Reasonable terms.

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Situated in park and grounds of 400 acres. Self-supported by its own farm and gardens, in which patients are encouraged to occupy themselves. Every facility for indoor and outdoor recreation. For terms, prospectus, etc., apply MEDICAL SUPERINTENDENT.

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Private Nursing Home for Neurasthenia and allied Functional Nervous Disorders, for general Convalescent Cases, and those requiring Electrical Treatment.

The Home, a Georgian mansion 14 miles from Nottingham and 6 miles from Derby, is for both sexes. In addition to the methods of general medicine, Psycho-Therapeutic treatment is used extensively in suitable cases. Certifiable cases are not received. Electrical Treatment, Radiant Heat, X-ray, Ultra-Violet Light, and Massage is available in the Nursing Home. Billiards, tennis, etc. Fees from 5 to 12 guineas per week. For further particulars apply to—
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Terms include (with rare exceptions) all forms of treatment, for which exceptions a tariff is in existence, there being a staff of consultant specialists and the central laboratory of London County Mental Hospitals being attached to the hospital. Inquiries of EDWARD MAPOTHER, M.D., M.R.C.P., F.R.C.S., Medical Superintendent.

SAINT LUKE'S HOSPITAL
(for Mental Disorders).

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situated in extensive grounds, amidst beautiful country and within easy distance from London, receives a few LADIES requiring treatment for mild Nervous and Mental Disorders.

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A REGISTERED HOSPITAL for the CARE and TREATMENT of LADIES and GENTLEMEN suffering from NERVOUS and MENTAL DISORDERS. Within two miles of the G.W. Railway and L. M. & S. Railway Stations at Gloucester, the Hospital is easily accessible by rail from London and all parts of the United Kingdom. It is beautifully situated at the foot of the Cotswold Hills, and stands in its own grounds of over 280 acres. Voluntary boarders of both sexes are also received for treatment.

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This DIETETIC ESTABLISHMENT is equipped for the complete investigation and treatment of patients on rational lines. Own X-ray and Laboratory. Biochemical investigation is made a special feature.

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Telegrams: Alleviated, London. Telephone: Rodney 4741—4742.

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A PRIVATE HOME for the treatment of patients of both sexes suffering from Mental Illnesses.
Conveniently situated four miles from Charing Cross. Easy of access from all parts.
Six acres of ground, highly situated, facing Finsbury Park.
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FOR THE TREATMENT OF MENTAL DISORDERS.

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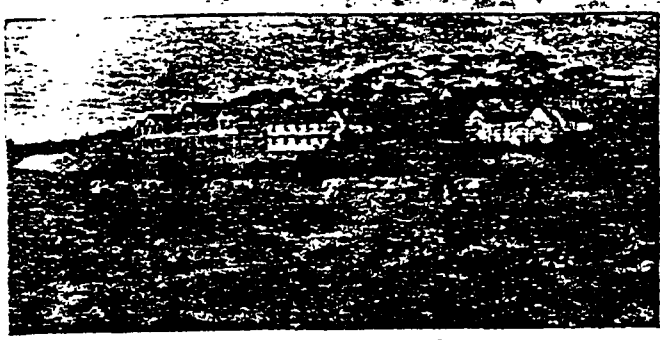
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Full day and night Nursing Staff.
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For full particulars apply to *The Secretary*, Nordrach-upon-Mendip, Blagdon, Bristol. *Telegrams*: Nordrach, Blagdon. *Telephone*: Blagdon 23.

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For particulars apply to the Secretary, Pendyffryn Hall, Penmaenmawr, N. Wales. ('Phone, 20.)

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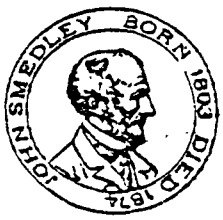
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Prospectus from Secretary. *Tele.* 341.

Resident Physician: W. JOHNSON SMITH, M.D.

Bishopstone House, Bedford.

PRIVATE HOME for MENTALLY AFFLICTED LADIES. Ten only received. Apply, Medical Officer or Mrs. PEELE. *Telephone* 2709.

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PRIVATE PATIENTS are received at a weekly charge of TWO GUINEAS and upwards.

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Large grounds, 400 ft. above sea. HOME for Ladies Mentally afflicted. Voluntary Boarders received. Stations: Brentwood and Shenfield 1 mile. Liverp'l St. 26 min.—Apply, Dr. HAYNES.

Grove House, All Stretton,
Church Stretton, Shropshire.

A Private Home for the care and treatment of a limited number of ladies mentally afflicted. Climate healthy and bracing.

Medical Superintendent: Dr. MCCLINTOCK.

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Medical, Convalescent and permanent patients. Ideal for Rest Cures. Comfort, sunny rooms, large gar., own poultry, veg., etc. Trained staff. 4 to 10 gns. weekly. Tel.: Haslemere 22.

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Unsurpassed situation, 600 ft. above sea-level, high sunshine record, own farm. Resident Medical Officer. Male cases only.

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Artificial Pneumothorax, etc.

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Royal College of Physicians of London.

The next ordinary PROFESSIONAL EXAMINATION for the MEMBERSHIP will commence on Friday, January 18th, 1929.

Candidates are required to give twenty-one days' notice in writing to the Registrar of the College, to whom all certificates and testimonials required by the By-laws must be sent at the same time.

Candidates who propose to submit published work under the Regulations now in force should apply in writing to the Registrar, *without delay*, for detailed instructions as to the procedure they should follow.

Pall Mall East, S.W.1. RAYMOND CRAWFURD, M.D., Registrar.

JOINT NURSING & MIDWIVES' COUNCIL for Northern Ireland.

EXAMINERS FOR MIDWIVES.

The above Council being about to revise their list of Examiners, invite applications from registered medical practitioners, including women, who would be willing to act.

Preference will be given to applicants resident in Northern Ireland.

Particulars on application to the Registrar, 113, Great Victoria Street, Belfast, to whom applications should be sent not later than December 15th.

JOINT NURSING & MIDWIVES' COUNCIL for Northern Ireland.

MEDICAL AND NURSING EXAMINERS FOR THE PRELIMINARY AND FINAL STATE EXAMINATIONS FOR THE GENERAL REGISTER.

The Council invite applications from (*a*) medical practitioners, and (*b*) registered nurses who are willing to act as Examiners.

Subjects: Anatomy, Physiology, Hygiene, Medicine, Surgery, Gynecology, and Nursing.

Preference will be given to applicants resident within reasonable distance of Belfast.

Particulars and application forms obtainable from the Registrar, 113, Great Victoria Street, Belfast, to whom all applications should be sent not later than December 15th.

F.R.C.S.(Edin.).

A TUTORIAL CLASS for the next Examination commences shortly. Particulars from CHARLES WHITTAKER, F.R.C.S., Anatomical Department, Surgeons' Hall, Edinburgh.

Medical and Dental Students.

Special Classes for Pre-Medical and Dental Exams., Matric., and Prelims.

Chemistry, Physics, and Biology Labs.

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Doctor's Widow has vacancy, Consul sent, Mental case, or Chronic invalid lady. Detached house, home life. Trained Nurses. Only four taken. Visiting London specialists. Fees inclusive from 6 gns. —Mrs Dove, Brightside, Crouch End Hill, N.8. 'Phone: Mountview 0038.

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UNIVERSITY EXAMINATION POSTAL INSTITUTION

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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

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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.)

UNIVERSITY OF LONDON. KING'S COLLEGE.

FACULTY OF MEDICAL SCIENCE.

COMPLETE COURSES OF STUDY ARE PROVIDED FOR THE PRELIMINARY AND INTERMEDIATE EXAMINATIONS OF:

(1) The University of London (Medical and Dental);

(2) The Conjoint Board (Medical and Dental);

and also for

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(4) The Primary Fellowship Examination of the Royal College of Surgeons of England.

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Seven Scholarships in Arts and Science, together with many valuable prizes, are awarded annually. In addition, students of the Faculty are eligible to compete for several Research Studentships, Scholarships, and Prizes in other Faculties.

The College has three excellent Hostels providing accommodation and facilities for personal study for a large number of students.

For detailed prospectus of the Medical and Dental Courses and for further information, apply to the Dean, Professor R. J. S. McDOWALL, or to—

S. T. SHOVELTON, M.A., Secretary.

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[illegible] ST., LONG [illegible], W.1. Tel.: Langham [illegible]

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¶ The Surgical Tutors of the College all hold either the M.S.Lond. or F.R.C.S.England, or both, and are highly experienced teachers.

¶ The Postal Courses are thoroughly clear, concise, and up to date, and the test questions are carefully selected from those set at previous Examinations, so as to embrace all parts of the subject. By working systematically through the Course the Student is brought up to the examination standard in the minimum time, and much unnecessary reading is saved.

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DIPLOMA IN PUBLIC HEALTH, &c.

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Assistant Director of Bacteriological Laboratories: E. GOODWIN RAWLINSON, M.D., D.P.H.Oxon.

Assistant Director of Chemical Laboratories: ALAN WEST STEWART, B.Sc., A.I.C., Public Analyst for the County of Berks, Oxford, Paddington, etc.

Lecturers on Public Health, etc.: ALBERT E. THOMAS, M.A., M.D.Oxon., D.P.H.Oxon., Barrister-at-Law, Medical Officer of Health for the Borough of Finsbury; CECIL W. HUTT, M.A., M.D.Camb., M.R.C.P.Lond., D.P.H.Oxon., Lecturer on Public Health, Charing Cross Hospital Medical School, Medical Officer of Health, Metropolitan Borough of Holborn, Examiner for the D.P.H., Conjoint Board of Physicians and Surgeons, London.

The Course of Instruction can be commenced at any time.

The Principal will be pleased to interview intending candidates for the purpose of advice.

Further particulars can be obtained from the Secretary, 37, Russell Square, W.C.1.

Telephone: MUSEUM 0766.

County of London.

A Course of Lectures and Practical Instruction for the DIPLOMA IN PSYCHOLOGICAL MEDICINE (UNIVERSITY OF LONDON) will be held at THE MAUDSLEY HOSPITAL, Denmark Hill, S.E.5.

The Course will begin on January 8th, 1929.

Applications should be made to the Director of the Central Pathological Laboratory, Maudsley Hospital.

MONTAGUE H. COX, Clerk of the London County Council.

F.R.C.S. (Edin.).

The TUTORIAL CLASS for the next Examination will commence shortly. Correspondence tuition if desired. — For particulars apply FRED. GRAHAM, M.D., F.R.C.S.Ed., Surgeons' Hall, Edinburgh.

H. E. Seiler, A Case of Pneumoconiosis, British Medical Journal (1928)
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THE UNIVERSITY OF LIVERPOOL.

FACULTY OF MEDICINE.

THE MEDICAL SCHOOL provides complete courses of instruction for the Examinations of the University of Liverpool, and also meets the requirements of other Universities and Examining Bodies in the United Kingdom.

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Master of Hygiene	M.H.	Licence in Dental Surgery	L.D.S.
Master of Orthopædic Surgery	M.Ch.Orth.	Diploma in Public Health	D.P.H.
Bachelor of Dental Surgery	B.D.S.	Diploma in Tropical Medicine	D.T.M.
Master of Dental Surgery	M.D.S.	Diploma in Tropical Hygiene	D.T.H.
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These Hospitals contain in all about 1,500 Beds.

The organization of these Hospitals to form one teaching Institution provides the Medical Student and Medical Practitioner with a field for clinical education and study which is unrivalled in extent in the United Kingdom.

Infectious Diseases are studied in the Local and District Hospitals, and Mental Diseases at the County Mental Hospital, Rainhill.

For information on all matters concerning the curriculum application should be made to the Dean of the Faculty of Medicine, the University of Liverpool.

W. J. DILLING, Dean.

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CONTINUOUS INSTRUCTION. CLINICAL WORK IN ALL DEPARTMENTS. CLINICAL ASSISTANTSHIPS. SPECIAL ANNUAL MEMBERSHIP TERMS FOR GENERAL PRACTITIONERS. ANÆSTHETIC COURSE.

WINTER SESSION COMMENCES MONDAY, OCTOBER 1st, 1928.

Prospectus from Sir Henry Simson, K.C.V.O., Dean, West London Hospital, Hammersmith, W.6.

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J. & J. PATON, Educational Agents, 143, Cannon Street, London, E.C.4. Tel.: 5053 Central.

LONDON SCHOOL OF DERMATOLOGY,

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For further particulars, fees, etc., apply to A. C. ROXBURGH, M.D., Dean.

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Qualified Medical Women are admitted to The Mothers' Hospital of the Salvation Army, Lower Clapton Road, E.5, for practical fortnightly Courses in Midwifery. These include delivery of normal cases, attendances at all abnormal cases, operations, ward rounds of visiting staff, V.D. clinics, and ante-natal clinics. For further particulars, fees, etc., apply to the Secretary.

F.R.C.S.(Edin.).

Prep. Classes and Museum Demons. for next Fellowship Exam. will commence shortly. Correspondence course for March and later exams. should begin now. Partics., Mr. H. C. OREBY, F.R.C.S., at Surgeons' Hall, Edinburgh.

Preliminary Examinations.

The COLLEGE OF PRECEPTORS holds Preliminary Examinations for Medical and Dental Students in London and at Provincial Centres in March, June, September, and December. For Regulations, apply to the Secretary, College of Preceptors, Bloomsbury Square, London, W.C.1.

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THE MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND, LIMITED.

Secretaries and Registered Office: Millar, Thomson & Dunlop, C.A., 113, St. Vincent Street, Glasgow.

ANNUAL SUBSCRIPTION £1. ENTRANCE FEE 10/-

No entrance fee to those joining within 12 months of obtaining qualification. Benefits include defence of claims for alleged negligence in professional work, including indemnity of £2,500 and costs, and advice on professional difficulties.

Particulars and forms of application can be obtained from the Secretaries at the above address.

Notice of Election.

MIDWIVES (IRELAND) ACT, 1918.

1. Notice is hereby given pursuant to the Midwives (Ireland) Act, 1918, as amended and adapted by the Central Midwives Board Order, 1923, and the Regulations under the said Act, that the Returning Officer will, at the Offices of the Board, 33, St. Stephen's Green, Dublin, on Friday, the 14th day of December now next ensuing, between the hours of 11 a.m. and 5 p.m., proceed to the nomination, and, if there is no opposition, to the election of FOUR MEMBERS of the Central Midwives Board.

Every registered medical practitioner is qualified to be nominated as a candidate.

Each candidate must be nominated by a separate nomination paper.

Every registered medical practitioner resident in Saorstat Eireann is entitled to take part in nominating four candidates, but no more.

Every nomination paper must state the names, address, and qualification or qualifications of the candidate nominated; it must be signed by not less than six registered medical practitioners resident in Saorstat Eireann, as nominating such candidate, and the address and registered qualification or qualifications of each medical practitioner so signing must be appended to his signature.

Every nomination paper must contain a declaration in writing signed by the person nominated, acknowledging that such person consents to be nominated.

2. Forms of nomination paper may be obtained at the Central Midwives Board Offices, 33, St. Stephen's Green, Dublin, between the hours of 11 a.m. and 5 p.m. on any day (not being a Sunday or public holiday) before the said 14th day of December, 1928.

Any application for a nomination paper to be sent by post must be accompanied by a prepaid addressed envelope.

Every nomination paper must be delivered to the Returning Officer by post or otherwise, either at the place above appointed for the purpose between the hours of 11 a.m. and 5 p.m. on the 14th day of December, or at any place at which the Returning Officer may be found at any time on any day before the said 14th day of December, 1928.

In the event of the election being contested, voting papers will be issued to the persons entitled to vote therein as soon as practicable after the said 14th day of December, and the day for the counting of the votes will be the 17th day of January, 1929.

Votes cast by voting papers received by the Returning Officer on or after the said 17th day of January will not be counted.

OLIVE G. MEYLER,
Returning Officer.

City of Liverpool.

FAZAKERLEY SANATORIUM.

ASSISTANT RESIDENT MEDICAL OFFICER.

The Port Sanitary and Hospitals Committee of the Council of the City of Liverpool invite applications for the above office. Salary £250 per annum, together with board, washing, and lodging at the Sanatorium.

The appointment is for a term of not exceeding one year and is not renewable.

Every candidate will be required to possess a registered Medical and Surgical qualification, and should have a knowledge of Bacteriological methods.

The person appointed will not be allowed to engage in private practice, and will be required to devote whole-time service to the duties of the office.

Applications, stating age and qualifications, accompanied by copies of testimonials, to be addressed to the Town Clerk, Municipal Buildings, Liverpool, and delivered not later than Tuesday, December 4th.

Envelopes to be endorsed "Resident Medical Officer."

Town Clerk's Office, Liverpool. WALTER MOON, Town Clerk.
November 20th, 1923.

University of London.

Applications are invited from Graduates of the University of London in Medicine and Surgery for the GEOFFREY DUVEEN TRAVELLING STUDENTSHIP IN OTO-RHINO-LARYNGOLOGY, which is of the value of £450 a year, and is tenable, in the first instance, for one year.

Applications should reach the University on or before December 31st, and must be made on the prescribed form, which may be obtained, together with further particulars, from the Academic Registrar, University of London, South Kensington, S.W.7.

University of London.

A Course of Five Lectures on "*The Role of Bacteria in Nature*" will be given by Mr. F. W. TWORT, M.R.C.S., L.R.C.P. (Superintendent of the Brown Institution), in the Theatre of the ROYAL COLLEGE OF SURGEONS (Lincoln's Inn Fields, W.C.), on DECEMBER 3rd, 5th, 7th, 10th, 12th, 1928, at 4 p.m.

Admission free, without ticket.

EDWIN DELLER, Academic Registrar.

The University of Sheffield.

SENIOR DEMONSTRATORSHIP IN ANATOMY.

The Council are about to appoint a Senior Demonstrator in Anatomy. Salary £400 per annum.

Intending candidates are requested to communicate with the Registrar, from whom particulars can be obtained. Applications must be received by December 11th.

W. M. GIBBONS, Registrar.

Salop County Council.

APPOINTMENT OF COUNTY MEDICAL OFFICER OF HEALTH.

The Salop County Council invite applications for the post of County Medical Officer of Health at a salary of £1,100 per annum, with an annual allowance of £200 for travelling, subsistence, etc., expenses within the County.

The appointment is subject to the provisions of the Local Government, etc., Officers Superannuation Act, 1922, and the candidate selected will be required to pass satisfactorily a medical examination.

Candidates must be duly qualified medical men and hold a Diploma of Public Health, and should preferably have had experience in Public Health administration in a County or County Borough.

Forms of application, with terms of appointment and list of duties, may be obtained from me on receipt of a stamped addressed envelope.

Applications (accompanied by copies of not more than three recent testimonials) must be sent to reach me not later than December 17th.

Canvassing, either directly or indirectly, will disqualify.

ARTHUR AINSLIE JOHNSON,
Clerk, Salop County Council.
Shirehall, Shrewsbury.
November 23rd, 1928.

County Borough of Brighton.

RESIDENT MEDICAL OFFICER at the Borough Infectious Disease Hospital and Sanatorium.

The Council invite applications for the above appointment from duly qualified unmarried medical practitioners.

The salary will be at the rate of £330 per annum, together with board and lodging at the Borough Sanatorium. Preference will be given to candidates entering the Public Health Service.

Forms of application and particulars of the duties to be performed, and of the conditions upon which the appointment will be made, may be obtained on application to the undersigned.

Applications (with copies of three recent testimonials enclosed), endorsed "Application for the Appointment of Resident Medical Officer," must be delivered at my office before 10 o'clock in the forenoon on Monday, December 10th.

Canvassing members of the Council, either directly or indirectly, will disqualify any applicant for the position.

Town Hall, Brighton. JAS. H. ROTHWELL, Town Clerk.
November 19th, 1928.

Shanghai Municipal Council.

PUBLIC HEALTH DEPARTMENT.

ASSISTANT PATHOLOGIST.

An Assistant Pathologist is required in the Public Health Department of the Shanghai Municipal Council.

Candidates, preferably unmarried, should not be more than 30 years of age, and must hold qualifications in Medicine and Surgery of University standard; a D.P.H. and D.T.M. & H., though not essential, are desirable.

Salary, Taels 650 per mensem, under three years' agreement, renewable at a higher salary in the event of satisfactory services. First-class passage is given, with half-pay during voyage.

Eight months' leave is given on full pay, with first-class passage, after every period of five years' service in Shanghai.

Free medical attendance is provided, and there is participation in the benefits of a Superannuation Fund.

A Tael at the present rate of exchange equals about 2/7. Exchange is, however, subject to fluctuation.

Particulars of the appointment, and full details as to the benefits enjoyed by Municipal employees under their Terms of Service, may be obtained from the Council's Agents.

Applications, in candidates' own handwriting, with full information as to their qualifications and experience, etc., accompanied by at least three recent testimonials, and endorsed "Assistant Pathologist" on the cover, should be forwarded to JOHN POOK & Co., Agents for the Municipal Council of Shanghai, 63, Fenchurch Street, London, E.C.3.

November, 1928.

Shanghai Municipal Council.

PUBLIC HEALTH DEPARTMENT.

ASSISTANT RADIOLOGIST.

An Assistant Radiologist is required in the Public Health Department of the Shanghai Municipal Council.

Candidates should be not more than 35 years of age, and must have Medical and Surgical qualifications of University standard.

A thorough knowledge of General X-ray Diagnosis and experience in Deep Therapy and Electro-therapy is required.

The possession of the Cambridge Diploma in Medical Radiology and Electrology, or its equivalent, would be a recommendation.

Salary, Taels 700 a month (equivalent at the present rate of exchange (one Tael equals 2/7) to £1,085 a year), with passage paid, participation in Superannuation Fund, and eight months' leave on full pay, with passage paid, every five years.

Agreement is for three years, and is renewable at an increased salary.

Private practice is not permitted.

Particulars of the appointment, and also full details as to the benefits enjoyed by Municipal employees under their Terms of Service, may be obtained from the Council's Agents; and applications, with full information as to experience, etc., accompanied by recent testimonials, should be forwarded to Messrs. JOHN POOK & Co., Agents for the Municipal Council of Shanghai, 63, Fenchurch Street, London, E.C.3.

November, 1928.

Newcastle Throat, Nose, and Ear HOSPITAL.

VACANCY FOR HON. ASSISTANT SURGEON AND ANÆSTHETIST.

A vacancy amongst the Hon. Assistant Surgeons and Anæsthetists of the above Hospital having been declared, the Committee will proceed to the election of one Assistant Surgeon and Anæsthetist to fill the vacancy after the expiration of ten days from the date hereof.

Candidates shall be registered Graduates in Surgery of any University recognized by the General Medical Council of Great Britain, or shall be a registered Fellow, Member, or Licentiate of one of the Royal Colleges of the United Kingdom.

Application for the appointment must be sent in writing to the undersigned within the time specified above.

2, Saville Place, Newcastle-upon-Tyne. ALFRED J. SPARE, Hon. Secretary.
December 1st, 1928.

H. E. Seiler, A Case of Pneumoconiosis, British Medical Journal (1928)
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WEST AFRICAN MEDICAL STAFF

VACANCIES exist for MEDICAL OFFICERS and MEDICAL OFFICERS OF HEALTH in the BRITISH WEST AFRICAN COLONIES.

SALARIES.

Medical Officers receive salaries at the rate of £660 a year, rising by annual increments of £30 to £720 a year, and then on confirmation £720 a year, rising by annual increments of £40 to £960 a year, together with a seniority allowance (payable only in West Africa) at the rate of £72 a year. After three years' service on £960, the salary may be raised to the scale of £1,000 a year, rising by annual increments of £50 to £1,150 a year, together with a seniority allowance at the rate of £100 a year.

Medical Officers of Health receive salary on the above scale beginning at £800 a year, together with seniority allowance of £72 a year. They also draw staff pay at the rate of £150 a year, half of which is payable during leave.

QUARTERS.

Free furnished quarters are provided or an allowance in lieu.

OUTFIT ALLOWANCE.

An outfit allowance of £60 is granted on first appointment.

PASSAGES.

Free first-class passages are provided on first appointment, and when proceeding on or returning from leave.

PENSIONS.

All appointments are pensionable; a minimum service of seven years is required to qualify for a pension. An officer may retire on reaching the age of 50 and may be called upon to retire at the age of 55. Officers of the West African Medical Staff are permitted to retire if they wish with a gratuity of £1,000 or £1,250 after nine or twelve years' approved service respectively, but in that event they receive no pension.

TOURS OF SERVICE AND LEAVE.

A tour of service in West Africa lasts from twelve to eighteen months at the discretion of the Colonial Government, and is followed by leave at the rate of one week for each completed month of residential service. Leave begins on the date of arrival in England.

PROMOTION.

There are good prospects of promotion in the West African Medical Staff.

COURSE OF INSTRUCTION.

Selected candidates are required to attend courses of instruction in tropical medicine and hygiene at either the London School of Hygiene and Tropical Medicine or the Liverpool School of Tropical Medicine or the University of Edinburgh.

Further information regarding the conditions of service, pensions, etc., may be obtained from the Private Secretary (Appointments), Colonial Office, 2, Richmond Terrace, Whitehall, London, S.W.1, to whom applications should also be addressed.

H. E. Seiler, A Case of Pneumoconiosis, British Medical Journal (1928)
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Birmingham Union.

SELLY OAK HOSPITAL.

CASUALTY OFFICER (Male).

Applications are invited from fully qualified medical practitioners for the appointment of Casualty Officer (male) at the Selly Oak Hospital, Birmingham.

The present Hospital accommodation is 500 beds, divided into General Medical, General Surgical, Gynæcological, Obstetrical, Children's and Infectious sections. There is a completely equipped Pathological Laboratory, also X-ray, Electro-therapeutic, Massage, and Sunlight Departments. Over 2,500 operations are performed annually.

The appointment will be for a period of six months in the first instance, but may be extended at the end of that time.

The person appointed will be required to assist at operations, administer anæsthetics, and undertake casualty work, and 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.

The salary attached to the appointment is at the rate of £200 per annum, together with full residential emoluments (rations, apartments, laundry, and attendance).

A deduction of 2 per cent. will be made from the salary and value of emoluments under the provisions of the Poor Law Officers Superannuation Act, 1896, and for this purpose the emoluments are valued at £200 per annum.

Further particulars of the appointment may be obtained from the Medical Superintendent, Mr. R. P. STANLEY KELMAN, M.B., F.R.C.S. (Eng. & Edin.), at the Selly Oak Hospital.

Applications, stating age, experience, and qualifications, accompanied by copies of recent testimonials, must be forwarded so as to reach me not later than Tuesday, December 11th.

Union Offices, Edmund St., Birmingham. C. P. BEECH, Clerk to the Guardians.
Nov. 24th, 1928.

Holborn Union, London.

TO MEDICAL PRACTITIONERS.

The Guardians of the Poor of the Holborn Union require the services of two medical practitioners: one as DISTRICT MEDICAL OFFICER for the South Clerkenwell District, and the other as VACCINATOR for the Holborn Eastern District of the Union. The salary for the office of District Medical Officer is £120 per annum, subject to deductions under the provisions of the Poor Law Officers Superannuation Act, 1896; the fees receivable as Public Vaccinator amount approximately to £50 per annum.

The gentlemen to be appointed must reside within the respective Districts or so contiguous thereto as to occasion no inconvenience in the performance of the duties. The District Medical Officer will be required to attend at the Administrative Offices, 53, Clerkenwell Rd., E.C.1, one hour each day—viz., from 10 o'clock to 11 o'clock a.m. He will also have to visit applicants for medical relief at their houses at any hour on receipt of a Relieving Officer's Order.

All medicines, etc., are provided by the Guardians.

Applications, stating qualifications and full particulars, should be made in the form of a letter, accompanied by not more than three testimonials, addressed to the undersigned, not later than noon on Tuesday, December 11th.

Selected candidates will have notice when to attend before the Guardians.

By Order,
CHAS. J. CROSS, Clerk to the Guardians.
Administrative Offices, 53, Clerkenwell Road, E.C.1.
November 22nd, 1928.

Burgh of Motherwell and Wishaw.

ASSISTANT TUBERCULOSIS OFFICER and ASSISTANT MEDICAL OFFICER OF HEALTH.

Applications are invited from duly registered medical practitioners (male) holding the Diploma of Public Health and with experience of Tuberculosis work for the post of Assistant Medical Officer of Health and Resident Tuberculosis Officer in the Tuberculosis Hospital, Wishaw. Salary £400 per annum, increasing by annual increments of £25 to £300 per annum, with board and residence in the Tuberculosis Hospital, Wishaw.

The duties will be whole-time and under the direction of the Medical Officer of Health, and will be mainly those of executive tuberculosis work. The person appointed will also undertake general public health work when required.

Applications, stating age, qualifications, and experience, with copies of testimonials, not exceeding three in number, to be lodged with the Subscriber on or before December 8th.

Town Hall, Motherwell. A. C. STEWART, Town Clerk.
November 14th, 1928.

Salford Royal Hospital.

Applications are invited for the following vacancies which will occur in the Resident Medical Staff (male) on December 31st next:

RESIDENT SURGICAL OFFICER. Salary at the rate of £200 per annum.

HOUSE PHYSICIAN. Salary at the rate of £125 per annum.

HOUSE SURGEON (attached to the Genito-Urinary Department). Salary at the rate of £125 per annum.

HOUSE SURGEON to Gynæcological, Aural and Skin Departments. Salary at the rate of £125 per annum.

CASUALTY HOUSE SURGEON. Salary at the rate of £125 per annum.

The appointments, except the Resident Surgical Officer, which is for twelve months, are for a period of six months, 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.
November 26th, 1928.

City and County of Bristol.

ASSISTANT RESIDENT MEDICAL OFFICER.

The Bristol Health Committee invite applications for the post of Male Assistant Resident Medical Officer, Ham Green Fever Hospital and Sanatorium. The appointment is for one year. Salary £300 per annum, with board, residence, and attendance.

Candidates should have held a resident appointment in a general hospital, and possess some knowledge of bacteriological work.

The salary will be subject to a percentage deduction in accordance with the provisions of the Local Government and Other Officers Superannuation Act, 1922, and the selected candidate must undergo medical examination.

Canvassing members of the Council will disqualify.

Applications by December 10th, with copies of three recent testimonials, to the Medical Officer of Health, Public Health Offices, 40, Prince Street, Bristol.

Ancoats Hospital, Manchester.

REGISTRARS REQUIRED.

ORTHOPÆDIC REGISTRAR required to attend Tuesday afternoons and Thursday mornings in the Out-patient Clinics and to assist the Honorary Orthopædic Surgeon. A small honorarium is allowed. Appointment for 12 months from January 1st next.

MEDICAL REGISTRAR required to assist in the Out-patient Department Medical Clinics, held each morning excepting Saturday and Sunday. Honorarium at the rate of £100 per annum. Appointment for 12 months from January 1st next.

Applications for the above vacancies to be forwarded to the undersigned on or before December 12th next, stating age, experience, qualifications, etc., together with copies of three recent testimonials.

By Order of the Board.
HERBERT J. DAFFORNE, Gen. Supt. & Secretary.

Bedfordshire Education Committee.

SCHOOL DENTIST.

Applications are invited from qualified Dentists for the post of Senior School Dentist. The salary will be £300 per annum, with approved travelling expenses, and the person appointed will be required to devote the whole of his time to the duties of the office.

Applications, stating age and qualifications, accompanied by not more than three recent testimonials, should be sent to the undersigned, endorsed "Senior School Dentist," not later than December 6th next.

Shire Hall, Bedford. J. B. GRAHAM, Clerk of the County Council.
Nov. 23rd, 1928.

Addenbrooke's Hospital, Cambridge.

Applications are invited for the post of HOUSE SURGEON (male). The appointment is tenable for six months from January 1st, 1929, but is terminable at an earlier date by one month's written notice on either side. Salary at the rate of £130 per annum, with board, residence, and laundry. Candidates, who must be unmarried and duly registered, are requested to forward their applications, stating age, qualifications, etc., together with copies of not more than four recent testimonials, on or before Monday, December 17th.

W. H. HEAD, Secretary-Superintendent.

Seamen's Hospital Society.

The Committee of Management invite applications for the appointment of MEDICAL SUPERINTENDENT at the TILBURY HOSPITAL (90 beds). The appointment will be for one year from January 1st, 1929, at a salary of £250 per annum, with board, residence, and laundry. The holder will be eligible for re-election for a second year.

Candidates must not be more than 38 years of age, and preference will be given to those who have had some surgical experience.

Applications, stating age, with copies of not more than three recent testimonials, to be sent in on or before Monday, December 10th, to the undersigned, from whom further particulars can be obtained.

R. E. V. BAX, Secretary.
Dreadnought Hospital, Greenwich, S.E.10.
November 26th, 1928.

Seamen's Hospital Society.

The Committee of Management invite applications for the appointment of MEDICAL SUPERINTENDENT at the Dreadnought Hospital, Greenwich, from January 1st, 1929.

The appointment will be for one year at a salary of £300 per annum, with board, residence, and laundry. The holder will be eligible for re-election for a second year at a salary of £330, and thereafter at a salary of £400.

Applications, stating age, with copies of not more than three recent testimonials, to be sent in on or before Monday, December 10th, to the undersigned, from whom further particulars can be obtained.

R. E. V. BAX, Secretary.
Dreadnought Hospital, Greenwich, S.E.10.
November, 1928.

Seamen's Hospital Society.

The Committee of Management invite applications for the appointment of ASSISTANT PATHOLOGIST in the Pathological Department of the London School of Clinical Medicine, at the Dreadnought Hospital, Greenwich, from January 1st, 1929.

The appointment will be for one year at a salary of £350 per annum. The holder will be eligible for re-election for a second year.

Applications, stating age and experience, with copies of not more than three recent testimonials, to be sent in on or before Tuesday, December 4th, to the undersigned, from whom further particulars can be obtained.

R. E. V. BAX, Secretary.
Seamen's Hospital, Greenwich, S.E.10.

Seamen's Hospital Society, Greenwich, S.E.

HOUSE PHYSICIAN and HOUSE SURGEON required at Dreadnought Hospital, Greenwich, for six months from January 1st, 1929. Salary £110 per annum, and a proportion of fees, with board, residence, and washing. Candidates must be male. Applications, with copies of three testimonials, to be sent in by December 12th to the undersigned.

R. E. V. BAX, Secretary.
Greenwich.
November 22nd, 1928.

Seamen's Hospital Society, Greenwich, S.E.

RESIDENT MEDICAL OFFICER required at Albert Dock Hospital, Connaught Road, E.16, for six months from January 1st, 1929. Salary £110 per annum, and a proportion of fees, with board, residence, and washing. Candidates must be male. Applications, with copies of three testimonials, to be sent in by December 5th to the undersigned.

R. E. V. BAX, Secretary.
Greenwich.
November 22nd, 1928.

Applications are invited for the post of RESIDENT MEDICAL OFFICER, JUNIOR (male) at the DUMFRIES & GALLOWAY ROYAL INFIRMARY. The Institution, which contains over 100 beds, is one of the premier Provincial Hospitals in Scotland, and offers exceptional opportunities of gaining experience in all branches of the profession. Period of engagement—fourteen months from February 1st. Salary £100 per annum.

Applications, with testimonials, to be forwarded to the Treasurer, Dumfries & Galloway Royal Infirmary, 34, Irish Street, Dumfries, by December 10th.

Clinical Pathologist.—Man, single, fully qualified and registered. Well-equipped laboratories and other facilities for original work. Salary £400 (or £450 with Diploma in Psychiatry), increasing £20 yearly to £700, with board, lodging, laundry, and attendance, or £100 in lieu of these emoluments should the man appointed eventually live out. No deductions from salary for pension or other purposes. Appointment terminable on three months' notice. Apply in writing to Physician-Supt. CRICHTON ROYAL MENTAL HOSPITAL, Dumfries.

H. E. Seiler, A Case of Pneumoconiosis, 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.

Town or District.	Town or District.	Town or District.
CONTRACT PRACTICE.	**CONTRACT PRACTICE** (*Contd.*)	**PUBLIC HEALTH** (*continued*).
EBBW VALE, MON. (*Workmen's Medical Society.*)	OAKDALE, MON. (*Medical Officer for Medical Aid Association.*)	GLASGOW EDUCATION AUTHORITY. (*Male Assistant Medical Officer.*)
GILFACH GOCH, GLAMORGAN. (*Workmen's Medical Scheme.*)	OGMORE VALLEY, GLAMORGAN. (*Wyndham Colliery Medical Aid Society.*) (*Workmen's Medical Scheme.*)	LEEDS EDUCATION COMMITTEE. (*Assistant School Medical Officer.*)
LLWYNYPIA, CLYDACH VALE, PENYGRAIG, GLAMORGAN. (*Workmen's Medical Scheme.*)	**PUBLIC HEALTH.**	SURREY ADMINISTRATIVE COUNTY. (*County Medical Officer of Health.*)
MARDY, GLAMORGAN. (*Workmen's Medical Scheme.*)	CORNWALL EDUCATION COMMITTEE. (*Assistant School Medical Officer—Female.*)	YORKSHIRE NORTH RIDING COUNTY COUNCIL EDUCATION COMMITTEE. (*Assistant School Medical Officer.*)
NEATH AND DISTRICT. (*Medical Aid Association.*)	FIFE COUNTY COUNCIL. (*Assistant Tuberculosis Officer and Assistant Medical Officer of Health.*)	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.

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 Ladye 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. G. F. V. ANSON (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. November 23th, 1928.

By Order of the Council of the British Medical Association.
ALFRED COX, Medical Secretary.

General Infirmary, Salisbury.
(142 Beds.)

The Committee of Management desires to appoint a PATHOLOGIST to the above General Hospital, and invite applications for the post. Laboratory, equipment, and materials are provided. The Committee guarantees emoluments up to £1,000 per annum. The successful candidate shall undertake all the pathological work of the Hospital, and will be allowed to do pathological work for private practitioners and Public Bodies. (It is estimated that work to the value of £300 per annum can be obtained from the latter.) He will be required to provide an Assistant, who shall be approved by the Committee, in order that continuity of service shall be assured. Applications should be sent not later than December 17th to the House Governor and Secretary, from whom further particulars can be obtained.

Derbyshire Royal Infirmary, DERBY.
(General Hospital, 338 Beds.)

Applications are invited for the posts of:
HOUSE SURGEON, General Surgery and Gynecology.
HOUSE SURGEON, General Surgery.
Candidates must be qualified and registered under the Medical Acts.
The appointments are tenable for 12 months, with a possibility of extension for a further period of 12 months. Salary will be £150 per annum, with apartments, board, etc.
Applications, with copies of not more than five testimonials, to be sent to the undersigned not later than December 14th.
WALTER BANKS,
November 30th, 1928. Supt. & Secretary.

Dorset Mental Hospital, HERRISON, DORCHESTER.

JUNIOR ASSISTANT MEDICAL OFFICER.

Applications are invited from candidates 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. Excellent laboratory facilities exist, with skilled assistance for research and clinical medicine. (960 beds).
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 at once.
November 19th, 1928.

Taunton and Somerset Hospital.
(104 Beds.)

JUNIOR HOUSE MEDICAL OFFICER (male) required. Candidates must be registered. Appointment for six calendar months. Salary at the rate of £100 per annum, with board, residence, and laundry.
Applications, with testimonials, to—
F. J. J. STACEY,
Taunton. Secretary.

Eccles & Patricroft Hospital, PATRICROFT, Near MANCHESTER.

SECOND HOUSE SURGEON (male) required. Salary attached to appointment £100, plus board, residence, laundry. Applications, stating age, qualifications (hospital experience preferred), accompanied by testimonials, should be addressed to the Secretary.

St. Peter's Hospital for Stone, ETC.,
Henrietta Street, Covent Garden, W.C.2.

CLINICAL ASSISTANTS are required by the following members of the Honorary Staff, who attend the Out-patient Department as indicated:

Mr. Swift Joly	Mondays 3 to 5 p.m.
Mr. Clifford Morson	Saturdays 2 to 7 p.m.
Mr. Barrington	Tuesdays 2 to 5 p.m. Thursdays 3 to 7 p.m.
Mr. Ogier Ward	Wednesdays 3 to 6 p.m. Fridays 2 to 3 p.m. (Women and Children)
Mr. Alban Andrews	Mondays 3 to 7 p.m. Fridays 5 to 7 p.m.

Appointments are for six months from January 1st, 1929, a fee of five guineas being payable to the Hospital.
Applications will be received by the undersigned up to the first post on Wednesday, December 5th.
BEECHEY ROGERS, Secretary.

Yorkshire Children's Orthopædic HOSPITAL, KIRBYMOORSIDE.

Wanted, HOUSE SURGEON. Salary at £150 per annum, with furnished quarters, board, and laundry.
Applications, with three copies of testimonials, to be sent immediately to the Surgical Supt.

Applications are invited for the post of JUNIOR HOUSE SURGEON. Salary £100 per annum. Duties to commence January 1st next. Applications, with testimonials, to be sent to the Secretary, BUCHANAN HOSPITAL, ST. LEONARDS, immediately.

H. E. Seiler, A Case of Pneumoconiosis, British Medical Journal (1928)
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ELLIOTT, SON & BOYTON
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are the BEST LOCAL AGENTS for HOUSES and CONSULTING ROOMS in the Harley, Wimpole, Queen Anne, and other Streets in the Cavendish Square district. Valuations for all purposes.
Telephone: 3204 MAYFAIR.

Dentist.—Surgery and living ACCOMMODATION to let in doctor's house. Densely populated working-class district, main road. S.E. district.—Address, No. 6883, B.M.A. House, Tavistock Square, W.C.

GROSVENOR HOUSE, PARK LANE, W.1.
TO CONSULTING SURGEONS.
Furnished Consulting Room for morning appointments, together with use of waiting room, dressing room, and services of Receptionist. Moderate inclusive rental. Buildings comprise luxurious Service Flats and Hotel. — Full particulars from Messrs. KNIGHT, FRANK & RUTLEY, 20, Hanover Sq., W.1.

For Sale or to Let, Cambridge House, 103, Fortess Road, N.W.5.—CORNER HOUSE, eleven rooms, main road. Front and side entrances. Large doors to yard admit motor cars. Been doctors' continuous residence 45 years. Vacant December 25th next. Excellent position and opportunity.—Apply Owner, FOXTON, Skirlaugh, near Hull.

Good opening for Doctor.—House FOR SALE, nearing completion, with garage, and 4 bedrooms, etc., in Doncaster. Position unique, in new residential district, and near new housing scheme. Price £775.—Apply E. WATERTON, Builder, Askern.

Harley Street. — Exceptionally attractive CONSULTING SUITE available in one of the best houses in this street, adjoining Cavendish Square. Immediate inspection recommended by BEDFORD & CO., 10, Wigmore Street, W.1.

In Queen's Gate.—Waiting and CONSULTING ROOMS, fitted with electric static machine, etc. Bedroom or suite available with service. Also saloon car. — 'Phone: Kensington 4221.

Radiologist in Harley Street district wishes to SHARE ROOM, with USE OF APPARATUS—Deep Therapy and Transformer Set.—Address, No. 6853, B.M.A. House, Tavistock Square, W.C.1.

Southampton. — For Sale, free-hold, CORNER PROPERTY in rapidly growing district where good practice could quickly be worked up. Ample scope for G.P.—Further details from the Agents: BLAKE & LANE, Southampton.

Wimbledon.—Freehold Corner BUILDING PLOT, 69 feet frontage, TO BE SOLD AT £500. Close to All England Tennis Courts, in rapidly expanding neighbourhood of high-class houses. Unique opportunity for medical man.—Write, OWNER, c/o THE CLUB GAZETTE, 151, Fleet Street, London, E.C.4.

HOSPITAL VACANCIES.

North Devon Infirmary, BARNSTAPLE.

Wanted, December 27th, duly qualified HOUSE SURGEON, gentleman. Salary £150 per annum, with board, apartments, and laundry. Appointment to be for not less than six months.

Applications, stating age, qualifications, with copies of testimonials, to be sent in on or before Saturday, December 8th, addressed Hon. Secretary.

Bootle Borough Hospital.

APPOINTMENT OF HONORARY OPHTHALMIC SURGEON.

Applications are invited for the above vacancy. Candidates are requested to send particulars of their qualifications and experience, accompanied by testimonials, addressed to the Secretary, Bootle Borough Hospital, Derby Road, near Liverpool, not later than Saturday, December 8th.

Royal Cornwall Infirmary, TRURO. (70 Beds.)

HOUSE SURGEON required with experience of X-ray work and Anæsthetics. Salary £170 per annum, rooms, board, and washing. Apply, with copies of three recent testimonials, to the Secretary, of whom further particulars may be obtained.

City and County of Kingston-upon-Hull.

RESIDENT MEDICAL OFFICER.

The Corporation of Hull invite applications from unmarried male registered medical practitioners, under the age of 40 years, for the appointment of Resident Medical Officer at the TUBERCULOSIS SANATORIUM, CUTTINGHAM, E. YORKS.

Salary £485 per annum, together with board, washing, and residence, at the Sanatorium. The appointment is subject to the provisions of the Local Government and Other Officers Superannuation Act, 1922.

Applicants must have held a resident post in a General Hospital and have had, in addition, practical experience in the treatment of Tuberculosis. The successful applicant will be required to devote the whole of his time to the duties of the appointment, which will include attendance, when required, at the Municipal Tuberculosis Dispensaries.

Candidates must have had experience in the working of an X-ray installation.

Particulars of the duties and forms of application may be obtained from the undersigned.

Completed applications (in envelope endorsed "Resident Medical Officer"), together with copies of three recent testimonials, must be received not later than the first post on Wednesday, December 12th.

Guildhall, Hull. W. ALLEN DALEY, Medical Officer of Health.
November 27th, 1928.

Prison Medical Service.

Applications are invited for the post of MEDICAL OFFICER, Class II, in the above Service. Salary £350, rising by £20 per annum to £600, with quarters, or an allowance in lieu. The pay is subject to a bonus, which at present on a salary of £330 is £125 14s. These posts are pensionable, and there are prospects of promotion to higher rank.

Candidates must be fully qualified and registered. Preference will be given to those who have held House appointments, have had experience in Lunacy and Psychological methods, and are under the age of 30. Forms of application can be obtained from the Secretary, Prison Commission, Home Office, London, S.W.1.

East Ham Memorial Hospital, Shrewsbury Road, E.7.

The New Hospital containing 100 beds will be opened for the reception of patients on January 1st next, and the Management Committee invite applications (male) for:

1. RESIDENT MEDICAL OFFICER.
2. RESIDENT HOUSE PHYSICIAN AND CASUALTY OFFICER.

The appointments are for six months, with salaries at the rate of £150 p.a. and £100 p.a. respectively, with board, residence, and laundry. Applications, stating age, experience, and full particulars, together with copies of testimonials, are to be in the hands of the Secretary by 10 a.m. on Wednesday, Dec 12th.

Metropolitan Hospital, Kingsland Road, London, E.8.

The Committee of Management are prepared to receive applications for the appointment of an ASSISTANT SURGEON.

Candidates must be Fellows of the Royal College of Surgeons of London, and not engaged in general practice.

There are fifteen members of the Medical Staff upon whom candidates will be required to call, and to each must be sent a copy of application and testimonials.

A list of the Staff and further particulars will be furnished upon application to the undersigned.

Applications should be received not later than first post on December 15th.

HERBERT F. RUTHERFORD,
Secretary & House Governor.

Metropolitan Hospital, Kingsland Road, London, E.8.

RESIDENT CASUALTY OFFICER, male, required until April 30th, 1929, to fill a vacancy occurring unexpectedly. Salary at the rate of £100 per annum. Candidates must possess a registered Medical and Surgical qualification of the United Kingdom.

Applications, with copies of three recent testimonials, and a certificate of ability to administer anæsthetics, should be sent to the undersigned forthwith.

HERBERT F. RUTHERFORD,
Secretary & House Governor.

Darlington General Hospital. (120 Beds.)

Wanted, JUNIOR HOUSE SURGEON, male, fully qualified, British nationality. Salary £125 per annum, board and residence. Applications, with copies of two recent testimonials, to be sent to me forthwith.

G. H. SHARPE, Hon. Secretary.

The Hospital for Sick Children, Great Ormond Street, London, W.C.1.

There will be a Meeting of the Joint Committee on Wednesday, December 19th, to elect an ANÆSTHETIST.

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, December 17th, 1928.

Candidates must be registered medical practitioners and be prepared to take up the duties of the appointment on January 1st, 1929.

The successful candidate will be appointed for a period of one year, and will be eligible for re-election. An honorarium of £15 15s. being voted on the expiration of each year of office, and an allowance of £6 6s. is granted also to provide a substitute during three weeks' annual leave of absence.

All candidates must appear before the Joint Committee at their Meeting on Wednesday, December 19th, at 3 p.m. precisely.

Forms of application and copies of the rules may be obtained from the Secretary.

By Order of the Board of Management,
JAMES McKAY,
November, 1928. Secretary.

The Hospital for Sick Children, Great Ormond Street, London, W.C.1.

There will be a Meeting of the Joint Committee on Wednesday, December 19th, to elect a SURGEON.

Gentlemen, who must be Fellows of the Royal College of Surgeons of England, 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, December 17th.

All candidates will be required to appear before the Joint Committee on Wednesday, December 19th, at 3 p.m. precisely.

Forms of application and copies of the rules can be obtained from the Secretary.

By Order of the Board of Management,
JAMES McKAY.
November, 1928. Secretary.

Queen's Hospital, Birmingham.

Applications are invited for the post of ASSISTANT OPHTHALMIC SURGEON.

Candidates must be Fellows of the Royal College of Surgeons of England, Edinburgh, or Ireland, or shall hold a Degree in Medicine and Surgery of a British University, together with a Degree or Diploma in Ophthalmology.

The appointment is tenable for three years and the holder is eligible for re-election.

Honorarium £50 per annum.

Any further particulars may be obtained from the undersigned, to whom applications, stating experience, qualifications, date of birth, and evidence of diploma, together with testimonials, should be sent by December 13th.

Birmingham. G. HURFORD,
Nov. 3rd, 1928. House Gov. & Sec.

Wigan Infirmary.

Wanted for six months commencing January 1st, 1929 a THIRD HOUSE SURGEON (male). Salary £150 per annum, with board, apartments, and washing. Doubly registered. Candidates are requested to state if they would be willing to remain a further period of twelve months, subject to satisfactory service, i.e., six months as Second House Surgeon and six months as Senior House Surgeon, in the latter instance at an increased remuneration. Applications, stating age, nationality, and qualifications, with copies of three testimonials, should reach the undersigned as soon as possible.

A. STANLEY BRUNT,
General Supt. & Secretary.

Royal Northern Hospital, Holloway, London, N.

Applications are invited for the post of HOUSE SURGEON. The appointment is for nine months (six months House Surgeon and three months Casualty Officer) from January 15th, 1929. Salary at the rate of £70 per annum, with board residence, and laundry.

Applications, with copies of testimonials, should be sent by December 8th to the undersigned, from whom forms of application and rules can be obtained.

GILBERT G. PAINTER, Secretary.

Beckett Hospital & Dispensary, BARNSLEY.

JUNIOR HOUSE SURGEON (male) required. Applicants must be fully qualified and registered.

Salary at the rate of £140 per annum, together with board, residence, and laundry.

Applications, stating age, qualifications, and experience (Ophthalmology desirable), accompanied by testimonials, should be addressed to the undersigned.

ARTHUR L. BOURNE,
November 20th, 1928. Secretary-Supt.

H. E. Seiler, A Case of Pneumoconiosis, British Medical Journal (1928)
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Hampstead General and North-West London Hospital,
Haverstock Hill, N.W.

APPOINTMENT OF HOUSE PHYSICIAN.

Applications are invited from registered medical practitioners for the appointment of House Physician vacant on January 1st next. The salary will be at the rate of £100 per annum, together with board, residence, etc., and the term will be for six months.

Applications, stating age, qualifications, experience, together with copies of not more than three testimonials, should reach the Secretary not later than noon on December 12th next.

Hampstead General and North-West London Hospital,
Haverstock Hill, N.W.

APPOINTMENT OF A HOUSE SURGEON.

Applications are invited from registered medical practitioners for an appointment of House Surgeon vacant on January 1st next. The salary will be at the rate of £100 per annum, together with board, residence, etc., and the term will be for six months.

Applications, stating age, qualifications, experience, together with copies of not more than three testimonials, should reach the Secretary not later than noon on December 12th next.

The London Lock Hospital,
91, Dean Street, London, W.1.

The Board of Management invite applications for the post of HOUSE SURGEON at the Male Lock Hospital. Candidates must be doubly qualified and duly registered. Salary at the rate of £200 per annum, with furnished flat, full board, and laundry. The appointment to be for six months. Duties to commence January 1st, 1929. Applications, enclosing copies (only) of three recent testimonials, to be sent to the undersigned at the Male Lock Hospital, 91, Dean Street, W.1, on or before December 10th.

By Order of the Board,
H. J. EASON, Secretary.

Liverpool Hahnemann Hospital,
HOPE STREET, LIVERPOOL.

Applications are invited for the post of RESIDENT MEDICAL OFFICER to the above Hospital, which falls vacant on January 1st, 1929.

Duties include casualties, occasional anæsthetics and assisting at operations.

Applications should be accompanied by copies of testimonials, and information as to age, sex, and previous experience.

Appointment is for six months, renewable.

Salary at the rate of £100 per annum.

Apply, Registrar, before December 15th.

Liverpool Hahnemann Hospital,
HOPE STREET, LIVERPOOL.

Applications are invited for the post of STIPENDIARY MEDICAL OFFICER to the above Hospital, which falls vacant on January 1st, 1929.

Post is non-resident, tenable for six months, renewable, mornings only. Some visiting.

Salary at the rate of £125 per annum.

Candidates must be willing to study and apply Homœopathy.

Apply, stating age, sex, experience, and enclosing copies of testimonials, to the Registrar, before December 15th.

Liverpool Hahnemann Hospital,
HOPE STREET, LIVERPOOL.

Applications are invited for the post of CLINICAL ASSISTANT to the Ophthalmological Department of the above Hospital, one half-day per week.

Apply, stating age, experience, sex and enclosing copies of testimonials, to the Registrar, before December 15th.

The Salvation Army,
THE MOTHERS' HOSPITAL,
Lower Clapton Road, Clapton, E.5.

Applications are invited from medical women for the post of SENIOR RESIDENT MEDICAL OFFICER, vacant February 1st, 1929. Salary £100 per annum, with board, residence, and laundry. The appointment is for one year. Applications, with testimonials, must be sent to the Secretary on or before December 8th.

The Salvation Army,
THE MOTHERS' HOSPITAL,
Lower Clapton Road, Clapton, E.5.

Applications are invited from medical women for the post of JUNIOR RESIDENT MEDICAL OFFICER, vacant January 1st, 1929. Salary £60 per annum, with board, residence, and laundry. The appointment is for six months. Applications, with testimonials, must be sent to the Secretary on or before December 8th.

St. Marylebone Hospital,
London, W.10.

VISITING CONSULTING NEUROLOGIST.

Applications are invited from the most Junior Consultants for the above appointment. Honorarium £100 per annum.

For further particulars and conditions of appointment, apply to the Clerk to the Guardians, enclosing stamped addressed envelope.

Applications, accompanied by copies of testimonials, to be delivered at the undermentioned address on or before Monday, December 17th.

By Order,
EDWARD A. FRITH,
Clerk to the Guardians.

Administrative Offices, Northumberland St., W.1.
November, 1928.

Queen Charlotte's Maternity
HOSPITAL, Marylebone Road, N.W.1.

ASSISTANT RESIDENT MEDICAL OFFICER (male) required to commence duty on January 1st, 1929. Applicants must be registered. Appointment for three months. On completion of this appointment the selected candidate will be expected to proceed to the post of Senior Resident Medical Officer (for three months) on the recommendation of the Medical Staff. The salary of the Assistant Resident Medical Officer is at the rate of £80 per annum, and of the Senior Resident Medical Officer £100 per annum, with board, residence, and washing allowance (4/- weekly). Applications, with copies (not originals) of not more than three testimonials, will be received by the Secretary up to December 10th.

ARTHUR WATTS, Secretary.

Queen Charlotte's Maternity
HOSPITAL, Marylebone Road, N.W.1.

DISTRICT RESIDENT MEDICAL OFFICER (male or female) required to commence duty on January 1st, 1929. Applicants must be registered. The appointment is for six months. The salary is at the rate of £80 per annum, with board, residence, and washing allowance (4/- weekly). Applications, with copies (not originals) of not more than three testimonials, should be sent to the Secretary by Dec. 10th.

Canvassing is prohibited.

ARTHUR WATTS, Secretary.

The Prince of Wales's General
HOSPITAL, Tottenham, N.15.

Applications are invited for the post of HONORARY ANÆSTHETIST, to attend on Monday afternoons. The appointment is for one year, subject to re-election. Honorarium of £20 per annum.

Applications, stating age and qualifications, accompanied by copies of three recent testimonials, must be sent in by the first post on Monday, December 3rd next, to—

FREDK. W. DREWETT,
Director.

November 12th, 1928.

The Prince of Wales's General
HOSPITAL, Tottenham, N.15.

Appointments of HONORARY CLINICAL ASSISTANTS to the various Departments of the Hospital (Surgical, Medical, Gynæcological, Ear, Nose, and Throat, Eye, Skin, X-ray, and Electrical) for the ensuing year will be made in December.

Applications should be addressed to me on or before Monday, December 3rd.

FREDK. W. DREWETT,
Director.

November 12th, 1928.

The King Edward VII Memorial,
ELIOT HOSPITAL (Incorporated),
HAYWARDS HEATH, SUSSEX.

The Board invite applications for the post of HON. ANÆSTHETIST. Applicants should reside within easy reach of the Hospital, and are requested to apply by letter to the Hon. Secretary at the Hospital.

The Royal Dental Hospital of
LONDON, 32, Leicester Square, W.C.2.

There is a vacancy for an HONORARY ANÆSTHETIST, who will be required to attend on Thursday afternoons from 2—3 p.m.

Applications, accompanied by three testimonials, stating age and experience, should be sent in not later than December 14th to the Secretary.

County Hospital, York.
(180 Beds.)

HOUSE PHYSICIAN wanted. Salary £150 a year, with board, residence, etc. Applications, stating age, together with copies of not more than three testimonials, to be forwarded not later than December 5th, addressed to the Secretary.

December 1st, 1928.

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19, Nottingham Place, London, W.1.
Telephone: Mayfair 5420.

Northern Branch.—Apply, Lady Superintendent, 57, Clarendon Rd., Leeds. 'Phone: Leeds 26165.

Hull Royal Infirmary.

Applications are invited for the post of CASUALTY HOUSE SURGEON (male).

Candidates must be fully qualified and registered.

The appointment will be for six months in the first instance, and afterwards will be terminable by one month's notice on either side.

Salary at the rate of £130 per annum, with board and residence.

Applications, with copies of testimonials, should reach the undersigned on or before December 5th.

R. J. CARLESS, House Governor.

National Hospital, Queen Sq.,
for the Relief and Cure of Diseases of the Nervous System, including Paralysis and Epilepsy, W.C.1.

HOUSE PHYSICIAN.

The Board of Management invite applications for the post of House Physician, which should be sent to the undersigned, accompanied by copies of three recent testimonials, not later than Monday, December 10th. The salary is £150 per annum, with board and lodging.

GODFREY H. HAMILTON, Secretary.

H. E. Seiler, A Case of Pneumoconiosis, British Medical Journal (1928)
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ESSEX.—NUCLEUS rural non-panel Practice. Receipts nearly £250 p.a. Excellent freehold house, to be purchased on mortgage, £1,200. Premium for practice to be mutually arranged.

LONDON, W.—Well-established G.P., suitable for husband and wife in partnership. Receipts £3,000. Panel 2,400. Premium, £5,000 or offer.

LONDON, S.W.—NUCLEUS G.P. in thickly populated locality. Panel 115, increasing. Receipts average £260 p.a. Premium, to include furniture, drugs, etc., £300.

LONDON.—Old-estab., easily worked, Ear, Nose, and Throat PRACTICE, with small G.P. connection, and panel of approx. 140. Could be worked evenings only if desired. Excellent detached house situated on main thoroughfare. Receipts approx. £1,200 p.a. Premium one year's purchase, or near offer.

MANCHESTER (near).—Old-established G.P. Receipts £1,900. Panel about 1,300 (increasing). Small detached house may be rented or purchased. Premium for practice and book debts £2,900.

We have Numerous Applicants for Practices and Partnerships, both Town and Country, with incomes of from £600 to £4,000.

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LONDON, S.W.—Middle-class G.P. situated on main thoroughfare. Medium-sized house to rent. Garage and garden. Receipts over £1,000 p.a. Appointments approx. £300 p.a. Panel 700. Premium £1,530, cash.

LONDON, E.—Thickly populated working-class locality. Shop-fronted house, on lease at pepp rental. Panel nearly 500. Receipts £971. Now at the rate of £1,400 p.a. Premium £1,250 for drugs, equipment, and lease, or £1,450 if by instalments.

LONDON, E.—PARTNERSHIP in firm of three in old-established middle and working-class practice in thickly populated locality. Receipts over £6,000 p.a. Panel 6,617. Medium-sized house to rent on long lease at £80 p.a., or would sell. Premium 2 years' purchase, or 1½ years' if house is bought.

MIDLANDS.—X-ray and Electrical PRACTICE situated in large town. Excellent corner detached house for sale, or would be rented on long lease. Receipts over £1,200 p.a. Two appointments worth £150 p.a., possibly transferable. Premium for practice, to include instruments and appliances, £1,500, payable to suitable candidate, part by instalments. Excellent scope for experienced man.

LONDON.—PARTNERSHIP in old-established mixed-class practice. Medium-sized house. Receipts nearly £3,600 p.a. Premium for 1/3rd share, with view to larger share later, at 2 years' purchase. Part may remain.

BERKS.—Middle-class G.P., situated in residential riverside town. Excellent house to rent or for sale. Receipts over £1,800. Small increasing panel of 200. Good fees. Premium £2,200.

LONDON, W.—Lock-up SURGERY in thickly populated locality. Receipts £400. Panel 356. Premium £550 payable £350 down and balance by arrangement. Suitable for one with knowledge of languages.

SURREY.—Middle-class NUCLEUS G.P. situated in large town. Shop-fronted surgery. Accommodation consists of 7 rooms and domestic offices. Receipts over £20 per month. Panel 122, increasing. Premium, open to offer.

LONDON, S.E.—Small G.P. in residential locality. Receipts £400. Panel approx. 300. House to rent at £70 p.a. Premium £575, or near cash offer.

LONDON, E.—Well-established Lock-up SURGERY situated in main thoroughfare. Receipts over £200 p.a. Panel 116. Premium £300 for practice and lease, or near offer.

SOUTH COAST.—Well-established G.P. Receipts approx. £ 00 p.a. Small panel. Medium-sized house to rent. Suitable for semi-retired practitioner. Premium 1 year's purchase.

If the investment you are seeking is not advertised here, let us know your wants, and we will gladly forward details of others suitable to your requirements.

WEST COUNTY.—PARTNERSHIP in well-established middle-class G.P. situated in market town. Suitable house to rent. Panel over 600. Receipts £1,500 p.a. One-third share to commence at 2 years' purchase. Scope for surgery.

LONDON, S.E.—Well-established NUCLEUS Lock-up Practice, situated in busy working-class locality. Accommodation to rent. Receipts £320. Panel 418. Premium £500.

LONDON, W.C.—Shop-fronted SURGERY. Receipts £130, plus profit rental of £200 p.a. Scope for energetic man. Premium £300 inclusive, or near offer.

LONDON, N.W.—Well-established good-class PRACTICE in residential locality, situated on main thoroughfare. Receipts £1,000. Excellent detached house may be purchased, with garden, garage, etc. Premium for house and practice £4,750. Part may remain on mortgage.

LONDON, N.—NUCLEUS lady doctor's practice. Increasing panel of 88. Receipts £200. Ground floor flat to rent. Premium £250.

GLOS.—PARTNERSHIP in small country town G.P. Average receipts over £1,000 p.a. Panel 670. Premium for half share £750. Suitable accommodation available.

LONDON, S.W.—Lock-up SURGERY on main thoroughfare in thickly populated middle-class locality, within easy distance of West End. Receipts approx. £200. Panel 220. Premium for practice and lease £300.

LANCS.—City PRACTICE with excellent scope. Detached corner house may be rented. Receipts over £1,000 p.a. Panel about 1,000. Fees 3/6 up. Premium £1,000 cash down.

HERTS.—In close proximity to London. Middle-class G.P. Good-sized house standing in own grounds. Receipts £1,500. Panel 800. Premium 1½ years' purchase. House £2,200. Part could remain.

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SUSSEX.—Charming locality.—THIRD PARTNER REQUIRED to take one quarter share in first-class practice in hospital town. Receipts £6,000. Suitable only for physician. Small house to rent. Premium £3,500.

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Partnership after preliminary Assistantship. Third share of £3,450 in (3) Country Town within 30 miles. Panel 1,300. Appointments £450.

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Midlands.—Unopposed Practice in beautiful district. Receipts £1,250. (5) Panel and appointments £900. Nice old house, with large grounds, can be bought.

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2. LONDON, S.E.—Cash and panel PRACTICE. Receipts at the rate of £1,000 a year. Surgery and living accommodation 17/6 per week. Premium £1,050. Good opportunity for energetic doctor.
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5. MIDLANDS.—Large Town.—Old-established middle-class private PRACTICE. Annual receipts £2,800. Good opening for panel. Reasonable premium for quick sale of practice and good house.
6. LONDON, S.E. — Old-established mixed PRACTICE in desirable neighbourhood, with 300 panel. Receipts capable rapid expansion. Good house £70, long lease. Vendor retiring account of old age. Reasonable premium.
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Kent. — Average £1,250 p.a. Mids. 7½ gns. up. Visits 7/6 to 21/-. Non-panel. House, 5 bed., etc.—No. 8330.

South Coast. — Over £2,400 p.a. 1/2 share for sale. Panel and appts. over £1,000 p.a. Visits 3/5 to 10/6. House, 6 bed., etc., to rent. Surgical scope.—No. 8373.

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Western County.—£600 to £700 p.a. Unopposed. Clubs and appts. over £100 p.a. Fees 3/6 to 12/6. Panel about £300 p.a. Good house and garden. Premium, house and practice, £2,100.—No. 8375.

Nr. South Coast.—1/2 share of £3,000 p.a. Mids. 3 to 10 gns. Visits 3/6 to 10/6. Panel and appts. over £1,200 p.a. Small house, tennis, etc.—No. 8370.

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Co. Durham.—About £700 p.a. Visits 3/6. Mids. 2 gns. Panel 652. House, 3 bed., etc., to rent.—Apply, No. 8334.

South Wales. — Residential. — £1,600 p.a. Panel 450. Fees 5/- to 21/-. Corner house, 6 bed., etc.—Apply, No. 8348.

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British Medical Bureau

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(Founded 1860.)

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2 N. OF ENGLAND. — Sound Practice £1,090 p.a. in Cathedral City. Panel 300. House (4 bedrooms and attics) in best residential part for sale. Premium 1 year's purchase.

3 N.W. COAST. — Partnership in Practice over £3,000 in first-rate residential seaside town. Panel 450. Suitable house to rent. Partner should be keen worker and a good surgeon. One-third to two-fifths share at 2 years' purchase.

4 S.E. COAST.—Partnership in sound Practice £3,700 p.a. in important town. No panel. House with 5/6 bedrooms to let. Partner should be aged about 30, married, and interested in medicine. Premium five-twelfths share 2 years' pur.

5 KENT.—Partnership in better middle-class Practice about £2,500 p.a. in delightful residential district. Premium one-half share 2 years' purchase. Public School or University man preferred.

6 S. MIDLANDS. — Partnership (with succession in 12 months) in Practice over £1,700 p.a. in country town 100 miles from London. No panel, appointments, or midwifery. House (5 bedrooms), with garage and garden, for sale. Premium—Practice 1½ years' purchase.

7 HOME COUNTIES.—Partnership in Practice about £8,000 p.a. in growing residential watering-place. House (4 bed and dressing rooms) to rent. Partner must be well qualified (Oxford, Cambridge, or London). Premium one-fifth share 2 years' purchase.

8 SOUTH OF ENGLAND.—Practice about £1,000 p.a. in Cathedral Town. Conveniently arranged house (6 bedrooms) for sale. Premium 1½ years' purchase.

9 MIDLANDS. — Practice about £350 p.a. in manufacturing village. Panel 190. House (4 bedrooms, etc.), and one acre of garden. Premium—Practice and house, £2,000.

10 SUFFOLK.—Country Practice averaging £560 p.a. in beautiful agricultural district. Panel 300. Very attractive residence (5 bedrooms, etc.) in half acre garden, etc., for sale. Premium—Practice £540.

11 N. WALES. — Seaside Practice, approximately £500 p.a. Furnished house (4 bedrooms) to rent, or others to rent or purchase. Premium £500 for quick sale.

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14 PEMBROKESHIRE. — Practice about £1,000 p.a. in small town. Panel 361. Well situated house (7 bedrooms) to rent. Scope for increase. Premium £1,500. Preliminary assistantship if desired.

15 SUSSEX. — Country Practice about £300 near coast. Picturesque house (3 bedrooms), with garden, for sale. Premium—Practice £300.

16 FULHAM. — Lock-up, nearly £550 p.a., including about £265 from panel (increasing). Rent 25/- weekly (part could be sub-let). Premium £850.

17 NORTH WALES. — Country Practice averaging £1,230 p.a. in Welsh-speaking district. Panel over 530. Centrally situated house (3 bedrooms). Premium one year's purchase.

18 S. WALES. — Easily worked Panel and Contract PRACTICE over £1,000 p.a. in colliery district. Small house (4 bedrooms) to rent. Premium one year's purchase.

19 N.W. COAST. — Practice of £534 p.a. in popular seaside resort. Panel 425. House, with 4 bedrooms, to let. Good scope.

20 N. KENT.—Practice averaging £286 p.a. in industrial district offering enormous scope. Small panel. House to rent. Premium £430.

21 ESSEX. — Practice averaging £1,216 p.a. in outlying district—30 minutes by rail from London. Panel 550. Nice detached house (3 bedrooms) for sale. Premium for practice 1½ years' purchase.

22 NEW ZEALAND.—Ear, Nose, and Throat PRACTICE averaging £1,500 p.a. in good town in N Island. Nice house with large garden for sale. Fine opening for one with experience who would obtain Hospital appointment. Premium £500.

23 SANATORIUM for Treatment of Pulmonary Tuberculosis and Allied Diseases (both sexes). Specially built (centrally heated) in 12 acres of grounds. Net profits average about £1,550. Capital required about £7,000.

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Practices and Partnerships for Disposal (continued).

24 SOUTH OF ENGLAND. — Partnership (after preliminary assistantship) in Practice about £3,000 p.a. (panel and appointments £960) in attractive town. Detached house (3 bedrooms) for sale. One-half share at two years' purchase.

25 LONDON, E.—Partnership in exceptionally old-established Practice averaging £3,580 p.a. Good fees and appointments. Two-fifths share for disposal at 1½ years' purchase, or one-third could be purchased at first. Small house may be bought or rented at a moderate figure.

26 MIDLANDS. — Partnership in Practice averaging £5,370 p.a. in first-rate Hunting centre. Small panel. House, with garage and garden, to rent. Partner should be fond of country life, and preferably have held Hospital appointments. One-fourth share at 2 years' purchase.

27 N. LONDON.—Practice of between £950 and £1,000 p.a. Small panel. No midwifery. Detached corner house (7/8 bedrooms) for sale. Premium—Practice 1½ years' purchase.

28 MIDLANDS. — Practice about £350 p.a. in manufacturing village. Panel 190. House (4 bedrooms, etc.), and one acre of garden. Premium, practice and house £2,000.

29 YORKSHIRE (W.R.). — Practice over £1,500 p.a. in developing district on outskirts of manufacturing town. Panel 1,284. House with 5 bedrooms to be sold or let. Good scope. Premium £2,500.

30 KILBURN, N.W. — Cash Practice in populous district. Receipts 1927, £830. Small panel. Rent of surgery 30/- weekly. Premium £1,000. Good scope.

31 MIDLANDS. — Partnership in Practice over £2,000 p.a. in good town. Panel 1,300. Good house (5 bedrooms) available. Partner should be able to undertake major operations. Well-equipped hospital. One-half share for disposal.

32 HOME COUNTY.—Partnership in Practice over £2,000 in residential district within 12 miles of London. Panel 750. House, with 5 bedrooms, to rent. Premium one-third share 2 years' purchase.

33 NORFOLK.—Unopposed Country Practice over £2,000 in delightful neighbourhood. Panel over 800. Convenient house (six bedrooms), with modern sanitation and well-stocked garden, for sale. Very good society. Scope. Prem. £2,700.

34 MIDDLESEX.—Partnership in increasing Town Practice over £2,000 p.a. Panel over 1,400. Partner should be good at midwifery. Premium one-third share 2 years' purchase.

35 YORKSHIRE (N.R.).—Partnership (with view to succession) in Practice about £1,000 p.a. in small country town. Panel 420. Good rooms available. One-half share at moderate premium. Scope for minor surgery.

36 N. DEVON.—Partnership in Practice about £1,500 p.a. in good town. Panel about 630. House (or rooms) to rent. Partner should be single, have held House appointment, and keen on sport. Share of about £700 at two years' purchase.

37 COUNTY TOWN within 45 miles of London. PRACTICE, about £1,150. Panel 485. Good house, with garage and 3/4 acre garden, for sale. Excellent educational facilities.

38 LONDON, E. — Partnership in non-panel Practice of £3,340 p.a. in thickly populated district. Detached house (7 bedrooms) to rent. Share of one-third to one-half at 2 years' purchase

39 LANCASHIRE.—Practice averaging over £3,700 p.a. in first-rate town. Panel 2,600. House (4 bedrooms) to be sold or let. Premium 1½ years' purchase.

40 CHESHIRE. — Partnership in old-estab. Town Practice near Manchester, £3,000 p.a. (not including appointments). Panel over 2,000. Third share at 1½ yrs.' purchase. Short preliminary assistantship if preferred.

41 MIDLANDS. — Mixed Practice nearly £2,800 p.a. in prosperous town. No clubs or panel. Modern house for sale. Premium—Practice 2½ years' purchase.

44 SCOTLAND.—Country Practice £735 p.a. in agricultural district in Kincardineshire. Panel 295. House, with 4 bedrooms and good garden, etc., for sale. Shooting and fishing, etc. Premium £750.

43 LONDON, N.—Practice about £1,000 p.a. Small panel. No midwifery or night work. House (8 bedrooms). Premium, house and practice, £1,500.

44 LONDON, E.—Rapidly increasing cash and panel PRACTICE. Receipts for year ending September, 1928, £971. Panel 450. Shop-fronted house on lease as a profit rental. Premium, to include drugs, surgery equipment, etc., £1,250.

45 LONDON, S.E. — Partnership in well-established Practice of £1,900 p.a. in good residential district. Exceptionally well-built detached house (6 bedrooms) to be rented. One-third share at two years' purchase (£700 p.a. guaranteed for three years). Good scope.

46 S. DEVON. — Old-established Country PRACTICE £700 to £800 p.a. Easy distance of the coast. Panel 400. House (2 sitting, 4 bedrooms, large garden, paddock, garage, etc.). Rent £45. Cottage Hospital. Premium £1,200.

47 N. WALES COAST. — Partner required in old-established Practice. Receipts £5,670 p.a. Panel 2,000. Short preliminary assistantship. Premium for one-fifth share 2 years' purchase. Applicants must be Welsh and have held H.P. and H.S. appointments.

48 N. YORKSHIRE. — Country Practice worth about £500 p.a. in agricultural district. Panel over 200. Modern house (6 bedrooms) for sale. Premium, practice £500.

49 MIDLANDS. —X-ray and Electro-therapeutic PRACTICE in first-rate town. Receipts average £1,283 p.a., including hospital appointments. Well-situated house to be sold. Premium, practice £1,000.

50 Nr. NEWCASTLE-ON-TYNE.—Old-estab. Town PRACTICE over £800 p.a. Panel 440. Pleasantly situated house (4 bedrooms) to rent. Plenty of scope. Prem. 1½ years' pur.

51 GLOUCESTERSHIRE.—Country Practice averaging £533 p.a. Panel 460. Convenient (small) house, and excellent garden, 1 acre. Garage small car. Premium, house and practice, £3,000.

52 NORFOLK. — Country Practice nearly £1,100 p.a. in agricultural district. Panel 530. Modernized house (6 bedrooms, electric light, etc.) and 1½ acres garden for sale. Sport of all kinds. Premium £1,500

53 S. WALES.—Non-dispensing Practice in large seaport town. Receipts for past 3 years averaged £1,543 p.a. Small panel. Pleasantly situated house (5 bedrooms). Premium £2,500.

54 MIDLANDS. — Country Practice about £1,000 p.a. in residential district and hunting centre. Panel 600. Large house (9 bedrooms) with over 13 acres of land for sale. Premium practice 1½ years' purchase.

55 N.W. COAST.—Ophthalmic Practice (with some general practice). Receipts average £1,850 p.a. Good house in excellent position. Premium 1½ years' purchase.

56 GLOUCESTERSHIRE.—Country Practice averaging £620 p.a. (600 feet above sea-level). Close to two good towns. Panel 500. Large house, with garden and paddock. Scope for increase. Premium £800.

57 SOUTH OF ENGLAND.—Partnership in Country Practice, £2,500 p.a., close to large seaport. Panel 1,355. House (6 bed and dressing rooms), with over acre garden, for sale. Premium 2/5 share 2 years' purchase

58 CO. DURHAM. — Practice of £1,460 in growing suburb of seaport town. Panel 646. House (5 bedrooms) on main road to be sold or let. Premium 1½ years' purchase.

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4. SOUTH WALES.—Old-established industrial class PRACTICE, situated in prosperous town. Average income over £1,000 p.a., including panel of 900. Fees from 2/6. Midwifery from 2 gns. Suitable house with 2 reception, 3 bedrooms, etc., and separate professional accommodation. Price for leasehold £600. Premium 1½ years' pur.
5. SOUTH OF ENGLAND.—FAVOURITE SEASIDE RESORT.—Mainly better-class PRACTICE, producing for the last twelve months about £700, and rapidly increasing. Panel of 150. One appt. worth about £40 p.a. Fees 3/6 to 7/6. Only a few cases of midwifery, 2 gns. upwards. Good house in excellent repair, with 2 reception, 5 bedrooms, etc. Electric light. Garden. Garage. Price for freehold £2,200. Premium £1,300.
6. MIDLANDS.—COUNTRY PRACTICE within 100 miles of London. Easily worked practice, producing about £1,000 to £1,200 p.a., including panel of 600. Large and exceptionally attractive house, in first-rate order, with 3 reception, 11 bedrooms, and professional accommodation, etc. Electric light. Stabling for four horses. Well-stocked garden of 1½ acres, and several acres of grassland. Good hunting centre. Price for practice and house £6,500.
7. PARTNERSHIP.—PLEASANT SURREY SUBURB.—The Third Share of an old-established Practice offers to a purchaser desirous of doing major and minor surgery owing to the retirement of the junior partner, through prolonged ill health. Held by senior 24 years. Cash receipts about £2,700 p.a., including appts. worth about £340, and panel 1,000. Visits 3/6 to 21/- Mids. 3 gns. upwards, 75 cases yearly. House available containing consulting room, dispensary, 2 reception, 6 bedrooms, bathroom. Garage. Rent £85 p.a. Premium 2 years' purchase. Hospital (27 beds) in the place and excellent scope.
8. PARTNERSHIP.—LONDON SUBURB (EAST).—The Third or Half Share of a very well-established middle and better-class non-panel Practice, averaging over £3,250 p.a. (including appts. worth £400 to £500) is for disposal. Visits 5/- to 10/6, and up to 2 gns. Mids. 3 to 7 gns., about 20 cases yearly. House available with ample accommodation. Rent £75 p.a., on lease. Premium for share 2 yrs.' purchase. Scotch Graduate preferred.
9. WESTMORLAND.—COUNTRY TOWN.—Old-established PRACTICE, held by Vendor many years. Income is a steady average one of about £1,450, including panel of nearly 300, which could be increased if desired. Visits 3/6 to 7/6, with medicine extra. Semi-detached house, with 2 reception, 5 bedrooms, etc. Separate professional accommodation. Small garden. Good garage. Price £1,350, or might be rented at £65 p.a. Premium 1½ years' purchase.
10. WEST OF ENGLAND.—Very easily-worked unopposed Country PRACTICE, averaging about £600 p.a., including panel of 300. Fees from 2/6 to 12/6. Midwifery 3 to 5 gns. Nice house, with 2 reception, 6 bedrooms, etc., professional rooms. Large garden and paddock. Price for freehold £1,200. Premium 1½ years' purchase.
11. BORDERS OF NORFOLK AND SUFFOLK.—Old-established middle-class PRACTICE, producing about £1,100 p.a., including panel of over 500. Visits 5/6 upwards. Midwifery from 2 gns., about 30 cases. Modernized old country house, with ample accom. and large garden; e.l.; all in good order. Price for f'hld. £2,500. Prem. £1,500.
12. YORKS.—LARGE TOWN.—Well-established mixed general PRACTICE, producing an income of over £900, including panel of nearly 640. Centrally situated house, with small garden. Can be rented on lease at £80 p.a. Very good sporting and social advantages, and excellent schools. Premium £1,250.
13. DERBYSHIRE.—PARTNERSHIP.—A half share in a very sound panel and club practice, producing £5,200 p.a. Panel of over 3,000. Fees 3/6 to 5/-, medicine extra. Expenses small. Modern house, in good order, with pleasant garden. Garage. Price for freehold £1,500, part on mortgage. Premium £3,200, half down and balance by instalments over 4 years.
14. BERKSHIRE.—Pleasant Town.—Well-established upper and middle-class PRACTICE. Income for the past year over £1,600, including panel of 200. Surgery fees from 2/6, visits 3/6 to 21/-. Little midwifery. Good house, with large garden, tennis court, etc. Garage. Rent on lease £150 p.a. Premium £2,200, to include violet-ray plant and all drugs, etc.
15. LANCS.—In a rapidly growing good-class suburb of large town (pop. nearly 200,000), a very old-estab. PRACTICE, held by Vendor over 30 years, and averaging about £900 p.a., including Unions (£80, with prospect of increase shortly) and panel of nearly 1,000. There is a surgery in centre of town to which bulk of practice and panel work is attached. Private residence contains 2 reception, 3 bedrooms, bathroom, etc., and small garden. Both Vendor's properties. Price £1,750, £900 on mortgage, or would be rented. Prem. 1½ yrs. pur.
16. NORTH CORNWALL.—PARTNERSHIP.—A two-thirds share (the only disposal (owing to the retirement of the senior of two partners) in an old-established good mixed-class Practice situated in a beautiful district within easy reach of the sea. Average gross cash receipts for the past three years £3,224. Panel of over 900. Fees 3/6 to 21/-. Good house, with 2 reception, and 9 bedrooms, etc., waiting room and dispensary, large garden, garage. Rent very moderate. Sporting of all kinds and preparatory school in town. Premium 2 years' pur.
17. WILTSHIRE.—Unopposed old-estab. Country PRACTICE, situated in very pretty district and averaging £700 p.a., including Union appt. £70, and panel producing £430. Nearest opposition 5½ miles. Railway station 1 mile. House stands in own grounds of 1½ acres with tennis court, garage, etc., and contains surgery, 3 reception, 5 or 6 bedrooms, bathroom (h. & c.). Electric light plant installed. Vendor's freehold, price £2,500, all of which could remain on mortgage if wished. Premium £1,050.
18. 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.
19. MANCHESTER.—Rapidly developing outlying suburb. Good middle- and working-class PRACTICE, increasing and producing for the last 12 months over £1,500. Panel of 700. Fees from 3/6. Particularly good house, specially built, and containing 3 reception, 5 bedrooms, etc. Electric light. Garden. Garage. Price £3,550, part on mortgage. Premium £2,250.
20. BEDFORDSHIRE.—Small Country PRACTICE, at present producing at the rate of £400 p.a., but offering good scope. Fees 3/6 to 10/6, medicine extra. Good house, with 2 reception; 6 bedrooms, etc. Separate entrance to professional rooms. Can be rented on lease. Premium £250, or practice and house will be sold for £1,050.
21. 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 3/6 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 £1,300.
22. KENT.—COAST TOWN.—Well-established mainly industrial PRACTICE. Steady average income of over £1,500. Panel of 1,350. Advice and medicine mainly 3/- and 5/-, and a few at 7/6; visits and medicine from 3/6 to 21/-. Convenient house, with 8 bedrooms. Rent on lease £100 p.a. Premium 1½ years' purchase.
23. SOUTH OF ENGLAND.—Within a mile of the sea.—In a pleasant Country Town (growing) amidst beautiful surroundings, an old-estab. PRACTICE (held 40 years by Vendor) averaging about £900 p.a., including appts over £400 and panel of 600. Visits 2/6 to 21/-. House contains 3 reception, 5 bedrooms, bathroom, etc. Price freehold £1,700. Premium 1½ years' purchase. Good sporting and educational facilities. Purchaser should possess the D.P.H.
24. CENTRAL WALES.—GOOD HOSPITAL TOWN.—Old-established non-dispensing PRACTICE. Income over £1,400, including £130 from appts. and panel of 500. Fees 3/- to 42/-. Little midwifery. Good house in centre of town, with pleasant garden. Price for freehold £1,300. Premium £2,100. Exceptional scope for surgery.
25. EASTERN COUNTIES.—MARKET TOWN.—Old-established General PRACTICE. Income for the past twelve months about £1,000, including panel of 700. Fees from 3/-. Good house, with 2 reception, 7 bedrooms, etc. Price for freehold £1,600, part on mortgage. Premium 1½ years' purchase.
26. NEW ZEALAND (North Island).—Increasing Town (pop. 2,500, with further 6,000 in district) amidst beautiful surroundings 30 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.
27. NEW ZEALAND (South Island).—In a delightful and popular seaside resort (pop., Town 16,000, Country 10,000, and greatly augmented by visitors in the summer), an old-established PRACTICE producing last year £1,895, including Lodges £243. Visits 10/6, with mileage extra. Midwifery 4 gns (a few) upwards: 25 cases yearly. No dispensing. Excellent brick-built house (surgery and waiting room separate), containing 12 rooms, bathroom, etc. Garden of half an acre. Garage for 2 cars. Electric light. Sport of all kinds and good educational facilities. Price for freehold house £4,500, and for practice £1,500, of which £1,500 will be accepted down and balance by yearly instalments of £500 at 6 per cent.

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Remarks on DRAINAGE OF BRAIN ABSCESS.*

BY

SIR PERCY SARGENT, C.M.G., D.S.O., F.R.C.S.,
Senior Surgeon, St. Thomas's Hospital.

THE general principles of treatment of abscess of the brain differ in no essential feature from those which obtain in abscesses elsewhere in the body, but the peculiar characters of the cerebral tissue, the existence of the cerebro-spinal fluid circulation, and the physical conditions of pressure within the cranial cavity create special difficulties and problems. While the primary object in dealing with these cases is the effective drainage of the abscess, yet the possibility of fatal complications following precocious or misdirected surgical measures, together with the dangers of serious damage to brain function, must be given due consideration in planning the operation.

The great variations of type which occur among cerebral abscesses, from a diffuse septic softening right down to an encapsulated mass of almost solid fibrous tissue, are apt to create confusion when treatment is being discussed; for measures clearly right for one variety may be obviously wrong for another. The frequent coexistence, especially in otitic cases, of other infective complications, meningitis, ventricular ependymitis, and sinus phlebitis, tends still further to confuse the issue.

In discussing the treatment of abscess of the brain, and especially perhaps in speaking of results, it is necessary to be quite clear as to the type of case with which we are concerned. Although the various kinds of abscess merge into one another, certain types can be recognized: (1) diffuse septic softening; (2) a pus-containing cavity with ragged wall consisting of softened brain tissue; (3) a cavity with a thin capsule consisting of young fibrous granulation tissue; (4) a cavity, perhaps small in relation to the size of the abscess, consisting of dense fibrous tissue, which may be the greater part of an inch in thickness.

In the first variety, which is not really an abscess at all, but a diffuse infective encephalitis, comparable with a cellulitis of the connective tissues, no surgical treatment is likely to be of any use, except perhaps a simple decompression.

When, however, as in the second class, this encephalitis is of a somewhat less virulent type, and necrosis with pus formation has occurred in its central part, drainage may be undertaken with some hope of success. This is a type of abscess which during the war was not infrequently encountered in the track of a shell fragment. The most intense septic reaction was apt to be found near the point of entrance, as if the most heavy microbic infection as well as the maximum devitalization of tissue existed just beneath the aperture in the skull, as indeed one would expect to be the case; in abscesses developing months or years after such wounds the same rule holds.

The third and fourth types differ chiefly in the thickness of the capsule, and naturally they merge imperceptibly into one another. At one end of the scale there is a thin capsule, varying, however, in thickness at different places, while at the other end is an almost solid mass of fibrous tissue containing perhaps but a few drops of pus. Around the thinnest-walled abscesses there is an area of oedematous brain, in which, naturally, extension may take place. By this route the ventricle may become involved.

With the very chronic thick-walled abscesses the changes in the surrounding brain may be inconspicuous and insignificant. In such cases the question of drainage scarcely arises; the proper treatment is complete enucleation, with closure of the wound. I have had five such patients, all of whom recovered. In one other similar case drainage was necessitated by the fact that, just as the mass was being delivered, a thin part of its wall gave way, causing soiling of the wound. This patient also recovered completely.

This discussion, however, is chiefly concerned with what is perhaps the commonest type of abscess—a cavity containing some drachms, or even ounces, of pus bounded by a relatively thin capsule, which in its turn is surrounded by an area of soft oedematous brain. Most of these are of otitic origin, and are situated either in the temporal lobe or in the cerebellum. The cerebellar cases are apt to present earlier indication of their presence because of the ventricular distension to which they tend to give rise. They are therefore likely to be operated upon at an earlier stage.

It is instructive, I think, at this point to recall the very remarkable series of cases upon which Macewen bases his classical monograph (1893). In Table III the astonishing figures are given that of 19 patients operated upon 18 recovered. No wonder Macewen was able to write, cautious Scot though he was, "One might almost conclude that in uncomplicated abscess of the brain, operated upon at a fairly early period, *recovery* ought to be the rule." His *recovery* rate is, as Mr. Miles Atkinson pointed out recently (*Lancet*, March 24th, 1928), much the same as the *mortality* rate of many other surgeons. Not only, as he says, has no one been able to improve upon Macewen's successes, but no one has ever been able even to approach them.

A perusal of Macewen's detailed yet lucid account of his cases brings out the fact that he was dealing with one particular group—namely, the definitely encapsulated abscesses with a long history, and usually containing a large amount of pus. The average duration of the illness before operation was, in the twelve cases in which it is stated, no less than seventy days. Macewen's cases at least lend no support to any plea for precocious operation. Early operation, however, as soon as the presence of an abscess is definitely diagnosed, must be undertaken, for the risks of delay are great. The chief dangers are rupture into the ventricle, rapid onset of cerebral compression from oedema, and, in cerebellar cases especially, sudden respiratory failure.

A spreading abscess tends to make its way towards the ventricle, or rather, perhaps, the ventricle filled with fluid under pressure tends to herniate into the softened brain.

This is also true after an abscess has been imperfectly drained, and in such cases the accident, not necessarily fatal, of a communication being established between abscess and ventricle is marked by the escape of cerebro-spinal fluid from the wound.

When an abscess has been properly evacuated and drainage established the intracranial pressure falls, provided that no complication exists such as meningitis, encephalitis, or a second abscess. The appearance of a fungus cerebri means that the intracranial pressure has not been relieved. A "fungus" must be clearly distinguished from a "hernia" cerebri. The latter means a protrusion of healthy brain, still covered by pia, arachnoid, and skin, with its circulation and functions unimpaired; a fungus is a protruding mass of strangulated, necrotic, and functionless tissue indicative of unrelieved intracranial pressure.

In operating for cerebral abscess the two most important technical considerations are the route to approach and the method of drainage. Ballance has frequently called attention to the fact that with abscesses originating in bone disease, as most of them do, there is a stalk, representing the inward track of the infection, connecting bone and abscess; this should furnish the ideal route of approach. The membranes are presumably adherent at this spot, so as to seal off the subarachnoid space. In otitic cases the surgeon, during the mastoid operation, may be fortunate enough to find the stalk, and it is possible that the drainage so established may be adequate. Several of Macewen's cases at any rate were successfully treated in this manner.

Failing this, the transarachnoid route must be adopted. The bony opening need not be a large one, as the evacuation of the pus will be followed by a fall in intracranial pressure. This diminution of pressure, it must be remembered, is followed immediately by a falling away of the brain from the surface, with the consequent opening up of

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the subarachnoid space. It is therefore necessary, before evacuating the pus, to shut off the subarachnoid space by strips of gauze tucked in beneath the dura; these guarding plugs may be left *in situ* for two or three days, just as is sometimes done in the transpleural drainage of a hepatic abscess, or the transperitoneal drainage of an abdominal abscess.

The presence of a subcortical abscess is usually indicated by bulging of the brain, with pallor, broadening, and softness of the exposed convolutions. If the abscess lies deeply these characteristic appearances may be lacking. Exploration with trocar and cannula is, in my opinion, to be deprecated. The instrument may pass by the capsule, or, failing to penetrate it, may push it towards, and cause it to burst into, the ventricle. My own practice is to use a small flat seeker, which passes with the least possible force through the softened brain tissue, and with which the resistance of an abscess wall can easily be felt. If by chance the instrument penetrates into a thin-walled abscess, pus at once flows out along it. The abscess having been thus located, I tie off such cortical vessels as may be necessary, and make a clean incision into the abscess with a sharp knife. The material of which the tube is made is of little importance provided it has sufficient rigidity; a rubber tube is rather too bulky for the size of its channel, but usually serves the purpose well enough. I have from time to time used tubes made of aluminium or of celluloid. Macewen employed decalcified bone tubes. Matters of greater importance concern the after-treatment. The tube, which should have been sutured to the edge of the dura or skin, must be kept clear by frequent gentle syringing, and should be retained in place for a long while, at least until all tendency for the brain to protrude has disappeared. It should be shortened only very gradually. If the brain protrudes persistently or increasingly either the abscess is insufficiently drained or some complication such as a second abscess or meningitis may be present. It is unwise, however, to interfere locally too soon, as there is always some oedema which tends to push the tube out. This period can be tided over by withdrawing fluid from time to time by lumbar puncture.

A British Medical Association Lecture

ON

SOME DISORDERS OF THE LYMPH GLANDS.*

BY

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THE lymphatic system consists of a widespread set of vessels, most abundant in the skin, the intestine, and the connective tissues, in the course of which are aggregations of lymphoid tissue, termed lymph glands or nodes. The lymphatics take origin in the tissue spaces as capillaries. They are provided with valves, and drain into nodes arranged for the most part in groups, from which arise larger efferent vessels; these pass to one or more groups of nodes situated more deeply, and discharge ultimately into the main lymphatic channels—namely, the thoracic duct and the right lymphatic duct, which open into the origin of the innominate vein on the left and right side respectively.

In addition to the lymph nodes, lymphoid tissue is widely distributed throughout the body. The tonsils, including the pharyngeal tonsil, the thymus, and the spleen are composed almost entirely of this tissue; the alimentary tract is richly supplied with lymphoid elements, both as solitary follicles and as agminations in the lower part of the ileum (Peyer's patches), the appendix, and the colon.

The lymph nodes are collected into groups, of which the cervical, axillary, and inguinal are the principal ones near the surface of the body; more deeply, there are important collections about the trachea, in the root of the lung, in the posterior mediastinum, in the transverse fissure of the liver, along both sides of the spine in relation to the aorta and its main branches, and in the mesentery. Over and above these are sundry collections and single nodes, the existence of which is scarcely appreciated until they are enlarged as the result of disease; examples are the epitrochlear, infraclavicular, and preauricular nodes.

It is by the lymphatics that certain substances are drained away from the tissue spaces with the help of phagocytic cells; fat is absorbed from the intestinal villi into the lacteals. The chief functions of the lymph nodes are to produce lymphocytes, and to form a barrier against infection of the more important tissues of the body. Not only microbes, but particles of soot, dust, and even neoplastic cells, are caught by this means and held back from the general circulation; no doubt many diseases of an infective nature abort at this line of defence. Lymphatic glands, then, are open to attack either by way of the lymphatics or of the blood stream.

Lymph nodes enlarge as the result of inflammation, of hyperplasia, or of infiltration by blood cells or new growth. An important series of changes, again generally associated with enlargement, is that which signifies retrogressive processes in the nodes; examples are fibrosis, caseation, the deposit of foreign substances, and abscess formation.

Lymph nodes in health are usually impalpable, and, unless the patient is unusually thin, nodes which can be definitely felt must be assumed to be pathological.

When investigating the lymphatic system of a patient in whom any enlarged nodes are found, let the first inquiry be upon an anatomical basis: in what group or groups is the enlargement present? The superficial nodes are examined systematically by careful inspection and palpation. Moderate enlargement of the cervical nodes may cause some fullness of the neck; the recognition of this feature may call attention to the presence of soft glands—as, for example, in acute leukaemia—which otherwise might escape detection. Stiffness of the neck, and perhaps torticollis, may be associated with enlarged cervical nodes; so also may a neuralgia accompanied by tenderness and hyperaesthesia of some part of the scalp or a headache which arises in the neck and spreads upwards over the vertex. In the axilla, care must be taken not to mistake fat for enlarged nodes. Sometimes superficial nodes in unusual places are to be seen or felt—for instance under the scalp, near the zygoma, and in the intercostal spaces. Of the deep groups, those within the abdomen when sufficiently enlarged may be recognized by palpation, or by signs of pressure upon neighbouring structures to which they give rise—as, for example, to jaundice with ascites when those in the transverse fissure of the liver are affected, and, be it remembered, multiple tumour formation within the abdomen is most often associated with lymphatic glands. It should also be borne in mind that an "odd" tumour within the abdomen—odd perhaps in regard to its characters or to the symptoms, or lack of them, to which it gives rise—is not seldom of lymphatic origin. An examination of the blood in such cases must always be made, lest a laparotomy be performed unwittingly in a case of, say, chronic leukaemia.

When disease of the lymph nodes has led, as in the case of tuberculosis, to caseation or to calcification, such nodes may frequently be demonstrated by x rays, and so the cause of indefinite abdominal pains, perhaps associated with more or less pyrexia, may be cleared up. Should caseous glands, as revealed by palpation and/or radiography, be situated mainly in the right iliac fossa, the portal of entry is most likely the appendix; less often it is the Fallopian tube. In either case, when associated with symptoms, laparotomy is indicated for removal of the offending structure.

Lymph glands within the thorax cannot be detected by ordinary physical examination, save when they are very considerably enlarged and coalescent. When this is so, however, they may give rise to certain physical signs. Greatly enlarged lymph nodes in the anterior mediastinum may cause a visible tumour in the neighbourhood of the sternum, with percussion dullness and signs of pressure upon veins. A similar state of things in the posterior mediastinum may yield impaired percussion resonance in

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the spaces between the vertebral border of the scapula and the spine. Weak breath sounds, with or without bronchial breathing, may also occasionally be present. These signs, however, are uncommon, and are only to be expected when the glandular enlargement is considerable. When present, they are probably caused as much by collapse of lung, or by actual infiltration of the organ by the same tissue as is concerned in the glandular enlargement, as by the nodal swelling itself. In the earlier stages of glandular enlargement within the thorax recourse must be had to x-ray examination, performed both in the antero-posterior and in the oblique positions; this investigation should always be undertaken in cases in which lymph nodes elsewhere are enlarged by a disease which is known to cause general lymphatic enlargement.

I.—Local enlargement results most often from local infection, the materies morbi being conveyed by the lymphatics. The area drained by the particular group enlarged must therefore be searched for the portal of entry. Local enlargement of nodes in the neck is very common, especially in children, the reason no doubt being that foci of infection are so frequent in the tonsils, teeth, nasopharynx, and scalp. This is so whether the infection is pyogenic or tuberculous. In an adult, in the absence of an obvious inflammatory focus, the possibility of metastatic deposits must be considered, seeing that carcinoma of the tongue and of the oesophagus are frequent diseases. If a gland is felt in the left supraclavicular fossa and none higher in the neck, a metastatic deposit from a carcinoma of the stomach or a retroperitoneal sarcoma must be thought of. Glands in the cervical group of one side, again in the absence of gross local infection, are generally the first to be enlarged in Hodgkin's disease.

In a case of acute axillary gland enlargement it is likely that this results from infection of the hand, in which case there may be red streaks extending up the arm, due to lymphangitis. The local wound on the finger may be a seemingly trivial affair—a prick by a rose thorn or by a needle. The infection, which develops with great rapidity, is mostly due to *Streptococcus pyogenes*, and it is in this class of case that sensitized *S. pyogenes* vaccine, combined with concentrated scarlet fever antitoxin, is proving so useful. Infection with *Spirillum minus*, the causal organism of rat-bite fever, may also result in an acute local enlargement and tenderness of lymph nodes—in which case there is a history of the patient having been bitten by a rat, a ferret, or a kitten, usually on the hand, three to four weeks previously. The bite heals, probably without incident, but with the onset of symptoms the site of the wound becomes red and painful, and pyrexia of a relapsing character develops. In a pyrexial period the whole limb may be swollen, and though the lymph nodes draining the area are those mainly affected there may be some generalized lymphadenitis; the specific rash may be found in the skin. This infection usually yields quite quickly to full doses of neokharsiran given intravenously; so much so that if a suspected case does not respond to two doses of 0.6 gram, given at an interval of five days, it is improbable that the illness is due to this cause.

II.—In generalized enlargement, when the nodes are found to be enlarged in two or more groups, the materies morbi may be conveyed by the blood stream; in some infections this general enlargement has a definite diagnostic value—as, for example, in glandular fever, in rubella, in the septicaemic or secondary stage of syphilis, and in bubonic plague. Another disease suggested by the discovery of general lymphatic enlargement in childhood and adolescence is acute lymphatic leukaemia, but here the nodal swellings are by no means the major part of the process, and may be relatively inconspicuous in comparison with the severity of the general state. If the glandular enlargement has arisen insidiously, and if the patient's general state is not acute, the probable explanation lies in the direction of such diseases as lymphadenoma, tuberculosis, leukaemia, and sarcomatosis. The differentiation of these conditions depends upon the specific features of the glands and certain general signs presented by the patient, including a consideration of the blood picture.

The specific features of enlarged glands calling for special note are: the number and distribution within the group; the size; whether the glands are discrete or coalescing; their mobility; involvement of the skin and surrounding structures; consistency; and sensitiveness. It is important to remember that nodes which are adherent to one another, or to surrounding structures, are the seat of a disease process which has spread through the gland capsule—as in tuberculosis frequently, acute pyogenic infection occasionally, and malignant disease—or that the affected nodes have been treated by irradiation. In chronic cases more or less enlargement of glands in several groups suggests lymphadenoma, chronic leukaemia, or lymphosarcoma. Of these three diseases chronic leukaemia gives rise to the least difficulty in diagnosis because of its distinctive blood picture; whereas lymphadenoma is the most difficult, seeing that there are no enduring criteria on which to rely.

Of chronic leukaemia there are two main varieties—chronic myelocytic and chronic lymphatic leukaemia. It is the patient suffering from the latter condition who is likely to consult his doctor because of swelling in the neck or axilla due to glandular enlargement. It is a disease of adult life and has, as a rule, an insidious onset. It may occur in elderly persons, in whom it is prone to be quite latent over a long period. All the superficial groups are apt to be affected, but often unequally, the mass in the neck, axilla, or groin perhaps causing considerable deformity. The individual nodes in a group are of much the same size, soft rather than hard, discrete yet bunched up together, showing no tendency to break down or to involve the skin, insensitive to palpation, and quite painless apart from any discomfort which may be caused by the size of the mass. Deep glands may also be involved, and the spleen is always enlarged; sometimes it is as large as in chronic myelocytic leukaemia. The disease is compatible with good general health for a number of years, but sooner or later more acute symptoms are wont to arise, with pyrexia, loss of flesh, marked anaemia, stomatitis, tonsillitis, diarrhoea, and haemorrhages, though the last-named symptom is less common here than in myelocytic or in acute lymphatic leukaemia. The diagnosis is established, or rejected, by examination of the blood. A typical count in a patient first presenting himself for examination is: Red cells 3.5 x 10^6 per c.mm., haemoglobin 65 per cent., colour index 0.9, white cells 200,000 per c.mm., of which 96 per cent., or 192,000, are lymphocytes. The Leishman stained blood film shows a monotonous blue expanse of lymphocytes, mostly of the small variety, like those of normal blood, in marked contradistinction to the variegated beauty of the well-stained myelocytic film. Glandular enlargement is not a marked feature of myelocytic leukaemia; the nodes in the superficial zones may be just palpable, but are not greatly swollen.

In lymphosarcoma the tendency is for the glandular groups to be unequally transformed into large masses, the individual nodes varying in size, insensitive, soft rather than hard, of limited mobility, and for the whole mass to be fixed to the deeper structures. The liability to deep gland involvement is great, especially of the mediastinum, so much so that the first signs are usually either those of pleural effusion, which may be bilateral and recurrent, or of intrathoracic pressure—for example, dysphagia, cough, fullness of veins, recurrent laryngeal palsy, or sympathetic paralysis. The patient is usually a young adult, and more ill in the early stages than in the corresponding phase of chronic leukaemia or lymphadenoma. The disease is often pyrexial; the diagnosis is confirmed by biopsy. A case of this sort which I saw with Dr. Gilbertson at Hitchin in 1923 is apparently unique in that the patient, a young woman aged 20, has seemingly made a complete recovery.

Her story was that for five months she had had pyrexia, which was irregular, but seldom rose above 100° F. The right pleural cavity had already been aspirated on four or five occasions, the quantity of fluid removed varying from half to three and a half pints; the fluid was not blood-stained and did not clot. Recently the left upper extremity had become swollen, and the face was a little puffy; signs of effusion in the left pleural sac appeared and the subcutaneous veins on the left side of the abdomen became prominent. Enlarged glands, which were painless, sensitive, firm, and fixed, were found in the left supraclavicular fossa. The patient was transferred to hospital, where a biopsy proved the disease to be endothelial sarcoma, and radiography showed

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a large mass in the mediastinum. During the four months she spent in hospital fluid was withdrawn from the right side of the chest eleven times, and from the left seven times. Dr. Finzi treated her with x rays; the mediastinal mass and cervical glands disappeared, and she remains in good health five years afterwards.

Concerning lymphadenoma much has been recently written, and I would call special attention to articles by Rolleston, MacNalty, Fraenkel, Bennet, and Ewing. The term "lymphadenoma," as at present ordinarily employed, probably does not indicate a single specific disease, but a variety of diseases more or less resembling one another in important clinical and pathological features; just as we now speak of the enteric group, which includes a number of fevers closely resembling one another in important features, but each one due to a specific bacillus, though formerly all were included in the term "typhoid fever."

The differential diagnosis of "lymphadenoma" on clinical grounds is often quite impossible, especially from tuberculosis (including endothelial tubercle) and from lymphosarcoma. But if the initial site of glandular enlargement is on one side of the neck, or, rarely, in the groin; if the whole group is affected, but not equally, the largest glands being towards the centre of the mass; if the area involved seems as though stuffed with glands, which are generally of equally firm consistency, discrete, and tending to remain so for a long time, relatively painless and insensitive, and with no indication of involvement of the skin or of abscess formation, the diagnosis is probably lymphadenoma. In lymphadenoma the liability to inclusion of all the superficial groups is relatively great; although there is much diversity in the rate at which this happens, there is a marked tendency for orderly spread of the enlargement from neck to axilla, and from axilla to groin, or vice versa. In the early stages the general condition of the patient is good, but, coincident with the spread of the glandular enlargement, a secondary anaemia is prone to develop; the patient becomes easily tired, is liable to sweats, pruritus, pigmentation of the skin (apart from that which may result from treatment by arsenic or by irradiation), loss of flesh, and pyrexia, which is sometimes of a relapsing character. Evidence of involvement of the intrathoracic glands, and, less often, of the abdominal groups, may be forthcoming; sometimes it is these nodes which are enlarged in the first instance. Lymphadenomatous tissue is prone to infiltrate other organs and tissues of the body, more especially the spleen and the liver, and the presence of palpable enlargement of the spleen is a valuable additional point in favour of the diagnosis. Lymphadenomatous deposits in the spleen arise both in the Malpighian corpuscles and in the pulp; the presence of these white deposits has caused the spleen to be called "hard-bake" or "German-sausage" spleen, and the recognition of these changes is of the utmost importance in confirming the diagnosis at the necropsy. Similar foci of infiltration are sometimes to be found elsewhere—in the pleura, in the lung, in the marrow, in the skin, and, most important of all from the clinical point of view, in the vertebrae; here they may cause pressure either upon the spinal cord with the production of paraplegia, or, by constriction of the intervertebral foramina, lead to severe "root pains" referred to the area of distribution of the corresponding spinal nerve.

The foregoing is an outline of a disease first described by Hodgkin in 1832; there are certain other features which are sufficiently common in the group to merit attention. The frequency with which some infection has occurred recently in the territory drained by those glands which are first affected is often a striking point in the history. A story of sore throat is by no means uncommon, and Sir Thomas Horder has told me of a case in which the axillary glands became the seat of lymphadenoma shortly after a septic infection of the finger. The tonsil is frequently the site of focal sepsis, and is regarded by many authorities as one of the portals of entry of the rheumatic virus and of the tubercle bacillus. It may possibly be the portal of entry also in those cases of Hodgkin's disease in which the cervical nodes are the first to be enlarged; yet it is very rarely that the lymphoid tissue of the tonsil, the thymus, or the Peyer's patches is involved in the disease. Though the enlargement of the nodes is usually slow and painless, it may, on occasion, be rapid and painful; I have seen a case in which a mammary abscess was mimicked, and, at another time, sudden painful enlargement of glands in the right lower quadrant of the abdomen might easily have cost the patient her appendix. Exceptionally, one group of nodes only may be affected, and it is my firm belief that visceral infiltration may occur in the absence of demonstrable enlargement of lymphatic glands.

Of great interest is the relapsing pyrexia sometimes seen in this disease. In a monograph on the subject recently published by the Ministry of Health (see *Journal*, May 12th, p. 819) A. S. MacNalty states that

> "Lymphadenoma with relapsing pyrexia may be classified into two main types:
>
> 1. A form in which the external lymphatic glands exhibit enlargement with or without enlargement of internal lymphatic glands.
>
> 2. A form in which the internal lymphatic glands are alone affected."

During the pyrexial periods the affected glands may become more swollen; the liver and spleen also, if involved, may increase in size, subsiding somewhat during the apyrexial interval. To quote MacNalty again:

> "In a typical case, following on a period of low pyrexia or of normal or of subnormal temperature, there is a steady rise, occupying two to four days to a maximum of 102°, 103°, 104°, or even 105° F. For about three days the temperature remains at a high level, and then there is a gradual fall by lysis which usually occupies about three days also. The temperature then becomes subnormal, at any rate for a few hours. During the pyrexial period, as a rule, the patient feels exceedingly ill; he has aching pains in the back and limbs, together with chills, profuse sweats, and loss of appetite. His expression is one of distress and anxiety."

The duration of either the pyrexial or the apyrexial periods is not constant, and they do not seem to bear any relation to one another.

Help in diagnosis is sometimes obtainable from the pathologist. Unfortunately, there is no blood picture characteristic of the disease—all that can be said is that a blood count showing an anaemia of the secondary sort, with no gross alteration in the absolute and differential leucocyte count, is not incompatible with lymphadenoma. The intradermal tuberculin test is negative save in those cases, by no means rare, in which tuberculosis and lymphadenoma coexist. There is as yet no serological test to help us. Even after the histological examination of a suitable gland—that is, one in which the disease process is still active—removed during life the diagnosis may be largely a matter of individual opinion; there is the typical variety which shows the characteristic histological features described by Sir Frederick Andrewes, and which all will admit as Hodgkin's disease, but in other varieties, which do not conform to this, the histologist who makes the diagnosis may make a lucky shot or be merely bluffing.

So also with regard to etiology there are many guesses, many suspicions, much perplexity. Lymphadenoma is probably an infection, and a stronger case has been made out against the tubercle bacillus than against any other known microbe, the indictment being that under unknown conditions the tubercle bacillus is able to produce these changes in some tissues and organs, especially in lymphoid tissue, which differ from those of true tuberculosis.

So the disease, at present, is a mystery. Even the nomenclature is not settled; it answers in various quarters to Hodgkin's disease, to lymphadenoma, to lymphogranuloma, or to lymphomatosis granulosa.

Clearly, then, lymphadenoma is a condition calling urgently for research. At St. Bartholomew's a special fund, the Rose Research Fund, has been received for the investigation of lymphadenoma; clinical and pathological workers are co-operating in a special endeavour to elucidate it further. A team is in being, and a certain amount of progress has been made. Material is as yet scanty, and the fund will not be available for an indefinite period. We therefore invite practitioners to help us to "pluck out the heart of my mystery" by sending any patients with enlarged glands of doubtful or uncertain nature for investigation. Sir Thomas Horder and I will readily take them into the hospital, and, if required, we have the surgical collaboration of Professor Gask.

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THE THERAPEUTIC VALUE OF NEPHROPEXY.*

BY

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TWENTY years ago this session I read a paper before this society entitled "The indications for nephropexy," a paper which was subsequently published in the *British Medical Journal*. At that time the subject was a very live one in Birmingham; the meeting was largely attended, and very strong views were expressed both for and against the operation. The question cannot even now be regarded as settled, and the object of this paper is to present as fairly as possible the results of my personal experience of nephroptosis and its surgical treatment, in the hope that it may assist in arriving at a true solution.

Time does not allow of my dealing with many points of great interest and importance in connexion with the causes, pathology, and symptoms of nephroptosis; nor can I enter into the methods I have employed in the selection of cases likely to benefit by operation. I intend to consider results only, and from them endeavour to show what therapeutic value has attached to nephropexy.

The results of nephropexy have to be considered from two aspects: (1) the surgical success of the operation in permanently replacing the kidneys in their normal position without unsatisfactory sequelæ, such as pain in the loin or back, hernia of the wound, and persistent sinus; and (2) its therapeutic value in curing or ameliorating the symptoms for which it is performed.

SURGICAL RESULTS.

At first these were very unsatisfactory. In a large percentage of cases the operation failed to cure the abnormal mobility of the kidneys, and they were found loose again almost as soon as active life was resumed. Many operations fixed the kidney to the muscles of the back and at too low a level, with the result that pain in the back was common, and sometimes hydronephrosis developed. The use of silk and other non-absorbable suture materials was followed by persistent sinuses, and extensive damage to the muscles of the loin led to a feeling of weakness and hernia.

A further and very common cause of failure is the incomplete character of the operation. One kidney only is replaced, while the other kidney, which may also be mobile, and a possibly diseased appendix are left untreated. Satisfactory therapeutic results cannot be expected unless the operation, as such, is successful. Only when the surgeon is satisfied that both kidneys are in a normal position, and that possible associated or secondary abdominal lesions have been excluded or treated, can success be claimed.

The operation which I have performed upon upwards of 1,500 patients has been carried out in this spirit. My object has been to replace both kidneys, if both are loose, and to make sure that no intra-abdominal lesion is left undetected and untreated.

The surgical results have been very satisfactory. In no single instance have I found a kidney loose again, although on a number of occasions I have reopened the loin, thinking that it had become so. The usual cause of error is a Reidl's lobe of the liver, and on the left side a prolapsed spleen, conditions which may simulate a movable kidney very closely. In my earlier cases, before I opened the peritoneum as a routine, an enlarged gall-bladder on several occasions was mistaken for a kidney which was thought to have broken loose after replacement. In no case has there been a persistent sinus, and no second operation on this account has been needed. In some twenty cases I have had to excise a length of the last dorsal nerve subsequently on account of pain caused by its implication in scar tissue, and a few cases have been operated upon for hernia of the scar. Very occasionally, where at the time of operation a moderate hydronephrosis existed this has increased and necessitated excision of the kidney. My experience has been that where the pelvis of the kidney is sufficiently dilated to hold more than about two ounces of urine replacement fails to prevent its destruction by hydronephrosis, while if the pelvis is dilated to a less extent the operation succeeds in doing so.

The results in my large series of cases extending over twenty-five years have been such as to justify the claim that movable kidney can be treated successfully by operation, and that the operation is safe and comparatively easy. It is essentially a plastic operation, and if therapeutic results justify it there are no surgical reasons why it should not be done.

THERAPEUTIC RESULTS.

Very widely differing views are held as to the importance of movable kidney as a cause of chronic ill health, and of the value of nephropexy as a therapeutic measure. In the early years of the present century extravagant claims were made that nephroptosis was responsible for a vast amount of functional disturbance of mind and body, and it was asserted that the kidneys should be fixed in such cases whenever any undue mobility was detected. The results of this were unfortunate, as they always are whenever the usual care in selection of cases is abandoned and a new treatment is applied indiscriminately. The claims that Koch's tuberculin is a cure for phthisis; that hunger pain in association with hyperchlorhydria indicates duodenal ulcer and calls for gastro-enterostomy; that the teeth are responsible for most cases of rheumatism and should be sacrificed wholesale; and that movable kidneys are the cause of much functional nerve disturbance and should be treated whenever found in association with it, have all led to disappointment when extensively acted upon. Medicine is much less simple than this, and a claim that a panacea has been discovered for any common disease or clinical syndrome generally brings disappointment when blindly accepted.

The wide and indiscriminate operating for movable kidney was attended by unsatisfactory results and caused the pendulum to swing in the opposite direction, with the result that it is often asserted that nephroptosis is rarely of importance and still more rarely calls for treatment. The truth lies somewhere between these two extremes. Unquestionably, anyone who has carefully studied the problem, and has brought to bear upon it the same care and judgement in the selection of cases suitable for operation, has paid the same attention to technique, and has followed up the operation by necessary after-treatment as for other surgical conditions, cannot fail to be convinced that nephroptosis may be a cause of lowered efficiency and chronic ill health, and that treatment of it by nephropexy may be called for.

Great care must be exercised in deciding the suitability or not of a particular case for nephropexy. The necessity for a satisfactory technique and a complete operation has been emphasized. It is, also, all-important to remember that time and suitable after-treatment are needed to complete the cure. So many operations are followed by immediate and dramatic benefit that disappointment is often caused to surgeon and patient when an interval of six months or a year must elapse between the operation and its beneficial result. No patient can emerge from a state of severe and long-standing neurasthenia in a short time, even though the cause has been removed. This is the reason why so many patients operated on for movable kidney recover slowly from the symptoms from which they were suffering at the time of operation. I never assess results until a full year has elapsed from the operation, and even this length of time is often insufficient, and only after two or three years is full health obtained. Two facts stand out in connexion with my results: (1) that the failures have never improved to any extent after operation; and (2) whatever benefit is obtained is retained; relapse is almost unknown. Also, the further back the investigation into results is carried the better they are. If only it became sufficiently realized that in a large proportion of cases the effect of nephropexy is to convert an incurable condition into a curable one, and not of itself to establish a cure, the percentage of failures would diminish and the true value of the operation be better understood.

I would most emphatically state that no moral value whatever attaches to the operation. In my opinion the

* Valedictory presidential address to the Midland Medical Society.

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moral effect on the patient is wholly bad, and there is not one redeeming feature. From the moment operation is mentioned until it has been completely recovered from and forgotten, the effect is to put a further strain upon a mind and body already over-stimulated and exhausted. The whole question of operation is fraught with greater responsibility than usual, and unless it is felt that the benefit likely to result justifies it, nephropexy should not be done. It is advisable to draw particular attention to this point because I have often heard it asserted that the benefit that follows nephropexy is due to the moral effect of the operation upon the patient, and I have frequently been requested to perform it for that purpose. On one occasion I saw a man who had had an incision made into the loin to impress him that his kidney, which he had been told was loose, had been put right. Such procedures are entirely wrong. It is questionable whether the mental and physical injury caused by an operation ever confers any benefit except in so far as it remedies a physical trouble, and the harmful effects of operations, as such, are considerably greater in neurasthenic patients. It is therefore reasonable to assume that any benefit following nephropexy is due, not to the fact that an operation was done, but to the replacement of the kidneys that it effected.

Results of Nephropexy in my own Series of Cases.

My personal experience of nephropexy extends, as I have said, over twenty-five years, and during that time I have operated upon more than 1,500 patients and replaced more than 2,000 kidneys, the double operation having been performed in the majority of cases. All my patients have been referred to me by practitioners, and it is their encouragement and support which has made me feel that the operation has justified itself. After all, in my opinion, it is the patient's own doctor rather than the surgeon who ultimately determines the value of any form of treatment. He has an intimate knowledge of his patient that no specialist can acquire; it is a knowledge based upon prolonged observation of the patient himself and his reactions to and upon those who come in contact with him. Where neurosis and functional disturbance are predominant features improvement is often more evident to the family doctor and the patient's relatives and friends than to the patient himself, and the doctor's verdict is perhaps the best test of value that can be obtained. On this verdict, rather than upon such tests as I have been able personally to apply, I have been content to rely. No more graphic description of the effect of the operation could be given than that volunteered by the husband of one of my patients —that "before the operation my home was a hell, and now it is a heaven."

It is very difficult to obtain accurate statistical evidence of the therapeutic benefit conferred by nephropexy. Some years ago I made two different investigations. For the purpose of the first I wrote to 100 consecutive patients in my series, one full year having elapsed in every case between the operation and the inquiry. I was successful in obtaining information about 87 of these patients, and from that I ascertained that about 60 per cent. were well in the sense that they were leading ordinary lives and did not need medical attendance; 20 per cent. were considerably better, 10 per cent. were better, and 10 per cent. were no better.

The second inquiry took the form of a questionary addressed to eleven practitioners, 70 of whose patients I had operated upon. The questions submitted to them were: In the case of ..... (1) Has the operation been a surgical success—that is, has it efficiently and permanently anchored the kidneys, and has it been free from unpleasant sequelae? (2) Has the general resulting benefit justified the operation?

Great care was exercised by the doctors to make the answers reliable, and each patient was either written to or personally interviewed. The actual replies were printed and circulated among the members at a meeting of the Surgical Section of the Royal Society of Medicine on January 13th, 1914. They indicated in all the 70 cases that the operation was a surgical success; in one case only, that of a lady, who complained of pain in her right side, was there any mention of after-trouble. Of the general benefit that resulted, only 5 were reported as failures, while many were described as having been changed from chronic invalids into absolutely normal people.

These satisfactory results do not appear to have been obtained by the majority of other surgeons, and the tendency is for fewer and fewer cases of nephroptosis to be operated upon. This led me to make a still further and more drastic investigation into my results. All the patients upon whom I had operated during the five years 1922-26 were written to and invited to answer the following questions:

1. Have the operation wounds troubled you? If so, in what way?
2. Have the symptoms for which the operation was performed been cured?
3. What is your present state of health?

Of the 213 patients written to replies were received from 163. It soon became evident from the replies that the answers to the first two questions were of little value, and that the answers to the third supplied the true test.

All these patients suffered from symptoms sufficiently severe to call for medical attendance, and had proved incurable by ordinary methods of treatment. The symptoms complained of were very variable, but in every case the renal mobility was held to be the principal cause. In every case the operation was a complete one—that is, both kidneys were fixed when both were loose; and an abdominal exploration from the loin was carried out. In nearly all the appendix was removed.

In order to obtain an independent and absolutely unbiased report the replies were submitted without comment to Professor Kauffmann, whose wide experience of both private and hospital patients peculiarly fits him to estimate their meaning. I am very much indebted to Professor Kauffmann for the great interest he has taken in this investigation, and I am convinced that his report will receive the consideration it deserves. It estimates, as impartially as is possible, the true results of the operative treatment of nephroptosis.

Professor Kauffmann's Report.

"The replies from 163 patients have been carefully considered with a view to my forming a conclusion as to the results of the operation for nephroptosis. I have, of course, only the patients' replies from which to judge, and a certain difficulty is introduced by the second question, inasmuch as many of them scarcely know or remember the groups of symptoms for which they sought advice. Guided by the kind of reply, and to some extent by the tone of the reply, I have divided these 163 cases into five groups—namely:

1. *Complete success*, where the statement warrants the name 29
2. *Success* 42
3. *Partial success*, where the benefit outweighs any remaining troubles 41
4. *Partial failure*, where the remaining troubles outweigh such benefit as the patient has derived 22
5. *Failure* 29

"I have not felt able to make allowances for such things as gravidity or possibly some new trouble coming on, as it must do in some proportion of the cases in an interval of several years. It is more than likely that some cases which would have been in one of the successful groups have been spoilt by a new disease thus intervening.

"It seems, therefore, that, taking complete success and success together, these groups account for 43.6 per cent.; partial success accounts for 25 per cent.; failure for 17.7 per cent.; and partial failure for 13.5 per cent. These figures are, I conclude, very satisfactory.

"By far the greater number which constitute groups 1 and 2 together have had appendicectomy as well as kidney fixation, generally double. But success is also found in those who only had a kidney fixation, single or double, done.

"I have considered the question whether the addition of appendicectomy, or other operation, has affected the results, but can get no satisfactory answer, since, in the successful group, nephropexies without other operation only formed 12.6 per cent., and in the partial failure and failure groups 13.7 per cent."

Commenting upon Professor Kauffmann's report, I would draw attention to the severity of the test applied. Results are mainly determined by the answer to the question "What is your present state of health?" Only those cases in which the answer indicates that the general health is satisfactory in every way have been placed in the

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successful group. Patients who state that although relieved of the symptoms for which the operation was done they do not enjoy normal health owing to other troubles are labelled partial successes or failures according to whether their general health and working efficiency appear to have been improved or not. The disappearance of one set of symptoms and the substitution of another set in their place with the result that comfort and working efficiency have not been materially improved is regarded as evidence of failure. Further, as Dr. Kauffmann points out, no allowance has been made for the entirely new troubles which may reasonably be expected to develop in a certain number of cases over an interval of several years. The report, therefore, may be taken as indicating in a conservative way the proportionate effect of the operation in raising to a normal standard of health patients who were in a state of chronic invalidism.

The following may be said to summarize the results of Professor Kauffmann's investigation of 163 cases, operated upon at intervals of from six and a half to one and a half years prior to the inquiry (13 of these patients were men and 150 were women).

Successful	71 = 43.6 per cent.
Partially successful	41 = 25.0 ,,
Failures	51 = 31.4 ,,

These results, taking into consideration the kind of patients operated upon, though by no means justifying a claim that nephropexy is a panacea for neurasthenia and functional disturbance when complicated by renal mobility, are satisfactory. The patients had all undergone prolonged treatment, and were referred to me because of their failure to benefit by it. They were the neurotic flotsam and jetsam who are the despair of their friends and medical attendants. Nearly all were in early adult life with many years of activity in front of them. Most of them were under the necessity of earning a livelihood or managing a household, and the change from chronic invalidism and inefficiency to normal health and efficiency that has been effected in nearly half of them would seem to justify the performance of an operation which is almost free from risk and which is essentially plastic in character.

Looking back over the long series of cases of nephroptosis that have come under my observation, in only about one-third of which I have operated, I cannot help feeling that the results would have been better had the condition been effectively treated at an earlier stage. In no branch of surgery can the best results be expected in the later stages of disease and in the medical failures, and nephroptosis is no exception to the general rule.

A BEDSTEAD FOR USE IN TREATING CARDIAC PATIENTS SUFFERING FROM CONGESTIVE FAILURE.

BY

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FOR many years the need of a bedstead specially constructed to suit cardiac patients suffering from congestive failure has been felt. Such patients are usually orthopnoeic and require propping up with bed-rests or a pile of pillows; from these they are apt to slip down at night, an accident usually occasioning distress and loss of sleep, and sometimes avoided by the rather clumsy device of tying a bolster across the bed below the buttocks. Some of the patients are oedematous, and drainage into the legs from the trunk, or from the legs by tubes or incisions, is required sooner or later. Drainage necessitates the sitting posture, and the patient must be moved into and nursed in a chair. Many of the patients are restless unless frequent changes of posture are allowed them: many prefer to sleep in a chair rather than in a bed at night.

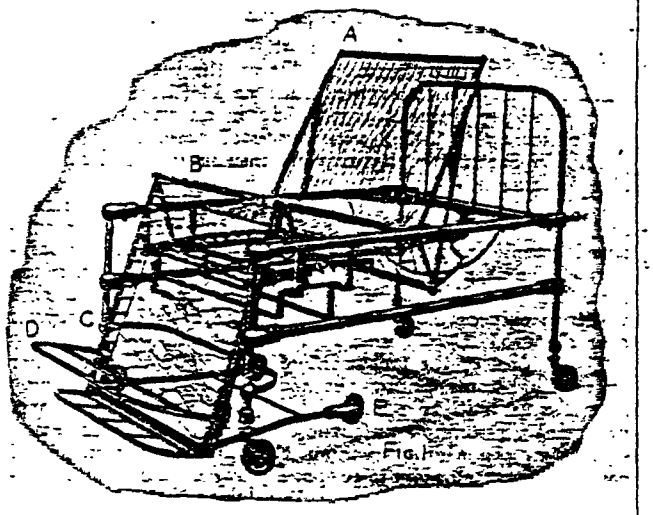
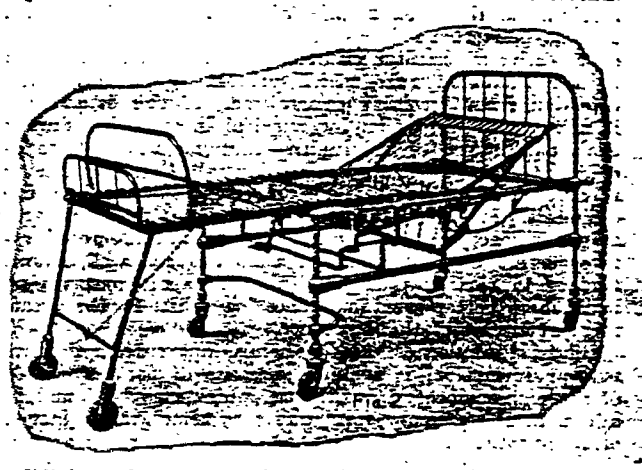


FIG. 1.

To nurse patients suffering from congestive failure often means very heavy work, and, unless special devices are used, these patients are apt to exert themselves much more than is good for them. It is sound to insist that patients of the class considered should make no muscular effort that can reasonably be avoided; they should be supported constantly, and should never support themselves. They should never move themselves, or put forward effort in assisting a nurse to move them. Experience shows that under such a regime improvement is more likely or is more rapid than under a less rigid system of treatment.

Very many of the difficulties of nursing otherwise encountered are overcome by using a bedstead that has been built for me by Messrs. Whitfield's Bedsteads, Ltd., of 10, Dane Street, High Holborn, W.C.1. This bedstead can be used completely flat or can be converted within a minute or two into a chair, as shown in the illustration. The back-rest *a* is raised into the position shown, or to any other desired angle, by a detachable crank handle moving a quick-thread screw at the head of the bed. A second, and independent screw, also at the head of the bed, raises the thigh-rest *b* to any desired position; this second rest prevents the patient from slipping downwards. Both these movements are executed quite smoothly, and the corresponding rests are at once stable at any angle to which they have been raised. The third movement, the lowering of the leg-rest *c*, is accomplished by hand, the leg-rest being adjusted at any desired angle on two strongly toothed racks, which drop upon a stiff steel bar. The foot-rest *d* is adjustable on the leg-rest to suit legs of different lengths.


FIG. 2.

The bed has four legs on the main rigid frame, and two additional legs *e*, carried on the end of the leg-rest and falling under the bed when the leg-rest is dropped. The additional legs were not included in the original design, but have since been added to support, not the patient, but the occasional visitor or student who throws his weight on to the end of the bed. The mattress is made in three

* Working on behalf of the Medical Research Council.

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pieces to fit the three parts of the bed, the three pieces being hinged together. The bed has been in use in my wards for two years, and is much favoured by both patients and nurses. Patients can be moved frequently and without effort; they are more comfortable and are more completely rested than formerly.

The original model of this bedstead was built with funds generously given for the purpose by Frederick Faust, Esq.

THE ACUTE PELVIS.*

BY

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THE object of the present short communication is to bring forward some points of interest in the diagnosis and treatment of cases presenting symptoms suggesting acute pelvic conditions. The observations are based on cases in my own experience. They may be conveniently grouped into those presenting symptoms accompanied by fever and those which present symptoms accompanied by shock. The symptoms may be associated with bilateral signs in the pelvis or by signs localized to one or other side.

Symptoms suggesting Acute Pelvic Lesions accompanied by Fever.

When a bilateral tumour or marked tenderness, situated at both sides of the uterus, is discovered in a woman of the child-bearing age the diagnosis of a pyosalpinx or acute salpingitis is suggested. The interest of the condition lies more in the matter of treatment than diagnosis, and centres round the time of election for operation. Comparison between the pathology of acute salpingitis and that of puerperal peritonitis illustrates the value of delaying operation until the inflammatory process has become well established.

In the very fatal peritonitis following labour or miscarriage the abdomen is found at laparotomy more or less filled with purulent discharge, and pus is seen issuing freely from the open mouths of the abdominal fimbriae. This suggests that salpingitis and pyosalpinx formation is a protective mechanism, and that it is in part the reaction in the Fallopian tube which prevents every ascending infection from becoming generalized. If this is granted it affords the indication for surgical intervention during the acute stage of salpingitis—that is, when there is evidence that the limiting process has failed and the disease is spreading, or when there is uncertainty as to the diagnosis. It may be true that surgery in the early stages will accelerate the convalescence, but the recuperative powers of the Fallopian tube are too well known further to remark upon, and the value of conservatism is nowhere better seen in gynaecology than in the treatment of disease of this structure.

Bilateral tenderness in the pelvis, apart from definite tumour formation, is included because of the occurrence of acute pneumococcal peritonitis, which may be found in adults in the primary form and may simulate an attack of salpingitis. It is mentioned because the symptoms in the earliest stages may be referred to the pelvis rather than to the general abdominal cavity. When the signs are unilateral the difficulties of diagnosis are greater. If the symptoms are accompanied by signs on the right side of the pelvis, the main point in the differential diagnosis will be to distinguish between appendicitis and salpingitis, in view of the divergence in the treatment of the two conditions. Either of them may present such a variable picture that a diagnosis based upon the inflammatory phenomena as they affect these two neighbouring viscera is bound to fail quite frequently.

In contradistinction to appendicitis, salpingitis is the last stage in a morbid process, and if attention is focused on the whole of the genital tract, the evidence of this will generally be found by the presence of signs of inflammation in the lower part of the tract.

Although less common, more interest attaches to cases with left-sided physical signs, owing to the fact that diverticulitis, with peridiverticulitis, frequently gives rise to signs and symptoms suggesting a lesion of the left tube or ovary. While the condition may occur during the child-bearing period, it is more usually a post-climacteric disease.

Inflammation is the commonest pathological change around the sac, and the accompanying inflammatory oedema and hyperplastic inflammation in the bowel wall lead to the formation of a definite tumour, while the formation of adhesions to the pelvic viscera adds to the difficulty in differential diagnosis. The development of a pyosalpinx after the climacteric, on the other hand, is very unusual, as the records of the gynaecological department of Charing Cross Hospital show.

The x-ray appearances after a barium enema are of considerable diagnostic aid, and further serve to distinguish the condition from malignant disease of the bowel, with acute symptoms superadded.

The treatment of these cases of diverticulitis is of very considerable interest, but space does not allow of its inclusion.

Symptoms suggesting Acute Pelvic Lesions accompanied by Shock.

In women of the child-bearing age the complications of ectopic pregnancy come first to mind, and seldom present difficulties in diagnosis or management. Some new diagnostic tests have been described within the last few years, but they do not materially aid in diagnosis.

One of these is called the phloridzin test. A positive reaction depends upon the production of glycosuria following the injection of phloridzin, and indicates only the condition of pregnancy. I have no personal experience of it, and two factors materially reduce its value in acute conditions. First, considerable time and the facilities of a laboratory are necessary for its performance. Secondly, after rupture and the formation of a haematocele the test becomes negative, according to some observers, even if previously positive.

Another is the "shoulder pain" test. Rubin has called attention to the occurrence of the same sign when gas enters the peritoneal cavity in the course of a tubal insufflation. It depends presumably on the presence of some irritating foreign substance, such as blood, in the upper part of the peritoneal cavity. It is an unreliable sign. While it may be found with ruptured ectopic pregnancy, yet the abdominal cavity may contain much blood and the sign be absent.

Cullen has described a sign which is known by his name, and, if found, is considered to be pathognomonic of a ruptured ectopic pregnancy. It consists of a bluish discoloration of the skin around the umbilicus, and has been noted from time to time by different observers. It is a sign which is only occasionally present, and I have not myself ever observed it.

The subject of the treatment of the gravid tube, whether by salpingectomy or by the more conservative salpingostomy, must still be considered an open question. It will presumably remain so until the etiology of ectopic gestation is known. In this connexion the increasing number of cases of repeated ectopic pregnancy reported in the literature is interesting.

The rare condition of haemorrhage into the ovarian tissue and the formation of a pelvic haematocele, which may accompany delay in ovulation, is only of academic interest. The etiology is unknown, and the differential diagnosis from ectopic pregnancy cannot be made prior to operation so far as I am aware.

A difficult differential diagnosis is presented when symptoms occur suggesting torsion of the pedicle of an ovarian cyst. It is well known that patients with an ovarian cyst may develop acute symptoms due to some other intra-abdominal or pelvic condition, and I recall three cases which well illustrate the point. In one of these the acute symptoms were due to acute haemorrhagic pancreatitis, in another they were due to volvulus of a portion of small intestine during early pregnancy, and in the third to acute appendicitis.

My experience leads me to believe that the importance of the urgent symptoms attending torsion of the pedicle

* A paper read in the Section of Obstetrics and Gynaecology at the Annual Meeting of the British Medical Association, Cardiff, 1928.

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of a cyst is exaggerated. These symptoms are usually described as the onset of sudden abdominal pain, together with vomiting or other alimentary disturbances. On examination some degree of shock is found and muscular rigidity of the abdominal wall.

Analysis of the cases of actual or supposed torsion of the pedicle of a cyst which I have seen leads to the conclusion that the more urgent the symptoms of internal strangulation the less probably is the case one of a strangulated cyst, but more probably of some other intra-abdominal catastrophe, accompanied by the presence of an ovarian cyst.

The explanation offered that when at laparotomy a cyst is found which had undergone torsion the occurrence of the twist was gradual rather than sudden in onset is, in the absence of any clinical signs suggesting it, equally difficult of proof or disproof. It must remain an open question until more is known concerning the mechanism of the torsion, which is certainly very obscure.

In conclusion, I wish to draw attention to two points only, which have impressed themselves upon me, and they are these: (1) the need for a thorough examination of the whole abdomen and pelvis in the matter of diagnosis, and (2) in treatment such an operative exposure as will allow of a thorough exploration of all the organs that may be diseased. In hospital out-patients we quite frequently see women with a small incision in the right iliac fossa through which an appendicectomy has been performed, still presenting a pelvic syndrome, and requiring a further operation on their pelvic organs. These "button-hole" incisions do not offer suitable exposure for the surgery of the female pelvic organs, and their use may be discontinued with advantage.

A CASE OF COMPLETE GASTRECTOMY FOR CARCINOMA OF THE STOMACH.

BY

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(*With Special Plate.*)

THE patient whose case is here recorded is a labourer, aged 44, who was under the care of Dr. Broughton of Batley; he was admitted to the Batley Hospital on May 24th, 1927. His complaint was painful indigestion, with loss of weight and appetite. He had been in good health up to two and a half years before, when the indigestion started. The pain came on within half an hour of taking ordinary food, was felt in the epigastrium, and gradually passed off before the next meal. At first the pain was relieved by lying down, and sometimes by pressure over the pit of the stomach. The attacks lasted some three or four weeks, and were followed by periods of several weeks of almost complete freedom from symptoms. During the attacks flatulence was a very troublesome feature, and in attempts to relieve himself of this by belching small risings of food occurred into his mouth; apart from this there was never any vomiting of food or blood, and no melaena had been noticed. The bowels were rather constipated. The last attack began in December, 1926, and was continuous up to the time of operation; it was during this period that his appetite failed and the main loss of weight occurred. He had lost about 1½ st. during this time.

On admission to hospital the patient was in fairly good condition, but anaemic and rather flabby. His weight was 8 st. Abdominal examination showed the abdomen to be thin and rather hollowed, and though there was nothing definitely abnormal on palpation, there was a suspicion of an ill-defined lump in the epigastrium. A diagnosis of carcinoma of the stomach was made, and it was thought it might have become implanted on a chronic gastric ulcer. Operation was advised and was performed on May 26th, 1927. The usual right paramedian incision was made, and a growth was found occupying the greater part of the stomach, which was small, thick, and nodular. There were thin adhesions to the pancreas, and several glands were noted along the lesser curvature, especially close to the oesophagus at the origin of the gastric artery. No secondary deposits could be felt in the liver or pelvis. It was quite obvious that nothing could be done to rid this man of his disease other than a complete gastrectomy, and I decided that it was worth while giving him his chance.

The pyloric artery was ligatured and two Payr's clamps applied to the first part of the duodenum. The duodenum was divided between the clamps and the two cut ends cauterized by heat, and the distal one infolded over the clamp; this was slipped out, the suture tightened, and then infolded by a second line of stitching. The gastro-colic omentum was divided along the whole length of the stomach about 2 in. from it, and the lesser curvature was similarly treated, the gastric artery being ligatured at its origin from the coeliac axis; this enabled me to remove the last palpable gland. Fortunately there were very few of the pancreatic glands involved. The whole stomach could now be lifted up, giving a very clear view of the lower end of the oesophagus. A clamp was applied across the cardiac orifice of the stomach, and by using this as a retractor enough oesophagus could be drawn down to enable me to suture it with reasonable ease to the jejunum. The jejunum was drawn up in front of the transverse colon so that there was no loop left between the part selected for suture and the duodeno-jejunal flexure. The stitching was carried out in the same way as for gastro-enterostomy without clamps, the stomach being cut away little by little as the sutures were inserted. By using the stomach as a retractor until the suturing was practically finished no great difficulty was encountered in uniting the jejunum to the oesophagus.

The patient bore the operation well, and on returning to bed was put on to continuous rectal saline at once. He began sipping small quantities of water at the end of twenty-four hours, and the quantities were gradually increased with the addition of milk and tea, until at the end of ten days he was taking as much as he asked for. Solid food was begun in a fortnight, and steadily increased. He was up within a month, and eating ordinary food in small quantities and often. Although he had lost all desire for food before operation he was now thoroughly enjoying his meals, but had to take them slowly, otherwise he felt a sensation of distension, and almost as soon as he had finished one meal he was feeling hungry again. This is rather a curious occurrence, for we are led to believe that the sensation of hunger is due to gastric contractions.

I had this man treated subsequently with deep x rays, but I am unable to say whether it did him any good or not. He had a kind of lienteric diarrhoea for some months after operation, which gradually disappeared. The man is now (October, 1928) back at work, eating well, enjoying his food, feeling well, and apart from a little anaemia has a normal healthy appearance.

The pathological report on the excised stomach was kindly made for me by Dr. M. J. Stewart, and is as follows:

"The specimen as received consists of the entire stomach, with about 1 in. of the duodenum. The pyloric three-fifths of the organ is largely occupied by a deeply cratered, ulcerated carcinoma, measuring 4½ by 4 in. in its two chief diameters. The centre of the lesion is on the posterior wall, 2¾ in. from the pylorus and exactly midway between the lesser and greater curvatures. The growth has extended across both curvatures so as to encircle the organ, only an inch or so on the middle of the anterior wall escaping. The lower margin of the tumour extends to within 3/4 in. of the pylorus. The appearances suggest a primary carcinoma with secondary ulceration. The margins are much thickened, undermined, and overhanging, and the contour, while generally circular, is very irregular. The floor, everywhere obviously composed of growth, is irregularly nodular and ulcerated. Externally there are extensive dense adhesions in the lesser sac between the stomach in the region of the growth and the pancreas and retroperitoneal adipose tissue. Pale masses of growth can be seen beneath the serosa, but there is no

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evidence of actual peritoneal invasion. Several glands along the lesser curvature are slightly enlarged.

"Histologically the tumour is a carcinoma of great cellularity. In general the structure is spheroidal-celled ('encephaloid cancer'), but there is occasional acinar formation, and in places there is an abundant fibrous stroma. The tumour tissue has completely penetrated the muscular coat over large areas, but nowhere is there a cancer-cell-free sclerotic mass indicative of pre-existing simple ulceration. Many nerve fibres are embedded in the surface layers of the growth subserosally, where there are also some touch-corpuscles in close relation to it. Three lymph glands examined microscopically show extensive invasion."

On November 1st, 1927, I admitted this man to the Leeds General Infirmary for investigation, as I was curious to find out, if I could, how he had compensated for the complete absence of his stomach. At this time he had gained about 1 st. in weight, was feeling fit, and eating ordinary food, though slowly and in small quantities. If he ate hurriedly or large amounts he felt distended and uncomfortable; however, he soon became hungry again. He had a craving for sugar and salt.



FIG. 1.—Showing the extent of the growth after laying open the stomach.

The following results were obtained from various investigations, and I wish to express my thanks to Dr. Seargill, radiologist at the Leeds General Infirmary, and to Dr. Fowenther and Dr. Hartfull, pathologists at the same institution, for their valuable help in this respect.

X-ray Report, November 3rd, 1927.

1. A solid cachet was given. This passed straight into the jejunum; no delay at the anastomosis.
2. Fluid meal. This floods the upper small intestine at once; none is seen to pass backwards into the duodenum.
3. Four hours after giving the barium meal, all the barium is in the lower ileum.
4. Six hours after giving the barium meal, caecum filled; some still in the lower ileum (normal findings).

Blood Examination, November 2nd, 1927.

The blood count showed red cells 4,500,000 per c.mm., leucocytes 2,960 per c.mm., haemoglobin 76 per cent., colour index 0.84.

Film: The red cells show slight variation in size and shape, but they stain well and evenly. The leucocytes show nothing for special comment beyond leucopenia.

Differential count: Eosinophil polymorphs 1 per cent., neutrophils 59.5 per cent., large mononuclears 5 per cent., lymphocytes 34.5 per cent.

Blood sugar: 0.11 per cent. (normal 0.08 to 0.12 per cent.).

Blood cholesterol: 15 per cent.

Urea nitrogen: 19.6 mg. per 100 c.cm. blood (normal 10 to 20 mg.).

CO_2 combining power: 57.5 c.cm. of CO_2 bound as bicarbonate by 100 c.cm. of plasma (normal 60 to 70 c.cm.).

The saliva on November 2nd, 1927, showed alkalinity equivalent to 0.08 per cent. sodium carbonate (normal 0.08 to 0.1 per cent.).

On November 9th an eighteen-hour culture of faeces showed growth of *B. coli*; no pathogenic organisms were isolated; bile salts present. Total solid matter 40.7 per cent. of dried faeces, containing: fatty acids as soaps 17.3 per cent., free fatty acids 16.3 per cent., neutral fats 7.1 per cent. of dry faeces. The faeces contained 17.07 per cent. of dry matter. Fat-splitting appears normal, but there is some deficiency in absorption of the split fat. Microscopic examination showed some undigested muscle fibres present, apparently in greater number than usual. Undigested vegetable material was also present. The urine on the same date was normal.

An attempt was made to recover some of the contents of the jejunum after giving a test meal on the lines of the usual gastric test meal; it was found impossible to get sufficient for examination, I assume because of the rapid passage onward of the food.

I think this case is worthy of publication as the number of cases of successful complete gastrectomy for carcinoma of the stomach is very small. It is remarkable how efficient has been the compensation for total absence of the stomach. Six months after operation, apart from slight anaemia and leucopenia and a little deficiency in fat-splitting, there seems to be no noticeable alteration in the functions of his various systems so far as these can be determined. Possibly the fact that he consumed large quantities of dilute hydrochloric acid at and between meals is partly responsible. It was found impossible to get him to continue this after he had returned to work.

It is now about eighteen months since the operation, and he is apparently quite fit and able to do reasonably hard work, and enjoys his food. He is free from anything which would suggest recurrence, and shows no sign of anaemia, though a blood examination has not been made since last November.

CYSTICERCOSIS OF THE BRAIN:

WITH REPORT OF A CASE.

BY

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(*With Special Plate.*)

Cysticercus cellulosae is rarely met with in this country, and, so far as we can ascertain, the following case is the only one for many years that has come to necropsy in England.

Description of Case.

History.—The patient enlisted in the army in June, 1918, at the age of 18, and proceeded to India in 1919. In July, 1921, he developed enteric fever, which was complicated by thrombosis of the right leg. In June, 1922, the vision of his left eye became rapidly impaired (vision 6/60), and a report states "atrophy of the retina due to retinitis"; but it is admitted in a note made in the following month (July) that "the diagnosis at present is not definite." Later the eye condition appears to have been attributed to an embolus of the retinal artery, but a further report in October, 1923, states "left vitreous occupied by mass of vascularized fibrous tissue." Eventually the eye was enucleated at the Royal London Ophthalmic Hospital on July 26th, 1924. Dr. H. Coverdale, from the records of this hospital, kindly informs us that the left eye showed ciliary injection, old keratitis punctata, posterior synechiae, and cataract, with no perception of light. The right eye was normal. Unfortunately the pathological notes are missing. In view of his subsequent history, however, it is practically certain that the eye was affected by cysticercus. In April, 1923, his first epileptic fit occurred on the ship returning from India. The fits recurred from time to time at variable intervals: he would have as many as seven in twenty-four hours, but might be free for as long as six weeks; they were both diurnal and nocturnal.

Description of Fit.—A warning usually occurred with loss of power in either hand or in the right leg; unconsciousness followed, and during the attack he frequently bit his tongue and passed urine. The fit was invariably followed by severe headache, and occasionally by paresis of the right arm lasting up to half an hour. After a series of seven fits he once had complete loss of power in

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E. R. FLINT: COMPLETE GASTRECTOMY FOR CARCINOMA OF THE STOMACH.



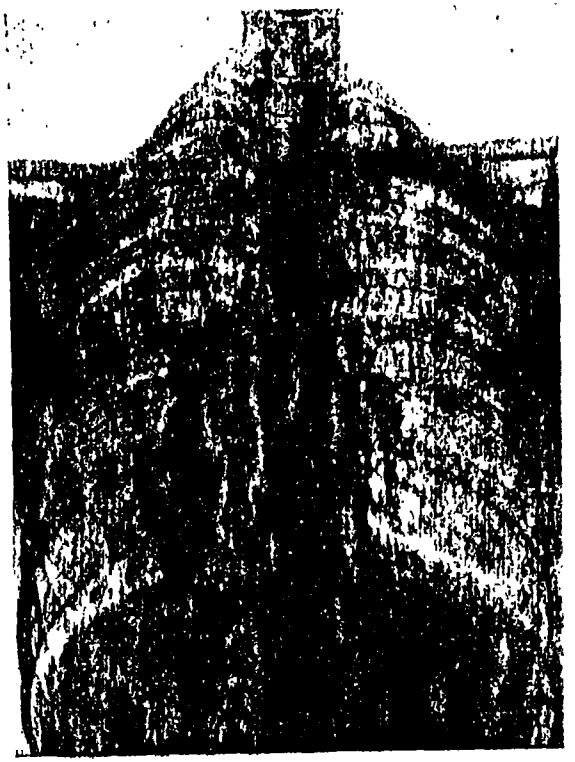
FIG. I.—Showing the state of affairs one hour after taking a barium meal. This suggests that the upper intestine holds back the meal to compensate for the loss of the stomach.



FIG. II.—Showing the state of affairs five minutes after taking a barium meal.

H. E. SEILER: PNEUMOCONIOSIS.

(*See page 982.*)



Radiogram of a case of pneumoconiosis, the result of the inhalation of asbestos dust. Showing fine mottling of a silicotic type in both lungs and some evidence of definite fibrosis, especially on the right side.

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CYSTICERCOSIS OF THE BRAIN.

(Illustrating the article by W. Broughton-Alcock, W. B. Stevenson, and C. Worster-Drought, printed at page 980.)



FIG. 1.—Longitudinal section through right cerebral hemisphere, showing cysticerci.

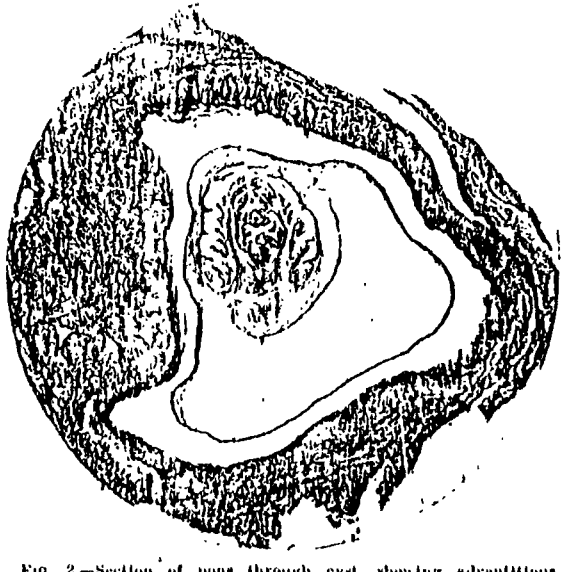


FIG. 2.—Section of pons through cyst, showing adventitious membrane and invaginated scolex. (× 12 diameters.)



FIG. 3.—Scolex of cysticercus, showing suckers and hooklets. (× 55 diameters.)

J. L. THOMAS: DIAPHRAGMATIC HERNIA.

(See page 985.)



A, Upper border of the hernia.



B, Upper edge of barium meal.

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the left arm and hand lasting three days, with gradual recovery. Occasionally he would vomit within twenty-four hours of the fit. In November, 1925, two definite attacks were witnessed by a resident physician in hospital; they were both Jacksonian in type, affecting the right side of the face, followed by a period of unconsciousness, but no generalized convulsion. During the latter part of 1927 the fits became more frequent, and his speech became affected.

Physical Signs (March 27th, 1928).—Cranial nerves: Right pupil sluggish to light; left eye absent. No nystagmus. Slight right-sided facial weakness. Speech of "bulbar" type. No muscular weakness of limbs. Deep reflexes brisk, but equal. Right plantar flexor; left doubtful. No definite inco-ordination. Mentally he was very dull and able to give but little account of himself. During the next two weeks he complained continuously of headache, vomited on one occasion, became very lethargic, and died suddenly on April 11th, aged 28.

Pathological Description.

The right half of the brain and a cyst attached to the dura mater were received for detailed examination.

On inspection of the cortex forty rounded white nodules, in size from that of a lentil to that of a pea, and lying both in sulci and in the middle of gyri, are seen irregularly embedded in the cortex, and in the greater number over the vertex of the hemisphere. On the mesial surface similar cysts are irregularly scattered, but are less numerous than on the outer surface. There is no macroscopic evidence of pus or inflammatory redness, nor of softening in the brain substance surrounding the cysts; and none of the cysts seen shows calcification. They are firm to the touch, giving one an impression rather than a thought of tuberous sclerosis.

It may here be added that at necropsy cysts were visible on the dura of the vertex as soon as the skull cap was removed. The one sent with the brain is from among those found in the basal membranes. The left hemisphere was cut up, examined, and then thrown away. It is reported to have been similarly infected.

On section of the right cerebral hemisphere a few cysts are seen scattered about the cerebral substance, and appear almost exclusively confined to the grey matter; when present in white matter they are at the border of grey matter (Fig. 1). A few cysts occur in the mesial portion of the occipital and frontal lobe, and in the basal ganglia there are relatively as many as in the cortex: they are present in both the lenticular nucleus and optic thalamus. In the pons, on section, a single cyst the size of a small pea is found lying nearer the ventral than the dorsal surface, about two-thirds the distance from the superior limit of the pons to the medulla. None are seen in the medulla. As far as we can estimate the number of cysts in the half-brain is about 100.

On the cortex of the cerebellum are three cysts, each the size of a lentil, while on section one cyst is seen deep in the substance of the organ.

No cyst in the cutaneous and muscular structures or other organs was detected at necropsy; the spinal cord was not examined. In the old clinical notes no mention is made of *Taenia solium* occurring in the intestine.

On section the cysts in the brain substance show the interior of the cystic envelope or adventitious membrane to be smooth and glistening, and to contain little if any clear fluid. Attached within this envelope at one site are much smaller, clear, brownish, circular cysts, varying in size, and rounded or ovoid in shape; some appear as swollen grains of rice covered with a brownish membrane, others that are larger are more balloon-like, and contain more fluid, the invaginated scolex lying like a grain of rice within, or partly within and partly without, the balloon-like membrane or cysticercus outer wall (Fig. 2).

By direct examination typical characters of the scolex with its hooklets and four suckers are seen (Fig. 3). An interesting feature in two of the cysticerci examined microscopically is the presence of numerous ovoid and round bodies, some of the larger with modified centres, of all shades of colour from clear to quite black. These bodies are not ova, but we understand are of a calcium substance, which forms gas on the addition of acid. They lie especially in and towards the invaginated head of the scolex. In other details the cysticerci resemble descriptions given in many textbooks. The cystic envelope or adventicious membrane is adherent to and formed from the surrounding brain tissue. As our microscopical findings do not conform to that which we understand is the more typical histological structure of this envelope we may report that sections of three complete cysts were made, and each shows a very heavy cell infiltration around the connective tissue stroma and extending for a short distance into brain substance; and, when a free vessel is present a little beyond this, perivascular infiltration is apparent. The majority of infiltration cells are plasma cells with fewer small round cells, and a fair number of endothelial cells are also present, while in one section two giant cells with massed nuclei are seen. The characteristic eosinophilia is present in one envelope only, and red blood cells are extremely rare. In one section a small vessel on the external border of the envelope shows a moderate degree of endarteritis. In one envelope the sclerotic tissue is much developed and has a pronounced cell infiltration external to this. In this cyst only a occasional chalk body is seen in the cysticercus, but a line of cuboid haematoxylin staining bodies are present.

(Our acknowledgements are due to Dr. C. Lovell and Mr. Crowe of Bethlem Royal Hospital Pathological Laboratory for their kind assistance in preparing the photomicrographs appearing as Fig. 2 and Fig. 3.)

COMMENTARY.

Cysticercus cellulosae is excessively rare in this country; it occurs chiefly in eastern Europe, India, and South America. Its occurrence in man has apparently been known since 1558,[1] and there is scarcely an organ in which the parasite has not been observed. The brain is one of the situations most commonly affected. Thus in 155 cases of cysticercosis compiled by Stiles,[2] the brain was involved in 117, the muscles in 32, the heart in 9, the subcutaneous tissues in 5, and the liver in 2. In Dressel's series[3] of 87 cases the brain was affected in 72 and the muscles in 13; while K. Müller, in 36 cases, found the parasite 21 times in the brain, 12 times in the muscles, and thrice in the heart. In Vosgien's series[4] the following was the incidence of the organs involved: eyes and adjoining structure 46 per cent., nervous system 40.9 per cent., skin and cellular tissues 6.32 per cent., muscles 3.7 per cent., and other organs 3.2 per cent. Titu Vasilu[5] (1921), in an analysis of 330 cases of cysticercosis of the nervous system, described the brain and meninges as affected in 279, cerebral ventricles in 41, pons and medulla in 5, and the spinal cord in 5 cases.

In a prolonged experience of men disabled following temporary military service we have only once met with a case of cysticercosis, and in this case the cysts were in the subcutaneous tissues. Lieut.-Colonel MacArthur, R.A.M.C.,* however, informs us that he has diagnosed clinically 5 cases of cysticercus infection with definite signs of central nervous system involvement amongst soldiers whose service in India and other places abroad has been more prolonged.

E. J. H. Roth[7] records a remarkable case in a man, aged 44, who had suffered from epileptiform fits for ten years. The patient had served with the army in India from 1908 to 1911, and came under observation in 1926 on account of pain in the left knee-joint of about five years' duration, with a discharging sinus which had appeared two months previously. Cysticercus infection was diagnosed from the radiogram of the knee-joint; scattered throughout the muscles around the joint were numerous opaque and ovoid bodies which were undoubtedly of the nature of calcifications. Further radiograms showed a similar condition in nearly every part, but with the main grouping of the calcified nodules on the extremities as far down as the ankles and wrists. The diagnosis of cysticercosis was confirmed by excision and microscopical examination of one of the cysts from the right forearm.

C. J. Hill Aitken[8] has recently recorded the case of a young man who had served in the army and complained of severe headache, diplopia, and "fits." Some small subcutaneous nodules were discovered, which on examination and pathological examination proved to be cysticerci.

Since von Graefe first demonstrated the presence of cysticercus in the vitreous of the eye, several similar cases have been recorded, and there can be no doubt that in the present case the enucleated eye showed the first symptoms of cysticercus infection.

When the brain is affected the symptoms are usually vague and general, and cases have been said to simulate hysteria, epilepsy, cerebral tumour, basal meningitis, and general paralysis. Transient tonic spasms and automatic movements have been described by Wollenberg. In Roth's case, radiograms showed at least three calcified cysts lying in the pia mater; one was localized in the middle of the motor area on the left side. In the present case the main symptoms appear to have been those of focal epilepsy, but with no constancy in the particular site affected.

Mental impairment is also a common symptom in cerebral cysticercosis, and usually consists of a simple weakness of intellect; conditions of excitement, confusion, and hallucination, however, have all been described. F. Hartmann[9] has recorded severe disturbance of orientation, impairment of stereoscopic vision, and a form of mind blindness. Involvement of the fourth ventricle by cysticercus appears to be frequent, and in this situation may lead to sudden death. Cases have been recorded by Hammer, Meyer, Rothmann, and others, while Burns, Oppenheim, Gerhardt, and Henneberg[10] have described combinations of symptoms arising from involvement of the cerebellum and medulla.

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In the present case no involvement of the medulla was found. Extensive fibrous meningitis resembling gummatous basilar meningitis has also been described by Askanazy[11] Rosenblath,[12] Henneberg,[10] and others. As far as is known, the cysts are very little toxic, although it appears that pyrexia occurred at the onset of infection or early in the course of a case of disseminated cysticercosis described by Major R. Priest[13] in 1926.

The case we record proved fatal after nearly six years of symptoms; but the parasites, especially when localized in the eye or brain, may live for long periods, very rare cases being noted up to twenty years (Küchenmeister, Roth-Ivanoff, Pfeifer, and others).

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A CASE OF PNEUMOCONIOSIS.

RESULT OF THE INHALATION OF ASBESTOS DUST.

BY

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(With Special Plate.)

THE asbestos industry has been in existence for over two thousand years, and it is remarkable that the possibility of damage to the lungs, arising from the inhalation of dust during its manufacturing process, has not been investigated until within comparatively recent years. Very few cases of pneumoconiosis due to asbestos dust have been recorded in medical literature, and for this reason the notes on the following case may be of some interest.

The first recorded case was that reported by the late Dr. Montague Murray of Charing Cross Hospital in 1900. No other case was reported, and the inference that asbestos dust might be the cause of an extensive pulmonary fibrosis was lost sight of for some time. In 1924[1] and 1927[2] Dr. W. E. Cooke published his exhaustive reports on another case, and described in detail the pathological changes and his "curious bodies," which are apparently a unique feature of the microscopical picture. This stimulated other investigations, and Simson[3] has reported similar findings in workers employed in the crushing of asbestos rock, as apart from the manufacturing processes. In most of the cases hitherto reported the extensive fibrosis has been associated either with pulmonary tuberculosis or an unresolved pneumonia, and there has always been the slight doubt as to whether the inhalation of asbestos dust was the primary cause of the fibrosis.

The patient, a man aged 40 years, was sent for an opinion of his chest condition to the tuberculosis dispensary. The question of tuberculosis was raised as a consequence of his complaint of cough and breathlessness, combined with loss of weight and lassitude, extending over a period of several months.

Previous History.—There was no history of tuberculosis in the family. No history could be elicited of any illness in early life which might have led to a pulmonary fibrosis, and, apart from the symptoms which he considered to be associated with his occupation as an asbestos worker, he has had no other illnesses.

Occupation.—When a boy he had worked for a very short period in a glass works. Thereafter, for a period of twenty-two years, he has been associated with the asbestos industry. During this period he has been employed in the various processes of asbestos work; for four and a half years he worked at a carding machine, which is considered the dustiest part of the work; for seven and a half years at the weaving of asbestos cloth, and for the remainder of the period at the manufacture of the millboard. The various processes differ considerably in their degree of dustiness, and therefore in the amount of asbestos dust inhaled by the various types of workers. As, however, a number of different processes, evolving a varying amount of dust, may be carried out in the same room, the dust produced at any one process may affect workers at another process. It will be noted that this man must have worked in the asbestos industry for a period during which less importance was paid to the prevention of dust than at the present time.

History of Present Illness.—The patient has had a cough from within a few months of starting work at asbestos, but he states that this was "from the throat," and appeared to have been purely the result of dust irritation. Within recent years the cough has increased in severity, and there has been a little sputum first thing in the morning. The first symptom to cause anxiety was breathlessness, which developed five years ago, and this has become accentuated since then. His general condition has remained satisfactory, and his particular symptoms were not sufficiently severe to interfere with his employment until six months ago. At this time he complained of lassitude, loss of weight, frequent night sweatings, and an occasional slight aching of the left shoulder. On no occasion has there been haemoptysis.

Notes on Examination.—He is a spare-built man; weight 7 st. 11 lb.; temperature, pulse, and respirations within normal limits. No obvious dyspnoea noted on examination. Cyanosis of lips and cheeks, but not a marked feature. Well-marked finger clubbing noticed by the patient for at least two years. Sputum scanty, and of a mucoid nature. Tubercle bacillus absent on frequent examination.

Examination of Chest.—Inspection showed expansion to be poor generally (one inch by measurement); there was hypertrophy of the extraordinary muscles of respiration; the supraclavicular fossae were markedly hollowed; the heart apex beat was in the fifth intercostal space within the nipple line. The percussion note was flattened throughout; there was relative dullness over the right upper lobe, both in front and behind. On auscultation the respiratory murmur was diminished generally, and of a harsh quality over the right upper lobe anteriorly and posteriorly; expiration was prolonged all over the chest; rhonchi were general, with fine pleural friction at both bases.

Other Systems.—Examination of other systems was negative.

X-Ray Examination.—The radiogram of the chest shows a fine mottling of a silicotic type throughout both lungs, more marked on the right side and at both bases, with indication of a definite fibrosis, especially on the right side. (See special plate.)

Progress.—The patient was admitted to hospital for observation, and has now been an in-patient for six months. During this period his general condition has improved considerably, and he has gained over 1 st. in weight. The cyanosis which had been noted on first examination has to a great extent disappeared, but there is still some evidence on the cheeks and lips. The cough, which is now manifestly less troublesome, is still present, and there is a scanty mucoid sputum. Physical examination of the chest reveals no new feature apart from the absence of bronchitic sounds. The temperature and pulse remained within normal limits during the period of observation and treatment in hospital.

Conclusion.

There seems little doubt that this is a definite case of pulmonary fibrosis, the result of the inhalation of asbestos dust. The recent development of symptoms of toxaemia, associated with long-standing pulmonary symptoms, was at first suggestive of a chronic pulmonary tuberculosis with an acute exacerbation. However, the physical signs, the persistent absence of the tubercle bacillus in the sputum, and the maintenance of temperature and pulse within normal limits demanded further investigation. The typical radiographic features (signs more marked in the basal portions of the lungs) and his long period of employment with asbestos point definitely in the direction of a fibrosis of occupational origin, especially as there is neither a history of other illnesses in childhood or adolescence to support a more common cause of pulmonary fibrosis, nor does this correlation of history, symptoms, and physical signs occur in these latter cases. Toxaemic symptoms in the absence of a tuberculous affection are of special interest; whether they are the result of the absorption of some constituent of the asbestos rock or not is a point which requires further investigation.

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AN ACHONDROPLASIC TWIN.

BY

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In an interesting communication on the etiology of Mongolism, which appeared in the *British Medical Journal* of June 30th, 1928 (p. 1106), Dr. Hubert Armstrong incidentally mentions that this form of mental deficiency is becoming increasingly common. After twenty-three years' experience of Leicester school children I had independently come to the same conclusion, so that any inquiry that would throw light on the cause and possibly lead to the prevention of this distressing condition would, I am sure, be very welcome.

In his article Dr. Armstrong records the case of a Mongol twin which he had recently seen, and, on reviewing the facts relating to it and similar cases, he comes to the conclusion that Mongolism is due to some maternal influence exercised upon the ovum during its maturation. In connexion with this case of Mongol twin it appeared to me that it might be useful to consider the causation of another form of imperfect growth—namely, achondroplasia—especially having regard to an achondroplasic twin that I saw at my clinic recently. The notes of this case are as follows.



FIG. 1.

Family History.—The father is healthy and his height is 66 inches. There is no history of dwarfism in his family. The mother is healthy and is 64 inches in height (her father was 74 inches in height). The great-aunt on the maternal side is said to have had a son who grew to adult life but always remained a dwarf and in many respects resembled the patient. The mother's first child, a girl, was born in 1909; she is healthy and is 5 inches in height. The second child, a boy, was stillborn in June, 1916. The third and fourth children, two boys, were born in December, 1917—the twins referred to above. The fifth child, a boy, was born in August, 1919. He is healthy and is 52 inches in height, being about two inches above the average for his age. The sixth child was stillborn two years later.

Personal History.—Photograph No. 1 shows the twins aged 10½ years. The boy on the left was the first born and weighed 7¼ lb. He is healthy and exceptionally tall for his age, being 50½ inches in height—that is, nearly the height of an average boy of 14 years. Apart from his stature the only thing noticeable about him is that whilst his hair as a whole is brown, he has a white patch about the size of a tennis ball, and his father has the same defect. The boy on the right weighed 7½ lb. at birth. "He was very different from his brother in appearance with his peculiar head and flat nose." For the first three months he was less vigorous than his brother. He is quite intelligent and healthy apart from his achondroplasic condition. He is now 40¼ inches in height. Photographs 2 and 3 show the head to be relatively large, with well-developed frontal and parietal bones; the up-tilted nose; high arched palate (mouth breathing); the relatively long body; the short limbs with proximal segments shortened more than the distal; the short stumpy hands; the marked lumbar lordosis; the well-developed muscles and general thickness of the bones characteristic of achondroplasia.



FIG. 2.



FIG. 3.

It will be seen from the above notes that the first twin and the boy born at the subsequent pregnancy are exceptionally tall for their age, and it is probable that they will eventually be much taller than their parents. I have often noticed that a mother who is comparatively short, but who comes from a tall stock, as in this case, transmits the character of tallness to her male offspring. This fact partly accounts for the stature of the first twin.

Although the twins are of the same sex, their physical characters are so remarkably different that they cannot be described as homologous or identical twins. Consequently it may be taken for granted that they were developed from two distinct ova. In these circumstances the placentæ may remain permanently distinct; but even in such cases fusion of the placental areas eventually takes place. It is generally accepted that the anastomosis of the placental vessels may be such as to result in marked differences in the general development and vigour of the two foetuses. This disparity is often explained by saying that the stronger foetus has made a special claim on the blood supply, which has enabled it to develop at the expense of the other. In the present case there was no great disparity in weight at birth, there was no general atrophy, but the smaller child had some special defect of the cartilages and bones. Even granting that this foetus had a smaller supply of blood than the other, it appears to me improbable that this could have had such a specific and selective effect.

Various theories have been suggested to account for achondroplasia. The resemblance of achondroplasia to rickets is so close that at one time they were thought to be the same morbid process, but Gilford[1] states that the points of difference are so great that most authorities now regard the two conditions as two distinct diseases. Marie[2] holds that the dystrophy of cartilage is an effect and not the cause, and that the disease is a general dystrophy comparable to myxœdema. On the other hand, Castin[3] has pointed out that the disease starts *in utero* before glandular activity begins, and so cannot be due to any defective internal secretion. He believes that it is toxic in origin and is akin to rickets. Peloquin[3] and others believe it to be due to maternal infection. Neither of these views, however, appears to me to be in harmony with a case of twins where one child is normal and the other achondroplasic. The question of possible relationship between achondroplasia and gigantism has been raised by Lannois,[3] who reported an instance in which an achondroplasic had brothers who were giants. Since the interval between the births of the giants and the dwarf was very short, Lannois suspected the cause to be due to some dyscrasia on the part of the mother owing to frequent pregnancies. But this view does not seem tenable in the case of the achondroplasic twin, for the pregnancies were not very close together, and, further, the mother gave birth to an exceptionally healthy child at the same time as the achondroplasic one.

The question naturally arises whether achondroplasia is an inherited variation; to my mind this is probably the case, for there is no doubt that the condition is sometimes transmitted from parent to offspring. In 1913 I examined and photographed three dwarfs who were being exhibited at the Leicester Fair. The family consisted of father, mother, and daughter. The father was extremely small, though fairly well proportioned. The mother and daughter were typical achondroplasics.

Many similar cases have been recorded, but one published by Dr. Porter[3] is extremely interesting. In this instance an octogenarian and his two sons were affected, and the father and the brother of the former were also said to be achondroplasic.

In my experience achondroplasia is uncommon; its rarity is probably due to this useless variation being naturally eliminated in many cases by the death of the foetus owing to early ossification, or to the difficulties of parturition in the case of the pregnant achondroplasic woman.

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H. E. Seiler, A Case of Pneumoconiosis, British Medical Journal (1928)
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THE TREATMENT OF RINGWORM OF THE SCALP WITH THALLIUM ACETATE.*

BY

J. E. M. WIGLEY, M.B., M.R.C.P.

AT the last meeting of this Section, held in Edinburgh in 1927, Dr. G. B. Dowling read a very interesting and complete paper on the treatment of ringworm of the scalp by thallium depilation. Since that time many communications have been made from different sources, some being records of series of cases—for example, that by Dr. Felden of New York in the *American Archives of Dermatology* of February of this year—others being notes of cases which have shown untoward or even alarming symptoms, such as that recorded by Dr. Davies of Brighton in the *British Medical Journal* of July 9th, 1927. Dr. MacLeod made a reference in a paper published in the *Journal* of April 21st, 1923 (p. 656), advising great caution in the use of thallium, and Dr. McKenna, in the last edition of his textbook, is of the same opinion.

Now that a year has passed I think that the presentation to you of some of the opinions I have formed of the general utility or otherwise of this treatment will provoke useful discussion, and the conclusions arrived at should be of value in placing the treatment in its correct place in our therapeutical armamentarium. I do not propose to trouble you with lists of figures beyond saying that I have treated some 50 patients at two children's hospitals in London. Their ages have varied from 18 months to 9 years, and the sexes have been about equally divided. The dose of thallium acetate has been 8.5 mg. per kilo of body weight, given in an ounce of sweetened water. (The drug has been obtained from three different sources; but I have observed no material difference in the effects.) As all my patients have been attending hospital as out-patients the conditions may fairly be said to be exactly the same as those of the cases depilated by x rays in Dr. MacLeod's clinic at Charing Cross Hospital, with which I compare them.

I have found that the average time for complete depilation with thallium is twenty-four to twenty-six days, and the depilation is entirely spontaneous in only about half the cases. In practically all the cases the infected stumps have been slower in falling than the healthy hair, whilst the recommencement of growth takes place very much sooner than with x rays. Here lies one of the chief reasons for which I regard the treatment as inferior to that of x rays.

Since Dr. Roxburgh brought to notice (in March, 1927) the method of detection of hair infected with ringworm by its fluorescence when illuminated by ultra-violet light passing through Wood's glass, I have been in the habit of checking all my "cures" by this method, and frequently with a very salutary effect. The routine use of this method has brought to light two facts which I have never seen reported and which are of some considerable importance. The first of these facts is that one frequently finds full-length, apparently healthy hairs fluorescent for the whole of their length. Examination of these hairs with a hand lens reveals no abnormality, nor do they appear to break more easily or to be more difficult to remove with forceps than normal hairs. Microscopical examination of these fluorescent hairs invariably showed the presence of ringworm fungus, and culture on several occasions further confirmed this. The importance of this observation will be referred to later.

The second fact I have observed is that hairs fully infected with endothrix ringworm completely failed to fluoresce. In these hairs the cuticle of the hair was seen under the microscope to be quite intact, which fact, I take it, explains the absence of fluorescence.

The point of this apparent digression becomes evident when the rapidity of regrowth after thallium depilation is considered, together with the difficulty of removing every single stump, some of which may not have been loosened by the drug. I have more than once failed to find evidence of infection by means of the microscope in a scalp apparently satisfactorily depilated by thallium, and revealed by means of Wood's glass have seen the full-length fluorescent hairs just described. This difficulty I have not encountered in the cases treated by x rays. Here I would like to say that the point I am making is not that x-ray treatment is infallible (it is too well known that it is far from that), but that its failures are not deceptive. I have never had any difficulty in immediately seeing the unfallen stumps in an under-exposed scalp, whereas I have just been at some pains to show that the failures of thallium depilation may camouflage itself very effectively.

Great stress was laid by Dr. Dowling and by several other writers on the importance of vigorous local treatment during the period of falling and recommencement of growth of the hair, and of this I am fully aware. But nearly all cases of ringworm are treated as out-patients, and as a rule are not seen more than once a week. Consequently most of the local treatment must, of necessity, be left to the mother, who, largely through force of circumstances, can seldom carry out the treatment satisfactorily. I have had the scalp painted with strong tincture of iodine, have used adhesive plaster, have ordered 12 per cent. sulphur and salicylic acid ointment, Whitfield's ointments, the iodide of sulphur ointment to be rubbed in, but have not been impressed with their power to combat the uncertainty of the depilation produced by the drug.

With regard to toxic symptoms, I have been struck with the fact that the older the child the more certainty is there of toxic symptoms supervening. Pain in the legs, usually coming on about the twelfth day and lasting about a week, is the most common symptom. It quickly responds to rest in bed, and seems to be of negligible importance. Drowsiness I have noticed in several cases, and have observed that such children were always of the pale, flabby type, though nothing abnormal was discovered on clinical examination. One case is worth reporting more fully.

> The patient was a boy aged 9, who was in hospital suffering from a generalized dermatitis associated with seborrhoeic dermatitis of the scalp. He was given a dose of thallium acetate with the object of attempting to clear his scalp. About twelve days afterwards he exhibited an acute erythematous eruption on his forearms, the backs of the hands, and the shins. His temperature rose to 101° F. and he was definitely ill. His hair all fell towards the end of the third week, his temperature subsided, and the rash disappeared. Unfortunately the condition of his skin was unchanged. The sequence of events seems to me to point to some auto-intoxication, the action of the thallium being to lower his resistance at the time.

A case reported by Drs. J. H. T. Davies and M. C. Andrews in the *British Medical Journal* of December 17th, 1927 (p. 1139), presented somewhat similar though much more alarming symptoms. This patient, a girl of 11 years, showed swelling, redness, and tenderness of the legs with effusion into both knee-joints. On the eighteenth day the child had an epileptiform fit and was found to be febrile, to have some ascites and evidence of acidosis, as shown by acetone bodies being present in the urine. A much older patient of Dr. Davies suffered from loss of sensation in the legs and feet, associated with inability to walk, so that a diagnosis of peripheral neuritis was actually made.

It seems to be established that thallium acts through the sympathetic nervous system, and these cases show how seriously that may be affected. Whether such affection is purely temporary or not time alone will show, but until it is proven I think we should be very chary of risking the development of children in order to cure (by no means with "certainty") a purely local infection.

In conclusion, I think that thallium acetate is distinctly inferior to x rays (in the hands of a skilled operator), for the following reasons:

1. The relative uncertainty with which it produces the desired effect—that is, depilation.
2. The slower fall of the infected hairs and the short time elapsing before recommencement of growth.
3. The necessity for more skilled and vigorous local treatment during this time.
4. The greater risk of reinfection of the growing hair owing to the short time of baldness.
5. The toxic effects produced by the drug.
6. The possibility of permanent serious damage to the growing organism.

* A paper read in the Section of Dermatology at the Annual Meeting of the British Medical Association, Cardiff, 1928.

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Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

A CASE OF DIAPHRAGMATIC HERNIA (EVISCERATION).

(With Special Plate.)

THE following details of a case of diaphragmatic hernia caused by trauma seem worthy of record; the nature of the injury is clearly indicated in the illustration.

A man, aged 64, was sent to one of the tuberculosis visiting stations as a case of spontaneous pneumothorax, after an *x*-ray examination had been made at a local hospital. The clinical history and physical signs did not altogether fit in with this diagnosis, and the patient was sent to the hospital at Cefn Mably, where he was screened and given a barium meal by Dr. W. Davies, the medical superintendent. The true nature of the case was then made plain.

There was a history of a severe crushing of the abdomen and chest by an accident in a colliery forty years previously. For more than three months the patient's life was said to have been in jeopardy, but he eventually recovered sufficiently well to resume his occupation of a coal miner. Throughout the subsequent years he enjoyed good health, with the exception of occasional attacks of vomiting and of dyspnœa on extreme exertion.

During the winter of 1928 an attack of influenza compelled him to visit his medical attendant, who discovered the unusual condition of his chest and came to the conclusion that the case was one of spontaneous pneumothorax.

The physical signs were certainly very suggestive of this condition, but they varied in character and extent when the patient was in the recumbent position. "Gurgling" could also be heard when he was lying down. The cardiac impulse was well over to the right side of the sternum, and its position did not vary. No evidence of pulmonary tuberculosis was forthcoming.

That such an abnormal condition should have caused so little inconvenience during so many years is of very great interest.

Newport, Mon. J. L. THOMAS, M.D.

THE TEAR-REFLEX TEST FOR ASTHMA OF NASAL ORIGIN.

I DESIRE to submit to the medical profession a test for asthma of nasal origin to which I attach considerable importance. It is, in my opinion, a ready and reliable way of differentiating between nasal and other forms of asthma. I have used it successfully for six years.

Definition.

The Tear-reflex Test.—In a normal nose, if the anterior mucous surface of the nasal septum or inferior turbinated bone be gently stroked with a smooth silver probe no reflex is produced; but if the same thing be done in a patient suffering from asthma and produces lacrymation in the eye on the same side as the nasal fossa so tested, but not in the other, then the asthma is of nasal origin, and is usually curable. (This test should be applied by exposing and illuminating the nasal fossae for examination in the orthodox manner.)

Anatomy and Physiology.

This reflex has no emotional significance, but appears to be confined to the first or ophthalmic division of the fifth nerve. It starts in the medial or lateral nasal nerves, which supply the anterior parts of the septal and lateral nasal mucous membrane respectively, and passes to the lacrymal gland by way of the lacrymal nerve. It is possible that a few impulses from the inferior turbinated bone pass through Meckel's ganglion. Its homolateral significance will no doubt be appreciated.

This test is one for a hypersensitive condition of the nasal mucous membrane, to which I believe the "nasal reflex" type of asthma is due. Where it is positive a cure may confidently be expected by using the orthodox methods of nasal desensitization and surgery. Where it is negative the outlook is less hopeful, even though the nose may stand in urgent need of treatment, because the nasal condition may be so bad that superficial sensation is lost. On the other hand, where it is negative and the nose is approximately normal, the cause may be looked for elsewhere.

H. MORTIMER WHARRY, F.R.C.S.

AN ATAVISTIC ANOMALY: SWALLOW-WINKING.

CASES of "jaw winking" and its allies are sufficiently rare to warrant the reporting of the following case.

A Jewish boy, aged 2, was admitted to Booth Hall Infirmary for Children as a case of pertussis. The nursing staff reported that he had exophthalmos of the right eye when he coughed or swallowed. Examination showed no obvious abnormality of the eyes or the palpebral fissures. The movements of the eyelids and of the eyes were normal. Chewing made no difference, but as soon as the child swallowed the right palpebral fissure was distinctly enlarged by the retraction of the upper eyelid. In other words, the child winked, but the wink was upwards, giving rise to a very curious appearance.

Cases of associated movements have been reported for a very long time. Dr. Rutherfurd of Manchester has kindly given me the following references: (1) It may be that Celsus, *De Medicina*, vi, 6, 36, refers to this, but the condition he mentions may quite possibly be nystagmus. (2) Martin Martin, in his *Description of the Western Isles of Scotland*, the second edition of which was published in 1716, on page 191 relates that "a weaver in Portrie has the faculty of erecting and letting fall his ears at pleasure, and opens and shuts his mouth on such occasions."

Mr. Bishop Harman, who investigated this phenomenon in 1903, has kindly referred me to his explanation in the *Transactions of the Ophthalmological Society* for October, 1903, assigning it to the origin of the nerve supply of the associated muscles to the seventh nerve.

The first case recorded, by Gunn, was one in which the upper eyelid nearly went out of sight when the child sucked, but this case of similar palpebral action only on swallowing appears to be an additional variety.

JOHN D'EWART, M.B.Lond.
Medical Superintendent, Booth Hall Infirmary for Children, Manchester.

British Medical Association.

CLINICAL AND SCIENTIFIC PROCEEDINGS.

OXFORD DIVISION.

The Clinical Signs of Mammary Disorders.

THE fifth meeting of the year of the Oxford Division was held at the Radcliffe Infirmary on October 24th. In the absence of Dr. G. N. Montgomery the chair was taken by Mr. E. C. BEVERS, and Sir G. LENTHAL CHEATLE read a paper on the clinical signs of important changes in the breast.

Sir Lenthal Cheatle pointed out that some pathological changes in the breast bore a definite relation to simultaneous physiological occurrences. The normal structure of the breast included (1) the pericanalicular and periacinous connective tissues round all ducts and acini; (2) the elastica which surrounded all ducts, occasionally some acini, and less frequently the lobule, being continuous with the elastica of the skin; (3) inside the elastica was the intra-elastica connective tissue continuous around all ducts and acini; and (4) superficial to this last, and lining all ducts and acini, was the epithelial layer resting on a single layer of unstriated muscle fibres. These structures formed the true breast tissue and were the sites of true pathological changes in the breast. They were embedded in the dense supporting connective tissue of the breast, which had little or no relation to any pathological changes, although it might be subjected to the same pathological changes which occurred in supporting connective tissue elsewhere in the body. At birth, puberty, and lactation, the pericanalicular and periacinous tissue underwent varying degrees of hyperplasia in which lymphocytes could be observed. New normal ducts and acini also formed at these times. At puberty fibro-adenomata developed, and were composed of an excessive hyperplasia of those tissues which were undergoing normal hyperplasia in the breast. In them there was a very marked growth of pericanalicular and periacinous tissue among which new ducts and acini could often be seen; these were lined by the normal epithelium, which in some instances was undergoing a desquamative epithelial hyperplasia. These tumours were

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lobulated because fresh areas of the breast in juxtaposition to, or a little distance away from, the original tumour became affected in the same way, so that lobulation was not due to an outgrowth of tumour formation from the periphery of the original tumour. The comparison between these tumours and the physiological changes occurring in the breast elsewhere was complete, and an etiological connexion was too true to be neglected. Breasts at birth had not completed their development. The solid columns of epithelium which dipped down into the gland and formed the secreting parts of the gland sometimes appeared morphologically as malignant because they were not confined within the barriers of normal tissue. More often in the breasts of married women who had borne children than in single women there appeared, between the ages of 35 and 45, a state that was generally described as "chronic mastitis." The condition was not inflammatory, and to distinguish it Sir Lenthal Cheatle stated that at the suggestion of Sir Humphry Rolleston he had termed the state "mazoplasia." The microscopical appearances of mazoplasia were distributed over the whole gland; in some parts they might be more marked than in others. They consisted of a hyperplasia of the pericanalicular and peri-acinous tissue among which lymphocytes were seen. New acini might be formed, and in the ducts and acini a marked desquamative epithelial hyperplasia might develop, giving rise to distension of these structures and causing pain. The desquamative epithelium consisted of small, irregular, badly staining epithelial cells. These changes were precisely similar to those at puberty and lactation, and in some respects also at birth. They were pathological only in respect of their irregularity and their appearance at a time when the breast should be at rest. Moreover, the breasts in mazoplasia resembled the changes at puberty in developing fibro-adenomata, which consisted of the same tissues as the fibro-adenomata of puberty. The multi-nodularity of these breasts was not due to changes in the gland itself, but to their becoming more pendulous, especially after lactation; the ligamenta suspensoria became thicker, and as their branches reached the true skin they isolated the fat between them into lobules. Recognition of the precise cause of all multi-nodularity therefore required discrimination. As a general rule it was not an important sign, but it might be due to a rare state of diffuse mammary carcinoma and multi-cystic formation of the breast. Max Cutler of New York had introduced transillumination as a valuable means of diagnosis in breast diseases. In mazoplasia and multi-cystic disease the breast was completely translucent; in carcinoma, whether localized or diffuse, there was a distinct shadow. In multi-cystic disease the swellings varied in size, and the largest ones gave a distinct sensation of fluctuation. Cystic formation in breasts and mazoplasia were quite distinct and separate conditions. The epithelial changes in the two conditions were morphologically different, and very frequently the desquamative epithelial hyperplasia which was so remarkable in the formation of cysts could be seen passing into that much more important form of hyperplasia which was not desquamative, and which Sir Lenthal Cheatle had named "dysgenetic." Such dysgenetic epithelial hyperplasia occurred in three different states: (1) the formation of papilloma; (2) the formation of epithelial growth in terminal ducts and acini, confined within normal boundaries; and (3) in the state of carcinoma where some cells had invaded structures outside normal boundaries. Therefore the formation of cysts was not only a different process to mazoplasia, it was also a more dangerous condition. In thin breasts multi-nodularity was also caused by ducts which had become convoluted after lactation and diffuse hyperplasia of the elastic element in their walls. Multi-nodularity was therefore not a very important sign. Where localized nodularity or a lump in the breast was discovered its nature should be established at once by an exploratory operation, undertaken with very great care in order to prevent transplantation of epithelial cells should the condition be malignant. A retracting nipple never occurred in mazoplasia; it might be due to a carcinoma immediately under the nipple or an advanced carcinoma some way from it, and it might also be caused by an inflamed cyst or tuberculosis. The diagnosis between these states in the case of a cyst was settled by transillumination, which in carcinoma and in tuberculosis would show a shadow. The diagnosis of tuberculosis of a breast was not always easy before it reached the skin—this might be puckered. The nature of the disease was made clear when it reached the skin and appeared as a soft, blue prominence. Moreover, lymphatic glands secondarily affected by tuberculosis differed from the glands secondarily affected in malignant disease by immediately becoming confluent in tuberculosis and remaining for a long time as hard, discrete lumps in malignant disease. Puckering of skin by an underlying swelling was also a symptom of fat necrosis, and it was difficult to distinguish clinically between it and early carcinoma. Puckering of the skin over a swelling was a serious sign that it indicated an exploratory operation. The lecturer drew attention to the importance of an intermittent, spontaneous discharge of blood or serum from the nipple, both of which, in the absence of any traumatic cause, were indications for removal of the breast. Another important sign was localized pain, especially of a stabbing nature.

Clinical Cases.

Mr. W. W. WAGSTAFFE showed a boy, aged 10, who had had a tumour removed from the dorsum of the tongue four years previously. During the last year a swelling had been noticed on the dorsum of the tongue on the site of the old incision, and in the course of the last few months it had been growing very rapidly. He had no pain, but the size of the swelling caused some discomfort. On examination a swelling was found on the posterior aspect of the dorsum of the tongue, extending about two inches forwards from the foramen caecum, and with a breadth of about one and a quarter inches. It stood out from the surface of the tongue about three-quarters of an inch at the greatest part, but at the posterior end the swelling projected considerably backwards. There was no interference with the mobility of the tongue, and no enlarged glands could be felt. In the absence of the original section it was impossible to say what was the nature of this growth. It felt firm and rather fibromatous, and the epithelium was somewhat thickened over it, but it had no papillomatous appearance. It did not appear to show an excess of blood-vessels. A provisional diagnosis of either a fibroma or an endothelioma was made. As regarded treatment, excision once had been unsuccessful, and would be extremely difficult now. It was suggested that the growth should be destroyed by means of diathermy.

Dr. SHEILA HUNTER showed a female patient, aged 43, who had developed pulmonary tuberculosis subsequent to old rheumatic valvular disease of the heart ("mitral stenosis"). She also read notes about a man, aged 32, who had been treated in the Osler Pavilion during the past year. This patient was refused for army service in the war because of his heart, but it was only comparatively recently that signs of pulmonary tuberculosis had developed. In both cases there was gross valvular disease of the heart and tubercle bacilli were found in the sputum.

Dr. W. STOBIE read notes about a girl, aged 12, who had suffered from pneumonia and empyema at the age of 4. There were signs of interstitial fibrosis and probable excavation at the base of the left lung, but owing to the density caused by the heart shadow an ordinary x-ray film revealed nothing definite. A film taken after the use of lipiodol, however, showed two definite dilated areas behind the cardiac shadow.

Mr. E. C. BEVERS showed a man, aged 56, suffering from an abdominal tumour. For three months he had noticed a swelling in his right iliac fossa, there being no pain and no bowel symptoms of any kind. On examination a hard, fixed swelling was found in the right iliac fossa, extending upwards in the line of the ascending colon and downwards to within one inch of the middle line. The swelling was very hard, and in one place appeared to be invading the abdominal wall. Both the barium meal and barium enema showed a filling defect in the region of the caecum and ascending colon. The diagnosis rested between a retro-peritoneal sarcoma and a malignant growth of the caecum which had invaded the abdominal wall.

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Dr. A. G. GIBSON showed a farm labourer, aged 20, suffering from a sudden pain in his left hip, which prevented him working. Five days after the onset he had sudden swelling in the tongue. Dr. Bostock of Buckingfound an enormously swollen and haemorrhagic condition of the jaw and tongue on the right side, causing difficulty in mastication. There was also haemorrhage in the region of the left ilium, where there was a swelling above Poupart's ligament in the hollow of that bone. There were numerous petechial haemorrhages elsewhere. The patient was very ill, with a high temperature and an overaction of the heart that suggested a cardiac lesion. Within a few days he rapidly improved, the temperature subsided, and all traces of haemorrhages disappeared from the skin and mucous membranes. The blood culture was negative. There was no trace of haemophilia in the previous or family history, and no evidence of scurvy, leukaemia, thrombocytopenic purpura, or cardiac disease. An *x*-ray investigation of the swelling of the ilium showed no bony change, but there was an old slipped epiphysis of the head of the left femur.

Reports of Societies.

JUVENILE DELINQUENCY.

AT a meeting of the Medico-Legal Society on November 22nd, with Sir WILLIAM WILLCOX in the chair, Dr. LIONEL A. WEATHERLY of Bournemouth opened a discussion on juvenile delinquency.

Dr. Weatherly confined his argument to those juvenile delinquents who, by reason of some anti-social act, had been brought to police courts or the juvenile courts, saying that in trying to envisage the mental growth of the average child aid must be sought from physiology, the science of the function of the organism, pathology, the science of disease, sociology, the science of human society, and psychology, the science of mental phenomena. A multiplicity of contributing factors would generally be found in any instance of juvenile delinquency, but in each case a major cause presented itself. As to physiology, any physical ill development, causing, for example, an infirmity of sight or hearing, or some deformity, led to the sufferer being dominated by his physical handicap, and unless compensated by training or education, or comforted by sympathetic treatment, he might drift into crime. The late Mr. Thomas Holmes, the well-known police court missionary, declared that in his long experience the most serious cases of crime were far more physiological than psychological in their basis. Again, to take pathology, dementia praecox made its victim subject to sudden inexplicable impulse, as a rule of an aggressive and destructive kind. Many children who suffered from epilepsy showed no anti-social or immoral activities, but this disease often did lead in the young to (generally motiveless) crime. Encephalitis lethargica, again, completely altered the character of the young people it attacked, and was now considered a certifiable disease under the Mental Deficiency Act. A peculiar morbid condition sometimes occurred in the young after injuries to the viscera of the abdominal cavity, or after an abdominal operation sometimes sexual perversion developed. Under the present beneficent system of probation, and with the establishment of observation centres, the early mental condition in these pathological cases should be revealed, and proper care, training, and treatment carried out. The cases of delinquency which might be grouped under the heading of sociological causes included those due to defective discipline, family history of vice, incapable parents, bad companions, too much amusement or lack of it, or defective family relationships, such as bad step-parents. There remained the psychological class, in which the speaker grouped the subnormals or moral imbeciles, many of whom were not deficient enough for certification under the Mental Deficiency Act. Most of these subnormals required some method between Home Office schools and Borstal institutions on the one hand, and simple supervision under the probation officer on the other. For some years he had advocated for these cases farm colonies, where other trades might be taught; these should be established by a combination of philanthropy, State aid, rate aid, and self-help. Occupation therapy would be the keynote of the treatment. Dr. Weatherly then sketched the immense change which had come over public opinion in relation to juvenile delinquency of recent years, seen particularly in the introduction of juvenile courts, Home Office schools, and probation officers. Recently, at a meeting of the Magistrates' Association, Sir Robert Wallace stated that 95 per cent. of the boys and girls put on probation did not again relapse into crime. Probation, Dr. Weatherly considered, was the greatest advance ever made in penal reform, but probation should always be conditional. The great handicap to probation was the absence of a home or institution for cases which could not possibly be supervised in their own homes. The difficulty that beset the Home Office was that while Acts might be passed, and suggestions and proposals made, there were no means of enforcement. The want of uniformity and the disposition not to act upon many of the Home Office's excellent proposals might be attributed to financial causes; to bias on the part of the magistrate or perhaps his clerk, and to the inherent dislike of interference with local authority. The suggestions of the Home Office should be made in some way imperative. Dr. Weatherly, after a tribute to the Salvation Army, the St. Giles's Mission, and other voluntary organizations, concluded with the remark that the objective was to get hold of "difficult" children when young and take them out of the danger zone in which anti-social acts were conceived; to recognize the inutility of sending young offenders to prison, where they were contaminated by adult offenders, and to insist upon kindly and careful supervision whereby they might have a proper start in life.

Lord RUSSELL said that he was sure many cases of delinquency could be explained, not as conscious and intentional criminal tendencies, but as the result of some psychological or physiological, or it might be sociological, defect in the upbringing. The one thing that should not be done was to send these offenders to prison. He believed the Home Office circulars and admonitions were now having effect among the country magistracy. Dr. T. B. HYSLOP raised the question whether it was a greater handicap to be sent to a prison or to be sent to an asylum. The prison might represent the frying-pan, and the asylum the fire. An asylum history extended its taint—for which, of course, there was no scientific basis—even to the third and fourth generation. He was glad to see rather more enlightenment in the courts, which had previously been difficult to persuade that some crimes might be committed in the subconscious state. Lieut.-Colonel C. T. SAMMAN thought that some juries were very much too lenient towards young offenders. Previous to committing his offence a boy knew perfectly well that if he could tell his counsel that he had never before been convicted he would probably only be bound over.

Dr. W. A. POTTS (Birmingham) said that many cases of juvenile theft were simply the result of an imperfect and misleading education. A child brought up in an extremely poor home, where everything was possessed in common, was likely to have little understanding of individual possession when he went to school. Sometimes the fault was overemphasis of one particular warning to the disregard of other phases of conduct. A boy at a preparatory school had been discovered in apparently motiveless stealing. In conversation with the lad's father the speaker asked him if he emphasized any particular principle of ethics in dealing with his son, and the father on reflection said that he had instilled into him continually the necessity of having nothing to do with the hire-purchase system! Encephalitis lethargica was a very important cause of many cases of delinquency. The initial attack was sometimes so slight that a doctor was not called, or, if he was called, did not realize what the nature of the illness was. Juvenile courts were valuable, but sometimes there was a danger that the mere establishment of such a court would be taken to have settled the problem. The mind of the child could not be reached in the public court with various officials about. Probation was also an important reform, but it should be continued until the offender was found satisfactory. It was ridiculous to think that six months' probation would

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be sufficient. Mr. W. A. CHADWICK pointed out the importance of checking early delinquency in the home among very young children. The important thing was to instruct parents in dealing with difficult psychological cases.

Dr. R. G. GORDON (Bath) said that very often in the home the young thief of 6 or 7 was regarded either as having performed an amusing trick or as having done something too shocking to talk about. Such asocial conduct required advice, not putting under a blanket. There was need for advisory clinics to which children with asocial tendencies could be brought. The difficulty in almost all cases was failure of adjustment between the child and society. Some institution was wanted in which there was a system similar to that of the industrial school, but to which children might be sent, not only from the police court, but through any responsible body interested in this work. There was a tendency to regard subnormality—a certain degree of feeble-mindedness—as the chief cause of delinquency. It was an important contributory cause, but not by any means the only cause. The real factor seemed to be a lack in the normal development of the personality of the child.

Dr. F. C. SHRUBSALL said that the British juvenile population was probably the most law-abiding in the world; but there was more delinquency now in this country than formerly, when the personal influence of the schoolmaster counted for more. Classes were now so huge that this personal influence was no longer possible; clinics offered a substitute. Once a child got even into a juvenile court it was too late to handle the problem as it should be handled. Dr. LETITIA FAIRFIELD, speaking with regard to industrial colonies for these children, said she hoped no one would suggest they were going to pay for themselves. They were as expensive relatively as the Ritz Hotel. They were only worth having if they were well run, the children well fed, and the supervision of the highest quality, and under the British system this could not be done cheaply. She described clinics on the American model, with careful investigation of the child as their aim, one or two of which already existed in London, while a very well equipped one was to be started in London next year under the Child Guidance Council. Lord RIDDELL thought that many of the "subnormals" might be improved if they received intelligent modern medical treatment. It was most important that the medical profession—the general practitioner in particular—should be trained in these matters, so that an abnormal child might be treated without having to be sent to a clinic. Dr. ELIZABETH SLOAN CHESSER spoke of her visits to prisons in various parts of the world; she praised the Japanese system, where 80 per cent. of the first offenders were so treated as not to relapse. She emphasized also two things which had not been so much as mentioned in the discussion: (1) the education of mothers; (2) decent housing.

ANTE-NATAL METHODS AND DISPROPORTION.

A MEETING of the Maternity and Child Welfare Group of the Society of Medical Officers of Health was held at the Royal Free Hospital on November 23rd, with Professor A. LOUISE MCILROY in the chair, to discuss ante-natal methods, with special regard to disproportion.

Mr. EARDLEY HOLLAND commented generally on the value of ante-natal clinics, and remarked that far more women lost their lives or suffered injury in consequence of lack of care during labour than for the want of ante-natal care. There was need for the institution of more large maternity hospitals, such as Queen Charlotte's or the Rotunda, Dublin. As regards the difficulty due to disproportion he suggested that external measurements ought to be taken, if only because they gave an early idea of the kind of labour a patient was likely to have; he also believed in fairly early vaginal examination. It was stated in text-books that in the primigravida during the last months of pregnancy the head was, or in all normal cases should be, engaged in the pelvis. The fact was that in about 20 per cent. of primigravidae in the thirty-sixth to the thirty-seventh week of pregnancy the head was still unengaged, and it should not be assumed that there was disproportion merely because, at any time during the last four weeks of pregnancy, the head was floating. In deciding what was the right proportion the reserve capacity of the pelvis was important. A woman with a normal pelvis could give birth to an infant up to the weight of 10 or 11 lb.; the normal being 7½ lb.; it would be a difficult labour, particularly if the first, but there should be no great obstacle. The pelvis accomplished the task by calling up its reserve capacity. It followed that if a normal pelvis would allow the passage of a 10½ lb. baby a slightly or moderately contracted pelvis would allow the passage of a 7½ lb. baby. There were two methods of treating the slighter cases of disproportion: induction of premature labour, or allowing the patient to go to spontaneous labour at term, have what was known as a "test labour," and adopting Cæsarean section early in labour if delivery by the natural passages was considered unlikely. The former was the time-honoured method in this country, but for some time he had been rather doubtful whether it was the best. He believed that in 80 per cent. of the cases induction of premature labour was performed unnecessarily, and at the London Hospital he began to try the other method mentioned, with improved results. To induce premature labour was to play for safety. The only known factor was the disproportion, yet there were a large number of unknown factors which, if favourable, might lead to spontaneous delivery. His method in moderate or slight cases of genuine disproportion, where the pelvis was shown by measurements to be contracted—he excluded all cases of merely floating head without disproportion—was at the thirty-sixth week to attempt to decide, often with the help of an anæsthetic, whether the patient should have Cæsarean section at term or whether there was a reasonable chance of spontaneous or forceps delivery. The object of the test labour was to decide very early in labour, whether the head would come through the pelvis or not. He mentioned various conditions which pointed to the need for Cæsarean section, and said that in 1927, out of 16 test labours at the London Hospital, spontaneous delivery occurred in 11, easy forceps deliveries in 3, and Cæsarean section was performed early in labour in 2. All the infants, except one, were born alive, and there was no maternal mortality.

Dr. ANNIE MCCALL spoke of the importance of dieting the mother so as to prevent the osseous development of the child's head beyond a certain point. The mother was kept off protein diet during the last month or two months of pregnancy, nor was she given milk, which tended to produce fat infants. Her digestive troubles were minimized by the sipping of hot water, and she was allowed to eat fruit to any extent she liked. Exercise was also important during the last two months, and every day the woman ought to walk not less than three or four miles, preferably uphill. Dr. McCall endorsed entirely the observations of Dr. Kathleen Vaughan in the letter published in the *British Medical Journal* of November 17th (p. 912). Hot baths as hot as could be endured—should be taken every day during the last month and every other day during the preceding month. She liked to give chloral hydrate every night or every other night during the ten days before labour. This made the first stage of labour a good deal easier, and left the mother was able to reserve her strength for the second stage, in which she was assisted by the softness of the pelvic floor induced by the hot baths. By hot baths, also, the danger of eclampsia had been wiped out. The speaker recited some lines which were used in the Clapham Ante-natal Service to impress these measures upon the women:

> In later months of pregnancy dispense with eggs and meat;
> Then drink hot water freely, take fruit—all you can eat;
> Hot baths are very useful, their value is untold;
> These rules, with daily exercise, are worth their weight in gold.

Professor F. J. BROWNE agreed with Mr. Holland that in a large number of primigravidae the head might be floating above the pelvic brim and still no pelvic contraction be present; he thought it might be specified that in those cases the condition was not always normal. In his own experience it was in a very small proportion of cases—certainly far less than 20 per cent.—that the head failed to engage without any ascertainable cause. He was satisfied that induction of labour was the method of treating

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these cases. "Trial labour" was not used at University College Hospital. Mr. Holland had criticized induction of labour as "playing for safety"; but what else should one ay for in labour? The trial labour was impossible in ivate practice; how was a busy general practitioner to atch such a case, listening to the foetal heart every hour? Induction of labour also caused far less anxiety; it was safe to induce labour at a date after thirty-six weeks, when the head, in the average case, was so hard that there was a fair chance of its passing without injury through the maternal passages. If there was found on examination definite overlapping of the foetal head over the pelvic brim, induction of labour was contraindicated; it was his practice to allow the case to go to term and then perform Caesarean section.

Mr. ALECK BOURNE remarked that disproportion could only be absolutely defined after birth. The infant with the over-moulded head was nearly always found in one type of pelvis. It was not the size of the pelvis which was so important as the shape, and it was because pelvic measurements rendered the shape ascertainable that he disagreed with those who said that they were useless. If the head overlapped just the thickness of the symphysis that head would almost certainly come through, but if it actually overhung the symphysis it would mean so much moulding that the child's life would probably be lost. As regards treatment he was a strong supporter of induction; in private practice trial labour was almost impossible. Its undertaking meant telling the patient and her relatives that at a critical time in labour it might be necessary to rush her off to hospital—a terrifying thing to her and to them. The importance of the error of inducing labour unnecessarily early—though never before thirty-six weeks—was less in his eyes than the error of letting the woman go to term too late, with difficult delivery, or an unnecessary Caesarean section. Of the three errors he would prefer the first.

Mr. CEDRIC LANE-ROBERTS supported Dr. McCall's contention that the protein diet should be cut down during the st weeks of pregnancy. On the question of trial labour *versus* induction, if midwives co-operated with doctors in taking their patients to the ante-natal clinics the floating head would be likely to be discovered by the doctor at the clinic, and the case would be met by induction rather than a trial labour, which involved much anxiety.

In further discussion Dr. MARY KIDD spoke of the need for a reliable drug to induce labour, quinine not being reliable, to which Mr. ALECK BOURNE replied that experiments on new preparations were proceeding, but he had examined the action of quinine on the contracting uterus by the introduction of a hydrostatic bag, and found its effect no more than to make the contractions irregular: he thought quinine quite useless for the induction of labour. Dr. ELWIN NASH, speaking as an administrator, protested strongly against any idea that midwives should have anything to do with inducing labour. Dr. CHODAK GREGORY, referring to Dr. McCall's diet for the pregnant woman, which was practically carbohydrates, asked how the child obtained the necessary iron. Dr. ETHEL CASSIE (Birmingham) thought that disproportion cases must be relatively few, and that it should be possible to make institutional provision for them all. Professor MCILROY said that at the Royal Free Hospital induction was performed very rarely before the thirty-eighth or thirty-ninth week, the majority being at term. It was not forgotten in teaching students there that the greater number of them would be concerned with domestic, not hospital, midwifery. The funnel-shaped pelvis seemed more common in London than in Glasgow. She described some tests on the reserve force of the pelvis which were being made at the Royal Free Hospital.

Mr. EARDLEY HOLLAND, in reply, agreed that trial labours were not suitable for general practice, but only in institutions. The method was in vogue chiefly in countries such ; Switzerland, most of Germany, Scandinavia, and large parts of America, where most of the midwifery was conducted in institutions, and few women were confined in their own homes. He had not the least doubt that that would eventually come to pass in this country.

Reviews.

THE EVOLUTION OF MAN'S BRAIN.

STUDENTS of man's evolution have been looking forward to the appearance of Professor TILNEY'S book entitled *The Brain from Ape to Man*.[1] Rather more than a year ago Dr. H. FAIRFIELD OSBORN, who contributes a preface to it, took them by surprise by declaring that man's relationship to anthropoid apes was of the most distant kind; man and ape, he informed them, had parted company at that remote geological period which saw the first appearance of primate animals. Dr. Osborn accounted for the many and close structural resemblances between man and anthropoids not by descent from an immediate common ancestry, but by evolution working in both the anthropoid and human lines of descent in a parallel direction. An opposite view was taken by Dr. W. K. Gregory, who is Dr. Osborn's chief lieutenant, and has devoted thirty years to a study of all known fossil remains of primates and of man. His studies have convinced him that the palaeontological and anatomical evidence can be explained in only one way—by accepting the Darwinian hypothesis that man and anthropoid have been evolved from the same stock in a recent geological epoch. In this Dr. Gregory finds himself in agreement with Professor J. H. McGregor—an authority on fossil man and a colleague of Dr. Osborn. Seeing that our conception of man's near relationship to the anthropoid apes is based largely on the structural resemblance of his brain to theirs, there was lively speculation as to whether Dr. Tilney would take the side of Osborn or of Gregory in this dispute. So well does Dr. Tilney hide his hand that it is not until almost the last page is reached that the reader discovers which has won his favour. On page 1043 we read: "We are wise if we turn our attention not to these simians, but rather to the generalized mammalian ancestors from which both apes and man took origin, to that stock which may be traced, as Huxley and others maintain, to the organization of some lowly mammal such as the tree-shrew."

To those who have plodded through the evidence which Dr. Tilney has adduced in the previous thousand richly illustrated pages his final judgement comes with a shock of surprise. His verdict does not reflect the evidence. Let us summarize the nature of Dr. Tilney's evidence. He has taken carefully preserved brains of eleven primate animals—namely, the lemur, tarsius, marmoset, howler monkey, baboon, macaque, gibbon, orang, chimpanzee, gorilla, and man—an ascending series, and cut them into serial sections. The sections which he figures and describes begin at the lower end of the medulla oblongata and end where the peduncles of the brain merge in the great basal ganglia—the corpus striatum and optic thalamus. Of these great and important masses he gives no account, nor does he deal with the most prominent of all the elements which enter into the formation of the primate brain—the cerebral cortex. All the important memoirs which have appeared in the present century on cortical areas of the brains of man and ape are left out of account. Dr. Tilney has stationed himself at the great gateway to the brain—its basal stem—and noted more carefully than anyone has yet done the highways which carry the chief tides of communications to and from the brain, and the relays of grey matters scattered along these highways. He figures the graded rise of the pyramidal system as one ascends from the marmoset to man—showing a growing domination of the cerebral cortex over the motor centres of the spinal axis; he traces a corresponding rise in the great afferent tracts which pour messages from

[1] *The Brain from Ape to Man*. By Frederick Tilney, Ph.D., M.D. With chapters on the Reconstruction of the Gray Matter in the Primate Brain Stem by Henry Alsop Riley, A.M., M.D. Foreword by Henry Fairfield Osborn, Sc.D., LL.D. London: H. K. Lewis and Co., Ltd. 1928. In two volumes. (8 × 11, pp. 1120; 557 illustrations, many in colour. £5 5s. net the two volumes.)

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the body into the basal stations of the brain stem. More especially has his attention been directed to stations and tracts concerned with cerebellar functions—the lower olive, the dentate nucleus, the red nucleus, and the pontine grey matter. Here again Dr. Tilney finds a graded series; the condition seen in the human brain is but the culmination of an evolutionary or developmental movement which has all its beginnings fully displayed in the brain of the marmoset. And yet this fact remains, which Dr. Tilney himself points out: the big steps do not occur in passing from the great anthropoid to man, but in going from the lower ape to the manlike ape. The cerebellar organization of the gorilla stands much closer to that of man than it does to that of the baboon. It will be seen thus that Dr. Tilney's evidence—that is, the facts on which he bases his final verdict—is drawn from an important but very restricted field of observation. All the rest of the body, save the brain stem, is left out of account.

This long and laborious investigation of the basal parts of the brain has made a deep impression on Dr. Tilney's outlook on evolutionary problems. The samples he examined represent the state of cerebral elaboration in all forms of primate animals, from the lowest to the highest, and in all of them he found processes at work which tend towards a common goal—the bringing of the lower centres under the control of the cerebral cortex—a process to which Dr. Tilney gives the term "neokinesis." The difference between the marmoset and man depends on the degree to which neokinesis has succeeded. On this matter it is best, perhaps, to let Dr. Tilney speak for himself.

"But these facts, correlated here, perhaps for the first time, and standing alone without the aid of commentary or special interpreter, speak in no uncertain terms of a structural unfolding in the brain of primates whose evolutional significance may be seen in the progressive extension of their behavioral capacities. In this aspect these factors may appear merely as a conventional formulation of scientific deductions. They may fail entirely to create an impression of the actual *dynamic force* which lies behind them."

The reviewer has italicized "dynamic force" because it is the power to which Dr. Tilney appeals when he desires to give an explanation of what he has found. Can a biologist visualize the power which Dr. Tilney postulates to explain the organization of the brain of man and ape? We know very little, so far, as to how the behaviour of developing nerve cells is regulated; the researches of Dr. Kappers and of others reveal the power of neuroblasts to move their position and also to alter their arrangements. If Dr. Tilney means by "dynamic force" the capacity of developing nerve cells to behave in a certain way, then we can visualize his meaning. But the behaviour of any group of nerve cells depends on their inheritance. When we find the nerve cells which go to form the olivary body behaving in a similar way in all primates we account for this common manner of behaviour by supposing a common inheritance which has come from a simple form lying at the very base of the primate stem of evolution. But when we find these olivary neuroblasts behaving in man and the gorilla in almost an identical manner we explain their particular agreement, and at the same time their difference from all representatives of the lower primates, by a much later separation of their evolutionary lines of descent. In support of such a conclusion evidence could be cited from hundreds of other structures which the gorilla and man have in common. Man and the great anthropoids are partakers not only in the general primate inheritance but in a particular share of that inheritance.

It would be unjust to Dr. Tilney and to the publishers of this truly magnificent book to permit this review to conclude on a note of criticism. The author has striven successfully to serve expert anatomists by supplying them with masses of fact of which they stood in need; he has sought to meet the needs of inexpert readers by supplying them with clearly expressed general conclusions and with faithful illustrations, often beautifully reproduced, of the structures which form the subject-matter of his text. The publishers have spared no expense in making the work attractive. Neurologists and anthropologists will be indebted to Dr. Tilney's labours for many years to come.

OCCUPATIONAL SKIN DISEASES.

We welcome the third edition of Dr. Prosser White's well-known work on occupational diseases of the skin.[1] It has now become a veritable encyclopaedia on all forms of skin disease in any way associated with industrial activities, whether actually caused by the industry or not, and the author has even included burns caused by heat, electricity, and x rays, and also frost-bite. Not only has Dr. Prosser White given us the benefit of his own very extensive experience in this field, but he has collected and collated all the scattered observations and experiments of every other worker. The result is a most valuable compilation. It is not only valuable to our own profession but also to all those who are interested in the welfare of the industrial community and to those members of the legal profession who are increasingly concerned with questions of compensation for injury or disease arising in the course of employment—questions open to serious debate, for it is often a matter of great difficulty to determine whether the employment is in any way responsible. One industrial complaint which has lately been much under discussion in this country is the so-called "baker's eczema." It will be remembered that quite recently the workmen's organizations have done their best to alarm the public by stories of the risks run by bakers of contracting this disease. Dr. Prosser White has come to the conclusion that eruptions caused certainly and solely by the materials handled by bakers in their trade are exceptional, and Stern, a German writer, is even more definitely of the same opinion. But as long as workers can obtain compensation for industrial dermatitis it is likely to remain common.

The author's remarks on sensitization—namely, heightened hyperaesthesia towards certain irritants—are interesting. He has formed the opinion that with the industrial inorganic chemical irritants sensitization is rare. Whatever the nature of the eruption, it is always due to direct physical, chemical, or mechanical injury or irritation. He states that if the eruption persists continuously or repeats itself when the offending substance is completely withdrawn, it should be inferred that the original agent is not the cause. But no doubt he finds it difficult to persuade the courts to take this view. Insurance records could provide scores of cases of patients drawing compensation allowances for dermatitis months after all contact with the original irritant. The importance of the whole subject is shown by the figures provided by various dermatologists. In some clinics the percentage of occupational diseases amounts to as much as 20 per cent. of all the cases seen. At the lowest computation there are in Great Britain between 18,000 and 19,000 new cases of skin diseases due to occupation every year. The employers' liability insurance companies can testify to the loss entailed thereby.

While we have nothing but praise for the industry and thoroughness devoted to the production of this book, we feel bound to point out that it possesses some irritating features—one of these is the excessive use of heavy type and italics in the text. The unnecessary employment of italics in places where no emphasis is called for reminds us of Topsy's communications to *Punch*. Dr. Prosser White is also fond of coining new additions to dermatological terminology, and the worst of these is the terrible word used by him as the main title of his book. "Dermatergoses" merits all the strictures that have ever been passed by scholars on medical nomenclature. This word is supposed to mean skin diseases caused by work. If he feels compelled to translate "occupational diseases of the skin" into Greek, the word "ergodermatoses," although nothing to be proud of, would at least do less violence to the rules of grammar. Having registered this protest we have only to add that the photographs are excellent and excellently reproduced, and that the generous and complete index (occupying over two hundred pages) is one of the best things in the book.

[1] *The Dermatergoses, or Occupational Affections of the Skin.* By R. Prosser White, M.D., C.M.Ed. Third edition. London: H. K. Lewis and Co., Ltd. 1928. (Demy 8vo, pp. xi + 754; 58 figures on 52 plates. 35s. net.)

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PROGRESS IN OBSTETRICS AND GYNAECOLOGY.

ONE of the essentials in a series of works dealing with "recent advances" in any branch of medicine is that the volumes should be brought out at reasonably short intervals. We are glad to see that this is being kept in mind in the case of Dr. BOURNE'S excellent little book *Recent Advances in Obstetrics and Gynaecology*.[1] Very little need be said to introduce this second edition, for we imagine that almost all those who are specially interested in the subjects are already familiar with the first edition. But if there be any such who are not in this position, then we cordially recommend it to their immediate notice. Briefly, the book is a short and lucid review of the results of research, both scientific and clinical, which have marked definite progress in obstetrics and gynaecology in recent years. In the case of obstetrics, for example, pride of place is very properly given to the subject of ante-natal care and to a study of the difficult question of maternal mortality. The causation of stillbirth, the chemistry of the blood and urine in pregnancy, the haemorrhages, the treatment of eclampsia, Caesarean section, and puerperal sepsis are the headings of the other chapters, and sufficiently indicate the scope of the work. In the second part, which is devoted to gynaecology, the recent methods of investigating and dealing with sterility and with prolapse are discussed. The newer work on endometrioma and the use of *x* rays, electrotherapeutics, and radium are all admirably discussed. In this second edition an interesting chapter has been added on the ovarian hormones, which summarizes very judicially the present position of this most interesting branch of research, and at the same time indicates the prospects which it opens out in regard to gynaecological therapy.

We congratulate Dr. Bourne on the success of his book, which ought, unquestionably, to find its way into the library of everyone who is engaged in obstetrical and gynaecological work.

FERMENT ACTION.

THE first two parts of *Die Methodik der Fermente*[2] (Methods of Ferment Investigation) were reviewed in our issue of March 17th (p. 454). Three more parts have now appeared, and these complete the volume, which altogether contains about 1,600 pages. The majority of contributors are German, but there are articles from other countries by such well-known authorities as Levene, Thunberg, Hopkins, Harden, and Newton Harvey. The articles are of a high average standard, and the following are some that appear to deserve special mention.

The first division of the book, which deals with general methods, is concluded by two valuable articles. A full account of Warburg's methods of measuring tissue respiration is given by Dr. Krebs, a worker in his laboratory, and Dr. Blaschko, one of Meyerhof's assistants, contributes an article on microcalorimetry. These articles are of particular interest because they come from the laboratories in which have been developed these new methods that are assuming more and more importance. The second division of the book deals with special methods for the investigation of the different classes of ferments—for example, saccharase, maltase, and nuclease. Most of these articles deal with highly specialized problems, but some are of wider interest. Thunberg describes the measurement of oxygen acceptors, and gives a full description of his methylene-blue method. Sir F. Gowland Hopkins contributes a short article on the important subject of glutathione. Schmidt, of Embden's laboratory at Frankfurt, writes an article of twenty-five pages on lactacidogen. A. Harden contributes a short article on yeast zymase. Lohmann, of Meyerhof's laboratory, gives an account of the chemical determination of glycolysis and the resynthesis of carbohydrate. Newton Harvey of Princeton gives a short account of work on luciferase. The third division of the book deals first with the demonstration of ferments in biological material, such as plant cells, animal tissue, and milk, and secondly, with methods for measuring the action of ferments of clinical interest. This latter portion is condensed into seventy pages; in it are described the chief methods for studying the ferments of the stomach and pancreas, and the anti-proteolytic action of serum.

The fact that the volume under review contains 1,600 pages devoted to the description of methods used to measure ferment action is a striking proof of the magnitude of the science of biochemistry. The size of the work has, however, been enlarged to a somewhat unnecessary degree by inclusion of articles dealing with subjects that are not strictly ferment actions. For example, one article describes the biological methods for standardizing insulin. The inclusion of articles that are not strictly relevant in works of this nature is very undesirable for the following reasons. It is nowadays impossible to follow the periodical scientific literature in more than a very restricted field; and hence scientific workers are forced to rely more and more on encyclopaedic works such as the volume under review. There is a tendency for even these works to swell to unmanageable dimensions, and their value depends very largely on the care with which they are edited, for if swollen unduly by the inclusion of extraneous matter they lose much of their value. In fairness to the volume under review it must be said that it errs in this respect less than many other of the encyclopaedic works on biochemistry that have recently been produced in Germany.

HOMONYMOUS HEMIANOPIA.

IN his monograph on homonymous hemianopia,[3] Dr. E. BUNGE, working in the ophthalmological clinic of Kiel, has collected a series of fifty-two cases showing this symptom, and recorded his findings. He has divided them, according to the site of the lesion, into two groups—that in which the optic tract or external geniculate body is involved, and that in which the lesion is supranuclear. The former group of eighteen cases is characterized by the retention of the hemianopic pupillary response in all, myosis and narrowing of the contralateral palpebral aperture (Behrshe phänomen) in half of the cases. In four cases the loss was only incompletely hemianopic. Of the other fourteen cases, in which it was complete, there was sparing of the macular region in six cases, and a completely vertical line of division through the fixation point in eight. Among twenty-nine cases of supranuclear lesion interruption of the visual apparatus there was a lesion of the occipital cortex in twenty-five, of the central nuclei in two, and of the internal capsule in two others. Of these twenty-five cases of lesions of the occipital cortex, six showed the blind field to be limited by a vertical line through the fixation point, while in eighteen it was encroached upon by a circle of macular sparing extending from five to ten degrees around this point. This sparing of macular vision the author explains by a greater resistance of the more essential macular fibres, not countenancing the view which attributes it to the double vascular supply of the extreme occipital cortical pole.

NOTES ON BOOKS.

BOOKS and articles from the pen of Professor FRASER-HARRIS appear with dazzling frequency. His new book, *The A B C of Nerves*,[4] is true to its title: it gives in a popular form the essential facts about the nervous system, its anatomy and physiology. Of special value is the emphasis it lays throughout on the use of the experimental method in establishing our knowledge of the working of the nervous system. In view of the statement repeatedly made that Sir Charles Bell discovered the function of the nerve roots without resort to animal experiment, the quotation from Bell's pamphlet, "An Idea of a New Anatomy of the Brain," printed in 1811, to the effect that

[1] *Recent Advances in Obstetrics and Gynaecology.* By Aleck W. Bourne, M.B., B.Ch.Camb., F.R.C.S.Eng. Second edition. London: J. and A. Churchill. 1928. (5 x 8½, pp. x + 382; 67 figures. 12s. 6d. net.)

[2] *Die Fermente und ihre Wirkungen.* Von Professor Carl Oppenheimer. Fünfte, völlig neu bearbeitete Auflage. Band iii: *Die Methodik der Fermente.* Unter mitarbeit von Fachgenossen. Herausgegeben von Carl Oppenheimer und Ludwig Pincussen. Lieferung iii, iv, und v. Leipzig: G. Thieme. 1928. (7¾ x 10½. Lieferung iii, pp. 625–944, 46 figures; Lieferung iv, pp. vii + 945–1254, 59 figures; Lieferung v, pp. xxx + 1265–1578, 57 figures. Each part M.28.)

[3] *Über Homonyme Hemianopsie.* Von E. Bunge. Berlin: S. Karger. 1928. (Sup. roy. 8vo, pp. 51; 1 plate. M.2.80.)

[4] *The A B C of Nerves.* By D. F. Fraser-Harris, M.D., D.Sc. London: Kegan Paul, Trench, Trübner and Co., Ltd. 1928. (Cr. 8vo, pp. ix – 223; 14 figures. 4s. 6d. net.)

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only after such an experiment did the meaning of the double connexion of the nerves with the spinal cord become clear to him, is of particular interest. The account of Pavlov's work, though good, is brief, and might well be expanded in a later edition. The diagrams are clear and adequately explanatory of the well-written text.

The question of propaganda in health matters is much before the medical profession at the present time, and a contribution by two experts is welcome. Dr. CLAUDE LILLINGSTON and Miss NORAH HILL, who jointly edit *The World's Health*, have collected nearly forty articles in a volume entitled *How to Enjoy Health*,[1] and it may be said at once that they are very good examples of their kind. Each article is by one of the authors, as indicated by initials, but in each case the work has been checked by both, so that what is called "technicalities and scientific jargon" has been censored by Miss Hill, while all facts have been verified by Dr. Lillingston. The result is clarity, accuracy, freedom from fads and personal prejudices, a pleasant style, and an interest which should arrest any reader's attention and keep it fixed. "The business girl's day" is a typical example; the daily life of Gertrude, from her "bachelor" quarters in the suburbs of a large town to her seat in the far corner of the office and so home again to bed, is faithfully described, with intelligent counsel for its betterment. On "constipation," the "common cold," or the "medical aspects of tobacco," Dr. Lillingston shows how a controversial subject may be presented to the public without bias and yet with definite conclusions, while on "whooping-cough" Miss Hill shows how facts may be set out so as to state an unanswerable case for an improvement in preventive measures. It is stated that these articles have been translated into various languages, and some have already appeared in many different Red Cross journals. They are worthy of careful study by medical officers of health and others concerned with health propaganda.

The treatise on the problems of the tics,[2] by Drs. J. WILDER and J. SILBERMANN of the Maria-Theresa-Schlössel Institute for Nervous Diseases at Vienna, is the first monograph on the subject since the classical work of Meige and Feindel. It is based on the study of 370 cases of tics of various kinds observed between the years 1914 and 1926. The work is divided into three parts. In the first, which is entitled "The modern view of the problem of the tics, with special reference to striate hyperkineses," Dr. Wilder discusses the varieties of tics, particularly tics in children and war tic, of which 213 cases were observed in the period 1914–18, their pathogenesis, nosology, and treatment. The second part, written by Dr. Wilder in collaboration with Dr. Silbermann, contains the histories of 57 cases of organic and functional tics, 17 of which have been abstracted from the literature and 40 are original. The third part contains a short description of a case of Gilles de la Tourette's disease.

The specialist, the general practitioner, and the medical student have all been liberally treated in the matter of manuals on venereal diseases. Mr. TURNER WARWICK, in his *Handbook on Venereal Diseases*,[3] has catered entirely for nurses, who up to the present have had to search for any information they may desire among textbooks whose wealth of technical details renders them inconvenient foundations to knowledge. In the numerous venereal disease clinics scattered throughout the country there are working many nurses and orderlies who will welcome the opportunity Mr. Warwick has provided for their obtaining information concerning the general principles that underlie the diagnosis and treatment of venereal disease. Moreover, this book deals not only with the clinical side of the subject, but also with questions that concern public health, and should do much to enlist the aid of nurses and orderlies in the fight against venereal disease.

Dr. JORDAN'S *Text-Book of General Bacteriology*[4] is a favourite book for students in America, and has had many readers in this country in the years that have passed since its first publication in 1908. We have now received the ninth edition, and notice that it is a little larger than its predecessors, that the chapter on the parasitic protozoa has been entirely rewritten, and that new material has been added on the bacteriology of scarlet fever, erysipelas, and rheumatic fever. Otherwise the book has the same appearance and arrangement as before.

[1] *How to Enjoy Health.* By Claude Lillingston, M.D., and Norah Hill, A.R.R.C. With a preface by Sir Squire Sprigge, M.D. London: Hodder and Stoughton. 1928. (4½ × 7, pp. 287. 2s. 6d. net.)

[2] *Beitrage zum Ticproblem.* Von Dr. J. Wilder und Dr. J. Silbermann. Berlin: S. Karger. (Sup. roy. 8vo, pp. 100; 2 figures. M.8.40.)

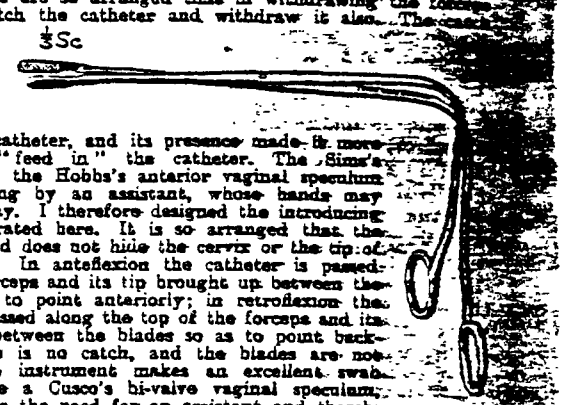
[3] *Handbook on Venereal Diseases.* By W. Turner Warwick, F.R.C.S. London: Faber and Gwyer, Ltd. The Scientific Press. 1928. (Cr. 8vo, pp. xi + 221; 18 figures. 6s. net.)

[4] *Text-Book of General Bacteriology.* By Edwin O. Jordan, Ph.D. Ninth edition, thoroughly revised. Philadelphia and London: W. B. Saunders Company. 1928. (Med. 8vo, pp. 778; 191 figures. 28s. net.)

PREPARATIONS AND APPLIANCES.

A FORCEPS FOR INTRAUTERINE APPLICATIONS.

MR. H. J. MCCURRICH, M.S., F.R.C.S. (Hove), writes: The application of glycerin to the interior of the uterus, advocated by Remington Hobbs for the treatment of infections of the endometrium, has, in my experience, yielded excellent results both in the puerperal and the non-puerperal types of infection. The apparatus described by him, however, has always struck me as being rather difficult to use. Owing to the introducer being straight, the surgeon's hand obstructs his view, and the blades of the forceps are so arranged that in withdrawing the forceps they may catch the catheter and withdraw it also. The coach I found a nuisance, as it was sometimes difficult to release without disturbing the catheter, and its presence made it more difficult to "feed in" the catheter. The Sims's speculum and the Hobbs's anterior vaginal speculum require holding by an assistant, whose hands may get in the way. I therefore designed the introducing forceps illustrated here. It is so arranged that the surgeon's hand does not hide the cervix or the tip of the catheter. In anteflexion the catheter is passed under the forceps and its tip brought up between the blades so as to point anteriorly; in retroflexion the catheter is passed along the top of the forceps and its tip lowered between the blades so as to point backwards. There is no catch, and the blades are not grooved. The instrument makes an excellent swab-holder. I use a Cusco's bi-valve vaginal speculum, which obviates the need for an assistant and thereby removes a further obstacle to the view. The external os is dried by wool held in this forceps. Clean wool is picked up and applied to the cervix and the soiled wool then dropped in a receiver. This process is repeated until the outside of the cervix is clean, then, without changing hands, the forceps is used to pick up, introduce, and propel the catheter into the uterus. I usually have the patient in the lithotomy position or in the gynaecological modification of that position (that is, feet lower than in the lithotomy position), but the Sims's position would be nearly as good. The catheter contains air until the glycerin passes through it, and some air will be expelled into the uterus, but this does not matter at all. It would, of course, be possible to fill the catheter with glycerin first, but this seems to me to be unnecessary. I suggest that the method described here will considerably simplify the process of applying this most satisfactory form of treatment.



The instrument was made for me by Messrs. Down Bros., Ltd.

NEW GLAXO.

"Prescription (humanised) glaxo" is a new preparation of this well-known infants' food, in which a full content of vitamin D has been ensured by the addition of ostelin.

The makers point out that in the past there was a tendency to recommend a high content of fat in infants' food, because only by this means could an adequate supply of the antirachitic vitamin be ensured. This high fat feeding, however, defeated its own object, because the excess fat hindered the absorption of calcium by forming insoluble calcium soaps. The provision of an adequate supply of vitamin D by the addition of a vitamin concentrate, such as ostelin, avoids this difficulty, and also avoids the production of digestive disturbances that frequently are caused by excess of fat.

The analysis provided by the makers is as follows:

	Dry powder.	Reconstituted 1 in 8
Fat	20.0	2.5
Proteins	17.0	2.1
Lactose	56.0	7.0
Ash	5.0	0.6
Moisture	2.0	87.8
	100.0	100.0

The reconstituted milk is therefore very similar to human milk in its percentage composition.

A SPIRIT-PROOF SYRINGE CASE.

We have received from the Security Druggist's Sundries Company (23, Greencroft Gardens, South Hampstead, N.W.6) their patent Maxse hypodermic syringe carrier, fitted with a hypodermic syringe and a serum syringe and needles. The instruments when not in use are attached to a plate, which fits into a metal case containing methylated spirit. The carrier has a patent foot mount, which enables it to stand upright securely. It is easily opened, and the syringe and needle can be quickly withdrawn and replaced in the fluid. The specimen supplied to us proved to be perfectly spirit-tight in all positions, and the apparatus is likely to be a very popular addition to the general practitioner's bag, since its contents can be kept sterile. The price of the complete outfit, with syringes, is 17s. 6d.; the patent case with the plate, but without the syringes, can be supplied for 8s. 6d.

STANIFORM.

Staniform is methyl stannic iodide, and the manufacturers (Whiffen and Sons, Ltd., London, S.W.6) claim that it combines the well-known usefulness of tin in staphylococcal infection with the powerful germicidal properties of iodine, and that it is indicated generally for use in local inflammations, such as boils, ulcers, chafed skin, etc. The drug is supplied as an ointment and also as a dusting powder.

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ON THE TREATMENT OF FRACTURES:

A PROBLEM OF ORGANIZATION.*

BY

ERNEST W. HEY GROVES, M.D., M.S., F.R.C.S.,

PROFESSOR OF SURGERY TO THE UNIVERSITY OF BRISTOL.

On the Acquisition and Application of Knowledge.

In the forward march of human progress it is the pioneer, or discoverer of new paths and fresh territory, who holds the public eye and captures the popular imagination. But if the new discovery is to be of any lasting value the pioneer must be followed by an organized band of workers who colonize and cultivate the new territory, whether this be actual land or a mere domain of knowledge. Quite rightly we shall always regard Columbus and Cabot as amongst the greatest of the world's heroes, but the practical value of their heroism would have been wasted if successive generations of seamen, engineers, and colonists had not established an easy and safe route to the New World and developed its resources. Thus it is, too, in matters of applied science—it is only given to the fortunate few to acquire new knowledge, but it is the duty of those who come after to see that this new knowledge is applied.

There is no doubt some danger at present in medical science of the attention being so concentrated on the quest for new knowledge of hidden mysteries that the patient and systematic application of knowledge already in our possession about everyday ailments may be neglected. It is quite right that ceaseless work should be expended on trying to discover the cause and cure of cancer, but we must nevertheless remind ourselves and instruct the public that the causation and treatment of tuberculosis are known, and that we ought to apply knowledge already in our possession at the same time that quests for new knowledge are being organized.

For the moment, however, I wish to discuss a problem which is even simpler than that of tuberculosis—namely, the treatment of fractures.

In this matter it may be well to begin by considering the conditions and lessons of the late war. There was no great medical problem at the beginning of the war which seemed so hopeless as that of the treatment of gunshot fractures, and there was certainly none which by the end of the war was so satisfactorily solved. And yet, when we come to ask, "To what discovery was this happy result due?" we are forced to admit that there was no new thing found, but that the whole progress was due to organization, team work, and the training of workers. It was not the acquisition of new knowledge, but the application of well-established principles which turned failure into success. As far as I know, there was no new discovery made about the treatment of fractures during the war. The importance of early excision of infected wounds was established; and this seemed to be more important than any of the chemical disinfectants—hypochlorates, hypertonic salt, bipp, or flavine—each of which proved useful, but could not be claimed as essentially new. Probably the Carrel-Dakin treatment, combining mechanical with chemical cleansing, was the nearest approach to a new discovery in the realm of fracture treatment.

On the other hand, progress was definitely hindered by what at that time was a comparatively new method—namely, the plating of fractures—and many limbs were lost or ruined before this was finally set aside. Success in fracture treatment during the war was achieved by organization, team work, the training of new men, and the segregation of difficult cases in special hospitals; this success was made possible by the fact that the general control of fracture treatment was entrusted to one (our own revered emeritus president) whose unrivalled knowledge of how to treat fractures was only equalled by his wonderful capacity for knowing how to deal with men—both men above him, in brass hats, and the men below him, in hide-bound traditions.

I think that we are all convinced that the fracture problem of to-day is one like that of the war, in that it requires not new knowledge, but the organized application of the knowledge we already possess. It requires the segregation of cases, the training of team workers, and the systematic tabulation of results. We want not merely a collection of x-ray records, but an accurate knowledge of functional results.

The Arguments for Reform.

Before discussing the details of reorganization of the teaching and practice of fractures it may fairly be asked, What evidence exists that such reform is necessary? Naturally the first argument which springs to the mind is the very great number of bad fracture results which are constantly met with in practice. The stiff shoulder-joints with the arm tied to the side, the fixed elbow-joint, the pronated hand, the unreduced Colles's fracture, the ununited neck of the femur, the short leg, the crooked shin, and the everted backwardly displaced foot—these are conditions which we are consulted about perhaps once or twice every week, and in nearly all we are oppressed with the thought that prevention of such deformities would have been easy, but that complete cure is almost impossible. In the great majority of these cases the original fault has been a matter of neglect or oversight. Either the patient has been in a large hospital, where in the press of work he has been relegated to the care of a junior resident and hurried out at the earliest possible moment, or he may have been in a small country hospital, where he was splinted and made comfortable for the time being, in the happy belief that if he did not make a good recovery he could be transferred elsewhere later on for "orthopaedic treatment"; in a small minority of cases the fault has been that of attempting too much. An open or a comminuted fracture has seemed to call for operative treatment, and this has been undertaken without the experience and training which are necessary to justify such.

The mere collection and review of any series of bad fracture results must, then, lead to the question as to frequency of such disasters, and whether it is sufficiently great to justify a demand for reorganization of the fracture service. And here we are at once faced with what in itself constitutes a strong reason for reform—namely, the absence of any systematic records of after-results. We really do not know what proportion of cases of broken limbs leads to permanent or to partial incapacity. And yet from an economic or industrial point of view this is surely important information which we ought to be able to get. Does there exist in this country a single hospital or fracture service which collects and tabulates the results of its fracture cases one year after the injury? Such information would be invaluable, both for noting the type of injury which gives the worst final result, and especially as a standard of comparison with which new methods and organization could be compared.

We certainly know that in most places, including the majority of the teaching and municipal hospitals and all the small hospitals, there is no attempt at organization of the immediate or the after treatment of fractures. There is no segregation, or team work, or systematic following up of cases. In fact, all those features of organization which the war taught us to value are conspicuous by their absence in modern civil practice.

There is, then, ample evidence of the need for improvement in the fracture service of this country, and we shall be justified in considering how this improvement may best be brought about in relation to different types of hospital and in general practice.

The Teaching Hospitals.

The university teaching hospital is usually one which contains about 300 to 500 beds, and it has long been obvious that the right policy to be adopted there is the

* Being the presidential address to the British Orthopaedic Association at Liverpool, October 19th, 1928.

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provision of a fracture department of a suitable size to deal with in-patient and out-patient fracture cases. The actual number of beds to be set aside for fracture work would probably be about 10 per cent. of the whole. It would be unnecessary and undesirable to make any rule that all fracture cases must go to the fracture wards. The department would be there, and the cases would go there naturally if the work was well done. The very great majority of general surgeons would be only too glad to rid their wards of fractures, although they might wish occasionally to keep some special case in their own hands.

The personnel responsible for the fracture department would consist of a surgeon, an assistant, a resident, sisters, an officer in charge of the physiotherapy, and the massage staff. In addition to these there ought to be a registrar, with sufficient clerical staff to carry out a regular tabulation of results with a good follow-up system. Every student would have to act as a dresser for two or three months, and during this time he would see both the in-patient and out-patient work; he would assist in putting up fractures in the first place, and he would see the after-treatment and the late results. This is, of course, no novel plan. Its adoption has been urged ever since the war. The reasons in its favour are convincing, while the arguments against it are so weak that it really no longer presents a debatable proposition. By providing a department the very *raison d'être* of which is the study, treatment, and cure of fractures, each patient admitted to the department would be assured of the best possible chances of a speedy recovery. On the other hand, in many of the teaching hospitals now the beds are overcrowded; the fracture case is regarded as a nuisance to be dealt with by a resident, who himself is probably more interested in abdominal work, and whose chief aim is to avoid blocking the beds with fractures. If, in spite of his vigilance, a fracture case is admitted, his next aim is to shift it as quickly as possible to the limbo of a general out-patient department or to a Poor Law hospital. Very naturally, then, if a fracture has been put up in plaster or other splint in a teaching hospital and then sent on to a Poor Law hospital, the medical officer at the latter institution, who is overdriven with routine work, will be content to carry on without himself making any critical examination or initiating any fresh treatment.

The present education of the student, too, is most unsatisfactory in relation to fractures; he often never sees any treated except in the casualty department, and then only for a brief moment. More often his experience of fractures includes seeing some difficult case operated upon while the more ordinary ward cases are wrapped up and got rid of. No wonder that when he comes to practise himself he carries out the same ideas—that is, if he is cautious, he always contents himself with giving some sort of rough and ready first aid, and then tries to find out how he can send the patient away to someone else. If he is adventurous and the patient is a suitable one, he will suggest doing an open operation, and provides himself with some plates and screws for the purpose.

If the argument for a special fracture department is so strong at every teaching hospital, if it will improve the quality of the treatment and expedite the patient's recovery, if it will improve the teaching of students and train practitioners to know this part of their work—then we may well ask why this reform has not been adopted long ago in all our chief institutions. The reasons must be of an obscure character, because they have never been put into plain words by those who deprecate any change. Probably reluctance on the part of the surgical staff to specialize in fracture treatment, together with a shortage of beds, are the two main factors which tend to block progress; but in this respect there is a very definite indication of a steady change in the right direction. Many of the teaching hospitals have now got either a fracture ward or even an orthopaedic department to which fractures are sent. In most cases the number of beds available for fractures is wholly inadequate, but this is being generally remedied. I would like to emphasize this one point very strongly: most hospitals now have 10 to 15 per cent. of their beds occupied by fractures, and it will not necessitate any provision of fresh beds if this 10 per cent. of the cases be put together in the same wards instead of being scattered about all over the hospital.

Municipal Hospitals.

It is quite clear, however, that the teaching hospitals, together with the other large voluntary hospitals, cannot deal with all fracture cases or even all of those of a serious character—for example, fractured spine, pelvis, femur, and tibia. At any rate, the voluntary hospitals cannot keep such cases for the full period necessary for functional recovery. Under existing arrangements one of two things happens. Either the bad case is refused admission to the overcrowded voluntary hospital and is sent direct to the municipal hospital, or, more commonly, it is first taken to the voluntary hospital, and then, after a few weeks, it is transferred to the municipal hospital. Sooner or later, therefore, the municipal hospital must take over many serious cases of fracture, and these will, of course, be just those which require the greatest care and skill in their treatment. The majority of municipal hospitals are, however, very much understaffed. For example, a municipal or Poor Law hospital of 500 or 600 beds often only has four whole-time medical officers and four visiting consultants—a total staff of eight, as compared with the twenty-five or thirty men who are on the staff of a voluntary hospital of the same size. In these circumstances it is almost impossible for fracture cases to receive anything but the most perfunctory treatment, and usually this is only of an expectant character. The remedy for this state of affairs is not difficult to suggest, but very difficult to carry out.

In the first place there ought to be a definite co-operation between the voluntary and municipal hospitals. Whatever else this includes it should certainly imply an active liaison between the staffs of the two types of institution. The surgical staff in charge of the fractures at the voluntary hospital should be consulting surgeons to the municipal hospital, and should superintend the work at both places. It will then be a matter of local circumstances whether bad fractures first go to the voluntary hospital and are later transferred to the municipal hospital, or whether from the outset certain types of fracture—for example, those of the femoral neck, pelvis, or spine—should from the outset go to the municipal hospital. The main and essential point is that in every city and large country town there should be secured a single fracture service for working-class patients. This would be carried out by a team of men working under a single chief, and the work would be partly done at the voluntary or teaching hospital and partly at the Poor Law or municipal institution. At the latter place there should be full provision for functional after-treatment—curative workshops where men during their recovery could be kept usefully employed, instead of drifting into that hopeless condition of compensation neurosis which awaits so many who are sent home with nothing to do. In any case such a man is a charge on the community during his invalidity, and it would really be much more economical to keep him at an institution where he is trained to resume work than to allow him to become a waster.

The Smaller Hospitals.

The problem of fracture treatment at the smaller hospitals in country towns is becoming more important every day, because of the large number of motor accidents which occur almost at their doors; and in the country hospitals there is a definite selective influence by which only the worst cases remain for treatment. The injured person is usually far from home, and his own wish is to be removed to an institution near his home; this may be effected after treatment has been given. Therefore a large proportion of the fractures in country hospitals are of a serious character. The character of these smaller hospitals, the extent of their equipment, and the work turned out by them varies very much in character. Some of them are modern and very well equipped; others are certainly bad, and if it were not for the protective halo of our cherished voluntary system they would be reformed or abolished.

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Probably in the better type of country hospital the fracture work compares very favourably with that done in the teaching hospitals in the service of men not interested in fractures; but, on the other hand, there are many small ...itals where the treatment is very bad. This may be ... to faults in the personnel or in the equipment; it is ...ch easier to deal with the latter than the former. It should be generally conceded that, except as a temporary emergency, no serious cases of fracture should be admitted to a hospital which is not provided with an x-ray plant and a proper supply of splints and appliances. An elaborate aseptic operating theatre is certainly not necessary. The matter of personnel is one of great difficulty, chiefly because, in the type of hospital in my mind—that of about twenty beds in a town with a population of two or three thousand—all the general practitioners are on the staff, and it is difficult for one or other to act as a specialist or consultant for the other.

Probably the easiest solution of the difficulty is the appointment of a resident house-surgeon who has a good knowledge of fracture work. Such a man will be of invaluable assistance to the whole staff, who will be only too glad to let him carry out routine fracture treatment. Unfortunately a large number—and I would say the majority of recently qualified men—do not possess this requisite knowledge, or, rather, practical experience. This brings us back to the first part of my thesis—namely, that our teaching hospitals do not give a student enough practical fracture work to fit him for this part of his profession. If we are asked where a man could go to in this country to get a three months' intensive post-graduate training in the treatment of fractures, we should have to admit that there are very few such places. Now this is certainly a most serious indictment of our surgical educational system.

To return to the small hospital and its fractures. At present what happens at the less satisfactory of these institutions is that fractures are put up within the first few days of admission and then nothing further is done ... perhaps six to eight weeks. If at the end of that time marked deformity is revealed when the bandages are removed, or the patient gets up, the case is sent off to a specialist at some teaching centre for further treatment. Such conditions as fracture of the neck of the humerus with bad position and a stiff joint, forearm bones with crossed union, an unreduced Colles's fracture, an ununited neck of the femur, a shaft of the femur with two or three inches overlapping, a malunited fracture of the tibia, or an unreduced fracture-dislocation of the ankle are common instances of serious crippling deformities which would have been comparatively easy to deal with during the first few days after injury, but which are not only difficult after several months, but at that period can seldom be restored to full functional recovery. Every case of fracture in which reduction and good position has not been attained by the end of the second week ought to have further treatment other than mere *laissez-faire*, and in the case of the small hospitals some arrangement should be made by which a consultant's opinion can be called for without any loss of prestige on the part of the practitioner in charge. This might be arranged by the national health insurance authorities, or else by the accident or compensation insurance companies, in whose interests it surely is that these cases should be quickly and efficiently brought to recovery.

The Relation to the Insurance Companies.

This opens up another point of view about the treatment of fractures. A man has a motor accident in which he sustains a fracture. If he is a better-class patient and is conscious after the accident, he is taken to his own doctor or to a nursing home, and the cost of the treatment which he undergoes is ultimately borne by the insurance company. But if he is far from home, or if he is a working man, he is taken to hospital, and it usually happens that all professional attendance is given gratuitously, the insurance company merely paying for loss of time on the scale of the Workmen's Compensation Act. It frequently occurs that the gravity of the case is overlooked, and that the fracture is put up in such deformity that the patient is either permanently crippled or else has to be sent to another institution for corrective treatment, which seldom gives such a good result as if the case had been efficiently treated from the outset. Surely, as a mere matter of economy, it would pay the insurance societies, in which should be included the national health insurance authority, to safeguard themselves in this matter. This could be done to some extent by providing for the services of a consultant in all severe fracture cases, soon after the accident, instead of delaying until a bad result is inevitable. Still better would it be if in all large centres of population good fracture clinics could be provided where the best treatment could be given in the first place, and where after-care until the patient is restored to work would be provided. Such an institution is actually in existence in Madrid, and is supported partly by a Government grant, but chiefly by the insurance societies. It is very desirable that some of the chief insurance companies should be persuaded, as a first step in this direction, to draw up a table showing the number and classification of their fracture cases, the length of time taken for recovery, and the cost of such cases during invalidity. I am confident that such a statistical inquiry would go a long way towards convincing the companies concerned that it would be in their own interests to help in the working out of some such scheme as has been suggested.

An Ambulance and X-Ray Service.

As far as I have been able to learn, many of the ambulance first-aid services have not modified their methods since the lessons of the war. In towns where accident patients have not far to be carried this is perhaps no great matter, but when fracture cases have to be transported for many miles over country roads we may well ask why it is that the Thomas splint is not used instead of the Liston. This point has been recently brought to my mind by a rigorous letter from my friend and fellow student Pearson, who writes urging this belated reform upon the overseas branch of the St. John Ambulance. The essential nature of good x-ray work, both in the first diagnosis and also in the after-treatment of fractures, is generally admitted, and the equally important provision of a good ambulance service is also necessary. Both these things are to hand in all cities and large towns, but they are often difficult to obtain in the country districts. Patients after an accident are frequently taken to their own homes, and sometimes—for example, in an injury to the hip-joint—it is not possible to be sure of the diagnosis without x rays. It ought to be possible to provide a portable x-ray apparatus which could be taken to such patients, and then, if serious fracture is discovered, the same motor ambulance could, if necessary, move the injured man to the nearest suitable hospital. The provision of such a service should be a part of our national hospital system; unfortunately, however, such a system does not exist, and the voluntary hospitals are overburdened already with the struggle for existence, and have, moreover, no sense of responsibility for national schemes. The charge would therefore have to be made out of the county rates, supplemented by the insurance funds.

Conclusions.

I am very sensible of the fact that I have been preaching to the converted, and that in the main I have only been saying what has been said so much better by our founder, Sir Robert Jones. But reforms do not come in a day, and it is better to repeat what we know to be true than to remain silent because good advice is not acted upon immediately.

We know now how fractures ought to be treated, and that correct treatment will save personal disablement and economize loss. We know, too, that organization, segregation, and team work are the essentials of good fracture work as much in peace time as in war. I have therefore thought it my duty in the high office you have conferred upon me to repeat these things you know so well, in the hope that we may be further stimulated to work for the much-needed reforms.

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British Medical Journal.

SATURDAY, DECEMBER 1st, 1928.

THE ASSOCIATION IN 1928.

MEDICAL men and women owe it to themselves to give a few minutes' thought every now and then to what is being done on their behalf and for the public good by the professional body which speaks in their name. Our present object is to offer them some material for consideration, but not to enter into details. An article of a few hundred words that tried to cover all the manifold activities of the British Medical Association during the past twelve months would make dull reading: it would be a mere catalogue, "a plate of bones." The full record of the year's work will appear next April in the Annual Report of Council, and in this brief survey we shall only point out some recent landmarks to those readers who are not as familiar as they might be with what goes on at the centre and at the periphery. By so doing we may perhaps give them also a better insight into the spirit and purpose of the great piece of living machinery known throughout the world as the B.M.A.

Speaking generally, it has been a year of consolidation and of progress along accustomed lines. There are no spectacular victories to record. Membership has grown by a thousand, and is now 34,500, so that in the past ten years there has been a total net gain of more than 14,000. Material resources expand with rising numbers; fresh activities open out, and new forms of service can be undertaken. When the centenary comes in 1932 the total ought to be 40,000 at least, for the field of recruitment is still large, and, unless we are mistaken in our judgement of the youth of to-day, the aims of the Association should make a special appeal to the generation of medical students who graduate during the next few years. Side by side with the growing membership there has been a steady growth of work at headquarters and a stirring of interest within the Divisions and Branches. From all parts of the country signs have come of vigorous life. We would not say that medical politics make a stronger appeal to the general body of members, but in the scientific and social spheres 1928 has seen a remarkable increase of local activity. Pages of our *Supplement* have been filled each week with notices of lectures, debates, demonstrations, and post-graduate courses, or of dinners, dances, golf matches, and excursions. A debt of gratitude is surely owed to the honorary officers in town and country who give time and trouble to the task of bringing their neighbours together by such admirable means. We may note also as a healthy sign of the times the disposition among individual members to make personal contact with the Head Office, both by requests for information and advice on professional matters, and by their ever-increasing use of the Association's Library, whose lending department has almost trebled its output in the last six years. Another means whereby members at the circumference can be brought into touch with the centre is the collective investigation of a clinical problem. Two very profitable inquiries of this kind have been set on foot this year by the Association, one into the treatment of varicose ulceration, and the other into the after-history of gastro-enterostomy cases. Useful information was also supplied by individual doctors in response to the questions drawn up by the Association's Committee on Puerperal Morbidity and Mortality when preparing its final report.

The leading event of the Association's year, its Annual Meeting at Cardiff under the presidency of Sir Ewen Maclean, was an unqualified success—well planned, well attended, and thoroughly informative in the clinical and scientific part of its programme. In this latter respect our organization does notable work for medicine. Every summer it visits a medical centre, and becomes "a gathering-point of specialized minds" and a clearing-house for new knowledge and new ideas; thus the Association fulfils one of its primary duties to the members at large. Our South African colleagues, following the lead of the parent body, held their first annual scientific meeting under the new constitution at Bloemfontein in March. Among many other services to medical science—apart from weekly publication of the *British Medical Journal* and periodical issue of two special journals—the Association at home has sent lecturers to Branches and Divisions throughout the country, and has added to the number of scholarships, prizes, and grants which it awards for the encouragement of research and clinical observation. A beginning has also been made with a series of articles in the lay press intended to guide the public in matters of general health.

On the political side (using the word in its widest sense) much useful work has been done in committee and elsewhere. A conference was held in June to discuss contributory schemes for hospital benefit, and medical representatives of 200 voluntary hospitals in Great Britain and Ireland attended. The Insurance Acts Committee has kept guard over the interests of panel practitioners, and nothing that bears upon insurance medical practice—whether it be the revision of disciplinary procedure, or allegations in respect of excessive sickness claims, or a questionable phrase in the latest bill—has been allowed to go by default. In like manner a special committee is watching the scheme for local government reform now before Parliament, and two memorandums of evidence were submitted to the Royal Commission before it finally reported. The encroachments upon private practice by local authorities are under investigation by another special committee, whose interim report is now before the Divisions. One more document may be mentioned here—the Association's memorandum on noise in relation to the health of the community, which has aroused great public interest and widespread support in the newspapers. Lastly, among the visible (and audible) activities of 1928 at headquarters we must record the rapid progress made with extensions to the Association's building in Tavistock Square, and the enlargement of the Scottish House in Edinburgh.

So much for a single year's work. Of the position generally it is true to say that no other vocational organization can be compared with the British Medical Association in respect of the scope and variety of its work, or its standing in the eyes of public authorities. It comprehends every aspect of professional life. Its conjoined aims are to advance the science and practice of medicine, to promote social intercourse among the members, to defend their interests, and to uphold professional standards. And beyond all these it stands for the public welfare. As Sir Robert Philip reminded us lately at the autumn Council dinner, this great organization a hundred years ago was simply a concept within the

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brain cells of a young man: "Charles Hastings did not seek material advantage; he had a spiritual inspiration." Ten years ago the British Medical Association, like every other institution, was suffering from the effects of a war unprecedented in scale and intensity. It has now far more than regained such ground as was lost, and is flourishing as never before. Nothing, however, could be worse than to end on a note of complacency, or to imply that material success, such as we see around us to-day, is all that matters. Charles Hastings had an inspiration.

THE LOCAL GOVERNMENT BILL AND HEALTH ADMINISTRATION.

In a leading article in the *Journal* of November 10th (p. 854), written before the Local Government Bill, 1928, was introduced in the House of Commons, we anticipated that the proposals of the Government would follow certain general lines, and the text of the bill shows that these anticipations were correct. The bill—that is, the measure applicable to England and Wales, but not to Scotland—is now under discussion in Parliament, and has been strongly attacked by both sections of the Opposition, as was to be expected, since it is the principal measure of the Government just prior to a general election. It is unfortunate that the concentration of attack mainly upon the financial aspects of the bill tends to divert attention from the very important provisions for the reform of local government machinery. It is only with these provisions so far as they affect health administration that the medical profession, as such, is concerned; and it may be said at once that, broadly, they will have the support of the British Medical Association, in so far as they are a step towards that unification of health administration which the Association has made its aim for so long. The whole object of any suggestions the Association has to offer is to make the bill a more effective instrument in securing the practical efficiency of health services. Some modifications of the bill seem essential if grave danger to these services, including the provision and management of hospitals, is to be avoided.

There are three aspects of the bill in its relation to health administration to which the attention of the medical profession will be mainly directed. One of these is its effect upon the position of medical officers of health and of Poor Law medical officers as regards their status, and their transfer, compensation, and superannuation if their offices are disturbed. The provisions of the bill in this respect may be regarded as almost entirely satisfactory. The interests of existing officers are secured; and the clause relating to the expediting of the appointment of whole-time medical officers of health, though it might with advantage be somewhat more specific as to the nature of the arrangements to be formulated, is clearly a great advance in the direction which the Association has for many years indicated as desirable. The Association will need, however, at a subsequent stage, to be watchful lest its general principle that whole-time medical officers should not undertake domiciliary practice is violated.

The second aspect of the bill in its relation to health matters concerns its main proposals for changes in administrative machinery with regard to both form and function. Here there is unfortunately room for some disappointment and need for early activity. Poor Law guardians, as such, are to be abolished, and their functions transferred to the councils of counties and county boroughs, but there is no guarantee of that "break-up of the Poor Law," as it has been called, without which there will still be much overlapping and reduplication of provision of health and other services. The new authorities may, if they wish, give assistance under the Poor Law in respect alike of attention to health, of hospital accommodation, of educational provision, and of money, food, and shelter, as one miscellaneous whole and through one entirely new Public Assistance Committee, instead of attending to all health matters under the Public Health, Maternity and Child Welfare, Mental Deficiency, and other Acts through the appropriate committees, and to educational matters through the Education Committee, leaving only the more material and immediate relief to be continued by way of the Poor Law. Indeed, this conglomerate method of administration, which perpetuates most of the old evils and leads but a little way towards the unification of health services, appears rather to be encouraged by the bill, though permission is given to authorities to adopt the alternative and only satisfactory method. In the case of counties, too, which may contain large urban districts or boroughs, which are themselves satisfactorily conducting health services within their boundaries, the council of the county may proceed to establish and manage alternative health services covering the same areas or families, instead of being compelled to delegate to the councils of such county districts all functions similar to those which they are already administering with success. Further, though councils are to be permitted to place on their committees (even on the Public Health Committee, on which this has not hitherto been allowed) persons who are not members of the councils themselves, there is no guarantee that this will be done, so that there may very likely be committees dealing with the supply and management of hospitals on which there is no one who has any knowledge or experience of such work, or has any acquaintance with the opinions of hospital staffs and other interested practitioners.

As was stated in the leading article to which we have already referred, the British Medical Association regards it as highly important that these principles of distribution of functions, of delegation of functions, and of co-optation on committees should be made compulsory on authorities instead of merely permissive. A fourth principle previously mentioned as having been put forward by the Association was that a statutory local medical advisory committee should be established in each area. This matter is not dealt with in the bill in any way. In present circumstances it may be found desirable not to press for this, especially as a satisfactory alternative may be provided by Divisions of the Association being urged to secure more effective and constant co-operation with local councils in health matters.

The third aspect of the bill in relation to health administration is the effect which its financial provisions may have on the efficiency of health services. The system of block grants over quinquennial periods is to be substituted for annual grants-in-aid. Under this system it will be possible for a council, if it wish, to spend but little money on health services and to divert the grant to, say, highways. At a time when many authorities have done little, or even nothing, with regard to mentally deficient persons or to maternity or infant welfare—when, indeed, they have no statutory duty with regard to the latter except to set up a committee—this may in some areas lead to lamentable neglect. Further, the present power which

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the Minister of Health has of withholding grant in cases of proved inefficiency will be abolished, or is made by the bill so remote and conditioned as to be wholly ineffective. The education service is exempted from this alteration to the block grant, and it has been suggested that certain of the health services should also be exempted for a limited period of years. It is at least true that there is grave danger to the needed development of such essential services unless this is done, or unless the Minister secures to himself further controlling powers in this connexion. We rejoice that Mr. Chamberlain, in his speech on the second reading of the bill, has undertaken that this matter shall receive sympathetic consideration.

THE KING'S ILLNESS.

No calling has warmer feelings of loyalty to the Crown than the medical profession, and the sympathetic interest shown by members of the Royal Family in the progress of medicine and the relief of suffering has endeared them to us all. The King's illness, therefore, is a matter of personal concern to our readers. They will have gathered some idea of the nature and course of the malady from the brief but explicit bulletins, issued regularly since the evening of Wednesday, November 21st, by Lord Dawson and Sir Stanley Hewett, who have throughout been in attendance upon His Majesty at Buckingham Palace.

The public nowadays expects to be taken into the doctors' confidence when the Sovereign is ill; and to any observant medical eye the recent bulletins, though necessarily restrained, have been informative, pointing to a serious infection such as must give rise to natural anxiety. His Majesty, it appears, was not in his usual health on November 17th, and began to suffer from what is called in homely speech a feverish cold. By November 21st there were definite signs of congestion in one lung, with some pleurisy. With an increase of fever on November 24th the inflammation of the pleura tended to increase. By that time bacteriological tests had been made, and the clinical diagnosis was confirmed by *x*-ray examination.

Doctors know well that an infection of this kind is always serious in a patient over 60 years of age. Many of our readers will be aware also that such infections are rather different to-day from those observed ten years ago. It is very difficult to put any precise limit to the probable duration of the illness; its tendency is to ebb and flow, and part of the anxiety of those in attendance centres round the length of these phases. While specific treatment appears to have some effect in controlling the force and intensity of the infection, such measures cannot of themselves bring it to an end.

Our study of the bulletins (including the temperature records) up to the time of going to press leads us to infer that the force of the infection is gradually spending itself, and with maintenance of the patient's strength we may look for a favourable issue, though early and dramatic signs of improvement are unlikely. Meanwhile the affectionate thoughts of every member of the Association will be with the King our Patron, and the Queen; and as doctors we shall wish to give a message of confidence to the colleagues who bear the heavy strain involved in attendance at the Royal bedside.

PROBLEMS OF THE SLUM.

It may be remembered that at the autumn dinner of the British Medical Association last year, Mr. Chamberlain, speaking as Minister of Health, stated that the supply of new houses was becoming so nearly adequate that he proposed in the immediate future to take action in regard to the very urgent matter of dealing with slum areas. He appealed to the medical profession, along with others, to help in this by expert knowledge and advice, and by assisting to create a proper and encouraging public opinion. It would scarcely be possible to have a better aid in this direction than the volume entitled *The Slum Problem*,[1] by Mr. B. S. Townroe. It has a short commendatory introduction by Sir J. Walker Smith, formerly Director of Housing at the Ministry of Health, and Mr. Townroe has himself had experience in that department of the Ministry, and has also for several years been chairman of the Housing Committee of the Hampstead Borough Council, and acted as consultant to the Building Research Board. Such an experience may be taken almost as a guarantee that the book contains facts on which reliance may be placed, and suggestions which are well balanced and practical. The problems of the present situation with regard to slum areas are extraordinarily difficult; their exposition correspondingly demands qualities which are not universal possessions. They lend themselves to easy generalizations and facile statements which may pass on the political platform, or even in Parliament, as evidence of good intentions, but do not contribute in any way to curative or ameliorative action. Mr. Townroe's book is intended to supply speakers and writers on its subject, members of local authorities and housing committees and associations, and others with information which can be turned to practical use. It may be strongly recommended also to medical men and women who are interested in health administration and propaganda, but who sometimes do not know as much of housing matters as of some others, and to elementary school teachers, who are not always sufficiently aware of the home conditions of some of the children in their charge, though these conditions, as was demonstrated by a report of the Medical Research Council,[2] influence the intelligence of the children to an extent of the order of one-third. It is an important consideration that progressive improvement in home conditions should react favourably, not only on health, but on intelligence. The complacency with which certain large industrial, or even residential, towns proclaim themselves as being "without a slum" is a little disquieting. It depends, of course, on the definition. It is possible for a lord mayor or mayor so to define a slum as to be able truthfully to say that there is none in his city or borough. Mr. Townroe quotes a definition, but it is not an exact one, and he deals broadly with his subject so as to include rural as well as urban conditions, whether they are due to the ancient timbered house, to back-to-back erections, to the cul-de-sac, to jerry-building, to the rows of depressing hovels in many mining villages, or to any other cause. Some localities are obviously much better than others, and the authorities of such places, whether their advantage be due to good fortune, or wisdom, or both, are to be congratulated. In some of the worst towns the local authority has made almost heroic efforts to cope with the worst spots therein, and they are heartily to be commended. So are many voluntary associations and individual landlords of property which, without assiduous and personal attention, would inevitably have so deteriorated as to have become unfit for human habitation. Yet the conditions over large areas remain appalling. As a metropolitan sample may be taken

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tion that has been allowed to envelop the whole subject would appear to be the first necessity. Mr. Donaldson raises two other issues in his letter—namely, the need for diagnostic centres at which cases of cancer might be recognized in their earliest stages, and the importance of teaching the public more about malignant growths. Both issues merit close consideration by those concerned with the public health. Whether, however, it is better to educate the public specifically in the symptoms of cancer, thus running the risk of inducing in many persons a morbid self-regarding vigilance, or to concentrate on the value of periodic medical examination, opens up problems too large for discussion in a brief annotation. But the education of the public is a matter on which the medical profession will soon have to make up its mind, in principle and in detail, for if the public is not given instruction by those qualified for the task it will seek other mentors, with perhaps disastrous results.

MIRROR-WRITING.

MIRROR-WRITING is that variety of script which runs in an opposite direction to the normal, the individual letters being also reversed. The writing is therefore illegible until held up before a looking-glass: a familiar example of mirror-writing is seen in the imprints upon a blotting pad. Mirror-writing is met with in most diverse circumstances, and in all classes of persons, from the mentally deficient to the genius. Adults and children may show it, and it may be done consciously and unconsciously. Yet it is sufficiently infrequent in its occurrence to render it a subject of interest when observed. Dr. Macdonald Critchley has written a most interesting little book entitled *Mirror-Writing*,[1] in which he tells all that is known about it. The book contains specimens of such writing done by infants in schools, where perhaps it is most often seen, and a page from a notebook of Leonardo da Vinci, of whom it has been said that he adopted this form of script to hide his observations from the inquisitions of the Papal authorities, though the suggestion seems to imply that his genius was less shrewd than his other work would make it appear. There are also specimens of spontaneous bimanual mirror-writing done by a normal individual conscious of his doings, and a beautifully written letter by an old lady, the subject of right-sided hemiplegia, who thought that she was writing just as she had always done and as everyone else did. An oddity such as this mirror-writing, so widespread and so different in its conditions of production, suggests that the finding of a common cause for such varied exhibitions may be difficult; and so it appears from Dr. Critchley's book. It is reasonable to explain that the paraplegic whose right side is powerless writes mirror-fashion with his left hand because there is probably a derangement of the visual component of speech present, and the patient is therefore subject to the independent activity of stored-up memories localized in the right hemisphere. Writing in such cases may be impossible to initiate at will, but when it arises in response to more primitive impulses it will be executed in its most automatic fashions, mirror-wise. But such an explanation would not seem to apply to the mirror-writing of children. Yet it is not as irrelevant as may appear. Reversals are common in infant attempts at writing. The child is taught to write in a certain fashion; there is no reason behind it, but only rule, and a rule that custom has not fixed in his mind. So that on occasions he breaks a rule that is of little weight to him. It has been said that mirror-writing is a sign of left-handedness, and observations lead the author to the conclusion that it is more common among the left-handed.

[1] *Mirror-Writing.* By Macdonald Critchley, M.D., M.R.C.P. Psyche Miniatures, Medical Series, No. II. London: Kegan Paul, Trench, Trubner and Co., Ltd. 1928. (Pott 8vo, pp. 80; 6 figures. 2s. 6d. net.)

WILLIAM BRINTON, M.D.

WE wonder how many of our readers, apart from those who have specialized in gastro-enterology, would know what was meant by "Brinton's disease." There are perhaps few better examples of the proverbial prophet than that of Dr. William Brinton, who was the first to describe the rare condition which he named linitis plastica, and was one of the founders of modern systematic gastro-enterology. In a sympathetic address delivered at the last general meeting of the American Medical Association in the Section on Gastro-enterology and Proctology, Dr. Joseph Sailer of Philadelphia gave an interesting account[1] of the life and work of this physician, who died in 1867 at the comparatively early age of 44. He was house-physician, demonstrator of anatomy, and medical tutor at King's College, lecturer on forensic medicine and afterwards on physiology at St. Thomas's Hospital and physician to the Royal Free Hospital. He was an excellent teacher; his clinics at the Royal Free Hospital were crowded, and he conducted a very large practice. In addition to about forty articles in medical journals, many on anatomical topics, he wrote four books, which dealt respectively with gastric ulcer, diseases of the stomach (which contains the description of linitis plastica), diet, and intestinal obstruction. Of these Dr. Sailer regards the last as the most valuable, and that on diet as the poorest. In the work on intestinal obstruction, Brinton advocates early operation, suggests the possibility of entero-enterostomy, which he appears to have tried on animals, objects to purgatives, and pins his faith on three drugs—namely, opium, tobacco (by enema), and belladonna. Apart from his contributions to medicine, Brinton was a keen Alpine climber, an excellent draughtsman, and a brilliant conversationalist. A portrait of him is to be found in the Royal College of Physicians.

MEDICAL MEMBERS OF LOCAL PUBLIC BODIES.

WE hope to publish shortly a list of medical men and women now serving on local public bodies, and we invite the help of our readers in obtaining the necessary information. Medical members of the following bodies are asked to send brief particulars to this office on a postcard addressed to the Editor: County Councils, County Borough Councils, non-County Borough Councils, Urban District Councils, Rural District Councils; also medical co-opted members of Education Committees, Maternity and Child Welfare Committees, Mental Deficiency Committees, and medical members of Boards of Guardians. Information is desired also about members of the corresponding bodies in Scotland—County Councils, Town Councils, Parish Councils, and Education Authorities, etc. Medical officers of health may be able to assist by furnishing notes of medical members of the local authorities with which they are associated. In response to the requests already published details have been received regarding medical members of more than sixty local bodies. Such information is always useful, and it will be especially valuable during the coming year in view of approaching legislation.

SIR LEONARD ROGERS, C.I.E., M.D., F.R.S., has been appointed Medical Adviser and President of the Medical Board, India Office, in succession to the late Major-General J. B. Smith.

WE regret to announce the death of Dr. James Wilkie Smith of Ryton-on-Tyne, one of the oldest and most widely respected medical practitioners in the North of England. A memoir will appear next week.

[1] *Journ. Amer. Med. Assoc.*, October 13th, 1928, p. 1080.

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THE ORGANIZATION OF MEDICAL RESEARCH IN INDIA.

RECENT events have brought into no little prominence the subject of medical research in India and its organization by Government, both in relation to the needs of India as a whole, and with due regard to scientific research work in other parts of the Empire, including Great Britain. Our consideration of the matter may appropriately be prefaced by a brief historical note.

HISTORICAL.

Organized medical research in India dates from the appointment, nearly sixty years ago, of Dr. Timothy Lewis and Dr. D. D. Cunningham as whole-time research workers in India. The first Indian Medical Congress in Calcutta at Christmas, 1894, which Mr. Ernest Hart attended when Editor of the *British Medical Journal*, sent resolutions to the Government of India advocating more medical research, and the outbreak of plague in Bombay in 1896 led to the establishment of the plague laboratory there under Haffkine. In 1899 Surgeon General Harvey recommended the formation of a bacteriological department; in 1905 thirteen officers were sanctioned for research work under the Government of India, and the Central Research Institute was opened at Kasauli in the following year.

In the year 1911 a great step forward was made when, on the advice of the late Sir Pardey Lukis, the Research Fund Association was formed under the Government of India with an annual income of five lakhs of rupees (£35,000) to administer the Medical Research Department (as the bacteriological department is now called), with the *Indian Journal of Medical Research* as its organ.

In 1920 the late Professor E. H. Starling visited India at the invitation of Government, and reported on a scheme to build a new central research laboratory; he recommended Delhi as its site, but financial stringency held up the project. Last winter a committee was formed under the chairmanship of Sir Walter Fletcher, F.R.S., secretary of the Medical Research Council, and with Colonel S. R. Christophers, F.R.S., as its secretary, to report on the reorganization of medical research in India, including the proposals of Professor Starling. The other members of the Committee were Lieut.-Colonel S. P. James, medical officer and adviser on tropical diseases, Ministry of Health, and Dr. R. Row, professor of pathology, Grant Medical College, Bombay. After visiting all the important research centres this Committee has recommended extensive modifications of the Starling scheme in accordance with the altered conditions of to-day. That scheme included provision for clinical and pharmacological work; this has since been provided for in the Calcutta School of Tropical Medicine and in proposed pathological institutes in connexion with the Bombay and Madras Medical College Hospitals. These changes have also done away with the necessity for locating the new Central Research Institute in a large city such as Delhi, with a great expenditure on buildings.

PROPOSALS OF THE FLETCHER COMMITTEE.

After studying the matter in all its bearings the Fletcher Committee has found a very appropriate site at Dehra Dun for the Central Medical Research Institute. This site is in close proximity to other scientific institutes, with ample land and some fairly suitable buildings, and also a very good climate for a station in the plains. Dehra Dun, though not one of the large cities of India, is a place of some importance, with direct access by rail to Delhi. It is in the Meerut division of the United Provinces.

The Committee's scheme for a headquarters for an All-India medical research organization includes provision for six sections. These, briefly enumerated, are as follows: (1) Epidemiology and Statistics; (2) Bacteriology, together with a serum and vaccine section in the present Kasauli Laboratory, and Immunology to include work at cholera and plague; (3) Biochemistry and Pharmacology, for which there is no provision at Kasauli; (4) Medical Biology, to include medical entomology, protozoology, and helminthology; (5) the Malarial Survey of India, already in existence under Colonel Christophers; and (6) Nutrition, now being carried on by Colonel McCarrison.

The Committee advises further development of provincial research institutes in the principal cities, with six additional superior research posts. In its opinion provincial institutes should continue to work as at present on their own lines, developing their particular spheres of usefulness, each under its own provincial Government. But direct and indirect assistance should be given to the work of these institutes, along lines indicated in the report.

In regard to administration, the Committee does not recommend any radical changes. The successful Research Fund Association should, it holds, continue to administer the Research Department; but the new Central Research Institute should have its own governing body. The Committee believes that the problem set before it can be solved by building upon the foundation of past experience and by securing continuity for the evolutionary process which has been going steadily forward since 1900.

In regard to the recruitment of research workers, the Committee advises that some of these should continue to be obtained from officers of the I.M.S., both British and Indian, but it suggests that an increasing number of research workers will have to be recruited from outside India. To allow the right stamp of men to be obtained it advises the formation of a Recruitment and Appointments Board of senior administrative and research medical men, and that this board should have the help of a consultative committee in Great Britain of four members nominated respectively by the India Office, the Ministry of Health, the Medical Research Council, and the Royal Society, who should also belong to the governing body of the Research Fund Association. This board should also make the appointments to the provincial research laboratories.

Not the least important and suggestive passages in the report are to be found near the beginning, where the terms of reference and their interpretation are discussed. The Committee insists that "medical research" must be read in its widest and fullest meaning, and that no sound system of medical research can be established unless living organic connexion is set up and maintained between applied work on the one hand and work not of immediate utilitarian character on the other. The Committee wisely places emphasis also on the importance of interpreting "medical research" to include much more than the study of actual disease. This phrase it takes to include all processes of advancing knowledge, whereby the human body may be brought to the fullest development of health and efficiency of which it is capable under good conditions of environment, and protected from disease and other injuries, or aided in its repair. Viewing the terms of reference in this broad manner it became apparent that the questions put to Professor Starling in 1920 now formed only one of a set of connected problems of the greatest importance to India, and reaching, indeed, far beyond that country.

What appears to us to be the keystone of the Fletcher Committee's report is its recommendation not only for enlargement of the medical research service in India, but for acknowledgement of the essential value of research-work as such, and as a corollary the assignment to its personnel (given due capacity and experience) of equal status recognition and pay with those in charge of administrative work. The problem of recruiting good men for the medical services of India would become far easier if it were known in the medical schools that India is once more prepared to offer really scientific careers in medicine with adequate remuneration and status.

NUTRITIONAL RESEARCH IN INDIA.

In a special section of its report the Committee deals with the future of "Nutritional research in India"—a problem it had been specifically directed to investigate.

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No part of the report is of greater interest than this, and in none is the path of progress for medical science more clearly indicated. The Committee recognizes that adequate provision for research on nutrition is essential, not only to the successful study of specific problems of disease in man and his domestic animals, but to the promotion of physical efficiency in both. Insistent as are the obvious problems of acute and epidemic diseases (such as plague, malaria, influenza, and kala-azar) to meet which research in India has been sporadically organized in the past, these are not more urgent in reality than the less dramatic medical problems of daily life. "In the light of modern discoveries we know, for instance, not only that recognizable and named diseases may come to vast numbers of a population from diet which is faulty in quality, even if adequate in quantity, but also that less defined but no less tragic evils may come in the form of diminished health and energy and lowered resistance to infection." In no country in the world is the truth of this statement more apparent than in India, where the work of McCay in 1910, and of McCarrison in later years, has demonstrated the connexion which exists between faulty nutrition and the physical inefficiency and low powers of resistance to infection exhibited by millions of the Indian people.

This section of the report deals at some length with the groups of phenomena to be studied in nutritional science, as well from the quantitative and qualitative as from the economic points of view. Emphasis is laid on the necessity for re-examining the older and basic knowledge of nutrition, derived from studies in temperate climates, in the light of climatic conditions in India; for while this knowledge may stand the test of re-examination it is possible that it may require some modification. Many current views of pathology and bacteriology require reconsideration in the light of the newer knowledge of nutrition. In these activities "it is not likely that any country in the world has more to gain than India herself, or more to give to other countries as the work progresses, in new knowledge of the greatest scientific and practical value."

In harmony with the recommendations of the Royal Commission on Agriculture, the Fletcher Committee recognizes the intimate community of interest between workers on nutritional science, whether in fields of "human," of "animal," or of "plant" nutrition; and it indicates the great and mutual value of close association between medical and agricultural interests in studies of human and animal physiology and pathology.

Having thus drawn attention to the importance of nutritional research to the Indian peoples and dealt with the inadequacy of the present provision for its prosecution, the Committee proceeds to make recommendations for the great increase and extension both of the existing unit for nutritional research, under Colonel McCarrison at Coonoor, and for the establishment throughout India of new units in every important centre of medical research and higher teaching. Particularly does the report deal with the part, in the scheme offered for a new Central Institute for Medical Research, which should be taken by nutritional studies. With the detail of these recommendations we do not propose to deal; since no doubt they will receive careful consideration by the authorities concerned. We hope, however, that it may be found possible to carry them into effect and to combine them with the independent recommendations of the Royal Commission on Agriculture, which provide not only for an Institute for Human Nutrition in India, but for an Institute for Animal Nutrition, both establishments working in close touch with each other.

In perusing this section of the report we are impressed by the masterly way in which the case for nutrition is presented, by the great importance attached to nutritional research as a result of the Committee's labours in India, by the vast opportunities which India presents for such research, and by the scope which it affords for young men of science imbued with the pioneer spirit of investigation. If the recommendations of the Fletcher Committee in regard to nutrition be adopted in combination with those of the Royal Commission on Agriculture then India will be equipped for nutritional research, and the ultimate benefit to India, to the Empire, and to mankind will be great in proportion to the culture and capacity of the men chosen to organize, systematize, initiate, and carry on the work.

The Rockefeller Offer and the Committee's Proposals.

Shortly after the comprehensive inquiry of the Fletcher Committee an announcement was made in India that the Rockefeller Foundation had offered to the Government of India about £100,000 to build and equip a Public Health Institute in Calcutta, opposite the School of Tropical Medicine, to be staffed and administered by the Government of India. On September 6th last the Simla correspondent of the Calcutta paper, the *Statesman*, reported that the Government of India had considered this offer in relation to the Fletcher Committee's recommendations, and had decided to adopt the suggestion of the latter to adapt an available site with buildings at Dehra Dun as the new Central Research Institute, at a cost of six lakhs of rupees, and to provide three lakhs yearly for the upkeep of the Calcutta Public Health Institute to be built by the Rockefeller Foundation (whose offer would be open until the autumn) at a cost of 15.61 lakhs.

As the two sets of proposals (which appear to fit very well into each other) have already been sanctioned by the Standing Finance Committee of Legislative Assembly in Simla there is every probability that these important advances will be carried through without much further delay, and that by such means medical research in India will be placed on a firm footing to the lasting benefit of the country.

Nova et Vetera.

A SEVENTEENTH CENTURY CURE FOR SCIATICA.

The prescription set out below was recently found in the archives of Rochester Cathedral by my friend Miss L. J. Churchill, F.R.Hist.Soc. It was written on a blank space in the *Register Spiritualium*. I should think that some poor clerk or official suffering from the complaint had had it given to him by another, and had made a note of it at the time on the only available bit of paper. It is so quaint and so characteristic of the period, seventeenth century, that I thought it would be worthy of a space in the "Nova et Vetera" column. It runs as follows.

A verie good medicine for the Sciatica.

Take an ounce of fine venice Treacle of the best, a penie worthe of neates fote oyle, an ox gall and two penneworthe of aqua vite, mingle all this together and make of as it weare a salve and spreade the same uppon a pece of white Leather one (on) the fleshie side and Laie the same to your place of Greafe, but before yow do the same take parte of the same mixture and annoynte your place of greafe with it ageinst a good fier and lett it soke in and when it is well Annoynted before the saide fier Laie yt unto the place of Greafe as afforesaide the Space of xxiiij houres. Then take it of(f) and Laie freshe unto the place, this is to be vsed the space of viij or x daies with freshe (annointing) everie xxiiij howers, annoyntinge and chafinge ye place of greafe ageinst the fier and with goddes helpe it will heale it.

The ingredients are simple and compound. Venice treacle as late as 1753 contained sixty-two different drugs. By 1785 it was called "a pompous and useless medicament." Its active ingredient was opium. It is interesting to note the use of bile; this was believed, and still is, to facilitate the penetration of a drug through the skin. I am afraid the aqua vitae, or strong alcohol, would somewhat thicken the gall, though it would prevent putrefaction. The white leather is still often made use of when applying a permanent plaster. When I was young Scott's dressing was generally applied on kid skin. Note: "Chafinge" = modern massage.

F. William Cock.

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NINETY-SEVENTH ANNUAL MEETING of the British Medical Association, MANCHESTER, 1929.



SHIP CANAL BUILDING

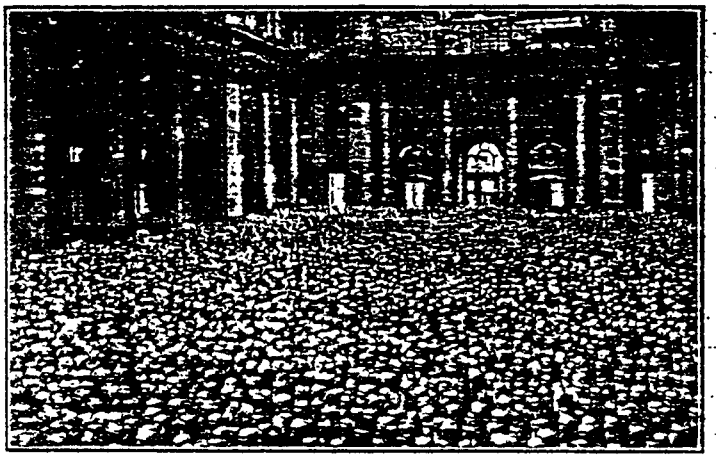
THE ninety-seventh Annual Meeting of the British Medical Association will be held in Manchester next summer under the presidency of Mr. Arthur H. Burgess, F.R.C.S., Professor of Clinical Surgery in the University of Manchester, who will deliver his address to the Association on the evening of Tuesday, July 23rd. The sectional meetings for scientific and clinical work will be held, as usual, on the three following days, the morning sessions being given up to discussions and the reading of papers, and the afternoons to demonstrations. The Annual Representative Meeting, for the transaction of medico-political business, will begin on the previous Friday, July 19th. The provisional programme for the work of the Scientific Sections is being drawn up by an Arrangements Committee, consisting partly of Manchester representatives and partly of members appointed by the Council of the Association. The names of the Presidents of Sections are given in a Current Note published in this week's *Supplement*; the full list of officers, together with other details of the arrangements for the Annual Meeting, will appear in later issues. During the week, and in particular on the last day of the meeting (Saturday, July 27th), there will be excursions to neighbouring places of interest in the North-West of England. The British Medical Association has met four times at Manchester—in 1836, in 1854, in 1877, and again in 1902. We publish below the first of a series of illustrated articles dealing with the history of Manchester and describing some noteworthy features of the city and its neighbourhood, with special reference to medical institutions.

MANCHESTER AND SALFORD.

BY

E. M. BROCKBANK, M.D., F.R.C.P.

THE Meeting of the British Medical Association is to be held in Manchester and Salford next July. The relations of the two cities are strange. They are so near together and yet so far apart. They are near because they are only separated by the River Irwell, a stream which at this part of its course rivals the Meander in finding the longest distance between two points. It is about fifty yards wide here, and Manchester is on its left-hand bank—a compass point is of no use—Salford on its right bank. But they are even nearer than this, for two important residential suburbs of Salford—Higher Broughton and Kersal—are on the Manchester bank and entirely continuous with the adjoining part of Manchester, their boundaries in daytime being marked only by policemen on point duty in different coloured helmets and at night by different lighting systems. Whilst so near and even interlocked in a territorial sense, they are as far apart as possible for local government purposes, each having an entirely independent mayor and corporation of its own, Manchester's head being a lord mayor. Originally Manchester was within the authority of Salford, which was a royal demesne with a royal manor, the King holding lands in it; but although once so united in a harmonious alliance they were granted a legal separation in the fourteenth century, and have never made it up again, in spite of various approaches for the purpose on the part of Manchester. By this deed Manchester became a common manor, Salford remaining a royal demesne, and still being a royal manor, which it proudly, and justly, mentions as occasion arises.



THE MANCHESTER ROYAL EXCHANGE.

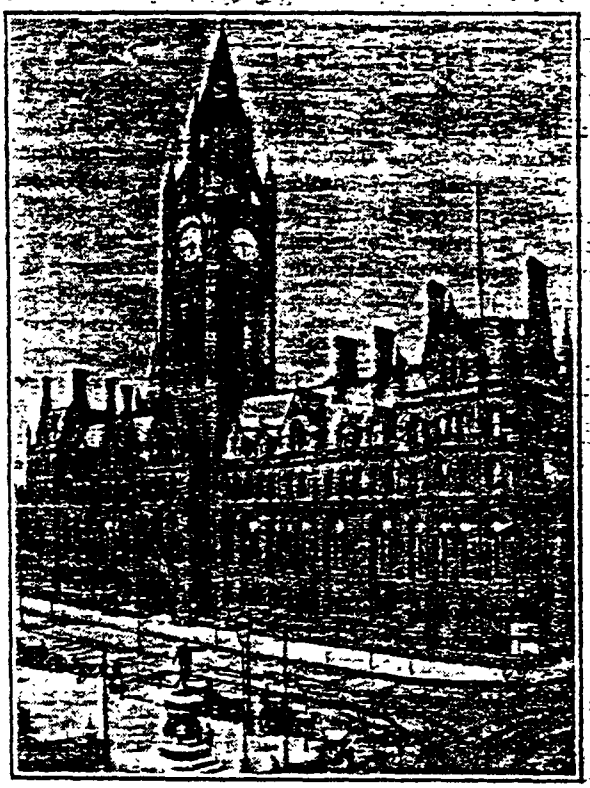
After the separation, over ensuing centuries Manchester forged ahead, and its population is now about 750,000, and that of Salford 250,000; but many of the latter number are Manchester people who live in the Broughton and Kersal suburbs of Salford.

Manchester's civic life centres in its Town Hall, which is a very large building in Gothic style facing Albert Square, an open space of proportionately large area from which a proper view can be had of the tall spire and its handsome clock with dial, figures, and hands that can be seen from miles away. The business centre of both towns is the Manchester Royal Exchange, the largest exchange in the world, where at high 'change 5,000 or more members transact business, chiefly in cotton, but in all trades except coal and produce, each of which has an exchange of its own. Millions of contracts are made yearly

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on the Royal Exchange by word of mouth, and confirmed afterwards by contract notes, and but few are not kept. Business has been sadly to seek with us lately, and many times may the following conversation have been heard on the "boards" between business friends: "Morning"; "Morning." "Owt?" "Nowt." "Morning"; "Morning."

Manchester is not uncommonly called "Cottonopolis," a term which, if ungainly, is not unjust, because it is the centre of the cotton industry of Great Britain, which, it is estimated, directly and indirectly gives employment to 10,000,000 of the population, and in the mills of which £210,000,000 are invested. Some of the finest cotton thread of the world is spun in the heart of Manchester, and has been since Robert Owen, the socialist reformer, began to spin fine yarns in 1790, and I have seen yarn so fine that 140 miles length of it weighs only one pound. It would require an Enobarbus to describe the infinite variety and fascination of some of our Cepea calico printers' work on gauzy muslins made from Egyptian cotton. It is hoped that visitors competent to judge will have an opportunity of checking the truth of this statement next July.



MANCHESTER TOWN HALL, ALBERT SQUARE.

Manchester has many industries besides that of cotton, and so has Salford, but space will only permit of reference to the great channel—the Manchester Ship Canal—by which is brought, in ocean-going steamers up to 15,000 tons burthen, the raw material for the factories, and our beef, corn, eggs, bacon, and cheese. The Ship Canal offices are in the fine new ten-story-high building in Upper King Street, which the company built and owns. In this building, the tallest in the city, the Manchester Chamber of Commerce has its headquarters.

Salford has many factories, but few warehouses or commercial buildings. All the commerce of the two towns is transacted in Manchester, with its miles of streets lined by magnificent warehouses, in which goods are stored and packed, and from which they start on their journey by rail or Ship Canal to the uttermost ends of the earth. Manchester is Salford's shopping centre, entirely for the classes and almost entirely for the masses. The only Salford shop that I have ever heard of that has supplied the "quality" with necessary things was Hobson's, the boot shop—and that was Hobson's choice.

The approaches to Salford from Manchester are not cheering; it is a striking contrast to cross the river from one of Manchester's busiest and finest shopping streets into cheerless Chapel Street, Salford's main artery. This is a wide street, running to Bexley Square, in which is Salford's small, handsome town hall. The architectural features of the street begin at the Education Offices and the fine Salford Roman Catholic Cathedral. Further on, Salford Royal Hospital adds dignity to the appearance, and then the broad north road to Bolton, beginning with a fine crescentic sweep which overlooks a typical Irwell horse-shoe bend and some of Salford's factories, and leads to the handsome buildings of the Technical School, is a worthy highway for any town.



SALFORD TOWN HALL.

Salford at present provides the cattle market for the two towns and neighbourhood, and if any citizen, informed as to local affairs, should forget the day of the week, he can always get a grip on Tuesday by seeing the raw material for food on its last appearance in its Anglo-Saxon forms of oxen, sheep, pigs, and calves on its way from Salford Market to the extensive Manchester abattoirs, where it is made suitable to appear on the menus of the two towns as beef, mutton, pork, and veal.

The relationship of the two towns, as I said before, is curious: Salford would be very badly off indeed without its big offspring, and the loaves of bread, not crumbs, received from its bountiful table. The Manchester (not Salford) Ship Canal has nearly all its extensive docks in Salford because of the need to use the River Irwell for dock construction. The Manchester Corporation has £6,735,000 invested in the Canal, with members of its corporation forming a majority of the Board of Directors. Salford has no money invested in it, yet its rates benefit from the docks and warehouses to the extent of 7½d. in the pound, whilst Manchester only receives 1⅛ farthings in the pound. Much the same benefit from rates results from the position of the railways. Yet with all this help Salford rates are 25 per cent. higher in the pound that Manchester's, and most of its valuable rateable ground is occupied. In further negotiations for amalgamation we may have an opportunity of seeing Manchester play the part of a modern commercial Sibyl in its offers to Salford.

Salford makes some amends to Manchester by providing space in a caterpillar loop of the Irwell for the Manchester racecourse, and Manchester's premier amateur Rugby football club has moved into Salford territory for a suitable ground. Salford favours professional Rugby football, whilst Manchester provides two Association teams, and is about to provide another.

In the cricket world the Old Trafford ground is unsurpassed anywhere in England for players and 30,000 onlookers. It is taxed to its utmost when the old struggle of the Wars of the Roses is renewed on a fine sunny Bank Holiday, when as many thousands as perished in the old wars and lie under the sod have to be accommodated on the turf within the playing ring for the three days' grim and dogged struggle. Both towns can compete favourably with each other, and with any other town, in the number of dog- and dirt-racing tracks, cinemas, and dance halls.

Manchester provides the two towns with their daily newspapers, including, of course, the *Manchester Guardian*, of world-wide circulation, fame, and good repute. The

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local doctors and the press are on very friendly terms in spite of our general professional distaste for personal publicity, which our journalistic friends do not appreciate and would like to see less of. Not even the premier paper, however, understands the difference between the British Medical Association and the General Medical Council, and the editorial thwackings that are administered to chastise the profession as occasions arise are, accordingly, liable to fall on the wrong shoulders. We have only two theatres now instead of four, the Theatre Royal and the Comedy Theatre, which have in their time played many parts in our social life, having recently been turned into picture houses.

Manchester has had a reputation as a great musical centre since a German pianist, Charles Hallé, settled in the town and formed an orchestra in 1858, mainly of principals of his own nationality, and which was supported chiefly by the many German residents of the town. Concerts have been given each succeeding winter by the Hallé band, and under various conductors since Hallé's death. Britishers have been taught the beauties of music by it, so that now they form the great majority of the audiences at the concerts. Hallé conferred a further benefit on the town and neighbourhood by securing the foundation of the Manchester Royal College of Music in 1891. This has had a very successful career, and has trained local students so well that, to take one side only of success, instead of the Hallé Orchestra being recruited from abroad, not only all the principals, but nearly forty members of the band have been educated at the School of Music. Under the present conductorship of Sir Hamilton Harty the Hallé Orchestra, as it is still called in honour of its originator, is a magnificent instrument, envied by all musical centres, and it is a matter for regret that it cannot be got together in July, when most of its members will be leading or conducting in holiday resort orchestras. "Listeners in," however, will have had the pleasure of hearing the orchestra play on several occasions.

Primary education in Manchester and Salford is carried out on similar and efficient lines, with all the modern fine buildings and fresh-air schools and school medical officer developments; but whilst in Salford the medical side of educational care is under the authority of the medical officer of health; in Manchester it is under the control of the Education Committee, which appoints a special medical officer to supervise it, and the Manchester medical officer of health has nothing to do with it.

The Manchester Grammar School, which was founded in 1515, and the Chetham Bluecoat School, founded in 1654, still carry on their good educational work. Secondary education is provided by both towns in the form of ordinary schools, domestic economy, art, and technical schools. Manchester's provision is naturally much more extensive than what Salford requires, and supplies the highest educational facilities in the Victoria University of Manchester, in which is a medical faculty, with hospital tuition provided in the Manchester Royal Infirmary, founded in 1752, which for the moment I will content myself with saying is second to none in the United Kingdom.

In religious matters Manchester has its Bishop and Cathedral of the Established Church; Salford its Bishop and Cathedral of the Roman Catholic faith. The Manchester Cathedral, with an ancient and honourable history as a collegiate church, has some impressive architectural features with very fine woodwork in its stalls. Salford Cathedral is a fine building, and so is the Church of the Holy Name in Manchester, with its handsome, newly completed tower, which will be admired by many visitors in July, 1929, because of its being near the centre of the Association meetings.

The John Rylands Library is one of the treasures of the city. Its priceless contents include 3,000 incunabula, many unique, and the famous St. Christopher print, the earliest known piece of printing in the Western world, with an indisputable date (1423), which is alone sufficient to make any library famous. The casket for such a collection of literary gems is a wonderful specimen of modern Gothic architecture. A fuller account of the library will be given in the *Book of Manchester*.

The British Medical Association Divisions of Manchester and Salford were formed in 1903, on a territorial basis, and contained an approximately equal number of members. They were the North, South, West, and Central Divisions, with the Central containing most of the consulting and specialist members. A need for co-operation soon became apparent, and in January, 1906, it was first proposed to form a standing committee of the four Manchester Divisions. This idea was developed further to include the Salford Division, and in June, 1907, the Joint Committee of the Manchester and Salford Divisions held its first meeting.

After the press of work involved in the inception of the National Health Insurance work was past, the feeling grew that still closer coherence would be useful, and in 1915 the Manchester Divisions amalgamated to form the Manchester Division, the Salford Division deciding to continue its separate existence, as serving a definitely distinct area. At the present time there are 414 members of the Association and 305 non-members in Manchester, and 105 members and 81 non-members in Salford.

Passenger traffic congestion is a great problem in Manchester as in other big towns, but Salford is only troubled by it because its tramcars must come into the busiest street of Manchester, which is already overfull with its own vehicles. The Manchester tramways system is said to be the most efficient and finest in the world, and it can well be so. Its large cars carry seventy to eighty passengers in the "rush" hours, when every vehicle in the sheds is turned out. Large motor buses for local and distant service also enter the town in increasing numbers. The Manchester Committee has adopted a bright scarlet coat for its vehicles, and its trams and buses give a cheerful dash of colour to the streets.

Scotland.

Diet and Disease.

A PUBLIC lecture on diet and disease was given on November 21st by Dr. D. Murray Lyon, professor of therapeutics at Edinburgh, who said that modern research had shown that certain ordinary mixed diets which had long been considered satisfactory might, in fact, be otherwise. It had been found that animals fed on a diet consisting solely of cereals, pulses, and tubers failed to grow as fast or as large as they ought, and were apt to age prematurely. Control animals receiving the same diet with the addition of a little green food were found to grow more rapidly and thrive better. Similarly, in the human dietary celery or spinach added to the food appeared to supply something which was essential for proper development. In these experiments milk might replace the green leaves with similar beneficial results, and it therefore appeared that the addition of green vegetables and milk to the diet of sickly, backward children would be beneficial. Rickets, which was a common scourge of city children in the past, was likely to be abolished altogether, now that the part played by vitamin D was more fully understood, and the adequate supply of this important ingredient might be ensured by adding to the diet fresh milk, butter, and eggs. The same group of substances also contained vitamin A, whose absence was apt to lead to increased susceptibility to infection. With regard to flour, the older methods of milling permitted all the necessary constituents of the grain to pass into the flour, but modern methods had robbed it of certain valuable elements. The resistant outer coat or bran of the grain, being indigestible, acted as roughage, and the wheat germ was rich in vitamins, but both were removed in the modern process of milling. Constipation might often be avoided by the use of wholemeal bread. On the other hand, over-indulgence in food might lead to various passing alimentary troubles, while chronic overeating was of great importance in regard to the production of disease. With advancing years food requirements became less, although the appetite might remain as before. Increasing stoutness lessened the inclination for activity and tended to produce a continually deteriorating habit of body. Everyone deplored the poor state of the nation's teeth, and many remedies had been suggested, but it was probable that better balanced diets during the

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growing period and more careful attention to mouth hygiene would go far to abolish what was really a national disgrace. Owing to the variation of individual likes and dislikes it was impossible to lay down an ideal dietary, but it might be said that most people ought to reduce the amount of sugar and concentrated starchy food which they ate, and exchange these for coarser forms of carbohydrates such as leafy vegetables and fruits, which yielded more vitamins and roughage, and at the same time more milk could advantageously be consumed even by adults.

Medical Service in the Field.

A lecture was delivered by Mr. G. H. Edington, M.D., F.R.F.P.S., on November 22nd, in Glasgow University, under the auspices of the West of Scotland Branch of the Historical Association of Scotland, on "Medical service in the field." The lecturer said that during the war the British army numbered 3,500,000, with R.A.M.C. personnel of all ranks amounting to 144,514, and that this corps had had to deal with sick and wounded arriving in the United Kingdom numbering well over two and a half million. At one time on the Western Front the regular R.A.M.C. officers were less than 10 per cent. of the total doctors employed, most of whom were medical practitioners temporarily engaged by the army. In describing the differences in sickness rate which existed between this and previous campaigns, Mr. Edington remarked that the contrast was nowhere more marked than in the case of typhoid fever. That cases of this disease had been remarkably few was, in his opinion, attributable to the value of protective inoculation and to the patient research work that had been carried on in laboratories during many years before the war. The wiping out of typhus, which had occurred in a severe epidemic in Serbia, was also due to the application of principles founded on laboratory work. The lecturer also dealt with the organization of medical services in the field and described the chain of medical units from the regimental aid post down to the base hospital, and illustrated this with lantern slides and photographs which he had taken in Gallipoli, Egypt, and Palestine.

Veterinary Training in Edinburgh.

An address on "The life and work of William Dick," founder of the Royal (Dick) Veterinary College, Edinburgh, was delivered in that college on November 20th, by Mr. Alexander Miles, president of the Royal College of Surgeons, Edinburgh. Dr. T. G. Nasmyth presided. The lecturer said that the meeting was being held for the inauguration of a founder's day and lecture at the Veterinary College because this was the centenary of the institution of professional examinations in veterinary art. William Dick had been in many ways a great man. He was born in the White Horse Close, off the Canongate of Edinburgh, and was the son of a blacksmith, from whom he early learned an interest in animals. Through his own efforts he had acquired a general education above the average for his time. Unaided, and often in the face of opposition, he had striven to raise the craft of farriery in Scotland to the rank of a recognized profession, and the Royal (Dick) Veterinary College was the visible result of his life's work. Having improved his own education he had felt impelled to pass on his knowledge of veterinary science to others, and he began to deliver lectures developing a comprehensive course of instruction in veterinary medicine and surgery. In 1823, on the suggestion of the University of Edinburgh, the Highland Society undertook to stand sponsor for a public lecturer on veterinary surgery, and Dick was appointed to this post. The lectures were delivered in his father's forge in Clyde Street, and buildings on this site remained the headquarters of the college till 1916. As time went on there were added to the forge a stable, an animal hospital, a dissecting room, and a lecture room, of which the cost was almost wholly borne by Dick himself. Before he died in 1866, at the age of 73, he had accomplished the aim of his life, and had established in Scotland a school of veterinary science which now had few equals. Dick had not only possessed exceptional skill in veterinary surgery, but as a teacher he had been clear and lucid, and his qualities might well serve as a model for those who were preparing to follow his profession at the present time.

Indian Appointment for Edinburgh Graduate.

Dr. William Happer has been appointed director of venereal diseases to the Provincial Government of Madras, India, at a salary of £1,500 per annum. This appointment is the result of recommendations made by delegates of the British Social Hygiene Council who visited India during 1926–27, and is the first of the kind to be made. The duties will include the organization of treatment centres in Madras General Hospital, Madras Maternity Hospital, and various child welfare centres managed by the Red Cross Society and the Corporation of Madras, and those of lecturer on venereal diseases at the Medical School, Madras. Dr. Happer, who is a native of Falkirk, after graduating in medicine at Edinburgh University, held the post of resident surgeon, and afterwards clinical assistant, in the Royal Infirmary, Edinburgh, under the venereal disease scheme of the Edinburgh Corporation. On the occasion of his departure Dr. Happer was presented with a writing bureau from his colleagues in the Royal Infirmary V.D. Department, the gift being handed over by Dr. David Lees, chief clinical medical officer under the corporation V.D. scheme.

England and Wales.

Medical Men and Public Affairs.

An appeal to medical men to take a more active part in civic and medical politics was made by Dr. L. G. Modlin, Mayor of Sunderland, at the annual dinner of the Sunderland Division of the British Medical Association, held at the Palatine Hotel on November 22nd. Dr. Roderick Macleod presided, and the principal guest was Professor Hugh MacLean. Mr. Stanley Ritson, proposing the toast of "The Mayor and Corporation," said that it was the first occasion they had had as their guest a mayor who was also a medical practitioner, and they could not but feel pride in his many achievements. He had managed to combine a busy civic career with a busy practice, and had found time to fulfil the duties of an honorary surgeon at the Monkwearmouth and Southwick Hospital, where for many years he had carried on a large amount of surgical work with great efficiency. Dr. Modlin, in his reply, referred to the changed conditions in the medical profession with the disappearance of the old family doctor. Doctors were now simply cogs in the wheels of social progress. Did they, he asked, take sufficient interest in politics, whether Parliamentary or civic, or the politics of the British Medical Association? The most dangerous foe they had to fight was the apathy of their members. After remarking that there was room for more members of the profession on the council, Dr. Modlin said that in medical politics there had recently been issued an interim report of the Private Practice Committee on encroachments by local authorities upon the sphere of private practice. General practitioners had already lost a large slice of their midwifery; they did not seem to take much interest in ante-natal work; tuberculosis and venereal disease were slipping from their grasp, infectious diseases they had almost lost, and the hospitals were making greater and greater inroads on their means of livelihood. Did it not behove the younger men to take a more active part in medical politics? It was not the older men who were going to suffer in the future; it was the interests of the younger generation of medical men that were at stake. The nation had entrusted to the corporations the care of the public health, and the nation demanded not only a lower death rate but a lower sickness rate. Public health work must progress, and unless the younger men grasped the present opportunity and took a share in co-operation with the authorities the independence and freedom of action of the medical profession would be lost, and they would become the victims of a bureaucratic service.

University of London Medical Graduates' Society.

The first extra-metropolitan dinner of this society was held at Birmingham on November 23rd, when some forty graduates were present, with the president, Sir StClair Thomson, in the chair. Sir Charlton Briscoe, Dr. Dorothy Hare, Mr. McAdam Eccles, and three other members came

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from London, and Professor Hey Groves from Bristol, whilst Birmingham was represented by the two professors of medicine, Dr. Wynn and Dr. Ball, the professor of surgery, Mr. Wm. Billington, the professor of midwifery, Mr. Beckwith Whitehouse, together with Mr. Seymour Barling, Dr. Graves, Dr. Elizabeth Moffett, Dr. Cloake, Dr. Sykes, Dr. Forsyth, Dr. Lucy Masterman, and others. The president, in proposing "The Health of the King," said he was sure the toast would be drunk with great sincerity. Mr. Billington expressed the pleasure of graduates in Birmingham at welcoming members from London and Bristol, and he hoped that future dinners would be the meeting places of members from many districts. He regretted that the Presidents of the Royal College of Physicians and the Royal College of Surgeons, both of them members of the society, had been unable to attend. Sir StClair Thomson, in an entertaining speech, traced the history and attributes of the University of London and its graduates, and of the society and its members, and complimented Birmingham in having at least twenty-five members. He was sure that the objects of the society, especially that of bringing medical graduates of the university into closer touch, was worthy of a greatly increased membership. Dr. Dorothy Hare, one of the honorary secretaries, drew attention to the fact that the university now had about 4,500 medical graduates, and that the life subscription of the society was only £1. Mr. McAdam Eccles alluded to the fact that these social gatherings were certain to foster a firmer university spirit, and that the society really had a function to perform which should have been exercised earlier. Mr. Herbert Tilley suggested that after a Friday night's dinner it would be well that an extra-metropolitan evening should be followed by golf, or even fishing, the next day, and hinted that he might present a cup for the former. After drinking the health of the president with acclamation the company adjourned for conversation and the renewing of old friendships. The next dinner will probably be held in Leeds, and the London dinner is fixed for the Tuesday night before Presentation Day.

Cumberland Infirmary, Carlisle.

The committee of management of Cumberland Infirmary, Carlisle, has decided to establish a pathological department in order to deal with the needs of the institution and also of a wide surrounding area in this respect. A subcommittee was set up at the end of June to investigate and report on this subject, and eventually it was decided to recommend the provision of accommodation in a new building, the cost of which is estimated at £3,000, including initial equipment. It is believed that a considerable sum of money will be obtained from public authorities in respect of pathological investigations, and it is deduced that the cost of the department to the hospital might be in the neighbourhood of £800 annually during the first few years. The suggestion is made that work on the provision of this very necessary addition to the Cumberland Infirmary should be taken in hand as rapidly as possible in order that the new department may be actively operating at the time of the official opening of the new out-patients' department, the new wards, and the enlarged nurses' home.

Diathermy in Surgical Practice.

In the course of a Chadwick Public Lecture delivered in the rooms of the Medical Society of London on November 21st, and repeated in the Guildhall, Bath, on November 22nd, Dr. E. P. Cumberbatch, medical officer in charge of the electrical department, St. Bartholomew's Hospital, gave an account of the history of physiotherapy, with special reference to medical electricity. Medical electricity, he said, was in bad repute until the end of the last century, because it was employed largely by charlatans ignorant of its mode of action, and applied to maladies in which its use was not indicated. It was now realized that electricity produced known chemical and thermal changes in the body. The galvanic current, for example, could generate chemical caustics, bringing about the destruction of small skin growths; it could cope with infection in the middle ear, uterus, etc., by introducing chemicals into them directly. The therapeutic properties of high-frequency currents were now known to be due to the production of heat, both in the superficial and deep regions of the body. All other agents merely heated the surface of the body, but this one, used therapeutically in a technique known as diathermy, heated the tissues throughout. Diathermy was valuable in the treatment of angina pectoris, pneumonia, arthritis, and many other conditions. By its means a malignant growth could be heated until it coagulated throughout, with the result that its blood vessels were sealed and the risk of dissemination of the growth was reduced to a minimum. Cases had been reported in which, after such treatment, patients were free from recurrence for three, four, or even more years. High-frequency currents were now used on occasion in place of the knife. A film-like electric arc was formed around a blunt needle used instead of a blade, and this not only divided the tissues but simultaneously sealed the small blood vessels. The advantages of such a proceeding in the removal of malignant growths was so great that a new surgery might be said to have commenced.

Ireland.

Request for Legislation on Milk Grading in the Free State.

A PETITION praying for the introduction of legislation to ensure a safe milk supply in the Irish Free State has been presented to the Minister for Local Government and Public Health by representatives of the Irish Clean Milk Society. The signatories include 89 doctors and matrons of hospitals, and, in addition to urban and rural district councils, many public bodies subscribed to the petition, among them being the Cork Chamber of Commerce, the British Legion (Benevolent Department), Irish Labour Party and Trades Union Congress, Dublin Cowkeepers' and Dairymen's Association, Irish Transport and General Workers' Union, County Westmeath Committee of Agriculture, Irish Nurses' Union, Women's National Health Association, Irish Women Workers' Union, God Save the Children Fund, and St. John Ambulance Brigade. The representatives of the society suggested the restriction of the use of terms designating milk, such as "Certified," "Grade A," etc., and further urged that pasteurized milk should be labelled as such until the introduction of legislation. At present those terms have no Governmental or departmental sanction, and therefore carry no guarantee as to the safety or purity of the milk. The Minister was extremely sympathetic, and gave an assurance that the report of the Inter-Departmental Committee on Milk Supply would not remain a dead letter, saying that the matters raised in the report were being fully examined by a specially appointed departmental committee, and that he hoped to receive this committee's report before Christmas. He intimated that he would receive another deputation from the Clean Milk Society in January, when he would be able to say how matters were progressing.

Salaries of the County Mayo Medical Officers.

The Secretary of the Department of Local Government and Public Health, in the course of a letter to the County Mayo Board of Health, stated that he was directed by the Minister to call the attention of the Mayo Board of Health and Public Assistance to the inadequacy of the salaries of the dispensary medical officers in the county, which have never been adjusted to meet in any way the increased cost of living, although other dispensary medical officers throughout the Free State have long since been accorded appropriate salaries. So far back as 1920 the inadequacy of the salaries was recognized, and on several occasions the Minister addressed the board on the matter, but without avail. The Minister feels that a point has now been reached when, in justice to the officers concerned, and in the interest of the public services for which they are responsible, steps must be taken to secure the payment of fair and reasonable salaries. He suggests that for the present a scale of £200 a year, rising by £5 a year to £300, to be applied retrospectively and to operate as from April 1st next, would meet the case, but does not propose to allow back pay at an increased salary under this scale to the

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medical officers. It is suggested that the board should also review the salaries of the medical officer and surgeon of the County Hospital, and the medical officer of the County Home, and it is pointed out that the duties of those officers are particularly onerous, and that the rates at which they are paid are much lower than those enjoyed by medical men in other similar institutions. The letter states that since the agricultural grant was doubled in 1924 the contribution from the central fund, including the proportion of the agricultural grant applicable to poor relief charges, towards the expenditure on public assistance in Mayo County, is approximately one-half of the entire expenditure of the Board of Health, and that in the circumstances an improved scale of salaries for medical officers will not press unduly on the ratepayers. The department's letter was received in an unsympathetic manner by the Health Board at a recent meeting, and action was deferred pending the receipt of a return of the recorded work of the medical officers.

Correspondence.

RADIUM AND CANCER.

SIR,—Few people have been more anxious than the writer that radium therapy should come into its own. This has happened, and at the present time there is a wave of enthusiasm for this line of treatment which threatens to be overwhelming, and will inevitably be followed by a reaction and much disappointment.

Unfortunately the public are already obsessed with the idea that radium will cure any case of cancer, *however far advanced*, and, moreover, they think that thousands of people are dying simply because they cannot afford radium treatment.

It is very necessary for us to keep a sense of proportion. What are the facts? First, that, as a pallintive measure in a great many malignant conditions, radium is by far the best agent that we have ever had, and the way that the local condition clears up is simply astounding. Secondly, as a curative measure, many of us believe that it is superior to "excisional surgery" in malignant disease of the uterus and tongue. There is no doubt that as the technique is improved it will be used for early cases in other malignant conditions, and the curative results will be much greater. This process of improvement must, however, be somewhat slow, and so long as we entirely neglect to educate the public so that they will consult their doctors on the onset of the earliest symptoms, the percentage of cures will remain relatively small.

The medical profession is quite rightly crying out for radium; the lay press says we must have many radium centres; but all this is useless unless we can get early diagnosis and surgeons adequately trained in the use of radium. The profession and the public must demand, and get, such diagnostic facilities. The time has come when the medical profession must also spread propaganda to teach the public more about malignant disease. The opponents of such propaganda are in fear of creating cancer phobia; I venture to think that for every case of cancer phobia produced ten patients are relieved of that haunting fear, by careful education. It is a common experience of all to see quite a large number of patients who never mention their fear of cancer, but who are relieved of all their symptoms when once they know, in the course of conversation, that there is no evidence of malignant disease. Such propaganda must, of course, be done very carefully, but that it is possible, and would be of the very greatest value, I have not a shadow of doubt.—I am, etc.,

London, W., Nov. 23rd. MALCOLM DONALDSON.

THE DIAGNOSIS OF GASTRITIS.

SIR,—In spite of Dr. P. J. Molloy's criticisms (November 24th, p. 963), I still maintain that the fractional test meal is the only safe and reliable method of diagnosing chronic gastritis. Even in the hands of the most experienced, gastroscopy is a method of diagnosis which is too dangerous and too unreliable to be of any real practical use. It would, for example, be quite unjustifiable in a doubtful case of early carcinoma to substitute gastroscopy for the less dangerous and much more reliable exploratory laparotomy. The radiological method, which Dr. Molloy saw practised in Berlin, was originally devised independently by Dr. Gilbert Scott and Dr. P. J. Briggs. It has been familiar to me for several years, and is invaluable in the investigation of cases of ulcer. But we have come to the conclusion that there are so many fallacies in using it for the diagnosis of gastritis that it is impossible to recognize that condition with any degree of certainty by means of the *x* rays alone. The so-called gastro-myxorrhoea mentioned by Dr. Molloy is, I am convinced, a myth. I have been on the look out for it for twenty-five years, and I have never seen a case.

I certainly agree with Dr. Molloy that the opinions of Aschoff and von Bergmann are worthy of consideration. I think I have read everything they have written on the subject of gastric and duodenal ulcer; but I have the support of the large majority of British and American writers in my opinion that the evidence in favour of an infective origin is overwhelming. I believe that the theories of Aschoff and von Bergmann are both in part correct, but that the factors they regard as primary are really accessory, the one essential primary factor being infection. I am also quite familiar with Kalk's work on milk test meals. If Dr. Molloy had read the English and American literature on the subject he would have realized that Kalk is only repeating experiments already performed in these countries by Rehfuss, Crohn, Ryle, Bennett, and many others. Kalk's findings do not clash in any way with those of Freezer, Gibson, and Matthews: what they proved is that *in vitro* milk neutralizes an equal volume of 0.3 per cent. hydrochloric acid. What Kalk and others before him have shown is that *in the stomach* milk calls forth a secretion of gastric juice. But if the milk is given hourly the juice secreted as a result of one feed is to a great extent neutralized by the milk given in the next feed. The result is that the total quantity of free acid in the stomach on hourly milk feeds is smaller than with any other diet.

Finally, I should like to suggest to Dr. Molloy that an "after-cure" of British medical literature and British clinics might be a useful sequel to his visit to Berlin.—I am, etc.,

ARTHUR F. HURST.

New Lodge Clinic, Windsor Forest, Nov. 23rd.

THE ETHER-URINE REACTION.

SIR,—Dr. Barber and Dr. Oriel in their interesting and suggestive paper on biochemical investigations in allergic conditions, which was published on November 17th (p. 880), describe a physical reaction between ether and urine which results in foam rigidity. On looking up my laboratory notes I find that I observed this phenomenon in 1905, and thinking that it might have some clinical significance I followed up the observation experimentally.

When 5 c.cm. of urine in a test tube are vigorously shaken for two minutes with 2 c.cm. of ether a foam structure results which is of variable durability and rigidity. The degree to which these two properties are developed varies with conditions which are only partially known, but among these are: (1) the ratio of solid to water in the specimen of urine; (2) the total acidity of the urine; and (3) the ratio of ether to urine. As regards the last condition a urine which forms a rigid foam when the ether-urine ratio is 2 to 5 may fail to do so when the ratio is 5 to 5.

Addition of acid results in the lowering of surface tension, but if the acidity of the urine is high such addition is not essential. The addition of 0.5 c.cm. of sulphuric acid (25 per cent.) effects a certain amount of hydrolysis, so that we are dealing with a chemically altered urine. A urine which fails to foam ordinarily may develop a highly rigid foam on the addition of 0.5 c.cm. of H_2SO_4 (25 per cent.) before the shaking.

The formation of rigid foam is dependent on the colloidal state of the urine, for if the colloids of the urine

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be precipitated by a 10 per cent. solution of phosphotungstic acid together with 5 per cent. sulphuric acid, and then filtered, the filtrate when shaken with ether fails to form the rigid foam. The degree of rigidity may be roughly calculated by inverting the test tube and noting the duration of time before the foam structure collapses and the superficial fluid escapes. Of course, in this estimation the quantities of urine, ether, and acid must be precisely measured, and repeated in all comparative experiments. It is also necessary to note the specific gravity of the urine whereby the ratio of solids to water may be determined.

So far I have failed to attach any definite clinical significance to this reaction. I have seen the reaction occur in normal urines in persons whom we would pass as normal. But, then, how difficult it is to decide who is normal and who is abnormal!—I am, etc.,

Liverpool, Nov. 21st. H. LESLIE ROBERTS, M.D.

RECENT RESEARCH ON URTICARIA.

SIR,—Embracing as this subject does a host of allied conditions having the same origin, upon which an inquiry into the nature of disease throws some light, I beg for a short space to show how this light helps to explain the phenomena encountered.

The clinical signs and symptoms of disease embracing urticaria and its allied conditions can be covered by the English work "shock" without having recourse to a meaningless verbiage. Shock results from the precipitation in the perivascular lymphatics, capillaries, and occasionally the arterioles and arteries, of protein particles in the plasma which have become too large or too agglutinated to continue circulating. Protein particles become increased in size by the imbibition of water, hence the use of the term "hydration" to cover this change. Protein particles become hydrated in two ways: (1) by chemical and physical agents causing a lowering of their surface tension; (2) by the adsorption of parts of other protein particles being broken up by chemical or physical agents which are sending them into true solution. Broken particles going into true solution lose water and undergo what can be termed "dehydration." Histamine, in virtue of its positively charged nitrogen atoms, happens to be one of numerous chemical substances capable of causing protein hydration, but there is no evidence that this substance, or any other chemically allied body, is the sole cause of the various manifestations of shock. The evidence is against the sole cause being such a definite chemical substance, for the main reason that hydration of some of the protein particles results from the dehydration of other protein particles. Indeed, this is the way in which most of the milder clinical manifestations of shock are produced, and it explains the other phenomena, the result of dehydration, associated therewith.

When protein particles undergo hydration the various adsorbed constituents of which the protein molecule is composed become more and more part and parcel of the colloid protein complex, and in virtue of this change they lose their characteristics as simple substances. For example, sugar, urea, amino nitrogen, etc., lose their identity and cannot be detected as such, hence explaining why their percentage in the blood falls. When the protein particles are subjected to dehydration the adsorbed constituents are detached from the protein nucleus and eventually find their way into solution in the liquid part of the plasma. The further the adsorbed constituents are separated from the protein nucleus the more they lose their colloid characteristics and the more identifiable they become as chemical substances, hence explaining why their percentage in the blood rises. In the severe forms of shock, where there is little or no dehydration, the percentage of the adsorbed constituents in the blood falls, and this is why and how insulin causes hypoglycaemia. In the milder forms of shock, where the hydration some of the protein particles undergo is the result of dehydration of other particles, the percentage of one or more of the adsorbed constituents may be raised. The adsorbed constituent which has its percentage raised depends upon the degree of the dehydration. That is to say, some constituents are more firmly adsorbed than others, amino nitrogen > urea > sugar > calcium > chlorine. Thus it comes about that a rise in the percentage of the blood-amino nitrogen denotes a more severe degree of dehydration than a rise in the percentage of the blood sugar. The constituents tend to be separated in turn from without inwards, so that when the percentage of the blood-amino nitrogen is raised the percentage of the blood sugar is either normal or lowered. As the stage of dehydration precedes that of hydration, and is absent when the latter reaches its acme, the blood picture varies according to when it is made and according to the strength in quality and quantity of the intoxicants, which are generally poisonous substances of intestinal origin. In the first stage there is a rise in the percentage of the blood sugar, in the second stage a rise in the percentage of the blood urea and blood-amino nitrogen, and in the third stage a fall in the percentage of all the adsorbed constituents. There is no blood picture typical of any clinical manifestation. The intoxicants may at the same time cause dehydration of the red blood corpuscles, and this may be sufficient to set free enough haemoglobin to appear in the urine, but there are no such bodies as specific lysins.

Hydrated protein particles act as dehydrators to the protein particles constituting the protoplasm of cells, and it is to this action that the urticarial wheal is due. The endothelial cells of the vessel wherein the precipitation takes place are the first cells to be attacked. This results in a dilatation of the vessel, an increased permeability of the wall, and an escape of the fluid and "solid" parts of the blood, according to varying conditions, into the tissues around, constituting what is known as oedema. Once protein particles have been subjected to these altered chemico-physical changes, the signs and symptoms resulting therefrom may be caused or aggravated by substances having no relationship to the original intoxicants. This fact explains why tests employed to detect so-called cutaneous allergy are useless, and throw no light upon the primary cause of the hydration or hypersensitiveness.

Bodies hydrated tend to become foreign in the blood, and readily find their way through the vessel walls, particularly when their permeability is increased. Some of these bodies escape through the glomeruli into the urine, and when the urine is shaken with substances insoluble in water the complex colloid substances undergo such enormous dispersion as to make in Barber and Oriel's test the ether opaque and frothy. Some years back I showed the same phenomena to occur in the cerebro-spinal fluid withdrawn from cases of parenchymatous syphilis of the central nervous system when shaken with toluene. The nuance of colours following the addition of nitric acid to urine, and the pink to violet coloration following the addition of a few drops of the hydrochloride of di-methyl-para-amino-benzaldehyde, are indicative of the presence of hydrated colloid particles in the urine, and hence in the blood, and are tests much easier to employ.

Cardiac failure is an expression of protein hydration; hence the reason it is overcome by drugs able to break up the hydrated particles (dispersion) and to restore them to the circulation (digitalis, strophanthus, camphor, cardiazol, etc.). Hydrated protein particles have their surface electricity more under control than other particles, thereby explaining why they appear less negatively charged and more "acid." Calcium, adrenaline, etc., sometimes relieve the milder symptoms of shock, but only when they are able to cause dispersion of the hydrated protein particles; in no instances do these or still more useful drugs touch the cause of the hydration. Calcium and adrenaline function as conductors, which, generally speaking, do not cause dispersion of hydrated protein particles so efficiently as do dehydrators. It is for this reason that the dehydrator glucose is so valuable in the more severe forms of shock represented clinically by insulin hypoglycaemia, eclampsia, coma, etc. There is an association between hydration and what is known as vagotonia. Space forbids the connexion being elucidated here, but the point is mentioned to draw attention to the fact that adrenaline does not act by stimulating the sympathetic nervous system.—I am, etc.,

London, W.1, Nov. 23rd. J. E. R. MCDONAGH.

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ETIOLOGY AND TREATMENT OF PAPULAR URTICARIA.

SIR,—In his article on urticaria in the *British Medical Journal*, November 17th (p. 879), Dr. Rupert Hallam states that:

"Papular urticaria is influenced neither by dieting nor drugs, but . . . the patient obtains a respite if he be removed from his own environment."

"There is a curious factor common to all . . . the sufferers recover immediately they are admitted to hospital, even though no treatment of any description be given. The rash returns after their discharge."

These are sweeping statements, and I cannot but feel that I shall not be alone in disagreeing with Dr. Hallam.

I can recall many cases in which the elimination of an offending food, sometimes only found after prolonged investigation, has led to the disappearance of the trouble. To quote a recent case in my private practice. A male child, aged just 4 years, was brought to me last September. He presented the typical rash of papular urticaria, which the mother stated had been present for eighteen months. There was severe itching at night and the child rarely experienced an unbroken night's rest. On questioning the mother concerning the diet I found that the child was particularly fond of bananas, a fruit which I have frequently found to be an etiological factor in this disease. The only remission in the disease had been for two weeks in August of this year, during the annual holiday, when the child had not eaten this fruit. I advised the elimination of bananas from the diet. On seeing the child two weeks later the parents reported that the spots had only appeared on one occasion since the first consultation. A week ago, that is six weeks after the last consultation, the parents stated that the rash had not reappeared during this time.

In this case the cause of the trouble was discovered with fortunate rapidity; in many cases it is only discovered after keeping a food chart for some time, and after repeated trial and error. From my own experience I believe that this disorder is influenced by dieting, and that it is unnecessary to invoke the aid of some virtue which is only to be found in the atmosphere of a hospital, the absence of which from the patients' homes produces this malady.—I am, etc.,

NORMAN BURGESS, M.A., M.B., M.R.C.P.

Clifton, Bristol, Nov. 21st.

DEFINITION OF DRUNKENNESS.

SIR,—As one of the prime movers in 1925 who induced the Council of the British Medical Association to set up a special committee on tests for drunkenness, on which I served, may I be allowed to comment on the present discussion. Periodically the question seems to reappear in your correspondence columns; and Dr. Sidney Matthews, having found himself recently in some difficulty, seeks for guidance. The advice given him does not seem to have been altogether satisfactory.

The definition adopted and recommended by this *ad hoc* committee is repeatedly referred to, but in no instance is it quoted in full: in order that your readers can form their own opinion with regard to Dr. Matthews's difficulties, it may be stated that the definition is:

"That the person concerned was so much under the influence of alcohol as to have lost control of his faculties to such an extent as to render him unable to execute safely the occupation on which he was engaged at the material time."

Now, Dr. Gordon Wilson stated on November 24th (p. 964) that this definition was specially drafted to apply to the offence of being drunk in charge of a motor vehicle. As a matter of historic fact that is not so; and it is obvious that that is not so. It applies equally well, for instance—and was intended to apply—to accidents in factories or other employments; to walking on a cliff or other height; to conducting a child through or near traffic.

Dr. Matthews says, in the case at issue, "the man *had* been drinking, but he passed every test that I could put to him, yet I knew he was not fit to drive a motor car." That is, without any applied test, Dr. Matthews was satisfied that his patient was "unable to execute safely the occupation on which he was engaged at the material time." If that is so, then why hesitate to apply the word "drunk"?

Many seem to fail to accept what I ventured to suggest in the *British Medical Journal* several years ago, that the word "drunk" is a *relative term*; if this were more fully appreciated the difficulties in certain classes of cases would be cleared away. For instance, one listens to a long story of a friend recounting an action taken, and in reply one says, "You were very wise to have done so" (or not to have done so, as the case may be). But by so speaking you do not intend to convey, nor does your hearer understand, that your recounter has the wisdom of the East. If subsequently in court that remark were to be referred to no one would conclude that it had been used except in relation to the circumstances at issue at the material time.

And yet when a doctor, having first, before examination of a patient, recited for his own use or, subsequently, in court quoted the definition of the Association's committee, then finds it necessary to decide that the word "drunk" should be, or not be, used in regard to the case, the facts being proved, he and the court seem to boggle over this question (that is, start with fright, shy, hesitate, demur, equivocate, fumble). Why should this be so? Is it not entirely because unconsciously there has been introduced into the use of the word "drunk" a moral aspect, and one dislikes to become publicly a judge of a neighbour's morals? Had the alcohol been absorbed involuntarily this hesitancy would not arise. Is it not desirable that the medical profession should ignore the moral aspect in all cases of "being under the influence of alcohol," and confine itself to the scientific aspects of a case?

The report of the special committee is well worth re-reading, and copies can, I believe, be obtained on inquiry at the Association's headquarters, price sixpence.—I am, etc.,

E. ROWLAND FOTHERGILL.

Hove, Nov. 26th.

SIMPLE PHLEBITIS AND EMBOLISM.

SIR,—When, recently, a colleague developed a "simple phlebitis" in the calf of the left leg, the validity of the traditional treatment—three weeks in bed—came into question. I think it will be generally agreed that women who do their own housework very often suffer from slight phlebitis without lying up and without evil effects. An admittedly inadequate examination of the literature in the libraries of the Royal College of Surgeons and of the Royal Society of Medicine was not fruitful. Romanis and Mitchiner (*Science and Practice of Surgery*, 1927) say: "*Simple Phlebitis.*—The thrombus does not become infected, and there is little or no tendency for pieces of it to soften and break loose." An ex-president of the College of Surgeons told me he had never known of a fatal embolus following a simple phlebitis.

I have heard of two fatal cases—one where an old man insisted on his cook massaging his leg; the other where the patient slapped his own thrombosed leg violently, declaring he was quite sound. I have, at the moment, under my care a lady, who, while being kept strictly in bed for phlebitis, has developed a small patch of dry pleurisy and a slight haemoptysis which suggest an infarct, but I have never heard of a fatal sequel to a patient getting up—after pain and fever have subsided—and leading an easy quiet life.

It would obviously save a great deal of nursing and worry if the three weeks with bed-pans and so forth could be avoided. It would be useful if others would record their experience and give evidence which would throw light on the problem of whether there is, in fact, danger in a patient leaving his bed in such circumstances.

O. HILTON.

Northwood, Nov. 12th.

POSSIBLE CUMULATIVE EFFECT OF EMETINE-BISMUTH IODIDE AND EMETINE PERIODIDE.

SIR,—I write to inquire whether any of your readers have observed a cumulative effect from either of these two chemicals. A case just concluded in South Africa has brought out the suggestion that emetine may sometimes be eliminated in an irregularly intermittent manner.

The use of "E.B.I." and "E.P.I." in amoebic dysentery carriers has been extensive, and it will be recalled that the

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Medical Research Council, as the result of an investigation, specially emphasized that large quantities of emetine bismuth iodide are essential, and total doses of not less than 30 to 40 grains, in daily doses of 3 to 4 grains, were advised.

A warning should, I think, be issued with regard to the treatment of schistosomiasis in children. Not only should the dose be carefully reduced in proportion to age, but the possibility of an accumulative effect should be safeguarded against by watching the general condition of the patient and by examining the urine with an alkaloidal reagent to see that proper elimination is proceeding.—I am, etc.,

London, W.1, Nov. 24th. W. H. MARTINDALE.

SPONTANEOUS PNEUMOTHORAX SUPERIMPOSED ON ARTIFICIAL PNEUMOTHORAX.

SIR,—In your issue of November 17th (p. 895) Dr. S. P. Wilson records an interesting case of spontaneous pneumothorax occurring in a patient with artificial pneumothorax. Certain features of this case do not correspond with the typical picture presented by Hutchinson and Blair (*Tubercle*, June, 1925), as deduced from their series of seven cases. In all these cases there was a very considerable rise of temperature (in six of the cases from 103° to 105°) coincident with the onset of symptoms. In all such cases, where air is not withdrawn, there occurs a typical "staircase fall" of temperature, extending over a period which varies with the height of the initial rise.

There is no doubt that lung rupture had occurred in Dr. Wilson's case in view of the x-ray evidence before and after the onset of symptoms. This would suggest that a rise in temperature, due, as Hutchinson and Blair suggest, to suddenly increased intrapleural pressure, is not a necessary manifestation of lung rupture. In view of the fact that of their seven cases two definitely developed pyopneumothorax, one a pleural fistula, another had to undergo thoracoplasty, and two others died (cause not stated), would it not seem that pyrexia only occurs with infection of the pleura in such cases, and is not a manifestation of increased pressure *per se*?—I am, etc.,

Leeds, Nov. 18th. HUGH G. GARLAND, M.B., M.R.C.S.

"THE RIGHT TO PRACTISE."

SIR,—The report of Dr. J. Gordon Macqueen's address to the Hyde Division, published in the *Supplement* of November 24th (p. 229), contains the following concrete statement made for the information and guidance of the profession:

> "No degree or diploma of itself, however high it might rank in the medical or surgical world, entitled anyone to practise; the inclusion of a practitioner's name in the *Medical Register*, and that alone, conferred this right."

This is wholly contrary to fact and law. There is no legal inhibition upon the practice of medicine and/or surgery by any of His Majesty's subjects, and registration under the Medical Acts confers no special privilege in this respect—that is, *qua* "the right to practise." As Dr. Macqueen's address proceeds from one who is qualified in law as well as medicine, and thereby bears the impress of authority, I have been induced to comment on the matter.—I am, etc.,

Tunbridge Wells, Nov. 24th. W. E. HEMPSON.

ULTRA-VIOLET RAY THERAPY.

SIR,—I would like to know upon what evidence Professor Dixon bases his statement on October 13th (p. 644) that "physicians are generally agreed that radiation by ultra-violet light is contraindicated in highly nervous and neurotic people." My own experience has been quite the reverse of this, and I regard these patients as the best subjects for the treatment.

In speaking of nerve cases I include the chorea of children; disseminated sclerosis; a myasthenic type of encephalitis lethargica; cases of menopausal neuroses which were actually borderland cases and sent to me after all other means of treatment had failed; neurasthenia; and the insomnia of anxiety or nerve pain. If any would be interested in the history of these cases I shall be glad to supply the information, since it appears to me that such a statement by Professor Dixon is bound to influence physicians who have not had the opportunity of testing it. I believe that many of the nerve-racked souls at present in the various institutions would rapidly show improvement if judiciously treated by ultra-violet rays.

In regard to the irradiation of children, it is said that they react much more readily than do adults. Such has not been the case in my own practice. Nearly all the children treated by me can stand a dose which would cause a second degree erythema in almost any of my women and some of my men patients. These children will tan, but do not redden.

I should perhaps add that every one of my patients undergoes a thorough clinical examination with tests of physiological excretions in doubtful cases, and, where necessary, the treatment is combined with an appropriate internal medicament to assist the good work of the mercury-vapour lamp. Like Professor Dixon, I do not regard artificial sunlight as a panacea, but I think he should revise his opinion about nerve cases, so that this great class of sufferers may receive the benefit of these healing and stimulating rays.—I am, etc.,

Glasgow, Nov. 4th. E. C. MUNRO.

Medical Notes in Parliament.

[FROM OUR PARLIAMENTARY CORRESPONDENT.]

THE House of Commons spent three days this week debating the second reading of the Local Government Bill; and then considered the final resolution accompanying the bill.

The Parliamentary Medical Committee met on November 27th, discussed the Local Government Bill, and adjourned in order, at a subsequent date, to confer with the special Committee of the British Medical Association before the committee stage of the bill begins in the House of Commons. The Committee discussed the bill's proposals on block grants and their effect on health services, particularly venereal disease services; it also discussed the proposals of the bill regarding hospitals, and opinion appeared to be generally in favour of each authority under the bill establishing a hospital subcommittee of the public health and housing committee. The Medical Committee further considered the proposal of the British Medical Association regarding transferred services under Clause 4 of the bill. This proposal would make obligatory the provision of assistance under the Public Health and kindred Acts by virtue of the appropriate Act, and not by way of poor-relief. The Committee passed no resolutions.

Local Government Bill.

On November 26th, Mr. CHAMBERLAIN moved the second reading of the Local Government Bill. Dealing with the history of the Poor Law he pointed out that in 1872 the whole country was divided up into urban and sanitary districts. The Act of that year was responsible for the origin of the medical officers of health, whose appointment was a statutory duty on those sanitary bodies. Since the Acts of 1872 and 1888 there had been no serious attempt to reform local government. Our system of local government was, in many respects, obsolete and out of date. Under the existing system there was a great deal of overlapping. From time to time Parliament had entrusted to the major local authorities the responsibility for the prevention or treatment of various diseases. There was tuberculosis, the charge of lunatics and mental deficients, and the great maternity and child welfare services, yet every one of those things had to be dealt with also by the guardians in the discharge of their duties. Thus there existed the remarkable and paradoxical circumstance that the question of whether a person should receive treatment at the hands of the county borough or the county council, or whether he should receive it under the Poor Law from the guardians, depended not upon the nature or need of his infirmities but merely upon whether he was destitute or not.

The Government had an overwhelming weight of authority in proposing to hand over to the county councils the functions of the guardians. The case did not depend merely on the easing of the financial burden, strong as it might be on that ground. It opened up a wide field for the improvement of our health services. The whole trend of practice in modern medicine and surgery was toward the treatment of many cases in institutions where there could be accumulated the specialized equipment and skill which were not always available in private homes. When the bill became law we should have a position in which there would be one single health authority in each area, whose duty and function it would be to survey the whole institutional needs of that area. They would have at their disposal all the institutions now in the hands of the guardians; in many the accommodation was not fully occupied. They would have an opportunity of reclassifying their institutions, of closing such as were no longer suitable for modern requirements at all, of altering and

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adapting others, and of using one for one purpose and another for another purpose. Even to-day there was a certain amount of classification attempted in many of the institutions of the guardians, particularly in the large areas, but it must be clear to everybody that, with the small opportunities that were to be found of each particular case in any one institution, it was quite impossible either to get the sort of classification that they wanted or, particularly, to bring to it that equipment and that specially skilled staff and nursing which were essential if they were to get the best results. Only a general review over comparatively large areas and a general readaptation of buildings would suffice if a satisfactory solution of this problem was to be obtained.

Clause 4 gave power to the county borough councils and county councils to treat persons either under the Poor Law or under a number of special Acts. If they adopted those Acts for the purpose, persons treated thereunder would be separated out and treated by other committees according to the nature of their ailments. The bill did not leave the county councils and county borough councils to deal with all destitute persons in future under the Poor Law as they had been dealt with in the past. The power now given to the councils was permissive and not mandatory, although he was disposed to think that some day it should be made mandatory. To say that Clause 4 must be mandatory would be to put upon local authorities duties which they were not to-day capable of carrying out.

Explaining the method in which these transferred functions were to be dealt with, Mr. Chamberlain said it was essential that the body which provided the money should retain financial control. He had been extremely anxious to provide that, as far as possible, the local knowledge, the local interest, and local experience that had been so valuable in the past should not be lost. In Clauses 3 to 7 provisions were set out which showed how they were going to try to combine central financial control with the fullest possible use of this local knowledge. It would be the duty of every county council and county borough to prepare an administrative scheme. In that scheme they were to appoint a Public Assistance Committee. This was not necessarily a new committee; it might be one of the existing committees of the council. To that committee, in the first instance, the council would refer these transferred functions, and it would receive the recommendations of the committee as to how they were to be dealt with. Of that committee two-thirds must be members of the council, and the remaining one-third might be co-opted; among the co-opted members must also be women. Clause 6 stated that each county must, under its scheme, divide up its area into a number of smaller areas, each of these comprising one or more county districts. In each of these areas there had to be set up a subcommittee of the Public Assistance Committee, specially designed to carry on as far as possible the duties of the old boards of guardians where it was compatible with the new financial arrangements. The subcommittees were to be called guardians' committees, and it was hoped that members of them would continue to call themselves, and to be called by other people, guardians. Two-thirds of the guardians' committees would be elected members, and there would be a considerable number of actual members of the old boards who would become members of the new guardians' committees. There would also be co-opted members, which again must include women. The duties of these committees included the examination of applications for relief and the determination not only of the amount but the nature of the relief; they would determine whether the applicant should or should not be admitted to an institution, and they were not excluded from visiting, inspecting, and even managing any Poor Law institution if the Public Assistance Committee thought fit.

Clause 13 provided for the recovery of expenses. Under the existing law, it was the duty of guardians to recover either the whole or part of the cost of relief from any person maintained in these institutions. It was not the law that the local authority must do it, although some of them did, and he thought in the case of maternity homes they always did so. But, obviously, if the functions of the guardians were to be transferred to the council they must not have a situation in which one person who happened to be destitute would have the cost of relief demanded from him, while another person, not destitute, who went into an institution of his own accord, did not. There must be one rule for both, and so the bill provided that the local authority would have the duty imposed on it of recovering such part of the cost of maintenance in an institution as an inmate could afford. But they excepted in that provision the case of an infectious hospital where persons went in for the good of a community, and that also included the case of the tuberculosis sanatorium.

He saw from the amendment paper that this was taken as involving some danger to the maternity services. At present, he did not see how that could be the case. It was the general practice of local authorities to make charges for institutional relief; and, seeing that a woman who had her confinement in an institution was relieved of the cost of a doctor or midwife, and that she had in most cases the maternity benefit secured to her, it was difficult to understand why she should not be asked to make some contribution to the cost of her maintenance in the institution. He would only say that he had an open mind on the subject. He was anxious that nothing should be done that would in any way hamper or check the development of the maternity services, to which he attached the utmost importance. If he could be convinced during the committee stage of the bill that this provision would have that effect, or that any amendment could usefully be inserted which would still further protect the maternity services, he would receive any such suggestion with respectful consideration. Clause 15 applied to London the provisions which applied to the counties in general, with the necessary adaptations. The Metropolitan Asylums Board and the Metropolitan Common Fund would disappear. The functions of boards of guardians were handed over to the London County Council, and the London County Council was left to make its own arrangements for the administration of the law through subcommittees. Part II. of the bill dealt with registration services; when the guardians disappeared their functions would be handed over to the counties and county boroughs. Registrars would be placed on a salary basis instead of being paid by fees.

Dealing with highways and road making, Mr. Chamberlain said that the question of town planning was bound up with the design and alignment of roads. Provision was made for the inclusion of the county councils in joint town-planning committees with other local authorities.

A number of clauses followed, which were all in accordance with the recommendations of the Onslow Royal Commission. Clause 15 provided that the county council might, out of the county rate, make a contribution towards the expenses of a rural district for the purpose of improving sewerage or water supply. Clause 16 was designed to bring together education authorities and maternity and child welfare authorities. It was provided that the maternity and child welfare services might be handed over to the authority which was also the education authority, so that continuous supervision might be exercised over the health of the child. Clause 50 dealt with the supervision of midwives; Clause 51 with the review of accommodation for infectious diseases in the counties, and Clause 52 authorized the delegation of certain functions from the London County Council to the metropolitan borough councils.

Turning to the finance of the bill, Mr. Chamberlain said that the Government's plan was that national contributions to local services should be distributed, not in accordance with what the local authorities spent, but with their needs, including, of course, their relative ability to pay. De-rating took away a large existing source of revenue of the local authorities and replaced it with a larger sum. That sum, instead of being a percentage grant based on something received twenty, thirty, or forty years ago, would be based on needs, reviewed from time to time. The block grant was to be recalculated every five years, and the amount was to be fixed for each year in any period of five years. The distribution among the counties and county boroughs was, first, to be partly, and ultimately entirely, made according to a formula. The result, he anticipated, would be that each local authority would be secured resources adequate, not merely to carry on the services as they were to-day, but to allow for reasonable expansion in accordance with the public conscience and the demands which the increasing revenues of the country would permit.

He had been very much astonished at suggestions which had been made that the system of block grants would injure, or even starve, the health services, and especially the maternity and child welfare services. If he thought for a moment that that would be so he would never allow it to go through, but he was convinced that those fears were utterly groundless. Leaving out of account three or four wealthy towns which had an exceptionally high expenditure on these services, the average grant received by the authorities throughout the country in respect of maternity and child welfare was about 5d. per head of the population. He took as instances one or two towns under the average which were therefore not receiving the average maternity and child welfare service. Oxford, a comparatively wealthy place, with nearly £8 10s. rateable value per head of the population, had a maternity and child welfare grant of 4d. Under the new scheme its grant in the first five-year period would be 25d., and the final grant, when the full formula came into operation, would be 31d. per head. In an entirely different case that of Merthyr, whose rateable value was only £2 6s. per head, the maternity and child welfare grant was now 44d. The grant in the first quinquennium would be 73d. per head, and, finally, 108d. In Tynemouth, where there was special need, the rateable value was £4 1s., and the maternity and child welfare grant was 3.8d.; the gain in the first quinquennium would be 162d., and, when the scheme became fully operative, 206d. per head.

Comparing these figures of the gain per head with the amount spent to-day on maternity and child welfare service, which, on the average for the whole country was 5d. per head, it was perfectly clear that the formula would give ample resources to every locality to deal with this service and to multiply it many times over. There could not be any question about the adequacy of the amount available; it was not an expensive service, and it did not take much money to produce considerable results. He had taken much trouble to protect it in the bill. Clause 75 provided that in the county districts voluntary associations would receive, in addition to the population grant, an increased grant to enable them to carry on the service. Again, under Clause 85, the voluntary associations were protected, because the schemes to be prepared by local authorities showing the contribution to be given to them must meet with the approval of the Minister, who had the final say as to what the contribution might be. Under Clause 86 the Minister had power—such as he had never before held—to take away the grant, or that portion of the grant which he might think right, from any local authority which failed to maintain this service adequately. If, in the committee stage, it could be shown that the clause gave insufficient protection to this service, he would consider any amendments which might be put forward. There was no service to which he attached more importance and in which he took a greater interest than maternity and child welfare, and he was not going to allow any consideration to interfere with its fullest possible development.

The needs of areas, in accordance with which the national contributions would be distributed, would be measured by an ingenious and carefully worked out formula, which would be found in the fourth schedule of the bill. Obviously, the popula-

H. E. Seiler, A Case of Pneumoconiosis, British Medical Journal (1928)
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tion was the principal factor which governed the need of a locality, but it was not the entire measure of the need. They had also to take into account the relative wealth and poverty of different districts, and so rateable value per head and number of children under 5 were used to weight the population. They would find a larger proportion of children in the poorer districts, and it would not do to rely only on rateable value as a measure of the relative wealth and poverty.

Having dealt at length with the financial provisions, Mr. Chamberlain concluded by prophesying that the scheme, though it might well be altered in details in its passage through the House, would, in its main outlines, still hold the field, and that it would prove to be a courageous, comprehensive, and successful attempt to remove anomalies and injustices which had too long been allowed to impair and weaken the magnificent structure of local government.

Mr. A. GREENWOOD moved the rejection of the bill on the grounds, among others, that it would perpetuate the evils of the Poor Law system and would arrest the normal and steady development of local health services by the establishment of fixed block grants from the Exchequer by the imposition of a charge for treatment in hospitals, especially maternity hospitals, which was calculated to increase the already high mortality among mothers. He contended that to combine roads and public health in a block grant was an absurdity. The block grant was a Treasury device for saving money to the Exchequer, because it meant the spending of less by the Government on local government services. The Government was allowing the spirit of the Poor Law to pervade the whole of local government. Their proposals would injure the health services of the country. Health authorities would be in the position of having to make inquiries and ascertainments, and to collect money, when they should be routing out disease; that would reduce medical officers to debt collectors.

Dr. FREMANTLE said that in the amendment of the Labour party, and in that on the paper in the name of the Liberal party, it was suggested that the gravamen of the case against the bill was the injury that would be done to the health services. The amendment before the House said that the bill would arrest the normal and steady development of local health services, and would increase the already high mortality among mothers. It was a challenge which must be met. When he read the bill he felt that it was a measure in regard to which they would have the general sympathy of those members of the Opposition who worked with Mr. Greenwood for the improvement of the health services. Here was a measure that was fulfilling a large number of the great objects which had been put forward in several Royal Commissions, and, above all, in the Royal Commission on the Poor Law—a measure, it seemed to him, in which they could gladly co-operate—at least in so far as the health service section was concerned—for the common cause, and obtain amendments. He wished to call attention to the most authoritative announcement that had yet been made by the medical profession. It had only recently been put into his hand, and he had had no share in preparing it. It was the considered statement of the British Medical Association Poor Law Reform Committee. The Committee sat for a long time on the subject, and their general conclusion was: "Resolved that the Council be recommended to express its approval of the Local Government Bill, 1928, in so far as it attempts to secure unification of the medical services of the country." The bill was discussed under three main categories: first, machinery of local administration; secondly, the effect of the bill on medical officers of health and Poor Law medical officers; and, thirdly, the effect of the finances of the bill on the health services. After endorsing the measure under these several heads in which they were particularly concerned, the Committee proceeded to suggest certain alterations, modifications, and amendments which could be produced in committee, and which would be put forward in due course. He hoped that members in all parts of the House would combine with him in helping to get amendments accepted further to improve the machinery of the bill.

Being himself a medical officer of health for a county area in which these matters were constantly to the fore, who for a period of twelve or fourteen years had had to consider, work, and report upon the complications which this measure hoped to simplify, he wished to state that, in the course of those many years, county medical officers of health had always felt the hopeless confusion of authority which existed between the different bodies dealing with health, and that, in every way, the work of public health had been crippled because of this complexity. There was no relation between the Poor Law authorities, whether in their relief services and their institutional services, and the sanitary authorities. There was no real combination between the sanitary authority on the one hand and the county authority on the other. The only powers that the county authority had over the sanitary authority was occasionally to report to the Local Government Board, as it formerly was, or to the Ministry of Health, as it now was, cases in which the sanitary authority was in default, and it appeared that the Ministry might take certain action. One of the most crying needs was for some kind of co-ordination among the different authorities. The bill met that need in a way that exceeded any proposals that had been made hitherto, and the fact that had been alleged against it, that it was a combination of different measures, was, from this point of view, clearly in its favour. It was taking the opportunity to bring together an enormous number of these different services in order to make a big move, a big change, and a big reform—indeed, more than a reform, for it was an absolute revolution of local government. One point on which obviously members on the opposite side must be agreed was that here was a measure of co-ordination and correlation that was essential for the public health service. The bill gave power to the county authorities to establish definite relations with the sanitary authorities responsible for hospitals, and at the same time to use the institutions of the Poor Law for combined purposes. There was the possibility of co-ordinating the whole of the fever hospital services of the country, which was of enormous advantage in regard to the cause of infection, and which might lead to economy. At the same time, they might secure much more efficient services and more efficient institutions for the patients.

Another point which required co-ordination, and which had not been mentioned that evening—it was not mentioned by the Minister of Health in his opening speech—was the question of mental hospitals and mental deficiency institutions. A very large amount of work in regard to dementia was the concern of the Poor Law and the Poor Law institutions, and a large amount of work in regard to the question of mental asylums, mental hospitals, and mental deficiency came under the county councils. Under this bill they had the possibility of co-ordinating this work, and the county councils would be able to deal with the mental ailments, dementia, and mental deficiency as one undivided authority for the whole county area.

They did not intend to give, continued Dr. Fremantle, and he certainly could not as a medical officer give, unstinted adherence to the bill without suggesting the necessity for considering the need for amendments. He had listened with gravity and anxiety to the suggestions that had been made against the bill from the point of view of those who are concerned with maternity and child welfare services. It was quite true that those were developing services, and were a great essential need of the country. They were administered largely by voluntary effort, and it was certain that many of those concerned with the services were seriously alarmed as to the possibilities of danger from the operation of the block grant. The Minister of Health had said that the last thing he intended was to hinder the maternity and child welfare services in any way, and he had put into three clauses definite provisions for easing their situation. Dr. Fremantle hoped that still further security would be given. He was not at all sure, although he believed in the block grant system in the long run for the sake of the eventual good to local government, that the time was ripe to apply it at once to the maternity and child welfare services, and it might be advisable and possible to give a little longer time—say, for the first quinquennium—under the present system while the voluntary associations were making the adjustments necessary to enable them to work the new system proposed.

In regard to the much debated subject of the local supervising authority under the Midwives Act, a further reservation had to be made in regard to co-ordination. It was a difficult subject, and obviously it would be better theoretically if the Act could be administered by the same authority which administered the Maternity and Child Welfare and other Acts. But the difficulty was that midwives and those associated with them felt strongly that the only authority capable of securing the proper experience and the proper inspection of midwives was the county authority. There were minor exceptions, and it was hoped, in regard, at any rate, to that aspect of the midwives' service, that the responsibility which was given by this bill to the Minister of Health to approve or not approve the transfer might be most carefully used.

He had shown that the Poor Law Reform Committee of the British Medical Association approved the bill in its attempt to secure unification of the medical services of the country. With regard to that, there were two reservations which should be mentioned, and which were capable of adjustment, he hoped, in committee. The first was in regard to the distribution of Poor Law functions under Clause 4. This clause provided that the Poor Law functions might be distributed in regard to health services among the committees of the county councils or county borough councils which dealt already with education and public health Acts, the Maternity and Child Welfare Act, and so forth. But it used the word "may." That gave authorities the option of transferring these functions to the new guardians subcommittees, which would make confusion worse confounded. It would perpetuate the present position, which would be right against the report of the Poor Law Commission, which this bill practically proposed to carry out. Members on all sides of the House who had been keen on public health development were even keener on the proper distribution of functions, and the British Medical Association and the medical officers of health were combined in saying that they wanted each committee of the county councils and county borough councils to be responsible for the whole sphere of service, quite independently of the separate individuals or class of individuals with which they were dealing.

The question of the hospitals was a most difficult and thorny one. There was naturally a great sensitiveness among all those who were keen upon the voluntary hospitals—and all that they meant—regarding the competition which might be set up between the voluntary hospitals and the municipal hospitals. The best arrangement for overcoming this difficulty was by mutual understanding and co-operation, and it was strongly suggested by the British Medical Association—and he backed the suggestion—that the county and county borough councils should be required to set up hospital subcommittees, who would be able to advise them regarding the efficient management of the hospitals, and effect co-operation with the voluntary hospitals. Some regret might be expressed that the Lunacy Acts were left out of Clause 4. The reason for the omission was that it was intended to deal with those Acts in pursuance of the report of the Royal Commission. They had pressed for that for a long time, and he hoped that it would be carried out in the next Parliament. He noted with satisfaction the co-ordination of the medical officer of health services as a step in the direction of the further increase of whole-time medical officers of health; he was, however, at loggerheads with the Minister of Health in regard to the rural areas. He maintained that they could not say that one system was ideal rather than

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another, and the suggestion that the only way to deal with rural areas was by whole-time medical officers who did not engage in private practice was, in his opinion, wrong. What was wanted in rural areas were men of the best character, with the best opportunity to carry out the work. There were obvious exceptions, but there must be some latitude allowed.

Lastly, he hoped that some further progress might be made in separating the health services from the system of relief. That had been the cardinal policy of the medical profession all along. It was a very difficult question, and he still thought that those who could afford to pay ought to do so, and that the public services ought not to be abused. But, on the other hand, they had the precedent of the Infectious Diseases Acts, and he hoped that by degrees, as these municipal health services developed under this new arrangement, the strictly health services might be considered as extra services and separate from relief. He challenged the Opposition parties in regard to their denial of the value of this bill to public health. The future of the measure must depend upon the backing given to it in the country. For that purpose they wanted publicity above all things. The best way to secure publicity for the bill was through the B.B.C., and he urged the Government to arrange that speeches, representing all parties, should be broadcast. If that were done, he believed that the country would be immensely enlightened regarding this bill, which might be rightly called the Magna Charta of public health and local government.

The debate continued until the evening of November 28th, when the House divided.

Replying to a question on November 26th, Sir KINGSLEY WOOD said he did not anticipate that any permanent addition to the staff of the Ministry of Health would be necessary in the event of the Local Government Bill becoming law. Work incidental to the inception of the scheme would involve some temporary addition to the staff, and the consequential expense was estimated at £50,000.

Preservation of Infant Life Bill.

Lord DARLING, in the House of Lords, on November 22nd, moved the second reading of the Preservation of Infant Life Bill, designed to prevent children being destroyed at birth. This bill passed through the Lords last session, but failed to obtain support in the House of Commons after its title had been changed to the Child Destruction Bill. Lord Darling now said that one of His Majesty's judges had drawn his attention to the number of cases where no punishment could be awarded to a person for the killing of an infant during birth, because the killing was neither murder nor abortion. The bill was in the form in which it left a Select Committee of the House of Lords last year.

Lord ATKIN said this gap in the criminal law had been recognized by many generations of justices. The bill in its present form was not a satisfactory piece of legislation. The practical effect of making an offence of the killing of a child during birth by the mother would be very small. It would be difficult to persuade a jury that a woman ought to be held criminally responsible for an act done in the pangs of an unattended, uncared-for, and possibly difficult labour. The bill applied to third persons, to doctors, and to midwives, and raised the position of the doctor who had to consider during delivery whether to save the life of the mother or that of the child. Under the bill such a doctor committed a criminal offence unless he proved that he acted in good faith and that his action was needed to save the mother's life. He objected to creating crimes by legislation, and throwing on anyone the onus of proving that he was innocent. Doctors had been harried quite enough by legislation, and should not have to consider whether a disappointed parent or a mischief-making attendant would charge them with this offence. The provision of the bill making it an offence to kill a child in the mother's body more than twenty-six weeks after conception was unnecessary, because it was impossible to do so without procuring, or attempting to procure, a miscarriage.

Lord DAWSON associated himself with Lord Atkin's arguments. The House should not be too anxious to fill this gap in the law. It was a good thing in many cases if the law turned a blind eye to this offence by unmarried mothers, committed after months of anxiety, often culminating in difficult labour. These girls, in many cases, did not require legal conviction, but the hand of understanding and fellowship. If he were a professional man who had knowledge of an act of this kind, and satisfied himself it had been done under stress of impulse and anxiety, he should not consider it part of his duty to divulge the fact to the powers that be. The bill would inflict a hardship on men in the profession to which he belonged, and on midwives. It threw on them the onus of proving that they were not committing a crime. It would go far to inhibit them and discourage them from doing their work. In fairness and justice to the doctor, and in the interest of the community, he urged the Lords to reject the bill.

Lord RUSSELL concurred in these arguments.

Lord HAILSHAM said Mr. Justice Talbot, in a charge to a grand jury, had pointed out the gap in the law, and had said: "The result of the law is that a fully born child in many cases can be destroyed with impunity, and I do not think it very creditable to our legislature that the defect in the law should be left unremedied." Lord Hailsham said he shared this view. He did not think anyone contemplated that a distraught mother should be punished if she killed her child before it was fully born any more than in similar circumstances just after it had been born. Such circumstances were always taken into account in the modern courts. He agreed that it was most important to safeguard the position of the doctor and the midwife. Largely because of representations by Lord Dawson on that point the original bill had been sent to a select committee, on which Lord Dawson served. Whether the exact phraseology of the bill was sufficient to safeguard the profession might be considered again by a select committee, or by the House of Lords in committee. As he read the bill, although, in fact, a doctor was mistaken in thinking it necessary to kill the child in preserving the life of the mother, yet so long as he acted in the honest belief that the necessity existed he would not be under any liability. Since Lord Atkin felt a doubt on that point it ought to be made clear in committee.

Lord ATKIN said he was content that the bill should be examined in committee.

The bill was then read a second time.

Protection of Animals (Amendment) Bill.

In the House of Lords, on November 22nd, Lord BANBURY moved the second reading of the Protection of Animals (Amendment) Bill. He explained that this short bill proposed that any owner of a dog found guilty of cruelty to the animal might, in addition to any other punishment, be debarred from receiving a licence to keep a dog or dogs.

Lord DAWSON OF PENN pointed out that the original Act contained no definition of cruelty. In view of recent controversies on what constituted cruelty in experiments on animals, Lord Dawson suggested that Lord Banbury should amend his bill by inserting a definition of cruelty as "pain inflicted wantonly and needlessly."

Lord DESBOROUGH, speaking for the Government, thought the proposal of the bill impossible to carry out. An applicant could go to any one of 12,000 money-order offices and take out a dog licence. The Government would not oppose the second reading of the bill, but could not offer facilities to the measure in its present form.

Lord BANBURY, replying to Lord Dawson's suggestion, said he had specially drafted the bill so that the House should not go into other questions, such as what constituted cruelty.

Lord DESBOROUGH remarked that 3,000,000 dog licences had been taken out last year.

The bill was read a second time.

National Health Insurance.

Definition of a Splint.—Dr. VERNON DAVIES asked Mr. Chamberlain, on November 22nd, to state his reason for deciding, under the National Health Insurance Regulations, that a spinal jacket required for the treatment of tuberculosis of the spine was regarded as a splint, but that a spinal jacket required for the treatment of lateral curvature of the spine, which was often due to tuberculosis, was not a splint, and therefore could not be supplied to insured persons. Mr. CHAMBERLAIN said the reason why a different view was taken with respect to the appliances was that he had to look not to the name given to an appliance, but to the precise object which it was intended to serve. He had invited the Insurance Acts Committee of the British Medical Association to discuss with the Ministry the difficulties of defining splints for the purposes of medical benefit. Mr. EASTER asked whether Mr. Chamberlain knew that many osteopaths cured curvature of the spine without any appliances.

Bills.

Young Persons in Offices.—On the motion of Miss WILKINSON the House of Commons, on November 21st, gave a first reading to an Offices Regulation Bill "to regulate offices and the employment of young persons therein." Introducing the bill, Miss Wilkinson said no protection, except the local sanitary by-laws, covered workers in offices. They were outside factory legislation and the Shops Acts. The grievances were growing worse with the overcrowding in great cities. Women were entering offices where the sanitary conditions were doubtful even for men, and inadequate for women. In some recently built offices there was no ventilation. In one of the most modern buildings in Regent Street the office was underground and artificial light was necessary all day. One girl there had been warned by a doctor that she was in danger of contracting pernicious anaemia if she continued to work underground. The bill recognized that it was not possible to reconstruct all offices in a year. It gave wide powers to local authorities and put the onus on the owner.

Mr. WARDLAW MILNE secured a first reading, on November 21st, for a bill making it obligatory for owners of motor vehicles to be insured against third party risks.

Post-vaccinal Encephalitis.—Mr. CHAMBERLAIN stated, on November 21st, that of the five cases of post-vaccinal encephalitis (four fatal) mentioned on page 145 of the Rolleston Committee's report, four were vaccinated with Government lymph and one was not. In the latter case, and three of the former, death occurred.

Nurses and the Midwives Acts Committee.—Asked, on November 22nd, by Mr. Kelly why the profession of nursing had been refused representation on the Departmental Committee appointed to consider the working of the Midwives Acts, 1902 to 1916, Mr. CHAMBERLAIN said he did not consider it necessary to appoint a registered nurse on this Committee as the various nursing organizations could give evidence before it. Only one of these organizations declined to avail itself of this opportunity.

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Obituary.

SIR HECTOR CLARE CAMERON, M.D., LL.D., C.B.E.,

Dean of Faculties and Emeritus Professor of Clinical Surgery in the University of Glasgow.

We have to record with great regret the death of Sir Hector Clare Cameron, the famous Scottish surgeon, which took place in his eighty-sixth year, on November 22nd, at his home in Woodside Crescent, Glasgow.

Sir Hector Cameron was born in Demerara, British Guiana, on September 30th, 1843. He was the second son of Donald Cameron, sugar planter. Sent home for his education, he first went to Madras College, St. Andrews, and afterwards was a student in the Arts classes of the ancient University of that city. His medical education began in Edinburgh University, but the greater part of his course was taken in the University of Glasgow, where Joseph Lister was then Professor of Surgery. He graduated M.B., C.M. in 1866, and M.D. in 1868. In the latter year he became assistant to Lister at the Royal Infirmary. The association then begun endured and deepened throughout his life; and although two years later Lister was transferred to Edinburgh, Cameron, who, despite many inducements to move eastwards with his chief, had decided to remain in Glasgow, became one of the leading propagandists of the young antiseptic school, and continued both in precept and practice to develop and spread the doctrines of his master. At the early age of 32 he was appointed surgeon to the Royal Infirmary, resigning this post in 1871, when he obtained a similar position in the Western Infirmary. In 1900, on the retirement of Dr. George Buchanan from the chair of clinical surgery in Glasgow University, Cameron was elected by the University Court, without advertisement, to that chair, which he occupied until 1910. He held from time to time many other appointments—surgeon to the Royal Hospital for Sick Children, consulting surgeon to the Glasgow Royal Asylum, surgeon to the Eye Infirmary and to the Lock Hospital. For many years he was a member of the University Court as a representative of the senate, and of the General Medical Council as representing the Royal Faculty of Physicians and Surgeons of Glasgow. He held examinerships in the Universities of Cambridge and Aberdeen. Such offices as his professional brethren could confer on him he also occupied with unanimous assent—among them the presidencies of the Royal Faculty of Physicians and Surgeons, the Pathological and Clinical Society, and the Royal Medico-Chirurgical Society of Glasgow. At the meeting of the British Medical Association in Toronto in 1906 he was president of the Surgical Section. During the war he became Red Cross commissioner for the Western District of Scotland, and since 1920 he acted as convener of the Ralston Red Cross Hospital. He was also dean of faculties in the University of Glasgow, and was appointed by the General Medical Council to supervise the examinations in medicine conducted by the medical schools of Great Britain and Ireland.



SIR HECTOR CLARE CAMERON.

These numerous services received signal marks of national and academic approval. He was knighted by Queen Victoria in 1900; in 1911 the University of St. Andrews made him an honorary LL.D.; in the following year his own university conferred the like honour; and after the war he was created C.B.E.

His contributions to medical literature were not numerous, but between 1870 and 1884 articles from his pen appeared occasionally in medical journals and transactions, on such subjects as colopuncture, tracheotomy, foreign bodies in the air passages, trephining, etc. At wider intervals in later years he wrote upon such questions as the treatment of hip-joint disease, and on the analogy of cutaneous cancer and tuberculosis. He was the author of valuable papers and addresses on Lister and his work, in particular the Dr. James Watt Lectures on the evolution of wound treatment during the last forty years, published as a book in 1907. This is a historical and documented account of the origin and development of antiseptic surgery, and bears the imprimatur of Lister himself, thus contributing a definitive record of the great surgeon's system and ideas.

The relative paucity of his publications was due principally to the fact that his bent was clinical rather than scientific. As has already been indicated, he began his professional life as a disciple of Lister. When his master left him the fallen mantle of apostleship descended upon him, and for the rest of his life he was content by voice and hand to expound and illustrate the truth of the new surgical learning. His opportunities for original research and writings were also restricted by the great and steadily growing pressure of private work. As an operating surgeon his reputation was not exceeded by that of any contemporary. The social stamping of his patients made no limit to his sense of duty. He was pre-eminently accessible to the less fortunate, and countless instances are on record of his generous and unsparing beneficence to the needy and humble who sought his services.

As a teacher he was always popular, alike in his Socratic and his didactic moods. An interesting expositor, he avoided set orations, and his lectures were replete with the results of his own experience, and illustrated with historical parallels and allusions. And likewise as operator he was methodical, calm, and self-reliant. Conservative in his outlook, he distrusted sensation and "brilliance" in surgery. "Gentlemen," he would say, "you must not make your light shine at a patient's cost." Or again, "To open an abdomen without a constructive diagnosis is the height of surgical curiosity." In his wards, theatre, and lecture room, his students never failed to realize the deep human sympathy that informed all his work: "*il n'y a pas de maladies, il n'y a que de malades*" was the motif of clinical discourse or ward visit. His belief in Listerian antisepsis, as distinguished from the illogically termed "aseptic system," remained unshaken to the end of his hospital term; and when, during the war, the foul infections of the soil of

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Flanders reproduced in casualty clearing stations and base hospitals the horrors of pre-antiseptic surgery, and necessitated a revisal of some post-Listerian modes of treatment, his gratification over the vindication of the older system was not concealed.

He retired from the clinical chair and from active surgical practice in 1910. This event was one of the severest ordeals of his life. When contemplating his imminent resignation he wrote in a private letter:

"De Quincey in the *Confessions* quotes a passage from Dr. Johnson, and he says that it is the only feeling remark that Dr. Johnson ever made. It is this. 'No one ever does anything consciously for the last time, of those things which he has been long in the habit of doing, without sadness of heart.' The sentiment is a feeling one, because it is so truly natural and human. When I therefore, some day soon, realize that I am making my last hospital visit (I have been making them for thirty-six years—since 1874) I know I shall feel very sad indeed. The mere anticipation weighs on my spirits."

On the occasion of this retirement he was entertained to dinner by fifty of his former assistants and house-surgeons, and presented with a loving-cup which bore the inscription:

H. C. C.
Magistro carissimo Discipuli
MCMX

No memoir, however brief, of Hector Cameron's life would be adequate did it not include a reference to the richness of his mind and the graces of his personality. In youth he had absorbed much of the spirit of the ancient classics and of the great works of English literature. In later years his retentive memory furnished him with many an apt allusion and quotation. He had an Augustan love of the Latin tag and the polished phrase; *le mot juste* had an ineluctable attraction. Unrivalled as a raconteur, he was delightful in social converse; and his correspondence provided many characteristic examples of the vanishing art of letter-writing. Outside of his scholarly interests fishing and shooting were his favoured recreations, and in both sports he excelled.

But to all who knew him the most abiding memory will be that of his almost old-world courtesy and graciousness. If in his public duties he ensued compromise more than controversy, it was because of his broad humaneness, his catholicity of spirit, and his innate kindness of heart. Alike as teacher, surgeon, colleague, administrator, and man of the world, he earned the respect and admiration of his associates: and, what is more rarely vouchsafed to outstanding men, the deeper homage of affection from his friends. His fine features, crowned for many years with a wealth of silvery hair, marked him out on any platform or in any society. Two eminent artists—Henry and Greiffenhagen—have painted the outward semblance; but no material portraiture will preserve to future generations the real picture of nobility and charm that is treasured by those who knew him best.

J. F.

Sir Hector Cameron married a daughter of Mr. William Hamilton Macdonald, who predeceased him in 1879. He is survived by a daughter and two sons—Colonel Donald Cameron of the Army Service Corps Staff College, and Dr. Hector Charles Cameron of Guy's Hospital.

We are indebted to Sir DONALD MACALISTER, Bt., President of the General Medical Council, Principal and Vice-Chancellor of the University of Glasgow, for the following tribute.

May I repeat here, what I felt moved to say in my presidential address to the General Medical Council this week, concerning Sir Hector Clare Cameron? I announced that but last week that veteran died, full of years and honours, at the age of 85. One of the last survivors of Lord Lister's personal assistants and coadjutors—he has fitly been described as Lister's "beloved disciple"—he held a high place, not only among Glasgow celebrities, but in the affectionate regard of the surgeons of the world. "To myself his loss is irreparable, for from time to time when, in 1889, he first welcomed me to this Council as a colleague, until the end, he was my unfailing friend and counsellor, on whose kindly wisdom and manifold experience it was ever my privilege to draw." To the Medical School and to the University of Glasgow he was a pillar of strength, revered and beloved for his unselfish interest in, and devotion to, their well-being. Eminent alike as teacher, as surgeon, as administrator, and as benefactor, he had a unique place in their regard. In testimony may be cited the honorary offices he held—as consulting surgeon to several of Glasgow's great infirmaries, his presidency of the Royal Faculty of Physicians and Surgeons, his dignified place, to which he was elected and re-elected, as Dean of Faculties in the University; his membership of its University Court and Senate, and many others, heaped upon him by bodies and institutions which he had nobly served or which desired to derive honour from association with his honoured name. His warmly affectionate nature, his ready helpfulness, his freedom from any trace of self-seeking, his transparent honesty of purpose, and the immediate impression of deep sagacity and practical wisdom which he conveyed, made him a very Nestor among us, and a Nestor loved and admired beyond others. His loyalty to Lister, his cherishing and setting forth of the valued memorials of his master which he possessed in rich abundance, and his lucid and cultured utterance on all occasions of ceremony, will long be remembered in Scotland. With him a great representative of a great generation passes away; and some of us cannot but feel that no one quite fitted to take his place is left to us.

Mr. G. H. EDINGTON, D.Sc., M.D., Lecturer on Clinical Surgery at the University of Glasgow, writes:

By the death of Sir Hector C. Cameron the community of Glasgow mourns one of her most prominent citizens, and the Medical School one who in the days of his active professional work occupied a foremost position in the ranks of surgery. I was privileged to receive my early training in his wards, and later to be associated with him in his work, and his death now severs a friendship which remained unbroken for a period of over thirty years.

As a teacher he had the gift of presenting problems to his students couched in language which, enriched by happy simile and apt metaphor, fixed itself in their memories. His description of the ailments of the patients brought to their notice was illustrated by examples drawn from his wide clinical experience and likewise from his readings in the literature of the subject. His operations were carried out with a meticulous attention to detail which was in itself a liberal education for the onlookers. There were, however, taught in his clinic things which were outside the mere bones of clinical surgery. He, by his example, taught us veracity, concern for the best interests of the patient, care for the feelings of others, and a warm and broad humanity. The humblest patient in his wards received the same consideration as any of his cases in private, and it was no uncommon occurrence for him to return to the hospital in the afternoon to see how those on whom he had operated in the morning were progressing, while very rarely did he miss paying a Sunday visit. He was a pattern of dignity and modesty, never thrust himself forward, never cried his wares in the market-place. We junior students took it, I am afraid, as a matter of course, and the degree of his modesty and his professional skill only became known to us when we moved to other clinics and saw very different post-operative results. We failed not then to draw a comparison, and were struck by our late chief's merits, and his equally marked unobtrusiveness. When later I came to enjoy his friendship and to talk with him in his home circle I was able to appreciate that I was in the presence of one who was not only a surgeon, but a man of wide education and wide interests. He was a keen lover of sport, and during his vacations he enjoyed shooting, fishing, and golf. He was keenly interested in birds, and delighted to draw attention to their various notes. He had a well-stored memory, and freely drew on it for anecdotes and quotations apropos whatever subject might be under discussion.

When, as they did, honours came to him they were fully appreciated. He never vaunted them. They were all unsought, and were conferred on him in recognition of good work well done, and they gave pleasure to his many

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friends and to his even more numerous patients. His attitude to honours was fittingly summed up in a brief note which he received from an old Scottish lady, a former patient, on the occasion of his knighthood. She wrote:

"Some ha'e sought it,
Some ha'e bought it,
You ha'e wrought it."

Concerning his knighthood, which was conferred on him by Queen Victoria during his tenure of the Presidentship of the Royal Faculty of Physicians and Surgeons, he was from home when the *Gazette* appeared. He was quite unaware of its coming, and he told me that his first intimation of it was a telegram of congratulation from one of his friends in Glasgow being handed to him in his hotel before breakfast. The telegram was vague, and it was not till he had gone downstairs and seen the newspaper that he knew definitely the cause of congratulation.

It was characteristic of Cameron that, although feeling the burden of years, he did not sink down under it, but kept going in and out, and calling for friends, till this summer, when increasing feebleness caused him gradually to keep to the house. Up till shortly before his death he was keenly interested in hearing of all that was going on; but he was perceptibly weakening, and the end came very quickly. A great gap has been caused; but it is some consolation to his many friends to know that he passed without obvious suffering. Those of us who knew him well and came under his influence feel thankful that we were privileged to have had him so long as an example. He was in truth

"... a verray parfit, gentil knyght."

[The photograph reproduced on page 1015 is by Lafayette of Glasgow.]

IMPERIAL CANCER RESEARCH FUND.

DR. MURRAY'S ANNUAL REPORT.

In the annual report of the Imperial Cancer Research Fund for the period 1927–28 the director, Dr. J. A. Murray, F.R.S., outlines a number of general features of the cancer problem frequently ignored in the discussion of special investigations. This report, the twenty-sixth of the series, was presented at the general meeting of the Fund, held on Wednesday, November 28th.

Variations in Susceptibility to Cancer.

The conclusion that cancer begins as a local disease has determined general recognition of the fact that in its earliest stage the disease is curable. This conclusion, however, has not always held the field, and, as Dr. Murray points out, it has been established only through the experimental investigation of cancer in animals. Tar cancers, experimentally produced, may be removed at an early stage, or after being allowed to grow for a time, or not at all; the former proceeding, it is found, is effective in preventing both local recurrences and the dissemination of cancer throughout the animal's body. Experiments on these lines have brought to light yet another fact of a general nature. Mice differ so much in their response to irritation that while some subjected to tar painting will show signs of cancer in about four months, others, similarly treated under identical conditions, may remain cancer-free for a much longer period, and a small percentage may fail to develop cancer even after being tar painted for a year. But if apparently susceptible mice, from which tar cancers have been surgically removed, are subjected to a second course of tarring, they are found to be distinctly resistant, and it is, in fact, very difficult to obtain the second tar tumour. The same phenomenon was noted in mice from which spontaneous cancers—for example, of the breast—had been surgically removed; their skin was found to be tar-resistant.

The conclusion, Dr. Murray suggests, appears to be inevitable that the factors determining differences in susceptibility are not locally restricted in particular tissues, but are of some general constitutional nature. If this theory is correct some statistical evidence would be expected showing such general factors to be active in determining the incidence of cancer in the different tissues of man. As a small piece of confirmatory evidence Dr. Murray cites the rarity with which multiple malignant new growths have been observed. Moreover, a comparison of the incidence of cancer in men and women in special relation to its incidence in organs peculiar to each sex and in organs common to both sexes, shows that in females over 30 per cent. of the incidence of cancer falls on the specific sexual organs, especially the uterus and breast, while in males the incidence on the specific sexual organs is very low. If such incidence were determined entirely by local factors in the different organs and tissues, one would expect a much higher total incidence of cancer in women, their special sexual organs being so liable to develop cancer. Actually the total incidence is the same for both sexes. In all organs common to both sexes, except the gall-bladder and thyroid gland, the incidence of cancer is higher in men than in women. To account for the apparently equal total incidence by the operation of a local factor in each organ one would have to assume first that something in the mode of life in men sets up with greater frequency local conditions leading to cancer in the organs common to the sexes, and that by coincidence this frequency happens to be of the same order as that of the incidence of cancer in the organs specifically female.

Comparative Mortality Statistics.

Cancer statistics of Holland, Switzerland, and Japan are generally comparable with those of England and Wales, and lead to similar conclusions. Of particular interest is the fact that though cancer of the breast is twice as frequent in English women as in Dutch women, and is rare in Japanese women, the total cancer mortality in women of these countries is the same. In Japan there is a very high incidence of cancer of the uterus; in Dutch women, though cancer of the uterus is also only half of that in English women, cancer of the digestive tract is far more frequent, the higher incidence in one group of cancers, both in the Japanese women and the Dutch, almost exactly balancing the lower incidence in the other. If the incidence of cancer were determined entirely by local factors this remarkable phenomenon would have to be attributed to coincidence. Italian figures are at some variance with those of other countries, showing not only a lower general cancer mortality, but a much lower incidence of cancer in males than in females. It is suggested in the report that this might be due to racial factors; it may, however, be accounted for by under-diagnosis of cancer in non-accessible sites, which is more likely to occur in men than in women. On the whole, Dr. Murray concludes that the incidence of cancer is determined by general factors, local factors determining merely the site at which the cancer develops.

The Filterable Fowl Tumour.

Work on the new fowl tumour, discovered by Dr. Begg in the laboratories of the Imperial Cancer Research Fund, is being continued. The importance of this tumour, which has been proved to arise from endothelial cells, lies in the specificity of the "agent" or "agents" responsible for its transmission, in that it restricts its activity entirely to endothelial cells. The view that the filterable fowl tumour is not a true malignant neoplasm, but an infective granuloma, cannot therefore be sustained. Dr. A. Carrel's experiments, in which he claims to have produced a typical Rous tumour by injecting into a fowl chick embryo, together with some simple chemical substance such as indol, have been repeated by other workers with negative results.

Diet and Cancer.

A large-scale repetition of Fujimaki's experiments has failed to verify his conclusion that stomach cancer may be induced in rats kept on a diet free from vitamin A. In such rats hypertrophy and keratinization of the fore-stomach epithelium is frequent; but no actual cancer, in the stomach or elsewhere, has been observed in the laboratories of the Imperial Cancer Research Fund to follow vitamin A starvation. Moreover, the phenomena described

H. E. Seiler, A Case of Pneumoconiosis, British Medical Journal (1928)
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by Fujimaki are not specific for vitamin A deficiency, but have been observed in conditions of B-avitaminosis, and even in old stock rats which had always received a diet adequate in vitamins. Dr. Murray states categorically that there is no reliable evidence—experimental, statistical, or clinical—which would indicate a causal correlation between cancer and the absence or presence or the excess of any particular dietetic constituent.

Evidence of Transmissibility of Cancer.

Experiments carried out in the laboratories of the Fund have shown that Professor Heidenhain's belief in the transmissibility of cancer from animals to man, derived from work purporting to prove its transmissibility from man to animals, is based on error. Dr. Murray emphasizes the fact that Heidenhain's conclusion, if correct, would revolutionize our conception of the nature and treatment of cancer, and, in so far as it meant that any case of cancer in animals or in man might be a source of infection, would spread profound alarm among the public. Dr. Cramer, however, has shown that the malignant growths observed by Professor Heidenhain were in reality spontaneous tumours and not the result of injecting the animals with human cancerous material.

The Warburg Phenomenon.

Experiments have shown that the Warburg phenomenon, that is, high aerobic glycolysis by cancer cells—normal tissues effecting glycolysis, if at all, only when oxygen is absent—cannot serve to distinguish cancerous from non-cancerous proliferations; a similar phenomenon has been observed in the study of cellular overgrowths produced by virus infections. These latter are also capable of effecting a partial splitting of carbohydrates under aerobic conditions. An investigation has also been made into the therapeutic possibility, suggested by Warburg, of affecting cancer growth by varying the oxygen pressure in the inspired air. Prolonged exposure of animals with cancer to high pressure of oxygen, within the limits of safety, produced no effect on the tumours, while low oxygen pressures delayed their growth and produced extensive necrosis. Even prolonged exposure, however, could not completely arrest the growth of tumours, and only produced their regression. Dr. Murray concludes that there is no evidence that alterations of oxygen pressure, even within the limits of safety, are by themselves of therapeutic value.

VOLUNTARY HOSPITALS IN GREAT BRITAIN.

A Survey of 1927.

THE ninth annual report on voluntary hospitals in Great Britain (excluding London) for the year 1927 has been compiled by Mr. R. H. P. Orde, and is published by the recently constituted Central Bureau of Hospital Information. This agency, which has been set up by the Joint Council of the Order of St. John and the British Red Cross Society in conjunction with the British Hospitals Association, has taken over the work of publication from the Joint Council, in addition to other duties in connexion with the accumulation and distribution of information relating to hospital affairs. Its services are placed freely at the disposal of the voluntary hospitals, and also of public authorities.

The report covers institutions containing over 99 per cent. of the voluntary hospital accommodation in Great Britain outside the London area, giving detailed surveys of the financial position of 755 hospitals containing 48,212 available beds; the total number of hospitals in Great Britain, outside London, is given as 790, with 48,696 beds, so that only a very small proportion of the available accommodation has not been brought within the scope of the review. Taken in conjunction with the statistical report for 1927 on the finance of London hospitals, issued by King Edward's Hospital Fund, which was noticed in the *Journal* of October 27th (p. 771), the report affords a practically complete account of the position of the voluntary hospitals. A general summary of the finances of the 755 hospitals reviewed shows that in 1927 the amount of income available for maintenance was £7,103,044, while receipts for capital purposes amounted to £1,511,024, giving a total income of £8,614,068; the expenditure on maintenance was £6,100,442, and on capital account £1,498,012, leaving a surplus of £1,015,614. The number of hospitals with a credit balance on their maintenance account was 562, or 74.44 per cent. of the total, 7 per cent. more than in 1926. As compared with this year, income available for maintenance increased in 1927 by £714,028, and expenditure on maintenance increased by £169,023; receipts for capital purposes decreased by £16,776, and capital expenditure by £237,165. The surplus of £1,015,614 compares with £250,220 in 1926, but was lower than that recorded in the three preceding years.

Details regarding the number of patients treated were obtained from 753 hospitals, which provided during 1927 for 729,[illegible] new in-patients and 2,907,198 new out-patients, showing increases of 36,599 and 149,783 respectively over the previous year. For purposes of analysis England and Wales, Scotland, are dealt with separately, and hospitals are divided into three main groups—the first containing those with 100 or more beds, the second those having from 30 to 99 beds, and the third those having less than 30 beds—and certain special groups are also differentiated, such as hospitals associated with medical schools, specially large hospitals, and those devoted to particular classes of disease. The tables relating to the volume of work done in the voluntary hospitals show that in England and Wales there has been a remarkable increase in the number of cases dealt with in the out-patient departments of the large hospitals; out of a total increase of 115,555 in this category the large hospitals were responsible for 113,690. The pressure for beds or accommodation in this class was also much greater than in the smaller hospitals. This was also true in Scotland, and in that country, further, the proportion of available beds occupied in all classes of hospital was higher than in England and Wales. A striking feature of the figures relating to these countries is the rapid extension of surgical operative work; it is only possible to give an approximate comparison, but it appears that from the details available, the number of operations per hospital rose from 698 in 1923 to 866 in 1927. In the x-ray, electrotherapeutic, and massage departments there has also been substantial expansion. It is satisfactory to learn that all classes of hospital in England and Wales shared in the general prosperity, and that the position of the large hospitals, which formerly were relatively worse off than others, has improved considerably, the ordinary income of this group having risen from £2,957,375 in 1926 to £3,292,298 in 1927. In Scotland, however, there was little change in the financial position, and the figures suggest that while the English hospitals have more than recovered the voluntary support they enjoyed before 1926 the Scottish are still below the 1925 level.

The main sources of income on maintenance account per available bed in 1927 were as follows for the hospitals of the two countries:—Voluntary gifts: England £80.75, Scotland £62.97. Receipts for services rendered: England £29.40, Scotland £16.30. Interest from investments: England £18.80, Scotland £29.75. Extraordinary income: England £18.95, Scotland £27.15. It will be seen that the Scottish hospitals received much less for services rendered, although income from this source is steadily increasing in both countries, while the accumulation of large invested funds is a notable source of strength, particularly in times of depression, which has been fostered in the North. The report contains a series of analyses of hospital expenditure which should be exceedingly valuable to all engaged in hospital management.

Sir Arthur Stanley contributes a prefatory note directing attention once more to the difficulties created by the increasing number of road accidents, and this subject is dealt with also in a series of special articles by representatives of the hospitals, of insurance, and of the motoring public. Mr. Orde, in his introduction to the report, states that from replies received to a questionary it is estimated that in 1927 approximately 26,000 in-patients and 39,000 out-patients were treated in provincial voluntary hospitals at a cost of about £230,000, towards which approximately only £26,000 was received from or on behalf of the patients. Lieut.-Colonel J. T. Woolrych Perowne gives an account of the development and working of the St. John Ophthalmic Hospital at Jerusalem. Among supplementary matter are a memorandum on the assessment of voluntary hospitals and an analysis of some contributory schemes for paying or private wards.

The report may be obtained from the Central Bureau for Hospital Information, 19, Berkeley Street, W.1, price 1s. 5d. post free.

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Universities and Colleges.

UNIVERSITY OF OXFORD.

AT a congregation held on November 24th the following medical degrees were conferred:

D.M.—R. J. Brocklehurst, H. F. Turney, D. G. T. Karr Cross.

UNIVERSITY OF CAMBRIDGE.

AT a congregation held on November 24th the following medical degrees were conferred:

M.D.—A. D. Whitelaw.
M.B., B.Chir.—N. R. Barrett, H. S. Waters, P. R. Buckton.

Mr. A. F. R. Wollaston, M.A., B.Ch., D.S.C., has been re-elected to a Fellowship at King's College, and appointed tutor.

Mr. J. F. Cameron, M.A., has been elected Master of Gonville and Caius College, in succession to the late Sir H. K. Anderson, M.D., F.R.S.

UNIVERSITY OF LONDON.

MR. H. L. EASON has been elected chairman of the Library Committee for 1928–29.

The following degrees have been conferred:

D.Sc. in Anthropology.—Mr. F. G. Parsons, F.R.C.S., University Professor of Anatomy, for thesis: "The Englishman of the Future."
D.Sc. in Physiology.—Mrs. Norah Edkins for thesis: "A Study of Absorption in the Stomach and Small Intestine."

UNIVERSITY OF LEEDS.

DR. H. H. MOLL has been appointed honorary demonstrator in pharmacology and therapeutics.

SOCIETY OF APOTHECARIES OF LONDON.

THE following candidates have passed in the subjects indicated:

SURGERY.—J. Freud, W. S. Ghai, W. D. Glynn-Jones, H. C. Johnson, T. K. S. Lyle, A. Weeks.
MEDICINE.—J. Freud, W. D. Glynn Jones, E. C. Gross, M. H. Rashwan, L. Wasef.
FORENSIC MEDICINE.—W. D. Glynn-Jones, D. F. Michrak.
MIDWIFERY.—N. Datta, J. D. B. Gaines, E. C. Gross, A. Liberis, T. K. S. Lyle, A. Weeks.

The diploma of the Society has been granted to Messrs. E. C. Gross, H. C. Johnson, T. K. S. Lyle, M. H. Rashwan, L. Wasef.

Medical News.

THE Fellowship of Medicine and Post-Graduate Medical Association announces that a lecture will be given on Monday, December 3rd, at 5 p.m., by Dr. G. A. Sutherland at the Medical Society of London, 11, Chandos Street, Cavendish Square, W.1, on "Some cardiac problems in childhood." A demonstration on cancer will be given on the following Wednesday by Mr. Herbert Paterson at the Wellcome Museum of Medical Science, 33, Gordon Street, W.C.1, at 4 p.m., and on the same day, at 2.30 p.m., a clinical demonstration in urology will be given by Messrs. Attwater, Coyte, Loughnane, and Levy at All Saints' Hospital. On Thursday, December 6th, at 10 a.m., Dr. Robert Hutchison will give a clinical demonstration at the Hospital for Sick Children. The lectures and demonstrations are free to members of the medical profession. From December 3rd to December 16th there will be a special afternoon course at the Infants Hospital, under the direction of Dr. Eric Pritchard, with visits to other centres. This course is of special value to medical officers of welfare centres—the fee is £3 3s. A special course in dermatology at the Hospital for Diseases of the Skin, Blackfriars, will also begin on December 3rd, ending on December 14th, and consisting of clinical instruction in the out-patient department each afternoon from 2.30 p.m., with two special demonstrations. The complete list of special courses for 1929 is now available, and may be obtained, together with particulars of the general course of instruction which is continuous throughout the year, from the Secretary of the Fellowship, 1, Wimpole Street, W.1. The Fellowship will resume its lectures at the Medical Society of London about the middle of January with a series entitled "Pitfalls in medicine and surgery." It is also proposed to hold a further series of demonstrations at the Wellcome Museum of Medical Science, and weekly clinical demonstrations in medicine and surgery will be given at various hospitals.

A LECTURE on life in the island of Tristan da Cunha will be given in the cinema theatre of the Empire Marketing Board in the Imperial Institute, South Kensington, at 5 p.m., on Thursday, December 6th, by Mrs. Rose A. Rogers, author of *The Lonely Island*. The lecture will be illustrated by lantern slides and films, including that taken of life on the island in connexion with the *Quest* expedition.

A NEW children's wing at the Wimbledon Hospital was opened on November 21st by Princess Arthur of Connaught. The wing includes a medical ward and a surgical ward (each of eight cots), two observation wards, two private wards, a casualty theatre, and other accommodation. New quarters for the domestic staff have also been provided. The cost of the extensions has exceeded £17,000, and only about half this sum has been received. It is hoped that a new x-ray and developing room and a laboratory will shortly be added.

MESSRS. EDWARD ARNOLD AND CO. announce for early publication a new edition of Garrod, Batten, and Thursfield's *Diseases of Children*, which has been revised throughout and largely rewritten under the editorship of Dr. Hugh Thursfield and Dr. Donald Paterson.

THE annual report of Livingstone College for 1927–28 contains an account of the annual meeting in the summer, to which we referred on June 23rd (p. 1096). Sixty-three students entered for various courses held during the year, of whom six took the full course; in addition to these, twenty-seven students attended a short course on the care of health in the tropics. It is stated that the deficit on the year's working is about £50, and an appeal is made for more substantial assistance. The report includes extracts from letters from past students in different parts of the world, emphasizing the value to missionaries of the elementary training in first aid and medical subjects which the College exists to provide.

THE following appointments have recently been made in foreign faculties of medicine: Professor Herzog of Innsbruck has succeeded Professor Marx in the chair of laryngology at Munich, Professor Poetzl of Prague has succeeded Professor Wagner-Jauregg as head of the psychiatric clinic at Vienna; Professor Werner Gerlach, prosector at the General Hospital at Barmbeck, has succeeded Professor R. Beneke in the chair of general pathology and morbid anatomy at Hamburg; Professor Kurt Brand of Giessen has succeeded the late Professor Johannes Gadamer in the chair of pharmaceutical chemistry at Marburg, and Professor Gruber has been succeeded in the chair of pathological anatomy at Innsbruck by his assistant, Dr. Franz Josef Lang.

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 9361, 9362, 9363,* and *9364* (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, *Mediocera 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, 7, Drumsheugh Gardens, Edinburgh (telegrams: *Associate, Edinburgh*; telephone 24361 Edinburgh).

QUERIES AND ANSWERS.

A PAGE-TURNING DEVICE.

"W. N." writes: Do any of your readers know of a mechanical device for turning the leaves of a book? I am writing on behalf of a friend who is paralysed in both upper and lower limbs, so that the only motive power could come from depression of the chin. I should be grateful for any suggestions.

INCOME TAX.
Allowable Expenses.

"R. H." inquires whether there is available for reference a detailed list of allowable expenses as officially approved.

*** We are not aware of any detailed list to which official agreement has been given, and the circumstances of different cases vary between such wide limits that a list sufficiently

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detailed to be really useful is not likely to become available. On the particular class of expense to which "R. H." refers—cost of motoring, cost and gloves, dust coat, etc.—we fear the law is against him; such expenses cannot be correctly said to be incurred wholly and exclusively for professional purposes—they are too personal in character.

Cost of Indoor Assistant.

"A. W." inquires what is "the usual amount allowed off income tax for the board and lodging of an indoor assistant." He suggests 30s. per week, but the inspector of taxes considers 20s. adequate in view of the fact that one-third of rent, rates, etc., have been allowed.

*** It is impossible to lay down any general rule where so much depends on the circumstances of each individual case. If the one-third allowed is adequate to cover that portion of the house which is occupied, wholly or partly, by the assistant, and also the relative cost of cleaning, laundry, general domestic service, etc., then the question is reduced to an estimate of the out-of-pocket expenditure on the assistant's food, etc. Prima facie the "one-third" is quite as open to attack as the 20s. per week.

Expenses of Employment.

"A. E. I." inquires with regard to expenses incurred as an assistant medical officer of health.

*** It is a fact that no deduction can be made in respect of interest which would have been received if he had not had to use the capital to build a garage; on the other hand, deduction can be made in respect of the rental value, as assessed to income tax, of the garage so erected. Further, the expenses allowable are those actually laid out for the purposes of the employment, and exclude any allowance for work done—for example, cleaning, etc., by himself. The authorities are within their rights in restricting the expenses allowed to exclude those which reasonably relate to private use.

LETTERS, NOTES, ETC.

SECURITY OF TENURE IN PUBLIC POSTS.

"A. M." writes: I watch with interest the discussion initiated by Dr. McManus under the title of "Security of tenure in public posts," setting forth as it does the many grievances of medical officers in the mental hospitals service, and my only fear is that the dread "This correspondence must now cease" may appear before the British Medical Association has been induced to do a little more on our behalf. The varied opinions already expressed only go to show the extremes of conditions that exist in different institutions, and the need for some uniformity to be brought about by an authoritative body. In my few years of service I have met several colleagues from other institutions, all with similar complaints, and there has been some talk of forming a society to further our interests without victimization, but a higher body, such as the British Medical Association, is needed for a task of this sort. The main points have already been stressed: security of tenure, participation in administration, access to the committee, fair promotion, and facilities for study; but, as may be seen from other letters, conditions vary from place to place. This is surely an urgent reason for advising against entering the service—the uncertainty of local conditions. Until the British Medical Association can see its way to agitate for justice and equality of conditions the mental service must perforce remain the pariah of those "with influence."

BIOCHEMICAL INVESTIGATIONS IN ALLERGIC CONDITIONS.

DR. R. CHALMERS (Darlington) writes: I am in full agreement with Drs. Barber and Oriel (November 17th, p. 880) when they say that "allergy is beyond question the most important biological and medical problem that exists or ever has existed." I have been doing routine chemical and microscopical examinations of urines in my cases for the past ten years, and some five years ago a letter of mine appeared in the *Journal* on what I termed "leucin bodies in the urine." I referred to them as being impure forms, and the only reason for calling them such was because of their microscopical appearance simulating those depicted in Simon's *Clinical Diagnosis*, and that I always found them in cases where I suspected there was present a chemical disturbance of the liver. In the intervening years I have sought, *ad nauseam*, to find an explanation of these bodies by sending them to laboratories and to high authorities in the medical world; at last I sent drawings and descriptions of these to the medical journals for publication, to try and get some enlightenment. These were returned to me, until I could tell what their nature was. I have, however, kept on noting and recording these and varied findings in my patients, and now have records of many hundreds of different kinds of cases. After reading Dr. Oriel's account of his other reaction I had an opportunity of trying it in a case of severe jaundice. I found it strongly positive, and on examination of the scum found minute oil globules as he describes, and also beautiful specimens of what I have designated "leucin" bodies. These did not show in the centrifugalized specimen of the urine itself. . . . I am very pleased to see that Dr. Oriel, who found his other reaction positive *first* in a case of cardiac failure, has raised the point of what relation this hepatic tendency may have on cardiac pathology. In a paper which I sent to the *Journal* a month ago, but which has not been published, I refer to the same point, and state that it is my belief, come to from continuous observation of my cases along these biochemical lines, that the hepatic chemistry is a very important element in such diseases as coronary disease, angina pectoris, and myocardial disease.

PREMATURE SEPARATION OF PLACENTA DUE TO RELATIVE SHORTNESS OF THE UMBILICAL CORD.

DR. C. J. HILL AITKEN (Kilnhurst, near Rotherham) refers to a previous account by him of a relatively short umbilical cord causing retention of the membranes (*British Medical Journal*, April 16th, 1927, p. 750). He now reports another case of the same kind, in which shortness of the cord caused delay in a breech case until birth of the shoulders, the placenta and membranes being torn from their site, with subsequent haemorrhage into the uterus. The patient's pulse, which had been normal, increased to 120, and she began to look pinched. She was lightly anaesthetized, and a bougy tumour was felt rising to above the umbilicus. Despite good pains, there was no progress in the birth of the head owing to distension of the uterus. The third stage of delivery was uneventful. Pressure on the abdomen was applied during delivery.

SANITARY INSPECTORS.

MR. WILLIAM G. KERSHAW, M.B.E. (President of the London Centre of the Sanitary Inspectors' Association), writes: I have read with considerable interest the remarks on the teaching of hygiene in your issue of October 27th. I hesitate to question any conclusions at which so great an authority as Professor Jameson has arrived, but I would point out that his observations in regard to the general educational qualifications for entrants to the inspectorate do a great injustice to those would-be candidates who have served their apprenticeship in one or other of the building trades, because he infers that apprentices in the building crafts to-day are so lacking in general education as to be unable to pass, if they have not already done so, one of the examinations mentioned in the regulations of the Joint Examination Board. If such is the case, then I doubt if they would be competent "to meet a builder upon his own ground," because, to-day, clerks of works, builders, and their managers and foremen are, generally speaking, highly educated men who have found it much more profitable to remain in the building trades, where higher remuneration is obtainable than that which the Ministry of Health permits local authorities to pay to their sanitary inspectors. I whole-heartedly admit the great advantage which a practical training in the building trade is to a sanitary inspector, and what a valuable asset it is to the authority he serves, but if craftsmen are to be encouraged to devote the time and money necessary to obtain the training and qualification in the many duties which a sanitary inspector to-day has to perform which have no association at all with the building trade, for example, as Professor Jameson points out, a certificate as inspector in meat and other foods, then they must be assured that the salaries which they will receive as sanitary inspectors shall be at least as good as those which they may reasonably expect to obtain if they remain in the building crafts. The remedy lies in this direction rather than in lowering the educational standard.

OUR LEARNED BROTHERS.

"N 3" writes: Dr. Herbert Spencer's story (November 17th, p. 915) of the American obstetrician who derived Cæsarean section from *cælo cædere*, reminds me of the surprise I felt when "tactous erudits" met my eye in (I think) the advertisement pages of a small medical periodical from across the Atlantic.

"HISTORY OF SCARLET FEVER."

DR. GORONWY JONES (Swansea) writes: In this article (November 24th, p. 926) I should like to point out one little error—that is, the date of the quotation from *Pepys' Diary*. In my copy of the *Journal* it is difficult to say whether it is 1654 or 1664. However, the correct date is November 10th, 1663.

AN ENGAGEMENT CALENDAR.

The Diary of Appointments for 1929, published by the Dental Manufacturing Company, Ltd. (1, Newman Street, W.1) is conveniently arranged and well produced. The pages are spaced for weekday engagements at quarter-hourly intervals from 9 a.m. to 9 p.m., and an address book is tucked into the end cover. Many medical practitioners, especially consultants, should find it just as useful as the dental surgeons for whom it is primarily intended. It can be had in various coloured bindings, and interleaved with blotting or ruled paper, at the price of 6s. 6d. or 8s., postage 6d. extra.

DISCLAIMER.

DR. STELLA CHURCHILL writes disclaiming responsibility for the use of her name in connexion with an advertisement of a brand of india-rubber hot-water bottle.

VACANCIES.

NOTIFICATIONS of offices vacant in universities, medical colleges, and of vacant resident and other appointments at hospitals, will be found at pages 74, 75, 76, 77, 80, and 81 of our advertisement columns, and advertisements as to partnerships, assistantships, and locumtenencies at pages 78 and 79.

A short summary of vacant posts notified in the advertisement columns appears in the *Supplement* at page 243.

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EPITOME OF CURRENT MEDICAL LITERATURE.

Medicine.

423. Hyperacidity and Burning Tongue.

J. SELLEI (*Deut. med. Woch.*, October 19th, 1928, p. 1758) distinguishes cases with burning and smarting of the tongue without visible lesions from cases of lingual neuralgia and the glossodynia which frequently occurs in functional nervous disorders (neurasthenia, hysteria and cancerphobia. This burning sensation is a combination of itching and stimulation of the heat nerve-endings, and resembles the sensation occurring in the extremities in Raynaud's disease. As this symptom often accompanies Hunterian glossitis, which is frequently the first sign of pernicious anaemia, Sellei considers that all these patients should have their blood and gastric secretion carefully examined in order to exclude this disease of the blood. In a number of cases of burning tongue which he investigated he found that the sense of taste was unaffected and that the saliva was chemically normal; there was also no evidence that the disturbance was due to sharp teeth or chemical alterations in the material used for dental fillings. It was, however, found that, in addition to the few cases in which achylia was demonstrated and the blood picture gave evidence of pernicious anaemia, a number of patients had other disturbances of gastric and intestinal secretion, and that in particular a moderate degree of hyperacidity of the gastric juice was common. In these cases washing the mouth out frequently with a weak solution of sodium bicarbonate, and the administration of sodium bicarbonate or a soda-magnesium mixture, with or without atropine, were usually effective, though it was sometimes necessary to continue treatment for two or three months.

424. Grave Anaemia in Chronic Nephritis.

L. RIVET and T. LAENNEC (*Rev. Méd. Française*, October, 1928, p. 553) call attention to the obscure pathology in that class of case of chronic nephritis characterized by excess of nitrogen in the blood. The anaemia is not always caused by dilution, for in some cases the blood concentration is normal. Urea is itself probably not responsible for the condition, which is attributed to the incomplete metabolism of some nitrogenous substances possessing high toxicity. The anaemia can either appear spontaneously or be provoked by unsuitable treatment, such as too strict a regime, and repeated bleedings. Gilbert and Tzanc advised the reinjection of the patient's own washed blood to prevent the anaemia arising in this class of case. Treatment consists in trying to raise the number of red cells without increasing the blood urea—a difficult dietetic problem. Repeated blood transfusions have given good results. The authors describe three cases of anaemia in nephritis showing red cell counts of 2,700,000, 1,580,000, and 1,600,000 per c.mm. respectively. The first two patients died with uraemia, but in the third case the count rose to 2,800,000 after three transfusions, and the patient felt so much stronger that she refused further treatment, left hospital, and tried to resume her work after a rest in the country. She had, however, a serious relapse after two months, and died at home after a further few weeks. The authors add that these observations, made before the methods of Whipple were commonly known, show that in some cases it is possible to produce by careful diet and appropriate treatment a marked and fairly lasting improvement.

425. Suboccipital Puncture.

E. DIAZ Y GÓMEZ (*La Med. Ibera*, September 22nd, 1928, p. 249) records thirteen cases, in patients aged from 7 to 49 years, on whom he had performed suboccipital puncture. The quantity of fluid removed was 20 c.cm. in three cases, 15 c.cm. in one case, 10 c.cm. in eight cases, and 5 c.cm. in one case. In each case the operation proved easier than lumbar puncture, and was not followed by any appreciable discomfort apart from slight headache. The technique is relatively simple. The patient sits up or is placed in the left lateral decubitus with the neck strongly flexed, and the head supported by an assistant. A lumbar puncture needle is inserted at the level of the third or fourth cervical vertebra and passed obliquely forwards and upwards until the needle strikes the hard surface of the occipital bone. It is then slightly withdrawn and the movement repeated until the sensation is obtained of a membrane being pierced, an indication that the cisterna has been reached. On each advance of the needle it is advisable to aspirate, since sometimes the liquid does not escape spontaneously.

426. Hair-plucking in Typhoid Fever.

J. D. ROLLESTON (*Clin. Journ.*, May 30th, 1928, p. 260) records a case of trichotillomania, which was first described by Hallopeau in 1889, but has not hitherto been recorded in connexion with typhoid fever. The patient was a mentally backward and undersized boy, aged 10, who at the end of the second week of a moderate attack of typhoid fever developed the habit of pulling out the hairs from his scalp. The habit continued for about a month, during a fortnight of which the temperature was normal, and could only be prevented by putting both arms in splints. There was no local source of irritation in the scalp, and no ringworm fungus could be discovered. When the boy was shown at the Royal Society of Medicine about two months had elapsed since he had pulled out any hair from his scalp, but he had recently been seen to pull out some of his eyelashes. The scalp in the left fronto-parietal region showed an area of alopecia resembling that caused by x-ray treatment of ringworm, and the eyelashes of the left upper lid were less numerous than those of the other lids, and some were broken. Hallopeau's cases occurred in adults, but several have since been described in children, not so much in Anglo-Saxon countries as in French, German, and Italian races. In some cases trichotillomania is associated with other tics, such as nail-biting or plucking at the penis, or with sexual perversion.

427. Rhino-vaccination against Diphtheria.

G. SALVIOLI (*La Pediatria*, July 1st, 1928, p. 687) reports his experience in protective vaccination against diphtheria by the nasal route. He injects a few drops of anatoxin into the nostrils alternately, starting with one drop at night and another drop next morning. When the children were subsequently examined by the Schick test it was found that 90.4 per cent. were immune. Preliminary experiments showed that the rhino-pharyngeal mucosa was perweable to diphtheria antitoxin. No general or local reaction was noted after instillation.

Surgery.

428. A Conservative Operation for Bunions.

E. D. MCBRIDE (*Journ. of Bone and Joint Surg.*, October, 1928, p. 735) describes an operation for the relief of hallux valgus by which the deformity is corrected without resection of the joint or fracture of the metatarsal. The normal architecture of the toes is also approached and the mechanical force which caused the deformity is corrected. Additional advantages are that the scar is protected from irritation and the time of disability is reduced. An incision, two inches in length, is made along the external border of the extensor hallucis longus with its centre over the joint. A downward dissection close to the metatarsal head is then made; the conjoined tendon of the adductor hallucis group is exposed and severed from its insertion. The internal sesamoid, which is embedded in the outer head of the flexor hallucis brevis, is carefully dissected out if necessary, small bone-holding forceps being of great use to hold the sesamoid; or a heavy tonsil tenaculum may be helpful. The conjoined tendon of the adductor muscles and the external head of the flexor hallucis brevis are transplanted into the dorsum of the head of the first metatarsal bone. The incision is then retracted medially and a subcutaneous dissection made to expose the bursa and bone prominence on the inner side of the metatarsal head, the vein being avoided. The bursa is dissected out, the bone prominence chiselled away, the toe corrected, and the capsule repaired. The toe is manipulated into a little over-correction and a light plaster slipper is applied, which, with the stitches, is removed in seven to ten days; the toe is held in place by adhesive plaster for from four to six weeks. Weight-bearing is allowed at the end of two weeks.

429. Cancer of Lower Lip.

F. R. FAIRCHILD (*Arch. of Surg.*, October, 1928, p. 630) suggests a composite technique for plastic repair for cancer of the lower lip. Made up of various steps in other operations, the advantages claimed are that: (1) contractures lessening the size of the mouth are avoided; (2) the most radical extirpation of tumour and glands can be performed; (3) the operation can be completed in one stage; (4) the tendency for the lower lip to tighten against the teeth is avoided; and (5) the sulcus in front of the lower incisors is of normal depth.

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The steps of the operation are as follows. A vertical incision through the entire thickness of the lip is made on each side of the growth, and the lower extremities of these are connected by a transverse incision at the level of the point of the chin. From the lower outer angles of the space so formed bilateral incisions are carried through the skin and fat downwards and slightly outwards for about three inches. When the flap so formed is dissected free it becomes possible to draw it up, without tension, sufficiently to fill in the deficiency caused by the excision of the lower lip, and a complete lymphatic dissection can be made. The mucous lining for the intraoral portion of this flap is formed by two horizontal incisions through the buccal mucosa, to form on dissection two flaps of mucous membrane, which can be drawn to the median line and sutured without tension, their lower borders being sutured to the cut edge of the mucous membrane at the margin of the gum. The skin and fat flap having been secured in place by dermal sutures placed obliquely to distribute any tension, the upper border of the united mucous membrane flaps is reflected over its upper margin and sutured to the skin with interrupted chromic catgut to form the vermilion line of the lip. Fairchild claims that this procedure more closely fulfils the requirements of a one-stage operation for removal of the growth and gland-bearing fat, and for the restoration of the lip, than does any other method.

430. Amniotic Fluid as a Preventive of Adhesions.

FOLLOWING previous experimental work on animals, H. L. JOHNSON (*New England Journ. Med.*, October 4th, 1928, p. 561) refers to his previous investigation into the use of amniotic fluid as a preventive of adhesions (see *Epitome*, January 14th, para. 41) and reports further progress. A concentrate of amniotic fluid has been prepared for clinical use; this is essentially a fractionated alcoholic precipitate containing the active principle of the whole fluid, and is obtained from the fluid of cows three to five months pregnant. As the residual proteins are discarded the use of the concentrate eliminates the fear of infection and foreign protein reaction. When employing it, the fluid is first raised to a temperature slightly above that of the body by means of a water-bath. The desired quantity is then poured into the field of operation just before closing the peritoneum, the viscera being retracted to allow the fluid to sink deeply into the cavity. Contact of the fluid with the edges of the wound is said to have no adverse effect on healing. Human amniotic fluid is as effective as that of cows. Tables are given showing the benefits resulting from the use of the fluid in 65 Caesarean sections and 30 laparotomies. The mode of action of amniotic fluid on serous surfaces is not entirely apparent, but it seemingly hastens coagulation and also acts as a lubricant. It is not an irritating or dehydrating agent. The fluid may be applied to all serous surfaces, but it should be reserved for use in clean cases. Its effectiveness is conservatively estimated to be 70 per cent. Its effect on post-operative convalescence is an apparent shortening of the usual period of distress.

431. Treatment of Plantar Perforating Disease.

THOUGH many authorities, including Leriche, are doubtful as to the efficacy of periarterial sympathectomy in plantar perforating disease, A. CONTARGYRIS (*Lyon Chir.*, September–October, 1928, p. 543) is inclined to advocate it. Several authorities of a similar opinion are cited, and a case is reported of trophoneurotic ulcers on each foot; one foot healed after sympathectomy; the other, which was not operated on, did not do so. In addition, five cases are reported in which definite cures were obtained by this method. In four of these there was a traumatic lesion of the sciatic nerve with a negative Wassermann reaction; the cause of the fifth was not determined, and a Wassermann test was not performed. The author found that the condition recurred in three cases, and believes that cure often takes place only after such recurrence, though he cannot explain this phenomenon. In sympathectomy for this condition the site usually recommended for operation is the femoral artery in Scarpa's triangle. Contargyris in four of his cases operated on the retro-malleolar portion of the posterior tibial artery (to an extent of 6 to 8 cm.), and in the fifth on the popliteal artery, as there was denudation of the sciatic nerve at this point owing to injury by a bullet. He maintains that the results will be the same whatever artery is chosen, and that, in case of post-operative accidents, it is wise to operate on a vessel of less importance for the vitality of the limb. Sympathectomy produces effects in this disease in two ways: by creating a nutritive activity of the tissues by an increased circulation of the blood, which causes a post-operative vaso-dilatation; and by increasing the number of leucocytes, thus producing a local phagocytosis and sterilization of the wound. Asepsis and rest also play a part, and are valuable adjuncts to operation.

Therapeutics.

432. Colloid Silver in Septic Conditions.

E. MOOS (*Med. Klinik*, September 28th, 1928, p. 1507) reports good results following the rectal injection of strong colloidal silver solution in the treatment of septic conditions. He does not follow any routine; each patient received treatment appropriate to the specific condition, with modification if anaphylaxis or other complications occurred. The author finds that in staphylococcal infections the daily rectal injection of 150 c.cm. of a 5 per cent. collargol solution is followed by more favourable results than when ordinary medicinal treatment has been employed. A woman, aged 36, with post-anginal staphylococcal sepsis had rigors, articular pains with arthritis of the right knee, endocarditis, and definite enlargement of the spleen. Salicylates and intravenous injection of colloid silver were given without benefit. When daily rectal injections of 5 per cent. colloid silver solution were substituted the arthritis disappeared, the temperature fell to normal, and a thrombo-phlebitis of the right brachial vein cleared up. A man, aged 46, was admitted with severe sepsis of unknown origin. He was jaundiced and had severe endocarditis and cardiac dilatation, with arrhythmia and pleurisy; there was enlargement of the liver and spleen, nephritis, and staphylococcaemia. All these conditions disappeared after daily rectal injections of 30 c.cm. of 5 per cent. colloid silver solution. A woman, aged 20, had bilateral pleurisy following puerperal sepsis. Staphylococci and streptococci were present in the blood, though the pleuritic exudate was sterile. Hyaline casts and blood were found in the urine. The patient made a good recovery after daily rectal injections of 25 c.cm. of the silver solution. Moos has cured ten other patients with staphylococcal sepsis by this treatment, and only one complained of severe burning pain in the rectum after the injections. The sole disadvantage of the treatment is said to be that patients who are seriously ill may not retain the injections. Since 1911, of 54 septic patients, 28 have died; 4 were discharged only slightly better or unimproved; while 50 per cent. of the patients recovered. Among the 32 recoveries, 4 patients had received collargol intravenously, and 12 had rectal injections of the silver solution. The remaining patients were treated with various other drugs, none of which appeared to yield such good results.

433. Chemotherapy of Pulmonary Tuberculosis.

G. COLLINA (*Riv. di patol. e clin. della tubercolosi*, August 31st, 1928, p. 681) remarks that the chemotherapy of pulmonary tuberculosis is still in an experimental stage, although numerous cures and encouraging results have been reported from the use of various preparations. None of these, however, has an invariably curative effect in pulmonary tuberculosis, even in cases of which the prognosis is generally favourable. The chemotherapeutic preparations which have no toxic action, and are not contraindicated in any circumstances, are the cinnamon derivatives, lipoid substances, and morrhuates. Next in order of efficacy are the copper preparations such as cuproiodase and cuprolycocoll, and the gold preparations tryphal and neocrisol. Two other gold compounds, krysolgan and sanocrysin, are liable to cause severe reactions, and are contraindicated in renal affections. Generally speaking, chemotherapeutic preparations are indicated in mild exudative forms of pulmonary tuberculosis in young patients who have no other visceral lesions or organic taint.

434. Dextrose Solution as a Styptic.

L. SCHÖNBAUER (*Zentralbl. f. Chir.*, September 22nd, 1928, p. 2378) recommends the employment of a 50 per cent. sterile solution of dextrose in distilled water as a styptic; he obtained good results in animal experiments. In liver resection the parenchymatous haemorrhage was arrested two minutes after applying a swab saturated in the warm solution of dextrose, but larger bleeding vessels required ligature. Healing was uneventful. Subsequently Schönbauer used a similar sterile solution in human patients during operations on the brain and spinal cord. Parenchymatous cerebral bleeding was arrested in two or three minutes after application of a 50 per cent. sterile dextrose solution when the use of swabs saturated in a hot solution of sodium chloride had failed. Schönbauer suggests that the styptic effect is due to the direct action of the dextrose solution on exposed muscle fibres, which contain glycogen. A weaker solution of sugar (5 to 10 per cent.) has also a styptic action, but the stronger solution acts more rapidly and certainly. The author has also used this solution to arrest haemorrhage in diathermic resection of the choroid plexus of the lateral ventricle in an operation for internal hydrocephalus.

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435. **Therapeutic Action of Magnesium Sulphate.**

J. ALSTON (*Caledonian Med. Journ.*, October, 1928, p. 442) discusses the treatment of inflammation, suppuration, and cancer by magnesium sulphate. From an experience extending over nineteen years he contends that, when directly applied, the salt has the power of restoring to their normal condition tissues disorganized by bacterial toxins and other agents; when administered orally regeneration of epithelium and bone takes place. From its action on tissue cells Alston suggests that this salt may be of use in the treatment of cancer. The method of employing it consists in the continuous application to the lesion of warm compresses, changed every three or four hours, soaked in a 10 or 40 per cent. solution which has been rendered sterile by boiling, the weaker solution being used where there is a limited blood supply; or the affected part of the body may be placed in a bath of the solution. The treatment seems to be equally effective when applied to the unbroken skin, and its value in tonsillitis is seen after the application of compresses to the neck and holding the solution in the mouth. Cures in cases of septic wounds, boils, carbuncles, dacryocystitis, erysipelas, dermatitis, arthritis with effusion, and phlebitis are reported; and notes of six cases of cancer are given in which improvement occurred. Alston refers to the work of Reding and Dustin, who claim good results from intramuscular injections of the drug, notably in the regression of bony and cutaneous metastases in mammary cancer; he contends that its beneficial action is upon the tissue cells rather than upon the bacterial toxin, since it restores something of which they have been deprived, to the detriment of their normal metabolism.

436. **Besredka's Antivirus.**

IT has been claimed that Besredka's antivirus, which is a filtrate of old bouillon cultures, assists the tissues in their defence against infective agents. According to K. CARSKY (*Bratislavske Lekarske Listy*, October, 1928, p. 555) its administration is advisable in infective processes where it can be brought into contact with the living cells, but not in processes with extensive necrosis and gangrene. The best results are said to have been obtained in suppurative affections of the skin, such as follicu itis, pyodermia, paronychia, suppurative axillary hydroadenitis, and also in cases of extensive injury with dirty wounds, as well as in operations on infected regions. The author favours the view that the antivirus has local and specific immunizing properties.

Disease in Childhood.

437. **Familial Pylorospasm.**

A. BRATUSCH-MARRAIN (*Arch. f. Kinderheilk.*, September 28th, p. 93), who records an illustrative case, states that pylorospasm has a certain tendency to attack several members of one family. Cases have been reported in which one of the parents had suffered from the disease in infancy, and one or more of the children have been similarly affected. It is, however, very unusual for three children in the same family to be attacked, previous examples of the kind having been recorded only by Heubner and Finkelstein respectively. Bratusch-Marrain now reports cases of pylorospasm in three children whose parents were healthy, though their mother was very nervous. The symptoms of pylorospasm developed in each child within the first few weeks of life; two of the cases ended fatally, but one patient recovered under treatment by injections of atropine and frequent small feeds. The author emphasizes the importance of being on the look out for more cases of pylorospasm in families in which there has already been one instance. Conservative treatment in such cases is the more likely to be successful the sooner it is started.

438. **Uveo-parotid Fever.**

L. P. HAMBURGER and A. J. SCHAFFER (*Amer. Journ. Dis. Child.*, September, 1928, p. 434) record notes of a case of uveo-parotid fever, which they regard as a manifestation of Mikulicz's syndrome, in which iridocyclitis is an outstanding symptom. The three essential features of the symptom-complex, described by Heerfordt as febris uveo-parotidea subchronica, are enlargement of the parotid glands, running a chronic course for several months, in contrast with the acuteness of epidemic parotitis; an ocular inflammation involving the uveal tract; and a coincident long-continued fever of low degree. In many cases no definite etiological agent can be demonstrated, though syphilis or tuberculosis may be a factor in their causation. The authors' patient, a boy aged 12, was admitted to hospital for "sore, red eyes, fever, and enlarged glands." He had had mumps two years previously. Three months before admission he complained of headache and was in bed for a week with fever, after which he returned to school, but a daily afternoon rise from 100° to 101° F. persisted. Two months later the left eye became "red" and the pupil irregular; this was followed in about a fortnight by involvement of the right eye and a gradually increasing swelling of the parotids, which eventually impeded mastication. The conjunctivae of both eyes were injected and there were some deposits on the posterior corneal membrane. Diagnostic tuberculin and Wassermann tests were negative. The condition remained unchanged for a month, until applications of radium were made to the parotid glands, when they rapidly diminished in size; the improvement obtained by three applications continued subsequently. The authors point out that, while antisyphilitic or tuberculin treatment should be given, when there is reason to suspect these conditions as possible causes, expert radiotherapy affords the best means of cure and prevents the destructive sequels in the eyes.

439. **Pneumonia in Infancy and Childhood.**

OLIVER SWIFT (*Arch. Dis. in Child.*, August, 1928, p. 194) comments on the diversity of opinion as to the relative frequency of lobar and lobular pneumonia in infancy and childhood, and remarks that the only sound criteria are those based on the *post-mortem* examination and a study of the histopathology. She concludes that broncho-pneumonia is the typical lesion of infancy and early childhood, and is the invariable type in the secondary and accessory forms; lobar pneumonia is thought to be exceptional in the first three years of life. In a study of the pathology of 65 cases of pneumonia only one typical instance of lobar pneumonia was found, and this was in a child of 5 years. Of 35 cases of acute primary pneumonia, all showed either typical lobular lesions, or lobular lesions with a lobar distribution and pathology. In the influenzal cases consolidation was always lobular in nature. Pure pneumococcal infections occurred in both lobar and primary broncho-pneumonia, but other organisms were also found.

Obstetrics and Gynaecology.

440. **Caecal Volvulus in Pregnancy.**

ACCORDING to G. RADAELI (*Ann. di Ostet. e Ginecol.*, September 30th, 1928, p. 1085) intestinal obstruction occurs in only one out of forty or fifty thousand pregnancies. To the seventeen cases already reported in which the caecum participated in a volvulus, the author adds another. A primipara, aged 45, in the ninth month of an otherwise normal pregnancy, was seized with sudden and violent abdominal pain, which was followed by vomiting; she died twelve hours later, shortly after Caesarean section. The necropsy showed intense congestion of the portions of the alimentary canal supplied by the superior mesenteric artery, and a volvulus of the caecum, ascending colon, and small intestine. As a predisposing cause a common ileo-colic mesentery was found to be present. Volvulus of the caecum has been reported to be associated in about one-fifth of cases with pregnancy from the fifth to the ninth month. Intestinal obstruction from caecal volvulus in pregnancy has proved lethal in the majority of cases—in three cases as early as the seventh to the twelfth hour after the first appearance of symptoms. It is most common in first and second pregnancies, and towards term; the patients are in general older than those suffering from volvulus of the sigmoid.

441. **Hydramnios with Uniovular Twins.**

M. MUTEL and H. VERMELIN (*Gynécol. et Obstét.*, September, 1928, p. 217) report that in a series of 100 uniovular twins 43 were normal, 43 were associated with hydramnios due to deep anastomoses between the two parts of the placenta, and in 14 the hydramnios was attributed to superficial anastomosis, or to causes which might be encountered in simple or twin pregnancy. The investigation of the anastomosis was carried out by the injection of a gelatinous solution containing metallic salts (opaque to x rays) in suspension, with different colouring matters added. X-ray photographs of the injected placentas were then taken. The results confirmed those previously obtained by Schatz, who considered that unequal development of twins was due to an unequal circulation caused by deep anastomosis, the extreme result of this condition being the oedematous foetus in a hydramniotic pouch. In the cases in which hydramnios was due to pathological conditions peculiar to uniovular twins, the authors invariably found that the deep placental anastomoses constituted a circulation of transfusion—a

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part of the blood of one foetus (transfuseur) passed into the circulation of the other (transfusé). Neither the difference in the size of the two foetuses, nor the difference in the superficial area of the placental territories, indicated which was "transfuseur" and which "transfusé." Moreover, the presence of hydramnios was not a characteristic peculiar to either; examination of the vessels was the only way to make this distinction. For example, the foetus A was the active "transfuseur" when it sent an artery into the territory of the "transfusé," B; and, whether A was equal to, less, or greater than B, it was always found that B had hydramnios. Alternatively, the foetus A was passive "transfuseur" when B sent a vein into the territory of A; but, whether A was equal to, less, or greater than B, it was always found that B had hydramnios.

442. Radiological Diagnosis in Obstetrics.

M. FAVREAU (*Journ. de Méd. de Bordeaux et du Sud-Ouest*, October 10th, 1928, p. 727) commends skiagraphy of the foetus as a valuable diagnostic method auxiliary to clinical examination. The results are considered unreliable before the fifth month of pregnancy, although the author claims to have been successful in taking a skiagram which showed a faint outline of the foetal vertebral column before the fourth month of pregnancy. The result may be uncertain when the actual age of the foetus is less than the estimated age, or when the foetus is dead and macerated. The differential diagnosis of pregnancy and of uterine or ovarian tumour is considerably facilitated, but the recognition of an extra-uterine pregnancy is more difficult. Foetal deformities, especially hydrocephalus and anencephaly, may be diagnosed prior to confinement, and also twin pregnancy, although in that case a very minute examination of the skiagrams is required to avoid error. Foetal death may be recognized by the overlapping of the cranial bones, accompanied by collapse of the cerebral contents. The presentation and changes in position will be recognized easily. The plates must be examined carefully with the negative screen. The author uses short exposures—namely, two seconds for an antero-posterior skiagram, and three seconds for a transverse exposure. He recommends a Potter-Bucky anti-diffusion screen in order to obtain sharp shadows. The technique must be precise if good results are to be obtained. Favreau adds that x-rays are absolutely harmless when the exposures are so short; they cannot injure either mother or foetus.

Pathology.

443. Sero-haemo-flocculation Test for Tuberculosis.

A. PRUNELL (*C. R. Soc. de Biologie*, October 19th, 1928, p. 1110) describes a new serological test for the diagnosis of tuberculosis which is similar to the ordinary complement fixation test, but, instead of using a specific red-cell haemolysin, a 1 in 500 solution of acetic acid in physiological saline solution is employed. In the first part of the test a mixture is made of the patient's serum, the tuberculous antigen (a modified Boquet and Nègre antigen), and the adjuvant disperser, which is merely a 1 per cent. solution of normal human serum, added to prevent the anti-haemolytic effect of certain serums. After fifteen minutes in the water-bath at 30° C. varying quantities of the acetic acid dilution are added, together with the washed red cells. After a further period of incubation, readings are made to determine that quantity of acetic acid solution which will cause haemolysis in five to ten minutes. In the second part of the reaction one tube is put up containing the serum to be examined, the normal serum, and the antigen; another tube contains the same mixture, except that the antigen is replaced by saline. After preliminary incubation, the acetic acid and red cells are added, and the tubes are again incubated. If the serum contains tuberculous antibodies there is no haemolysis in the first tube; the second tube, which contains no antigen, acts as a control and should always show haemolysis. The author has examined the serum from 50 patients whose sputum contained tubercle bacilli; in 35 a strong reaction was obtained, in 9 a weak one; altogether a positive reaction was therefore observed in 88 per cent. of cases.

444. Extraction of Toxic Substances from Bacteria.

N. FUJIOKA (*Zeit. f. Immunitäts*, September 1st, 1928, p. 456) has continued Eisler's work on the extraction of toxins from different bacteria by the use of salt solutions. He first worked with the haemotoxin of the *Vibrio kadiköj*, using rabbit blood cells for its titration. In 8- and 16-hour broth cultures of this organism there is no trace of toxin; in 24 hour cultures a small amount can be detected, while in 48-hour cultures large quantities are present. The author found, however, that considerable quantities of toxin could be extracted if the centrifuged cells from young cultures were treated with sodium or potassium chloride, or sodium or potassium iodide. Treatment with the divalent metallic salts, such as the chlorides of calcium, barium, and magnesium, had no such effect. It appeared from this experiment that the sodium and potassium salts increased the permeability of the cell wall and allowed the toxin to diffuse out. The calcium, barium, and magnesium salts have the opposite effect; they decrease the permeability of the cell wall and prevent the diffusion of toxin. That this is true was shown by a second experiment. The bacilli from a young broth culture were treated with the different salt solutions and with broth; they were then centrifuged down and treated with potassium chloride solution. It was found that the bacilli treated with broth yielded up a large amount of toxin when extracted with the potassium chloride; the bacilli treated with sodium and potassium salts yielded a small quantity, while those treated with barium, calcium, or magnesium salts yielded scarcely any or none. Working with the diphtheria bacillus, he found again that toxin could be extracted from very young cultures with the sodium and potassium chlorides, but not with the calcium, barium, or magnesium salts. Similar results were obtained likewise with the Shiga dysentery bacillus. From these experiments Fujioka concludes that bacteria do not *secrete* toxin at all; the toxin diffuses out in broth cultures only from dead bacilli. However, under the influence of sodium, and especially potassium, salts the permeability of the cell wall is so increased that the toxin can diffuse out from living cells.

445. The Mechanism of Pulmonary Silicosis.

P. HEFFERNAN and A. T. GREEN (*Journ. Indust. Hyg.*, October, 1928, p. 272) discuss the two explanations offered up to the present to account for the action of silica dust in the lungs, and show the inadequacy of these to explain silicotic fibrosis and silicotic tuberculosis. The oldest of these explanations is the "direct injury" theory, according to which silica dust, owing to the hardness, sharpness, and insolubility of its particles, produces minute wounds in the lung substance; the resulting little nodules of scar tissue constitute the typical silica fibrosis. The second explanation is the chemical theory of Gye, Purdy, and Kettle, according to whom silica is a cell poison, and brings about its results by its chemical action on the tissues and cells. The present authors suggest an alternative theory to explain the phenomena occurring in pulmonary silicosis. They show that silica is an ordinary constituent of animal and vegetable tissues, and is found in the urine; and they hold that the evidence is strongly against the theory that the silica ion is toxic to animals. Silica in stable combination and crystalline silica appear to be harmless while in those states. Colloidal silica is harmful to certain animal tissues when brought into surface contact with them; when administered intravenously in sufficiently large doses and in an active colloid condition it may cause immediate death. The harmful effects of colloidal silica appear to be due to its powerful potentialities as a colloid, rather than to any toxicity of the silica ion. The authors suggest that pulmonary silicosis is probably caused by the colloidal action of hydrated silicon, formed from minute particles of silica dust disseminated through the lungs. The activity of colloidal silica in the lungs can be prevented by protecting the silica dust with a coating of something, such as clay substance, carbon, or shale dust, which is known to coagulate colloidal silica. Evidence of this has been obtained in the lungs of silica-brick makers, noted by Smith and Collis in Yorkshire, and by Heffernan in Derbyshire. The authors believe that possibly other colloids, such as stannic acid sol, may be capable of acting in the tissues in a similar manner to hydrated silica, and they add that perhaps other phenomena bearing on immunity, susceptibility, and resistance to disease may be explained on the basis of colloidal physics.

446. The Testicular Hormone.

G. PERACCHIA (*Arch. di Chir.*, August, 1928, p. 636) admits that beneficial results have followed testicular transplantation, and has tried to determine experimentally which part of the organ is responsible for these effects. The test he has used to determine what change followed such transplantation was the estimation of basal metabolism as shown by the respiratory metabolism. As the result of experimental work on dogs he concludes that any changes due to the testicle depend on the seminiferous cells, and not on the interstitial tissue, as some authors have stated. His investigation convinced him that the interstitial cells, as tested by their effect on basal metabolism, were unimportant as far as the internal secretion of the testicle is concerned, and he believes that the cells of Leydig are only connective tissue elements.

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SUPPLEMENT
TO THE
BRITISH MEDICAL JOURNAL.

LONDON, SATURDAY, DECEMBER 1st, 1928.

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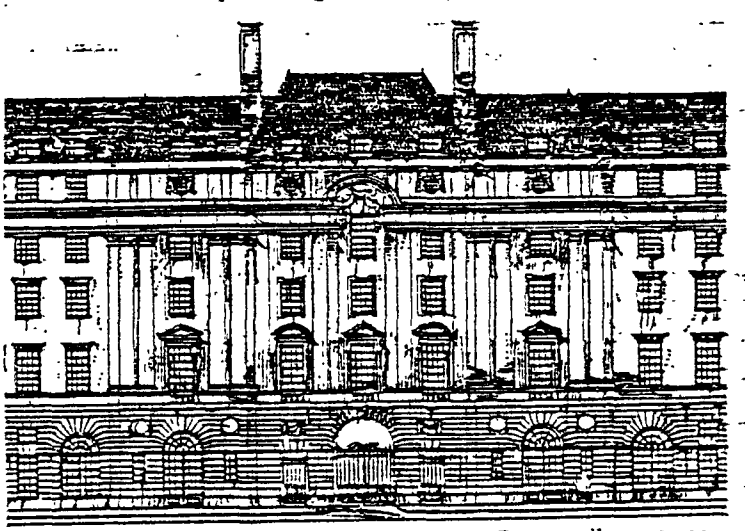
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British Medical Association.

CURRENT NOTES.

Growth of the Association.

The membership of the British Medical Association is now over 34,500, an increase of nearly a thousand in 1928, exclusive of a large number whose membership will begin on January 1st next. Figures as to the numbers of newly qualified practitioners joining the Association were before the Medical Students and Newly Qualified Practitioners Subcommittee at a recent meeting. These are of special interest, inasmuch as the ability of the Association to attract and retain within its membership each successive generation of practitioners is the most obvious measure of its vitality. The figures show that 50 per cent. of those who qualified during the year October, 1926, to September, 1927, had already by the latter date joined the Association, and from the record of previous years it seems likely that a very considerable proportion of the remaining 50 per cent. will soon join. From the Welsh National School of Medicine (Cardiff Division) 100 per cent. of those who qualified during the period had joined; from Durham University (Newcastle-upon-Tyne Division) 96 per cent.; from Glasgow University and the Colleges there (Glasgow and West of Scotland Branch) 93 per cent.; from Edinburgh University (Edinburgh and Leith Division) 59 per cent.; and from Birmingham University (Birmingham Central Division) and Queen's University, Belfast (Belfast Division) 57 per cent. each. Of the 2,429 practitioners who registered in 1923, only 863 were, at the end of September last, still outside the Association.



British Medical Association House Extension.—Proposed Elevation of Central Portion facing Tavistock Square.

Help to Individual Members.

The Association is in possession of a very large amount of information on all matters affecting medical practitioners in their professional lives. Thus it is often able to help its members individually in difficulties of a professional nature, and doing so constitutes a considerable part of its daily work. The Medical Department alone has some 5,000 files, dealing with all branches of medical activity. The Intelligence Department, besides assisting in the collecting and recording of information, has a supply of press-cuttings on matters concerning the profession, and this information, together with that arising in the course of correspondence and otherwise, is so far as possible filed in such a way as to be readily available for the assistance of members through the medium of the Medical and Editorial Departments. Inquiries by members, whether through the honorary secretaries of Divisions or Branches or otherwise, on any matter of doubt or difficulty affecting them in their professional capacity are welcomed. Such inquiries should be addressed to the Medical Secretary, British Medical Association House, Tavistock Square, W.C.1. Expert opinion on income tax questions affecting members of the profession is published in the *British Medical Journal*. The Solicitors of the Association are consulted when legal matters arise which affect the general interests of the profession.

The Association's "Handbook for Recently Qualified Medical Practitioners."

This *Handbook*, the first edition of which was published in 1923, has been in such demand that a second edition became necessary. The new edition, considerably enlarged and revised throughout, contains authoritative information,

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such as is not available in any other single publication, about a large number of matters affecting medical practitioners. The volume should be found of assistance by all members of the profession, although it is issued by the Association primarily to meet the needs of newly qualified members of the profession and give useful information and advice on matters known to be often the subject of doubt or difficulty to those who are planning their careers. The *Handbook* gives, *inter alia*, information as to main careers open to members of the profession; some practical aspects of medical work (including especially some legal and ethical aspects); registration and privileges of practitioners; national health insurance; post-graduation study and special diplomas; specialization; dangerous drugs regulations; fellowships, scholarships, studentships, prizes, and research grants; individual medical defence; the work of the Association; and the work of the Medical Insurance Agency. The price of the *Handbook* is 3s. 6d. (post free 3s. 9d.). Copies can be had on application to the Financial Secretary and Business Manager, British Medical Association House, 19, Tavistock Square, London, W.C.1.

Annual Meeting, Manchester, 1929.

The ninety-seventh Annual Meeting of the British Medical Association will be held in the latter part of July, 1929, in Manchester, under the presidency of Mr. Arthur Burgess, F.R.C.S., Professor of Clinical Surgery in the Victoria University of Manchester. The clinical and scientific work of the meeting will be divided among nineteen Sections, meeting on Wednesday, Thursday, and Friday, July 24th, 25th, and 26th, and we publish below the names of the Sections and their Presidents. The first six Sections will meet each on three days; the next ten on two days; and the last three on one day. The full list of officers of Sections and further information about the meeting generally will appear in later issues.

Presidents of Sections.

Medicine.—Professor GEORGE R. MURRAY, M.D., F.R.C.P.
Surgery.—Professor E. D. TELFORD, F.R.C.S.
Obstetrics and Gynaecology.—Professor W. FLETCHER SHAW, M.D.
Diseases of Children.—CHARLES PAGET LAPAGE, M.D., F.R.C.P.
Neurology and Psychological Medicine.—Professor JUDSON S. BURY, M.D., F.R.C.P.
Physiology and Biochemistry.—Professor HENRY STANLEY RAPER, C.B.E., D.Sc., M.B., Ch.B.

Pathology and Bacteriology.—Professor JOHN SHAW DUNN, M.D.
Oto-rhino-laryngology.—F. H. WESTMACOTT, C.B.E., F.R.C.S.
Ophthalmology.—JOHN GRAY CLEGG, M.D., F.R.C.S.
Anaesthetics.—EDWARD MOIR, L.S.A.
Dermatology.—GEORGE HERBERT LANCASHIRE, M.D.
Radiology and Radio-Therapeutics.—W. J. S. BYTHELL, O.B.E., M.D.
Venereal Diseases.—WILLIAM COATES, C.B., C.B.E., F.R.C.S.
Orthopaedics.—Sir ROBERT JONES, Bt., K.B.E., C.B., F.R.C.S., Ch.M.
Tuberculosis.—D. P. SUTHERLAND, M.B., B.S.
Public Health.—R. VEITCH CLARK, M.B., D.P.H.

Occupational Diseases.—W. P. DEARDEN, M.R.C.S., L.R.C.P., D.P.H.
History of Medicine.—E. M. BROCKBANK, M.B.E., M.D., F.R.C.P.
Medical Sociology.—E. KATE LE FLEMING, M.B., B.Ch.

Life Insurance without Medical Examination.

Members of the Association not infrequently write saying that they have been asked to give information about the previous health of patients who have been accepted for life insurance without medical examination, and who have died shortly afterwards. The advice given by the Association to members in reply is invariably that the doctor should not give any information without the written consent of the relatives of the deceased. It can hardly be doubted that the object of an insurance company in making such an inquiry is the chance of getting such information regarding the previous health of the deceased as may enable it to dispute the claim, and thereby evade a financial liability which it has incurred, without having previously taken the usual steps to protect itself against undue risk. Whether a fee is offered is beside the point; the fact remains that the insurance company would seem to be looking to the doctor to pull the chestnuts out of the fire. The practice which should be adopted by doctors in cases of this kind is to refuse information to the insurance company and to suggest to the relatives of the deceased that they should tell the insurance company quite plainly that if the claim is not settled promptly they will sue in the courts. This advice has been given by the Association to a number of correspondents, and it may be useful to make it more widely known.

Social Life and the Association.

It is of interest to note that a large and rapidly increasing number of the Divisions and Branches of the Association now make their meetings as sociable as possible—for example, by the members taking tea together before the meetings. Many have, in addition, definite social functions—for example, teas, dinners, suppers, dances, garden parties, and sports fixtures. There are always many social events in connexion with the Annual Meetings of the Association. At the latter also there are played off the golf competitions for the Childe and Ulster Cups, and the competition for the Notts Ladies' Challenge Cup. At the Annual Meeting there is also played off the final round for the Treasurer's Cup, the first stage of which is played in the Divisions in the British Isles. In addition, there are frequently tennis and other sports fixtures in connexion with the Annual Meetings.

The Association's "Annual Handbook, 1928-29."

The *Annual Handbook* of the Association for 1928-29 is now available. Copies can be had by members, gratis and post free, on application to the Medical Secretary, British Medical Association House, 19, Tavistock Square, London, W.C.1. Primarily intended as a work of reference for honorary secretaries of Divisions and Branches and other workers of the Association, the *Handbook* should prove of interest and assistance to all members. The new edition is completely revised. It contains the decisions of the Representative Body of the Association on matters of policy; a sketch of the constitution and working of the Association, local and central; lists of the members of Council and central committees, and the officers and officials of the Association, local and central; a brief record of some of the work of the Association in the past year; and other information about the doings of the Association.

Medical Organization in Hertfordshire.

A meeting of the members of the Association resident in Hertfordshire is being held at the House of the Association, Tavistock Square, London, W.C., on Friday, December 7th, at 2.30 p.m., to consider the question of the organization of the Association in the county. As matters stand, Hertfordshire is assigned to Divisions of two different Branches—namely, to an East Hertfordshire Division of the Cambridge and Huntingdon Branch and a West Hertfordshire Division of the Metropolitan Counties Branch, but owing to their wide and scattered areas these Divisions have found it difficult to get good meetings. In consultation with the officers and late officers of the Divisions and Branches, it is proposed that the Hertfordshire members should consider whether a separate Branch for Hertfordshire should be formed, coterminous with the county, with a sufficient number of Divisions to make it easy for the members to attend the meetings thereof. It is a cardinal principle of the constitution of the Association that its local units should be so arranged that each member should be able, without undue loss of time, to attend a Division meeting.

Association Professionnelle Internationale des Médecins.

The A.P.I.M. announces that it has decided to put on sale its official organ, the *Revue Internationale de Médecine Professionnelle et Sociale*, which is in future to be published quarterly and is to contain all the documents and reports which the national correspondents of the A.P.I.M. furnish in reply to the questionaries which are issued. Those members of the profession who are interested in international medical organization and politics will find this publication invaluable if they are able to read French fairly easily. The numbers will appear in February, May, August, and November, and the annual subscription will be 4 Swiss francs. Subscriptions should be sent to Dr. Fernand Decourt, Secrétaire Général de l'A.P.I.M., 25, Rue Louis-le-Grand, Paris. The second number of the

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Review is expected very shortly, and will contain a complete report of the third general session of the A.P.I.M., which took place in Paris on September 27th to 30th. The February number will contain, *inter alia*, the results of the inquiry into the various national customs with regard to the illegal practice of medicine.

Association Notices.

BRANCH AND DIVISION MEETINGS TO BE HELD.

BIRMINGHAM BRANCH: COVENTRY DIVISION.—A meeting of the Coventry Division will be held at the Coventry and Warwickshire Hospital on Tuesday, December 4th, at 8.30 p.m. Dr. Wilson will read a paper on modern clinical tests of renal function.

BORDER COUNTIES BRANCH: ENGLISH DIVISION.—A meeting of the English Division will be held at Cockermouth on Friday, December 7th, when Dr. H. J. Moon (Ullswater) will give a lecture on local bird life.

DUNDEE BRANCH.—A meeting of the Dundee Branch will be held in the O.T.C. Hall, University College, Dundee, on Tuesday, February 5th, at 8.30 p.m., when Dr. George A. Allan (Glasgow) will give a lecture on rheumatism in children.

GLASGOW AND WEST OF SCOTLAND BRANCH: AYRSHIRE DIVISION.—A meeting of the Ayrshire Division will be held at the Ayr County Hospital on Wednesday, December 12th. Dr. Norman N. Dott of Edinburgh will deliver a lecture with lantern illustrations.

GLASGOW AND WEST OF SCOTLAND BRANCH: LANARKSHIRE DIVISION.—A meeting of the Lanarkshire Division will be held at St. Enoch Station Hotel on Wednesday, December 5th, at 3.30 p.m. Dr. J. Stanley White will give an address on how biological products are made, illustrated with cinematograph film.

LANCASHIRE AND CHESHIRE BRANCH: ROCHDALE DIVISION.—A meeting of the Rochdale Division will be held at the Rochdale Infirmary on Wednesday, December 5th, at 8.30 p.m. Dr. J. Logan Stewart, consulting tuberculosis officer, Lancashire County Council, will give a lecture on the place of radiography in diagnosis of diseases of the chest, which will be illustrated by his very fine collection of radiograms.

METROPOLITAN COUNTIES BRANCH: CAMBERWELL DIVISION.—A meeting of the Camberwell Division will be held at the Bermondsey and Rotherhithe Hospital on Tuesday, December 11th, at 9 p.m. Dr. J. Stanley White will read a paper on some recent aspects of biological therapy, with lantern slides and cinematograph films.

METROPOLITAN COUNTIES BRANCH: CITY DIVISION.—There will be a meeting of the City Division at the Metropolitan Hospital, Kingsland Road, E., on Tuesday, December 4th, at 9.30 p.m. Mr. F. N. Reynolds will read a paper on placenta praevia. The annual dinner of the Division will be held at the Trocadero Restaurant on Thursday, December 6th (tickets 12s. 6d. each). At the subsequent clinical meeting of the Division at the Metropolitan Hospital on Friday, December 14th, at 4.30 p.m., Mr. W. G. G. Ashdowne will demonstrate surgical cases.

METROPOLITAN COUNTIES BRANCH: HENDON DIVISION.—A special medico-political meeting of the Hendon Division will be held on Friday, December 14th, at 8.30 p.m., at Hendon Cottage Hospital, for the purpose of hearing an address by Dr. H. B. Brackenbury (Chairman of Council, British Medical Association) on encroachments on the sphere of private practice by the activities of local authorities, to be followed by a discussion (vide *Supplement*, November 3rd). Members are requested to bring the *Supplement* to the meeting.

METROPOLITAN COUNTIES BRANCH: LEWISHAM DIVISION.—The following programme of meetings has been arranged by the Lewisham Division:

Dec. 18th.	Mr. Philip Figdor: The diagnosis and treatment of chronic arthritis.
Jan. 15th.	Mr. Zachary Cope: The use and abuse of antiseptics.
Feb. 7th.	Clinical Meeting at South-Eastern Hospital for Children, Sydenham, S.E.26, at 4 p.m.
Feb. 19th.	Demonstration of Medical Cinematograph Films by Kodak Limited: (1) Intestinal peristalsis—Mayo Clinic. (2) Craniotomy—London Hospital. (3) Amputation of the breast for duct carcinoma—King's College Hospital. (4) Diagnosis and treatment of infections of the hand, and other films.
Mar. 19th.	Dr. Reginald C. B. Ledlie: The modern treatment of varicose veins and haemorrhoids.
April 9th.	Dr. P. Hamill: Cholecystitis.
April 16th.	Clinical Evening at St. John's Hospital, Lewisham, S.E.13, arranged by Dr. E. Offenheim.
May 21st.	Annual Meeting. Mr. E. Roberts: Colporrhaphy
June 18th.	Mr. J. E. R. McDonagh: The nature of disease.

Meetings will be held at 8.45 p.m. at the Town Hall, Catford, S.E.6, unless otherwise stated.

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, December 11th, at 9 p.m. Dr. Dan McKenzie will give a lecture on ear diseases in general practice.

METROPOLITAN COUNTIES BRANCH: SOUTH-WEST ESSEX DIVISION.—A special meeting of all doctors resident in the South-West Essex area will be held in the Wesleyan Schoolrooms, High Road, Leyton, on Tuesday, December 11th, at 3.30 p.m., to consider the interim report on the encroachments on the sphere of private practice by the activities of local authorities. Dr. Badenoch, chairman of the Division, will open the discussion.

MIDLAND BRANCH: CHESTERFIELD DIVISION.—A special general meeting of the Chesterfield Division will be held at the Maternity Hospital, Chesterfield, to-day (Friday, November 30th), at 8.30 p.m., to consider the interim report of the Private Practice Committee on encroachments on the sphere of private practice by the activities of local authorities (*Supplement*, November 3rd). It is hoped that there will be a thoroughly representative meeting and a full and candid discussion. Dr. Ash, county medical officer of health, will take part. All medical practitioners, whether members or non-members of the British Medical Association, are invited to be present. If time permits the following resolution from the Burton Division will also be considered:

> That the [Burton] Division is of the opinion that voluntary lectures to schools given by members at the request of the Derbyshire Insurance Committee during the annual health week are undesirable and should be discontinued.

MIDLAND BRANCH: HOLLAND DIVISION.—A meeting of the Holland Division will be held at the White Hart Hotel, Spalding, to-day (Friday, November 30th), at 3.30 p.m. Mr. R. St. Leger Brockman, assistant surgeon, Sheffield Royal Infirmary, will give an address on the early diagnosis of intestinal obstruction.

NORFOLK BRANCH: NORWICH DIVISION.—A general meeting of the Norwich Division will be held in the Medical Library on Wednesday, December 5th, at 8.45 p.m. Agenda: Report of Executive Committee *re* annual entertainment; consideration of report of the Private Practice Committee of the British Medical Association (*Supplement*, November 3rd).

NORTHERN COUNTIES OF SCOTLAND BRANCH.—The first clinical meeting of the Northern Counties of Scotland Branch for the winter will be held at the District Asylum, Inverness, on Wednesday, December 5th, at 3.30 p.m., when Dr. W. MacWilliam will give a demonstration of neurological cases. Two other clinical meetings have been arranged this winter, one at Dr. Gray's Hospital, Elgin, in February, and the other at the Northern Infirmary, Inverness, in March.

NORTHERN COUNTIES OF SCOTLAND BRANCH: BANFF, MORAY, AND NAIRN DIVISION.—A meeting of the Banff, Moray, and Nairn Division will be held at Dr. Gray's Hospital, Elgin, on Friday, December 7th, at 4.30 p.m. As matters of considerable importance will be discussed, it is particularly requested that all members will attend, and bring with them the *Supplement* of November 3rd. Agenda: Consideration of the report of the Private Practice Committee: reorganization of hospitals in Scotland (result of Conference at Edinburgh, November 17th); payments by education authorities (replies to letters of July 14th); clinical meeting in February.

NORTH OF ENGLAND BRANCH: BLYTH DIVISION.—A clinical meeting of the Blyth Division will be held in the Thomas Knight Memorial Hospital, Blyth, on December 5th. Mr. J. Gilmour, surgeon to the hospital, will give a lecture on internal derangements of the knee-joint.

NORTH OF ENGLAND BRANCH: GATESHEAD DIVISION.—A special meeting of the Gateshead Division will be held at 9, Walker Terrace, Gateshead, on December 11th, at 7.45–8 p.m., when Dr. Anderson, Deputy Medical Secretary, will be present to give an address. This event will be followed by a supper, to which all members and non-members are invited (inclusive cost 3s. 6d.). Members intending to be present at the supper are requested to notify the honorary secretary. A presentation will be made to Dr. Speirs.

NORTH OF ENGLAND BRANCH: TYNESIDE DIVISION.—A meeting of the Tyneside Division will be held at the Tynemouth Victoria Jubilee Infirmary on Tuesday, December 4th, at 8.30 p.m. Dr. J. Stanley White will read a paper on some recent aspects of biological therapy, with cinematograph and lantern illustrations.

OXFORD AND READING BRANCH: WINDSOR DIVISION.—A joint meeting of the teaching and medical professions and of others interested in education, called by the Windsor Division, will be held at the Town Hall, Windsor, on Friday, December 7th, at 5.15 p.m. A discussion on the mental hygiene of the school child will be opened by Dr. Letitia D. Fairfield, and the chair will be taken by Dr. J. J. Paterson, medical officer of health for Maidenhead. All doctors, whether members or not of the British Medical Association, and all teachers, school managers, and other educationists, are invited to attend.

SOUTHERN BRANCH.—The annual meeting of the Southern Branch will be held at the Queen's Hotel, Southsea, on Thursday, December 13th, at 3 p.m.; Major-General Sir S. Guise-Moores, K.C.B., C.M.G., will take the chair. Agenda: Correspondence; financial statement; election of officers, 1928–29.

SOUTHERN BRANCH: PORTSMOUTH DIVISION.—A meeting of the Portsmouth Division will be held at the Queen's Hotel, Southsea, on Thursday, December 13th, at 9.30 p.m., preceded by supper at 9 p.m. An address will be given by Sir Thomas Lewis on the recognition of cardiac failure. Members from other Divisions will be welcomed. Cost of supper 3s. 6d. (including gratuities).

SOUTHERN BRANCH: WINCHESTER DIVISION.—A meeting of the Winchester Division will be held at the Royal Hampshire County Hospital on Wednesday, December 5th, at 3 p.m., to discuss the question of encroachments by public health authorities on private practice.

SOUTH MIDLAND BRANCH: BEDFORDSHIRE DIVISION.—A general meeting of the Bedfordshire Division will be held at the County Hospital, Bedford, to-day (Friday, November 30th), at 3 p.m.

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Agenda: To consider (*a*) memorandum from the Maternal Mortality Committee of the Ministry of Health; (*b*) interim report on encroachments on the sphere of private practice by the activities of local authorities (*Supplement* of November 3rd); (*c*) clinical notes by Mr. S. J. Ross.

SOUTH WALES AND MONMOUTHSHIRE BRANCH: CARDIFF DIVISION.—A meeting of the Cardiff Division will be held in the Cardiff Royal Infirmary on Wednesday, December 19th, at 3.30 p.m. Dr. Eric Pritchard will give a British Medical Association Lecture on the relationship of early mistakes in infant feeding to the dyspepsias of later infancy and childhood. The lecture will be open to non-members. The annual dinner and dance of the Division will be held in Cox's Rooms, Queen Street, Cardiff, on Wednesday, January 16th, 1929.

SOUTH WALES AND MONMOUTHSHIRE BRANCH: SWANSEA DIVISION.—A meeting of the Swansea Division will be held on Thursday, December 13th. Dr. W. Langdon-Brown will deliver a British Medical Association Lecture on some modern methods of treatment in nephritis.

SOUTH-WESTERN BRANCH: PLYMOUTH DIVISION.—The clinical lecture arranged by the staff of the South Devon and East Cornwall Hospital on Thursday, December 6th, at 8.15 p.m., will be on blood transfusion.

SOUTH-WESTERN BRANCH: TORQUAY DIVISION.—The annual dinner and dance of the Torquay Division will be held in the Palace Hotel, Torquay, on Thursday, December 20th, at 7.45 p.m. Dancing and bridge from 9.30 p.m. to 2 a.m. Tickets, price 15s. for dinner and dance (excluding wines), and 10s. for dance only (including light refreshments), can be obtained from Dr. W. Cameron Davidson, Avonleigh, Acadia Road, Torquay. Any member of the profession in Torquay at that date will be made welcome by the committee.

STAFFORDSHIRE BRANCH: NORTH STAFFORDSHIRE DIVISION.—A meeting of the North Staffordshire Division will be held on Tuesday, December 4th, when an address will be given by Dr. G. C. Anderson, Deputy Medical Secretary, on the encroachments our private practice by public health authorities.

SUFFOLK BRANCH: SOUTH SUFFOLK DIVISION.—A meeting of the South Suffolk Division will be held in the board room of the East Suffolk and Ipswich Hospital to-day (Friday, November 30th), at 3.30 p.m. A lecture on the nature of disease will be given by Mr. J. E. R. McDonagh.

SUFFOLK BRANCH: WEST SUFFOLK DIVISION.—The lecture arranged at the West Suffolk General Hospital, Bury St. Edmunds, for Saturday, December 8th, at 8.45 p.m., is by Dr. Geoffrey Evans on constipation. Coffee served at 8.30 p.m.

SURREY BRANCH: CROYDON DIVISION.—A general meeting of the Croydon Division will be held at the Croydon General Hospital on Tuesday, December 4th, at 8.30 p.m. Agenda: Correspondence; to discuss report on encroachments on the sphere of private practice by the activities of local authorities (*Supplement*, November 3rd).

SURREY BRANCH: KINGSTON-ON-THAMES DIVISION.—A meeting of the Kingston-on-Thames Division will be held at the Surbiton Hospital on Tuesday, December 4th, when Dr. M. A. Cassidy will read a paper.

SURREY BRANCH: REIGATE DIVISION.—A meeting of the Reigate Division will be held at the East Surrey Hospital, Redhill, on Tuesday, December 11th, at 8.45 p.m. Dr. A. H. Douthwaite will read a paper on injection treatment of varicose veins.

SUSSEX BRANCH: HASTINGS DIVISION.—The following programme has been arranged by the Hastings Division:—

Dec.	4th.	At Royal East Sussex Hospital, Hastings, 8.15 p.m. Dr. R. A. Gregg (M.O.H., East Sussex): Preventive medicine and the medical practitioner. Discuss report on encroachments on the sphere of private practice by the activities of local authorities (*Supplement*, November 3rd).
Dec.	14th.	Annual Dance. Albany Hotel, Hastings, 7.45 p.m. to 12.15 a.m. Light refreshments. Tickets 7s. 6d.
Jan.	8th.	Clinical Evening and Discussion at Buchanan Hospital, 8.15 p.m. Subject: Treatment of varicose veins and varicose ulcers.
Feb.	5th.	At Royal East Sussex Hospital, Hastings, 8.15 p.m. Mr. J. E. R. McDonagh: The nature of disease.
Mar.	5th.	Clinical Evening at Buchanan Hospital, 8.15 p.m. Subject: Kidney disease and pyelography.
April	9th.	Clinical Evening at Royal East Sussex Hospital, Hastings, 8.15 p.m. Subject: Bronchitis and asthma.
April	—	Annual Dinner.
May	7th.	British Medical Association Lecture.
June	4th.	Clinical Evening at Royal East Sussex Hospital, Hastings, 8.15 p.m. Subject: Dyspepsia.
July	2nd.	Annual Meeting at Buchanan Hospital, 3 p.m.

WORCESTERSHIRE AND HEREFORDSHIRE BRANCH: WORCESTER DIVISION.—A meeting of the Worcester Division will be held at the Worcester General Infirmary on Thursday, December 13th, at 2.45 p.m., to discuss with Dr. Alfred Cox, the Medical Secretary, the centenary meeting of the Association. The meeting will be preceded at 1.15 p.m. by a lunch, at which Dr. Cox will be the guest of the Division.

YORKSHIRE BRANCH: DEWSBURY DIVISION.—A meeting of the Dewsbury Division will be held at Lidbetter's Café, Dewsbury, on Wednesday, December 5th, at 8.30 p.m. Mr. Harry Lee (Leeds) will give a lecture. The meeting will be preceded by a supper.

YORKSHIRE BRANCH: WAKEFIELD, PONTEFRACT, AND CASTLEFORD DIVISION.—A meeting of the Wakefield, Pontefract, and Castleford Division will be held at the Red Lion Hotel, Pontefract, on Thursday, December 6th, when Dr. W. MacAdam (Leeds) will give a lecture on acidosis and alkalosis. The meeting will be preceded by supper (3s.) at 7.45 p.m. A special meeting of the Division will be held at the Strafford Arms Hotel, Wakefield, on December 13th, at 3 p.m. Agenda: Alleged encroachments of public health authorities on private practice; report of representatives.

Meetings of Branches and Divisions

METROPOLITAN COUNTIES BRANCH.

MEMBERS of the Metropolitan Counties Branch Council on November 21st, paid a very instructive and agreeable visit to the Wellcome Bureau of Scientific Research in Endsleigh Gardens, on the invitation of Dr. S. H. DAUKES, who, in welcoming them, said he was grateful for the opportunity of demonstrating to the Branch a system of medical teaching which presented certain ideas.

Specialization in medicine, Dr. Daukes said, while [illegible] carried with it certain disadvantages; the first line of defence in the war against disease was the general practitioner, and any tendency which might cramp his outlook or limit his activities must constitute a danger. The Wellcome Museum of Medical Science was so arranged as to counteract this tendency. It was not a pathological museum nor a clinical museum nor a therapeutic museum nor a hygiene museum, but it aimed at blending these various branches of medicine so that they presented a complete picture. Each disease was divided up into the following sections: etiology, pathology, symptomatology, treatment, and prevention. A graphic picture was presented by means of photographs, paintings, specimens, and models, and, so far as possible, pathology was demonstrated from the clinical standpoint. Pathological museums generally adopted a pathological or anatomical arrangement—the lesions of each organ were grouped together, or similar pathological states placed side by side. Such an arrangement was strictly scientific and of great value for purposes of study and research. In practice, however, one was not concerned with an organ but with an individual, and, for example, in a case of mitral stenosis the condition of the stomach, liver, lungs, and intestines was of equal importance with that of the heart itself. An effort was therefore made to group together all the affected organs from a given case. The minute pathology was difficult to demonstrate in a museum, but illustrations might be used and were at hand. In the Wellcome Museum colour photomicrography had been used with good effect, and the picture presented was a very accurate one of what was seen with the microscope. There were shown by this method the eggs of helminths, pathogenic protozoa, bacteria, blood films, and sections illustrating the morbid anatomy of various diseases. The general arrangement of the museum, Dr. Daukes said, was easy to follow; there were twenty halls, each numbered and subnumbered, so that the complete course of demonstration was indicated. Over a hundred diseases were demonstrated, embracing those caused by the metazoa, the protozoa, bacteria, food deficiency, endocrine deficiency, skin diseases, new growths, etc. Each disease was fully described, and at the end of each section was a yellow file, which was kept up to date with all recent work. The museum was of special value to students and practitioners, and was open to all members of the profession and to those engaged in any branch of public health work. At stated intervals post-graduate demonstrations were given, and at any time teachers might bring their classes and teach in the museum. It was scarcely necessary, he concluded, to add that the museum was always at the disposal of Branches and Divisions of the British Medical Association.

After the inspection of the museum tea was provided, and a vote of thanks to Dr. Daukes on behalf of the Branch Council was proposed by Dr. CHRISTINE MURRELL, the president, and seconded by Dr. R. L. LANGDON-DOWN. Both speakers emphasized the value of this museum—the only one of its kind—and felt sure many other members of the profession would welcome an opportunity of visiting it. The senior honorary secretary, Dr. C. F. T. Scott, received an invitation from Dr. Daukes to any other Branch or Division which might desire to arrange for a conducted visit.

SOUTHERN BRANCH: PORTSMOUTH DIVISION.

THE second meeting of the session of the Portsmouth Division was held at the Queen's Hotel, Southsea, on November 8th, when Dr. PHILIP GREEN was in the chair.

Professor HUGH MACLEAN gave an address on glycosuria as it occurred in medical practice, emphasizing the necessity of understanding the changes in the blood. Normally the percentage of blood sugar was 0.1 per cent.; after a meal it rose to 0.2, and then gradually fell with a characteristic curve. In hepatic glycosuria the liver failed to store sugar; this condition might pass into the glycosuria. Some fat persons might be cured by reducing their weight, and consequently the fat in the liver, which organ was then capable of storing sugar. There was no acidosis in these cases, and it was not necessary to give insulin unless there were eye symptoms or skin trouble. Alcohol lowered the power of the liver to store sugar. In renal glycosuria there was a lowered threshold for sugar excretion. In true glycosuria it was essential to pay attention to the acetone and diacetic acid. In patients under treatment it was difficult to tell diabetic coma from coma due to insulin; even experts could not tell without a blood sugar test. Finally, some cases of rheumatism might be found to be due to glycosuria; some obscure cases of wasting could be cured by the administration of insulin and glucose.

A discussion followed in which Drs. FARNCOMBE, LYMAN, JEANS, MCASKIE, MARTIN, Surgeon Commander KELLEY, and Mr. PAGE, the city analyst, took part.

The meeting was brought to a close with a vote of thanks to Professor MacLean for his address, proposed by Dr. JEANS, and seconded by Mr. MARTIN: sixty members were present, of whom forty-one sat down to supper.

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GENERAL COUNCIL
OF
MEDICAL EDUCATION AND REGISTRATION.

WINTER SESSION, 1928.

THE one hundred and twenty-eighth session of the General Medical Council opened on Tuesday, November 27th, at Hallam Street, London, W., Sir DONALD MACALISTER, Bt., K.C.B., presiding.

New Members.

Official notification was made of the appointment of the following new members: Alexander Miles, F.R.C.S.E., as representative of the Royal College of Surgeons of Edinburgh for five years from July 19th, 1928; Ernest Kaye Le Fleming, M.B., and John Wardle Bone, M.B., as representatives elected by the registered practitioners resident in England and Wales.

Mr. Miles was introduced to the President by Sir Norman Walker, Dr. Le Fleming by Sir Jenner Verrall, and Dr. Bone by Dr. Brackenbury.

PRESIDENT'S ADDRESS.

The President then spoke as follows:

GENTLEMEN,—On November 23rd, 1858, seventy years ago, the General Council of Medical Education and Registration first met, in the Hall of the Royal College of Physicians, pursuant to a summons by the Secretary of State. Sir Benjamin Brodie was elected the first President of the Council, and Dr. Francis Hawkins the first registrar, and committees were appointed for the conduct of business, for registration, and for the *National Pharmacopœia*. It does not appear that the President delivered an opening or any other address to the Council. I have sometimes wished that this precedent had been followed by his successors. But it is recorded that in a dignified communication, with reference to a proposed petition by the Council to the Government of the day, he stated his view of the functions and relations of the new Council in these terms: "The Medical Council is appointed by Parliament to act in those matters which affect the medical profession, both on the part of the profession and of the public. It is not to be supposed that they have any interests of their own to serve; and it is as much out of their way to proceed by way of petition as it would be for the Board of Trade to do so. Where they conceive that any alteration is required in laws concerning the profession, it is their duty to represent this in the proper quarter, not as petitioners, but as coadjutors of the Government in one department of the public business." That conception of the Council's place and function in the State has been sustained, I think worthily, for seventy years; and it has underlain the several statutory changes which in the interval have modified in various ways the legal constitution and powers of the Council as a public body. I do not propose to survey these changes in retrospect, for they have not altered the essentials of the Council's statutory relations to the public or the profession. It remains the law-appointed guardian, in the public interest, of professional education and professional behaviour, the coadjutor of the Government in its own domain.

The officers of the Council propose to celebrate the seventieth anniversary by a domestic dinner to present and past members, to be held during this session; and I understand that the acceptances of their invitation assure us that the gathering will be numerous and cordial. Some, alas! of those who but lately we might have expected to welcome to our board will be missed. Death has been busy since we last met in May.

Recent Losses.

Sir James Hodsdon passed away suddenly and untimely on his way home from our last session. An able and conscientious member since 1906, he had won the confidence of his colleagues for his zealous devotion to all the tasks that fell in increasing number to his share. Sober and cautious in judgement, his opinions were not hastily formed, and they carried the weight which always attaches to sincere and well-matured utterances. His long services to the Council and to the Scottish Branch will not lightly be forgotten.

Sir Arthur Chance also, brilliantly critical at times, but always helpful, contributed much during the last thirteen years to the efficiency of our labours and the interest of our debates. To his wisdom and foresight during the discussions on our relations with the Irish Free State the working agreement which is now operative was largely due.

Sir Charles Tomes for twenty-two years was a Crown member of the Council appointed in the interest of dental surgery. His scientific and professional eminence in that specialty, together with his wide knowledge in other branches and his competence in finance, gave him a unique place in our counsels. The Council for sixteen years profited by his sagacity as treasurer during the difficult time of transition to our present building, and of complications due to the war. He also, as a trusted adviser of the Government, had much to do with shaping the Dentists Act of 1921, and of preparing the way for the devolution of certain of our duties as regards dentistry to the new Dental Board.

Sir Nestor Tirard was for only five years a Crown Member of the Council itself; but his intimate connexion with its work on successive *Pharmacopœias* extended over thirty-three years. As secretary of the Pharmacopœia Committee he assisted in the editorial preparation and supervision of the issues of 1898 and 1914, and of the *Addendum* of 1900. I can speak, perhaps better than any other, of the capable and unselfish manner in which during that time he assisted me as chairman of the committee, and of the wide and varied knowledge of the subject-matter which he acquired and applied to his duties. The *British Pharmacopœia*, 1914, of which he was senior editor, will remain as a monument to his mastery of pharmacopœial science and practice.

And, but last week, the veteran Sir Charles Hector Cameron died full of years and honours at the age of 85. One of the last survivors of Lord Lister's personal assistants and coadjutors—he has fitly been described as Lister's "beloved disciple"—he held a high place not only among Glasgow celebrities, but in the affectionate regard of the surgeons of the world. To myself his loss is irreparable, for from the time when, in 1889, he first welcomed me to this Council as a colleague, until the end, he was my unfailing friend and counsellor, on whose kindly wisdom and manifold experience it was ever my privilege to draw.

But while we miss and mourn these veterans, with grateful acknowledgement of what they were and did for us, we may be thankful that there is never wanting a supply of good and faithful men to take their places. Thus, in the room of Sir James Hodsdon, the Royal College of Surgeons of Edinburgh has appointed Dr. Alexander Miles, eminent as a surgeon and a surgical teacher in that famous school, honorary Doctor of Laws, and joint-editor of the *Edinburgh Medical Journal*. And in the room of the late Dr. Macdonald, and of Sir Robert Bolam, transferred to the University of Durham, the registered practitioners resident in England and Wales have elected by overwhelming majorities Mr. Ernest Kaye Le Fleming of Wimborne and Mr. John Wardle Bone of Luton as their direct representatives on the Council. To these new members we offer the right hand of fellowship, being confident both of their power and of their will to share our labours and to increase our efficiency.

An All-India Medical Council.

Our relations with the Government of India, on the question of the recognition for practice in this country of Indian medical degrees, are approaching a more stable and satisfactory position. A bill for establishing an All-India Medical Council, which will exercise effective supervision over professional teaching and examination in the Provinces, having special regard to the external and central or non-provincial aspects of medical qualification, is now under discussion by the Central Legislature. And a proposal for the appointment in the meantime of a central Commissioner of Medical Qualifications and Standards has been approved by the Government of India and by the Provincial Governments. We may hope, therefore, before long to be able to conduct our negotiations

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and inquiries regarding the recognition of particular Indian degrees through a central Indian body or officer, whose reports we may accept as authoritative. It is much to be desired that the Commissioner appointed should be familiar with British standards of qualification, as well as with those current in India. For the essential consideration for the Council is the maintenance of substantial equivalence between the two. Our primary interest is, that recognized Indian medical degrees shall guarantee a standard of proficiency sufficient for practice in this country. It is this interest, which we cannot forego, that alone justifies our intervention in Indian medical education.

In the meantime, the Executive Committee, after considering the reports received from the Indian universities (including Calcutta) concerning their progress in education and examination, have agreed to recognize their degrees for another year, subject to further inspection of their qualifying examinations during the current session by inspectors appointed by the Government of India and approved by the Council.

Reciprocity with New Zealand.

New Zealand has, by recent legislation, raised a question regarding reciprocity which is receiving serious consideration. Hitherto, New Zealand medical degrees, under an agreement of many years' standing, have been recognized for registration in this country on the condition that all medical practitioners of Great Britain were registrable without further examination in the Dominion. By an Act of the Dominion Parliament, passed without notice to the Council, such registration in New Zealand is in future limited to practitioners who hold a medical qualification granted in this country. If this limitation were accepted it would mean that New Zealand graduates registered in the United Kingdom would be free to practise not only here but in all the British possessions and foreign countries with whom we stand in relations of reciprocity, but only certain practitioners on the British *Register* would have the like privilege in New Zealand. The Dominion Government suggest that a new arrangement might be made, by which the privileges of New Zealand graduates might be limited to the United Kingdom only. This would seriously affect the whole system of imperial and foreign reciprocity which has been established under the Medical Act, 1886, and we are advised that it would require new legislation amending that Act. A memorandum on the subject has been prepared for submission to His Majesty in Council, who has power to declare whether the New Zealand arrangements can be regarded as "just" to the medical practitioners of the United Kingdom. If under the present law the new conditions are not held to be "just" it will be for the Privy Council to order that Part II of the Medical Act, 1886, shall be deemed no longer applicable to New Zealand. It is probable that the opinion of the law officers of the Crown may be taken on the scope and bearing of the Act as hitherto interpreted. If it proves that the Act does not admit the serious limitation proposed by New Zealand, the recent legislation in that Dominion will have to be amended, or New Zealand graduates must forego the advantages of British registration.

The Revision of the Pharmacopoeia.

The proposals contained in the report of the Committee on Civil Research, on the subject of the revision of the *British Pharmacopoeia*, which you approved and adopted at the last session, have been carried into effect by the Pharmacopoeia Committee. A Selection Committee, consisting of members nominated by the Council, the Medical Research Council, and the three pharmaceutical societies, has been constituted, and has carefully considered the composition and membership of the Pharmacopoeia Commission, to which the preparation of the draft *Pharmacopoeia* will be entrusted. The Commission will consist of seven members, including a chairman, possessing expert knowledge of the several subjects and branches of pharmacopoeial science—medical, pharmacological, and pharmaceutical. The several members will act as chairmen, and representatives on the Commission, of special subcommittees of reference to be appointed to deal with and make representations on the different departments of knowledge and practice concerned in the framing of the *Pharmacopoeia*. In this way it is hoped that the fullest information may be gathered, from a wide field of experience and science, and that the Commission will have at its disposal and harmonize into a consistent and comprehensive whole, all that is necessary for the revision of the old, and the preparation of the new, *British Pharmacopoeia*.

At the close of the address a vote of thanks was accorded to the President on the motion of Mr. Sinclair, seconded by Sir Norman Walker.

The Council then proceeded to disciplinary business, of which reports will appear in later issues of the *Supplement*.

National Insurance

LONDON PANEL COMMITTEE DINNER

At the New Prince's Galleries, Piccadilly, on November 22nd, London insurance practitioners held their ninth annual dinner and dance. Dr. H. J. CARDALE, chairman of the London Panel Committee, welcomed practitioners and guests on arrival, and also presided at the dinner. In proposing the toast of "The London Panel Committee," Dr. ALFRED COX, Medical Secretary of the British Medical Association, expressed the pleasure he had felt in watching the growth of what was really a great experiment in local government, for the organization of Panel Committees was a new departure in the sense that never before, he thought, had the representatives of a particular profession or calling as such been made responsible for the running of a public service. He had noted with satisfaction the tendency, when alterations were made in insurance regulations, to place more and more responsibility on Panel Committees. His acquaintance with the London Panel Committee was not as intimate as with some others. One of its outstanding features, however, was that it had apparently a permanent chairman. Dr. Cardale was well known as a chairman of whom any committee might be proud. The speaker recalled some very good friends who had been associated with the London Panel Committee in its earlier and more difficult days, notably the late Dr. Lauriston Shaw, who had done so much to raise its standard of work and status.

Dr. CARDALE, in responding to the toast, spoke of the difficulty which the Panel Committee found in keeping in touch with, and ascertaining the views of, the approximately two thousand doctors now on the London panel. It seemed to him that there was need for more organization in this respect, and that it might be well for the London Panel Committee to employ an organizing secretary in addition to its present whole-time secretary, so that from the meeting of small groups of insurance practitioners in the various parts of London the Panel Committee could have a body of opinion upon which to draw at need. He appreciated Dr. Cox's reference to Dr. Lauriston Shaw as one of the great names associated with the Committee in the past, and to this he would add the names of the late Sir James Galloway and the late Dr. Farman.

The toast of "The Guests" was entrusted to Dr. A. E. GREGG, who did it full justice. Responses were made by Dr. R. T. WORTHINGTON, as a regional medical officer; by Mr. C. G. IZARD, the newly elected chairman of the London Insurance Committee, who said that he hoped his term of office would coincide with the further growth of a real spirit of fellowship between the medical and lay members of the Committee; and by Dr. A. WELPLY, on behalf of the medical guests. The formal proceedings were not unduly prolonged, and a pleasant evening was rounded off with a dance.

LONDON INSURANCE COMMITTEE

At the meeting of the London Insurance Committee on November 22nd particulars were given regarding notifications by insured persons of their desire to change doctors in the same district. For the thirteen months from October 1st, 1927, to October 31st, 1928, the number of such notifications in London was 25,600. During the same period the number of irregular transfer acceptances sent in by practitioners and rejected was 5,774, and the number of transfers with the consent of both doctors was 3,662.

Medical Service Subcommittee Cases.—In a case recently before the Committee it was decided that there had been failure on the part of the practitioner to comply with the terms of service with regard to the treatment afforded by him to the insured patient, and that the practitioner should be cautioned, but that no representation should be made to the Minister with regard to deduction from his remuneration. A communication from the Ministry was now reported in which it was observed that "having regard to the action taken in other areas in respect of similar breaches of the terms of service, the Minister is of opinion that the facts of this case seem to warrant the withholding of money." The Medical Service Subcommittee's reply was that the Committee

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"fortunately or otherwise have to deal with such a large number of cases concerning the conduct of insurance practitioners that they have no difficulty in establishing the standard of comparison between one case and other. . . . In appropriate cases we have not hesitated to recommend that a substantial amount of money should be withheld. With regard to the present case we would point out that we interviewed the insured person and the practitioner and we were thus afforded an opportunity of examining the practitioner and of observing his demeanour, and this, in our opinion, is of incomparable advantage in assessing the extent of the failure or neglect of the practitioner to comply with the terms of service. Having taken all the circumstances into consideration we came to the unanimous conclusion that this particular case was not one in connexion with which money should be withheld, and to that decision we adhere."

Chairman of the Medical Service Subcommittee.—In April last, on the death of Mr. Henry Mills, the chairman of the subcommittee, the Committee appointed Mr. R. W. Harris, formerly an officer of the Ministry of Health, but not a member of the Committee, as chairman. At the close of the Committee's year with this meeting, the subcommittee accorded a very cordial vote of thanks to Mr. Harris, adding, "we cannot speak too highly of the extremely able and impartial manner in which he has discharged the onerous duties entrusted to him."

Complaints Against Chemists.—In six cases in which the Committee, on the recommendation of the Pharmaceutical Service Subcommittee, had found proved certain complaints for failure in dispensing, and had remitted the matter to the Ministry of Health, it was now reported that the Ministry had decided to fine five of the chemists £1 each, and the remaining one £2.

Naval and Military Appointments.

ROYAL NAVAL MEDICAL SERVICE.

Surgeon Lieutenant C. R. Boland to the *Peterel*.

To be Surgeon Lieutenants: J. J. Benson, R. Russell, R.N.V.R., Jr. Y. Woodhouse.

ROYAL NAVAL VOLUNTEER RESERVE.

Surgeon Lieutenant S. B. Borthwick to be Surgeon Lieutenant-Commander.

Surgeon Lieutenant F. E. Stabler to the *Victory* for R.N. Hospital, Haslar, for training.

Probationary Surgeon Lieutenant H. P. Widdup to the *Victory* for R.N. Hospital, Haslar, for training.

ROYAL ARMY MEDICAL CORPS.

Captain W. Millerick, M.C., to be Major, January 10th, 1928. (substitute for notification in the *London Gazette*, January 24th, 1928).

Captain E. O. A. Singer to be Major.

Lieutenant (on probation) H. W. Daukes, from the seconded list, is restored to the establishment.

ROYAL AIR FORCE MEDICAL SERVICE.

Squadron Leader R. J. Aherne, M.C., to Palestine General Hospital.

Flight Lieutenant A. Briscoe is promoted to the rank of Squadron Leader.

Flight Lieutenants E. J. Jenkins to No. 14 Squadron, Middle East; R. G. Freeman to R.A.F. Depot, Middle East, instead of Headquarters, Middle East, as previously notified; F. W. Goodread to Headquarters, Air Defence of Great Britain, Uxbridge; T. J. D. Atteridge to Central Medical Establishment; G. M. Anderson to R.A.F. Station, Donibristle.

Flying Officers E. P. Carroll to Station Headquarters, Hinaidi; B. A. Porritt to Station Headquarters, Cattewater; J. L. Groom to R.A.F. Base, Calshot; N. M. Jerram to Electrical and Wireless School, Flowerdown; G. W. Paton to R.A.F. Station, Upper Heyford; G. O. Williams to No. 5 Flying Training School, Sealand.

AUXILIARY AIR FORCE.

Flying Officer E. D. W. Reid, M.B., No. 601 (County of London) Bombing Squadron, to be Flight Lieutenant.

INDIAN MEDICAL SERVICE

Captains to be Majors: S. L. Bhatia, M.C., G. R. McRobert, A. C. Chatterji.

Lieutenant Surendra Nath Lahiri has resigned his commission.

REGULAR ARMY RESERVE OF OFFICERS.

ROYAL ARMY MEDICAL CORPS.

Lieut.-Colonels C. H. Purnivall, C.M.G., and J. G. Gill, C.B.E., D.S.O., having attained the age limit of liability to recall, cease to belong to the Reserve of Officers.

TERRITORIAL FORCE.

ROYAL ARMY MEDICAL CORPS.

Major W. H. A. D. Sutton, R.A.M.C., to be Divisional Adjutant, 44th (Home Counties) Division, T.A., vice Captain G. W. B. Shaw, R.A.M.C., who vacates the appointment.

Captain V. W. Hallchurch to be Major.

Lieutenants to be Captains: P. Mumford, R. G. Addenbrooke, and T. H. Sansome.

L. G. Llewellyn to be Lieutenant.

COLONIAL MEDICAL SERVICES.

Dr. C. G. Grey promoted Senior Medical Officer, Nigeria; Dr. J. D. S. Thomas appointed Medical Officer, Kenya; Dr. W. E. Heimse appointed Health Officer, Malayan Medical Service; Dr. E. C. Smith confirmed in his appointment as Assistant Bacteriologist, Medical Research Institute, Nigeria.

VACANCIES.

BEDFORDSHIRE EDUCATION COMMITTEE.—Senior School Dentist. Salary £500 per annum.

BELFAST: JOINT NURSERY AND MIDWIVES' COUNCIL OF NORTHERN IRELAND.—(1) Examiners for Midwives. (2) Examiners for General Register.

BIRMINGHAM UNION.—Casualty Officer (male) at the Selly Oak Hospital. Salary at the rate of £200 per annum.

BOOTLE BOROUGH HOSPITAL.—Honorary Ophthalmic Surgeon.

BRIGHTON COUNTY BOROUGH.—Resident Medical Officer at the Infectious Disease Hospital and Sanatorium (unmarried). Salary at the rate of £350 per annum.

BRISTOL CITY AND COUNTY.—Assistant Resident Medical Officer, Ham Green Fever Hospital and Sanatorium. Salary £300 per annum.

CAMBRIDGE: ADDENBROOKE'S HOSPITAL.—House-Surgeon (male). Salary at the rate of £130 per annum.

DARLINGTON GENERAL HOSPITAL.—Junior House-Surgeon (male). Salary £125 per annum.

DERBYSHIRE ROYAL INFIRMARY.—(1) House-Surgeon (general surgery and gynæcology). (2) House-Surgeon (general surgery). Salary £150 per annum each.

DORSET MENTAL HOSPITAL, Herrison.—Junior Assistant Medical Officer (unmarried). Salary £300 per annum, rising to £350.

DUMFRIES: CRICHTON ROYAL MENTAL HOSPITAL.—Clinical Pathologist (male, unmarried). Salary £400 per annum (or £450 with diploma in psychiatry), rising to £700.

DUMFRIES: DUMFRIES AND GALLOWAY ROYAL INFIRMARY.—Junior Resident Medical Officer (male). Salary £100 per annum.

ECCLES AND PATRICROFT HOSPITAL, Patricroft.—Second House-Surgeon (male). Salary £100 per annum.

GOVERNMENT OF BIHAR AND ORISSA.—Chief Medical Officer for the Jharia Mining Settlement, Bihar. Salary Rs.1,200 a month, rising to Rs.1,500.

HAMPSTEAD GENERAL AND NORTH-WEST LONDON HOSPITAL, Haverstock Hill, N.W.3.—(1) House-Physician. (2) House-Surgeon. Salary at the rate of £100 per annum each.

HOLBORN UNION, London.—(1) District Medical Officer for South Clerkenwell District; salary at the rate of £120 per annum. (2) Vaccinator for the Holborn Eastern District; fees approximately £50 per annum.

HOSPITAL FOR SICK CHILDREN, Great Ormond Street, W.C.1.—(1) Surgeon. (2) Anæsthetist; honorarium £15 15s.

HULL ROYAL INFIRMARY.—Casualty House-Surgeon (male). Salary at the rate of £130 per annum.

KING EDWARD VII MEMORIAL, ELIOT HOSPITAL, Haywards Heath.—Honorary Anæsthetist.

LIVERPOOL CITY.—Assistant Resident Medical Officer at Fazakerley Sanatorium. Salary £250 per annum.

LIVERPOOL HAHNEMANN HOSPITAL.—(1) Resident Medical Officer. (2) Clinical Assistants to the Ophthalmological Department. (3) Stipendiary Medical Officer. Salary for (1) at the rate of £100 per annum, and for (3) £125 per annum.

LONDON LOCK HOSPITAL, Dean Street, W.1.—House-Surgeon. Salary at the rate of £200 per annum.

MANCHESTER: ANCOATS HOSPITAL.—(1) Orthopædic Registrar; small honorarium. (2) Medical Registrar; honorarium £100 per annum.

METROPOLITAN HOSPITAL, Kingsland Road, E.2.—Assistant Surgeon.

MOTHERWELL: BURGH OF MOTHERWELL AND WISHAW.—Assistant Medical Officer of Health and Resident Tuberculosis Officer in the Tuberculosis Hospital. Salary £400 per annum, increasing to £500.

NATIONAL HOSPITAL, Queen Square, W.C.1.—House-Physician. Salary £150 per annum.

NEWCASTLE THROAT, NOSE, AND EAR HOSPITAL.—Honorary Assistant Surgeon and Anæsthetist.

PRINCE OF WALES'S HOSPITAL, Tottenham, N.15.—(1) Honorary Clinical Assistants to the various Departments. (2) Honorary Anæsthetist; honorarium £20 per annum.

QUEEN CHARLOTTE'S MATERNITY HOSPITAL, Marylebone Road, N.W.1.—(1) Assistant Resident Medical Officer (male); salary at the rate of £80 per annum, rising to £100 on appointment as Senior. (2) District Resident Medical Officer; salary at the rate of £80 per annum.

ROYAL DENTAL HOSPITAL, Leicester Square, W.C.2.—Honorary Anæsthetist.

ST. MARYLEBONE HOSPITAL, W.10.—Visiting Consulting Neurologist. Honorarium £100 per annum.

ST. PETER'S HOSPITAL FOR STONE, etc., Henrietta Street, W.C.2.—Clinical Assistants.

SALFORD ROYAL HOSPITAL.—(1) Resident Surgical Officer. (2) House-Physician. (3) House-Surgeon attached to Genito-urinary Department. (4) House-Surgeon to Gynæcological, Aural, and Skin Departments. (5) Casualty House-Surgeon. Males. Salary at the rate of £200 per annum for (1) and £125 for others.

SALISBURY: GENERAL HOSPITAL.—Pathologist. Guaranteed emoluments up to £1,000 per annum.

SALOP COUNTY COUNCIL.—County Medical Officer of Health. Salary £1,100 per annum.

SALVATION ARMY: THE MOTHERS' HOSPITAL.—(1) Senior Resident Medical Officer. (2) Junior Resident Medical Officer. Women. Salary £100 and £60 per annum respectively.

SEAMEN'S HOSPITAL SOCIETY.—(1) Medical Superintendent at the Dreadnought Hospital, Greenwich; salary £200 per annum, rising to £250–£400 if re-elected. (2) Assistant Pathologist in the Pathological Department of the London School of Clinical Medicine at the Dreadnought Hospital; salary £350 per annum. (3) House-Physician and House-Surgeon at the Dreadnought Hospital; Resident Medical Officer at Albert Dock Hospital; salary at the rate of £110 per annum each, and a proportion of fees. (4) Medical Superintendent at Tilbury Hospital; salary £250 per annum.

SHANGHAI MUNICIPAL COUNCIL.—(1) Assistant Pathologist. (2) Assistant Radiologist. Salary, Taels 650 and 700 per mensem respectively.

TAUNTON AND SOMERSET HOSPITAL.—Junior House Medical Officer (male). Salary at the rate of £100 per annum.

TRURO: ROYAL CORNWALL INFIRMARY.—House-Surgeon. Salary £170 per annum.

YORKSHIRE CHILDREN'S ORTHOPÆDIC HOSPITAL, Kirbymoorside.—House-Surgeon. Salary £150 per annum.

YORK: COUNTY HOSPITAL.—House-Physician. Salary £150 per annum.

H. E. Seiler, A Case of Pneumoconiosis, British Medical Journal (1928)
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CERTIFYING FACTORY SURGEONS.—The following vacant appointments are announced: Walton-on-the-Naze (Essex), Hormondon (Kent).—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.

MACLEOD, C. B., M.B., Ch.B., Medical Referee under the Workmen's Compensation Act, 1925, for the Island of Lewis, vice Dr. G. Sutherland, deceased.

MARTIN, Frank William, M.B., Ch.B.Glas., Divisional Surgeon, City of Glasgow Police.

CERTIFYING FACTORY SURGEONS.—D. C. Prowse, M.R., Ch.B.Bristol, for the Thornbury District, Gloucester; G. S. W. Evans, M.B.Camb., for the Crewe District, Chester.

DIARY OF SOCIETIES AND LECTURES.

ROYAL SOCIETY OF MEDICINE.

Section of Orthopædics.—Tues., 8.30 p.m., Discussion: The Stiff and Painful Shoulder. Opener: Mr. George Perkins. Other Speakers: Mr. Mecrae Aitken, Mr. Alan Todd, Dr. Alexander Mercer, Mr. J. R. Lee, Mr. B. Whitchurch-Howell, Dr. Bensteard, and others.

Section of Pathology.—Tues., 8 p.m., Laboratory Meeting at St. Bartholomew's Hospital, E.C.1.

Section of Surgery.—Wed., 4.30 p.m., at Guy's Hospital, S.E.1. Operations, Demonstration of Cases.

Section of Tropical Diseases.—Thurs., 8.15 p.m., Dr. H. Harold Scott and Dr. H. S. Day: Clinical and Pathological Correlation in Typhoid and Allied Diseases.

Section of Otology.—Fri., 8.30 a.m., Cases. 10.30 a.m., Discussion: Meningitis. Papers by (1) Mr. C. J. Jenkins; (2) Mr. T. B. Layton: An Otitic Meningitis; (3) Mr. E. D. D. Davis: The Morbid Anatomy, Prevention, and Early Diagnosis of Otitic Meningitis. Mr. E. Watson Williams will also speak.

Section of Laryngology.—Fri., 4 p.m., Cases. 5 p.m., Demonstration of Lamp for Local Application of Ultra-violet Rays by Dr. A. Eldinow. Cases and specimens.

Section of Anæsthetics.—Fri., 3.30 p.m., Mr. Stanley Rowbotham: Preliminary Medication in Anæsthetics.

UNIVERSITY COLLEGE HOSPITAL MEDICAL SCHOOL, W.C.1.—Mon., 4.15 p.m., Dr. Charles Singer: History of Medicine—Diphtheria.

POST-GRADUATE COURSES AND LECTURES.

FELLOWSHIP OF MEDICINE AND POST-GRADUATE MEDICAL ASSOCIATION, 1, Wimpole Street, W.1.—Lectures at Medical Society of London, 11, Chandos Street, W.1: Some Cardiac Problems in Childhood, Mon., 5 p.m.; no fee. *Wellcome Museum of Medical Science*, 33, Gordon Street, W.C.1: Wed., 4 p.m., Demonstration on Cancer; no fee. *All Saints' Hospital*, Vauxhall Bridge Road, S.W.1.: Wed., 2.30 p.m., Clinical Demonstration in Urology; no fee. *Hospital for Sick Children*, Great Ormond Street, W.C.1: Thurs., 10 a.m., Clinical Demonstration; no fee. *Hospital for Diseases of the Skin*, Blackfriars Road, S.E.1: Special Course, afternoons only: fee £1 1s. *Infants Hospital*, Vincent Square, S.W.1: Afternoon Special Course: fee £3 3s. *West End Hospital for Nervous Diseases*, 73, Welbeck Street, W.1: Lecture Demonstrations daily, 5 p.m. Copies of all syllabuses of special courses sent on application.

CENTRAL LONDON THROAT, NOSE AND EAR HOSPITAL.—Fri., 4 p.m., Oesophagoscopy.

EAST LONDON HOSPITAL FOR CHILDREN, Shadwell, E.1.—Wed., 4 p.m., Clinical Afternoon: Respiratory Affections of Children.

HOSPITAL FOR SICK CHILDREN, Great Ormond Street, W.C.1.—Thurs., 4 p.m., Congenital Syphilis.

LONDON SCHOOL OF DERMATOLOGY, St. John's Hospital, Leicester Square, W.C.2.—Chesterfield Lectures: Tues. and Fri., 5 p.m., Eczema.

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.

ROYAL INSTITUTE OF PUBLIC HEALTH, 37, Russell Square, W.C.1.—Wed., 4 p.m., Rheumatism in Relation to Industry.

ST. PAUL'S HOSPITAL FOR GENITO-URINARY DISEASES, Endell Street, W.C.2.—Thurs., 4.30 p.m., Common Infection of the Genito-urinary Tracts. Tea at 4 p.m.

SOUTH-WEST LONDON POST-GRADUATE ASSOCIATION, St. James's Hospital, Ouseley Road, Balham, S.W.12.—Wed., 4 p.m., Acute Infections of the Central Nervous System.

WEST LONDON HOSPITAL POST-GRADUATE COLLEGE, Hammersmith, W.—Mon., 10 a.m. to 1 p.m., Genito-urinary Operations, Surgical Ward Visit, Skin Department; 2 p.m., Medical, Surgical, Eye, and Gynæcological Out-patients' Departments. Tues., 10 a.m. to 1 p.m., Medical Ward Visit, Venereal Diseases Demonstration, Dental, and Electrical Departments; 2 p.m., Medical, Surgical, Throat, Nose, and Ear Out-patients, Operations, Medical Ward Visit. Wed., 10 a.m. to 1 p.m., Medical Ward Visit, Pathological Demonstrations, Children's Out-patients; 2 p.m., Medical, Eye Out-patients, Surgical Ward Visit, Operations. Thurs., 10 a.m. to 1 p.m., Neurological, Massage Out-patients; 2 p.m., Medical, Surgical, Genito-urinary, and Eye Out-patients, Operations. Fri., 10 a.m. to 1 p.m., Medical Ward Visit, Dental, Skin, and Electrical Departments; 2 p.m., Medical, Surgical, Throat, Nose, and Ear Out-patients, Operations. Sat., 9 a.m. to 12 noon, Throat, Nose, and Ear Operations. Bacterial Therapy and Children's Departments.

GLASGOW POST-GRADUATE MEDICAL ASSOCIATION.—The Mother and the Newborn Infant: At Royal Hospital for Sick Children, Tues., 4.15 p.m. At Research Department, Royal Maternity and Women's Hospital, Fri., 4.15 p.m. Cases at Ear, Nose and Throat Hospital, Fri., 4.15 p.m.

LIVERPOOL UNIVERSITY CLINICAL SCHOOL ANTE-NATAL CLINICS.—Royal Infirmary: Mon. and Thurs., 10.30 a.m. Maternity Hospital: Mon., Tues., Wed., Thurs., and Fri., 11.30 a.m.

MANCHESTER ROYAL INFIRMARY.—Tues., 4.15 p.m., Oesophageal Obstruction. Fri., 4.15 p.m., Obesity.

SHEFFIELD UNIVERSITY POST-GRADUATE CLINICS.—At Royal Infirmary: Fri., 5.30 p.m., Medical 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).

MEDICAL SECRETARY (Telegrams: Medisecra Westcent, London).

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

Telephone numbers of British Medical Association and British Medical Journal, Museum 9861, 9862, 9863, and 9864 (internal exchange, four lines).

SCOTTISH MEDICAL SECRETARIES: 7, Drumsheugh Gardens, Edinburgh. (Telegrams: Associate, Edinburgh. Tel.: 24361 Edinburgh.)

IRISH MEDICAL SECRETARY: 16, South Frederick Street, Dublin. (Telegrams: Bacillus, Dublin. Tel.: 4737 Dublin.)

Diary of the Association.

NOVEMBER.

30 Fri. London: Ophthalmic Committee, 2.30 p.m.
Bedfordshire Division: County Hospital, Bedford, 3 p.m. Discussion on Report of Private Practice Committee.
Bishop Auckland Division: Cottage Hospital, Bishop Auckland, 8 p.m. Dr. Nattrass on Common Neurological Symptoms and their Significance.
Chesterfield Division: Maternity Hospital, Chesterfield, 8.30 p.m. Discussion on Report of Private Practice Committee.
Holland Division: White Hart Hotel, Spalding, 3.30 p.m. Mr. R. St. Leger Brockman on the Early Diagnosis of Intestinal Obstruction.
South Suffolk Division: East Suffolk and Ipswich Hospital, 3.30 p.m. Dr. J. E. R. McDonagh on the Nature of Disease.

DECEMBER.

4 Tues. London: Maternity and Child Welfare Subcommittee, 2.15 p.m.
City Division: Metropolitan Hospital, Kingsland Road, E., 8.30 p.m. Mr. F. N. Reynolds on Placenta Praevia.
Coventry Division: Coventry and Warwickshire Hospital, 8.30 p.m. Dr. Wilson on Modern Clinical Tests of Renal Function.
Croydon Division: Croydon General Hospital, 8.30 p.m. Report of Private Practice Committee.
Hastings Division: Royal East Sussex Hospital, Hastings, 8.15 p.m. Dr. R. A. Clegg on Preventive Medicine and the Medical Practitioner.
Kingston-on-Thames Division: Surbiton Hospital. Paper by Dr. M. A. Cassidy.
North Staffordshire Division: Address by Dr. G. C. Anderson, Deputy Medical Secretary, on the Encroachments on Private Practice by Public Health Authorities.
South-West Essex Division: Livingstone College, Knotts Green, Leyton, 3.30 p.m. Dr. Jay on Medical Experiences in Nigeria.
Tynemouth Division: Tynemouth Victoria Jubilee Infirmary, 8.30 p.m. Dr. J. Stanley White on Some Recent Aspects of Biological Therapy.

5 Wed. London: Middle Class Hospital Policy Subcommittee, 2.15 p.m.
Blyth Division: Thomas Knight Memorial Hospital, Blyth. Mr. J. Gilmour on Internal Derangements of the Knee-joint.
Dewsbury Division: Lidbetter's Café, Dewsbury, 8.30 p.m. Lecture by Mr. Harry Lee (Leeds).
Lanarkshire Division: St. Enoch Station Hotel, 3.30 p.m. Dr. J. Stanley White on How Biological Products are Made.
Northern Counties of Scotland Branch: District Asylum, Inverness, 3.30 p.m. Demonstration of Neurological Cases by Dr. W. MacWilliam.
Norwich Division: Medical Library, 8.45 p.m. Report of Private Practice Committee.
Rochdale Division: Rochdale Infirmary, 8.30 p.m. Dr. J. Logan Stewart on the Place of Radiography in Diagnosis of Diseases of the Chest.
Winchester Division: Royal Hampshire County Hospital, 3 p.m. Report of Private Practice Committee.

6 Thurs. London: Psycho-Analysis Committee, 2 to 4 p.m.
City Division: Annual Dinner, Trocadero Restaurant.
Plymouth Division: South Devon and East Cornwall Hospital, 8.15 p.m. Clinical Lecture on Blood Transfusion.
Wakefield, Pontefract, and Castleford Division: Red Lion Hotel, Pontefract. Dr. W. MacAdam: Acidosis and Alkalosis.

7 Fri. London: Consulting Pathologists Group Committee, 2.30 p.m.
London: Meeting of Members of Hertfordshire Division, to discuss Association Organization.

12 Wed. London: Council, 10 a.m.
14 Fri. London: National Formulary Subcommittee, 11.15 a.m.
20 Thurs. London: Parliamentary Elections Committee, 2 p.m.

BIRTHS, MARRIAGES, AND DEATHS.

The charge for inserting announcement of Births, Marriages, and Deaths is 9s., 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.

BIRTH.

WARBURTON.—On November 21st, 1928, at 33, Parsonage Road, Withington, Manchester, the wife of Gilbert Bertram Warburton, Ch.M., F.R.C.S., of a son.

MARRIAGE.

ARMSTRONG–SKINNER.—At Northumberland Square Presbyterian Church, North Shields (by special licence), on November 21st, by the Rev. J. Hope Scott, Dr. J. Reay Armstrong, eldest son of Mr. and Mrs. Armstrong of 26, Percy Gardens, Tynemouth, and grandson of the late Mr. Joseph Reay of Gateshead, to Nora Isabelle, youngest daughter of Mr. Alexander Skinner of London.

DEATHS.

COKER.—On November 16th, at 15, Chamberlain Street, Wells, Somerset, Owen Cole Coker, L.R.C.P.Lond. (who passed peacefully away after a long illness), late of 155, Uxbridge Road, W., and of The Towers, Bigbury-on-Sea.

DAVIES.—On November 5th, Philip Lys Davies, *M.C.*, M.B., D.P.H., late Medical Officer of Health for Linton, Cambridge, beloved husband of Evelyn Davies, 5, St. George's Square, London, S.W.1.

Printed and published by the British Medical Association, at their Office, Tavistock Square, in the Parish of St. Pancras, in the County of London.

H. E. Seiler, A Case of Pneumoconiosis, British Medical Journal (1928)
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The British Medical Association.

PATRON: HIS MAJESTY THE KING.

President: SIR EWEN MACLEAN, M.D., F.R.C.P., F.R.S.E.,
Professor of Obstetrics and Gynæcology, Welsh National School of Medicine; Senior Gynæcologist, Cardiff Royal Infirmary.

AN OPEN LETTER TO NON-MEMBERS.

DEAR SIR OR MADAM,

THE close of the year affords an opportunity to draw your attention to the chief aims of the British Medical Association, and to give you some information as to its work and organization.

The Association is the largest, oldest, and most powerful of British medical organizations. It was founded in 1832 to promote the medical and allied sciences, to maintain the honour and interests of the medical profession, and to foster a feeling of friendship among the members of the profession. The work of the Association is thus fourfold: (i) It acts for the profession collectively in medical matters affecting the common weal; (ii) it guards the profession against unfair attack, whether legislative or other; (iii) by its work in promoting medical science and the spirit of comradeship, it helps the individual practitioner to be more efficient and of greater use to the community; and (iv) it helps its members individually.

With these aims in view the Association and its local groups—namely, the Divisions and Branches mentioned below—hold many thousands of meetings yearly, at which medical, medico-sociological, and allied subjects are dealt with; nor is the social side forgotten. It publishes the *British Medical Journal*, the *Archives of Disease in Childhood*, the *Journal of Neurology and Psychopathology*, an Annual Handbook, a Handbook for Recently Qualified Medical Practitioners, and other publications; gives scholarships, grants, and prizes for clinical and research work; owns a commodious building for the housing of its central activities; is in possession of very considerable funds and resources; and spares no effort in assisting its members individually in all aspects of their professional lives.

ASSOCIATION PREMISES.

The new House of the Association at Tavistock Square, London, opened in the summer of 1925 by His Majesty the King, is a popular meeting-place for its members when visiting London. There are also Houses or Offices of the Association at Adelaide, Brisbane, Cape Town, Dublin, Edinburgh, Melbourne, Perth (W.A.), Sydney, Wellington (N.Z.), and elsewhere.

CONSTITUTION AND ADMINISTRATION.

The Association is practically a federation of local medical societies, called Divisions. A Branch is a Division or (more frequently) group of Divisions. A member of the Association is, *ipso facto*, a member of the Division and Branch in the area of which he or she lives. The Divisions and Branches, and the Association of which they form part, are democratic bodies, the government of which is in the hands of their members.

The funds and resources of the Association are commensurate with a membership of over 34,500.

The general control and direction of the policy and affairs of the Association are vested in the Representative Body, which is elected by the Divisions throughout the Empire, and meets annually. The Council, or executive, of the Association is elected partly by the Branches throughout the Empire, and partly by the Representative Body, and also includes representatives of the Royal Naval, Royal Air Force, Army, and Indian Medical Services. Among the Committees of the Association are Ethical, Finance, Hospitals, Insurance Acts, Journal, Medico-Political and Parliamentary, Naval and Military, Organization, Public Health, Science, Scottish, Irish, Welsh, and Dominions, India, Colonies, and Dependencies Committees. The Insurance Acts Committee is the executive of the Annual Conference of Representatives of Local Medical and Panel Committees, which are the statutory local professional committees under the National Health Insurance Acts.

PRIVILEGES OF MEMBERSHIP.

The privileges of a Member of the Association include:—

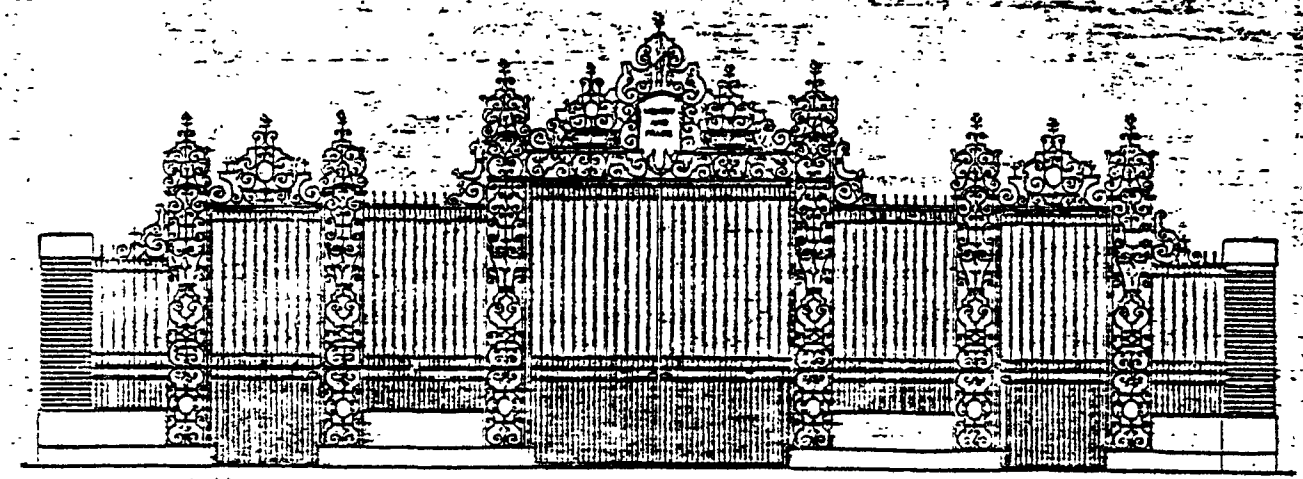
1. Participation in the clinical, scientific, medico-political, ethical, and social activities of the Association, local and central.
2. Receipt weekly, free by post, of the *British Medical Journal* and its *Supplement*, one of the leading medical journals of the world, and one of the most widely read.
3. Participation in the government of the Association, local and central, and in the formulation of its policy.
4. Use of the Headquarters Houses of the Association. At the London House the facilities include Reference and Lending Libraries; club-room accommodation, with facilities for light refreshments; garage and telephone facilities (the garage facilities are for the moment in abeyance, owing to the building of extensions to the House). From the Lending Library, Members in the British Isles can borrow books free of charge.
5. The advice and help of the Central Staff in professional matters affecting him or her individually.

SOME RECENT ACTIVITIES.

The question of encroachments on private practice is the subject of a special report which appeared in the *Supplement* of November 3rd. The questions of treatment by radiation and electricity by untrained and unqualified persons, the formulation of a middle-class hospital policy of the Association, and the method of dealing with contributory hospital schemes are under active consideration. A collective investigation of the treatment of varicose ulceration has been carried out, and a report will be published in the *Journal* at an early date.

The new Medical Benefit Regulations under the National Health Insurance Acts, about to be put into operation, embody amendments agreed to after negotiation between the Insurance Acts Committee and the Ministry. It is believed that the new arrangements, especially those in respect of disciplinary machinery and transfer of practices, will be of great help to Insurance practitioners.

H. E. Seiler, A Case of Pneumoconiosis, British Medical Journal (1928) Published by AsbestosClaims.Law
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The Memorial Gates, British Medical Association House, London.

ORDINARILY, NO APPROVING SIGNATURES ARE NEEDED, NOR ARE THEY REQUIRED IN THE CASE OF OFFICERS OF THE ROYAL NAVAL, ROYAL AIR FORCE, ARMY, INDIAN OR COLONIAL MEDICAL SERVICE, ON THE ACTIVE LIST.

In the case, however, of a Candidate (other than a Service Candidate) resident within any of the Branches mentioned below, or resident in an area outside the British Isles in which there is no Branch, the certificate at the foot of this page should be filled in by a Member or Members of the Association (1, 2, or 3 as indicated), to whom the Candidate is personally known.

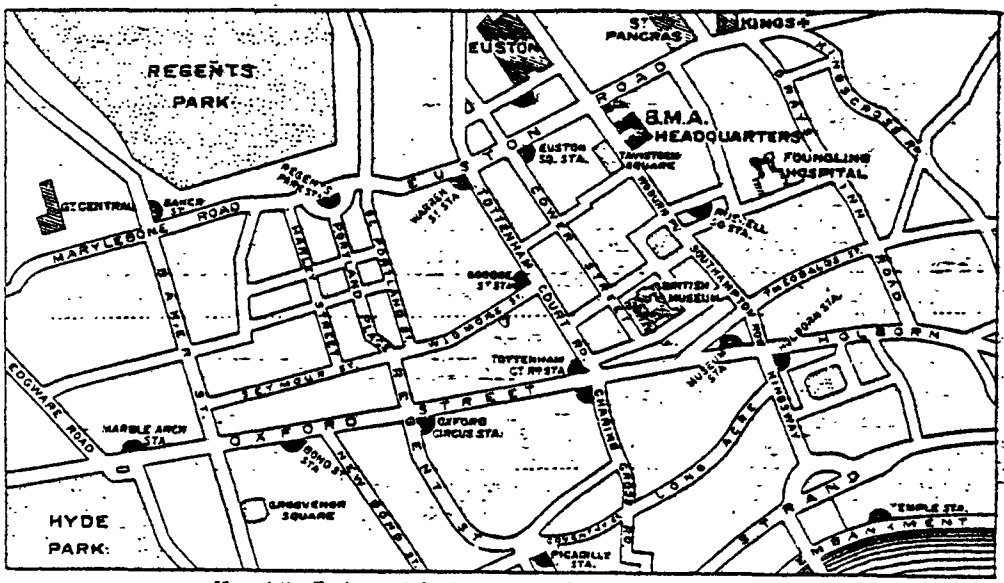
In any case of doubt or difficulty, Candidates are invited to communicate with the Head Office, British Medical Association House, 19, Tavistock Square, London, W.C.1.

***Home** Branches which require Approving Signatures.*

	No. of Signatures.
Connaught ...	2
Munster	2
North of England	1
South Wales and Monmouthshire	2
Staffordshire ...	2

***Overseas** Branches which require Approving Signatures.*

	No. of Signatures.
British Guiana ...	3
Kenya	3
Mesopotamia ...	3
New South Wales	2
New Zealand ...	2
Punjab	2
Queensland ...	2



Map of the Environs of the Association's House in Tavistock Square.

CERTIFICATE.

[For use only in the case of a Candidate (other than a Service Candidate) resident within the area of one of the Branches named above, or resident outside the British Isles where no Branch is organized.]

I (We), the undersigned Member(s) of the BRITISH MEDICAL ASSOCIATION, *hereby certify that*.....
... .named on the front page hereof, is personally known to me (us), and is a suitable person to be elected a Member of the BRITISH MEDICAL ASSOCIATION.

Signature(s) (1) .....
(2) .....
(3) .....

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The Association has continued to watch the interests of medical officers of health. In the great majority of cases the salaries now offered for whole-time posts give at least the minimum laid down by the Association. The scale has been made to apply as regards Ulster, and has been specially modified to meet the case of Scotland.

The new arrangement whereby the Scholastic, Clerical, and Medical Association Ltd. now (under the name of "The British Medical Bureau") works in co-operation with the British Medical Association is proving highly satisfactory. Of the board of directors of the Bureau, one-half represent the British Medical Association. All agency and accountancy business is transacted, and members of the British Medical Association are given the advantage of a reduced scale of charges.

The Association's work benefits every member of the profession, and, as this work can be made more and more effective as it includes more and more practitioners, the Association unhesitatingly claims the support of every medical man and woman who is registered in the British Empire.

Application for Membership.

You are most cordially invited, if not already a member of the Association, to apply for membership, and I would especially direct the attention of practitioners resident outside the British Isles, and of those recently qualified, to the liberal concessions made to them as regards subscription. Members of the Medical Services of the Navy, Army, Air Force, and India, on whose behalf the work of the Association is unceasing and invaluable, also enjoy a substantial concession in this respect.

The form of application for membership, printed at page iii of this *Supplement*, should be signed and sent to the Medical Secretary, British Medical Association House, Tavistock Square, London, W.C.1.

Inquiries as to the work of the Association are welcomed.

Alfred Cox

Medical Secretary.

GROWTH OF THE ASSOCIATION.

FIFTY YEARS' PROGRESS.

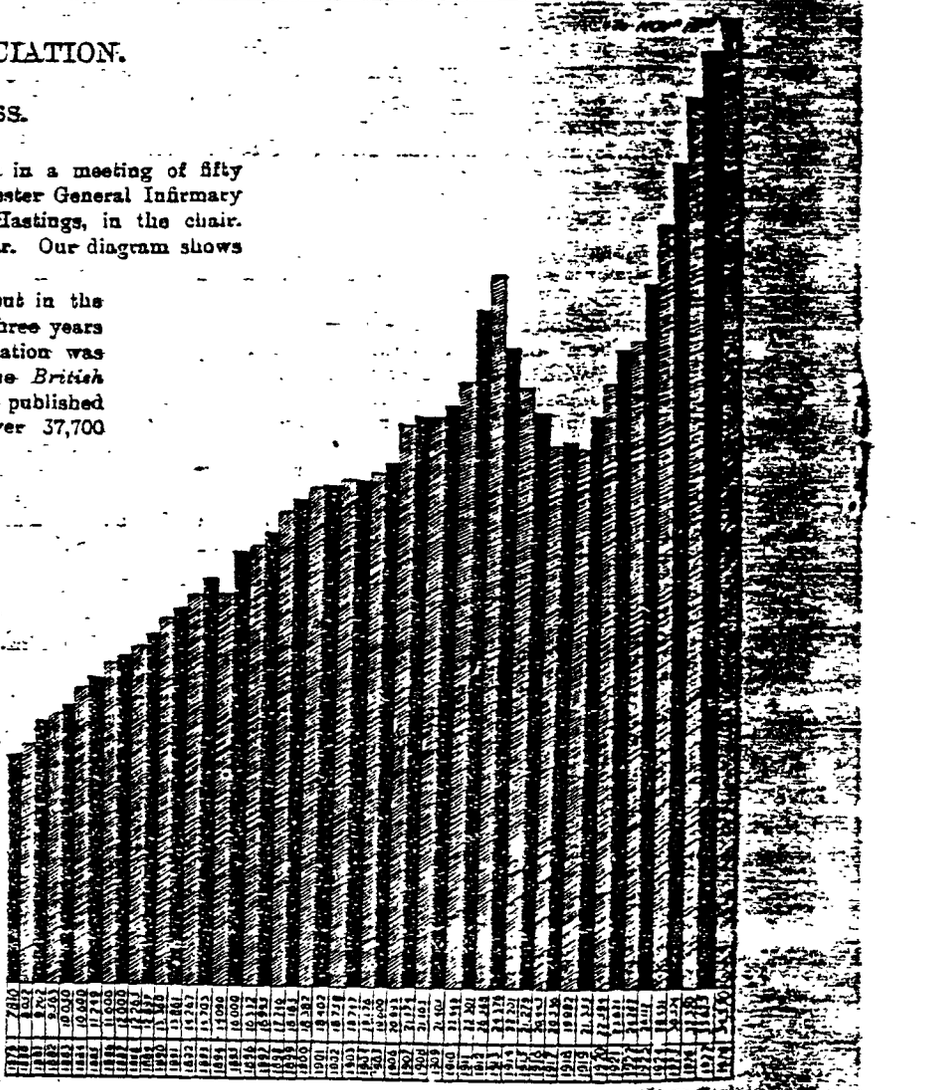
The British Medical Association had its origin in a meeting of fifty medical men held in the Board Room of Worcester General Infirmary in July, 1832, with the Founder, Sir Charles Hastings, in the chair. The Association is thus in its ninety-seventh year. Our diagram shows the membership figures for the last fifty years.

From 1832 to 1854 the growth was slow, but in the latter year the figure of 2,000 was reached. Three years later, in 1857, the weekly Journal of the Association was issued for the first time under the title of the *British Medical Journal*. The *Supplement* began to be published in 1904. The issue of the Journal is now over 37,700 copies a week.

From 1866 to 1912 the membership rose in staircase fashion from 2,462 to 26,568. In some of those forty-six years the step was comparatively small, in others large, but the ascent was continuous.

The rapid rise in 1911 and 1912 was due to the professional upheaval that followed the introduction of the National Insurance scheme. Many practitioners who joined the Association solely on that account resigned soon afterwards, and the fall from 1913 to 1918 was due to that and to the dispersal of a large part of the profession during the war. Since 1918 the ground lost has been far more than regained.

In 1914 the annual subscription was raised to 2 guineas, and this may have contributed in some degree to the fall in membership. Nevertheless, though the subscription was again raised, in January, 1921, to 3 guineas, no decrease of membership followed. On the contrary, the total number of members has grown year by year, and during the past twelve months there has been a further net gain of over 1,000. The membership is now over 34,500, representing a net increase of 14,500 since the war.



BRITISH MEDICAL ASSOCIATION.

FOUNDED 1832.

Patron: HIS MAJESTY THE KING.

THE BRITISH MEDICAL ASSOCIATION is established for the promotion of the Medical and allied Sciences, and the maintenance of the honour and interests of the Medical Profession. It has Divisions and Branches throughout the British Empire. There are 43 Branches and 211 Divisions in the British Isles, and 51 Branches and 35 Divisions in the British Empire Overseas.

Any Medical Practitioner registered in the British Isles under the Medical Acts; any Medical Practitioner who does not reside within the area of any Branch of the Association and who, though not so registered, is possessed of any qualification entitling him or her to be so registered; and any Medical Practitioner residing within the area of any Branch of the Association not in the British Isles who is so registered or possesses such medical qualification as shall (subject to the By-laws) be prescribed by the Rules of the said Branch, is eligible as a Member of the Association. Members of the Association are, *ipso facto*, Members of the Division and Branch in the areas of which they reside.

The liability of Members is limited.

The annual subscription, which is due in advance on January 1st in each year, and entitles the Member to all the ordinary privileges of Membership of the Association, including Membership of the Division and Branch in which he or she resides, and the weekly supply of the *British Medical Journal* post-free, is as follows:—

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In the case of a Member elected after June 30th in any year, the subscription for that year is one-half the current annual subscription.

If you desire to become a Member of the Association, please fill in and post this form to the Association, British Medical Association House, Tavistock Square, London, W.C.1, with a cheque or postal order for your first subscription.* Cheques or postal orders should be crossed and made payable to "The British Medical Association." Election is ordinarily by the Council of the Branch in the area of which the Candidate resides, but in the case of Candidates resident in any area outside the British Isles where no Branch is organized, is by the Council of the Association. In the case of most Branches, NO signature, other than that of the Candidate, is required (for Branches which require approving signatures see overleaf). For election by the Council (as above), 2 approving signatures are ordinarily required. Under no circumstances are approving signatures necessary in the case of Officers of the Royal Naval, Royal Air Force, Army, Indian or Colonial Medical Service, on the Active List.

DETACH HERE

APPLICATION FOR ELECTION.

TO THE BRITISH MEDICAL ASSOCIATION,
BRITISH MEDICAL ASSOCIATION HOUSE, 19, TAVISTOCK SQUARE, LONDON, W.C.1.

Full Christian and Surnames. Please write distinctly.

I,.....
a Registered Medical Practitioner, am desirous of being, and hereby apply to be, elected a Member of the BRITISH MEDICAL ASSOCIATION, and I agree, if elected, to pay the subscription and to abide by the Articles and By-laws of the Association for the time being in force, and the Rules of the Division and Branch to which I may at any time belong.

Signature.....

Qualifications.....

Permanent Address.....

.....

Address for Journal.....

.....

Date.....192

Additional Forms of Application for Membership and all particulars may be had on application to the MEDICAL SECRETARY, British Medical Association House, Tavistock Square, London, W.C.1.

* Applicants for Membership resident in the areas of the *Oversea Branches* should send their applications and remittances to the Honorary Secretary of the Branch if his or her address is known to them, failing which the application and remittance should be sent to the Financial Secretary and Business Manager, British Medical Association House, 19, Tavistock Square, London, W.C.1.

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