St. Bartholomew's Hospital

Journal.

1915 - 1916

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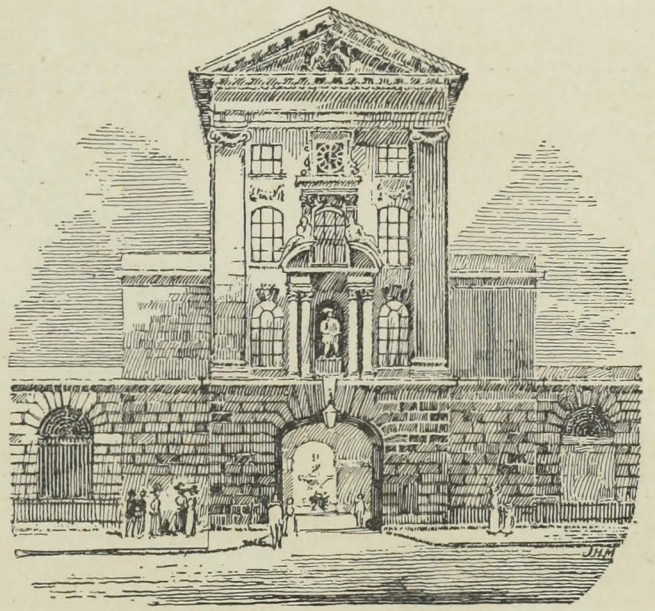
Journal Office.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL. XXIII.

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St. Bartholomew's Hospital Journal.

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

VOL. XXIII.—No. 1.] OCTOBER 1ST, 1915. [PRICE SIXPENCE.

CALENDAR.

Fri., Oct.	1.	**Winter Session begins.** Exam. for Part II of Second M.B.Cantab. begins. Cambridge Michaelmas Term begins. Dr. Calvert and Mr. McAdam Eccles on duty.
Mon., ,,	4.	Exam. for D.P.H.Camb. begins. Second Exam. of Society of Apothecaries.
Tues., ,,	5	Final Exam. Conjoint Board (Medicine) begins. Dr. Morley Fletcher and Mr. Bailey on duty.
Wed., ,,	6.	First Exam. of Society of Apothecaries begins.
Thurs., ,,	7.	Final Exam. Conjoint Board (Midwifery) begins.
Fri., ,,	8.	Dr. Drysdale and Mr. Rawling on duty. Final Exam. Conjoint Board (Surgery) begins.
Sat., ,,	9.	Oxford Michaelmas Term begins.
Mon., ,,	11.	Exam. for D.P.H.Camb. (Part II) begins.
Tues., ,,	12.	Dr. Tooth and Mr. D'Arcy Power on duty.
Fri., ,,	15.	Dr. Garrod and Mr. Waring on duty.
Tues., ,,	19.	Dr. Calvert and Mr. McAdam Eccles on duty.
Fri., ,,	22.	Dr. Morley Fletcher and Mr. Bailey on duty.
Mon., ,,	25.	Exam. for M.B., B.S.(Lond.) begins.
Tues., ,,	26.	Dr. Drysdale and Mr. Rawling on duty.
Fri., ,,	29.	Dr. Tooth and Mr. D'Arcy Power on duty.
Tues., Nov.	2.	Dr. Garrod and Mr. Waring on duty.
Wed., ,,	3.	Primary F.R.C.S. Exam. begins.
Fri., ,,	5.	Dr. Calvert and Mr. McAdam Eccles on duty.

EDITORIAL NOTES.

WE very much regret to learn of the death of Capt. A. W. Scot-Skirving, of the 5th Royal Irish Fusiliers. He was qualified in Sydney, New South Wales, but came over to England to study at this Hospital for the Fellowship of the Royal College of Surgeons. He passed his Primary Fellowship a little over a year ago, and on the outbreak of war joined the 5th Royal Irish Fusiliers as a combatant. He was wounded in Gallipoli and unfortunately succumbed to his wounds. Scot-Skirving was a man of brilliant promise, and though of a retiring disposition was exceptionally popular with those who knew him intimately. Our deepest sympathy is extended to Mr. and Mrs. Scot-Skirving in their sad bereavement.

* * *

We have just heard, with great regret, of the death of Capt. B. M. Hughes, of the 4th Norfolk Regiment (T.F.), who was killed in action at the Dardanelles on September 15th. He gave up a lucrative medical practice in Wymondham in August, 1914, to rejoin his old regiment, with which he had served in South Africa in 1901, where he earned the Queen's Medal with four clasps. He was a Justice of the Peace for Norfolk. Our deepest sympathy is given to Mrs. Hughes and her two children.

* * *

We have also to record with sorrow the death of another of our students, Lieut. George Francis Juckes, who has been killed on active service in France. He was twenty years of age and received his commission soon after the outbreak of war. Our deepest sympathy is given to his parents, Mr. and Mrs. F. H. Juckes, upon whom the blow will fall the more severely since his younger brother, Lieut. T. R. Juckes, was killed at Richebourg L'Avoué on May 9th last.

* * *

We heartily congratulate Sir Anthony Bowlby, who has been promoted to the rank of Surgeon-General.

* * *

We heartily congratulate Surgeon B. A. Playne, R.N., R.N.D., who has received the D.S.O. for gallantry and good service during operations near Gaba Tepe from April 28th to May 1st, 1915. On several occasions he rushed across the open (the communication trench being incomplete) into the fire trenches and attended the seriously wounded, regardless of the severity of the enemy's fire; on one occasion he carried a wounded officer on his back from the fire trench to the communication trench under heavy fire. His conspicuous bravery not only inspired the stretcher bearers to perform fine work, but gave confidence and spirit to all ranks. He was again several times brought to notice for gallant deeds when attending wounded on May 3rd and 4th.

* * *

The Rede Lecture for 1915, delivered by Dr. Norman Moore, was entitled "St. Bartholomew's Hospital in Peace and War," and must not be passed over without notice. Essentially it consists of a brief history of the Hospital since its foundation. It is lightened throughout by curious and interesting details, such as Dr. Moore knows so well how to weave into his writings and discourses. He narrates how during the Great Rebellion the Hospital was full of wounded soldiers, who "drank and quarrelled a great deal," and he shows throughout "how in a free country, such as ours, where everything is not dominated by Government, an ancient institution like St. Bartholomew's Hospital, whether in peace or war, lives with the nation and is in touch with the national life in every period."

* * *

Once again it is our pleasant duty to offer a hearty welcome to those who are coming to Bart.'s for the first time. These are arriving at a period which will ever be memorable in their lives, not only because they have reached one of the important milestones upon their career, but also because they come at a time when the Hospital is mobilised for war. At the same time we are glad to be able to inform new students that the social life of the Hospital, though not by any means what it is in times of peace, is by no means neglected. The various sports clubs are kept going, for we must get exercise and keep fit, and the Abernethian Society still holds meetings from time to time. We regret, however, that the Rifle Club is for the time being dormant, owing to the fact that the miniature range, being underground, is now filled with specimens from the Museum ; a precaution taken in case a Zeppelin managed to drop a bomb by unlikely accident within a radius of two miles of the Hospital. There is also the Officers Training Corps of the University of London, to which we hope the majority of new students will attach themselves.

A small booklet, containing the constitution and rules of the Students' Union, with the rules of the constituent societies and clubs, will be issued to each student, and we hope that these will be read and that each student will be able to play his part in one or the other of these constituent clubs. The secretaries of the various clubs are only too anxious to meet with each student. W. F. Eberli and I. Braun are the respective secretaries of the Rugby and Association Football Clubs. The secretaries of other clubs which may be active at a later date will post notices on the boards in the Abernethian Room. The Cricket and Swimming Clubs are, of course, not active during the winter.

We congratulate all new students upon having selected St. Bartholomew's Hospital as their *Alma Mater*, because not only is it the senior London hospital, with a history dating back some 800 years, but it undoubtedly possesses the finest traditions and the highest examination records, particularly in surgery, in which subject it is approached by no other hospitals, however excellent they may be in other respects.

While we are by no means sure that we should encourage men to become doctors while there are still vacancies to be filled in the army, we cannot refrain from pointing out that those who join the profession just now and in the near future are assured not only of a life of interest and human service, but also of a very fair income, for there are unfor tunately not enough doctors to "go round."

We wish the best of luck to all, and may you remember that the future of the Hospital is in your hands. The future senior physicians and surgeons are in all likelihood just entering upon their careers. Another Lord Lister or a Poet Laureate may be amongst you. But whoever it be that enters the Hospital to-day—remember that to-morrow the traditions of Bart.'s will be in your hands.

THE DUCHESS OF WESTMINSTER'S HOSPITAL.

By CAPT. W. P. S. BRANSON, M.D., F.R.C.P.

THE war had not been in progress many days when the Duchess of Westminster laid the foundations of the Hospital, which has since borne her name, by inviting Mr. Gordon Watson, through Mr. R. C. Ackland, to collect the *personnel* for a hospital of 200 beds and to take the professional charge of it. The scheme was blessed by the authorities, and after some laborious weeks for the chief actors (including, of course, the Duchess and Watson, and also a number of others, whom I do not mention by name simply because this is not a history) the second week in September found us ready to start at twenty-four hours' notice.

Our military Commandant was Major (now Lieut.-Col.) Douglas, V.C., D.S.O. Our medical staff of six all hailed from Bartholomew's—Gordon Watson and Sydney Scott, Surgeons ; W. P. S. Branson and Harold Pritchard, Physicians ; D. M. Stone, Assistant Surgeon and Radiographer ; and J. S. Burn, Assistant Surgeon and Anæsthetist. We had four Bart.'s dressers—Bowes, Derry, Robinson, and Tresidder. Our nursing staff consisted of twenty trained Sisters, including Mrs. Llewellyn Phillips, our Matron, and married to a Bart.'s man. Several of our Sisters were from Smithfield at one time or another—Miss Kilner, Miss Bailey, Sister Casualty (Miss Clowes that was), Miss Hallett, and Miss Vincent. Indeed, I think the predominance of Smithfield in the *personnel* brought qualms to the hearts of some of the other Sisters, but I hope and think we have lived it down. Our sixty orderlies were

provided by the F Bearer Company of the St. John Ambulance Brigade, from Bristol.

We left Waterloo for France on September 27th, 1914, but not at our full strength, for Mr. Woodhouse, who was to have been our Quartermaster, fell sick at the last moment with appendicitis. Pritchard also defaulted for the time, having, by a bitter irony, knocked himself out by his own anti-typhoid inoculation, which made the rest of us merely unhappy, but kept him on his back for upwards of a fortnight. The vacant quartermastership was very sportingly filled by Mr. H. L. Etherington-Smith, brother of our lamented "Ethel"; but he was unable to accompany us because he required a few days to put his affairs as an architect into order before immersing himself in rations and bedding and plumbing and the fifty thousand other things which have since littered his ambit.

The Duchess, having successfully inaugurated an ambitious undertaking, had reserved enough enterprise to secure the transport of the hospital to Havre in Sir Thomas Lipton's "Erin," and so it fell out that we started most auspiciously and in great luxury with the kindest of hosts. It was expected that the ninety odd of us would be on the "Erin" for about sixteen hours. In fact, what with one *contretemps* and another, we were there for three days; but nothing seemed capable of disconcerting Sir Thomas and his chief steward. So we came to Havre and went on to Paris, at this time under sufficient suspicion of being insecure to warrant the transference of the Government to Bordeaux. Certainly it was a dead city. We thought we were to make a start there at first, for a fair number of British wounded were coming into it at the time, but we soon learned the uncertainty of any kind of war service; for, though we lived from day to day in expectation of marching orders, we had spent a tedious month of waiting before being finally ordered to Le Touquet. This very deadly month (for, of course, we were all in a fever of impatience) was unrelieved by anything of interest beyond the occasional visits of marauding Taubes, which came at this time, you will remember, to impose true culture upon Nôtre Dame and other mean relics of a barbaric past. But even these visits were generally brought to our notice by the daily paper of the following day, although on one occasion two of us, who were wrestling with French verbs in the Tuileries Gardens, did actually see something of the performance. Our attention was drawn by a small crowd of gesticulating Frenchmen, who pointed out the aeroplane above the northern part of the city, and a very pretty sight it made; for the day was sunny, with a small amount of cloud, into which the pilot would disappear for a minute or two, his reappearance being generally followed very shortly by a distant detonation. It was on this Sunday that a bomb actually fell on Nôtre Dame, but fortunately failed to explode.

Apart from the tedium of the time, it was particularly galling to people of our sensibility to be the cynosure of all eyes in our khaki (which was at this period still a moderate rarity in Paris) when we knew very well that we had done nothing at all to deserve the flattering recognition so lavishly bestowed upon us by the populace. Altogether we were very discontented, and I could fill a volume with accounts of the work and voyages put in by the Duchess and Douglas and Watson in their efforts to get going without loss of time; but on retrospect one can see how difficult it must have been for the authorities to select a site for a hospital at a time when the line was still subject to violent and rapid changes of position. Nevertheless, you may guess how the waiting taxed our patience and how we hailed the prospect of making a start when at last a site had been found for us by the joint efforts of the Duchess and the Quartermaster.

This site was the Casino de la Forêt at Le Touquet, most generously placed at our disposal, rent free, through the offices of M. Soucaret, one of the chief citizens of the neighbourhood, and this has been our home ever since. We arrived on October 28th, one of the most critical days of the first battle of Ypres, and set to work to convert the Casino into a hospital. As such things go, our task was easy, for the building is in many ways ideal. Three great and lofty halls devoted respectively in piping times to dancing, petits chevaux, and baccarat. I think even the most rigid moralists will have to admit that the casinos in France have justified their existence during this war, for, as regards the improvisation of hospitals, no class of building can compare with them, since the largeness of the rooms and their situation upon the ground floor qualify them particularly well for hospital wards. These three large halls became our principal wards, holding respectively 58, 67, and 125 beds. The fencing-room upstairs became the operating-theatre, the reading-room an officers' ward of 10 beds; the American bar fell naturally to the dispensary; Stone seized an outhouse and made a first-rate X-ray room of it, with the aid of a bathing-machine impounded from the beach. The Duchess and Mrs. Whitburn (another very generous supporter of the hospital) joined our mixed mess of nurses and doctors and voluntary dressers in a wing of the then unoccupied Hôtel des Anglais, kindly put at our disposal by its owner, Mr. Tanqueray. Mr. Norman Evill, an architect at home, who had come out with his car to do ambulance work, took charge of our transport arrangements and continued to look after this branch until a few weeks ago, when a variety of transport rearrangements, due to local changes, left him short of a job and robbed us of a good worker and a loyal colleague.

Within a week of our arrival we were ready and received our first convoy of 230 patients on November 4th. A large number of these patients were badly wounded men from the Ypres fighting, and I must say it was an experience to deal with so many new and bad cases at one time in a recently-

established hospital. But as a large proportion of my readers will have been through the same kind of mill themselves, it is not worth while to dilate upon the difficulties that have to be met.

Having got us fairly started, Douglas was presently taken off to other duties. Our idle time in Paris must have been even more trying for him than for the rest of us. But he put up with our grumbling impatience with consistent good temper, and, as I have said, gave us a good send-off on our career. From this time Watson became our commandant as well as our surgeon-in-chief, it being possible for him to administrate in the mornings and operate in the afternoons, though the double task was no light one. None but those who have tried it can really appreciate what it means to plunge a civilian unit into a network of cog-wheels, such as the R.A.M.C., and to get it to work as a cog-wheel in the series; I mean as a help to the whole machinery and not an obstruction, however well-meant it be. We are sanguine enough to think that we have achieved this adjustment during the greater part at least of our eleven months' existence. It is no particular part of my business to puff my colleagues; indeed, I am too occupied doing that for myself to have the time, but I do not mind going so far as to say that Watson has a peculiarly practical grasp of administrative essentials, and that Etherington-Smith is about the most versatile, persevering, persuasive, and generally helpful person that I know, and between them they have succeeded in fitting us into the scheme of things.

We had not been many days at work when it became evident that we were inadequately staffed for the beds we had. We came out equipped for 200 beds, but the building admitted of our accommodating easily 250 men and 10 officers (that is to say, the figures of half a general hospital), so we expanded to that size, borrowing doctors and nurses from the Red Cross, and have continued so until about six weeks ago. At Christmas time Scott had to go home, to our greatest regret; otherwise our original medical staff remains intact, but has been supplemented from time to time by a changing series of helpers. L. T. Giles, Crichton Starkey, C. S. Myers, Tom Body, Whitehead-Reid, "Monkey" Nunn, Forbes Fraser, Neve, and Kenneth Walker, all Bart.'s men, have done a turn with us. F. P. Young is with us now. J. P. Hedley, of Thomas's, also worked with us for a time, and a regular member of our band is James Erlank, who hails from South Africa, *viâ* Edinburgh, and leads a busy life as assistant surgeon and registrar. He is our war-worn veteran as regards this campaign, having been taken by the enemy on their entry into Brussels. Our present complement, as regards doctors, is completed by Mr. R. J. Dick, of the London, a partner of Giles's in Scarborough. At Christmas time we also parted regretfully with three of our dressers, Bowes, Derry, and Tresidder, who went home to get qualified, and with several of our Sisters. I cannot pretend to give a detailed account of our fortunes, but all went well with us till April, when Watson, while home on leave, fell sick with enteric and had a bad time from a tiresome relapse, which laid him by the heels for a good long time. However, we managed to hold the fort between us in his absence, and have now had him back for a month or more. While he was away changing circumstances induced the authorities to suggest our conversion into a hospital entirely for officers, and he returned just in time to take over the supervision of the change. This is now accomplished, and we have 120 officers' beds, the majority of them being potentially cubicled, surrounded, that is to say, by woodwork frames carrying curtains which can be drawn at will. This is a convenient arrangement and less bothersome than movable screens. It is better also than permanent partitions, since if two adjoining patients want to gossip they have but to draw a curtain back.

During the nine and a half months of our active existence we have had 4281 patients through our hands, and have received as many compliments as are good for us. We are most lucky in having in charge of our district an A.D.M.S. and a D.A.D.M.S., who are sympathetic and do all they can to help us to be useful. The Duchess continues to live near the hospital and to take an active part in the work. She has steadily declined the temptation to pose as a nurse, and has earned all our admiration by sticking to the tedious, but vital, business of administering the linen room—a big and unpleasant business in our earlier days when we had 260 beds and extemporised laundry arrangements, but easier now. All things considered I think we can look back upon our past with a reasonable amount of self-complacence, and the recent promotion of Watson to be Hon. Lieut.-Col. seems to argue that the Powers-that-be share a view which might possibly be thought to be biassed if it lacked some such external support.

FROM THE FRONT.

SIMPLE RHYMES FOR "FRIGHTFUL" TIMES.

1. "LITTLE WILLIE," OR "THE WHIZZ-BANG."*

Whizz-bang, whizz-bang, little Willie:
Really it is rather silly;
Making such a foolish noise
Doesn't frighten soldier boys.

* A small noisy shell fired at close range doing very little harm.

2. Gas-shell.

When the Boche puts over shell
That make a funny sort of smell;
And the water in your eye
Looks as though you're going to cry;
'Tis but the Boches' morning hate,
Brothers let us respirate.

3. Sniping.

When at night *giou, giou*
By Tommy's heard (or piou-piou),
He's no need to duck his head,
For the silly bit of lead
Is passed and gone away
Before you ever hear it say
Giou, giou.

4. Trenches.

(*This may also be said when troubled by the Staff.*)

When within your tiny trench
There's a rather horrid stench;
When the shells are falling thick
(And perhaps you wish that you were sick);
When the rain has made a river
Of the trench in which you shiver;
When the *fauna* of your shirt
Make you feel a little hurt;
When the flies in myriads swarm
On the bacon that you warm . . .
Don't forget that ageing cares
Might have given you grey hairs
Had perhaps you chanced to be
General Somebody's A.-D.-C.

J. R. R. T.

LONDON AMBULANCE COLUMN.

THE number of beds which are at the disposal of the Medical Department of the War Office in London is great, and the number of men who have to be conveyed to them is correspondingly large. Practically the whole of the work of such transport is carried out by the London Ambulance Column. The work is absolutely voluntary, and a few figures showing what has been accomplished during the first twelve months will give some idea as to its magnitude. Since August 30th, 1914, the date of the arrival in London of the first train of wounded and sick from the Western Front, the Column has met 662 trains. From these trains 7091 officers (2727 being stretcher cases) and 38,625 N.C.Os. and men (10,726 being stretcher cases) have been conveyed to the sixty odd hospitals which receive the wounded and sick. It will be seen that this makes a total of no fewer than 45,716 men conveyed in the motors lent to this efficient Column.

For the year the average number of "calls" per day has been seven, and the average number of patients transported per day has been 125. Every one of these has received individual attention in handling and transport. Many of the trains arrive in the "small hours" of the morning, and, although it is often in these hours that human vitality reaches a low ebb, not a single man has died during his journey in the ambulances.

More cars, the ordinary car, not an ambulance, are needed for the work, and anyone wishing to offer one should communicate with the Hon. Secretary, London Ambulance Column, 83, Westbourne Terrace, Hyde Park, W., stating type of car and days and hours available.

ARTIFICIAL LIMBS.

By R. C. Elmslie, M.S.

Part II.

Mechanism of Standing and Walking.

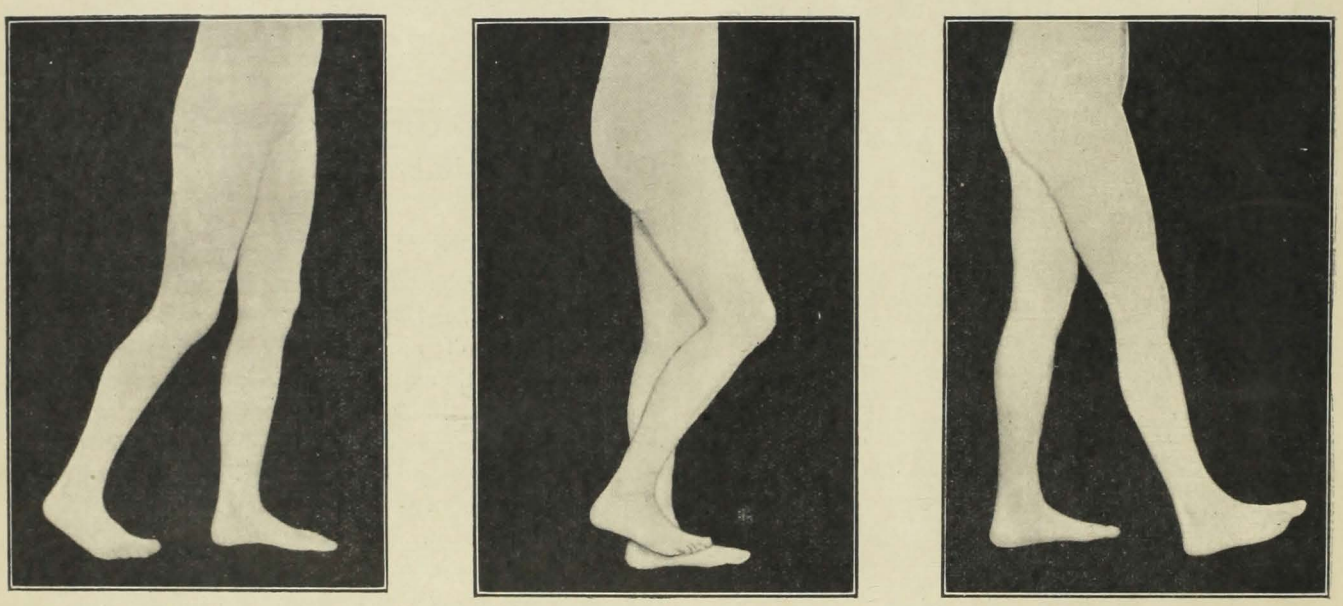
In order to understand properly the principles of construction of artificial legs it is necessary first to realise the mechanism of normal standing and walking. In standing, very little muscular effort takes place in the lower limb; the line of the centre of gravity of the body falls behind the centre of rotation of the hip-joint and in front of that of the knee-joint. The hip is extended by slight action by the glutei and locks in this position, the Y-shaped ligament being taut. The knee is extended and locks without any muscular action being required. The foot is kept in proper position by a balance of its muscles.

In walking upon level ground, for example, in stepping off the right foot the weight is first thrown forward on to the left foot; the right heel is then raised, the knee slightly flexed, and the limb swung forward; the foot is made to clear the ground by (1) raising the right side of the pelvis, (2) keeping the knee flexed and the foot at a right angle; the knee is then extended, the foot pointed down slightly, and the right side of the pelvis dropped so as to bring the heel on to the ground; the weight is then shifted on to the right leg. A very large proportion of the muscular work is carried out by the muscles of the pelvis and hip. Flexion of the knee requires only a slight effort; extension is carried out by the swing of the limb without any effort (patients who have lost the use of the quadriceps can walk perfectly upon the level), and the movement of the foot is very small. The ankle only moves from a right angle to a position of about 25° of plantar flexion; there is no lateral movement, but the toes dorsiflex considerably but passively.

Walking down a slope requires considerably more effort. In the first place the weight is kept upon the rear leg

longer, whilst the knee is flexed and the heel raised, so that the quadriceps does work eccentrically, supporting the weight whilst it lengthens, and the gastrocnemius and soleus actively raise the heel. Then the fore foot is placed upon the ground with the knee flexed, so that the quadriceps has again to do work. In walking up a slope the quadriceps again must be used, in this case concentrically. In walking sideways along a slope lateral movements of the foot come into play.

In walking upstairs the advancing limb is first raised by flexing the hip, the knee flexing passively and the foot being kept at a right angle; the foot is then dropped upon the upper step either flat or with the heel raised; the weight is shifted on to this foot and the limb straightened by action of the glutei, quadriceps, and gastrocnemius and soleus. In coming downstairs the action is reversed, the same muscles work eccentrically, *i.e.*, lengthening gradually whilst supporting the weight.



a. *b.* *c.*

FIG. 1.—POSITIONS IN WALKING: *a*, RIGHT FOOT LEAVING THE GROUND. *b*, RIGHT FOOT BEING SWUNG PAST LEFT. *c*, RIGHT FOOT JUST MEETING THE GROUND.

In the above description the actions of walking have been reduced to as simple a form as is possible; they can be verified easily by personal trial. It will be convenient next to take the most general problem in the making of an artificial leg, that of the construction of an artificial limb for an amputation through the thigh, the muscles of the hip being intact.

MECHANISM OF AN ARTIFICIAL LIMB FOR AMPUTATION THROUGH THE THIGH.

In an artificial limb it is desirable to reduce movements and mechanism to the simplest possible. In the first place it will be seen that extension of the knee is carried out automatically by the swing of the limb in walking upon the level, provided that the centre of rotation of the joint is properly placed behind the line of the centre of gravity. So that an arrangement for extending the knee by means of an accumulator or spring is not essential. It is safer, however, to have some such arrangement, both because it gives a greater sense of security and because the slight power of extension is sufficient to enable the wearer to walk up a moderate slope without discomfort. Extension of the knee can be carried out by means of an elastic accumulator in front of the joint; this is the usual method adopted in the English type of leg, although it is sometimes replaced by a spring mechanism placed inside the limb. In this way the extension is automatic and involuntary, but in the American type of leg a voluntary method of extension is introduced. Straps from the front of the leg below the knee are carried up into the suspender which supports the limb over the shoulders; the action of raising the shoulders then tightens these and extends the knee. No method of extending the knee with sufficient strength to enable the wearer to walk up a step in the natural manner has been devised, and it appears that this is not capable of accomplishment.

Flexion of the knee can be made automatic if the dorsal extension of the foot is limited to a right angle; the pressure of the toes upon the ground then flexes the knee, and this flexion will persist until the limb is swung forward.

It will be seen from the description of walking that only a very limited movement of the foot and ankle is essential. The most important movement is dorsal extension of the

toes. This is arranged for by putting in a spring or rubber joint at the level of the heads of the metatarsals. Extension then takes place by the pressure of the weight upon this, and the toes straighten out as soon as the pressure is removed. In the ankle region movement is required from the right angle position to about 25° of plantar flexion at the most. There are two essentially different methods of getting this movement, and these are bound up with the corresponding methods of arranging for the knee movement. They are best described as the English and the American types of artificial leg.

The English type of artificial leg is also called the tendon leg. Its essential characteristic is the fitting of an artificial tendo Achillis which is attached at one end to the thigh piece and at the other into the heel. When the knee is extended this tendon is taut and the foot consequently

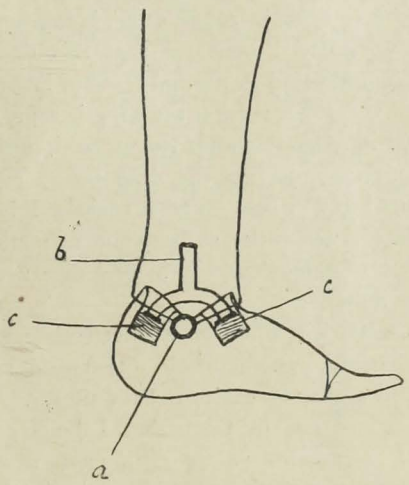


Fig. 2.—Diagram of American Spring Ankle Movement. *a*. Ankle Bolt; *b*, Steel Bolt Fixed in Leg Piece with Prongs Pressing into *c*, Rubber Compression Pads.

plantar flexed to its utmost. As soon as the knee is flexed the tendon relaxes and the foot is extended dorsally by an opposing spring. This dorsal movement of the foot is limited to a right angle. In this type of leg the knee is kept extended by an anterior elastic accumulator or by an internally fixed spring. But when the wearer has become accustomed to the leg this can usually be dispensed with, the extension of the knee being automatic through the swing of the limb.

To recapitulate in walking on such a leg the movements are as follows: In stepping off the leg, the knee being at first extended, the foot is plantar flexed by the tendon, so that the heel is raised from the ground; the pressure of the toes on the ground flex the knee, this brings the foot to a right angle and the limb is swung forward in this position with the knee flexed and the foot at a right angle, the ground being thus well cleared. The forward swing of the limb extends the knee, the foot becoming plantar flexed, and the foot is thus dropped on to the ground with the knee straight and the toe pointed down. The walk thus obtained is very natural, the chief defect being that the foot is a little loose in its mid position, and is apt to meet the ground with rather a flop. A more important defect in this type of limb is that there is considerable mechanism which may get out of order.

In the American type of limb the foot movement is isolated from that of the knee, and consists in a simple spring action. The foot is balanced in its mid position (one of slight plantar flexion), movement in either direction being resisted by a spring. In the best type the resistance is given by the pressure of a metal plate against a solid mass of rubber. The spring action thus given is smooth and sufficient, and rubber, when subjected to compression and not to stretching, does not tend to perish at all rapidly. Moreover, the rubber pads lie in simple cups and can, if

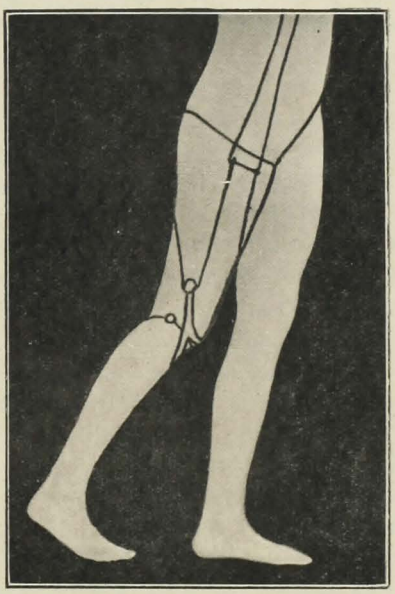


Fig. 3.—Diagram of Arrangement of Sling to Extend Knee.

necessary, be replaced in a few minutes. The knee action is automatic, assisted, when necessary, by the mode of fitting of the sling. All artificial limbs must be held on by a sling of some sort. In the usual type of sling there are simply straps passing from the top of the limb over the opposite shoulder. The objection to this is that, as the limb is swung to and fro the sling must work backwards and forwards on the shoulder. The American type of sling is not attached to the top of the bucket, but is carried on down the limb by two cords—an inner and an outer. Each cord from the front of the sling passes through a pulley in the thigh, and turns up to be attached to the corresponding part of the back of the sling. The play when the limb is swung thus takes place upon the cords around the pulleys, and not over the shoulder. In order to give a voluntary power of extension of the knee, it is only necessary to attach the pulleys to straps which are fixed to the front of the leg

below the knee. Raising the shoulders will then tighten these cords and extend the knee.

The great advantage of this type of limb is its simplicity. There are no concealed tendons or springs, except the rubber pads in the foot, and, as already explained, these can be easily changed.

ARTIFICIAL LEGS FOR OTHER AMPUTATIONS.

In amputation through the knee-joint or condyles of the femur the bucket can be so shaped that weight is taken upon the end of the stump—a great advantage. On the other hand, it is impossible to fit the ordinary type of knee-joint with a bolt right through. As it is important to keep the knee movement at the correct level the joints must be steel ones fitted on the inner and outer side of the knee, the thigh piece being rounded at its lower end and the leg piece hollowed to glide over it on flexion and extension.

In amputations below the knee the weight should be taken on the sides of the tibia and fibula. For this purpose very accurate modelling of the fitting to the leg is necessary, and it is usually advisable to line the bucket part of the leg with leather to keep the fitting accurate; paraffined leather gives the most perfect and comfortable fitting. To hold the limb in place it is necessary to connect it by side steels to a leather lacing thigh piece. The foot is the same as in the limb for amputations through the thigh.

In a Syme's amputation and similar amputations through the ankle region, in which the weight can be borne upon the end of the stump, the chief point is that the fitting must be to the leg, and must hold it so closely that movement is impossible. Lateral steels with ankle-joint and limited spring movement connect this with the foot.

This brief description of artificial legs pretends only to give the barest outlines of their principles. There are many ways of arranging and fitting the mechanism; each maker has his own methods. But the principle described should be sufficient to enable anyone to examine these methods himself, and to judge of their efficiency.

PITUITARY EXTRACT AND OBSTETRICS.

By R. STLEGER BROCKMAN, M.R.C.S., L.R.C.P.

THE following remarks are the records of some observations I made while I was working as Internal Midwifery Assistant in the wards of St. Bartholomew's during the summer of 1915. In all cases of labour two people have to be considered, and though in some cases what is best for the mother is worst for the child, one does not like to have recourse to such treatment unless one is forced to.

The only advantage in a normal case in the use of pituitary extract is to get the labour over quickly for the mother. The danger of post-partum hæmorrhage I do not think exists any more under such circumstances than if no use had been made of the drug. On the other hand, the other party concerned runs considerably more risk if use is made of this means of quickening its delivery. Labour pains are intermittent in character, a provision of Nature whereby the circulation is allowed to proceed and undue pressure on the umbilical cord prevented. In cases where this drug is used this provision of Nature is swept aside, and the intermittent painful uterine contractions become one continued pain with no relaxation until either the child is born or the effect of the drug wears off. My experience of the use of this drug in normal cases stopped me very soon. The children were born in a precarious condition, and in one case it was only after a great deal of trouble that the child was ever brought round at all, being born in white asphyxia. Personally I consider that this drug is most strongly contra-indicated in normal cases of labour.

In cases of Cæsarean section the drug is especially useful when injected immediately after the extraction of the child, but the practice of injecting the drug before commencing the abdominal incision has, on all occasions I have seen it so administered, made the subsequent extraction of the child a matter of difficulty, and in one case nearly ended fatally for the infant.

Pituitary extract will often save interference in cases of inevitable abortion, which would otherwise require an anæsthetic and digital evacuation of the uterus.

But it is not in any of these that I believe this drug may prove of the greatest value, but in cases where a rapid delivery is essential for the well-being of the mother.

CASE 1.—A woman, seven months pregnant, was brought into the ward bleeding severely from a misplaced placenta. A bipolar version was performed, but the hæmorrhage was not controlled, as the woman was obviously bleeding into her uterus. The os was the size of five shillings. 1 c.c. of pituitary was injected into the buttocks, and in twenty minutes everything was over.

CASE 2.—A woman suffering from chorea of pregnancy had been in labour for thirty-six hours. Curiously enough the fits in no wise abated during labour, but continued with more vigour. As she was getting worn out 1 c.c. of pituitary extract was given intramuscularly, the os being dilated at the time of injection. The child was born in fifteen minutes, and was followed by the placenta three minutes later.

In making use of this drug in such cases care must be taken to ascertain the character of the cervix. A hard undilatable cervix would be a strong contra-indication for such treatment, and also in cases of placenta prævia it must be borne in mind that under these conditions the lower uterine segment is much thinned and very friable.

I have recorded these cases as I feel convinced that in

this drug we have a very useful aid in treatment of obstetric cases where we wish for a speedy delivery, and in which the life of the child is not of equal import with that of the mother's.

THE MEDICAL ESSAYS OF OLIVER WENDELL HOLMES.

By Alex. Macphail, M.B., C.M.Glas.

ONLY rarely have recruits been raised to the Olympus of Literature from the ranks of the medical profession. Among these, Oliver Wendell Holmes, for thirty-five years (1847–1882) Professor of Anatomy in the University of Harvard, occupies a foremost place. His name and fame lie securely enshrined there, through the lasting appeal of his essays, novels, and poems. The distinction of his genial style as an essayist was first revealed in the *Autocrat at the Breakfast Table*—the forerunner of the equally delightful *Poet* and *Professor. Elsie Venner*, a romance of heredity, proclaimed him a prince among story-tellers. His fertility in verse was amazing; among many gems, both grave and gay, his "Deacon's One Horse Shay" perhaps holds most perennial charm.

But to many who have made of the genial "Autocrat" a life-long friend, his early years of training in medicine and his distinguished record as a Professor of Anatomy remain unknown. The Chair of Anatomy was to him, however, no insulating stool. He kept to the end a watchful eye on the currents and counter-currents of medical practice, and his little-known volume of *Medical Essays* is full of brilliant observations thereon. On his own confession, he would have been content had one of these essays—on the "Contagiousness of Child-bed Fever"—been all that he had ever written.

That puerperal fever is contagious had been recognised in our own country long before, but that it was still denied by many, and ignored by most American practitioners aroused his indignation to fever heat, and in this essay, first published in 1843, he accumulated a vast amount of evidence which, he claimed, "laughed all sophistry to scorn and rendered argument an insult." The mere handling of the facts seemed to cause him pain; he had no tone deep enough for regret at the too plain evidences of epidemics of dying mothers and no voice loud enough for warning—"The solemn prayer of the Liturgy singles out the mother's sorrow to plead for her in the hour of peril—God forbid that any member of the profession to which she entrusts her life should hazard it negligently or selfishly." The great outcry against this essay on the part of some members of the profession, some of them distinguished teachers of obstetrics, only showed that it carried conviction. But reproach was not his motive; he sought to teach a lesson—not in vain abstractions merely, for he indicated the remedy—and by the time he wrote the preface to a second edition, the case had long been decided in favour of the views he advocated.

Strenuous in opposing all that he deemed unsound, he next grapples with Hahnemann in a merciless exposure of "Homœopathy and its Kindred Delusions," making the nakedness of the German patentee stand out all the plainer by comparisons with the dark doings of mediæval times. Though brief, the essay is a vast collection of facts, and these are examined with a delightful mixture of keen logic and bitter ridicule.

In "Currents and Counter Currents" he reviews the ebb and flow of the extent of "drugging" in medical practice, and fights against the high tide of his day with a vigour which again got him into trouble. He reduces within very small scope the ailments that cannot be cured by simply *spitting out*—forsooth!—the morbid agent. He would take out opium and one or two specifics, wine, which he regarded as a food, and the vapours which produce anæsthesia, "and if the whole of the rest of the pharmacopœia," as then used, "could be sunk to the bottom of the sea, it would be all the better for mankind and all the worse for the fishes." This is extreme language certainly, but the current practice it was aimed against was even more extreme, and, with stinging irony, our author attributes this to the weak point in the temperament of his native land—"How could a people who send out yachts to outrun and checkmate all the rest of creation, be content with anything but heroic practice? What wonder that the Stars and Stripes wave over doses of ninety grains of quinine, and that the American Eagle screams with delight to see three drachms of calomel given at a single mouthful!"

"Border Lines of Medical Science" is a wide-reaching review of the state of our knowledge in all departments of Medicine about the year 1860. It is full of graphic accounts of interesting discoveries, which were then modern achievements, though now ranked in history.

Less subject to the changing perspective of time is his fascinating study of "Scholastic or Bedside Teaching." Though published in 1867, more than twenty years after he had taken any part in clinical work, it shows unabated clinical enthusiasm; wonderfully graphic is the description of the round of visits paid by a practitioner "of the old School" with his young apprentice Luke. The clinical pictures are perfect; Luke sees despair in the writhing of the sturdy yeoman sick with the belly-ache, and hope in the flushed cheek and bright eye of the consumptive maiden, till with fatherly care his experienced master sadly reverses his prognosis. In this same essay he draws a vivid picture of an early anatomist hastily dissecting the corpse stolen from

a lonely gibbet—"Ever and anon he turned to his book as he laid bare the hidden organs, to his precious Vesalius or to the grand folio of Spigelius, just fresh from Amsterdam, in which lovely ladies display their viscera with a coquettish grace, implying that it is rather a pleasure than otherwise to show their lace-like omentum, and hold up their appendices epiploicæ as if they were saying 'Behold our jewels!'"

Only brief mention can be made here of the remaining essays.—"The History of Medicine in Massachusetts," beginning with the worthy Dr. Fuller, who landed with the Pilgrim Fathers; "The Young Practitioner," an address to young graduates, full of encouragement and sound advice to the young knight buckling his armour for life's battle; "Medical Libraries," an invaluable treatise on their institution and uses; "Some of My Early Teachers," his valedictory to Harvard. This last includes a delightful sketch of the Paris School and its great men in the early years of last century—Dupuytren, Piorry, whom he reveals as poet as well as percussionist, Cruveillhier, and Ricord, whom he calls the Voltaire of Pelvic Literature, a "sceptic as to the morality of the Race in general, who would have submitted Diana to mercurial treatment and ordered a course of blue pills for the Vestal Virgins!"

VIXERE FORTES ANTE AGAMEMNON.

There have been soldiers who didn't fight at Crecy.
Dead Physicians, no traditions; who can sing a Leech?
There have been Surgeons before Abernethy,
Learned men, deft men, able men to teach.
Now any quack shares in bromides or in sepias
Fleeting over Fleet Street—and other life than Art,
Others by the back stairs Moses and Asclepius
Follow, wise and quiet serpents, sound of brain and heart.
Yet, is there one with the sacerdotal function—
(Lest after ages should altogether doubt them—)
To anoint them with History, extreme Unction,
To build imperishable monuments about them?
Possibly some doctors know more about the tissues,
More about the arteries or some selected limb,
More about diseases, their crises and the issues,
Possibly, as doctors, are senior to him.
This I will leave to the College of Physicians,
But of this thing I am reasonably sure;
We shall want continual reprinting of editions
Of the history of the Hospital by Dr. Norman Moore.
Maybe some were poor and wise, baited with scurrility,
Living in delivered cities compassed with vexations.
Here shall they be written "Rich men, furnished with ability,
Dwelling peaceably (at length) in their habitations."

E. L.

ST. BARTHOLOMEW'S HOSPITAL CHRISTIAN UNION.

IT is interesting to note that Christian Unions in the medical schools of London had their origins over half a century ago. At St. Bartholomew's Hospital meetings commenced in 1874, and have been held interruptedly ever since.

While the Christian Union cannot be affiliated to the Clubs Union, it is nevertheless an integral part of the social organisation of the Hospital and School life. Among the objects of the Union are to promote in Students of the Hospital regular habits of prayer and Bible study; to keep before them the importance of the Christian solution of social problems, and the permeation of public life with Christian ideals; and to enlist them in whole-hearted service of these ideals. The inter-relation of medical study with the problems of life and death and the Christian teaching thereon has always been a subject of deep and serious interest, and some of the meetings of the Union are directed to such study.

In the coming year of international unrest, spiritual problems dealing with the war will be discussed.

The opening meeting of the Session will take the form of an "At Home" on Monday, October 18th, at 8.30 p.m., at 124, Harley Street, W., at the invitation of the President, the Officers, and the Committee, at which full details of the Union programme during the Winter Session will be announced.

Any Freshman who may not have received an invitation is requested to write to the President at 124, Harley Street, if he can attend.

UNIVERSITY OF LONDON MILITARY EDUCATION COMMITTEE.

THE University of London Officers Training Corps, under the command of Lt.-Col. D. S. Capper, will begin its eighth year of training under exceptional conditions, as the Colleges of the University are largely depleted of students. In the infantry unit, the largest in the contingent, the training since the outbreak of the war has been mainly of a continuous character, cadets being accommodated in premises near London. As a rule, a few months of training under these conditions have been sufficient to qualify cadets for commissions. The artillery and engineer units of the contingent are also in active training. Their work is especially important at the present time, as there are so few facilities for the training of technical officers. The artillery unit has been permitted to keep its guns and equipment for training purposes. In the medical schools of the University a considerable number of students are completing their medical training with a view to taking commissions as soon as qualified. The strength and training of the medical unit of the University O.T.C. have, therefore, not been much affected by the war, and the cadets attended camp as usual.

Since the outbreak of the war, the number of commissions obtained by cadets and ex-cadets of the contingent up to the end of

August, 1915, amounts to 1521, and 189 commissions were obtained before the war, giving a total of 1710. In addition, 245 commissions have been obtained, up to the same date, upon the recommendation of the University, by graduates and students who were not cadets or ex-cadets of the University O.T.C. Before the end of September the University will have supplied well over 2000 officers to the army through the O.T.C. or by direct recommendation, and many other graduates and students have obtained commissions through other channels. Distinctions obtained by ex-cadets of the University O.T.C. include: Military Cross, 6; Medaille Militaire, 1; Mentioned in Dispatches, 14.

Under War Office Regulations membership of the University of London O.T.C. is not restricted to members of the University, and other men of suitable education, desirous of qualifying for commissions, are accepted. Candidates for enrolment should apply personally to the Adjutant at the Headquarters, 46, Russell Square, W.C.

REVIEWS.

Medical Annual Synoptical Index to Remedies and Diseases. For the ten years 1905 to 1914. (John Wright & Sons.) Price 8*s.* 6*d.* net.

Great pains have been taken to make this an exhaustive index. Lavish use has been made of cross-indexing, so that the references appear under all their conceivable headings—a process which entails the expenditure of a considerable amount of time and labour. One notices, however, in not a few instances that the references under one heading are not identical with those under its alternative heading, so that to get a complete list it is desirable that all the headings be looked up, *e. g.*, *Pneumococcal peritonitis* should be looked for not only under this heading but also under *Peritonitis, pneumococcal.* There are, too, occasional misprints, *e. g.*, *Labour, premature, indications for induction*, 11/534 should be 11/543.

The Index should prove to be very useful.

Oxford War Primers. (Henry Frowde, Hodder & Stoughton.)

Medical Hints. By Colonel J. E. Squire. Price 2*s.* 6*d.* net.

Wounds in War. By Lieut.-Colonel D'Arcy Power. Price 2*s.* 6*d.* net.

Surgery of the Head. By Major L. Bathe Rawling. Price 3*s.* 6*d.* net.

Injuries to Joints. By Major Robert Jones. Price 3*s.* 6*d.* net.

Abdominal Injuries. By Prof. R. Morison and Lieut.-Colonel W. C. Richardson. Price 2*s.* 6*d.* net.

This series of books dealing with both medicine and surgery is especially intended for the use of medical officers temporarily employed with troops, and naturally deals largely with the question of wounds, but this is by no means the only subject dealt with. Among such large forces as we have now mobilised almost every aspect of disease is presented, and general diseases have their chapters in these primers. We can cordially recommend them, not only as useful handbooks for army officers, but as excellent books for the student to carry in his pocket to refer to in odd moments.

The New Psychiatry. By W. H. B. Stoddart. Pp. 66. (Baillière, Tindall and Cox). 3*s.* 6*d.* net.

This book consists of three lectures delivered by the author. We could have wished that he had written at much greater length, because we must admit that in spite of our desire to approach the subject with an open mind we are far from convinced. We are willing to admit, however, that this is largely due to the fact that the author produces but little *evidence* to account for the faith which is in him. Psycho-analysis seems to have much in its favour; we are a little doubtful, however, when we find those interested in it attempting to turn nearly every state of mental unrest into a result of sexual abnormality. We read a book of Freud's on the *Interpretation of Dreams*, and in spite of our open mind we regarded him as an erotic lunatic. This book, however, while in many ways unconvincing is at the same time absorbingly interesting, and without doubt furnishes much food for thought. It is well worth reading, but we hope that the author will amplify it at a future date, and give us not dogmatic theories, but evidence.

Manual of Surgery. By A. Thomson and A. Miles. (Henry Frowde and Hodder & Stoughton.) 2 vols. Fifth edition. Price 10*s.* 6*d.* net each.

This well-known work needs very little praise from the hands of a reviewer. The whole of the text has been completely revised, and in many parts re-written, in order to bring it into line with recent advances in pathology and treatment. In this edition debatable questions and such subjects as can only be taught in hospitals have been eliminated in order to keep the size of the book within reasonable limits. A third volume, dealing exclusively with operative surgery, has, we understand, been added; this, however, we have not yet seen. The two volumes before us are clearly and interestingly written, and are illustrated with 590 blocks, the majority of which are excellent, although one or two have perhaps scarcely sufficient contrast in shading to show the requisite detail. We can confidently recommend this work to students, as it is quite up to date in every respect.

Practical Organic and Bio-Chemistry. By R. H. A. Plimner. (Longmans, Green & Co.) Pp. 635. Price 12*s.* 6*d.* net.

This volume is an attempt to give a complete course on physiological chemistry as part of the subject of organic chemistry. In this attempt the author has succeeded very well. The work is divided into sections, and each section has a short explanatory summary of the essential points, so as to connect the various sections together. The book should be of very great service to all taking the London. degree, and should, of course, be read in conjunction with both the organic chemistry and the physiology classes.

Aids to Tropical Medicine. By G. E. Brooke. Second Edition. Pp. 230. (Baillière, Tindall & Cox.) Price 3*s.* 6*d.* net.

An exceptionally useful little book, this second edition is all that can be desired in the way of being up to date. New chapters on three-day fever, verruca peruana, snake-bites, rats, etc., have been added, and the amount of solid information crowded into so few pages is really wonderful.

The arrangement of the subject matter in this, as in the previous edition, is strictly alphabetical throughout, which method of arrangement adds greatly to the convenience for reference.

There are thirty excellent charts and illustrations.

Essentials of Human Physiology. By D. Noël Paton. (W. Green & Son.) 4th edition. Pp. 535. Price 12*s.* net.

This well-known work keeps to its original plan in many respects and especially in its emphasis of such parts of physiology as are of cardinal importance in medicine and surgery. A number of parts have, however, been rewritten and re-arranged so as to bring the book thoroughly up-to-date and constant references have been introduced to the disturbance of functions which occur in morbid conditions. The text is clearly and interestingly written and the diagrams, which accompany it, are sufficiently simple to render them of great value to the student.

Manual of Embryology. By A. M. Paterson. Pp. 391. (Henry Frowde and Hodder & Stoughton). Price 10*s.* 6*d.* net.

This excellent little work is divided into two portions—general embryology and organogeny. It should be of very great service to the student, as it is exceptionally clearly written. As a rule embryology is found a somewhat difficult subject to follow, but with the aid of this book we think that it may be considered as a comparatively light subject, for not only is the text very concise, but the illustrations, of which there are over 300, are without exception simple and beautifully executed. The book, though small, is quite up to date, and covers the ground required by both ordinary and honours degrees; moreover, it will be found an exceedingly useful reference book for the student engaged on ordinary dissections, enabling him to understand clearly intricate or abnormal points. Without hesitation we say that every student would be well advised to possess a copy of this book.

APPOINTMENTS.

HERNAMAN-JOHNSON, F., M.D., Ch.B.Aberd., in charge of X-ray and Electrical Department, Cambridge Military Hospital, Aldershot.

WILLIAMS, H. O., M.B., B.S.Lond., appointed Certifying Surgeon under Factory and Workshop Acts for the Milford Haven District of the County of Pembroke.

WOODMAN, MUSGRAVE, M.S.Lond., F.R.C.S., Capt. R.A.M.C. (T.), appointed Assistant Surgeon to the Birmingham and Midland Ear and Throat Hospital.

WRANGHAM, W., M.D.Lond., M.R.C.S., L.R.C.P., appointed Honorary Physician to the Royal Infirmary, Bradford.

NEW ADDRESSES.

BAINBRIDGE, F. A., National Liberal Club, Whitehall Place, S.W. (temporary).

BOKENHAM, T. J., 26, Devonshire Street, Portland Place, W.

DOBSON, J. R. B., "Dagmar," Farnborough, Hants.

FAWKES, M., Naval Airship Station, Walney Island, Lancashire.

HARRIS, U. A. C., 6, Montpellier Terrace, Cheltenham.

HENDLEY, Col. H., I.M.S., Inspector General Civil Hospitals, Lahore, Punjab, India.

HERNAMAN-JOHNSON, F., 33, Cavendish Square, W. (Tel. Mayfair 2384).

PICKERING, H. J., St. George's Hospital, Malta.

BIRTHS.

BIRD.—On September 14th, in London, the wife of Lieut.-Colonel Robert Bird, C.I.E., M.V.O., Indian Medical Service, Calcutta, of a son (stillborn).

BURROUGHES.—On September 21st, at 35a, Hertford Street, Mayfair, the wife of Capt. H. N. Burroughes, R.A.M.C. (T.F.)—a son.

FOSTER.—On September 14th, at Widey Grange, Crownhill, Devon, the wife of Reymond L. V. Foster, Royal Army Medical Corps, of a son.

HANBURY.—On August 31st, at Foxbury, Woldingham, Surrey, to Mr. and Mrs. Reginald Janson Hanbury—a son.

SLADDEN.—On August 12th, at the Park House, Port Talbot, to Arthur F. S. Sladden, M.D., Lieut., R.A.M.C., and Mary Christabel Sladden—a daughter.

MARRIAGES.

DAY—WARREN.—On August 22nd, at St. Peter's Church, Ravenscourt Park, W., by the Rev. W. R. Gill, M.A., Cyril D. Day, son of E. J. Day, M.D., of Dorchester, to Winifred Warren, daughter of W. J. Warren, of Charlton, Wilts.

DOBSON—POOLE.—On July 19th, at Christ Church, Streatham Hill, S.W., by the Rev. C. C. Dobson, Vicar of St. Peter's, Paddington, William Townsend Dobson, M.R.C.S., L.R.C.P., youngest son of the late George Dobson, F.R.G.S., of Penarth, Glam., to Catherine Grace, eldest daughter of Henry Poole, Esq., Streatham Hill, S.W.

GANDY—HONY.—On September 16th, at St. John the Baptist, Kidmore, Reading, Thomas H. Gandy, M.B.Lond., of Peppard Common, Henley-on-Thames, to Ida, daughter of the late Rev. Charles Hony, Vicar of Woodborough, Wilts.

HEALD—MASON.—On September 18th, at St. Peter's Church, Hersham, Surrey, by the Rev. E. P. Pelloe, Charles Brehmer, elder son of Mr. and Mrs. Walter Heald, of Weybridge, to Edith Hildegarde, only daughter of Dr. and Mrs. Mason, of Walton-on-Thames, and granddaughter of the late E. J. Tarver, F.F.A.

HUME—STREETER.—On August 7th, at the Parish Church of St. Peter and St. Paul, Wadhurst, Douglas Walker Hume, M.B., B.S.Lond., F.R.C.S.Eng., eldest son of W. A. Hume, Esq., M.R.C.S., and Mrs. Hume, of Riseholme, Great Headland Road, Paignton, to Dorothy, second daughter of Edwin A. Streeter and Mrs. Streeter, of Wadhurst.

LEE—FARNWORTH.—On September 11th, at St. Martin-in-the-Fields, Crichton Stirling Lee, Lieut., R.A.M.C.T., to Olive, daughter of the late Ernest and Mrs. Farnworth, of Broadlands, Wolverhampton.

MACKAY—SAVAGE.—On August 25th, at St. Mary's, Ambleside (very quietly), by the Rev. E. U. Savage, Vicar of Levens, brother of the bride, Ernest Charles Mackay, M.D., of St. Leonards-on-Sea, son of the late Thomas Mackay, of Inverness, to Nina, youngest daughter of the late Canon Savage and of Mrs. Savage, Iveing Cottage, Ambleside.

PARRY—DAVID.—On September 21st, at the Parish Church, Llanover, by the Rev. R. David, Vicar of Llantwit Major, uncle of the bride, assisted by the Rev. E. Davies, Vicar of the Parish, Guy W. Parry Lieut., R.A.M.C., to Anne, only daughter of Mr. and Mrs. David, Ty Mawr, Llanover.

TAYLOR—PETO.—On September 15th, very quietly, at St. Stephen's, West Ealing, by the Rev. W. H. Thompson, LL.D., Cedric Rowland Taylor, M.B., B.C., Lieut., R.A.M.C., second son of the late Rev. R. E. Taylor, M.A., Vicar of Cresswell, Northumberland, and of Mrs. Taylor, of 86, The Avenue, West Ealing, to Frances Muriel, youngest daughter of Mr. and Mrs. Frank Peto, of St. Leonards-on-Sea.

WHITEHEAD—DUNPHY.—On September 11th, at Belvedere, by the Rev. Lewis Low, uncle of the bride, assisted by the Vicar, the Rev. G. Hartwright, and the Rev. Victor Dunphy, brother of the bride, Brian Whitehead, Lieut., R.A.M.C., son of Mr. and Mrs. Arthur Whitehead, of Rougemont, Salisbury, to Winifred Florence, eldest daughter of James Overton Dunphy, of Park Lodge, Belvedere.

DEATHS.

GREEN.—On July 10th, at Cleve Side, Newbridge Hill, Bath, F. K. Green, F.R.C.S.

HUGHES.—Killed in action in Gallipoli on September 15th, Burroughes Maurice Hughes, M.R.C.S., L.R.C.P., Captain, 1/4th Norfolk Regiment, of Wymondham, Norfolk, aged 43.

MACADAM.—Died, on August 18th, from wounds received in action at the Dardanelles, Lieut. John Macadam, 4th Essex Regiment, aged 23 years, elder son of Mr. and Mrs. J. H. Macadam, 31, The Drive, Ilford, Essex.

SAUNDERS.—On August 29th, at Hythe, Frederick William Saunders, M.B. and B.C.Cantab., late of Donnington Hurst, Newbury, and Assouan, Egypt, youngest son of the late Deputy-Inspector George Saunders, C.B., aged 52.

ACKNOWLEDGMENTS.

St. Bartholomew's Hospital League News, The Nursing Times, The National Medical Journal, The British Journal of Nursing.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, Smithfield, E.C.*

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All communications, financial, or otherwise, relative to Advertisements ONLY, should be addressed to ADVERTISEMENT MANAGER, *the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City 510.*

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St. Bartholomew's Hospital Journal.

Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

VOL. XXIII.—No. 2.] NOVEMBER 1ST, 1915. [PRICE SIXPENCE.

CALENDAR.

Tues., Nov. 2.—Dr. Garrod and Mr. Waring on duty.
Wed., ,, 3.—Primary F.R.C.S. Exam. begins.
Fri., ,, 5.—Dr. Calvert and Mr. McAdam Eccles on duty.
Tues., ,, 9.—Dr. Morley Fletcher and Mr. Bailey on duty.
Fri., ,, 12.—Dr. Drysdale and Mr. Rawling on duty.
Tues., ,, 16.—Dr. Tooth and Mr. D'Arcy Power on duty.
Thurs., ,, 18.—Final F.R.C.S. Exam. begins.
Fri., ,, 19.—Exam. for D.P.H.Oxford begins.
Dr. Garrod and Mr. Waring on duty.
Tues., ,, 23.—Dr. Calvert and Mr. McAdam Eccles on duty.
Fri., ,, 26.—Dr. Morley Fletcher and Mr. Bailey on duty.
Tues., ,, 30.—Dr. Drysdale and Mr. Rawling on duty.
Wed., Dec. 1.—First and Second Exams. for M.B.(Oxford) begin.
Fri., ,, 3.—Dr. Tooth and Mr. D'Arcy Power on duty.
Mon., ,, 6.—Exams. for M.D. and M.S.(Lond.) begin.
Tues., ,, 7.—Dr. Garrod and Mr. Waring on duty.

EDITORIAL NOTES.

WE have to record with sorrow the death of Dr. W. G. Grace. Comparatively few of the younger generation seem aware of the fact that he was a Bart.'s man; and yet it must be conceded that he is perhaps the most widely known of all men who have passed through our Hospital curriculum. Wherever English is spoken, there has "W. G." been known and revered as the greatest cricketer the world has seen; the father and pioneer of all modern cricket. We do not know how much of the game he learned at Bart.'s, nor how much he gave to Bart.'s in the way of high scoring or silver cups. We have no records of those bygone matches. Elsewhere we publish a portrait and obituary of this grand old sportsman who has at last passed away. *Requiescat in pace.*

* * *

It has been decided to erect a suitable memorial to the late Dr. Grace, and all Bart.'s men, past and present, are invited to assist. Subscriptions should be sent to the Treasurer of the Students' Union—Mr. W. Girling Ball—The Warden's House, St. Bartholomew's Hospital.

* * *

It is with much sorrow that we learn of the death, on active service, of Lieutenant E. H. Brunton, R.A.M.C., who has been killed in France. He was House Physician to Dr. Morley Fletcher in the early part of the year, and at the end of July became attached to the 4th Grenadier Guards. He won the esteem and regard of all with whom he was associated, and his able work was very highly valued. Our deepest sympathy is extended to Sir Lauder Brunton.

* * *

It is with very much regret that we learn of the death of Second Lieutenant Charles Douglass-James, aged 20 years. He was a student of this Hospital, and soon after the outbreak of war he took a commission in the South Staffordshire Regiment. A short time ago he was severely wounded at the Front, and since then he has died of his wounds. Our deepest sympathy goes out to his parents, who, like others we have mentioned in previous issues, have had a double sorrow, for another son of theirs, Lieutenant W. Douglass-James, R.G.A., was killed in the same action.

* * *

As we go to press we hear with great sorrow of the death of another of our students at the front—John Gay. He joined the City of London Yeomanry at the outbreak of war, and in March received a commission in the Royal Flying Corps, and was sent to France four months ago. He was taking photographs of the German trenches in company with other aeroplanes on October 10th, when he was shot down and came to earth within the enemy's lines. We now hear that he has since died of his wounds. His commanding officer writes: "He was a splendid officer doing most valuable work." Our deepest sympathy is extended to Dr. and Mrs. John Gay.

* * *

The War continues its importunate call upon our Hospital staff. We learn that both Dr. Horder and Mr.

Harmer are going to Russia to join the Anglo-Russian Hospital. Dr. Horder, on return from active service in France, has relinquished his temporary commission as Major in the Royal Army Medical Corps and is remaining seconded from the 1st London General Hospital. At the moment of writing Mr. Harmer has not apparently been "retired temporarily," but no doubt notice to that effect will appear shortly in the *Gazette*. While much regretting the loss which the Hospital will for the time being sustain, we have no doubt that the services rendered to the Anglo-Russian Hospital will be of more than temporary importance, and we wish the best of luck to Dr. Horder and Mr. Harmer in their new venture.

* * *

When Lord Sandhurst accepted the position of Lord Chamberlain a little over three years ago, he felt that his new duties would prevent his efficient work as Treasurer of the Hospital. Accordingly, Mr. Acton Davis kindly consented to take the office of Acting Treasurer, Lord Sandhurst nominally remaining Treasurer. Now, however, there are no Court functions, and no doubt Lord Sandhurst finds that he has more time at his disposal. Consequently, we are glad to say he is once more resuming his duties.

Mr. Acton Davis has held the duties of office of Acting Treasurer with great advantage to the Hospital. While we have real feelings of regret that Mr. Acton Davis has to retire, we may be allowed to express our pleasure at the return of Lord Sandhurst.

The following is a copy of the Resolution passed at a General Court of Governors held on Thursday, October 28th, 1915.

It was proposed by the Right Honourable Lord Sandhurst, P.C., G.C.S.I., G.C.I.E., Treasurer of the Hospital, seconded by Mr. Almoner Jacomb, and unanimously resolved:

"That this Court hereby records its unqualified appreciation of the very able manner in which Mr. Acton Davis has presided over the affairs of the Hospital for the past three and a quarter years.

"In the discharge of the duties of the office of Acting Treasurer, which he is now relinquishing, Mr. Acton Davis has given generously of his time, while his special knowledge and experience have been of the greatest advantage to the Hospital in dealing with the many important questions which have arisen during his administration.

"That this Court is deeply sensible of its indebtedness to Mr. Acton Davis, and tenders him its most cordial and grateful thanks for his devotion to the welfare of the Institution."

* * *

We congratulate Major McAdam Eccles, whom, we understand, has been asked to act once again as Examiner in Surgery for the M.C. and M.B., B.C. Examinations at the University of Cambridge.

* * *

We congratulate Dr. Alfred Francis Street, who has been promoted Esquire (from Honorary Serving Brother) in the Order of the Hospital of St. John of Jerusalem in England.

* * *

The entry of full students has been much as usual. For the five years immediately preceding the war the average entry of full students was seventy-one. Last year the entry was sixty-five, and this October it is seventy full students.

* * *

A good many students have been receiving letters from Lord Derby suggesting that they should join the army. Many have been puzzled at the meaning of this, more especially since some of them on applying to the War Office have been informed that they were better employed in sticking to their jobs and getting qualified as quickly as possible. A definite statement has, however, been made in the House of Commons upon this subject, and we reprint the following extract from the *Times*, which should make it quite clear to every student what is his own personal duty:

Mr. Tennant, in answer to questions asked by Mr. Snowden (Blackburn, Lab.) and Sir P. Magnus (London University, U.) concerning recruiting among medical students, said: I would now, in the light of the experience of the last few months, make this modification of the statement I made on June 21st. I think we must remember that we have first to win the war and afterwards to encounter problems arising out of it, if they do arise. I would, therefore, answer these questions by saying that the view of the War Office at the present time is that fourth or fifth year students should continue their studies, but that students in the first, second, and third years must consider for themselves what answer they should make to the recruiting appeal addressed to them, and not to regard themselves, so far as the War Office is concerned, as under the duty of continuing their medical studies.

Should any still have doubts on the ground that Mr. Tennant's method of speech is not sufficiently direct, may we call their attention to the following extract from the *Morning Post*:

A small deputation waited upon Lord Derby at the War Office yesterday to ascertain his views with regard to the propriety of medical students enlisting, or continuing their medical studies. The deputation consisted of the President of the College of Physicians (Dr. Frederick Taylor), the President of the College of Surgeons (Sir William Watson Cheyne), the Vice-Chancellor of the University of London (Sir Alfred Pearce Gould), and Dr. Shore. In reply, Lord Derby said: It is the duty of medical students other than those in the fourth and fifth years of their studies to join his Majesty's Forces.

* * *

Early in the war we received numerous letters from the Front, which we were able to publish, and which were of great interest to those of us who were unable to leave the country for various reasons. Lately, however, news has been scarcer, and we would again appeal to Bart.'s men abroad, and to relations at home, to let us have accounts of the doings at the seat of war. Letters which friends and relations may hand on to us will be much appreciated, and will be carefully preserved and returned to them after they have been used.

FROM THE FRONT.

OLD STUDENTS' DINNER IN FRANCE.

AN Old Students' Dinner in miniature took place somewhere in France on October 2nd, 1915, on the invitation of Lieut.-Col. Gordon Watson and the officers of the Duchess of Westminster's Hospital. Twenty-nine of us met to dine—not a bad attendance all things considered. A list of those who came is given below, as also of those who accepted but failed at the last moment owing to difficulties of transport and exigencies of the Service. The guests of the evening were Sir Anthony Bowlby (recently promoted Surgeon-General) and Sir Wilmot Herringham, who, luckily, were able to spare an evening from the G.H.Q.

The promoters of the dinner had been a little upset by the rumour that criticisms were being passed upon them for undertaking something in the nature of jollification at times like these, but they concluded ultimately that there was no reason to suppose that those who came would be the less efficient because they had escaped for a few hours from the sombre atmosphere of their professional engagements; so the matter went forward. I was one of the hosts, otherwise I should have had pleasure in affirming that our cook did well under difficulties. I can, however, assert with decency that the company was cheery and light-hearted and that the meeting was voted a success.

After dinner, Watson gave "The King." Then Col. C. E. Harrison, C.V.O., the oldest Bart.'s man present, read a Roll of Honour of Bart.'s men dead or wounded or decorated during the war. Then Branson gave "The Guests" and got Sir Anthony up. Sir Anthony was his old, breezy, reminiscent, and always interesting self, and was followed by his fellow guest of honour, Sir Wilmot, who gave us some details of the achievements which have filled our Roll of Honour so full. There followed songs by Scawin and by Miss Frost, one of the Sisters, known to many generations of patients here as "Martha." She has a beautiful voice and an unending fund of good nature which prompts her to put it freely at the disposal of the wards and other deserving objects such as this festival I tell of.

Later Warwick and Paul, our mess waiters, gave some—well—picturesque, character songs. Mr. Fitzpatrick, the Duchess' uncle, who joined us after dinner, was soon forced to bear a hand. He gave us an Irish song, and then, on the strength of some apocryphal custom of County Mayo, claimed the right to call the Colonel for a speech, or song, or sentiment. However, Watson was quite equal to the occasion, and retorted with a recitation of much merit.

By this time several people bethought themselves that they had a good way to go. So we broke up, very glad that we had met. On the whole, the most sensational event of the evening was the admission by Sir Anthony that on that occasion for the first time did he become aware that he had ever been known as "the Baron."

GUESTS PRESENT.

Surgeon-General Sir A. Bowlby, K.C.M.G.; Colonels Sir W. P. Herringham, C.B., and C. E. Harrison, C.V.O.; Lieut.-Cols. E. M. Hassard and C. Gordon Watson; Majors D. Cowin, I.M.S., T. C. Littler Jones, H. D. Gillies, and W. W. Jeudwine, I.M.S.; Capts. W. P. S. Branson, H. Pritchard, Forbes Fraser, H. H. Pirrie, A. W. Stott, H. Burrows, Colin Clarke, M. B. Oliver, T. K. Boney, and S. A. Burn; Lieuts. E. N. Russell, D. M. Stone, J. S. Burn, H. Scawin, E. H. Drinkwater, J. M. Bennion, A. E. Quine, J. Erlank, and H. L. Etherington-Smith; Mr. R. C. Ackland.

The following accepted but were prevented from attending: Lieut.-Colonel W. E. Miles; Majors T. J. Horder, C. S. Myers, and E. B. Waggett; Capts. Clementi-Smith and H. F. Marris; Lieuts. N. G. Horner, G. W. Stone, C. H. T. Ilott, and W. Attlee.

AN AID-POST BY NIGHT.

THE scene is a cavern of the earth, low-roofed and dank-smelling, the floor rudely boarded with rough-hewn planks, the whole feebly lit by one spluttering candle. Outside the rain is falling and the night is uncannily dark. Along the road near by bullets are whistling, some striking low with a dull thud, sending up vicious little spurts of mud and stones, others, flying higher, hit with a nerve-rattling "crack" the side wall of a ruined farm fifty yards away. The spitful, evil "crack" of bullet on brick has to be heard to be fully appreciated. In reality fifty yards away, the sound seems within a hairbreadth of the listener. Inside the rude "dug-out" and post lie two sick men on stretchers, tossing restlessly in their fitful sleep. On a rough bench are stacked the panniers, haversacks, and dressing-boxes—the stock-in-trade of our butcher's business—laid out in neat regimental rows.

Suddenly the sound of footsteps is indistinctly heard mingling with the whistling of bullets down the road. The orderly on watch, whose trained ear can distinguish the slow, broken-stepped, laborious tread of laden stretcher-bearers, steps out on to the road to investigate. Straining his eyes, he can distinguish nothing in the blackness till suddenly a trembling whitish-blue light flickers round the horizon—faint at first, then, bursting into vivid brightness, the enemy's "star-shell" shows the watcher a little company of men down the road bearing their helpless load.

He rushes off to awaken the regimental "M.O.," who lives in another burrow across the fateful road. The latter, sleeping heavily in all his clothes, is quietly awakened, rubs his eyes, and turns out, shivering at the inky blackness and wetness outside.

He then hurries across the danger zone of the road, an expectant "receptive" feeling in the side of his body turned enemy-wards. He breaks into a run, for in the dark no one can see, and reaches the shelter of the aid post cave.

A third stretchered figure now occupies the floor, groaning and calling in his agony for the blessed relief of death, his head a red mass of blood-saturated bandage and brain-pulp.

The bearers stand around, their shadows making grotesque figures on the candle-lit wall.

The two sick men are awake now, but, after one horrified glance, they turn their backs on the pitiful scene and practise the deception of pretended sleep.

The "M.O." stoops to remove the blood-stained bandage, but at that moment, with a sighing gasp, the poor battered head sinks back and another hero is gone to his long rest, a rest almost envied by the weary living left.

Out of the cave of death, across the bullet-spitting road, slipping in the mire and grease, the "M.O." returns to his earthen home to sleep, if that be possible, but a sleep broken with horrid dreams.

A CASE OF CIRSOID ANEURYSM INVOLVING THE WHOLE OF THE RIGHT INDEX FINGER.

By C. HAMILTON WHITEFORD, M.R.C.S., L.R.C.P.,
Military Hospital, Devonport.

Previous history.—The patient, a private, while on active service, tore the skin over the terminal joint of the right index finger with barbed wire. The wound was badly infected, and took six weeks to heal. For some years previous to the injury he had noticed, on the same finger, a painless swelling situated over the proximal inter-phalangeal joint.

Present condition.—The movements of the finger are greatly impaired, and the finger cannot be flexed.

The whole finger is a dusky blue, very hot, and larger than the left index finger, and pulsates violently. The skin is extremely thin and covered with dilated veins. Palpation gives the sensation that all the tissues between the skin and the bones had disappeared, and had been replaced by fluid.

The radial artery at the wrist is much larger than that of the left hand, and the superficialis volæ artery is hypertrophied. Pressure on the radial artery checks the pulsation, but does not cause disappearance of the fluid between the skin and the bones. Pressure on the superficialis volæ artery only partly controls the pulsation.

The finger being useless, and the risk of severe hæmorrhage from slight trauma being great, amputation was advised. This the patient declined.

Comments.—While the term "cirsoid aneurysm" does not entirely cover the condition, it is difficult to find a more appropriate description. It is possible that the tumour, noticed for some years by the patient, was a form of nævus, which, as a result of the infected wound, had extended over the whole finger.

It is difficult to believe that a relatively slight injury in the region of the terminal joint could, in the absence of a pre-existing lesion, produce such a general involvement of the finger. The situation and extent of the involvement appear very unusual.

A CASE OF CONCEALED ACCIDENTAL HÆMORRHAGE SUCCESSFULLY TREATED "ON THE DISTRICT" BY THE DUBLIN METHOD.

By CLEMENT COOKE, M.B., B.S.(Lond.), Extern.

THIS case, which I must thank Dr. Barris for permission to publish, is one of some interest. In the first place, I think, a case of this kind always must be interesting, because it has been called by a great authority "one of the most serious accidents that can possibly happen to a pregnant woman." To me, personally, it is of special interest, as having caused me graver anxiety than any other case which I have been called upon to treat; and as having come nearer than any other case to spoiling the fortunate record which I have maintained, of four months' work as Extern without maternal mortality. Perhaps I may add that I have it on good authority that this is the first case of the kind ever successfully treated on our district.

L. S—, æt. 38, of Clerkenwell, being gravid for the tenth time, and apparently about full term, sent to the Hospital for assistance just before midnight on October 3rd, and was seen by a District Clerk at 12.5 a.m. on the 4th.

She then gave an account of several fainting attacks, which had begun in the previous afternoon, whilst the patient was walking out of doors. Since 9 o'clock of the evening, she had noticed slight pain in the abdomen; and at 10 p.m. a small discharge of blood, which she described as "a show."

Something after 1.30 a.m. the Extern was awakened by a message from the clerk which suggested the possibility of twins, stating that the circumference of the mother's abdomen, just above the iliac crests, measured 41¾ in., and that the clerk thought he could palpate two backs and two heads. The note remarked that there had been hæmorrhage of perhaps ½ oz.; that the pains were slight and infrequent; the temperature 97·6° F.; pulse-rate 84, and not increasing; and lastly, commented on the pallor of the patient.

For some reason the possibility of concealed hæmorrhage immediately crossed my mind.

Arriving at the patient's home at 2.20 a.m., I was at once struck by her extreme pallor; the lips being almost destitute

of colour. She was in a condition of "drowsy restlessness," complaining of feeling very faint, and appeared several times to be on the point of losing consciousness. She also said she was suffering from a continuous pain in the abdomen, not sharp or severe, and not resembling the ordinary pains of labour.

Her pulse was now beating 96, and was of poor volume and tension. There had been a further small hæmorrhage, staining the night-dress and bed-clothing.

On examination, the abdominal swelling was of abnormally large size and felt hard all over, particularly in the flanks; rather as if a child's back were lying on each side; yet no fœtal parts could be definitely palpated. The abdomen was rather tender on palpation. At this time, the fœtal heart could be auscultated on each side of the middle line, below the umbilicus, beating at 120 to the minute, and faintly heard. Afterwards, no heart-sounds were audible.

The vagina contained a quantity of blood-clot and a little recent blood. The cervix was found to be dilated to the size of nearly two fingers, and the vertex felt presenting.

I diagnosed the presence of concealed accidental hæmorrhage, and elected to treat the case by the Dublin method. Perhaps I shall be criticised for not employing Champetier de Ribes' bag; but, having before me the choice of these two methods, I preferred the former. It will be urged that the use of the bag is more certain and more rapid. Yet, in my limited experience, I have found the method of packing to be sufficiently reliable; and the greater rapidity of the alternative treatment appears to be, in such a case as the present, not a recommendation but a strong argument against it.

I have not spoken of the difficulty and danger of a general anæsthetic, in such a case, which is essential when the bag is to be used. The main consideration seemed to be the extreme collapse of the patient, from which it was desired to extricate her as far as possible by restorative measures, before bringing upon her the additional strain of the second stage of labour. The subsequent account of the case persuades me that I followed the better course. I feel that, if I had adopted the alternative, and had succeeded in delivering rapidly by the bag, the case would, in all probability, have terminated unfavourably by the sacrifice of the patient's strength.

At 2.30 a.m., 10 ♏ Curschmann's solution were injected hypodermically. Then, with a view to lessening the intra-uterine tension, the membranes were ruptured by means of a probe, allowing a fair volume of clear liquor amnii to escape.

The cervical canal was next plugged with pieces of sterilised gauze, and afterwards the same material was tightly packed into the vaginal fornices, finishing off with two tampons of wool.

Half c.c. pituitrin was then injected intramuscularly into the right buttock. After this the patient's pallor was slightly increased, and her pulse remained stationary at 96. Her general condition not improving appreciably, and as she continued to be restless and agitated, a dose of tr. opii ℥ss., in ℥j of brandy, was given by mouth at 3.15.

Subsequently a second injection of Curschmann's camphor solution (10 ♏) was administered subcutaneously, followed by 5 ♏ of injectio strychninæ hypodermica (B.P. 1898).

A further dose of strychnine was given later, as the patient was almost fainting away.

In the meantime, Dr. Barris had been notified by telephone; and at his advice ¼ gr. morphine was injected under the skin of the forearm, and rectal saline (⊙ij) administered. The patient's condition was now considerably improved, and I returned to bed.

By 6.15 a.m. patient was having strong pains, regularly every two minutes; and at 7.10 a message was brought to me from the clerk (who had remained with the case) that the child's head was ½ in. from the vulva.

Arriving at 7.30, I found the woman distinctly less pale, with a pulse of 90 to the minute, of fair volume and tension, having strong pains. The child's head was already appearing at the vulva.

At 7.45 a.m. a dead female child was born, of about 8 lb. weight, followed immediately by a large mass of dark clotted blood, which amounted to fully two pints.

Five minutes later the placenta was expressed from the vagina. This was of large size, soft, and largely broken up by blood-clot.

Now came the most critical moment of the whole case. The mother collapsed very badly, her pulse running over 140, very feebly and rather irregularly, the temperature was 95·8°, and for a time she appeared to be dying.

A hypodermic injection of strychnine was given. Two pints of normal saline were introduced into the rectum, and the foot of the bed was raised twelve inches. A tight abdominal binder was applied.

The patient's condition then improved considerably.

At 3.30 *p.m.*—Pulse 124. Temperature 99·2° F. Rectal saline was given that evening and twice a day subsequently, of the same volume as the first injection. The breasts were bandaged, and a mixture given three times a day containing belladonna and ergot.

October 5th.—Patient much better. Pulse 120. Temperature 99·4° F.

October 6th.—Clerk's note says: "Patient extraordinarily well, considering her original condition."

The temperature remained above normal during the following week, reaching 102·4° F. on October 10th; while the pulse-rate persistently exceeded 100. But on October 14th temperature was 98·2° F., and pulse 104.

On October 16th the patient was discharged, being in good condition. Temperature normal, pulse 88. No lochia; uterus not felt above the pubes.

CALCIUM.

[*Dedication:* TO THE GIN'AL.]

The sick lists ran from page to page,
The Gin'al gave up hope,
When cheerily The I.M.S.
Bade us no longer mope.

"I've found at last the cause and cure,
I'm glad it's not too late,
It has been proved that all you need
Is calcium lactate.

"If pemphigs scar the marble brow
And lost is beauty's picture,
Be not afraid, for blisters blanch
Before the albant mixture.

"Appendicitis is a curse
We wholly can avoid;
No operations any more,—
B. Wellcome's chalk tabloid.

"When jaundice with its dainty green
Tinges our skins and views,
Nor food nor life a charm possess,
Be not dismayed, but use

"Before and after every meal,
Or if you have not dined,
At any other time that suits,
A dose of lime calcined.

"And dysentery is much the same;
There's been a lot of talk,
But only one thing's any use
And that is calcined chalk.

"Ah! Apoplexy; here's the test
Of theory and of fact.
I must confess this is a point
For treatment with *some* tact.

"But if you look around you'll find
Of cases a sufficiency
Where experts swear that there exists
A palpable deficiency —→

"Of calcium in the brain—Enough!
Trepanning's out of date,
The only certain cure is this,
Give calcium lactate.

"It's funny, isn't it?" he said,
"It wasn't known before,
It needs a man of brain and faith . . .
There's only one thing more.

"Lime- (fruit not mineral of course)
Juice I must quite forbid
And lemonade and ginger ale,
Meant only for a kid.

["Kid" 's only in to end the line,
What really does the tune in
Is when you've got to find a rhyme
For calcium lactalbumin.]

"Then, when at last Death's bon'y clutch
Tells you you've done your time,
Cheer up! If faithful you have been
You'll still exist—as lime."

RECENT ADVANCES IN PHYSIOLOGY OF CLINICAL IMPORTANCE.

I. DILATATION OF THE HEART.

By J. W. TREVAN.

1. PHYSIOLOGY.

BY the combined efforts of that school of physiology so often, with blighting sarcasm, called "paper scratchers," and that of more obviously direct experimentalists, an advance has been made of immense importance in the elucidation of failure of cardiac compensation.

In 1892 Blix, a Scandinavian physiologist, discovered that up to a certain point the work done by a muscle fibre varied directly with the length to which that fibre was passively stretched before the contraction took place. Anything more dry-as-dust and open to the criticism of the "I-don't-see-that-it-takes-you-any-further" scoffer, could scarcely be imagined, yet in the fulness of time that discovery has illuminated much that was obscure in cardiac pathology.

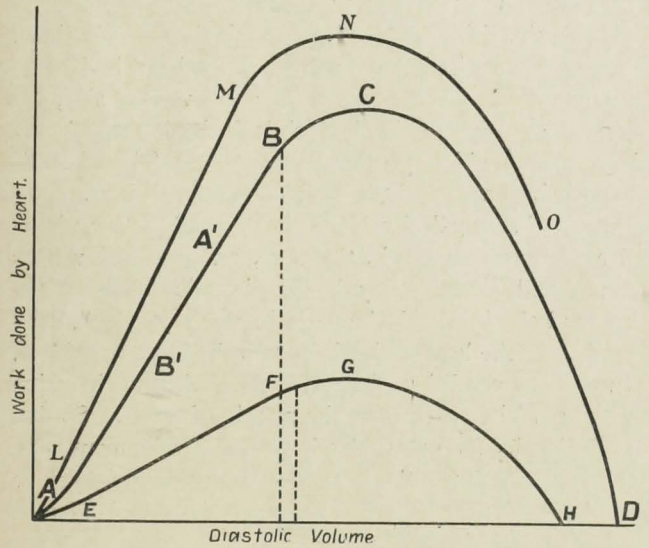
The explanation of this fact seems to be that a contraction of a muscle fibre is a function of the surface only, not of the whole mass of the fibre. The surface is increased by stretching, the mass is not.

The experiments that have connected the contraction of the heart with the abstruse principle enunciated by Blix have been, for the most part, carried out in Prof. Starling's laboratory, and an account will be found in various papers published in the *Journal of Physiology*, vol. xlviii, 1914, p. 465.

The work was, for the most part, done on what is now known as the "heart lung" preparation. The heart of a dog was freed from the pericardium, a cannula placed in the innominate, and the blood allowed to flow (after the addition of herudin) through rubber tubes to a resistance, variable at will, representing the arteriolar bed and back to the right auricle. The variable resistance consisted of a thin-walled rubber tube through which the blood flowed, surrounded by

a closed glass tube connected to a pressure bottle. The resistance could be varied by altering the pressure in the pressure bottle. The systemic circulation was cut out and this system of tubes substituted for it; the pulmonary circulation was retained intact, and artificial respiration by positive ventilation kept the blood oxygenated. The alterations in volume of the heart were recorded by a piston recorder and a cardiometer made from a glass thistle funnel and a piece of rubber membrane. Venous pressure and arterial pressure were measured by manometers in the ordinary fashion.

The results can be best expressed in the form of a diagram (see Fig.), which is not quantitative, but merely represents the general relationship of the two quantities.



RELATION OF WORK DONE TO DIASTOLIC VOLUME. A B C D, IN NORMAL HEART. E F G H, IN MYOCARDITIS. *L M N O*, IN HYPERTROPHIED HEART.

The absolute numbers to be attached to the diagram depend on—

(1) The weight of the heart.

(2) The state of the muscle fibre, *e.g.* fatigue or degeneration, drugs, etc.

It will be seen that the work done by the ventricles varies directly with the volume of the heart during diastole over a large range (A—B, Fig.), then with increase of volume increases less rapidly (B—C), and then finally falls off (C—D) until the heart does not work at all, remaining as a dilated almost spherical cavity, with the individual beats represented by mere quivers to be seen on the surface, but entirely ineffectual in expelling blood into the arterial system.

The part A—B we will discuss first. It corresponds entirely to that famous principle enunciated by Blix. Up to the point C the length of the muscle fibre is directly proportional (for all practical purposes) to the volume of the heart; beyond this part the heart becomes more nearly spherical, and the length of the muscle fibre becomes in consequence less in proportion to the volume.

From A to B the work which the heart does is directly proportional to the volume, *i.e.* the length of the fibre. A B being a straight line above this point, the work done increases less rapidly as one approaches the limit of extensibility of the muscle fibre, and finally actually falls off with increasing volume, until no blood is expelled at all. The heart remains a dilated spherical ball with an occasional quiver on its surface, representing a beat. All these stages were paralleled in skeletal muscle.

The curve expresses the alteration in work done. This may be varied in one of two ways; either arterial pressure may be varied or the amount of blood expelled.

Let us consider the effect of increase of pressure in the arterial system. In an actual experiment on a dog's heart (Patterson, Piper, and Starling, *Journal of Physiology*, xlviii, p. 493, 1914), with a rise of arterial pressure from 68 mm. to 166 mm. Hg. the output remained constant at 88 c.c. per minute. Again, in another dog with a fall from 132 mm. to 52 mm. the output remained constant at 153. That is, there is some mechanism which, whatever the blood-pressure, enables the heart, when separated from the nervous system, to maintain a constant outflow—which is just what is essential for the body's needs. On the other hand, variations in the venous supply cause equal variations in the outflow.

The mechanism which brings about these changes is the same for both rises in arterial pressure and alterations in quantity of venous inflow, and is the one we have been discussing previously, as will be seen by an illustration used in the paper by Starling, Piper, and Patterson already referred to. Consider a heart "putting out 600 c.c. per minute against a mean arterial pressure of 80 mm. Hg. The mean arterial pressure is then raised to 140 mm. Hg. On measuring the total output it is found to be 600 c.c. as before." The mechanism of adaptation is as follows: At 80 mm. pressure the heart is developing just enough energy to put out 8 c.c. of blood against a resistance which may vary from 65 at the beginning of outflow to 100 mm. Hg. towards the end. The arterial resistance is then increased, so that it needs a pressure of 90 mm. to force any blood through it and a mean pressure of 140 to keep up an outflow of 600 c.c. per minute. The next heart-beat gets up sufficient pressure to force blood "into the aorta, say 5 c.c. The outflow then stops. Then, at the beginning of the next beat since the venous inflow is unaltered there are 8 c.c. + 3 c.c. of blood present in the cavity," *i.e.*, the diastolic volume is increased. As we have already shown, the next beat will be correspondingly more vigorous because of the lengthening of the muscle fibres in its walls, and it may be vigorous enough to maintain the original output of 8 c.c. per beat—leaving still 3 c.c. of residual blood. Then at the next beat, 8 c.c. more enter the venous side; the

diastolic volume is 8 + 3 c.c.; the next beat effects 8 c.c., leaving 3 c.c. of residual blood again. If the first beat at a diastolic volume of 8 + 3 c.c. is not sufficient to pass on 8 c.c., but say only 7 c.c., extra residual blood is left = 8 + 3 − 7 = 4 c.c, and the diastolic volume at the next beat is 8 + 4 c.c. This may be sufficient to pass on 8 c.c., leaving a constant 4 c.c. of residual blood.

The influence of increased venous inflow due to increased venous pressure is exerted by the larger volume present at the beginning of each beat, leading to the expulsion of more blood at the next beat.

The end of the whole matter is this: The work done by the heart depends not on the arterial pressure, nor directly on the venous pressure, but on the size of the heart at the beginning of systole, or, what is the same thing, the diastolic length of the fibre.

2. Clinical Applications.

When any lesion of the heart is established there are two classes of phenomena that may follow:

(1) Aberrations due to a physiological compensation for mechanical difficulties. These aberrations are mostly cardiac.

(2) Phenomena due to failure of that compensation, which are mostly systemic.

The facts discussed above explain how some of these are produced.

Let us take some of the common cardiac disorders.

Myocarditis.—In this condition the sequence of events seems to be the following.

The first effect of any toxin on the heart muscle is to reduce the amount of work each fibre can turn out at a given length. Therefore, if the blood-pressure remains the same in the venous and arterial systems the same dilatation must occur as has been described for *rises* of pressure in the normal animal. When sufficient dilatation has been established to maintain the circulation at its correct level, the heart remains constant in size. The change in the properties of the muscle is very well represented by the curve E F G H. It will be seen that the general form of the curve is the same but the amount of work per unit volume is less, and since the failure of the heart from over distension sets in at the same volume in each case, there is a much more limited field of response. In the normal heart, all the calls made on it lie along the lower part of the curve, *e. g.* between A and A^1, probably never above, but, as will be seen by comparing B with F, the maximum amount of work that the heart can do is much diminished and falls within the limits of what it may be normally called upon to do. Hence the heart becomes further dilated but the work done falls off (G to H). Blood is not passed on as fast as it is received and increasing venous pressure with all its symptoms is set up. If the call is very sudden, as in those spasmodic increases of blood-pressure associated with angina pectoris, the volume may reach the point H and sudden death occur from complete failure of the heart.

Valvular lesions, apart from myocarditis, have a somewhat different relationship.

Aortic regurgitation is the simplest. In this case part of the blood pumped out during systole returns during diastole, and increases the diastolic volume by an equivalent amount. Suppose aortic regurgitation suddenly established. If the heart were previously pumping out 10 c.c. per minute, when the regurgitation started 4 c.c. might be returned, so the diastolic volume at the next beat would be 10 c.c. (flowing in from veins) + 4 c.c. (regurgitant), and in consequence the length of fibre contracting, and therefore the work done, is increased to correspond.

In obstruction at the aortic orifice there is the same effect produced as in raising the blood-pressure in the normal animal.

In aortic regurgitation, the volume of the heart in diastole depends not only on the filling from the venous side, but also on the amount of blood which leaks back through the valves under the high pressure in the aorta. The diastolic volume is increased and the work done at each beat.

In *mitral regurgitation* blood is pumped backwards as well as forwards—there is, therefore, an increased venous pressure and consequently better diastolic filling of the heart, and the inevitable increase in the work done, compensating for the loss of blood through the imperfect valves.

In all these conditions the part of the work curve in action is that from B^1 to B—nearer the margin of safety. So that abnormal calls for extra blood or the development of a myocarditis may push the heart over into the region when dilatation no longer increases the work done and "failure of compensation" sets.

So with all the other lesions.

Hypertrophy is a factor not represented in experiments extending only over a few hours. It arises, however, from the physiological fact, represented in all muscle, that increased work increases the bulk of the muscle. As in myocarditis there is no increase in the work actually done (although that work is only done by a dilated heart) dilatation takes place without hypertrophy. With a valvular lesion the work done is increased and the muscle increases in bulk. The increase in weight of the heart enables it in the end to perform the normal work at the original volume, and the condition of the heart may be represented by the curve *L M N O* in the figure.

This ends an imperfect sketch of the factor of dilatation.

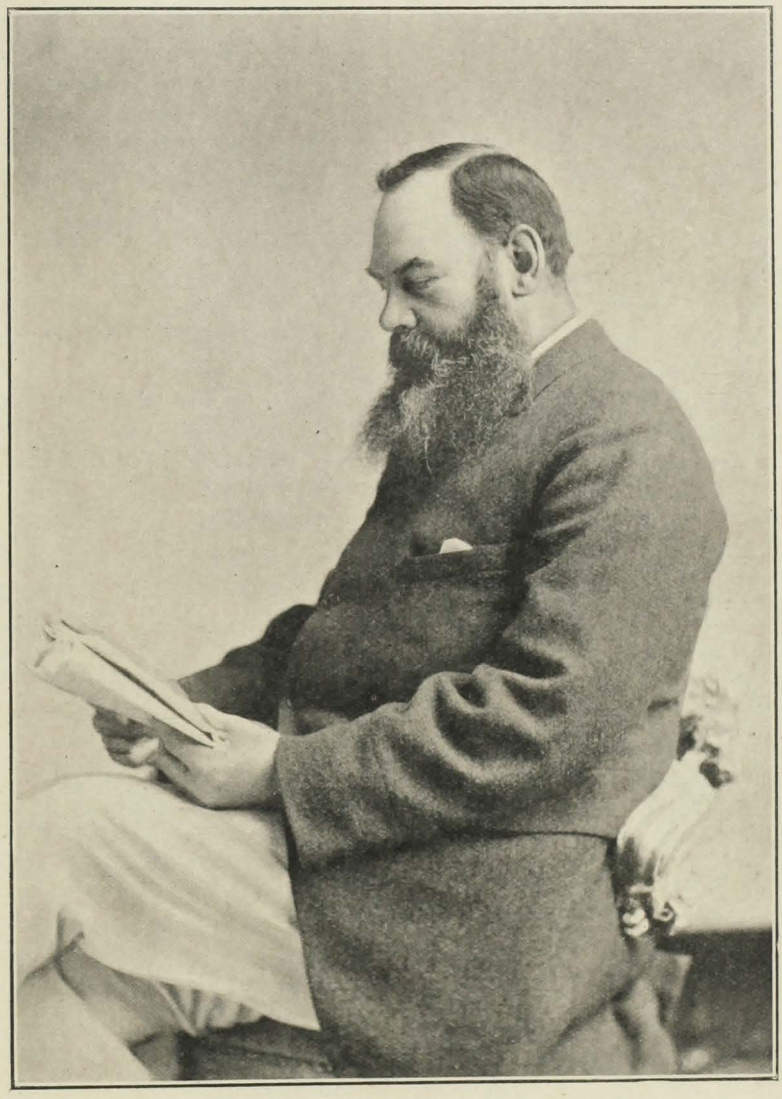
There are others not less important for which there is no room to discuss, such as, for instance, the influence of carbon dioxide, of adrenalin, of the pericardium, of rhythm, and last, and most important, of rate, upon which Prof. Bainbridge has cast a new light in a paper not yet published.

And yet again I would venture to expostulate with the severely practical man who does not see what good is coming out of the mountains of abstract physiology, and ask

him to seek in the original papers what is poorly set forth above, and see how at every step some apparently useless investigation has filled its little part in building up the great whole. For "the eye cannot say to the hand, I have no need of thee; nor again the head to the feet, I have no need of you. Nay, much more those members which seem to be more feeble are necessary" (I Cor. xii, 21–22).

When our new ground at Winchmore Hill was to be opened by a match, Past *v.* Present, W. G. accepted, with great pleasure, a place in the Past team. Unfortunately ne couldn't play on the day, greatly to his and everybody else's regret.

I think, perhaps, one of his finest traits was his kindness and consideration to young cricketers, whether on his side



The late Dr. W. G. Grace.

OBITUARY.

W. G. GRACE, L.R.C.P., M.R.C.S.

OVER and above our losses in these terrible times, we have to deplore the death of our greatest cricketer, and one of the best sportsmen known to any of us. That he was a member of our Hospital and always spoke with affection of it makes us at the same time sadder and prouder.

or the opposite. His greatness as a critic of the game was due to the freedom from partiality and the extreme and open fairness in which he expressed his opinions; no one could, I think, add up the form of a player more exactly.

His soundness as a bat probably is unique—the whole of his strokes were sound. There have been, and still are, a few men who execute certain strokes which, owing principally to his colossal physique, were difficult for W. G. These he never attempted; he didn't want them; he had

enough of his own. I don't think he ever borrowed a shot from any player. The brilliancy he displayed against fast bowling, especially on a fiery wicket, was due chiefly to two things—courage and the quickness of his eye. No one ever saw him working away to short-leg, or getting himself out in preference to being hit.

The great point in his bowling always seemed to me to be the deceptive length; he got rid of the ball, if anything, a little behind the shoulder and followed it with his hand—very clever, as it pitched in a length, instead of the expected half-volley, and fed the field.

W. G. was always busy in some sport or another and keeping himself fit, and always very, very keen. Running with the beagles he was untireable; he got a lot of the younger ones with their tongues out while he was still going strong. He was a good shot with a scatter gun, and nothing moved near his stand that escaped his notice, and probably did not appreciate his attentions.

As a golfer he was quite good, and deadly when getting near the pin. At his house, about two months ago, he played with me against K.S.R. and A.C.M. at bowls; after a desperate struggle we just won. The keenness our old friend displayed would not have disgraced an England and Australia fixture.

I am sorry the powers that be didn't make him at least a "baronet"; the cricket world, at any rate, have made him a "king." W. G. H.

EDWARD HENRY POLLOCK BRUNTON.

An Appreciation.

It is a privilege to be allowed to say something in praise of Edward Brunton, whom I first met at Bart.'s when he was working for his primary F.R.C.S., and afterwards came to know well during the six months of his house appointment there and some ten weeks in April, May and June, in which we shared a tent in a training centre and learnt something of the functions of officers in the R.A.M.C. and of the ways of the Army.

By his death many have lost a valued friend and his country a loyal and efficient medical officer of a sort that can ill be spared. In his medical work he showed the qualities of a keen, diligent, conscientious, and skilful practitioner. The human side of his work appealed more strongly to him than did the purely theoretic, and he took more interest in the welfare and recovery than in the morbid anatomy of his patients. His opinion on a case was always worth having and was given carefully with intent to help, while if he asked for a diagnosis or suggestion he did so prepared to judge the opinion given without prejudice and to act on it if he thought it good. Two rare great qualities—an unfailing and absolute honesty and a deep and very real modesty—coloured all his work. How far he would have pursued any definite medical or surgical career is hard to say, for he had no distinctive professional ambitions, but like many more he interrupted his career at Hospital to serve as medical officer in the Army.

In a letter written shortly before his death and just after he had distinguished himself by his good work in the advance on Loos he wrote: "I never thought I was built for a soldier, and now I am sure," but, as a fact, he possessed the qualities and cultivated the character of an efficient officer and a worthy commander. He had no natural love for the forms, routines, and procedures of army life, but deliberately set himself to acquire military methods and virtues, and in his temporary post of section commander in a field ambulance he worked with the same unselfish thoroughness that distinguished his work at Hospital.

He was attached as Medical Officer to the 4th Grenadier Guards and went out with them to France at the end of July.

He took an active part in the great advance to the assault of Loos—an advance made in daylight over open country and under heavy artillery, rifle, and machine-gun fire.

When Loos was taken he worked steadily for many hours in his aid post, while the town was shelled to pieces round him. He wrote after the end of that day's work: "Looking back on it I regard it as the experience of my life."

He was an excellent companion in leisure, a loyal friend, a useful colleague, with a love of life, and an ever present sense of humour, which by themselves would have served to carry him through very tough places, and he has not lived in vain. L. W. B.

STUDENTS' UNION.

A MEETING of the Council was held on Thursday, October 28th, at which several matters of interest were discussed.

National Guard.

Permission was given to the section of the National Guard which now comes to the Hospital every evening, to use the Abernethian Room, except on such Thursday evenings as it may be required for the meetings of the Abernethian Society.

The Late Dr. W. G. Grace.

It was decided that a memorial of some kind should be erected to the memory of this famous Bart.'s man, and a sub-committee was appointed to consider what form this should take.

Opening of Abernethian Room on Sundays.

It was suggested that this would be in the interests of resident members of the Hospital, and it was decided to ask

the School Committee to sanction the opening on Sundays of the Abernethian Room.

FURNITURE REPAIR.

It was decided to accept the estimate of Messrs. Tapling & Co., Ltd., for the repair of furniture in the Abernethian Room.

RESIGNATION OF SECRETARY.

Mr. P. H. Wells handed in his resignation, and a hearty vote of thanks was accorded him for his services. A new Secretary will be elected at the next meeting.

ST. BARTHOLOMEW'S HOSPITAL WOMEN'S GUILD.

THE following ladies have kindly promised to hold the Working Party at their houses on Wednesdays in November and December at 3 o'clock :

November 3rd : Mrs. Calvert, 113, Harley St., W.
" 10th : Mrs. Richard Gill, 17, Albert Hall Mansions, S.W.
" 17th : Lady Kempe, 22, Pembridge Sq., W.
" 24th : Mrs. Girling Ball, The Warden's House, St. Bartholomew's Hospital.
December 1st : Mrs. Trechmann, 88, Eccleston Square, S.W.
" 8th : Mrs. Hayes, St. Bartholomew's Hospital.
" 15th : Mrs. Ranking, 28, Westbourne Terrace, W.

Work Party Hon. Sec.: Miss Helena Calvert, 113, Harley St., W.

CORRESPONDENCE.

ECONOMY.

To the Editor of the 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—Bart.'s, I presume, has been hit, like everybody else, by the war, and wants to economise. Let me tip the authorities a wrinkle. At Bart.'s, as at most places I have seen, there's a tremendous amount of avoidable waste in the absorbent cotton-wool used for dressings (not to mention bandages). The amount so wasted must cost many, many golden sovereigns a year. Sphagnum moss, loosely packed into suitable bags of the cheapest butter-cloth, can be used for almost everything that cotton-wool is used for, and the cost is practically nothing. The moss can be got on numbers of moors, etc., in England, simply for the picking. It then requires to be handpicked and dried, the picking being to remove twigs, roots, grass, etc., and is then ready for use. The bags simply require the usual sterilisation ; so that the only cost is the bags and the cost of conveyance of the moss. I should think that with a very little organisation numbers of people could be got to gather it gratis, as a labour of love. Several papers on the subject have already appeared in the *B.M.J.*, so I need say no more. I have occasionally seen compressed pads of what I believe was sphagnum used at Bart.'s, in suprapubic cystotomy cases ; but why not make more use of it, uncompressed ?

G. F. ROWCROFT,
Colonel, Temp. Major, I.M.S.

REVIEWS.

A PRACTICAL MANUAL OF BANDAGING. By Capt. D. C. L. FITZWILLIAMS. (Baillière, Tindall & Cox.) Price 3*s.* 6*d.* net.

An excellent little work for surgeon or student. Every essential form of bandage is described, and, moreover, well illustrated. The artist, a Hungarian prisoner of war, has a fine touch of humour, too. The frontispiece shows a well-executed foot-sling—but—it is hung, together with an iron cross, round the neck of His Satanic Lowness the Crown Prince of Germany ! So complete is this work that we only miss one form of bandage or sling—the neck-sling or hangman's rope. An illustration of this, at the end of the work, placed round someone's neck, would be a welcome feature in the next edition.

OXFORD WAR PRIMERS. (Henry Frowde and Hodder & Stoughton.)
CEREBRO-SPINAL FEVER. By Major T. J. HORDER. Price 3*s.* 6*d.* net.
NERVE INJURIES AND SHOCK. By Capt. W. HARRIS. Price 3*s.* 6*d.* net.
WOUNDS OF THE THORAX IN WAR. By Staff-Surgeon J. K. MURPHY. Price 2*s.* 6*d.* net.
GUNSHOT INJURIES OF BONES. By Capt. E. W. HEY GROVES. Price 3*s.* 6*d.* net.

We have received the above four additions to this series, and the same remarks apply to these as to those commented upon in our last issue. They should prove of exceptional interest to the surgeon or physician on war service, as not only will they revive in his mind special facts which he may have forgotten, but they will teach many new aspects which the war has brought forth. They are of convenient size for carrying in the pocket.

A TEXT-BOOK OF SURGERY. By R. WARREN. (J. & A. Churchill.) Two vols. Pp. 1400. Price 25*s.* net.

Modern surgery covers such a vast ground that it is difficult to imagine its efficient treatment even in two large volumes ; however, the work under our consideration comes very near to this ideal. The author has attained this excellence by a process of simplification which leaves out many of the more classical methods of treatment, retaining alone those which bear the hall-mark of practical utility. Special attention has been paid to those sections where, in the last few years, surgery has made such great strides, *i.e.*, with regard to blood-vessels, bones, joints, the air-passages, the abdomen, and the urinary system. The two volumes are concisely and clearly written, and the original illustrations, of which there are 504, are excellently produced and quite sufficient to elucidate the text. The work forms a valuable book of reference and should certainly be read by all students taking the higher examinations in surgery.

FIBROSITIS. By LL. J. LLEWELLYN and A. B. JONES. Pp. 693. (Heinemann.) Price 25*s.* net.

A long-needed work has at length been published in this book. The difficulties of diagnosis in all questions of rheumatic pains, whether of muscle or joint, are recognised by everyone. Difficult also are such troubles as lumbago, sciatica, and neuralgia. The importance of a correct diagnosis of such symptoms cannot be over-estimated, for only by treating the underlying lesion can we hope to relieve permanently the sometimes excruciating pain. How often do we find, for instance, the dread sciatica treated in an off-hand manner with pot. iod. and tr. hyoscyamus, or perhaps with heavy doses of aspirin ? Sometimes relief is given, more often it is not. Why ? Because sciatica may be surely a symptom of many things. It may be primary, due to neuropathic inheritance, gout, arterio-sclerosis, diabetes, and other toxic causes. Syphilis, gonorrhœa, malaria, tuberculosis may all cause it. It may be secondary, due to extra-pelvic or intra-pelvic causes, pressure, over-extension of the nerve-trunk, osteo-arthritis of the hip, or gluteal fibrositis. Intra-pelvic pressure or irritation, such as pregnancy, or neoplasm, engorged veins, or even appendicitis, may be the root of the trouble. All these conditions and their differential diagnosis are set forth in this work, together with similar dissertations upon "rheumatism," "gout," lumbago, neuralgia, and various forms of synovitis. When we realise how very

often the general practitioner is called upon to treat local pains of one kind or another we cannot fail to see how exceptionally useful such a book of reference as this becomes.

Indications for treatment are also given, but we could have wished for a few more prescriptions useful from the authors' experience in one or two of the less common conditions.

The illustrations also are excellent, and we can confidently recommend this work as of exceptional value to every practitioner.

EXAMINATIONS, ETC.

CONJOINT BOARD.

First Examination, October, 1915.

Part I. Chemistry.—S. G. Harrison.
Part II. Physics.—D. P. Guilfoyle, S. G. Harrison, P. Lindsey.
Part IV. Practical Pharmacy.—K. R. Chapple, D. D. Evans, H. R. V. T. Lauder.

Second Examination, October, 1915.

Anatomy and Physiology.—C. E. E. Herington, W. A. Jolliffe, H. C. C. Joyce, A. E. A. Khair, L. K. Ledger, N. Synn.

SOCIETY OF APOTHECARIES.

October, 1915.

The Diploma of the Society was granted to the following candidate entitling him to practise medicine, surgery, and midwifery:
C. P. C. Sargent.

NEW ADDRESSES.

BATHURST, L. W., 143, Harley Street, W. (Tel. Mayfair 4831.)
CANE, Capt. L. B., R.A.M.C., H.M. Hospital Ship "Devanha," Mediterranean Expeditionary Force, c/o G.P.O., E.C.
FRY, A. P., 2, North Place, Whetstone, Middlesex.
HAMILTON, Major W. G, I.M.S., Registrar, Bombay Presidency General Hospital, Alexandria, Egypt.
HURTLEY, W. H., 28, Chestnut Road, W. Norwood, S.E.
JOHNSON, F., Pellhurst, Cypress Road, Newport, Isle of Wight.
LOWE, G., 42, Langworth Gate, Lincoln (Tel. 283.)
MURPHY, Capt. L. C. E., R.A.M.C., attached to 49th Divisional Ammunition Column, B.E.F.
PHILLIPS, L. L., No. 2 Ambulance Train, Southampton Docks.
TREWBY, J. F., 4, Duchess Street, Portland Place, W.

BIRTHS.

BELL.—On October 21st, at Cosham Park House, Cosham, the wife of Staff-Surgeon K. Digby Bell, R.N., H.M.S. "Iron Duke," of a son.
CATES.—On September 28th, at Laurel Mount, St. Helen's, the wife of Joseph Cates, M.D.Lond., D.P.H.Camb., of a daughter.
DOWNER.—On October 16th, at "Craiglea," Woking, to Daphne Marguerite and Reginald L. E. Downer, M.D., R.A.M.C., of "The Firs," Matlock—a daughter.
FERGUSON.—On October 19th, at "Deepdene," Haslemere (the residence of her parents), to Eileen (*née* Nash-Wortham) and Archibald Ferguson, M.B., D.P.H., Lieut., R.A.M.C.—a son.
GILBERTSON.—On October 18th, at "Newstead," Bancroft, Hitchin, the wife of Dr. H. Marshall Gilbertson, of a son.
RANKING.—On October 24th, at Hanover House, Tunbridge Wells, the wife of Dr. Robert Ranking, of a son.
THACKER.—On September 28th, at 164, Chesterton Road, Cambridge, to Dr. and Mrs. C. R. A. Thacker—a daughter.

MARRIAGES.

DAVIS—LLOYD.—On October 23rd, at St. Jude's Church, South Kensington, by the Rev. Prebendary Pennefather, assisted by the Rev. Prebendary Eardley Wilmot, Vicar of the Parish, Kenneth James Acton Davis, F.R.C.S., M.C.Cantab., of 24, Upper Berkeley Street, W., second son of Mr. G. Acton Davis, J.P., and of Mrs. Acton Davis, Julian Hill, Harrow, to Vera, younger daughter of Mr. E. Honoratus Lloyd, K.C., and of Mrs. Lloyd, 30, Collingham Gardens, W.
HILL—MACLEAN.—On September 19th, at St. Andrew's Church, Plymouth (quietly), Staff Surgeon Horace B. Hill, R.N., eldest son of Dr. R. B. Hill, of Tywardreath, Cornwall, to Edith Clara de Vere Maclean, youngest daughter of Kaid Sir Harry Maclean, of Tangier, Morocco.
RANSOM—SHILCOCK.—On October 23rd, at Brampton, by the Rev. S. I. W. Shilcock, uncle of the bride, assisted by the Rev. L. H. Ransom, uncle of the bridegroom, Capt. Peter Warwick Ransom, M.B., R.A.M.C., son of Mr. and Mrs. H. C. Ransom, of Clifton, to to Margaret Lindsay, eldest daughter of the Rev. W. A. and Mrs. Shilcock, Brampton Rectory, Norwich.

DEATHS.

ADDENBROOKE.—On October 15th, at The Platts, Kidderminster, Edward Homfray Addenbrooke, M.R.C.S., L.S.A.
BRUNTON.—Killed in action in France on October, 8th, 1915, Lieut. Edward H. P. Brunton, R.A.M.C., attached to the 4th Battalion Grenadier Guards, younger son of Sir Lauder Brunton, Bt., M.D., F.R.S., aged 25.
DOUGLASS-JAMES.—In France, on September 30th, died of wounds received September 25th, 2nd Lieut. Douglass Charles James, South Staffordshire Regiment, and St. Bartholomew's Hospital, second beloved son of Charles Henry James, Esq., J.P., of Ingledene, Plymouth, aged 20.
GAY.—On October 10th, 2nd Lieut. J. Gay ("Jock"), Royal Flying Corps, only son of Dr. and Mrs. Gay, of Putney, aged 22.
GRACE.—On October 23rd, suddenly, William Gilbert Grace, the dearly-loved and loving husband of Agnes N. Grace, and father of Capt. H. E. Grace, R.N., and Capt. C. B. Grace, K.F.R.E., of Fairmount, Mottingham, Eltham, S.E., aged 67.
MEADEN.—On October 15th, at Beech Lawn, North Finchley, George Anderson Meaden, M.R.C.S., of South Walsham, aged 73.

ACKNOWLEDGMENTS.

L'Attulita Medica, The British Journal of Nursing, The Nursing Times, The Hospital, The Medical Review, The Shield, Guy's Hospital Gazette, St. Thomas's Hospital Gazette.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, Smithfield, E.C.*

The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., *at the Hospital.*

All communications, financial, or otherwise, relative to Advertisements ONLY, should be addressed to ADVERTISEMENT MANAGER, *the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City 510.*

A Cover for binding (black cloth boards with lettering and King Henry VIII Gateway in gilt) can be obtained (price 1s. post free) from MESSRS. ADLARD AND SON, *Bartholomew Close. (Temporary offices: 76, Newgate Street, E.C.)* MESSRS. ADLARD *have arranged to do the binding, with cut and sprinkled edges, at a cost of 1s. 9d. or carriage paid 2s.—cover included.*

St. Bartholomew's Hospital Journal.

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

VOL. XXIII.—No. 3.] DECEMBER 1ST, 1915. [PRICE SIXPENCE.

CALENDAR.

Wed., Dec.	1.	—First and Second Exams. for M.B.(Oxford) begin.
ri., ,,	3.	—Dr. Tooth and Mr. D'Arcy Power on duty.
Mon., ,,	6.	—Exams. for M.D. and M.S.(Lond.) begin.
Tues., ,,	7.	—Dr. Garrod and Mr. Waring on duty.
Fri., ,,	10.	—Dr. Calvert and Mr. McAdam Eccles on duty.
Mon., ,,	13.	—First Exam. for Med. Degrees (London) begins. First, Second, and Part I of Third Exam. for M.B. Camb. begins.
Tues., ,,	14.	—Part II, Third M.B.Camb. begins. Dr. Morley Fletcher and Mr. Bailey on duty.
Fri., ,,	17.	—Oxford Michaelmas Term ends. Dr. Drysdale and Mr. Rawling on duty.
Sat., ,,	18.	—Cambridge Michaelmas ends.
Tues., ,,	21.	—Dr. Tooth and Mr. D'Arcy Power on duty.
Wed., ,,	22.	—**Winter Session divides**.
Fri., ,,	24.	—Dr. Garrod and Mr. Waring on duty.
Sat. ,,	25.	—Christmas Day.
Tues., ,,	28.	—Dr. Calvert and Mr. McAdam Eccles on duty.
Fri., ,,	31.	—Dr. Morley Fletcher and Mr. Bailey on duty.
1916.		
Mon., Jan.	3.	—D.P.H. (Conjoint) Exam. begins. Second Exam. of Soc. of Apothecaries begins.
Tue., ,,	4.	—First Exam. Conjoint Board begins. Dr. Drysdale and Mr. Rawling on duty.
Wed., ,,	5.	—First Exam. of Soc. of Apothecaries begins.
Thur., ,,	6.	—**Winter Session resumes**. Second Exam. Conjoint Board begins.
Fri., ,,	7.	—Dr. Tooth and Mr. D'Arcy Power on duty.

EDITORIAL NOTES.

IT is with very much regret that we learn of the death of Lt. J. M. M. Marshall on active service. While repairing a part of the parapet on the night of October 19th, he was shot by an enemy sniper. The bullet entered his left arm and passed through his side, penetrating the lung. He died at 6 a.m. on October 21st. Our deepest sympathy is extended to his parents in their sad bereavement.

* * *

We heartily congratulate Staff-Surgeon G. M. Levick on his promotion to Fleet-Surgeon, which appeared in the following Admiralty notification on November 22nd: "Staff-Surgeon G. M. Levick has been specially promoted to the rank of Fleet-Surgeon for his services with the British Antarctic Expedition in 1910, with seniority, November 21st."

* * *

We announced in our last issue that Mr. Harmer would shortly leave us to take up the post of surgeon in the Anglo-Russian Hospital. Mr. Rose takes charge of the wards in his absence, and Major W. Kent Hughes, an old Bart.'s man, and a well-known laryngologist of Melbourne, will take his place temporarily in the out-patient department.

* * *

The Mid-Sessional Address to the Abernethian Society will be delivered on January 6th, by Major McAdam Eccles. The subject will be "The Little Things of Medicine and Surgery." The number of men in the School has appreciably lessened, and it is hoped that those from the outside will rally with their friends to make a good audience.

* * *

The War Office has recently applied to the Governors of the Hospital for further accommodation. Unfortunately, it is scarcely possible to give up any more of the civilian wards at present, but the convalescent home at Swanley with its 70 beds has been offered as a substitute, which the War Office has accepted. Preparations are now all complete, and the first patients are expected to arrive on Friday, December 3rd. Dr. J. Dawson Crawford has been appointed Medical Officer in Charge.

* * *

At a meeting of the Students' Union Council on November 4th it was decided that the memorial to the late Dr. W. G. Grace should take the form of an engraving framed in oak and suitably inscribed, and that this should be placed in the Abernethian Room. Subscriptions should be sent to Mr.

W. Girling Ball, The Warden's House, St. Bartholomew's Hospital.

* * *

1st LONDON GENERAL HOSPITAL.
Y.M.C.A. Hut.

It is proposed to erect a large recreation hut in the grounds of the 1st London General Hospital. Of the initial cost of about £1000, the Y.M.C.A. have promised £300 and another £450 has already been subscribed by friends, including several old St. Bartholomew's men and nurses. We venture to think that others may care to send a donation for this good object. Cheques should be forwarded to the Hon. Treasurer, Major W. McAdam Eccles, 124, Harley Street, London, W.

MEDICAL STUDENTS AND THE WAR.

IT is to be hoped that the methods employed in determining the value of the medical student to the nation have not so great a vogue in all other Governmental problems. Not only has there been discrepancy of opinion and contradiction of one authority by another, but for many a long day there seem to have been rival authorities, each claiming the right to label the medical student. At one time the students were evidently under the Ministry of Munitions—at any rate that Department sanctioned the use of their distinctive Red Cross badges. But other cooks have also stirred the pudding until the currants in it have turned giddy. We know of one instance in which a student, in the early days of the war, applied at the War Office for a commission. He was informed that he would be better advised and of more value to the country if he remained at the Hospital. Latterly he received one of Lord Derby's famous letters; again he went to the War Office, and again he was advised to go back to the Hospital, with the added information that no doubt the letter was a mistake. Thus is the left hand ignorant of what the right hand doeth. Nor is this the only student who has been juggled with, as if part of some monstrous conjuring trick. The following letter received from yet another student serves as a measure of what their perplexity has been:

"*To the Editor of the 'St. Bartholomew's Hospital Journal.'*

ST. BART.'S,
October 25th, 1915.

DEAR SIR,—What is the official attitude concerning medical students enlisting?

Personally I applied for leave of absence to enlist in August, 1914. The Dean then replied that it was contrary to the wish of the War Office that medical students should throw up their professional studies.

After that we have had Col. Tooth's announcements on the O.T.C. board and Mr. Tennant's statement in the House of Commons. Also the Dean has been against any man applying for a commission in the Navy as surgeon probationer; this was as recently as last week.

Then more recently still some few have received 'Lord Derby's' letter. And yesterday the Dean entered the dissecting rooms and made a little speech, the gist of which was: Reply to Lord Derby's letter and say that directly you have passed your second examination you intend to apply for commissions in the Navy.

What are we to do, and where are we among all the conflicting advices, etc.?

Yours truly,
PERPLEXED."

No doubt the magnitude of our needs has greatly exceeded the expectations of those in authority twelve months ago, and of necessity a change in their opinions and policy has taken place. At the beginning of the war they advised medical students to remain at their posts, and even released those who had already enlisted in order that they might go back to their studies. Now that policy is reversed. There is no fault to find with a change of policy *qua* such, for to change one's mind is by no means a sign of weakness—it is essential to progress. But the vacillating and uncertain methods displayed and the apparent lack of forethought and of departmental cohesion certainly create grave doubts as to whether the change of mind under consideration is a wise one. In the writer's opinion there is only one possible justification for the new orders, and that is an extremely urgent need of young *officers*. Should it be intended, if conscription becomes necessary, to bring the remaining medical students into the ranks as *privates*, the loss to the country would be out of all proportion to the infinitesimal gain. These matters have been represented both to Lord Derby and to Mr. Asquith by various persons and deputations.

So short a time ago as June 21st Mr. Tennant reiterated his intimation that medical students were of more use at their hospitals than serving in the Army. About three months afterwards this was rescinded by an announcement that the War Office "would be very unwilling to suggest that junior medical students should be discouraged from taking combatant commissions." It will be here observed that the War Office makes no definite announcement of its needs as compared with the medical needs of the country. In the guarded and foolish phraseology of the professional politician, it merely succeeded in confusing hospital authorities and medical students as to what was really required of them. The Medical Correspondent of the *Times* on August 25th called attention to the dangers arising to the country in the event of the medical student relinquishing his professional studies. But it was not till the beginning of this month that any clear pronouncement was actually forthcoming in the House of Commons, when

according to the *Times* the following definite statement was made.

"Mr. Tennant, in answer to questions asked by Mr. Snowden (Blackburn, Lab.) and Sir P. Magnus (London University, U.) concerning recruiting among medical students, said: I would now, in the light of the experience of the last few months, make this modification of the statement I made on June 21st. I think we must remember that we have first to win the war and afterwards to encounter problems arising out of it, if they do arise. I would, therefore, answer these questions by saying that the view of the War Office at the present time is that fourth or fifth year students should continue their studies, but that students in the first, second, and third years must consider for themselves what answer they should make to the recruiting appeal addressed to them, and not to regard themselves, so far as the War Office is concerned, as under the duty of continuing their medical studies."

And in the *Times* of November 3rd the following confirmatory evidence appeared:

"In view of the recent issue of Lord Derby's appeal, which was received by the junior students at the medical schools, the question has again come to the front, and yesterday a deputation consisting of the President of the College of Physicians, the President of the College of Surgeons, the Deans of the medical schools, and the Vice-Chancellor of the University of London waited upon Lord Derby to discuss the matter with him. It was pointed out to him that the medical curriculum extends to five years, and in view of the fact that Lord Derby's letter was being received by students in their first, second, and third year the authorities were anxious to know whether it would not be possible to exempt them. It was urged very strongly that the medical student would be of much more service to the nation if he continued his studies and qualified as a doctor in three, four, or five years' time than if he joined the Army as a combatant at present.

"Lord Derby, after hearing the views of the deputation, gave his decision on the point in the following words: 'It is the duty of medical students (other than those in the fourth and fifth years of study) to join his Majesty's Forces.'

"According to the statistics published at the beginning of September, the number of students in ten leading medical schools during the first year of the war was 1891, as compared with the normal total of 2562. The effect of Lord Derby's decision will be, of course, to deplete the number of students still further."

On November 4th the following circular was sent out by the General Medical Council:

"The President of the General Medical Council is requested by the Council to inform the licensing bodies, medical schools, and approved teaching institutions, that the Director-General of the Army Medical Service has intimated to the Council his entire agreement with the Earl of Derby's decision regarding the recruiting of medical students, namely, that—"It is the duty of medical students (other than those in the fourth and fifth years of study) to join His Majesty's Forces.

"The President hopes that in every medical school steps will be taken to convey this information to the students who are eligible for military service."

One would have thought that matters were now definitely settled. At any rate here was a definite statement reiterated, curt, and final. By no means. Further deputations and correspondence beat upon the Governmental doors, and beat successfully. At the moment of writing, the following notice is exhibited upon the School notice board:

"TO JUNIOR STUDENTS.

The Dean desires to inform first, second, and third year men that he has received the following letter:

10, DOWNING STREET,
WHITEHALL, S.W.
November 11th, 1915.

DEAR SIR,—The Prime Minister desires me to thank you for your letter of November 1st, to which he has given careful attention.

Mr. Asquith desires me to inform you that he is unable to differ from the view already expressed by Lord Kitchener in the letter of August 11th addressed by him to Prof. Halliburton.

Mr. Asquith is of opinion that students of their fourth and fifth years should complete their studies, while those in earlier years should be free to offer themselves for service with His Majesty's Forces.

Yours faithfully,
M. BONHAM CARTER.

T. W. SHORE, Esq., M.D.

N.B.—The view in Lord Kitchener's letter to Prof. Halliburton on August 11th is:

'The War Office would be unwilling to suggest that junior students should be discouraged from taking combatant commissions.'

The position created by Lord Derby's expression of opinion on November 2nd is modified by the Prime Minister's letter of November 11th.

Junior students, instead of being told that it is their 'duty' to join His Majesty's Forces, are now informed that they—

'*Should be free to offer themselves for service with His Majesty's Forces.*'

The decision must rest, therefore, with each student individually.

Meanwhile—

All lectures and practical classes for first, second, and third years students will continue as usual.

T. W. SHORE."

So now it is no longer the medical student's *duty;* once more it has been left to his discretion. The general has informed the rank and file that the attack will be left to their discretion! The medical student is now on a footing with the rest of the unmarried young men. Again we feel the confusion of the issues.

We know perfectly well that the powers that be want the medical students to join the Army. But as they give us no figures as to the number of officers either available or required, nor do they even say whether the medical student is essential or not essential as a combatant officer, we have no indication that they are not merely urging the medical student in an omnivorous orgy of plethoric accumulation—part of the comprehensive and excellent scheme for enlisting all the available men of England. It seems clear that the medical student should not be thus treated in a general scheme, and it becomes extremely difficult for the individual student to know his duty, especially when he reads the views of such an authority as Sir Donald MacAlister, who expressed these views in his Presidential Address at the opening of the 102nd Session of the General Medical Council on November 2nd:

"They had it on the highest authority, he said, that within the next few months every qualified man of suitable age who was fit for the work of an officer in the Medical Corps would be needed. The profession looked to the public to lighten the sacrifices and burdens which all practitioners must endure in these days both by loyalty to the absent and by consideration for those who took their place. The proportion of country practitioners who had been set free for military service was higher than that from the large centres of population. The town doctor, owing to the somewhat loose attachment of his patients to him, feared that they might be alienated if he went into the Army. The Medical War Committees were endeavouring to promote equitable agreements between practitioners who remained on civil duty and their colleagues on active service, and he thought the profession had given abundant proofs that it would not be wanting in duty or in self-denial.

"From the British Dominions and from other countries over 240 practitioners had been registered this year, and it was believed that when certain reciprocity arrangements had been completed, the number from Canada would be considerably increased. Although the War Office authorities recognised that the withdrawal from professional instruction of large numbers of medical students of the first three years would have a serious effect on the future, they had deemed it inadvisable to discourage junior students who offered themselves for combatant service. It was much to be desired, he thought, that the Army authorities should give clearer guidance on this perplexing question. The result of medical students accepting commissions and enlisting was that the prospective shortage of 250 qualified practitioners per annum which he had mentioned on a former occasion as probable during the coming years would almost certainly be exceeded.

"There was one direction in which it appeared likely some economy of medical students might be effected. The minor vessels of the Fleets carried a surgical 'probationer,' and for this work medical students who had completed their physiological and anatomical studies and had been instructed in surgical dressing are preferred. He was authorised to make it known that any 'probationer' who, after, say, six months' service, desired to present himself for a professional examination or to resume his studies, would be granted leave of absence or be demobilised, and a less senior student appointed in his place. By such a rotation of service a succession of students might continue to be employed in war work, and yet the qualification of none would be unduly delayed."

In the words of Dr. Shore "the medical student is no shirker," and we believe that the public are well aware of this fact; indeed the *Star* of Nov. 5th described the scenes which took place at St. Bartholomew's Hospital when Lord Derby's decision was first announced, and we cannot do better than quote this article at some length.

"The decision of Lord Derby that medical students in their first, second, and third years should join the Army has caused a considerable amount of excitement in the London hospitals. The students almost to a man are delighted at the decision, although in some quarters the desirability of taking the few students that are left is still a debatable point.

"The scene at one of the largest of the medical schools when the news was made known was one which will not easily be forgotten. Work was quite at an end. Several students at once applied for commissions, and the possibility of the school closing was discussed at considerable length.

"The dissecting room presented a sight which almost beggars description. Several students arrived with large recruiting posters, with which they immediately proceeded to decorate what, in the ordinary course of things, is at the best a rather gruesome place.

"The numerous subjects in the course of dissection were carefully draped with vividly coloured posters, such as

Have you done your best?

Your King and country need you,

etc. The walls and the gallery also received similar decorations.

"The original contributions, mostly executed in coloured chalks by the students of more or less artistic type, caused the most excitement, and certainly the most amusement. On the concrete floor such messages as

Join up, and *This way to the recruiting office*

met one's eye, large arrows indicating the direction the would-be patriot should go. A khaki hat, bearing the words

Is this yours? and *Does this hat fit you?*
occupied a prominent position on a gas bracket.

England expects every 1st, 2nd, and 3rd year man
will this day do his duty.
Glorie aux Allies.
Don't sit by this fire, get up and join.
Don't study diagrams, study maps.
Cut up live Germans, not dead Englishmen.

are typical of the messages, some of which were executed with a considerable amount of skill.

"A wooden anatomical model of a man was adorned with the words, 'Why are you not in khaki?' written on his chest, and an excellent sketch of Lord Kitchener had attached to it the words, 'Men, and still more men, till the enemy is crushed.'

"A budding artist had executed a sketch of a Tommy, and demanded to know, 'Would you like to look like this?' The retort, 'Not for worlds,' was evidently the work of a humorist. A photograph of the room taken by one of the students will, no doubt, be treasured in years to come.

"The culminating point, however, was the speech by the Dean to the students. 'Medical students are not shirkers,' said the Dean—a statement which was decidedly to the students' liking, for the theatre fairly shook with the applause which greeted this remark.

"The meeting ended with a strong appeal to the eligible men to join, and the cheers for those who intended to put this into practice left little doubt that for some time to come the hospital would be very short indeed of first, second, and third year men."

It is, of course, since this article was printed that the new doubts have been cast upon the student's duty. There appears on consideration, however, less real cause for doubt. The authorities may not know the requirements of the country, the medical student knows still less; but in his ignorance it is well for him to reflect that the services of the requisite number of officers may not be obtainable elsewhere. He cannot run the risk of leaving his country short of officers. If he be wrong, if the country suffer hereafter from lack of doctors, the mistake will be upon the heads of the Government, who have asked us to make a decision without giving sufficient material to do so. Unless the Government issue more definite instructions within the next fortnight, the student ought to go. He should *not* go as a private, but as an officer. If he cannot obtain a commission he should stay at the Hospital. Moreover all those who remain at the Hospital, whether of the first or fifth year, should, without doubt, obtain some elementary military training by joining the O.T.C. We would urge, however, the necessity which exists for

THE DISSECTING ROOMS ON "DERBY DAY," NOVEMBER 5TH, 1915.

filling up the ranks of the profession, and those who have sons who, through some slight physical defect, are unable to join the Army, let them remind their sons that a slight defect would not hinder them from becoming valuable assets to their country in the medical profession.

PAUL BOUSFIELD.

THE WORK OF A CAVALRY FIELD AMBULANCE.

By MAJOR H. NORMAN BARNETT,
Commanding 3/2nd South-Western Mtd. Brigade Field Ambulance.

THE work of a mounted brigade field ambulance is perhaps the most interesting and exciting that the medical service of the British Army has to offer.

The ambulance forms an integral part of a brigade and is the highest authority on all matters appertaining to its branch of the service in the brigade.

All officers attached to units other than medical are under the jurisdiction of the C.O. field ambulance on all matters other than disciplinary, and though they may be appointed by the O.C. under whom they serve, they render all reports on special matters to the O.C. field ambulance, who is their Commanding Officer.

The usual procedure in action is that the ambulance is divided into tent and bearer sections, the former of which establish a temporary hospital of fifty beds some five miles behind the firing-line. The bearer section goes forward and gets into touch with the regimental attached R.A.M.C. Officer at his regimental aid post when the cavalry are engaged in *reconnaissance*.

From the aid post they will move cases in light wagons to the temporary hospital.

When the cavalry are engaged in concentrated action the regimental attached R.A.M.C. Officer moves forward with his regiment, and the ambulance collects the wounded from the field of action and evacuates them to its base; or the cases may be sent back to a heavy ambulance *rendezvous*, the latter transferring the cases to the ambulance operating base, the light wagons returning to the regimental aid post or to the field of action, as the case may be.

Professional work for officers consists of emergency operations and quick evacuation of wounded to the lines of communication. It does not burden itself with chronic cases, as it is a highly mobile force and must be ready to move forward at the shortest possible notice in conjunction with the cavalry brigade.

The present war has seen many alterations in procedure, and it frequently happens the general idea outlined above cannot be followed. This is especially so with regard to the pitching of the operating tent and the establishment of the hospital.

Very frequently it is an unwise procedure, especially on the part of a mobile force, to pitch any tents or make any more or less permanent arrangements. It would interfere with its rapid movements.

Under these circumstances it would often be necessary to use heavy ambulance wagons as improvised operating shelters and to move the wounded in them from place to place as required, especially if the cases are such as can soon be returned to the firing-line.

Should a forward movement be carried out in the present war, which there is no doubt there will be in the future, there will be a larger scope and more exciting work for this branch of the Service.

THE NATIONAL GUARD AND ST. BARTHOLOMEW'S HOSPITAL.

IN the event of further air raids on London, the hospitals will not be found unprepared, but there is probably no institution at which more thorough precautions have been taken than at St. Bartholomew's. The scheme in operation at that Hospital originated with the 1st Battalion of the City of London National Guard, whose Commandant, Colonel Cobbett, has made arrangements for a detachment of the Guard to attend at the Hospital every night.

THE GUARD ARRIVES.

At seven o'clock every evening sixty members of this unit arrive at the Hospital, and at eight o'clock they are reinforced by sixty more. The first sixty remain on duty until nine o'clock, and those who come at eight stay till midnight, so that between the hours of eight and nine there are 120 men on duty, and should news be received that a raid is expected, the whole force would remain on duty until their services were no longer required. The duties of the guard are very clearly defined, and the men are prepared for them by regular drills. It may be assumed that in the event of a raid on the Hospital one wing only would be hit by a bomb, in which case the maximum number of patients who would have to be removed is estimated at sixty. The work of removing them would be done by the members of the National Guard on duty, and for this purpose every man is provided with an ash stretcher pole.

REMOVING THE PATIENTS.

The cases that would require removal are divided into three classes—namely, (*a*) those in bed who cannot walk or be carried; (*b*) those who can be carried on the back, or by bandy chair; (*c*) those who can walk.

The mattresses of the first group at all times have under them a special canvas sheet with a wide hem on each side through which poles can be passed, thus forming a stretcher. A supply of these sheets is provided in each ward, and it is the duty of the sister to see that one is placed under the mattress of every bed occupied by a patient who is too ill, or is otherwise unable to walk. Each of these beds is indicated by a crimson tape, so that the stretcher-bearers would know at a glance which patient they had to remove on the improvised stretchers. The second and third group would be directed and aided to leave the wards by the emergency staircases at the ends of the wings while the stretcher cases were being removed by the main staircase.

The destination of the patients on removal from a wing would depend upon circumstances; it would either be to another wing or to the surgery. In the event of the removal of patients becoming necessary, the sisters are instructed to see that all doors giving access to the wards and to the emergency staircases are opened.

To give a better idea of how precise the arrangements are, it should be added that each night printed forms are filled in showing the number of patients on each floor of each of the wings. These are in the following form, but, of course, much larger:

NUMBER OF PATIENTS TO BE REMOVED FROM WARDS.

(*a*) by stretcher; (*b*) requiring help.

First floor:

	Name of Wards.					
	On Right.			On Left.		
		(*a*)	(*b*)		(*a*)	(*b*)
EAST WING	Pitcairn ...			Hope ...		
SOUTH WING ..	President...			Mark ...		
WEST WING ...	Annie Zunz			Henry ...		
					(*a*)	(*b*)
CASUALTY WING.....	Lucas					

It is fervently to be hoped that such a tragedy as the dropping of a bomb on St. Bartholomew's will never occur, but the authorities have acted with great wisdom in making these admirable arrangements. Rumours that Zeppelins are about are not infrequent, and it needs no effort to imagine that such reports, notwithstanding that they are generally untrue, have a disturbing influence on those whose duties lie in the Eastern Counties. But there is certainly much comfort in the knowledge that six score trained men are keeping watch and ready to help at the first signal of danger. It also gives a sense of security to hear the tread of the sentries as they walk the quadrangle. Should an official notice be received at the Hospital that an air raid is expected the sisters will be informed, so that they can disregard all unfounded rumours. Either Captain Girling Ball, the medical officer in charge of the military wing, or Mr. Hayes, the chief resident administrative officer, is always on duty in the Hospital to receive any warning, so that there will be no delay in taking action.

In addition to utilising the services of the National Guard, it need hardly be said that the Hospital authorities have made supplementary arrangements for dealing with outbreaks of fire. For instance, there is a Hospital fire brigade under the direction of the resident fireman; and there is also a volunteer fire brigade of students. Further, the nurses are practised in the use of hand-pumps, and the Hospital is very adequately provided with electric fire alarms, fire hydrants, hose, and chemical extinguishers. The arrangements are that upon an outbreak of fire information is given to the porter, who communicates with the London Fire Brigade, and a horn is sounded in the square to call up the Hospital fire brigade. In the case of an air raid the services of the London Fire Brigade might not be immediately available, and if the Hospital were struck by incendiary bombs these arrangements might be inadequate. Hence the wise policy of the authorities in availing themselves of the services of the National Guard. The action taken at St. Bartholomew's is recommended to all hospitals in the Zeppelin zone.

[Reprinted, by kind permission of the Editor, from the *Hospital*, November 20th, 1915.]

A SEVERE CASE OF DYSENTERY TREATED WITH ANTIDYSENTERIC SERUM (LISTER'S).

By C. DE CHANVAL PELLIER, Lt., R.A.M.C.,
H.M.H.S. "Salta."

THE case described below is one of severe dysentery, similar to many others to be seen on every trip which our hospital ships make from Gallipoli, but I have selected this case to write a few notes on, because it is so very typical of the disease as we see it out here.

Private E—, æt. 20, R.A.M.C., admitted to this ship on October 21st as a stretcher case. Attached to him was a label stating that he had dysentery, that temperature was 102° F., and that he had been given emetine, gr. $\frac{2}{3}$.

On admission the patient was very blue, cold, and collapsed, and was treated at once with hot bottles, blankets, and a hot drink. He gradually became warmer and less collapsed, but his pulse still continued to be very weak.

On the morning of the 22nd he presented the typical

picture of a severe case of dysentery, and the stools were very frequent and consisted of blood and slime.

I gave him a hypodermic injection of ℞ emetine, gr. ss + liq. strychnine ♏iv. In the evening I again gave him an injection of ℞ emetine, gr. ss, followed later by morph., gr. $\frac{1}{4}$, administered hypodermically.

The stools now contained much less blood and were of a green colour.

October 23rd.—The patient had obviously lost ground. The pulse was very weak and uncountable, the breathing gasping and irregular, and he was unable to move himself in the bed. He looked thoroughly toxic.

I gave him 20 c.c. of Lister's antidysenteric serum at 10 a.m., and, as his pulse was very bad, at 2 p.m. strychnine, gr. $\frac{1}{40}$. There was some improvement in his pulse after this was injected.

The patient remained in a profoundly collapsed condition for the next twenty-four hours, passing urine and fæces unconsciously, and it became increasingly difficult to get him to take nourishment.

October 24th.—The morning temperature was 97·4° F., but the stools, though still passed unconsciously, contained less blood.

In the evening of the 24th the patient's temperature rose to 100·2° F., and from this time his condition gradually improved.

With regard to the further treatment of this case, the patient was given morphia, gr. $\frac{1}{4}$, each evening to relieve his pain and to obtain sleep.

The feeding of the patient from October 22nd to 26th consisted of small quantities of albumin water, egg-flip, jelly, brandy, and champagne, given every two hours.

On the 27th I placed him on a milk diet, but still continued the stimulants.

The patient was landed at the base on the afternoon of October 28th, and though he still had a good deal of diarrhœa he was steadily gaining strength, and his general condition appeared to be improving.

To add a few facts which have struck me in connection with these Peninsula dysenteries, of which this ship has carried 855 cases, sent on as such, besides a large number of cases which were sent on as diarrhœa with blood and mucus, etc., of which I have not the number.

Most of the cases came to us having had ol. ricini and injections of emetine on shore, so I "carry on" on the following lines in straightforward cases:

A saline purge (soda sulph.) each morning until the tongue is clean, and inject emetine hypodermically at the rate of gr. j per day, given as follows:

In the morning ℞ emetine, gr. ss, + liq. strych., ♏iv. At night ℞ emetine, gr. ss, with or without brandy, ♏xx.

If, at the end of thirty-six hours, the case does not seem to be improving, I inject 20 c.c. of antidysenteric serum into the subcutaneous tissues of the chest and stop the emetine.

I also stop the emetine if the pupils become greatly dilated, if there is much irregularity of the pulse or marked præcordial pain.

Usually the blood disappears from the stools on the third day.

After this stage, or before it is reached, in severe cases, I give morphia hypodermically (gr. $\frac{1}{4}$ to gr. $\frac{1}{2}$) as required to relieve the pain, tenesmus, and strangury.

I am convinced that the morphia should be given early, and not as a last resource when the patient is broken-down and the heart is failing.

The effect of a single injection of morphia is very prolonged, and there is no need to repeat the dose until the pain returns with severity.

Other points to be observed in the treatment of these cases are:

(1) That they require all the fresh air that can be given them, and that they bear cold much better than a close, stuffy atmosphere.

(2) The necessity for scrupulous cleanliness—a very difficult task, especially when the patients are passing their stools involuntarily; the vitality of their tissues is so much lowered that they develop bedsores very readily. Packing is essential in these cases.

With regard to the feeding of these patients, one would naturally like to start these cases on a fresh milk diet—an absolutely impossible thing; so one is driven back on to working with as suitable a light diet as resources will allow—*i. e.*, tinned milk, cereals, egg flip, broths, with albumin water for the worst cases. Tea and cocoa are not well borne by them, but small doses of brandy and champagne can often be retained when it is impossible to get the patient to take anything else, and, as the disease is usually of short duration in its acute stage, there can be no objection to the moderate use of stimulants.

Hot-water bottles are of great use, both to relieve pain and to combat the cold collapsed condition.

A CASE OF RECURRING VOLVULUS.

By S. W. ISAACS, M.R.C.S., L.R.C.P.

AS cases of volvulus are rare and have a very high mortality, I think the following to be one of extreme interest, since on two different occasions the patient has had a volvulus, the first of her cæcum and the second of part of her small intestine.

The patient, Annie N—, æt. 54, a theatre cleaner, awoke on October 19th, 1915, with abdominal pain, which was at first a little more marked on the right side below the umbilicus but which soon became generalised. The pain was not very severe and was accompanied by a feeling of

"tightness and much flatulence." The patient's bowels had been opened the previous day, but they were now unopened, and she was unable to pass any flatus, although she made frequent attempts to do so. There was no nausea or vomiting. On October 20th the pain was more severe and the distension more marked. In the evening she vomited a little "green bitter fluid." She was still unable to pass flatus, and the bowels were still unopened, although she had taken castor oil.

On October 21st, the patient vomited "green bitter fluid" three times and was still unable to pass flatus. She gave herself an enema, but only very little fæcal material was passed. As she was getting more and more distended she came to the Hospital and was admitted. She looked ill and appeared to be in much pain, but her general condition was good. Her temperature varied from 97·8°–99·8° F., and her pulse from 84–94. Her abdomen was very distended, especially to the left of the umbilicus, and moved poorly but uniformly on respiration. There was no respiratory distress. Peristalsis was distinctly visible. On palpation, there was a little rigidity and tenderness all over the abdomen. No definite swelling could be felt. The abdomen was resonant all over, but on the left side, where the distension was most marked, there was a drum-like note on percussion. Rectal examination revealed nothing abnormal. An enema was given, but was returned clear.

An operation was performed the same evening by Mr. Harold Wilson. The abdomen was opened in the middle line below the umbilicus, and distended coils of small intestine presented. When these had been displaced, a large, enormously distended, very tense piece of intestine was found, lying more to the left than to the right of the middle line and chiefly occupying the umbilical, left lumbar, and left hypochondriac regions. Its limits, however, could not be defined, partly on account of its size and partly because it was very tense and appeared as if it would easily burst. A portion of it was surrounded by gauze, a trocar and cannula were inserted, and a large amount of gas and about two pints of very offensive liquid fæcal material escaped. The hole was then closed by a layer of Lembert's sutures.

The swelling, the nature of which could now be more thoroughly investigated, was found to consist of a piece of intestine about 9 in. long and 3–4 in. in diameter, which had twisted round its mesenteric attachment. The mesentery was about as long as that of adjacent small intestine. The affected portion of intestine was congested but showed no signs of gangrene. At its proximal end it was continuous with distended small intestine, and at its distal end it was lost among adherent coils of small intestine, which were closely matted together and not distended. The twisted intestine had no appendices epiploicæ or longitudinal muscular bands. No large intestine was seen. The volvulus was untwisted, a Paul's tube was inserted, and the abdomen closed as far as possible.

The patient vomited a little after the anæsthetic, but next morning she felt much better. A large amount of liquid fæcal material escaped from the Paul's tube, and on the fourth day an enema was given with a very good result. The amount of fæcal material that escaped from the tube now began rapidly to diminish, and on the eighth day the bowels acted normally. The tube came out on the ninth day. The fæcal fistula gradually got smaller, but continued to discharge liquid fæces, especially so when the patient drank much. For another three weeks her bowels were not opened naturally except by enemata, but the result from these was always very satisfactory. On November 18th the patient was able to get up, and appeared to be very well. On November 21st her bowels again commenced to act normally without enemata, and since then the fistula has got considerably smaller, and scarcely any fæcal material now escapes from it. The fistula, at the time of writing, is about $\frac{1}{8}$ in. in diameter. The patient is now able to get up every day, and as soon as the fistula closes will be able to return to her work.

In January, 1914, the same patient was in President Ward with a volvulus of her cæcum. Her symptoms then were almost identically the same as they were on the present occasion. When admitted there was a history of flatulence, constipation, and increasing distension of six days' duration —a somewhat longer history than on the present occasion. The abdomen showed visible peristalsis and was markedly distended and resonant, but there was again not much tenderness or rigidity. When the abdomen was opened the cæcum was found to be twisted on its mesentery and enormously distended. The twisted mesentery was untwisted, and fæcal material and flatus were allowed to escape *viâ* the appendix before it was removed and its stump invaginated into the cæcum. The abdomen was then closed, but, unfortunately, later on a portion of the abdominal wall sloughed and a fæcal fistula resulted. The patient rapidly recovered, and Mr. Waring operated to close the fistula. The operation was successful, and the patient left the Hospital feeling very well.

I have looked up the records of the cases of volvulus in this Hospital during the last twenty years, and have found in all 24 other cases. Out of these 21 died and 3 recovered, giving a mortality of nearly 88 per cent. It is thus very rare for a patient to recover from a single attack. It is the only case of recurring volvulus that I have been able to find in the Hospital records. Cases of recurrent volvulus are, I think, on record, but they are very rare, and usually occur soon after the first attack and in the same place. In this case the second volvulus occurred one year and nine months after the first, and the site of the volvulus was different on each occasion.

From the records of the 24 cases I have found, the causation of a volvulus, especially the exciting cause, seems very obscure. In no case has the volvulus been

attributed to a fall, a strain, or other sudden movement. In the case above described, however, the patient felt quite well when she went to bed, but awoke with pain. It is conceivable that the volvolus resulted from her turning over in bed.

In 5 cases there is a history of chronic constipation previous to the onset of symptoms, but this cannot be a very potent etiological factor, because normally about five in every twenty-four people are constipated. I asked twenty-four people, excluding those suffering from febrile conditions, in the surgery one morning whether they were constipated or not—seven said they were and seventeen said they were not.

The commonest predisposing cause of a volvulus is a congenital defect, namely, the presence of a meso-cæcum, a meso-colon, or an abnormally long mesentery. This being the case, one would expect cases of volvulus to occur early in life, but the following figures do not bear this out:

Under 20 years	2 cases.
20–30 „	1 case.
30–40 „	6 cases.
40–50 „	3 „
50–60 „	7 „
60–70 „	4 „
Over 70 „	1 case.

Volvulus appears to be commoner in males than in females. In the 24 cases, 16 were males and 8 females.

It is more common in the small than in the large intestine:

Small intestine	13 cases.
Large intestine	11 „
Cæcum	7 „
Sigmoid	3 „
Position not stated	1 case.

All occurring in the small intestine proved fatal.

Of those occurring in the large intestine, the following recovered:

Cæcum	1 case.
Sigmoid	1 „
Position not stated	1 „

All the cases, except one, were due to twisted mesentery. In the other case the bowel was twisted on itself. It occurred in the large intestine (position not stated) and the patient recovered. Nineteen cases were discovered by operation and 5 cases post mortem. In 20 cases a volvulus was the only abnormal condition found; in 2 cases the appendix was inflamed; in 1 case a pyosalpinx was found, and in 1 case an annular carcinoma. The cases in which the appendix was inflamed are interesting because in one of them the volvulus was in the small intestine, extending to the ileo-cæcal valve. There was a four days' history of absolute constipation, and the abdomen was resonant, especially in the right iliac fossa, where there was a little tenderness. A diagnosis of appendicitis was made, and the appendix, which had perforated, was removed. The patient died, and post mortem the volvulus was found. From the symptoms it appears as if the volvulus existed from the commencement of the illness, and as the cæcum was not involved it seems as if the appendicitis may have caused the volvulus. In the other case the whole of the cæcum was involved, and part of it showed patches of gangrene. The appendix also was gangrenous, and thus it seems as if the virulent bacteria in the twisted cæcum had invaded the appendix. This being so, the volvulus caused the appendicitis.

In the majority of cases when an operation has been performed, the volvulus has, if practicable, simply been untwisted. In the majority of cases, however, it has first been necessary to puncture the distended intestine in order to allow gas and fæces to escape.

In none of the cases has a diagnosis of volvulus been made. In 1907 Mr. Harold Wilson published a paper on "A Case of Migration of the Cæcum," * and in it laid stress on certain symptoms which might suggest the possibility of a volvulus occurring in part of the large intestine. Among these he mentioned a subacute onset of partial intestinal obstruction, vomiting which was rarely fæculent, and the presence of a visible globular and tympanitic abdominal tumour.

In the majority of the 24 cases the intestinal obstruction was not at first complete, a little fæcal material being, as a rule, either passed normally or by means of enemata. The average history before the patient came to the Hospital was of about five days' duration, and the vomiting was very rarely fæculent. In 3 cases it is stated that a swelling was seen in some part of the abdomen over which the note was more tympanitic than elsewhere.

I am extremely grateful to Mr. Harold Wilson for his kind permission for me to publish this case, and to Mr. Waring for allowing me to make use of the former notes.

FOREIGN BODY IN STOMACH OF DOG; GASTROSTOMY; RECOVERY.

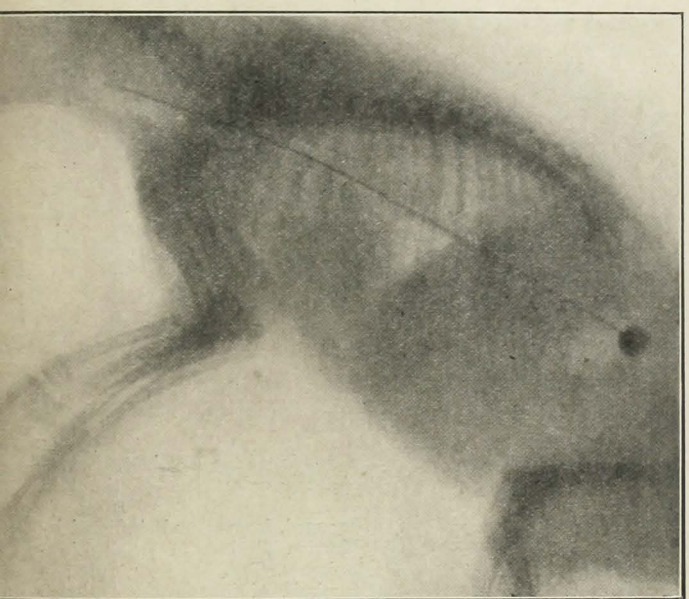
By GERALD SMYTHE, M.B., B.C.Cantab.,
Late House Physician, St. Bart.'s Hospital.

A SMALL mongrel dog, æt. 4 months, was brought up to me on the evening of January 22nd, 1913, at the General Hospital, Bristol. The story was that he had swallowed a hat pin a week previously. The dog was evidently very ill, and, as nothing definite could be felt by palpation, an X-ray photograph was taken (see picture) under chloroform.

If nothing were done it was obvious that the dog would die, so we decided to operate at once. The dog was still

* *St. Bartholomew's Hospital Reports*, vol. xliii.

under the influence of the anæsthetic. The abdomen was shaved and painted with iodine, and a one inch incision made, starting above at the ninth right costal cartilage and extending downwards. The incision was deepened through the rectus muscle and peritoneum. A finger was inserted into the wound, and the hard, round head of the pin felt in the stomach, which had been displaced downwards and to the right; the point of it could be felt in the right side of the neck. A small incision was made into the stomach, the head of the pin isolated and the whole pin withdrawn through the stomach opening. The pin was fully nine inches long and had a large black head—such as is usually worn in the hats of women of the lower classes.



HAT-PIN IN THE STOMACH OF A DOG.

A purse-string suture closed the aperture into the stomach, and the peritoneum, muscles and skin were sewn up separately in the ordinary way. A binder was placed over the dry dressing, and $\frac{1}{12}$ gr. morphia injected subcutaneously. The patient was placed in a basket and sent to the ward, where he was kept for ten days, making an uninterrupted recovery. I saw him every fortnight for several weeks; he thrived exceedingly and showed no ill effects from his experience.

STUDENTS' UNION.

A MEETING of the Council was held on November 4th.

Memorial to the late Dr. W. G. Grace.—The following report of the Sub-Committee *re* the memorial to the late Dr. W. G. Grace was received and approved by the Council:

"The Sub-Committee thought that the memorial should take the form of an engraving framed in oak, with a suitable inscription.

"That this memorial be placed in the Abernethian Room.

"That the students, staff, and Old Bart.'s men be asked to subscribe towards the cost of the memorial.

"The following amendment was proposed and carried: 'That if any more money is available, the Committee be asked to consider any further form of memorial.'

"It was also carried that the Warden and Secretary be asked to be responsible for the means of collecting the subscriptions."

Election of Secretaries.—Mr. Powell was elected as Senior and Mr. Watson as Junior Secretary.

ABERNETHIAN SOCIETY.

THE following officers have been elected for the present year:

Presidents.—Mr. S. W. Isaacs, Mr. P. H. Wells. *Vice-President.*—Mr. S. L. Green. *Secretaries.*—Mr. E. B. Barnes, Mr. C. H. Terry.

NOTICE.

Major McAdam Eccles has kindly undertaken to deliver the Mid-Sessional Address on Thursday, January 6th, at 8.30 p.m. His subject will be "The Little Things of Medicine and Surgery." The address will be illustrated by the epidiascope. It is hoped that as many past and present Bart.'s men as possible will endeavour to be present and bring their friends with them. The nursing staff has been invited.

CORRESPONDENCE.

"THE BARON."

To the Editor of the 'St. Bartholomew's Hospital Journal.'

SIR,—It is with feelings blended of amazement, indignation, wounded *amour propre*, and humiliation, that I read in this month's JOURNAL that on October 2nd, 1915, Sir Anthony Bowlby "became aware, for the first time, that he had ever been known as 'The Baron.'"

You, sir, will appreciate the depth of my composite emotions when I remind you of an editorial by one of your predecessors which appeared in the JOURNAL of July, 1911. I quote from memory; but you will perhaps refer to your office files, and correct me if I am wrong. This official utterance, which took upon itself the authority of voicing the sentiments of the whole Hospital, said: "Sir Anthony's distinction has been long expected, and for years we have affectionately regarded him as 'The Baron' with such intensity of intelligent anticipation that no change seems to have occurred now that he *is* Sir Anthony."

To me the only lamentable conclusion is that our Sir Anthony could not have read the JOURNAL in those days, or that he must at least have sedulously avoided its ponderous editorials, whilst

the editor of those days has for four years and four months been living in a fool's paradise fondly imagining that he treasured every word.

And now this fool's paradise has been disturbed. Verily another notable addition to be laid to the charge of this dreadful war!

I am, yours obediently,

ADOLPHE ABRAHAMS.

THE CONNAUGHT HOSPITAL, ALDERSHOT.
November 14th, 1915.

THE LATE DOUGLASS JAMES.

To the Editor of the 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—I think perhaps your readers would be interested to know the circumstances under which Second Lieut. Douglass James, 2nd Battalion South Staffordshire Regiment, met his death. He was wounded during a most gallant attack on September 25th while leading his men in the advance on that date. He sustained a fractured femur as the result of a shell wound, and, though he was so badly wounded, betrayed no signs of pain, being unflinching to the last. While I was dressing his leg and splinting it he smoked a cigarette and gaily cracked jokes, and made even badly wounded men smile. He asked to be remembered to his old Hospital. I was very shocked to hear a few days afterwards of his death.

I remain, Sir, yours truly,

M. O.

EXAMINATIONS, ETC.

UNIVERSITY OF CAMBRIDGE.

The following degrees were conferred on November 29th, 1915:
M.D.—F. A. Roper, J. A. Nixon.

UNIVERSITY OF LONDON.

Third (M.B., B.S.) Examination for Medical Degrees. November, 1915.

Honours.—G. C. Linder (University Medal), distinguished in Medicine, Surgery, and Pathology.

Pass. Group II.—W. H. Dupre, P. O. Ellison.

CONJOINT BOARD.

Final Examination, October, 1915.

The following candidates have completed the examination for the Diplomas of M.R.C.S. and L.R.C.P.:

C. F. Beyers, G. K. Bowes, E. G. Dingley, N. G. El-Gawly, H. H. L. Ellison, C. L. Emmerson, S. C. W. Iredale, L. G. C. Ytriago, C. S. J. Kearney, S. R. Prall, H. E. Robinson, T. J. Taunton, P. H. Wells, W. R. Wilson.

L.M.S.S.A.

The Diploma of the Society was granted to F. H. Young.

APPOINTMENT.

J. M. Nicholls, M.R.C.S., M.R.C.P., appointed Acting Medical Officer and Public Vaccinator for the St. Ives District of the Penzance Union.

NEW ADDRESSES.

BRIGSTOCKE, P. W., The Old Rectory, Scole, Norfolk.
DAVIS, K. J. A., 24, Upper Berkeley Street, W.
HAYES, Major A. H., R.A.M.C., 86, Tombs Road, Lucknow, U.P., India.
HUGHES, Major W. Kent, A.M.C., 45, Weymouth Street, W.
TREWBY, J. F., 4, Duchess Street, Portland Place, W. (Tel. Mayfair 3950 and 1200.)

BIRTHS.

MARRETT.—On October 25th, at Merivale Sanatorium, near Chelmsford, Essex, the wife of H. Norman Marrett, M.R.C.S., L.R.C.P., of a son.

NEVE.—On November 18th, at 31, Dingwall Road, Croydon, the wife (*née* Elsie Pedley), of Clement Treves Neve, F.R.C.S., Lieutenant R.A.M.C., of a daughter.

WILLIAMS.—On November 17th, at 102, Lansdowne Road, Clapham, S.W., the wife of C. Williams, M.R.C.S., L.R.C.P., of twin daughters.

WOODWARK.—On November 2nd, at 38, Queen Anne Street, Cavendish Square, W., the wife of A. S. Woodwark, M.D., Temporary Lieut.-Colonel, R.A.M.C., of a daughter.

MARRIAGES.

DAND—SCRYMGOUR.—On November 18th, at Whitstable Parish Church, by the Venerable Brook Deedes, Archdeacon of Hampstead, assisted by the Rev. Hyla Holden, Vicar of Whitstable, the Rev. Robert Beaty Dand, Vicar of Brockham, Surrey, lately of St. Bartholomew's Hospital, E.C., and of Meadow Croft, Whitstable, to Nan, elder daughter of W. H. Scrymgour, Esq., and Mrs. Scrymgour, Mill Strood, Whitstable.

DYSON—CORNISH.—On November 20th, at St. Stephen's, Hampstead, very quietly, by the Venerable A. F. Sharp, Captain Ernest Andrews Dyson, M.B., R.A.M.C., elder son of Dr. W. Dyson, J.P., and Mrs. Dyson, of Westbourne Road, Sheffield, to Minnie, younger daughter of Mr. and Mrs. H. J. Cornish, of 2, Lawn Road, Hampstead, N.W.

DEATHS.

ARCHER.—On November 2nd, the result of an accident, Ernest George Archer, M.R.C.S., L.S.A., the eldest son of the late George Archer, of Feltwell.

MARSHALL.—In Gallipoli, on October 23rd, from wounds inflicted by a sniper on October 21st, John Morrice Maitland Marshall, Lieutenant 1/4th Battalion, Essex Regiment, T.F., aged 24, only son of Mr. and Mrs. J. Maitland Marshall, of the Grove, Dulwich Village, S.E.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, Smithfield, E.C.*

The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., *at the Hospital.*

All communications, financial, or otherwise, relative to Advertisements ONLY, should be addressed to ADVERTISEMENT MANAGER, *the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City 510.*

A Cover for binding (black cloth boards with lettering and King Henry VIII Gateway in gilt) can be obtained (price 1s. post free) from MESSRS. ADLARD AND SON, *Bartholomew Close. (Temporary offices: 76, Newgate Street, E.C.)* MESSRS. ADLARD *have arranged to do the binding, with cut and sprinkled edges, at a cost of 1s. 9d. or carriage paid 2s.—cover included.*

St. Bartholomew's Hospital Journal.

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

VOL. XXIII.—No. 4.] JANUARY 1ST, 1916. [PRICE SIXPENCE.

CALENDAR.

Mon., Jan.	3.	—D.P.H. (Conjoint) Exam. begins. Second Exam. of Soc. of Apothecaries begins.
Tues., ,,	4.	—First Exam. Conjoint Board begins. Dr. Drysdale and Mr. Rawling on duty.
Wed., ,,	5.	—First Exam. of Soc. of Apothecaries begins.
Thur., ,,	6.	—**Winter Session resumes.** Second Exam. Conjoint Board begins.
Fri., ,,	7.	—Dr. Tooth and Mr. D'Arcy Power on duty.
Sat., ,,	8.	—Cambridge Lent Term begins.
Mon., ,,	10.	—Exam. for Matriculation (London) begins.
Tues., ,,	11.	—Final Exam. Conjoint Board (Medicine) begins. Dr. Garrod and Mr. Waring on duty.
Wed., ,,	12.	—Clinical Lecture (Surgery). Mr. D'Arcy Power.
Thur., ,,	13.	—Final Exam. Conjoint Board (Midwifery) begins.
Fri., ,,	14.	—Oxford Lent Term begins. Final Exam. Conjoint Board (Surgery) begins. Dr. Calvert and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine). Dr. Drysdale.
Tues., ,,	18.	—Dr. Morley Fletcher and Mr. Bailey on duty.
Wed., ,,	19.	—Clinical Lecture (Surgery). Mr. D'Arcy Power.
Fri., ,,	21.	—Dr. Drysdale and Mr. Rawling on duty. Clinical Lecture (Medicine). Dr. Drysdale.
Tues., ,,	25.	—Dr. Tooth and Mr. D'Arcy Power on duty.
Wed., ,,	26.	—Clinical Lecture (Surgery). Mr. Waring.
Fri., ,,	28.	—Dr. Garrod and Mr. Waring on duty. Clinical Lecture (Medicine). Dr. Calvert.
Tues., Feb.	1.	—Dr. Calvert and Mr. McAdam Eccles on duty.
Wed., ,,	2.	—Clinical Lecture (Surgery). Mr. Waring.
Fri., ,,	4.	—Dr. Morley Fletcher and Mr. Bailey on duty. Clinical Lecture (Medicine). Dr. Hartley.

EDITORIAL NOTES.

1916. MAY the coming year be fraught with good luck and improved conditions to the whole country, and to readers of the JOURNAL in particular. During this last year of war there have been many changes which have been duly noted in the JOURNAL from time to time—but to-day we realised how really inconvenient these changes are becoming. The Editorial chair having been shifted for the period of a week to a small village some fifty miles from London—we entered the village newsagents and ordered our morning paper. We were then informed that it could not arrive before 10 o'clock. Only 50 miles from London, and no paper to read at breakfast! *O Tempora* . . . !

* * *

The Christmas festivities in Hospital this year were exceedingly well organised, and, if possible, went off in a manner surpassing former years. It is not the way of a Britisher to show his mental disturbance when things are not altogether going his way, or in the way that he would like; it must be said in the Hospital, at least, that there was no semblance of pessimism.

It is on record that one of the "Tommies" started as early as four o'clock in the morning to give his views as to how the day was going to be spent, and it is true that as far as the soldiers were concerned merriment prevailed. After the usual preliminaries of the day, Father Xmas made his tour of the wards, surrounded by various troupes of the smaller inhabitants of the institution. After dinner early evidence of having had a good repast was forthcoming in the arrival of bands of soldiers decked in caps of paper in the Square, each provided with an instrument, trumpet, whistle, comb and paper, tin trays, and sticks, or other weapon; selections of quite unknown melodies rent the air.

As the day passed on a large number of troupes, who had offered their services, arrived. Those from the outside were brought by old friends of the Hospital, including Mrs. Le Breton, the "Roland Ramblers," the "Cherrohs," Miss Fletcher, Miss Fisher, Miss Castelle, and others who had not formed themselves into parties. From amongst the residents two excellent troupes masquerading under the titles of the "Dry Dressings" and the "Optimists," respectively, were provided, each vieing with the other to obtain the greatest respect of the audiences; it is difficult to say which party had the better of the other.

The wards were beyond description in the beauty of their decorations. Many colour schemes were devised, and in such

a manner as to harmonise with the surroundings; the scene in each ward was a reminder of the many hours of work which had been put in by the sisters and nurses of the wards in order to make the occasion a success. It was almost impossible to refuse the proferred cup of tea in each of the twenty-eight wards, in order to survey the scene.

The National Guard, as usual, arrived at the Hospital on Xmas night to carry out their self-imposed duties as recorded in a past number of this JOURNAL. The occasion was, however, unique in that a special supper was provided for them, followed by a musical programme. This was carried out in the Abernethian Room. The Junior Staff joined the Guard in the latter part of the evening, and a large number of songs were got through.

* * *

The Faculty of Medicine of the University of London have appointed Professor F. W. Andrewes, F.R.S., as one of their representatives on the Senate for the remainder of the period 1915–19, to fill one of the vacancies caused by members of the Senate who have resigned on account of military duties abroad.

* * *

The annual Bradshaw lecture was delivered at the Royal College of Surgeons on December 20th, by Surg.-General Sir Anthony Bowlby. The subject being "Wounds in War." The comparison made between wounds in the present war and those of the South African war was by no means one of the least interesting items, in a lecture which throughout was of exceptional interest.

* * *

We have to record with very deep regret the death of Mrs. Mary Anne (Minnie) Griffith, wife of Dr. Walter S. A. Griffith, which sad event occurred on December 14th, at the age of 58, to the great sorrow of a large number of friends by whom she was held in the highest regard and esteem.

The late Mrs. Griffith was well known in London circles for the many charitable and other useful organisations with which she connected herself, in which sphere she will be greatly and sadly missed. In Hertfordshire she also had many friends and acquaintances, made by her geniality and kindly disposition, and by whom her death is much lamented.

TRIGEMINAL NEURALGIA.

A Paper read before the Abernethian Society.

By C. M. HINDS HOWELL, M.D., F.R.C.P.

PART I.

MR. PRESIDENT AND GENTLEMEN, — The term "neuralgia" signifies pain in the distribution of a particular nerve or nerves unaccompanied by any gross pathological condition of the nerve involved. It is by no means synonymous with "neuritis," although there may be, and often is, intense pain associated with this condition. Take, for instance, brachial neuritis, where the nerve affection is diffuse, or sciatic neuritis, where a single nerve trunk only is involved. In both these conditions the most severe pains are often experienced. But the pain of neuralgia differs materially in one particular from that experienced as the result of an inflammatory process involving the nerve—its onset and termination are both likely to be abrupt. Thus one of its most characteristic features is seen to be its paroxysmal nature. Periodicity is another characteristic during a bout of neuralgia, attacks often recurring at the same hour each day.

The causes of neuralgia are often quite obscure. In many cases a hereditary tendency seems to exist, whilst in others convenient but illusory toxic agencies are invoked to explain its origin and periodicity. Fatigue and emotional disturbance both seem sinister influences which in certain individuals will determine an attack; whilst "nerve strain" belongs nearly to the same category of exciting causes. What "nerve strain" exactly means is a question which I trust nobody here to-night will pursue with too relentless curiosity. Certain it is that, for example, the strain on visual accommodation imposed by uncorrected errors of refraction will often give rise to violent neuralgic attacks.

Nevertheless, in certain instances neuralgia arises from some quite definite lesion, which is not, however, primarily neuronic. Neuralgic pains in the head are very frequently caused by disease of one or other of the sinuses of the skull. Supra-orbital neuralgia is common as a symptom of frontal sinus suppuration, and neuralgia in the distribution of the second or third division of the fifth cranial nerve is often found consecutive to disease of the antrum or of the teeth. An exposed and inflamed pulp may cause wide-spread neuralgia involving the whole of the distribution of the fifth nerve. Supra-orbital neuralgia never occurs alone as the result of dental trouble; but I have noted in several instances that a temporal neuralgia has been associated with pyorrhœa, and has disappeared when the teeth have been adequately treated.

Seeing that neuralgic pains in the face are of common occurrence, it is important to distinguish between them, pains due to gross organic lesions affecting the fifth nerve, and true trigeminal neuralgia. There is no real difficulty in effecting this division, except in the early stages. Gross disease, which is commonly tumour, soon declares its true character by giving rise to sensory loss in the fifth area, with diminution or absence of the corneal reflex. It is, of course, often associated with weakness of muscles supplied by the fifth nerve, and with involvement of other cranial nerves. As an instance of this we may quote the cases of extra cerebellar tumour, where the seventh and eighth cranial nerves are evenly involved with the fifth, or in sarcoma of the base of the skull.

I would like to emphasise the point that any sensory loss in the distribution of a nerve precludes the diagnosis of neuralgia.

In its early stages trigeminal neuralgia is almost always mistaken for a severe attack of ordinary neuralgia. The teeth early fall under suspicion, and by the time that cases come under my observation in private practice have almost always been extracted. This brings no relief, and the denture provided to replace them cannot as a rule be worn on account of the attack which their presence in the mouth usually produces.

I cannot pretend to do justice to the terrors of trigeminal neuralgia by any word picture. Victims of this terrible disease become emaciated, worn out mentally as well as bodily, and not infrequently suicidal unless relief can be obtained. I have known one or two cases who have developed morphino-mania as a result of their sufferings, and this eventuality should always be borne in mind by the medical man who may be tempted to bring relief by the syringe. On no account should morphia be given.

A peculiar feature of the disease is that its onset is usually followed by a more or less prolonged period of freedom from pain. In a lady, whom I have recently treated in the way I shall presently describe, a whole year passed between the first and second attack. Subsequent attacks are almost invariably more severe than the first, and the periods between them become progressively shorter till the paroxysms of pain occur daily. The pain, as I have said, is unbearable and if there is any doubt as to the diagnosis, one can almost certainly decide against the case being true "tic douloureux." At the height of the paroxysm the facial muscles often pass into spasmodic contraction. There may be lacrymation or salivation during the attack. A feature which is, I think, of diagnostic significance is furring of half of the tongue on the affected side.

Most of the cases occur in middle life or old age. The youngest patient that has come under my observation was in the fourth decade, and I do not know that any case under thirty years has been described. It is common for the disease to appear during the sixth and seventh decades, and two patients that I have seen recently were 80 and 81 respectively. Trigeminal neuralgia very rarely indeed affects the first or ophthalmic division of the fifth nerve alone. The third division is more frequently affected in the first instance than either of the other two branches, though the pain which was first confined to the lower jaw and side of the tongue is often found to extend during the progress of the disease to the other divisions. Fortunately bilateral disease is almost unknown. There is little that we can say as to the pathology of this condition. It seems clear that the seat of the disorder is not in the ganglion itself, since division of one or other of the three main trunks will bring complete relief of the symptoms for a time. When regeneration of the divided fibres has occurred the pain will almost certainly begin again. Only by effectively preventing such regeneration can success be obtained.

It has been suggested that the disease is set up by a septic process involving the dental nerves first of all and gradually spreading along the nerve towards the ganglion, but I know of no proof that this assumption is correct. I have examined the ganglion itself in six cases; of these four had been successfully removed by operation, and the other two were cases which came to autopsy as the result of the operation. I do not wish to give the impression that this represents the average mortality from operation, because that would be giving an entirely erroneous impression. The mortality, according to the earlier operation results, was 15 per cent. (Krause), but has now been reduced to about 4 per cent. (Horsley). In none of the ganglia which I examined could I find any evidence of definite gross disease. In some cases there seemed to be an increase in the fibrous tissue between the bundles of nerve-fibres and ganglion-cells—but this was not sufficiently marked to amount to what could be called a definite fibrosis. The cells in some cases stained rather darkly, and in others showed a considerable amount of pigment as being present, but such appearances are within physiological limits. I have not had an opportunity of examining the main nerve trunks, or rather it would be more correct to say that in the two post-mortem cases I omitted to do so.

Now as to treatment of trigeminal neuralgia. The application of electricity, injection of the peripheral foramina, supra-orbital, infra-orbital, and mental, with various chemicals, and, indeed, division of the nerve-trunks at their exit from the skull, have not produced really satisfactory results. In the latter case the nerve-fibres were found to degenerate and the pain in most cases returned within varying periods. In the cases of the nerve divisions there is of necessity the formation of much scar-tissue, intensified by the hæmorrhage which is bound to occur in operations for nerve-section, owing to oozing from the numerous venous plexuses which surround the nerve-trunks at the base of the skull. This fibrosis renders a second operation of a similar kind difficult or impossible, and as the pain almost always returns mere division of nerve-trunks has now been practically abandoned.

With regard to drugs, many have been tried and all have failed to produce permanent effects. The most successful drugs have proved to be tinct. of gelsemium combined with butyl chloral hydrate. It is, however, only when toxic effects are produced by pushing the gelsemium that any result can be obtained in the more severe cases. This obviously limits the usefulness of the drug. It is stated to give the best results in neuralgia of the first division, but this, as we have seen, is rarely involved alone in trigeminal disease, and the cases in which improvement is said to have occurred were probably not true trigeminal neuralgia, or only the disease in its mildest early stages.

Owing to the unsatisfactory results of treatment referred to, Krause devised his operation for removal of the Gasserian ganglion. If this is successfully accomplished the disease will be cured, but the operation is a difficult one, and in any but the most skilled hands, dangerous, and often unsuccessful. I have on two occasions examined pieces of dura mata which were said to represent the Gasserian ganglion, but in which no trace of nerve-tissue was to be found. Of course no relief was afforded by the operation.

Even if successfully performed, there are two most undesirable complications which may arise. One of these is ulceration of the cornea on the affected side. This has been quoted as an illustration of the trophic function of the nerve-cell, but in reality this assertion cannot be accepted as proved, for the normal mechanisms of defence against external injury have been rendered powerless by the anæsthesia of the cornea, with loss of its reflex, and disturbance of the normal tear secretion produced by the operation. To obviate this ulceration the eyelids are usually stitched together, for a time at any rate, after the operation. The second complication is injury to the motor root of the fifth, which is often damaged in removing the ganglion. As a result, the muscles of mastication become paralysed and atrophic, producing an unsightly disfigurement and much inconvenience to the patient. Mr. Hutchinson merely removes that part of the ganglion which gives origin to the second and third divisions, and leaves the inner and upper portion and the first division intact.

I have seen a case in which an incomplete removal of the ganglion has been performed, though not, I think, intentionally, in which much pain was subsequently complained of, and which remained resistant to all treatment.

Schlosser in 1903 devised the plan of injecting the main trunks of the fifth nerve at their exit from the foramina at the base of the skull with alcohol, the strength used being 80 per cent. This produces anæsthesia in the distribution of the nerve injected and relief from the pain. This relief lasts until the nerve-fibres have regenerated, a period on an average of about ten months in successful cases. It is comparatively easy to inject the third division at its exit from the foramen ovale, but more difficult to hit off the second division outside the foramen rotudum. Moreover, the optic nerve lies within $\frac{1}{2}$ in. of the second division of the fifth at this point, and may be injured if the alcohol be unsuccessfully placed. The objection to this method of procedure is that the nerve-fibres regenerate and further injections become necessary. If the operation has been performed in the ideal manner, a second injection should be no more difficult than the first, but, as a matter of experience, there is often found scar tissues around the nerve, formed partly from alcohol which has been placed outside the nerve sheath, and partly from organisation of effused blood, which almost always takes place to a greater or less degree. Wilfrid Harris has improved on Schlosser's method by injecting the ganglion itself, with the object of destroying its nerve-cells and thus preventing any regeneration of nerve-fibres. He does this by attacking the foramen ovale from the sides of the cheek. If you look at a skull with lower jaw attached, you will see that the foramen ovale presents from this angle a small oblique opening, and it is sometimes exceedingly difficult to enter the needle through this, and unless the patient is conscious it is almost, if not quite, impossible to be certain that the needle is actually in the ganglion itself. It is really impossible to do this injection without anæsthesia of some kind. Eucaine injected hypodermically is useless, as the most painful process occurs when the needle hits the floor of the skull. Harris uses morphia gr. $\frac{1}{3}$, and hyoscine gr. $\frac{1}{150}$, given twenty minutes before the operation. In my experience this is often successful, but in some nervous people it is not, and I now almost always carry out the injection under a general anæsthetic. I am able to do this because, in co-operation with E. G. Stanley, I have devised a route which enables me to tell with certainty when the needle has passed through the foramen ovale. I attack the foramen from in front and below, thus having its whole circumference open, instead of the oblique opening which the approach from the side offers. I enter the needle through the cheek in the naso-labial fold, just opposite the position of the last molar tooth in the upper jaw. A stilet points beyond the point of the needle, and is not withdrawn till the foramen has been entered. The needle is passed upwards and backwards at an angle of about 45° with the vertical till it strikes the sphenoid bone above the foramen. That is the first point to make for. Next the point of the needle is lowered, trial probes being made against the floor of the skull till the foramen is found. Its edges are then defined, and the needle now pushed through the foramen into the cavum Meckelii. The stilet is then withdrawn. It does not follow that the point of the needle is within the ganglion, it may be lying outside it. The position is now tested by injecting a few minims of sterilised saline, when it is easy to judge whether the needle is within the ganglion or outside it by the resistance experienced. If there is no resistance to the flow of saline the point of the needle is shifted somewhat until the necessary resistance is met with. The syringe with saline is now changed for one containing 90 per cent. alcohol, and 2 c.c. are injected slowly, a few minims at a time, into the ganglion, the point of the needle being moved systematically through the ganglion. The needle is then withdrawn, and the small puncture wound closed with collodion and gauze. The exact distance from the skin at which the foramen will be found differs in individuals according to the amount of fat present, but if the needle is directed in the first instance towards the sphenoid bone above the foramen there will be no danger of going too far. When the foramen has been found the needle may be pushed a full centimetre within it without

fear of doing any damage whatever. The internal carotid artery, unless very abnormally placed, does not come in the line of fire, and there is no fear whatever of damaging the cavernous sinus which is more likely to be injured when the injection is made from the side. The results obtained by this method are very satisfactory, but it must not be assumed that they are always successful. Unless considerable anæsthesia be produced in the affected area the relief obtained will be of comparatively short duration. Sometimes when the alcohol has been placed around the ganglion or nerve trunk temporary relief will be obtained, although no anæsthesia has resulted from the injection, but it is much wiser to inject again at once for such relief will be short-lived. I have done this injection on nine cases this year. Of these six have been successful—that is to say, lasting anæsthesia was produced and there has so far been no recurrence of pain. One case has been a complete failure; I have been unable to obtain any anæsthesia, and the woman has only been improved for a very short time. Another case was one in which the Gasserian ganglion had been removed to a considerable extent by operation, and in which there was already fairly wide special anæsthesia. I think this hardly a fair case to include in the series, but the patient certainly derived no benefit from the injection I gave her. The last case was a man on whom the operation was performed on account of intense pain produced by a sarcoma at the base of the skull. Here again I was only partially successful, in producing a slight additional anæsthesia to that which already existed, and practically no relief of the pain. The difficulty in this case was due to the fact that I found the bone infiltrated by growth and quite soft, so that I was unable to define the limits of the foramen accurately. Excluding these last two cases, six out of seven of the cases were successful.

The advantages of this method over the serious operation for removal of the ganglion are, I think, obvious, and in my opinion the major operation should only be performed when injections of alcohol have been tried and failed. Nobody, however, should attempt the injection unless they have made themselves familiar with it by constant practice on the cadaver, where the root to be followed and the pressure indicating that the needle is in nerve-tissue can be accurately studied. I have had no serious results of the operation to contend with. In some cases keratitis does follow alcohol injections, and must be treated by sewing up the lids. Hæmatoma I have met with on two or three occasions. On one of these a large hæmatoma formed rapidly, and I was somewhat apprehensive as to what the result would be. I was, however, much relieved to find the patient next morning eating a hearty breakfast and none the worse otherwise.

(*To be continued.*)

A CLINICAL LECTURE ON ANEURYSMS OF WAR WOUNDS.

Delivered at St. Bartholomew's Hospital, November 17th, 1915.

By MAJOR W. MCADAM ECCLES, M.S., F.R.C.S.,
Surgeon to St. Bartholomew's Hospital and the 1st London General Hospital, R.A.M.C., T.F.

GENTLEMEN,—The war is multiplying instances of lesions which, although observed in civilian practice, are not common therein. Traumatic aneurysm is an instance of this.

By a traumatic aneurysm is understood an abnormal

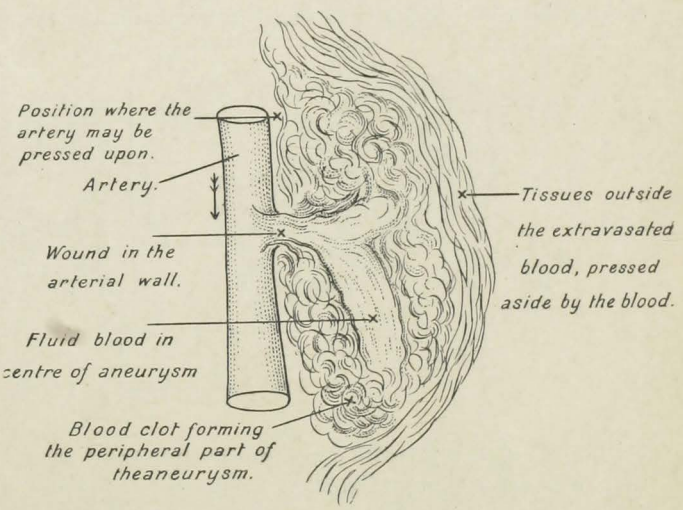


FIG. 1.—DIAGRAM OF A DIFFUSED TRAUMATIC ANEURYSM.

swelling associated with a blood-vessel, and caused by a trauma or wound of the vessel. There are several varieties of such swellings, and these may be conveniently classified thus:

(*a*) Traumatic arterial aneurysm.
  (i) Diffused.
  (ii) Circumscribed.
(*b*) Traumatic arterio-venous aneurysm.
  (i) Aneurysmal varix.
  (ii) Varicose aneurysm.

The characters of these varieties will be seen by reference to the diagrams.

TRAUMATIC ARTERIAL ANEURYSM.

The first is a diffused traumatic arterial aneurysm, and shows all three coats of the artery damaged (Fig. 1). Immediately blood pours out from the aperture and clots externally, though liquid blood still remains in the centre. The surrounding tissues are pushed away from their proximity to the artery, consequently a cavity is formed without any real

wall; hence there is no sac, and the lesion is not a true aneurysm, for an aneurysm has a sac wall.

Then there are three varieties of circumscribed traumatic arterial aneurysm. In the first of these the blood is poured out in exactly the same way as above, but by clotting it has acted as a foreign body, and inflammation occurs around and produces condensation of the tissues so as to form a pseudo-sac, so that for all practical purposes there is a sacculated aneurysm circumscribed by a false sac wall (Fig. 2 *a*).

The second variety is much less common. Frankly, I am not sure that it really occurs, but as it is given a place in some text-books I mention it. There has been a wound of the external and middle coats of the artery, the internal coat remaining undamaged. Obviously, the pressure of blood on the thin internal coat is enough to make it bulge, and for the time being a circumscribed traumatic aneurysm exists, but as the pressure becomes greater, the thin sac wall gives way ere long (Fig. 2 *b*).

The third variety is that in which there has been a wound of the artery which has healed, but the scar is a weak spot. This may afterwards become distended by the intra-arterial pressure, and an aneurysmal sac will be formed (Fig. 2 *c*).

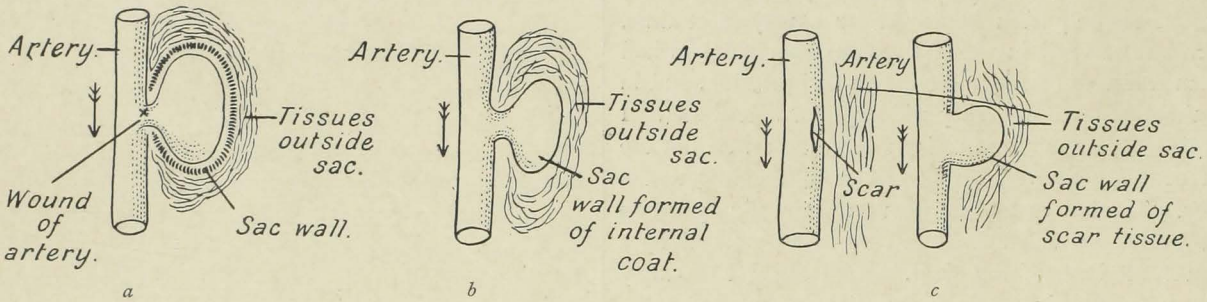


FIG. 2.—DIAGRAMS OF CIRCUMSCRIBED TRAUMATIC ANEURYSMS.

TRAUMATIC ARTERIO-VENOUS ANEURYSM.

The next diagram will show you the two varieties of arterio-venous aneurysm, in which there is a wound of both the artery and the adjacent vein, and a communication between the two. The commonest form of an arterio-venous aneurysm is an aneurysmal varix (Fig. 3). As a result of the communication which has been established between the two, part of the arterial blood passes through this communication, and goes distalwards along the vein, thereby obstructing somewhat the return of blood through the vein, and the vein becomes enlarged at the level of the junction of artery and vein.

The other variety is where there is a true aneurysmal sac lying between the artery and vein (Fig. 4). There has been a wound of the artery and the vein. The two vessels have not come into contact, but blood passes from one to the other, and a pseudo-sac forms between the two. The blood-pressure in the artery being the higher, the blood passes through the sac and into the vein, and the vein tends to bulge opposite the site where the sac communicates with the vein. The war has produced a larger number of these cases than we have had for a long time, and I think it will go on producing them.

ANALYSIS OF FIFTY CASES.

In the October, 1915, issue of the *British Journal of Surgery* are collected fifty cases of traumatic aneurysm. I have analysed them in the table below:

Analysis of Fifty Recorded Cases of Traumatic Aneurysm.

Number, 50.

Types: Arterial, 30; arterio-venous, 20.

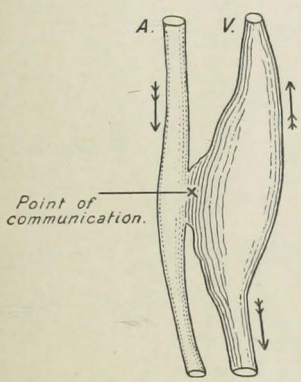
Position:		
Head and neck		7
Upper limb		14
Lower limb		29
Arteries involved—		
Head and Neck:		
External carotid	1	
Facial	1	
Superficial temporal	1	
" Base of skull	1	
Common carotid	3	= 7
Upper Limb:		
Subclavian	2	
Axillary	5	
Brachial	5	
Ulnar	1	
Radial	1	= 14
Lower Limb:		
Common femoral	1	
Superficial femoral	8	
Deep femoral	1	
Popliteal	13	
Posterior tibial	5	
Anterior tibial	1	= 29

Mortality. Deaths: 4 = 8 per cent.

Vessels involved:	
Common carotid	1
Subclavian	1
Superficial femoral . . .	2 = 4

With regard to the arteries of the head and neck the cases were 7 in number. It might have been thought that arteries in this region would have been more commonly injured than those elsewhere. But it has to be remembered that if a man is shot in the neck and even has his common carotid artery wounded, he may not get very much external bleeding, but other important structures in the neck may be damaged, such as the vagus, and death results.

The lower limb is the site in which traumatic aneurysms mostly occur. The superficial femoral was injured in 8 and the popliteal in 13, and it is a very interesting fact



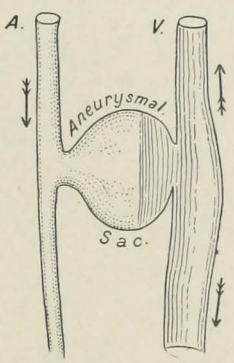


FIG. 3.—ANEURYSMAL VARIX. FIG. 4.—VARICOSE ANEURYSM. TWO TYPES OF ARTERIO-VENOUS ANEURYSM.

that the popliteal artery is also the commonest site in a limb for a pathological aneurysm. I think this may be explained in two ways. First of all, wounds of the leg are common; at any rate, soldiers who receive wounds in the leg frequently survive. The second reason is that the popliteal artery has very little tissue surrounding it except fatty tissue, which gives very little support.

With regard to the mortality shown in the table, this is strikingly low, because it would have been expected, in these cases, to have a very much higher mortality than this series shows. There were 4 deaths in the 50 cases, a percentage of only 8. None of the popliteal cases died.

SIGNS AND SYMPTOMS.

Now, a word or two with regard to the local signs and symptoms of these traumatic aneurysms. The first is a swelling in the line of the vessel. It may be very slight, but it is usually quite evident. Secondly, this swelling pulsates, and the pulsation has practically all the signs of that of an aneurysm seen in civilian practice, *i. e.* it is expansile; it ceases when the main artery is compressed on the proximal side of the swelling, and it begins again with a series of pulsations corresponding to the pulsations or beats of the heart when the pressure is removed. There is also a bruit, and the bruits of these traumatic aneurysms are usually much more marked than of the ordinary pathological aneurysm. The bruit of an arterio-venous aneurysm has its own distinctive character, namely, that of being a continuous humming or buzzing bruit. It is very distinctive when once heard. Again, the thrill which is present in these traumatic cases is more harsh than in aneurysms met with in ordinary practice. Sometimes, when there is a good deal of clot, there are few, if any, local symptoms or signs other than swelling. Pulsation may disappear, bruit may cease,

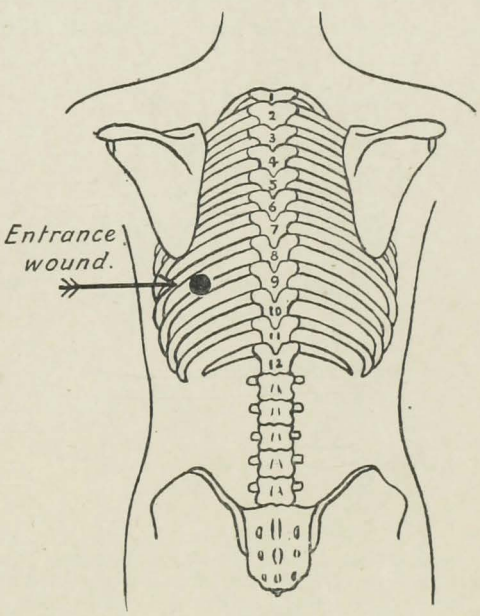


FIG. 5.—CASE OF SAPPER G. W—.

and thrill may entirely go, so that swelling alone is left, and the aneurysm is on its way to become cured. With regard to the distal signs and symptoms, there is practically always some œdema of the distal part of the limb, which is due to the aneurysmal swelling pressing upon the vein, and so preventing a proper return of blood; and secondly, that the *vis a tergo*, the force behind in the artery, is diminished in the periphery, with the result that the blood does not come back so easily in the veins, and so œdema results. For the same reasons congestion, due to dilation of the superficial vessels, is produced. Further, there is an alteration of the pulse. The pulse on the affected side is smaller, and very frequently it is delayed as compared with the sound side. And, lastly, there is very characteristic pain, pain due to pressure upon the main nerves at the site of the aneurysm, but referred to the periphery.

Before proceeding, I want to give you the history and some diagrams of two cases of injury of arteries—the

second with a distinct aneurysm—which have been treated at the 1st London General Hospital since the publication of the fifty cases in the *British Journal of Surgery*.

The first is a case of wound of the right common femoral artery. Sapper G. W— was wounded on August 26th, 1915, the bullet entering the thorax below the lower angle of the *left* scapula (Fig. 5). There was immediate dyspnœa, and later he had hæmoptysis. From the latter he soon recovered.

On September 30th, 24 oz. of blood-stained pleural fluid were evacuated. He had pain on the left side of the chest running up to the axilla. He was admitted under our care at the 1st London General Hospital on October 16th, and on that date he had no physical signs on the left side of the chest. No exit wound could be discovered, and on X-ray examination a bullet was discovered in the *right*

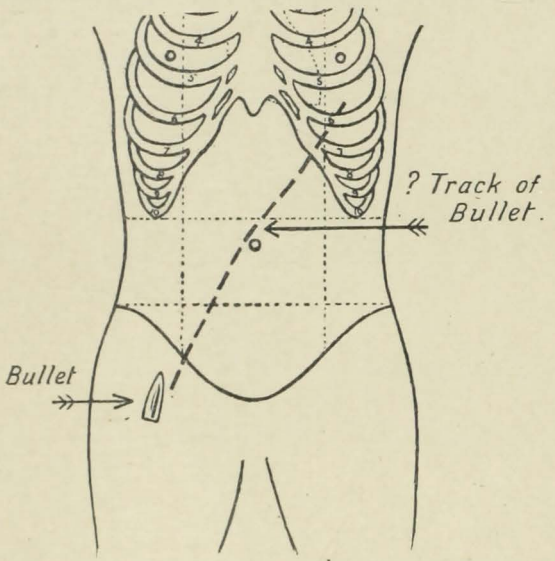


FIG. 6.—CASE OF SAPPER G. W—.

groin, with the point turned upwards; evidently it had turned during its passage through the tissues, as the entrance wound was very small (Fig. 6).

It will be observed that the bullet traversed part of the thorax downwards across the abdomen and into the groin. At the operation, nine weeks after the wound, the sharp point of the bullet was found to have penetrated the wall of the common femoral artery (see Fig. 7), and was surrounded by blood-clot. I ligatured the vessel on the proximal side, but on removing the bullet there was furious hæmorrhage. This was due to the fact that in the interval between receipt of the wound and the operation there had been time for an efficient collateral circulation to be established, and it was from the superficial and deep femoral arteries that the hæmorrhage occurred. I had perforce to ligature both these branches of the common femoral before bleeding could be arrested.

The case has made an uninterrupted recovery, the pulsation in the posterior tibial being now quite strong, and there has been no œdema of the foot, or any suspicion of even superficial gangrene. There was no damage to any of the veins.

The next case is that of Sergeant James F—, æt. 25, who was wounded on September 24th, 1915, by a bullet from a machine-gun. It entered above the inner side of the right knee, and made its exit on the outer side of the right calf (see Figs. 8 and 9). He was admitted to the Liverpool Merchants' Hospital on September 28th, 1915. The right foot was at that date cold, bluish, having no perception of touch, and no pulsation could be detected in the posterior

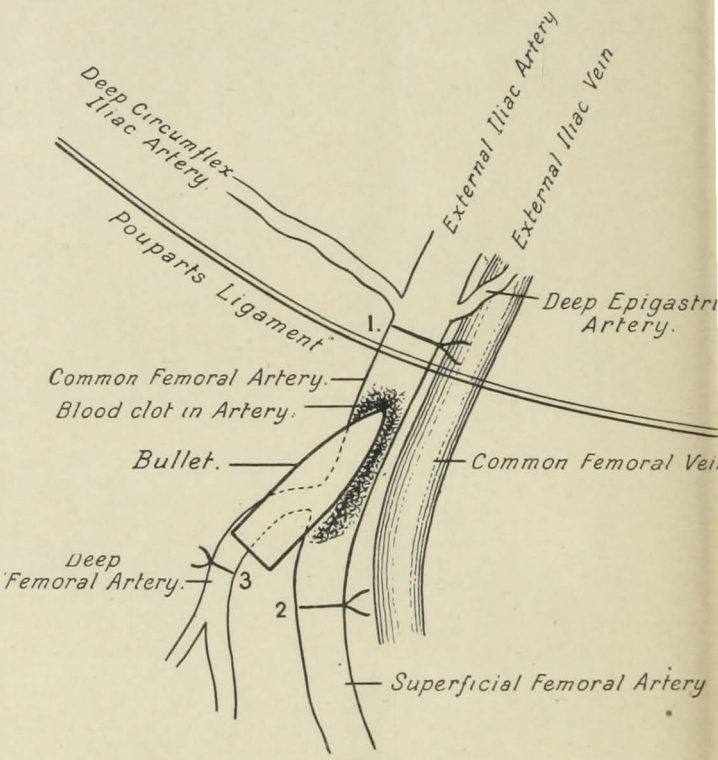
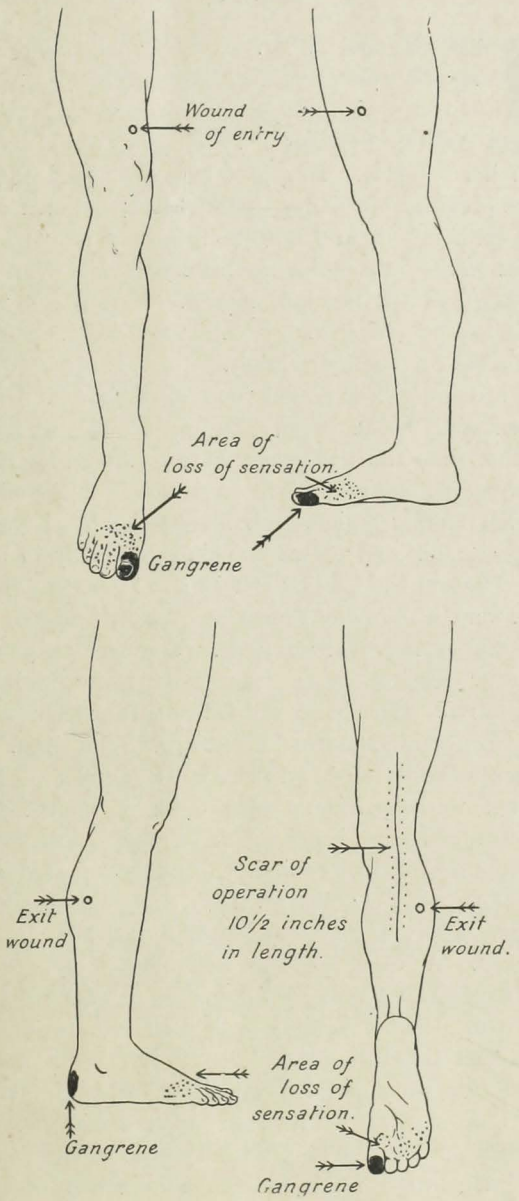


FIG. 7.—DIAGRAM TO ILLUSTRATE THE POSITION OF THE BULLET BEFORE EXTRACTION. 1. LIGATURE ON THE RIGHT EXTERNAL ILIAC ARTERY. 2. LIGATURE ON THE RIGHT SUPERFICIAL FEMORAL ARTERY. 3. LIGATURE ON THE RIGHT DEEP FEMORAL ARTERY.

tibial artery. There was no swelling to be either seen or felt in the right popliteal space; but by means of the stethoscope a loud bruit could be heard which was conducted some way down the right leg.

On October 3rd he complained of severe pain in the right calf, and there was some discoloration. There was no improvement in the condition of the right foot, and gangrene was threatening. On October 4th an incision was made over the back of the lower part of the thigh and upper part of the leg, 10½ in. in length. The contents of the aneurysm were turned out, and the popliteal artery was tied on the proximal and distal sides of the sac. The popliteal

vein was also found to be damaged, and was therefore ligatured in two places. The leg was discoloured, but that was chiefly due to extravasated blood. The next note is dated October 29th, and then there had been steady improvement since the operation, though a good deal of pain was still

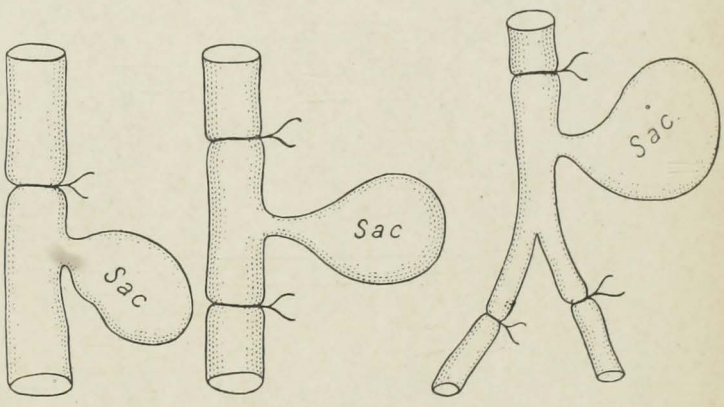


FIGS. 8 AND 9.—DIAGRAMS TO ILLUSTRATE A CASE OF TRAUMATIC ANEURYSM OF THE RIGHT POPLITEAL ARTERY. (SERGT. JAMES F—.)

being felt in the foot, and the end of the right big toe was black. No definite line of demarcation had, however, yet formed. There were to be seen superficial gangrenous patches on the heel and the fifth toe, and some œdema about the ankle. The range of movement of both right knee and ankle was somewhat restricted. He was admitted to the 1st London General Hospital on October 30th, and on November 5th the patches of gangrene still remained, and though movement of knee and ankle was still restricted, the limitation was less than formerly (Figs. 8 and 9).

TREATMENT.

With regard to the treatment of traumatic aneurysms there are one or two important general points. First, do not deal with them by operation until such a procedure becomes absolutely necessary, for by waiting as long as possible there is a chance for a collateral circulation to be established, and there is less likelihood of the occurrence of gangrene. Another case of mine, recorded in the *British Journal of Surgery*, was that in which I had to ligature the common femoral artery, because the man had a rapidly enlarging aneurysm following trauma. The operation was performed within four days of his injury, and gangrene immediately supervened, and I had to amputate through the middle of his thigh in order to save his life.



A. Ligature of the main artery on the proximal side only. B. Ligature of the main artery on the proximal and the distal side. C. Ligature of the main artery on the proximal side and of two branches on the distal side.

FIG. 10.—TRAUMATIC ARTERIAL ANEURYSM.

Secondly, be prepared for violent hæmorrhage. It may not always be possible to apply a tourniquet on the proximal side of the aneurysm. It is in these cases that a skilful assistant is of the highest value.

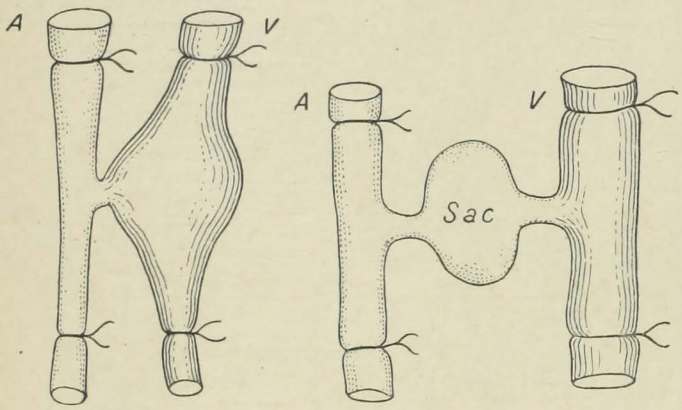
Thirdly, make a good incision so as to have abundance of room within which to work.

There are at least three possible methods of dealing with traumatic arterial aneurysms: (i) Ligation of vessels. (ii) Operation on the sac. (iii) Amputation.

(i) *Ligation of vessels.*—To ligature the main artery on the proximal side of a traumatic aneurysm is almost certain to be followed by gangrene in the periphery unless there has been time for a sufficient collateral circulation to become established. To ligature the main artery alone on the proximal side, even when no gangrene follows, is a somewhat risky procedure, and never a certain cure. It is risky because it may not control the bleeding; it is uncertain

because the aneurysm may advance even in spite of the ligation. The application of ligatures on the artery or arteries, on the proximal and distal sides of the aneurysm, is quite the best method of treating these cases. It is fairly easy, it should effectually stop hæmorrhage, and is not more likely to be followed by gangrene (Fig. 10).

(ii) *Operation on the sac.*—A tourniquet having been applied on the proximal side, the aneurysmal sac is exposed by a good length of incision, and an opening made into it. The clot is turned out, and the mouth of the vessel entering and leaving it found. A probe may now be passed into each vessel, the vessels exposed externally above and below, and a ligature applied to each. The sac itself may be excised in many cases. This is an ideal method of treatment but not altogether an easy one, and causes a good deal of disturbance, particularly if the wound is septic.



A. Proximal and distal ligatures in an aneurysmal varix.
B. Proximal and distal ligatures in a varicose aneurysm.
FIG. 11.—TRAUMATIC ARTERIO-VENOUS ANEURYSM.

(iii) *Amputation.*—Not only is amputation required if gangrene has supervened, but it may be the safest as a primary treatment where there is a diffused traumatic arterial aneurysm.

An arterio-venous aneurysm, whether of the type of aneurysmal varix or varicose aneurysm, is best treated by a ligature of both vessels on both sides of the communication between the artery and vein, and if possible an excision of the portion intervening, and of the sac if there be one (Fig. 11.)

The mortality after these operations is not so great as would be supposed. In the table it will be seen there were only four deaths, making a mortality of only 8 per cent.

The vessels involved in the fatal cases were the common carotid once, the subclavian once, and the superficial femoral twice.

A CASE OF PYELITIS COMPLICATING PREGNANCY.

By D. A. BLOUNT, M.R.C.S., L.R.C.P.

I AM indebted to Dr. Barris for his kindness in allowing me to publish the following case.

E. S—, a multipara, æt. 19, was admitted to Elizabeth Ward on September 17th, 1915, complaining of pain in her left side. Her past history showed that she had one previous pregnancy which was terminated at the fifth to sixth month in Highgate Infirmary for "pyelitis." Previous to this, there was no history of kidney trouble, and when she left the infirmary she was perfectly well. She had had no illness in her childhood which would be likely to leave a damaged kidney.

The history of her present condition showed that her last menstrual period began May 14th, and was normal. Since that time she had amenorrhœa. About the middle of July, patient commenced to have a continual dull pain in the left lumbar region, with increased frequency, especially nocturnal. There was no pain or difficulty in micturition. She had had fainting attacks and rigors two or three times a week with frontal headaches and drowsiness.

On admission patient was pale. Temperature 98·6° F.; pulse 104; respiration 24. Her tongue was moist and slightly furred. Her breasts showed signs of present activity. There was nothing abnormal discovered in the chest. Her abdomen was distended and there was a rounded resistance rising out of the pelvis reaching 6 in. above the pubes. There was tenderness in both kidney regions in front, and also in the renal angles behind. Both feet and ankles were œdematous. *Urine:* Sp. gr. 1015, neutral, + albumin, − sugar. There was a heavy deposit of pus cells; no casts were seen. A bacteriological examination of a catheter specimen showed *Bacillus coli communis* in pure culture.

The treatment of pyelitis is divided into two groups: (1) Medical, (2) obstetrical.

Cases seen early are always treated medically first, and only if they show no improvement after a fair trial is the pregnancy in any way interfered with. The medical treatment consists of rest in bed, a milk diet with extra fluids, such as lemonade, imperial drink, tea, coffee, and cocoa, up to ten pints in the twenty-four hours. Urinary antiseptics, such as urotropine, are given, and the patient's bowels are made to act freely with purges which do not interfere with the milk secretion.

If this treatment fails to alleviate the symptoms, then the pregnancy must be terminated.

This may be done by three different methods:

(1) The cervix may be dilated and the canal and vagina plugged by the Dublin method.

(2) The membranes may be ruptured.

(3) Bougies may be passed into the uterus between the membranes and the uterine wall (Krause's method).

The main thing aimed at is to get the uterus to contract and retract, for it would be courting disaster to empty a uterus of a quick placenta while in a state of complete inertia.

The case in question was treated as a first group case but failed to improve, as will be seen from the following daily notes.

September 21st.—Patient felt slightly better. Temperature varied from 98° F. to 102·6° F. Pulse steady at 100. Blood pressure 90 mm. Hg.

September 22nd.—Temperature varied between 97° F. and 103·6° F., and her pulse and respirations had both increased in rate, so she was given 5 × 10^6 *Bacillus coli communis* vaccine.

September 23rd.—Patient was worse. Her pulse-rate had increased and her temperature was up to 104·8° F., so it was decided to place her in the second group of cases and induce labour. At 8.15 p.m. chloroform was given, and she was put in the lithotomy position. The cervix admitted one finger with difficulty, so the canal was dilated with metal dilators, and the membranes were separated from the lower uterine segment as far as was possible. The cervix and vagina were then plugged by the Dublin method, and the patient returned to bed.

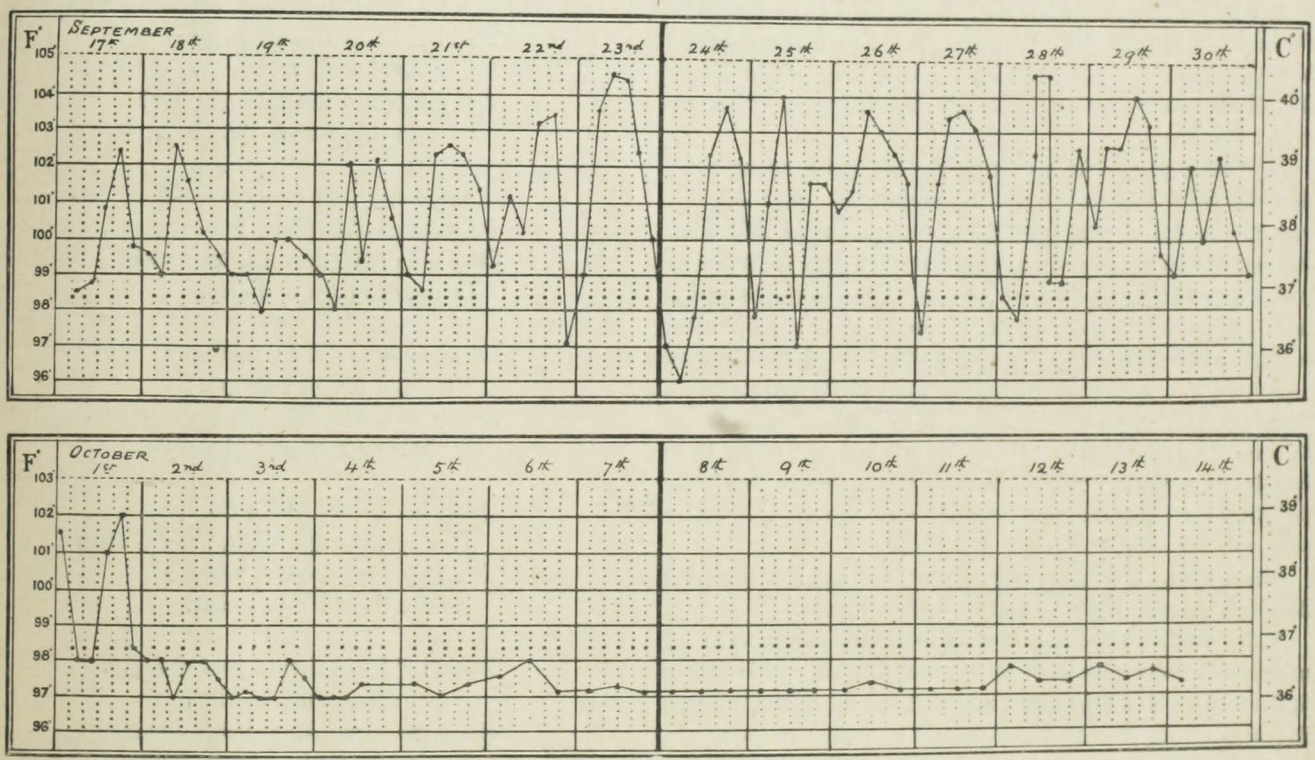
It was at this stage that I took over the case from Dr. Vischer. Her temperature was making a daily excursion from 96° F. to 104° F., the pulse was 120, and she could not pass urine naturally. Her fluid intake was five pints, and she excreted ʒxviij urine in the twenty-four hours loaded with pus and albumin.

At 8 p.m., September 24th, as she had had no labour pains, I decided to rupture the membranes without an anæsthetic. The plugging was removed, and it was found that the canal had closed down so much that it was practically impossible to get a finger through the internal os. We were faced with another difficulty, namely, that the cervix was drawn up practically out of reach, and as the manipulations caused so much pain I decided to abandon the attempt.

The next day she was anæsthetised by open ether and placed in the lithotomy position. The cervix was pulled down by a volsellum, and a bougie was passed laterally into the uterus between the membranes and the uterine wall. A second bougie was then passed opposite to the first, but it hit the edge of the placenta and separated a large part of it. As there was a great deal of hæmorrhage from the placental site, I withdrew the second bougie and left only one in position. A tampon was inserted and pituitary extract 1 c.c. was given.

On September 26th, at 6 p.m., she had slight labour pains and the bougie was seen to move. At 8 p.m. on the same day the bougie was expelled and the membranes ruptured.

On September 27th, at 2 a.m., she had a few very strong pains, but she went into secondary inertia soon afterwards. She was given 10 × 10^6 *Bacillus coli communis* vaccine and 1 c.c. pituitary, and had ergot and hydrastis three times each



CORRESPONDENCE.

MEDICAL STUDENTS AND THE WAR.

To the Editor of the 'St. Bartholomew's Hospital Journal.'

SIR,—Referring to "Medical Students and the War," in the December JOURNAL, I would submit that the Prime Minister's reply to the Dean is not ambiguous.

For, under Lord Derby's scheme, *all men* within the named age limit have the duty to "offer themselves for service with His Majesty's Forces." The responsibility for their disposal rests with the Department concerned to "star" those considered to be most advantageously employed in non-military duties.

Now, Sir, to make the matter clearer still, a certain body of men, to wit medical students in their first, second, and third years, are *specifically declared "free"* to offer themselves for service with His Majesty's Forces.

The legend over the Medical School reads "What thy hand findeth to do, do it with thy might." If the hand cannot find this duty, its owner is surely ataxic.

I am, Sir,
Your obedient servant,
J. R. R. TRIST,
Capt. R.A.M.C. (S.R.).

111th Field Amb.,
R.A.M.C. Training Centre,
Farnham.

[In the article referred to it was pointed out that so great is the responsibility of the choice to be made that students *should not have been declared "free"* to offer themselves. It was, however, also stated that unless further official instructions were very shortly forthcoming it was every junior student's duty to apply for a commission, but that it was against his duty to enlist in the ranks.—EDITOR.]

EXAMINATIONS, ETC.

ROYAL COLLEGE OF SURGEONS.

The following Members were admitted Fellows, December 9th, 1915:

R. H. Bridge, A. Chance, A. H. Southam, M. G. O'Malley.

NEW ADDRESSES.

CHANDLER, F. G., 12, South Square, Gray's Inn, W.C.
DUNN, P. H., 37, Piccadilly, W.
FOSTER MOORE, R., 91, Harley Street. Tel. Padd. 5557.
GRAHAM, G., 84, Wimpole Street, W. Tel. Padd. 2452.
MERCER, W. B., c/o John Mercer & Sons, 65, George St., Manchester (temporary).
SALE, J. C., Lieut. R.A.M.C., attached 11th Essex Regiment, B.E.F., France.
SHAH, J. M., Lieut., I.M.S., c/o H. S. King & Co., 9, Pall Mall, S.W.

BIRTHS.

DALLY.—On December 13th, at 19, Upper Wimpole Street, W., to Dr. and Mrs. Halls Dally, a son.
DRU DRURY.—On November 28th, at Corfe Castle, Dorset, the wife of Godfrey Dru Drury, M.R.C.S.Eng., L.R.C.P.Lond., of a daughter.
DUNN.—On December 6th, at Beaufort House, Bath, the wife of Lieut. T. W. Newton Dunn, M.D., R.A.M.C., of a son.
FAWKES.—On December 6th, at Biggar Bank, Walney Island, Lancashire, the wife of Surgeon Marmaduke Fawkes, R.N., (attd. R.N.A.S.), of a son—Ayscough.
HARRISON.—On December 20th, at 1, De Montfort Street, Leicester, the wife of Captain Everard Harrison, M.B., B.C.Cantab., R.A.M.C. (T.), of a daughter
LAIDLAW.—On December 3rd, at Hyefield, Uffculme, Devon, the wife of Frank Fortescue Laidlaw, M.R.C.S., of twins (son and daughter).
LITLER-JONES.—On December 12th, at 48, Rodney Street, Liverpool, the wife of Major T. C. Litler-Jones, R.A.M.C., of a son.
STACK.—On December 7th, at "Arvalee," Clifton, Bristol, the wife of E. H. E. Stack, Captain, R.A.M.C. (T.), of a son.

MARRIAGE.

BATT—GELSTON.—On December 13th, at St. Mary's, Ixworth, by the Rev. G. R. Harrison, Vicar, and Canon Wilson, Cathedral, Bury St. Edmunds, John Dorrington Batt, Lieut., R.A.M.C., second son of C. D. Batt, Esq., The Hill, Witney, to Olive Edyth, elder daughter of Dr. and Mrs. J. Seymour Gelston, of Ixworth House, Bury St. Edmunds.

DEATHS.

BOULTER.—On November 26th, at Richmond, Surrey, after a long illness, Harold Baxter Boulter, F.R.C.S., aged 63.
BREWER.—On December 18th, at 7, Victoria Place, Newport, Mon., Reginald E. Wormald Brewer, M.R.C.S., L.R.C.P., aged 65.
DUDLEY.—On December 21st, after a short illness, at 112, Henley Road, Ilford, Samuel Robert Dudley (temp. Capt., R.A.M.C.), aged 54.
GRIFFITH.—On December 14th, at 96, Harley Street, W., Mary Anne (Minnie), the beloved wife of Walter S. A. Griffith, M.D., and youngest daughter of the late T. Kinder, Esq., J.P., of Sandridge Bury, Herts, aged 58.
MARSH.—On November 26th, suddenly, at 7, Abercromby Square, Liverpool, Nicholas Percy Marsh, M.B., M.R.C.S., dearly loved husband of Mabel Cannon Marsh, aged 56.

ACKNOWLEDGMENTS.

The British Journal of Nursing, The Nursing Times, Long Island Medical Journal, New York State Journal of Medicine, The Medical Review, Charing Cross Hospital Gazette, St. Thomas's Hospital Gazette, Guy's Hospital Gazette, The Student, The Hospital, The Middlesex Hospital Journal, London Hospital Gazette, The Sphinx.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, Smithfield, E.C.*

The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., *at the Hospital.*

All communications, financial, or otherwise, relative to Advertisements ONLY, should be addressed to ADVERTISEMENT MANAGER, *the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City 510.*

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TIMES OF ATTENDANCE OF THE STAFF IN THE WARDS AND OUT-PATIENT DEPARTMENTS.

This Time-table will be Published Quarterly and also whenever there are any Important Alterations.

		Monday.	Tuesday.	Wednesday.	Thursday.	Friday.	Saturday.
Medical Wards	Dr. DRYSDALE (for Sir W. HERRINGHAM)	1.30	1.30	—	1.30	1.30	—
	Dr. TOOTH	1.30	1.30	—	1.30	—	—
	Dr. GARROD	1.30	1.30	—	1.30	1.30	—
	Dr. CALVERT	1.30	1.30	—	1.30	1.30	—
	Dr. MORLEY FLETCHER	1.30	1.30	—	1.30	1.30	—
Medical Out-patients	Dr. DRYSDALE	—	—	10	—	—	—
	Dr. H. S. HARTLEY	10	—	—	—	—	—
	Dr. HORDER	—	—	—	10	—	—
	Dr. LANGDON BROWN	—	10	—	—	10	—
	Dr. THURSFIELD	—	—	—	—	—	10
Surgical Wards (*operation days in heavy type*)	Mr. RAWLING (for Sir A. BOWLBY)	1.30	—	1.30	1.30	**1.30**	—
	Mr. D'ARCY POWER	**1.30**	1.30	—	**1.30**	1.30	—
	Mr. WARING	1.30	**1.30**	1.30	**1.30**	—	—
	Mr. ECCLES	1.30	**1.30**	—	1.30	**1.30**	—
	Mr. BAILEY	1.30	**1.30**	1.30	**1.30**	—	—
Surgical Out-patients	Mr. RAWLING	10	—	—	—	—	—
	Mr. GASK	—	10	—	—	—	—
	Mr. WATSON	—	—	—	—	10	—
	Mr. WILSON	—	—	—	10	—	—
	Mr. BALL	—	—	10	—	—	10
Gynæcological Wards	Dr. GRIFFITH	2	—	2	—	2	—
Diseases of Children	Dr. THURSFIELD	1.30	—	—	—	—	—
	Dr. MORLEY FLETCHER	—	—	1.30	—	—	—
Diseases of Women	Dr. WILLIAMSON	—	—	—	1.30	—	—
	Dr. BARRIS	9	—	—	—	—	—
Orthopædic Department	Mr. ELMSLIE	1.30	—	—	1.30	—	—
Diseases of the Throat and Nose	Mr. HARMER	—	—	—	1.30	—	—
	Mr. ROSE	—	9.30	—	—	—	—
Ophthalmic Department	Mr. JESSOP	—	—	—	—	1.30	—
	Mr. SPICER	1.30	—	—	—	—	—
Aural Department	Mr. WEST	1.30	—	—	1.30	—	—
	Mr. SCOTT	—	—	—	—	9	—
Diseases of the Skin	Dr. ADAMSON	—	9	9	—	9	—
Dental Department	Mr. ACKLAND	—	10	—	—	—	—
	Dr. AUSTEN	—	—	—	—	10	—
	Mr. COLEMAN	—	—	9	—	9	9
	Mr. FAIRBANK	9	9	—	9	—	—
Electrical Department	Dr. CUMBERBATCH	1.30 (males)	1.30 (females and children)	—	1.30 (males) 1.30 (operations)	1.30 (females and children)	—
X-Ray Department	Dr. WALSHAM	9.30 and 1.30	9.30 and 1.30	9.30 —	9.30 and 1.30	9.30 and 1.30	9.30 —
Exercises and Massage Department	—	1.30 (females) 3 (males)	1.30 (males) 1.30 (females)	1.30 (females)	2 (males)	1.30 (females) 2.30 (males)	—

St. Bartholomew's Hospital Journal.

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

VOL. XXIII.—No. 5.] FEBRUARY 1ST, 1916. [PRICE SIXPENCE.

CALENDAR.

Tues., Feb. 1.—Dr. Calvert and Mr. McAdam Eccles on duty.
Wed., „ 2.—Clinical Lecture (Surgery). Mr. Waring.
Fri., „ 4.—Dr. Morley Fletcher and Mr. Bailey on duty.
Clinical Lecture (Medicine). Dr. Hartley.
Tues., „ 8.—Dr. Drysdale and Mr. Rawling on duty.
Wed., „ 9.—Clinical Lecture (Surgery). Mr. McAdam Eccles.
Fri., „ 11.—Dr. Tooth and Mr. D'Arcy Power on duty.
Clinical Lecture (Medicine). Dr. Hartley.
Tues., „ 15.—Dr. Garrod and Mr. Waring on duty.
Wed., „ 16.—Clinical Lecture (Surgery). Mr. McAdam Eccles.
Fri., „ 18.—Dr. Calvert and Mr. McAdam Eccles on duty.
Clinical Lecture (Medicine). Dr. Morley Fletcher.
Tues., „ 22.—Dr. Morley Fletcher and Mr. Bailey on duty.
Wed., „ 23.—Clinical Lecture (Surgery). Mr. Bailey or Mr. Ball.
Fri., „ 25.—Dr. Drysdale and Mr. Rawling on duty.
Clinical Lecture (Medicine). Dr. Calvert.
Tues., „ 29.—Dr. Tooth and Mr. D'Arcy Power on duty.
Wed., Mar. 1.—Hichens Prize. Applications for Luther Holden Scholarship to be sent in.
Clinical Lecture (Surgery). Mr. Bailey or Mr. Ball.
Fri., „ 3.—Dr. Garrod and Mr. Waring on duty.
Clinical Lecture (Medicine). Dr. Hartley.
Tues., „ 7.—Dr. Calvert and Mr. McAdam Eccles on duty.

EDITORIAL NOTES.

IT is with profound regret that we have this month to record the death of no fewer than three Bart.'s men on the battlefields of France. Lieut. O. G. Maginness, R.A.M.C., succumbed to wounds on date as yet not ascertained. Lieut. W. Frank Thompson, R.A.M.C., was wounded severely in the head and foot on December 28th, and he passed away on January 1st, after having undergone two operations. Second Lieut. F. E. Harger, R.F.A., who was a student at the Hospital during the early part of the war, was killed in action on December 16th. Our deepest sympathy is extended to the bereaved relatives and friends of these gallant officers who were with us so short a time ago.

* * *

We learn with much regret of the death of Dr. Herbert Williams, Medical Officer of the Port of London. He took his M.B. in 1888 and his M.D. in 1890, and was appointed Medical Officer of Health for the Port of London in 1901, since when he has discharged his duties with exceptional ability. He was at one time a Major in the 1st Kent Royal Garrison Artillery Volunteers and acted as Adjutant of the corps during the South African War.

* * *

The King has been graciously pleased to confer the honour of Knighthood upon Mr. Milsome Rees, C.V.O., and to appoint Temporary Surg.-Gen. Sir Anthony Bowlby, K.C., M.S., to be K.C.V.O., and also to appoint Temporary Surg.-Gen. H. D. Rolleston, R.N., to be C.B.

* * *

Dr. Calvert has been elected a Member of the Council of the Royal College of Physicians of London.

Sir Francis Champneys has been elected representative of the College of the Central Midwives' Board.

* * *

Colonel A. E. Garrod, A.M.S., left last month for the Mediterranean, where he has been appointed Consulting Physician to the Expeditionary Forces. On his arrival at Malta a "Bart.'s dinner" was held to welcome him, at which the following were present: J. A. Arkwright, A. B. Burnett, L. T. Burra, A. E. Carsberg, Eric Donaldson, W. D. Edes, R. A. Farrar, A. F. Flower, G. B. Nicholson, G. B. Price, N. F. Rowstron, W. H. Scott, H. H. Serpell, J. S. Williamson.

Colonel Garrod was enthusiastically received, and in reply to his toast made a most excellent and humorous speech on the subject of Zeppelins over London —— [deleted by Censor].

* * *

On December 22nd a presentation was made to Mr. H.

Gilbert Barling, F.R.C.S., Vice-Chancellor of the University of Birmingham, on the occasion of severing his active connection with the Birmingham General Hospital after thirty-six years' service. The presentation took the form of an illuminated address and of his portrait in oil colours, which latter is to be hung in the board room of the Hospital.

* * *

The committee appointed by the Minister of Munitions of War, with the concurrence of the Home Secretary, "to consider and advise on questions of industrial fatigue, hours of labour, and other matters affecting the personal health and physical efficiency of workers in munition factories and workshops," includes Sir George Newman, M.D. (Chairman), and Dr. W. M. Fletcher, M.D., F.R.S. (Sec. of the Medical Research Committee).

* * *

Alderman C. O'Brien Harding has again been elected Mayor of Eastbourne.

* * *

We congratulate Mr. Cecil Christopherson, M.R.C.S., L.R.C.P., who has been placed on the Commission of the Peace for the Borough of Hastings.

THE TYPHUS FEVER EPIDEMIC IN SERBIA, 1915.

By B. WHITCHURCH HOWELL, M.B., B.S., F.R.C.S.

THESE notes, the result of my (somewhat limited) experience as Médecin-chef of the British Red Cross Unit at Vrnjatchka Banja, Serbia, may be of interest, especially to those who have no first-hand knowledge of the disease, and who may in the near future find themselves in Serbia, and come into contact with it themselves.

Typhus exanthematicus is an acute specific fever, highly contagious, and of unknown origin, producing a typical eruption over the whole of the body.

Cause.—Quite recently Topley discovered a Gram-positive diplococcus growing aerobically and quickly degenerating into pleomorphic forms. Some authorities have described an anaerobic bacillus; others have considered it due to an ultra-microscopic filterable organism.

There seems to be no doubt that lice are the carriers of the disease, and perhaps fleas and bugs to a slighter degree.

The Serbs themselves believed in an inhalation theory; it was difficult to get them to give definite scientific reasons to substantiate this.

It was impossible on account of the surgical work of the Unit, and lack of time and accommodation, to carry out any research whatsoever on the pathology of the disease.

The majority of patients treated in this epidemic were Austrians, the rest were Serbians, with a few civilians and English nurses. The mortality was much greater amongst the former, probably owing to the fact that they were *prisoners*, of poor physique, and not accustomed, like the Serbs, to live on "pork and beans."

Admission of patients.—The patients arrived in ox-waggons or on stretchers, and were received into the fever baraques—three modern wood and canvas buildings supported on piles. Each contained about twenty-four beds.

There was no bath-room accommodation, so each patient had to be washed in bed; perhaps this was a good thing, as they arrived in various stages of collapse. It was found essential that the hair of the head and pubic region should be cut short (and in some cases shaved), and then treated with paraffin oil or unguentum hydrargyri. Even then fresh broods of lice constantly made their appearance.

The *incubation period* is about twelve days. As we passed north for Serbia from Salonika, we stopped at Gevgelhi to see the American hospital there. It was here or in the train that the first case of infection amongst our nurses took place, for twelve to fourteen days afterwards she developed a typical attack of typhus fever.

SIGNS AND SYMPTOMS.

The *initial symptoms* were often like those of influenza—aches and pains over the whole body, especially in the back, frontal headache, and *pain behind the eyes.* Deafness was frequently present at the onset, and persisted throughout the disease; it was sometimes very obstinate and remained long after convalescence had been well established, as in the case of one of our nurses, who was deaf for some time after she had returned to work.

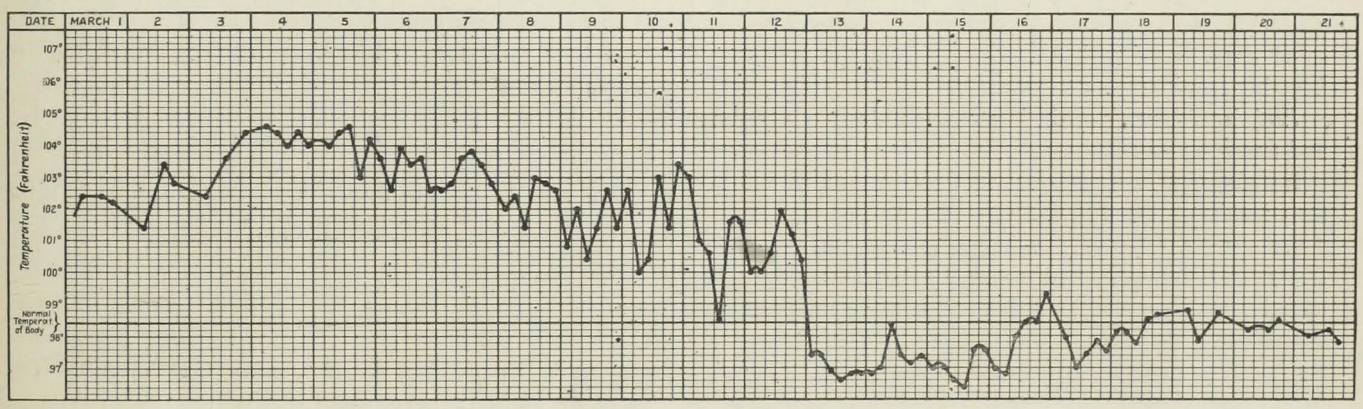
The tongue was furred. Nausea was present, and, in acute cases, vomiting. The patient generally had a rigor, with a rise in temperature to 103°–104° F. The pulse and respiration rate went up in proportion to the fever. As the disease progressed some of us thought the pulse was slowed out of proportion to the temperature. Although I noticed this from time to time, it did not seem to be a general rule. On the other hand, the pulse frequently remained rapid and running after the temperature had fallen to normal. It was very necessary at this point to watch for any sign of collapse.

The face was flushed. The drunken look about the eye was very characteristic, the conjunctivæ being much injected. This was an early sign, beginning just after the onset and before the rash; hence the diagnosis could often be fairly safely made before the appearance of the rash.

The temperature remained up at about 103° F., or in bad cases higher, for about seven to twelve days, sometimes rising

a degree in the late afternoon, and then in the majority of cases fell by *lysis* to normal about the fourteenth day. This fall by lysis is contrary to the usual text-book teaching. It was quite common to have "kicks" on the chart just before or during the lysis, and the temperature frequently remained subnormal for nearly a week afterwards. It was at times impossible to chart the temperature, as it went below 95° F.

Rash.—On an average this appeared on the fifth day, first on the lower half of the chest and upper half of the abdomen, as small, faint, discrete macules. This was implanted on a generalised subcuticular flush. The macules were at first red, and later became slightly raised and purplish in colour, fading on pressure in the early stages. A number of them became regular petechiæ, extravasation of blood taking place. The rash then spread over the whole of the body. On the forehead it was particularly like the eruption of measles. I noticed that it appeared fairly



common on the palms of the hands, a fact not often alluded to in the text-books, generally in the form of faint discrete macules. It seemed to bear no relation to the gravity of the disease. I thought, on the whole, that the more intense the rash the graver the prognosis—generally the "malignant" type of case referred to later. The eruption was fully out within the first week, and tended to disappear by the end of the second, when a very fine desquamation took place.

The rash is very characteristic. I had a case of smallpox, however, which for the first twelve hours I thought was typhus. But at the end of that time the typical *nodular* rash of variola had developed on the face and elsewhere, and the case soon became one of confluent malignant smallpox.

General Progress of the Disease.

Within a day or so of the onset the patient was completely prostrated, and complained bitterly of the intense frontal headache. Epistaxis was often noted. With the appearance of the rash the mental symptoms became more marked, and were generally of two varieties. One was a low muttering delirium, with much muscular weakness; the other, wild and maniacal. The one was difficult to nurse because of his inertia; the other because of his almost superhuman violence. The extraordinary jumble of languages in the violent form of the delirium was very interesting. One Greek doctor whom I saw rang the changes on French, Serbian, Greek, and a little German. At first the delirium was at night only, but as the second week was reached it became continuous day and night, being more marked at night.

The mouth became dry, and sordes appeared on the lips and teeth; the throat was often ulcerated. Later the patient became comatose, and the rectum and bladder were paralysed. It was sometimes necessary to pass a catheter to relieve retention of urine.

In bad cases irregular muscular movements, subsultus tendinum, and coma-vigil were observed. The patient lay unconscious, staring at the ceiling, with jerky movements of the limbs, especially of the hands and fingers, reminding one somewhat of strychnine poisoning. The prognosis in these cases was generally poor; death usually took place at the end of the second week. The temperature fell rapidly (sometimes first rising to a great height), and the pulse became imperceptible and finally stopped. In cases that recovered, the temperature fell by lysis, the patient became more peaceful, and finally regained consciousness. During the fall in temperatnre profuse perspiration generally took place. He soon regained his appetite and complained once again of his deafness. The patient was considered free from infection if his temperature had remained normal for fourteen days. In a month or six weeks he was often at work again.

Complications.

The following were the principal ones: Broncho-pneumonia, otitis media and deafness, parotitis, laryngitis, gangrene, hemiplegia, neuritis, melanuria.

When we first took over the fever barracks pulmonary complications were common, several of the patients dying of a rapid form of *broncho-pneumonia*. Later, as the difficulties in nursing were surmounted, the *infections* of the *parotid*, *middle ear*, and *lungs* became less and less frequent. It seemed to me at one time as if the typhus-pneumonia were contagious, as I had cases, side by side, not in the same stage of the fever, who had had their lungs simultaneously affected.

The *parotid* and *middle ear* were probably secondarily infected through the mouth and pharynx. Deafness was frequently present, and one nurse I had suffered from it for a long time after she was in full work again.

Gangrene was commonest in the more "malignant" type of case. The prognosis was generally hopeless. The rash was intensely hæmorrhagic and confluent in patches, especially over the sacrum and buttocks and heels. Later, gangrene of the feet set in.

I saw one case of *hemiplegia*, in the sister of a Serbian general; it came on suddenly during the disease and lasted some days. The patient recovered from the typhus and from her hemiplegia.

Peripheral neuritis of the lower extremities was a common and annoying sequel.

I had only one case of *melanuria*, in a nurse well over forty; this occurred about the twelfth day, and caused some anxiety, especially as her liver was much enlarged. She rallied, however, and about the sixteenth day it had completely disappeared, and her temperature and pulse were normal.

Mortality and Prognosis.

The mortality was heavier amongst the Austrians (compared with the Serbs) on account of their poorer physique, and the hardships they had endured. The older the the patient the higher the mortality. Violently delirious patients did badly. I thought on the whole the more ntense the rash the graver the prognosis.

Treatment.

This varied only in detail; in general it was, of course, stimulating. Plenty of fresh air, good, plain, easily digested food, *e.g.* milk, egg and meat jellies, custard, Bovril, cornflour pudding, Benger's food, egg-flip, was given. Later, as the patient improved, the diet consisted of coffee, scrambled egg, fruit, chicken, etc.

The alleviation of oral and faucial sepsis was imperative —to avoid such complications as parotitis, otitis media, and laryngitis. Peroxide of hydrogen was chiefly used for this purpose.

The Serbians were not in favour of alcohol; *we*, on the contrary, used it a good deal in half-ounce doses, increasing it steadily as the pulse got weaker, especially about the eighth to twelfth day. The most critical period was during and after the lysis.

Aspirin and phenacetin and caffein citrate were given for the headache; we had no ice.

Digitalis was given by the mouth and hypodermically—we had no digitalin; by the mouth in 20 to 40 minim doses every four hours; subcutaneously in 10 to 20 minim doses. Strychnine also was given hypodermically. I sometimes prescribed ether in 10 to 20 minim doses subcutim in very severe cases, generally alternating with strychnine. The ether piqûre sometimes gave rise to local necrosis of the skin; still this was of small moment, as I am sure the patient occasionally rallied as the result, when all else had failed.

As regards *personal prophylaxis* we wore long linen gowns tightly buttoned over the collar and the wrists, and gum boots or Wellingtons, changed our linen frequently, and made systematic search for lice. Some of us anointed ourselves with paraffin oil or with Vermijelly. We generally fumigated clothes and rooms with sulphur dioxide. The dead were buried as quickly as possible, as they rapidly decomposed.

THE LITTLE THINGS OF MEDICINE AND SURGERY.*

By W. McAdam Eccles, M.S., F.R.C.S.

MR. President, Ladies, and Gentlemen,—To-night I have the temerity to preach you a sermon in the shape of the Mid-Sessional Address before the ancient and honourable Abernethian Society. I take as my text the words of Agur—now more than twenty-five centuries old—"There be four things which are little upon the earth, but they are exceeding wise." Over and over again a little thing has proved to be exceeding wise.

The Profession of Medicine.

Our profession of medicine had humble beginnings, and its foundations though sure were small. I have before me a book entitled *Experimental Philosophy*, in three books, containing New Experiments (Microscopical, Mercurial, Magnetical), by Henry Power, Dr. of Physick, printed close by our Hospital, "at the Bell in S. Paul's Churchyard," in the year 1664, only some 250 years ago, in which a by-gone worthy of a name well known to us in this Society, Henry Power, a Doctor of Physick, discourses on the "little things" of nature. His "Preface to the Ingenious

* The Mid-Sessional Address delivered before the Abernethian Society on January 6th, 1916.

Reader" is delicious. Listen: "Dioptrical Glasses (which are now wrought up to that height and curiosity we see) are but a Modern Invention: Antiquity gives us not the least hint thereof, neither do their Records furnish us with anything that does Antedate our late discoveries of the Telescope or Microscope. The want of which incomparable Artifice made them not onely erre in their fond Cœlestial Hypothesis, and Crystalline wheel-work of the Heavens above us, but also in their nearer Observations of the Minute Bodies, and smallest sort of Creatures about us, which have been by them but sleightly and perfunctorily described, as being the disregarded pieces and hustlement of the Creation; when (alas!) these sons of Sense were not able to see how curiously the minutest things of the world are wrought, and with what eminent signatures of Divine Providence they were inrich'd and embellish'd without our Dioptrical assistance." Thus said our learned writer in his first book on "Microscopical Observations." And what "little thing" has the honour of his initial observation? Could it be otherwise than "the Flea," our old, but ever new companion, the "pulex irritans?" "It seems as big as a little Prawn or Shrimp, with a small head, but in it two fair eyes globular and prominent of the circumference of a spangle, in the midst of which you might (through the diaphanous Cornea) see a round blackish spot which is the pupil or apple of the eye beset round with a greenish glistening circle, which is the Iris, (as vibrissant and glorious as a cat's eye), most admirable to behold. How critical is Nature in all her works! that to so small and contemptible an Animal hath given such an exquisite fabrick of the eye, even to the distinction of parts" (p. 1). Could any modern writer on the microscopic features of the eye of the common flea use more entrancing language?

Our author proceeds to give his Observations on the Bee, the Common Fly, the Gray or Horse Fly, the Butter-fly (!), a Louse—the little white Field-Spider with short legs, the Field-Spider with long legs, another Field-Spider, Mites, and so on. I will venture to quote one short dissertation of his on "The Mites, in Jujubes and Sebestens." (What luscious fruit the sebestens of the seventeenth century represented I am unaware.) "From Jujubes and Sebestens, being long kept, there falls a brownish kind of powder, which being laid upon the Object-plate, you shall discover in it small whitish Mites, very little ones, and all besett with bristles and hairs round over like a Hedgehog, but not of so quick and lively a motion as the other Mites" (p. 19). Think of them ladies, when next you slowly dissolve the hoary jujube, and remember they are "very little ones."

From such small beginnings has sprung our modern "microscopic" knowledge. I am reminded thereby of Pasteur in 1878 at the French Academy of Medicine drawing on the blackboard the minute form of the germ of puerperal fever, and then turning to his audience with the words: "Tenez, voici sa figure!" So little and yet so great, the germ and the man.

The small things of medicine and surgery touch the student, the medical practitioner, the nurse, and last, but not least, the patient. I fancy I have representatives of each class before me to-night, but as I address each separately I trust I may interest all.

The Student.

The medical curriculum is no little thing, at least I have never come across a student who thought it was. And yet, even this big thing is made up of small divisions which constitute one compact whole.

Lectures.—Nearly all of us have listened to lectures in this theatre; some of us have delivered them, and others have been bored by them.

Looking back—as those of us who are beyond that indefinite military age we hear so much about to-day, can do—many years ago when we sat at the feet of our worthy teachers of those days, among them Paget, Savory, Matthews Duncan, Gee, and Marsh, what can we remember of the lectures to which we listened?

I think the prescribed number of lectures, the minimum of which in some cases we attended, has left an indefinite impression upon us which has been invaluable in our general medical education, but of the theme or substance of the lectures, how little are we able to recall?

It is extraordinary, however, how a few "little things" in some of the lectures have remained impressed on our memory. Here are some which I think I shall never forget.

Sir William Savory, who had much of the eloquence of Paget, was Lecturer on Surgery in my student days, but frankly without turning to my note-books all I remember are his scathing remarks about the drainage of wounds, and particularly his dictum: "Do not put a drain pipe in a wound like a chimney pot and expect fluid to run up hill." A trite saying, but a little one among the great ones of surgery.

Mr. Howard Marsh, whose recent death we deplore, was joint Lecturer on Anatomy. Here are two "little ones" of his which savour of the long bow, and remain fixed in my mind.

Illustrating the wonderful journeys of bullets, of which some of us are learning much at the present time, he said: "There is an instance in which a bullet passed between the common carotid artery and the jugular vein without damage to either in spite of the close relationship between the two, which relationship you will see in this specimen"!

Wishing to press home upon us the place the astragalus holds in the malleolar arch, he narrated the following tale: "A man had been into a loft to steal some eggs. Being half-way down the ladder he perceived the farmer in the

distance, and in order to escape detection he jumped the remaining distance to the ground. Alighting forcibly upon the toes of his right foot, the astragalus shot forward through his boot a yard in front of him, and the malleoli coming down on either side of the upper surface of the os calcis passed through the heel of his boot and six inches into the ground, thus fixing him until the arrival of his captor"! A little story, but great in its power of producing a memory retention.

Some of the little things of the preliminary sciences are truly stupendous in their significance.

In *Biology* we are shown an ovum, a "mighty little thing" when we think of the potentialities locked up in this morsel of protoplasm. Here in this egg lie all the beginnings of a Shakespeare or a Kaiser.

In *Chemistry* small changes are the manifestation of unfathomable laws. Have you ever experimented with solutions of mercuric chloride and iodide of potassium? In certain proportions a mixture of the two throws down a heavy precipitate. While a very small excess of either redissolves the cloud. Can any of you explain how or why? A little thing truly, but within it how much is hidden.

In *Physics* such a small circumstance as the fall of the apple from the tree involves the whole of the transcending law of gravitation, and yet how simple the descent seems.

In *Physiology* we are apt to think that the ingestion, digestion, and assimilation of a piece of bread is a very minor every-day matter, but I defy even the most learned physiologist here to-night to explain the whole process.

In *Anatomy*, when I was a demonstrator, I used to urge men to see the little things when dissecting, for they were the difficult ones to remember, and were best fixed on one's memory through visual perception. Let me give you an example. If I were to ask the soaring second year's man —if we have one of these rare birds left—which was the the most important muscle in the body I should expect the prompt answer that it was the heart. Then if I inquired for the second in value, I should, perhaps with some hesitation, be informed that it was the diaphragm. But if I went further and sought for the third in importance, I fancy I might have quite a long pause for a reply, even if I got one at all. Even in the adult this muscle is not more than $\frac{1}{2}$ in. in breadth and $\frac{3}{4}$ in. in depth. It is hidden, and often, I believe, a man becomes qualified without ever having seen it except in a drawing! Withall, so small, it possesses quite a respectable prenomen and cognomen, although the latter is certainly hyphenated. Allow me to introduce to some of you the posterior cricoarytenoid as the third vital muscle, for without it and its fellow inspiration through the abducted vocal cords is impossible, and death may be imminent.

The study of *Medicine* bristles with little things. Two must suffice to illustrate my meaning. The optic disc is but a small area at the fundus, and an evasive one at that. How many a time has the clerk in the ward attempted to fix it with his ophthalmoscopic eye, but once seen it is always seen, and the value of its little surface becomes great in diagnosis.

The occult blood of a duodenal ulcer is a small matter in itself, but accumulatively it is one of the causes of the persistent anæmia from which the patient suffers, and it must not, therefore, be overlooked.

Make a habit of writing prescriptions legibly, particularly the directions. I remember a fine length of City policeman lying in Mark ward, and the house physician of that day had a handwriting which was that of a genius—atrociously bad. Following his almost illegible prescription were the words "*ter die*," but they so much resembled "to die" that the officer glancing at them determined to die at home rather than in hospital!

And what shall I say of the study of *Surgery*? I fear those of you who are good enough to come with me into the wards and operation theatre are too much aware of the small things which obtrude at every turn. I may be permitted to linger over some few of them.

Take a fracture of the bones of the leg. A bleb may form, quite a small thing in itself, but if not treated aseptically it may lead to dangerous infection. Its existence may be wholly unknown to the patient, but should not escape the eye of the dresser. The heel may have its soft tissues compressed between the hard splint and the hard os calcis, and a pressure sore may form. Often is it the patient does not complain until his attention is drawn to it.

Allusion to a fracture leads me to recall the common little mistake of speaking of a long Liston's splint. I have never heard that Liston was a tall man, but the reverse, so it is preferable to say Liston's long splint. The splint is long, not the surgeon, but the splint may easily be fashioned too long, and its upper ends may press against the folds of the axilla. Attention to this small detail may save the patient much needless suffering.

Many of you will remember Mr. Lockwood. One thing I shall always look back upon with the utmost satisfaction in relation to his teaching, and it is that he taught me to observe small, but not thereby unimportant, things. It was so in the dissecting room, and it was so in the wards. He had a horror of the man who tried to pass through life merely as an average man. This was exaggerated, but kept green in one's memory in some lines of doggerel verse written by one whom we have been pleased to see amongst us again recently as a Major from Melbourne:

"Who tries to learn his work by Gray
A helpless, hopeless lump of clay,
The Average Man."

Let me give to you two examples of the observation of small things which tend to show a student's powers therein in a graphic way. A dresser is standing at the end of the

bed of one of his cases, and on being asked how long the patient has been in the hospital ought to be able to answer in a surgical ward even if he has temporarily forgotten without having to refresh his memory by turning to the notes of the case. How? By observing the temperature chart exposed to view. The chart is ruled vertically so as to be available for four weeks. Even if the patient has been in for more than four weeks he ought to be able to say for how much longer period. He will know that there is a four weeks' chart hidden beneath the current chart, so that if there are only the temperatures three days visibly recorded he can readily assert the patient has been warded four weeks and three days. It sounds to the unobservant like Sherlock Holmes, but it is just a little thing of observation.

Here is a specimen from our museum. The most important side of the specimen is that on which the number has been placed, but do not forget there are other sides as well, the opposite, the top, and the bottom. If you observe this specimen you will see it is a cyst. How can we determine the nature of the cyst? The tooth hidden behind the number label is the clue to its identity, but this tooth might be unnoticed unless the bottom of the specimen is observed, and the nature of the cyst—a dentigerous cyst—overlooked. A little matter of observation.

Time will not allow me to venture into the realm of the study of *Obstetrics*, but I record an anecdote of that astute teacher of my student days, Matthews Duncan. He hated the man who was verbose, particularly if he entered into detail which was irrelevant. It is related that in a certain scholarship paper he placed the single question, "What would you do in a case of prolapsed cord which was pulseless?" Some hunters after the prize are said to have delivered up many a closely-written sheet recording their reply. When the meeting of the assessors took place, Duncan remarked: "I would have given full marks to the man who answered that question with the word 'Nothing'!"

Speaking of *examinations* I would like to allude to a few of the "little things" connected with them, things which, although small, are apt to trap the unwary.

(*a*) Read the questions carefully. It is astonishing how frequently a candidate will answer a question which does not appear on the paper. I confess to having done so myself on one occasion, and it was not until I was leaving the examination room that I discovered to my horror the stupidity of my blunder.

(*b*) Answer first the little question, *i. e.*, the one requiring the shortest answer. There is nearly always such a question on the paper.

(*c*) Write legibly. Examiners are but human beings, and become weary when wading through pages of scrawl, and marks are not under these circumstances so readily forthcoming.

(*d*) Paragraph well. The arrangement of paragraphs in your answers with underlining of the important headings is very desirable. I have actually known a candidate commence his reply to a second question on the same line as he finished his answer to the first. This he may have done to show his sense of economy, but paper is provided, and his examination fee was assuredly high enough to warrant his liberal use of the same.

(*e*) Spell properly. Bad spelling generally indicates slovenly reading, or a defective education. Here are two glaring errors constantly recurring in examination papers: venous is spelt *venus* and callus is written *callous*. The omission or the insertion of such a little thing as a "o" just makes all the difference in the real sense.

And here are two others—*asceptic* for aseptic, and *abcess* for abscess.

(*f*) Do not use wrong names. Anatomical terms are frequently mixed, much to the amusement of the examiner and the loss of the candidate. Although sustentaculum tali has somewhat the same sound as receptaculum chyli they cannot be interchanged except with extraordinary result. Fancy a candidate writing: "The receptaculum chyli supports the greater part of the weight of half of the body by the articulation of part of the astragalus with its upper surface," and the candidate scaled nearly 16 st.!

Again, wrong proper names are tacked on to various anatomical structures, such as Pacchionian bodies for Pacinian corpuscles, and to various diseases. And yet again, proper names are wrongly spelt, as when Halsted is written Halstead. It would perhaps, be better if all these proper names were dropped, but if they are still used, let them be employed correctly.

(*g*) Do not use wrong terms. Perhaps two of the most glaring are those when "ligature" is written when "suture" was the right term, and when "aseptic" is confounded with "antiseptic."

Before leaving student life I would venture to urge for more attention to small matters in relation to patients.

In particular, I would desire to pick out the following little things: Learn to walk with a "light and airy tread." Our wards and staircases are excellent places for practice. The heavy-footed, ponderously walking student will rarely make the light-footed, elegantly walking practitioner. I have known of at least one man who lost, or failed to obtain, several patients because his walk was so tremendous that he always made the staircase shake, and usually woke a sleeping patient by his entrance. Rubber heel pads, even on a nurse's boot, are not efficacious if there be an ungainly gait.

Do not needlessly frighten or hurt patients by the use of such words as cancer, tumour, syphilitic, and alcoholic in their hearing; substitute the terms "carcinoma," "neoplasm," "specific," and "C_2H_6O."

Remember to wash your hands just as carefully for an operation before donning rubber gloves as if you were going to operate without gloves. Think rather of the gloves as

a protection for yourself than for the patient, and then should they become torn no harm will accrue to the patient.

Gain the confidence of your patient before and during your examination. This is particularly important with children. If there are two sides still existent, examine the sound side first. This would seem to be a very little point, but it is of the greatest importance in certain cases. Take the instance of disease of the left hip-joint in a child æt. 5. Examination of the right hip first will give the child confidence, will enable you to determine the normal range of movements of the hip in this particular individual, will show the child what movements you want to elicit, and will give you a guide for comparison when you come to move the affected side.

I remember once hearing of a child being taken to an ophthalmic surgeon who proceeded, without any preliminaries, to plant the little patient down on a stool in a darkened room, and to throw a beam of light into its eye. Naturally the child screamed, being scared out of its wits, and the examination was a failure. Another surgeon, probably profiting by the discomfiture of his professional brother, suggested to the mother that the pet "Teddy Bear" should accompany the little patient, and the inanimate plaything was the first to be subjected to the ophthalmoscope, after which his owner considered it a privilege to submit to a similar investigation.

Never examine the abdomen with chilly, much less with cold, hands. I have seen appendicitis diagnosed because the lower part of the right rectus was thrown into contraction reflexly by the iciness of the examining fingers.

THE PRACTITIONER.

It has been said that it is not the degrees of which a practitioner is possessed which causes him to be successful, but the amount of his attention to the details of his patient's case. In the old days of apprenticeship much of the valuable knowledge of how to deal with a sick person in his own dwelling was learnt by the student before he qualified. Now in hospital many a man qualifies without having gained those small things which make up the daily round of the practitioner.

The "bedside manner" may be overdone, but it can be woefully underdone. Probably sympathy is one of the best assets in dealing with the sick, but surely this may be acquired and practised in the hospital, and we need not wait until we go out into our life's work until we show it.

I remember the case of a wealthy man who was literally dying from hepatic deposits of carcinoma secondary to that of the rectum. His friends desired final advice, and the latest "specialist" in rectal diseases was called in. He was a man of little sympathy or tact. He hardly looked at the patient—so obviously was the death sentence written on his features—and his words to the relatives were: "He is dying, no one can save him"; and with this remark he demanded his fee. The friends were unsatisfied; nay, they were shocked.

How different was the behaviour of another surgeon called in next day. He, too, saw that it was clear that the patient had only a short while to live, but he felt the pulse, looked at the tongue, examined the abdomen, although he made no attempt at a rectal examination, which could only distress the patient and give no valuable information. He made suggestions for the relief of minor troubles, such as sanitas in the room to overcome the odour of the discharge, an air-ring for the buttocks, and oysters, of which the patient was fond, as a change in his diet. Then interviewing the friends, he truthfully stated that the end was not far distant, but mentioned that real suffering would not be great, and alluded as it were accidentally to the trifling suggestions he had made. Small things they were, but how much they meant to the patient and relatives. That man did not have to ask for his fee, it was pressed upon him.

You will find—and particularly after the War—that a considerable part of your practice will concern women and children. Many a young practitioner has fallen into disgrace with a young mother because he has not known the date of the eruption of her darling's first tooth! It is a good thing to be wise over these small creatures, the babies. Tell the mothers something about them which they do not know, even if it be only that the pulsation of the anterior fontanelle does not mean that the child's brain is in imminent danger, and by so telling you will gain kudos which will stand you in good stead. Ignore the minor ailments of the infant and you are likely to fall unalterably in the mother's estimation.

May I venture to suggest that every practitioner should pay scrupulous attention to his or her clothing and cleanliness. To be slovenly in dress is a sin in which only the genius can indulge, certainly not the family practitioner of the present day. To be dirty in anything savours of ignorance and neglect, and must engender a lack of respect.

Speaking of cleanliness, but few of you can realise what a vast change asepsis has necessarily wrought in our ideas of what is real cleanliness. Even I can remember the day when a surgeon to this hospital used to have a coat, hanging up in a cupboard in the operation theatre, which he donned each operation day, and which became heavier from material derived from blood vessels and abscess cavities each time it covered his august person, and another surgeon who made a habit of biting off the end of his suture material if it did not easily pass through the eye of the needle!

I trust I shall not appear to descend to very little things if I remind you of two small places in regard to asepsis when preparing for an operation, perhaps the two most septic parts of the body.

In the patient the umbilicus—that small pit teeming with small creatures, and which may be said to be filthy from a surgical point of view in the most cleanly—requires the utmost care in its sterilisation.

In the surgeon, the space beneath the end of the finger nails, where lurks many a germ, which has led to the death of many a patient.

Easily writes the candidate in his examination answer, "the operation is to be carried out with all antiseptic precautions," as if such a formula was the beginning and the end of the matter. Teeming with difficulty often does the practitioner find the carrying out of these precautions, precautions upon which many a life depends.

Punctuality is one of the little things of medical practice which is of great moment. To say you will visit a patient at a certain time, and you arrive half an hour later means, in many cases, that your patient has been worrying for your coming for at least twenty-five minutes, which worry does not tend to help recovery.

To keep a nervous individual waiting five or ten minutes past the hour fixed for an operation is cruel. That five minutes before the time of proceeding to the trial is bad enough, but a conscious five minutes after the hour is almost torture. It is far better to call for the patient five minutes early rather than five minutes late.

Another small point in relation to the preparation of a patient for operation is to administer the aperient the morning before, and not the night before, operation. A distressed night is not desirable just previous to the ordeal of an operation.

The overnight arrangements for, and the orderly carrying out of, the day's work are small matters to some, but they have a considerable bearing upon the amount of strain of practice. It is important that the medical practitioner should conserve his energy, and should take care of his physical frame. To this end the doctor should practise what he preaches, although it is hard frequently to do so. Meals should be as regular and as little hurried as possible. The night's rest is bound to be disturbed by professional calls, but it need not be curtailed by late card-playing. Smoking should be indulged in only in strict moderation and stimulants altogether abandoned. Many a practitioner has unconsciously slipped into immoderate indulgence and therefore finds it hard to pull up. The little beginnings may have stupendous ends.

Little business habits are easily learnt, and are of much value in a professional life. Always reply promptly to letters needing an answer. Always acknowledge the receipt of a report or letter from a brother practitioner, if only by a post-card. I know a very busy St. Bartholomew's man who uses a printed post-card for such acknowledgments, and however pressed he may be it always promptly arrives, but I know many another practitioner who never deigns to send even this acknowledgment, much less a letter.

I once kept a record of the letters and reports which I sent out during a year and of the acknowledgments I received, and I found the latter were only 10 per cent. of the former, a fact which I do not consider is creditable to the politeness of the profession.

Finally, I would urge every young practitioner to join the Medical Defence Union, for one can never tell when the necessity for help from such a Society will come.

THE NURSE.

I can remember something of the earlier days of real nursing in this Hospital—a hospital which has been the pioneer in the progress of the education of the trained nurse. I can recall the two worthy creatures who used to preside over the old "Surgery," and whose word in the "Middle Room" was law. One we used to call the "Fairy," because no scale with less than a 16 st. weight would take her light and airy form. The other always went by the name of the "Angel," chiefly on account of the sweetness (?) of her temper. Both were trained observers, and their powers of rapid diagnosis were worthy of emulation. Pediculi capitis —one of the "minor horrors" of the old times and not altogether gone even in this twentieth century—were the "Angel's" *bête noir*, and her method of diagnosis was quite original and can be summed up in the remark she once made to me when I was a dresser, "Why, you can see the hat rising up over them."

The modern nurse is a member of a profession but little less important in the treatment of the sick than our own.

I wonder whether I shall carry the nursing staff with me if I say that the daily round of the life of a nurse is made up of "little things," often tedious to her, but of the greatest moment to her patient.

The ideal nurse is the one who, while she can be trusted in the big things of the sick room, can carry out the details properly and without fussing. Nothing worries a patient so much as a fussy and withal incompetent nurse. Of course, I have not met one of these for many a year, at or from St. Bartholomew's! Not so very long ago a short article appeared in one of our daily papers congratulating the recipient of the gold medal given by the Clothworkers' Company to the "best" nurse at this Hospital. She had just completed the three years' training, and had—the paper said—emerged triumphant from the following tests:

Preparing a Tray for an Invalid.

Her remarks about this little matter were good. "There is an art in arranging a tray. The food needs to be set out with care and with regard to the patient's whims."

I remember once seeing a tray quite well-prepared placed by a rather nervous nurse before a patient exactly in the reverse position to that which it should be. This irritated the querulous patient, and was the final straw which broke the camel's back, and led to the dismissal of the nurse.

Application of a Bandage.

Bandaging is a lost art, except in the hands of a nurse. It is a pity that slovenly methods of bandaging have been common in recent years, and I am glad at least that the little matter of the neat application of a bandage is still considered a worthy one in the nursing curriculum.

Preparation of a Room for Operation.

Apart from the actual nursing of a patient nothing perhaps shows the capabilities of a surgical nurse better than the rapid preparation of a room in a private house for, say, an urgent abdominal operation. I have known some nurses, so-called trained nurses, who have collapsed when this test came. Particularly has this been so in the question of small details. In one instance a nurse insisted on having a carpet up from the floor—certainly a desirable thing—because of the probability of infection therefrom, but failed to be consistent in that she allowed the boiled water to cool in a bedroom jug which had not been sterilised, and which actually stank!

A nurse's life in a patient's room is fraught with minor details. If these are carried out quietly and efficiently the comfort of the patient is greatly enhanced and the chances of a speedy recovery certainly improved. And therein lies the inestimable value of a well-trained resourceful nurse.

THE PATIENT.

Someone has remarked that a student's training is incomplete unless he himself has been a patient. That is very true.

It is difficult for a strong healthy man to put himself in his patient's position unless he has experienced some illness in, or operation on, his own person. The little things when experienced under these trying conditions are of the utmost value. I cannot, of course, wish that you should all be warded during your passage through your curriculum, but if this does not happen, then try the next best thing. Observe your patients carefully by day, get your resident to allow you to accompany him on his night round when on duty, watch the details of nursing by keeping an open eye on Sister and nurse.

I owe much to a Sister, who is no longer with us, for having taught me, while a student, many a small matter for the comfort of the patient, such as the manipulation of a draw-sheet, the proper filling of a water-bed, the giving of an enema. These appear to be little things, but they become important when you go into practice, and your patient demands them from you.

I know of nothing so trying to a patient than the monotony of a long illness, whether this be medical or surgical. Change is not only helpful in maintaining cheerfulness on the part of the patient, but is actually remedial.

Take a case of enteric fever, about which perhaps I have no right to speak, the prolonged milk diet is so tedious. The resourceful practitioner, however, will minimise the sameness by giving, between the actual "food" drinks, others of mild fruit juices, a small cup of coffee, flavoured whey, and clear soups.

Take a case of an open fracture of the femur with suppuration, how tedious becomes the daily dressing, or the continuous irrigation, the immobilisation upon the splint, or the horrid looking forward to the pain on movement. Change the details of the dressing, do it yourself a little more often, shift the tubes, put in two smaller ones when one large one is causing discomfort, massage the limb, just alter the position of pad here and a bandage there, and how much these little things will add to the patient's comfort.

Then, too, the small manœuvre of changing the position of the bed in the room, or, better still, moving the patient into a fresh bed in another room, helps greatly to break the monotony of always seeing the same picture in exactly the same spot on the wall, and observing the same pattern on the paper day in and day out.

I often think that one of the most trying parts of being "warded" are the inevitable noises in a hospital. There is the creak of a particular floor board, the rattle of a certain window, the drip from a tap, the noisy foot-fall of a heedless clerk, each and all more or less terribly irritating. How often patients lie awake just because they cannot go to sleep by reason of that distressing sound which they are sure is going to happen again! Sometimes it is not so much the sound itself as the anticipation of its recurrence which is so annoying. I think it was Carlyle who wrote of the horror of waiting in the sleepless early morn for the next cock-crow. It is just these little things which irritate that the doctor and nurse must see banished.

And now, ladies and gentlemen, I must close, for I have inflicted upon you a longer sermon than any you would listen to elsewhere, and I fear you may have been wearied by the length and littleness of my remarks. But I make no apology for having spoken to you of some of the "little things" in our joint great professions. Few of us are destined to touch the great things of life, but we can all handle the little things which mean so much.

To most of us our environment will consist of the "minor" details, and in our medical life, whether as students, practitioners, or nurses, it is assuredly the little things which tell.

Cervantes it was who said, "There is a time for some things, and a time for all things, a time for great things and a time for small things," Faber who stated that "Exactness in little duties is a wonderful source of cheerfulness," and S. Augustine, who summed up the whole matter in his words:

> "Little things are little things,
> But faithfulness in little things
> Is something great."

NOTES ON A FURTHER CASE OF FEVER DUE TO BACTERIUM COLUMBENSE.

By ERIC C. SPAAR, B.A. (Lond.), L.M.S.

A SINGALESE woman, æt. 30, was admitted into the General Hospital, Colombo, on August 10th last, with a history of fever of seven days' duration and a temperature on admission of 101·4° F. *Râles* of various kinds were audible over the left lung, but there were no signs of consolidation and her other organs were healthy; the spleen was not enlarged. Her temperature rose in the evening to 103·2° F., and continued to be high till the morning of the 21st, when a marked remission was noticed, the thermometer registering 101·8° F. Thereafter the temperature gradually fell and she was free from fever on the 30th instant, that is, on the twenty-eighth day of illness. Her blood was examined for Widal's reaction on the 26th instant, but was found to be negative to *B. typhosus* and paratyphoid A and B. There was a marked agglutination for the *Bacterium columbense*. The blood examined again two days later gave the same reactions and was negative for malaria. Dr. Castellani suggested that I should bacteriologically examine the stools, and this was done from a specimen which was kindly procured for me, and had been collected in a large sterile Petri dish. The stool was plated on McConkie's red agar; numerous red colonies and some white ones developed; several of the whitish colonies which developed were further investigated and a bacterium was isolated, the cultural reactions of which were identical with those of the *B. columbense* kept in stock, in every particular. It may be of advantage to give here a short description of this bacterium which was first isolated by Castellani in 1905* from the stools of a patient whose blood gave repeated negative results for Widal's reaction, and was stated by him to be the cause of one type of continued fever prevalent in the tropics. My description is taken almost *verbatim* from Dr. Castellani's previous papers, as my strain corresponds in every detail to his.

CHARACTERS OF BACTERIUM COLUMBENSE.

It consists of rods 2 to 5 micron in length, resembling the typhoid and paratyphoid bacilli; motile. It is easily stained by the ordinary aniline dyes, but not by Gram.

Cultural characters.—Broth: Abundant growth with diffuse turbidity; after twenty-four to forty-eight hours a delicate pellicle may be present.

Agar: The growth may be typhoid-like, but generally the germ grows more luxuriantly than is the case with that of typhoid.

Gelatine: Growth fairly abundant, medium, not liquefied.

Serum: Nothing characteristic; the medium is not liquefied.

Litmus milk: It may be said that in general it becomes acid at first and alkaline later, and that bleaching of the medium is of very frequent occurrence, but occasionally it is rendered permanently acid. After three weeks the medium, if tubes are capped with rubber caps, may occasionally become thickened, or even real clotting, though of rare occurrence, may take place.

Sugar broths and action on lactose.—Some remarks may be made on the action of the germ on lactose; when freshly isolated from the stools or urine it has generally no action on lactose, but after several transplantations may produce a very slight amount of gas at times. At other times it does not touch it however, the usual technique with Durham tubes being adopted. The experiment has been repeated many times, and all precautions have been taken to avoid mistakes as far as possible. It is remarkable, as stated by Dr. Castellani, that even when gas is produced the medium remains apparently alkaline. It is notable, also, that on McConkie's lactose red agar the colonies are always whitish—never red.

Biological tests.—All strains of *B. columbense* have been repeatedly tested with typhoid serum, paratyphoid A serum, and paratyphoid B serum derived from patients suffering or convalescent from such diseases, as well as from hyper-immunised animals, always with absolutely negative results. The results were negative even when using dilutions of 1 in 20. The strains have been treated also with very powerful paratyphoid A and paratyphoid B sera obtained from the Berne Institute, with the same result, viz., no agglutination whatever has been observed. The absorption tests completely confirmed the agglutination tests. There cannot be any doubt, therefore, that the organism is neither paratyphosus A nor paratyphosus B. The germ has been tested also with various coli and coli-like sera, always with negative results.

Botanical position of the bacterium.—This bacterium is difficult to classify owing to its inconstant action on lactose. As already stated, though all precautions to avoid a mistake have been taken, the conclusion arrived at is that the same strain, while at times a non-lactose fermenter, at other times give rise to very slight production of gas. When it does not ferment lactose its reactions are practically identical with those of *B. paratyphosus* B; when it ferments lactose it is more closely related to *B. coli*. Agglutination and absorption tests clearly show that the germ is a separate species, as it is never agglutinated by paratyphoid A and B sera, even powerful ones, such as those imported from the Berne Institute, nor by any coli and coli-like serum tested. Nor can it be identified with *B. paratyphosus* C of Uhlenhuth, as the latter is culturally identical with the *B. suipestifer*, and in man, at least, is apparently not pathogenic.

* *Journal of the Ceylon Branch of the British Medical Association.*

It cannot, of course, be excluded that *B. columbense* may be identical with one of the so-called paratyphosus D, paracolon bacilli, etc., isolated by certain authors, as we had not in our hands at the Bacteriological Institute the whole series of such germs to enable us to carry out comparative researches; but if any of those interested in the matter should care to make any further investigations I shall be most happy to procure for them one of my strains.

RÉSUMÉ AND CONCLUSION.

I would conclude by remarking that in a Singalese woman suffering from fever, which lasted about three weeks, the blood was found to give a negative agglutination result for *B. typhosus*, *B. paratyphosus B*, and *B. paratyphosus A*, while it gave a strong agglutination for *B. columbense*. From the stools a bacterium was isolated, culturally and biologically, identical with *B. columbense*, Castellani, 1905. This leaves no doubt in my mind that the case was one of "febris columbensis."

ELEMENTARY PSYCHO-THERAPY.

A paper read before the Medical Society of the Connaught Hospital, Aldershot.

By ADOLPHE ABRAHAMS, M.D., M.R.C.P.,
Temporary Captain, R.A.M.C.

IT was, perhaps, unnecessary for me to have employed the adjective "elementary" to remind you that I come to you this evening with no special knowledge or experience of this subject, the importance of which is recognised to a greater or less degree by everybody who practises medicine in any form. But to a number of general practitioners and surgeons it may be not without interest to hear a consideration of a subject which is not an *ex-parte* view from a specialist, but an impression from one who, as a general physician, can describe himself as an elementary student like many of yourselves.

Although greater prominence has been given to psycho-therapeutic study during the last few years, such study, it is hardly necessary to remind you, is older than medicine itself; it is in fact as old as man. All religions have applied it, Roman Catholicism *par excellence;* for, after all, what is the psycho-therapist but the confessor or director of the lay conscience?

Yet, as a result for the most part of his education, the average modern medical man has a tendency to look askance at the idea of disease without lesions of even the slightest degree. We have been educated in a time when diseases which had hitherto not been classified became anatomically and pathologically connected; and the constant contemplation of concrete material in its most complex form has a tendency to prejudice the mind against indulgence in abstract conceptions which might seduce one from the path of practical reality. Medicine and metaphysics seem indeed to be as widely separated as the poles.

The majority of doctors, then, have a tendency to subordinate the disturbances of psychic life to those of the physical, and never to rest content until some initial somatic change has been discovered. They can think only in terms of the physical, and can never be brought to see that an illness may owe its origin solely to some antecedent psychic or moral disturbance, the symptoms being merely a secondary manifestation. Of course we, that is to say, those of us who will refuse point blank to be denied the existence of some physical disease, quarrel *inter nos* as to what that initial somatic change may be. Some of us smile pityingly at the rest of the world which cannot understand why every symptom cannot be explained as a result of oral sepsis; others of us there are who are equally contemptuous of the stupidity which fails to recognise the universal influence of the ductless glands in the excess, deficiency, or perversion of their secretions. Some of us become annoyed because everybody else will not kow-tow to our ideas upon the extraordinary pathological disturbance which a restless, frolicsome kidney may produce. Some of us will never recognise the possibility of any male remaining healthy so long as his cuticular redundancy remains unshorn. Though extravagant the claims, the demand for treatment is comparatively modest in the case of those of us who can never see man or woman unrelieved of tonsils or appendix; more modest than the case of those of us who stretch out hands for the greater part of the human alimentary canal, and who, quite honestly, I believe, imagine that the timid ones who cannot see eye to eye with them are devoid of fundamental knowledge of their profession.

Quite apart from all these obsessions, there will always be two schools of thought, the physical and the psychical; for in many cases no judgment between them is possible when the verdict is influenced solely by the point of view. Take, for example, that familiar phenomenon, the improvement of the dyspeptic chlorotic girl by marriage. To the pure organicist here is obviously the influence of ovarian secretion. To the psycho-therapist it is as clearly the massive diversion of nervous impulses into another channel. A patient complains of pain in the back. To one type of mind aneurysm of the abdominal aorta immediately suggests itself as a possibility. The other type of mind runs through the sequence—flabby *morale*, flabby muscles, unsupported ligaments.

And yet, of course, everybody appreciates the enormous influence of the mind, as we put it, over the body. A pupil can actually be made to dilate and contract by *thinking* of a dark cellar or a blaze of light. I personally do not possess that useful accomplishment, but I have been assured by

several people that they can soon produce a tingling and eventually a sensation of warmth in their cold feet simply by concentrating their attention upon their extremities. Exophthalmic goitre is well known to depend upon some nervous disturbance, and emotional jaundice is a category well recognised even by the most materially disposed clinicians. The influence of Pavlov's work upon recognition of the psychic element in the gastric juice secretion prepares us to believe that emotional disturbance might well be productive of almost any form of dyspepsia.

Just as a person's face blushes because he loses his psycho-vascular control, so he may blush in his lungs and suffer from asthma, or in his stomach with consequent nervous dyspepsia. And the Christian Scientists have claimed on these lines their ability to cure hæmorrhoids by producing a sufficiently powerful effect upon the vascular system of their patient.

Needless to say, the danger of the other extreme is imminent: that the student of psycho-therapy is unduly prone to see nothing but neuroses. His triumph over the surgeon who had wished to perform laminectomy on a hysterical paraplegic, or his cure in three days of a supposed malignant disease of the stomach, is apt to induce a sort of disdainful contempt for organic disease which is certainly fostered by many text-books on the subject, a perusal of which invites the wonder whether there is such a thing as organic disease at all. Psycho-therapy studied without the attendant inhibitory influence of general clinical medicine is only too fascinating to the young physician who can start straight away on a sort of ready-made specialty which does not demand the usual probation of many weary years in a pathological laboratory or in hospital out-patient departments. Psycho-therapy is a specialty right enough, but it will not do to enter its sanctuary with unwashed hands.

It would be manifestly so impossible an undertaking to refer to even a representative number of the symptoms which distinguish the neuropath that I think it best to make no attempt to consider any. Instead, I will deal simply with a few general points, and principally with popular misconceptions. The first and most important and also the commonest error is to describe a patient's sufferings as imaginary. Now the neurasthenic who complains of pain is describing a purely subjective sensation; to say he imagines that he has a pain is as absurd as to say he imagines he feels cold or hungry. His sufferings are real, only instead of their having a peripheral origin they have a central psychic starting point. Call the pain psychogenic if you like, but not imaginary. Nothing annoys a neuropath more than to be confounded with the hypochondriac; and the advice to grin and bear it is not likely to be accepted with unprotesting resignation unless it is presented with accompanying phrases of a mellifluosity to which few of us can attain. Even the patient who screams before she is touched, though her cry is often educed by fear, may actually be feeling a painful sensation which she believes to be distinct and localised, but which is only a mental representation.

(*To be continued.*)

OBITUARY.

HERBERT WILLIAMS.

IT is with profound regret that we announce the death, on January 16th last, of Herbert Williams, M.R.C.S., L.R.C.P., M.D.Lond., D.P.H.Camb.

Dr. Herbert Williams suffered an attack of appendicitis last June. A large abscess was found and drained, but it was impossible at that time to remove the appendix. He was again attacked on January 7th, and a second and more severe operation was performed on January 9th. The patient progressed satisfactorily until the morning of the 16th, when he was seized with an attack of syncope and died in a few minutes.

The son of Mr. Thomas Henry Williams, J.P., the first Mayor of Greater Weymouth, Herbert Williams was born and educated at Weymouth. He entered St. Bartholomew's Hospital in the year 1880.

He served in the ophthalmic wards as a dresser under Messrs. Power and Vernon, and later he was appointed House Physician by Dr. Gee. Outside the hospital he held office as Assistant House Surgeon at the Metropolitan Hospital.

In 1892 he joined the medical staff of the Port of London Sanitary Authority, and in 1901 was appointed Port Medical Officer of Health.

Dr. Williams was thus brought into close touch with the conditions appertaining in the Port of London at the beginning of a new period. In this period the enlightened policy of dealing with shipping on lines based upon a scientific knowledge of disease prevention was put to the test of practical experience. With this policy he became identified, and indeed so intimately that his name is known throughout the world in association with all matters of port sanitary administration. To him came all who wanted information and instruction in regard to public health subjects relating to shipping, for the prevention of the introduction of infectious disease into this country forms only a small part—though an important one—of the duties of the London Port Medical Officer of Health.

When it became indicated that the rat was a carrier of plague, Herbert Williams, with characteristic energy, set up plant for the destruction of rats on board ships, and instituted, in addition, the measures so successfully carried out for the destruction of the rats in the port and for the bacteriological examination of suspected rats.

In order to be able to deal personally with foreigners,

he learnt to speak French, German, Spanish, and Yiddish. He possessed the entire confidence of his committee, the esteem of his staff, and the respect of all those with whom he was brought into official relationship. Stern and inflexible in purpose, he allowed no one to trifle with him in the discharge of his official duties. His probity and uprightness were well known. Naturally kind, considerate, and sympathetic, he could be written of as one who loved his fellow-men. He carried with him a buoyancy of spirits, a keen sense of humour even in trying circumstances, and an enthusiasm for his work which favourably influenced all who came within his sphere of action.

No student has ever been prouder or more mindful of the best interests of his hospital than was Herbert Williams; and it may safely be said that St. Bartholomew's Hospital was proud of this distinguished son.

In addition to his private and professional friends, there are many official friends who will mourn his loss. To his aged father we offer our sincere sympathy.

EXAMINATIONS, ETC.

UNIVERSITY OF CAMBRIDGE.

M.C. Examination.

R. A. Ramsay.

Examinations for M.B., B.C.

First Examination.

October, 1915.

Part I: Chemistry.—B. H. Cole, C. A. Horder, J. Russell.
Part II: Physics.—C. A. Horder, J. V. Sparks.
Part III: Elementary Biology.—F. B. Hobbs, C. A. Horder, J. V. Sparks.

Second Examination.

October, 1915.

Part II: Pharmacology and General Pathology.—H. Chadwick, L. Cunningham, E. A. Fiddian, A. Orr-Ewing, H. B. Jackson.

First Examination.

December, 1915.

Part II: Physics.—J. Russell.
Part III: Elementary Biology.—J. Russell.

Second Examination.

December, 1915.

Part I: Human Anatomy and Physiology.—H. B. Bullen, G. G. Havers.

Third Examination.

December, 1915.

Part I: Surgery and Midwifery.—S. R. Prall, M. K. Robertson, H. W. Scott,* F. H. Young.
Part II: Medicine, etc.—H. W. Hales, S. R. Prall, H. G. E. Williams.

UNIVERSITY OF LONDON.

Second Examination for Medical Degrees.

December, 1915.

Part II: Anatomy, Physiology, and Pharmacology.—G. Day.

UNIVERSITY OF DUBLIN.

At the Winter Commencements held at Trinity College on December 20th, 1915, the following Degrees were conferred:
M.B., B.Ch., B.A.O.—F. W. O'Connor.

CONJOINT BOARD.

First Examination.

January, 1916.

Part IV: Practical Pharmacy.—E. G. P. Bousfield, C. V. Braimbridge, B. Haskins, J. F. Haynes, K. Masson.

* Surgery only.

Second Examination.

January, 1916.

Anatomy and Physiology.—M. V. Boucaud, T. Carlyle, W. B. Christopherson, H. C. Cox, T. G. Evans, J. B. Flamer-Caldera, C. L. Hewer, M. Jackson, A. V. Lopes, G. Millar, W. D. Nicol, R. J. Perkins, B. B. Sharp, N. B. Thomas, A. D. Wall.

APPOINTMENTS.

HAWKINS, A., M.R.C.S., L.R.C.P., appointed Senior R.M.O. to the Royal National Hospital for Consumption, Ventnor, Isle of Wight.
SKELDING, Surgeon-Major H., 1st Beds Yeomanry, B.E.F., appointed Special Surgeon to 24th General Hospital, B.E.F.

NEW ADDRESSES.

BAINBRIDGE, Prof. F. A., 37, Clarence Gate Gardens, Regent's Park, N.W.
BOKENHAM, T. J., New Tel. No., Mayfair 5137.
CLARKE, Capt. COLIN, R.A.M.C., 34, West Street, Bognor.
CLARKE, HUNTLEY, Newham House, Truro.
DUNN, T. W. N., Lady Howard de Walden's Hospital, Moustapha, Egypt.
FERGUSON, J., Hospital Ship "St. Denis," c/o Embarkation Office, Southampton.
FITZGERALD, E. D., 16, Clifton Gardens, Folkestone.
GOSSE, Capt. P. H. G., R.A.M.C., 69th Field Ambulance, B.E.F.
HAWKINS, A., Ventnor Hospital, Isle of Wight.
MAPLES, E. E., The Warren, P.O. Box No. 44, Calabar, S. Nigeria, West Africa.
OXLEY, W. H. F., The Manor House, Poplar.
SKELDING, Surgeon-Major H., 24th General Hospital, B.E.F.
SPEECHLEY, A. J. L., c/o Messrs. T. Cook & Son, Ludgate Circus, E.C.
WHITAKER, F., Montana, Savile Park Road, Halifax.
WINTER, Lieut.-Col. H. E., R.A.M.C., United Service Club, Calcutta.

BIRTHS.

DUNN.—On January 19th, at Monteagle Nursing Home, Harold Road, Upper Norwood, the wife of J. C. S. Dunn, Captain, R.A.M.C. (T.), of a son.
HARRISON.—On December 20th, at 1, De Montfort Street, Leicester, the wife of Captain Everard Harrison, R.A.M.C. (T.), of a daughter.
NEAVE.—On January 23rd, at 24, De Vere Gardens, W., the wife of Sheffield A. Neave, of a son.
POPE.—On January 17th, at 54, Eversfield Place, St. Leonards-on-Sea, the wife of Charles A. W. Pope, M.B., Lieutenant, R.A.M.C., of a daughter.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, Smithfield, E.C.*

The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., *at the Hospital.*

All communications, financial, or otherwise, relative to Advertisements ONLY, should be addressed to ADVERTISEMENT MANAGER, *the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City 510.*

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St. Bartholomew's Hospital Journal.

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

VOL. XXIII.—No. 6.] MARCH 1ST, 1916. [PRICE SIXPENCE.

CALENDAR.

Wed., Mar.	1.	—Hichens Prize. Applications for Luther Holden Scholarship to be sent in.
Fri., ,,	3.	—Dr. Garrod and Mr. Waring on duty.
Tues., ,,	7.	—Dr. Calvert and Mr. McAdam Eccles on duty.
Fri., ,,	10.	—Dr. Morley Fletcher and Mr. Bailey on duty.
Mon., ,,	13.	—Kirkes Scholarship and Gold Medal.
Tues., ,,	14.	—Dr. Drysdale and Mr. Rawling on duty. Harvey Prize. Junior Practical Anatomy.
Wed., ,,	15.	—Senior Practical Anatomy.
Thur., ,,	16.	—Senior Scholarship. Junior Scholarships.
Fri., ,,	17.	—Dr. Tooth and Mr. D'Arcy Power on duty.
Mon., ,,	20.	—Second Exam. for Med. degrees (London) Part II begins.
Tues., ,,	21.	—Dr. Garrod and Mr. Waring on duty.
Thur., ,,	23.	—Second Exam. for Med. degrees (London) Part I begins.
Fri., ,,	24.	—Dr. Calvert and Mr. McAdam Eccles on duty.
Tues., ,,	28.	—Dr. Morley Fletcher and Mr. Bailey on duty. First Exam. Conjoint Board Begins.
Thur., ,,	30.	—Second Exam. Conjoint Board begins.
Fri., ,,	31.	—Dr. Drysdale and Mr. Rawling on duty. **Winter Session ends.** Essays for the Wix and Bentley Prizes to be sent in.
Mon., April	3.	—Cambridge Lent Term ends. Second Exam. of Soc. of Apothecaries begins.
Tues., ,,	4.	—Dr. Tooth and Mr. D'Arcy Power on duty. Final Exam. Conjoint Board (Medicine) begins.
Wed., ,,	5.	—Exam. for D.P.H. (Cambridge) begins. First Exam. of Soc. of Apothecaries begins.
Thur., ,,	6.	—Final Exam. Conjoint Board (Midwifery) begins.
Fri., ,,	7.	—Dr. Garrod and Mr. Waring on duty. Final Exam. Conjoint Board (Surgery) begins.

EDITORIAL NOTES.

IT is with very much regret that we have to record the death of Sir William Turner, K.C.B., F.R.C.S., Principal and Vice-Chancellor of Edinburgh University. He was born in 1832, and was a student at this Hospital some sixty-five years ago. A portrait and obituary of Sir William will be found on another page of this JOURNAL. He leaves three sons and two daughters, to whom we extend our deepest sympathy.

* * *

We learn with much regret of the death of Sir Francis Henry Lovell, Dean of the London School of Tropical Medicine, at the age of 71. He began his life work as Colonial Surgeon of Sierra Leone, 1873–1878. From Sierra Leone he went to become Chief Medical Officer of Mauritius and member of the Legislative Council, 1878–1893; later he was appointed Surgeon-General of Trinidad and Tobago and member of the Executive and Legislative Councils, 1893–1901. He retired from the Colonial Service in this latter year, and in 1903 was appointed Dean of the London School of Tropical Medicine.

Sir Francis was created C.M.G. in 1893 and knighted in 1900. He was a Fellow of the Royal College of Surgeons.

* * *

It is with the utmost regret that we have to record the death of Lieutenant Alfred Noël Garrod, M.R.C.S., R.A.M.C., 100th Field Ambulance, who was killed by a shell in France on January 26th. He received his commission in the R.A.M.C. in July, and went to France on November 13th with the 100th Field Ambulance. He was educated at Marlborough, Cambridge, and St. Bartholomew's Hospital, where he was house surgeon in 1915. He was the eldest son of Dr. A. E. Garrod, Colonel, A.M.S., and Mrs. Garrod, and grandson of Sir Alfred Garrod and Sir Thomas Smith, Bt., K.C.V.O. His second brother, Lieutenant T. M. Garrod, Loyal North Lancashire Regiment, was killed on May 10th.

Our deepest sympathy is extended to Dr. and Mrs. Garrod in this second great blow that has fallen upon them.

* * *

It is with great regret that we have to announce the death of Dr. W. G. Clark, which took place on January 23rd. He was a house-surgeon in this Hospital from October, 1895, to September, 1896, and Resident Midwifery Assistant from October, 1896, to March, 1897. In May, 1897, he was appointed Assistant Demonstrator of Physiology, which post he retained until June, 1899. To his sorrowing relations and friends we offer our deepest sympathy.

* * *

The Council of the University of Sheffield have appointed Dr. Arthur J. Hall (Senior Physician to the Sheffield Royal

Hospital) to the Professorship of Medicine at the University. We extend to him our heartiest congratulations.

* * *

We cordially congratulate Col. H. Hendley, I.M.S., who has been appointed Hon. Surgeon to the King.

* * *

Sir Dyce Duckworth has been elected a "Membre Correspondent étranger" of the Academy of Medicine in Paris. We believe that this is the highest position that a foreigner can reach in that distinguished body, and we heartily congratulate Sir Dyce Duckworth on the honour conferred upon him, and through him upon St. Bartholomew's.

FROM THE FRONT.

NOTES ON THE EXISTENCE OF A REGIMENTAL M.O.

By THE LATE LIEUT. A. NOËL GARROD, R.A.M.C.

I SHOULD not advise anyone with any desire to practise their surgical or medical skill to take on the job of medical officer to a battalion, but from the point of view of seeing the war, understanding military methods and the spirit of the men it is the best post open to a medical man. It is also very refreshing to eat a meal during the course of which the conversation does not turn to some such nauseating topic as diathermy, so reminiscent of cooking, or carcinoma of the rectum. A man must be either very young and zealous, or else very hardened, who can stand the usual hospital meal-time conversation without some slight feeling of nausea. From the medical point of view, it has, however, one great disadvantage in that whenever your men become at all ill you lose them by evacuation to the nearest field ambulance. The field ambulance is not much better off, and hands over anything of any interest to the Casualty Clearing Station (C.C.S.). The only diseases the M.O. is called upon to treat are slight sprains, myalgia, and last, but not least, diarrhœa. Diarrhœa is a very popular army disease, possibly caused by the large quantityof tinned food consumed. It is best countered by what is known in army jargon as a "No. 9." A No. 9 is compounded as follows:- Calomel gr. ij, pil. colycinth co. gr. ij, pil. Rhei co. gr. ij; and as many as three have been said to have been taken without fatal result. The story is, however, legendary. The No. 9 is followed some hours later by a No. 8, compounded of lead and opium, and intended to soothe the outraged bowel. The method is drastic but usually effective, if a cure may be deduced from the victim's absence at the next sick parade. Strains of feet are treated in a highly scientific manner. Attached to my staff, which consists of an invaluable corporal who does all the dressings and detects all the malingerers, and a private secretary who does all the necessary writing, is an expert masseur, who, in private life he informs me, has massaged the feet of the best-known actors of America. This massage performance takes place usually at 9 o'clock in the morning and as, at the present moment, owing to the badness and scarcity of billets, the medical inspection room is also my bedroom, I take great care to be clear by that hour. Such an unusual arrangement has its disadvantages, especially the other day when a man entered the room and vomited twice on the floor in rapid succession. Usually, however, one manages to have two rooms, one for the patients and one for oneself. The masseur is also, at the present moment, busy teaching massage to sixteen men per platoon. All this apparent fuss about massage is really of great importance in the prevention of "Trench Foot," of which so much was seen last winter. Now an arrangement is arrived at by which each man before entering the trenches thoroughly washes his feet and then well rubs in either whale oil, anti-frost-bite grease, or better a mixture of lard and mustard. This process is continued until the feet are quite dry, then dry socks are put on and over the whole, gum-boots reaching well up the thighs are drawn on. This process, if possible, is repeated every twenty-four hours, the greatest importance being paid to keeping the feet dry and warm and to seeing that no constriction of any sort, such as garters, impedes the circulation in the legs. The use of puttees is now, I believe, universally condemned and if they have to be worn should be very lightly rolled.

The corporal who does the dressings is also a most invaluable person. Whenever anything is doing and we hear that there is anything on he buckles on his haversack containing dressings, etc., and we sprint up the road to the scene of the trouble. This, of course, when we are in advanced billets, that is to say within a mile or a mile and a half of the firing line. Periodically we retire to rest some eight or ten miles back, and then there is not much to do except sick parade in the morning, which usually occurs about 6 30 a.m. I have held sick parade at 5 a.m., but that is unpleasantly early. Of course, when the battalion is in the trenches the M.O. lives for that period in the Regimental Aid Post, which is usually situated in a dug-out in a communication trench or in a house just at the end of the communication trench. The wounded are brought down to the R.A.P. by the regimental stretcher-bearers, of whom there are thirty-two to a battalion, and conveyed from the R.A.P. to the advanced dressing station of the field ambulance by the field ambulance bearers, two or three of whom are always kept in readiness in the R.A.P. Very little in the way of surgery is ever attempted in either the R.A.P. or the A.D.S. of the field ambulance. Even at the field ambulance headquarters, usually situated in the nearest town, nothing but amputations are performed; all the major surgery being performed at the Casualty Clearing Station.

Sanitation is, perhaps, the most important work that the M.O. is called upon to perform, and in northern France it

is an extremely difficult task to carry this out efficiently. Earth latrines are practically useless in the winter owing to the ground being so water-logged, and recourse has to be had to the use of biscuit tins, pails, etc., which can be buried, and the free use of chloride of lime will prevent the latrines becoming completely insanitary. The difficulty of securing efficient sanitation is much handicapped by the extremely uncleanly habits of the people, who seem to be under the impression that an odour is essential to bodily welfare. It is hard to keep men cleanly when the local example is so bad.

Billets in these parts are very bad, the people very poor, and the villages near the firing line have all been shelled at one time or another, and the roofs are by no means waterproof. The men, of course, usually sleep in barns on straw, and as one wag wrote home, "Our billets here are more holy than righteous." You cannot expect to keep men healthy if they are perpetually wet, and yet my daily sick report rarely exceeds between 20 and 30 in a battalion, *i. e.* 1070 men, and has fallen as low as 7. Most of these are feet and diarrhœa. A man with flat feet is useless, especially if he knows he has flat feet, a fact which does not seem to be generally recognised. I repeat, if you wish to do medicine or surgery don't be a regimental M.O.; if you want to see life, do.

A CASE OF "GAS GANGRENE."

By Capt. L. B. Cane, M.D., R.A.M.C.

THE following case of emphysematous gangrene is remarkable for complete absence of any wound or apparent point of entry of the infection.

Pte. O—, æt. 22, was admitted from 16th Casualty Clearing Station, Suvla Bay, to H.M. hospital ship "Devanha," on August 29th, 1915, with "pyrexia of uncertain origin."

Condition on admission.—Temp. 103° F. Most prominent symptom, severe diarrhœa. He complained of pain in the epigastrium and was very restless.

History.—In good health until a few days before, when he developed diarrhœa.

Progress.—He continued in this condition in spite of treatment throughout the next two days. Temperature remained high, but diarrhœa became less frequent. He became rapidly emaciated, but was fully conscious. Was treated as a possible case of enteric or dysentery.

September 1st.—Temp. 103·6° F. Pulse 110. Tongue thickly coated and rather dry. Patient drowsy and very weak. Diarrhœa continued. No pain. No blood passed.

September 2nd.—Patient obviously worse. About 7 p.m. he first complained of pain in his right forearm. His medical officer, Lieut. J. W. Grice, R.A.M.C., was called to see him at 11.30 p.m., and reported his condition to me. He had then typical symptoms of gas gangrene in the right hand and forearm.

Col. V. Warren Low, F.R.C.S., Consulting Surgeon to M.E.F., was called in consultation, and with his permission I give the following extracts from his notes of the case:

"First saw patient at midnight with Capt. Cane and Lieut. Grice. Patient appeared very ill, with much fever. Pulse about 150; right radial artery not felt.

"Right forearm and arm was swollen to a point about 2 inches above elbow-joint, where the tissues appeared to be healthy.

"The swollen area was tense, mottled, and distinctly emphysematous. The area above the elbow-joint was dusky in colour, like a superficial bruise, but with a very definite line of demarcation. There did not appear to be any emphysema in the area above the elbow. There were several yellowish blebs on the radial side of the forearm, but nowhere could be found any wound or even abrasion.

"Circular amputation at level of insertion of deltoid. Some frothy serum escaped at one point where the involved area was encroached upon. No blocking of brachial artery. No sutures.

"Patient died about six hours afterwards.

"An incision into the right forearm after amputation liberated definitely frothy serum and bubbles of gas. Not particularly offensive. No pus."

The point of interest in this case is that, unlike other cases of gas gangrene we have met with, there was no wound or abrasion, nor any apparent point of entry of the organisms either in the affected arm or elsewhere.

The most careful examination was made without avail. There was no other case of gas gangrene on the ship at the time, nor did any develop throughout the voyage.

The beds had been, as usual, thoroughly disinfected at the Base, and clean, disinfected blankets and bed-linen supplied there.

There was no blocking of the brachial artery to account for the gangrene, and, except for the above points, it seemed an absolutely typical case of gas gangrene in every respect.

I give these few notes on the chance that others may be meeting similar cases.

THE MEDICAL STUDENT OF THE WAR PERIOD.

IT takes at least five years to train a medical practitioner. Medical practitioners are male and female, but it is questionable whether they can be as yet, or ever, completely interchangeable. Female medical students are increasing in number, and especially so since August, 1914. General practice may in the future of necessity be more open to the female practitioner than in the past, particularly on account of the larger proportion of women and children and old persons for some years

after the termination of the war. Numerous medical posts both institutional and municipal may also be thrown open to women.

Male medical students of the first, second, and third years are a decreasing quantity, and if the war continues for another two years may become extinct for the time being. Every medically fit man of military age must now join His Majesty's Forces, or be specifically exempted or excepted. This means that nearly all the young men who would desire to commence a medical training are thereby debarred from entering a medical school. Such a lack of fresh medical students of the male sex will mean a serious shortage of male medical practitioners five years hence.

Under these circumstances many consider that the time has come when a definite pronouncement should be made, preferably by the President of the General Medical Council, to the effect that young men who are in some special manner unfit physically for military service, but who possess good brain power and whose school record is sound, should be encouraged to enter the medical schools, in May and October of this year.

It would be easy to instance many disabilities that would render military service impossible but would not debar from a highly useful medical career. Certain defects of vision, unilateral deafness, minor cardiac lesions, slight infantile paralysis, some degree of scoliosis, or flatfoot, ankylosis of one of the larger joints, or even imperfect descent of the testis, would in the majority of instances cause rejection for active military service but would offer no real bar to taking a medical training and engaging in most valuable medical practice subsequent to qualification.

SOME NOTES OF STUDENT DAYS IN 1872.

By PERCY DUNN, F.R.C.S.

WHEN some months ago a paper was contributed to the JOURNAL containing a *causerie* upon the Hospital days in 1850, a perusal of it recalled a few memories of the Hospital in 1872 and onwards, during the years in which my student days were passed. In offering to supply the Editor with some notes in relation thereto, he was good enough to reply that he would be "delighted to receive them"; fortified, therefore, by this approval, I have jotted down my recollection of some experiences, incidents, and impressions, which, in the following narrative, speak for themselves, and which, in a sense, continue the account with which the former article deals.

A striking feature noticeable by the students in 1872 was the fine physique of the staff generally, but especially so on the surgical side. The surgeons were all men, with one exception, of commanding height, or proportionately big. The exception was Holmes Coote, then senior surgeon, who, however, was plainly in the evening of his life, and who, as a matter of fact, died before the end of the year. The other surgeons were Holden, Savory, and Callender, and the assistant-surgeons, Tom Smith, Willett, Langton, and Baker. The vacancy created by the death of Holmes Coote was filled by the appointment of Marsh, as junior assistant-surgeon. Here, then, was the beginning of the decline in size, which was soon destined to become greatly accentuated. Marsh was not a small man, but he looked so in comparison with his tall and conspicuous colleagues. The death of Callender in 1879, on board a liner while crossing the Atlantic from America, led to the election of the late Sir Henry Butlin as assistant-surgeon. Butlin in appearance was always a puzzle, and sometimes a snare, to the students in his early days. Apparently fragile in physique, he was noted, too, for a facial youthfulness, curiously out of harmony with his position and his years. As President of the Abernethian Society in 1872, he seemed to be a boy, with a pale, boyish face. Such was the impression his appearance conveyed. But, apart from what he seemed to be, he was always the man; never was there a trace in his manner of any consciousness of the looks which belied him, or of the diminutiveness of his stature. He told me once a good story of himself. While crossing the Square one day, in pursuance of his duties as surgical registrar, he suddenly experienced an arresting concussion effect over his cervico-dorsal spine. This was caused by the hand of an exuberant, powerfully built student. "Well," said his aggressor effusively, "and when are *you* going up for your first college." "Oh," replied Butlin deprecatingly, "I think I shall have a shot next time." In these days it seems curious to recall that the Hospital was not distinguishable for any original workers in the early seventies; original work, as such, was not identified with the name of any member of the staff. But Butlin made use of his opportunities; as surgical registrar he devoted himself to the pathology of tumours, employing his time especially upon their microscopical characters. Upon his work in this direction his early reputation was based. He used to tell that the leisure hours of his honeymoon were employed in cutting sections, of course with the assistance of his wife. Again, the appointment of Sir Lauder Brunton in 1872 as lecturer on materia medica, whose first lecture I heard, secured for the Hospital one whose reputation as an original worker was already universally known. Next, and later, was the appointment of Dr. Klein, as lecturer on physiology, through whose reputation again the Hospital benefited. Much interest was evinced by the staff in the performance of his first lecture. In the topmost gallery of the old anatomical theatre several of the staff popped in for a few moments, apparently just to see how things were proceeding.

The next recruit upon the surgical staff was W. J. Walsham,

He was generally known as "little Walsham." His first appointment was that of demonstrator of anatomy in which he was particularly successful, excelling as a dissector and as a "coach." Students flocked to his private classes. He told me once that he made £300 in his first year as demonstrator from coaching fees. About this time the novel idea came to him of examining the abdominal viscera by means of the rectum. Having a very small hand he coaxed it through the anal sphincter, and his arm being correspondingly small, both were insinuated into the rectum, and so he claimed that he could palpate the kidneys and other organs. An innovation of such degree from a diagnostic standpoint created not a little sensation among the staff, as well as the students. After a due trial, however, the interest in the method dwindled, and soon it ceased. Nevertheless the students turned it to account. One day a student bustled into the old dissecting room and inquired of a friend, "Where is Walsham, have you seen him?" "Yes," was the reply, "the last time I saw him he was up the ——." Well, his hand and arm were, which was not quite the same thing.

In the summer of 1872, a clinical surgical lecture was given by the late Frederick Skey, then one of the consulting surgeons. He was a man of commanding appearance despite his age, but it so happened that the entertainment upon this occasion did not appeal to the students. There was much laughing, interruptions were continuous, it was only at intervals that the lecturer could be heard, but to these disturbances Skey paid but little heed, struggling on to the end. At length he paused—the noise of the students ceased. Afterwards in plaintive tones he said, without a trace of rebuke, "Gentlemen, I have a very bad headache to-day, I am going to ask you to excuse me." That was his last visit to the Hospital. In a few weeks time he was dead. Towards the latter end of his life he came greatly into public notice through the publication of a pamphlet, condemning as harmful the strain to young undergraduates of Oxford and Cambridge demanded by the training for the University Boat Race. Turning to the senior members of the surgical staff, Holden was chiefly noticeable for his popularity. Nevertheless, his clean cut, handsome features, his debonair manner, his perfectly groomed appearance would have made him distinguishable anywhere. As an operator, he was slow, deliberate, and perhaps unattractive. For some reason, he became associated with operations for necrosis—which proved tedious and unilluminative to watch. Savory, on the other hand, could always command a full theatre attendance. But those gory, worn-out frock coats, used by the staff at their operations! These coats were thick with plastered gore, contributed by many generations of patients. Besides their filthy appearance they were embroidered with plaques of dried adipose tissue, and other evidences of matter in a wrong place, and yet, tenderly, and even with some show of affection, they were taken from the cupboard beneath the theatre seats, preparatory to being used for an operation. What became of those tragical landmarks of a past age? Surely they should have been preserved in the Museum as object lessons of septic iniquity, surrounded by the mounted specimens showing the havoc of the septic crimes of which they were guilty. Each of these frock coats could scarcely have been less than a veritable cesspool of sepsis, by means of which the operator became sure of his goal, namely, that of the presence of pus in his operation wounds—without taking into account the proximity of the pathological museum, and the facilities it provided for preserving specimens. Apart from his gifts, Savory possessed a strong and a distinctive personality. It is said that he modelled himself upon the character of the late Sir William Lawrence. This may or may not have been true. But mannerisms in some men are apt to prove curiously attractive to others, and in such cases their adoption by the latter is scarcely a matter of surprise.

Through his examinerships at the College of Surgeons, Savory became widely known among the various medical schools, and the reputation he gained in this regard was not altogether favourable. But it is certain that in his work as an examiner he was often misjudged. He always had a standard which he exacted; when students failed to reach this he might have shown impatience. He was perfectly fair and straight-forward in his questions, though by his manner candidates were apt to be deceived. Here is an instance. A Bart.'s student had been "up" for his second college, and had failed. On the following morning he came to the Hospital and declaimed in no measured terms concerning the wickedness of his rejection, and laid the accusation of this upon Savory. In time, the student's complaint reached Savory. On hearing it he heaved with merriment: "Why," he said, "I was the only one who gave him a good mark." Holden and Cooper Foster were the examiners at one of the tables in the Second Fellowship. To them there came a candidate, flushed, perspiring and looking as if he had had enough of everything, especially surgery. He had just left a table at which Savory presided. Holden noticing the candidate's appearance, turned to Cooper Foster and whispered, "Foster, he seems to have had a Savory meal." The following is a personal incident. In examining me for the Second Fellowship, Savory asked me to ligature the posterior tibial artery. This having been done, I was told to cut the piece of artery out. I did so, and awaited further instructions. "Now open it," he said. Then after a pause he added, "It's all right, its got a 'ole in it." This brings under review the atrophied aspirate, of which upon the staff, Savory was the only representative. I used to think that this feature was with him, more a matter of choice than an inherited proclivity. A trait in Savory's character was that of aiming at personal distinction in everything with which he was connected; an atrophied aspirate

made him distinctive, and it seemed that he preferred not to correct it, merely in order to maintain an ideal—an ideal which in more or less degree contributed to the noteworthyness of his personality. He was far too gifted a man to be insensitive of the inexpediency of exhibiting a dereliction of speech condemned by all educated communities. Moreover, he must have learned, in his study of the art of oratory, that no such dereliction was permissible. He may or may not, however, have considered that an atrophied aspirate usually means the betrayal of the origin of those who practise it. As a matter of fact, this was precisely the effect it produced upon the minds of the students. Weird were the speculations current as to Savory's parentage. Two of these were mostly favoured. One, that he was the son of a lock-keeper at Teddington; the other, that his father used to keep a butcher's shop in Little Britain. And there the matter remained. Savory was what he was. His atrophied aspirate—I never heard him use an hypertrophied one—belonged to him as a distinctive feature, as distinctive of a personal attribute, as was his gift of oratory.

A notable incident in these days occurred in the operating theatre once, of which Savory was the somewhat unhappy cause. He brought for consultation a small child, about 3 years of age, showing a swelling in the middle third of the right thigh. Briefly discussing the case, he expressed the conviction that the swelling was a sarcoma. It happened upon that occasion that Sir James Paget was present, as it was his habit to be, as a consulting surgeon, at irregular intervals. By him a ball was started rolling, namely, nothing less than the fact that the case plainly illustrated the ordinary features of a green stick fracture. Savory flushed, but nevertheless, according to custom, proceeded to appeal to his other colleagues, with the result that one and all reiterated the opinion expressed by Sir James. As soon as this began to become apparent he hurried from one to the other, and by the time that he came to Marsh his patience was exhausted. Marsh was barely allowed to complete his support of the concurrent opinion. The situation became one of some tension in the theatre. How was Savory to meet the exigency of his untenable diagnosis? It was apparent that he was annoyed. No man can complacently "face the music" when the exposure of a fault reduces him to a position of inferiority. At last he stepped forward, and with tremulous lips addressed the students: "Well, gentlemen," he said, "the question only, as you have heard, of diagnosis has been discussed. I presume that the treatment is accepted as a matter of course." And then through the theatre a feeling of relief seemed to pass.

In 1872 there were three students of whom special mention may be made. Two of these had already earned a wide, if not a world wide, reputation, and the third was destined in after years to attain a unique position as an alumnus of St. Bartholomew's. Their names were W. G. Grace, S. D. Darbishire, and Robert Bridges. Grace, with his powerful build, showed himself, nevertheless, as a quiet, unobtrusive, somewhat reticent man. I sat next to him once in a class in the old materia medica theatre. He had a grievance. Having agreed to play in an important match, he afterwards found that the engagement would interfere with his first College examination. Naturally he declined to play. But this refusal was met by threatened legal proceedings, and he added, "I don't care a fig for lawyers' letters; but what I do care about is passing my exam."* How the matter was settled I never heard. Darbishire, owing to his great renown as an Oxford stroke, was always a centre of attraction. I remember him as of medium height, lithe and thin, and by no means suggestive of a powerful physique. Naturally his services were in great request for the Hospital "boat." Guy's at the time was "head of the river," and a wonderful story used to be told of the stupendous efforts of Darbishire upon one occasion to place the Bart.'s boat in the premier position. Dr. Robert Bridges was at this time a senior student, and later became one of the casualty physicians. He recorded his experiences as such in an illuminative article contributed to the Hospital Reports for 1878. There he propounds an amusing rule of three sum. Referring to the multitudinous crowd of out-patients, he writes: "I will leave it to the reader to calculate the rule of three sum—if in thirty-five years 0 patients increase to 190,000, how many will 190,000 have become at the end of the world?" The work of the department required him to see 148 patients daily. These were disposed of at an average rate of 1·28 per minute. The article throws a curious and somewhat lurid light upon the duties devolving upon the casualty physicians. Personally he saw 30,940 patients in the course of a year, and two other casualty physicians were doing the same. How many of those casualty patients are now aware that their borborygmous or other ailments were speedily cured by the future Poet Laureate?

OBITUARY.

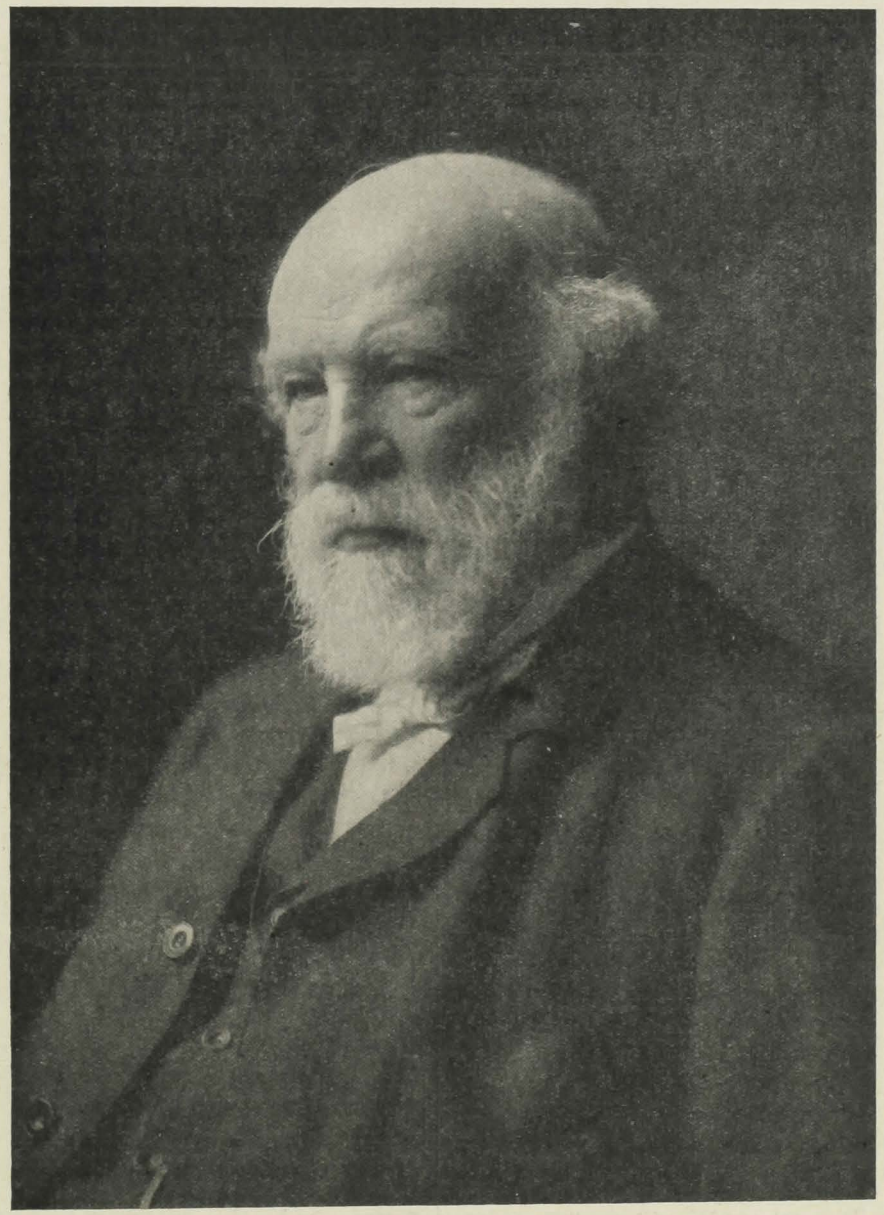
SIR WILLIAM TURNER, K.C.B., F.R.S.

THE death of the venerable Principal and Vice-Chancellor of the University of Edinburgh will not arouse many memories even in the present working staff of St. Bartholomew's Hospital. The Consulting Staff, however, counts two of his pupils in their number, and a warm friend in Sir William Church.

William Turner came up from his native town of Lancaster to our Hospital School in 1849. He must have been prominent as a student, for he early secured the recognition of Paget, who was probably Warden of the College at that time. He took his M.B. degree at the University here in 1857. His excellence as an anatomist

* The College Calendar records that he became M.R.C.S. in 1879.

secured for him a post as Demonstrator of Anatomy to John Goodsir, the Edinburgh professor, one of the greatest of European anatomists. From that date Turner severed his connection with London till 1873, when he represented the University of Edinburgh on the General Medical Council, which maintained his services till he succeeded to its Presidency in 1898.



The late Sir William Turner, K.C.B, F.R.S.

On Goodsir's death he was elected Professor of Anatomy, and taught one of the largest classes in anatomy in Europe with remarkable vigour and acceptance. The success of his professorship was soon manifested by the appointment of his best pupils to various chairs of anatomy in these islands and the Colonies. By degrees he grew into the position of an important personage in Edinburgh, one rarely attained by an Englishman, and was held in high regard as a man of large sympathies and wide outlook. Turner was a great organiser and a financial expert. His output of work was enormous, and this never told upon his powers and vivacity. On the death of Sir William Muir he was at once acknowledged as his successor in the office of Principal of the University, resigning his chair and throwing all his well-trained faculties into academic affairs.

Lister was one of his firmest friends, and they worked together and helped one another. His original work and his reorganisation of the Anatomical Museum in the new buildings of the University led to the reception of many

honours. He was knighted in 1886. Ten Universities conferred honorary degrees upon him. He was a Fellow of the Royal Societies of London and Edinburgh and of numerous British and foreign societies. The Prussian Order of Merit was awarded to him, and in 1901 he was made a K.C.B. Edinburgh conferred the freedom of the City upon him. For many years he was an officer of the University Rifle Volunteers and became their Colonel. In all that he undertook he put his full powers, and was a born leader of men, always enforcing duty and discipline, yet simple, kindly, generous, and ever approachable. Sir William Turner was a great power and a great man. All who knew him loved him. They have lost one of their best and noblest friends. He was in excellent health, with few indications of advancing senility, up to the time of his short fatal illness, at the age of eighty-four years, on the 15th ult. St. Bartholomew's will always be proud to have reckoned him *olim alumnus*. As we mourn the loss of so good a friend, we can only add, "*exstinctus amabitur idem*."

D. D.

The late Sir William Turner has for so long been the Nestor of British anatomy that his loss will be mourned by all who have the interests and the progress of that science at heart. The width of his outlook and the power of his personality are abundantly shown in the many distinguished offices he was called on to fill, even outwith the life-work in which he was acknowledged so great a master.

An original member of the Anatomical Society of Great Britain and Ireland, he was its second President; from its inception to his death he was one of the Editors of the *Journal of Anatomy and Physiology*.

His long tenure of the Chair of Anatomy in the University of Edinburgh displayed equally his remarkable powers of teaching, research, and organisation. His teaching is a great tradition of studied clarity and eloquent style; his researches on the topography of cerebral convolutions, the comparative anatomy of the placenta, and in craniology, are epoch-making in the history of the science; the organisation of the very large classes under his charge was always magnificently done. His genius for affairs was of inestimable value to the University in the reorganisation of the Medical School, which was completed, largely through his instrumentality, some time before he finally relinquished his Chair to become Principal and Vice-Chancellor.

No achievement in his brilliant career deserves higher praise than the successful way in which he inspired younger men with his own robust enthusiasm and love of work. No Chief could have been more helpful or more devoted to the advancement of his pupils. It is a striking testimony to his loyalty in the latter regard that, at the present moment, no fewer than twenty of them, at home and in the Colonies, are the occupants of University Chairs and Lectureships. This constitutes a record which is surely unique in the annals of academic parenthood in any subject.

A. M.

A BI-CENTENARY CELEBRATION.

WANT of space has prevented us referring earlier to an interesting meeting held in December to celebrate the two hundredth anniversary of the foundation of the firm of Messrs. Allen & Hanbury.

Mr. F. W. Gamble, one of the Directors, in making the presentations, referred to different members of the firm, including, amongst those deceased, William Allen and Daniel Hanbury, both Fellows of the Royal Society. The former, a man of the most strenuous activities and of European renown as a scientist and philanthropist, was the first President of the Pharmaceutical Society on its foundation in 1841; the latter, an indefatigable worker and keen observer, has his name and work commemorated by the Hanbury medal which is awarded periodically to the most distinguished international worker in pharmacognosy. Amongst those living were Mr. Cornelius Hanbury, who will attain next year to his golden jubilee as a partner, and had created an easy record of long and earnest devotion to his responsibilities; Mr. Frederick J. Hanbury, whose work, whether scientific or philanthropic, had been performed in the true spirit of his illustrious predecessors; and Mr. W. Ralph Dodd, whose name was inseparable from the progress made since the incorporation of the Company twenty-two years ago.

Mr. F. J. Hanbury, in his reply, said that when he became associated with the firm all its business—retail, wholesale, and manufacturing—was carried on in two old houses built after the Great Fire of London in Old Plough Court. A year or two later these old houses were pulled down, but the present Lombard Street Offices had been erected on the same site, so work was still being done on the identical spot occupied 200 years ago, although the Company now possessed works, laboratories, branches, and Subsidiary Companies scattered over the world.

Mr. W. Ralph Dodd spoke of the striking growth of the business, and attributed the progress to the exertion and co-operation of everyone on the staff with the management, and to the personal friendliness existing between all. He also referred to the "Allenbury's" system of Infant Feeding which had saved many thousands of lives.

After other speeches the proceedings terminated with a vote of thanks to the Chairman, Mr. F. W. Gamble.

DEATHS.

CLARK.—On January 23rd at Bulawayo, Rhodesia, William Gladstone Clark, M.A.Cantab., F.R.C.S., aged 48 years.

GARROD.—Killed by a shell in France, on January 26th, Alfred Noel Garrod, M.R.C.S., Lieut. R.A.M.C., 100th Field Ambulance, eldest son of Archibald E. Garrod, M.D., F.R.S., Colonel A.M.S., and Mrs. Garrod, of 9, Chandos Street, W., and Wilford Lodge Melton, Suffolk, aged 28.

HEARN.—On July 16th, 1915, in St. Bartholomew's Hospital, as the result of a cycle accident, Richard Stirk Flemying Hearn, M.R.C.S., L.R.C.P., of Southbury Dene, Southbury Road, Enfield, aged 50.

LOVELL.—On January 28th, 1916, at 62, Holmdale Road, West Hampstead, Francis Henry Lovell, Kt., C.M.G., F.R.C.S., LL.D., in his 72nd year.

MILLER.—On February 4th, at Alum Chine Towers, Bournemouth, Frederick Richard Miller, R.A.M.C.T., D.A.D.M.S., of the 60th Division, 3rd Army, son of the late T. Lanfear Miller, late of Cape Town, dearly beloved husband of Effie Miller, aged 50 years.

SAUNDERS.—On February 11th at Staines Lodge, Staines, Frederick Herbert Saunders, M.D., etc., eldest son of the late Lieut. Frederick Saunders, aged 67.

SPICER.—On January 9th, at Durstons, Chard, Somerset, Northcote William Spicer, aged 85.

STONEY.—On November 23rd, 1915, Percy Butler Stoney, M.R.C.S., L.S.A., of Holborn Hill, Millom, Cumberland.

TANDY.—On December 30th, at the Red Cross Hospital, Finsbury Square, while acting as Resident Medical Officer, Barre Latter Tandy, L.R.C.S.I., L.R.C.P.Ed., aged 70.

THOMPSON.—On January 1st, from wounds received in France, Lieutenant W. Frank Thompson, R.A.M.C., of The Leys School, Cambridge, and St. Bartholomew's Hospital, dearly loved elder son of Mr. and Mrs. W. W. Thompson, of 3, The Avenue, Brondesbury, aged 28.

TURNER.—On February 15th, 1916, at 6, Eton Terrace, Edinburgh, after a short illness, Sir William Turner, K.C.B., F.R.S., Principal and Vice-Chancellor of the University of Edinburgh, in his 85th year.

Published with 'St. Bartholomew's Hospital Journal,' March, 1916.

St. Bartholomew's and the War.

SUPPLEMENTARY LIST, No. 2.

The following supplementary list, made up to February 16th, 1916, of those connected with the Hospital and Medical School who are serving in the Navy, Army, and Territorial Force in the present crisis will, it is felt, be welcomed both by all old St. Bartholomew's men and by present students. Great care has been taken to make it as accurate and complete as possible, but the Editor will be glad to hear of any errors or omissions.

This List brings the total number of those serving to more than 1600.

Roll of Honour.

Killed.

Capt. B. M. Hughes, 1/4 Norfolk Regt.
Lt. E. H. P. Brunton, R.A.M.C., attd. 4th Battn. Grenadier Guards.
Lt. A. N. Garrod, R.A.M.C., attd. 100th Field Ambulance.
Lt. G. F. Juckes, 6th Rifle Brigade.
2nd Lt. F. E. Harger, Royal Field Artillery.

Died of Wounds.

Capt. A. W. Scott-Skirving, 5th Royal Irish Fusiliers.
Lt. O. G. Maginness, R.A.M.C.
Lt. J. M. M. Marshall, 1/4 Battn. The Essex Regt.
Lt. W. Frank Thompson, R.A.M.C.
2nd Lt. C. Douglass-James, S. Staffs Regt.
2nd Lt. J. Gay, Royal Flying Corps.

Died.

Capt. G. W. Buxton, R.A.M.C., attd. 2nd S. Midland Mtd. Brig. F.A.
Capt. J. F. Fairley, R.A.M.C.
Lt. S. R. Dudley, R.A.M.C.
Miss Buckingham, Matron, 2nd Birmingham War Hospital.

Wounded.

Lt.-Col. R. M. West, R.A.M.C.T., 2nd N. Midland Field Ambulance.
Maj. C. H. Turner, R.A.M.C.
Capt. W. C. Spackman, I.M.S., attd. 48th Pioneers.
Capt. O. Teichmann, R.A.M.C.T., attd. Worcester Yeomanry.
Capt. J. R. R. Trist, R.A.M.C., attd. 2nd York & Lancaster Regt.
Lt. D. D. R. Dale, 4th Essex Regt.
Lt. T. E. Hammond, R.A.M.C.
Lt. E. G. D. Milsom, R.A.M.C., attd. 7th Gloucester Regt., Med. Exp. Force.
Lt. N. A. Scott, R.A.M.C.
Lt. D. H. Wippell, 10th Yorkshire Regt.

Wounded and Prisoner of War.

2nd Lt. D. J. Cowan.

Mentioned in Despatches

By Sir John French, November 30th, 1915, for gallant and distinguished service in the field in France.

Staff.

Col. O. R. A. Julian, C.M.G., R.A.M.C.

A.M.S.

Surg.-Gen. F. H. Treherne (3rd time). } General Headquarters Staff.
Col. W. H. Starr (2nd time) } General Headquarters Staff.
Capt. J. J. H. Beckton } General Headquarters Staff.

R.A.M.C.

Lt.-Col. J. E. Brogden.
Lt.-Col. C. W. Mainprise.
Lt.-Col. A. O. B. Wroughton.
Maj. A. A. Meaden (2nd time).
Maj. R. Storrs.
Maj. C. H. Turner (2nd time).
Capt. D. C. G. Ballingall.
Capt. (temporary) W. S. Danks.
Capt. (temporary) M. Donaldson.
Capt. (temporary) S. Gurney-Dixon.
Capt. (temporary) F. L. Nash-Wortham.
Capt. (temporary) J. E. H. Roberts.
Late Lt. (temporary) P. W. James (3rd time).
Lt. (temporary) O. Maginness (killed).
Lt. (temporary) C. A. Smallhorn.

R.A.M.C., T.

Lt.-Col. R. Pickard.
Lt.-Col. (temp. Hon., R.A.M.C.) C. Gordon Watson.
Maj. H. L. de Legh.
Maj. A. D. Ducat.
Surg.-Maj. E. G. Stocker.
Capt. D. M. Johnston.
Capt. A. W. Nuthall.
Capt. R. M. Vick.

I.M.S.

Maj. H. Boulton (2nd time).
Maj. G. Browse.
Maj. H. M. Cruddas.
Maj. W. W. Jeudwine.

Nursing Service.

Miss A. Beadsmore-Smith, R.R.C., Q.A.I.M.N.S. (3rd time).
Miss E. E. Appleton } Civil Hospital Reserve.
Miss A. C. Binnian } Civil Hospital Reserve.
Miss H. L. Brakefield } Civil Hospital Reserve.
Miss E. V. Gascoyne } Civil Hospital Reserve.
Miss S. A. Jarvis } Civil Hospital Reserve.
Miss K. Latham } Civil Hospital Reserve.
Miss E. Ward } Civil Hospital Reserve.
Miss A. M. Bailey, Duchess of Westminster Red Cross Hospital.
Miss M. A. Caine, Q.A.I.M.N.S.R.
Miss E. Willoughby, Q.A.I.M.N.S.R.

By Sir Ian Hamilton from Gallipoli.

Lt.-Col. W. R. Pearless, N.Z.A.M.C.
Maj. W. R. Battye, I.M.S.
Maj. J. Corbin, A.A.M.C.
Maj. (temporary) B. M. Hughes (killed).
Maj. H. A. Powell, A.A.M.C.
Capt. T. J. C. Evans, I.M.S.
Capt. H. E Quick, R.A.M.C.T.
Capt. L. St. V. Welch, A.A.M.C.

By Maj.-Gen. Melliss from Persian Gulf Expedition.

Maj. L. Cook, I.M.S.
Capt. H. E. Stanger Leathes, I.M.S.
Capt. E. B. Allnutt, R.A.M.C.

Promotions and Decorations for Field Service following Despatches.

K.C.V.O.

Surg.-Gen. (temporary) Sir Anthony A. Bowlby, A.M.S.

C.B.

Surg.-Gen. (temporary) H. D. Rolleston, R.N.
Lt.-Col. W. W. Giblin, A.A.M.C.

C.M.G.

Lt.-Col. R. Pickard, R.A.M.C.T.
Lt.-Col. (temporary Hon.) C. Gordon Watson, R.A.M.C.
Maj. H. M. Cruddas, I.M.S.
Maj. W. W. Jeudwine, I.M.S.

D.S.O.

Maj. W. R. Battye, I.M.S.
Maj. R. W. Knox, I.M.S.
Maj. A. A. Meaden, R.A.M.C.
Maj. C. H. Turner, R.A.M.C.
Surg. B. A. Playne, R.N.

Military Cross.

Capt. E. B. Allnutt, R.A.M.C.
Capt. D. C. G. Ballingall. R.A.M.C.
Capt. T. M. Miller, R.A.M.C. (S.R.)

Territorial Decoration.

Lt.-Col. W. P. Peake, R.A.M.C.T.

Bt. Lt.-Col.

Maj. H. Boulton, I.M.S.
Maj. G. Browse, I.M.S.

ROLL OF HONOUR—*continued.*

LEGION OF HONOUR (*Croix de Chevalier*).
Maj. W. R. BATTYE, I.M.S.

ROYAL RED CROSS (1ST CLASS).
Miss R. COX-DAVIS (Principal Matron, 1st London General Hospital).
Miss E. HOLDEN (Matron, 3rd London General Hospital).
Miss E. M. MUSSON (Principal Matron, 1st Southern General Hospital).
Miss M. S. RIDDELL (Matron, 2nd London General Hospital).

ROYAL RED CROSS (2ND CLASS).
Miss A. C. BINNIAN } Civil Hospital
Miss K. LATHAM } Reserve.

PRINCIPAL MATRON.
Miss A. BEADSMORE-SMITH, R.R.C. (Matron) Q.A.I.M.N.S.

ROYAL NAVAL MEDICAL SERVICE.

TEMPORARY SURGEONS.

COURTIS, A. O., M.R.C.S., L.R.C.P.
GIBSON, T. S., D.P.H.Cantab., M.R.C.S., L.R.C.P.
HORNABROOK, R. W., M.B., B.S.Adelaide, M.R.C.S., L.R.C.P.
KINDERSLEY, C. E., M.R.C.S., L.R.C.P.
MORGAN, R. G., M.R.C.S., L.R.C.P.
SCOTT, M. B., F.R.C.S.Edin.
WILDE, A. N., M.R.C.S., L.R.C.P.

LIEUTENANT, R.N.V.R.

AUSTEN, H., M.D.Lond., L.D.S.

SURGEON PROBATIONERS, R.N.V.R.

HERINGTON, C. E. E.
PRIDHAM, H. L.

Hospital Ship "Glengorm Castle."
Major (formerly Col. Indian Army) G. F. ROWCROFT, M.R.C.S., L.R.C.P., I.M.S.

Hospital Ship "Massilia."
Lt. A. L. SAUNDERS, M.R.C.S., L.R.C.P.

Hospital Ship "St. Denis."
Lt. J. FERGUSON, M.B., B.S.Lond.

Monitor No. 28.
Surg. R. E. R. BURN, M.R.C.S., L.R.C.P.

ROYAL NAVAL AIR SERVICE.

Surg. M. FAWKES, M.B., B.S.Lond., R.N.
Flight Sub.-Lt. I. DE B. DALY.

ROYAL NAVAL AUXILIARY SICK BERTH RESERVE.

LEITCH, I. N.
WELLS, A. Q.

ARMY MEDICAL SERVICE.

ASSISTANT DIRECTORS OF MEDICAL SERVICES.

Col. F. W. HARDY, M.B., B.C., D.P.H.Cantab.
Col. H. S. THURSTON, M.R.C.S., L.R.C.P.
Lt.-Col. C. AVERILL (V.D.), M.D., B.Sc., D.P.H.
Lt.-Col. H. E. WINTER, M.R.C.S., L.R.C.P. (Presidency Brigade).

DEPUTY ASSISTANT DIRECTORS OF MEDICAL SERVICES.

Major E. H. MYDDELTON-GAVEY, M.R.C.S., L.S.A. (2nd Central Army).
Capt. C. H. GREGORY, M.D.Cantab. (Home Counties Division).

TEMPORARY COLONEL.

A. E. GARROD, M.D.Oxon., F.R.C.P. (Consulting Physician to H.M. Forces in Malta).

ROYAL ARMY MEDICAL CORPS.

TEMPORARY LIEUTENANT-COLONELS.

LEGG, T. P., M.S.Lond., F.R.C.S.
MORRIS, R. J., M.D.Durh., M.R.C.P.
MYERS, C. S., M.D.Cantab., F.R.S.
WRIGHT, A., M.R.C.S., L.R.C.P.Edin. (local). whilst senior M.O. Cape Town.

TEMPORARY MAJOR.

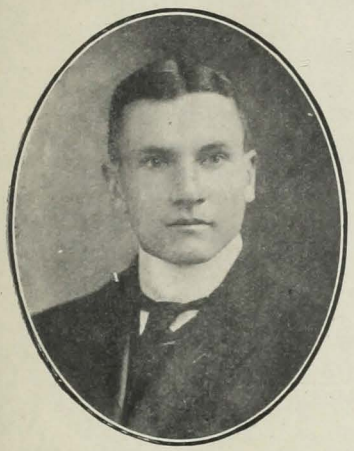
FARRAR, R. A., M.D.Oxon.

TEMPORARY CAPTAINS.

ARKWRIGHT, J. A., M.D.Cantab., M.R.C.P.
BAINBRIDGE, Professor F. A., M.D., D.P.H. Cantab., F.R.C.P.
BURFIELD, J., M.B., B.S.Lond., F.R.C.S.
CONNOLLY, J. H., M.D.Edin., F.R.C.S.
CURREY, E. F. N., M.R.C.S., L.R.C.P.
DAVIES, S. T., M.R.C.S., L.R.C.P.
DOBSON, E. L., M.B., B.C.Cantab.
DOUGLASS, W. C., M.R.C.S., L.R.C.P.
EDDISON, F. R., M.R.C.S., L.R.C.P.
EVANS, EVAN, M.R.C.S., L.R.C.P.
GILLIES, H. D., F.R.C.S. (Aldershot Command).
GRAHAM, G., M.D.Cantab., M.R.C.P. (Assistant to Dr. Garrod at Malta).
HUTCHENS, H. J., D.S.O., D.P.H.Oxon.
LE BROCQ, C. N., M.D.Cantab.
MCFALL, J. E. W., M.D., D.P.H.Liverp.
PRINGLE, E. G., M.D.Lond.
RECKLESS, P. A., F.R.C.S.
ROWE, R. M., M.D.Edin., F.R.C.S.
SCOTT, H. H., M.D.Lond.
SMITH, J. A., M.D.Lond.
WOOLLRIGHT, A. P., L.M.S.S.A.

TEMPORARY LIEUTENANTS.

ADAM, G., M.R.C.S., L.R.C.P.
ALDRIDGE, A. H., M.R.C.S., L.R.C.P.
ALMOND, G. H-H., M.B., B.Ch.Oxon.
ANDERSON, A. J., M.B.Oxon., D.P.H.Cantab.
BARBER, A., M.B., B.S., D.P.H.Lond.
BATES, T., M.B., B.S.Lond., F.R.C.S.
BATT, B. E. A., M.B., B.Ch.Oxon.
BAYNES, H. G., M.B., B.C.Cantab.
BERRY, H. S., B.C.Cantab., M.R.C.S., L.R.C.P.
BINNS, J. B., M.R.C.S., L.R.C.P.
BISHOP, F. M., M.R.C.S., L.R.C.P.
BLOXSOME, H. E., M.R.C.S., L.R.C.P.
BODY, T. M., M.R.C.S., L.R.C.P.
BOWER, H. J., M.R.C.S., L.R.C.P.
BREMRIDGE, R. H., M.B., B.Ch.Oxon.
BREWITT-TAYLOR, R., M.B., B.S.Lond.
BRIGSTOCKE, P. W., M.B.Lond.
BRISCOE, J. R., M.B., B.C.Cantab.
BROWN, A. B., M.R.C.S., L.R.C.P.
BROWN, F. N., M.R.C.S., L.R.C.P.
BROOK, T. S., M.R.C.S., L.R.C.P.
BULLAR, J. F., M.B.Cantab., F.R.C.S.
BURNETT, L. B., M.B., B.C.Cantab.
BURRA, L. T., M.D.Oxon.
CLEMINSON, F. J., M.C., F.R.C.S.
COGHLAN, M., M.B., B.Ch.R.U.I.
CROPPER, J., M.D.Cantab.
CUNNINGHAM, A. J. W., M.B., B.C.Cantab.
CUNNINGTON, E. C., M.R.C.S., L.R.C.P.
CURGENVEN, J. S., M.R.C.S., L.R.C.P.
DAVIES, J. K., M.R.C.S., L.R.C.P.
DAVIES, J. Ll., M.R.C.S., L.R.C.P.
DERRY, D. H., M.R.C.S., L.R.C.P.
DOBSON, J. R. B., M.B., B.S.Lond.
DOTTRIDGE, C. A., M.B., B.C.Cantab.
DUDLEY, S. R., L.M.S.S.A. (died from disease).
DUNCAN, E. H. G., L.R.C.S., L.R.C.P.Edin.
EAST, G. D., M.B., B.C.Cantab.
EDMOND, W. S., F.R.C.S.
ELLISON, H. H. L., M.R.C.S., L.R.C.P.
ELLIOTT, J., M.D.Lond., F.R.C.S., F.R.C.P.
EMMERSON, C. L., M.R.C.S., L.R.C.P.
FEILING, A., M.D.Cantab., M.R.C.P.
FISHER, J. C., M.B., B.Ch.Oxon.
FRY, A. P., M.B., B.S.Lond.
FULLER. R. A., M.R.C.S., L.R.C.P.
GANDY, T. H., M.B.Lond.
GARROD, A. N., M.R.C.S., L.R.C.P. (since killed).
GEACH, R. N., F.R.C.S. (since relinquished his Commission).
GEMMILL, W., M.B., Ch.B.Edin., F.R.C.S.
GILES, L. T., M.B., B.C.Cantab., F.R.C.S.
GILL, G. F., M.R.C.S., L.R.C.P.
GRACE, N., M.D., C.M.McGill Univ.
GRAHAM, C. H., M.D.Durh., F.R.C.S.Edin.
GRIFFITH, J. R., M.R.C.S., L.R.C.P.
HARDY, E. W. D., M.R.C.S., L.R.C.P.
HATHAWAY, F. J., M.D.Edin.
HILL, R. A. P., M.D.Cantab.
HINDE, S. L., L.S.A.
HOLTHUSEN, A. W., M.B., B.S.Lond.
HUTT, H. A., M.R.C.S., L.R.C.P.
JACOBSON, G. O., M.R.C.S., L.R.C.P. (since relinquished his Commission).
KENNEDY, R. P., M.R.C.S., L.R.C.P.
KIMBELL, H. J. S., M.R.C.S., L.R.C.P.
KINGSTON, C. S., M.R.C.S., L.R.C.P.
LAMPLOUGH, W. H., M.D.Durh.
LEONARD, N., M.D.Brux., M.R.C.S., L.R.C.P.
LINDEMAN, S. J. L., M.R.C.S., L.R.C.P.
LINDER, G. C., M.B., B.S.Lond.
LITTLE, A. H., M.R.C.S., L.R.C.P.
MACKAY, E. C., M.D.Lond.
MANSELL, R. A., M.B., B.C.Cantab.
MAYO, T. A., M.B.Cantab., F.R.C.S.
MCFARLAND, J. B., M.R.C.S., L.R.C.P.
MEAD, J. C., M.B., B.S.Lond., F.R.C.S.
MERCER, W. B., M.B., B.C.Cantab.
MILLEN, S. A., M.R.C.S., L.R.C.P.
MILSOM, E. G. D., M.R.C.S., L.R.C.P.
MOORE, W. F., M.B.Durh., D.P.H.Cantab. and Vict.
MORRIS, G., M.D.Brux., M.R.C.S., L.R.C.P.
MUSSON, W. E. C., M.R.C.S., L.R.C.P.
NICHOLAS, C. F., M.R.C.S., L.R.C.P.



Arthur Keith Armstrong, M.R.C.S., L.R.C.P., Lt. R.A.M.C. [September 29th, 1899.] *Died of wounds* September 15th, 1914.

Charles Hunter Donaldson Banks, Lt. 3rd Worcester Regt. [September 27th, 1910.] *Died of wounds* July 1st, 1915.

Edward Henry Pollok Brunton M.R.C.S., L.R.C.P., Lt. R.A.M.C., attached 4th Battn. Grenadier Guards. [September 28th, 1910.] *Killed in action* October 8th, 1915.

Gurney White Buxton, M.R.C.S., L.R.C.P., Capt. R.A.M.C.T. [January 29th, 1887.] *Died of dysentery* October 7th, 1915.

Samuel Robert Dudley, L.M.S.S.A., Lt., R.A.M.C. [October 1st, 1882.] *Died of illness contracted whilst on active service* December 21st, 1915.

George Alfred Edsell, M.D.Durh., D.P.H., R.C.P.S., Lt.-Col. R.A.M.C. [October 1st, 1882.] *Died of illness contracted whilst on active service* August 15th, 1915

James Fairbairn Fairley, M.D.Melb., F.R.C.S., Capt. R.A.M.C. [June 12th, 1913.] *Died of illness contracted whilst on active service* November 9th, 1915.

Alfred Noel Garrod, M.R.C.S., L.R.C.P., Lt. R.A.M.C., attached 100th Field Ambulance. [September 30th, 1905.] *Killed in action* January 26th, 1916.

John Gay, 2nd Lt. Royal Flying Corps. [September 13th, 1911.] *Died of wounds* October 10th, 1915.

Date of entry to Hospital is bracketed.

ROYAL ARMY MEDICAL CORPS—*continued.*

NOLAN, B. J., L.M.S.S.A.
O'HEA, J. P., M.B.Lond., F.R.C.S.
OKELL, C. C., M.R.C.S., L.R.C.P.
PADWICK, J. C., M.R.C.S., L.R.C.P.
PAGE, C. H. W., M.D.Cantab.
PAYNE, J. R., M.R.C.S., L.R.C.P.
PETERS, R. A., M.B., B.C.Cantab.
PHILLIPS, L. L., M.R.C.S., L.R.C.P.
PRETTY, K., M.B.Cantab.
PRING, F. A., M.R.C.S., L.R.C.P.
PUGH, A. B., M.R.C.S., L.R.C.P.
PUTTOCK, R., M.B., B.C.Cantab.
RANDALL, J. B., M.B. B.S.Lond.
RENDALL, P., M.D.Brux., M.R.C.S., L.R.C.P.
RENDALL, S. S., M.B., B.S.Lond.
ROBERTSON, J. F., M.R.C.S., L.R.C.P.
RUCK, J. E., M.R.C.S.
SCOTT, N. A., M.R.C.S., L.R.C.P.
SHEPARD, R. H., M.R.C.S., L.R.C.P.
SIMPSON, R. H., M.B., B.S.Lond.
SMITH, R. E., M.R.C.S., L.S.A.
SNOWDON, A. R., M.R.C.S., L.R.C.P.
SPEECHLY, A. J. L., M.R.C.S., L.R.C.P.
TAUNTON, T. J., M.R.C.S., L.R.C.P.
TAYLOR, E. L., M.R.C.S., L.R.C.P.
THOMPSON, ARTHUR, M.R.C.S., L.R.C.P.
THOMPSON, C. C. B., M.R.C.S., L.R.C.P.
THOMPSON, W. FRANK, M.R.C.S., L.R.C.P. (since died of wounds).
URWICK, R. H., M.D.Cantab.
VAUGHAN, A. LL., M.R.C.S., L.R.C.P.
VERRALL, P. J., M.B., B.C.Cantab., F.R.C.S.
WAKELING, T. G., M.R.C.S., L.R.C.P.
WALKER, G., M.D.Brux., M.R.C.S., L.R.C.P.
WATKYN-THOMAS, F. W., B.C.Cantab.
WELCH, T. B., M.R.C.S., L.R.C.P.
WELLS, W. W., M.B., B.Ch.Oxon.
WELLS-COLE, G. C., M.R.C.S., L.R.C.P.
WHITAKER, F., B.C.Cantab.
WHITEHEAD, B., M.R.C.S., L.R.C.P.,
WILSON, W. R., M.R.C.S, L.R.C.P.
WILLIS-BUND, H. D. H., M.R.C.S., L.R.C.P.
WORLEY, W. E. A., M.R.C.S., L.R.C.P.
WORTHINGTON, G. V., M.B., B.C.Cantab.
WOODFORDE, A. W. G., M.B., B.S.Lond.

TEMPORARY HONORARY LIEUTENANTS.

ACKLAND, J. G., M.R.C.S., L.R.C.P.
BARNES, E. B., M.R.C.S., L.R.C.P.
DINGLEY, E. G., M.R.C.S., L.R.C.P.
ISAACS, S. W., M.R.C.S., L.R.C.P.
MAGUIRE, J. E. C., M.R.C.S., L.R.C.P.
PRALL, S. R., M.R.C.S., L.R.C.P.
WELLS, P. H., M.R.C.S., L.R.C.P.
WHITE-COOPER, W. R., M.R.C.S., L.R.C.P.

R.A.M.C. SPECIAL RESERVE OF OFFICERS.

CAPTAINS.

WILSON, J. G., M.R.C.S., L.S.A., D.P.H. Cantab.
YOUNG, T., M.R.C.S., L.R.C.P.

AUSTRALIAN ARMY MEDICAL CORPS.

TEMPORARY CAPTAINS.

CULLEN, A. E., M.B., B.C.Cantab.
DEANE-BUTCHER, C. B., M.R.C.S., L.R.C.P.
PARKER, G. M., M.B., B.C.Cantab.
WALLACE, R. A. R., F.R.C.S.

1st Australian General Hospital, Heliopolis, Cairo.

Capt. W. A. JAMES, M.R.C.S., L.R.C.P.
Capt. C. A. PAYNE, M.R.C.S., L.R.C.P.
Capt. C. B. PYM, M.R.C.S., L.R.C.P.

1st Australian Casualty Clearing Station.

Col. W. W. GIBLIN, M.R.C.S., L.R.C.P.
Maj. J. CORBIN, M.R.C.S., L.R.C.P.

NEW ZEALAND MEDICAL CORPS

LT.-COL.

W. R. PEARLESS, M.R.C.S.

New Zealand Hospital Ship "Marama."

Maj. W. R. STOWE, M.R.C.S., L.R.C.P.

EXPEDITIONARY FORCES.

2nd Cavalry Division.

Capt. F. H. CLEVELAND, M.R.C.S., L.R.C.P.

1/3 East Anglian Field Ambulance, 54th Division.

Capt. M. A. CHOLMELEY, M.R.C.S., L.R.C.P.

24th Field Ambulance.

Lt.-Col. R. PICKARD, C.M.G., M.D., M.S. Lond., F.R.C.S., D.P.H.
Capt. G. W. LLOYD, M.B., B.S.Lond.

69th Field Ambulance.

Capt. P. H. G. GOSSE, M.R.C.S., L.R.C.P.

No. 9 General Hospital.

Capt. F. E. WITHERS, M.R.C.S., L.R.C.P.

17th General Hospital, Alexandria.

Lt. A. L. WEAKLEY, M.B., B.S.Lond., F.R.C.S.Ed., Ophthalmic Specialist.

24th General Hospital.

Surg.-Maj. H. SKELDING, M.B., B.C.Cantab., Special Surgeon.

27th General Hospital.

Lt. F. J. SADLER, M.D., B.Ch., D.P.H.Oxon.

Cameroons.

F. E. WHITEHEAD, M.R.C.S., L.R.C.P.

Rawal Pindi British General Hospital.

Lt.-Col. S. F. GREEN, M.D.Durh.

No. 10 Stationary Hospital.

Maj. H. C. SIDGWICK, M.B.Cantab., M.R.C.S., L.R.C.P.

No. 16 Stationary Hospital, Mudros.

Lt. G. HADFIELD, M.D., B.S.Lond.

St. David's Camp Hospital, Malta.

Lt. C. H. G. PRANCE, M.R.C.S., L.R.C.P.

St. George's Hospital, Malta.

Lt. H. J. PICKERING, L.R.C.P., L.R.C.S.Edin.

29th Casualty Clearing Station.

Lt. C. R. HOSKYN, M.D.Lond.

Lucknow Casualty Clearing Station, Indian Cavalry Corps.

Maj. W. H. CAZALY, M.B., B.S.. D.P.H, Lond., I.M.S.

Mobile X-ray Unit 2nd Army.

Capt. B. T. LANG, B.C.Cantab., F.R.C.S.

49th Divisional Ammunition Column.

Capt. L. C. E. MURPHY, L.R.C.P.I., L.R.C.S.I.

Meerut Hospital for Infectious Diseases, Rouen.

Capt. A. F. S. SLADDEN, M.D., B.Ch.Oxon.

MEDICAL OFFICERS ATTACHED TO UNITS OTHER THAN MEDICAL UNITS.

COLONEL.

Sir GEORGE HASTINGS (V.D.), M.D.Brux., 3/1 Co. of Lond. Yeomanry, and doing duty for the 3/3 Co. of Lond. Yeomanry.

CAPTAINS.

COOKE, J. G., M.B., B.C.Cantab., N. Midland Bgde, R.E.
FOLLIT, H. B., D.P.H.Cantab., 9th Light Horse Regt., M.E.F.
GRUMMITT, C. C., M.R.C.S., L.R.C.P.
HOSKEN, J. G. F., M.R.C.S., L.R.C.P., 4th Battn. The Norfolk Regt.
KEYNES, G. L., M.B., B.C.Cantab., 23rd Brigade R.F.A., III Division B.E.F.
MICHELL, R. W., M.D.Cantab., F.R.C.S., 2nd Brigade Heavy Artillery.
SMYTHE, G. A., M.B.., B.C.Cantab., 1st Coldstream Guards.

SURGEON-CAPTAIN.

A. J. CLARKE, M.B., B.S.Lond., British W. Indies Regt.

LIEUTENANTS.

CRAWFORD, C. R., M.R.C.S., L.R.C.P., 3rd N. Staffs Regt.
SALE, J. C., M.R.C.S., L.R.C.P., 11th Essex Regt., B.E.F.
SUNDERLAND, R. A. S., M.R.C.S., L.R.C.P., 8th Heavy Brigade R.G.A., B.E.F.

W. T. DOBSON, M.R.C.S., L.R.C.P., M.O. in charge of Troops, Cardiff.
W. GRIPPER, M.B., D.P.H.Cantab., M.O., "C" Co., 9th Battn. (Sutton) Surrey V.T.C.

R.A.M.C. TERRITORIAL FORCE.

FIELD AMBULANCES.

(*a*) MOUNTED BRIGADE FIELD AMBULANCES.

South Midland.

Capt. A. G. HENDLEY, M.R.C.S., L.R.C.P., formerly Lt.-Col. I.M.S. (retired).

(*b*) FIELD AMBULANCES.

East Anglian.

Capt. B. H. C. LEA-WILSON, M.R.C.S., L.R.C.P.

2/1st Home Counties.

Capt. C. H. GREGORY, M.D.Cantab.
Capt. A. Maude, M.R.C.S., L.R.C.P.

3rd West Lancashire.

Lt. A. H. PINDER, M.R.C.S., L.R.C.P.

Frank Eric Harger, 2nd Lt. Royal Field Artillery. [April 21st, 1914.] *Killed in action* December 16th, 1915.

Miss Maude A. Buckingham. [November 1st, 1896.] Matron of the Queen's Hospital, Birmingham, and of the 2nd Birmingham War Hospital. *Died on* December 4th, 1915.

Burroughes Maurice Hughes M.R.C.S., L.R.C.P., Capt. 1/4th Norfolk Regt. [May 1st, 1890.] *Killed in action* September 15th, 1915.

Howard Tomlin Hunter, Capt. 6th Northumberland Fusiliers. [May 1st, 1911.] *Killed in action* April 26th, 1915.

Charles Douglass-James, 2nd Lt. S. Staffs. Regt. [October 7th, 1912.] *Died of wounds* September 30th, 1915.

John William Jessop, M.R.C.S., L.R.C.P., Lt.-Col. 4th Battn. The Lincolnshire Regt. (T.) [October 1st, 1880.] *Killed in action* June, 1915.

Leslie Phillips Jones, Lt. 9th Royal Berks. Regt. [January 19th, 1914.] *Died of wounds* about June 20th, 1915.

Theodore Stewart Lukis, M.D.Lond., M.R.C.P., Capt. 13th Kensington Battn. The London Regt. [September 19th, 1902.] *Died from wounds* March 15th, 1915.

Date of entry to Hospital is bracketed.

1st West Riding.

Capt. H. W. SHADWELL, M.R.C.S., L.R.C.P
Capt. ERNEST WHITE, M.B., B.S.Lond.,

Wessex.

Capt. J. KEARNEY, M.R.C.S., L.S.A.
Capt. H. J. PECHELL, M.B., C.M.Edin.

NO. 2 AMBULANCE TRAIN.

Southampton.

Lt. L. L. PHILLIPS, M.R.C.S., L.R.C.P.

GENERAL HOSPITALS.

EASTERN.

Maj. T. S. HELE, M.D., B.C., D.P.H.Cantab.

1ST LONDON (CITY OF LONDON).

Capt. J. D. L. CURRIE, M.R.C.S., L.R.C.P..

4TH LONDON.

Lt. J. A. WILLETT, M.D.Oxon., M.R.C.P.

3RD NORTHERN.

Lt. F. HARVEY, M.R.C.S., L.R.C.P.
*Maj. A. J. HALL, M.D.Cantab., F.R.C.P.
*Maj. A. E. NAISH, M.B., B.C.Cantab., M.R.C.P.
*Capt. F. A. HEPWORTH, M.B., B.C.Cantab., F.R.C.S.

* Seconded.

2ND SOUTHERN.

Capt. A. G. T. FISHER, M.B., Ch.B.Bristol.

SANITARY SERVICE.

Major R. FARRAR, M.D.Oxon. (Malta).

CASUALTY CLEARING STATIONS.

66TH (EAST LANCASHIRE).

Lt. J. RAMSAY, M.D.Lond.

NORTH MIDLAND.

Lt. C. S. J. KEARNEY, M.R.C.S., L.R.C.P.
Lt. N. H. HILL, M.R.C.S., L.R.C.P.

WESSEX.

Capt. F. A. ROPER, M.B., B.C.Cantab.

MILITARY HOSPITALS.

BRADFORD WAR HOSPITAL.

Lt.-Col. W. WRANGHAM, M.D.Lond.

CAMBRIDGE MILITARY HOSPITAL, ALDERSHOT.

Lt. F. HERNAMAN-JOHNSON, M.D.Aberd., in charge of Electrical and X-ray Dept.

CAMPBELL HOSPITAL FOR OFFICERS, CAMBRIDGE SQUARE, W.

E. C. BRIDGES, M.D.Durh., Hon. M.O.

CONNAUGHT HOSPITAL, ALDERSHOT.

Capt. A. ABRAHAMS, M.D.Cantab., M.R.C.P.
Lt. W. B. MERCER, M.B., B.C.Cantab.

DORCHESTER HOUSE, PARK LANE, HOSPITAL FOR OFFICERS.

E. C. BRIDGES, M.D.Durh., Visiting M.O.

COUNTY OF LONDON WAR HOSPITAL, EPSOM.

Capt. H. L. WHALE, M.D.Cantab., F.R.C.S., Visiting (Ear, Throat, and Nose) Surgeon.
W. GRIPPER, M.B., D.P.H.Cantab., Visiting Anæsthetist.

FULHAM MILITARY HOSPITAL.

J. GAY, M.D.Durh.
H. G. WHARRY, M.R.C.S., L.S.A.

HALIFAX WAR HOSPITAL.

Major J. C. WRIGHT, M.B., B.C.Cantab.

QUEEN ALEXANDRA'S HOSPITAL FOR OFFICERS, HIGHGATE.

Capt. H. E. G. BOYLE, M.R.C.S., L.R.C.P., Hon. Anæsthetist.
ERNEST CLARKE, M.D.Lond., F.R.C.S., Hon. Ophthalmic Surgeon.
A. C. JORDON, M.D.Cantab., M.R.C.P., Hon. Radiologist.
H. J. PATERSON, M.B., M.C.Cantab., F.R.C.S., Hon. Surgeon in charge.

FEDERATED MALAY STATES HOSPITAL, KIMPTON.

G. D. FREER, M.B.Lond., *In Charge.*
C. S. ATKIN, M.R.C.S., L.R.C.P., *M.O.*

MILITARY HOSPITAL, LICHFIELD.

Lt. P. RENDALL, M.D.Brux., M.R.C.S., L.R.C.P.

MILE END WAR HOSPITAL.

Major J. H. BROOKS, M.D., C.M.Aberd.

PRINCE OF WALES HOSPITAL, STAINES.

E. BURSTAL, M.B., B.Ch.Oxon., M.O. in Charge.

WOUNDED ALLIES RELIEF COMMITTEE HOSPITAL, COURTFIELD GARDENS.

E. C. BRIDGES, M.D.Durh., Hon. M.O.

RED CROSS HOSPITALS, ETC.

NO. 1 RED CROSS (DUCHESS OF WESTMINSTER'S) HOSPITAL.

Temp. Lt. F. P. YOUNG, M.D.Cantab.
Capt. J. W. NUNN, M.R.C.S., L.R.C.P., relinquishes his temporary honorary commission on ceasing to be employed with the above.

NO. 7 BRITISH RED CROSS (ALLIED FORCES BASE) HOSPITAL.

*Lt.-Col. W. E. MILES, F.R.C.S.
*Maj. H. D. GILLIES, F.R.C.S.
*Capt. S. A. BURN, M.R.C.S., L.R.C.P

* Relinquish their temporary honorary commissions on ceasing to be employed with the above.

WELSH HOSPITAL, NETLEY.

Lt. B. G. KLEIN, M.D., B.Ch.Oxon., relinquishes his temporary honorary commission on ceasing to be employed with the above.

BRITISH RED CROSS HOSPITAL, NETLEY.

Lt. W. E. N. DUNN, M.B.Lond.

ANGLO-RUSSIAN HOSPITAL, PETROGRAD.

Capt. W. D. HARMER, M.C.Cantab., F.R.C.S.
J. M. FLAVELLE, D.P.H.Cantab.

KINGSTON, SURBITON AND DISTRICT RED CROSS HOSPITAL.

NORRIS, F. B., M.D.Cantab.

RED CROSS HOSPITAL, EBBW VALE.

ELWORTHY, H. S., F.R.C.S., Commandant.

HÔPITAL ANGLAIS MILITAIRE, NEVERS (CROIX ROUGE SERVICE).

STANGER, G., M.B., B.Ch.Oxon.

HÔPITAL TEMPORAIRE, D'ARC-EN-BARROIS.

B. W. HOWELL, M.B., B.S.Lond., F.R.C.S. (*formerly* Chief M.O. and Surgeon in Charge of British Red Cross Unit in Vrnjatchka Banja, Serbia).

BELGIAN FIELD HOSPITAL.

Capt. H. L. WHALE, M.D.Cantab., F.R.C.S. (Surgeon).

RED CROSS HOSPITAL, SERBIA.

KNOBEL, W. B., M.D.Cantab.

LADY HOWARD DE WALDRON'S HOSPITAL, MUSTAPHA, EGYPT.

Lt. T. W. N. DUNN, M.B., B.C.Cantab., Commandant.

FIELD AMBULANCE AND RED CROSS DRESSERS.

SPACKMAN, E. D. (Field Ambulance).

INDIAN MEDICAL SERVICE.

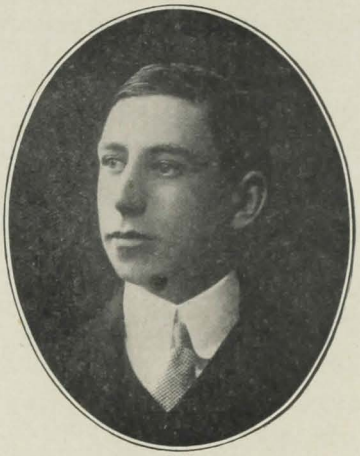
TEMPORARY LIEUTENANT.

SHAH, J. M., M.R.C.S., L.R.C.P.

COMMISSIONS IN REGULAR ARMY.

Lt. P. E. H. CHAMBERS, 4th Battn. County of London Regiment.
2nd Lt. E. R. BATHO, Medical Unit (A Section).
2nd Lt. H. S. BELL, Royal Field Artillery (S.R.).
2nd Lt. A. B. BERNARD, 1st K.R.R.C. (from 11th Battn. Lancashire Fusiliers).
2nd Lt. N. CARTLEDGE, 21st Battn. The Middlesex Regiment.
2nd Lt. P. C. COLLYNS, Royal Garrison Artillery (S.R.).
2nd Lt. A. B. COWLEY, Royal Field Artillery (S.R.).
2nd Lt. T. A. ECCLES, Royal Garrison Artillery (S.R.)
2nd Lt. E. J. C. ELAND, Royal Regiment of Artillery.
2nd Lt. D. C. FAIRBAIRN, Royal Garrison Artillery (S.R.)
2nd Lt. (temporary) K. C. J. JONES, 3rd Battn. the Bedfordshire Regiment.
2nd Lt. G. B. MCMICHAEL, 3/1 Herefordshire Regiment.
2nd Lt. G. R. NICHOLLS, Royal Garrison Artillary (N. Midland).
2nd Lt. C. S. PRANCE, Royal Garrison Artillery (Devon).
2nd Lt. F. P. SCHOFIELD, Royal Field Artillery (S.R.).

John Macadam, Lt. 4th Essex Regt. [September 21st, 1910.] *Died of wounds* August 18th, 1915.



Oscar Gladstone Maginness, M.R.C.S., L.R.C.P., Lt. R.A.M.C., attached R.F.A. [January 6th, 1908.] *Died of wounds* December, 1915.

John Morrice Maitland Marshall, Lt. 1/4th Battn. The Essex Regt. [August 25th, 1910.] *Died of wounds* October 21st, 1915.

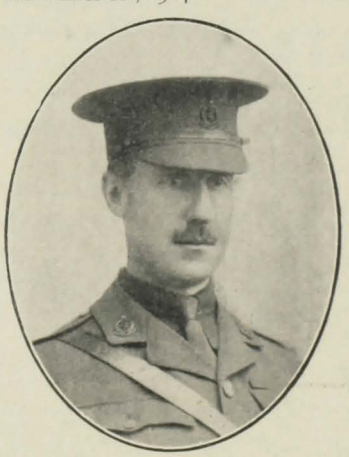
Richard Dominie O'Connor, M.R.C.S. L.R.C.P., Capt. R.A.M.C. attchd Sherwood Foresters. [October 1st, 1901.] *Killed in action* October 25th, 1914.

Francis Graham Richards, M.R.C.S., L.R.C.P., Maj. R.A.M.C. [October 2nd, 1893.] *Killed in action* March 5th, 1915.

Francis Charles Searle, M.B., B.S. Lond., Surgeon R.N. [March 31st, 1902.] *Lost on H.M.S. "Good Hope"* November 1st, 1914.

Archibald Waller Scott-Skirving, M.R.C.S., L.R.C.P., Capt. Royal Irish Fusiliers. [May 13th, 1913.] *Died of wounds* September, 1915.

William Frank Thompson, M.R.C.S., L.R.C.P., Lt. R.A.M.C. [October 1st, 1909.] *Died of wounds* January 1st, 1916.



Eric Alfred Wright, M.B., B.C., D.P.H.Cantab., M.R.C.S., L.R.C.P., Lt. R.A.M.C. [September 10th, 1900.] *Died of septic poisoning* June 20th, 1915.

We regret that no photographs are available for reproduction of the following:
Pairaylal Atal, M.R.C.S., L.R.C.P., Maj. I.M.S. [September 15th, 1894.] *Killed in action* December, 1914.
George Francis Juckes, Lt. 6th Rifle Brigade. [September 27th, 1912.] *Killed in action* about July 14th, 1915.

Date of entry to Hospital is bracketed.

COMMISSIONS IN TERRITORIAL ARMY.

2nd Lt. D. SPURWAY, 4th Battn. The Yorkshire Regiment.

REGULAR AND TERRITORIAL ARMY.

In the Ranks:
Pte. T. J. D. ATTERIDGE London Irish Rifles.
Pte. E. A. AUSTEN, "D" Co. London Scottish.
Pte. B. L. JEAFFRESON, No. 2 Co. 3rd Battn., H.A.C.
Pte. W. MCKENZIE, London Scottish Regiment.
Pte. HENRY MORRIS, "C" Co., 24th R. Fusiliers (since returned).
Pte. A. C. VISICK, 32nd General Hospital, Aldershot.

OFFICERS' TRAINING CORPS.

UNIVERSITY OF LONDON.

Infantry Unit:
J. D. JOHNSTONE.
A. E. LORENZEN.
N. S. B. VINTER.

INNS OF COURT.

Infantry Unit:
P. LINDSEY.

Artillery Unit:
C. M. HICKS.
W. E. M. MITCHELL.

VOLUNTARY AID DETACHMENTS.

EXETER.

No. 1 Military Hospital.

M.O. in charge: CANDLER, A. L., M.B., B.S.Lond., F.R.C.S.
M.O. attached: CLAPP, G. T., M.B.Cantab.

No. 3 Military Hospital.

M.O. in charge: ATKINS, S. E., L.R.C.S.I., L.S.A.
M.O. attached: PULLIN, B., M.R.C.S., L.S.A.

No. 5 Military Hospital.

M.O. attached: Col. J. RAGLAN THOMAS, M.D.Lond., D.P.H.Cantab., A.M.S.T.F.

ROPER, A. C., F.R.C.S.Edin., Ophthalmic Surgeon
HARRIS, J. D., M.D.Durh., Pathologist and Bacteriologist
} Assist at Nos. 1, 2, 3, 4, 5 Milty. Hosps. in Special Depts.

SALOP (36).

(*Auxiliary Hospital to Fazackerley Military Hospital.*)

M.O.: W. R. L. DRAWBRIDGE, M.R.C.S., L.R.C.P.

SURREY (112).

M.O.: W. GRIPPER, M.B., D.P.H.Cantab.

PRESENT AND FORMER NURSES OF ST. BARTHOLOMEW'S HOSPITAL SERVING IN CONNECTION WITH THE WAR.

TERRITORIAL RESERVE.

1st London General Hospital.

Sisters.

Miss L. APPLEYARD.
Miss F. C. BERKELEY.
Miss M. HORDER.
Miss N. MCPHERSON.
Miss D. WATT.

Staff Nurses.

Miss A. ARMITAGE.
Miss H. FRAMPTON.
Mrs. L. FRANKAU.
Miss B. S. MILNE.
Miss H. POPE.
Miss E. PHILLIPS.
Miss M. ROOMDELL.
Miss Rose.
Mrs. R. B. SWANSTON.
Miss SHAW.

Transferred to the Army Nursing Reserve for Foreign Service from 1st London General Hospital.

Nurse.

Miss J. B. WRIGHT.

Miss C. ELWELL (returned from Foreign Service).

QUEEN ALEXANDRA'S ROYAL NAVAL NURSING SERVICE.

Sister.

Miss IRVINE.

Nurse.

Miss BAIRD.

TERRITORIAL FORCE NURSING SERVICE.

Sisters.

Miss HESKETH.
Miss MCGREGOR.

Nurses.

Miss BROWN.
Miss CAWS.
Miss COLLYER.
Miss CRONIN.
Miss D. GARDNER.
Miss A. L. GIBSON.
Miss GILLBEE.
Miss CARDROSS GRANT.
Miss N. B. HODGSON (left for France).
Miss LODGEN.
Miss MCCLAVERTY.
Miss MURPHY.
Miss J. NICHOLSON.
Miss NORSTER.
Miss TILLBROOK.
Miss LUCY E. WAY (left for France).

Crag Head Military Hospital, Bournemouth.

Mrs. LATTER, Matron.

Dublin Castle Hospital.

Miss E. W. TAYLOR, Matron.

Federated Malay States Hospital, Kimpton.

Miss E. M. WILLIS, Matron.

Hanover Park Hospital (Camberwell Division of British Red Cross Society).

Miss E. J. HURLSTON, Matron.

No. 17 Durham V.A.D. Hospital, Etherley.

Sister KILBURN.

Base Hospital, Duala, Cameroons.

Miss MOULTON.

Chateau d'Annel (Anglo-French Committee).

Miss CAIRD.

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St. Bartholomew's Hospital Journal.

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

VOL. XXIII.—No. 7.] APRIL 1ST, 1916. [PRICE SIXPENCE.

CALENDAR.

Mon., April	3.	—Cambridge Lent Term ends. Second Exam. of Soc. of Apothecaries begins.
Tues., ,,	4.	—Dr. Tooth and Mr. D'Arcy Power on duty. Final Exam. Conjoint Board (Medicine) begins.
Wed., ,,	5.	—Exam. for D.P.H. (Cambridge) begins. First Exam. of Soc. of Apothecaries begins.
Thur., ,,	6.	—Final Exam. Conjoint Board (Midwifery) begins.
Fri., ,,	7.	—Dr. Garrod and Mr. Waring on duty. Final Exam. Conjoint Board (Surgery) begins.
Tues., ,,	11.	—Dr. Calvert and Mr. McAdam Eccles on duty.
Fri., ,,	14.	—Dr. Morley Fletcher and Mr. Bailey on duty.
Sat., ,,	15.	—Oxford Lent Term ends.
Mon., ,,	17.	—D.P.H. (Conjoint) Exam. begins.
Tues., ,,	18.	—Dr. Drysdale and Mr. Rawling on duty.
Fri., ,,	21.	—Dr. Tooth and Mr. D'Arcy Power on duty.
Sun., ,,	23.	—Easter Sunday.
Tues., ,,	25.	—**Summer Session begins.** Cambridge Easter Term begins. Dr. Garrod and Mr. Waring on duty.
Wed., ,,	26.	—Oxford Easter Term begins.
Fri., ,,	28.	—Dr. Calvert and Mr. McAdam Eccles on duty.
Mon., May	1.	—Exam. for M.B., B.S. (London) begins.
Tues., ,,	2.	—Dr. Morley Fletcher and Mr. Bailey on duty. Exam. for Part II. of second M.B.
Wed., ,,	3.	—Primary F.R.C.S. Exam. begins.
Fri., ,,	5.	—Dr. Drysdale and Mr. Rawling on duty.

EDITORIAL NOTES.

WE are officially informed by the War Office that, in accordance with their previous announcements, doctors who have undertaken to accept a commission in the Royal Army Medical Corps (if offered one) will not be taken for general service, and therefore that any doctor in England and Wales who (whether attested under the Derby scheme or not) has enrolled under the scheme of the Central Medical War Committee, or has offered his services in the Royal Army Medical Corps direct to the War Office, should, if he receives a notice paper from a recruiting officer calling him up (whether by reason of attestation or under the provisions of the Military Service Act), return it to the recruiting officer, together with his certificate of enrolment, or the War Office acknowledgment of provisional acceptance, as the case may be; and the notice will then be cancelled and the practitioner remain in the Reserve until selected for a commission in the Royal Army Medical Corps.

Doctors will not be called up, whether by reason of attestation or under the Military Service Act, until after March 31st, 1916.

Doctors in England and Wales who have not undertaken to accept a commission (if offered one) in the Royal Army Medical Corps will, when called up (whether by reason of attestation or under the Military Service Act), have the same rights of appeal for exemption as men who are not doctors, but all cases coming before the Central Tribunal will be decided by that tribunal after receiving advice from the representative committee of the medical profession specially recognised for the purpose.

Analogous arrangements will obtain in respect of doctors in Scotland.

* * *

The following notice appears in the *Sudan Government Gazette*, No. 288:

"On Wednesday, the 20th October, 1915, being the first day of the Feast of the Kurban Beiram, His Excellency the Governor-General El Ferik Sir Reginald Wingate, G.C.B., G.C.V.O., K.C.M.G., D.S.O., made the following announcement:

"'That His Highness the Sultan (of Egypt) has been most graciously pleased to confer decorations upon the following officers and officials for services rendered by them.

"'THE ORDER OF THE NILE.

"'3rd Class.

"'J. B. CHRISTOPHERSON, M.D., F.R.C.P., F.R.C.S.Eng., Director of the Khartoum and Omdurman Civil General Hospitals.'"

With much regret we hear of the death of one of our Governors, Mr. Henry Louis Florence, which took place on February 17th, in his seventy-fifth year. Mr. Florence was appointed a Governor in 1903, and has been an Almoner since 1905. He has always been a very generous supporter of the Hospital, which benefits immediately by £10,000 under his will, and later to a substantial share of the residue of his estate subject to two life-interests. Our deepest sympathy is extended to his brother and to his many friends.

* * *

Apropos of Mr. McAdam Eccles' recent lecture on "The Little Things that Matter," a well-known practitioner (not of this Hospital) writes of his own experience in little things. Among other remarks, one under the heading of "Faulty Spelling" engages our attention. "I find romantic, novel-reading nurses invariably spell 'Heroin' with an 'e' at the end of it. I have seen this note made: '11 p.m., gave him a dose of Heroine.'"

* * *

We have lately received several items of correspondence, two or three poems, and some alleged humorous skits from various anonymous contributors. May we remind our readers that their name and address must accompany contributions, otherwise the latter cannot be published. If contributors do not wish their names to be published we do not, of course, publish them, but we must know from whom the MSS. comes. We should be very glad if those who have recently sent us anonymous material will kindly rectify their omission.

* * *

We regret that in our last number we omitted to acknowledge the loan of four of the illustrations in the Roll of Honour from the *Lancet*, and one from the *British Journal of Nursing*.

ON PAINS IN THE ARM.

Part II of a paper read before the Abernethian Society.*

By C. M. HINDS HOWELL, M.D., F.R.C.P.

PAINS in the arm, from whatever cause arising, are commonly diagnosed by the more educated members of the public as "neuritis"! This is at present rather a popular disorder, and, indeed, some patients appear disappointed unless the physician concurs in their diagnosis.

When one remembers that pain in the arm may be caused by lesions which are situated in the brain, spinal cord, meninges, posterior roots, the brachial plexus, peripheral nerves, bones or muscles, it becomes clear that the clinical examination must not only include the *whole* nervous system, but must also include the skeletal structures in the limb.

Cerebral lesions do not commonly give rise to pain in the arm, but spontaneous pains are a classical feature of lesions which involve the optic thalamus, and these pains, as a rule, have a hemiplegic distribution, and thus include the leg as well as the arm. They do not usually make their appearance till some weeks after the initial lesion—which is usually a vascular one. Unless, therefore, one is familiar with the "thalamic syndrome," considerable difficulty may be caused by their appearance, and much time and useful energy may be expended on local measures for the relief of a neuritis which is in fact non-existent. These pains from cerebral lesions do not always involve the leg. As an instance of this, I may quote the case of a man who was under my care at the National Hospital. He came complaining of darting pains in the left arm, and a certain amount of clumsiness and weakness in the left hand. He also complained, when questioned, of constant but not very severe headache, which he referred to the right frontal region. Examination showed that the power of the limb was only slightly diminished, but that there was profound sensory disturbance in the left arm, which increased towards the extremity of the limb. There was no thermal loss, and pin-prick was everywhere recognised as sharp, but there was complete astereognosis in the hand, and passive movement of the fingers and wrist was not appreciated, and the sense of position was lost. The threshold for the compass test was very much raised; there was no optic neuritis, but an extension of the symptoms to include the face showed that the lesion was a progressive one, and there can be no doubt that the man has a tumour situated between the thalamus and the cortex.

With regard to spinal lesions there are several conditions to consider. First of all tabes dorsalis, in which pains, usually described as "rheumatism" or "neuritis," are an early feature. Unless a complete examination of the nervous system is made the nature of these pains will escape detection. The presence of the Argyle Robertson pupil is a very early sign in such cases, but it is important to emphasise the fact that the presence of the knee-jerk by no means excludes a diagnosis of tabes. It is often present in the early stages, and in that type of the disease known as cervical tabes may persist for a long period. In these cases, however, one may expect to find definite alteration of sensibility in the arm, especially a strip of cutaneous analgesia along the ulnar border of the forearm, and also alteration in deep sensibility.

Meningeal lesions, caused by tumour or pachymeningitis of either syphilitic or tuberculous origin, may also give rise to brachial pains. Tumours and tuberculous lesions as a rule soon produce other symptoms which indicate their presence, but syphilitic lesions sometimes do not. This,

* Part I published January, 1916.

however, is exceptional. Usually, as in the condition known as cervical pachymeningitis, you will find muscular wasting, and sensory loss accompanying the pain, and often evidence of pressure on the cord, causing paraplegia in greater or less degree. As an example of the rarer condition, where the symptoms were purely subjective, consisting of most acute pain in the right arm, I might mention the case of a woman, æt. 42, who has recently been under my care. I may say at once that I mistook the case for a "rheumatic" one at first; but, as the pains persisted unrelieved by the ordinary remedies, a Wassermann examination of the blood was undertaken, and proved positive. Under mercury and iodide the pains completely disappeared.

Pressure on nerve trunks outside the cervical spinal canal is responsible for sensory disturbances in the arm. Tumours of various kinds, malignant glands, and occasionally aneurysm of the subclavian or carotid arteries are all occasionally responsible. More commonly pressure in the neck is caused by the presence of a 7th cervical rib. These abnormalities are fairly common, and in a number of cases give rise to no symptoms at all. The cervical rib may be a normally developed structure, resembling in all respects a thoracic rib, but not articulating with the sternum. One often finds, however, a fibrous prolongation from the tip of the rib, which extends sometimes to the sternum, but more commonly to the 1st thoracic rib. This fibrous band moves with respiration, becoming stretched with inspiration, and may itself be the cause of the painful pressure. Other ribs are merely rudimentary structures, extending to a greater or less extent beyond the transverse process of the vertebra. Curiously enough, it is usually the shorter ribs which give rise to symptoms. These symptoms are found much more commonly in women than in men, and usually after the age of thirty. This at first sight appears peculiar, but Professor Keith has furnished what is undoubtedly the true explanation. In women the shoulders slope from the neck more than they do in men, and loss of muscular tone appears earlier and to a greater degree, causing this slope to be still more pronounced. This drags the lower trunk of the brachial plexus closer on to the rib, and thereby brings about the symptoms. These are most noticeable in connection with the 8th cervical and 1st dorsal roots, which unite to form the lowest trunk of the plexus.

In fully developed cases, besides the pain, there is also muscular wasting involving the intrinsic hand muscles, and the flexors of the wrist and fingers, together with a patch of anæsthesia and analgesia along the ulnar border of the forearm and hand. There is also, as a rule, well-marked vasomotor disturbance in the peripheral part of the limb, caused either by direct pressure on the subclavian artery or by irritation of the sympathetic vasomotor fibres accompanying the nerve.

Many cases, however, only exhibit pain and paræsthesia as the result of the rib, and difficulties in diagnosis may arise unless the possibility of its presence is remembered. Many of these patients state that the pain is relieved considerably by sitting in an armchair with the elbows supported, thus reducing the strain on the nerve trunks, and some few cases actually at night sling their arms up, as in this position they obtain relief from the pain.

Injury of a peripheral nerve trunk in the arm may give rise to excessive pain, which, if it persists, indicates a partial lesion of the nerve. Such cases, to which Meir Mitchel gave the name "Causalgia," have been frequently met with recently, as nerve injuries from bullets are unfortunately very common. Injuries to the *median* nerve are more likely to give rise to these symptoms than a lesion involving any of the other nerves in the arm. A curious and rather uncommon symptom is glossy skin, which is always due to irritation of a partially divided nerve, and is especially liable to occur when any septic trouble occurs in the vicinity of the injured nerve: the skin becomes red and shiny, and the area involved is exceedingly painful. Sometimes, if the nerve is explored, no obvious damage can be found nor involvement in scar tissue, even when motor paresis and objective sensory loss can be demonstrated. These may be examples of "nerve concussion," in which the fibres have been injured within the nerve sheath without any direct contact of the bullet with the nerve itself. I will leave the consideration of rheumatic or gouty neuritis for a moment, and conclude what I have to say about other causes of pain in the arm which may be mistaken for neuritis.

Diseases of joints are particularly liable to cause pain in the arm, perhaps owing to a secondary neuritis; but unless the joint condition is recognised and treated the pain will not be relieved. This is especially liable to happen in arthritis of the shoulder joint with periarticular adhesions. Such cases, especially in elderly subjects, often have a traumatic origin, and bear a close analogy to cases of sciatica due to arthritis of the hip joint. Malignant disease of the bone sometimes leads to error in diagnosis; but this is more likely to occur in connection with the leg than in the arm. I have seen two cases of the kind in which sarcoma —in one case of the pelvis, and in the other of the femur— were both treated for a time as cases of sciatica. Spontaneous fracture in one case, and the appearance of a large tumour in the other cleared up the diagnosis, which, however, ought to have been made earlier in both cases.

Pains caused by a rare condition, multiple myelomata of bone marrow, I have seen on one occasion regarded as neuritis and treated as such for some time. Examination of the urine would always clear up the diagnosis, for one finds that peculiar body, the Bence Jones protein, constantly present in such cases. Its reactions are so characteristic that it is not likely to be missed; but the mistake was actually made in the case in point, the patient being alleged to suffer from chronic nephritis.

Referred pains of visceral thoracic disease are often experienced in the arm, as, for instance, in anginal attacks, or in connection with some forms of cardiac disease, but these should rarely cause any difficulties in diagnosis.

I will conclude these remarks with reference to true rheumatic or gouty neuritis. This condition may vary from comparatively slight tingling and paræsthesia to the most acute pain which prevents sleep and renders the unfortunate victim worn out physically and mentally. The slighter type of this disease is commoner in hospital than private practice, but, like the more severe type, affects women more frequently than men. It usually affects the peripheral part of the limb, and is then designated acroparæsthesia. It is most intractable, and is always made worse by washing and wringing out clothes, an unavoidable occupation in the class of patient most affected.

The exact pathology of the condition is not very clear. It has sometimes been thought to be due to arteriosclerosis of the vasa nervosum, and though this may be true in particular cases there is usually no evidence to justify such an assumption. The iodide of iron occasionally gives relief, but a cure is rarely achieved, probably because the occupation which aggravates it has to be continued. In a few cases that I have had under my care guaiac has undoubtedly brought relief, and in these cases one has assumed that the condition was a gouty one.

In the more severe forms there is, as a rule, no objective sensory loss to be found, and no true muscular wasting. The grip, however, is usually weaker on the affected side. Pain is complained of around the shoulder and in the muscles of the arm. A particularly painful spot is commonly to be found between the spine of the scapula and the vertebræ. This represents the cutaneous branch of a posterior division of the spinal nerve. A characteristic feature of the pain is that it is almost invariably worse at night and when the patient comes into a warm room from the cold. The skin and nails sometimes, but only rarely, show atrophic changes, and these but slight. In a severe case, however, the skin may be thin and smooth and the nails brittle and grooved longitudinally. I have seen a case in which the bones of the wrists and fingers shared in this atrophic process and were definitely rarefied according to the X-ray picture. With the cure of the neuritis the bones resumed their normal density. There is no true nerve degeneration in these cases, the condition being a perineuritis, or inflammation of the nerve sheath. In this respect it resembles sciatica. There is, however, an important point of distinction. Whereas in a severe sciatica the ankle jerk is, as a rule, lost, in these cases of brachial neuritis the tendon jerks in the arm are usually, but not always, increased. The irritative phenomena are clearly more marked than the destructive.

I have looked up records of my recent cases and find that, out of twenty cases, fifteen were women. The disease is rare before the age of thirty, and commoner after forty than before it.

It is most important when treating such cases to endeavour to find any septic focus that may be present, and to deal with this, the two most commonly associated conditions being constipation and pyorrhœa, but the nasal cavities and the tonsils should also be carefully examined as possible sources of infection.

HINTS ON EARLY VENEREAL DISEASES.

By W. J. JAGO, M.R.C.S., L.R.C.P.

MARS and Venus have always been closely associated, and this war has been no exception to the rule, with the unfortunate result that there has been a serious increase in the number of persons under treatment for venereal diseases. The enormous addition to the personnel of the Services has helped towards this by affording an opportunity for young men to live "the Service life" who would not have otherwise done so.

At present the question of venereal diseases is one that mainly concerns the medical departments of the Army and Navy; but once that glad day arrives when the "hostilities only" men are disbanded it will become one that concerns the civilian practitioner. In the past venereal diseases have been uncommon in most classes of medical practices, but later on, owing to the democratic nature of our present Services, this will be altered. This has led me to think that a brief article on the practical side of these diseases, gained from over twelve months' experience at both the "venereal lounge" at the Chatham Barracks and the venereal wards of the "Royal Sailors' Home," R.N. Hospital, Chatham, might be of service.

SYPHILIS.

There are certain etishes regarding syphilis that it would be as well to discard. A chancre may be proved to be syphilitic long before the time-honoured "six weeks since connection." Again, to wait until induration occurs in a sore may mean waste of valuable time in getting the patient under treatment, for all syphilitic chancres do not become indurated, at any rate, not to the "pearl button" extent. Chancres of the lip and in a long lax foreskin may be late in becoming indurated, whilst those in that very common situation, the coronal sulcus, may soon become stony-hard. The naked-eye appearances are perhaps the best means of diagnosing between syphilitic and non-syphilitic chancres; but this requires an experience of a fair number of cases.

We have a very useful means of early diagnosis in the examination of the serum from a sore for the *Spirochæta pallida*.

J. J—, stoker, after three months at sea, had coitus during his first night ashore. Three days later he reported at the sick bay with a small sore on the frœnum, in which, the following morning, the spirochætæ were found.

Any doubtful sore, no matter how small or how soon after coitus, should be looked upon as syphilitic until all reasonable doubt is over; and this requires three considerations:

(1) The sore should be examined once or twice for spirochætæ.

(2) About three weeks after infection the Wassermann reaction should be done, and if negative repeated twice or three times at weekly intervals.

(3) The patient should be overhauled periodically during the first three months for other syphilitic manifestations.

Both 1 and 2 are best carried out by a skilled pathologist; and considering the importance that the average patient attaches to a definite diagnosis of syphilis, there should be little trouble in inducing him to pay the necessary fees for these. There is one precaution needed for the success of the spirochæta test. If the sore has received no treatment, it should be covered with *plain lint soaked in saline solution*, but if antiseptics have been used, especially mercurials, these should be discontinued, and the saline applied (to allow the spirochætæ to develop, if present) for two or three days, until it can be examined by the pathologist.

A single positive Wassermann (in the absence of other signs of active syphilis) is of doubtful value, and you may subject your patient to a long course of treatment and mental anxiety unnecessarily if you rely on the Wassermann test alone. A negative which later becomes positive (which in syphilis usually occurs about the thirtieth day) is much more suggestive of active disease.

The later and more ordinary signs of syphilis are too well described in the special monographs to need mention in a brief article, but there are one or two points not usually mentioned. A sharp epistaxis frequently precedes the appearance of the rash by four to seven days, and this, combined with malaise and a slight rise of temperature, may suggest typhoid. A dusky mottling of the skin over the chest and abdomen can often be noticed for a week before the macular rash comes out, more especially if the patient is allowed to stand without his vest in the coldest part of the room. It is as well to be suspicious when a patient complains of a phimosis of recent origin, for I have several times during circumcision in such cases found a deep-seated induration that was more apparent to the scissors than to the touch. A bluish coloration of the edge of the prepuce should put you on your guard in this condition, as this is usually present in preputial chancres.

The introduction of neo-salvarsan and galyl has simplified the methods of treating syphilis, for being ready-prepared, they can be administered intravenously without any of the cumbrous apparatus required for salvarsan. Incidentally, it is of interest to English practitioners that the palm in syphilology is being wrested from the Germans by the recent discovery of intramine by Dr. J. E. H. McDonagh.* We still have to rely on mercury for the main part of our treatment, and this is preferably given intramuscularly. Attention to one or two little details makes the injection easier. The patient should be standing close to the desk or wall (he may want to jump forward if the needle is not very sharp), and told to arch the back and look up to the ceiling, in order to relax his muscles. Just before plunging in the needle, a few taps on the buttock with the disengaged hand will tell if the muscles are fully relaxed, and disguise the actual moment of inserting the needle.

The routine carried out at Chatham is twelve mercurial (1 gr. in 5 ♏) injections, with further injections of galyl (·4 grm.) before the 1st, 5th, and 9th.

Gonorrhœa.

The treatment of gonorrhœa recalls the nursemaid's dictum regarding the child's pimple, "It won't get well while you pick it"; and undoubtedly a large number of chronic cases are due to injudicious, if well-meant, methods. It is well known amongst the older naval surgeons and in the merchant service that a large percentage of discharges will cease altogether if left alone; but how many of these cases are responsible for strictures at forty it is hard to tell. Nor did the discovery that the silver-salts kill the gonococcus give us a rapid means of curing the disease, for, if personal experience counts for anything, they are of most service as a *final* application in those cases where the discharge is sluggish in responding to other and less expensive drugs.

The *vis-a-tergo* method with various balsams is becoming out of date, except, perhaps, with the "prescribing chemist." Gin, the treatment once in vogue amongst naval officers, is perhaps more rational owing to its diuretic properties. Utropine is sometimes a useful adjunct, but a long course of this causes dyspepsia or sometimes albuminuria.

The simplest method for general use is urethral irrigation, carried out by the patient himself. Where a large number of persons are under treatment a douche can and Marioche's tube may be used, but with single patients a 4-drachm glass syringe with a tapering nozzle is quite satisfactory. If there is much scalding during the first few days local treatment is withheld. At first pot. permang. (1 : 4000) is used three times a day until the discharge has passed the "creamy" stage and become "milky" in consistency, which is usually about the eighth to tenth day. After this zinc sulpho-carbolate (2 gr. to the ounce) is used until there has been only "a morning drop" for three or four days. If after three weeks there is still a slight discharge or a morning drop for several mornings a 5 per

* *Practitioner*, December, 1915.

cent. solution of protargol usually clears this up. Zinc permanganate can be used in place of the potassium salt.

It is best to warn patients against using solutions, with the mistaken idea of hastening the cure, stronger than those prescribed. Treatment with the isotonic and exosmotic solutions advocated for other mucous membranes has not proved as satisfactory as the above drugs, though patients say they are more soothing. The average time taken for the discharge to cease completely in uncomplicated cases under my charge has been eighteen to twenty-three days.

Although cessation of the discharge for ten clear days is counted sufficient in the Navy as a "cure," it does not necessitate that the urine is free from threads. The electrolosis treatment brought out by Dr. C. Russ at the London Lock Hospital has the advantage of not only clearing up the discharge in three weeks, but the threads as well, thus bringing about a perfect cure. Unfortunately, the special apparatus and the time required for each application (twenty-five minutes) rather precludes its being used in general practice.

A persisting morning drop may be due to a small ulcer just inside the meatus which ung. hyd. ammon. will heal, though it is as well to bear in mind in these cases the possibility of an intra-urethral chancre.

Whilst "complications" scarcely come within the scope of a short article, there is one point worth mentioning, and that is that on the occurrence of a complication there is a slackening, or even a total cessation, of the discharge, only to reappear as the secondary condition improves. The absence of a discharge (or the patient's denial) at the first attendance in a case of epididymitis or acute (especially non-articular) arthritis does not necessarily mean that the case is not gonorrhœal in origin.

The warts which sometimes occur with gonorrhœa (though some are non-venereal) can best be removed by touching with fuming nitric acid. Circumcision is not always satisfactory in this condition, as the wart may occur in the scar.

CHANCROIDS.

Before starting the local treatment of a chancroid it should be examined for the presence of the *Spirochætæ pallida*. After that, three times a day it should be well dried and then touched with a solution of camphor and phenol (which liquify when ground together). There is a slight stinging at first, but this is stopped by the anæsthetic action of the phenol. At the end of three or four days ordinary boric fomentations usually suffice to remove the sloughing base.

Should a bubo occur after a chancroid it should be treated by rest and evaporating lotions, in the hope that it will subside. If, later, it shows signs of softening, fomentations should be used until the skin over the softened area has become adherent to the gland, and then only a tiny incision must be made. Neglect of these precautions, or an attempt at more drastic operative measures, may result in producing a very indolent ulcer, Ulcus molle serpiginosus, which may take months or years to heal. In connection with this point it should be remembered that a bubo may not develop until some time after the sore has healed, so before incising or removing a gland in the groin it is as well to inquire for a history of a recent soft sore.

ELEMENTARY PSYCHO-THERAPY.

A paper read before the Medical Society of the Connaught Hospital, Aldershot.

By ADOLPHE ABRAHAMS, M.D., M.R.C.P.,
Temporary Captain, R.A.M.C.

(*Continued from p.* 63.)

Neurasthenia is a term used to cover a large field of neuropathy. It is too big an undertaking even to attempt to define the condition properly. Suffice it to say that the neurasthenic is, in a word, simply an over-sentimental person who takes things too much to heart and cannot get outside his own personality. As a matter of fact only those who have a neurasthenic constitution really accomplish anything great in life.

Distinguish at once the *psychasthenic*. He is a weakling and fundamentally unsound—his condition is the neurasthenia of the degenerate, and the prognosis in his case is far worse. The neurasthenic, on the other hand, is often regarded as the product of auto-intoxication or of overwork. But overwork never gave anybody neurasthenia. People who are overworked are always potential neurasthenics, rushing themselves to death often for no reason and without aim or object. Overwork and fatigue are no more a cause of neurasthenia than of sepsis or tuberculosis. They create a condition which predisposes to the one no less and no more than to the others.

I have described the neurasthenic as over-sentimental; a more technical description is one with a lowered threshold of consciousness. It is easy to see how neurasthenia may be encouraged by a system of therapy which fixes the patient's attention on the part affected and thereby renders him susceptible of feebler and feebler stimuli, in other words still further lowers his threshold of consciousness. So that removal of an appendix on a mistaken diagnosis of appendix dyspepsia in a neuropath not merely does no good, but does positive harm.

Whilst the neurasthenic recognises the absurdity of his fears and is able to dispel them, although he requires constantly to reassure himself of their erroneous character, the *hypochondriac* on the contrary regards the subjects of his fears as actual conditions, and nothing can convince him to the contrary. He is, of course, incurable.

Hysteria is a still more complicated condition, even more difficult to define. It belongs to the same family as neurasthenia with a different development. To quote another popular error, the hysteric is regarded as a person who imagines herself ill for the fun of the thing. Unlike neurasthenia hysteria is not a popular disease. It is a disease of pose, not of suggestibility. The hysteric must be the centre of interest and she will be satisfied to manufacture for a circle of medical men a host of symptoms of which consciously she is quite unaware. It is what Janet terms a disease of dissociation. The hysteric always has germs of dual personality, she witnesses the performance of her *alter ego*. The hysterical paraplegic has forgotten that she has limbs or, if you will, has lost the mental representation corresponding to the limbs. And whilst the neurasthenic is restless and pre-occupied, and worries about his symptoms, nothing of the sort is observed in the hysteric, who would be quite indifferent were she quadriplegic.

It becomes fairly obvious upon reflection that the only difference between pure hysteria and malingering is probably a matter of the degree to which the wilfulness to be blind, deaf, or paralysed is buried in the depths or flourishes on the surface of consciousness. And it must be candidly admitted that it is frequently a matter for the judgment of the physician, whose verdict is only too often biassed by his personal feeling towards the patient.

Treatment

When one consults text-books on psycho-therapy for detailed instructions of the actual treatment disappointment is inevitable. The tendency of the reader is to expect an insight into the method of special reasoning which the psycho-therapist has at his disposal and the secret phraseology of remarkable persuasiveness which he employs. Instead he meets with a sort of Barmecidal feast—a windy banquet of interdictions and generalisations—which leaves him with the impression that trade secrets are being deliberately withheld. Such a charge is, of course, unjustified. No writer could possibly enter into details of treatment, so infinite is the range of psychological possibilities; but, what is even more to the point, I do not think that any psycho-therapist knows exactly what he does do. In all therapy the personal element plays the largest part, the psychic side is developed to a far greater extent in some people than in others, and success is determined by the confidence the physician can inspire, an achievement which is generally brought about by simply getting completely *en rapport* with the patient's sentiments and saying things which from another person's lips may be absolutely unconvincing. To deal with simple generalisations one may say that the average conception of psycho-therapy is embodied in the word *suggestion*, which should, however, be reserved for a special form of treatment, and for that only. But in average phraseology suggestion and psycho-therapy are synonymous. Using suggestion in that perverted sense it is interesting to glance briefly at its influence in every form of therapy, orthodox and heterodox. For Christian Science is suggestion plus absurdity; magnetic healing, suggestion plus imagination; Divine healing, suggestion plus faith in God; Dowiesm, suggestion plus prayer and fear of Hell fire.

Osteopathy is suggestion plus massage. The allopaths will tell you that homœopathy is suggestion plus drops of nothing, the homœopath retorts by regarding allopathy as suggestion plus gallons of useless drugs.

Rational medicine, we may finally add, is suggestion plus commonsense.

But to describe the various forms of psycho-therapy exactly we must accept: (1) Persuasion; (2) suggestion; (3) re-education; (4) psycho-analysis.

Persuasion is the best form of treatment of all, since it implies the introduction into the patient's conciousness of new ideas or the destruction of morbid existing ideas *with the patient's full consent and understanding*. Obviously it demands the intelligent patient who is prepared to accept logically your demonstration of the inconsistency and improbability of his complaints. It is a method which yields very permanent results, especially in the case when the consciousness can be gradually trained to lift the threshold above the level of stimulation, and so gradually to become indifferent to previous sufferings. Some of you have seen several cases of men here who had become confirmed in their idea of the existence of heart disease through being kept in bed for several weeks. They complain of præcordial pain, and protest their inability to walk ten yards without distress. You have seen them persuaded gradually in the course of a morning to extend their exertion until they were doubling three hundred yards as well as any average person.

Suggestion, employing that term exactly, means the introduction of a new idea *without the patient's consent*. For this reason it is by certain schools belittled and even deprecated. It is, of course, closely bound up with *hypnosis*, but it may be just as well to emphasise once and for all that hypnosis by itself never cured anybody of anything. A great deal of rubbish is talked about hypnosis, a popular idea being the making of a few passes and a complete and permanent relief of the patient from all suffering. Hypnosis is merely the production of a state in which a person is susceptible to the influence of suggestion, and it has to be adopted to break down resistances and permit the force of suggestion to enter the consciousness. We may, in fact, regard the relation of hypnosis to suggestion as that of chloroform to surgery.

The third therapeutic method is that of *re-education*. It is the one which is the easiest for what we may call the amateur to apply. It is *par excellence* the treatment of hysterical patients who have to learn control over their mental machinery. Some of you have seen the five and

twenty "gassed" patients who have been admitted here at various intervals during the past few months. All exhibited dyspnœa in varying degrees of distress. All were "cured" in from five minutes to three hours simply by re-educating their system of respiration.

What the onlooker mainly sees of psycho-therapy are its adjuvants important enough, but still only adjuvants—rest, over-feeding, isolation. The latter is of overwhelming importance. It suppresses all external causes for emotion by concentrating the patient's psychism. In itself it has elements of conviction, and it exercises constraint and encourages the patient to throw off his symptoms by auto-suggestion. For bad cases, isolation is an imperative necessity.

Naturally, the moment one has the slightest suspicion that a neuropath is being encountered, questions are put to ascertain any possible relation between the symptom complained of and any disturbing event in his moral or emotional life. A certain amount of advantage is gained by treating symptomatically, so to speak, even when psycho-therapy is in question. But the real root of the mischief is what one should aim at ascertaining; the psycho-therapist does not, for example, refer gastric symptoms to some primitive disturbance of the solar plexus or gastric innervation, it is necessary to go back to the generating psychic cause.

(4) Which brings me finally to *psycho-analysis*. When the underlying cause cannot be ascertained the neuropath may fail to make any progress. Attempts may then be made to bring the skeleton in the cupboard to light by one or other of the elaborate systems of word association or of psycho-analysis. The former, which is particularly favoured by Prof. Jung, of Zurich, is simple and is even utilised as a preliminary to the more spectacular psycho-analysis, of which much has been heard during the last few years.

It is manifestly ludicrous to try to describe this complicated process in a few words at the end of a short paper, especially when one knows very little of the subject. My attempt will therefore be, indeed, a formal introduction to those who know even less than I. The essential feature of this method is that the pathological condition to be dealt with is due to the relegation of certain mental complexes to the unconscious by the mechanism of repression. We do not put things, as we say, "out of mind," but psychologically considered we put them "into the mind." Psycho-analysis consists in the exhumation of such mental complexes by the interpretation of dreams; it drags, as it were, from the memory a buried sorrow and once brought to light, some long-held delusion is eradicated and the balance of the mind restored. In other words, investigation and treatment are synonymous, and, of course, simultaneous. The sin confessed is forgiven.

We are to conceive of dreams as our safety-valve, permitting the escape of our memories, which are packed away under pressure like steam in a boiler. Bergsen's idea is that nothing in our lives is ever forgotten; every thought, emotion, sensation of our past life to the tiniest detail he believes to survive indestructibly.

According to Freud every dream is a wish fulfilment, the wish being repressed in waking life but fulfilled in dream life. He analyses the dream into the manifest and the latent content. The two are identical in a child, whose dream plainly represents the imaginary fulfilment of an ungratified wish. In the adult the manifest content is the dream as you relate it, the latent content is the real factor, the true meaning, the unfulfilled wish, which, in the dream assumes a disguised form, and has to be interpreted.

To continue Freud's hypothesis, the reason why these thoughts are repressed in our waking life is that they do not penetrate to the consciousness, but are suppressed by what he calls the censor of consciousness. During sleep the activity of the censor is relaxed and now the repressed memories have their chance. But the censor sleeps with one eye open, so to speak, and, although they pass, they can do so only if disguised, that is, unrecognisable. Such a disguise may take all sorts of forms, and there is no limit to the ingenuity with which the psycho-analyst unravels the manifest content and translates it into the latent content. Further, according to Freud, no neurosis is possible with a normal sexual life, and practically all unfulfilled wishes are, in his conception, predominantly sexual. In this connection it must be pointed out that Freud has been at some pains to reply to his critics that he uses the term sexual in a very wide sense, embracing much of the emotional life of the individual.

To those who follow him, Freud is regarded, as Dr. Ormerod puts it, as a sort of Moses who points the way to the promised land. There are rebellious physicians who say with Korah and his company "We will not come up." For it is by no means a small objection that the things which come into the patient's mind during his psycho-analysis are by no means representative of his real thoughts in his past life, which thoughts may, in the meantime, have become obscured and modified out of all recognition. Further, the influence of the examining physician in directing the trend of the patient's thoughts is considerable. Freud himself admits that in the symbolic interpretation of dreams the key to the symbol is arbitrarily chosen by the operator. Which seems to say that the operator establishes some conclusion and then sets to work to elaborate data to support it.

You must not condemn a thing simply because it is open to abuse and may fall into the hands of the ill-trained and unscrupulous. But this process of mental vivisection which, as I have suggested, is by many authorities regarded as inaccurate, is by others regarded as positively dangerous. Above all, it is distinctly nasty. The unconscious mind, according to Freud, is one great heap of sexuality unfulfilled or perverted. Psycho-analysis drags into the light of day the soiled clothes of the subconscious mind. Most of us

would never know that we had a subconscious mind unless we dragged it to the surface as the Freudians do in order to regard it as the real us. For the purer the conscious mind the more apparently we repress. Sometimes, of course, the soiled linen becomes so dirty that it calls aloud to be brought out and washed. But in the majority of cases, as a clever writer has put it, the advice of the frog door-keeper to *Alice in Wonderland* is quite sound enough, "You let it alone and it'll let you alone!"

EXTRACTS FROM A LETTER FROM MISS SIMPKIN, LATE SISTER HOPE.

Kota Kota,
Nyasaland;
January 9th, 1916.

"IT is some time since I received your nice long letter, which I was very pleased to have. Dr. Tooth would be horrified every day if he knew the things I have to do alone. I often wonder how I dare, but when it seems to be a question of losing a limb, or life and death, one does one's best. So far nothing dreadful has happened, I am thankful to say. I have had to give chloroform and do the operation myself five times in the year. I am terrified at the anæsthetic.

"I had a strenuous time in the late autumn. The Priest-in-Charge had enteric fever, and that meant night and day for six weeks. Again, I was very thankful for Dr. Tooth's teaching.

"When the patient was rather bad we had a message to say our layman, who was building a church forty-four miles away, was very ill with 'blackwater.' I was all there between them!

"I sent off a machila and team and my head dawa boy to fetch the other patient and started at 5 a.m. myself the next day to meet him half way, or go on to him if they had not dared to move him. The Resident Magistrate here, the only European besides ourselves, lent me his mono-wheel bath car. I got to the village agreed on as a meeting-place at 11 a.m., and the patient was brought in terribly exhausted soon after 11.30. I put him to bed in a tent and did what I could for him. It was very hot (104° F. in the shade), so we waited until 4 p.m., and then started back on our seven hours' trek. The night was very dark, and we were five hours passing through the forest. It was a strange experience. I dared not let the carriers make their usual noise because of the patient. There were forest fires here and there. Sometimes the carriers got frightened (there were thirty of them). I could tell when they did, and they required some managing. However, we saw no wild beasts. I was thankful when the patient was safely in bed at the Hospital. We got our doctor a few days later, and the second case soon got well. When the other patient was convalescent I took him up to Dowa to recruit. He stayed with the Resident and his wife there, right up in the hills. They are delightful people, and have a lovely garden with all sorts of English flowers. It was a five days' journey, and I stayed there three days and a half and came back here alone."

ABERNETHIAN SOCIETY.

OFFICERS FOR 1916.

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1. Mr. W. Simpson.	Mr. White Cooper.	Mr. Maingot.
2. Mr. R. H. Maingot.	Mr. Pracy.	Mr. Green.

The above officers were elected unopposed.

CORRESPONDENCE.

SOME MORE NOTES OF '72.

To the Editor of the 'St. Bartholomew's Hospital Journal.'

Sir,—I hope your readers will not be tired of them; but I am anxious to add a few words to Mr. Dunn's article, and mainly because I wish to give a totally different account of Skey's last appearance to that given by Mr. Dunn. His account, I feel sure, must have given pain to many an old Bart.'s man. That an old member of the staff, the Senior Consulting Surgeon, one of the glories and traditions of the Hospital, should have come down, in his old age, to once more visit the Hospital which he loved, to once more address a class in the old theatre wherein so many of his work-a-day hours had been passed, and where he had always been listened to with respect, should be refused a hearing by a pack of rowdy young cads, and should have been practically driven out by them, is altogether too sad a story to be passed over. If it were true, it would have left a stain on the dear old school which even forty-and-four years would not have entirely effaced.

That rowdyism and interrupting at lecture always appeared to me a low-down, caddish kind of trick, which, I hope, is as dead as the Dodo and Bob Sawyer.

Now, please, for the correct version, and I remember the facts distinctly. In the first place, Skey was not billed to give "a lecture." It was a series of four lectures, and I was at the first three. I can remember his opening to-day as well as if I had heard it last week. "Gentlemen, can anyone here tell me what's the use of tincture of iodine? because I don't know. But this I do know, that every swelling, of every nature, is, at some period or other of its growth, painted with tincture of iodine." This was rather a promising beginning, and led one to hope for much originality as he passed on to consider the early stages of different "swellings." But it must be confessed that he was a "light of other days"; and he soon became discursive and wandering, and failed to hold the men's attention. Still, I am happy to say, I do *not* remember the disgraceful scene described by Mr. Dunn. In another lecture he told us how the steward of the Hospital appealed to him concerning the stimulants bill. I dare say it was three or four times what it is now. "Yes," said Skey, "it is a disgraceful amount. I will do my best to double it." And his tale of being called in consultation in a case of carbuncle, and his suggestion for treatment: "Give him a bottle of port every day; and if he does not drink a whole bottle of brandy

during the day, he'll die during the night." And the patient recovered. Which proved the soundness of his views!

But on the afternoon of his fourth lecture there were only four men in the theatre. Skey came in, looked round, and said: "I never have lectured to four men, and I'll be damned if I ever do." And he turned round and walked out of the theatre.

That was sad and pathetic enough, but it was not so utterly beastly as the scene depicted by Mr. Dunn would have been.

I suppose "Richard," who used to mark the men's attendance at lectures, must long ago have gone over to the vast and silent majority; but if not, it is an incident which must have graven itself on his memory.

Those were the only times I ever saw Skey. But from all accounts he was the last man in the world who would have put up with rude interruption. He would have turned on the men like a tiger.

Skey had the reputation of being a very good hater; and the legend was that he and Savory were, at best, in a condition of armed neutrality, with quite a readiness on either side to lay aside the neutrality and take up the arms. The tale goes that, soon after being appointed full surgeon, Savory had a lithotomy. The usual artistic pass was made. The outer wound enlarged in the withdrawal. Then in went the finger. All according to regulation. But nothing further happened. Savory got crimson. At last he turned to Holden. Holden examined. "I don't think you are in the bladder, Mr. Savory." "I'll take my oath I am in the bladder." Skey was sitting on the front seat. He was Consulting Surgeon to the Hospital. Savory perforce turned to him. "See what you think, Mr. Skey." Skey turned up a cuff, inserted a finger, rolled it round, and with a smile which was almost a snarl, solemnly pronounced his diagnosis: "Deep incised wound in the perineal region; not entering the bladder; probably the rectum—and God knows where!" If the tale is not *vero*, it is at all events *ben trovato!*

One other member of the ancient surgical staff I remember seeing, and that was connected with rather an amusing incident. We were going round with Holden one day, when we were joined by a bluff old country squire. Holden shook hands, and went on with his clinical remarks. The old countryman walked round with us for some time. Then he again gave his hand to Holden, saying, "Well, good-bye." When he had gone Blank, a very affected, long-frock-coat-and-tall-hat-man, had the impudence to say, in the hearing of us all, "I hope that gentleman was not a member of our profession, Mr. Holden?" Holden halted, looked very straight at the man, and very quietly, but equally in the hearing of us all, said: "That was Mr. Wormald." I hide his name as "Blank." He got over his youthful affectations, and became a really great surgeon and an honour to Bart.'s. But if he reads this, I would lay pretty long odds that he still remembers it.

It is very interesting to read Mr. Dunn's paper, and recall many happy days at dear old Bart.'s. We must have been there together, and attended the same lectures, but I can't for the life of me remember him, and I dare say he has no recollection of me. I also was at Lauder Brunton's first lecture. At the foot of the stairs, when we came out of the old medical theatre, I turned to Sam Greensill and said: "That man will be a baronet, and President of the College of Physicians." I fancy I must have been rather good at the prophecy business! I remember soon after Bastian's book *On the Beginnings of Life* appeared, a lot of us were arguing the matter with all the glorious cocksureness of youth, and my saying: "I believe in time nearly every disease will be found to be fungoid in origin. That each spore will produce its own disease, just as each spore produces its own mushroom." But another man, I can't remember who, countered heavily; he said: "Look here, four men escape in a boat from a wreck. They suffer cold, privation, hardship. They are rescued. One man has pneumonia; one has rheumatic fever; one has iritis; and the other, after being nursed up a bit, has nothing at all. Now, do you imagine that your spores were hanging about on the surface of the sea waiting to attack separate individuals?" Well, I had no satisfactory answer in readiness. But, after all, my groping for the truth was not so very far from grasping it. (For goodness sake forgive me, Mr. Editor. I am painfully aware how much of the first person singular there is in all this; how many sentences begin with I. But, after all, it is difficult to avoid it when your are writing personal reminiscences.)

Before, at, and after that time, there was a desperate band of criminals, as we were taught to regard them, who bore aloft a banner with a strange device—*similia similibus curantur*. They even taught that tuberculous sputum from a phthisical patient could be made first a "trituration," then an "attenuation," and administered as a remedy in tubercular disease. Various other strange beliefs they had, which brought upon them the scorn and anger of the profession. I never heard that any of them were executed; but great efforts were made to exclude them from the *Medical Directory*, and to visit pains and penalties upon them, until all the rest of us took to their views and began squirting preparations of "attenuated" tubercle, and all sorts of other things, into the connective tissue. And now, when a homœopath hears of an allopath filling up the connective tissue of his patients with autogenous cultures and such like, he slightly depresses his left eyelid, and has a faint twitching of the angles of the mouth. And the irony of the thing is that these injections appear to cure patients. So that the heresy for which men are bound to the stake in one generation, becomes the orthodoxy of the next. I myself was in practice long enough to be asked to administer a course of serum subcutaneously to a very charming lady, who had one, barely discernible, spot of acne on her fair forehead. It seemed to me rather like calling out the fire brigade—captain, silver helmet and all, with a powerful engine—to put out a cigarette. However, I got out of doing it, and I don't think the patient suffered.

This is a wandering, discursive sort of scribble. Suppose we get back to Bart.'s! When I joined, the surgeons were Paget, Coote, Holden, and Savory. Paget, of course, was the pride of the Hospital and the object of our young idolatry. Did ever any man go up those stairs at the pace Paget did? He would turn in at our wing; scoot up to the third storey; and leave a tail behind him, after the fashion of Pretty Polly and the Tetrarch. I came on to dress for Paget just as his illness kept him away. Callender took over his wards, and Paget never returned to them, for he resigned after his illness. I was with him in the post-mortem room when he was examining the case to which he attributed his infection. I forget what the case was originally, but the pleura was full of pus. I was also in the theatre when Millais sat opposite him and had his sitting for the well-known portrait.

Not very long after Coote died; and that brought Callender and Tom Smith on full surgeons.

I remember my very first case as dresser for Callender. It was a remarkable one. A tailor, with the lappet of his coat full of needles, was engaged in political discussion in a public. In the heat of debate he was forced against the pewter-covered top of the bar and felt a wound. One of his needles had been driven in. Its end could be felt under the skin. Callender cut down upon it; and when he had cleared the intercostal space there was the head of the needle swinging round in a short ellipse. The point was firmly embedded in the heart. Callender took hold of the projecting head with forceps and withdrew it, and there was an end of the matter. No symptoms of any sort ensued. I imagine the point was fixed firmly in the interventricular septum.

Holmes Coote was a good-natured, kindly old gentleman who somehow was not in the picture with Paget, Holden, and Savory, who *looked* as distinguished as *they were*. He had a habit of smudging his forehead with his fingers. By the end of an operation his appearance was somewhat fearsome and decidedly of the "twopence coloured" variety.

Holden was a favourite with everybody. It would be sheer hypocrisy to say the same of Savory; but he was always very kind to me, and it would ill become me to say a word against him. He was by no means ready to accept Lister's theories. I remember Stoney getting leave to try the carbolic acid putty (strange that the current ST. BARTHOLOMEW'S HOSPITAL JOURNAL should contain the announcement of his death). After a day or two Savory did not like the appearance of the wound, and it was "Now, Stoney, we'll put on a poultice!"

But oh! what lecturers Paget and Savory were! It was an intellectual treat to listen to them. Men who have heard both said that Paget was as great an orator as Gladstone. Never once, in many hundreds of hours, did I ever hear either of them pause or falter for a word. Savory, as Dunn says, might be contemptuous of the legitimate claims of the "h"—"A man comes into 'orspital, and 'is arm 'angs down"—but his language was superb.

The "move up," before alluded to, brought Tom Smith into the lecture theatre. I heard his first lecture. Very few Bart.'s men will find it possible to connect Tom Smith and nervousness in their thoughts. And he showed no trace of it in beginning. Rather he showed that he was worthy to lecture where Paget and Savory had lectured before him. But when Richard came in to mark, it upset him directly, and he was lost and floundering. Turning, he said, "Richard, would you mind going out?" When Richard had gone he was as calm and collected as ever, and the "marking" never troubled him after that first appearance.

I remember going round with Tom Smith soon after he succeeded

to his wards. He was giving his clinical instruction, and paused to take down the bed card and fold back the paper pinned to it, to refer to a note, when he stopped altogether, smiled, and read out to us:

"Of all the ills to which man's heir,
There's none what's any sadder,
And none what is so bad to bear,
As pains about the bladder."

The patient was a poet, you see!

Morant Baker lectured on physiology. He was taking a class of a lot of us going up for first college one day, when he asked one man: "If I cut through half the spinal cord, above the decussation of the fibres, what would the result be?" The answer came: "Hemiplegia on the opposite side." "Yes; and if I continued the cut, and divided the other side also?" Answer: "Hemiplegia on both sides"—a slight pause—"complete plegia"! "Complete plegia" was a joke for some time. But the man who coined it was a surprise to us all; for he not only passed "first college," but in time became F.R.C.S., and, I believe, a brilliant surgeon. I fancy his little difficulties may have been due to language, though it was very difficult to detect it. He was a foreigner, and knew the speciality of every restaurant in Soho; and was popularly supposed to be acquainted with every nihilist in London. And I am not at all sure that the belief was entirely void of foundation.

This rather reminds me of a tale Marsh told me once of one of our men who was up at the College. He was shown thickish, coppery-looking eruption, and asked about it—giving very satisfactory answers till the last: "Yes, and how would you treat it?" "Oh, I would put him on a mild course of mercury." "Yes; what would you give him?" "Oh! I would give him ten grains of calomel, three times a day."

At all events he had the courage of his opinions. Whether he would have retained a private patient treated on those lines is another matter.

Langton and Marsh were Demonstrators and were very popular with the students. At the "move up" they succeeded to the out-patient room, and were succeeded by Cumberbatch and Doran.

On the medical side the physicians were Black, Harris, Andrew, and Southey. After all these years it is difficult for me to write in any restrained terms of dear old Black. I clerked for him. I was brought in contact with him day by day. And I learnt to appreciate the gentleness and nobility of the man's nature. So many members of the staff not only showed me many kindnesses, but also honoured me with their friendship, that I naturally had a warm regard for them all. But of all I think that none other ever filled quite the same place in my affection as Black. Norman Moore and Vincent Dormer Harris were fellow clerks with me. The latter, it so happened, I saw nothing more of after the period of our clerkship. Of Norman Moore it is pleasant to think that Black's wards saw the beginning of a life-long friendship—though we have not seen each other for years. The last time I saw him I dined with him at the Reform Club. John Bright was dining at the next table. I carefully concealed the fact that I was an unregenerate old Tory. Otherwise, I might perhaps have been led out into Pall Mall and burnt at the stake.

I remember being well chaffed for literally taking down a patient's statement in my "clerk" notes. "States that he has always been a strictly moderate man in the use of intoxicants; only taking about nine glasses of spirits in the course of the morning." But he was a meat salesman, and his morning began early; afterwards I dare say he had a rest.

Harris, I fancy, few of us knew much of. He was supposed to be wealthy, and to live mainly in the country, and to have some very good shooting.

Black and Andrew lectured on medicine, Southey on jurisprudence. Black, I must confess, was not an inspiriting lecturer. It seemed as if all diseases ended in "coma and death," and the treatment of most of them was "A.AcC."

Church was Senior Assistant Physician. I was a pretty regular attendant in his out-patient room. He was a good teacher, and was always ready to teach those who wanted to learn.

I remember several of the students mentioned by Dunn. Darbishire and Grace had places close by me in the chemical laboratory; but I only knew them very slightly. Grace was very often absent, and must have continued to be so, as it was long ere he qualified. Darbishire did not impress me as the "slim" man described by Dunn. I should rather have described him as a powerfully built man, with great development of the shoulder muscles. The boat club in those days was at Biffins', by Hammersmith Bridge. Is it still? I used to go down in the evenings and row in the eight and in scratch fours.

There was a man who used to sit bang in the middle of the anatomical theatre in a salmon-coloured frock coat. About the most *prononcé*-looking garment I ever saw off the stage.

There were two black students. One, Davis, was a fine, intelligent-looking fellow. He went out to Paris, with an ambulance, in the siege winter; caught small-pox, and died there. He had a glorious epitaph—just one line in the "*Daily News* War Correspondence"—"He was known to all the sufferers in the neighbourhood as 'Le bon docteur noir.'" Not one of us could desire anything better. He must have been older than we were, for he was qualified in the siege winter, '70-'71—in fact, I think M.D.

The other "gentleman of colour" was an altogether inferior specimen to Davis—of a lower negroid type. He always spoke of Davis as "that damned nigger Davis." I never heard what became of him.

Another old master of mine—also an old Bart.'s man—Hussey of Oxford—once gave me a book he had written, *Miscellanea Medica-Chirurgica*, with the words, "There is not one sentence in the book, sir, which begins with 'I.'" How he would have criticised this effort of mine! But now farewell. Bart.'s was always dear to me. But at length there came the day when I walked into the square and did not see one face that I knew. And not one man that I met knew me. I walked out with a quivering lip, and I have never been there since. May all Bart.'s men of the present generation have the same loving reverence for their old school that I have.

Harry Lupton.

P.S.—I wonder if any Bart.'s man since my time has ridden on horseback right through the City? I once got upon a horse at Keston, the other side of Bromley, and rode right into town by the Old Kent Road, London Bridge, Cheapside, and so on. I have no other title to fame, so I will pin my claim on this: "He was the last Bart.'s man who rode on horseback through the City of London." And my very postscript begins with "I."—H. L.

REVIEWS.

Materia Medica. By W. Hale White. (J. & A. Churchill.) Pp. 712. Fourteenth edition. Price 6*s.* 6*d.* net.

This work is so well known as a standard text-book amongst medical students that it needs but little comment from us. The new edition is, of course, necessitated by the great alterations to be found in the new British Pharmacopœia. These alterations are well known by now, and it would be out of place to reiterate them in connection with this volume, which of course includes all the alterations, and, like most other new editions on this subject, gives all the doses in both the imperial and metric systems.

The text of the book does not seem to differ materially from the previous edition, but we may point out that it is nevertheless right up to date, and many of the descriptions of the actions of drugs are more complete than in some of the more pretentious works on the subject. Particularly is this the case in many of the important alkaloids and glucosides, such as cocaine and digitalis. Every student should possess a copy of this book.

Manual of Surgical Anatomy. By L. Beesly and T. B. Johnston. (Henry Frowde, Hodder & Stoughton.) Pp. 557. 164 illustrations. 12*s.* 6*d.* net.

In many respects this is an excellent little work, concise and well written. We are sorry to see that the Basle Terminology has, however, been adopted throughout. Examiners, as a whole, wisely have nothing to do with this terminology, which has not been officially adopted in England, and which *will not be adopted*, for an Anglo-American Commission is—at a later date—to revise the terminology. Why authors insist on trying to foist this on the student we do not know, but we *do* know that a large manual of anatomy which has been left in the old official terminology has been through two impressions in the course of about eighteen months.

In this work the official nomenclature is placed in brackets after the innovation, while the index contains both nomenclatures with cross references. It is a cumbersome method, though, perhaps, a saving grace. Apart from this both the arrangement of the matter and of the illustrations is excellent.

EXAMINATIONS, ETC.

UNIVERSITY OF OXFORD.

In the congregation held at Oxford on January 27th, 1916, the following degrees were conferred:
M.B., B.Ch.—M. R. Lawrence.

UNIVERSITY OF CAMBRIDGE.

The following degrees were conferred:
February 4th.—M.D.: A. J. S. Fuller.
February 12th.—M.D.: S. Gurney-Dixon.
February 25th.—M.B., B.C.: E. J. Y. Brash.

CONJOINT BOARD.

Final Examination. January, 1916.

The following candidates have completed the examination for the diplomas of M.R.C.S. and L.R.C.P., and have been recommended for diplomas:
J. Andrew, A. O. Courtis, D. Crellin, H. E. Griffiths, A. E. Hamlin, G. E. Heath, C. E. Kindersley, R. H. Maingot, D. S. Pracy, M. K. Robertson, H. G. E. Williams.

D.P.H.

At a meeting of the Royal College of Physicians, held January 27th, 1916, the Diploma of Public Health was granted, jointly with the Royal College of Surgeons, to:
R. D. Dalal, L.M. & S.(Bombay), M.R.C.S., L.R.C.P.; P. Hamill, M.D.(Cantab.), M.R.C.P.

APPOINTMENTS.

BULL, G. V., M.B., B.C.(Cantab.), appointed Certifying Surgeon under the Factory and Workshop Acts for the Hoddesden District of the County of Hertford.
HEBBLETHWAITE, S. M., M.D.(Lond.), M.R.C.P., appointed Honorary Physician to the Cheltenham General Hospital.
HENDLEY, Col. H., M.D.(Durh.), D.P.H.(Cantab.), I.M.S., appointed Honorary Surgeon to the King.
LEBLANC, L. G., M.R.C.S., L.R.C.P., appointed Assistant Medical Officer of the Westminster Union Infirmary.
MACFADYEN, N., M.B.(Lond.), D.P.H., appointed Certifying Surgeon under the Factory and Workshop Acts for the Baldock District of the County of Hertford.
SALMON, A. G., M.D.(Lond.), M.R.C.S., L.R.C.P., appointed Temporary M.O. for the Workhouse and No. 2 District, by the Bodmin (Cornwall) Board of Guardians.
WILLOUGHBY, W. M., M.D., D.P.H.(Cantab.), appointed M.O. of Health for the Port of London.

Dr. E. G. KLUMPP has changed his name by deed poll to ERNEST GEORGE KAYE.

NEW ADDRESSES.

BOWEN, J. W., 94, Park Lane, Croydon.
BOWEN, O. H., 94, Park Lane, Croydon.
DRAPER, T. M., The Limes, Rickmansworth, Herts.
GIRVIN, Col. J., A.M.S., D.D.M.S., 9th Army Corps, M.E.F.
HAY, K. R., 18, Savile Row, W. Tel. Regent 594.
HUGHES, G. S., 39th Casualty Clearance Station, B.E.F.
MCLEAN, W. W., Board of Trade, Canning Place, Liverpool.
MOLL, J. M., 9, Anstey's Buildings, Kerk Street, Johannesburg.
RICHARDS, Maj. W. G., I.M.S. (retired), Grove Lodge, Burgess Hill, Sussex.
SODEN, W. N., 15th Welsh Field Ambulance, B.E.F.
TURTON, J. R. H., R.N. Hospital Ship "Berbrie," No. 18, c/o G.P.O., E.C.
WILLIAMSON, J., The Rhallt, Epsom.
WINTER, Lt.-Col. H. E., R.A.M.C., A.D.M.S., Presidency Brigade, Calcutta.

BIRTHS.

ADAMS.—On December 17th, 1915, at Wellington, New Zealand, the wife of G. Basil Doyne Adams, M.D.Oxon., of a son.
BOULTON.—On March 9th, at a Nursing Home at Brighton, the wife of Lt.-Col. Harold Boulton, I.M.S., of a daughter.
DIXSON.—On February 12th, at 51, Woodhurst Road, Acton, W., the wife of Dr. C. F. Lyne Dixson, of a son (prematurely).
FOWELL.—On March 13th, at Woodcroft, Kenley, Surrey, the wife (*née* Violet Hood) of Patrick Harvey Clive Fowell, M.D., of a son.
GILMOUR.—On February 15th, at West Meon, Hants, to the wife of R. Withers Gilmour, M.B.—a daughter.
HILL.—On January 31st, 1916, at Greenhayes, Banstead, Surrey, the residence of her parents, Mr. and Mrs. Howard Trollope, the wife of Captain F. T. Hill, R.A.M.C., British Expeditionary Force, of a daughter.
WESTON.—On February 17th, at 2, East Ascent, St. Leonards-on-Sea, to Dr. and Mrs. H. J. Weston—a son.
WHITE.—On February 22nd, at West Knoll, Bournemouth, the wife of Edward How White, M.B., Oxon, of a son.

MARRIAGES.

AINGER—WILLIAMS.—On January 7th, at St. James's Church, Brighton, by the Rev. W. Breton, M.A., and on December 29th, by H.B.M. Consul-General, at the British Consulate, Rouen, William Bradshaw Ainger, F.R.C.S., Captain, R.A.M.C. (T.F.), late of 58, Sloane Street, and No. 2 Red Cross Hospital, Rouen, son of the late H. J. Ainger, of Christchurch, N.Z., to Elsie Mary, daughter of the late William Williams, of Courts Heart, Britton Ferry, S. Wales.
DAVIES—FOSTER.—On January 5th, at St. Michael and All Angels' Church, Northampton, by the Rev. Canon Foster, cousin of the bride, assisted by the Rev. Louis Lethbridge, Captain J. P. H. Davies, R.A.M.C. (T.), only son of the late Dr. Idris Naunton Davies and Mrs. Davies, of Ystrad Rhondda, to Marjorie Etheldred, only daughter of Leonard Burtchaell Foster and Mrs. Foster, 9, East Park Parade, Northampton.

DEATHS.

BURNAND.—On March 24th, at Durban, Natal, Dr. W. E. Burnand, youngest son of L. W. Burnand, M.A.
HARPER.—On the 24th inst., at 25, Rosary Gardens, S. Kensington, James Harper, M.D., Col., R.A.M.C.(T.), the loved husband of Annette E. Harper, aged 58.
KEOWN.—On February 26th, at 44, Windsor Road, Ealing, W., David Boyd Keown, M.R.C.S., L.R.C.P.Lond, youngest son of the late Lieut.-Col. Henry Keown, 15th Hussars, aged 50.
SMITH.—On March 13th, at Croft Cottage, Crawley, Thomas Smith, aged 68.
WILLIAMS.—On January 16th, Herbert Williams, M.D.Lond., of 7, Ulundi Road, Blackheath, Medical Officer of Health for the Port of London, son of Alderman T. H. Williams, J.P., of Weymouth.
WOODBURN.—On December 30th, at Longlands, Stamford Bridge, Yorks, William Harrison Woodburn, M.R.C.S., L.R.C.P.

ACKNOWLEDGMENTS.

The British Journal of Nursing, The Hospital, Nursing Times The Student, Guy's Hospital Gazette, The Middlesex Hospital Journal, The Medical Review, St. Mary's Hospital Gazette, L'Attualita Medica, New York State Journal of Medicine, St. Thomas's Hospital Gazette, The Medical Review, The Cambridge Magazine, Long Island Medical Journal, Sphinx.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, Smithfield, E.C.*

The Annual Subscription to the Journal is 5s., including postage Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., *at the Hospital.*

All communications, financial, or otherwise, relative to Advertisements ONLY, should be addressed to ADVERTISEMENT MANAGER, *the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City 510.*

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St. Bartholomew's Hospital Journal.

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

VOL. XXIII.—No. 8.] MAY 1ST, 1916. [PRICE SIXPENCE.

CALENDAR.

Mon.,	May	1.—Exam. for M.B., B.S. (London) begins.
Tues.,	,,	2.—Dr. Morley Fletcher and Mr. Bailey on duty. Exam. for Part II. of second M.B (Camb.) begins.
Wed.,	,,	3.—Primary F.R.C.S. Exam. begins.
Fri.,	,,	5.—Dr. Drysdale and Mr. Rawling on duty.
Tues.,	,,	9.—Dr. Tooth and Mr. D'Arcy Power on duty.
Fri.,	,,	12.—Dr. Garrod and Mr. Waring on duty.
Mon.,	,,	15.—Exam. for Matthews Duncan Medal.
Tues.,	,,	16.—Dr. Calvert and Mr. McAdam Eccles on duty.
Thur.,	,,	18.—Final F.R.C.S. Exam. begins.
Fri.,	,,	19.—Dr. Morley Fletcher and Mr. Bailey on duty.
Tues.,	,,	23.—Dr. Drysdale and Mr. Rawling on duty.
Wed.,	,,	24.—Exam. for Brackenbury Medical Scholarship begins.
Thur.,	,,	25.—Exam. for Brackenbury Surgical Scholarship begins.
Fri.,	,,	26.—Dr. Tooth and Mr. D'Arcy Power on duty.
Sat.,	,,	27.—Sir G. Burrows Prize. Skynner Prize.
Tues.,	,,	30.—Dr. Garrod and Mr. Waring on duty.
Fri.,	June	2.—Dr. Calvert and Mr. McAdam Eccles on duty.
Mon.,	,,	5.—Exam. for Matriculation (London) begins.
Tues.,	,,	6.—Dr. Morley Fletcher and Mr. Bailey on duty.

EDITORIAL NOTES.

IT is with great regret that we learn of the death of James Morrison, M.D., who died on Good Friday from pneumonia, æt. 48. He will be remembered by many of our readers as a brilliant student of St. Bartholomew's. Entering in 1887, he took Honours in Biology at the Preliminary Scientific Examination of the University of London, and later obtained the Matthews Duncan Medal and the Bentley Prize. At the M.B. examination in 1893 he was awarded first class Honours in Obstetrics, with marks qualifying for the Gold Medal, and second class Honours in Medicine, and in the following year he took his M.D. degree.

Morrison held the posts of Extern and Resident Midwifery Assistant here and for three years that of Demonstrator of Practical Midwifery, whilst for several years he acted as Honorary Physician-Accoucheur to the Farringdon General Dispensary. His widow survived him for only three days.

* * *

It is with the utmost sorrow that we learn of the death of Captain C. T. Tresidder on April 22nd, having been seriously wounded on the night of the 18th. Educated at Uppingham and Dulwich College, he studied for the Medical profession at St. Bartholomew's Hospital, and would have taken his final examination just before the war broke out but for the accident of breaking his leg when playing football for the hospital. On the declaration of war he volunteered as a dresser with the Duchess of Westminster's War Hospital, and served in France for three months in that capacity. On January 9th, 1915, he joined the Lancashire Fusiliers, and afterwards received a commission. On May 4th, 1915, he was promoted to his lieutenancy, and a few days later, having taken a first-class instructor's certificate with distinction in machine-gun work, was gazetted captain. Later he transferred to the Gloucester Regiment, in which his greatest friend was serving, and was given the post of brigade machine-gun officer.

Our deepest sympathy is extended to his relatives and friends in their bereavement.

* * *

We very much regret to learn that Lieut. C. Heald, who is a medical officer in the Royal Flying Corps, has received serious spinal injuries. Desiring to reach a dangerously wounded man with the least possible delay, he decided to travel by aeroplane. Unfortunately, as the result of a side-slip, the machine fell to earth, with the result that Lieut. Heald received his injury.

Lieut. Heald has been in the army in France for about a year. Before that he served for six months of the war in the navy.

* * *

A few new students are joining the Hospital this session, in spite of the exigencies of the Army. Some will be under age—some possibly over age—and others there are who, having passed their second examination at one of the universities, come to St. Bartholomew's as fourth-year students. The total number, now and in the immediate future, is likely to be few, however, and in extending our welcome to these few we must call their attention to the fact that everybody must now join the Officers Training Corps, full particulars of which will be found upon the School notice boards.

* * *

We have to congratulate Dr. J. Stratton Warrack, who has been appointed Medical Officer of Health for the Port of London.

* * *

A lecture on "Amputations and Artificial Limbs" will be given by Mr. Elmslie on Tuesday, June 13th, at 12.45 p.m. in the Medical and Surgical Theatre. The subject is a most important one at the present time, and will, no doubt, interest any old St. Bartholomew's men who are holding medico-military appointments and who are not too far from London to be present.

FROM THE FRONT.

LETTER FROM LIEUT. J. M. SHAH, I.M.S.

I DON'T think any Bart.'s man has so far sent you an account of any Indian General Hospital or Field Ambulance from any of the numerous theatres of war, and so I thought a brief report concerning the Indian General Hospital in Alexandria, to which I am at present attached, may not be without interest to your readers.

The hospital has been rendering useful service to the Indian sick and wounded for more than a year. During the progress of the Gallipoli campaign it was mainly used as a base hospital for the Indian Expeditionary Force, and our register to-day shows that over 13,000 patients have been treated here so far, the majority being Indian soldiers. At times of emergency, when casualties from the Dardanelles have been heavy and British hospital accommodation in Egypt fully taxed, we have had British, Australian, and New Zealander patients as well.

The place has latterly been used more as a clearing nospital for the reception and subsequent transfer of Indian sick and wounded from France, either to India or other centres.

This hospital was mobilised as an Indian General Hospital at Peshawar in India in November, 1914. The medical staff consists of I.M.S. officers with Lieut.-Col. W. G. Pridmore, C.M.G., as our C.O., and Major R. McCarrison as the Registrar. The junior officers are principally young medical men, who have been given temporary commissions in the I.M.S.

We are occupying magnificent premises, and the hospital has indeed one of the finest positions in Alexandria, facing the sea and situated some miles outside the town itself. No pains have been spared to equip the hospital as completely as possible. Our two operating rooms, X-ray rooms, bacteriological laboratory, etc., etc., are indeed possessions of which any hospital would be justly proud.

There is a well-equipped camp adjoining the hospital, where our convalescent patients are accommodated under canvas pending their departure from Alexandria. The camp possesses a fine playground, and every afternoon Sikhs, Gurkhas, Rajputs, and Pathans may be seen indulging in various games, while now and again one also notices some of the officers thoroughly enjoying themselves at a "knock-up" when proper tennis cannot be had. Whilst talking of tennis, I may perhaps mention that one of our officers, Lieut. Fyzee, who is not unknown on the tennis-courts in England, is the holder of last year's championship of Alexandria.

We have lately had several cases of relapsing fever in the hospital. A clinical meeting was recently held here to discuss the ætiology, prophylaxis, symptomatology and treatment of this disease, at which the observations, made at this hospital by Major McCarrison, Capt. Phipson, and Lieut. Gupta from the cases actually under treatment here, were placed before a large audience of medical officers from the various military hospitals in Alexandria. Our C.O. was in the chair, and amongst those who took part in the discussion were Col. Sandwith, A.M.S., Lieut.-Col. Wenyon, R.A.M.C., and Dr. Kirton (P.M.O., Egyptian Prisons). A full report of the proceedings will be shortly published, and will no doubt be found very useful by those interested in the question.

Besides relapsing fever, jaundice and dysentery have also claimed the attention of the workers in our laboratory, and their investigations have proved not only of great interest but also of great assistance in the treatment of these ailments, which were so prevalent amongst our troops on the Peninsula last summer.

The X-ray work is done by the C.O. himself, who is also in charge of our ophthalmic department. Colonel Sir Victor Horsley and Colonel Tubby, who are both Consulting Surgeons in Alexandria, are frequent and welcome visitors.

Our surgical cases are, of course, no different from those seen elsewhere, whereas on the medical side we have also had our full share of dysentery, jaundice, and scurvy, contracted by the Indian troops, as by the Australians and others, in Gallipoli, with perhaps a larger percentage of tropical diseases, such as malaria, which, of course, are always found in a certain number of cases amongst the Indians.

Only those acquainted with the conditions of the East could adequately realise the full extent of the care and trouble necessary in the successful management of a general hospital for Indian sick and wounded, drawn, as they are, from the numerous martial races, casts, and creeds which form the Indian Army. The significant fact that the little Gurkha or the stalwart Sikh has not only had his pains and sufferings alleviated and his health restored as satisfactorily as surgical skill and medical treatment could accomplish, but has also been able to scrupulously observe and follow the sacred rites and rituals of his ancient religion during the period of his stay here, so far away from his home, speaks volumes for the able management of the responsible authorities.

There is no other Bart.'s man on the staff here, but the JOURNAL—which I receive regularly, I am glad to say—is being perused by my friends here as keenly and with as great interest as it is always done in the dear old Square or the Abernethian Room. Mr. McAdam Eccles' recent lectures on "Traumatic Aneurisms" and the "Little Things of Medicine and Surgery," published in the last two issues, have been immensely appreciated.

I hope to contribute to your columns from time to time, if you think my "Indian" letters will be of interest to your readers. I trust Bart.'s is going as strong as ever.

LETTER FROM SURGEON M. ONSLOW FORD, R.N.

PORTSMOUTH,
April 16th, 1916.

DEAR SIR,—On September 1st, 1914, I was admitted as Temporary Surgeon, and sent forthwith to Haslar Hospital. To me, saying "good-bye" to my wife and children was the greatest hardship that I have had to bear. Since that time to now I find the "saying good-bye" is harder and harder every time. At Haslar there was very little work to do, but plenty of naval routine and red tape to get used to. September 8th: I and Waldo and Balance were despatched to Dover to join a hospital ship. At Dover—no ship—so we were sent to Sheerness. We learnt when we got on board that eight Temporary Surgeons and a Fleet Surgeon, Gaskell, were to form a hospital in Antwerp for the R.N.D., who had already crossed over. The next day we anchored at the Nord Light, and we were kept very busy checking all our stores. When we were sent on to Flushing we heard of the danger Antwerp was in, and then I had my first taste of the horrors of war. The river was simply black with craft floating down with all the people leaving Antwerp, and at the end of two days Flushing contained nearly a million starving, dying, raving souls. Every particle of clothing and food was taken out of our ship, and at last, when the Naval Division were interned, I had nothing to give except my own underclothing, including my bootlaces. Of course we never saw Antwerp, and returned to Haslar, there to find 900 wounded Belgians, so that soon we were busy again.

The whole month of November, 1914, I spent at Fort Grange as M.O. to a Naval Flying Wing. There I had a lovely time. Wing Commander Longmore and Flight Commander Bigsworth, whose names are now so well known, were my senior officers. I started learning observation work with Bigsworth, and should have been appointed observer if the Admiralty had not rushed me down to Chatham Barracks to be M.O. of the Chatham Marines. There as Battalion M.O. I had charge of 1016 men and officers, and I found much to do preparing the men for our future work. On January 31st we learned that we were going to camp, and we left the next day, but our battalion was billeted at a charming little village. Here we were only allowed to stay a week. As a battalion we were fully equipped and ready for service. Helmets were served out, and we sent for our respective wives to say good-bye. February 6th: We embarked in a transport, —— Battalion embarking in a similar ship. There was much sickness amongst the subalterns, but the marines smoked and smiled.

February 11th: Passed the Straits of Gibraltar, and then we knew we were going east, and guessed the Dardanelles. February 19th: We left Malta, having had three happy days ashore. Called at Port Said, and on February 21st arrived at Tenedos, and it was blowing very hard. We received a flashlight signal from the "Lord Nelson" to return to Mudros Bay. We had the greatest difficulty in turning round, as our bows were so high out of the water that we acted like a wind vane. The "Queen Elizabeth" steamed across our bows; it was the first time I had seen her at sea, having seen her gradually grow in Portsmouth Dockyard. The next morning we arrived at Lemnos, the first troops to arrive, and at once our Colonel started to work out schemes for rapidly landing men on the beach and to re-embark, and at the end of a month we were absolutely polished in the art in getting sixty men out of a boat in a few seconds. February 27th: We were ordered to join the Fleet at Mudros, and then we had our first view of the Peninsula. The Fleet was busy. Up to March 4th we were standing to arms nearly all night and day with torpedo boats alongside, ready to land at the Cape Helles forts.

Plymouth Battalion landed at Kum Kale and Cape Helles and suffered frightfully. I shall never forget seeing the Village of Kum Kale being levelled down by gunfire.

March 5th: We returned to Mudros and found the Australians there, and the rest of the R.N.D. gradually turned up. March 17th: Ian Hamilton arrived. March 18th: The real bombardment began. To see "Queen Lizzie" cough a broadside is wonderfully impressive. March 20th: Heavy storm, and we dragged our anchor and ran ashore, but got off safely. March 28th: We arrived at Port Said and went under canvas. It blew hard for ten days, and we seemed to eat nothing but sand. April 3rd: Hamilton

reviewed the R.N.D. 16,000 strong. April 7th: Left Port Said, and up to the 16th we played about looking for derelict lighters. April 16th: Ordered to Skyros. On this day the "Manitou" (B. 12) was torpedoed unsuccessfully by a small Turkish torpedo boat, which was very soon caught. We could see the chase going on at the horizon. That night we entered the exquisite harbour of Skyros. Very high hills, steep to the water, round a beautiful sea-lake, volcanic formation covered with sweet and beautiful flowers.

The Colonel and I went for a botanical walk, and I found over one hundred different flowers, several quite new to me and unknown in England. We also found a ruined Greek fort that had been built out of the ruins of an ancient marble temple. The next day I landed with a working party and salved some beautiful white marble carvings and got them back to the ship, but, of course, I have lost them.

April 20th: The whole division landed in boats for a divisional exercise. We found it very hard work climbing the hills with all our equipment on, and when we were having a rest, the voice of a marine below me said: "I have been seven —— times to see the doctor, and he has always sent me back to duty. I am —— well going to be sick to-morrow." Then somebody told him that I had heard him, and he looked up at me with a smile and said: "Beg 'pawdon,' sir; didn't know you was there." He did not come to see me the next day.

On April 25th we all steamed out to the Gulf of Xeros in battle formation and steamed up the whole north coast of the Peninsula to the Bulair lines. We did a small landing at Bulair, and the whole world knows of the landing at Anzac and Cape Helles.

April 28th: We landed for twenty-four hours to help the Australians, so that we only took equipment and what we stood up in. It is very curious coming under fire for the first time. A hail of bullets met us at the beach and my work soon began. Night came on and we had to find our way to the trenches. We had fifteen days in the trenches. I never had my clothes off or got a proper wash, and I was simply soaked in blood; I was only hit three times slightly. On one of the days Lt.-Commdr. ——— was shot right through the neck, tearing both his carotids and larynx right out, and all the blood burst into my face and mouth. We lost two-fifths of our battalion, all our company captains, and our beloved Adjutant. No words can describe the horrors of days and nights. Surgeon Playne did splendid work and got his D.S.O.

On Bloody Monday, when we made a charge to Razor Back by Quin's Post, I shall never forget the sight of human bodies piled up four deep that had rolled down the steep hill to the bottom of the gully. Stretcher work was impossible. Sand-bags, reinforcements, water for men and machine guns had to o up the narrow way we had to bring the wounded down, and in most cases I simply had to carry them on my back. On May 13th we were ordered to re-embark on our ship, and those dear ship's officers slaved like lions to try and make us comfortable. We were exhausted to a man. The ship's baths were never empty at night. The next morning we had to land again at Cape Helles, through the "River Clyde," and march inland to the bivouac, which we had to make for ourselves. The firing line was only a mile and a half ahead of us, so that the battle noise was continuous all the time. The Turks spotted our arrival and greeted us with shelling, so that we had to lie low and do all our digging at night. It sounds almost stupid, though under fire from the Turk's batteries we enjoyed our few days' "rest." The Colonel and I explored the whole Peninsula, visited all the trenches, "skinning" our eyes for good positions, water, cover, etc. We also enjoyed botanising. On May 17th our bivouac was simply swept with shrapnel. I was hit in the left calf but managed to carry on. May 19th: Medical stores were blown to pieces as a shell dropped right into it and buried my servant. I had to dig him out. This shelling was getting on our nerves, and we were losing men for nothing every day. We were longing to get into the trenches again, for in Cape Helles the safest place was the first line trench. We discovered that an oak tree, the only tree in our bivouac, was a marked range for their artillery. We felled that tree and the shelling stopped. On the 22nd a shell passed within 4 ft. of my face and knocked me down, burst 12 ft. away, and because I was flat on the ground my life was saved. Several men were wounded, and one man was 200 yds. away.

On May 25th we moved up to the trenches under great difficulties, as a water-spout had burst over Krithia and flooded the whole country. No carts or mules could move, and everything had to be man-handled. One man was drowned *en route*. The next few days the mud in the trenches was horrible. Every day and night the Padre and I went round the whole of our section of trenches. The Marines have wonderful faith in a doctor, and the mere fact of my being present always cheered them up. On the night of the 28th we advanced 210 yds., fortunately with no casualties. On the 29th, Playne was slightly shot in the neck, so we started to improve the dug-outs. May 20th we all were busy shaving and killing lice. My servant felt disgraced that his master was infested with lice, and his labours were endless "strafing the lice." My uniform now consisted of an old surgical-dresser's coat soaked in Condy's fluid, marked "Kenton" (it was given to me by J. E. H. Roberts a long time ago), a vest, shorts, socks, and boots. On June 2nd we tried a great advance, and the roar of artillery was fearful.

On June 11th I was asked by my Colonel to bury dead. A scout took me to the spot, where I discovered a large number of bodies lying in extended order. The bodies were quite macerated, and the stench was frightful, and I

was very sick. I collected the discs from fifteen bodies by digging in the black mass with a bayonet for the string round the neck. When I got to the sixteenth body I was heavily sniped and had to bunk and report to Colonel. He did not believe me, and sent me back with the Adjutant, and we crawled out again, but again at the sixteenth body we got it hot and we both had to bunk. So this time the Colonel did believe, and we had to finish the work at night, but it was very difficult finding the discs in the dark. We got in all the personal effects and rifles and buried the bodies simply by covering them with surrounding earth. They had been there since the original landing—nearly six weeks, twenty-six bodies in all. It seemed to me that after that nearly every night the Padre and I were digging graves and setting up a simple wooden cross inscribed with a pencil. June 20th: Surgeon Rees was killed a few yards away from me

"'St. Bart.'s Journal' in the dug-out."

when we were in rest camp. He had taken Playne's place as Playne had got conjunctivitis. At the end of June our numbers were getting thin, and dysentery began. July was one incessant toil of nursing our sick men. The men were wonderful. They held on and would not give in. My servant was severely wounded. He had gone down to the canteen on the beach when a shell burst near him and a splinter passed through his left biceps muscle and tore off nearly the whole of both sternal ends of the clavicles, exposing the upper end of the sternum and clavicular joints. He managed to carry back the basket of eggs he had bought for me, as I had already got dysentery, but at my dug-out he fell down in a faint. He flatly refused to go to hospital, so that I looked after him. The splinter of shell had torn a tip of a bird's wing off the tattoo on his arm, and he always said after that his wings were clipped and he would never go home to his wife. Neither did he, poor fellow, for he died the second week of August, just after I left, of dysentery, at Mudros.

At the end of July our numbers were sadly reduced, and we were rapidly becoming of little effective force. We had a certain amount of reinforcements from home. It is a curious thing being carried away on one of your own stretchers. I don't remember much about it. I do remember going up in the air and being landed on deck, and picked up in strong arms and carried below. It was the chief engineer of the ship doing what he could to help. The luxury of a bed did not appeal to me that night, for I was unconscious; but when I came round the next day and saw the Sister's face, I could not believe myself, and—I am not ashamed to say it—I turned over and cried my eyes out.

I was in bed at No. 15 General Hospital at Alexandria for seven weeks with typhoid. I left Alexandria on October 13th in H.S. "Marathon" with 1000 sick and wounded. I arrived home on September 27th. I claim a real understanding of the meaning of that heavenly word, Home. February this year I returned to duty, and am now in Portsmouth Dockyard working in the ships.

I enclose a photograph of the three medical officers of the Royal Marine Brigade, who happened to be all Bart.'s men, namely (from left to right), Meller, Playne, Onslow-Ford, reading the Bart.'s Journal in the dug-out in which Playne was slightly hit in the neck. It was about 400 yards behind the firing-line where we had our joint dressing-station at Cape Helles.

NOTES ON TWO CASES OF ULCERATIVE CHOLECYSTITIS.

By D. S. Pracy, M.R.C.S., L.R.C.P.

CASES of ulceration through the gall-bladder wall are not very common, so the notes on the following two cases which came to the Hospital on the same day may not be without interest. I am indebted to Mr. Cozens Bailey for permission to publish them.

Case 1.—F. J. T—, æt. 60, carpenter, was admitted at 12.30 p.m., giving the following history:

In October, 1915, he had been treated at this Hospital for an appendix abscess. The case presented no unusual features, and he was discharged on November 1st, 1915. He returned on November 3rd complaining of diffuse abdominal pain and vomiting; his temperature was 101° F. and pulse 106 per minute. The patient was readmitted and watched. The abdomen was tender all over, but nothing else abnormal was found. A few days later all the symptoms had cleared up, but a tender spot was found opposite the tip of the ninth costal cartilage. The patient left the Hospital on November 12th free from pain. He says that from November 12th until December 25th he was

able to do his work, but that on December 26th he had a similar attack to that on November 3rd, which cleared up in a few days, and he was able to return to work.

On February 4th, 1916, whilst at work, he was suddenly seized with a very severe pain in the abdomen, which could not be localised to any one area. He was sick three or four times—the vomit, as he says, tasting of bile—and his bowels acted several times, but the character of his motions he had not noticed. On February 5th the pain continued; he was sick several times; his bowels acted once.

On the morning of February 6th patient was seen by his doctor, who sent him to hospital. On admission the abdomen was rigid, pain and tenderness were most marked above the umbilicus. Temperature 96° F. Later, in the ward, temperature rose to 100° F.; pulse 140 per minute. Bowels had not been opened since morning of previous day. At 4.30 p.m. an exploratory laparotomy was performed.

On opening the abdomen a quantity of bile escaped, and the biliary passages were accordingly examined.

At the junction of the cystic duct with the gall-bladder an ulcerated area was found which admitted a finger. In the fundus of the gall-bladder a stone was found. The cystic duct was ligatured close to the common duct, the inferior surface of the gall-bladder removed, and the mucous membrane of the remaining portion cauterised with carbolic. The abdomen was then closed. The stone causing the ulceration was not found.

On February 15th the patient burst his stitches, and had to be resutured. Apart from this he has steadily improved since the operation, and is now a long way on the road to recovery.

CASE 2.—M. M—, æt. 56, housewife, was admitted at 7.30 p.m. on February 6th complaining of pain and vomiting. She gave the following history:

For fourteen months she had not felt as well as she had previously done, and had lost weight.

On the evening of February 4th she was seized with a sudden severe pain above the umbilicus, and was sick several times. The pain and vomiting continued until her admission, when the vomit was fæculent. The bowels had not acted nor had flatus been passed since the morning of February 5th.

On admission patient was seen to be an enormous woman, who looked ill. The abdomen was distended and tender, especially above the umbilicus, but nothing else could be made out on account of the patient's fat. At 9.30 p.m. an exploratory laparotomy was performed. The intestines were collapsed, but the stomach was very distended. A hard mass was found in the situation of the pyloric antrum, which gave way on examination and permitted the escape of stomach contents and proved to be a mass of adhesions between the stomach and the gall-bladder shutting off a large ulceration between these two viscera.

At the topmost part of the jejunum a large gall-stone was found firmly impacted. This was removed through an enterotomy wound in the distal part of the jejunum. The patient, however, never recovered from the shock of the operation, and died the following afternoon.

THE BATH WARD AT 1ST EASTERN GENERAL HOSPITAL, CAMBRIDGE.

THE Bath Ward is a recent addition, and is the first ward of its kind in any hospital. The present system was devised by Major Apthorpe Webb, R.A.M.C. (T.), Registrar of the 1st Eastern General Hospital, Cambridge (Bart.'s, 1890), and the apparatus for the automatic thermal control has been kindly provided by the Scientific Instrument Company of Cambridge.

It contains six baths in which patients remain for periods of days or weeks. The water is kept at a temperature of about 100° F., and is constantly renewed by a circulation system. The hot-water tank and the recording thermometers and regulating appliances are shown on the end wall.

The bath treatment is specially suitable for all cases of extensive septic infection of the trunk and lower limbs. Whenever possible the infected areas are freely opened by large incisions. Subsequently the patient is returned to the bath from the theatre, and all plugging, etc, is completely removed, thus allowing the water free access to the wounds.

ADVANTAGES.

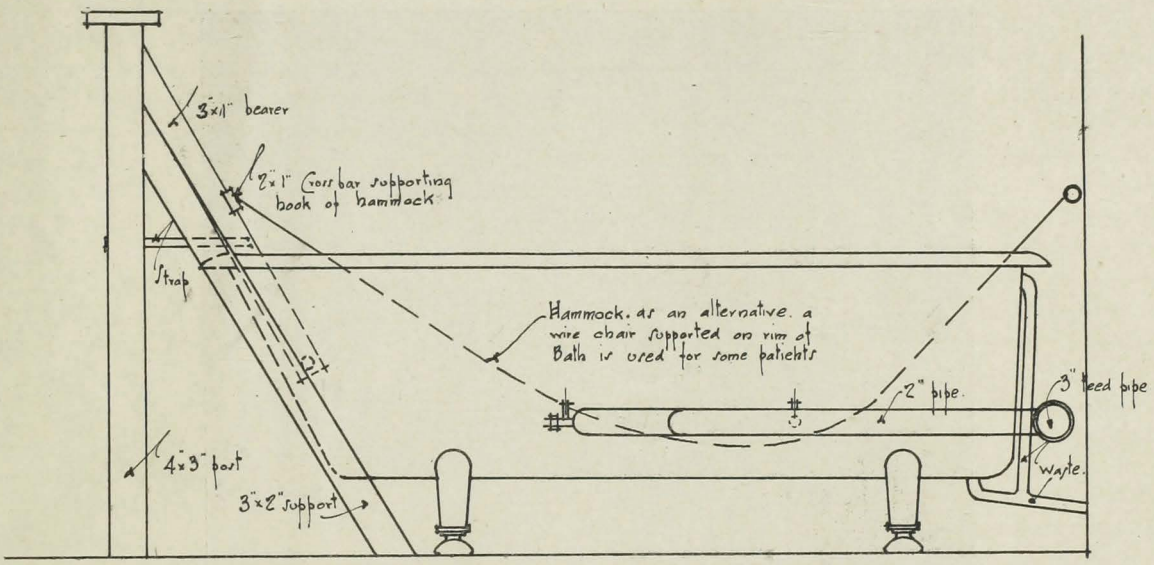
(1) No accumulation of septic discharge which the ordinary system of dressing collects in the interval between each dressing.

(2) Added comfort to the patient who is spared the pain of frequent dressings, and also is enabled to sleep better, as there is complete relief of tension from exudates of pus, etc.

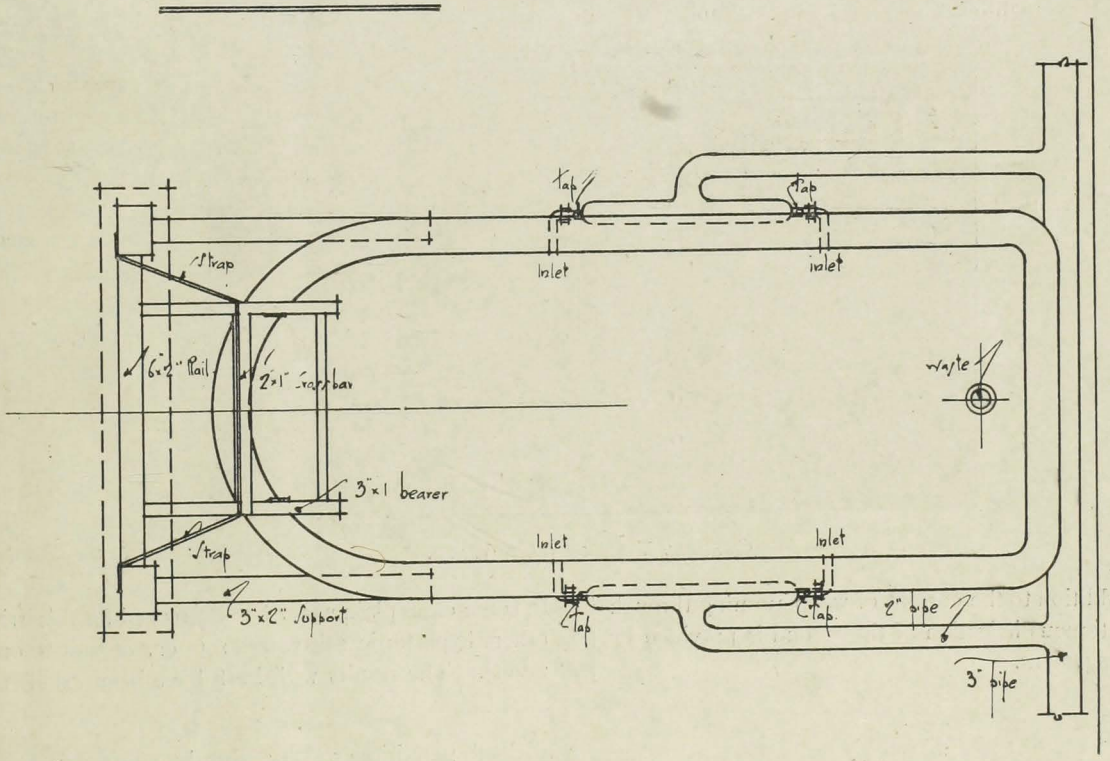
(3) Rapidity of convalescence. Healthy granulations grow very quickly, and in a short time a complete change for the better takes place in the condition of the wound. Even when for mechanical or other reasons it is considered advisable to amputate, it enables the surgeon to perform the operation as a "clean" case instead of an extremely infected one.

Up to the present ordinary water has been used in the bath, but for abdominal cases it would be possible and perhaps advisable to use normal saline. If it is not found possible to devise a method of keeping the strength constant the bath could be fed by hand with prepared solution.

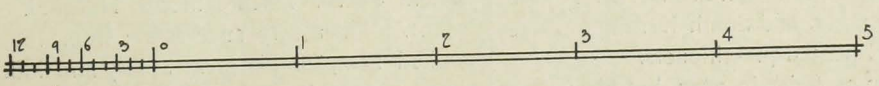
In cases where there is a deep wound without a counter

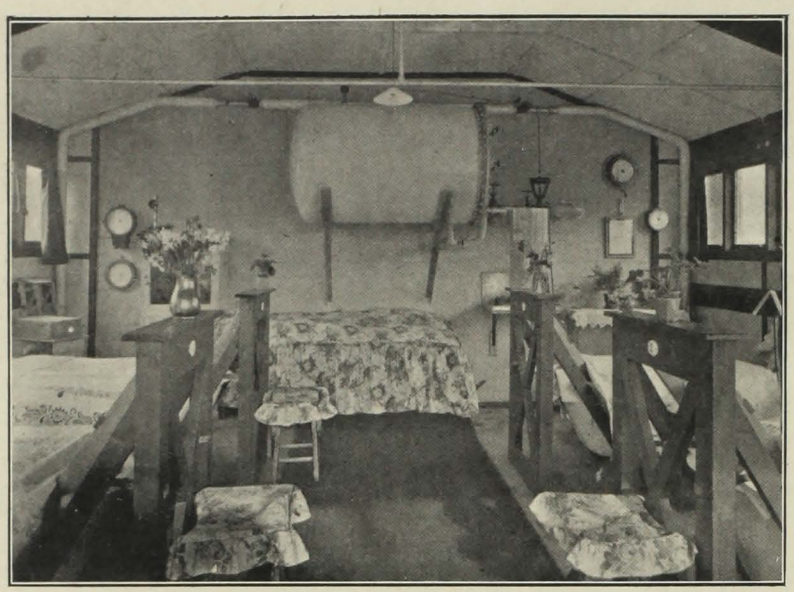


ELEVATION

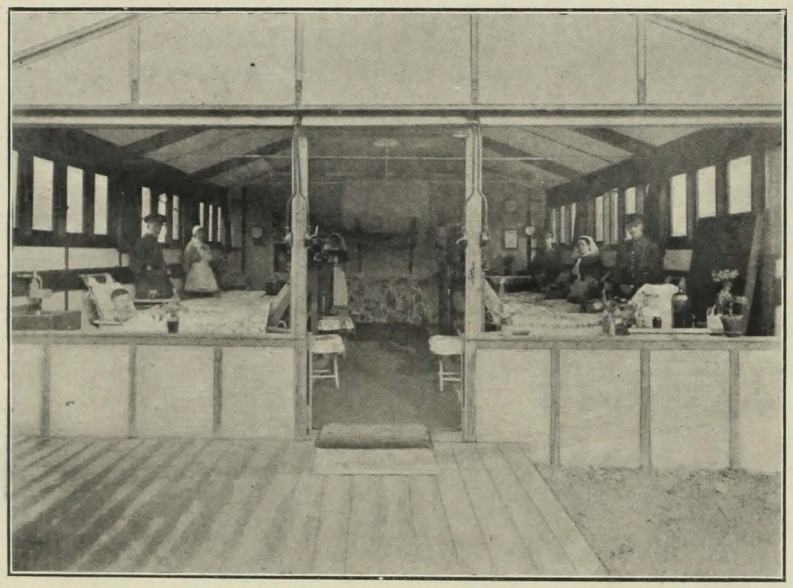


PLAN





CORNER OF BATH WARD.



GENERAL VIEW OF BATH WARD.

opening, in addition to the current of water running through the bath, continuous irrigation of the wound is provided by a siphon arrangement.

In some cases plain water has been used for this irrigation, in others hypertonic salt solution (1 oz. of salt to one pint of water). The results with both have been excellent.

OBITUARY.

JAMES HARPER, M.D.

BY the death of Dr. James Harper, of 25, Rosary Gardens, S.W., the profession has lost a very able and notable member, and South Kensington one of its most prominent and trusted practitioners.

James Harper was born at Leith in 1857, but his father, a medical practitioner, very shortly afterwards moved to Windsor, where Harper's boyhood was spent. He was educated at Amersham Hall School, Reading, and having matriculated at the University of London he entered as a student at St. Bartholomew's Hospital. His career at "Bart.'s" was very successful; from the first he was a marked man, for his great ability and industry were associated with such a robustness of character and also such a

merry humour that all who knew him were drawn to him and were helped by his example.

He passed his medical examinations with ease, took Honours in Obstetric Medicine at the Final M.B. examination, and in 1883 graduated as M.D.Lond.

He filled the office of House Surgeon at St. Bartholomew's and afterwards was successively House Physician to the Royal Hospital for Diseases of the Chest, and Resident Medical Officer and Anæsthetist to the Hospital for Women, Chelsea.

Having thus fitted himself for practice he took a house in South Kensington, and quickly gathered about him a large practice. His patients highly valued him, for his medical knowledge and experience were combined with such kindliness of heart and strong common sense that they found him to be not only a wise medical adviser but a strong and true friend. The high esteem in which he was held was strikingly shown by the large gathering of mourners who attended his funeral service.

But Harper's activities were not limited by the demands of his practice, and for many years he devoted a good deal of time to the Medical Corps of the Volunteers.

Joining the volunteer M.S.C. in 1894, Dr. Harper in due course became Captain, Major, and then Lieut.-Colonel in that Force. In April, 1908, he was appointed to the 3rd London Field Ambulance, and in 1912 he was promoted to the rank of Colonel and made A.D.M.S. 1st London Division. He was intensely interested in his military duties, and threw himself into the work of training his Ambulance Units with great enthusiasm and success. At the outbreak of the war he laid aside his practice and devoted himself wholly to his work as A.D.M.S., and he only gave up this work when he was a broken man, too ill to do it.

Harper was a man of fine presence, and in his physical vigour as well as in his strength of character, tempered by a deeply religious spirit, he showed the influence of his Scottish parentage. About four years ago he underwent a serious operation, and although he recovered and resumed his practice, his work afterwards was often carried out under difficulty. Early this year signs of increasing illness showed themselves, and, in spite of rest and the efforts of trusted and attached medical friends, his weakness increased and he passed away on March 24th.

None who ever knew James Harper will ever forget him. His elevation of character placed him quite above the ordinary run of men. His perfect integrity made him a tower of strength.

Dr. Harper was twice married, first to Miss Helen Watson Brand, daughter of the late Alexander Brand, U.S. Consul, Aberdeen, and later to Miss Annette Ellen Grant, youngest daughter of the late Admiral Henry Duncan Grant, C.B. He left three sons and two daughters, and one son was lost in the war, in the explosion of the "Princess Irene."

CORNELIUS HANBURY.

ANOTHER grand old Bart.'s man has gone to his rest. Cornelius Hanbury was born in 1827, and so had reached the fine old age of 89. He came of long-lived stock, his mother being 108 years of age at her death.

After qualifying from St. Bartholomew's as M.R.C.S. in 1849, he never engaged in private practice, but associated himself with the firm of Allen and Hanbury, founded in the City of London in the year A.D. 1715. In 1868, with his cousin, Daniel Hanbury, F.R.S. he became virtually the head of the firm, and initiated those developments which have since raised the firm to its present flourishing position in its bi-centenary year. His old Hospital always had a warm place in his affection, and this has been transmitted to other members of his family.

Mr. Hanbury was a past Treasurer of the Pharmaceutical Society, and a Governor of our Hospital for many years.

STUDENTS' UNION.

THE Annual General Meeting of the Students' Union was held in the Abernethian Room on March 13th, 1916.

Mr. Waring was in the chair.

The minutes of the last general meeting were read, altered in detail, and confirmed.

The Hon. Treasurers' report was then read by Mr. Girling Ball, who announced that the expenditure in general had been less owing to the lessened activity of the various clubs, and that the profits of the JOURNAL, together with the generous gift of the Catering Company, had ensured a small but satisfactory balance when added to the £100 given by the Medical School.

It was proposed by Mr. Powell, and seconded by Mr. Mackenzie, that the Secretary be directed to convey the thanks of the Union to the Medical School and Catering Company for their help. Carried unanimously.

The Secretaries' report was then read. Mr. Braun proposed, and Mr. Powell seconded, that the report be received. Carried without discussion.

The election of officers was then taken:

Mr. Waring was re-elected President.

Messrs. Gask and Girling Ball were re-elected Hon. Treasurers.

The results of elections to the Council were then read:

Constituency A.—Messrs. L. I. Braun, J. P. Ross, F. E. G. Watson, N. F. Smith, E. I. Lloyd.

Constituency B.—Messrs. H. L. Sackett, C. Shaw.

Constituency C.—Messrs. H. C. C. Joyce, K. A. I. Mackenzie, E. H. Glenny.

Constituency D.—(Not yet elected.)

Special Business.—Mr. Joyce, seconded by Mr. Mackenzie, proposed that the following addition be made to Rule 27:

"The Senior Secretary so elected shall be *ipso facto* a member of the Council for the following year, and shall represent ConstituencyA."

An amendment was brought forward by Mr. Davenport, who said that it was desirable for the Secretary to be a full voting member without representing any constituency. Mr. Watson seconded, and discussion took place.

A formal motion was then proposed by Mr. Ison and seconded by Mr. Davenport that the rule be amended thus: "The Senior Secretary so elected shall be *ipso facto* a full member of the Council for the following year." This was carried unanimously, and the Secretary was directed to make the necessary alteration.

Mr. Green, in an able speech, in which he showed how much the Union was indebted to Mr. Waring, proposed a hearty vote of thanks to the Chairman. His proposal was carried with acclamation. Mr. Waring replied.

A vote of thanks to Hon. Treasurers and Hon. Secretaries was proposed, seconded, and carried unanimously.

Mr. Girling Ball for the Hon. Treasurers and Mr. Joyce for the Hon. Secretaries, replied, and the meeting was then adjourned.

ST. BARTHOLOMEW'S HOSPITAL WOMEN'S GUILD.

THE Fourth Annual Meeting is fixed for View Day, Wednesday, May 10th, at 4.45 p.m. in the Great Hall. The Hon. Secretary, Mrs. Norman Moore, 67, Gloucester Place, W., will gladly send a card of invitation to anyone who will apply to her.

REVIEWS.

ON MODERN METHODS OF TREATING FRACTURES. By ERNEST W. HEY GROVES, M.S., M.D., B.Sc.Lond., F.R.C.S.Eng., Surgeon to the Bristol General Hospital. Bristol: John Wright & Sons, Ltd., 1916.

"The problem of the treatment of fractures (occurring in the extremities. Rev.) consists in the rapid restoration of the injured limb to certain and complete function. To this end three things are necessary: (1) The will of the patient; (2) a sufficiently perfect restoration of the form of the bone to allow of perfect joint action; and (3) the preservation of the full vitality of the circulation and neuro-muscular apparatus."

By the above quotation it will be seen at once the task Mr. Groves has set himself, and any fresh and convincing light thrown upon the question must commend itself to every surgeon and to most general practitioners. The nature and number of the fractures of bones of the limbs in the present war brings the subject into particular and important prominence just now, and makes the book most opportune.

The author begins his work with a survey of old methods, which he sums up, and perhaps quite rightly, in the words: "Hence it is that the method which goes back to the Pharaohs seems likely to flourish for generations to come, so long in fact as 'laissez-faire,' 'solvitur ambulando,' and 'wait and see' are still popular mottoes."

The volume of 286 pages is a lucid, not to say bold, statement of the opinions of this surgeon based upon theory, careful observation, experiment, and practice.

He rightly avers that it is by the introduction and proper use of the X rays that it has now become possible to diagnose and treat fractures in something like a scientific manner. The chapters which follow the introductory one are concerned with massage and mobilisation, extension methods, operative treatment of closed fractures, the treatment of open fractures, and ununited fractures.

Because the book contains much which is novel, much which is useful, and much which has come to stay, it should be in the hands of every surgeon and all R.A.M.C. officers.

PRINCIPLES OF GENERAL PHYSIOLOGY. By W. M. BAYLISS. (Longmans, Green & Co.) Pp. 850. 259 illustrations and diagrams. Price 21*s.* net.

This work does not pretend to deal in specific detail with every branch of human physiology. Rather it is an attempt to bring together all that is known of the mechanism and principles underlying physiology as a whole. In this attempt the author has been eminently successful. He has brought out remotely hidden facts which do not often come within the view of the average student of this science, facts published in papers which have little or no other bearing upon physiology. There is a very full bibliography nearly a hundred pages in extent which should be of inestimable service to those engaged in research or interested in the subject beyond the mere examination standpoint. The book is a literary masterpiece, and the incisive and well moulded sentences which follow one another throughout are a pleasure in themselves. We can confidently recommend this book to all students taking the higher examinations in physiology and to all others with a real interest in its hidden wonders.

DISEASES OF THE THROAT, NOSE, AND EAR. By W. H. KELSON. (Henry Frowde, Hodder & Stoughton.) Pp. 270. 89 illustrations. Price 8*s.* 6*d.* net.

This book is intended for the use of general practitioners and senior medical students. It is probably of more use to the former than to the latter, for although the author deals with most of the pathological conditions in a lucid manner, he does not describe the major operations in any detail, devoting most of his teaching on treatment to the minor operations likely to be performed by the general practitioner. The student, however, at the time of his examination, is expected to know details of major operations, and is, therefore, more likely to read a more comprehensive work than this. As a book of reference for the practitioner it is, however, excellent, being concise, well indexed, and up to date in diagnosis and treatment. The anatomical notes should also be of service, and the illustrations, which are clear and well executed, are sufficient to render all the more complex descriptions readily assimilable.

SURGICAL NURSING AND TECHNIQUE. By C. P. CHILDE, F.R.C.S. Eng. Second edition. Crown 8vo. Pp. xvi + 229. (London: Balliere, Tindall & Cox.) Price 3*s.* 6*d.* net.

At a time when nursing all over the country has become even more popular than it was, the appearance of a second edition of this book is opportune. Although the first edition was written mainly for the Nursing Staff at the Royal Portsmouth Hospital, the second edition should have a wider interest.

The principles underlying antiseptic and aseptic surgery are explained, and the working routine employed by the author laid down in a clear and useful manner. What deviations from the author's ideal various institutions make can easily be assimilated

provided that the underlying principles are clear, as they are made in this book. Some useful sections deal with urine testing, and the preparation and after-treatment of the patient.

We can recommend this as a small but useful nurse's manual.

Physiology for Nurses. By W. B. Drummond, M.B., C.M., F.R.C.P.Edin. Pp. 204. (London: Edward Arnold.) Price 2*s.* 6*d.* net.

It is almost as difficult to criticise as to write a small book on a large subject. Books on physiology have now so grown as to be hardly recognisable as the outcome of the smaller books of years ago, and now when an elementary book is written, the essentials or foundations of the subject have again to be compressed into the compass of those smaller books. Also, the subject has to be made intelligible to those who know nothing, and at the best require only to learn little of this great and important science. It is extremely difficult to determine at what point to leave off, for there is enough for the nurse to study without going into unnecessary detail, and yet it is so often the little more that makes the subject of interest. We are inclined to think that the standard of intelligence this book credits to the modern nurse is rather low—in other words, the subject is dealt with in a manner a little too elementary. We cannot, at this Hospital, overlook that William Harvey, who gave prominence to the circulatory theory, was one of our physicians, and do not like to see his Christian name given as John.

CORRESPONDENCE.

IN THE DAYS OF 1872.

To the Editor of the 'St. Bartholomew's Hospital Journal.'

Sir,—I regret that the reference to Skey's last lecture should have introduced a discordant note into the happy memories which Mr. Lupton has retained of his student days at Bart.'s. Nevertheless, the facts were as I stated them. Had Mr. Lupton been present at the lecture doubtless, also, his memory would have been burdened with the continuing vividness of a regrettable scene. I hold no brief for those who were the offenders; but in justice to them some additional facts may be stated. There was nothing of personal offensiveness directed against Skey. The students, with whom the theatre was half-filled, were merely in a boisterous mood. The occasion was a stifling, perspiring afternoon in July, just before the end of the session. Up to this point, under the laxity of authority, the students acted perhaps as students, naturally, at times are disposed to do. But the regretfulness of the scene arose from the fact that Skey looked ill: that the disturbance plainly hurt his feelings. Possibly, too, from the effort his task was plainly causing him, there was sadness passing through his mind that the end of his lecturing days had come; that never again would he be able to stand in that theatre and discharge his duty as a teacher; conceivably, also, he was desirous to avoid, whatever his virility had been in former days, any contentious or disciplinary encounter with the students, feeling himself unequal to the task. In this way may be explained his complete disregard of the disturbance, his restraint of resentment, his forgiveness, shown by the absence of any rebuke for the interruptions to which he had been subjected. The chief disturber sat in the top row of the theatre, close to the doorway, and were I to mention his name it would at once be recognised as that of a prominent official connected with a medical organisation, to which in this connection it would be impolitic to make further allusion. And now may be added a few more "notes." Holmes Coote was "cutting for stone" one day in the theatre; Tom Smith, as his assistant surgeon, was holding the staff. Coote, after in vain trying to grasp the stone with the lithotomy forceps, suddenly desisted, threw the forceps down upon the floor, and without a word walked out of the theatre, leaving Smith to complete the operation. It is surprising nowadays to recall the frequency with which lithotomy appeared in the list of operations performed at the hospital in the early seventies, and while dressing for Callender I can recall a case of lithotomy—that of a lad of 16—in which death occurred from general septic peritonitis. A student was attending Gee's out-patients' department one day. "Please, sir," he said, "can you tell me the difference between a hypodermic and a subcutaneous injection?" "Yes, Mr. ——, I think I can," replied Gee, a quaint smile passing over his face. "The only difference that I know is that hypodermic is a Greek word, and subcutaneous is a Latin one, and they both mean the same." It was the same student, I believe, who attended a clinical lecture on Pseudo-Hypertrophic Paralysis. He took copious notes, and they were headed with the legend beginning with the word "sudo"—and thus we are confronted with the egregious folly of many of the Universities adopting the policy of refusing to recognise that a knowledge of Greek and Latin is necessary to a medical student's education. What, in the days to come, will the educated patient, of the University class, think of his medical man displaying a glorious ignorance of the common elements of these two classical, though indispensable languages?

With, however, pardons numerous, though at the same time healthy on section showing no amyloid reaction with iodine—almost now a vestigial incident in a bygone pathology—nor fibrositic features, nor yet the results of an angiomatous installation—for the length of this letter,

I beg to remain, Mr. Editor,
Yours truly,
Percy Dunn.

Wimpole Street, W.,
April 12th, 1916.

BRIBING THE LORD MAYOR TO GIVE PARTIES IN MARCH.

To the Editor of the 'St. Bartholomew's Hospital Journal.'

Sir,—In a paper which will be read with much interest by many who, like myself, have not the honour of being "Bart.'s men," Mr. Lupton refers to a distinguished member of the bygone Hospital staff, the late Dr. James Andrew. This reminds me that Dr. Andrew told me that there was a tradition that the doctors of London, three hundred years ago, had bribed the Lord Mayor to give parties in March! As St. Bartholomew's is the only medical centre within the City, may I ask whether anyone connected with the Hospital knows of any evidence to support such a tradition? At the present time both the Mayoralty and the profession stand so well in public favour that inquiry into such a matter is not likely to do harm, while, as a matter of historic medical gossip, the tradition may be worth recording.

Yours, etc.,
S. D. Clippingdale, M.D.

April 12th, 1916.

EXAMINATIONS.

Conjoint Examination Board.

First Examination. March–April, 1916.

Part I: Chemistry.—M. N. Eldin, J. A. Mackay-Ross, H. L. Sackett.

Part II: Physics.—M. N. Eldin, J. A. Mackay-Ross.

Part III: Elementary Biology.—L. E. R. Carroll, D. H. Cockell, B. Goldfoot, J. A. Mackay-Ross, J. A. Morton, T. B. Thomas, J. S. White.

Part IV: Practical Pharmacy.—G. E. Burton, S. G. Harrison, N. F. Smith, C. H. Terry, I. G. Williams.

Second Examination. April, 1916.

Anatomy and Physiology.—L. Handy, F. W. Lemarchand, L. D. Porteous, V. A. T. Spong, W. S. Tunbridge.

NEW ADDRESSES.

Bennett, F. D., 18, Savile Row, W. Tel. 594 Regent.
Cane, L. B., Capt., R.A.M.C., c/o Chartered Bank of India, Bombay.
Chandler, F. G., 29, Nottingham Place, W. Tel. Mayfair 5288.

GILL, J. F., David Lewis Northern Hospital, Liverpool.
GILLIES, H. D., Cambridge Hospital, Aldershot.
HILTON-HUTCHINSON, R., The Lindens, Arundel Road, Littlehampton, Sussex; and c/o Holt & Co., 3, Whitehall Place, S.W.
HOGAN, C. E., 124, Barons Court Road, W. Tel. Hammersmith 1605.
LOW, G. HARVEY, 6B, Cavendish Parade, Clapham Common, South Side, S.W.
RYLAND, A., Cambridge Hospital, Aldershot.
SMALLHORN, C., Thorpe House, Billinghay, Lincolnshire.

Lieut. S. W. ISAACS, R.A.M.C., has changed his name by deed poll to S. W. BURRELL.

Dr. N. S. KOCH has changed his name by deed poll to N. S. SHERRARD, and his address to 3, Cromwell Place, Highgate, N.

APPOINTMENTS.

CHANDLER, F. G., M.B., B.C.(Cantab.), M.R.C.S., L.R.C.P., appointed Temporary Assistant Physician, Queen's Hospital for Children.
GILL, J. F., M.B., Ch.B.(Aberd.), appointed House Surgeon at the David Lewis Northern Hospital, Liverpool.
MORGAN, A. T., M.D.(Brux.), L.S.A.(Lond.), appointed Public Vaccinator for the Ashley District by the Bristol Board of Guardians.
VAKIL, C. B., M.R.C.S., L.R.C.P., appointed to X-ray Department of Islington School-children Treatment Centre.

BIRTHS.

CLARKE.—On March 28th, the wife of Lieut. H. H. Clarke, R.A.M.C., of a daughter.
FRAZER.—On March 8th, at 33, Colville Square, W., the wife of Prof. J. E. Frazer, F.R.C.S., of a son.
GASKELL.—On March 20th, at 23, Ladbroke Grove, W., the wife of John Foster Gaskell, M.D., Capt., R.A.M.C. (T.), of a son.
LAMPLOUGH.—On March 25th, at Bredon, Alverstoke, the wife of Wharram H. Lamplough, M.D., temp. Lt., R.A.M.C., 31st General Hospital, Port Said, of a daughter.
REICHARDT.—On April 4th, at Dorset House, Ewell, Surrey, the wife of E. N. Reichardt, M.D.Lond., of a son.
STRANGEWAYS.—On April 14th, at Luard Road, Cambridge, the wife of T. S. P. Strangeways, of a son.
WALLACE.—On April 24th, at Woodrouffe House, Milford-on-Sea, Hants, the wife (*née* Agatha Baily Harris) of 2nd Lieut. C. R. P. Wallace, East Yorkshire Regt., of a son.
WINTER.—On April 19th, 1916, at John o'Gaunt's House, Lincoln, the wife of Capt. E. S. Winter, R.A.M.C. (T.), of a son.

MARRIAGES.

CLARKE—WAKELING.—On April 5th, at Christ Church, Shooter's Hill, by Rev. R. S. G. Sampey (Vicar), Roger H. Clarke, Surg. Prob., R.N.V.R., son of the late Edward Nalder Clarke and Mrs. F. J. Powell, to Marjorie Blanche, elder daughter of Mr. and Mrs. H. Wakeling, of Chesterton, Cambridge.
JONES—BULLEN.—On February 29th, at St. Margaret's, Westminster, by the Rev. F. E. Coggin, assisted by the Rev. E. R. Price-Devereux, Philip T. Jones, Capt., R.A.M.C., M.R.C.S., L.R.C.P., third son of the late Richard Jones and Mrs. Jones, of Poulstone, Hereford, to Eirene Annie, elder daughter of the late Rev. R. Ashington Bullen and Mrs. Bullen, of Hilden Manor, Tonbridge.
PHILLIPS—GANBRILL.—On March 3rd, at the Parish Church, Edgbaston, Birmingham, by Canon Reader Smith, Capt. Alfred Percy Phillips, R.A.M.C., third son of G. A. Phillips, Esq., J.P., of Hardwick Lodge, Streetly, to Norah, third daughter of N. S. Ganbrill, Esq., Brockley, S.E.
SMERDON—WHITE.—On March 7th, at the Church of St. Mary Magdalene, Enfield, Edgar Wilmot Smerdon, M.D., F.R.C.S., Lieut., R.A.M.C. (T.C.), son of Col. and Mrs. F. G. B. Smerdon, of Oaklands, Binfield, Berks, to Hilda Mercédes, daughter of the late Mr. John White and Mrs. White, of Valencia, Spain, and "Alameda," Palmerston Crescent, London, N.
TOLLER—COURT.—On March 1st, at St. Peter's Church, Malvern Wells, by the Rev. Canon Park, M.A., Vicar of Highnam, Gloucester, assisted by the Rev. G. K. M. Green, Vicar of the Parish, Charles W. E. Toller, M.D., of Ilfracombe, only son of the late C. H. Toller, Esq., late Commissariat Dept., to Ella Milward Court, of Shelsley, Malvern Wells, elder daughter of the late Philip Wathen Court, of Tankatara, Port Elizabeth.
WILSON—MOTTERSHALL.—On the 12th inst., at the Church of St. Bartholomew the Great, London, by the Rev. M. G. Davis, Walton Ronald Wilson, Lieut., R.A.M.C., only son of Dr. and Mrs. Wilson, Forest Hill, to Emily Constance Mottershall, niece of Mr. and Mrs. Walter Southern Hunt, "Castle Mount," Eastbourne, formerly of "Castle Mount," The Park, Nottingham.

DEATHS.

GRELLET.—On April 26th, at Orford Lodge, Hitchin, Charles John Grellet, M.R.C.S., L.S.A., aged 73.
GUNDLACH.—On March 26th, 1916, at 138, Upper Clapton Road, N.E., John Gundlach, M.R.C.S., L.R.C.P., aged 42.
HANBURY.—On Tuesday, April 11th, 1916, at the Manor House, Little Berkhampstead, near Hertford, Cornelius Hanbury, in his 89th year.
HUMPHRY.—On April 16th, at 2, Marlborough Terrace, Glasgow, Arthur Dumville Humphry, M.R.C.S., L.R.C.P.Eng., late of Kurseong, India, aged 49.
MORRISON.—On April 21st, at 23, Weymouth Street, Portland Place, W., James Morrison, M.D.Lond.
PHELPS.—On April 8th, at Baxter Gate, Loughborough, Philip Phelps, M.R.C.S.Eng., L.R.C.P.Edin., L.M., aged 63.
STRICKLAND.—On March 25th, at Naringla, Craneswater Park, Southsea, Fleet Surgeon Charles C. Strickland, R.N. (Retired.)
TRESIDDER.—On April 22nd, C. T. Tresidder, Captain, Gloucester Regiment, from wounds.

ACKNOWLEDGMENTS.

British Journal of Nursing, Nursing Times, New York State Journal of Medicine, Guy's Hospital Gazette, L'Attualita Medica, Long Island Medical Journal, The Medical Review, The Hospital, St. Mary's Hospital Gazette, Magazine of the London (Royal Free Hospital) School of Medicine for Women, St. Bartholomew's Hospital League News.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, Smithfield, E.C.*

The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., *at the Hospital.*

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St. Bartholomew's Hospital Journal.

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

VOL. XXIII.—No. 9.] JUNE 1ST, 1916. [PRICE SIXPENCE.

CALENDAR.

Fri., June	2.	—Dr. Calvert and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Hartley.
Mon., ,,	5.	—Exam. for Matriculation (London) begins.
Tues., ,,	6.	—Dr. Morley Fletcher on duty.
Wed., ,,	7.	—Clinical Lecture (Surgery), Mr. D'Arcy Power. Applications for Lawrence Scholarship to be sent in.
Fri., ,,	9.	—Oxford Easter Term ends. Clinical Lecture (Medicine), Dr. Horder. Dr. Drysdale and Mr. Bailey on duty.
Sat., ,,	10.	—Oxford Trinity Term begins.
Sun., ,,	11.	—Whit Sunday.
Mon., ,,	12.	—First and Second Exams. for M.B.(Camb.) begin.
Tues., ,,	13.	—Dr. Tooth on duty.
Wed., ,,	14.	—Clinical Lecture (Surgery), Mr. Waring.
Fri., ,,	16.	—First and Second Exams. for M.B.(Oxford) begin. Dr. Garrod and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine) Dr. Horder.
Tues., ,,	20.	—Dr. Calvert on duty.
Wed., ,,	21.	—Clinical Lecture (Surgery), Mr. Bailey.
Fri., ,,	23.	—Dr. Morley Fletcher and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Calvert.
Sat., ,,	24.	—Cambridge Easter Term ends.
Mon. ,,	26.	—D.P.H. Conjoint Exam. begins.
Tues., ,,	27.	—Dr. Drysdale on duty.
Wed., ,,	28.	—Clinical Lecture (Surgery), Mr. Bailey.
Thur., ,,	29.	—Exam. for Shuter Scholarship begins. Second Exam. Conjoint Board begins.
Fri., ,,	30.	—Dr. Tooth and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Hartley.
Mon. July	3.	—Second Exam. for Med. degrees (London), Part II, begins. M.D. and M.S. Exams. (London) begin. Second Exam. of Soc. of Apothecaries begins.
Tues., ,,	4.	—Final Exam. Conjoint Board (Medicine) begins. Dr. Garrod on duty.
Wed., ,,	5.	—First Exam. of Soc. of Apothecaries begins.
Thur., ,,	6.	—Final Exam. Conjoint Board (Midwifery) begins.
Fri., ,,	7.	—Final Exam. Conjoint Board (Surgery) begins. Dr. Calvert and Mr. Bailey on duty.

EDITORIAL NOTES.

IT is with the greatest regret that we have to announce the death of Captain R. K. Macgregor, R.A.M.C. He was accidentally killed in France on April 28th. Educated in the first place at Edinburgh and University College School, London, he studied medicine at this Hospital, and was qualified in 1911. He went to France with the first Expeditionary Force, being promoted Captain at the end of his first year of service. Our deepest sympathy is extended to his parents, Dr. and Mrs. Macgregor, in their bereavement.

* * *

Since our last issue Major Rawling and Lieut. Mackenzie Wallis have left the Hospital for an unnamed destination. They, together with Captain Stanley, have been appointed to the 34th General Hospital (the Welsh Hospital). We understand that another old Bart.'s man, Lieut. J. S. Burns, has also been appointed to that unit.

Major Gask has also left for the front "somewhere in France."

We wish them all luck during their absence.

* * *

Our heartiest congratulations are extended to Mr. D'Arcy Power, who has been elected President of the Medical Society of London for the Session commencing October, 1916.

* * *

It is with great pleasure that we record that Colonel A. E. Garrod has had the Order of Companion of St. Michael and St. George conferred upon him for distinguished service in the Field.

* * *

We congratulate the following recipients of Birthday Honours:

Privy Councillor. Dr. Christopher Addison.

C.I.E., Major F. N. White, I.M.S.

C.B. (Military Division). Additional Members. Surg.-General W. G. A. Bedford, C.M.G., M.B., Col. O. R. A. Julian, R.A.M.C.

C.M.G. Additional members. Col. C. E. Harrison, C.V.O., M.B., F.R.C.S., Army Medical Service (T.F.); Lt.-Col. L. Humphry, R.A.M.C.

Lt.-Col. E. P. Sewell, R.A.M.C., has been awarded the Distinguished Service Order.

* * *

Sir C. P. Lukis, K.C.S.I., K.H.S., V.D., Director-General of the Indian M.S., has been appointed Commissioner for the St. John Ambulance Brigade Overseas, within the Empire of India.

* * *

It is interesting to note that three sons of members of the staff have received the Military Cross, viz.: John Dennison Eccles, Lt., Queen Victoria's Rifles, son of Major McAdam Eccles; D'Arcy Power, Captain, R.A.M.C., S.R., son of Lt.-Col. D'Arcy Power; L. R. Shore, Captain, R.A.M.C., son of Dr. T. W. Shore.

Other old Bartholomew's men on whom the same decoration has just been bestowed are: Capt. G. E. Dyas, R.A.M.C.; Capt. T. J. C. Evans, I.M.S., Tempy. Capt. A. J. Kendrew, R.A.M.C.; Surg.-Capt. W. T. Rowe, S. Notts Hussars; and Lt. (now Capt.) C. J. Stocker, I.M.S.

* * *

A lecture on "Amputations and Artificial Limbs" will be given by Mr. Elmslie on Tuesday, June 13th, at 12.45 p.m. in the Medical and Surgical Theatre. The subject is a most important one at the present time, and will, no doubt, interest any old St. Bartholomew's men who are holding medico-military appointments and who are not too far from London to be present.

CHRISTMAS DAY IN THE DESERT.

THERE was trouble on the Western Frontier of Egypt, and the "Western Frontier Force" had been rapidly collected and had partially assembled at Mersa Matruh—a port on the Mediterranean 180 miles west of Alexandria—in order to cope with the trouble. Thus it was that I found myself in December, 1915, at a spot I had never heard of before, engaged in operations against an enemy whose name was unknown to me until a few weeks previously. My humble *rôle* in the subsequent performance was that of A.D.M.S. of the force. After a little indecisive skirmishing our aeroplanes located the enemy, some 3000 to 4000 strong, camped in a nullah or wadi about seven miles west of Matruh, and our G.O.C. chose Christmas Day as a suitable occasion to do a little "strafing," on the principle, I suppose, of "the better the day, the better the deed." This decision, however, touched our mess in a tender spot, as we had with some difficulty and commendable foresight collected a plum pudding, some mince pies and a bottle of port; and with these we had planned to celebrate Christmas in the usual way. The situation was met by the simple expedient of keeping Christmas on the previous day, the proposal of waiting till the day after being instantly vetoed.

An early start being ordered, we all turned in soon after dinner; but not to sleep, as snipers kept firing into the camp and our pickets wasted a good many rounds of ammunition on them. At last all was quiet, and it seemed only a few minutes afterwards that the bustle and noise of the stirring camp warned one that it was time to get up. A plunge into the cold and dark, a hasty breakfast, and then a brisk canter to the head of the column, where we fell into our places behind the General and started off on the march. It was a curious effect in the moonlight—the long column of men, horses and guns moving silently in the sand, with ambulances and transport wagons in the rear, and a column of camels shuffling along without a sound. The presence of so many men and animals close to one in the dim light, coupled with the uncanny silence, gave a weird effect of unreality, almost as if the whole thing were a cinema show.

We had marched about three miles when my attention was attracted by a sharp exclamation, "What's that on the right?" A small spot of light, apparently about 600 yards ahead and to the right, suddenly appeared and rapidly grew bigger, and it was soon obvious that the enemy had spotted us and lighted a beacon fire to warn their friends of our approach. The column was halted, and a squadron of cavalry sent out to see if they could round up the lighters of the fire. The latter fired a few shots and ran off, and were lost in the darkness.

Soon after this a faint light began to show in the east, and in due course the sun rose in Oriental splendour, and our greatcoats and mufflers were discarded.

About 8 a.m. a shrapnel from the enemy brought us the greetings of the season, and some heavy explosions on our right directed our attention to the sea, where we could just see a naval ship firing her big guns, the shells of which were kicking up a great dust on the hills a mile ahead.

Our guns now came into action, and the infantry deployed. The guns did good work, as they put their fourth shot right into the enemy's gun emplacement and silenced the gun for the rest of the day. The enemy had other guns, but for some reason or other they never brought them into action.

The infantry now advanced steadily over an open plain against the enemy's position in the hills, and casualties began to trickle back to the Field Ambulance. These were dressed, fed, and sent back to Matruh by motor ambulance all day long, so that the wounded were in a comfortable bed within two hours of being wounded, in many cases. In the meantime the cavalry had done a wide turning movement, and had arrived in rear of the enemy. This made matters too hot for them, and they retired into their wadi—Wadi Majid as it was called—in the caves and recesses of which they kept up a scattered fight for the rest of the day, being gradually driven down the Wadi towards the sea. It was intended that the cavalry should completely surround them and block their exit to the west; and if they had

succeeded in doing this, all the leaders of the enemy's forces would have been captured and the campaign brought to a close prematurely. Unfortunately they were unable to complete the ring, and the leaders escaped.

In the late afternoon the enemy were in full flight, and we were in possession of their camp, where a large quantity of ammunition and supplies were captured.

It only remained for us to collect our forces and return to Matruh, as scarcity of water and transport rendered it impossible for us to follow up our victory.

By 9 p.m. all the troops had returned to the rendezvous, but one regiment reported that some of their men had not come in, so we had to sit in the cold and dark waiting for them with some anxiety, as they might easily get cut off in the dark. Large fires of brushwood were lit as a guide, and at 10 p.m. a man found his way into camp and said he had been sent in to say that there was a party of his regiment, including the medical officer, and some wounded and prisoners left out some miles away. A relief party was instantly collected, and disappeared into the darkness with the man as a guide. They were fortunate enough to find them, and brought them in at 2 a.m.

Unable to sleep for the cold, we were glad when at 4 a.m. it was decided to march home, and we eventually arrived at our camp at 7 a.m., after twenty-six hours' absence, tired but pleased with our first effort.

The humour of the situation did not come out till afterwards when we captured Gafar, their Commander-in-Chief, who confessed that he thought all British soldiers got drunk on Christmas Day, and so he had planned to make an attack on our camp on Christmas night. Our attack rather spoilt his plans for our Christmas entertainment.

Our casualties were light. The most interesting case was a Yeomanry officer who was hit in the abdomen close to the umbilicus. There was no wound of exit. He had fæcal vomiting on the second day, and his life was despaired of. But to our astonishment it stopped, and he made an uninterrupted recovery.

No. 15 General Hospital, Alexandria.
April 15th, 1916.

E. P. SEWELL,
Lt.-Col. R.A.M.C.

SOME OPHTHALMIC LESSONS OF THE WAR.*

By WALTER H. JESSOP, M.B., F.R.C.S.Eng.

THE *first* subject I wish to consider is *sympathetic ophthalmitis*, or rather its absence, as far as I know, amongst the wounded treated by our surgeons at the Front.

* Abstract of Presidential Address delivered at the Congress of the Ophthalmological Society of the United Kingdom on Thursday, May 4th, 1916.

To Colonel Lister and the other ophthalmic surgeons at the Front has been primarily due the prevention of sympathetic ophthalmitis. I have corresponded with practically all our colleagues at the military hospitals, and have not as yet heard of one case of sympathetic ophthalmitis, and the war has been on for 21 months. The number of eyes wounded has been very great, and especially the number of those very seriously damaged by shrapnel—the cases so aptly described by Colonel Lister as split "like the corolla of a very much faded flower."

In the American Civil War 41 cases of sympathetic ophthalmitis occurred in 254 cases of destruction of the eyeball—that is, 16·14 per cent.

The German official returns for the Franco-German War gave the very high percentage of 55·6 in all cases of injury to the eyeball. The number of sympathetic ophthalmitis cases was 97, and 52 of these occurred within one year of the injury; the seriously damaged eyeballs gave the highest percentage of sympathetic trouble.

The extraordinary immunity from sympathetic ophthalmitis must be due to care in diagnosis, careful primary operative treatment, and especially the early and complete removal of all portions of the globe in much smashed eyeballs.

The *second* subject is *papillœdema* following gunshot injuries to the vault of the skull. In this war wounds of the head by bullets, etc., have been more frequently met with than in any previous war.

In cases of fracture of the vault * a large percentage (about 60 per cent.) showed signs of papillœdema, and the opportunities given of following the course of the papillœdema strengthens the view that the old chapters on optic neuritis, choked disc, neuro-retinitis will have to be quite rewritten.

The ophthalmoscopic changes were usually slight swelling of the papilla, sometimes amounting to 1 or 2 D.; the edges of the discs were blurred and indistinct, often there was a narrow yellowish-white ring round the optic disc, and the changes were, as a rule, within the equator and near the papilla—in fact, these changes were an œdema of the papilla and the retina. In some cases there were soft woolly looking plaques, and in a few cases there was extreme swelling of the optic discs with hæmorrhages, plaques, etc. These conditions were associated with increased intracranial pressure, and on relief of the intracranial pressure the œdema disappeared in a short time, and in most cases no after changes are to be seen by the ophthalmoscope. This coincides with the findings of Paton and Holmes, who, in cases of cerebral tumours, have demonstrated that the swelling of the papillæ is an œdema and not an inflammation primarily, and that such cases usually called optic neuritis ought to be named papillœdema.

The *third* subject is the condition of the retina in *trench nephritis*, which is a disease that has affected numerous

* *The Ophthalmoscope*, vol. xiii, p. 593.

soldiers in this war, and of which the actual cause has not been found.

These cases of trench nephritis, according to Capt. W. Langdon Brown,* are examples of acute nephritis, and are epidemic, infective, and due to some specific infection resembling, but not actually, the organism of scarlet fever.

I have had the opportunity of examining the eyes of about 150 cases of trench nephritis; the ophthalmoscopic examinations have been made with the pupils dilated by homatropine and cocaine, the source of illumination being a candle (Priestley-Smith) lamp, or ordinary daylight.

Some of these cases have also been mentioned by Mr. Foster Moore, and have been referred to by him in an interesting paper in the *Lancet*, December 19th, 1915, p. 1348.

I wish first to refer to my last consecutive forty-five cases, as I have examined these more carefully for slight signs of œdema; my first cases were looked at chiefly for gross changes as hæmorrhages, white plaques, detachments, etc. In twenty-one of the cases (46·6 per cent.) there were signs of œdema of the retina; in many these signs in a few days cleared up, so that the percentage of cases of œdema is probably much higher. In three cases with œdema of the retina there were other changes—one had a single, superficial, flame-shaped hæmorrhage, one commencing retinitis with plaques, and one the signs ordinarily described as albuminuric retinitis. Of this last case, a man æt. 27, the great interest is that all the ordinary changes up to resolution took place in twelve weeks from the onset of general symptoms. The œdema of the retina commencing three weeks after the symptoms of dyspnœa, œdema of legs, etc., was succeeded by white, soft-looking plaques, hæmorrhages, macular star. In eight weeks the only changes to be seen were small, hard-looking, white spots at the maculæ, in twelve weeks the left-eye changes had quite disappeared, and there were in the right eye six small, very bright white spots near the macula. In sixteen weeks there was nothing to be seen in either eye. This case was undoubtedly one of acute nephritis, and all the signs of soft, woolly-looking, white plaques, and hard-looking white spots were present. One was able, as Charcot said, to use the ophthalmoscope to investigate living pathological anatomy, practically as a microscope on the living tissues.

In none of these forty-five cases were there any signs of pathological changes in the retinal vessels; this fact is true in nearly every other case I have observed. Curiously, in only three cases was there a previous history of scarlet fever, and in these three cases the ophthalmoscopic appearances were normal. The constant signs in every case were albumin in the urine and œdema in the extremities or face. The blood-pressure varied very greatly in different cases. The detachments of the retina mentioned by Mr. Foster Moore due to œdema and sometimes a solid or nearly solid œdema, all cleared up. During the clearing-up stage there were white plaques, hard white spots, hæmorrhages, etc. All these symptoms help to confirm the diagnosis of trench nephritis being toxæmic.

For a long time it has been known that pregnant women are liable to manifestations of toxæmia,* and Mr. Fisher has published a very interesting paper on "The Retinitis of Pregnancy." As he said, and I thoroughly agree with him, it might have been headed Toxæmic Retinitis of Pregnancy.

Some years ago I had written a paper for our Society on tuberculous retinitis, which was never published. The main points are effusions, limited or diffuse, in the retina followed during the process of resolution by a retinitis with white plaques which cleared up completely. This clearing up, according to Rochon-Duvigneaud and Mawas, is due to the action of phagocytes, and one can almost by the ophthalmoscope see the process—the periphery of the plaques becoming ragged-looking. Since then I have had cases where no signs of tubercle could be found, which must have been due to septic infection.

In our *Transactions*, vol. xxv, p. 102, is the drawing of an analogous case recorded by Mr. R. E. Bickerton. I am showing another case at this present meeting. These cases of toxæmic retinitis in trench nephritis, gravidic retinitis, and tubercle are characterised by an œdema, sometimes amounting to a definite detachment, diffuse or limited, of the retina, the presence of white soft woolly plaques, hard white spots or dots, hæmorrhages, but not primary affection of the blood-vessels.

We find the same conditions in the so-called diabetic and albuminuric retinitis. Are not all these generic terms misleading, or rather unscientific? It has long been known that exactly the same signs as, some writers say, are pathognomonic of albuminuric retinitis are found without any signs of kidney mischief and without any albumin in the urine. Is there a typical albuminuric retinitis? Are there any definite ophthalmoscopic signs which would establish an absolute definite diagnosis by themselves alone? These questions cannot be answered in the affirmative.

I would suggest that there is at first an œdema of the retina in all these cases, which may be toxic in origin. Like the œdema of the eyelids, extremities, etc., in nephritis, the cause is not proven, and therefore there is no reason to suppose it may not be toxic.

In many cases the presence of fibroblasts produces the solid œdema, the white plaques, etc.

As to the definite toxin, this may vary in different diseases, but the signs of the toxæmic retinitis or retinœdema are practically the same.

It is an interesting lesson this war has taught us that in the last two of my subjects the presence of œdema either as papillœdema or retinœdema is so often to be found, and

* The *Lancet*, February 19th, 1916, p. 391.

* *Proc. Roy. Soc. Med.*, vol. viii, p. 127.

may be so fugitive. It will be still more interesting if these conditions lead to a clearer and more correct understanding of the so-called albuminuric retinitis.

TWO CASES OF DISLOCATION OF CERVICAL VERTEBRÆ, WITHOUT DEATH.

By Major W. McADAM ECCLES, M.S., F.R.C.S., and D. S. PRACY, M.R.C.S., L.R.C.P.

Traumatic Dislocation of the Fourth Cervical Vertebra Forwards and Downwards on the Fifth.

M. B—, a woman, æt. 43, fell downstairs on November 28th, 1915, whereby her head struck the ground, and her

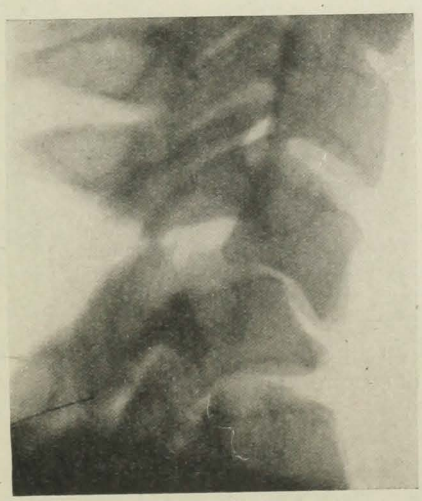

FIG. 1.—LATERAL VIEW. THE FOURTH CERVICAL BODY HAS SLIPPED FORWARD ON THE FIFTH.

neck was bent forcibly forwards. She was unconscious for two hours. A large hæmatoma developed on the occiput and extended on to the cervical region. On the advice of her medical man, Dr. M. Ryan, she was kept in bed for a month. On getting about after this she found stiffness in the neck with considerable pain on attempting to move the cervical spine, the pain running down into both upper extremities, and being particularly marked in the digital area of both ulnar nerves.

There was no evidence of any distinct muscular paralysis, whether of upper limbs, diaphragm, trunk, or lower limbs, although the intrinsic muscles of the left hand supplied by the ulnar nerve did not contract voluntarily so strongly as those of the right side. The sphincters were quite normal.

On examination no irregularity of the cervical vertebræ could be detected, but there appeared to be somewhat of a hollow between the fourth and fifth cervical spinous processes.

The patient was only able to flex her neck slightly in the antero-posterior and lateral directions, some fixation being apparent about the level of the fourth vertebra.

X-ray examination showed a very significant deformity. In the lateral view (see Fig. 1) it will be observed that the head with the four upper cervical vertebræ has slipped forwards and downwards. The body of the fourth vertebra is lying so that its lower lipped edge is almost in contact with the lower lipped edge of the centrum of the fifth vertebra. Further, there is clearly discernible a marked gap between the spinous processes of the fourth and fifth cervical vertebræ, that portion of the ligamentum nuchæ attached to these spines having probably given way.

In the antero-posterior view there will be seen (see Fig. 2) a separation between the transverse processes of the fourth and fifth vertebræ, the cervical spine at this level

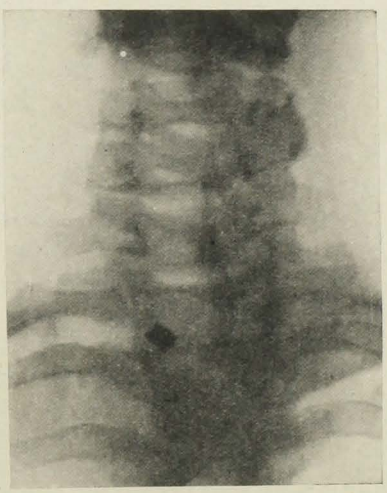

FIG. 2.—ANTERO-POSTERIOR VIEW. THE FOURTH CERVICAL VERTEBRA IS SOMEWHAT SEPARATED ON THE RIGHT SIDE FROM THE FIFTH.

having been forcibly flexed to the left. There is no evidence of any fracture.

The case is of interest from the following points:

(1) The level of the lesion.

(2) The fewness of the symptoms.

(3) The fact of recovery of the patient.

The most common level for a dislocation or a fracture dislocation of the cervical spine is between the fifth and sixth vertebræ. At this level, even if the spinal cord is injured, respiration is carried on through the action of the diaphragm, the phrenic nerves remaining intact. But when the level is higher than this death is almost certain.

That there should have been so marked a dislocation forwards of the body of the fourth cervical vertebra without greater involvement of the cord is remarkable. Where dislocation occurs as the result of disease there is time for the cord to accommodate itself to its altered relations, but where the displacement is the result of traumatism

the sudden compression of the cord causes, as a rule, most marked symptoms. In this case the absence of muscular paralysis is of great interest, for it shows that the cord must have almost entirely escaped injury. The fact that the patient, after a prolonged rest in the recumbent position, has recovered with only a slight anæsthesia in the ulnar distribution is highly gratifying.

It was somewhat difficult to decide whether any manipulative treatment should be adopted. None was carried out because, the symptoms being slight, it was felt that they might be increased by any attempt to reduce the dislocation.

It was also difficult to determine when the patient might be allowed to move her head and neck without fear of any likelihood of further slipping of the vertebræ; but after four months it was considered safe, and so far no untoward result has followed. W. McA. E.

Dislocation Forwards of Atlas on Axis due to Disease.

This case was under the care of Mr. Bailey, who has kindly given permission for the following notes to be published.

L. W—, a schoolboy, æt. 14, noticed, in the middle of December, 1915, that he had a dull diffuse pain in the suboccipital region and a certain amount of stiffness on attempting to move his head. These symptoms increased in severity gradually until his admission to hospital on March 15th, 1916. At that time he also complained of a swelling on the right side of his neck, but this, on examination, proved to be the transverse processes of his cervical vertebræ made prominent by the position of the head.

On admission the condition was as follows:

The patient was an unhealthy-looking boy, and kept his head thrown slightly backwards with the chin rotated to the left. This position he apparently maintained by spasm of the deep muscles of the neck, probably the left superior and inferior obliques. The more superficial muscles were not contracted.

Movements.—Patient was able to rotate his head a little, but could not painlessly bring his chin to the middle line. Nodding movements were much more easily executed. Patient had no pain on percussing the top of his head, but the spines of the upper cervical vertebræ were distinctly tender.

No enlarged glands were palpable in the neck or elsewhere. No abnormality was discovered in the chest or abdomen. Temperature, pulse, and respirations were normal.

Nervous system.—Knee-jerks present but not easily elicited. Sphincters natural. Sensations: No objective abnormality, but patient said that occasionally his right hand felt numb, and he would be unable to hold a pen to write a letter.

Several skiagrams were taken at different times without any discovery of disease in the vertebræ, but one taken on March 27th showed that the atlas and cranium were dislocated forwards on the axis and other cervical vertebræ. The transverse ligament of the atlas had apparently given way and the odontoid process was nearly touching the posterior arch of the atlas. Probably the position appears a little exaggerated in the skiagram, as the view is not absolutely a lateral one.

This case is of interest:

(1) As a contrast to Major Eccles' case.

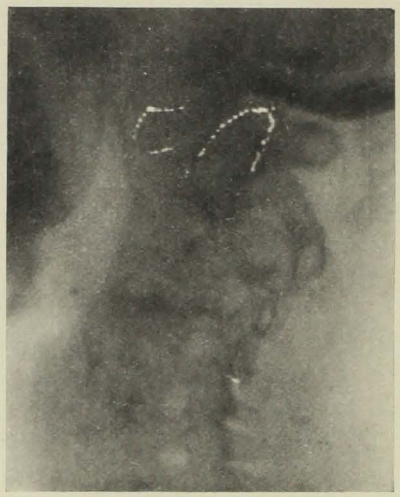

FIG. 3.—L. W—. DOTS OUTLINE ANTERIOR ARCH OF ATLAS AND ODONTOID PROCESS OF AXIS. IT WILL BE SEEN THAT THE ATLAS IS DISLOCATED FORWARD ON AXIS.

(2) As illustrating his remarks regarding the absence of symptoms of compression of the cord in dislocation due to disease. In this case nearly total compression of the cord must have occurred. D. S. P.

"HOUSE SURGEON ON DUTY."

IT is well known that the life of a house surgeon is one full of experience, but how many can realise what it is to be house surgeon on duty unless they have at some time fulfilled that onerous task? The experience gained during these three or four days, as the case may be, is great and far reaching. H.S./D. for once in his life seems to hold an important position; he has a bell of his own which reminds the whole hospital of his existence; he has, or thinks he has, numerous people at his beck and call—porters, dressers, nurses, the steward, whom he can worry endlessly when he has no beds of his own, and, last but not least, his chief who sleeps at his mercy. H.S./D., though a prisoner in the hospital, comes much in contact with the outside world.

H.S./D., if he is lucky during the night and does not have to get up in the small hours of the morning, commences his day's work at 10.0 a.m. by starting his morning round in

the wards. Of course, after one bad night's rest, when he still feels a little sleepy, he notices that one or two sisters are a little irritable; after two bad nights, sisters and perhaps "blue belts" are not so pleasing as they might be; but after three or four bad nights, when H.S./D. feels just alive, sisters, nurses, dressers, porters and everyone else do something wrong and try to hinder instead of helping him. He appears to be the only person who can do anything right.

It is not until duty is well over and his weary mind has been rested that he begins to realise how tired and irritable he has been. He then sees how sisters, dressers, nurses, and porters have helped him, and he begins to wonder why he does not appear to have made for himself many enemies. Fortunately, tired looks win a lot of sympathy.

When the round is finished an appetite for lunch begins to make itself felt. Unfortunately, one's board has to be altered before this can be satisfied, and one usually finds messages there such as "Case in S——," "Wanted in ——," or "Please ring up ——." The main importance of such messages to H.S./D. is that they disturb his lunch.

H.S./D. is seldom allowed to have his meals in peace. To sit down and prepare for a meal in comfort is a sure signal for someone to worry him; especially is this the case at dinner when he is also on duty in the Surgery. I well remember a busy Sunday on duty when I had tried hard to find time for tea. I had just sat down and commenced tea when a porter came and said that a doctor who knew my father very well wanted to see me about a patient he had sent in. As he was waiting at the top of the steps leading to the dining hall, I hurriedly finished my tea and went to see him. I had never seen him before, and I am certain that my father had never seen him. The conclusion I came to was that the old gentleman thought that a house surgeon was the son of the surgeon.

After lunch, the surgeon arrives and either "goes round" or operates. From what I have already said, it is obvious that, especially towards the end of duty, he appears to make his round very long and to talk at great length about every case to his following, who also appear for some reason to be abnormally interested and to encourage him to continue his words of wisdom. It never dawns on H.S./D. when he is very tired and has more work to do than appears possible, that duty cases are very interesting and provide much scope for learning. All H.S./D. thinks about is getting the round over as soon as possible.

At 6.0 p.m. the surgical receiving officers go off duty, and H.S./D. is on duty both for in-patients and out-patients in addition to being on duty for a variable number of house surgeons, including throat and ophthalmic house surgeons, who may go out. This is the time at which H.S./D. commences to be really busy. There is always plenty of work to be done in the wards, and though the night dresser tries hard to keep the surgery under control, yet casualties have a wonderful way of making one very late for dinner. It is impossible to give any accurate idea of the work of H.S./D. from now onwards. His work is most variable and so cannot be described except at great length. One evening on duty I did not see a single patient after dinner, on other occasions I have never ceased seeing patients till well into the small hours of the morning.

As a rule, a patient comes to the hospital in the evening who requires an operation. As soon as the case has been examined the surgeon is telephoned for, and while he is on his way to hospital the theatre has to be got ready, an anæsthetist has to be provided, porters have to be told what ward to take the patient to and what time the patient has to be in the theatre, and the sister of the ward has to be told that a patient is being sent in. What an offence it is if the sister is not told! Most sisters seem quite satisfied if they are told one minute or less before the arrival of the patient in their ward.

When the surgery is full of patients to be seen before the arrival of the surgeon, it is very easy to forget to tell someone that an in-patient has arrived. The result will obviously be disastrous. Either the patient will not arrive at the theatre, or there will be no anæsthetist, or the theatre will not be ready, as the case may be.

The surgeon, when he arrives, seems to have a wonderful gift for asking his H.S. questions that he cannot answer. He may know all the surgeon expects about the history and physical signs, but such questions as "What is the name of the doctor who sent this case up?" "When did he first see a doctor?" "What is the age or occupation of the patient?" are very puzzling. I could never remember to ask them all, and if I managed to ask the doctor's name I was sure to forget to ask the age of the patient.

When everything is ready for the operation to commence the H.S. longs to hear his chief say, "You do this." There is much more to be learned by doing one operation than by watching several. A surgeon who, when he is tired after a day's work, is content to help his H.S. who will take much longer to do the operation than if he did it himself, is doing his H.S. a very good turn, and one that will not be forgotten. When the operation is over and when the surgery is cleared, H.S./D., accompanied by his night dresser, does his night round and then retires to the "middle room" in the Surgery, where he and his dresser find cocoa always ready. This is about the only time when H.S./D. can expect to be left unmolested. Cocoa in peace after rushing about all day is greatly appreciated. The time has arrived when there is an opportunity of easing one's mind by giving vent to the most important scandal of the day, and for soothing one's temper before going to bed if it has been unduly irritated.

The time at which H.S./D. retires to bed is variable. He can never retire before midnight, and he often does not get to bed till after 2.0 a.m. When he does get to bed his sleep is an uncertainty. Some nights he will be unmolested; others he will be worried one or more times. Much

depends on having a competent night dresser, and much depends on the porter. Nothing is more annoying than to have a porter come and wake one up by mistake for someone else, and perhaps offering you a district clerk's letter, but I suppose there are very few who have not had this experience. H.S./D. may be called to patients in the wards or to cases in the Surgery, especially police cases. The latter seem frequently to come about 8.0 a.m.—a very bad time if he has got to bed late, because by the time the patient has been seen it is too late to return to bed, and an hour's sleep has been lost.

So much for the life of H.S./D. I will now pass to those he comes in contact with. Humour and pathos are often closely associated, especially in the Surgery. Some patients have trivial maladies, some, especially when of military age, have no maladies, and some are struggling hard between life and death. The former usually come direct to the Surgery; the latter are, as a rule, sent up by some doctor outside, unless the case is an accident. Trivial maladies are usually the ones which are apt to test the temper of H.S./D. Some of these patients say immediately that there is nothing much the matter and do not try to over-estimate their maladies. They are easily dealt with and soon satisfied. The chief offenders are talkative mothers who bring small children and who try to exaggerate to a most wonderful degree. A mother one day brought a small boy who frequently had mild attacks of facial erysipelas. When asked what she had brought the boy up for, she started at a terrific rate explaining what a good boy he was, how well he did at school, and how well he behaved to his brothers and sisters. After a lot of persuasion she got more to the point and finished emphasizing the degree of swelling by saying that "Yesterday his little face was as flat as yourn." Some patients regard it as an unpardonable offence if they are not attended to immediately. Returning from the operating theatre one evening, I looked into the female duty box to find an excited young lady on a police stretcher—she had been knocked down by a bus but did not appear to be badly hurt. She gave me the following greeting: "Now, young man, when am I going to be attended to?" A more polite patient was first attended to, and then we returned to this excitable nuisance. She said she had hurt her arm and back. Her arm she allowed to be examined, but she flatly refused to have her back looked at. The police demanded the nature of her injuries; they were, of course, not forthcoming. They decided to telephone to their station to ascertain what was to be done in such cases. In the meanwhile the patient was aided off the stretcher by two confederates and limped out of the hospital. When the police returned from the telephone they ran out into the street carrying their stretcher, in search of their *protégé*, much to the amusement of the waiting patients.

I gently rebuked a patient one day for coming very late when she could have come earlier. Her reply was somewhat embarrassing: "Go on; I don't want to see you, I want the head doctor"—the night dresser.

Duty brings one in contact with an interesting type of patient—one who finds it profitable to meet with a trivial so-called accident. His disease is "Kompensitis." He is, as a rule, easily found out, but sometimes one cannot be absolutely certain that he is a fraud when seen for the first time. Write on his paper "Kompensitis," and when he comes again whoever sees him will be on guard, and will often be able to save the hospital the expense of skiagrams and medicine. When he returns he is sure to ask for a certificate.

Having made a few remarks about patients with trivial maladies, I will say a few words about those who are seriously ill. These patients, as I have already said, are usually sent up by a doctor from outside under whose care they have been, some for a short time and some for a considerable time. How many doctors realise that they can lighten the arduous duties of H.S./D. to a very great extent by sending a letter with the patient, giving an account of the symptoms while under observation, and stating what conclusions they have arrived at? What a help it is if a doctor takes the trouble to telephone to the hospital and ask if he may send a patient up, and to give an account of his patient. What a help it is if a doctor sends a patient up at a reasonable hour, and does not wait until he sees him late at night and then in despair sends him up. Unfortunately a large majority of medical practitioners do not seem to consider the hospital and those working there in the least. They seem to regard the hospital as an institution where they can put the responsibility for their patients on other shoulders at any time they like. I wish it were possible to publish prints of some of the documents sent by doctors with patients. Some patients are sent without anything at all, others bring a doctor's card or a dirty, ragged piece of paper with some such remark on as the following: "Admit this patient suffering from appendicitis," "This is to certify that —— is suffering from acute appendicitis and should be operated on immediately," "Hip disease ? ? lameness, etc." (a case of cerebro-spinal fever), "Speech defective, slight nasal obstruction, bad teeth, eczema of scalp."

I will give one example of what thoughtlessness on the part of the doctor may lead to. One night, at 11.45 p.m., a porter fetched me and said there was someone in the Surgery who wanted to see me about a patient. When I arrived in the Surgery I found two women there who had been sent by a doctor to know if we would take a patient in who was very ill. I asked if the doctor had said what he thought was the matter with the patient, or if he thought she needed an operation. I was at once informed that the doctor had told me all about the patient in a letter he had sent by them. The letter consisted of the doctor's card, on the back of which was written: "Abdominal symptoms, etc., etc." I was told that it would take them an hour to

get home and an hour to bring the patient up. That is to say, that the patient would arrive at 2 a.m. Supposing, now, that an operation had been necessary. The patient would first have to be examined, then the surgeon would have to be telephoned for and brought to hospital—not an easy thing when there are no taxis or 'buses—then an anæsthetist would have to be fetched out of bed, and finally the night dresser would be kept up, to say nothing of the troubles the nursing-staff would be put to. The operation could not commence till 3 a.m. at the earliest and would be over, roughly, at about 4 a.m. The surgeon would then have to go home before returning to bed. How much sleep would any of us get, all of whom have to face another hard day's work? Fortunately, the case was not a severe one. The doctor, however, thought an operation would be necessary and could easily have sent the case up earlier, for she had been under his care for some few days. He was on the telephone, and could have saved time by telephoning instead of sending up relatives who knew nothing about the case.

From time to time one hears complaints that house-surgeons do not let the practitioner know the progress of their patients. Is it surprising?

Patients occasionally send or bring humorous letters to hospital. The following is one brought by a Russian Pole, who knew very little English: "Dear Sir, I am asking you to cure my hand, because when I take anything up into my hand, it falls down. I have not got any strength in my hand and it hurts me very much. Will you please oblige me by curing it as soon as you can? My head also hurts me very much and will you please give me a medicine to it."

The next was one sent from Scotland: "Dear sir I should Esteem it a favour if you could oblige me by sending to the above address a few doses of medicine or a plaster for my back I get such pain round the Kidneys and feel tired when I rise in the Mornings has if I had never seen Bed I think it Must be a laxy liver I am a Married Woman age 3–6 years my husband is a Disabled Soldier we are here has he is doing light Work for goverment and there is not a shop yet in this village or a doctor for a good few miles of course we will get all in good time has they are Building fast I have been a out-patient at good old St. Barts on and off from a girl and here we are in a small village without Medical advise and dont know how to Manage I hope you will pardon me for asking I am Enclosing a postal order for a shilling and will willingly pay more if it is required from an old patient."

The last is from a patient whose name is on the books for admission. She had an inguinal hernia. "Sir, Would you kindly let me know when I am coming in to go under my operation as I think I have waited long enough it is just 10 weeks since I first came to the hospital, and I came up a fortnight ago and you said it was a mistake and you would look it up and send the next week and I have not heard yet and my husband is get rather out of temper over it he said while I am waiting I am get worse and not better so you might let me know as soon as you can as I should like to get the operation over as soon as I can as I am feeling very bad lately." S. W. B.

THE DUGGOUT MSS.

From "The Athenæum," April 6th, 3333.

IN the course of recent excavations on the frontiers of northern Boschia the distinguished archæologist, Prof. Cyrus G. Whizz, of Toshville, Pa., has discovered a most interesting series of remains dating back to the barbarian invasions of the twentieth century, including MSS. probably cœval with the famous "Mud Hall" or "Errorregretted" Tractate. One document in particular (S/mr 54321) gives most valuable information on the religious tenets of this epoch. The MS., which is English of the Middle Georgian dynasty, is in holograph, written on sheets of poor quality paper, headed in printed letters "A.F.2121." The document, probably a protocol, abounds in glosses and erasions. From other papers found in the same cave—MSS. bearing the formula of invocation, "Foryourinformationandactionplease," and incunabula relating to "Feet bitten frost prevention of"—coupled with the discovery of a very well-preserved mummy in an adjoining cave, Professor Whizz deduces that the author was a Reggi-mentalmedikkalorfisser, a member of a lowly but dreaded class of the priestly or Luddybrahzat caste, who died—as these men frequently did—of mental inanition and hæmorrhagic kyphosis. From internal evidence it is safe to assume that the MS. dates to the first ten or fifteen years of the war, as reference is made to "rifles"—archaic weapons abandoned in favour of primitive bows and arrows at least fifty years before the final extirpation of the Hunderpest.

Translation of the document:—

During the past months and years of subterranean seclusion I have reviewed all the sins of my past life—after all, there is no other amusement. I have meditated on the normal tonsils I enucleated, on the furuncles I submitted to Schwartzes, on the straight septa I resected; but most of all have I pondered on the night when I accidentally became a [two words illegible]. It was two years before the war—to be precise on Tuesday, February 28th, 19—. I was a cutter then, and my firm came off duty at midday. On that day I did thirteen blood counts. When I handed the last three to my HS and expectantly awaited his thanks, he informed me casually

that one patient had discharged himself, one had already died, and the third had been recognised by Herbert and several members of the Senior staff as a gentleman suffering from an inordinate passion for laparotomies. He then wrote "HSD" on his board and left hurriedly. Shaking the dust of the R.S.Q. from my feet with a suitable word or two, I went in search of a beefsteak which I found somewhere near Chancery Lane. By 8.30 I felt much better and returned to my rooms. With great presence of mind I carried a volume of Choyce, which looked offensively aggressive, with a newspaper, and took a Kipling at random. Then things began to go wrong. The fire smoked, a cinder fell into the milk, my pipe would not draw, and I had got hold of "The Plain Tales" and wanted "Kim."

I went to the window. It was a beastly night. The wind was getting up and the rain was coming down. Lamps shone sulkily on wet pavements, and in a house opposite someone played ragtimes. Then down the deserted street there pranced stealthily a conspirator. He was obviously a conspirator and obviously in love with his profession. For no other reasons would anyone prance stealthily on a wet night in so uncomfortable and conspicuous a costume as a black mantle, a mask, sombrero and cock's feather. Exactly how I got into the street I never know, but I do know that a desire for vengeance on the upper middle classes in general, and my HS in particular, lent me speed. The stranger gripped my arm. "Any Tb. found?" he hissed. Automatically I breathed the familiar reply, "None present!" "Good—Good!" He almost ejaculated, "I knew you were one of us! But hurry! Hurry! We are already late, and to-night we brew the vaccine of vaccines!" Strangely thrilled by his words I joined in his headlong course. Faster and faster we went; we crossed the river; we passed through Clapham and through Balham—through places, such as Tooting, that I had never believed in before; and as the country grew wilder and more desolate, so we went the faster till we seemed to outstrip the howling wind. And now the night was full of noises. Strange shapes flapped past us yelling and muttering, but all were crying the same thing, "The vaccine—the vaccine!" Suddenly we stopped in a dreary and ghoulish plain waste. A large notice-board showed the words "To the Blasted Heath," and in the distance the sky was lit by the sinister glow of a red-hot autoclave, round which there danced a ring of white-coated figures shrieking a horrible chorus that seemed to run :—

"Colonies of streptoccocus,
Tubes of Agar grey;
Stain and Culture—Stain and Culture,
Ye that Culture may!"

Then, too late, I realised what I had done. Unwittingly I had intruded on a witch-sabbat of Pathologists! My blood nearly coagulated with terror, but there was no means of escape. I plunged into the thickest part of that unholy concourse, and listened in horror to the frightful blasphemies that resounded on every side. An elderly wizard entered into conversation with me. He introduced himself as Dr. Faustus. I asked him if it was true that he had been torn in pieces by several devils? He protested, on his honour, that the episode had been greatly exaggerated. "That was Marlowe's doing," he said. "Dear old Bill Shakespeare, that most original pathologist . . ." "Pathologist?" I asked. "To be sure; it was he who first worked out the so-called Wassermann reaction. Surely you remember the preparation of the antique, 'Liver of birth strangled Babe . . .'" Suddenly we were interrupted by a most extraordinary uproar. "The Amboceptor!" cried all the sorcerers, "The Amboceptor himself!" and a stately personage advanced through the crowd. I recognised him at once. That was not exactly the name under which he was usually known; but his frontal development, his well-marked caudal vertebræ and the curious malformation of his feet made mistakes impossible. Enthroning himself on the red-hot autoclave and fanning himself gently with his tail, the Amboceptor began a short speech: "My most beloved subjects—A few hundred years ago witches and sorcerers were my special *protégés*, and it is with the deepest and most heartfelt gratitude that I meet you to-night. Truly you carry on the good work. They drew their victims' blood—so do you! They cooked it according to a careful ritual—so do you! They readministered the fluids like you, and their subjects died in horrid agonies—so do—ahem!" (here his Majesty was seized with a violent fit of coughing). He continued: "To-night I am with you for a great event—we brew the vaccine of vaccines! You know how some of my dear servants in that spiritual home of mine upon the Elbe have discovered a new disease—the pan-lecithin syndrome of Dumpkorf and Doustor-swivel! It has only one disadvantage—it doesn't exist. But this can be remedied. Once the vaccine is brewed . . ." He stopped, then suddenly: "There is an intruder among us!" he thundered. "Oh, impossible, your majesty!" said one of the courtiers. "Nonsense! I tell you there is! I distinctly saw a man with a stain of aniline gentian violet on his forefinger! Do you mean to tell me that any demonstrator would so far forget himself as to stain a film or a section? That man has been working—yes, working!" Only one thing could have saved me, and that one thing happened; the autoclave exploded, and I was hurled through the air till I came down on the floor of my sitting-room. . . .

The rest of the MS. is missing. "ESTOC."

STUDENTS' UNION.

COUNCIL Meeting May 4th, 1916, Mr. Waring in the chair.

It was suggested and agreed to that the small surplus remaining over from the subscription to the Etherington Smith Memorial Fund be applied to the purchase of one or more shares in the S.B.H. Catering Co.

Any old Bart.'s men who wish to dispose of shares are invited to communicate with the Secretary.

CORRESPONDENCE.

SKEY'S LAST LECTURE.

To the Editor of the 'St. Bartholomew's Hospital Journal.'

SIR,—On reading over Mr. Dunn's letter in your current issue, a possible explanation of our differing accounts occurs to me.

Skey was announced to give four lectures. At the first two I was present, and I remember them perfectly. The first began, as aforesaid, "What's the use of Tincture of Iodine?" The second began, "Gentlemen, I once delivered a lecture before the Royal College of Surgeons on a piece of string." Then he held up a piece of ligature silk, and proceeded to lecture on the various surgical uses of a piece of silk—ligatures, sutures, and "old, forgotten, far-off things, and setons long ago." He was keen on the treatment of fistula in and by a loosely-tied ligature, left to cut its way out. So was Holden. On the strength of their teaching, I tried it myself a few times in the early years of practice; but I never got very satisfactory results from it, and gave it up.

There remains a third lecture. That, frankly, I remember nothing whatever about. And it is probable, as Mr. Dunn suggests, that I was not there, and that he was. That accounts for his having witnessed the painful scene which he describes, and which, I am happy to say, I did not witness. And that *was*, as a matter of fact, Skey's last lecture; but it was *not* his last appearance at the hospital. He came to lecture again the following week. I was going to this lecture, and somehow I was a few minutes late, and as I reached the foot of the stairs of the Anatomical Theatre, there were three or four men coming down. One said to me, "No lecture." "Why, what's up?" "The old man came to the door, looked in, said he never had lectured to four men, and he'd be damned if he ever would!—turned on his heel and walked out again. Poor old buffer!"

As to that I am absolutely certain. Circumstance and phrase fixed it firmly in my recollection. I wish I could remember who were the men coming downstairs; but that is a sheer impossibility. Is it not possible that, even now, one of them may see this letter, and remember the circumstance?

I am sorry that the old tale has been dug up, and put into cold print, forty-and-four years after its occurrence. It would have been better left to the forgetfulness that must have soon been its portion.

HARRY LUPTON.

To the Editor of the 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—An error has crept into your Editorial Notes of May number. Dr. Warrack has recently been appointed as my "deputy."

Yours faithfully,
W. M. WILLOUGHBY,
M.O.H., Port of London.

P.S.—The appointment of M.O.H. was made on February 3rd.

May 22nd, 1916.

ST. BARTHOLOMEW'S HOSPITAL WOMEN'S GUILD.

THE Fourth Annual Meeting was held as usual on View Day, in the Great Hall, in which were spread two tables decorated with flowers. Lady Sandhurst received the guests and afterwards presided at the Meeting. The usual business was transacted, and a resolution, moved by Capt. Elmslie and seconded by Mrs. Tooth, was passed, authorising the Guild to spend £5 a year on helping children referred to the Hospital by the Invalid Children's Aid Association. It is not a large sum, and we wish our funds enabled us to do more social work in connection with the patients; however, this is a beginning, even though a small one.

In the absence of Lord Sandhurst, who was unable to stay for the Meeting, Sir Anthony Bowlby, on leave from the Front, proposed a vote of thanks to Lady Sandhurst. In eloquent terms he spoke of the heroism of our soldiers, and how well indeed they are worth all the Guild can do for them.

Our membership showed last year a great increase owing to the war. This year we have nearly one hundred fewer names in our Report. We much hope our next Report will show an improvement. Are there not many ladies interested in St. Bartholomew's who have not yet joined us, and may we hope they will do so now?

MILLICENT MOORE,
Hon. Sec.

REVIEWS.

CLEFT PALATE AND HARE LIP. By Sir W. ARBUTHNOT LANE, Bart., M.S., F.R.C.S. Third edition. Pp. 102. (London: Adlard & Son.) Price 10*s*.

Sir Arbuthnot Lane's book on cleft palate is not to be recommended to students; it is meant for those engaged in the practice of surgery. The book is a monograph, not only in the sense that it treats of a single subject, but also in the fact that it deals only with the views of the writer. In the main part of the work no changes of importance have been made, although a short statement has been introduced dealing with the immediate mortality of the author's method of operation, the reader will still look in vain for any consideration of the ultimate results. This is surprising, in view of the excellence of recently published series of cases treated by the older operation of Langenbeck, and considering the widely held belief that the results of the "turn-over flap operation" compare unfavourably with these.

The book now contains very interesting new chapters on "Speech Training," by Mr. Cortlandt MacMahon," and on "Dental Treatment," by Mr. Warwick James.

SERUMS, VACCINES, AND TOXINS. By W. C. BOSANQUET and J. W. H. EYRE. (Cassell & Co.) Pp. 456. Third edition. 9*s*. net.

A fairly complete little volume dealing with treatment, diagnosis, and prophylaxis. The usual chapters on immunity and resistance open the book, and are not as full or concise as would seem necessary to us; the later portions of the work, dealing with specific diseases and reactions are, however, excellent. In this new edition considerable space has been devoted to chemotherapy and the action of arsenical compounds and dye-stuffs upon protozoal para-

sites. We agree with the author that, although these are scarcely serums, vaccines, or toxins in the usual meaning of those words, yet their action depends upon fundamentally the same principles and makes their inclusion necessary.

THE AFTER-TREATMENT OF OPERATIONS. By P. LOCKHART-MUMMERY. (Baillière, Tindall & Cox.) Pp. 275. Fourth Edition. Price 5*s.* net.

This little work is well known to many of our readers, and its importance to house-surgeons cannot be over-rated. At the present moment, with so many "physicians" pitch-forked by the war into surgical wards, the appearance of a new edition is very opportune. A new chapter on gunshot wounds has been added, and the chapter on surgical shock has been re-written. The after-treatment of abdominal cases has received special attention and is excellent in every way. The book can be confidently recommended to all newly qualified men and to such others as have charge of surgical wards or operation cases.

THE PATHOLOGY OF TUMOURS. By E. H. KETTLE. (H. K. Lewis & Co.) Pp. 224. Price 10*s.* 6*d.* net.

This excellent little work deals chiefly with neoplasms and their differential diagnosis. The text is short and concise, and the illustrations, many of which are coloured, are very clear and in the main typical, though, as might be expected where most of the illustrations are original, a few appear to be so atypical that one would not recognise them without a close perusal of the text. The photographs of naked-eye specimens are especially good, and the book should be of great service to students taking the higher examinations.

DISEASES OF THE NOSE AND THROAT. By SIR STCLAIR THOMSON. (Cassell & Company, Ltd.) Pp. 858. Coloured plates 22. Second edition. 25*s.* net.

This well-known work was first published four years ago, but since that date advance in rhino-laryngology has been steady, consequently this edition has been revised from beginning to end, and most of the new methods have been included. A description of suspension larygoscopy has been added, as also the technique of nerve blocking to obtain laryngeal anæsthesia. New sections on intra-nasal dacryocystostomy, and on the nasal route to pituitary tumours, have also been added. The text is clear, and the many illustrations are excellent. The volume is quite up to date, and should be of great service to senior students, and the increasing importance attached to the diseases of the nasal passages in everyday work should render the book of much value to practitioners as a work of reference.

EXAMINATIONS.

UNIVERSITY OF CAMBRIDGE.

Second M.B. Examination. May, 1916.

Part II: Pharmacology and General Pathology.—B. F. W. Armitage, C. V. Braimbridge, G. E. Burton, A. J. Copeland, E. G. D. Murray, E. D. Spackman, H. F. Squire.

UNIVERSITY OF LONDON.

Second Examination for Medical Degrees. March, 1916.

Part I: Organic and Applied Chemistry.—C. L. Hewer, J. N. Leitch, W. E. Lloyd, N. S. B. Vinter.

Part II: Anatomy, Physiology and Pharmacology.—W. B. Christopherson, H. C. Cox, R. Coyte, H. N. Hornibrook, M. Jackson, R. J. Perkins, B. B. Sharp, G. P. Staunton, N. Synn, A. D. Wall.*

* Distinguished in Anatomy.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

At the meeting of the Royal College of Physicians of London held April 27th, 1916, the following were admitted:

Fellows.—J. A. Arkwright, E. A. Cockayne.

Member.—H. H. Scott.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

Final F.R.C.S.

The following were successful at the Final Examination for the Fellowship held in May, 1916:

R. S. Lawson, C. W. B. Littlejohn.

Primary F.R.C.S.

The following were successful at the Primary Examination for the Fellowship held in May, 1916:

H. B. Bullen, R. J. Perkins.

CONJOINT BOARD EXAMINATION.

April, 1916.

The following have completed the examinations for the Diplomas of M.R.C.S. and L.R.C.P.

P. O. Ellison, K. D. Atteridge, E. A. Fiddian, N. N. Haysom, D. S. Brachman, S. G. Dunn, R. C. Davenport, L. W. Evans, P. S. Clarke, J. Aydon, R. R. Powell, H. M. Cohen, W. F. Eberli.

NEW ADDRESSES.

L. B. CANE, Station Hospital, Dilkusha, Lucknow.

G. CAWLEY, Port Shepstone, Natal, South Africa.

G. V. WORTHINGTON, Mangalore, Llandrindod Wells. (Has relinquished his temporary Commission in the R.A.M.C.).

APPOINTMENTS.

W. E. L. DAVIES, M.R.C.S., L.R.C.P., appointed District Medical Officer of the Newtown and Llanidloes Union.

Lt.-Col. F. E. SWINTON, I.M.S., appointed Deputy Director-General of the Indian Medical Service.

J. S. WARRACK, M.D.(Aberd.), D.P.H.(Cantab.), appointed Deputy Medical Officer of Health for the Port of London.

BIRTHS.

BODY.—On May 11th, the wife of Thomas M. Body, R.A.M.C., of Dowlais House, Middlesbrough, of a daughter.

DOTTRIDGE.—On April 4th, at 12, Portland Court, W., the wife of Cecil A. Dottridge, M.B., of a daughter.

MARRIAGE.

RYLAND—MOORE.—On May 17th, at The Hirsel Private Chapel, Coldstream, N.B., Capt. Archer Ryland, F.R.C.S.Ed., and R.A.M.C., son of Mr. and Mrs. Woodcoat Ryland, of 43, Holland Park, London, W., to Gladys Mary, daughter of the Rev. C. A. Moore, Domestic Chaplain to the Rt. Honble. the Earl of Home, K.T., and Mrs. C. A. Moore, of The Hirsel, Coldstream, N.B.

ACKNOWLEDGMENTS.

Guy's Hospital Gazette, The Nursing Times, New York State Journal of Medicine, Long Island Medical Journal, Middlesex Hospital Journal, The Shield, St. Mary's Hospital Gazette, St. Thomas's Hospital Gazette, British Journal of Nursing, The Hospital, London Hospital Gazette, Giornale della R. Società Italiana d'Igiene, L'Attualita Medica, The Medical Review, Otago University Review.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, Smithfield, E.C.*

The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., *at the Hospital.*

All communications, financial, or otherwise, relative to Advertisements ONLY, should be addressed to ADVERTISEMENT MANAGER, *the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City* 510.

A Cover for binding (black cloth boards with lettering and King Henry VIII Gateway in gilt) can be obtained (price 1s. post free) from MESSRS. ADLARD & SON AND WEST NEWMAN, *Bartholomew Close. (Temporary offices: 76, Newgate Street, E.C.)* MESSRS. ADLARD & SON AND WEST NEWMAN *have arranged to do the binding, with cut and sprinkled edges, at a cost of* 1s. 9d. *or carriage paid* 2s.—*cover included.*

St. Bartholomew's Hospital

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

JOURNAL.

VOL. XXIII.—No. 10.] JULY 1ST, 1916. [PRICE SIXPENCE.

CALENDAR.

Mon.	July	3.—Second Exam. for Med. degrees (London), Part II, begins. M.D. and M.S. Exams. (London) begin. Second Exam. of Soc. of Apothecaries begins.
Tues.,	,,	4.—Final Exam. Conjoint Board (Medicine) begins. Dr. Garrod on duty.
Wed.,	,,	5.—First Exam. of Soc. of Apothecaries begins.
Thur.,	,,	6.—Final Exam. Conjoint Board (Midwifery) begins.
Fri.,	,,	7.—Final Exam. Conjoint Board (Surgery) begins. Dr. Calvert and Mr. Bailey on duty.
Sat.,	,,	8.—Oxford Trinity Term ends.
Mon.,	,,	10.—First Exam. for Med. degrees (London) begins.
Tues.,	,,	11.—Dr. Morley Fletcher on duty.
Thur.,	,,	13.—Second Exam. for Med. degrees (London), Part I, begins.
Fri.,	,,	14.—Junior Scholarship Exam. Dr. Drysdale and Mr. D'Arcy Power on duty.
Sat.,	,,	15.—**Summer Session ends.**
Tues.,	,,	18.—First Exam. Conjoint Board begins. Dr. Tooth on duty.
Fri.,	,,	21.—Dr. Garrod and Mr. Waring on duty.
Tues.,	,,	25.—Dr. Calvert on duty.
Fri.,	,,	28.—Dr. Morley Fletcher and Mr. McAdam Eccles on duty.
Tues.,	Aug.	1.—Dr. Drysdale on duty.
Fri.,	,,	4.—Dr. Tooth and Mr. Bailey on duty.

EDITORIAL NOTES.

THROUGH the instrumentality of Dr. Horton Smith Hartley, a gift of a billiard table has been made to the Junior Staff. The donor is Sir Lumley Smith, K.C. The table is in excellent condition and is supplied with all the necessary equipment.

The Governors of the Hospital have very kindly divided off a section of the basement of the new Surgery and fitted it up as a billiard room. The manner in which this has been done makes the room one of great comfort and a suitable housing for the very fine table which has been presented.

The thanks of the Junior Staff to both Sir Lumley Smith and the Governors of the Hospital cannot be expressed in any other way than by the good use which they make of it. On May 3rd, 1916, the Junior Staff entertained Sir Lumley Smith to dinner in their quarters, and on this night the table was used for the first time. Mr. Hayes, as representing the Governors of the Hospital, was invited, but unfortunately he was unable to be present. The Warden took the chair, and Mr. Green, in a speech of well-chosen words, thanked the donor. Sir Lumley Smith, in replying, hoped that the Junior Staff would benefit in their recreations by utilising the table.

* * *

The billiard room is for the use of the members of the Junior Staff only. Others are not allowed to play in this room unless they are invited to do so by a member of the Junior Staff, and if they so play, one of those playing must be a member of the Junior Staff. The room is not to be opened until after 5 o'clock in the evening. The control of the room is in the hands of the Warden.

* * *

With very much regret we learn that the son of yet another of our Consulting Staff has died as the result of wounds. Lieut. J. D. Champneys was officially reported "missing, believed wounded," in France on November 22nd, 1915. He is now known to have been captured by the Germans and to have died of his wounds the following day. He was educated at Rossall School and Balliol College, Oxford, taking honours in the Final School of Laws. Our deepest sympathy is extended to Sir Francis and Lady Champneys in their bereavement.

* * *

It is with the greatest regret that we have to record the death of Lieut. H. J. S. Kimbell, R.A.M.C., who died of pyæmia on May 28th after a lingering illness. At the time he contracted his illness he was holding an appointment at the Preston Hall Hospital, near Maidstone. Our deepest sympathy is extended to his relatives and friends.

* * *

It is with much pleasure that we are able to announce

that Colonel H. Hendley, M.D., I.M.S., has been appointed to hold charge of the office of the Director-General, I.M.S., in addition to his own duties of Inspector-General of Civil Hospitals of the Punjab; also that Lieut.-Colonel F. E. Swinton, I.M.S., has been appointed to be Deputy Director-General, I.M.S.

FROM THE FRONT.

SOME EXPERIENCES AND TIPS FROM A BASE HOSPITAL.

THE following notes may be of some interest to any recently qualified men who happen to find themselves at a Base Hospital. Senior men will certainly make the remark that there is nothing new in all this, and scientific men will quite rightly say that statements are made that cannot be backed up by any scientific data.

The surgical work at a base hospital consists chiefly in fighting against sepsis.

For the first four months of the war my work consisted in treating the lightly wounded. I was then put in charge of the surgical cases, and was persuaded to use hypertonic saline for the acute stages of sepsis. It may be worth mentioning here that a number of people consider this treatment to be useless, but this, I think, is because they continue using hypertonic saline after the acute stage is over. There is no doubt that it is possible to overdo the salting treatment. This is also true of continuous baths.

At the time when the hypertonic treatment was suggested I had several cases which had been treated by antiseptics, and the change that took place after using salt was little short of miraculous. About August, 1915, it was suggested that I should open up the septic wounds and pack them with tablets of salt wrapped in gauze and then leave them for several days without dressing them. I found that in spite of the accumulation of pus the temperature did not rise, and that on cleaning this pus away one found the most beautiful granulating surface that one could wish to see. There are, however, one or two things that I should like to emphasise.

The question of "non-dressing" is an important point. The exposed surface in some of these patients with multiple wounds amounts to a square foot or more. Imagine then what it must mean to have that dressed three times a day. The anticipation of the pain is always present. In some cases it is true that anæsthetics are given, but the effect of the anæsthetic is extremely harmful in such toxic cases. As the result of nine months' experience in this treatment one can definitely state that if the pulse and temperature do not fall considerably in the first three days the wound should be dressed in order to see *whether further drainage* is necessary, but in the majority of cases the dressing *per se* will do no good at all. As a rule, after the first dressing we do not use "soloids," but pack with gauze soaked in eusol 5 per cent. and saline 10 per cent. Personally I prefer during the acute stage to keep the dressings moist by watering them with saline. The triangular bandages will be found very useful, as they can be tied on the top of the limb and untied whilst the patient is asleep without disturbing him. At the same time they do not prevent the air from getting at the wound. Before leaving this part of the subject I would urge a prolonged trial of the "non-dressing principle," and that whilst temperature and pulse are falling pus and smell *per se* will do no harm.

Talking of temperature and pulse, I should like to impress the very obvious fact that a temperature chart without the pulse rate is waste of time and paper.

In dealing with large numbers of wounded such as occur after a big engagement, it is the feel of the pulse and the pulse rate which indicate whether a man can travel further without danger. Again, when one has to decide whether it is necessary to amputate a septic limb, it is the pulse rate during the last week that decides the question. The question of amputation is one perhaps which causes me more anxiety than any other, and there is much truth in the remark made by Major Hull in his book: "The loss of a limb is a surgical failure, but the loss of life is a calamity; and the loss of life after amputation is a frank admission that the surgeon did not know when to operate." Experience alone can teach one when to amputate, and it is useless to try and write down hints. The importance of flapless operation has been emphasised by Colonel Gordon Watson and others, but I do not think that enough emphasis has been laid on the benefit of lumbar anæsthesia in amputation of the lower extremities. This question is so important that I should like to pass on a few hints that bitter experience has taught me.

(1) Do not think it is difficult to give a spinal anæsthesia.

(2) Do the first two or three under general anæsthesia on patients who are not very ill.

(3) Give the patient omnopon, a third of a grain, half an hour before.

(4) See that the buttocks and shoulders are raised enough to give the curve with convexity downwards, the lowest point corresponding to about the first lumbar vertebra.

(5) Put the patient on the side of the affected lower limb.

(6) Boil cannula in water *without* soda. Distilled water is best. Soda destroys the stovain.

(7) Do not put cannula or syringe in any antiseptic such as alcohol, etc. Most people consider stovain and glucose, as prepared by Poulene Frère, to be the best. Anæsthesia, in the majority of cases, is complete after three to eight minutes. As soon as the anæsthesia has reached the level of the buttocks the patient should be turned on to his back. Not infrequently the patient feels a little sick about

ten minutes after the injection, but if he takes a deep breath and holds it this feeling of nausea soon passes off. I am convinced that lumbar anæsthesia is the very best way of diminishing surgical shock. To see a patient who ten minutes previously has had an amputation through the thigh, sitting up eating a hearty meal, is the best advertisement for this method, and why it is not more used I cannot understand.

(8) Insert the cannula *in the middle line* between the spines of lumbar vertebræ three and four—not to one side, as so many books suggest.

(9) Make the patient "round" his back as much as possible.

The treatment of compound fractures is one of great importance. Everybody now is familiar with the splints devised by Colonel Robert Jones, and so there is no need to describe them here. The "bed lifts" made by Messrs. Carters do not seem to be used as much as they deserve. They are invaluable, and can be easily put together without disturbing a patient at all. There is one important point, however, namely, to see that the canvas slings are loosened every time after use, otherwise the patient will get bed-sores. The advice about "non-dressing" applies equally to compound fractures as to simple flesh wounds. The question of removal of bone in some cases is a difficult one, but, in my experience, it is best to leave as much bone as possible the first time the wound is drained. If, however, the case runs an unfavourable course and further drainage is necessary, then it is advisable to remove all the small pieces.

The other two lines of general treatment I mentioned are continuous irrigations and continuous baths. Since adopting the method of "saline packing" we have not used baths and irrigations to the same extent. The cases for which a bath seems to be of greatest benefit are those where the circulation is poor and the whole limb is swollen. Frequently patients have arrived in hospital with a leg or arm tense and swollen, and the question of immediate amputation has arisen. In such cases multiple incisions and continuous baths for forty-eight hours or more have often saved the limb. The leg bath described in the *Lancet*, May 8th, 1915, is a very useful one, but it must be remembered that, after the acute stage is over, baths are of little use.

Fomentations, like the Dodo, are extinct, but, unlike that noble bird, they have their use occasionally to relieve pain, and give great benefit for superficial infections such as cellulitis.

One final tip let me give. Keep a note of all your failures, and write down at the time what you think might have been done in such cases.

MALCOLM DONALDSON.

THE INTERNMENT OF SICK PRISONERS OF WAR IN SWITZERLAND.

By A. L. VISCHER, M.D.Basle, M.R.C.S.Eng.

IT may interest the readers of the ST. BARTHOLOMEW'S HOSPITAL JOURNAL to hear some details about the scheme for the tending of sick prisoners of war which is now being carried out in Switzerland.

The first suggestion to intern sick prisoners of war in a neutral country came from Monsieur Gustave Ador, President of the International Committee of the Red Cross at Geneva. Thanks to the efforts of the Pope, who acted as intermediary at the beginning of 1916, an agreement was signed between France and Germany to the effect that a certain number of sick and wounded prisoners were to be removed from the prisoners' camps and interned in Switzerland for the rest of the duration of the war. As there are more French prisoners in Germany than Germans in France it has been stipulated that for three Frenchmen one German was to be sent to Switzerland. Two Commissions, each consisting of twenty officers of the Swiss Army Medical Corps, were appointed, and entrusted with an inspection of the various prisoners' camps in France and Germany in order to select the men to be interned. The agreement mentioned as proper cases for internment chiefly tuberculosis, chronic diseases of the respiratory tract, heart disease, arteriosclerosis, nervous diseases, and invalidity through gunshot wounds.

The practical realisation of the whole scheme is the work of Colonel Hauser, the Chief of the Swiss Army Medical Corps. For that purpose Switzerland has been divided into a certain number of districts, at the head of each of which is placed a Swiss army doctor. Each place where there are interned prisoners has a commanding officer, to whom a hotel manager is attached as special adviser. The home countries of the prisoners are paying four francs per diem for each soldier and six francs for each officer. This shows that there can be no question for the hotel-keepers of making fortunes by the arrangement. The appetite of the men is astonishing. In one place the average gain of weight of the soldiers during one week was 2 kilograms. A few details about the food may be interesting. Breakfast consists in milk, coffee, butter, and jam. The daily ratio of bread is 400 grm., of milk 750 grm. Dinner consists in soup 500 grm., meat 175 grm., 500 grm. potatoes, and 100 grm. vegetables. For supper the men receive soup, cheese or lard, rice, macaroni, etc.

The places which have been selected for internment are all well-known health resorts like Thonne, Grindelwald, Zermatt, Weggis, etc. The men are quartered in good second-class hotels. Those suffering from phthisis are sent to Leysin, Montana, Arosa, and Davos.

As there are many soldiers who need special surgical or orthopædic treatment, a special hospital has been organised by the Swiss authorities at Lucerne. At the head of this institution a distinguished surgeon, Mr. H. Brun, lecturer on Surgery at the Zurich University, has been appointed.

Only a few weeks ago an analogous agreement has been signed between Great Britain and Germany. At this moment Swiss officers are proceeding to England and Germany to select in the prisoners' camps of those countries a certain number of patients for internment. The Swiss authorities have already received numberless offers from places which would like to receive English soldiers. It is expected that most of the Englishmen will be quartered in Château-d'Oex, the famous winter resort in the Canton de Vaud.

These are only the outlines of this great work of internment and care for the sick. Switzerland will do her utmost to make it a full success and a real blessing for all those brave men who in the fight for their country have lost their health and their freedom.

BREATHING AND PHYSICAL EXERCISES FOR USE IN CASES OF WOUNDS IN THE PLEURA, LUNG, AND DIAPHRAGM.*

By CORTLANDT MACMAHON, B.A.Oxon.
Instructor for Speech Defects at St. Bartholomew's Hospital.

THE exercises herein described have been used since the early months of the war on a large number of soldiers suffering from wounds of the pleura, lung, and diaphragm, in St. Bartholomew's Hospital, Guy's Hospital, King Edward VII's Hospital for Officers, Princess Henry of Battenberg's Hospital for Officers, No. 1 Base Hospital, the Hospitals for Officers at 17, Park Lane, and Dorchester House, Mrs. Hall Walker's and Mrs. Herbert Samuelson's Hospitals for Officers. The exercises are now set out in the hope they may be of general use in similar cases.†

The chief objects of the exercises are :

(*a*) To prevent pleural adhesions forming and to break down existing adhesions by careful and gradual movements.

(*b*) To enable lungs, which have collapsed owing to pressure due to empyema, hæmothorax, and pneumothorax, to regain their normal condition.

(*c*) To reduce hæmothorax and pneumothorax.

(*d*) To restore the normal shape of the chest walls which have fallen in owing to collapse of the lungs.

(*e*) To assist the discharge of pus, where there is a drained empyema, by increasing the lung inflation.

(*f*) To improve the general condition by the tonic effects of the exercises, and especially to overcome breathlessness on exertion.

The early exercises can be carried out without moving the patient from his bed. At first an operator is necessary, who should, if possible, give the exercises daily for about a fortnight, after which time the patient can perform most of them for himself, and they should then be carried out night and morning half an hour before a meal. Great care must be taken that there is no exhaustion to the patient ; only a few exercises should be given at each treatment, and after every six movements of each exercise a rest of at least two minutes should be given. It is advisable that only the first three movements of the exercises should be given for the first three days of the treatment, and, in a case of empyema that has recently undergone operation, the first four movements only should, as a rule, be given until the drainage-tube is removed, but when the temperature has remained normal for some days more extensive movements may be applied.

When the patient can be moved from bed the exercises should be carried out on a narrow couch or table. The free movement of the arms in all directions is essential. Special attention is called to the fact that all the exercises are carried out in a recumbent position, and that on the correct performance of the first three exercises depends the success of the others. Care must be taken that the upper chest is not drawn up nor the abdominal wall contracted during inspiration. These are the two great faults often found. Any protrusion of the abdominal wall during inspiration must also be guarded against. The time of commencement of the exercises, their extent and duration, are matters entirely for the physician or surgeon who has charge of the case. A marked improvement in the appetite, the sleeping, and the general appearance will, as a rule, be noticed within a week of the commencement of the treatment.

The exercises are as follows, it being clearly understood that only a few should be carried out at each treatment, and the advance through the exercises should be gradual, and special exercises selected to suit the individual condition. Each particular exercise should be carried out eighteen times, with a rest, as already stated, after each six movements of the exercise.

(1) The operator places his hands on the side of the lower ribs level with the breast-bone. The patient should breathe in through the nose, and the lower ribs should be felt to be expanding strongly. There should be as little movement as possible of the upper chest. When the fullest inferior lateral costal expansion is acquired, the patient should breathe out through the open mouth and the ribs should be felt to regain their normal position.

* See also the *Lancet*, October 2nd, October 9th, December 4th, 1915, and January 29th, 1916, and the *Brit. Med. Journ.*, January 22nd, 1916.

† For a description of cases treated see paper by C. MacMahon in vol. xxxix of the *Proceedings of the Medical Society of London.*

(2) The abdominal wall should be contracted inwards and then allowed to recover its normal position, so that an in-and-out movement is made. (This is a physical and not a breathing exercise and can be carried out twenty to fifty times.)

(3) Combine the above movements, *i. e.* the patient breathes in through the nose and the lower ribs are felt to be strongly expanding. The mouth is opened wide and the abdominal muscles slowly and strongly contracted, so that the air is driven from the lungs.

(4) The same inspiratory movement, but the breath should be held and the abdominal muscles contracted in three to five deliberate movements before breathing out.

(5) Bend the body laterally away from the side of the injured lung to the fullest extent, so that the uninjured side of the thorax is partially compressed. The patient is on his back, and the head and feet are drawn round as far as possible. The operator should press over the uninjured lung with both hands and the patient should breathe, as before, in through the nose and out through the mouth, contracting the abdominal muscles as he breathes out. (When there has been considerable collapse of the ribs on the side of the injured lung, and especially when there has been an abscess in the lung, great care must be taken in doing this movement, otherwise considerable muscular discomfort will occur within a few hours. A certain amount of pain will necessarily be felt if there has been a serious collapse in the chest wall, but this can, of course, be relieved.)

(6) The same movement and position, but the operator should press with his hands on the side of the uninjured lung with a pressure of thirty to sixty pounds, and the patient should contract the abdominal wall, with the breath held, at first once, afterwards increasing by degrees to five times.

The following exercises are done with the breath held in :—

(7) Grasp the wrists of the patient as the arms lie at the side of the body, the operator standing behind the patient. Draw the arms outwards and upwards to above the head, pull on the arms steadily when the arms are at their fullest extent, then relax the pull. The patient should then breathe out quickly.

(8) Arms as before. Bring them together in front and carry upwards to a right angle. Part the arms strongly backwards and horizontally.

(9) The same exercise as the preceding one, but the arms are carried backwards at an angle of 45° upwards.

(10) Commence with the patient's arms above the head, with the palms of the hands facing each other. The operator grasps the arms between the wrists and the elbows and presses the arms strongly downwards, and when the elbows approach the sides the abdominal muscles should contract. Force the elbows into the side and make the patient breathe out strongly.

(11) Grasp the right wrist of the patient with the left hand, carry the arm forwards, and bring it to a right angle with the body. The operator should then place his right hand well under the scapula of the patient and pull the arm backwards and downwards as the patient strongly contracts the abdominal wall. Changing the hands, do the same movement on the other arm of the patient.

(12) When there is marked collapse of one side of the upper chest the body should be bent as in Exercise 5, and the wrist of the arm on the wounded side grasped, the arm being fully extended above the head; the patient should then pull the arm downwards with the elbow into the side, and should strongly contract the abdominal muscles as the arm descends. The operator gently pulls against the patient. (This exercise is exhausting unless carried out very carefully; six movements are sufficient during the first few applications of it.)

The earliest time at which the exercises have been commenced has been fifteen days after the insertion of the drainage-tube in cases of empyema, and thirty-three days in cases of hæmothorax from the date of the wound.

Very great care must be taken that the instructions given above are carefully followed, otherwise harmful results might ensue.

When a patient suffering from the effects of a lung wound is convalescent, he should be encouraged to sleep on the side of the injured lung, and when resting by day to adopt the body position described in Exercise 5. This will help recovery by enabling the injured lung to inflate more easily.

A CASE OF ENTERIC FEVER IN WHICH THE B. TYPHOSUS WAS RECOVERED FROM THE BLOOD ON THE 150TH DAY OF THE DISEASE.

BY G. K. BOWES, M.R.C.S., L.R.C.P.

I AM indebted to Dr. Drysdale for his kindness in allowing me to publish the following case. Although cases of similarly or even more prolonged duration of enteric fever have been reported, they are very uncommon.

A. S—, æt. 15½ years, a glass-blower, was admitted to Enfield Isolation Hospital on September 23rd, 1915. According to information kindly furnished by Dr. Cook, the Medical Superintendent, the patient's illness began about September 20th. He was the last of seven cases coming from one house. Four Widal's tests had been made with positive results on some of the others, but this was not done in his case. Another child from the same house was admitted to Great Ormond Street Hospital with

enteric, and three next-door neighbours were admitted to Enfield Hospital with the same disease. The patient had an enlarged spleen, great meteorism, pea-soup stools, but no rose spots. Except for a slight rise of temperature on November 9th he was afebrile as from October 28th.

According to the patient's own statement, he suffered from giddiness and headaches, but no diarrhœa for five days before admission to Enfield Hospital. He was in hospital about eight weeks, and went to bed again for a week on returning home. On getting up he felt very weak, and towards the middle of December his left foot began to swell, the swelling lasting three weeks. Beyond this and a general feeling of malaise he noticed no definite symptoms. On January 6th, 1916, he was sent to a convalescent home at Bexhill, where he remained till January 12th. On the evening of admission at Bexhill his temperature was 99° F., and on the following days it was intermittent, ranging between 96° and 102·2° F. The pulse-rate was from 100 to 132, and did not vary with the temperature. The bowels were open regularly once or twice a day.

From Bexhill he was admitted to St. Bartholomew's on January 12th. On admission the abdomen was somewhat distended and tender, and the spleen was just palpable. No rash was visible. For the week following admission the patient was afebrile. The pulse-rate was frequent, usually rather over 90. The patient was very constipated.

On January 19th the temperature suddenly rose to 101·8° F. and remained up with remissions till February 1st, reaching 103·2° F. on January 22nd. The pulse-rate was frequent, usually between 120 and 130. The patient during this time complained of pain in the right upper quadrant of the abdomen, and of headache; the gall-bladder was not palpable. The abdomen generally was distended but not tender. The spleen was palpable 1 in. below the costal margin, and was somewhat hard. Constipation and diarrhœa alternated. On January 26th the stools were examined and about 30 per cent. of the colonies on Rebipel agar were non-lactose fermenting, but did not give the bio-chemical reactions of *B. typhosus* nor of *B. paratyphosus*, nor of any recognised pathogenic organism. Dreyer's agglutination test was performed on January 26th with the patient's serum, and gave negative results in dilutions of 1 in 25 to 1 in 250 against *B. typhosus* and *B. paratyphosus* A. and B. On January 22nd the leucocyte count was 14,800 and on February 1st 11,600. The heart at the end of this period showed evidence of dilatation and weakness. The lungs were natural.

From February 2nd till February 12th the patient was afebrile, except for occasional slight rises of temperature. His general condition improved. The spleen became softer and smaller. The bowels were not constipated, nor was there diarrhœa. On February 7th the leucocytes numbered 6700; Dreyer's test was positive in a dilution of 1 in 50 for typhoid.

On February 10th the temperature began to rise, and by the 12th reached 102·8° F.; it remained high, generally between 102° and 100° F. The abdomen was tense, and the spleen again became larger. On February 15th a blood culture was made and typhoid bacilli were obtained. The stools were examined, but no non-lactose fermenting organism was obtained. A vaccine was prepared from the organism recovered from the blood, and on February 19th the patient was given two millions of the dead bacilli. The vaccine was repeated in gradually increasing doses at intervals of forty-eight hours, the last dose given on March 13th consisting of 250 millions. No febrile reaction was produced by the vaccines. On March 8th the leucocytes numbered 7200 per c.mm. The temperature began to decline definitely on February 22nd and reached normal on March 5th, where it remained, except for slight rises on the 13th, 16th, and 18th. After March 7th the spleen was no longer palpable. During this period the bowels were open naturally once or twice a day. The mental condition of the patient remained good throughout the illness.

The heart still showed evidence of weakness. The apex beat extended $4\frac{1}{2}$ in. from the middle line in the fifth space. The first sound was heard weakly at the base. The pulse-rate was rather frequent, usually about 100. For this reason the patient was kept in bed for a further period till March 30th, when he was first allowed to get up. On March 27th Dreyer's agglutination test was performed against *B. typhosus* and gave a positive result in a dilution of 1 in 500. The patient was discharged on April 20th, 216 days after the onset, apparently well, except for a rather frequent pulse.

In this history I wish to draw attention to the following points. The duration of the attack is remarkable. The patient first became finally afebrile on the 170th day after the onset of the disease. During this time the patient had at least two relapses, namely, those when he was under observation at St. Bartholomew's Hospital. It is possible that the patient may have had one or more relapses at home. The history to some extent suggests this. Otherwise we must assume a very prolonged interval between the original attack and the first relapse. He became afebrile after the original attack on October 28th, and had fever at Bexhill on January 6th; that is an interval of seventy days, assuming this fever to have been due to a relapse.

The character of the fever at Bexhill, however, is unlike that of the two relapses which the patient had while in St. Bartholomew's Hospital, the large daily range in the former case being especially noticeable. We must consider the possibility that this attack of fever was not due to a relapse, but was an attack of cholecystitis due to *B. typhosus*. The situation of the pain during the first observed relapse suggests this. If this was the case we may then consider the possibility that the *B. typhosus* remained quiescent in the gall-bladder after the symptoms of the disease had subsided, that after a time they multiplied locally, giving rise to a

cholecystitis, and were thus enabled to reinfect the alimentary tract and the system generally.

It is to be noted that the agglutination reaction was negative on January 26th, and was first found to be positive on February 7th, and this absence of the agglutination reaction till the last stages of the prolonged attack may be connected with the tendency to relapse.

Finally the recovery of *B. typhosus* from the blood as late as the 150th day of the disease, although on the fourth day of a relapse, shows the value of blood cultures for diagnosis late in the disease.

THE SO-CALLED "SIMPSON LIGHT": WHAT IT IS AND WHAT IT DOES.

By E. P. CUMBERBATCH, M.B., M.R.C.P.

MUCH has been heard during the past year of the "Simpson light." Announcements of a remarkable discovery have been made in the papers, and fantastic accounts of surprising cures of intractable diseases have been disseminated among the public. Letters of inquiry have reached the writer from different parts of the country, from America, from the "land of ranches and rattlesnakes" (as the inquirer called it), and it seems that reports of the "Simpson light" may spread as far and as wide as the influenza epidemic of 1889-90. In the following pages an account will be given of the origin of the "Simpson light," its nature, how it is produced, and its therapeutic properties.

Origin of the "Simpson light."—In March, 1913, Simpson, a Scottish engineer, was making a research on the affinity of the rare metals for each other. Ores of the metals were raised to the temperature of the electric arc, and it was noticed that the light emitted had "curative effects on the workmen's hands." Cases of "acne" and "eczema" were said to have been cured. Efforts were then made to construct a lamp so that the healing properties of the light could be further investigated. The greatest difficulty was experienced in the preparation, from the ores, of electrodes suitable for use in an arc lamp. Eighteen months and £5000 were said to have been expended before even a partial success was attained. The electrodes had to conduct the electric current, burn as steadily as possible, and not break when heated to the high temperature of the arc. With those that are at present in use the arc is not perfectly steady. It splutters and flares and minute incandescent particles are frequently thrown off from the heated ends of the electrodes. Impurities in the ores melt and form a slag which occasionally bridges the gap between the electrodes, so that the light goes out and further adjustments have to be made. When the lamp is burning a white smoke is formed as a result of the combustion of the electrodes. It rises into the air, and, after a time, the atmosphere of the room is rendered misty. The smoke is ultimately deposited on objects in the room in the form of a white sublimate. It is probably an oxide of tungsten.

The makers of the lamp do not consider it advisable to state the composition of the electrodes, as efforts are continually being made to improve them. They state, however, that the chief constituent is *wolfram*. Wolfram is a tungstate of iron and manganese.

Nature of the "Simpson light."—The light is intensely brilliant. Besides *visible* rays, the arc emits *heat* rays and *ultra-violet* rays. There is no evidence of the existence of any other form of radiation. The therapeutic properties of the light are due, mainly, if not wholly, to the ultra-violet rays. The most familiar and generally used source of ultra-violet light is the Finsen lamp. This also is an electric arc light, but the electrodes are composed of gas carbon. We have to consider, then, in what ways the ultra-violet light from the "Simpson lamp" differs from that emitted by the Finsen lamp. The question has been investigated by Prof. Burstal, Prof. Horton, and Dr. Russ. According to Prof. Horton's measurements the light from the Simpson lamp is from five to ten times richer in ultra-violet rays than that from the Finsen lamp. This means that the duration of the exposure to the light can be much shortened—an important matter in busy hospital practice. Further comparisons can be made by studying the spectra of the light from the two lamps. This can be done by allowing a beam of the light to pass through a prism of quartz and fall on a white screen. The visible rays are thus separated and a coloured spectrum is obtained. The ultra-violet rays are also separated, but as they are invisible to the eye and are not shown on the screen, the latter must be coated with some fluorescent substance which glows when ultra-violet light falls upon it. If this is done, it is seen that the light from the Simpson lamp produces fluorescence over an area that is nearly twice as long as that seen when the carbon arc lamp is used. The ultra-violet spectra can be more accurately compared by allowing the light to fall upon photographic paper. When the latter is developed, the spectra are seen to consist of a number of lines of varying degrees of darkness. Each of these corresponds to a bundle of ultra-violet light rays of definite wave-length. If the exposure is made for a few seconds, it is seen that the spectrum from the carbon arc lamp consists of comparatively few lines except in the region just beyond the visible spectrum; there they are darker and set closer together. In the case of the Simpson lamp the spectrum is longer, the lines are darker and set so closely together that the appearance is almost that of a continuous black band. Longer exposures cause the spectrum of the carbon arc lamp to appear continuous, but only in the region just beyond the visible. It may be concluded from the preceding observations that exposure to the light from the

Simpson arc lamp means irradiation with ultra-violet rays of several different wave-lengths and of relatively even intensity. Exposure to the light from the carbon arc lamp for the same time means irradiation with ultra-violet rays fewer in number, of less variety of wave-length, those of shorter wave-length being relatively much fewer.

We do not know the *modus operandi* of ultra-violet light in producing physiological and therapeutic effects. It is possible that these effects are produced only by rays of definite wave-lengths. The Simpson arc light provides ultra-violet rays of several varieties of wave-length; we may therefore say that if we try to cure disease by ultra-violet light we are less likely to fail when using the Simpson lamp than when using the carbon arc lamp.

It was mentioned earlier that the composition of the electrodes used in the Simpson lamp was not stated by the makers. Wolfram is an important constituent. This contains tungsten. The spectrum of an arc light with tungsten electrodes is apparently identical with that produced by the Simpson arc lamp.

How the "light" is produced.—The Simpsom lamp consists of a metal stand, on which are mounted a pair of electrode-holders. In these the electrodes are fixed, and, by means of a hand-screw, the points of the latter can be moved to and from each other. Behind the electrodes is mounted a plane or concave mirror, and in front of them is a metal tray to catch the flying incandescent particles. The points of the electrodes are brought into contact, and a current of 5–7 ampères at 50 to 70 volts is passed along them. The points are then slightly separated, and a brilliant arc appears. If a large area of the body requires treatment the plane mirror is used so that the light can be diffused over a large area. For smaller areas, the light can be concentrated by the concave mirror.

The smoke given off from the arc has some therapeutic value. By placing a hood over the arc the smoke can be inhaled as it emerges from the summit of the hood. If a paper hood is held over the arc the smoke is deposited as a white sublimate, and the latter can be then collected and afterwards placed in water, so as to form a fine suspension. The smoke is probably an oxide of tungsten.

The properties of the "Simpson light."—The properties of the "Simpson light" are the properties of ultra-violet light. The rays penetrate only for a very short distance into the skin. Those with the shorter wave-length are almost entirely absorbed by ½ mm. of skin. Those with the longer wave-length penetrate a little further, but very few pass beyond 1 mm.

They produce no sensory impression on the skin. After a few hours an erythema arises if the exposure has been for more than a short duration. If the light is 12 inches from the skin it will develop an erythema if the exposure has been for about two minutes, though the time varies with different skins. Longer exposures produce a more intense and long-lasting erythema, and the skin may "peel." No permanent injuries have been produced.

Therapeutic properties of the "Simpson light."—The therapeutic properties are those of ultra-violet light. If cure follows treatment by the "Simpson light" it is necessary, before giving the credit wholly and solely to the Simpson lamp, to be sure that the same result would not have followed exposure to ultra-violet light from other lamps, or other forms of treatment. Some cases of advanced rodent ulcer and lupus that had resisted other forms of treatment have been treated by the "Simpson light" and considerably benefited. With regard to the results obtained in other cases that are worth recording, it must be said that other forms of arc lamp were not tried. With the Simpson lamp, however, the exposures are very short—an obvious advantage. With the mercury vapour lamp the exposures are short, but this lamp does not give rays with such a great variety of wave-length, and the same remark is true of arc lamps with silver, copper, iron, and carbon electrodes. We do not know the *modus operandi* of ultra-violet rays in healing disease. The healing properties may be possessed only by rays of a certain range of wave-length, and if ultra-violet light has the power of curing any disease we are most likely to get the cure if we use the lamp which produces rays of the greatest variety of wave-length.

The white smoke that is produced during the burning of the Simpson lamp can be inhaled, and it may benefit some disorders of the respiratory system. Two cases of asthma have been improved (not cured). A case of tuberculous laryngitis, now under treatment, has benefited considerably. His voice has regained power, and the swelling of the epiglottis has diminished to one half its original size. Time will show whether further and permanent improvement will take place.

THE ROMANCE OF TEXT-BOOKS.

By PERCY DUNN, F.R.C.S.

THERE is a romance about books—text-books which form the close companions of students. Woven in the student's mind is the friendship with which he comes to regard them. Through their pages he sees his way to gaining his ambition, namely, examinational success. Figuratively, he stands facing the banks of a broad river: his aim is to reach the other side. But there is no bridge. He has to make one, and he does so mainly by means of his books. From them he extracts the necessary knowledge, and the bridge being thus firmly and solidly built he passes over the river successfully, attaining the goal of his ambition from an examinational standpoint. And so in after years a student is apt to regard with some

affection the books which formed the constant companions of his student days. Old memories are recalled whenever he happens to glance again at the well-thumbed pages. There are the pencil marks, and the underlined paragraphs calling attention to special details which he desired to memorise; some pages may remind him of midnight hours of study, prolonged by adventitious aid destined to banish sleep; other pages may bring to his recollection occasions when friends joined him for mutual study; and there are the *memoria technica*, pencilled on odds and ends of spaces, now almost or quite forgotten, to remind him of his laborious task. And yet the admission must be made that apart from their old associations, thus depicted, text-books do not belong, generally, to the happy things of life. Sad and inexorable neglect becomes their lot in most cases. Such is their fate, a fate decreed by fashion and time—from which but few escape. From an enviable popularity they may pass to disdainful recognition, and from this to absolute oblivion. The demand for them ceases, nothing can arrest their progress into the unknown, and from that moment their "strange eventful history" comes to an end.

It is not an easy matter to define or explain the causes which precisely determine the popularity of a text-book. To this happy fortune, perhaps, many features contribute. There is first the personal element—that belonging to the author. If the author be popular, and his methods of teaching commendable to students, his book will probably become a reflex of his popularity. His personality is diffused through his pages; throughout an approvable note is sounded, appealing to those to whom his teaching has proved a valuable and a sound acquisition. Thus, edition after edition of his work during his lifetime may be called for, always supposing that the advances of knowledge are incorporated therein.

The test of the enduring popularity of a text-book comes with the death of the author. Then, however, it often happens that his book dies as well. Living authors are always in more request than those whose work has ended with their life, despite even the enterprise of publishers placing the books in the hands of an active and a well-accredited editor. Such a policy, however, is undeniably successful in some cases; thus is explained the survival of certain text-books at the present day, whose title pages evince their early parentage, and which continue, nevertheless, to maintain their supremacy. But, in accord with the advance of knowledge, careful scrutiny will show that with every succeeding new edition, in such cases, there is less and less evidence of the work of the original author. The book is re-vitalised by the spirit of the editor; he raises a new structure upon the old foundations, introducing all the latest modern requirements, and upon the success with which he accomplishes his task depends the continued popularity of a work with which has become identified the teaching of so many generations of students. Literary style, again, in a text-book is an important factor; the style must be easy, attractive, and good, with the information conveyed so well predigested as to allow of rapid absorption by the student. There is, too, the matter of illustrations. Modern enterprise, perhaps demand, has led to a profuseness of figures in the text. Some doubt may be expressed as to the wisdom of this policy, at least to the extent to which it is now being pursued. Profuse illustrations add greatly to the size and cost of a book. In some cases, of course, art reproductions are indispensable, for example, in books upon anatomy. But whether in many other instances the added cost is compensated for by the explanatory value of the illustrations is, I believe, a matter open to question. Still, nowadays, such is the fashion, and inasmuch as author competes against author in this regard, the modern text-book will presumably continue to be thus endowed.

It may now be of some interest to allude to a few instances of the text-books in vogue in the seventies, so far, at least, as Bart.'s students were concerned.

In the dissecting room two books only were generally noticeable, namely, *Holden's Manual of Anatomy*, and the ever green "Gray." Holden's book was popular and had reached its fourth edition at the time under review. The attractiveness of its style and the word pictures of its descriptive details were a predominant feature of its success. One day Walsham asked me a question in the dissecting room in the course of a demonstration. After giving him the answer he said, "I like that." And so did I, and that was the reason I had learnt the answer by heart from "Holden," and was able to repeat it from memory in Holden's words. This incident, of course, was merely a coincidence, nevertheless it shows how the author of a text-book has the power to attract a student's mind by some mode of expression which makes a strong appeal to the memory.

Then as a text-book there was *Holden's Osteology*, of which I feel compelled to add a few words of praise, prompted by a conviction of its value. His descriptions were everywhere interwoven with little sun-light gleams of medical and surgical detail, raising apparent osteological trifles to a position of clinical importance. By this means the bones were endowed with a vitality and an interest wholly unsuspected. The style was eminently attractive; it was as if the dead and dry bones themselves were speaking with the interest which belongs to a personal narrative, and with the intention to excite enthusiasm in the story they had to unfold. And yet this book has passed into the region of the forgotten. Noah, we may presume, possessed an occipital bone. But there is no reason to believe that this differed from the one from which Holden wrote his description. That description, therefore, may be held to remain always true of every occipital bone, differing, however, at the present time, only in the detail of nomenclature which has followed the

B.N.A. innovation. The plates, moreover, of Holden's osteology were distinguishable from having been drawn on stone, and profound testimony is furnished, by their excellence, to the artistic skill of the late Mr. Thomas Godart, of Bart.'s.

The ever green "Gray" may be recognised as the wonderful example of a text-book surviving the onslaught of modern competition. Even in its early days it was a bulky tome, somewhat to its disadvantage. Issued first as long ago as 1853, it has passed through the hands of several editors since the death of the author, and now it is basking in the sunshine of its eighteenth edition, published in 1913, an unprecedented period of sixty years. There seems to be no reason why its popularity should not continue as long as anatomy is taught. Another book, less frequently seen, was *Ellis' Demonstrations of Anatomy*. The author was Professor of Anatomy in University College, London. This book was deemed to be indispensable for the higher examinations in anatomy, those, for example, at the London University. So excellent did this book prove for its purpose that surprise can only be felt that the publishers should have made no effort, after the death of the author, to prevent it from lapsing.

Of physiology, then an unprogressive science, with a great future before it, there is not much to be said. Mr. Morant Baker was the lecturer, and naturally *Kirke's Handbook*, which he edited, was available for the purpose The numerous editions, however, through which it has passed show that it has enjoyed a popularity beyond the purlieus of Bart.'s. It gained a firm hold upon students from the beginning, inasmuch as for many years it was the only text-book on physiology provided for their use, and its popularity is still being maintained under the guiding hand of Professor Halliburton, of King's College.

A small but very popular manual on Elementary Physiology was that by Professor Huxley. It enjoyed a great vogue as an introduction to the science. To students, however, it was scarcely comprehensive enough for examinational purposes, and was only rarely seen in the school.

A short digression may here, perhaps, be permissible in order to call attention to a curious report, current among the students, in respect to the Lectureship on Physiology. At the time of the appointment of Mr. Morant Baker, Professor Huxley was a candidate for the post. Here, then, we are confronted with the fact that the most noted physiologist in th country, one whose reputation was world-wide, one whose pre-eminence as a teacher was universally recognised —an alumnus who had conferred honour upon the school—was rejected for the appointment of Lecturer on Physiology at Bart.'s. Of course there was a reason for this somewhat incomprehensible decision of the school authorities. But while to us in these days that reason would afford a subject for ridicule, it is necessary to remember the peculiar circumstances of the time at which his rejection was recorded. Just prior to the early seventies the acute stage had been reached of the controversy between science and religion. The public mind had become agitated upon the question. The tendency, it was held, of the advances of science was to lead to what was called materialism. Scientific workers were revealing problems, startling in their comprehensive development, altogether transcending anything which had hitherto come within the sphere of human knowledge. Here was held to be a source of danger, a danger the evil of which was clearly manifested in the scientists themselves. Becoming elated with their discoveries, so it was believed, they began to propound a materialistic doctrine, and Huxley and Tyndall were the chief of those concerned in this regard. Their views, openly expressed, disturbed the public conscience; the feeling was that they were harmful to religious orthodoxy, and even constituted a menace to the national life. In short, the conviction became generally prevalent that science, carried to its extreme limits, would ultimately usurp and destroy the authority of the Bible. In keeping with this impression, Huxley introduced the term, and labelled himself, an "Agnostic." The position he assumed, as such, frequently exposed him to vehement attacks, and upon science, as a whole, was laid the blame for his hostile controversial attitude, and the methods he employed for defending himself. That was the position when Huxley was rejected for the post of Lecturer on Physiology at Bart.'s. His views were regarded as being probably unacceptable to the parents of intending students, and as likely to imperil the reputation of the school. Looking back through the years that have passed, this controversial warfare of the early seventies is reminiscent of a nine days' wonder.* For subsequently it began to appear obvious that the more science advanced the wiser the world became, and with this added wisdom there followed the realisation of the great value of scientific discovery. Thus the alarms of materialism ceased under the enlightened conviction that between science and religion there could be no antagonism.

But a new era in physiology began in 1875 by the appearance of a translation of a work by the Professor of Physiology at the University of Zurich, Professor Hermann. The late Dr. Arthur Gamgee, of Owen's College, was responsible for the translation, and he tells us in his preface why he undertook the task. "I was actuated," he writes, "by the conviction shared in by nearly all teachers, that an urgent need existed for an English text-book which should represent the actual state of the science. It appeared to me, at the same time, that no text-book on physiology existed in any European language at once so concise, comprehensive and philosophical as the work which I now introduce to the English reader." Truly the book was a

* Huxley's last statement upon the subject appears in a lengthy and somewhat satirical article published in the *Nineteenth Century* for February, 1889.

fascinating revelation of the science; the light it shed upon old-time physiology revealed a new world of knowledge. However, it was barely a student's book, its science was too new and elaborate. Coming, as it did, like a bomb into the still waters of physiological teaching in this country, it almost created a sensation. My copy was bought for the purposes of the first Fellowship, for rumours "gathered and spread" that one of the examiners in physiology had adopted the plan of reading up some pages of Hermann, and testing the candidates' knowledge by means of them. Curiously enough, the translation never passed into a second edition, despite its attractive value, and now the book must be entirely forgotten. In general medicine a wider scope existed for the choice of text-books. Two, however, were mostly favoured, those by Dr. F. T. Roberts and the late Dr. Bristowe respectively. Both were bulky; the former, later, emerged into two volumes, and the latter possessed an examinational interest, inasmuch as the author was one of the examiners in medicine at the College of Surgeons. Some years ago each of these popular and excellent text-books passed into the reserve, and are not likely to be recalled for active service. Another book was also in vogue, but copies were difficult to obtain—*Tanner's Clinical Medicine*. The book was a small one, and proved to be especially useful, but it was out of print owing to the author's death. Nevertheless, it was greatly in demand, so much so that available copies changed hands at the price of 30*s*., the publishing price being 7*s*. 6*d*. Some students again found time to indulge in *Trousseau's Lectures on Clinical Medicine*, issued by the New Sydenham Society. These lectures at the time were universally held in high esteem, and were often quoted. But now in the far and distant past they have faded out of sight and knowledge, while during the zenith of their popularity they reached a pinnacle of greatness, forming a beacon guide by which many sought to secure pearls of illuminative wisdom. *Sic transit gloria mundi.*

Even in these days it may be asked, "What has become of *Quain's Dictionary of Medicine?*" A very fat volume on its first appearance, with a weak back which, through use, soon became broken. It proved a success; in later editions it blossomed forth into two volumes. Unhappily, however, its success was the cause of its undoing. The idea it suggested was soon appropriated. At various intervals since, numerous competitors have appealed for similar support, thus modern bookshelves are called upon to provide space for dictionaries, medical and surgical, encyclopædias, indices of treatment and of practice, some of these with a regiment of volumes, while others, confined within the limits of a single volume, are more adapted in price for the student's purse.

In the seventies, surgery, in the form of a text-book, was mostly represented by Erichsen's work, in two volumes. This work passed through several editions and was generally regarded as the best reflex of British surgery throughout the world. Its end, however, came with the ninth edition, thoroughly brought up-to-date, published in 1888. A curious criticism used to be repeated, in regard to this *magnum opus* of Erichsen. "What," it was once asked by a hospital surgeon, "can Erichsen know of surgery, when he has only twenty beds at his hospital?" Another book was noticeable among the less ambituous students, namely, *Druitt's Vade Mecum*. This was a stout little volume which, in 1870, had reached its tenth edition. But the profitable field of surgical text-books was destined soon to be invaded, and the first competitor was *Practical Surgery*, by Mr. Thomas Bryant, of Guy's. The success immediately acquired by this work was well deserved. Based upon the long and proved experience of a hospital surgeon and teacher, new editions were rapidly called for; then came another work, *The Principles and Practice of Surgery*, by Mr. Timothy Holmes, of St. George's. This tended to dim from the popularity it gained, the glamour of Mr. Bryant's work. Dressers almost exclusively favoured *Heath's Minor Surgery*, which still survives. Students at this time heard much also of *Billroth's Surgery*, another product of the New Sydenham Society in two volumes. It commanded notice because of the advanced scientific views of the author. As such, the volumes were recognised as useful for the higher surgical examinations, those in which degrees were concerned. In pathology there was only one book, known as *Green's Pathology and Morbid Anatomy*. It was small and handy, and otherwise conveniently and pleasantly supplied the student's requirements. Its second edition was issued in 1873, and it still survives, much enlarged and under new control. Of the same size, and belonging to the same series, was the sole eye book, that by Mr. Lawson, of the Middlesex Hospital. At that time the student had no choice, and it was not until *Nettleship* appeared on the scene in 1879 that another eye book became available. This proved a marked success, and in time reached its sixth edition. Each of these small books have long since lapsed into the unknown, despite the value of their teaching. In later years the eye student has been confronted with an *embarras de richesses* of text-books competing for his kindly favour. This special class of medical literature has greatly expanded of late. The results, however, judging from the demand, do not seem in most cases to have been directly encouraging to the authors, notwithstanding the reputation the latter enjoy in the ophthalmic world. Presumably of such books there are now too many, the field being overstocked to allow of any conspicuous success, with, perhaps, one exception.

And so from the above observations a reflection emerges, arresting in the conviction of its unassailable truth: What "classics" in medicine have passed into the dismal chamber of oblivion? Can such classics be held even now to be useless, centred, as they may be, around the science of the past? Can that suggestive work, *Hilton on Rest and*

Pain, long ago dead, be unworthy of perusal in this century? Let anyone read it and try afterwards to persuade himself that this question can be answered in the affirmative. But these classics often contain many pearls of wisdom, apart from their out-of-date scientific teaching, such wisdom being the special product of thoughtful minds. Science is ever advancing with the progress of time, but minds trained by observation and experience, manifestly exhibiting exceptional power, have often proved to be in advance of their generation. The wisdom, therefore, of a classic nevertheless valuable is apt to be lost and forgotten, submerged amid the all-pervading attractiveness of modern scientific discovery. The fault lies in the rush and hustle of the times, restricting our opportunities to wade through the tomes of the past. Our energies must be centred in the present; the claims of the present are urgent, inexorable, and always increasing, and so the classics of the past, despite their pre-eminence in the days of their popularity, and notwithstanding the greatness which still remains to them, fall by the way, overwhelmed by the demands of which each generation becomes the active source. Thus reaching their inevitable doom—they fade imperceptibly, irrevocably, into the gloomy, inglorious shade of obscurity.

CORRESPONDENCE.

To the Editor of the 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—The reference to Skey's lectures in recent letters induces me to tell you of a lecture given by him on June 7th, 1870, of which I have my notes before me.

It was on burns, and the two chief points impressed on my mind (which without notes I could never forget) were:

(1) That he described carron oil as "that rascally compound."

(2) That the treatment he advised for burns was a strong solution of nitrate of silver to be washed over the burn; and, he added, the more pain caused by this application, the better for the patient and the quicker the relief!!!

At this lecture by Skey there was no rowdy behaviour nor excitement of any kind.

I must add a personal incident about Savory. This occurred in 1873, when I was in for the final College of Surgeons examination. Savory was the *bête noir* of candidates, and was feared almost as much by his co-examiners. I was being examined by Smith, of St. Mary's, who was a ponderous gentleman with a long beard. He examined me on diseases of the testicle and then went on to the bladder, and, after various questions, he asked me if cancer of the bladder could be felt through the abdominal wall. I did not know more than the man in the moon, and I hazarded a reply, "Yes." To which Smith promptly objected. Whereupon Savory, who was marking, turned to him, and in the suavest manner said: "Why, Mr. Smith, it was only last week I was called to see a patient at Hounslow with cancer of the bladder, and I could distinctly feel it through the abdominal wall." Mr. Smith never said a word, as he would not dare to disagree with Savory. As in 99 cases out of 100 of cancer of the bladder Smith would be right, Savory's intervention was very welcome.

Yours truly,
JAMES ADAMS.

4, CHISWICK PLACE, EASTBOURNE,
June 21st, 1916.

EXAMINATIONS.

UNIVERSITY OF LONDON.

Third M.B., B.S. Examination. May, 1916.

Group I. Medicine.—E. C. Spaar.

Group II. Surgery and Midwifery.—R. M. Dannatt.

L.S.A.

The Diploma of the Society of Apothecaries has been granted to E. G. D. Murray.

NEW ADDRESSES.

H. M. GREY, Fir Vale Hospital, Sheffield.
F. LLOYD HOPWOOD, Janefield, Aberdour, Fife.
E. W. J. LADELL, Eiffel Flats, S. Rhodesia.

APPOINTMENT.

J. WILMOT ADAMS, M.B., B.C.Cantab., appointed Lieutenant, Singapore Field Ambulance Company, whilst acting as Surgical Specialist to the Troops in the Singapore Garrison.

MARRIAGES.

CROWTHER—WOODLEY.—On June 14th, at Emmanuel Church, Plymouth, by the Rev. G. B. Berry, assisted by the Rev. Dr. Flynn, Capt. Charles Rowland Crowther, R.A.M.C., son of the late James Addington Crowther, of Bryn Tirion, Mannamead, Plymouth, to Kathleen Olive Mary, daughter of the late George W. A. Woodley, of Stonehenge, Natal, and niece of Mr. and Mrs. Woodley, of Evadne, Mannamead, Plymouth.

FRASER—BAILEY.—On June 13th, at Golden Hill Parish Church, by the Rev. J. H. Bailey, Vicar of Norton, Letchworth, brother of the bride, and Canon Hughes, Rector of Tarporley, Capt. Forbes Fraser, F.R.C.S., R.A.M.C., of Bath, to Agnes Mary, daughter of the Rev. G. R. Bailey, Vicar of Golden Hill and Rural Dean of Newcastle, and Mrs. Bailey.

PAVEY-SMITH—NORTHWOOD.—On June 3rd, at St. James's, Camberwell, by special licence, A. Bernard Pavey-Smith, Capt., R.A.M.C. (T.), younger son of Mr. and Mrs. A. E. Smith, of The Hollies, Nailsworth, to Elizabeth, youngest daughter of Mr. and Mrs. Northwood, of Spondon, Derby.

DEATHS.

KIMBELL.—On May 28th, at a Nursing Home in London, Lieut. Harry John Sullings Kimbell, R.A.M.C., of Richmond Road, Hackney, until recently in charge of Preston Hall Hospital, Maidstone.

PRESTON.—On June 2nd, through an accident to his car, Francis Harrison Preston, M.R.C.S., L.S.A., of The Grove, Brill, Bucks.

ACKNOWLEDGMENTS.

The Hospital, Long Island Medical Journal, New York State Journal of Medicine, Guy's Hospital Gazette, The British Journal of Nursing, The Nursing Times, The Medical Review, St. Mary's Hospital Gazette.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, Smithfield, E.C.*

The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., *at the Hospital.*

All communications, financial, or otherwise, relative to Advertisements ONLY, should be addressed to ADVERTISEMENT MANAGER, *the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City 510.*

A Cover for binding (black cloth boards with lettering and King Henry VIII Gateway in gilt) can be obtained (price 1s. post free) from MESSRS. ADLARD & SON AND WEST NEWMAN, *Bartholomew Close. (Temporary offices: 76, Newgate Street, E.C.)* MESSRS. ADLARD & SON AND WEST NEWMAN *have arranged to do the binding, with cut and sprinkled edges, at a cost of 1s. 9d. or carriage paid 2s.—cover included.*

St. Bartholomew's Hospital Journal.

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

VOL. XXIII.—No. 11.] AUGUST 1ST, 1916. [PRICE SIXPENCE.

CALENDAR.

Tues., Aug. 1.—Dr. Drysdale on duty.
Fri., ,, 4.—Dr. Tooth and Mr. Bailey on duty.
Tues., ,, 8.—Dr. Garrod on duty.
Fri., ,, 11.—Dr. Calvert and Mr. D'Arcy Power on duty.
Tues., ,, 15.—Dr. Morley Fletcher on duty.
Fri., ,, 18.—Dr. Drysdale and Mr. Waring on duty.
Tues., ,, 22.—Dr. Tooth on duty.
Fri., ,, 25.—Dr. Garrod and Mr. McAdam Eccles on duty.
Tues., ,, 29.—Dr. Calvert on duty.
Fri., Sept. 1.—Dr. Morley Fletcher and Mr. Bailey on duty.
Tues., ,, 5.—Dr. Drysdale on duty.

EDITORIAL NOTES.

COLONEL TOOTH has gone to Malta in the capacity of Consulting Physician to the Expeditionary Forces. Major Harnill has also left for Malta. We wish them both the best of luck while they are away from us.

* * *

At a meeting of the Royal College of Surgeons held on July 14th, Mr. D'Arcy Power was elected a member of the Executive Committee of the Imperial Cancer Research Fund.

* * *

At the Annual Meeting of the Medico-Legal Society, Dr. Robert Armstrong-Jones was elected a Vice-President.

* * *

The Military Cross has been awarded to Capt. R. S. Townsend, I.M.S., and to Temp. Lieut. C. C. Okell, R.A.M.C. Our heartest congratulations are extended to both.

* * *

It is with very much regret that we have to announce the death of Captain Robert Williams Michell, M.D., F.R.C.S., R.A.M.C., æt. 56. He was educated at Caius College, Cambridge, and St. Bartholomew's Hospital. He served through the South African War, gaining the Queen's medal with three clasps, and he volunteered again immediately on the outbreak of the present war. He was first appointed to the hospital ship "Asturias," and was on board when she was attacked by a submarine. Since May, 1915, he had been attached to the heavy guns, and he was fatally wounded on July 3rd. After helping a neighbouring medical officer who was in great difficulties, he organised and led a rescue party to bring in wounded men who had been lying out in "No Man's Land" for two days. Although wounded himself he continued his work for some hours, until he was struck a second time and paralysed. Our deepest sympathy is extended to his widow and only son.

* * *

We have also to record with much sorrow the death of Captain George Oliver Maw, R.A.M.C., who died of wounds on July 10th. He was educated at Clifton and Pembroke College, Cambridge, and completed his medical training at this Hospital. Our deepest sympathy is extended to Dr. and Mrs. Maw in their bereavement.

* * *

With much sorrow we also learn of the death of Lieut. Walton R. Wilson, R.A.M.C., who died on July 12th of wounds received the previous day. He was educated at Epsom College and Emmanuel College, Cambridge, and completed his medical training at this Hospital. Lieut. Wilson was married so recently as last April, and our heartfelt sympathy is extended to his young widow.

* * *

We very much regret to hear that Private Leonard Lovell, of the Canadian Infantry, was killed in action on July 11th. He was the son of Mr. John C. Lovell, one of the governors of this Hospital, and until recently one of its Almoners, to whom our deepest sympathy is extended.

* * *

As we go to press we learn with very much sorrow of the death of Lieutenant Stanley Walter Burrell, R.A.M.C., who died in France of cerebro-spinal meningitis on July 22nd. He was the second son of the Rev. F. W. Isaacs, vicar of Chiswick, having taken the old Yorkshire family name of Burrell shortly after qualifying. He was educated at St. Paul's School and St. Bartholomew's Hospital, where he gained the Warham prize for surgery. He threw himself whole-heartedly into whatever he undertook, and although in one of his last letters he said, "I never knew before what it means to work till one drops," his cheerfulness and keen sense of duty never faltered. Our deepest sympathy is extended to his parents in their bereavement.

* * *

At the same time we also hear with great regret of the death of Captain R. M. Dennys, who held a commission in the Loyal North Lancashire Regiment. He died from wounds received in action on July 12th. Our deepest sympathy is extended to Mr. and Mrs. E. A. Dennys and his many friends.

FROM THE FRONT.

EXTRACT OF A LETTER FROM DR. ANTHONY FEILING IN MESOPOTAMIA.

SOME time ago, while I was still enjoying the flesh-pots of civilisation in Alexandria, I wrote to Stansfeld, but the holiday which I was then enjoying has come to an end. We foresaw Mesopotamia when rumours began to percolate to Egypt that things were not quite what they might have been in the way of "medical comforts"! So we left Alexandria on March 19th with orders to report ourselves at "X——." We trained to Suez—a tedious and hot all-night journey—and embarked there on board the "B——," a P. and O. Hospital ship. We had a most delightful voyage round to the Persian Gulf, stopping only at Aden for twenty-four hours to coal. Aden is a singularly torrid and unwholesome place. We reached "Z——" in the Gulf on the fourteenth day out, and there had to lie to for nearly a week, in order to be transhipped to a boat shallow enough to pass over the bar of the river. The process of transhipping was much hindered by a violent gale, but we finally got off and came up to "X——" all right, arriving there on April 9th. The lower reaches of the Shat-el-Arab are rather picturesque—giving one an entirely erroneous impression of the country—as the river is about half a mile wide and fringed on each side by deep groves of date-palms—outside these nothing but bare desert, then still very swampy. "X——" is quite an interesting place for a few days, but awfully hot and steamy. Such town as there is is built on creeks, which run up from the river and cut the whole place up into little islands. One moves about entirely by water in belunis, a sort of enlarged Canadian canoe, but inferior and smaller than a gondola. As soon as we reached "X——" the inevitable happened, viz. our unit was at once broken up, and officers sent flying in all directions, some straight back to Bombay on hospital ships—these were the lucky ones. I was detailed for temporary duty at one of the existing hospitals, where I had charge of all the medical cases in the officers' hospital. The building had been the Turkish Governor's house, and ran to electric light, so we did pretty well. I had just settled down and got to know the men in the mess, when fresh orders came for me to "proceed" up the Tigris to a place on the line of communication, 140 miles above "X——." The voyage up, which took exactly three whole days, was most amusing, and certainly gave me a vivid idea of the difficulties of transport in this country. We were on an old stern paddle-wheel river-boat, converted into a hospital ship (so-called). She drew only 2½ feet of water, and was very top-heavy, consequently the combined effect of the wind and the current, which is anything from 4½ to 5 knots an hour, was too much for her, and she was blown about in the most absurd way. We spent a good deal of time drifting rapidly downstream broadside on. And one day we ran unusually hard into the bank, and had to lie there till the next morning! However, all good things come to an end, even voyages on the Tigris, and we eventually arrived one Sabbath morning. I was immediately attached to the hospital for duty, and have remained here, luckily for me, as it is certainly the best hospital here, and this place has the reputation of being the best place in Lower Mesopotamia—though that is saying but little! The hospital is placed right on the bank of the river, which rolls down a rapid, muddy stream, the colour of *café au lait*. This, I may add, is the sole supply of water for all purposes. At first, to my horror and consternation, I was put on to surgical wards, full of fractured femurs and skulls, secondary hæmorrhages, etc. Mercifully I was soon transferred to the charge of the medical wards, 120 beds in all, in huts. There is just enough to do to keep me amused. This is really a most God-forsaken country. No trees, no roads, nothing but the desert and the Tigris. It has become infernally hot, too; 108° in my tent at midday yesterday, and that is an Indian tent with a thick double roof with air space. Flies and mosquitos are a perfect pest, to say nothing of scorpions and hornets. Considering the country we do very well in the way of messing, though drinks are expensive, and apt to run out entirely at times. No ice, unfortunately, though we are promised an ice factory soon. I have kept quite fit in spite of a bout of the usual Tigris diarrhœa, which everyone has sooner or later. There is a lot of sickness, of course, chiefly typhoid, paratyphoid, and malaria, and diarrhœas of sorts, including *cholera*, of which I have had about ten cases, luckily not of a very acute type.

Last week I had to give four lectures to the whole of the troops of the station on the subject, delivered in the Y.M.C.A. in the "popular" style; they were quite well patronised. The fall of Kut was naturally rather a blow to us out here, but it was not unexpected. Now things seem rather at a deadlock, except for rumours of Arab raids. We have had a few sick from Kut, bags of skin and bone merely. I see great talk in the papers about the breakdown of medical arrangements here. With the material provided I think personally the R.A.M.C. have done very well, but there was a most appalling lack of decent supplies. Transport has been the difficulty, and the same ships which take up live sheep, mules, ammunition, etc., to the front, have had to bring down the sick and wounded.

DREAMS AND THEIR INTERPRETATION.

(*An Address to the Abernethian Society.*)

By Robert Armstrong-Jones, M.D., F.R.C.P.Lond., F.R.C.S.Eng.,

Lecturer on Mental Diseases, St. Bartholomew's Hospital, and Consulting Physician in Mental Diseases to the Military Forces in London; Resident Physician and Superintendent of the London County Asylum, Claybury.

THIS is the third time that I have been honoured by the Executive Committee of the venerable Abernethian Society, founded 1795, to address its members and visitors. Upon the first occasion we discussed the question of Temperaments, on the second the relationship of Genius and Insanity, and on this I have been requested to bring before you the subject of Dreams. John Abernethy (1764–1831), whom this Society commemorates, was no dreamer—although Sir James Paget described him as naturally indolent—and he never disdained facts which were within the range of physiological and anatomical experience. He possessed in no small degree a vivid and attractive power of exposition, as was testified by a great and appreciative audience of St. Bartholomew's men who crowded to hear his lectures at his house in Bartholomew Close.

It may seem out of place, whilst we are face to face with so grim a reality as war, which has affected us here at St. Bartholomew's (there are 1400 Bartholomew's men serving) as much if not more than any other institution or industry, that we should be discussing the realms of the unconscious, but we can claim that such a discussion is a relief to the strain and stress of reality, and that the "Bowmen" in the early days of the war laid particular emphasis upon dreams of the "Angels of Mons." Moreover, dreams have been regarded as one of the strongest forces wherewith to unravel the mysteries of the unconscious mind, and it is claimed that their interpretation may bring out of the unconscious mind what is perplexing and hidden, and may restore the balance in an unstable and wandering mind.

The laboratory of the mind is open to all, and I see before me some who are apt students in the field of mental exploration, those who have recently had special opportunities for probing into this dark territory. I also see others (among whom is the able nursing staff of St. Bartholomew's) who take an academic interest in the subject, but who nevertheless are justified in seeking for explanations in regard to facts which are within the experience of all.

The subject of dreams has interested mankind since the earliest days of primitive culture, and long before the dawn of history. Many and varied have been the speculations in regard to them, and the philosophers of antiquity entertained great diversities of opinion as to their cause and meaning. Dreams may be said to have a world of their own, and to have no links of connection with any other facts in human experience. The savage regarded the dream-world as similar to, only more remote than, the one he dwelt in. When he fell asleep his second self left his body for unfamiliar haunts, where he met the second self of his dead ancestors. Socrates believed in the divine origin of dreams. Lucretius accounted for them on the principle that ideas or thoughts were material things which could be detached from each other and be made to strike upon the mind. Porphyry ascribed dreams to the influence of a good demon who warned the dreamer of the evil the bad demon was preparing for him. Baxter, in his work upon the soul, attributed dreams to the agency of good spirits which descended from their proper sphere and condescended to weave midnight vision for poor mortals! As sleep has something awe-inspiring and inexplicable, so dreams viewed from the waking state have no less strange or perplexing a reality.

Dreams have been defined as "conscious processes during sleep" a definition which implies a self-contradiction, for conscious processes deny sleep, and normal sleep is attended with unconsciousness; but this unconsciousness may indeed be slight, yet it is not infrequently profound and even complete. During deep sleep the senses are unaffected by external and even by internal impressions, yet it has been asserted that the mind is never at rest during sleep, and that there is always some dreaming. Dreams have also been defined as thoughts, or a series of thoughts, experienced in sleep—*i. e.* a train of ideas presenting themselves to the mind during sleep. To-day the definition of a dream is "the symbol of an unfulfilled wish," the meaning of the symbol having to be interpreted by an assumed psycho-analytic "code"; and because of its symbolic function a dream is looked upon to-day as having its root firmly fixed in the experience of the waking life, whilst its superstructure lies in the unreality of phantasms It may help us to understand the terms symbol and symbolism if we state that they

are only applicable when the dream is interpreted, *i. e.* the dream then becomes the symbol of the meaning elicited. The terms themselves apply to the dream as recorded, or the manifest dream, which is always centralised round certain subjects connected with the waking experience, and not, as erroneously believed by some, always and invariably connected with sexual matters.

The history of dreams is a long and ancient record, and authorities in the past have offered many explanations as to the process and import of dreaming. The Old Testament describes many dreams, also their interpretation. We have the beautiful dream of Jacob's ladder, and that of Joseph, which he related to his brothers, also the dream of Pharaoh and of Pharaoh's servants, of Solomon's choice of wisdom, through which he obtained in addition riches and honour. The dream of Nebuchadnezzar, which, as frequently happens, he himself had forgotten, was, with Daniel's help, revealed and subsequently interpreted, often the quickest way then to royal favour, and in acknowledgment of which the "king made Daniel a great man." The influence of dreaming upon the conscience is shown by the dream of Job, when he affirmed that "God speaketh once, twice; yet man perceiveth it not." "In a dream, in a vision of the night when deep sleep fell upon man and sealed his instruction, He withdraws man from his purpose." In the New Testament there is Joseph's dream, both before and after the birth of the Saviour; the dream of the three wise men, and the dream of Pilate's wife, which were all quoted as messages from the spiritual world. Shakespeare puts into the mouth of Mercutio the cause of dreams: "Which are the idle children of a brain, begot of nothing but a fantasy." Byron, Milton, Robert Louis Stevenson, who stated that the motives for his best romances were inspired by dreams, Coleridge, Moore, and John Bunyan have all dwelt upon this attractive subject, and Bunyan stated that the whole of the *Pilgrim's Progress* was revealed to him in dreams. Certain races, like the North American Indians, are stated to look upon a dream as a sacred event, being the most ordinary way in which the gods make known their will to man. In the *Journal of a Voyage to North America*, Charlevoix relates how an Indian dreamed he had his hand cut off, which occurred the next day. The poor still have their dream-books, and they often pay for the "meaning" of their dreams.

It may help to clear our conception of the working of a dream if we briefly state how the mind works normally in the waking state. All of us are brought up to observe certain conventionalities, and to regard with solicitude certain social laws and amenities; in consequence of which feelings of undue assuredness, aggression, and self-assertiveness are kept under or repressed; and out of regard for social customs certain tendencies or passions are also kept under control, a feeling of self-restraint and inhibition being thus exercised. All of us, who are properly brought up, look upon ourselves with a certain compulsion in regard to observing the courtesies, ceremonies, and conventions of life, and our conduct is formulated accordingly. These compulsions eventually become automatic restraints, and they tend to keep up the structure and wholesomeness of human society. They constitute the feelings of social obligation and of personal regard for others, and are based upon certain instincts which have emotional representations, such as fear, anger, joy, sorrow, love, hate, and disgust. When, let us say, an object is presented to one of the senses—for instance, to the sense of sight—all the unconscious feelings of restraint which have been instilled into us in youth and which in grown-up people act automatically, are applied to the object we have in view, and our conduct or reaction towards it varies accordingly; for our unconscious life is always acting in numberless and unsuspected ways upon our conscious mental life. Supposing, for example, that we were watching a lady at some social function who was wearing a green carnation—certain rays of light from this object impinge upon the retina, these are conveyed to the brain and there stimulate a mental picture, *i. e.* the outward form, figure, surrounding circumstances, time and place of the person are appreciated as an external object, which, when absent, may be restored as an image, a picture, or idea upon the cerebral cortex, so that, in the absence of the object, an impression of the lady can be revived in memory upon the mind, the person being "remembered" with all her attendant associations. The mind recalls the occasion either with pleasure, or perhaps with pain, and in idea the whole previous scene can be re-enacted, even to the recognition of personal charms, gestures, verbal movements, conversation, habits and ways; these are accompanied by their emotional reactions; all can be revived as representative images, so that the mind is not only able to cognise an object, and associate it with a definite feeling, and with all the voluntary movements, but the image itself, or the memory picture, may also be revived with all the accompaniments belonging to the original presentation. These three factors, viz. cognition, feeling, and will, are the invariable accompaniments of every mental process, whether an object is presented from without or its picture is experienced from within. The same analogy applies to presentations and representations referring to the organic sensations. In dreams these three factors tend to become dissociated, the will alone remains in abeyance, whilst the cognitive elements may be represented, either by themselves, or they may be grouped with others which are similar or dissimilar; the feelings may also be represented to the mind, and may either be painful or pleasurable. It is the will which refuses to act, and it is questionable whether a dream, once initiated, can ever be modified by the will, although some persons state that they are able to modify a dream, and that they have frequently done so whilst dreaming. The recollection of these dissociated elements

of a dream when recalled by the memory is often so weird, so striking, and so suggestive, that an attempt to interpret their meaning is inevitable, and the phenomena of dreams have thus become objects of conjecture, of curiosity, as well as of vivid interest. In consequence many persons have endeavoured to read into them some hidden meaning, whilst others regard them with heedless indifference, considering them to be only a confused and jumbled record of sleep memories unworthy of serious reflection. Possibly the truth in regard to dreams lies between these two extremes of undue scepticism and a too *facile* credence. It is difficult not to suspect a meaning in some dreams, as in the dream of Mrs. H—, whose husband went to New York on business. She dreamed one night that he was sleeping on the tenth floor of a hotel which took fire, and that he escaped with difficulty. The next morning, feeling very uneasy, she cabled asking how he was, when he replied: "Quite well and safe, but had a narrow escape last night, when the hotel was burnt down." The following, sent to me by Dr. Leonard Guthrie, relates the experience of a credible witness, E. W. M—, a distinguished scientist and F.R.S. In his own words he writes:

"When I lived in Canada the following incident occurred:—

"An Englishman and an American clubbed together to try to reach the Klondike gold field by the overland trail, *i. e.* by going due north from the prairies instead of following the usual course of crossing by the Canadian Pacific Railway to Vancouver, then taking steamer up the coast to Seattle, and crossing back over the mountains *viâ* White Horse Pass. After the pair had on their journey passed what the American judged to be the outposts of civilisation, he shot the Englishman while he lay asleep, tried to destroy his body by burning it, rifled his baggage, taking everything of value, and returned. When he was questioned as to what had become of his companion, he replied that he (the American) had become discouraged and had given up the expedition, but that the Englishman had pushed on. But there was an encampment of Indians close to the spot where the crime had been committed. The old chief saw two men come north and encamp; in the night he heard a shot, and next morning saw one man go south. He went to the camp, saw the body, and informed the nearest post of North-west Mounted Police. They trailed the murderer and arrested him before he could escape across the United States border. He was brought to Regina. Meanwhile the brother of the murdered man in England had a dream in which he saw his absent brother lying dead and bloody on the ground. He came down next morning very depressed, told his dream, and announced his intention of going straight out to Canada to see if anything had happened to his brother. He did so and arrived out as the trial of the murderer was progressing. He identified several articles in the possession of the murderer as the property of his late brother. The murderer was hanged at Regina."

Another dream of a prophetic nature, and relating to the assassination of Perceval, is recorded in the *Book of Days*, i, p. 617. I am further indebted to Dr. Guthrie for calling my attention to it. It was the dream of Mr. John Williams, of Sarrier House, near Redruth, in Cornwall. He died in 1841, and was described in the *Gentleman's Magazine* as a man of the highest integrity. On the night after the assassination, when the facts could not have been known to him by any ordinary means, he dreamt that he was in the Lobby of the House of Commons, although he had never been there in his life. He saw a short, small man enter, dressed in a blue coat and a white waistcoat. Immediately after him entered another man in a brown coat with yellow buttons. The latter drew out a pistol and shot the former, who instantly fell, blood pouring from a wound a little below the left breast. In his dream Mr. Williams heard the report of the pistol, saw the blood flow out and stain the waistcoat, and he noticed the colour of the victim's face change. He further saw the murderer seized, and observed his countenance. When asking, in the dream, who had been shot, he was told "the Chancellor"—Perceval was Chancellor of the Exchequer at the time. Mr. Williams then awoke and mentioned the matter to his wife, who made light of it. At her suggestion he went to sleep again, but dreamt the same dream a second time, and then a third. After this, between 1 and 2 a.m., he got up and dressed. In the forenoon of the next day he went to Falmouth and related his dream again to Mr. Tucker, of Tremanton Castle, and to his wife. Mr. Tucker replied that the description was like the Chancellor of the Exchequer Perceval, although Mr. Williams had never seen Perceval nor had anything to do with him. Just then the news of the assassination reached Truro, which was seven miles away. Six weeks after the event Mr. Williams went to London and to the House of Commons. He recognised the Lobby, the exact spot where Perceval fell; and the dress of both men in the dream corresponded precisely with those actually worn at the time. The extraordinary thing about this dream was that a minute account of it was published in the *Times*, another was given to Dr. Abercrombie, whilst Mr. Williams' grandson communicated an account drawn up from his grandfather's words. All these agreed in every detail with the first narrative of the dream recorded by Mr. Williams.

Whether we regard dreams as in any way prophetic or not, Andrew Lang has stated it is remarkable, when we consider the enormous number of dreams, that there are not more than occasional coincidences. The successes only are noted whilst the failures as to prophecy have been forgotten. It was, probably, through the effort to elicit some meaning from dream phenomena that the idea of a soul first arose, and that this soul could exist apart from the body and survive its dissolution. The phenomena of dreams, or "visions" as they were called, suggested, as stated, excursions of the soul into some distant regions which it

explored, and reported what it had experienced to the waking soul, so that if the dream were of the dead the soul was believed to have travelled to the regions of the dead, and, if of the living, then the soul had wandered into the society of other living souls, and had some message of importance to convey to the dreamer, if only it could be properly and adequately interpreted or explained. Thus they were "symbols" of some message to be imparted by a supernatural being, *i. e.* if the dream could be properly solved. This "symbolical" view has been revived to-day, although the symbols are erroneously interpreted to be those of sexual disturbances. The interpreter of dream messages, or the "seer" as he was called in ancient times, was, naturally, a sacred person, who came to be regarded with considerable importance, if not with prophetic awe and as of divine origin. Thus arose the magician, or the "wise man," whose survival was formerly represented by uncultured and irresponsible fortune-tellers, but who are to-day represented, speaking generally, by competent and able psychologists, who, by methodically arranging and sorting the spontaneously uttered thoughts of a person who submits to examination, or by comparing the verbal association of a series of responses, ascertain the workings of the unconscious mind which lies beneath the manifest dream. According to the teachings of certain psychologists all thoughts and actions are assumed to be coloured by, if indeed they do not directly arise out of, the unconscious mind.

(*To be continued.*)

A CASE OF CEREBELLAR ABSCESS.

By J. SIMPSON WHITE, M.B., B.Ch.

I AM indebted to the courtesy of Mr. C. Ernest West for permission to publish the following case.

Patient J. M—, admitted to hospital on Monday afternoon, May 29th, with the following history: For five years has had discharge on and off from the left ear. For the past three weeks has suffered from pains in the head, giddiness, drowsiness, and frequent yawning. Three days ago these additional symptoms appeared: shivering fits (? rigors) and free perspiration. No vomiting; exceedingly deaf, had to be spoken to loudly.

Condition on admission.—Temperature 97° F., pulse 88. Covered with cold, clammy perspiration, furred tongue, drowsy, slow cerebration, took some time to answer questions, then spoke slowly as if he found it difficult to get the words he wanted. Headache was present, also pain over the occipital region. He vomited once. There was pendulum nystagmus to the left, slight exaggeration of the left knee-jerk, left ankle clonus, but normal plantar reflex; dysdiadokokinesis (left), a mitral systolic murmur at the apex conducted outwards. The spine was kyphotic, owing to old tubercular trouble.

A left radical mastoid operation was performed by Mr. Scott that same evening. The antrum was exposed and opened into; the bone was found to be very dense. The lateral sinus was then exposed and blood for pathological examination drawn off. (Result of examination: films showed no organisms. Culture sterile after two days.) The dura mater was not found exposed. A large cholesteatoma was discovered, which had made an opening into the labyrinth, destroying the ossicles. It had a very foul odour. The facial nerve had been laid bare for a considerable portion of its course. It was quite evident that left facial paralysis would inevitably follow such marked exposure of the nerve, and such was the case, the left side of the face being completely paralysed.

After this operation there was some slight elevation of temperature—99° F.—but it soon dropped again to subnormal, *i. e.* 97° F. There was also occasional slowing of the pulse-rate, 62 being the slowest rate. He indulged in sullen fits, sometimes refusing to be washed, also trying to get out of bed. His speech was still rather slow and laboured, but he did not complain of headache, nor did he vomit. Lumbar puncture was tried, but no cerebro-spinal fluid could be obtained.

This state of affairs went on until Thursday night, June 8th, when he vomited once or twice and complained of pains in the head. The temperature was still subnormal. On Friday morning his headache had got worse, also he could not raise his head from the pillow without the assistance of his hand. He vomited a few times during the morning. Examination showed a positive Kernig and nystagmus of an oscillating character to both sides; slight optic neuritis was also present. That afternoon Mr. West decided to operate.

Lumbar puncture was first tried, this time successfully. A test-tube full of clear fluid was drawn off. Then the wound of the previous operation was opened up. Landmarks were not easily discovered, the facial nerve not being visible at all now. The dura mater was incised and an expanding brain trocar was thrust into the lateral lobe of the cerebellum. Its blades were opened, with the result that pus immediately gushed forth. Fully 2 drachms were thus evacuated. The pus had a very foul odour. A drainage-tube, without any lateral openings, was inserted into the abscess cavity and secured firmly in position by means of a catgut suture. The edges of the skin wound were not sutured together. The drainage-tube protruded about the middle of the wound. The cavity around it was packed with gauze soaked in hypertonic saline solution. A small strip of gauze was also inserted into the tube. The wound was then dressed and bandaged in the usual manner.

After this second operation the temperature kept steadily down, never rising beyond normal. The pulse-rate again showed slowing at intervals, 60 being the lowest rate this time. He tried once or twice to tear off the bandage, and, for a short period, became somewhat unruly. Nystagmus was still present to both sides, and some occipital pain, which disappeared in a few days.

The wound was packed with gauze soaked in hypertonic saline solution every day, and the tube leading into the abscess cavity irrigated out, first with hydrogen peroxide, then hypertonic saline solution. This irrigation was accomplished by passing a tube of smaller diameter than the drainage-tube through the latter, and then letting the fluid run into the abscess cavity at a slow rate. At first there was a slight serous discharge from the abscess cavity, but this gradually ceased. Fourteen days after the operation the suture securing the tube in position was removed and the tube gently taken out for about $\frac{1}{4}$ of an inch of its length. This $\frac{1}{4}$ inch was then snipped off. The result of this was a small gush of pus. A few days afterwards the tube was again taken out another $\frac{1}{4}$ inch, and there was another slight gush of pus. Exactly three weeks after the operation, when dressing the wound, the tube came out altogether, having crept up unnoticed. It was not again replaced, but the small cavity still remaining was packed with hypertonic saline gauze.

Such is the condition of affairs at present, four weeks after the opening and draining of the abscess cavity. For the past few days he has been up and out in the hospital square. He is able to walk quite steadily, and the nystagmus has disappeared. He is quite bright and cheerful, and fully conscious of all he says and does. His only anxiety was to be allowed to smoke. The left facial paralysis is not noticeable to a casual observer. There is still some slight weakness in rotatory movements of the left forearm (left dysdiadokokinesis).

SIMPLE RHYMES FOR FRIGHTFUL TIMES.

No. 4.—CRUMPS.

When perhaps you've got the hump,
And a rather nasty crump
Makes a very horrid din
And spoils the dug-out you are in;
Then its price you calculate . . .
'Tis such things depreciate
The Hunnish *mark;* and much depress
The Hunnish people . . . *vide* Press.

J. R. R. T.

A CASE OF MALIGNANT ENDOCARDITIS GRAFTED ON A CONGENITAL SEPTAL DEFECT.

BY G. K. BOWES, M.R.C.S., L.R.C.P.

I AM indebted to Dr. Drysdale for his kindness in allowing me to publish the following case.

Considered as a whole the case is straightforward, and does not present any features of great rarity, but I regard its main interest as lying in the problem of differential diagnosis, to which it at one time gave rise. It also illustrates the value of pathological methods in deciding such a problem, for had it not been for the application of one of such methods, itself of quite recent origin, the diagnosis would have remained in doubt, and could not have been made by clinical methods alone till quite a late stage in the course of the case, and even then would have been uncertain.

W. P—, æt. 34, a clerk, was admitted to St. Bartholomew's Hospital on February 19th, 1916, complaining of abdominal pain and general weakness. The history of the case was as follows: Since he was an infant the patient was known to have had some affection of the heart, which, as there was no history of causative disease, was presumed to be congenital. This had caused him no trouble or inconvenience till the beginning of his present illness. He was last quite well in January, 1915; and from this time till July, 1915, he suffered from loss of appetite, langour, and occasional pains behind the eyes. He first consulted a doctor in August, 1915. At this time his temperature was raised, and he used to sweat profusely. He remained in bed for a few days. In September he became weaker, and was troubled by abdominal pain, which was localised around the umbilicus, and was worst about half an hour after food. He remained in bed for about three weeks and returned to work in the middle of November, still suffering from loss of appetite and abdominal pain. From the end of December till his admission to hospital he remained in bed most of the time. During the last three weeks before admission he vomited three or four times. During the period of this history he was suffering from fever when he was seen by his medical attendant.

On admission on February 19th the patient was pale and thin, his weight being 7 st. 11 lb. His temperature during the first three days ranged from 97·6° F. to 102° F., and his pulse-rate from 96 to 124. The eyes were natural and no retinal hæmorrhages were seen. On the chest and abdomen were large areas of pigmentation with scaly skin due to a skin infection. The lungs were natural. The heart showed a diffuse pulsation, most marked in the fifth interspace, about 4 in. from the middle line. On percussion it was found to be somewhat enlarged, the deep dulness extending $1\frac{1}{2}$ in.

from the middle line in the fourth space to the right, and 4¼ in. in the fifth space to the left of the middle line. A loud, harsh, systolic murmur was present, which was heard best over the fourth left costal cartilage, and propagated widely all over the front of the chest, but not outwards to the axilla. The second sound at the pulmonary base was slightly accentuated. The abdomen was somewhat distended, and there was some shifting dulness in the flanks. The liver was enlarged, extending 6¼ in. when measured vertically in the nipple line, its edge being palpable well below the costal margin. The spleen was also enlarged and tender, its edge being palpable 3 in. below the costal margin. There was no œdema of the legs. The urine contained ·1 per cent. of albumin and some blood. There were no superficial enlarged glands anywhere. A blood-count showed that the patient was anæmic, the number being:

Red cells	2,570,000 per c.mm.
Hæmoglobin	50 per cent.
Colour index	·97.
White cells	10,400 per c.mm.

The differential count showed:

Polymorphs, 73 per cent.	7600 per c.mm.
Lymphocytes, 25 per cent.	2600 ,,
Mononuclears, 2 per cent.	200 ,,
Eosinophiles, none seen.	
Basophiles, none seen.	

Slight poikilocytosis, anisocytosis, and polychromatophia were present; no abnormal white cells or nucleated red cells were seen.

At this stage the facts known about the patient may be summed up as follows: A congenital heart lesion, continued fever for six months, a slightly enlarged heart with a widely propagated systolic murmur, an enlarged liver and spleen, a high degree of anæmia with colour index ·97, and with 10,400 leucocytes per c.mm. It was thought probable that the heart murmur, taking into account its localisation and the absence of any other signs such as cyanosis or venous regurgitation in connection with it, might be due to an imperfect interventricular septum. At this stage of the possible diagnoses the two which seemed most probable were (*a*) Hodgkin's disease, and (*b*) malignant endocarditis grafted on a congenital heart lesion. It was impossible without further knowledge to decide between these two alternatives. Although the absence of superficial enlarged glands pointed against Hodgkin's disease, cases are known where only the internal glands have been enlarged, with an enlarged spleen and liver, and a blood-count and temperature chart not unlike those of the case under consideration. With the second alternative would agree the continued fever, the signs in the heart, and the enlarged liver and spleen, the enlargement being in this case due to back pressure and to septicæmia, and, in the case of the spleen, perhaps to infarction as well. Other possibilities were the following: Splenic anæmia, with which the high colour index of the blood and the high leucocyte count did not agree at all, nor did the fever well, which, although it may be present, is in this degree unusual; familial acholuric jaundice with enlarged liver and spleen, which would not explain the fever; and the possibility that the condition might be connected with syphilis. The length of the history, as well as the absence of characteristic symptoms, rendered typhoid fever very improbable.

To decide between these possibilities the following investigations were undertaken. A skiagram was taken to determine the presence or absence of enlarged glands in the chest. Some enlarged glands were seen to be present in the posterior mediastinum. The fragility of the corpuscles was investigated and found to be normal, thus excluding congenital acholuric jaundice. A culture made from the fæces showed that no abnormal members of the coli group were present, thus excluding typhoid. The Wassermann reaction was strongly positive. On February 23rd a blood-culture was made, and the blood was shown to contain large numbers of a streptococcus, giving the fermentative reactions of *Streptococcus salivarius*. The result of the blood-culture enabled the diagnosis to be made that the patient was suffering from malignant endocarditis.

A vaccine was prepared from the organism present in the blood. The first dose, consisting of five million organisms, was given on February 29th, and the vaccine repeated in increasing doses up to fifty million, the last being given on March 12th. From February 19th till 29th the temperature varied between 97·6° F. and 103° F., being several times over 102° F. The pulse-rate was frequent, up to 136. After March 2nd, when the second dose of vaccine was given, the temperature began to fall, and from that time onwards remained on a considerably lower plane, being only occasionally over 100° F., but the pulse-rate became rather more frequent, and the general condition of the patient became worse. A second blood-culture was made on March 21st, and showed a much smaller number of organisms. A vaccine was prepared from this possibly more resistant strain, and a single injection of twenty-five millions given on March 24th.

At the beginning of March a change was noticed in the condition of the heart murmur, this becoming softer in character. The patient complained at times of tenderness over the spleen. On March 29th he began to suffer from diarrhœa, and on March 31st began to pass a large amount of altered blood with the stools. It was thought at the time that he might have an intestinal infarct. On April 3rd the patient complained of pain in the left axilla. The percussion note was impaired in this situation, the breath sounds were feeble, and friction was heard. The sputum was blood-stained. These signs were thought to be due to a pulmonary infarct, and before death signs pointing to the presence of fluid were evident. The patient died on April 8th.

To complete the history I will mention the fact that the patient was on February 24th given potassium iodide in 5-gr. doses three times a day, and in all had 35 grs. This led to the appearance of an eruption, first bullous, then pustular, on the face and neck. This special susceptibility to iodides may have been connected with the septicæmic condition.

The post-mortem examination showed that the diagnosis made during life was correct in most particulars. The heart weighed 11 ozs. The right auricle was considerably dilated. Large verrucose vegetations were found projecting into the right auricle from the tricuspid valve, to which some ante-mortem, but recent, clot was adherent. On opening the right ventricle the tricuspid valve was found covered with a mass of verrucose vegetations, which extended to the ventricular walls, both septal and parietal; also both chordæ tendineæ and musculi papillares. On opening the left ventricle the mitral valve was found to be natural. Two of the aortic valves contained small vegetations attached to the corpora aurantii, and in one case the vegetations extended to the anterior aspect of the cusp. Beneath the septal aortic cusp there was an opening which communicated with the right ventricle. This was funnel-shaped, being larger at the left ventricular side and smaller at its opening into the right ventricle behind the septal cusp of the tricuspid. It was lined by what appeared to be a thickish white-coloured continuation of the endocardium. There were no vegetations on this, but a mass obscuring its opening into the right ventricle. With regard to the lungs and pleuræ, the right lung showed the remains of a small infarct at the hilum in the base of the upper lobe. The left plural cavity contained about a pint of blood-stained, turbid effusion, and there was some fibrinous pleurisy at the base posteriorly. The posterior part of the lung was found to be solid and greyish, with hæmorrhagic mottling and purulent exudation from the bronchioles. The intestines showed congestion, but no infarction. The liver showed evidence of chronic congestion and fatty degeneration, and was enlarged. The spleen was enlarged, soft, and congested, with perisplenitis, but no infarction. The kidneys showed red and yellow mottling, with many minute petechiæ on the cortex. Of these conditions one which requires further consideration is that of the white infarct of the lung. It is usually stated that, owing to the double blood supply, white infarcts do not occur in the lungs, but I think that in this case its occurrence may be explained by the fact that, when the infarct occurred a short time before death, the circulation was so feeble that the infarct passed from the condition of red to that of white infarction, as is the usual occurrence in organs with a single blood supply.

CHLOROFORM-ETHER ANÆSTHESIA.

By H. F. PARKER, M.D.(Cant.).

IT may be of sufficient general interest to call attention to a method of chloroform-ether anæsthesia which, though not new, is one that appears to be not as generally adopted as it deserves to be.

It consists simply in giving a mixture of chloroform and ether in suitable proportions from an ordinary Clover's inhaler, discarding the bag altogether.

The method of administration is as follows: A mixture of 1 vol. of chloroform to 2 vols. of ether is prepared. Some ℥iifs of this mixture having been poured into the chamber of the Clover, the patient is allowed a few breaths with the indicator standing at 0. The chamber is then slowly rotated until the indicator points to $3\frac{1}{2}$ or 4, and the latter is maintained at this point or thereabouts until the patient is ready for operation—usually a matter of some five to eight minutes. The indicator is then gradually moved back to approximately $1\frac{1}{2}$, which will suffice to keep the patient fully anæsthetised. In robust patients it may occasionally be necessary to put on the bag for a few breaths at the commencement. A fresh supply of the mixture will have to be added at the end of a quarter of an hour and subsequently about every half-hour.

The undoubted advantages of this method may be tabulated as follows:

(1) It is an open method. As no bag is used there is no re-breathing.

(2) The percentage of anæsthetic-vapour in the inspired air remains absolutely constant except in so far as the administrator desires to vary it; and this he can do with any degree of precision that he likes, his aim being to maintain the requisite degree of anæsthesia by the employment of a minimum quantity of anæsthetic.

(3) It is easy and simple in its mode of application. One hand is sufficient for holding the mask in place and for keeping up the jaw, thus leaving the other hand free for feeling the pulse, testing the lid-reflex, or for other purposes. The mask need not be removed from the face during the whole of the operation except momentarily for replenishing the chamber; in fact, under a light anæsthesia it is better not to remove it for more than a few seconds at a time, so as not to alter the proportion of vapour present in the alveoli of the lungs. In a prolonged operation it is a great relief to be able to dispense with the usual drop-bottle and lint face-piece. Moreover, the inhaler can be easily retained on the face, whatever position of the head may be required by the exigencies of the operation.

(4) The face is not completely covered, consequently the patient's colour—one of the most important points to observe in the giving of an anæsthetic—is always obvious.

(5) The mixture is not unpleasant to inhale—a point of some importance in the case of nervous patients.

The respiration is remarkably quiet and free from stertor, and there is little tendency to salivation.

(6) It is a safe method, for the reasons that will be obvious from a consideration of the above headings.

(7) It is economical as regards the consumption of anæsthetic, as there is no waste caused by needless evaporation.

(8) There is no danger of spilling anæsthetic upon the patient's face.

(9) In the event of a doctor being single-handed he can, after inducing anæsthesia by this method, set the indicator at a perfectly safe position—say $1\frac{1}{2}$—give the mask to a nurse to hold in place, instructing her to hold up the jaw and watch the patient's respiration.

In cases where scopolamine-morphia has been injected this same method seems perfectly satisfactory, though in such cases I usually use a proportion of 1 vol. chloroform to 3 of ether.

Ethyl chloride is an anæsthetic that is not now so much in vogue as previously, largely, I believe, because accidents happened in consequence of the use of inhalers of a closed type.

A convenient way of giving it consists in spraying some 5 c.c. into the chamber of a Clover's inhaler, and then rotating this—probably not much beyond the figure 1—until the requisite degree of anæsthesia is obtained.

RAHERE LODGE.

THE Installation Meeting of the Rahere Lodge, No. 2546, was held in the Great Hall of St. Bartholomew's Hospital on June 20th. The W.M., W. Bro. Anderson, initiated E. D. Whitehead Reid, and then installed W. Bro. W. J. Gow as W.M. for the ensuing year. The following officers were appointed :

W.Bro. C. H. PERRAM, P.P.G.W. Beds.	W.S.
W.Bro. A. HEPBURN, L.R.	J.W.
Bro. The Rev. H. S. CLOSE	Chaplain.
W.Bro. ERNEST CLARKE, P.M., P.G.D.	Treasurer.
W.Bro. E. LAMING EVANS, P.M., L.R.	Secretary.
W.Bro. T. G. A. BURNS, P.M., P.G.D.	D.C.
Bro. A. W. STOTT	S.D.
Bro. H. PRITCHARD	J.D.
W.Bro. M. L. TRECHMANN, P.M., L.R.	1st Asst. D.C.
W.Bro. H. MORLEY FLETCHER, P.M.	2nd Asst. D.C.
W.Bro. P. S. ABRAHAM, P.M., P.G.D.	Almoner.
Bro. NORMAN F. SMITH, Asst. G. O. Oxfordshire	Organist.
Bro. A. L. MORETON	Asst. Secretary.
Bro. B. T. LANG	I.G.
Bro. A. S. WOODWARK	Sen. Steward.
Bro. W. R. READ	Steward.
Bro. J. H. GRIFFITHS	Steward.
W.Bro. E. P. FURBER, P.P.G.J.W., Surrey	Steward.
Bro. W. G. BALL	Steward.
Bro. E. BURSTAL	Steward.
W.Bro. A. H. COUGHTREY	Tyler.
Bro. E. W. HALLETT	Asst. Tyler.

CORRESPONDENCE.

THE MERCANTILE MEDICAL SERVICE.

To the Editor of the 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—At the present time, when every trade and profession is looking anxiously ahead, it is essential for the welfare of the medical profession that it in its turn does not fail to guard in so far as it can the interest of its members. It is seldom realised by the majority of medical men that a most necessary, useful and pleasant branch of the profession has its "dwelling upon the waters." I refer to the Mercantile Medical Service, which for many years has offered health-giving, instructing and entertaining work to medical men. Nevertheless at the present moment it is the most unsatisfactory and neglected branch of the medical profession. The reasons for this are (i) that medical men, regardless of the welfare of their sea-going brethren, take for their own pleasure or convenience nominal remunerations in permanent sea-going posts, and (ii) that it is a branch of the profession in which the drunkard, the morphiomaniac and the waster-in-general can usually find employment—the "dumping-ground," in fact, for the "professional degenerate."

Thus in the past the shipping companies have found it possible to provide medical men for their vessels without difficulty, and at a rate of pay inferior as a rule to that of their second mates! It is then incumbent upon us to secure an adequate remuneration for the ships' surgeons (i) by refusing to accept a permanent appointment at sea for a remuneration less than that necessary to support one of the regular sea-going medical men, and (ii) by insisting that those shipping companies which continue to employ the "medical degenerates" and "black-legs" for the sake of economy, are prevented from securing the services of other medical men. It is to the younger men of the profession that we must look for the necessary assistance in bringing about a long-needed change in the conditions of the Mercantile Medical Service, for it is in great part due to the past inconsideration and selfishness of the younger members that improvement has not already taken place.

In conclusion, may I suggest that the so-called "medical agents" be carefully avoided, and that eighteen guineas per month be regarded for the present as a *minimum* wage for the medical man at sea.

I am,
Yours faithfully,
L. T. RUTHERFORD, M.B.Cantab.

St. Thomas's Hospital,
London, S.E.,
June, 1916.

ROYAL MEDICAL BENEVOLENT FUND.

To the Editor of the 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—The Royal Medical Benevolent Fund, the great Benevolent Society of the Medical Profession, is sorely in want of money now.

Though in ordinary times the medical profession supports its own poor, in these war times this is no longer possible. At the May meeting the Committee had a balance of only £17 in hand, and at the June meeting was faced with a deficit of £16. The demands were heavy and had to be met, and this could only be done by withdrawing £500 from the bank.

As the direct outcome of the war, not only are the ordinary cases of poverty greatly increased in number, but an entirely new class of case has arisen urgently requiring relief, in which without actual poverty there is great temporary distress—distress, however, which it is hoped will relieve itself soon after the war is over and the doctors serving return to their civil duties.

At the outbreak of war, the medical profession responded freely to the nation's call. The Territoral Medical Officers were at once called out, and other medical men volunteered. Both alike had to leave their practice at very short notice, and often without being able to make adequate provision for its continuance and maintenance during their absence. Their pay went but little way to supply the loss which their absence entailed, for the working expenses of the practice could not be materially reduced. The result was that many families found themselves in very straitened circumstances. Rent, rates and insurance brook no delay, but, worst of all, school bills could not be paid, and if help had not been quickly forthcoming the children would have suffered for the patriotism of their father.

The following are typical of the cases with which our Fund has had to deal:

A young doctor who had only been in practice a few years, volunteered for service, and was killed in action a few days later. He left a widow, æt. 35, with two young boys, æt. 3½ and 1 year, entirely without means. The Fund voted £25 for her immediate necessities, and put her into communication with the Officers' Families Association, which gave further help.

A practitioner, æt. 38, earning £700 to £800, volunteered for service, leaving his practice in the hands of a neighbour who was not a success. There were two young children, and another baby was born shortly after the husband left. The wife contracted pneumonia and nearly died. A resident patient had to leave the house. Rent and other expenses led to a debt of about £80. This the doctor could not meet, and he hurried back from the trenches to save his home from being sold up. The Fund voted £25, the Guild gave £15, the Officers' Families Association £25, and the Professional Classes War Relief Council further help, with the result that he returned to the Front with his immediate anxieties relieved.

A captain in the Territorials was called out and had to leave his practice in the hands of a *locum*, who proved a failure. There were seven children, æt. 2 to 14. Financial difficulties arose and payment of the school fees became impossible. Between the Fund and Guild and the Officers' Families Association the necessary fees were raised, and clothing, which was greatly required, provided.

These cases show well the way in which the Fund works, not only by giving relief itself in money and kind, but also by obtaining, through co-operation with other benevolent societies, more substantial assistance than it could afford alone.

But there is another class in which the distress is perhaps even greater, and adequate relief more difficult. It is that of men who left home and a good practice in vigorous health and who have come back, crippled by wounds or with health impaired, to a practice severely damaged by their absence, and without the strength or energy to regain the practice and position which they sacrificed.

Our Fund has set apart a special sum to meet emergency claims of this kind, yet the demands are so great that it will soon be exhausted. We cannot now rely on the profession alone to supplement it largely, for the medical profession, like all other professions, is hit very hard by the war and has no longer its old resources to draw upon.

What is required is an Emergency Fund large enough to deal adequately with these emergency cases arising directly out of the war, and for this we are driven to appeal to the public as well as to our own profession.

We trust that our appeal will meet with a liberal response both from the public and from the medical profession, for unless fresh funds are quickly forthcoming it will be impossible to continue the relief which is so urgently required.

We are, faithfully yours,
JOHN TWEEDY, *President.*
SAMUEL WEST, *Hon. Treasurer.*
G. NEWTON PITT, *Hon. Secretary.*

11, Chandos Street, Cavendish Square,
London, W.
July 3rd, 1916.

REVIEWS.

URINE EXAMINATION MADE EASY. By THOMAS CARRUTHERS. (J. & A. Churchill.) Third Edition. Price 1*s.* net.

A most excellent little book for nurses, and be it also said for students. The ordinary tests are set out clearly, and their exact technique is minutely explained, the reasons for the apparent failures of the various tests being given. The table at the end of the book giving the meaning of various phenomena is very useful, especially in so far as the colouring of urine due to drugs is concerned.

GRAY'S ANATOMY. Edited by R. HOWDEN. (Longmans, Green & Co.) Pp. 1304. Nineteenth Edition. Price 32*s.* net.

We are sorry to see this famous old work still clinging to the Basle terminology, in spite of the fact that this is not our official terminology and never likely to be in its present form. The student who attempts to use this work will be muddled by finding that the musculo-spiral nerve has become the radial nerve; he will then be taught by one of his demonstrators that the radial nerve supplies no muscles, and—we need not, however, beat a dead horse. Apart from the terminology, the new edition is all that may be desired; many new illustrations have replaced old ones, and the text is as it always has been, clear and concise. But when we try to read it, and then refer to a recent examination paper where the second question commenced, "Describe the musculo-spiral nerve," we feel that it would scarcely be our duty to recommend it to students, at any rate so long as there are other anatomy text-books on the market which adhere to the official nomenclature.

MANUAL OF OPERATIVE SURGERY. By J. F. BINNIE. (H. K. Lewis & Co., Ltd.) Pp. 1363. Seventh edition. Price 32*s.* net.

The regular appearance of new editions of this work speaks more than anything of its usefulness. It is a work which devotes itself principally to the less common and unusual operations in surgery. To quote from the Preface: "The constant endeavour has been to give aid to the surgeon when he is in trouble, hence much greater space has been devoted to some rather rare operations than to many . . . which ought to be familiar to everyone."

Thus there is an excellent chapter on cardiac surgery, and another on retro-peritoneal neoplasms, and a short chapter on war surgery has been added.

The work is invaluable to, and should be read by, all who are taking the higher examinations in surgery.

RADIUM X RAYS AND THE LIVING CELL. By H. A. COLWELL and S. RUSS. (G. Bell & Sons, Ltd.) Pp. 324. Price 12*s.* 6*d.* net.

An excellent little work dealing mainly with the chief experimental facts which have been established in regard to this subject. The early part of the work is devoted to a description of the properties of the radiation, while the latter portions deal in considerable detail with the actual microscopic alterations which take place in the various tissues, both healthy and diseased, under the influence of these rays. The illustrations and coloured plates are excellent, and the authors are to be complimented on a very complete little work.

ESSENTIALS OF HISTOLOGY. By Sir E. A. SCHÄFER. (Longmans, Green & Co.) Pp. 563. Tenth edition. Price 10*s.* 6*d.* net.

This almost historic text-book for students needs but little commendation at the hands of a reviewer. It is the *vade mecum* of many thousands and will probably remain so of years to come. In the present edition, which is somewhat larger than the last—alas poor student!—there has been a complete revision of the text and many additional illustrations appear, most of them being photographs of microscopic preparations. We can only continue to recommend a book which has already recommended itself to the majority.

EXAMINATIONS.

CONJOINT BOARD.

July, 1916.

First Examination.

Chemistry.—L. E. R. Carroll, J. A. Morton.

Physics.—L. E. R. Carroll, J. A. Morton.

Elementary Biology.—M. N. Eldin, E. D. Macmillan.

Practical Pharmacy.—L. E. R. Carroll, D. H. Cockell, B. Goldfoot, J. A. Morton, T. M. Payne, C. G. J. Rayner, E. J. G. Sargent, P. A. Smuts, T. B. Thomas.

Second Examination.

Anatomy and Physiology.—F. C. Cozens, E. Gallop, J. N. Leitch J. G. Williams.

Final Examination.

The following candidates have completed the examination for the Diplomas of M.R.C.S. and L.R.C.P.: T. B. Bailey, G. A. Beyers, W. H. Blackburn, E. G. P. Bousfield, C. V. Braimbridge, L. J. F. Bull, G. E. Burton, J. B. Flamer Caldera, P. N. Cook, W. R. Dickinson, D. D. Evans, J. J. Gasperine, J. B. Hume, T. Joekes, H. M. C. Macaulay, W. E. Wilson, H. M. Wharry.

UNIVERSITY OF CAMBRIDGE.

First M.B. Examination. June, 1916.

Part III. Elementary Biology.—A. Jephcott.

Second M.B. Examination. March and May, 1916.

Part II. Pharmacology and General Pathology.—B. F. W. Armitage, C. V. Braimbridge, G. E. Burton, A. J. Copeland, G. A. Fisher, E. G. D. Murray, E. D. Spackman, H. F. Squire.

Second M.B. Examination. June, 1916.

Part I. Human Anatomy and Physiology.—C. A. Horder, J. L. Potts.

Third M.B. Examination. June, 1916.

Part I. Surgery and Midwifery.—K. B. Bellwood, W. H. Blackburn, C. V. Braimbridge, A. Orr-Ewing, H. G. E. Williams.

Part II. Medicine, etc.—K. B. Bellwood.

UNIVERSITY OF LONDON.

M.S. Examination. July, 1916.

Branch I. Surgery.—A. L. Moreton.

Second Examination for Medical Degrees.

Part II. Pass List.—L. Handy, C. L. Hewer†, L. D. Porteous, E. S. Rose, V. A. T. Spong, N. B. Thomas.

† Dist. in Physiology.

APPOINTMENT.

MASTERMAN, E. W. G., M.D., F.R.C.S., D.P.H., Medical Superintendent (for the duration of the war) of St. Giles' Infirmary, Camberwell, *vice* W. C. Keats, resigned.

NEW ADDRESSES.

G. O. JACOBSEN, Wellington, New Zealand.
F. E. WHITEHEAD, Medical Officer, Berbera, B. Somaliland (*via* Aden).

BIRTHS.

BANGAY.—On June 26th, at Westlands, Warblington, Hants, the wife of Surgeon J. D. Bangay, R.N., H.M.S. "Antrim," of a son.

BLAKEWAY.—On July 1st, at 1, Weymouth Street, W., to Mr. and Mrs. Harry Blakeway, a daughter.

BREWERTON.—On June 25th, at 36, Portland Court, W., the wife of Elmore Brewerton, of 84, Wimpole Street, of a daughter.

FISON.—On June 18th, at Lawnswood, Wigmore, Chatham, the wife of James Fison, Surgeon, R.N., of twin sons.

HAY.—On June 17th, at 14, Vicarage Gardens, Kensington, W., the wife of Dr. K. R. Hay, of a daughter.

LEA-WILSON.—On June 20th, at the residence of her mother, 57, Beauchamp Avenue, Leamington Spa, the wife of Capt. B. Lea-Wilson, R.A.M.C., of a son.

O'CONNOR.—On May 29th, at 21, Alexandra Mansions, Chelsea, to Capt. F. W. O'Connor, R.A.M.C. (temporary), and Zella O'Connor, a daughter.

SIDGWICK.—On June 12th, at "Fircot," Ashby Parva, Lutterworth, the wife of Major Sidgwick, R.A.M.C., a daughter.

WAKEFORD.—On May 31st, at 728, Fulham Road, the wife of V. D. C. Wakeford, M.B., B.S., of a son.

MARRIAGES.

BRASH—BARNETT.—On July 7th, at St. Margaret's, Lee, Capt. E. J. Y. Brash, R.A.M.C., M.B. Camb., M.R.C.S., L.R.C.P. (Bart.'s and Camb.), son of E. A. Brash, M.R.C.S., L.R.C.P. (Bart.'s), of Exeter, to Gwendolene Barnett, third daughter of F. Septimus Barnett, M.R.C.S. (Bart.'s). Among those present were Burgess Barnett, M.R.C.S., L.R.C.P. 'House Physician (Bart.'s), and Mrs. Burgess Barnett, brother-in-law and sister of the bride.

CANE—PERKINS.—On July 24th, at St. John's, Meads, Eastbourne, by the Rev. John Salwey, Capt. Maurice H. Cane, R.A.M.C., third son of the late Leonard Cane, M.D., of Peterborough, and Mrs. Cane, of Eastbourne, to Marjorie Amy, second daughter of H. I. Perkins, I.S.O., F.R.G.S., F.G.S., Surveyor-General, British Honduras, and Mrs. Perkins, of Wimbledon Park, and granddaughter of Major-General E. Norman Perkins, Bengal Staff Corps.

DEATHS.

BURRELL.—On July 22nd, of cerebro-spinal meningitis, Lieut. Stanley Walter Burrell, R.A.M.C., M.R.C.S., L.R.C.P., of St. Bartholomew's Hospital, second and dearly loved son of the Rev. F. W. Isaacs, Vicar of Chiswick, and Mrs. Isaacs, aged 25. He took the old family name of Burrell on qualifying.

DENNYS.—On July 24th, in hospital, from wounds received in action on 12th inst., Capt. Richard Molesworth Dennys, M.R.C.S., L.R.C.P., Loyal North Lancashire Regt., dearly loved only son of Mr. and Mrs. E. A. Dennys, 125, Coleherne Court, S.W.

MAW.—On July 10th, from wounds received in action on the 9th, George Oliver Maw, Capt., R.A.M.C., son of Dr. and Mrs. Maw, Shortlands, Kent.

MICHELL.—On July 20th, of wounds received on July 3rd, Robert Williams Michell, M.D., F.R.C.S., Capt., R.A.M.C., of Brook House and 3, Trinity Street, Cambridge, dearly loved husband of Emily S. Michell, aged 56.

TREVAN.—On July 16th, at Pendrean, Salcombe Regis, Sidmouth, Frederick A. Trevan, late Staff Surgeon, R.N., and The Firs, Bideford, N. Devon.

WILSON.—On July 12th, died from wounds received the previous day, Walton Ronald Wilson, B.A.Cantab., M.R.C.S., L.R.C.P., Lieut. R.A.M.C., M.O. Seaforth Highlanders, only son of Dr. and Mrs. Wilson, Forest Hill, S.E., and dearly-loved husband of Emily Constance Wilson (*née* Mottershall), aged 25.

ACKNOWLEDGMENTS.

The Nursing Times, L'Attualita Medica, The British Journal of Nursing, New York State Journal of Medicine, Guy's Hospital Gazette, The Medical Review, St. Mary's Hospital Gazette, The Shield, The Middlesex Hospital Journal, The Hospital, The Medical Press and Circulator.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, Smithfield, E.C.*

The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., *at the Hospital.*

All communications, financial, or otherwise, relative to Advertisements ONLY, should be addressed to ADVERTISEMENT MANAGER, *the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City 510.*

A Cover for binding (black cloth boards with lettering and King Henry VIII Gateway in gilt) can be obtained (price 1s. post free) from MESSRS. ADLARD & SON AND WEST NEWMAN, *Bartholomew Close. (Temporary offices: 76, Newgate Street, E.C.)* MESSRS. ADLARD & SON AND WEST NEWMAN *have arranged to do the binding, with cut and sprinkled edges, at a cost of 1s. 9d. or carriage paid 2s.—cover included.*

St. Bartholomew's Hospital Journal.

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

VOL. XXIII.—No. 12.] SEPTEMBER 1ST, 1916. [PRICE SIXPENCE.

CALENDAR.

Fri.,	Sept.	1.—Dr. Morley Fletcher and Mr. Bailey on duty.
Tues.,	,,	5.—Dr. Drysdale on duty.
Fri.,	,,	8.—Dr. Tooth and Mr. D'Arcy Power on duty.
Mon.	,,	11.—Exam. for Matriculation (London) begins.
Tues.,	,,	12.—Dr. Garrod on duty.
Fri.,	,,	15.—Dr. Calvert and Mr. Waring on duty.
Tues.,	,,	19.—Dr. Morley Fletcher on duty.
Fri.,	,,	22.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Mon.,	,,	25.—Exam. for Entrance Scholarships begins.
Tues.,	,,	26.—Dr. Tooth on duty.
Wed.,	,,	27.—First Exam. Conjoint Board begins.
Thurs.,	,,	28.—Second Exam. Conjoint Board begins.
Fri.,	,,	29.—Dr. Garrod and Mr. Bailey on duty.
Mon.,	Oct.	2.—**Winter Session begins.**
		Cambridge Michaelmas Term begins.
		Exam. for Part II of Second M.B.(Camb.) begins.
		Exam. for D.P.H.(Camb.) begins.
		First Exam. Society of Apothecaries begins.
Tues.,	,,	3.—Dr. Calvert on duty.
		Final Exam. Conjoint Board (Medicine) begins.
Wed.,	,,	4.—Second Exam. Society of Apothecaries begins.
Thurs.,	,,	5.—Final Exam. Conjoint Board (Midwifery) begins.
Fri.,	,,	6.—Dr. Morley Fletcher and Mr. D'Arcy Power on duty.
		Final Exam. Conjoint Board (Surgery) begins.

EDITORIAL NOTES.

WE have again to record the passing of another year of war. And this period has not passed us by without leaving its mark heavily impressed upon us. Twice the number of Old Bart.'s men have given their lives for their country this year than in the first year of the war. The hospital staff has been further depleted, so much so that on the surgical side it is now necessary to extend the "duty periods" to the duration of a week—a time of extremely heavy work for both the visiting and resident staff on duty.

But, in spite of all, we have succeeded in rubbing along in an amazingly cheerful and normal manner considering the conditions and times. The clubs have kept themselves together, and when unable to get "fixtures" they have arranged practice games among themselves. The Abernethian Society has held several very successful meetings. The Students' Union still pursues its avocation, albeit with somewhat diminished funds. The JOURNAL still manages to hand a small profit over to the Students' Union.

Now we are entering upon a third year of strife and turmoil—may we still be able to carry on.

* * *

It had been the intention of the JOURNAL to publish a further supplementary list of those whose names are engraved upon the Roll of Honour, or who are serving in the forces in one capacity or another. Considerations of economy have, however, induced us to postpone the Supplement upon this occasion, but we hope to produce one in the Spring of next year, when we may also be able to publish further photographs of our companions who have fallen in the fight.

* * *

We note with great regret that Dr. Robert Armstrong-Jones, acting on medical advice, has tendered his resignation as Medical Superintendent of Claybury Asylum, a post which he has held for nearly twenty-four years.

Dr. Armstrong-Jones's record as a worker in the field of psychological medicine is a distinguished one. As the first Medical Superintendent of Claybury he laid the foundations upon which have been built a great part of our present system of treatment in asylums. As a clinical worker Dr. Armstrong-Jones was very successful, and his activities ran parallel to those of Dr. Mott, at Claybury, in the branch of pathology. Further, Claybury was the first asylum to establish the control of private patients under municipal direction.

The Asylums Committee of the L.C.C. have presented Dr. Armstrong-Jones with their resolution of regret as an

illuminated address, and the Home Secretary has just sanctioned a special pension to him recommended by this committee of the Council.

Dr. Armstrong-Jones is now one of the Consulting Physicians in Mental Diseases to the Military Forces in London, and also Lecturer on Mental Diseases to St. Bartholomew's Hospital.

* * *

The King has granted to Dr. Ll. C. P. Phillips, Professor at the Government School of Medicine, Cairo, and Physician to the Sultan of Egypt, his authority to wear the Insignia of the Third Class of the Order of the Nile.

* * *

It is with mingled pride and sorrow that we notice the name of Captain J. L. Green, R.A.M.C., V.C., among the fallen. Pride because one of our Old Bart.'s men should have gained the coveted Victoria Cross, sorrow because by the deed which gained it he has lost his life. Captain Green was educated at Felstead School, Downing College, Cambridge, and St. Bartholomew's Hospital. He took his M.R.C.S., L.R.C.P., in 1913, but had not quite completed his course for the Cambridge M.B. when on the outbreak of war he obtained a commission in the R.A.M.C. He was at first attached to the 5th South Staffordshire Regiment, then to a field ambulance in France, and lastly to the Sherwood Foresters, with whom he was serving when he met his death. During a recent action he was wounded, but though wounded he went to the assistance of an officer in similar plight who was hung up on the enemy's wire-entanglements. He succeeded in dragging this officer to a shell crater, where he dressed his wounds, notwithstanding that bombs and rifle grenades were thrown at him the whole time. Captain Green then endeavoured to bring the officer into safe cover, and had nearly succeeded in doing so when he was himself killed. Our most heartfelt sympathy is extended to Mr. and Mrs. J. G. Green in their sad bereavement.

* * *

With great sorrow we have to record the death of Captain A. J. Waugh, R.A.M.C., who was killed in a recent action in France. He was attached to the 1st North Staffordshire Regiment at the time of his death, and his commanding officer speaks very highly of his attainments and companionship. The following extract from a letter written by this officer to his father tells how he met his death on the battle-field: "We were being relieved, and our relief was very late. . . . I sent the adjutant with a message to the brigade, and your son and I stood waiting together as it was possible the adjutant might miss us in the darkness and confusion; I told your son to keep a look-out at one point while I did the same at another. . . . He moved perhaps ten yards from me. Hardly had he done this when a 4·2 shell fell almost at his feet, killing him instantly. We had several more shells close to us, and presently the adjutant and I went to look for your son and found him lying where he had been standing. He did not appear to have been struck, and must have been instantly killed by the explosion and shock. . . . We placed his body in a safe spot, and early next morning sent a limber up for it and removed it to Carnoy, some little distance from the front, and he was buried by the chaplain in the cemetery there. . . ." Our sincerest sympathy is extended to Mr. and Mrs. Waugh in their sad bereavement.

* * *

It is with the deepest regret that we learn of the death of Captain Douglas Henry David Wooderson, R.A.M.C., who was killed in action on August 6th. He was well known and well liked by his many friends at the Hospital, and at the time of his death was M.O. to the King's (Liverpool) Regiment. Our deepest sympathy is extended to Mr. and Mrs. H. D. Wooderson in their bereavement.

* * *

Another of our past students has died of wounds received during the recent advance. Captain Richard Molesworth Dennys, to whom we refer, was educated at Winchester School and took his M.R.C.S., L.R.C.P., at this Hospital. Early in the war he offered his services to the Red Cross Society and to the Royal Army Medical Corps, but was at that time informed that no more medical men were wanted, and in October, 1914, he accepted a combatant commission as temporary Lieutenant in the Loyal North Lancashires. In the following December he was promoted to be Captain. He was a very hard worker and thoroughly understood his men, and of him a brother officer writes that "the men worshipped him." Our deepest sympathy is extended to his parents, Mr. and Mrs. Edward A. Dennys, in their sad loss.

* * *

With much sorrow we learn of the death of a well-known Old Bart.'s student, Sir William Henry Power, K.C.B., F.R.S., F.R.C.S., who died on July 28th in his seventy-fifth year. He was educated at University College and at this hospital and took his M.R.C.S. in 1864. During his very active life he filled many public posts and carried out many investigations of exceptional utility. In 1908 he was created K.C.B. A fuller obituary notice appears on another page of this issue.

OUR RETROSPECT.

ONCE again, in reviewing the last year, our attention must be drawn to our Roll of Honour rather than to the usual work and progress of our Medical School. A year ago over fourteen hundred of our physicians, surgeons, students, past students, nurses,

and lay staff were serving with the Forces either at home or abroad. Since then this number has been augmented by a further four hundred, bringing our total up to over eighteen hundred. Unfortunately, during the twelve months many of these have been killed in action, or have died of wounds, or from causes directly attributable to active service; indeed, the number is twice as many as during last year, twenty-six old Bart.'s men having been killed since last August as against thirteen in the previous year. The number of wounded we do not know accurately, but it is considerable. The decorations which have been bestowed upon our more fortunate brothers on service will be mentioned in a later paragraph.

Several members of our staff have left England on active service.

Colonel A. E. Garrod left for the Mediterranean as Consulting Physician to the Expeditionary Forces.

Colonel Tooth went to Malta in the capacity of Consulting Physician to the Expeditionary Forces. Major Hamill has also left for Malta.

Major Gask joined the Expeditionary Force in France.

Major L. B. Rawling, Captain Stanley, and Lieutenant Mackenzie Wallis left England for India.

Mr. Harmer went to Russia to join the Anglo-Russian Hospital.

Turning our attention to the Medical School, we may congratulate ourselves on the work which it has been able to carry on. Of necessity the number of new students has fallen somewhat, and early in the year a large number of Junior Students joined the Forces, thus reducing our numbers. Nevertheless, full courses of lectures and laboratory classes have been held, and these have been well attended. As for the examinations themselves, the war seems to have acted as a stimulant, for the percentage number of successful candidates has been even higher than our previously good records.

The permanent staff of the Hospital has fortunately suffered no loss by death during the past year, but several of our past students, since famous in their different spheres, have to our grief passed to the Great Beyond.

Sir George Newman has retired from the Lectureship on Public Health, and the Governors have appointed him Emeritus Lecturer in recognition of his valuable services to the School. He has been succeeded by Dr. R. A. Lyster.

Mr. R. Gill has resigned the post of Chief Chloroformist to the Hospital.

We have to record with sorrow the death of Dr. W. G. Grace, the finest cricketer the world has ever known. Probably he was more widely known than any other Bart.'s man, although, of course, his fame was as a sportsman, and not as a physician. That he was one of the kindliest and best of men is well known, and many are those who can speak of the "good turns" which he has done for them.

We have also to record with sorrow the death of Dr. Herbert Williams, whose work as Medical Officer of Health for the Port of London was of vast importance to the country, although seen and understood by comparatively few. So many reforms did he institute or administer that his name became known throughout the world in all matters of port sanitary administration. In order to be able to deal personally with foreigners, he learnt to speak French, German, Spanish, and Yiddish. Stern and inflexible of purpose, yet was he kind, considerate and sympathetic; he could be written of as one who loved his fellow men. No student has ever been prouder or more mindful of the best interests of his Hospital than was Herbert Williams, and by his death London has lost a great and useful man.

We have also to note with sorrow the death of Sir William Turner, K.C.B., F.R.S. He joined the Hospital School in 1849 and took his M.B. in 1857. He was an excellent anatomist and secured the post of Demonstrator of Anatomy to John Goodsir, the Edinburgh professor. In 1873 he represented the University of Edinburgh on the General Medical Council, which maintained his services until he became its President in 1898. On Goodsir's death he became Professor of Anatomy, and later, on the death of Sir William Muir, he became his successor as Principal of the University. Lister was one of his firmest friends and they did a great deal of work together. In 1901 Turner was awarded the K.C.B., and Edinburgh conferred the freedom of the City upon him. St. Bartholomew's will always be proud to reckon him *olim alumnus*.

It is with much regret that we have also to record the death of Sir Francis Henry Lovell, Dean of the London School of Tropical Medicine, at the age of 71. He began his life work as Colonial Surgeon of Sierra Leone, 1873–1878. From Sierra Leone he went to become Chief Medical Officer of Mauritius and member of the Legislative Council, 1878–1893; later he was appointed Surgeon-General of Trinidad and Tobago and member of the Executive and Legislative Councils, 1893–1901. He retired from the Colonial Office in this latter year, and in 1903 was appointed Dean of the London School of Tropical Medicine. Sir Francis was created C.M.G. in 1893 and knighted in 1900. He was a Fellow of the Royal College of Surgeons.

Among the appointments which reflect credit upon our School we may mention the following: Colonel H. Hendley, I.M.S., has been appointed Honorary Surgeon to the King. Lieut.-Colonel F. E. Swinton, I.M.S., has been appointed Deputy Director-General of the Indian Medical Service. Dr. W. M. Willoughby has been appointed Medical Officer of Health for the Port of London, while Dr. J. S. Warrack has been appointed his Deputy.

Among other distinctions awarded to St. Bartholomew's men we may mention the following:

Dr. Calvert has been elected a member of the Council of the Royal College of Physicians of London.

Sir Francis Champneys has been elected representative of the same College on the Central Midwives Board.

Sir Dyce Duckworth has been elected a "Membre Correspondent étranger" of the Academy of Medicine in Paris.

Mr. D'Arcy Power has been elected a member of the Executive Committee of the Imperial Cancer Research Fund: he has also been elected President of the Medical Society of London.

Dr. Robert Armstrong-Jones has been elected a Vice-President of the Medico-Legal Society.

Dr. Arthur J. Hall has been appointed to the Professorship of Medicine at the University of Sheffield.

Sir C. P. Lukis, Director-General of the Indian Medical Service, has been appointed Commissioner for the St. John Ambulance Brigade Overseas, within the Empire of India.

Professor F. W. Andrewes has been appointed to the Senate of the University of London as representative of the Faculty of Medicine.

Among the Birthday, New Year, and Military Honours there are several well-known names.

Dr. Christopher Addison has been made a Privy Councillor.

Surgeon-General Sir Anthony Bowlby has been created K.C.V.O.

Mr. Milsom Rees has received the honour of knighthood.

The following have been appointed C.B.: Surgeon-General H. D. Rolleston, Surgeon-General W. G. A. Bedford, Colonel O. R. A. Julian, Lieut.-Colonel W. W. Giblin.

The following have been appointed C.M.G.: Colonel A. E. Garrod, Colonel C. E. Harrison, Lieut.-Colonel C. Gordon Watson, Lieut.-Colonel L. Humphry, Lieut.-Colonel R. Pickard, Major H. M. Cruddas, Major W. W. Jewdwine.

Major F. N. White has been appointed C.I.E.

Dr. J. B. Christopherson and Prof. L. C. P. Phillips have had the Order of the Nile (third class) conferred upon them by the Sultan of Egypt.

The coveted honour of the Victoria Cross has been awarded to Capt. J. L. Green, R.A.M.C., who, alas, was killed in performing the deed which gained it.

The following have been awarded the Military Cross: Capt. R. S. Townsend, Capt. D'Arcy Power, Capt. L. R. Shore, Capt. G. E. Dyas, Capt. T. J. C. Evans, Temp. Capt. A. J. Kendrew, Surg.-Capt. W. T. Rowe, Capt. C. J. Stocker, Lieut. C. C. Okell, Capt. D. C. G. Ballingall, Capt. T. M. Miller, Capt. E. B. Allnutt, Capt. R. C. Clifford.

The following have received the D.S.O.: Lieut.-Colonel E. P. Sewell, R.A.M.C., Major R. W. Knox, Major A. A. Maden, Major C. H. Turner, Major W. R. Battye, Surgeon B. A. Playne, R.N.

Major W. R. Battye has also had the Decoration of the Legion of Honour Croix de Chevalier bestowed on him by the President of the French Republic.

The Order of St. Sava, 5th class, has been conferred by the King of Serbia on Capt. L. A. Walker, Capt. G. Whittington, and Capt. J. S. Williamson.

During the year we have maintained a high reputation at the various examinations.

At the University of Cambridge four have obtained the M.D. One has obtained the M.C., six have taken the M.B., B.C., while several others have taken the examination for either the first or second part of the M.B. or B.C.

At the University of Oxford one has taken the M.B., B.Ch.

At the University of London one has taken the M.S. and three the M.B., B.S. (G. C. Linder obtaining honours and the University Medal).

At the University of Dublin one has obtained the M.B., B.Ch., B.A.O.

At the Royal College of Surgeons of England six have obtained the F.R.C.S.

At the Royal College of Physicians of London two have been elected Fellows and one has obtained the M.R.C.P.

Of the Conjoint-Board examinations two have obtained the D.P.H., and fifty-six have obtained the diplomas of M.R.C.S., L.R.C.P.

Three have taken the diploma of L.M.S.S.A.

The Scholarships and Prizes have been well contested, and the following is a list of the winners during the year 1915–16.

Luther Holden Scholarship.—F. W. Watkyn-Thomas.

Brackenbury Medical Scholarship.—H. G. E. Williams.

Brackenbury Surgical Scholarship.—A. R. Dingley, J. B. Hume (æq.).

Willett Medal.—K. A. I. Mackenzie.

Walsham Prize.—A. Morford.

Bentley Prize.—J. B. Hume.

Wix Prize.—A. Morford.

Sir George Burrows Prize.—A. Morford.

Skynner Prize.—H. M. Wharry.

Shuter Scholarship.—E. B. Verney.

Junior Scholarships: Biology, Chemistry, and Physics, 1915.—(1) Not awarded; (2) J. T. Long.

Junior Scholarships: Anatomy and Physiology.—(1) C. L. Hewer; (2) W. E. Lloyd, I. G. Williams (æq.).

Harvey Prize.—A. D. Wall.

Kirkes Scholarship and Gold Medal.—J. B. Hume, S. G. Dunn (*prox. acc.*).

Senior Scholarship in Anatomy, Physiology, and Chemistry.—A. D. Wall.

Junior Practical Anatomy (*Treasurer's Prize*).—(1) I. G. Williams; (2) W. E. Lloyd; (3) J. N. Leitch.

Senior Practical Anatomy (*Foster Prize*).—(1) A. D. Wall; (2) B. B. Sharp; (3) H. C. Cox; (4) M. Jackson; (5) H. N. Hornibrook.

Senior Entrance Scholarships in Science.—(1) L. P. L. Firman-Edwards, I. G. Williams.

Junior Entrance Scholarship in Science.—C. Shaw.

Entrance Scholarship in Arts.—J. V. Landau.

Jeaffreson Exhibition.—A. C. D. Telfer.

NOTES FROM A MILITARY HOSPITAL.

BY C. HAMILTON WHITEFORD, M.R.C.S., L.R.C.P.

Aneurysm of Right Superficial Temporal Artery.

FOUR months previously a bullet entered the skin over the base of the right mastoid process, passed through the ear and emerged on the face, one inch in front of the external meatus.

Present Condition.—The right superficial temporal artery is dilated for two inches to a diameter of a quarter of an inch, being three times as large as its fellow. The dilation commences at the upper border of the zygoma and extends upwards.

There is no paralysis of the upper branches of the facial nerve. Since the injury the hearing power of the right ear has greatly diminished, a watch being heard only at half an inch from the ear. The symptoms produced are slight. The patient complains of vague pains in many areas of the scalp, and is conscious of the pulsation whenever he takes active exercise.

If severe symptoms develop, or if the aneurysm increases, it is proposed to excise the dilated portion of the artery.

Gunshot Wound of Neck.—Paralysis of Deltoid Muscle.—Treated by Relaxation of the Paralysed Muscle, aided by Massage and Electricity.—Recovery without Operation.

On October 13th, 1915, a rifle bullet entered the back of the right shoulder and emerged in the right side of the neck.

The right arm at once became paralysed and anæsthetic throughout. Sensation began to return four hours after the injury, and was gradually followed by return of movement.

For the next six weeks he was in a hospital and was treated with massage and electricity, but the arm was allowed to hang by the side.

On admission to the military hospital, Devonport, he was found to have a small scar of entry one inch above the upper angle of the right scapula, and a wide scar of exit two inches in length situated in neck, two inches above the centre of the right clavicle.

The right deltoid muscle was paralysed and atrophied. The arm could not be voluntarily raised from the side.

The only area of anæsthesia was situated below the centre of the right clavicle, probably due to injury of cervical cutaneous nerves.

A skiagram failed to show any foreign body or bone lesion.

The right arm was supported on a platform splint made of poroplastic with wooden supports. This splint held the arm and forearm on a level with the shoulder and kept the deltoid muscle relaxed. Electricity and massage were continued.

After two months of the above treatment the condition was as follows: The right arm could be fully extended above the head to the same extent as the left arm; the deltoid muscle was increasing in volume and could be seen to contract voluntarily.

The above is one of a number of cases of paralysis following gunshot wounds in which the writer has seen recovery follow similar treatment.

If recently paralysed muscles are treated systematically by prolonged relaxation, assisted by massage and electricity, the necessity for operation frequently disappears.

Inexperienced operators are apt to jump to the conclusion that the presence of a scar in the neighbourhood of a nerve, if associated with either anæsthesia or paralysis, is an indication for immediate operation, and if improvement follows operation, ignore the fact that the operation has often been quite unnecessary, and that improvement has occurred, not because of, but *in spite of*, the operation. In the above case, if an operation had been performed, what an excellent result might have been claimed for the operation.

Gunshot Wound of Skull.—Death Six Months later from Multiple Cerebral Abscesses.

On September 26th, 1915, the patient was hit in the centre of the forehead by a cross-fire rifle bullet, which produced a horizontal gutter fracture, commencing half an inch to the right of the mid-line, two and a half inches above the root of the nose, and extending to the right for two and a half inches.

The result was unconsciousness for two days, during which an operation was performed.

He passed through several hospitals, and the wound did not heal till January, 1916.

When seen on March 25th, 1916, his condition was as follows: The headache, which had been present since his injury, had during the last seven weeks (*i.e.* since the healing of the wound) become intense. Pain commenced in the scar and spread round the right side of the head. There was no marked tenderness. The scar pulsated slightly. The gap in the right frontal bone could be plainly felt and measured 1 in. by 2½ in. There was no vomiting. There was slight weakness of the muscles at the left angle of the mouth. Cerebration was slow and speech was drawling. Incontinence of urine and fæces occasionally occurred. Temperature 98° F. Pulse 58. Respiration 20.

The skiagram shows four spicules of bone apparently embedded in the right upper frontal lobe, also a long fissured fracture, which extends from the gap in the frontal bone horizontally on the right side to the back of the skull. The leucocyte count was 9400.

The Ophthalmic Surgeon reported: "There is commencing optic neuritis, the amount of the swelling is small."

Operation.—On March 30th, 1916, a large semi-circular scalp flap, with the scar in the centre, was turned downwards, exposing the gap in the right frontal bone.

On incising the scar-tissue, which filled the gap in the bone, the underlying tissues were found to be œdematous. A finger, inserted into the softened brain, palpated, one inch beneath the cortex, fragments of bone which were firmly embedded and partly encapsuled.

Two drachms of pus escaped and five pieces of bone were removed with forceps.

The fragments of bone were flat, the largest piece measuring three-quarters by half an inch.

The abscess cavity was drained by a perforated metal tube $\frac{3}{4}$ in. in diameter and $1\frac{1}{2}$ in. in length.

The tube was brought out through the scar in the scalp flap, and was filled with glycerine.

A small drainage-tube was placed at each angle of the scalp flap. Irrigation, with saline solution, was freely employed. During operation the pulse-rate rose from 54 to 100.

Post-operative condition.—First and second days.—The metal tube was rotated and washed out daily, and was refilled with glycerine. The general condition at first improved, and then relapsed to the state prior to operation.

Fourth day.—Temperature, 98 ; pulse 56. Cerebration much slower. Under a general anæsthetic two lumbar punctures, made by a bacteriologist of large experience, failed to find fluid. The metal drainage-tube was taken out, cleaned, and replaced, a small amount of softened brain matter being removed with forceps.

Fifth day.—More drowsy.

Sixth day.—Coma and death.

Autopsy.—There was no meningitis and comparatively little softening in the right frontal lobes, in which there were a few minute spicules of bone.

The anterior portion of the right temporo-sphenoidal lobes was occupied by two thick-walled abscesses. The smaller abscess was 1 in. in diameter. The larger abscess contained 2 oz. of thick green pus and a piece of flat bone $\frac{1}{2}$ in. square. The rest of the brain was normal.

Comments.—Neither the abscess nor the contained bone appeared in the skiagrams.

The only localising symptom was the very slight facial paralysis round the left angle of the mouth.

Drainage of the frontal abscess by means of the perforated metal tube and glycerine appeared to be efficient.

Chronic Internal Derangement of Knee-joint.—Results of Operations.

The writer has had many opportunities of noting the end-results of operation, usually removal of the internal semilunar cartilage.

The primary lesion has often occurred at football.

It is the exception to find a knee which, after operation, does not, on commencing hard work, develop either pain, swelling, or lameness.

Reports from medical officers in charge of troops state that, after operation, these knees give out as soon as the patients route-march or jump into trenches.

Contrary to the opinion generally held, it is the writer's firm conviction that, in these chronically deranged knees, operation can only very rarely be expected to make the man fit for active service, and that the taking of such knees into a military hospital for operation means the useless blocking of badly-needed beds.

Disintegration of Testis following Tapping of Hydrocele, the Tunica Vaginalis being Posterior to the Testis.

Previous history.—During the past four weeks three attempts to tap the hydrocele had been made. Little, if any, fluid had been withdrawn, and the punctures had caused most acute pain.

On admission.—The left testis was three times as large as the right. The front of the scrotum was ecchymosed.

Operation.—The testis was exposed from the front. The subcutaneous tissues were greatly thickened. On deepening the incision the tunica albuginea was opened, and the testis was found converted into a diffluent stringy mass, which was wiped out with gauze. The epididymis was not seen, being probably buried in the thickened tissues. The tunica vaginalis was found behind the testis, much thickened and containing half an ounce of clear fluid. The tunica albuginea was closed by sutures, and the tunica vaginalis, brought forward from behind, was sutured over the front of the tunica albuginea. The scrotum was drained. Slight suppuration occurred.

Comment.—The above is a recognised abnormality. In a virgin case (*i.e.* where no attempts at aspiration have been made) transillumination is the best method of ascertaining that the testis lies in front of the tunica vaginalis. At the three attempted tappings the trocar probably entered the testis, which had undergone a necrosis which was almost, if not quite, aseptic.

No attempt had been made to inject the hydrocele with iodine or other liquid.

DREAMS AND THEIR INTERPRETATION.

(*An Address to the Abernethian Society.*)

By ROBERT ARMSTRONG-JONES, M.D., F.R.C.P.Lond., F.R.C.S.Eng.,

Lecturer on Mental Diseases, St. Bartholomew's Hospital, and Consulting Physician in Mental Diseases to the Military Forces in London; Resident Physician and Superintendent of the London County Asylum, Claybury.

(*Concluded from page* 126.)

The careful study of the mental life, normal and morbid, has been the work of modern science, which has elucidated and solved many of the dream combinations—together with other products of the imagination—by the acceptance of that intimate union which exists between mind and body.

Upon the close relationship between mind and body, it has been found that the chaotic play of images in dreams is able to throw much light upon normal mental processes and upon the laws which are observable in the working of the mind during the waking state; hence the appropriateness of studying dreams in this new light and the justification of a claim for those who study dreams to-day, truly to be called "interpreters," for they investigate, upon the solid and substantial ground of science, the intimate and fundamental activities of the human mind in health and disease, without the need of resorting to supernatural agencies which were evoked in former days.

The interpretation of dreams by the psycho-analytic method is based upon the theory that in the hidden mentalities or "unconsciousnesses" of our minds are found the explanation—perhaps the secret—at any rate the quite sufficient interpretation of many abnormal mental occurrences and divergent mental states, such as dreams, lapses of memory, absent-mindedness, obsessions, delusions, and all kinds of intrusions and dominations of semi-repressed thoughts, but it is extravagant to seek for these in any one instinct, as is claimed for sex.

It is hardly necessary to state that dreaming is not confined or limited to human beings. We are familiar with the appearance of dogs which jump and bark in their sleep, more especially after active excursions, or following upon hunting expeditions; those who keep canaries have doubtless heard their unexpected pipings whilst asleep.

In order to understand the nature of dreams it may be desirable to consider the physiology of sleep, and, although the exact cause of sleep is not definitely known, the concomitants of sleep are familiar. We know, for instance, that in sleep all the normal activities of the organism are appreciably lowered, and it is not certain that sleep itself is not a state of debility, for there is a lowering of the pulse-rate and of the blood-pressure; there is also a slowing down of respiration. There is probably, in addition, a state of venous engorgement, permitting the products of fatigue to pass by osmosis into the blood-stream or into the lymph channels during this engorgement, which is favoured by the supine position of the body when at rest, thus giving a fuller supply of blood to the head, and so predisposing the brain to dreaming; yet we do not know the inner state of the organ of mind, *i.e.* the intimate structure of the cells in the brain cortex during sleep, nor their relation and dependence upon the ductless glands, in particular the pituitary, as has been pointed out during hibernation. In regard to the nerve-cells, therefore, conjecture must take the place of certainty. The brain cortex, normally, is composed of innumerable cells and fibres, the latter forming the connecting links and threads between the cells, their function being to convey sense-impressions from without the body, and then to convey these transformed impressions outwards for the control and proper working of the various organs in the body.

In an average brain the cells or neurons are computed to number 9000 millions, so a thought, or an idea, or a purpose initiated in one cell, or a group of cells, is immediately linked up with thoughts from scores or hundreds of others by means of fine connecting fibres. It is believed (Lepine) that the fine fibres of the neuron—which are called dendrites from their tree-like appearance—undergo a retraction during sleep leading to a partial separation of their terminations, thus leaving a space, so to speak, which cuts off nerve currents and thus induces sleep. This being a theory only, it has naturally evoked another and an opposite explanation of sleep, viz. that sleep accompanies a greater and more extensive prolongation outwards of the fine nerve processes of the cells (Lugaro), which then touch each other more closely and intimately, thus diffusing rather than concentrating nerve energy, the effect of such a diffusion being to lower nerve-potential, and so to bring about a general loss of nerve energy, and thus to favour sleep. The whole nervous system thus presumably participates in the lowering activity of the circulatory and other systems during sleep, yet it is not ascertained whether this lowering is sufficient to interrupt the continuity of the unconscious as well as of the conscious life.

Dreaming, as is well known, can be induced by such agents as opium, alcohol, and tobacco, and this would favour the view that dreaming was a morbid process. It is certainly a process which more often occurs just before or just after the actual state of sleep, and for that reason these dreams are called "hypnagogic." It is general experience that there are more clear as well as more fantastic images just before going to sleep or just before being thoroughly awakened than occur during complete unconsciousness. It is doubtless also within the experience of everyone that the vivid scenes of the day are more clearly impressed upon the mind during the intermediate state between sleeping and waking than during sleep. Children often dream before going to sleep of events which occurred the previous day. The *Daisy Chain*, by Charlotte Yonge, caused dreams of carriage accidents, and *Peter Pan* caused dreams of flying to the "Never, Never Land" in the case of a clever, impressionable child.

The materials of which dreams are made are chiefly the *memories* of past experiences, although they are often modified by the influence of temperament and environment. Most dreams are buried in the unconcious mind, which is partly the reason that they can be so rarely remembered fully after waking; this is certainly the case with children. It is believed that the age of greatest dreaming, as well as that of the most vivid dreams, is between twenty and twenty-five years. Women sleep more lightly, and dream more than men do; it is certain, at any rate, that more women than men relate their dreams, and women who are accus-

tomed to dream sleep longer. The majority of dreams occur after 6 a.m., although many occur before four o'clock. The time during which a dream is enacted is wonderfully short; a few seconds of time in a dream would be equivalent to days in the waking state, and many dreams may be recorded in support of this statement. The precipitation of images in a dream is so great and the attention so lacking in precision that there is nothing to regulate them in time. An analysis of dreams points out that the great majority, 60 per cent. of them, relate to sight; thus the ancients were correct in describing them as "visions," whilst only 5 per cent. relate to the sense of hearing. Three per cent. have reference to taste, and only 1·5 per cent. to smell. In dreams the two senses, taste and smell, which are the oldest, most primitive, fixed, and organised of the senses, frequently attach themselves to sight and hearing, which nevertheless are easier disturbed because more highly evolutionised, the objects to which taste and smell relate being thus visualised or heard. The faculties of the mind, to borrow an abstraction, "go to sleep," as it were, in certain orders. We know that we feel fatigue so far as our "judgment" is concerned sooner than we do in regard to our sensory life; we hear sounds during a light sleep, and are sensitive to rays of light or to the sense of touch; but because the power of forming a judgment is affected early in sleep, there are imperfect associations and images, phantasies and pictures arise which are the common experience of all. Some power of association and some power of judgment are left in light sleep, but the lessened power of these two "faculties" in dreams reveals the unrestrained, incongruous, and disorderly pictures left on the mind.

It has often been pointed out that insanity and dreams are so closely allied that insanity has been described as a "waking dream," and a dream as a "sleeping insanity." The insane, like dreamers, are under the domination and control of illusions and hallucinations, but they adhere to their dreams or delusions, and no appeal to the senses, to reason, or to the judgment can reconstruct their mind; whilst dreamers, so long as they remain in the dream state, continue to experience their insanity, a reference to a fixed objective standard being impossible during sleep, so that the mind, for the time being, remains unsound. Here, however, the similitude ends, for upon an appeal to the senses and to reason the dreamer awakes, whereas the insane person continues in his unreason. It has been stated that dreams may be followed by insanity, and my experience confirms this, although it is doubtful if a dream can ever be the actual cause of insanity, both being probably the product of an already existing mental weakness. A lady under my care, C. W—, dreamt she had during the night cut her husband's throat and thrown his body out of the window. She grieved, worried, and became so distressed at her imagined murderous conduct towards her innocent partner that her mind became deranged, and she lapsed temporarily into acute insanity. A man, C. V—, used to dream that he had destroyed St. Bartholomew's Church, and was so alarmed at the notion he could be guilty of such sacrilege that he feared going to sleep, and he also became insane. Another man, H. E—, after the last air raid, dreamt that his room was being "bombed"; in his dream he saw the explosion, smelt the asphyxiating gas, heard the crackling of the fire, and from that moment his mind seemed to give way; but it is quite open to argument whether in each case the dream was not the first symptom of the mental breakdown caused by fear. It may not always be easy to separate hallucinations from dreams, but it is a fact that insane persons dream more often than do the sane, and the continued presence of hallucinations in them, together with the natural wish to explain hallucinations by some plausible, but erroneous factor, causes the insane mind to be one which is readily responsive to slight stimuli. It certainly explains why the insane are light sleepers and are more frequently disturbed by imagined causes than the sane. The rays of the moon penetrating between the folds of a curtain or along the margins of a window blind not only disturb sleep by the light they shed, but the rays may also suggest the figures of persons sent to watch them, or to endanger their lives—hence the wakefulness and dreams of the insane; and the general belief is true that these frequently experience exacerbations of their illness during a full moon. It is a fact, known to physicians, that many of our wounded soldiers home from the trenches suffer from dreams of a fearful and horrifying kind, due to the memory of constant explosions and of the awful effects of exploding shells upon human life. These dreams are accompanied with all the physical symptoms of fear; there is present a lowering of the surface temperature, there is also the blanched face, the anxious expression, and the perspiring skin.

Dreams are closely related to the condition described as somnambulism, which is one of intense abstraction and nearer to wakefulness than is the dream state. The sleep-walker is guided by the motive which actuated his waking moments, and he sometimes executes performances with a degree of perfection which is not even possible to one in perfect possession of his senses. I have known a nurse get up in the middle of the night, collect all the patients' day attire, and arrange the clothing for about forty patients at the foot of each bed, after which she proceeded to collect all plants and flowers from an adjoining bath-room and place them in the ward, as in the day-time. She then retired to rest, but upon awakening she had forgotten all the details of the sleep-walking incident.

The state described as "Abstraction," or "Reverie," is also related to the dream state. In this the attention is so fixed and concentrated upon a train of ideas that, although the eyes are open and sounds are heard, yet no impression

is made upon them by external objects. In the condition described as "Ecstasy," figures and landscapes may be seen as real; the former are most often seen by religious devotees and sojourners in the cloister. Blake, the artist, was able to concentrate his attention upon his dreams so as to remove all distraction. He could paint pictures without sitters, who were so real to his imagination that he could carry on conversations with them whilst painting their portraits. Among persons whom he thus painted were King Edward I and Queen Catherine of Arragon.

Another state of mental abstraction is the pleasant and extravagant kind called "Castle-building in Spain"; a condition in which imaginary scenes of an agreeable form are constructed and indulged in for the enjoyment or satisfaction anticipated. "Day-dreaming" is another state which is an entertainment that has probably been practised on occasion by each of my audience. "Trance," "lethargy," and "catalepsy"—when the mind is concentrated upon an absorbing but narrow range of ideas—are also related to dreams, and so are the "hypnotic" and other states of partial consciousness, but they cannot be entered into here.

We have referred to the "unconscious mind"; the phrase is so frequently met with that it is used in various senses. Carpenter used it in reference to certain psychical states which he described as "unconscious cerebration," during which acts were performed without the knowledge of the cognitive self; one forgets, for instance, a line of poetry, but remembers it later when one has ceased, consciously, to think of it. In the course of conversation one may forget a word, and having "waited and seen" the word recurs later without effort, perhaps, when the attention is engaged elsewhere. This tends to show that there are unconscious mental excitations going on of whose nature we are ignorant, but the thoughts are there in the unconscious mind all the same, and they seem to be interposed between conscious ideas, and to be dug up, as it were, with them. Possibly every conscious idea arises out of, and dies away into, an unconscious mental state, and according to some there are three degrees or kinds of thoughts. Firstly, thoughts of which we are conscious, and which, when given attention to, are raised into what is called the "focus" of consciousness; secondly, thoughts which are in the rest of the field of consciousness, which are present, but only in a state of inattention—for instance, in the theatre we are intent upon the evolution of dramatic situations, but are inattentive to the audience or oblivious to the staging; the third depth whence thoughts emerge is the unconscious area which could not attract attention until their position had been raised into the full and clear focus of attention by some association or suggestion.

It is preferable, I think, to limit the term "subconsciousness" to the second of these states, in which there is still present a certain limited sensitiveness left to ordinary sense-impression, whilst the "unconscious" state represents the third, *i. e.* the primitive mind, so to speak, out of which conscious thoughts and intellectual processes rise and grow. The motive force of our acts is believed by some to take its origin in the unconscious mind, whilst the directive and controlling force is in the upper conscious levels which thus regulate the lower.

The technical analysis of dreams assumes that there is a dynamic trend of "desire" in the unconscious mind which is ever seeking for the gratification of personal feelings, passions, and sentiments, as against the controlled thoughts of the conscious mind. Psychologists who urge this trend or tendency in the unconscious mind assert that it is kept back and restrained by some imagined power called the "endo-psychic censor," a purely fictitious and artificial ego which is continually struggling to repress the natural impulses and thoughts not acceptable to consciousness, this "censor" exercising a guardianship over sleep, even the deepest sleep. These psychologists describe the unconscious mind as an under-world of painful memories and wishes, always seeking to obtrude themselves, and always in health being more or less successfully kept under, "like steam in a kettle," by the artificial censor. When the passions emerge in the conflict they become the "latent" cause of dreams, obsessions, and longings; if dreams be the result, then the dream as remembered or recorded is the "manifest" dream, and the interpreter immediately attempts to elicit the latent wish of which the manifest dream is the symbol. By this analysis a clue is furnished to the real aim and personality of the dreamer.

Dreams are thus the resultant of a conflict between the censor and the repressed idea, the dream being the "compromise," and only to be solved by a code, for which an array of symbolism has been invented to serve as a key for its interpretation. If the dream be of the sea, for instance, then, according to the followers of Freud who have initiated this sex-meaning, it stands as a symbol for "life," as in their own words, "life needs the mightiest symbol, because existence depends upon the mighty and profound procreative force." If the dream be of an old house, then it is interpreted to be "the abode of life," and, to use the Freudian expression of the dream analyst, "we find it necessary to predicate a creative, myth-making tendency in the structure of the mind by means of which the currents of life beneath all thought become articulate."

This sexual theory is over-emphasised, and the Freudians who urge sex as the basic origin of all dreams, of all obsessions, and of all longings, impulses, and neuroses, are "sex-intoxicated," for in life's reality there are other primary and original instincts as well as sex, of which fear, anger, and hunger are the most common examples. All these run deep in the unconscious mind, and each has suffered far more repression than sex. It is against human experience that all dreams are desires, and it is repulsive that all dreams should be interpreted as relating to sex, and such an ex-

planation has brought these conclusions of what have been called "chimney-sweeping investigations" into deserved disrepute. In the analysis of dreams the method adopted for exploring the unconscious mind depends upon inferences drawn (i) from what has been described as free or spontaneous association, (ii) "word association," and (iii) reaction time. The latter has been much used in America as an auxiliary for the detection of crime by means of an instrument of extremely delicate mechanism, the examination revealing a shortened reaction period to word association if the accused be innocent, whilst the reaction period is longer if the accused be guilty, for he is endeavouring to keep back thoughts suggested to the mind in connection with the words presented to it.

What is the association of dreams with crime? I have questioned insane criminals about their dreams in connection with specific crimes, and although there is always some reserve about admitting revelations in connection with criminal acts, I find that they dream much as do other people. In this class there is a considerable difficulty in proving their hidden personal secrets, and in overcoming the resistance of the so-called "censor." In these cases the conscious and the unconscious cannot easily be brought together, and a clue as to their desires, impulses or wishes, is extremely difficult to ascertain. Moreover, this class is not an easy one to investigate; many of the criminal classes are mentally defective, although some are only morally so, especially as regards prudential considerations, for they cannot postpone present pleasure for future good. They are easily tempted and easily yield, and they have a diminished emotional as well as intellectual endowment. The "criminal type" is impulsive, and though these persons may not be insane they have often a psychopathic inheritance and tendencies. Their psycho-anthropological characters may be summarised as egotistic and anti-social, and they are not easy material for the psychological analyst. The discovery of crime through a dream, when the dreamer has by his own dream given himself away, is unknown to me in real life, and this is supported by the extensive experience of Dr. W. C. Sullivan. Dr. Leonard Guthrie reminds me of the story of the murder of Maria Martin by Corder in 1827, when dreams led to the discovery of the victim's body. As he also points out, there are numerous instances of murders having been discovered and avenged by the appearance of the murdered person's ghost. Shakespeare presents two instances in Hamlet and Macbeth. "The Bells," in which Irving represented the Jew Polonais, exemplifies a drama in which the murderer is being continually haunted by the dream-sound of the sleigh-bells, and in "Tom" Hood's *Dream of Eugene Aram* "the unknown facts of guilty acts are seen in dreams from God." The usher Eugene Aram dreamed of the murder he had committed, and which he related long afterwards to the boy—"the horrid thing pursues my soul, it stands before me now"; "that very night two stern-faced men set out from Lynn and Eugene Aram walked between with gyves upon his wrists." The suggestion here made connects the dream with the murderer's arrest. Hack Tuke relates a remarkable instance of a man dreaming that he had performed an act which rendered him liable to legal consequences, and for which he had been arrested. On awaking he was greatly relieved to find it was only a dream, but in the course of two or three days he committed the act in an insane condition of mind. He was arrested and brought before the court for trial, but was released to the care of his friends. There is no record of psycho-analysis asisting in or leading to the detection of crime, not even crimes relating to sex, for which the Freudians claim a peculiar affinity.

It will be admitted that a most puzzling terminology has arisen from the efforts made by medical psychologists to analyse dreams. If the dreamer fails to recognise the new and strange scenes in which the manifest dream is located, this is owing to its "dramatisation," but if the characters themselves are unrecognisable there is "distortion." Should the chief characters be given a subordinate position there is a "displacement," but not infrequently there occurs a fusion of the characters, which is "condensation." When the ideas or "complexes" in a dream become detached from their usual association and are "converted" into some other psychic sphere, then they are being "sublimated" into some obsession or delusion. Hysteria, for instance, is the "conversion" of a "repressed" idea into some motor and sensory discharge, and if only the idea can be disclosed to the sufferer and by him disregarded, the result is claimed as a cure obtained by a "cathartic," a word which is meant to signify suggestion, auto-hypnosis, or, as more recently hinted, "auto-gnosis."

I have quoted the above to show the complicated vocabulary invented by some psychologists to explain dreams which, as Bergson points out, are only states of "relaxed consciousness." In the waking state we are always adapting ourselves to our needs, but in sleep we have ceased to select and choose. The mind in its relaxed state brings together memory associations which were formerly packed away in the "storehouse of the unconscious mind," the reason fills up the gaps, and a confused impression results which is the material of dreams.

As is well known, the brain cortex is restored and refreshed only during sleep, and it is a comfort to know that we dream most about events to which no attention has been paid; were it not so, our sleep would be distracted and preoccupied by events that are of importance and which have been our concern during the day, so that our waking life would be prolonged as a permanent dream into the sleeping life and the necessary rest and nutrition of the brain would be impossible.

It is most welcome that the revival of interest in dreams

should have awakened the psychologist, physiologist and the philosopher, but progress must be at the expense of offending many susceptibilities and cherished proprieties. The decencies of sex have, I venture to think, suffered from this investigation, and I think there has been a pandering to the lower instincts in human nature through this revival, but I trust the matter has not been beyond the interests of the Abernethian Society.

OBITUARY.

SIR WILLIAM HENRY POWER, K.C.B., F.R.S., F.R.C.S.

IT is with feelings of deep regret that we announce the death of one of the most distinguished students of our Hospital, Sir William Henry Power, who died at East Molesey on July 28th, 1916.

His life's work was devoted to public health medicine, and as an epidemiologist he had no peer.

Born in London in 1842, he was educated at University College, and apprenticed at an early age to his father, a man well known as a successful medical coach. On entering St. Bartholomew's Hospital, Power was apprenticed to Fred Wood, the Hospital dispenser, who was a person of great importance in the medical wards, for there were no house physicians in those days. Power qualified in 1864 as M.R.C.S., L.S.A. He served as house surgeon for Mr. Holmes Coote, and then as resident medical officer first at the Royal Albert Hospital, Devonport, and then at the Victoria Hospital for Diseases of the Chest. Afterwards he did temporary work for the Medical Department of the Privy Council; and when, in 1871, the Local Government Board was constituted as the central office to deal with public health questions in England, Power was appointed a medical inspector of the new department. From 1887 to 1900 he was assistant medical officer, working successively with Sir G. Buchanan and Sir R. Thorne, and from 1900–1908 was principal medical officer of the Board. Some of Power's best-known work was done in the earlier period, in the local investigation of outbreaks of infectious diseases and their causation. He then showed, in a way hardly before realised, how much can be learnt about diseases and their prevention by painstaking inquiries into all the facts connected with epidemics, and by balancing all direct and circumstantial evidence with regard to them. He first demonstrated in this way in 1878 the spread of diphtheria by means of milk, and also the manner in which this disease is ordinarily carried, especially in schools, by unrecognised cases of slight sore throat—observations since fully confirmed by the advance of bacteriological knowledge. The relation between certain milk-borne outbreaks of scarlet fever and a diseased or "carrier" condition of the cow was brought out in reports made in 1885. An important series of investigations into smallpox between 1881 and 1886 proved conclusively that smallpox hospitals in London and elsewhere spread the disease characteristically among persons living in their neighbourhood, notwithstanding the administrative precautions taken. These reports led to the routine removal of smallpox cases to hospitals away from populous areas—a measure to which the diminution of smallpox in this country in recent years may be largely attributed.

When promoted to headquarters at Whitehall, Power continued his scientific and investigatory work under new conditions, acting as the trusted adviser and consultant of all the medical staff of the department, and of many other workers in the public health service. He closely guided and followed the work of the Board's medical experts, and gave it the stamp of his unrivalled knowledge, memory, and power of constructive criticism. The results are illustrated by the well-known series of annual medical reports issued by the Local Government Board during this period, and in the various special supplements, some of which, like those on shellfish and disease, lead-poisoning by water supplies, and the use and influence of tuberculosis sanatoria, have become classic. As a reference to these annual reports will show, Power's tenure of office covered a period when very considerable, if irregular, advances were being made in the application of medical science to central and local government, and in public health legislation, during which the lines of work of his own department became greatly extended.

Power's talents for administrative work were of a high order, and his sound judgment and knowledge of affairs were put unsparingly at the disposal of the Government Departments. He left himself no leisure for, and had little inclination to, public work outside his department. He was a Crown nominee to the General Medical Council, and succeeded Sir M. Foster as Chairman of the Royal Commission on Human and Animal Tuberculosis, the experimental work of which he largely directed. He gave similar services to the Royal Commission on Sewage Disposal, of which he was a member. He was created K.C.B. in 1908, and was the recipient of the Buchanan medal of the Royal Society and other honours.

STUDENTS' UNION.

A MEETING of the Council was held on August 22nd, Mr. Girling Ball being in the chair. Among other business done was the following:

The House Committee's report on the furniture in the Abernethian Room was read, and Mr. Perin's tender for repair of chairs was accepted.

It was agreed to allow the Special Constabulary to use the Hospital grounds at Winchmore Hill, and also to allow the use of the ground for the entertainment of soldiers.

An engraved portrait of Dr. Grace was submitted, but it was not thought to be sufficiently good for use as a memorial, and further search for a suitable portrait was decided upon.

Mr. Green's resignation from the Council was accepted with much regret, and a vote of thanks for his good services was unanimously adopted.

EXAMINATIONS.

UNIVERSITY OF LONDON.

First Examination for Medical Degrees, July, 1916.

T. Adam, C. H. Andrewes, K. H. Doouss, W. C. V. Higginson, J. V. Landau, C. W. Narbeth, H. L. Sackett, W. G. D. H. Urwick.

Second Examination for Medical Degrees, Part 1, *July*, 1916.

R. W. P. Hosford, A. E. Lorenzen, H. L. Sackett, Campbell Shaw, A. W. Taylor.

APPOINTMENT.

K. D. PRINGLE, M.B., B.C.Cantab., M.R.C.S., L.R.C.P., appointed Medical Officer to the Empire of India and Ceylon Tea Company, Borjuli, Assam.

NEW ADDRESSES.

L. A. ARNOULD, Bhusaval, Bombay Presidency, India.
F. BRICKWELL, 5, Hatfield Road, Ipswich.
T. H. F. CLARKSON, Lieut.-Col., R.A.M.C., 24, Festing Road Southsea.
C. H. FOWLER, Athol Cottage, Shottermill, Haslemere.
R. N. GEACH, 19, Hobart Place, Grosvenor Gardens, S.W.
P. J. LUSH, 48, Avenue Road, South Hampstead, N.W.
K. D. PRINGLE, Thakurbari, Darrang, Assam.
D. L. SPENCE, 80, New Cavendish Street, W.
H. E. WINTER, Lieut.-Col., R.A.M.C., Club of Western India, Poona.

BIRTHS.

FIDDIAN.—On August 12th, at Cambridge, to Capt. J. V. Fiddian, R.A.M.C., and Mrs. Fiddian—a daughter.

GRANDAGE.—On August 16th, at 74, Gloucester Road, S.W., the wife of Lt.-Col. W. B. Grandage, R.F.A. (T.F.), of a son.

GRAY.—On July 31st, at Yew Tree Cottage, West Malling, the wife of Henry Gray, M.R.C.S., of a daughter.

GRIFFITH.—On July 31st, at 2, Cavendish Road, St. John's Wood, N.W., to Helena and Harold Kinder Griffith, F.R.C.S. (Capt., R.A.M.C., T., 2/2 City of London Field Ambulance), a son.

JORDAN.—On August 17th, at 6, Maxted Park, Harrow, to Dr. and Mrs. Alfred C. Jordan (of 13, Upper Wimpole Street, W.), a daughter.

LEVY.—On July 31st, at 67, Wimpole Street, Cavendish Square, W., the wife of A. Harold Levy, F.R.C.S., of a daughter.

NICOLL.—On August 2nd, at Runfold, near Farnham, Surrey, the wife of Charles Vere Nicoll, Capt., R.A.M.C., Special Reserve, late of the Federated Malay States and Ceylon, a son.

ROSE.—On August 21st, at 68, Wimpole Street, W., to Mr. and Mrs. Frank A. Rose, a daughter.

SANKEY.—On August 23rd, at 35, St. Giles, Oxford, the wife of R. H. Sankey, Capt., R.A.M.C.(T.), of a son.

SEWELL.—On July 26th, at Coonoor, South India, of Dorothy, wife of Capt. R. B. Seymour Sewell, I.M.S., a daughter. (By cable.)

STANSFELD.—On Wednesday, August 16th, at 48, Bryanston Street, Portman Square, W., to Dr. and Mrs. A. E. Stansfeld, a son.

WALKER.—On June 22nd, to Dr. and Mrs. Norman H. Walker, of Davenport Road, Durban, Natal, a son.

MARRIAGES.

ALLNUTT—GAINSFORD.—On July 27th, at St. Saviour's Church Hitchin, by the Rev. G. B. Gainsford, Vicar, Edward Bruce Allnutt, Capt., R.A.M.C., to Joan Cicely, daughter of the Rev. G. B. and Mrs. Gainsford, of Woodside, Hitchin.

ATKINSON FAIRBANK—SALMON.—On August 1st, at St. Mary's Priory, Bodmin, by the Reverend Father McElroy, John Gerald Atkinson Fairbank, M.B., elder son of the late John Harrison Atkinson and Mrs. Atkinson, of 50, St. Charles Square, W., to Gladys Isatt, only daughter of Dr. and Mrs. O. G. Salmon, Bodmin, Cornwall.

CANE—PERKINS.—On July 24th, 1916, at St. John's, Meads, Eastbourne, by the Rev. John Salwey, Vicar, Maurice Hereward Cane, temp. Captain, R.A.M.C., youngest son of the late Leonard Cane, M.D., and Mrs. Cane, of Eastbourne, formerly of Peterborough, to Marjorie Amy, second daughter of H. J. Perkins, I.S.O., F.R.G.S., F.G.S., Surveyor-General, British Honduras, and Mrs. Perkins, of Wimbledon Park.

PRATT—WINCKLEY.—On August 8th, at the Parish Church, Houghton-on-the-Hill, Leicestershire, by the father of the bride, Capt. Oliver Beakley Pratt, R.A.M.C. (attached 8th Battalion Suffolk Regiment), son of Lieut.-Col. R. Pratt, R.A.M.C., T.F., and Mrs. Pratt, of Leicester, to Catharine Rose Thorold, eldest daughter of the Rev. S. Thorold Winckley, Rector of Houghton and Rural Dean, and Mrs. Winckley.

SAVORY—SUTHERLAND—On August 16th, at St. Mary-the-Virgin, Ringmer, by the Rt. Rev. the Bishop of Barking, assisted by the Rev. Preb. Poole, of Lewes, the Rev. Lawrence Gee, Rector of Hemel Hempstead, uncle of the bride, and the Rev. G. R. Leefe, Vicar of Ringmer, Charles H. Savory, Surgeon, R.N., eldest son of Arthur L. Savory, of 31, Bramham Gardens, S.W., to Aileen Mary, elder daughter of the late William Tudor Sutherland and Mrs. Sutherland, of Whitehall, Maidenhead.

DEATHS.

GRAY.—On August 15th, at 19, Beaumont Street, Oxford, Edward Benjamin Gray, M.D., in his 85th year.

GREEN.—Killed in action in France on July 1st, Capt. J. L. Green, V.C., M.R.C.S., L.R.C.P., R.A.M.C., attached 5th Sherwood Foresters, eldest and only surviving son of J. G. Green, J.P., of "Birchdene," Houghton, Huntingdon, aged 27.

LOBB.—On August 16th, 1916, at Kano, Nigeria, Hubert Peché Lobb (of "Endsleigh," New Milton, Hampshire), Provincial Medical Officer, Northern Nigeria, aged 40.

POWER.—On July 28th, at Holly Lodge, East Molesey, Sir William Henry Power, K.C.B., F.R.S., aged 73.

WAUGH.—Killed in action on August 18th, Captain Arthur John Waugh, R.A.M.C., attached to North Staffs Regt., third son of Mr. and Mrs. Walter Waugh, Chigwell Hall, Essex, aged 28 years.

WOODERSON.—Killed in action, on August 6th, Capt. Douglas Henry David Wooderson, M.B., R.A.M.C., Medical Officer in Charge of the King's (Liverpool) Regiment, dearly-loved elder son of Mr. and Mrs. H. D. Wooderson, 39, Dartmouth Road, Brondesbury, N.W., aged 24.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, Smithfield, E.C.*

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