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Hospital

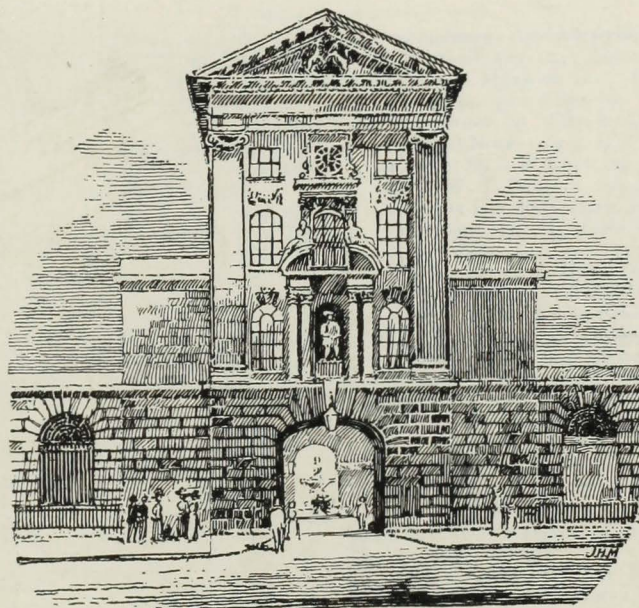


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1918-1919.

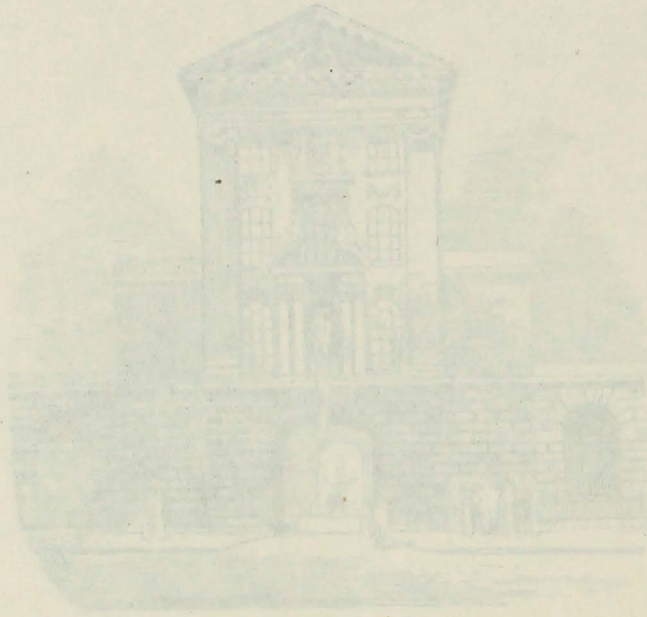
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St. Bartholomew's Hospital



"Æquam memento rebus in arduis
Servare mentem."

—Horace, Book ii, Ode iii.

JOURNAL.

VOL. XXVI.—No. 1.]

OCTOBER 1ST, 1918.

[PRICE SIXPENCE.

CALENDAR.

Tues., Oct.	1.—	Dr. Drysdale and Mr. McAdam Eccles on duty.
Fri., "	4.—	Dr. Calvert and Mr. D'Arcy Power on duty.
Tues., "	8.—	Dr. Morley Fletcher and Mr. Waring on duty.
Wed., "	9.—	Clinical Lecture (Surgery), Mr. D'Arcy Power.
Fri., "	11.—	Dr. Drysdale and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Drysdale.
Tues., "	15.—	Dr. Calvert and Mr. D'Arcy Power on duty.
Wed., "	16.—	Clinical Lecture (Surgery), Mr. D'Arcy Power.
Fri., "	18.—	Dr. Morley Fletcher and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Drysdale.
Tues., "	22.—	Dr. Drysdale and Mr. McAdam Eccles on duty.
Wed., "	23.—	Clinical Lecture (Surgery), Mr. D'Arcy Power.
Fri., "	25.—	Dr. Calvert and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine), Dr. Fletcher.
Tues., "	29.—	Dr. Morley Fletcher and Mr. Waring on duty.
Wed., "	30.—	Clinical Lecture (Surgery), Mr. Waring.
Fri., Nov.	1.—	Dr. Drysdale and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Fletcher.

EDITORIAL NOTES.

NCCE more it is our duty at the commencement of the academic year to welcome Freshmen to the Hospital, and to congratulate them on the choice of their *Alma Mater*. Bart.'s has established a wide reputation as a teaching centre, and is, of course, the oldest Hospital in the Metropolis, if not in the country.

Our new colleagues—especially those coming to us from the Universities—will realise that the social side of the Hospital, of necessity, must be curtailed. But brighter days are ahead, the spirit of victory is in the air, and St. Bartholomew's will not be far behind when we can enjoy again the piping days of peace.

Meanwhile it is the student's duty to carry on. He should regard his work—as indeed it is—of national importance, endeavour to qualify at the earliest possible moment, and thus maintain not only the reputation of the Hospital, but also do his bit towards ensuring that the most glorious

of all professions shall not fail the nation in its greatest hour of need.

* * *

We note with much interest and not a little satisfaction that the debate on Medicine *versus* Surgery, held under the auspices of the Abernethian Society and reported in the July issue of this journal, formed the basis of the editorial article in the educational number of the *Lancet*.

In spite of what the surgeons may say as to the seriousness or otherwise of the debate, and whilst agreeing to a certain extent with the *Lancet* that "the champions of medicine and surgery were not so judgmentic in the expression of their views as they would have been on a more responsible occasion," we still contend that the majority of those present regarded the discussion in quite a serious light. Naturally the evening was not without its humorous side; but taken as a whole, and certainly when it came to voting, the serious and intelligent interest of the men appeared to us to be a feature of the evening.

We are glad to learn that the *Lancet* endorses the victory of Medicine, and that this conclusion has been repeatedly forced upon medical teachers on both sides of the Atlantic.

Major Rawling's vigorous reply to Major Stanley will be read with much interest. We may add that our columns are always open to our readers, and we shall welcome any further contributions to this most interesting discussion.

* * *

Much is being said and written concerning "reconstruction" at the present time. Many will have seen Sir George Newman's "Some Notes on Medical Education in England," and will appreciate much of what he has written on the subject.

Postgraduate study is another branch of the same matter, and it is to be hoped that London will be able to obtain, and retain, much of the prestige which before the war was acceded to enemy countries. St. Bartholomew's must not be behind in all this.

Perhaps it may disappoint some, but after very careful consideration our School has decided against throwing open its doors to women, in spite of the fact that it is recog-

nised that they will have a very important share in the care of the health of the nation in the future. Several other well-known medical schools are, however, receiving them.

* * *

We desire to warmly congratulate Major-Gen. W. G. A. Bedford, C.B., C.M.G., A.M.S., on being made a K.C.M.G.

* * *

The following St. Bartholomew's men have been honoured in connection with the military operations in Mesopotamia. To these gentlemen we offer our heartiest congratulations:

C.B.: Col. W. H. Starr, C.M.G., A.M.S.

M.C.: Temp. Capt. J. A. Noble, R.A.M.C.

To be Brevet-Major: Capt. A. M. Dick, I.M.S., Capt. T. J. C. Evans, M.C., I.M.S.

* * *

Several Bart.'s men have been mentioned in despatches by Lieut.-Gen. W. R. Marshall, Commander-in-Chief of the Mesopotamia Expeditionary Force. The list is as follows:

R.A.M.C.: Lieut.-Col. (Brevet Col.) M. H. G. Fell, C.M.G., Lieut.-Col. (Temp. Col.) S. F. St. D. Green, Temp. Capt. H. H. Raw, Col. W. H. Starr, C.M.G., A.M.S., Temp. Capt. C. A. Weller.

R.A.M.C. (Special Reserve): Capt. W. B. Wood.

R.A.M.C. (T.F.): Major (Temp. Lieut.-Col.) F. E. Fremantle.

I.M.S.: Capt. A. C. L. O'S. Bilderbeck, Major (Acting Lieut.-Col.) H. M. Cruddas, C.M.G., Capt. A. M. Dick, Capt. T. J. C. Evans, Major W. H. Leonard, Major F. P. Mackie, Capt. C. J. Stocker, M.C., Capt. A. J. Symes.

* * *

We have pleasure in congratulating Fleet Surgeon F. J. A. Dalton, C.M.G., R.N., on being made a Chevalier of the Legion of Honour, the decoration being conferred by the President of the French Republic for distinguished services rendered during the war.

* * *

We have to congratulate Lieut.-Col. R. F. Standage, I.M.S., on being appointed Consulting Surgeon to the Forces in East Africa.

We notice also that Lieut.-Col. Standage has been elected an Associate of the Order of St. John of Jeru-alem.

* * *

The following are the official statements of services for which the Military Cross has been conferred:

"Temp. Capt. E. W. D. Hardy, R.A.M.C.—His dressing-station was situated at cross-roads, the only place available, and during a whole day was obviously a target for exceptionally intense bombardment. He displayed the greatest courage and supreme contempt of danger, remaining at his post and dressing wounded the entire day while everybody else was dug in."

"Capt. C. Newton-Davies, M.B., I.M.S.—During the attack, when the battalion was brought to a standstill by

frontal and enfilade fire of all kinds, he exposed himself continually in moving from place to place to render aid to wounded cases. It was owing to his courage, devotion to duty, and skilful organisation that the wounded were successfully collected and evacuated."

"Temp. Capt. R. Stansfeld, R.A.M.C.—During an engagement he carried his medical pannier forward through a heavy barrage, and moved about under heavy shell-fire over the captured ground, collecting and bringing in the wounded. He set a splendid example of courage and devotion to duty."

"Temp. Capt. R. B. Taylor, R.A.M.C.—He searched for a missing stretcher-bearer for two hours under heavy shell-fire, at last finding him in a shell-hole and assisting to carry him back. Throughout nine days' fighting he was constantly going forward under fire, searching for and bringing in wounded."

* * *

We note with much pleasure that Sir Dyce Duckworth has been elected *Membré Correspondant*, "*honoris causa*," de la Société Médicale des Hôpitaux de Paris.

* * *

We are glad to hear that Capt. F. G. Chandler, M.D., R.A.M.C., has been awarded the Raymond Horton Smith Prize of Cambridge for 1917.

* * *

The Index for Vol. XXV (1917-1918) of the JOURNAL will be published and distributed with the next issue.

* * *

ROLL OF HONOUR

It is with very deep regret that we learn of the death of Lieut. W. M. Heald, R.A.M.C. He was attached to the Lancashire Fusiliers, and died of wounds on September 8th. Lieut. Heald was the only son of the Rev. C. W. and Mrs. Heald, of Chale Rectory, Isle of Wight, and was educated at Marlborough and St. John's College, Cambridge. During the first two months of this year he acted as house-physician at this Hospital.

We desire to express our deepest sympathy with the Rev. and Mrs. Heald in their sad bereavement.

FROM THE FRONT.



HE following interesting letter has reached us from Capt. Haldin Davis, R.A.M.C.(T.), who is now serving with the troops in Palestine:

"We are now actually holding a portion of the line, and my position is on the reverse slope of a high hill, which slopes precipitously down to a waddy or watercourse at the bottom, and if I fall out of bed I am likely not to stop rolling till I get there. Things, however, are very quiet, and (*Deo gratias*) very few casualties about at present. This battalion has been here just a week without any, and

the battalion that we relieved was here six weeks without any. We shall have some malaria, however, as we have to hold a place in the bottom of a waddy which swarms with *Anopheles*. Two cases have occurred already. All the field ambulances now are officered by the British officers who came out with them.

"It never rains here from April to late October, and the heat is not very excessive. It must be one of the best climates in the world, especially in the hills. I have not had a single case of chest or nasal trouble since we left Egypt, and the health of the men is extremely good. Malaria is the only dangerous disease here. One of my duties is to go into No Man's Land and to oil certain wells to circumvent the *Anopheles*.

"The hills are rocky but fertile, and there are heaps of vines, figs and mulberries and grapes, which are just beginning to get ripe.

"Notwithstanding these delights, however, I would not mind being back in civilised parts. I feel bound to confess that the simple life has no particular charm for me. I should be glad to come out here for a holiday to admire the scenery, but to stay here indefinitely is a prospect which leaves me cold."

MEDICAL NOTES.

By Sir THOMAS HORDER, M.D.

(Continued from Vol. XXV, p. 105.)

ON CARDIAC BRUITS—continued.

(31) The most important of the cardiac bruits to elude discovery is probably the diastolic bruit indicative of aortic regurgitation in the early stages of the disease. The reasons for this are two: (i) The bruit is prone to be "soft" and "distant," requiring a trained ear and a quiet room for its detection; (ii) it may only be heard to the left of the sternum, and sometimes only to the left of the sternum at its lower end. If either or both of these conditions be present the diagnosis may be entirely missed. It is therefore a good rule never to quit the auscultation of a heart, and certainly never to quit the auscultation of a hypertrophied heart (*vide* §18), until the observer is sure that the bruit is not present in this situation.

(32) The cases in which the bruit of aortic regurgitation is of maximum intensity at the lower end of the sternum, and to the left of the mesial line, are not uncommon. More uncommon are the cases in which the maximum intensity of the bruit is at the pulmonary base. In a few rare instances the bruit may be confined to this last-named situation, in which event mere anatomical considerations suggest a diagnosis of pulmonary regurgitation; but the presence of the arterial signs of aortic incompetence—jerking pulse at

the wrist, visible arterial pulsation at various points and capillary pulse, together with signs of hypertrophy of the left ventricle, demonstrate that the defect is in the systemic and not in the pulmonary system. It may be added that if the diastolic bruit is heard only in the pulmonary area, and none of these concomitant features is present, a diagnosis of aortic regurgitation cannot be made. But this reservation also holds good when the bruit is heard in the more common situations.

(33) Bruits which "come and go" from day to day, and in some instances even from hour to hour: (i) The systolic bruit of mitral regurgitation, when that condition is secondary to failure of the left ventricle, as in dilated heart complicating renal disease (*vide* § 30); less often when primary mitral regurgitation is complicated by severe heart failure with great dilatation; and in acute endocarditis. (ii) The presystolic bruit of mitral stenosis both at the beginning and at the end of the course of this disease—when the disease is in a stage of evolution, as may be observed in prolonged cases of subacute rheumatism in children; and when "auricular fibrillation" supervenes, with general dilatation. (iii) The bruits associated with acute ulcerating endocarditis (but see § 29.)

ON MORBUS CORDIS.

(34) Between patients suffering from aortic disease and patients suffering from mitral disease certain broad clinical differences are observable.

(i) *Facies*.—In aortic disease patients tend to pallor, because the arterioles are badly filled; in mitral disease patients tend to cyanosis, because the venules are badly emptied.

(ii) *Pain*.—This is common in aortic disease, and may be of all degrees of severity up to true angina. (But when true angina is present, consider the question of associated lesions, such as coronary atheroma, etc.). In mitral disease pain is quite uncommon.

(iii) *Night starts* and *bad dreams* are more common in aortic than in mitral disease.

(iv) *Sudden death* is not uncommon in aortic disease; it rarely occurs in mitral disease.

(v) *Heart failure*, when it supervenes, shows three important differences: (a) Dropsy is both less common and less marked in aortic than in mitral disease. (b) Heart failure proceeds more rapidly in aortic than in mitral disease, and, once it has arrived, compensation is much less likely to be re-established in the former than in the latter condition. This is because the burden of the extra work has been borne by the ventricle throughout in aortic disease, so that by the time dilatation sets in the myocardium is no longer intrinsically sound. On the other hand, in mitral disease, at the time of initial dilatation, the myocardium has potential energy which can be called forth by treatment. Hence it follows that "mitral" patients not uncommonly give a history of

one or more bouts of heart failure with dropsy, etc., from which good recovery has been made, but "aortic" patients rarely do. (c) In the response to treatment the difference may be inferred from (b).

(35) The ætiology of pure mitral regurgitation is quite different from pure mitral stenosis. Mitral regurgitation is a residual condition resulting from an old acute rheumatic endocarditis; mitral stenosis is a progressive condition due to sclerosing (? rheumatic) endocarditis. Hence the rule is to get a history of rheumatic fever in cases of mitral regurgitation, and a history of chronic rheumatism, or chorea, or growing-pains, or of no rheumatic affection at all, in mitral stenosis.

(36) Ascites may be the first sign of cardiac dropsy in mitral stenosis, preceding for a considerable time œdema of the legs. (Ignorance of this fact sometimes leads to an erroneous diagnosis of cirrhosis of the liver.) The explanation of this fact is as follows: In mitral stenosis, owing to the inability of the left auricle to discharge its contents into the left ventricle, and the consequent inability of this latter chamber to assist in overcoming the valvular defect, there is a gradually increasing venous reservoir formed by the left auricle, the pulmonary circulation, the right heart and the venæ cavæ. The hepatic veins, the largest tributaries of the inferior vena cava, become dilated and share in this venous reservoir, leading to great congestion of the liver and to increased pressure in the portal system. (It is to state this same fact in terms of morbid anatomy to say that the most marked instances of "nutmeg liver" occur in mitral stenosis.) This state of things may become definitely established before as yet there is any appreciable failure on the part of the heart muscle. Hence local dropsy of the peritoneum may precede general œdema. Conversely, in mitral regurgitation, although a similar venous reservoir forms, it does not proceed to anything like the same extent, because the left ventricle comes into play from the first in the compensating mechanism. Hence it is that in this disease, dropsy, when it appears, appears as the result of heart failure; and inasmuch as the whole venous system is equally affected, it appears first in the legs, since gravity determines the disposition of the œdema.

(37) The same considerations explain the relatively greater frequency of hæmoptysis in mitral stenosis than in mitral regurgitation, whether the hæmorrhage results from a general pulmonary engorgement or from hæmorrhagic infarction. The pulmonary veins participate in the reservoir formation quite early; it is not, therefore, surprising that hæmoptysis should occur at a period in the course of mitral stenosis when other complications are absent. In short, hæmoptysis in mitral stenosis by no means indicates the arrival of dilatation of the heart; in mitral regurgitation, however, it generally does.

(38) Another important clinical difference between mitral stenosis and mitral regurgitation is the greater tendency to embolism in the former disease. The emboli consist of fragments of clot which forms in the dilated left auricular appendix, not of "vegetations from the mitral valve." The valve cusps in mitral stenosis are thick, smooth, and fibrotic, and are quite free from vegetations; moreover, the thrombosed auricular appendix can be demonstrated post-mortem, and not infrequently the embolus can be seen to correspond to the free surface of the clot in texture, colour, and microscopic appearances.

(39) Certain general features characterise patients who are the subjects of congenital morbus cordis (as against acquired morbus cordis)—marked cyanosis, clubbing of fingers and toes, polycythæmia, immaturity, and attacks of pulmonary and cerebral congestion. But it should be observed that if morbus cordis is acquired *very early in life*, the patient approximates to the congenital type in some or all of these features.

(40) Every branch of natural science pauses in its progress after a time, awaiting the introduction of a new method or a new instrument which shall open a fresh field for investigation. By means of the polygraph and the electro-cardiograph a brilliant chapter has been added of late years to our knowledge of the cardiac arrhythmias, and in the attempt to segregate these there have been advanced several valuable hypotheses which serve as bases for further work.* But let us not decry the instrument that ushered in the last advance, nor forget that the workman will probably prove to be just as fallibly over-confident of the tool he now handles. Yesterday's observer with a familiar instrument to help him; to-day's observer with a new instrument to learn; his mistakes may be different, but they will not be less.

"With that injudicious enthusiasm which has at all times heralded a new method of observation, fabulous qualities were at first attributed to the stethoscope." True; but for "stethoscope" read "electro-cardiograph," and in a hundred years the same sentence will be written again.

(41) "Failure of compensation"—a term that has fallen into disrepute, not to say disrespect. But why? "Heart failure," proposed as a substitute, means nothing else, for the definition offered—"That condition in which the heart is unable to maintain an efficient circulation during the efforts necessary for the daily life of the individual"—is the definition that clear-minded teachers give of "failure of compensation." And in minds that are not clear "heart failure" is quite as liable to become "attendant verbiage" as is "failure of compensation" or any other nomenclature. But in this matter the critic is not quite fair to traditional teaching. He speaks as though "compensation" and

* A chapter in which British medicine, as represented by Mackenzie, Lewis and others, takes a foremost place.

"decompensation" were terms applied to *all* forms of heart disease, whereas they were only applied to cases of primary valvular disease. In primary myocardial disease, in angina, in toxic heart states, and in dilatation consequent upon extrinsic factors these terms were not used.* In these last-named conditions "heart failure" is certainly as apt a generic term as can be desired with which to express the signs and symptoms of cardiac inefficiency.

(42) "No one ever dies of mitral regurgitation." Nor of tabes dorsalis, cirrhosis of the liver, nor pulmonary phthisis—chronic diseases all, but subject to developments that are prone eventually to be lethal.

(43) "When I have looked at the enormous mass of muscle which forms the ventricular wall in these cases" (of heart failure in aortic regurgitation), "I have often wondered whether those muscle-fibres represent a genuine hypertrophy, or whether some disease condition has taken part in the increase." It has; the microscope reveals, in greater or less degree, degeneration of the muscle-fibre, interstitial myocarditis, and sclerosis of the arteries.

A CASE OF CHONDRO-SARCOMA OF THE HUMERUS TREATED BY FORE-QUARTER AMPUTATION.

By H. C. Cox, M.R.C.S., L.R.C.P.

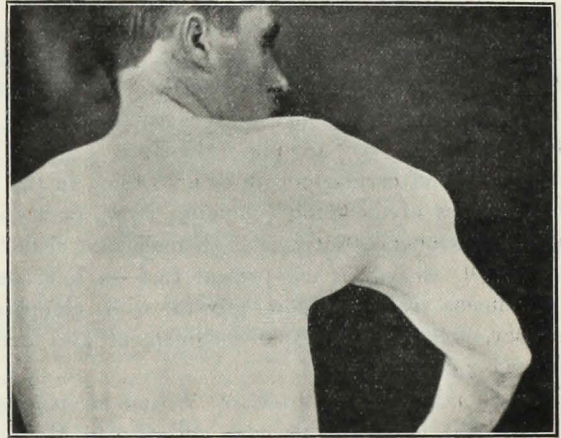
THE patient, a man, æt. 28, was admitted to Colston Ward, on June 17th, 1918, under the care of Capt. Harold Wilson, complaining of a lump at the upper end of the right arm. He gave the following history: At the age of eight, his father noticed a lump, about the size of a walnut, which appeared at the outer side of the upper end of the right humerus. It was hard, painless, caused no inconvenience, but steadily grew larger. He was first seen by Capt. Wilson at the beginning of 1915, and in February of that year was admitted to Annie Zunz Ward. The mass, which was now 6 in. long and about 3 in. broad, was found to be arising from the upper end of the shaft of the right humerus, and was composed of cartilage. It was locally excised. Sections of the growth showed a typical ossifying chondroma of a non-malignant character.

In March, 1917, patient was re-admitted to Annie Zunz Ward, the growth having recurred to about its former size. There was, in addition, an enlarged gland felt in the right axilla. The mass was again excised, and the histological

* The writer holds no brief for the "physicians" who "give a good prognosis in cases of extreme exhaustion (*sic*) because compensation was good, and there was no objective sign of heart failure." Nor for that "professor of medicine who rejoiced the heart of a man with aortic disease, who could not walk a hundred yards without being pulled up by pain, by telling him that his outlook was good as there was no dropsy, and, therefore, compensation was good."

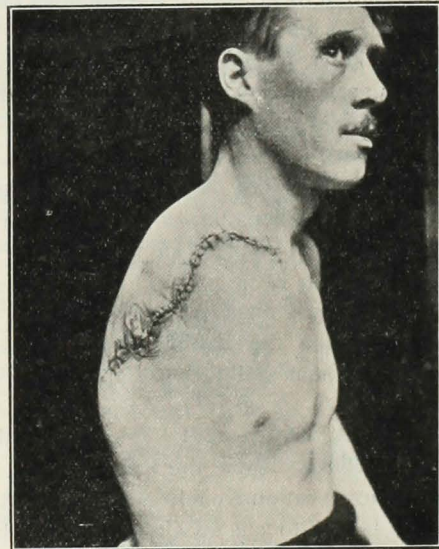
report showed again an innocent chondroma. On discharge there was still free movement of the right shoulder-joint, and the arm was still quite useful.

On re-admission in June of this year, the patient showed an irregular swelling occupying the upper one-third of the



BEFORE OPERATION.

right humerus. It was very hard and nodular, painless, and the covering skin was not attached. There was now considerable impairment of movement at the right shoulder joint. The enlarged gland in the right axilla was also felt. The general condition of the patient was excellent.



FOUR DAYS AFTER OPERATION.

A diagnosis of chondro-sarcoma of the right humerus was made, and at Surgical Consultations the unanimous opinion was that the best treatment was removal of the arm by a fore-quarter amputation. This procedure was accordingly carried out by Capt. Wilson, and the whole of the right arm, together with the scapula, outer half of the clavicle and axillary contents, were removed.

Except for the sudden development of post-operative shock two hours after the operation, successfully treated by intravenous saline infusions, the patient made an uninterrupted recovery, and was discharged on July 4th, thirteen days after the operation.

Pathological investigation on this occasion showed the growth to be a typical chondro-sarcoma.

The interest of this swelling lies, perhaps, in its pathology. The common situations for chondromas to occur are in the long bones of the hand and foot, and such tumours are essentially non-malignant.

In the event of cartilaginous tumours arising in the long and flat bones of the body (humerus, ilium, or scapula), they always, sooner or later, take on malignant characters. This is well shown in the present case—a long period of seventeen years of slow growth with comparative innocency, followed by rapid enlargement and definite final sarcomatous structure.

The writer is indebted to Capt. Wilson for permission to publish the notes of this case, and also to Mr. Zerolo for the excellent photographs with which it is illustrated.

ANCIENT "SURGERY."



are indebted to Capt. Philip Gosse, R.A.M.C., The Sassoon Hospital, Poona, for the following translation from *Avesta*, the religious book of the Parsees.

In a covering letter, Capt. Gosse says that the translation is from a very ancient Sanskrit book, and, amounting to practically an ancient form of "College Final in Surgery," may prove of interest to readers of the JOURNAL. Capt. Gosse adds that it must have had its distinct disadvantages in those days to be a dissenter, as the unbeliever seems to have been used as a living "subject" in the practical Operative Final.

Book: *Fargard*, vii; verses 94 and onwards:

"Creator! When the Faithful wish to make themselves Physicians whom shall they first cure, the Unbelievers or the Faithful?"

"Then answered the Creator: 'They shall make trial of healing the Unbelievers before the Faithful.'

"If he begins to cut an Unbeliever for the first time and he dies: if he begins to cut an Unbeliever for the second time and he dies: if he begins to cut an Unbeliever for the third time and he dies, then he is incapable for ever.

"The Faithful shall not consult him afterwards: he shall not cut the Faithful; nor shall he wound by cutting.

"If the Faithful afterwards try him, if he cuts the Faithful, if he wounds them by cutting, then shall he atone for the wound of the wounded with the punishment of the Baodh-varsta.*

* "Sins committed wilfully."

"If he cuts one of the Faithful for the first time and he recovers: if he cuts one of the Faithful for the second time and he recovers: if he cuts one of the Faithful for the third time and he recovers, then is he capable for ever.

"According to their wish the Faithful afterwards make trial of him: he shall cut the Faithful as he pleases; he shall heal them by cutting at his will."

Scale of Fees allowed to be charged by a Surgeon.

The cure of:	Fee:
A priest	A pious blessing.
Master of the house	Value of a small beast of burden.
Ruler of a clan	Value of a middle-sized beast of burden.
Chief of a tribe	Value of a large beast of burden.
Ruler of a territory	Value of a chariot with four oxen.
Mistress of a house	A female ass.
Wife of chief of clan	A cow.
Wife of chief of tribe	A mare.
Wife of ruler of district	Female camel.
A boy from the village	Value of a large beast of burden.
Large beast of burden	Value of a middle-sized beast of burden.

OBITUARY.

FREDERICK EUSTACE BATTEN, M.D.Cantab.,
F.R.C.P.



HE announcement in the *Times* of the death of Dr. Frederick Batten on July 27th, after a severe operation, was sad news to all who knew him, and especially to those friends, of his who were his contemporaries at Cambridge and St. Bartholomew's.

The profession has lost in him one of its most loyal and devoted workers, and his friends, one whom they can never replace.

My first introduction to Fred Batten was at Cambridge some thirty odd years ago, where he had matriculated after leaving Westminster School. We were at practical work in one of the laboratories, and I remember it was his entire absorption in his work in hand, to the oblivion of everything else, which first attracted my attention. It is a trivial recollection, but the love of work for its own sake and his power of concentration upon it were so characteristic of him afterwards, that there is some little interest in recalling it as a first impression.

Coming up from the rowing school at Westminster, it was natural he should take to the river, and he soon found a place in one of the Third Trinity boats in training for the Lent races. I do not know that he arrived at high distinction as a "wet-bob," but he was more than useful in a boat, and always pulled his weight and a little bit over.

The only other diversion I remember him at all prominent in was as a member of the "Owls" Debating Club, of which he was a great supporter, and occasionally he would speak at the "Union."

At St. Bartholomew's, which he entered in 1887, he passed four years in his quiet and rather retiring way, taking his Cambridge M.B. in 1891, and becoming House-Physician to Sir William Church soon afterwards.

At the end of a year in that capacity he was for some time Casualty Physician, after which he spent some six months in Berlin, doing post-graduate work and learning the language.

On his return he soon settled down to the work, to which his inclinations and qualities were inevitably leading him, and appointments which he obtained at the Hospital for Sick Children, Great Ormond Street, as well as at the Hospital for the Paralysed, Queen Square, became the starting-point of the work with which his name has ever since been associated.

For over twenty years his life was devoted to work associated with these hospitals, to scientific research, to the work of various societies, to teaching, and to fulfilling the innumerable and exacting obligations inseparable from the life of a consulting physician.

In 1901 he was elected to the Fellowship of the Royal College of Physicians, of which he had been a member for seven years.

As a consultant his methods were simple and direct. Preliminaries as brief as courtesy would allow, a very thorough examination, and a diagnosis prompt and decisive. He abhorred "sloppiness" and indecision, and was assuredly not guilty of such things himself. It has been said that he faced psychological problems and their modern aspects with some diffidence and reluctance. I believe this was true, and I can quite understand it. His own mind was itself so direct and free from anything morbid, that it must have been uncommonly difficult for him to follow the mental vagaries of patients suffering from a psychosis only, but his sympathy and patience were never wanting, and always equal to the occasion.

Batten had the kindest and most genial temperament, which showed itself to everyone with whom he came into contact.

In manner and conversation he was sincere and unaffected, keenly interested in almost any subject under discussion, and frequently enlivening it with a half-humorous and cheery laugh very characteristic of him.

His attitude to mankind was so simple and unobtrusive that it was difficult to realise, unless you knew him well, what strength of character lay behind it.

Natural instinct and good taste, the best traditions, and education in its widest sense, combined early to put him on a course of life from which he never seems to have swerved for a moment—a course directed by a code of morals beyond criticism. To attempt to lift the veil and look for the source of such unusual strength of character would be vain, and perhaps impertinent, especially as he was the last man to discuss his deepest convictions himself,

Enough for us that what he gave the world was of the best, and for which those who knew him well will always be thankful.

He died at the early age of 52, in the full vigour of his life, and when the fruits of his work were just coming to full maturity.

Dr. Batten was the son of the late John Winterbotham Batten, K.C., and brother of Dr. Rayner Batten, who also was educated at St. Bartholomew's.

In 1907 he married Jean, the daughter of the late John Stevenson, F.R.I.B.A., who survives him and to whom a host of friends extend their deepest sympathy. F. J. D.

CORRESPONDENCE.

MEDICAL NOTES.

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

SIR,—Reading the Medical Notes written for the JOURNAL by Sir Thomas Horder emphasises the little aid the average text-book gives in teaching the principles and practice of medicine. The Notes strongly recall the critical style of *Fagge's Medicine*, and deepen regret at it being so long since a new edition of that work appeared. A work is much needed to deal more critically with the principles and practice of medicine than does the ordinary text-book; it is much to be hoped that one may be written, or a revision of Fagge's work on its original lines undertaken.

Possibly the JOURNAL could do much to further these suggestions.

I am, Sir, etc.,

J. H. P. GRAHAM,
Lieut.-Col., R.A.M.C.(S.R.).

MEDICINE VERSUS SURGERY.

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

SIR,—It is very interesting to hear that our humble debate on the relative merits of surgery and medicine "at the present time" have sufficed to give Major Stanley "much amusement" in his leisure hours. Major Stanley, however, would have been wiser not to rush into print in order to criticise so freely the merest abstract of a debate, with no knowledge whatsoever of the conditions thereof. It may interest him to know that it was common knowledge throughout the Hospital that neither I nor Capt. Ball, the proposer and seconder of the motion, were in agreement with the terms of motion. The Secretary of the Abernethian Society, however, persuaded us to act, and, being sportsmen, we complied with his request. The attendance at the meeting—a record one—and the enthusiasm displayed, showed clearly that we were fully justified in so doing, the debate being replete with interest and humour. Major Stanley may have periods of luxury and ease, but we, at home, have no such leisure hours, and the debate was a very welcome relaxation.

Major Stanley would probably retaliate by saying that even a Parliamentary debate does not justify one in making "fallacious, dangerous and untrue statements"—*vide* his criticism of my remark that "in France at the present time it is the surgery that counts, not the medicine." I would remind Major Stanley that R.A.P.'s, A.D.S.'s, and C.C.S.'s do not occupy the whole field—he forgets that there are hundreds of hospitals in England, manned by thousands of medical men, the greater proportion of whom are engaged in the treatment of the wounded and sick, and that we have every opportunity of estimating the relative importance, both for the present and the future, of the surgical and medical cases arriving from France and elsewhere. From the time at which the debate was held, and ever since, we have been overrun with surgical cases. For example, at No. 1 London General, Camberwell, to which hospital I have the honour to be attached, surgical cases bear to medical a present relation of about 3½ to 1. And this has been going on for the greater part of this year, at the time of the debate, and both before and after. And what about France? Is Major Stanley still of the opinion that surgery is of so much lesser importance? Has he still leisure hours in which to offer criticisms on debates and papers on subjects of which he can have so little real knowledge?

Of course there are innumerable medical cases treated in France, admitted perhaps to C.C.S.'s, but only a small proportion of these require the services of a consulting physician. Any medical officer is perfectly capable of dealing with such cases, whether he knows more surgery than medicine or more medicine than surgery.

Does Major Stanley appreciate in the slightest degree the fact that the great excess of surgical cases transferred to this country throws such a burden on those who practise surgery that it is almost beyond our powers to deal with them? We have no leisure in which to criticise other men's statements and works.

And what a prospect for future surgery amongst these countless thousands that we see daily in hospital and in the streets! Truly, after all, Sir, there is more in our motion than appears at first sight.

I would add also that if the surgery in France were all of the nature as described and as carried out by Major Stanley—mere "butchery" and "excisions"—our attempts at home to cope with the surgical work would be doomed to absolute failure. Perhaps his version accounts for the many nerves we have to mend, the limbs we have to straighten, the deformities we have to rectify. Thank goodness there are others who hold different views and who act in other ways—*vide*, for example, the excellent results of cranio-cerebral surgery that are admitted to my wards.

In Major Stanley's second criticism, in relation to my statement "that the physician is not wanted, except here and there," he carefully omits the last four words. Such an omission is quite inexcusable. In addition, if he had not been quite so hasty in his criticisms, he would have been able to find out that, as per context in my speech, "physician" referred to "consulting physicians" only.

As regards the "conscripting of the medical profession and converting them into surgeons," there may be some justifiable exaggeration; but, after all, there is a good deal of truth in the statement. Hundreds of medical men, many of whom have done no surgery for many years, are perforce converted into surgeons. Major Stanley says he can carry out this quick change. Lucky surgeons; but, alas, poor patients!

Major Stanley is obviously labouring under some confusion of mind, for, after strafing the surgeons, more especially myself, he turns the vials of his wrath on to the devoted heads of the physicians, and such is his mental balance that he at once contradicts all his previous statements. For example, he admits that, after a raid or push, "as many as nine teams have been added to a C.C.S., and yet that it is good work if 30 per cent. of all wounded are operated on." Is not this, Sir, an argument showing that the Government motion was, after all, not so far from the truth?

In conclusion, Sir, I would add that it is a pity that Major Stanley, in his C.C.S., cannot view the whole question from a broader point of view, with some glimpse into futurity, with some thought of the thousands of surgically maimed and crippled in England at the present time.

I am, Sir,
Yours sincerely,
L. BATHE RAWLING,
Major, R.A.M.C.T.

REVIEW.

MEDICAL ELECTRICITY. By H. LEWIS JONES. Seventh edition. Revised and edited by LULLUM WOOD BATHURST. (H. K. Lewis & Co. Ltd.) Pp. 588. Price 15s. net.

No man has done more to bring electro-therapy to its present high standard than the late Dr. Lewis Jones, whose lamented death was regretted by so many Bart.'s men.

Dr. Bathurst is to be congratulated on the production of the new edition, which has been brought quite up to date—no easy matter when we consider that electro-therapy is a subject which must, of necessity, be constantly undergoing improvement. This was well shown by Dr. Lewis Jones in the last edition, in which he ventured to predict the possibilities on the one hand of the ionic, and on the other the thermal effects of electricity, both of which are being fulfilled.

A lot of new data has been included in the section relating to the electrical testing of muscles, a subject which is daily becoming of more importance as a routine test.

The book contains nearly 200 illustrations—a most necessary feature in a volume which deals with a subject so highly technical.

APPOINTMENTS.

CARLYON, Capt. T. B., R.A.M.C., appointed R.M.O. 1st London General Hospital, Camberwell.
EL-DAAB, S. A., M.R.C.S., L.R.C.P., appointed Casualty Officer, St. Thomas's Hospital, S.E.
VALERIE, Lieut. J., R.A.F., in charge of No. 1, M.T. Depot, Hurst Park.

CHANGES OF ADDRESS.

CANE, Major A. S., R.A.M.C., D.A.D.M.S. Base and L. of C., G.H.Q., British Salonika Force.
CARLYON, Capt. T. B., R.A.M.C., R.M.O., 1st London General Hospital, Cormont Road, Camberwell, S.E.
RAW, Capt. H. H., R.A.M.C., 23, St. Hilda's Terrace, Whitby, Yorks.

BIRTHS.

CATES.—On September 8th, at Laurel Mount, St. Helens, the wife of Joseph Cates, M.D., D.P.H., of a daughter.
DAVIES.—On August 29th, at Loretto, Ystrad-Rhondda, to Marjorie, the wife of Dr. J. P. H. Davies—a daughter.
EVANS.—On August 25th, at Plas Darland, Wrexham, North Wales, Ermine, wife of Temporary Surgeon Geoffrey Evans, Royal Navy, of a son.
GOVER.—On August 18th, at Penarth, Glamorgan, the wife of Lieut.-Col. John Maxwell Gover, D.S.O., R.A.M.C., of a son.
STACK.—On Sunday, August 25th, at Arvalee, Clifton, the wife of Capt. E. H. E. Stack, R.A.M.C.(T.), of a daughter.

MARRIAGES.

DICKINSON—MALCOLM.—On August 6th, 1918, at St. Pancras Church, by special licence, by the Rev. E. L. Metcalfe, Capt. W. R. Dickinson, R.A.M.C., only son of Mrs. and the late J. Dickinson, of Maryport, Cumberland, to Euphemia Livingstone, eldest daughter of Mr. and Mrs. Alexander Malcolm, Balam, Kimmage, co. Dublin.
MILLER—KELSON.—On September 3rd, at St. Wilfred's, Hayward's Heath, Capt. Robert Molineux Miller, D.S.O., R.A.M.C., son of the late Robert Miller, of Wimbledon, to Annie Mortimer, daughter of the late Thomas Mortimer Kelson, Captain 6th Royal Regiment, and Mrs. Kelson, Birling, Hayward's Heath.

DEATHS.

HARRIS.—On August 9th, 1918, at Southampton, Florentia Caroline Harris, widow of William John Harris, M.R.C.S., of Worthing.
HEALD.—On September 8th, 1918, in hospital abroad, from wounds, Lieut. William Margetson Heald, M.R.C.S., L.R.C.P., R.A.M.C. (S.R.), only son of the Rev. C. W. Heald, of Chale Rectory, Isle of Wight.
HODGSON.—On April 3rd, 1918, William Joseph Hodgson, M.D. St. And., M.R.C.S., of Thornbury, Rochdale, aged 84.
MAGUIRE.—On September 21st, 1918, at a nursing home, John Edward Carbery Maguire, M.R.C.S., L.R.C.P., of "Burgoyne," Elm Park Road, Winchmore Hill, N 21, from pneumonia and typhoid.

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.

St. Bartholomew's Hospital



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

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NOVEMBER 1ST, 1918.

[PRICE SIXPENCE.]

CALENDAR.

Fri., Nov.	1.—Dr. Drysdale and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Fletcher.
Tues., "	5.—Dr. Calvert and Mr. D'Arcy Power on duty.
Wed., "	6.—Clinical Lecture (Surgery), Mr. Waring.
Fri., "	8.—Dr. Fletcher and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Fletcher.
Tues., "	12.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Wed., "	13.—Clinical Lecture (Surgery), Mr. Waring.
Fri., "	15.—Dr. Calvert and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine), Dr. Drysdale.
Tues., "	19.—Dr. Fletcher and Mr. Waring on duty.
Wed., "	20.—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri., "	22.—Dr. Drysdale and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Calvert.
Tues., "	26.—Dr. Calvert and Mr. D'Arcy Power on duty.
Wed., "	27.—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri., "	29.—Dr. Fletcher and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Calvert.
Tues., Dec.	3.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Wed., "	4.—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri., "	6.—Dr. Calvert and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine), Dr. Calvert.

EDITORIAL NOTES.

THE Dean informs us that the entry of new students shows a substantial increase on that of last year. Whilst there is a slight decrease in the numbers of Oxford and Cambridge men this year, the new London University students have increased, and this is the case also with Conjoint Board men. The total number of full-time students who have joined this year is 107, against 78 in 1917.

* * *

The large attendance of doctors at the Steinway Hall meeting on October 1st proved the great interest taken by the profession in the agitation having as its object the support of medical men as candidates for Parliament. It certainly is a gross anomaly that the profession finds so little representation in Parliament. With the Ministry of

Health in a state of incubation, and with so many of the problems of reconstruction intimately bound up with the national health, the resolution unanimously passed at the meeting should receive a cordial welcome from all medical men, and, if it knows the things that make for its salvation, from the public also. As the result of the meeting an Executive Committee has been formed, consisting of representatives of a number of corporate bodies within the profession and also of several unofficial members; amongst the latter we note the name of one of our medical staff, Sir Thomas Horder, and of two old Bart.'s men, Mr. Howard Marshall and Col. Woodwark.

* * *

In a sympathetic leader in *The Times* the difficulties facing the profession in regard to the whole question were fully stated. It was more than hinted that the situation would not be helped if young men with axes to grind were sent into the House. We might add that it would be helped just as little by sending old men with a hobby. And unfortunately the men between these two extremes, really representative men who are alive and who are successful in their profession, are so busy that they cannot possibly find time for campaigning. University seats are few, and the political caucus is jealous of the "safe" seats which might be available. It will be the work of the Committee, no doubt, to convince the party whips that a few up-to-date doctors would be a definite asset in the House, and a relief to the public, from an equivalent number of the traditional carpet-baggers who sit there year by year.

* * *

Since writing the above we hear that Sir Wilmot Herringham has decided to stand as a candidate for the University of London. It occurred to us that Sir Wilmot's views would be of considerable interest. We accordingly wrote asking him for his opinion on two subjects: (1) the desirability or otherwise of a State medical service; and (2) the question of a larger representation of medical men in Parliament. We had two objects in view, first, the "pumping" of a candidate—and candidates are designed for that purpose—and secondly, that the subjects might be

presented to our readers in a controversial form, which is usually the more interesting aspect.

* * *

We are pleased to congratulate Temp. Lieut.-Col. A. G. P. Gipps, R.A.M.C., on receiving the D.S.O., the official notice stating that the award was given for distinguished and gallant services rendered on the occasion of the destruction or damage by enemy action to hospital ships, store ships, and transports.

* * *

Our congratulations to Capt. J. J. H. Beckton, R.A.M.C., who has received the Italian Bronze Medal "*Della Salute Publica*," and also to Temp. Lieut. A. R. Jennings, R.A.M.C., on receiving the Order of St. Sava. Both these decorations have been conferred by the Allied Powers for distinguished services rendered during the course of the campaign.

* * *

In a recent issue of the JOURNAL we reported that Major F. G. Lescher, M.C., R.A.M.C., was a prisoner in German hands. We now have to congratulate him on being awarded a second bar to the Military Cross. The official announcement is as follows: "When his camp was heavily shelled he had the wounded removed, and attended them in the open for six hours. Again during the night, when the transport was bombed, he proceeded to the scene and extricated the wounded men and attended to them, although the enemy continued to shell the position."

* * *

Our congratulations to Capt. J. A. Bell, M.C., R.A.M.C., on being awarded a Bar to the Military Cross. The official record states that he "was ordered to replace a medical officer, who was wounded, and at once went up through a very heavy barrage, established a dressing-station in the open, and showed the greatest coolness and devotion to duty in attending the wounded under very heavy shell-fire. He continued his fine work for several days, and was the means of saving many lives. His courage and fine example greatly inspired all ranks with him."

* * *

We had recently to congratulate Surgeon Eric Fiddian, R.N., on being awarded the Board of Trade Bronze Medal for saving life at sea. It now affords us much pleasure to be able to give the following official details:

"A British steamship stranded on a rocky coast. The vessel broke in two amidships, and was then abandoned by her crew, who lowered themselves by ropes on to the rocks.

"On the following day the wreck was observed by an officer who had been sent out to look for her, but on account of the heavy seas he was unable to land or render any assistance to the crew. On January 3rd he arrived again on the spot in one of His Majesty's trawlers, and after great difficulty found anchorage. He then, with Surgeon Fiddian and two leading deck hands, succeeded

in reaching the crew and in gradually transferring them to his trawler, for which purpose it was necessary to make three trips. On each occasion the rescuers were obliged to wade up to their waists in water in order to get the boat away from the beach. The temperature of the atmosphere at this time was 20 degrees below zero. The rescue, however, was successfully completed."

* * *

A month or two ago it was with deep regret that we had to report the death in action of Temp. Capt. E. P. W. Wedd, R.A.M.C. It will be recalled that a few weeks before being killed he was awarded the Military Cross. The official details have just appeared and these we gladly publish:

"For conspicuous gallantry and devotion to duty in traversing shell-swept roads and searching trenches under heavy fire till he found and tended the many wounded."

* * *

The following official details of services for which the Military Cross was awarded are now to hand:

"Temp. Capt. D. Crellin, R.A.M.C.—For conspicuous gallantry and devotion to duty in remaining at an advanced dressing-station till all the wounded were clear, in spite of the enemy's approach, and the rain of gas and high-explosive shells."

"Temp. Capt. A. P. Fry, M.B., R.A.M.C.—For conspicuous gallantry and devotion to duty in going from place to place across the open under heavy machine-gun, rifle, and shell fire, to attend to the wounded. His absolute fearlessness undoubtedly saved many men from bleeding to death. Throughout he displayed devotion to duty of a high order."

"Temp. Capt. S. J. L. Lindeman, R.A.M.C.—For ten days he worked unceasingly, tending wounded under heavy fire, saving many lives. On one occasion, under intense machine-gun fire, he still continued dressing and collecting wounded, and his complete disregard of danger set a fine example to those under him."

"Capt. C. G. Meade, R.A.M.C.—While brigade headquarters were being shelled this officer worked unceasingly, attending wounded gunners and infantry. Later, on receiving an urgent message from a battery, he set off by himself through a heavy barrage, and though suffering from the effects of gas, performed his duties in the open, regardless of all danger. He behaved splendidly."

"Capt. (Act.-Maj.) J. M. Smith, M.B., R.A.M.C.—For conspicuous devotion to duty when an enemy shell exploded an ammunition dump near his dressing-station. He rushed to the spot, organised a rescue party regardless of exploding shells, and continued to attend to the wounded until all were removed to safety. He saved many lives by his gallant conduct."

"Capt. (Act.-Maj.) A. L. Yates, M.D., R.A.M.C.—He maintained his medical posts under heavy shelling as long

as it was possible, and was responsible for the collection and evacuation of several hundred wounded of other divisions, as well as a great many of his own."

* * *

In the list of Bart.'s men who have been elected officers of the Royal College of Physicians of London, and which was reported in the September issue of this JOURNAL, we omitted to mention the names of Dr. Arnold Chaplin, who was elected to the office of Harveian Librarian, and Dr. Arthur T. Davies, who was elected a member of the Finance Committee of the College.

To these gentlemen we offer our apologies for the omission.

* * *

The Entrance Scholarships this year have been awarded as follows:

In Science (Senior).—C. L. Pasricha, Caius College, Cambridge.

In Science (Junior).—B. M. Tracey, Monkton Coombe School, Bath.

In Arts.—J. Maxwell, Highgate School.

Jeaffreson Exhibition.—N. E. Laurence, Queen's Royal College, Trinidad.

ROLL OF HONOUR.

It is with very deep regret that we have to report the death whilst on active service of three more St. Bartholomew's men. Practically no details are yet to hand, but these we hope to publish in a later issue:

Capt. G. M. Cowper, R.A.M.C., was educated at Cambridge University and at this Hospital, and qualified in 1914. He joined up on the outbreak of war, and was latterly attached to 35th Field Ambulance.

Lieut. W. L. Dandridge, R.A.M.C., attached 103rd Field Ambulance, qualified in November, 1917, and joined up early in the present year.

Both Capt. Cowper and Lieut. Dandridge are reported to have died from wounds.

Lieut. Howard Glenny, R.A.M.C., died of pneumonia on October 9th at Basra, Mesopotamia. He had only been ill a few days, and just prior to his death was doing the work of the Medical Quartermaster.

To the relatives and friends of these Bart.'s men we extend our deepest sympathy.

STATE MEDICAL SERVICE: MEDICAL REPRESENTATION IN PARLIAMENT.

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



IR,—You ask me what I think on two questions: (1) A State Medical Service, and (2) Medical representation in Parliament. I will try to answer you.

The material I have for answering the first question is only the articles in the *Lancet* of July 20th, 1918—one by Prof. Moore and Mr. Parker on behalf the State Medical Service Association, one by Sir Bertrand Dawson, and one by Dr. Lauriston Shaw. The first quotes the views of the British Medical Association, of the Panel Medico-Political Union, and of the London Panel Committee. These I have not seen first-hand, but the article seems to analyse them clearly.

Of these various statements there is only one, that of the S.M.S.A., which proposes any radical change in the present system. This body suggests a system of a military character. In each area it would establish—

(1) A group of chief practitioners with senior and junior assistants—call them majors, captains, and lieutenants for clearness.

(2) A lower grade, say second lieutenants, including house-surgeons and registrars.

(3) Higher grades of local and central administrative officers, like lieutenant-colonels and colonels, who would be employed by the Ministry of Health to control the service and keep it up to a high standard of efficiency.

All would be whole-time officers, and promotion would take place from the lower grade to the higher.

The authors employ no military terms, but the scheme is military in design, and is, in fact, very much like the organisation of the R.A.M.C.

I have been working in this system for the last four years, and have, therefore, some means of judging its effects. I have no hesitation in saying that though it is the only possible system for an army, and has done its work in an admirable way, it is the worst for civil life that can well be conceived.

Let me grant at once that in the Army it secures certain objects mentioned in the article.

(i) An easy provision of substitutes to take the duty of an absentee.

(ii) Distribution of officers in proportion to needs.

(iii and iv) Regular pay and holidays, and, if wished, study-leave.

But it does not (v), as the authors of the article suppose insure against waste of time. These unfortunates of the R.A.M.C. serve tables if ever men did. If you want to know how much time and how much paper a system can waste, from the highest to the lowest rank, go to the office of an army, or, indeed, of any Government department.

Nor does it (vi and vii) render a man more independent.

He is not in the Army dependent upon his patients, but he is far from independent of the public or of his superior officers. I remember even, when I first came out, a certain reluctance to allow post-mortem examinations for fear of what would be

said, though these were necessary if we were to learn anything about wounds and disease. I once was told by an officer, "Of course a word from you might ruin me." As far as I was concerned that was quite untrue, but it might have been true if I had been a Regular, and it seems to me horrible that a man should think such a thing. An official system does, in fact, prevent independence and discourage originality, not by the wish of anyone, but because where a man's prospects depend upon the opinion of his superiors—well, it cramps his style.

And yet (viii) it does not relieve him from the competitive struggle. This is keen and anxious in the R.A.M.C. as it is elsewhere. *(a. Stat. Medical Council)*

Take now the drawbacks to the proposed system. The first is the question of promotion. In every Government service the leading fact is seniority. The men are so uniform and have so little opportunity of being otherwise that selection is extremely difficult. It is equally difficult to get rid of an incompetent. When selection is exercised it invariably gives rise to dissatisfaction. I heard the last lists of the R.A.M.C. freely discussed, and I was surprised at the amount of distrust that was exhibited. If that happens in a small body, what would happen in a body twenty times the size? What knowledge could the inspector possibly have of the real character of a man's work in practice, or whether he was doing it well or ill? Supervision in such matters would be a farce.

The second drawback is the bad effect upon a man's efforts which is exercised by the possession of very moderate prospects, which he can hardly be deprived of, but can hardly hope to improve. Professors naturally make light of this. A professor has the most interesting work a man can have, and has a natural love of work or he would not be a professor. A general practitioner has—and do what you will must have—an immense amount of the dullest work in the world, and there is no one who can tell whether he does it well or ill. What do you suppose will be the effect upon a man not naturally industrious (and how many of us are?), who, working out his attendances at an average of a few pence for each, thinks that he is paid too little, yet sees no prospect of getting more by working harder?

And akin to this is the effect upon the general level of the profession. At present we recruit from a very good intellectual class. Men feel when they come to us that the system is elastic and that there is room for a good man to make his way. If you turn it into a rigid organisation where the power of individual effort is reduced to a minimum you will get recruits no doubt, but they will be as a rule of a much lower class of mind. There are, no doubt, exceptions. I have known one or two. But the other is the broad rule, and includes the vast majority of men.

So far I have argued the scheme upon its merits. But

in addition it is worth while to think of the practical difficulties of putting the scheme into practice. It would be a proposal nothing less than revolutionary, and, as far as I can gather, would be opposed by the great majority of the profession. The Insurance Act was difficult enough to pass, but this would be twice as difficult. The Insurance Act resulted in a much-needed and considerable increase in professional incomes, and it relieved doctors from slavery to the clubs. This change would offer no increase of income, and very small advantages of other kinds. The only grounds on which a Government would take it up would be a general desire for it on the part of the profession, and an obvious advantage to the public by improvement in practice. I think it would be resisted by us, and would not only not improve, but would greatly lower the standard of practice. It does not seem to me to be within the range of practical politics.

On the other hand, I anticipate a considerable increase in part-time appointments such as those now in existence, which will be not only a public advantage, but also will, I hope, provide some compensation to those who have lost their practice through military service.

None of the other statements contain anything more than a few additions and improvements of the present system. They suggest further provision of hospitals, and especially of scientific equipment and *personnel*, so as to bring their advantages within the reach of many more patients. They propose further that not only shall these be provided, but also the hospital staff, so far as they treat insured persons, shall be paid out of public funds. Sir B. Dawson wishes the hospital to be the centre of medical advance in the neighbourhood. Dr. Lauriston Shaw's article, though rather long, adds nothing fresh except a proposal for a National Medical Council.

In such proposals we should all concur. They are only aids to a process which has been going on all my life. Hospitals are increasing everywhere, and they are everywhere improving practice. Their staff is chosen, except in the great centres, where specialism has become necessary, from the local practitioners, and though those who are not on the staff do not attend the hospital for instruction, the staff brings its experience to the local meetings. There is no doubt whatever that in the last forty years medicine and surgery have improved not only in country hospitals, but also in private practice, quite as much as in the big centres. The public are infinitely better treated than they were. This has been the course of things—the natural course of things—under the present system. What sufficient ground is shown for turning it upside down? I am firmly opposed to any radical change because I believe it would be a disadvantage to the profession, and I am equally forcibly opposed to it because I am convinced it would be a disadvantage to the public.

In answer to your second question I think it is highly desirable that there should be a certain number of medical Members of Parliament.

It is important in the first place for the discussion of matters relating to public health. The Prime Minister said truly that you cannot make an A1 nation out of a C3 population. The aim of the Public Health service has always been to improve the very bad conditions under which many of our people live. We have had no one inside the House to support them except a few men who were members of the old parties, imbued with that party wisdom which is national foolishness. Our profession has had to speak as outsiders, and medical officers of health as servants. Improvements have been made, but much more remains to be done, and there are none who realise so well as doctors the extreme importance of the subject.

It is important also for individual practice. I have already discussed various schemes for this part of our work. If any legislation affecting practice is proposed, it is most important that it should be discussed in the House by medical men. No one can realise its probable effect upon the public but those who can understand its effect upon our own profession.

I foresee changes in the position of the hospitals and in many parts of medical education. It is most important that they should be discussed by medical members.

The improvement that has taken place in public health and individual practice has been the result of scientific discovery. This depends upon the provision of equipment and *personnel*. No one but ourselves can realise the immense importance of research in the advancement of both these sides of our work, and whether there be a Minister of Research or no, the knowledge that a medical M.P. can bring forward on this subject will be of great service.

Nor would this support be confined to medicine. All branches of science are akin, and though we are not chemists or physicists, we speak the same language and think in the same way. We know what research means to our own art, and therefore realise its necessity for all.

I will go further. We are a learned profession and a teaching profession. In a world of business and material interest the claims of learning and of teachers are of little account. I do not suppose that any class is so likely as ourselves to insist upon better education of all kinds and a better treatment of the teacher.

And that brings me to the last point, namely that medical members will be able to represent the just claims of our profession and state its grievances. One, the subordinate position of the Medical Adviser to public bodies, I have already mentioned. Another is the administration of the Insurance Act. These come to my mind at the moment, and, writing here in France, I have not by me the means of reference to others. A medical M.P. would not represent

medical men if he put professional before national interests. Our profession would be indignant if he did. But he certainly ought to make it his business to defend the former when the two do not clash. A profession gains no honour or influence by not pressing its claims. On the contrary, it is despised for its want of self-respect. I see that the Government asked the staffs of voluntary hospitals to undertake consultative service for military patients gratuitously. I wonder whether they would make such a proposal to lawyers!

And so with the whole of science. I hear that before the war Government offered 42s. a week for a qualified chemist,* and the present rate does not seem to be much above three guineas. That appears scandalous to us who know what a scientific training means, and it is suicidal if the nation needs chemistry. But I do not suppose anybody but people like ourselves would look upon it as other than natural, or think it of much importance.

You may ask perhaps, How should we work in the House? The Minister of Health will no doubt be the proper person to initiate legislation. I am not very hopeful about a National Medical Council, to include laymen, such as Dr. Lauriston Shaw suggests. It seems to me that a Medical Council or Advisory Board to assist the Minister would be better formed by medical men alone. That, if set up, will be his main reliance in preliminary stages. But the support of medical members will be of great assistance in the House and in committees, and they will also be of use in bringing necessary matters to notice by means of questions. I should hope that they would form themselves into a private committee, which would be in constant consultation with the various representative professional bodies, and would act as their spokesmen in the House. I do not believe that any layman can speak with half as much weight as one of ourselves on matters of public health, of practice, or of medical education, or can represent nearly so well the problems of a life which we alone have seen at first hand.

I am, Sir,

Your obedient Servant,

W. P. HERRINGHAM,

Major-General (tempy.),

*Consulting Physician to the Forces
in France.*

G.H.Q., France;

October 15th, 1918.

[* We take it that Sir Wilmot Herringham refers to an analytical chemist. Some few years ago we remember seeing an advertisement for qualified analytical chemists at Woolwich Arsenal. The candidates were required to possess the qualification of the Institute of Chemistry, and preferably should have had a university training. The salary offered was £100 per annum. Such a condition of affairs of course, is nothing short of monstrous.—Ed.]

MEDICAL NOTES.

By Sir THOMAS HORDER, M.D.

*(Continued from p. 5.)*MORBUS CORDIS *(continued)*.

(44) Aortic disease evolving in youth or adolescence is the result of acute endocarditis complicating rheumatic fever or scarlet fever; arising between twenty-five and forty it is generally due to syphilitic aortitis; coming on after the age of forty it generally signifies atheroma of the base of the aorta and of the aortic cusps.

(45) If the symptoms in a case of aortic regurgitation advance somewhat rapidly, without recurring rheumatism, and especially if they include anginoid attacks, the cause is probably syphilis, producing gummatous infiltration of the wall of the aorta. The recognition of the cause in these cases is of the greatest importance, because thorough treatment usually leads to good results.

(46) Embolism in morbus cordis occurs as a complication of two conditions—mitral stenosis and ulcerating endocarditis. It is uncommon in any other form of heart disease. The source of the embolus is different in the two diseases; in mitral stenosis it is the clot which forms in the left auricular appendix (*vide* § 38); in ulcerating endocarditis it is the vegetations which form upon the infected valves, or, less often, upon the mural endocardium. But the organs chiefly affected by the embolic process are the same in both cases—the spleen, kidneys, brain and extremities. And even the results of the process are not so dissimilar as is often thought, because the infarcts produced in the case of ulcerating endocarditis, though infective, rarely suppurate, the reason for this being that the pathogenicity of the streptococci, which are by far the most common micro-organisms in the disease, is very slight.

(47) Embolism may occur at a stage in the course of mitral stenosis when as yet there is very little deviation from the normal cardiac response to physical effort, and it may occur long before the onset of "auricular fibrillation." This fact should be remembered in considering the question of prognosis in this disease.

(48) When embolism in morbus cordis is cerebral in distribution, the most common result is right hemiplegia with aphasia: right hemiplegia because the embolus enters the left common carotid artery more often than the innominate, the former vessel arising from the top of the aortic arch; hemiplegia because the embolus comes to rest in the middle cerebral artery, the direct continuation of the internal carotid; with aphasia because the lesion is virtually a cortical one, the obstruction of the middle cerebral producing ischæmia of Broca's convolution followed by softening.

(49) Shortness of breath on moderate exertion is due either to anæmia, emphysema, myocardial inadequacy or mediastinal disease. The first and second of these causes are not difficult to determine. When they are absent it is probable that the breathlessness is due to changes in the heart-muscle. But if careful examination and inquiry reveal no other evidence of myocardial disease, care must be taken to exclude a mediastinal lesion by radiographic investigation before it is decided that the heart is responsible for the symptom.

(50) "The patient had a 'heart attack.'" When presented with this fact in a medical history it is of great importance to get the patient's analysis of his symptoms at the immediate onset, during, and immediately after, the attack. He should be encouraged to make the account as full as he pleases. If the patient expands her sensations over-much, and enlarges the zone of reference beyond the known limits of a cardiac response, this fact itself is of value in assessing the nature and the significance of the event. The interrogator should ask as few leading questions as possible, but after the patient's own account has been given some questions of a leading character will probably be necessary; the interrogator must be prepared to attach less weight to the answers given to these latter questions than he has done to the information spontaneously afforded. An effort should be made to collate the patient's experience in terms of *breathlessness, pain, loss of consciousness, exhaustion, palpitation, sweating, flushing*. But due regard must also be paid to other sensations, of nervous, vaso-motor and visceral origin, included by the patient in his general account. In assessing values to these sensations the intelligence of the patient should go for much, his imagination for very little.

The analysis of the "attack," conducted in this manner, will in most cases take the observer pretty far towards a decision as to its nature, whether *paroxysmal dyspnoea* ("cardiac asthma"), *syncope* ("a faint"), *angina, heart-block*, or simple *palpitation*. Two other types of heart attacks—*paroxysmal tachycardia* and "auricular flutter"—require actual observations at the time of their occurrence to determine their nature correctly. Needless to say, any one of the five types first mentioned may be impossible of differentiation without objective data gleaned by the observer at the time of the attack. These objective data include the *facies* (distress, pallor, cyanosis, sweating, flushing), the *posture* (orthopnoea, restlessness, immobility) the state of the *arterial and venous pulse*, and, in the case of auricular flutter, a *polygraphic tracing*.

(51) ". . . there is no sufficient evidence that a healthy heart is ever damaged by muscular exertion, however severe or prolonged that exertion may be. . . . Is it to be supposed that the organ (*i.e.* the normal heart) is so ill-protected that it is to be damaged by actions natural to man?" (Lewis). But surely it is in the qualification

expressed by the word "natural" that the explanation of cases of—to many quite critical observers—undoubted heart-strain lies. Can the excessive effort of the rowing-man and the track-racer, for example, be termed "natural"? And if it is not natural, then is it not unnecessary to explain the damaged heart in these cases, which all physicians of experience occasionally meet with, as "examples of heart-poisoning from foci of infection or of undetected structural heart disease."

(52) In treating a case of heart-failure the heart should not be conceived of as a whole, but rather as a series of chambers, in one of which the main trouble lies. Is it the left ventricle that is in difficulty? Or the left auricle? Or is it the right side of the heart? If the burden falls primarily or chiefly upon one of these rather than upon the others—and this fact is clearly recognised—the indications for treatment are more definitely established, and, therefore, response to treatment is more likely to be effectual.

(53) Angina pectoris is by no means always associated with high arterial tension and diffuse arteriosclerosis. What may not inappropriately be called the "asthenic" type of the disease is not at all uncommon. In this type the blood-pressure is often subnormal, the circulation is poor, peripheral venous stasis is common and a condition of asystole is present. The patients are usually over sixty years of age. Post-mortem, the heart is not enlarged, it may even be small and under weight, with the appearance termed "brown atrophy." Atheroma is usually present in one or more of the coronary arteries.

(54) Anginal pain is often induced by cold, and especially by walking against a cold wind. A patient suffering from aortitis will be able sometimes to walk briskly upstairs without discomfort, and yet will be unable to walk even slowly on the level, if faced by bleak air, without considerable pain.

FROIN'S SYNDROME.

By R. G. CANTI, M.B.(Cantab.).

TWO cases exhibiting Froin's syndrome have occurred recently and at the same time in the wards of this Hospital. This condition has not often been recorded, and as it seems probable that examples are not infrequently overlooked, I am taking the opportunity of giving a brief *résumé* of the subject together with short notes of the cases.

Froin's syndrome is not a disease *per se*, but a morbid state of the lumbar puncture fluid which may be found in several diseases when certain well-defined conditions are

fulfilled. The two chief characters which constitute it are the formation of a heavy coagulum and a yellow colour of varying intensity. The coagulum is such that frequently the test-tube may be turned upside down without spilling the contents. Thus, apart from the other characters presently to be described, observations may be carried out and interpreted by the bedside without the aid of laboratory apparatus.

The condition was first noticed by Lépine in 1903, and in the same year Froin collected several cases and drew attention to the syndrome, which has since been observed by a number of workers, including Mestrezat,* who gives an excellent account of it. The latter, up to the year 1912, had collected twenty-one cases, including those of Froin.

The conditions essential for the production of the syndrome are as follows:

There must be some lesion in or about the cord which blocks the subarachnoid space, so that the flow of cerebrospinal fluid is obstructed and stasis exists in the closed cavity below the lesion.

Further, there must be some changes in the walls of the blood-vessels of the meninges permitting passage of plasma and red blood-cells to take place into the closed cavity.

Appreciating, then, the kind of lesion that is necessary for the production of the syndrome, it is not difficult to draw up a list of diseases which might bring about these essential conditions, and such a list is actually found to correspond with one prepared from the clinical observations and autopsies of the cases recorded. The majority of them are found to have been caused by meningo-myelitis or chronic meningitis, and for these syphilis has been occasionally responsible, but more often, as usually happens with cases of this nature, the aetiology has remained obscure. Of the remainder, a new growth, either primary or secondary, situated in the cord or its surrounding structures, has proved to be the most important cause, and cases of Pott's disease and tuberculous meningitis have been described.

On examination of the cord the obstructive lesion is most often seen in the dorsal or lumbar region, but is not necessarily confined to this situation. The following alternatives, of which one or more may be present at the same time, have been recorded: The meninges may be bound down to the cord by fibrinous adhesions; the cord may be swollen and oedematous so as to fit tightly in the dural sheath as a finger in a glove; a mass of pus, shut off by adhesions from the remainder of the subarachnoid space, may surround the cord; an inflammatory exudate may lie in the extradural space and press upon the dura mater and its contents; a new growth may obstruct the subarachnoid space.

With regard to the blood-vessels, macroscopical examination usually reveals hyperæmia of the meninges with

* *Le liquide céphalo-rachidien*, Paris, 1912.

engorgement of the larger vessels. Even if this is not present to the naked eye, histological examination always discloses inflammatory processes with accompanying engorgement of capillaries and extravascular collection of their contents. In cases of neoplasm small hæmorrhages may take place directly into the cerebrospinal fluid from the vessels or blood-spaces of the growth.

More extensive examination of the cerebrospinal fluid reveals certain other characters, among which the quantity and quality of the protein are of importance.

The *tension* is variable. The *quantity* of fluid obtainable is generally small—often only a few drops—owing to the rapid fall of tension in the circumscribed subarachnoid space.

In *appearance* the fluid is usually clear or slightly turbid, this being dependent in some degree on the nature of the disease. The consistency is usually watery whilst the fluid is being collected, but clotting may take place so rapidly that the needle becomes plugged. Usually clotting begins in about ten minutes, but it is sometimes delayed for many hours. The typical clot is heavy and gelatinous, and, as previously stated, is sufficiently firm to withstand inversion of the containing tube.

The *colour* is golden-yellow, or sometimes brownish or greenish-yellow, and is due to pigments derived from the breaking-down of the hæmoglobin of the red blood-cells. It is usually sufficiently obvious to claim immediate attention, though occasionally it may only be detectable as a pale straw tinge when the fluid is viewed axially in the test-tube.

The total *protein* content is extremely high, being generally in the neighbourhood of 1 per cent., though more than 2 per cent. has been recorded several times. Globulin is always present, and may form as much as one-third or more of the total protein. Albumoses and peptone are present, and are due to the slow breaking down of the more highly organised proteins which have remained in the closed meningeal sac for a prolonged period.

The *reduction of Fehling's solution* varies in accordance with the disease. The test is frequently obscured by the biuret reaction.

There is usually a slight increase in the total *cell content*, and a differential count shows a preponderance of lymphocytes. Red blood-cells may also be present. Both kinds of cells may be found either normal in appearance, or in various stages of disintegration.

To sum up, the following characteristics of the cerebrospinal fluid constitute Froin's syndrome:

- (1) The formation of a heavy coagulum.
- (2) A yellow colour.
- (3) The presence of a large quantity of protein.
- (4) The presence of albumoses and peptone.

The conditions under which it may take place are:

(1) Obstruction to the flow of cerebrospinal fluid in the subarachnoid space by a lesion usually situated in the dorsal or lumbar region.

(2) Changes in the blood-vessels of the meninges.

The diseases in order of frequency in which these conditions may be met, and consequently in which Froin's syndrome may occur, are:

(1) Meningo-myelitis or chronic meningitis of various origins.

(2) New growths, primary or secondary, in or about the cord.

(3) Tuberculous meningitis.

(4) Pott's disease.

I have to thank Major Morley Fletcher and Capt. Girling Ball for their kindness in allowing me to quote the two following cases:

CASE I.—*Syphilitic meningo-myelitis*.—C. H.—, male, æt. 50, was admitted on July 25th, 1918, complaining of pains and weakness in the right leg, which had begun three months previously.

The patient was able to walk and looked fairly healthy. On examination of the nervous system the eyes were found to react to light and accommodation, and there was no ocular or facial paralysis. The triceps and supinator reflexes were brisk and the knee-jerks present, though difficult to elicit on the right side. Ankle clonus was absent, and neither extensor nor flexor response could be obtained on plantar stimulation. The abdominal reflexes were normal. Weakness was present in the hamstring muscles of the right side, and there was a wastage of 2 in. of the right thigh, the muscles of which gave weak normal electrical reactions. The sphincters were normal. The patient complained of pain at the back of the neck and of tingling in the left arm. There was diminished sensation to light touch on the inner sides of both thighs, and a lack of discrimination between heat and cold over the same areas. There was a loss of sense to the tuning-fork in the bones of the legs and pelvis.

The Wassermann reaction of the blood was positive. The patient remained in hospital for seven weeks, during which time he improved slightly under treatment.

Pathological examination of the cerebrospinal fluid, August 13th.—*Quantity obtained*: About 4 c.c. *Colour*: Faintly yellow. *Appearance*: Slightly turbid large spontaneous clot throughout. When examined twelve hours after withdrawal, the clot was just free from the walls of the test-tube, whose shape it retained. *Cells*: Total number not counted owing to the clot. A stained film showed almost all the cells to be lymphocytes, a few endothelial cells were present, and no polymorphonuclear cells seen. *Albumen* (Aufrecht): 0.8 per cent. *Globulin* (ammonium sulphate): Very marked ring. *Reduction of Fehling's solution*: Obscured by biuret reaction. *Wassermann reaction*: Strongly positive.

CASE 2.—*Tuberculous meningitis*.—W. T—, male, æt. 17½, was admitted on June 27th, 1918, with the diagnosis of tuberculous glands in the neck. An abscess in the neck was incised on two occasions, the last of which was on July 26th. Subsequently to this, though he was able to get up and go about the ward, he did not do well, and suffered at times with intense frontal and vertical headache, and pain in the back of the neck. On August 8th he became worse and was kept in bed. The fundus oculi was found to be normal. There was an internal squint of the left eye. The neck was stiff, but there was no retraction. There was paresis of both legs, which was more marked on the right side, where there was some loss of sensation to light touch, though pain could be felt. On August 13th he first became drowsy and tremulous, and later unconscious, rolling his head from side to side. On August 15th he was still unconscious and sinking, and exhibited aimless and tremulous movements. On August 16th he died.

Pathological examination of the cerebrospinal fluid, August 9th.—*Quantity obtained*: About 15 c.c. *Colour*: Faintly yellow. *Appearance*: Rather large clot present, which fell to the bottom of the test-tube. Supernatant fluid moderately turbid. *Cells*: Total number not counted owing to clot. A stained film showed the great majority to be lymphocytes. *Albumen* (Aufrecht): 1·3 per cent. *Globulin* (ammonium sulphate): Present. *Reduction of Fehling's solution*: Absent.

August 15th.—*Quantity obtained*: About 5 c.c. *Colour*: Golden-yellow. *Appearance*: Moderately turbid firm spontaneous clot throughout. The test-tube could be inverted. *Cells*: Total number not counted owing to clot. A stained film showed them to be practically all lymphocytes. *Albumen* (Aufrecht): 1·1 per cent. *Globulin* (ammonium sulphate): Very marked ring of granular appearance. *Reduction of Fehling's solution*: Obscured by biuret reaction.

Autopsy.—The lesions found were: Tuberculous meningitis, extensive pulmonary tuberculosis, tuberculous tonsils, early tuberculous ulceration of ileum, tuberculous cervical, mediastinal and mesenteric glands. The brain weighed 52 oz. Much slightly turbid watery fluid was seen beneath the membranes at the base. Numerous grey tubercles were present there and extended along the courses of the anterior and middle cerebral vessels and around the medulla to the roof of the fourth ventricle. The cerebral ventricles were slightly distended, and the choroid plexuses were injected but showed no obvious tubercles. The lesions in the cord were more marked than those in the brain. Over the cervical swelling the vessels were much engorged and stood out prominently. Here the membranes were hyperæmic, œdematous, and adherent posteriorly to the cord, so that stripping was carried out with difficulty. Obstruction appeared to be complete at this place. The greater part of the canal and surface of the cord were studded with

tubercles, which, though sparse in front of the cord, were confluent behind it. The corda equina was densely matted together and studded with tubercles.

A CASE OF INTUSSUSCEPTION OCCURRING AS A COMPLICATION OF TYPHOID FEVER.

By H. W. TOMS, M.R.C.S., L.R.C.P., and C. LANGTON HEWER, M.R.C.S., L.R.C.P.



E are indebted to Dr. Drysdale and Mr. Moreton for permission to publish details of this case.

The patient, Edith R—, æt. 24, was admitted to Hope Ward under the care of Dr. Drysdale on April 13th, 1918, complaining of headache and feverishness.

She stated that she had been quite well until April 3rd, ten days previous, when she began to have headache. The next day she was worse, had no appetite and felt feverish, and on the 5th she took to her bed. During this time she had no cough, epistaxis, or nausea, and she stated that the action of her bowels was quite normal. On the 7th she was seen by her doctor, who diagnosed enteric fever, and on the 13th she was admitted to this hospital.

On admission, patient looked pale, with cyanosed lips; her tongue on each side of the middle line was coated with a thick fur, and on examination of the trunk several small rose-spots were found on the thorax and abdomen. Nothing abnormal was discovered in the chest, and the abdomen was not noticeably distended or tender, but the spleen was palpated, extending 1½ in. below the costal margin in the left nipple line. No nervous manifestations were found, and cerebation was normal. Temperature 102·2° F., pulse 116, respirations 20. A white blood-count showed 11,000 white cells, and Dreyer's test a titre to *B. typhosus* of 1 in 500.

More rose-spots appeared from time to time, and on the 18th patient became gradually more drowsy and toxæmic, had several attacks of epistaxis, and developed a cough. The temperature was not very typical, the fever being rather of the remittent type. Since admission constipation had been marked.

On the 23rd patient was very drowsy, and the abdomen was a little full. The liver dulness, however, was normal. On the 25th, 26th, and 27th she vomited, and the pulse-rate increased in frequency; but on the 29th she was much better, constipation was less marked, and the temperature began to come down slowly. During the next fortnight patient continued to improve, and, with the exception of a little peripheral neuritis, developed no new symptoms. On the 16th, however, her temperature began to rise, one fresh rose-spot was discovered, and constipation returned. On the evening

of the 19th the temperature dropped from 101° to 97.8° F., there was some vomiting, and the patient complained of vague pain in the abdomen. The pulse-rate, however, was lightly decreased, distension was not more marked, and the liver dulness was normal. The abdomen moved well on respiration.

On the afternoon of the next day, the 20th, the pulse-rate rose from 120 to 140, the temperature remaining about the same, and the pain became more localised to the right iliac fossa, and more of the nature of colic. Three small stools were passed, but contained no blood. Vomiting continued, and it was decided that a leucocyte count should be taken. This showed 13,400 white cells—a moderate leucocytosis, which could not be taken as any definite evidence of perforation, as a typical leucopenia had never been present. Surgical opinion was in complete agreement that laparotomy was not indicated. At mid-day of the 21st pain was obviously increasing in intensity, and as it was thought likely that the patient had a leaking ulcer with some localised peritonitis, Mr. Moreton was asked to explore the abdomen.

This he did at 3.45 p.m. An incision, 4 in. in length, was made through the right rectus muscle. On opening the peritoneal cavity a fair quantity of straw-coloured and faintly blood-stained fluid escaped. No gas was present, however. On exploration an intussusception, enteric, becoming entero-colic, was discovered. The neck appeared to be about 5 in. from the ileo-cæcal valve, and extending 4 in. up the ascending colon. The cæcum was not involved, but was distended with gas.

Reduction was effected without great difficulty and the gut inspected. It was stiff with œdema, and the apex was congested, but it appeared viable. On palpation no apparent cause for the intussusception could be found. The gut was therefore returned to the abdominal cavity, and the wound closed in layers without drainage.

The patient was taken to Lawrence Ward, and, with the exception of some anæsthetic vomiting, passed a good night. The following morning an enema was given, with fair result. This was repeated in the evening. The patient passed flatus, and stated that she was quite relieved from the pain prior to operation. The temperature in the evening rose to 101.4° F. Albumen water, whey and brandy were given by mouth. The temperature remained irregular, and on the 25th rose to 103° F. She improved considerably, however, in the next few days, and her bowels acted well. On the 30th she had slight epistaxis and bleeding from the gums. Hæmorrhagic spots also appeared on the chest and back. The stitches were removed, and the wound looked perfectly healthy.

She was re-transferred to Hope Ward on the same day with a temperature about 100° F., and still very toxæmic. She improved slowly, her temperature came down, and on June 8th she felt "hungry." Her condition became steadily

better, but unfortunately she developed the carrying habit, which considerably prolonged her stay in hospital.

The above case, we think, is interesting both on account of the rarity of the complication—we have only been able to find one other such case on record—and the difficulties attendant upon its diagnosis.

THORACOTOMY AND COMPLETE SUTURE.

By J. E. A. BOUCAUD, M.R.C.S., L.R.C.P.

TH recent years, many papers illustrating the good results of modern surgery of the chest have been published in medical journals. These dealt with war wounds of the chest and their complication and treatment, as carried out in France, and the possibilities of the application of the same methods in civilian practice. As most cases of gunshot wounds of the chest require immediate treatment, surgeons in England have to their credit only a small proportion of the total number of such cases. Many cases have been admitted to the Military Wing of St. Bartholomew's Hospital, but one which with the kind permission of Capt. Girling Ball I am able to record below is of special interest, it being the first case in which thoracotomy with complete suture was performed at this Hospital.


The patient æt. 30, a corporal of the Canadian Infantry, was wounded on August 8th, 1918, had slight hæmoptysis for four days and some dyspnoea and pain in his left side. He was admitted to the Military Wing of St. Bartholomew's Hospital on August 18th with a small superficial wound just below the inferior angle of the left scapula; he complained of pain in his side on breathing, and shortness of breath; there were signs of fluid at the left base. X-ray examination showed the presence of a hæmothorax, fracture of the seventh rib, and a shrapnel ball, the position of which altered when the patient moved.

The treatment consisted in (1) excision of the entry wound, which was sutured, and healed by first intention; (2) resection of 3 in. of the seventh rib in mid-axillary line, evacuation of the blood, removal of the shrapnel ball, and irrigation of the pleural cavity with water, and finally complete and careful suture of the wound in layers.

The fluid removed was examined bacteriologically and found sterile. But for a great deal of surgical emphysema the patient made a straightforward recovery, the wound healing by primary union.

Early in October there was still flattening of the chest on the left side but fair expansion, and the breath-sounds were feebler than on the right side. He was put on graduated exercise but his reaction was poor; his general condition is such as to warrant the most sanguine expectations after further exercise treatment.

HOSPITAL STAFF IN WAR TIME.

1.  HIS tragic never-ending fight
Has made us callous creatures quite,
Nor weep we longer at the sight
of anguish ;
The vasty numbers of the slain
Have dulled the feelings of the brain
For those who lie in deadly pain,
or languish.
2. We've grown so very cold of late,
We'll leave a baby to its fate
Whose heart has slowed its anti-natural
rhythm ;
Our condescension will not stoop
To treat an infant with the coup
Unless he's brought his little coup-
on with 'im !
3. We rise to join the Junior Staff ;
And then we surely have the laugh,
For see those patients in yon draugh-
ty passage !
We keep them waiting in a bunch
While we have breakfast, tea or lunch,
Maybe we'll tend them in the Röntg-
en gas age.
4. And when we toddle to the War
We shed no liquid teardrops for
A shrapnel-wound, a gassing, or
"a piff-rent,"*
Each man is but a case, you see,
With whom a purge must needs agree—
Unless that wounded man is me—
That's diff'rent.

D. W. W.

CORRESPONDENCE.

MEDICINE VERSUS SURGERY.

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

SIR,—Through your columns I really must thank Major Rawling for again contributing "much amusement" to my "leisure hours"; his reply to my letter is too delightful. Major Rawling, I know, is a fisherman. In his letter he tells us that he is a sportsman; he knows therefore how pleasant and satisfying it is to see his fish rise and take the bait so carefully selected and temptingly displayed. Ten days past the Somme has been far behind my back and only small frogs are to be found in the water of the shell-holes. Nevertheless, sir, that pleasant satisfaction has been mine.

* "Piff-rent": a rent caused by rifle bullet.

I can well believe that the debate was replete with humour; did I not say that it gave me much amusement to read even the "merest abstract" thereof? How could it be otherwise when the proposer of the motion was not in agreement with its terms, and when, therefore, he spoke contrary to his convictions for fear that the Secretary of the Society might call his sporting instincts into question? Why deny me the humour of the scene? Scenes from *Alice in Wonderland* spring to mind.

I might take up all the points raised by Major Rawling in his letter, and further support my view in the cause of medicine (and I see that the *Lancet* also takes my view), but as he assures me he has no "leisure in which to criticise other men's statements and works," I will not tempt him to contradict himself again on this statement and criticise once more my statements in a very lengthy letter to your valuable JOURNAL!

Were it not for the humour of the situation and the great amusement Major Rawling has given me, I should be inclined to reply to the gibes and sneers levelled by him at my professional ability and judgment; this sort of thing from one whom one respects as a man and as a surgeon are calculated to hurt and do harm.

As to Major Rawling's remarks about "luxury and ease" and "leisure hours" out here, this merely makes one smile and clinches one's contention that he is quite ignorant, not only of surgical and medical affairs in the front area, but also of all other affairs there.

In conclusion, sir, I would invite Major Rawling's mind to dwell on this before repeating such statements.

With apologies, Sir, for thus trespassing on your space.

I am, Sir, etc.,

GERALD STANLEY,
Major, R.A.M.C.

B.E.F.;

October 14th, 1918.

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

SIR,—The reply of Major Rawling to Major Stanley's letter concerning the debate upon "Medicine versus Surgery" at the meeting of the Abernethian Society indicates throughout that Major Rawling was "stung," for anger is the prominent feature of his contribution. The angry man is generally unconvincing, and the perusal of Major Rawling's letter led many who read it to the opinion that he had "given himself away." He derides the opinion of his opponent, and in a loud voice declares the priority of claim of the surgeon specialist. The very same attitude is being adopted by some with regard to the proposed State Medical Service, and at a time when unselfishness is proved to be the very essence of patriotism. Was not Major Stanley's letter to be interpreted as the chivalrous attempt of a gentleman to defend the person unfairly attacked? "Methinks" Major Rawling "doth protest too much." His impassioned rhetoric does not lead us into a fallacious train of thought.

One has often noticed in this country that the Tommy, finding that the native fails to appreciate his French, raises the pitch and volume of his voice. Abuse is no argument, and if Major Rawling wishes to enter into a controversy many further points might be adduced to show him that he is quite wrong in adopting this attitude. Further, I would like to tell Major Rawling that it is evident that he has the most meagre knowledge of the work of C.C.S.'s in France, and that in the opinion of his colleagues Major Stanley is a surgeon of unexceptionable skill and indubitable ethics.

Yours faithfully,

C. W. T. BALDWIN,
Major, R.A.M.C.T.

CASUALTY CLEARING STATION, B.E.F.;

October 9th, 1918.

REVIEWS.

ANATOMY, DESCRIPTIVE AND APPLIED. By HENRY GRAY. Twentieth Edition. Edited by RICHARD HOWDEN. (Longmans, Green & Co) Pp. 1324. Price 37s. 6d. net.

It says much for any work that, although the first edition appeared as far back as 1858, it should still rank as a standard book on that particular subject. Gray's *Anatomy* has, of course, undergone many changes since it was first published. The first edition covered 750 pages, while the present volume has increased to nearly double that

size. Prof. Howden has been associated with the editorship since 1901, and the present volume is probably as good as any work on Anatomy in the English language.

We feel it our duty to have again to deplore the fact that preference is given to the Basle terminology, although in all fairness it should be stated that where a new name differs materially from an old one the latter is placed within brackets after the former. But this does not alter the fact that throughout the volume the recognised terminology is the "new"—a condition of affairs which is all the more remarkable in view of the recent decision of the Anatomical Society to abandon the Basle nomenclature, which they regard as a totally unnecessary change.

Not the least interesting part of the present edition is a biographical sketch, with photograph, of Henry Gray, F.R.S., F.R.C.S. At the early age of 25 he was elected a Fellow of the Royal Society, and was only 34 years of age when he died.

We should perhaps state that the notes on applied anatomy in the present edition have been revised by A. J. Jex-Blake and W. Fedden Fedden, and there are, at least, 60 new illustrations.

A MANUAL OF PHYSICS FOR STUDENTS OF MEDICINE. By HUGH C. H. CANDY. (Cassell & Co., Ltd.) Pp. 451. Price 7s. 6d. net.

This is a text-book which we have every confidence in recommending to the student. It is concisely and clearly written, the author taking great pains to make his meaning clear in as few words as possible, and yet at the same time neglecting nothing which would be of help from an examination point of view. Its handy size enables it to be slipped into the pocket—an innovation which other publishers might well copy. We congratulate the author upon being modern enough to introduce an aeroplane by the way of illustration, but we express lack of confidence in its flying ability. Also we hesitate to accept the statement that the movements of camphor floating upon warm water are due to its partial solution.

THE ERRORS OF ACCOMMODATION AND REFRACTION OF THE EYE. By ERNEST CLARKE. (Baillière, Tindall & Cox.) Pp. 243. Price 6s. net.

The fourth edition of this well-known work does not materially differ from the last edition. The book is mainly intended for students and is essentially practical, all unnecessary details being rigorously excluded.

Some ninety-two illustrations are included in the text, and the book has been thoroughly revised and brought up to date.

We regard the volume as quite one of the most readable and practical of the many books available on this important subject, which, for some reason or other, appears to be out of favour with the average student.

AIDS TO DIAGNOSIS. By ARTHUR WHITING. (Baillière, Tindall & Cox.) Pp. 167. Price 3s. 6d. net.

The basis of this useful little book is essentially clinical and not pathological. As pointed out in the preface, the plan has been to start with the leading symptom or symptoms, and, after arranging the diseases presenting these symptoms in groups, to differentiate the members of each group, so far as possible, as clinical entities.

The result is a collection of extremely useful data, although, as the author points out, the power of diagnosis is largely a matter of practice.

The section on "The Differential Diagnosis of Infectious Fevers," by Dr. Henry Cuff, still remains one of the best chapters in the book.

In the light of recent work, the chapter dealing with "Diseases of the Heart" has been considerably revised.

We can recommend the book with every confidence to the student, who often finds it so difficult to piece together all the evidence which goes to make an accurate diagnosis.

APPOINTMENT.

ROBERTS, Surgeon W. E., R.A.N., made Acting Staff-Surgeon, Aug. 27th, and appointed to H.M.A.S. "Brisbane" from H.M.A.S. "Tingira."

CHANGES OF ADDRESS.

- BOUSFIELD, P., 7, Harley Street, W. 1.
 MAPLES, E. E., "The Warrens," Calabar, Southern Provinces, Nigeria.
 SAMY, A. H., 16, Naser Street, Abbassieh, Cairo, Egypt.
 SHIRLEY-JONES, E., Royal Societies Club, St. James's Street, S.W. 1.
 STOCKER, Major E. G., R.A.M.C.T., O. i/c Medical Division, Military Hospital, Sutton Veny, Wilts.
 TAUNTON, T. J., 102, Lansdowne Road, Clapham, S.W.
 WILLIAMS, C. O. O., St. Albans, Shakespeare Road, Worthing. (Temporary address.)

BIRTHS.

- ILOTT.—On October 16th, at Seaton, Devon, the wife of Capt. Cyril H. T. Ilott, R.A.M.C., of Bromley, Kent, of a daughter.
 LAWRENCE.—On October 1st, at Kenley, Gravesend, to Margaret (née Cleghorn), the wife of Stephen M. Lawrence, M.D., B.S.—a daughter (Sarah Hilary).
 PETERS.—On September 7th, at 24, High Street, Petersfield, to Frances Williamina (née Vérel), wife of Capt. Rudolph A. Peters, M.C., R.A.M.C.—the gift of a son.
 PRITCHARD.—On September 19th, at 33, Harley Street, W., the wife of Major H. Pritchard—a daughter.
 RAMSAY.—On September 14th, at Eldon Place, Blackburn, the wife of Capt. J. Ramsay, R.A.M.C.(T.), of a daughter.
 STRAHAN.—On August 30th, at Hong Kong, the wife of Stuart Séguin Strahan, M.B., of a son.

MARRIAGE.

- HAMILL—ZEHETMAYR.—On Thursday, October 24th, at St. Bridget's Church, Isleworth, by Rev. Fr. Green, Philip Hamill, M.D., D.Sc., M.R.C.P., Major, R.A.M.C., younger son of the late Philip Hamill and of Mrs. Hamill, of 5, Avonmore Mansions, Kensington, to Louisa Maude, second daughter of the late F. F. Zehetmayr and of Mrs. Zehetmayr, of Belle Vue, Ailsa Road, St. Margaret's.

DEATHS.

- CARLYLE.—On October 21st, 1918, at St. Bartholomew's Hospital, from pneumonia, Thomas Carlyle, Surgeon Probationer, R.N.V.R., only son of Lieut.-Col. and Mrs. Carlyle, aged 24.
 COWPER.—On October 3rd, 1918, of wounds, Capt. Geoffrey Moore Cowper, R.A.M.C., late 35th Field Ambulance, son of Mrs. Cowper, 67, Duke Street, Darlington.
 CUNNINGTON.—Killed by the explosion of a bomb in an advanced dressing station on March 23rd, 1918, Edward Charles Cunnington, only son of Capt. B. Howard Cunnington, of Devizes.
 DANDRIDGE.—On October 5th, 1918, of wounds received in action, Lieut. W. Leslie Dandridge, R.A.M.C., attached to the 103rd Field Ambulance, the dearly loved and youngest son of Mr. Alfred Dandridge, Brooksleigh, Albemarle Road, Beckenham, Kent, aged 24.
 GLENNY.—On October 9th, 1918, of pneumonia, on active service, Lieut. E. H. Glenny, R.A.M.C.
 HAMILTON.—On September 16th, 1918, suddenly at Heathfield, Heswall, Robert J. Hamilton, F.R.C.S.E., of 82, Rodney Street, Liverpool.
 HOBDAV.—On September 29th, 1918, at Llandudno, James Hobday, B.A.(Cantab.), M.R.C.S., L.R.C.P., beloved husband of Nancy Hobday, aged 47.

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.

becomes Matthew, and the Ophthalmic Ward is known as Albert Edward. The whole of this block, with the exception of Casualty, is now given over to the military.

* * *

The following gentlemen were nominated to the Resident Staff, commencing November 1st, 1918:

House-Physicians—

Dr. Tooth.	G. J. Sophianopoulos.
Dr. Calvert.	R. J. Perkins.
Dr. Fletcher.	G. Lyon-Smith.
Dr. Drysdale.	G. A. Fisher.

House-Surgeons—

Mr. D'Arcy Power.	M. V. Boucaud.
Mr. Waring.	G. Millar.
Mr. Eccles.	R. D. Jones.

Medical Receiving Officers

W. L. Berry.
H. J. Pollard.
H. Franklin.

Surgical Receiving Officers

H. Corsi.
D. P. Guilfoyle.

Intern Midwifery Assistant

J. A. van Heerden.

Extern Midwifery Assistant

C. F. Krige.

House-Surgeon to Throat, Nose, and Ear Department

F. T. Birkitt.

House-Surgeon to Ophthalmic Dept.

N. J. Macdonald.

House-Surgeon to Venereal Dept.

C. W. Bennett.

House-Surgeon to Military Wing

J. E. A. Boucaud.

Resident Anæsthetist

D. A. Blount.

* * *

The influenza epidemic has meant an exceedingly busy time for the Hospital staff, and the number of out-patients treated has been unprecedented. Many members of the Hospital have themselves been victims of the disease, no less than twelve of the Junior Staff being down at one time. These, we are glad to state, are convalescent again, but it is with very great regret that we have to report the death of two well-known and popular students, who had both only recently resumed their medical studies after some years of absence with His Majesty's Forces. Surgeon Sub-Lieut. T. Carlyle and J. L. Dunstan both succumbed in Hospital to pneumonia following influenza.

A Memorial Service was held in the Hospital Church on each occasion. It is hardly necessary to state that their death cast quite a gloom over the Hospital.

* * *

We regret to have to record the death of Dr. C. A. Patten, who for more than fifty years was Medical Officer of Health for Ealing. After study at this Hospital, Dr. Patten qualified M.R.C.S.Eng. in 1861. Deceased had held many appointments, and was Honorary Consulting Medical Officer at the King Edward VII Memorial Hospital, Ealing. He had also been Divisional Police Surgeon. Dr. Patten was seventy-nine years of age.

* * *

ROLL OF HONOUR.

It is with feelings of very great regret that we have to report the death of several more Bart.'s men under this

heading. Again we beg to offer our deepest sympathy to their relations and many friends.

Capt. R. Brewitt-Taylor, M.C., R.A.M.C., was killed in France by a shell on August 22nd when he was on his way to the front line with his stretcher-bearers. Capt. Brewitt-Taylor left England for France in August, 1914. He served as Regimental M.O. through 1915, was in Mesopotamia in 1916, and in France again during 1917-18. At the time of his death he was attached to the 7th Field Ambulance.

Surgeon Sub-Lieut. T. Carlyle, R.N.V.R., died of pneumonia in St. Bartholomew's Hospital on October 21st, aged 24. The only son of Lieut.-Col. Carlyle, he entered the Hospital in October, 1913. He volunteered as a Probationary Surgeon two years ago, and only returned to Hospital at the beginning of this session.

Capt. James Harris Connolly, R.A.M.C., died at the Acheson Military Hospital, Regent's Park, London, on October 23rd, aged 42. He was educated at Edinburgh University, where he graduated M.B. and B.C. in 1902, and M.D. with commendation in 1906; and also studied at King's College Hospital, London, at St. Bartholomew's, and at the London and Middlesex Hospitals. After filling the posts of House-Surgeon to the Royal Albert Hospital, Devonport, of Senior House-Surgeon to the Chesterfield and North Derbyshire Hospital, and of Resident Medical Officer to the Throat Hospital, Golden Square, London, he went into special practice in London, and held the appointments of Chief Assistant in the Aural Department at St. Bartholomew's and of Surgeon-in-Charge of the Throat, Nose and Ear Department at the Queen's Hospital for Children. He took a temporary commission as Lieutenant in the R.A.M.C. on October 10th, 1914, and was promoted to Captain after a year's service.

Surgeon Lieut.-Commander John Hadwen, R.N., was reported as having died on service in the casualty list published on November 2nd. He was educated at St. Bartholomew's Hospital, and took the diplomas of M.R.C.S. and L.R.C.P.Lond. in 1907. He graduated B.Sc.Lond. in 1905, and M.B., B.S. in 1907. He entered the Navy as Surgeon on May 14th, 1909, and in the early part of the war was serving in H.M.S. "King Edward VII."

Capt. Walter Malden, R.A.M.C.(T.F.) died at Cambridge on October 28th, aged 60. He was educated at Cambridge, where he graduated M.A. in 1885, M.B. in 1886, and M.D. in 1905, and at St. Bartholomew's Hospital, taking the diplomas of M.R.C.S. in 1886 and the M.R.C.P.Lond. in 1909. He held the posts of Clinical Pathologist and Director of the Clinical Laboratory at Addenbrooke's Hospital, Cambridge, and was Honorary Medical Officer of the Charity Organisation Society and of the Cambridge Rescue and Prevention Society. He took a commission as Captain in the R.A.M.C.(T.F.) on the staff of the 1st Eastern (Cambridge) General Hospital on May 6th, 1908, and was Pathologist to that hospital.

STATE MEDICAL SERVICE.

The views of Sir Wilmot Herringham on this all-important question have been the subject of much interest. The following letter from a well-known Bart.'s man, who, however, wishes to remain anonymous, will be read with equal interest, especially as the writer takes the opposite view to Sir Wilmot, and is all in favour of some form of State Medical Service:

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

DEAR SIR,—I venture to forward to you some reflections which have been gradually shaping themselves in my mind, and, I doubt not, in the minds of many other medical men now serving with the R.A.M.C. in France. The singular smoothness and, on the whole, great efficiency with which the machine works, both on its administrative and its more purely professional side, naturally lead to the question whether such a service as now exists for the benefit of the Army should not be extended after the war for the benefit of the nation. I do not think I am exaggerating if I say that not a few medical men who would have unhesitatingly rejected the idea four years ago as either impracticable or as undesirable have become less contemptuous, and even strong advocates, of such a change owing to their experience of the advantages of a great organisation such as the R.A.M.C. Of course the problems faced and solved by the R.A.M.C. in France are infinitely smaller and less complicated than those which would confront the organisers of a national service scheme; yet if the whole question be faced boldly and without too great a deference for tradition and usage the problems are not, I think, unsolvable. Certainly practical experience in the R.A.M.C. is sufficient to convince most men that it is possible to handle efficiently and quickly the diseases and injuries of two, three, or four million individuals; and if for such a number, why not for a whole population of forty millions?

But taking a further point, such a service may be possible, but is it desirable—(a) for the patient, (β) for the profession, (γ) for the general advance of medical knowledge? Speaking for myself and for, I believe, the majority of men who have served with the R.A.M.C. in France, I have not the least doubt as to the answer to the first of these questions. The ready access to specialist opinion, even for the more trifling ailments, and the concentration of skilled surgery at important centres, and the rapidity and ease of transport are advantages which are not, under our present system, available for the bulk of the civil population. But perhaps the most willing admiration is given by medical men to the system of convalescent camps, which serve to bring back to full efficiency the soldier incapacitated by injury or disease. With all our resources at home we have never approached the Army results, though the methods are well within our reach. I would not deny, however, that there are obvious disadvantages to the individual patient in the development of routine methods of dealing with all

cases of injury or disease, nor maintain that a national service would necessarily be entirely without reproach. "Official methods" is a sneer which, though often undeserved, yet has sufficient truth in it to cause some degree of trepidation to the advocate of an extension of a "service" to the needs of a nation. Yet the balance, in my own judgment, inclines to such a service.

The advantage to the medical profession as a whole is more dubious. I have heard much *pro* and *con* argument, and at present, with Omar, have "come out by the same door wherein I went"—that is, I am at a loss; with a tendency, however, to believe that the inevitable levelling-up which takes place in a covenanted service would be a disadvantage without some safeguards, which could, I think, be devised. There is the encouraging fact that the level in such a service as for example the Indian Civil Service is, and is maintained high; and the maintenance of this high level depends, among other reasons, upon a scale of rewards and honours sufficient to attract the right type of men. If our National Medical Service is to reach and maintain a similar high level of efficiency the rewards and honours must be sufficient to attract able and industrious men, and there must be such opportunities of securing promotion, and such provision for removing the incompetent or the idle, as will serve to keep the whole *personnel* contented, and in good reputation with themselves and the rest of the nation.

On the financial side I may say in parenthesis that the terms suggested in a pamphlet suggested by the Medico-Political Union are ludicrously inadequate. Such inducements to enter a National Medical Service would serve to attract only the "duds" of the profession.

The ideal which I have at least partially shaped is of a service which should include the whole medical profession, men and women, the R.A.M.C., the Naval Medical Service, the Colonial, the Prison, and all other medical services; that qualification in the profession would mean the entering into the service of the nation, and the devotion of one's life-time to that service. The private practitioner would disappear; the medical man would be as much the servant of his country as the soldier, the sailor, or the civil servant.

Lastly—and to my mind this is a potent argument in favour of such a service—the gain to medical knowledge enabled by the power to direct and endow research would be enormous. No one who has followed the achievements of such bodies of medical men as those controlled by the Home Office, in recent years, or by the Medical Research Committee in the present war, can have any doubt upon this point.

These reflections are crude, and immature, but they may serve, Sir, to stimulate some of your readers to consider the problems involved, and to deal in print with the difficulties they meet. My own mind has not yet reached a clear conception either of what is necessary, or of methods,

but I hope that I may later return to the subject, and sketch in greater detail the essential features of a National Medical Service.

Yours sincerely,


B.E.F.

Major, R.A.M.C.T.

SURGICAL APHORISMS.

By D'ARCY POWER, F.R.C.S.(Eng.).

*"Till old experience doth attain
To something like prophetic strain."*
Milton—"Il Penseroso."

(1) IR GEORGE HUMPHRY crystallised the rules for the examination of surgical patients in the words, "*Eyes first and much; hands next and least; tongue not at all.*" It is useless to begin by asking about the family history in a case of acute intestinal perforation, yet many do so.

(2) In appendicitis trust to the physical signs rather than to the symptoms. Local tenderness remains when the appendix has perforated or is gangrenous, even though there be no abdominal tension. Many have died because the surgeon has trusted the pulse and the temperature when he ought to have examined the abdomen.

(3) In appendicitis the most sure way to convert a mild into a severe attack is to give aperients and mask the pain with morphia. In these cases, if the bowels must be opened, administer an enema; if pain is to be deadened give aspirin.

(4) Remember the pithy French saying, "*There should be no third day in appendicitis.*" On that day the patient is either on the high road to recovery or his appendix has been removed.

(5) In appendicitis beginning suddenly there is a rise of temperature; in acute perforation of the stomach or duodenum the temperature falls.

(6) In London a patient with acute perforation of the stomach or duodenum rarely walks to a hospital. He is so ill that he seeks advice instantly, and will either call for an ambulance or will take a cab without counting the cost.

(7) In acute perforation the patient lies still fearing to breathe; in gall-stone colic he rolls about with pain.

(8) Acute duodenal perforation may occur without any previous history of indigestion.

(9) In acute perforation there may be an entire absence of abdominal rigidity when the patient is first seen, but there is always local tenderness at some point above the umbilicus.

(10) In acute gastric and duodenal perforation there is a point of maximum tenderness over the seat of perforation, and there may be a tender spot in the right iliac region. The patient refers his pain to this spot, and is often operated upon therefore for appendicitis.

(11) In acute perforation the pulse, temperature and general condition improve as the shock passes off, and more quickly in duodenal than in gastric perforation. Be not deceived. Operate at once. Intestinal paresis will surely occur, the abdomen will swell, and the time for successful operation is then well nigh past.

(12) Remember that the contents of the stomach and duodenum are sterile, and that after rupture of these organs the contents soon trickle into the iliac fossæ. Drain the fossæ and remove the drainage-tubes within forty-eight hours, for they will then have done their work.

(13) Influenzal peritonitis *does* sometimes occur, but so rarely that the more usual causes of obstruction should be rigorously excluded before a diagnosis is made and an expectant treatment adopted.

(14) Many conditions of the gall-bladder produce the symptoms of biliary colic besides gall-stones. It is unwise, therefore, to tell a patient before an operation that he has gall-stones. It is safer to say that his gall-bladder is inflamed or that he has cholecystitis.

(15) Patients with intra-peritoneal secondary hæmorrhage occurring after abdominal operations when the external wound has healed are usually found to give a positive Wassermann reaction.

(16) Persistent pain and sleeplessness are of extremely bad import after an operation for acute suppurative peritonitis.

(17) Want of confidence and the use of too small a catheter are the common causes of failure to relieve the retention of urine due to senile hypertrophy of the prostate. In these patients the catheter must be pushed well home or the bladder will not be reached; as there is no stricture, a full-sized catheter is passed more easily than a smaller one.

(18) The incidence of syphilis often falls upon a single group of tissues, the rest of the body remaining comparatively healthy. Such incidence often depends upon unusual strain or use of the affected tissue, as is seen in the aneurysm of athletes.

(19) The French say that "*Tubercle is often born on the bed made by syphilis.*"

(20) Gummatous synovitis closely resembles tuberculous inflammation. In gummatous synovitis the articular carti-

lage is usually unaffected, and there is consequently less pain and a more useful joint.

(21) Every chronic inflammation of bone and of the vertebræ is not tuberculous.

(22) Acute osteomyelitis is still diagnosed too often as acute rheumatism. Examination of the affected part in acute osteomyelitis shows that the seat of pain is at the epiphysial line, the joint in the earliest stage being as yet unaffected.

(23) Operate in osteomyelitis before pus is formed, and tell the friends of the patient why you do so, or they may say that you operated unnecessarily.

MEDICAL NOTES.

By Sir THOMAS HORDER, M.D.

(Continued from p. 15.)

ON PULMONARY TUBERCULOSIS.

(55) Certain physiological differences between the two sides of the healthy chest, when it is subjected to physical examination, are frequent sources of error in the diagnosis of phthisis. These differences, which are found especially in young patients, in females, and in those in whom the chest-wall is thinly covered, are these: Expansion and percussion resonance are relatively deficient over the upper lobe of the right lung, and in the same situation the breath-sounds may be bronchial in quality. It is this last sign, in particular, which so often leads to error, and it is not at all uncommon to find a diagnosis of phthisis based almost entirely upon it. It follows, from the facts above stated, that less significance should be attached to any of these three signs when present on the right than when present on the left side. The explanation of these physiological differences is doubtful, but it is probable that the chief factor in their causation is the relatively higher level at which the right bronchus lies as compared with the left.

(56) In a well-established case of phthisis the lesion is much more often bilateral than the physical signs lead one to suppose. This is due to the fact that in physical examination of the chest the less affected side is taken as the standard wherewith to compare the side on which the disease-process is more advanced.

(57) Just as the lesions in phthisis may be regarded as being, in most cases, more extensive than the physical signs suggest, so the time that the lesions have been present may be regarded as being, in most cases, longer than the history indicates.

(58) Skiagrams in cases of suspected phthisis must always be interpreted in conjunction with the clinical features. Events prove pretty conclusively that many of the cases of

so-called hilus-phthisis are really due to old (arrested) glandular disease. And what is true of shadows at or near the root of the lung is equally true of shadows about the bronchial tubes and near the diaphragm; their significance cannot be properly judged apart from general considerations. Beneficial though it may be in all these cases to treat the patient as though he were the subject of active tuberculosis—and there are few of us whose health does not benefit from abundance of fresh air, rest and good food—the good results of treatment by no means prove the diagnosis of active disease to have been correct.

(59) When examination of the chest reveals the signs of bronchial catarrh, any or all of the following features should raise a suspicion of phthisis. (i) The signs are largely or entirely unilateral; (ii) the signs are more marked at the apex than at the base; (iii) the *râle* has the consonating quality, indicating that it is produced near to solid lung or in a cavity; and (iv) the constitutional symptoms (fever, sweating, anæmia, loss of weight and strength) are disproportionate to the amount of the catarrh, and are more marked than is usual in simple bronchitis. The final court of appeal must always be the search for tubercle bacilli in the sputa: three successive negative examinations of material *which is properly chosen* may be considered to exclude phthisis.

(60) It is not common to find the "physical signs of phthisical cavity" of which some authors speak—hyper-resonant percussion note and cavernous breathing. Nor is this surprising, because it is reasonable to suppose that the fibrosed lung and thickened pleura which generally cover a phthisical cavity lead to deficient, rather than to increased, percussion tone; and seeing that the cavity is by no means empty, there is no special reason why the breath-sounds should be cavernous. But in point of fact cavity is diagnosed more by the knowledge that the disease is advanced and that the sputa are purulent and abundant than from special signs. Yet if amphoric breathing and bell sound are present, and if pneumothorax can be excluded, cavity may be diagnosed with confidence.

(61) Tuberculosis of the lung, considered from the point of view of morbid anatomy, exists in three main types:

(i) *Chronic caseating broncho-pneumonia*.—This is the lesion in "ordinary phthisis." The physical signs may be those of broncho-pneumonia, but are quite as often those of the associated lesions—bronchitis, emphysema and thickened pleura.

(ii) *Acute caseous pneumonia* ("pneumonic phthisis").—A somewhat uncommon disease. The signs are those of an extensive lobar pneumonia.

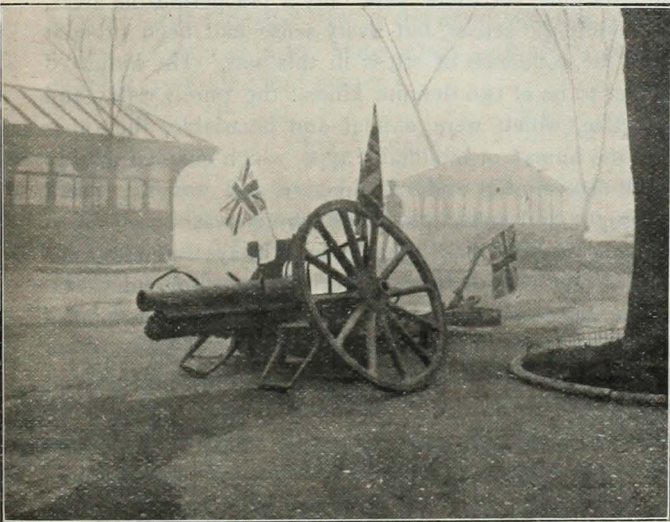
(iii) *Acute miliary tuberculosis*.—The signs, when present, are those of wide-spread capillary bronchitis.

(To be continued.)

BART'S "CAPTURE" A GERMAN GUN.

AT ten o'clock on the third night of the armistice a three-ton A.S.C. motor waggon, procured by stealthy and nefarious bribery and corruption and crammed with conspirators, left the Smithfield Gate of the Hospital.

A banner (debtor to Catering Company—one tablecloth) floated over the canopy bearing the words "BART'S FOR EVER" in large, if somewhat straggly, black letters, and from within came the sound of ironmongery violently beaten with pokers, and so the avalanche of noise swept down Giltspur Street into the night. On it went down Holborn, heralding its approach by *fortissimo* cries of "BA-A-A-RT'S," the



THE GUN AS "CAPTURED."

only incident in the comparatively deserted streets being an invasion by boy scouts. This being an exclusively Hospital show, all hands were piped to repel boarders, and the invaders were gently but firmly deposited in the road.

Speed slackened somewhat in Trafalgar Square, which was crowded with people. We cheered: the crowd cheered: everybody cheered: stately policemen looked on with a kindly and sympathetic eye, regarding us merely as joy riders.

Then came the *coup d'état*. The lorry swung round at the Admiralty Arch and stopped, the tailboard dropped, and a crowd of pirates, led by a strange and fearsome figure with a coil of rope round his waist and brandishing a femur in his hand, streamed off the lorry and through the Arch. Somewhat amazed, the crowd gathered round. Back came the landing party at full speed, towing behind them a 77 mm. German field gun. The inevitable and ubiquitous policemen appeared:

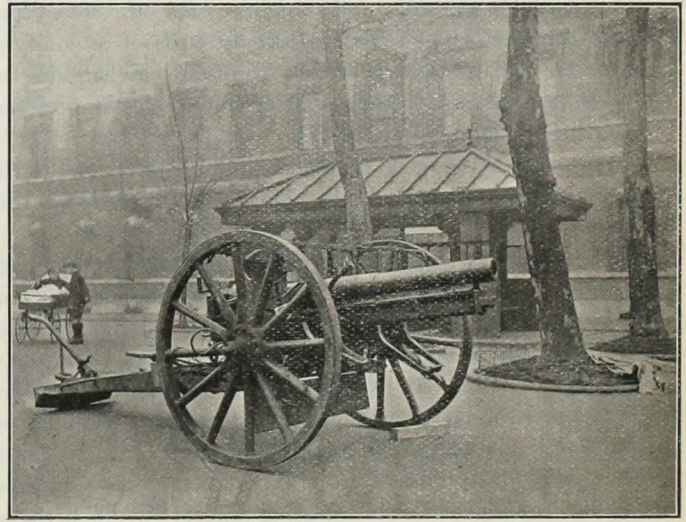
"You can't have that gun!"

The reply was obvious:

"Can't we?" And what were two among so many?

By superhuman exertions some self-sacrificing individuals got the trail of the gun lashed up to the frame of the waggon, despite the pressure of the too curious crowd and the suffocating blast of the exhaust pipe in their faces.

It was done. Everybody climbed on board; members of the crowd who had taken their places *in absentia* were slung out, and the lorry started with a jerk. The tailboard not being fastened up, at least five people fell out into the road. By good luck the rope broke at the same time or the gun would have gone over them. The casualties were collected, the rope re-tied, and a fresh start made. This time the gun started satisfactorily, but after going about ten yards one of the wheels came off. In spite of the shouts from those



THE GUN AS "RESTORED."

behind, those in front heard not and heeded not, and on went the car of Juggernaut, the gun reeling drunkenly behind on one wheel and the axle, striking sparks out of the road and making a truly satisfying noise. By the sides ran men armed with stretcher poles to clear a passage through the crowd. On the steaming bonnet (there was no water in the radiator when the sorely tried engine got back to the Hospital) there sat, with Spartan fortitude, one with burnt-corked face and an unspeakably disreputable bowler hat, minus the brim, who blew unceasingly upon a whistle. High overhead on the canopy rails, one of Gamage's cheapest and noisiest drums added to the din.

Having got safely through Trafalgar Square without killing anybody, so far as is known at present, there was a check in the Strand. Two resolute policemen stood in the way and the waggon had to stop. A moment later it started again, the policemen disappeared (exactly how I know not), and their places were taken by Colonial soldiers who ran on ahead to

clear the way. The pace quickened and the rest of the Strand and Fleet Street were taken non-stop. Several "specials" waved a greeting when they saw the lorry with its banner, but as it passed them and the trophy came into view, their faces changed and once again took on their most official look, but too late to do anything.

Up Ludgate Hill and across to Holborn, up Giltspur Street and round to the Smithfield Gate came the trophy—a flying vision of sparks and noise. The gate was shut but in a few minutes it opened—again I know not how it was wangled—and a thunderous din arose as the gun went through the archway. On meeting the second archway the driver, who had driven so well the whole way, made his first mistake. The gun being dragged along as it was did not ride behind the waggon centrally but swung out to one side. Hence the waggon got through safely, but the one remaining gun wheel hit the arch and straightway fell off. The rope snapped again. The remaining twenty yards of its journey into the Square were slow and painful—man-handling a wheel-less gun is not easy—but at last it was in position near the Fountain.

Of the other events of that night, of interviews with detectives and of visits to the police station, this is not the place to speak!

Next day the gun was propped up on its one remaining wheel and a wooden stool, and was surrounded by an admiring crowd most of the morning. However, the crowning touch—unhoped for and unexpected by most—was yet to come. At half-past one in the afternoon, when the crowd was at its greatest, including many members of the staff, a taxi dashed into the Square, and out of it came four men who produced from it, as a conjurer produces rabbits from his hat—the missing wheel! Well, perhaps not *the* missing wheel, but at any rate, and good enough, a wheel. It was looted in broad daylight. *Succès épatant!*

The gun now stands in the Square as it stood in the Mall—complete except for the damage done to it by shell-fire.

The following morning it was securely chained to the Fountain, for an ultimatum arrived from some envious rivals to the effect that if not delivered up to them they would take it. So far they have not done so.

This, then, is a chapter of that gun's adventurous journey from Essen to Bart.'s. The earlier chapters remain an unknown epic of valour, which will probably be revealed some day; as for its future history, it is unfortunately a "claimed" gun, so it will probably have to be restored to its rightful captors. But it is a trophy that eclipses the milk-churn of our envious rivals!

W. S. S.

THE MIND : ITS DEFECTS AND DISORDERS.

An Epitome of Four Lectures on Physic delivered at the Gresham College,

By Sir ROBERT ARMSTRONG-JONES, M.D., F.R.C.S.,
F.R.C.P.

LECTURE I.

SIR ROBERT ARMSTRONG-JONES described the structure of the brain, and indicated the indescribable stress endured by those engaged in active warfare under modern conditions, which had undermined the resistance of the bravest troops. He described the human body as immersed in a world full of energy manifestations, yet there were only a few permeable areas, which were the senses, but every sense had been brought under the influence of stress in this war. He indicated conduct to be of two definite kinds: the purely reflex and instinctive, which were animal and invariable, the other being the human or modifiable type, which enabled man to be self-determining and self-directive, and was the result of thought and reflection. The former was based upon definitely inherited lines of nervous pathways; the latter was based upon a fine network of nerve-fibres which education and training brought into use, and it should be the aim of all teachers to make full use of all the native impulses, of all spontaneous interests, of all the native automatisms, and even the useless movements of the child so as to fit him for fresh "associations," and to adapt the child for his future life of activity. He described the history and evolution of the nervous system from its most rudimentary forms in animal life, and indicated that the human brain had in its microscopic structure an infinite capacity for further development and progress; that as speech and the upright position of man had taken *eras* to develop, so there was a vast future for the progress of the human mind towards spiritual perfection.

LECTURE II.

Sir Robert Armstrong-Jones described the avenues of the mind, which were "windows" admitting different forms of energy into the brain, and urged that the medium should be kept clear by the exercise of attention and the will. Distraction by temptation should be avoided by inspiring ideals of self-sacrifice and usefulness. The greatest pleasure to thinking man is in the exercise of his intellectual faculties, and the human organism was an example of the most beautiful adjustments adapted to make use of information coming in to the mind in a world full of activities. The value of the individual to the community depended upon a ready adaptation to ever-changing conditions, and progress must depend upon being able to use material

reaching the mind through the senses, and education should emphasise attentive observation, recording accurately and arriving at correct conclusions.

LECTURE III.

Sir Robert Armstrong-Jones described the elements of the mind, which consisted in an evolution from simple to more complex elements, just as the brain developed from the simple reflex cell into an aggregation of independent neurones. He laid great stress on the power of the will, and stated that many persons suffering from shell-shock were fortified by suggestion, and that habit was an important factor in the development of the will. He referred to the emotions and recent discoveries which tended to demonstrate that they were biological reflexes, having a teleological end—the welfare of the body. He believed there was support for the idealist view of the mind, and the war had shown the error of a too materialistic view of the relationship between mind and matter.

LECTURE IV.

Sir Robert Armstrong-Jones delivered the last of the series of Gresham Lectures on Physic upon mental abnormalities. He laid stress upon the attention and the will being the great conditioning factors in the intellectual life. He referred to the great number of functional nervous cases resulting from the stress of war, and that provision for re-education and re-evolution should be provided for these, and soon; as otherwise the force of habit would set in to mar recovery. He also urged the necessity for an immediate change in the law relating to the insane, as the best treatment during the early stages was now impossible of attainment under present legal conditions. He considered mental diseases to rest upon a tripod of causes, viz. heredity, alcohol, and venereal diseases, which are all remediable and should be controlled; two of these were receiving immediate attention, and social work was necessary to inform the people of their deadly effects; one of these, alcohol, was the source of all the others.

A CASE OF "SPANISH INFLUENZA" TREATED BY INTRAVENOUS INJECTION OF SODIUM SALICYLATE.

By Surg.-Lieut. R. MURRAY BARROW, R.N.

ON October 26th, in the forenoon, Lieut. F—, R.N.R., reported himself to the surgeon on duty, complaining of shivering, headache and backache. No cough; bowels constipated. On examination patient looked ill; complexion pale; expression anxious.

Temperature 100° F., pulse 88, respirations 24. Headache, frontal; throat slightly injected; tonsils not enlarged. Chest: Nothing abnormal discovered. Pulse full and bounding. Abdomen: Nothing abnormal discovered. Bowels always irregular. Urine normal. Muscles generally tender, particularly erector spinæ. Nervous system normal.

Patient was put to bed on milk diet. Dover's powder gr. x was given *statim*, and a mixture containing sod. sal. gr. xx, sod. bicarb. gr. xxx was given four-hourly.

Condition not improved by the evening. Temperature 103° F., pulse 92, respirations 28. Calomel gr. iij was prescribed.

October 27th: Patient developed cough and rusty sputum. The cough was painful towards the front of the chest. Examination failed to find anything but harsh breathing over both upper lobes. Patient's expression was then such as to give cause for alarm, resembling that of cases of fatal peritonitis. The complexion was grey, eyes sunken, with dull expression. Mental condition was that of great depression and a desire not to be disturbed.

It was then decided to give an injection intravenously of sodium salicylate gr. v. This was dissolved in 8 c.c. sterile water warmed to blood heat and injected. In half an hour the patient felt relief from his pains and more restful. Strychnine gr. $\frac{1}{16}$ was given hypodermically directly after to counteract any depressing effect on the heart, and was repeated four-hourly till 6 a.m., October 28th. The patient had a good night up to midnight, but slept badly thereafter. Temperature at midnight was 102.4° F., pulse 96, respirations 24. There was relief in the cough, and the sputum became less blood-stained.

October 28th, 6 a.m.: Temperature 102° F., pulse 88, respirations 24. Intravenous injection repeated, followed by strychnine as before. Again the patient expressed relief of his subjective symptoms, and only complained of headache. The sputum was now yellow and thick; cough very slight. I then decided to repeat the injections six-hourly, followed by strychnine gr. $\frac{1}{16}$. As the ship was under way the patient found it hard to rest, and could not sleep for the vibration of the propellers. A draught of chloral \bar{c} pot. brom. $\bar{a}\bar{a}$ gr. xx was given at 10 a.m., but he only slept for twenty minutes. At noon temperature 102° F., pulse 84, respirations 28. Patient complaining of no pain at all, but inability to rest. The sleeping draught was repeated at 2 p.m., and gave him forty minutes' sleep, the pulse being regular and full. Inj. morphinæ hyp. gr. $\frac{1}{4}$ was given at 4 p.m. Temperature 102.2° F., pulse 88, respirations 26. After the morphia patient slept well for four hours, and was much rested.

No intravenous injection was given till 10 p.m., when it was repeated in the same dose and solution. Temperature 102.6° F., pulse 82, respirations 28. Patient feeling much better altogether; took some hot cocoa and milk. Calomel

gr. ij was given. He perspired then slightly for the first time since the beginning of his illness, and slept till 12 midnight. He had very occasional cough; no complaint of pains anywhere.

October 29th: Patient did not sleep till 4 a.m., when his temperature was 102.4° F., pulse 86, respirations 28. He slept on and off till 8 a.m. and felt better. Temperature 101.6° F., pulse 86, respirations 24. He was given salts, and his bowels were moved; he took some toast and tea. It was then decided to move him to a hospital ship.

It is difficult to claim anything specific for this form of treatment, but in view of the rapidity of the course of the complaint and of the necessity to find a mode of controlling it early, I suggest that the intravenous injection of salicylate of soda might be tried in these cases.

I did not keep the patient sufficiently long to increase the dose of salicylate, nor apparently was there any need. It would be interesting to see how much one could give without harmful effect.

OBITUARY.



THE following have already appeared under our Roll of Honour. Some additional facts have since come to hand, and these details we gladly publish.

Capt. G. M. Cowper, who died of wounds on October 3rd, was educated at Darlington Grammar School and Trinity College, Cambridge, going on to St. Bartholomew's Hospital, London, where in 1914 he took the Conjoint Diploma. He joined the R.A.M.C. on the outbreak of war, and after six months of duty as anæsthetist at a base hospital in England he went to Le Treport with a hospital unit, where, in addition to his regular duties, he had charge of surgical huts and acted also as honorary secretary and treasurer of the officers' mess. Last year he became attached, first to a West Riding Regiment (Duke of Wellington's), and later to a field ambulance. Finally, just before his death, he was transferred to a Dorset Regiment, and it was while working at his regimental aid post that a direct hit by enemy artillery inflicted wounds which shortly proved fatal. Capt. Cowper's superior officers write of his whole-hearted devotion to the work in hand, whether professional or recreative, which made him a true comrade, while his considerateness endeared him to the patients and nursing staff. His loss is keenly felt by all his associates.

Lieut. W. L. Dandridge, who died of wounds on October 5th, was the youngest son of Alfred Dandridge,

of Beckenham, Kent. He was educated at Sherborne School, going on in 1912 to Emmanuel College, Cambridge, where he graduated in Arts. In 1916 he went to the Isonzo front with a Red Cross ambulance, returning to England after a few months to complete his medical curriculum. After obtaining the diplomas of the Conjoint Board, he joined the 103rd Field Ambulance in France, and it was while accompanying a party of stretcher-bearers to the front line on October 3rd that he was wounded, surviving his injuries only for a few days. Enthusiastic in his work and of a bright and cheery disposition, Lieut. Dandridge will be missed by a large circle of friends.

Lieut. Ernest Howard Glenny, youngest son of Mr. and Mrs. Edward H. Glenny, of Manor Park, London, died of pneumonia at Basra, Mesopotamia, on October 9th, 1918, aged nearly twenty-seven years. He was educated at Redland Hill House, Clifton, Bristol, and at the Leys School, Cambridge. Having in 1913 decided to take up Medicine, he entered St. Bartholomew's Hospital, gained the Willett Medal, and qualified M.R.C.S. and L.R.C.P. in 1917. After three months as House-Physician at this Hospital, he was called to join the R.A.M.C., and from Blackpool was sent to Mesopotamia, where he was appointed Medical Officer at No. 3, British General Hospital, in March, 1918. He remained there until he was removed to the Officers' Hospital, Beit Naama, Basra, seriously ill with pleuro-pneumonia on October 4th, and died on October 9th.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. ST. PAUL'S SCHOOL.

The Hospital Football Club opened their season on October 5th with a match against St. Paul's School, which was won by 2 goals (10 points) to 1 try (3 points). The game throughout was keenly fought, and the schoolboys, though the lighter side, played a determined game, the result being uncertain until late in the second half. The Hospital owed their success mainly to the superiority of the outsides, M. Thomas scoring two clever tries, both of which C. F. Krige converted.

ST. BARTHOLOMEW'S HOSPITAL v. NATIONAL PHYSICAL LABORATORY.

On October 12th the Hospital opposed the National Physical Laboratory at Teddington and won by 66 points to *nil*. The Laboratory were quite outclassed and the play was entirely in their half. The game was merely a succession of tries; all the outsides, including the full back, crossed the line, and also several of the forwards. C. F. Krige and M. Thomas ran through the defence whenever they had the ball.

ST. BARTHOLOMEW'S HOSPITAL v. THE PUBLIC SCHOOLS SERVICES.

The Public Schools Services XV were the opponents on October 26th at Richmond, the Hospital winning by 4 goals and 6 tries (38 points) to *nil*. The Hospital showed their superiority from the outset and held the upper hand throughout. The game was keen

St. Bartholomew's Hospital



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

JOURNAL.

VOL. XXVI.—No. 3.]

DECEMBER 1ST, 1918.

[PRICE SIXPENCE.

THE END OF THE GREAT WAR.

THE BEGINNING OF TRUE RECONSTRUCTION.

THE War is over. The Allies have conquered. Right has triumphed over Might. A great sacrifice has been made, but a great recompense will result. Our brothers have died—have died gloriously—in order that we may reap the fruits of a lasting peace. Our Hospital has given nobly to the service of King and Country. Every student, unless physically prevented, has served on sea, on land, or in the air. Nearly two thousand Bart.'s men have answered the call to every front and every clime. Hundreds of our nurses have pressed into the ranks and shown that the British Nursing Profession is second to none. Of one and all we are justly proud. We reverence our dead, we uphold our maimed, and we welcome back our safe and sound.

Now we must turn to what the termination of the World War is to mean to us as a Hospital and as a Profession. It should mean the beginning of greater things in our history, already truly great. It is not enough for us to rest on our past; we must consider the future. A true reconstruction does not mean the destruction of our heritage, but the building up on its sure foundation of an edifice which will be of still greater service to humanity. The ideals of our profession—both the medical and the nursing—are essentially scientific and humanitarian, and unless we keep these ideals always in the foreground, our reconstruction will be but an empty sham.

We shall have to "reconstruct" in our Medical School, in our Nursing School, in Research, in Medical Practice, and in the new relations which are arising between our professions and the public. Let us therefore put our whole energy into the matter, and let us make ourselves worthy of the men and women who have set us so great an example in their unparalleled devotion and sacrifice. x

CALENDAR.

Fri.,	Nov.	29.—	Dr. Tooth and Mr. Waring on duty.
Tues.,	Dec.	3.—	Dr. Calvert and Mr. McAdam Eccles on duty.
Wed.,	"	4.—	Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri.,	"	6.—	Dr. Fletcher and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine), Dr. Calvert.
Tues.,	"	10.—	Dr. Drysdale and Mr. Waring on duty.
Fri.,	"	13.—	Dr. Tooth and Mr. McAdam Eccles on duty.
Tues.,	"	17.—	Dr. Calvert and Mr. D'Arcy Power on duty.
Fri.,	"	20.—	Dr. Fletcher and Mr. Waring on duty.
Tues.,	"	24.—	Dr. Drysdale and Mr. McAdam Eccles on duty.
Fri.,	"	27.—	Dr. Tooth and Mr. D'Arcy Power on duty.
Tues.,	"	31.—	Dr. Calvert and Mr. Waring on duty.
1919.			
Fri.,	Jan.	3.—	Dr. Fletcher and Mr. McAdam Eccles on duty.

EDITORIAL NOTES.

AT the moment of going to press we hear with deepest regret of the death, from pneumonia following influenza, of Dr. A. E. Stansfeld. Our sense of loss lies beyond any expression in words. In his day one of our most brilliant and popular students, his later work had more than fulfilled the promise of his earlier years. The tremendous amount of work always so willingly undertaken by him in this and other Hospitals had brought him a reputation unique for a man of his years. There can be little doubt indeed that the result of overwork lessened his chances of recovery. The Hospital, and indeed the medical profession as a whole, has lost one of its most promising members.

To his wife and family we offer our very deepest sympathy.

* * *

Sir Wilmot Herringham's letter on State Medical Service and Medical Representation in Parliament has roused widespread interest. The *Lancet* refers to it in their issue of November 23rd, while in the *British Medical Journal* of the same date the letter forms the basis of the weekly editorial article. In an extremely interesting note the *B.M.J.* contrasts Sir Wilmot's views with those put forward by Col. Maurice in an article in *The Hospital*. The view taken by this writer is very much on the lines of the letter which appears in this issue, namely, that some form of State Medical Service is most necessary. For our part we would regret to see any scheme in force which would tend to the elimination of that all-important factor in general practice, namely, the personal element.

* * *

In a recent editorial we ventured to suggest that Bart.'s would not be far behind when we could enjoy again the piping days of peace. We were not far wrong in our prophecy. The news of the signing of the Armistice was received with tremendous enthusiasm. Lectures—in fact

anything approaching work—were at a standstill. Guy's paid a visit to the Hospital in the afternoon, and St. Mary's came in force the following day. But the climax was reached on Wednesday evening, when Bart.'s certainly came into their own. The programme was nothing more or less than the capture of one of the German guns from the Mall, and right well was it carried out. A description of the "capture" appears elsewhere in this issue, and is certainly more accurate in detail than the highly picturesque report which appeared in the *Star*.

Bart.'s men are tremendously proud of their achievement, and it is to be hoped that the War Office authorities will allow the Hospital to keep their trophy, especially as quite a number of the students are artillery officers.

* * *

We note with pleasure that Temp. Major W. J. Gow, R.A.M.C., has been brought to the notice of Lieut.-Gen. Sir J. L. van Deventer for distinguished services rendered.

* * *

Three Bart.'s men have been decorated recently by the President of the French Republic, and to these we offer our congratulations:

Lieut.-Col. J. H. Hugo, D.S.O., I.M.S., receives the Croix de Chevalier of the Legion of Honour, and Temp. Capt. J. B. McFarland, M.C., R.A.M.C., and Temp. Capt. (Acting Major) H. B. G. Russell, R.A.M.C., the Croix de Guerre.

* * *

We are pleased to be able to congratulate Capt. (Acting Major) J. M. Smith, R.A.M.C., on being awarded the Military Cross.

* * *

Our congratulations to Lieut. K. C. J. Jones, M.C., the Bedfordshire Regiment, on being awarded the M.B.E. for an act of gallantry not in the presence of the enemy.

The award should have been included in our note of the Birthday Honours of June last.

* * *

The subject of the Bradshaw Lecture delivered by Lieut.-Col. D'Arcy Power before the Royal College of Surgeons on November 14th was "Carcinoma of the Tongue." A distinguished audience was present, and the lecturer is to be congratulated on the masterly way in which he handled the subject.

* * *

Col. H. H. Tooth, C.M.G., has resumed his duties at the Hospital after two years' service with the Forces abroad.

* * *

There have been several alterations lately in the arrangement of the wards. They are as follows:

South Wing: Matthew is now Lucas, and Elizabeth and Martha are re-opened.

West Wing: Radcliffe is now Abernethy, while Coburn is entirely devoted to war pensioners.

North-east Wing: Abernethy becomes Radcliffe, Lucas

and fast, but the Hospital three-quarters were altogether too clever for their opponents. C. F. Krige (2), C. Griffith-Jones and M. Thomas scored in the first half, Krige converting twice. In the second half Krige (2), Thomas, Griffith-Jones, Johnstone and Llewellyn crossed the line, and Shaw was successful with two kicks at goal.

ST. BARTHOLOMEW'S HOSPITAL v. WELSH GUARDS.

Played at Ranelagh on November 2nd, and probably better left without comment. The Guards team found, early in the game, that they would not have the football all their own way, consequently they gave up football and tried to win by "any means," with the result that the game was of the most unpleasant type. It ended in a draw of a goal and a try each; Thomas scored twice for Bart.'s and Krige converted once. The Hospital has scratched further fixtures with the Welsh Guards as a protest.

ST. BARTHOLOMEW'S HOSPITAL v. MILL HILL SCHOOL.

Played at Mill Hill on November 9th, and won by the Hospital by 3 goals and 3 tries to *nil*. The outstanding feature of the game was the splendid way in which the School forwards, light as they were, hustled the Hospital forwards from the very beginning. The Hospital outsidies were much better than their opponents, and so crossed the line six times, but the forwards had a splendid lesson in "how to get on with it." Johnson, Krige and Thomas each scored twice, and Krige converted three of the tries.

ST. BARTHOLOMEW'S HOSPITAL v. GUY'S HOSPITAL.

Played at Honor Oak Park on Saturday, November 16th, in the presence of many students and nurses from both Hospitals. The game was very keen and very closely even, but Guy's were just superior in all departments of the game. Their forwards got the ball very much oftener than ours, and their three-quarters always knew exactly where to find each other (while our "three's" did not), and always managed to break up any attack on our part. The game, as a whole, was devoid of incident except very occasionally. The first half was give and take with the game up and down the field—rather more in the Bart.'s half. We had hard luck when Orchard dribbled away from the pack, picked up and "dropped" at goal; it was a splendid kick and only just missed. In the second half Guy's scored twice. A wild pass amongst our three-quarters was intercepted by Krige, of Guy's, who raced through and punted for Keet to follow up and score. The second try was again an "opportunity" score. From a long kick the ball bounced off Salmon's shoulder; Krige, of Guy's, following up, seized the chance and scored. Crook converted the first try, but failed with the second. Salmon was injured and had to leave the field, but no further score was made while Bart.'s were one short. On the game Guy's were the better side—eight points better—but they were fortunate in getting them, for none of their concerted movements were successful. A. J. Trollope's refereeing was ideal.

"Medical Notes" in the current number of the JOURNAL) Dr. Lewis dogmatically expresses this view.

To this Sir Thomas Horder demurs. He points out first of all quite logically that in writing of "actions natural to man" Dr. Lewis is begging the question, and that the feats of exertion which lead to damaged hearts could not be termed "natural."

It is not for me to defend Dr. Lewis, still less to interpret what may have been in his mind; but if I had been writing this paragraph on my own behalf, I would boldly have gone further and substituted for "natural" the unambiguous adjective "possible."

And so at once I become most embarrassingly in conflict with my old teacher, who states that these are "cases [of damaged hearts] which all physicians of experience occasionally meet with."

I wonder if I dare regard myself as a physician of experience! Perhaps, after all, in this connection I may, for I have had exceptional opportunities to observe prominent athletes from many parts of the world, and so equally exceptional opportunities for studying "heart-strain." I have been hunting the genuine "athletic heart" for many years now, and I have never caught it.

I know that whenever a prominent athlete dies, particularly of some affection of the chest, his demise is always written down and credited to the evils of athletics; but the type of fellow I have come across who "strained his heart in a race" is invariably a man with vasomotor instability, who never had much pluck, and who takes for granted that his symptoms of distress indicate that his heart was permanently injured. And yet what athlete of experience has failed to suffer from such symptoms during his career without the slightest permanent ill-result?

Even the statistical method has shown that the life-expectation of athletes actually exceeds that of the average healthy man. Taking the first Harvard crew of 1852, the increase was 1.6 years per man as compared with the selected lives of insurance tables in which a man of twenty had a life-expectation of 42.2 years: and the same result was found by the late Dr. Morgan in his investigation into the life-histories of men who had rowed in the inter-Varsity race.

I am writing in no spirit of criticism, but with the earnest desire to thresh out the subject. Sir Thomas's clinical experience is, of course, immeasurably greater than mine; my experience of athletes and athletics is probably greater than his. I have seen a large number of what I have taken to be healthy hearts showing no trace of having been affected by admittedly severe exertion. It is perhaps a question of criteria and of weighing evidence, but I really should like to be convinced that "heart-strain" is so common that most physicians of experience have an opportunity of satisfying themselves in the case of men with athletic ability, first, that undoubted damage to the heart was present, and secondly, that such damage could be directly traceable to some physical effort.

I am, Sir,

Yours faithfully,

ADOLPHE ABRAHAMS,

Major, R.A.M.C.

THE CONNAUGHT HOSPITAL,
ALDERSHOT;

November 9th, 1918.

CORRESPONDENCE.

"HEART-STRAIN."

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

SIR,—Long before I was qualified to practise medicine—before I was permitted, therefore, to open my mouth at all, let alone with the hope that anything I could say would be treated as of any authority—I held the view that the healthy heart could not be damaged by muscular exertion, however severe. This view was not, as I say, the outcome of clinical knowledge or experience, but resulted from the observation of first-class athletes engaged in the most strenuous physical exertion, and their after-histories.

It has been no small source of gratification to me to observe during the past few years a growing tendency for cardiologists of whose ability and reputation there can be no question to support this opinion; and in his last edition of *Clinical Disorders of the Heart-Beat* (from which Sir Thomas Horder quotes in paragraph 51 of his

REVIEWS.

A TEXT-BOOK OF MIDWIFERY. By R. W. JOHNSTONE. Second Edition. (A. & C. Black, Ltd.) Pp. 495. Price 12s. 6d. net.

Johnstone's *Midwifery* is deservedly popular, in spite of the fact that students in the Metropolis are often prejudiced against text-books emanating from "across the border." It is not to be expected that a book of this size should go into such elaborate details as are to be found in larger works on the subject, but the essential facts are clearly stated, and this is what is required for examination purposes.

The present edition does not materially differ from the first, but the notes on the use of pituitary extract in labour and the details regarding the use of scopolamine and morphine are noteworthy additions.

THE PRACTICE OF SURGERY. By RUSSELL HOWARD. Second Edition. (Edward Arnold.) Pp. 1244. Price 25s. net.

This most excellent work on surgery has been thoroughly revised, the paragraphs on "Military Surgery" receiving special attention. Some thirty-seven chapters go to make up the text. The illustrations are extraordinarily good, especially the eight coloured plates, which do great credit to both artist and printer.

Students are often in doubt with regard to a suitable book on what is perhaps the most difficult of the "Final" subjects. To such students we have every confidence in recommending Russell Howard's work, and we do so because special emphasis has been laid on that very important side of surgery, namely, diagnosis and treatment.

The volume can be recommended with equal confidence to practitioners who are desirous of obtaining a thoroughly reliable and up-to-date treatise on the subject.

A MANUAL OF PHYSIOLOGY. By G. N. STEWART. Eighth Edition. University Series. (Baillière, Tindall & Cox.) Pp. xxiv + 1245. Price 21s. net.

In spite of war conditions this well known work on physiology has undergone many changes, and several additions have been added since the appearance of the last edition. The chapters dealing with the chemical phenomena of respiration and the functions of the endocrine organs and metabolism receive special attention; Cushny's recently formulated fixation-reabsorption theory of urine formation is also dealt with at some length. The bibliography, which has been added as an appendix, is an extremely valuable addition, and should prove most useful to teachers and also to advanced students.

Stewart's volume has always been very practical in character, and we are glad to note that the Practical Exercises are still retained in the one complete volume.

We still have hopes that one day a book on physiology will be written which embraces more clinical work. This is, perhaps, the only fault we have to find with this really valuable work. Possibly the author may see his way to correct this omission in a future edition.

EXAMINATIONS, ETC.

UNIVERSITY OF OXFORD.

In a Congregation held November, 1918, at Oxford, the following degree was conferred:

M.D.—E. H. White (in absence).

THE ROYAL COLLEGE OF PHYSICIANS.

The following has been admitted a Member of the College: G. Bourne.

CONJOINT EXAMINING BOARD.

First Examination. October, 1918.

Part I. Chemistry.—E. A. Austen, R. G. Cochrane, W. Moody Jones, I. Kinsler, E. Obermer.

Part II. Physics.—G. L. Brocklehurst, R. G. Cochrane, I. Kinsler, C. A. Moody, E. Obermer.

Part III. Elementary Biology.—R. A. E. Klaber, A. J. D. Smith.

Part IV. Practical Pharmacy.—C. H. Bulcock, R. H. Clarke, B. H. Cole, A. W. Taylor, C. J. L. Wells, D. O'Donovan.

Second Examination. October, 1918.

Anatomy and Physiology.—G. K. Arthur, T. A. Eccles, C. S. C. Prance, S. R. Simaika.

Final Examination. October, 1918.

The following have completed the examination for the diplomas of M.R.C.S. and L.R.C.P.: L. H. Bartram, W. L. Berry, F. T. Burkitt, W. M. Casper, E. A. Crook, G. A. Fisher, D. P. Guilfoyle, R. D. Jones, G. Lyon-Smith, G. Millar, H. L. Pridham.

CHANGES OF ADDRESS.

HADFIELD, C. F., 42, Devonshire Street, Portland Place, W. (From December 7th, 1918.)

LITTLEJOHN, C. W. B., Scotch College, Melbourne.

MYERS, C. S., Lieut.-Col. R.A.M.C., 16, Bryanston Square, W.

BIRTHS.

BURNE.—On October 19th, at Singapore, C. V. (née Turner), the wife of Dr. T. W. H. Burne, of a daughter (Diana).

GILLIES.—On November 6th, at Twydens, Foots Cray, Kent, Kathleen, the wife of Major H. D. Gillies, R.A.M.C., Queen's Hospital, Sidcup, of a daughter.

JONES.—On October 30th, at Coleford House, near Bath, the wife of Capt. P. T. Jones, R.A.M.C., T.F.R., of a son.

TATCHELL.—On November 3rd, the wife of Percy Tatchell, 29, Barkston Gardens, S.W. 5, of a daughter.

SILVER WEDDING.

JONES—ROBERTS.—On November 4th, 1893, at Christ Church, Lancaster Gate, by the Rev. Canon Hughes, uncle of the bride, assisted by the Rev. W. Page Roberts, of St. Peter's, Vere Street, and the Rev. C. J. Ridgeway, Vicar of the Parish, Robert Jones (now Robert Armstrong-Jones), M.D., B.S., of Claybury, Woodford Bridge, Essex, to Margaret Elizabeth, eldest daughter of Sir Owen Roberts, J.P., D.L., of 48, Westbourne Terrace, and of Plás Dinas, Carnarvon, N. Wales. Present address, 9, Bramham Gardens, S.W., and Plás Dinas, Carnarvon.

DEATHS.

FAVELL.—On November 2nd, 1918, at Brunswick House, Glossop Road, Sheffield, Richard Favell, Ch.M., M.R.C.S., aged 70.

MALDEN.—On October 28th, 1918, at Bateman House, Cambridge, Walter Malden, M.D.(Cantab.), Capt. R.A.M.C. (T.), aged 60.

PATTEN.—On October 22nd, 1918, at 17, Mount Park Road, Ealing, Charles Arthur Patten, L.R.C.P., M.R.C.S., aged 79.

STANSFELD.—On November 25th, 1918, at 19, Bentinck Street, Cavendish Square, W. 1, of pneumonia following influenza, Alfred Ellington Stansfeld, M.D., F.R.C.P., aged 35.

ACKNOWLEDGMENTS.

New York State Journal of Medicine, Guy's Hospital Gazette, The Nursing Times, The British Journal of Nursing, The Hospital, The League News, Journal of the Department of Public Health, Hospitals, and Charitable Aid, Long Island Medical Journal, Otago University Review, St. Mary's Hospital Gazette, The Hospital, The Medical Review, Giornale della Reale Società Italiana d'Igiene.

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.

St. Bartholomew's Hospital



JOURNAL.

"Æquamemento rebus in arduis
Servare mentem."
—Horace, Book ii, Ode iii.

VOL. XXVI.—No. 4.]

JANUARY 1ST, 1919.

[PRICE SIXPENCE.

CALENDAR.

1918.	
Tues., Dec.	31.—Dr. Calvert and Mr. Waring on duty.
1919.	
Fri., Jan.	3.—Dr. Fletcher and Mr. McAdam Eccles on duty.
Tues., "	7.—Dr. Drysdale and Mr. D'Arcy Power on duty.
Fri., "	10.—Dr. Tooth and Mr. Waring on duty.
Tues., "	14.—Dr. Calvert and Mr. McAdam Eccles on duty.
Fri., "	17.—Dr. Fletcher and Mr. D'Arcy Power on duty.
Tues., "	21.—Dr. Drysdale and Mr. Waring on duty.
Fri., "	24.—Dr. Tooth and Mr. McAdam Eccles on duty.
Tues., "	28.—Dr. Calvert and Mr. D'Arcy Power on duty.
Fri., "	31.—Dr. Fletcher and Mr. Waring on duty.
Tues., Feb.	4.—Dr. Drysdale and Mr. McAdam Eccles on duty.

EDITORIAL NOTES.

DURING four long and what at times seemed interminable years, New Year Greetings have necessarily been touched with sadness. It seemed a paradox to speak of happy and prosperous times in the face of a world calamity.

With the advent of peace all this has been changed, and we desire to take full advantage of this unique opportunity in wishing our readers the happiest of new years.

The year just ended, crowded as it has been with suffering and anxiety beyond the memory of man, is past; we are entering a new world. The future offers unparalleled prospects, in which the medical profession must play a big part. At this glad season of the year let us resolve to do our bit. Bart.'s has done nobly in the past: it will not fail in the great problems of the future.

* * *

What might be described as the Armistice Christmas was celebrated at Bart.'s with great enthusiasm. In the morning Santa Claus went round the wards of the Hospital, attended by one of his assistants, a "nurse," and Fred, his donkey. He received an uproarious welcome from children of all

ages, from ten to three score years and ten! After he had distributed presents, he paid two visits to the nurses' dining-room and had an enthusiastic reception.

In the afternoon there were several concert parties going round the wards. The "Beery Bolsheviks," five most dreadful-looking ruffians in gory operation gowns and red, dishevelled wigs, in private life members of the Resident Staff and students, worked extremely hard the whole afternoon, giving no less than eleven performances. Their ingenious limericks and burlesque opera caused great amusement.

The Roland Ramblers were even better than last year. The two other parties, Miss Kelly's and Miss Fathers', both gave excellent shows, though unfortunately the latter were handicapped by the absence of their pianist. There were also impromptu sing-songs in various wards. The thanks of the Hospital are due to all those ladies and gentlemen who gave up their Christmas Day to the patients.

It would be an impossible and invidious task to attempt to describe the wards. Much time and trouble had evidently been spent on them, and the results, though widely different, were all good.

That important function, tea, was more in evidence than during the last four years, and late that night, after hearing the Resident Staff serenading Mr. Hayes, the Warden, and the Steward, those with sensitive consciences went to bed and dreamt uneasy dreams of that moribund maiden, Dora, and her decree that "between the hours of 3 p.m. and 6 p.m. no meal shall consist of more than one and a half ounces of cake, scone or biscuit"!

* * *

May we suggest that an early opportunity should be taken to put the Museum into something like working order? Bart.'s is justly proud of its collection of pathological specimens, and quite rightly steps were taken to guard these valuable treasures from hostile aircraft. We realise that it is impossible to get back to pre-war conditions at a moment's notice, but we certainly think the Museum should receive early attention.

Now that the war is over, the question of a fitting memorial to commemorate Bart's men who have fallen should receive early consideration. We shall be glad to have any suggestions from our readers regarding the form which they consider the memorial should take. One suggestion which appears to us to be excellent is that a tablet inscribed with the names should be put up in the Abernethian Room, where it would remain as a permanent Roll of Honour. Some of our readers may have other ideas, and we shall be pleased to hear from them.

* * *

We have always known that Col. Waring had some very definite ideas on medical education and its reconstruction, and we feel sure his views reported in this issue will be read with considerable interest.

With the great majority of his proposals we are in entire agreement, although doubting very much the desirability of extending the curriculum to six years. This might be possible, of course, providing that it was made compulsory to complete the Chemistry and Physics (we would not include Biology as Col. Waring suggests) prior to entering the Hospital.

There is one suggestion we would like to add, and that is that the student should receive more definite instruction in the wards in the writing of prescriptions. A student just qualified generally has a fair working knowledge of his Hospital Pharmacopœia, but without that he is more often than not completely at a loss. This is certainly a point in reconstruction which might be considered.

Anent Col. Waring's statement that at least half the British Pharmacopœia could be conveniently deleted, we would like to point out that while this might apply in this country, the B.P. is of an international character, including as it does Colonial Addenda.

Discussing the subject with the Pharmacist to the Hospital, we gather that a considerable amount of progressive medical treatment is dependent upon unofficial preparations—a fact well illustrated in the popularity of pituitary, camphor, and other injections. Another cogent example is the various biological products which constitute such an important factor in modern treatment.

It follows therefore that whereas possibly half of the preparations in the British Pharmacopœia could be conveniently dispensed with, additions might be made which would more than compensate for any deletions.

* * *

It affords us unusual pleasure to learn that Capt. T. E. Osmond, R.A.M.C., and Capt. E. G. S. Cane, R.A.M.C., who were taken prisoners after the capitulation of Kut-el-Amara, have arrived at Alexandria.

* * *

Amongst the recently repatriated officers from Germany we are glad to see the name of Major M. Donaldson, R.A.M.C.,

who was taken prisoner last March. We shall look forward to his early return to the Hospital.

* * *

Our congratulations to T/Capt. P. Selwyn Clarke, R.A.M.C., on receiving the Military Cross. The official details are as follows:

"For conspicuous gallantry and devotion to duty. After an unsuccessful attack he went out into 'No Man's Land' and attended to many wounded, being exposed to heavy shell and machine-gun fire the whole time. His courage and coolness were a fine example to the stretcher-bearers working under him, and encouraged them in their difficult and dangerous task."

* * *

Major Sydney R. Scott, M.S., F.R.C.S., having completed the investigations on the ear and aviation which he undertook at the request of the Army authorities in France, has relinquished his temporary commission in the R.A.M.C., and has returned to his duties at this Hospital.

Capt. Foster Moore has also relinquished his commission, and is back at work in Hospital.

* * *

Our congratulations to Major F. P. Mackie, I.M.S., on being awarded the O.B.E. for distinguished services in connection with military operations.

* * *

Capt. A. R. Cook, Uganda Medical Service, has been made a Chevalier, Ordre de Leopold. We congratulate Capt. Cook on receiving this honour, which was conferred by the King of the Belgians.

* * *

In a recent despatch from General Sir Charles Munro, Commander-in-Chief in India, we note with pleasure the name of Col. H. J. Barratt, I.M.S., whose services, we understand, have been of particular value.

* * *

We are asked to state that a Final Fellowship Class will be held for the next Examination, which takes place in May.

* * *

Sir Thomas Horder's "Medical Notes," which have been the subject of so much interest, are unavoidably held over. The next of the series will appear in the February issue.

* * *

We regret to have to record the death of Lieut.-Col. James More Reid, late of the Royal Army Medical Corps, at the age of sixty-two years. Educated at Edinburgh and the Medical School of this Hospital, he joined the Medical Service of the Army in 1884, and took part in operations on the North-West Frontier of India in 1897-98 with the Tirah Expeditionary Force, receiving the medal with two clasps. He was also engaged in China in 1900, was mentioned in despatches and received the medal.

We also learn with deep regret of the death from pneumonia of Dr. Percy J. F. Lush, youngest son of the late Lord Justice Lush. He took the M.A., M.B., and B.Ch. degrees at Oxford, and was a student at this Hospital. Dr. Lush, who was in his sixty-first year, had been House-Surgeon and House-Physician at the West London Hospital, and Clinical Assistant in the Throat and Ear Department of the Hospital for Children, Great Ormond Street. At the time of his death he was Medical Superintendent of St. Columba's Hospital, Avenue Road, St. John's Wood.

* * *

ROLL OF HONOUR.

In spite of the fact that hostilities have ceased we regret to have to include several additional names under this heading.

To the relatives and friends of these Bart.'s men we offer our deepest sympathy.

Capt. Bertram Walter Cherrett, M.B., R.A.M.C., died at Nairobi on November 4th from pneumonia following influenza.

He was attached to the East African Medical Force, and was Medical Officer of Health for Nairobi.

Capt. Andrew Monro Jukes, M.D., I.M.S., died in Egypt on October 18th from heart failure after rheumatic fever. He was the only son of Dr. and Mrs. A. Jukes (C.M.S., retd.).

Capt. Lawrence Amos Winter, M.D., R.A.M.C., died on November 15th at the 20th General Hospital, France, from pneumonia following influenza.

He was 50 years of age, and prior to joining the Service was in practice at Sheerness.

SURGICAL APHORISMS.

By D'ARCY POWER, F.R.C.S.(Eng.).

(Continued from page 26.)

(24) The cricoid cartilage is the guide both for laryngotomy and for high tracheotomy. Its position, therefore, must be verified before an incision is made for either operation.

(25) In the operations of laryngotomy and tracheotomy the windpipe has not been opened in the living body unless air rushes out. Inexperienced operators assign many reasons to account for the absence of this outrush.

(26) The first outrush of air is usually followed by a short period of apnoea. Put in the laryngotomy or tracheotomy tube, and then wait until the respirations become regular before proceeding farther.

(27) Do not suture the incision after laryngotomy lest surgical emphysema follow. A dressing of dry gauze kept in place by strapping is sufficient.

(28) Remember that the advance of science now permits of visual exploration of the trachea, bronchi, œsophagus, stomach, rectum, and bladder. It is no longer necessary to guess about the condition of these parts nor to be content with skiagrams. Look and see what ails them.

(29) A bacillary infection of the urinary tract is easily mistaken for appendicitis or ureteric calculus by those who rely more on the statements of the sufferer than upon the results of a thorough examination.

(30) An examination of the breast should be made with the patient recumbent. The tension of mammary tumours, their consistence and extent can thus be more readily determined than when the patient is sitting in a chair.

(31) Injury may produce a galactocele even in a virgin breast.

(32) It is better to have attention drawn to a tumour of the breast by pain than accidentally. Mastitis is often painful, whilst mammary cancer is usually painless in the early stages.

(33) The presence of a mammary cyst does not exclude malignant disease. It is unsafe, therefore, merely to aspirate such swellings. They should be excised.

(34) It is rare to get cancer of both breasts simultaneously; it is usual to get symmetrical mastitis.

(35) Tubercle and the gonococcus cause epididymitis; cancer and syphilis affect the body of the testicle. These four infections must be excluded before the rarer causes of enlarged testicle are considered.

(36) I do not remember to have seen a child with acute intussusception in whom the temperature rose above normal. The temperature, therefore, is important in making a diagnosis between this condition and acute inflammation of the intestinal canal in children.

(37) "Exploratory laparotomy" should be expunged from the list of surgical operations. It shows that the case has not been considered in every aspect.

(38) There are three stages in the career of a surgeon: in the first he loses the fear of hæmorrhage; in the second he ceases to multiply operations; in the third he acquires the moral courage to stop in the middle of an operation when he finds the conditions inoperable. There is a final stage which he never attains with the present span of life—the ability to gauge correctly the vital resistance of the patient, yet upon this depends the success of every operation.

EXPERIENCES IN MESOPOTAMIA AND INDIA.

By P. HAMILL, M.D., D.Sc., M.R.C.P., Major R.A.M.C.

TWO years' experience in Mesopotamia and Bombay is not a sufficient foundation for anything more than a few general observations on matters of medical interest. Perhaps I have been unusually fortunate, for in addition to the experience of a war hospital and a military infectious hospital for British troops, I have also, through the courtesy of many European and Indian practitioners, had an opportunity of seeing a number of interesting cases in Indians.

As regards the diseases, the difference between Eastern and London experience lies chiefly in the relative proportions and severity of the cases. Some common disorders were quite new to me; of these sand-fly fever and dengue were the chief. We had smallpox in all degrees of severity, but not very often, and occasionally cholera and plague. We had two cases of kala-azar and one of rat-bite fever, which recovered completely. Malaria, the enteric group, dysentery and liver disease, which are the cause of so many admissions in India, were already familiar; while relapsing fever and typhus, which were prevalent in one batch of Turkish prisoners, had once or twice been seen at home.

Febrile and intestinal affections form a large proportion of the total admissions. The reason of this is not far to seek. The combination of warmth and moisture favours the growth of micro-organisms productive of jaundice and diarrhoea. In those who have been long in the East, and in many natives, the whole bacterial content of the gut is often greatly changed. Yeasts abound in many patients, and in others lactose-fermenting organisms may be hard to find. Intestinal parasites are common. Worms of various kinds—particularly threadworms and *ankylostoma*—are very frequent, and the latter must be constantly borne in mind as a cause of the anæmia, which is so common in the tropics. Protozoa were found in a considerable percentage of the cases which passed through my hands; amœbæ of various kinds, and flagellates, such as *Lamblia* and *Trichomonas*, were the chief. All the bilharzia cases were imported.

This is not the occasion for a discussion of the pathogenicity of the intestinal Protozoa. They have a way of being more easily found at some times than others, particularly during an attack of diarrhoea. That may mean a variety of things—that they are not then broken up, that the factor producing diarrhoea produces a condition favourable for their development, or even that at these times one searches more diligently. My own impression is that one becomes tolerant of these creatures—as of many larger—and that whilst they may not be very detrimental, they are a nuisance and should be discouraged. The *Amœba histo-*

lytica is definitely pathological. A careful series of investigations showed that a considerable percentage of people harbours it, albeit unknowingly. Not only may this parasite produce serious, and even fatal, dysentery, but it is responsible for a good deal of ill-health, and even death, from the hepatitis which it may set up.

Though liver abscess is not at all uncommon, its incidence bears but a small proportion to the total number of cases of amœbic dysentery. Hepatitis—both acute and chronic—is, on the other hand, very common indeed. How much we owe to Sir Leonard Rogers for the introduction of emetin in the treatment of this disease it is hard to estimate. Its action in the majority of cases is almost miraculous, and has to be seen to be believed. Again and again one sees patients very ill, with the liver rapidly enlarging, high fever, leucocytosis, etc., in whom the development of an abscess seems imminent; but a few injections produce great relief, and a thorough course leads in time to resolution.

The possibility of amœbic hepatitis must always be kept in mind as a cause to be considered in any case of slight right-sided dulness of the lung, with or without pleurisy or pain. The characteristic pain referred to the point of the shoulder is by no means always present. Many early cases are most baffling, but careful clinical observation leads one in time to recognise them with comparative ease. When an abscess is suspected, exploration of the liver with a needle is indicated. It is fraught with little risk, and, even if pus be not found, often appears to afford relief. Puncture should be performed only on the operating-table, and everything should be in readiness for the immediate evacuation of the abscess should pus be found. Nowadays with emetin there is a tendency to avoid open operation, and to be content with evacuation of the abscess with an aspirator. A patient may sometimes be walking about within two or three weeks of the removal of over a pint of pus from his liver.

Malaria is wide-spread, and the parasite is always ready to take one at a disadvantage. At home one is taught in diagnosis to find, if possible, a single cause which will explain all the phenomena. In the East patients are ambitious, and often aspire to two or even three affections at the same time. Malaria and chronic or acute colitis—frequently of amœbic origin—or an attack of hepatitis are among the commoner complications chosen. In England it is not considered "good form" to be so grasping, but it must be remembered that "there ain't no Ten Commandments" east of Suez.

P.U.O.—How often one sees a patient so labelled! At least it is honest, if not used as a cloak for slackness—and I am glad to say it seldom is. We are almost entirely ignorant of the causative agent of the commoner acute febrile diseases—sand-fly fever, dengue and seven-day fever. The latter is common enough in April and May, and sometimes simulates mild enteric so closely even to the presence

of rose-spots, slight enlargement of the spleen, low pulse-rate, etc., as to deceive even the elect. But there are differences in the tongue and other points, which enable one to differentiate the cases after short experience. Typhoid and paratyphoid organisms cannot be isolated from the blood and stools, and there is no increase in agglutination titre. From two or three cases we have isolated coliform bacilli in the blood-culture, but their precise nature was not definitely established. Recent observations on cases classed as "Enteric Group" have shown that *B. fecalis alkaligines* and *B. coli* may be found in the blood-stream from time to time. There is obviously a large field open for investigation.

So many acute febrile diseases begin with shivering, headache, and pains in the back and limbs that in the early stages it is often well-nigh impossible to make a diagnosis. If there be an epidemic one naturally thinks first of the disease commoner at the moment, whether it be influenza, sand-fly fever, dengue, malaria or smallpox. Thus, a man who returned to England many months ago was seized this year in London with characteristic headache and pains. When admitted to hospital he was convinced that it was another attack of dengue, from which he had suffered in India. He turned out to be a typical case of influenza. I have had two or three cases admitted to my wards as P.U.O. which I thought at first to be dengue or influenza. Next morning they developed beautiful smallpox rashes—in one case whilst I was examining him. They were transferred to the Infectious Hospital, but beyond disinfection of bedding and re-vaccination of all in the wards no further steps were necessary, and the wards were not closed. I wonder if it would have been as safe to retain these patients as it is to keep enterics. We have had no smallpox among the attendants in the infectious hospitals, and the risk of transfer of the disease by contacts is probably not appreciable in an efficiently vaccinated population.

The most difficult cases are those in which for weeks or even months there is an evening rise of temperature of one or two degrees without much indisposition. Sometimes, especially in new-comers, it is malarial in origin, and there may be an increase of mononuclears, though the parasite is hard to find. In such cases a course of quinine affords relief, or a frank malarial attack supervenes and the parasite is detected. It is important to examine carefully for signs of tubercle and the other causes of continued fever common at home.

Nevertheless one cannot help thinking that the heat-regulating centre is unstable in a warm climate, and that mild infections produce greater disturbances of temperature than they would in England. Heat regulation is undoubtedly more difficult, especially when the humidity is high and the conditions unfavourable to evaporation, so that heat is not readily lost. However, I am not satisfied that this is the sole cause, for I have seen patients who were

apparently in normal health, except that their temperatures rose nearly every evening to 99° or 100° F., with but slight malaise. There appears in some cases to be a seasonal variation, for I have seen a Parsi whose temperature for several years rose to 102° or 103° F. daily from about the middle of April until the onset of the rains (usually the middle of June), but did not rise during the equally warm, damp weather of September and October. In this case and in that of one or two others under my care the most searching investigations were repeatedly carried out by different observers with negative results. The condition is well recognised, and has been discussed fully by Rogers. A voyage to Europe usually breaks the "habit," but it is apt to relapse after the patient has been back in India for a few years.

At first it is surprising to find how profusely one perspires on slight exertion, especially in the warmer and damper months. Stone in the bladder and kidney is very much more common in India than in England, and is probably due to excessive concentration of the urine.

Baghdad boil, known also as Delhi button and Punjaub sore, is not common in Bombay. Most of my cases have been in patients returning from Mesopotamia. My colleagues, Capt. Shorten and Capt. Barnard, in the radiographic department, were very successful in treating these most indolent and unsightly lesions by doses of X rays. We have also used the vaccines prepared by Dr. Roy in a few cases with good results. It is interesting to note that microscopically a section of a Baghdad boil may very closely simulate an epithelioma, though anaplasia is not present. This fact should be borne in mind when confronted with an indolent ulcer with raised edges on a limb.

Amongst the Arabs of lower Mesopotamia one sees occasionally on the ankle the pigmented scar of a healed Baghdad boil, and I am informed that they differentiate two types and practise inoculation—possibly with a view to prevention of further attacks. Whether infection with the Leishman-Donovan bodies which produce Baghdad boil yields any immunity against kala-azar it is hard to say. I do not know whether the latter disease occurs amongst the Arabs; it is, however, worthy of record that I have seen two patients invalided from Mesopotamia in whom I diagnosed kala-azar clinically, though the parasite was not found in blood-culture or on spleen puncture. One of these was under my care, and recovered after a course of injections of antimony tartrate; the other was in another hospital, and under similar treatment had already greatly improved when I left India.

Amongst minor disorders may be mentioned prickly heat and crops of boils. Not everyone is affected by prickly heat. The onset is surprising; most of those in my unit first experienced it in the Red Sea on our voyage out in August, 1916. On leaning back in a deck chair it felt as though dozens of pins had been driven in between the shoulders. Later there

was violent itching, and a good rub against a friendly stanchion or davit was most grateful. One can sympathise with the Scot who blessed the Duke of Argyll! The following verse from the *repertoire* of a Mesopotamia concert party was received with acclamation :

"The greatest trial in life for us has been the prickly heat,
It makes us want to scratch ourselves all day from head to feet ;
It really is the worst complaint a man could ever catch,
And the only thing to do for it is scratch and *scratch* and
SCRATCH !

"I don't suppose we'll cease to scratch for months and months and months,
I don't suppose we'll cease to scratch for months and months and months ;
The natives tell us here that when you've had it once
There's nothing to do but scratch and scratch for months and months and months."

Bombay, though seldom very hot (on but few days in the year does the temperature much exceed 90° F.), is never very cold—even the "cold weather" corresponds fairly well with an English June. The difference between day and night temperature is small and the humidity is high. This lack of temperature variation is one of the chief disadvantages, for the hot weather with the heavy rains is relaxing, and there is no stimulus of cold to restore vigour. It is surprising how great an improvement results both in patients and ordinary residents from a few days' change to a cooler and drier climate at a short distance from the coast.

As an all-year-round station Bombay is probably as good as any. It possesses the advantages of a large town, good shops, electric light and fans (a great comfort), and a water-carriage system of drainage, which is a joy to the eye and ear of those who have long been up-country. There are delightful drives in the surrounding country, good bathing, golf, etc.

The central meeting-place for Europeans is the Yacht Club. Considering that the harbour is particularly beautiful, it is a matter for some surprise that there are not more sailing members. No regatta was held during the two seasons I was in Bombay, but club races took place every Saturday from October to April. There are three classes, of which the Tom-Tits (Clyde Sea Mew Class) provide the largest entry. They are splendid little vessels, and are to be found at all the chief yachting centres in India and Ceylon.

Nearly everyone in India and Mesopotamia passes through Bombay sooner or later, and it is surprising how many old friends one meets. Bart.'s men are to be found everywhere. A good story is told of a Bart.'s dinner at Calcutta : A — Hospital man was dining alone at another table, and the chairman sent him a note inviting him to join the gathering. He refused with regret, and expressed his surprise that they had failed to observe that the — were dining !

RECONSTRUCTION IN MEDICAL EDUCATION AND PRACTICE.

By H. J. WARING, M.S., M.B., B.Sc.(Lond.), F.R.C.S.,
Col., R.A.M.C.

[We are indebted to the courtesy of the Editor of the *Lancet* for permission to print the following report of Col. Waring's remarks on this interesting topic at a recent meeting of the Medical Society of London.]

IN his opening statement Col. Waring said it was impossible to divorce medical education from medical practice. The objects to be aimed at in medical reconstruction could be put in the following brief form : (1) To improve the education of students so as to make them more efficient for medical practice ; (2) to improve the conditions under which medical practice is carried on ; (3) to obtain the largest output of good work from medical men with the least expenditure of energy ; (4) so to arrange the conditions of medical practice that the practitioner could have more time for recreation and more opportunities for bringing his medical knowledge up to date. He was assuming that it was not the intention of the State to create a whole-time medical service ; the draft Bill did not foreshadow that.

THE MEDICAL CURRICULUM.

Five years was too short a period of study if clinical subjects were to be adequately taught. When, in 1892, the medical curriculum was lengthened to five years, it was the intention that the added year should be devoted to clinical work, but owing to some deficiencies in organisation and to some matters concerning the organisation of the schools the preliminary subjects still occupied the whole period. Two suggestions had been made to remedy that. The first was that the chemistry, physics, and biology course should be completed before the commencement of medical study ; this could be done by rearranging the work at the public and secondary schools in the case of students who did not go to the older universities. In many public schools the courses of instruction were so arranged that the chemistry, physics, and biology taught sufficed for the first examination ; the same was also true, to a lesser extent, of many secondary schools. If the need were made very clear, the public schools would also fall into line. In Scandinavia the period of study had been extended to six years, and he was told by medical men there that it was satisfactory ; but he thought the better solution of the difficulty was the completion of the chemistry, physics, and biology before entering the five-year course of medicine and surgery.

MEDICAL EDUCATION.

He felt that anatomy should be taught by professed anatomists, but taught less from the morphological than from the surgical side. These professors should be shown

the need for emphasising the latter aspect—*i. e.* in the use of the living model and the normal X-ray appearances, especially in regard to the bones. It was also absolutely necessary to teach the lymphatic system of the body more thoroughly. There should be a schedule of anatomy, for some parts need not be taught in detail, such as learning every individual muscle of the back. Owing to the paucity of material, he thought it necessary that there should be a new Anatomy Act; and if that were the general view there should be a collective representation made, for the present was an opportune time. Applied anatomy would have a fitting place during the clinical period, and should be taught by a surgeon. Physiology had become such an enormous subject that its professors showed a tendency to teach it as a science apart, rather than human physiology as a factor in general medicine. The chemist should be attached to this department, and the time had now arrived for the general inclusion of a bio-chemist. Pharmacology should be taken in the intermediate period, in close association with physiology. He thought that the essentials of bacteriology should be taught before the student commenced his actual medical work; it could be done in a compulsory three months' elementary pathology and bacteriology course.

With regard to *materia medica* the student had an enormous amount to learn, as the Pharmacopœia was now very extensive. A number of physicians and surgeons could probably cut it down to one-half with advantage to the medical student and without material disadvantage to medical practice. General medicine and surgery were well taught in all the medical schools. He had a suggestion to make, however, with regard to midwifery and gynaecology—namely, that separate teachers should be appointed for these two subjects. There had been a great tendency for the teaching of midwifery to be left to the younger man; when the teacher was older he inclined to the gynaecological or surgical side. There were now many special departments, and as medical education was at present constituted it was almost impossible for the ordinary student to go through all of them satisfactorily. The medical student should go through a special course in each one of these. Owing to the difficulties in providing material, the majority of students never went through any satisfactory course in operative surgery; it was usually only those who went in for the higher degrees who did so. Concerning the equipment of the medical student for practice, he thought the teaching of mechano-therapeutics and massage was not satisfactory in any of the schools, yet many conditions could only be treated satisfactorily in that way. Consequently, that branch of practice went, by default, to quacks. In the States the gentleman who called himself an osteopath got a big practice. Mechano-massage should not be taught alone to the medical student; nurses should be included. He would have much more done in the teaching of preventive medicine; he did not mean public health work and sanitary

science, but the prevention of the occurrence of disease. That was very much wanted in English medical schools. There should also be included in the curriculum a definite course on medical ethics. At present, to a great extent, the student had to learn it after he had entered on practice. It need not be an extensive course. Nurses should be regarded as part of the medical profession, but in the past they had not been catered for as they should have been. He did not think nurses were given sufficient opportunities for doing surgical dressing. It was also a question whether surgical sisters and those in charge of operation theatres should not have practical instruction in administering anæsthetics. In military practice during recent years they had done very useful work of this kind.

POST-GRADUATE STUDY; MEDICAL SCHOOLS; CONDITIONS OF MEDICAL PRACTICE.

With regard to post-graduate schools, he thought that in London the profession had made a mistake. In most of the schools an attempt was made to teach graduates and undergraduates together. It would attract many to the wealth of clinical material in London if graduates could have courses distinct from those for undergraduates. At the present time most of the medical schools in London were associations of private individuals for the instruction of students, and their emoluments were derived from the fees paid by the students. He did not think university education could be satisfactorily carried out on the fees paid by the student. Recently the Board of Education had given grants to some schools, and those had during recent years enabled some of them to survive. He did not think the method of giving grants was a good solution. Every medical school should be a corporate body; should be controlled by a governing body, both professional and lay. The large hospitals should, he thought, have an arrangement by which the members of the Navy, Army, and Air Services could have definite study courses in the schools. It seemed a pity that as men became seniors in these services they were made administrators, to the loss of the scientific side.

He also made a plea for team work in ordinary practice. Practices should not be a one-man concern, but should consist of men with varied qualifications, so as to ensure thorough investigation for every patient. London was worse provided than any other place with private institutions for medical and surgical treatment. Many of the "surgica homes" had been chosen because the property was cheap, and in some the sanitary and other arrangements were very unsatisfactory. Some were a definite disgrace to the profession. Under the new Ministry of Health he would have it as a condition that every one of these houses should be passed as in a fit sanitary condition before it was allowed to be so used. An interesting question was as to how far it was desirable for a nursing home to belong to a medical man. He thought such homes ought to be legitimately

possible provided they were certified by some public body as suitable.

Much had recently been heard about making an A 1 community out of C 3 material. As things were at present constituted he did not think that was possible. The criminal, the congenital idiot, the feeble-minded, and such people were allowed to go free so long as they were not dangerous to the community. Two feeble-minded folk married, or did not marry, and additions to the C 3 ranks ensued. That could probably only be effectively stopped by means of sterilisation. Lastly, how far was the profession justified in prolonging the dreary lives of people suffering from incurable and crippling conditions, such as ectopia vesicæ and imperforate anus?

OBITUARY.

ALFRED ELLINGTON STANSFELD, M.D.(CANTAB.),
F.R.C.P.



GLOOM has been cast over our Hospital by the untimely death of Dr. A. E. Stansfeld, which took place on November 25th from pneumonia following influenza.

Alfred Ellington Stansfeld was born at Stoke Newington in 1882. He received his earlier education at the Central Foundation School and entered St. John's College Cambridge, in 1902 with a Major Scholarship in Mathematics. This he held for five years, although, shortly after going into residence, he received permission to relinquish his studies in Mathematics in favour of Natural Sciences. He gained First Class Honours in the Natural Sciences Tripos, receiving the degree of B.A. in 1905. In the second part of the Tripos he took Physiology as his subject, and once more gained First Class Honours. In 1907 he entered St. Bartholomew's Hospital with an Entrance Scholarship, and during his brilliant career as a student won the Kirkes' Scholarship and Gold Medal, and the Burrows' Prize in 1908, the Brackenbury Medical Scholarship in 1909, and the Lawrence Scholarship and Gold Medal in 1910.

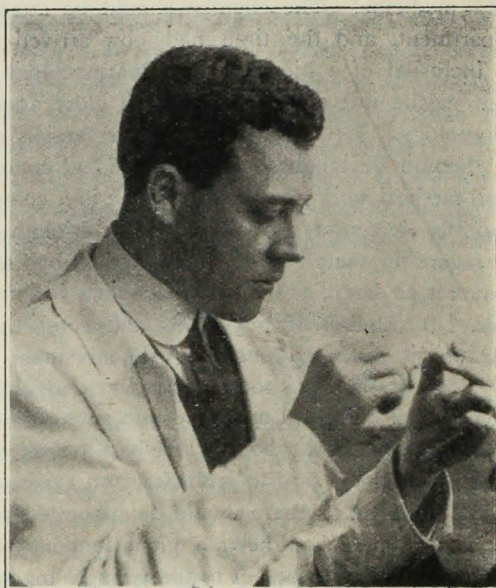
After qualifying at Cambridge in 1909 he went on a voyage round the world, returning to St. Bartholomew's Hospital in 1910 as House-Physician, and afterwards held the appointments of Casualty Physician, and Clinical Assistant to the Skin Department. He entered the Pathological Department in 1912, being first Junior and later Senior Demonstrator of Pathology, which post he held at the time of his death.

He was also Pathologist to the Special Treatment Centre for pregnant women at Thavies Inn.

At the Metropolitan Hospital he was elected Assistant Physician in 1912 and full Physician in 1916.

He became Member of the Royal College of Physicians in 1911, took the degree of M.D. at Cambridge in 1915, and was this year elected Fellow of the Royal College of Physicians.

Stansfeld's death has robbed the Hospital and the medical profession of one of its most brilliant members. He was a man of great intellectual achievements, and possessed powers of perception which were rapid and accurate. His clearness of thought and his simple and lucid methods of reasoning, tempered with kindness and understanding, made him not only a successful and popular teacher, but a friend to whom all could go in their difficulties. He was ever willing and eager to give a helping hand, to advise and encourage those who came to him, and it



DR. A. E. STANSFELD.

was not only students who came, but there was scarcely a member of the Hospital with whom he had not some close association. His room in the Pathological Laboratory was often to be seen filled with men who collected there to ask his opinion and advice.

At the Metropolitan Hospital he took an active part in administration and gave great assistance to the Committee. He was a good disciplinarian, and arranged many difficult matters with tact and forethought. Though full Physician he still continued to attend out-patients, and acted as Pathologist to the Special Treatment Department. In the formation of the latter he took a great part, and it owes its success largely to his untiring energy. He was Secretary to the Medical Committee, and a medical representative on the House Committee and Committee of Management.

The greater part of his time, however, was taken up by work in the Pathological Department of St. Bartholomew's Hospital, in performing the routine work, teaching the

students, and organising their classes and lectures. Research had necessarily to take second place, but he was able to perform much valuable work, and interested himself in problems connected with blood and its diseases and in immunity. His apparatus for the transfusion of blood is now in frequent use in the wards. In pathological technique he excelled, and was never satisfied with an experiment unless it was done to the best of his ability. His studies in asthma and anaphylaxis were much interrupted during the war, and have remained unpublished, being in an incomplete form at the time of his death. Among his published works are: "The Treatment of Diseases of the Blood" and "The Treatment of Diseases of the Spleen," *Practitioners' Encyclopædia of Medical Treatment*, 1915; "The Present Position of Vaccine Therapy," *St. Bartholomew's Hospital Reports*, 1916; "The Principles of Treatment by Transfusion of Blood," *Lancet*, 1917; "Apparatus for Transfusion of Blood by the Citrate Method," *Lancet*, 1917.

It was perhaps in Clinical Medicine that Stansfeld shone brightest, and he owed his success to every attribute which makes the brilliant physician. In his examination of his patients he was extremely thorough and systematic. He applied his extensive physiological and pathological learning in a masterful manner, and left no stone unturned in his endeavour to arrive at the diagnosis, or to treat his patients to the best possible advantage. He approached his cases, too, from the human side, and made them feel that he took their ills personally upon himself, and gained their lasting love and confidence.

Stansfeld leaves behind him a widow and three children, and to them we offer our most sincere sympathy. His death at so early an age comes upon us as a great shock, and we mourn his sad loss. His career, so brilliantly begun, gave full promise of a great future and of upholding our most noble traditions.

R. G. C.

AN APPRECIATION.

One of the penalties of friendship has again fallen to my lot: this is the third occasion I have contributed to the JOURNAL a few words in memory of a departed friend. The privilege, though a sad one, is one which I would not lightly forego; it affords an opportunity to relieve over-charged feelings by giving expression to the crowding memories of old associations; and on this, as on the other occasions, I am grateful thus to be identified with one who I am proud to remember was my friend.

When I was appointed House-Surgeon to the late Mr. C. B. Lockwood we corresponded with Dr. Ormerod's "firm" and Stansfeld was my contemporary house-physician. Hitherto our acquaintance had been pleasant, but limited. I had known him first at Cambridge as having a reputation for brilliancy which can hardly have been equalled. I had met him and had been delighted to claim him as an

acquaintance, but our paths did not lie together: he was soaring on the highest peaks of Physiology; I was toiling laboriously up the smaller heights leading to the first part of the Natural Sciences Tripos.

So that it was as fellow House-men that our friendship really began. I doubt if colleagues of the Junior Staff ever consulted with the same enthusiasm that Dr. Ormerod's House-Physician and Mr. Lockwood's House-Surgeon spent those twelve months together. I am not ashamed to admit that the advantage was all on my side; and whilst Stansfeld would generously fetch me in order that I might be shown some rare or peculiar feature in medicine, I for my part perpetually called upon him for his opinion upon an admittedly surgical condition. Yet in the most charming way Stansfeld never failed to create the impression that so far from his conferring a favour, he himself had reason to be grateful and was under an obligation.

Often and often on full duty when retiring to bed in the small hours of the morning I would say to him half jokingly and half in earnest, "I shall fetch you out later on if I am in trouble," and he would invariably reply with unmistakable sincerity, "Oh, I shall be so glad if you do."

How many H.-Ps. even of the keenest enthusiasm would be prepared to accept such a gratuitous burden and submit to a deprivation of their scant leisure? Yet I am perfectly certain that in his greatness of heart Stansfeld regarded this appeal to his assistance as actually the accordance of a favour to him.

And when time brought him higher up the ladder of professional distinction he was just the same. To help a friend or even a casual acquaintance who had no sort of claim upon him no amount of trouble was too great. Like most young physicians and surgeons of ability Stansfeld ran the gauntlet of exploitation, but from his glorious wealth of intellect he gave ungrudgingly and uncomplainingly. In the face of the most heartbreaking meanness of a professional colleague he would express no resentment, although his own strict sense of duty towards his brethren permitted no slightest departure from financial obligations whenever he was in a position to dictate.

Of Stansfeld's early scholastic career I know nothing. He came to Cambridge as a Major Scholar of St. John's College, and with an ability which so impressed the College authorities that, although he had gained his Scholarship for Mathematics, they permitted him to study Natural Science, as indeed they would have permitted him to read History or Music or Oriental Languages, or anything else he liked.

Of course he took a Double First in the Natural Sciences Tripos. Still more, of course, he never failed in an examination. I doubt if he ever competed for a prize or scholarship which he did not win, and the Honours List at Bart.'s bears tribute to the extent of these. *Inter alia*, he achieved that very rare distinction, the Lawrence Scholarship (under old regulations), and had he sat for the Final

Fellowship—of course he had passed the Primary quite casually!—or the M.Ch., I am perfectly certain they could never have ploughed him.

Perhaps I may be permitted just one story of an examination. When he was up for the Final M.B. at Cambridge, his papers naturally demonstrated to the examiners that they were dealing with a candidate of exceptional merit. A fellow-examinee overheard Sir Clifford Allbutt during the clinical examination taking Stansfeld to a case and asking him to examine it and give an opinion—"not as an examinee, but as a colleague." And the Regius Professor of Physic was subsequently heard discussing the result with another examiner in this wise: "By Jove, Stansfeld is a clever fellow. I showed him that case over there [it was an obscure condition of mediastinal disease], and 'pon my word he really persuaded me that the opinion I had formed of it was wrong!"

Stansfeld was academically so brilliant that I doubt if the full extent of his capacity was ever generally realised. Without appearing to read very much—indeed, his practical work gave scant leisure for reading—his knowledge of medical literature was almost encyclopædic. But in addition he had rare clinical acumen, a clear-headed capacity for the utilisation of the knowledge he possessed, and a practical acquaintance with physical signs which gave him at the bedside a faculty for diagnosis far beyond the experience of his years. Add to all this the possession of remarkable vitality, energy, and patience. I never saw him ill or even seedy, and after three or four successive nights of work as Senior H.P. one invariably found him in the morning fresh, smiling and good-humoured as ever, keenly anxious to begin another full day's work.

I suppose no genius is ever unaware of his superiority, and with all his sublime simplicity and modesty Stansfeld possessed a pleasing dogmatism which arose out of the sense of power in his knowledge. And yet nobody was ever more tolerant of other people's inferiority, and nobody more enthusiastic—almost absurdly enthusiastic—about other people's capacity in those directions in which he himself did not excel or upon which he did not regard himself as an authority. And whilst his eyes shone and his face lit up with a merry smile as he positively gloried to hear of the achievements of any of his friends, of his own successes it was almost impossible to get him to speak, and only casually did one gather how his brilliancy over difficult cases had brought him in front of others far more eminent in the profession whose judgment one would have expected to be much greater. And Stansfeld was no mere academic diagnostician. With a real bull-dog tenacity he would fight every inch of the road to save a patient whom others had abandoned as hopeless. I could, indeed, quote striking examples out of my own knowledge, but these would appeal only to readers who knew Stansfeld, and they could all supply for themselves examples equal to mine.

Stansfeld had no enemies. This is a rash generalisation to say of any man, but I utter it without hesitation. Some men disliked him I have no doubt; his code of honour was so high that men of poorer clay resented even this evidence of superiority, whilst envy of his ability impelled inferior minds to doubt his clinical capacity on the principle that a clever man is always unpractical. But the true nobility of his character shamed into silence his most adverse critics, and so Stansfeld could never have had an enemy.

Fearless in every undertaking, he allowed no personal considerations to stand in the way of his duty. I remember once on the question of an appointment he gave his vote in favour of a man for whom he had no liking rather than to an admitted friend, because he was convinced that the former was the better man for the appointment, and felt that he was in honour bound to support him. How many of us would be disposed thus fearlessly to submerge our personal prejudices in the cause of justice! Can it be wondered at that if Stansfeld may have lost a "friend" he never made an enemy?

* * *

Once the first sting of personal grief is past, it is almost a duty to remember that not only must this hospital mourn one of her greatest sons, but that British Medicine itself has sustained a loss. Stansfeld would have gone far, and the highest honours must inevitably have been his. Nothing could have resisted that combination of mighty intellect, untiring application, and unswerving rectitude.

But my thoughts swing back inevitably to the days when we were on the House together, two boys just beginning the practice of their profession, and I shall always remember him for his kindness of heart even more than for his brain.

A common friend (G. G—) who may read these lines may remember in a conversation several years ago expressing to me the opinion—"Stansfeld is one of the very few men one can really call 'a friend.'"

I think that Alfred Stansfeld himself would be prouder of this epitaph than of any other to which his great intellect and Christian character would entitle him.

A. ABRAHAMS.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. ST. THOMAS'S HOSPITAL.

Thomas's, unfortunately, could only field a very weak side at Chiswick on November 23rd, the result being a win for the Hospital by 54 points to *nil*. As the score suggests, the game was a very one-sided one. Beaten for possession in the scrum and outclassed behind, Thomas's were on the defensive during the whole game. Receiving from almost every scrum, Cockell made full use of his opportunities and opened up the game in excellent style, with the result that the Thomas's line was crossed on twelve occasions. Tries were scored by Johnstone and Hendley (3 each), Krige and Thomas (2 each), Cockell and Orchard (who also dropped a clever goal). Krige was successful with 7 placed kicks.

ST. BARTHOLOMEW'S HOSPITAL *v.* R.A.F. WIRELESS STATION.

On November 30th the Hospital visited Biggin Hill, the opponents being a R.A.F. team. Although the game itself was not of the highest order, the visit was most interesting and greatly enjoyed. The ground was altogether against good football, and the team never settled down, most of the tries being the result of clever individualism. As in most of the previous matches our outsides quite outclassed their opponents, and the score would undoubtedly have been a heavier one had the forwards given them more opportunities. The final score was 34 points to 3, and the tries were shared between Thomas, Hendley, Cockell, Orchard, Llewellyn and Johnstone, the latter being also responsible for a clever dropped goal. Shaw, Johnstone and Macdonald converted.

ST. BARTHOLOMEW'S HOSPITAL *v.* R.M.A. (WOOLWICH).

The Hospital had little difficulty in defeating the "Shop" at Woolwich on December 7th, the final score being 42 points to *nil*. Their team, however, was a weak one, Camp claiming several members of the regular XV. Playing up the slope, the Hospital maintained a steady pressure for the whole of the first half, but were only successful in crossing the line on four occasions, the half-time score being 16 points to *nil*. On changing ends, however, the Woolwich defence completely broke down. In spite of the heavy ground and greasy ball, Bart.'s played their most convincing game of the season, and the handling of the outsides—especially Johnstone and Hendley, was extremely clever. Hendley (5), Thomas (3), Orchard and Llewellyn (2 each) were the scorers, and Johnstone (2) and Macdonald (1) placed the goals.

ST. BARTHOLOMEW'S HOSPITAL *v.* NEW ZEALAND CONVALESCENT HOSPITAL.

The first home match of the season was played at Winchmore Hill on December 14th, when the powerful New Zealand team from Hornchurch were the opponents. The heavy state of the ground rendered handling almost impossible, and on the whole the game was fought out between the two packs. The New Zealanders undoubtedly held the advantage forward, their short kicks and fast following up being quite a feature of the game. The Bart.'s pack, although without Krige and Sanford, played pluckily throughout, and their tackling was especially good. Crossing over with 8 points against them, the Hospital continued to improve, and tested the New Zealanders' defence on several occasions. After about twenty minutes' play Cockell, receiving from the scrum, made a clever opening for Johnstone to drop an excellent goal. This was all the scoring, and Bart.'s lost a most interesting game by 4 points to 8. The narrow margin of 4 points was in a large part due to the clever fielding and touch-finding of Thomas, who frequently saved the Hospital line.

REVIEWS.

OTITIS MEDIA (MASTOID DISEASE). By CHARLES J. HEATH. (Baillièrre, Tindall & Cox.) Pp. 58. Price 2s. 6d. net.

We have no hesitation in describing Heath's paper (it was originally read before the Hunterian Society) as epoch-making. It is the first occasion in which the diagnosis of invisible tympanic conditions has been made possible as a guide to treatment. In the preface the author points out that he was asked to give this information during a discussion of his paper on "The Prevention of the Deafness and Mortality which results from Aural Suppuration" at the last International Otological Congress, which took place at Boston, U.S.A., in 1912, and he has certainly responded fully to that request.

We consider it the duty of every surgeon who has charge of ear cases to make himself acquainted with Heath's methods of diagnosis of the tympanic conditions which call for the "conservative" mastoid operation in order to prevent deafness through aural suppuration.

LESSONS ON MASSAGE. By MARGARET D. PALMER. Fifth Edition. (Baillièrre, Tindall & Cox.) Pp. x + 340. Price 10s. 6d. net.

This deservedly popular book has been thoroughly revised and brought up to date. Several new chapters have been added, the most important being those dealing with "The Treatment of Wounds," and with "Swedish Remedial Gymnastics." The chapter on "Bandaging" has been much amplified, and adds to the usefulness of the volume. Massage is a branch of medical work which has developed enormously during the last four years. For those requiring a really practical work on the subject we have every confidence in recommending the book under review.

WAR WOUNDS OF THE LUNG. By PIERRE DUVAL. (John Wright & Sons, Ltd.) Pp. 100. Price 8s. 6d. net.

This volume is an English translation of a work which originally appeared in French. It describes the very successful efforts of French surgeons in dealing with a most difficult branch of war surgery. Before the war surgery of the lung was not much in evidence. To-day it takes its place in the routine of general surgery, and affords perhaps the most striking example of the remarkable advances in surgery during the last few years. The book is extremely well illustrated, and should meet with a cordial reception.

CLINICAL CASE-TAKING. By ROBERT D. KEITH. (H. K. Lewis & Co., Ltd.) Pp. 104. Price 3s. 6d. net.

A useful little book originally written for the students of the King Edward VII Medical School, Singapore. The general arrangement does not differ materially from several other books on this subject, but the matter is very concise and to the point. We were not greatly impressed with the chapter dealing with microscopical examination; some notes on urinary deposits might very conveniently have been included in this section. Nevertheless, the student will find much useful information in this little volume, especially if he is just commencing his clinical work.

CORRESPONDENCE.

"HEART-STRAIN."

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

SIR,—I was greatly interested in Major Abrahams' letter on "Heart-strain" in the December number of the BART'S JOURNAL. My experience entirely coincides with his, and I am strongly of the opinion that the *healthy* heart cannot be damaged by the muscular exertion involved in the training and life of an athlete. Many hearts undoubtedly break down under athletic strain, but I am convinced that these hearts were not healthy to start with. The present haphazard method practised at public schools of not only letting, but making, all boys go in for athletics, unless they have a doctor's certificate of unfitness, is responsible for many broken lives. No doubt at some schools the boys are "passed" by the doctor before they indulge in athletics, but the usual method of examination of the heart is not detailed enough to exclude those small abnormalities which are often the only indications of a defective heart.

During the last three years I have seen a good many young officers whose hearts have broken down under the physical and mental strain of trench warfare. All these young men were passed as physically fit for active service, but in every instance a careful inquiry elicited a history of former heart trouble, such as a "strain" in school athletics, fainting attack, or rheumatic fever in boyhood. In most of these cases the only signs of defective cardiac action were a slight increase in the area of cardiac dulness to the right and sinus arrhythmia. The increase in the area of cardiac dulness had been overlooked because, as a rule, I found the area of cardiac dulness had not been percussed out, and no doubt the sinus arrhythmia had also been overlooked in the rush of an army examination. Yet all these young men were supposed to have entered the Army with sound hearts, whereas it was evident from their former histories that they all had defective hearts before they joined up. No doubt the cases in which athletes break down under training or after races can be explained in a like manner.

The accurate percussion of the area of cardiac dulness is not, in my opinion, sufficiently impressed upon the student—indeed, some teachers maintain that the area of cardiac dulness cannot be accurately percussed out. There are no doubt some medical men with a defective

sense of sound, as there are also some with "no ear" for music; but the average medical man could undoubtedly percuss out the area of cardiac dulness with accuracy if he had been taught to do so as a student and had kept up the practice. No cardiac examination is complete or trustworthy unless it includes a carefully traced area of cardiac dulness.

The above remarks may seem somewhat wide of the subject of the possibility of "heart-strain" in athletes, but they are necessary to illustrate my contention—that the athlete who breaks down is the athlete who has always had a more or less defective heart, and that, if more care was given to a detailed examination of school boys' hearts before they indulged in athletics, there would be fewer, if any, chronic cardiac troubles attributed to athletic overstrain.

I am, Sir,

Yours faithfully,

LESLIE THORNE-THORNE, M.D.

108, HARLEY STREET;
December 9th, 1918.

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

SIR,—In his interesting letter on this subject Dr. Adolphe Abrahams quotes one of my "Medical Notes" in which I ventured, perhaps with less temerity than the occasion warranted, to dissent from Dr. Lewis in his expressed belief that a healthy heart is never damaged by muscular exertion, however severe or prolonged. Dr. Abrahams agrees with this belief of Dr. Lewis. Opinions can only be expressed; they scarcely admit of discussion. I do not therefore propose to try and convert Dr. Abrahams from his belief in the immunity of the healthy heart from strain. But two or three considerations present themselves for comment. In the first place my note did not refer to the so-called "athletic heart," to which most of Dr. Abrahams' letter refers, and for which I hold no brief any more than does he. I have not met with this type of heart, and I submit to Dr. Abrahams, with his much greater experience of athletes, when he says that it does not exist. But I do not think "exceptional opportunities of observing prominent athletes from many parts of the world" cover the ground that must be gone over in coming to a decision in this matter. And for this reason I am not conscious of any embarrassing conflict between my old pupil and myself.

The ordinary citizen is not an athlete. He is not always a young man. And he does not train. He is prone to emerge from his office or warehouse and to embark upon relatively sudden and violent exercises—of late years he has been digging trenches (or potatoes) in an admirable spirit of patriotism, to give one instance only—and to say that it is proof that he was in a fool's paradise as regards the condition of his heart, because some hours or days of these efforts produce the picture of heart-strain, seems to me to be very like special pleading.

Of course if an untrained heart is to be regarded as a diseased heart, or if the hearts of all unhealthy persons are to be regarded as diseased hearts, then we have adjusted our terms and there is no more to say, but in this case the terms are given meanings which are quite different from those given to them in connection with every other muscle or organ of the body.

Dr. Thorne-Thorne, who shares Dr. Abrahams' belief, and who also deals chiefly with athletes, introduces criteria by which he thinks hearts of dubious character may sometimes be detected early. One of these criteria is sinus arrhythmia. But the chief apostles of modern cardiology do not agree with him. Mackenzie says he regards sinus arrhythmia as "a physiological sign and not as evidence of impairment of the heart. Far less do I look upon it as evidence of disease of the heart." And Lewis writes that "the commoner forms of sinus irregularity . . . are to be regarded either as slight exaggerations of a normal phenomenon or as evidences of a mild and insignificant instability of tonic inhibitory nerve action. They should not be allowed to influence the habits of those who exhibit them." And yet Dr. Thorne-Thorne tells us they should put a veto upon a boy's athletics!

But it seems not unreasonable to ask, "Why should the healthy heart possess this fine, this enviable aloofness from the effects of strain?" We admit effects of strain in the healthy erector spinae, in the healthy shoulder-joint, in the healthy urinary bladder, even in that master tissue—the healthy central nervous system; why not in the healthy heart? But it may be said by some that when these structures show effects of strain they, too, are not healthy. (And I remember an eminent surgeon telling a young giant, who had ruptured some fibres of his deltoid muscle whilst trying to mount an untamed horse, that the injury proved quite clearly he was the subject of an

ileal kink.) If so, then my note and this letter must be regarded as being at the most a mild protest against that school-man attitude, which bases ideas of pathology upon things as they ought to be and not upon things as they are.

I am, Sir,

Yours faithfully,

THOMAS HORDER.

[In order to save space we have taken the liberty of forwarding an advanced proof of Dr. Thorne-Thorne's letter to Sir Thomas Horder, hence the latter's reference to Dr. Thorne-Thorne's communication.—Ed.]

EXAMINATIONS, ETC.

UNIVERSITY OF OXFORD.

At examinations held recently the following candidates were successful:

M.B., B.Ch.—C. F. Krige, H. W. Toms.

CHANGES OF ADDRESS.

CAPON, H. V., 9, Cambridge Street, W.

COLLINGS, D. W., The Mount, Southwold.

SOAMES, R. M., Ridgway, Reigate Hill, Reigate.

TURNER, P. E., Catherine Booth Hospital, Nagercoil, Travancore, India.

VOSPER, S., York House, Peverell, Plymouth.

WALKER, K. M., Argentine Club, 1, Hamilton Place, W.

BIRTH.

SCAWIN.—On November 27th, at Selway, Fairford, Glos., the wife of Major Scawin, R.A.M.C., of a son.

DEATHS.

CHERRETT.—On November 4th, 1918, at Nairobi, B.E. Africa, of pneumonia following influenza, Bertram Walter Cherrett, M.B., Medical Officer of Health, Nairobi, and Captain East African Medical Force, aged 35.

JUKES.—On October 18th, 1918, in Egypt, of neuritis and heart failure after rheumatic fever, Capt. Andrew Monro Jukes, M.D., I.M.S., the loved husband of Gertrude (née King) and the beloved and only son of Dr. and Mrs. A. Jukes (C.M.S., retired).

LLEWELYN-JONES.—On August 14th, 1918, A. W. Llewelyn-Jones, of Westholme, Torquay, aged 52.

LUSH.—On November 28th, 1918, at 48, Avenue Road, N.W., from pneumonia, Percy J. F. Lush, M.B., B.Ch.(Oxon.), dearly-loved husband of Lydia Lush and youngest son of the late Right Hon. Lord Justice Lush, aged 60.

REID.—On November 18th, 1918, suddenly, James More Reid, Lieut.-Col., R.A.M.C., aged 62.

WINTER.—On November 15th, 1918, at 20th General Hospital, France, while on active service, from pneumonia, following influenza, Capt. Laurence Amos Winter, M.D., R.A.M.C., late of Sheerness, formerly of Farnborough, aged 50.

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.

St. Bartholomew's Hospital



JOURNAL.

"Æquam memento rebus in arduis
Servare mentem."

—Horace, Book ii, Ode iii.

VOL. XXVI.—No. 5.]


FEBRUARY 1ST, 1919.

[PRICE SIXPENCE.

CALENDAR.

Fri., Jan.	31.—Dr. Morley Fletcher and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Tooth.
Tues., Feb.	4.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Wed., "	5.—Clinical Lecture (Surgery), Mr. Waring.
Fri., "	7.—Dr. Tooth and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine), Dr. Calvert.
Tues., "	11.—Dr. Calvert and Mr. Waring on duty.
Wed., "	12.—Clinical Lecture (Surgery), Mr. Waring.
Fri., "	14.—Dr. Morley Fletcher and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Calvert.
Tues., "	18.—Dr. Drysdale and Mr. D'Arcy Power on duty.
Wed., "	19.—Clinical Lecture (Surgery), Mr. Waring.
Fri., "	21.—Dr. Tooth and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Morley Fletcher.
Tues., "	25.—Dr. Calvert and Mr. McAdam Eccles on duty.
Wed., "	26.—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri., "	28.—Dr. Morley Fletcher and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine), Dr. Drysdale.
Tues., Mar.	4.—Dr. Drysdale and Mr. Waring on duty.

EDITORIAL NOTES.

E are glad to learn that the New Year entry at the Hospital is an extremely heavy one, and considerably in excess of what is general at this time of the year. A large number of students are returning from the Army under the Order whereby Group 43—consisting of students and teachers—are to be demobilised rapidly, and there is scarcely a vacant place in any of the laboratories.

* * *

The East Wing, which for four and a half years has served for the housing of soldiers to the number of 5500, was evacuated at the end of last month and placed in the hands of the decorators preparatory to its return to civilian purposes. It is, indeed, gratifying that the old Hospital has done so well by its country, not only in giving its men and women to serve abroad in their professional capacity, but also in helping to house the wounded and sick on their return from the fray. The men in hospital have been royally treated, and it speaks well of the administration that everything has gone quietly and smoothly throughout the war. A letter of thanks has been received from the Army

Council and also from the D.D.M.S. of the London district thanking the Governors and all the Staff for their services, which we much appreciate. We hope at a later date to give some short account of the happenings in the Wing during this period.

* * *

In the last issue of the JOURNAL we asked for suggestions from our readers enent a suitable memorial to commemorate Bart.'s men who have fallen in the war. We still await the suggestions. It is a very extraordinary thing, but our Hospital is often very slow in making a start, and yet they invariably get there at the finish. Several incidents occur to us as we write which demonstrate this fact. But this is an occasion when we feel that something should be done. One hospital in London has collected already nearly £3000 for a similar purpose. Bart.'s must not be behind in doing honour to its gallant sons.

* * *

We are quite aware that Peace is not yet signed, but to all intents and purposes the war is over. A large number of our students who were on active service are back in Hospital, the majority of our staff have recommenced duty, and we have a large entry of new men. In spite of all this, the social life still remains to all intents and purposes dead.

With the sole exception of the Rugby Football Club, which we are glad to note is having a remarkably successful season, games are quite at a standstill. For some reason or other there have been no evening meetings this winter; the usual mid-sessional address has not been delivered—in fact the Abernethian Society might not be in existence.

We realise that it is impossible to get back to pre-war conditions at a moment's notice, but we think that an effort might be made to restore the Hospital to something like its normal self.

* * *

The following Bart.'s men have been included in the New Year's Honours, and to one and all we offer our heartiest congratulations:

C.B. (Military Division).—Maj.-Gen. R. C. Munday, R.A.F. (*Civil Division*).—Surg.-Capt. A. S. Nance, R.N.

C.M.G.—Temp. Col. G. E. Gask, D.S.O., A.M.S.; Temp. Col. J. A. Nixon, A.M.S.; Temp. Col. E. P. Sewell, D.S.O., R.A.M.C.

C.I.E.—Lieut.-Col. F. E. Swinton, I.M.S.

C.B.E.—H. H. Dale, F.R.S.

O.B.E.—Lieut.-Col. F. E. A. Webb, R.A.M.C.T.; Act.-Maj. H. Burrows, R.A.M.C.T.; Temp. Maj. W. S. Dickie, R.A.M.C.; Temp. Maj. M. G. Pearson, S.A.M.C.; Maj. C. S. de Segundo, R.A.M.C.T.; Maj. G. C. Taylor, R.A.M.C.T.; Temp. Capt. J. C. M. Bailey, R.A.M.C.; Temp. Capt. F. H. Diggle, R.A.M.C.; Capt. J. C. Newman, R.A.M.C.T.; Capt. E. I. P. Pellew, R.A.M.C.; Capt. J. Ramsay, R.A.M.C.T.; Temp. Capt. K. M. Walker, R.A.M.C.; P. G. Selby.

M.B.E.—Temp. Capt. J. N. Martin, R.A.M.C.

Bar to M.C.—Capt. E. J. Bradley, M.C., R.A.M.C., S.R.

M.C.—Act.-Maj. G. O. Chambers, R.A.M.C.; Capt. F. H. Guppy, R.A.M.C., S.R.; Act.-Maj. B. Whitehead, R.A.M.C.; Act.-Maj. A. B. P. Smith, R.A.M.C.; Temp. Capt. W. B. Wilson, R.A.M.C.

To be Brevet-Major.—Capt. (Temp. Maj.) R. E. Barnsley, M.C., R.A.M.C.

* * *

The following Bart.'s men have been mentioned in recent Despatches:

A.M.S. (Staff).—Maj. (Temp. Col.) G. E. Gask, D.S.O.; Capt. (Act.-Maj.) G. F. P. Gibbons, R.A.M.C., S.R.; Capt. (Temp. Col.) J. A. Nixon; Lieut.-Col. (Temp. Col.) R. Pickard, C.M.G., R.A.M.C.T.; Col. H. S. Thurston, C.B., C.M.G.; Temp. Col. H. H. Tooth, C.B., C.M.G.; Temp. Col. C. G. Watson, C.M.G.

Consultant.—Temp. Maj.-Gen. Sir W. P. Herringham, C.B.

R.A.M.C.—Temp. Capt. C. J. Armstrong Dash; Temp. Capt. (Act.-Maj.) W. S. Danks; Temp. Maj. W. S. Dickie; Capt. J. H. Gurley; Capt. (Act.-Lieut.-Col.) I. R. Hudleston; Temp. Capt. E. T. C. Milligan; Temp. Capt. E. I. P. Pellew; Temp. Capt. H. J. Pickering; Capt. (Act.-Lieut.-Col.) R. B. Price, D.S.O.; Capt. (Act.-Maj.) J. A. Renshaw; Temp. Capt. (Act.-Maj.) A. Richmond; Temp. Capt. (Act.-Maj.) J. E. H. Roberts; Capt. (Act.-Maj.) R. H. Rollinson Whitaker; Temp. Capt. H. S. Thomas; Temp. Capt. K. M. Walker.

R.A.M.C.T.—Capt. (Act.-Maj.) H. Burrows; Capt. (Act.-Maj.) H. D. Clementi-Smith; Capt. (Act.-Maj.) R. V. Favell; Capt. N. S. Finzi; Capt. J. C. Newman; Capt. J. Ramsay; Capt. S. E. Rigg.

Canadian Army Medical Staff.—Col. C. A. Peters, D.S.O.

* * *

Surg.-Lieut. L. F. Strugnell, R.N., has been mentioned in Despatches for services rendered in the Adriatic.

* * *

We are pleased to congratulate Temp. Capt. (Act.-Maj.) H. B. G. Russell, R.A.M.C., on being awarded the Croix de Guerre.

* * *

It affords us much pleasure to congratulate Capt. P. H. Wells, M.C., R.A.M.C., on receiving a Bar to the Military Cross. The official details are as follows: "When moving up to an aid-post with the battalion headquarters a shell fell on the party, causing many casualties, including the only other officer. Capt. Wells, showing complete disregard for personal safety, organised the party and attended to the wounded. Throughout the day he ceaselessly carried on his duties, and under most trying conditions, being exposed to heavy shell-fire the whole time. In spite of the number of wounded he managed to attend to all and arrange for their evacuation."

* * *

As announced in this issue, Capt. W. B. Wilson has been awarded the Military Cross. The following is the official record: "For conspicuous gallantry and devotion to duty. He treated the wounded of his own and other battalions; this involved passing backwards and forwards over shell-swept areas. Later, he went forward with his stretcher-bearers and searched all the ground up to the front line. He showed splendid zeal and disregard of danger, and set a fine example to those under him."

* * *

Our congratulations to Dr. H. Fairley Morris, who has been jointly awarded the Raymond Horton-Smith Prize at Cambridge, which is given for the best thesis for the degree of Doctor of Medicine during the academical year.

* * *

The following members of the Staff have resumed or are immediately resuming their duties at the hospital; to these gentlemen we extend a warm welcome: Mr. C. Gordon Watson (Surgeon with Charge of Out-patients), Dr. J. Barris (Assistant Physician Accoucheur), Dr. J. Trevan (Demonstrator of Physiology), Dr. A. E. Gow (Medical Registrar), Mr. R. M. Vick (Senior Demonstrator of Pathology), Capt. N. S. Finzi (Medical Officer in Charge of X-Ray Department), Mr. J. E. H. Roberts (Surgical Registrar), Dr. T. H. G. Shore (Demonstrator of Pathology).

* * *

It may interest our readers to learn that the Bishop of Marlborough, recently deceased, was a lineal descendant of Percival Pott.

* * *

We are now in a position to state that the Final Fellowship Classes, to which we referred in our last issue, will commence on Thursday, February 13th. The course will include Surgical Hospital Practice, Clinical Classes, Surgical Anatomy, Museum Work, Pathological Histology, and Bacteriology. There will also be classes in Ophthalmology, Laryngology, Otology, Orthopaedic Surgery, and Venereal Diseases. During the last month a course of Operative Surgery will be held.

Anyone wishing to attend these classes should apply to the Dean of the Medical School.

Dr. B. W. Cherrett, whose death was included under our Roll of Honour last month, was Medical Officer of Health to Nairobi. He went out to East Africa in 1910, and was engaged in sleeping-sickness investigation until May, 1913, when he received the appointment of M.O.H. From September, 1914, until December, 1916, he held a commission as captain in the E.A.M.S., afterwards reverting to his civil duties as M.O.H. Dr. Cherrett was a keen, hard-working man, he was always cheerful, and his death is greatly felt by all who knew him.

* * *

It is with very much regret that we have to record the death of Dr. Leonard George Guthrie as a result of an accident on the Central London Railway on December 23rd.

Dr. Guthrie, who was 60 years of age, was the second son of the late Mr. Thomas Anstey Guthrie, and brother of Mr. Anstey Guthrie, the dramatist and novelist. Educated at King's College School, London, and Magdalen College, Oxford, he studied medicine at this Hospital. The study of nervous disease interested him, and as Physician to the Paddington Green Hospital for Children and Physician to the Hospital for Epilepsy and Paralysis in Maida Vale he soon made for himself a name in this branch of medicine, more especially in regard to the nervous diseases in childhood. Among other professional appointments he held were those of Physician to the Hospital for Epilepsy and Paralysis, Maida Vale; Consulting Physician to the Home of Rest for the Dying, Clapham, and the Potter's Bar Cottage Hospital; and a member of the Medical Board, which examined medical men called up for military service. His leisure was devoted to the study of antiquities, and the past of his own profession formed the subject of careful and earnest research.

We hope to publish an appreciation of Dr. Guthrie in an early issue of the JOURNAL.

* * *

We regret to have to announce the death of Dr. Colin Sadler Hawes, which took place at Bexhill after a long illness. Dr. Hawes had held an appointment as House-Surgeon at this Hospital, and more recently had acted as Civil Medical Officer (Anæsthetist) at the South African Hospital in Richmond Park.

THE LATE DR. A. E. STANSFELD.



HE lamented death of Dr. A. E. Stansfeld occurred so early in his career that he had been unable to make adequate provision for his family. He has left a wife and three small children with insufficient means for a proper education. Many of his friends have thought that the best form in which they could show their regard and affection for his memory and their appreciation of his many services would be to assist in raising a sum of money which might either be devoted to the education of his children, or to such other purpose as might seem more

immediately useful. It is in the hope that many of his old friends and pupils will share this view that the present appeal is published in the columns of the JOURNAL. Some, we know, are willing to contribute substantial amounts; others may be glad to share, according to their means, on a smaller scale. Dr. R. G. Canti has consented to act as secretary of the fund and Dr. F. W. Andrewes as treasurer. Cheques may be sent to the latter at the Pathological Department, St. Bartholomew's Hospital, and will be gratefully received.

(Signed) F. W. ANDREWES,
J. H. DRYSDALE,
R. G. CANTI.

ST. BARTHOLOMEW'S HOSPITAL;
January 21st, 1919.

ON MEDICAL EDUCATION IN LONDON.

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



IR,—Now that the Great War is over we are all thinking of the changes that are needed throughout the country. For myself, I have always thought that if the first great aim of the War was the establishment of liberty, and the destruction of that brutal principle of force which threatened the whole of civilisation, the second and almost equally important result would be the reforms which would in every belligerent country follow as a necessary result.

Not the least among them is the reform of education, and I have no doubt that as a part of it medical education needs—and will obtain—improvement. Now is the time to discuss the subject, and I therefore take the opportunity to bring before your readers the views which I hold upon it. We are proud, and justly proud, both of the practical education which London students receive and of the achievements of British Medicine. Yet it cannot be denied that improvements might be made in the former, or that the reputation or prestige of the latter in other countries has decidedly fallen below that which it once held.

If we look back upon medicine we can see the steps by which it has progressed. Up to the sixteenth century European medicine was as scholastic as theology. The Renaissance which enlivened the latter spread its influence into all learning. In Italy anatomy began to be studied afresh, and medicine also awoke from its slumbers, and began again to follow the example of Hippocrates and to use its eyes. Yet even in the early seventeenth century Bacon criticised the lack of observation and comparison which marked the medicine of his time. From that day to this, however, observation of the symptoms and course of disease has continued to increase, and from the latter part of the eighteenth century systematic study of morbid anatomy has been pursued. In observation both of the living and of the dead British medicine rivalled that of any other country.

But Harvey in the seventeenth century founded a new method, that of experiment, and a new science, that of the natural functions, which we call physiology. Hunter carried the same spirit into the study of pathology or abnormal function. That method took a fresh start in the nineteenth century. Since the days of Magendie and Bell an army of physiologists have ceaselessly laboured both by physical and chemical experiments to advance the knowledge of natural function. Pathology broke new ground under Pasteur, who founded bacteriology, and gave the impetus to Lister, and pathological chemistry first made itself felt in the studies of Garrod, Frerichs and Pavy on gout and diabetes.

Since this new movement began medicine has been as much engaged in the laboratory as in the wards, and whereas we have retained to the full our powers of clinical observation and have made many notable contributions to neurology, pediatrics, and especially to the study of cardiac diseases, we have not kept pace with other countries in the experimental side of pathology. This is the more remarkable, since the pre-eminence of English physiology is acknowledged. It is not due to lack of aptitude on our part, since physiology and pathology pursue the same methods and are practically the same science. It arises from the fact that with few exceptions English physicians have not risen to the occasion, have not taken a broad view of the science of medicine, have been content for the most part to confine themselves to tutorial work while young and to their wards in later life, and though often complaining of the lack of scientific facility, have not reformed their system so as to admit of it.

It is quite untrue to say, as some have said, that these defects have reacted unfavourably upon the treatment of the general public. It is indubitable, first, that the general level of practice is as high, to say the least of it, in England as in any other country; and, secondly, that the competence of general practitioners has within the last fifty years progressed to an extent that is astonishing. English physicians, too, have not only treated their own patients with judgment and skill, but have been most conscientious in their teaching, and very successful in infusing these qualities into their students. In some ways it might almost be said that their lack of the experimental method has been a source of safety.

But, on the other hand, it has had a deplorable effect on both teachers and students in fostering a spirit of content with a hand-to-mouth existence, of content to let others do the work while we take the results, of content to forego that keen desire for discovery which is the soul of science, even to belittle the laboratory as the regimental officer in his moments of discontent belittles the staff. What the teachers think the students will think too, and we in medicine are typical of the whole English race in our neglect of exact experimental methods.

Although we are ourselves partly to blame for this state

of affairs, yet the main difficulty has been the financial impossibility of increasing the expense of medical education out of the students' fees, which, up to a few years ago, were in London its only source of income. In the eighties the schools were simple affairs. Almost all subjects, except chemistry and physics, were taught by members of the staff. Physiology was confined to histology and a course of lectures. Since that time biology has been added to the preliminary subjects, and the instruction in chemistry and physics greatly extended, while anatomy and physiology have been given over to specialists, and the equipment, especially for the latter, greatly increased. Pathology has grown out of all recognition, and pharmacology has laboratories of its own. In all these branches the *personnel* also has been increased, and, though still poorly paid, costs a great deal more in salaries than in former times. There has been no money left for the scientific needs of the final subjects. We have talked about them, we have wished for them; but we have known that we might just as well ask for the moon.

The Haldane Commission was the first recognition by a Government authority of this pressing want. To it we certainly owe the idea of adding to the excellences of the present teaching a professorial system specially designed to supplement its scientific deficiencies. It remains to be seen whether Government will be prepared to give that financial help which is necessary if this idea is to be realised. It implies a Professor and a certain number of assistants working under him. The Professor must have wards for in-patients and an out-patient department. He must also have adequate laboratory accommodation and equipment in convenient connection with his wards. The whole forms what, in technical phrase, is known as a Hospital unit.

Although I suppose the details of the Professor's work will vary somewhat according to the wishes of his school, the main object of the appointment is that he should devote himself, not to the making of a livelihood by practice, but to teaching and discovery.

His influence will be felt in several directions. As a teacher I do not expect him to give his students the result of a large clinical experience: that the present medical staff of a hospital can themselves supply. Nor do I think that he will be able to train them in accurate observation and record of clinical cases any better than is now done by ourselves. In these ways the present staff of a General Hospital School have brought teaching as near to perfection as it is ever likely to reach, and their function will, I hope, continue unimpaired. But I expect the Professor, first by a wider knowledge of science in general, and of medical science in particular, to be able to throw a new light even upon common problems, and I expect him, secondly, from the fact that both he and his assistants will be actively engaged in discovery, to infuse into his students not only the spirit of criticism—I can do that myself—but the hope-

ful spirit of inquiry for which contact with discovery at first hand is almost essential.

In the next place I expect him to be not only himself a discoverer, but an inspirer of such work in others. Many of us can do such work when it is set us by a superior. Some of us can invent such work for ourselves. But the rarest gift—and this I expect of a professor—is the inspiration of other men. His assistants would be the first circle. But I should hope that his influence would spread more widely, and that he would be of assistance to all his colleagues in working out the problems, some of which most of us are attempting to solve, just as he himself will be assisted by them, both in the supply of such special cases as he may need, and also by advice in special subjects which they know better than he.

For it must not be forgotten that the Professor of Medicine will not be omniscient. He will not know as much chemistry or physics or bacteriology as the special teachers of those subjects. He will, like the rest of us, be better acquainted with some parts even of medicine than with others. The better man he is the more ready will he be to acknowledge this and to ask help from his colleagues. He will give, but he will indubitably receive.

In the third place I expect him, both by the quality of his work and by the quantity which, under his guidance, his unit will be able to turn out, to advance medical science in general, and to recover for England that place in it which she has lost.

It need not be said that it will be difficult at present not only to find a man capable of this work, but also to guarantee that he will do it. The name of "Professor" does not possess any magical charm. There are plenty of places both in England and abroad where the existence of a professor (I am not thinking of medicine) has not raised the level of teaching or research in the very least. We all know men who are professors with no original fitness for the position, and others who, though originally brilliant, have subsided into useless drones.

Various precautions can be suggested, and a terminable tenure is probably desirable. But the chief guarantee will always be the character of the man himself, and that is generally ascertainable upon inquiry. At forty a man usually has enough enemies to enable one to obtain a good idea of his vices, and his virtues he can tell you himself.

There are a few desirable men on the market now, and as the system grows it is to be expected that others will develop out of the staff of the Professor's assistants.

I do not despair of the possibility of the system, and that it is desirable I have long been entirely convinced.

Yours obediently,

G.H.Q., France.

W. P. HERRINGHAM.

[A supplementary communication on post-graduate teaching from Major-General Sir Wilmot Herringham will appear in our next issue.]

SOME PRACTICAL POINTS IN THE USE OF THE CYSTOSCOPE.

By Capt. W. GIRLING BALL, F.R.C.S.

IT is not so many years ago that the cystoscope was first used in this Hospital, yet during this period, so rapid has been its development, that it is now regarded as an essential in the armamentarium of the general surgeon, not only in making a diagnosis of cases of vesical disease, but also as an instrument in aiding the diagnosis, prognosis and treatment of both vesical and renal affections. This has become possible by the introduction of the irrigating and catheterising cystoscope. The introduction of the former of these marked an exceedingly important step in the evolution of the instrument, for whereas previously it was frequently impossible to make a diagnosis owing to the turbidity of the distending fluid in the bladder, which arose in the interval between distension and introduction of the cystoscope, it is now possible to obtain the necessary view before such a condition arises. Whereas cystoscopy previously had to be delayed often for days and weeks owing to the discharge of pus and blood into the interior of the bladder, it can now be carried out at any time—in fact, it is an advantage to do so during such periods in order to discover the source of origin of the abnormal urinary constituents. It is for these reasons that the irrigating cystoscope has replaced the older types of instruments. It is not my intention to dilate on this, however, but rather to point out the value of the catheterising cystoscope in connection with a number of conditions found in the urinary tract. The instrument used is also of the irrigating type, with the addition of a tube alongside and encompassed in the wall of the main shaft of the apparatus, capable of carrying specially made bougies and catheters.

Catheters can be used for a variety of purposes :

- (1) To define the presence or absence of one or both kidneys.
 - (2) To collect the urine from either kidney.
 - (3) To empty a hydro- or pyonephrosis.
 - (4) To fill the renal pelvis with fluid opaque to X rays (pyelography).
 - (5) To wash out the renal pelvis.
 - (6) To act as insulators of platinum terminals for diathermic treatment of bladder lesions.
- Bougies have a more limited use :
- (1) To define the presence and abnormalities (*e.g.* strictures) of both ureters.
 - (2) To outline the position of both ureters by radiography if opaque instruments are used.
 - (3) To demonstrate the relation of small shadows discovered by X rays to the lumen of the ureter.

(4) To mark the course of the ureter in certain abdominal or pelvic operations.

For many of these purposes catheters can be equally well utilised, but as they are more liable to kink and thus destroy the lumen of the tube and render it useless, bougies are to be preferred, thus avoiding the destruction of an expensive piece of apparatus. Both catheters and bougies can be rendered opaque to X rays by impregnation of the necessary materials into their composition, which renders them exceedingly valuable for radiographic purposes. Moreover, alternate translucent and opaque markings on the catheter serve a purpose of locating the exact distance of an obstruction or shadow from the vesical orifice in the bladder. Let me now turn to some of the points of advantage of these instruments.

THE DEMONSTRATION OF THE PRESENCE OF A KIDNEY.

There are, unfortunately, a number of instances in the annals of surgery in which the only kidney present has been removed for some diseased condition, with the obvious unbeneficial result. Congenital absence of one kidney is a rare condition, however, but unless some investigation has been made to certify the fact that both kidneys are present, an accident will happen from time to time. Again, even though both kidneys are present, it is oftentimes important to know that they are each of them carrying out their allotted task; more especially is this the case if one kidney is known to be diseased, and one must be satisfied that the other is capable of carrying out the renal function to an extent compatible with safety in the event of some radical operation, such as nephrectomy, being carried out on the diseased organ. No operation ought to be performed on a kidney, especially if it is likely that it may have to be removed, unless the surgeon is satisfied that the opposite kidney is present, and further, that if it is known to be present, before he has ascertained the fact that it is capable of maintaining equilibrium during the temporary and possibly permanent inaction of the kidney operated upon.

It is not sufficient to make a cystoscopic examination to observe the ureteric orifices; both of these may be present, and both appear to be working, and yet a kidney may be missing. Routine ureteric catheterisations, prior to the recommendation of renal operations, should always be performed on the grounds of safety to the patient.

Separation of the urine.—The natural sequence of events to the recognition of the presence of both kidneys relates to their respective capacities of carrying on the renal function. By far the best method of performing this examination is by the passage of catheters into the ureters of the two kidneys.

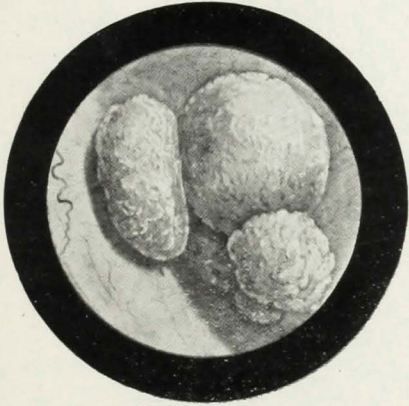
The older methods of segregation are becoming obsolete and are unreliable; it is impossible to be quite sure in the case of disease of both kidneys that the bilateral collections have not become contaminated by the condition present in the bladder-wall, and that the kidneys are really the cause

of trouble. This is specially tiresome in those diseases in which both the kidneys and the bladder are so often involved—*e.g.* tubercle, pyogenic pyelitis, etc. A negative result on one side with positive evidence on the other is obviously valuable information, but the simultaneous collection of pathological urinary contents in both tubes is not of the same value. The passage of the catheters obviously avoids this fallacy, eliminating the bladder as a possible source. The argument may be put forward that it is not without its dangers, and that the chances of infecting an otherwise undiseased kidney are considerable. This is, of course, a possibility, and has occurred, but very rarely. Attention to obtaining free diuresis before the examination, scrupulous care in sterilisation of all the instruments used, and repeated and thorough washing out of the bladder, are essential. The use of a direct-vision cystoscope still further minimises the risk. It has fortunately been my lot never to see any harmful result from this method of investigation.

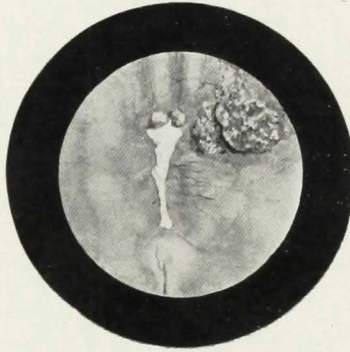
There are one or two points of practical importance. It is desirable to have complete information as to the character of a 24-hours' specimen of the urine before the examination is made, in order to be able to compare the composition of each renal specimen with the combined excretion. The patient should be given large measured quantities of fluids to drink prior to the catheterisation; the use of diuretics is also indicated. No anæsthetic is necessary for the examination—in fact it is better that such should not be used, so that the patient can continue to drink while the catheters are in position. The information to be obtained from the specimens collected (in sterilised flasks) includes an estimation of the amount of urine passed by each kidney in a given time, the specific gravity, the presence or absence of abnormal constituents, the estimation of the urea, and, if large quantities are collected, the nitrogen content, the reaction of each to the phloridzin and phthalein tests which constitute the more important pieces of evidence which are required to estimate the renal function of each kidney. With regard to the value of this examination, it corresponds to the demonstration of the presence of both kidneys, in that unless the remaining kidney is sound or has sufficient renal capacity, nephrectomy must not be performed, and other operations should only be advised under conditions of great urgency. It frequently happens that both kidneys are involved in calculus disease, giving rise to considerable trouble, and requiring operation for the relief of suffering. Such an examination as the above will define which kidney is to be tackled, if either, and so forth. The test is of exceeding value, and in my experience has avoided a catastrophe on more than one occasion.

To diagnose a hydro- or pyonephrosis.—The diagnosis of these conditions does not commonly present any formidable difficulty, but on occasion the distinction of cystic swellings in the abdomen is not easy. The time-honoured trio of gall-bladder, kidney and ovary, to which may be added

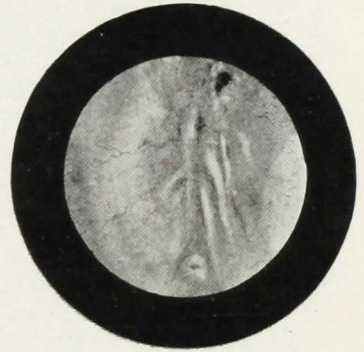
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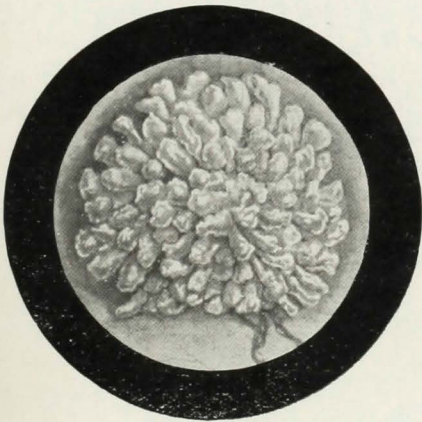
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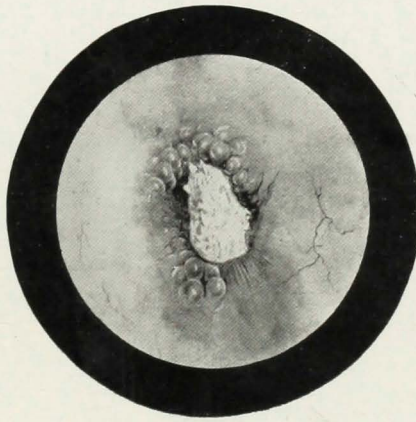
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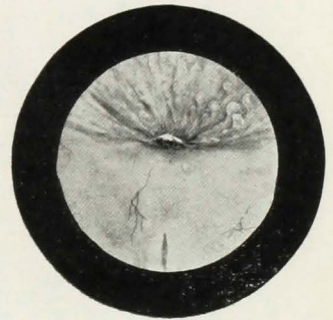
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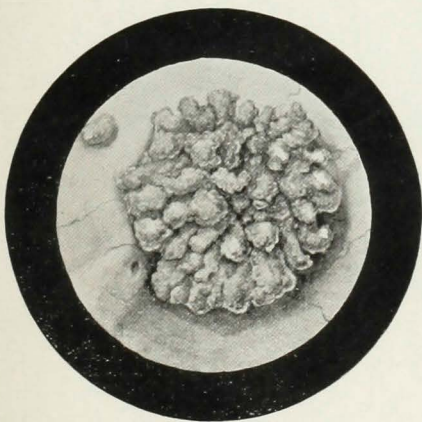
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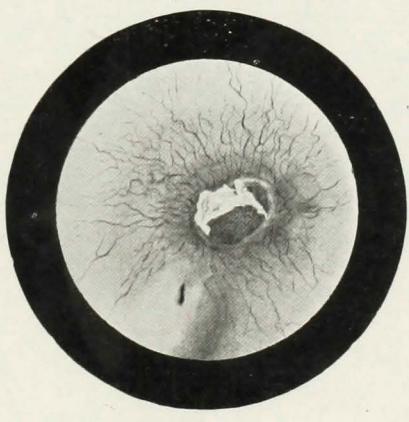
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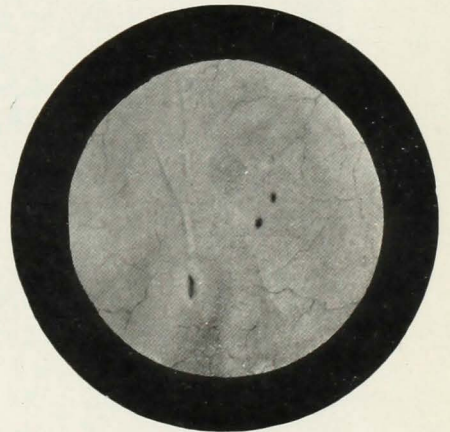
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TO ILLUSTRATE CAPT. W. GIRLING BALL'S PAPER ON "SOME PRACTICAL POINTS IN THE USE OF THE CYSTOSCOPE."

W. Thornton Shiells.

Adlard & Son & West Newman, Ltd.

pancreas, may each and all of them resemble each other, and that which any may resemble more than another is a distended renal pelvis. The passage of a catheter into the ureter will soon decide the point. The contents of a pyonephrosis are often too thick to pass along the lumen of the catheter, and thus the investigation may be misleading in its results, but it is always worthy of a trial, for should the swelling collapse, the diagnosis is certain. There is yet another value of the method: granted that an abdominal tumour is connected with the kidney, it serves to differentiate between a solid and a fluid swelling.

PYELOGRAPHY.

Of recent years the catheter has been utilised in order to define the shape and capacity of the renal pelvis by the passage of measured quantities of fluid along the catheter after it has been passed. Certain innocuous fluids such as collargol or thorium citrate—the latter for preference—are used for this purpose, owing to their opacity to X rays, thus serving the double purpose mentioned above. The latter fluid is preferred, owing to its being a cleaner fluid to work with, its greater opacity, and thus possible use of dilute solutions, its apparently harmless effect on the kidney tissues, for in no case that it has been used has albuminuria followed—a condition frequently seen with the use of collargol, although the same method of introduction has been used. The fluid is run into the renal pelvis under the pressure of height rather than by means of a syringe, although the latter, if carefully carried out, is not harmful. This is best done under the X-rays screen, the in-flow thus being watched. When the pelvis is filled the back-flow can be observed to pass down the ureter; the second indication of full distension of the pelvis is noted by the patient, who has a sensation of pain in the renal region under examination. Over-distension of the pelvis is rigorously to be avoided, otherwise albuminuria, and even hæmaturia, usually lasting for a few days, may be set up, suggesting damage to renal tubules, which has been shown by experimental evidence to occur.

In my opinion this method of examination should not be carried out as an experiment, but only when it is considered desirable as a means of making an exact diagnosis of some of the more obscure abdominal conditions. The occasion for its use does not thus arise very frequently, but it has given very valuable information.

Normally the renal pelvis holds from 4-10 c.c. of fluid when fully distended. An amount of fluid required to give the above tests beyond this indicates a distension of the pelvis.

The use of an anæsthetic in carrying out the investigation is contra-indicated, the pain experienced by the patient acting as the chief indicator in defining full distension. It is inadvisable to pyelograph both kidneys at the same sitting.

Let us now pass on to define some of the uses of pyelography. A knowledge of the normal appearance of the renal pelvis as seen in a pyelogram is essential. Certain definite types are recognised; deviations from these types are evidence of abnormality. The demonstration of a normally shaped pelvis is sometimes an important clinical observation; for example, the absence of a distended pelvis in a case of ren mobile serves as an indicator as to the inadvisability for a fixation of the kidney in that type of person whose symptoms are largely those of the neurasthenic type; conversely, the demonstration of a distended sac demands that nephropexy should be performed. Again, the presence of a normal pelvis by this method in a case of cystic swelling in the region of the kidney excludes a disease of that organ. The following case is interesting in this connection: A patient was admitted to hospital with symptoms suggesting appendicitis, but with an associated hæmaturia. Cystoscopy and radiography failed to demonstrate the cause of the latter; there was no bacilluria. The patient had a moveable kidney, and it was thought that the hæmaturia might have been due to this condition, possibly with an abnormal renal artery over which the ureter was kinked. A typical picture can be obtained of this condition, and thus pyelography was performed. No such picture was obtained. Beyond the presence of blood, there was no other renal abnormality in the urine. Appendicectomy was performed, the tip of the appendix being found attached to the renal pelvis. The normal pyelogram, in this case, excluded the kidney or the ureter as being the primary cause of this condition.

Cases of early hydronephrosis associated with moveable kidney cannot be diagnosed by any other method than that under discussion. It is easy enough to do this when a definite sac can be felt, but at this period a certain amount of destruction of renal tissue has occurred, which can be avoided if pyelography is carried out when symptoms first appear, as a routine measure, and repeated, if necessary, at intervals. Not only can the early dilatation of the pelvis and the calices be observed, but the actual site of the ureteric kink can be demonstrated. So far as an abnormal renal artery is concerned as being the cause of the kink, a typical picture aids materially in making an exact diagnosis. In the more advanced cases of hydronephrosis, as a rule pyelography is not called for, except as a means of demonstrating the full extent of the disease and if there is any doubt in confirming clinical observation.

Yet a further value of the method is to demonstrate the shape of the pelvis in cases of renal growth. In this condition the growth usually bulges into the pelvis and distorts its shape, giving rise to a characteristic picture. The clinical diagnosis of these growths is frequently difficult, and can only be arrived at by a process of exclusion of other conditions. This method may thus be helpful in confirming the diagnosis. Other conditions have been met with in which

some help has been obtained, but in the main these are the most important so far as the kidney in its normal position is concerned. The following case, however, is an instructive one, as illustrating its use in diagnosis of a kidney in an abnormal position. A man came under observation with a firmly fixed swelling in the right iliac fossa. It was thought to be a carcinoma of the cæcum, although there was little clinical evidence of this beyond some pain in this region. The kidney, however, on that side of the abdomen could not be felt, although the patient was thin. Pyelography demonstrated this swelling in the right iliac fossa to be the kidney abnormally placed, which proved to be the case at a subsequent exploratory operation for the removal of his appendix. Kidneys abnormally placed often give rise to difficulty in diagnosis, hence the obvious application of the method.

USES OF THE OPAQUE CATHETER OR BOUGIE IN URETERIC CONDITIONS.

The ureter does not frequently depart from its normal relationship to the surrounding structures with which it is in contact. On the other hand, it quite frequently happens that in radiograms of the abdomen and pelvis shadows are demonstrated which, though lying in the neighbourhood of the ureter, have in reality nothing to do with lesions of it. It is often important to demonstrate whether such shadows are in the lumen of the ureter or not, especially if renal symptoms suggest that such may be the case. From time to time cases of hæmaturia come under observation in which the routine radiography demonstrates a shadow which, although lying in the region of the ureter, from its appearance indicates that it is due to some other condition than appertaining to the ureter—for example, pelvic phlebitis, tuberculous glands in the iliac fossa, appendicular concretion, fæcal concretions in other parts of the bowel, and so forth. The passage of an opaque bougie and the demonstration of the relation of the latter to the shadow by radiography confirms the suspicion that such are not connected with the renal tract. On the other hand, if the shadow is really one of a stone in the ureter, the intimate contact of the bougie will the better confirm the diagnosis. Passing still further, the passage of the bougie in a case of ureteric calculus serves two other purposes; it proves whether or not the calculus is blocking the ureter completely, if it cannot be passed beyond it, and this serves as an indicator for early operative procedures; and, secondly, it may serve to dislodge a temporarily arrested calculus and encourage its passage down the ureter. This has happened more than once in my experience. Yet again, by the use of bougies with alternate opacities of equal measure marked on them, the exact distance of the calculus from the vesical orifice may be estimated, and if necessary on a subsequent observation, any alteration in its position notified. The method can also be used to

demonstrate the site of a ureteric stricture, or by the passage of opaque fluids through a catheter, the cause of a ureteric or renal fistula—clinical evidence of primary importance preceding radical operations. Furthermore, a bougie can be inserted into either or both ureters preceding an operation on structures with which they lie in intimate contact, and where they can be easily damaged during the course of such—for example, in such operations as removal of the uterus in malignant disease, or abdomino-perinæal resection of the rectum. It is also useful to carry out this procedure in certain operations on the bladder such as local excision of papillomata or carcinomata, which may be situated near or at the ureteric orifice. Recently it proved to be a useful guide in the transplantation of the bladder with its ureters into the sigmoid flexure in a case of ectopia vesicæ.

USES OF CATHETERS IN TREATMENT.

Not only does ureteric catheterisation prove to be useful in diagnosis, but there are a variety of instances in which it can be utilised in treatment. At the present moment the ground has been comparatively little explored, but with experience it is recognised that there are many conditions in which advantage can be taken of the apparatus.

Hydronephrosis and Pyonephrosis.—During the course of an operation for the removal of a large hydro- or pyonephrosis it is sometimes necessary to aspirate the sac on account of the large amount of fluid which it contains. It may even be necessary to perform this operation in two stages, first a nephrostomy being done and later a nephrectomy; even if this is not the case, the sac may be accidentally punctured during the operation, thus filling the wound with the contents of the sac. It is obvious that it would be an advantage to get rid of this collection prior to the operation in order to avoid these disadvantages during its performance. This is the case. Moreover, when a pyonephrosis is present, by irrigation through a catheter carried out for some days previously a better condition of affairs can be reached than would otherwise be the case. Unfortunately it is not always possible to drain a pyonephrosis owing to the mucoid consistency of its contents; this does not, however, preclude an attempt being made; even if the fluid fails to be evacuated, the mere passage of a catheter frequently stimulates the evacuation of pus alongside the catheter, or down the ureter itself after its removal. The passage of a catheter is also helpful in displacing a calculus from the mouth of the ureter in cases of temporary acute hydronephrosis associated with severe symptoms of renal colic. Some years ago I reported a case in which this was done for acute kinking of the ureter in a case of mobile kidney with very severe pain lasting for some hours, with considerable relief of the symptoms.

The avoidance of two operations, and the lessening of the chances of fouling a wound, together with the relief of

acute symptoms, are the advantages claimed for this plan of procedure.

Pyelitis.—The renal pelvis has been the site of attention of urinary surgeons of recent years. In cases of chronic pyelitis due to *B. coli communis* or micro-organisms other than *B. tubercle*, in which there is no causative factor such as a renal calculus or ureteric kink, irrigation of the renal pelvis has been tried, and is said to be of service. It is difficult to satisfy oneself that this is the case. It is still a question much in dispute as to the origin of these infections, but in all probability it takes place through the blood or lymph stream, at least through the kidney substance itself. It is difficult, therefore, to understand the rationale of pelvic irrigations unless there is some blockage to the discharge of the urine. Moreover, if this method is to prove of any service at all it is obvious that it must be carried out frequently, or the catheter must be left in for considerable periods, which has obvious disadvantages. Views on this form of treatment are very various.

"FULGURATION" OF BLADDER GROWTHS.

This is not in reality connected with this question except that the instruments used are the same, the catheter serving as the insulating material for the platinum wire which is used as the terminal for burning the growth. The operation consists in the removal of bladder papillomata by passing a high-frequency current along this wire, the circuit being completed by affixing a leaden plate to some other part of the body.

The platinum terminal is embedded into the portion of the growth which it is intended to destroy.

This method of treatment is chiefly applicable to dealing with papillomata of the bladder, either single or multiple and of moderate size; the tissues are burned until whole of growth has been destroyed, special attention being paid to its base. For the most part it is useful in the treatment of small papillomata, either single or multiple, which can be completely destroyed in quite a short period of time. As a matter of fact it is applicable to even the larger growths, if the surgeon is prepared to spend a considerable period of time in the performance of the operation, which may last for anything up to two hours. It is desirable from the point of view of the patient that as far as possible the destruction should be carried out at one sitting, but frequently several attempts must be made ere the whole has been destroyed. It may not be necessary to destroy the growth if the pedicle of the growth can be reached and dealt with; in this way the whole can be washed out through an evacuator. It is not essential that an anæsthetic should be given unless the sitting is likely to be prolonged. The advantages of dealing with growths in this way are considerable. The liability to recurrence is said to be diminished; certainly there is no fresh tissue, such as along the site of the suprapubic incision, for

implantation to occur upon. In my series there has been no recurrence.

Secondly, the disagreeable consequences of a suprapubic cystotomy are avoided.

Thirdly, the patient seldom requires to remain in bed for more than forty-eight hours and not at all in the case of small growths.

Fourthly, in none of the cases that I have treated in this way has there been any subsequent cystitis—a sequel of suprapubic cystotomy which is liable to occur.

Fifthly, it is quite easy to avoid damage to the ureter or its orifice—a factor not always the case with the open operation.

These, then, are the many uses to which the cystoscope has been put, and no doubt with the improvement both in the instruments and surgical technique there are other methods which will follow. It is not essential for me to point out that many of the facts that have been described are purely of theoretical value, but at the same time the methods of research which have led to these findings have so improved the technique of genito-urinary surgery that the theory has led to practical results of primary importance. Both in diagnosis, prognosis and treatment the cystoscope is having and will continue to have its day.

The illustrations demonstrate the effect of high-frequency currents on bladder papillomata. 1, 4, 7 are pictures of the original papillomata. 2, 5, 8, the appearance seen ten days after the treatment has been carried out, namely ulceration at the root of the pedicle. In Case 2 a further application of the current was necessary. 3, 6, 9 show the appearance at the end of a month. All have been examined since; the lesions are completely healed and there is no evidence of recurrence.

MEDICAL NOTES.

By Sir THOMAS HORDER, M.D.

(Continued from p. 26.)

ON PULMONARY TUBERCULOSIS.—*continued*.

(62) Hæmoptysis in a young man who is apparently healthy should be regarded as evidence of phthisis, and he should be treated accordingly. But the practitioner who gives this advice must be prepared for a lack of gratitude, if not for actual complaint, later on. The prompt treatment of phthisis at this early stage usually results in a cure, in which event the patient may throw doubt upon the diagnosis, and may resent such interruption of his career as was entailed by his treatment. If, however, the practitioner makes light of the hæmoptysis, the disease is likely to become more firmly established, in which case he lays himself open to a charge of neglect in that he did not insist upon treatment after the initial hæmorrhage.

Whence it is seen that, whether the doctor is competent or careless, he stands an equal chance of incurring his patient's displeasure.

(63) Hæmoptysis occurs at three different stages in the course of phthisis. The source of the blood and the significance of the hæmorrhage are also different in the three stages:

(i) *Early in the disease.*—The hæmoptysis is often the first symptom (*vide* § 62), and it may be the only one. The blood is small in amount, rarely more than a couple of drachms. It is unaccompanied by sputa, and often unaccompanied by cough, welling up into the mouth by the act of clearing the throat (*fluor sanguinis*). Constitutional symptoms are often quite absent. Not infrequently the incident wakens the patient in the night. The source of the blood is the congested bronchi near to the tuberculous focus. The chief significance of this type of hæmoptysis is its relation to diagnosis.

(ii) *During the course of a well-established case.*—The hæmorrhage is accompanied by cough and often by slight fever. After the first bout of bleeding the hæmorrhage "tails off" slowly, the whole process lasting from a few hours up to a week or ten days. Recrudescences sometimes occur, especially if treatment is casual. The blood comes from an ulcerated vessel in the wall of a cavity. A period of considerable betterment may follow the event, or it may usher in a serious set-back with extension of the disease-process.

(iii) *As a late event in an advanced case.*—The hæmorrhage is large in amount and is often fatal. The blood comes from a ruptured pulmonary aneurysm lying in a cavity. The cavity fills rapidly, the blood overflows into the neighbouring bronchus and reaches the trachea, whence it is in part inhaled into other parts of the lung and in part escapes from the mouth.

(64) The blood of a hæmoptysis in a suspected case of early phthisis is often sent to the laboratory to be examined for tubercle bacilli—a futile proceeding, and, if the practitioner is influenced against a diagnosis of tuberculosis by receiving a negative report, a dangerous one. Even when the disease has reached the ulcerating stage blood is very unlikely material in which to find tubercle bacilli; in the blood which is expectorated at the outset of the disease (*vide* § 62) the search is hardly worth undertaking.

(65) Never neglect to confirm the diagnosis of phthisis by the demonstration of tubercle bacilli in the sputa, however "classical" the signs and symptoms may be. Anæmia, wasting, sweats, quotidian intermittent fever, purulent sputa, hæmoptysis—in association with physical signs of consolidation or of cavity—may all of them occur in new-growth, lymphadenoma or bronchiectasis.

(66) There are three diseases in which the normal

resistance to infection by the tubercle bacillus is so much lowered that phthisis may be present in a latent fashion for a considerable time without discovery—diabetes, cirrhosis of the liver and leukæmia. So low is the tissue reaction to the tubercle bacillus in diabetes that it is not uncommon to find the development of pneumothorax the first evidence of the presence of phthisis.

(67) There is a marked family tendency to phthisis; there is also a marked family tendency to particular types of phthisis. In one family hæmoptysis is common, in another pleurisy with effusion, in a third extensive fibrosis of the lung. In reference to any particular case, it is useful to know not only the family incidence of the disease but the family type of tissue reaction.

(68) Although certain general principles governing treatment in phthisis are well established, there are so many differences observable in the manifestations of the disease in individual cases that it is of great importance to select carefully a scheme of treatment which gives promise of success in each case. This selection calls for judgment and experience on the part of the medical adviser, who does well to consider not only the type of case as regards the pathological process in the lungs and other organs, but also the patient's temperament; for intelligent co-operation is essential to success.

(69) Some of the most difficult patients to help are those who leave the whole burden of the treatment to the doctor and themselves evince complete inertia. It is true that in a few cases, despite this attitude, things go well; but in many more cases such an attitude spells failure, and patients should be warned against it at the very beginning of their treatment. It should be explained to them that in order to regain health, and to keep it, they must make the business of their cure a matter of hard work over a lengthy period, just as they would make any other goal that is worth reaching a matter of concentrated effort under expert guidance.

(To be continued.)

A CASE OF SARCOMA OF TONGUE.

By W. E. HEATH, M.R.C.S., L.R.C.P.



AM indebted to Colonel D'Arcy Power for permission to publish the details of this case.

The patient, Emma A—, æt. 50, came to the Hospital in March, 1918, complaining of a lump at the back of her tongue.

She stated that she had been quite well until January, 1918, when she noticed a lump at the back of her tongue. As the lump was increasing in size, the patient was advised to come to Hospital.

In March, 1918, she was seen in the Out-patient Department by Mr. Blakeway, and a diagnosis of sarcoma of the tongue was made.

On first coming to Hospital the patient seemed to be a fairly healthy-looking woman, but was said to have lost weight for the last two years. Her eyes reacted to light and accommodation, and her teeth were mostly false. There was found to be a hard, round lump at the back and left side of the tongue, which was $1\frac{1}{2}$ in. in diameter, and invading the left anterior pillar of the fauces. There were no glands palpable in the anterior or posterior triangles of the neck.

The growth had not caused the patient any pain, nor had it caused any difficulty in swallowing.

The case was shown at "consultations," where it was suggested that the lump might be a gumma, so a course of injections of arsenic was given, extending over some weeks, but the lump did not seem to get any smaller.

On September 7th, 1918, the patient was admitted to Hospital for the removal of the growth, which, by this time, had become a little larger. She still appeared quite healthy, and the lump was not causing her any pain.

On September 13th, 1918, Major Rawling removed the growth. It was found to possess a capsule, from which it was shelled with a certain amount of difficulty. The edges of the wound were brought together with silk sutures, and the operation was completed with a very small amount of hæmorrhage. The patient made a rapid recovery, and was feeling quite comfortable when discharged from Hospital.

The tumour which was removed was found to be a round lump of hard consistency, about $1\frac{1}{4}$ in. \times $1\frac{1}{2}$ in., covered on its dorsal surface with epithelium. Tongue muscle could be recognised in the growth.

On microscopical examination the growth was found to be a round-celled sarcoma.

On October 8th, 1918, the patient came to the Hospital with a recurrence at the site of the original growth. She was admitted to Hospital for further operative treatment.

On October 14th Colonel Power removed the growth with a wide margin of healthy tissues. It was not encapsuled, and microscopically it resembled the original growth in all respects. Up to now there has been no further recurrence.

The rarity of cases of sarcoma of the tongue makes it worth while publishing individual cases. The record of those hitherto operated upon will be found in the *Guy's Hospital Reports*.

REFERENCE.

A paper by Fripp and Swan in the *Guy's Hospital Reports* for 1902, vol. lvii, pp. 89-131.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. ARTISTS' RIFLES XV.

On January 4th the Hospital visited Gidea Park to meet the Artists' Rifles, but unfortunately they could only field a somewhat

weakened side on account of the recent demobilisation, and were defeated by 3 goals and 5 tries (30 points) to a try (3 points). Settling down at the outset Bart.'s soon asserted their superiority, and showing excellent form behind the scrum crossed the Artists' line on six occasions.

During the whole of this half the play was in our opponents' half, and it was their keen tackling alone which prevented even a bigger score.

Crossing over, Bart.'s were content with their lead of 24 points, and the play was left largely to the rival packs, which were very evenly matched, with the result that the Hospital three-quarters had few opportunities of adding to the score.

Tries were scored by Thomas (3), Griffith-Jones (2), Melle, Sanderson and Johnstone, who also placed 3 goals.

ST. BARTHOLOMEW'S HOSPITAL v. N.Z.M.G.C. (GRANTHAM).

The New Zealanders—one of the strongest teams in the Midlands—were the opponents at Winchmore Hill on January 18th.

The game, which was most keenly contested throughout, ended in a well-deserved win for the Hospital by 3 goals (15 points) to *nil*.

Attacking from the start, a clever movement sent in Melle on the right wing with an excellent try, which the same player converted, while shortly afterwards Krige, breaking away from the line-out, scored a typical individual try for Johnstone to goal.

The remainder of the half was vigorously contested by the forwards, in which department the New Zealanders were especially strong, but no further score resulted.

For some time after the re-start the Hospital were kept on the defensive—the spoiling tactics of our opponents being most effective—while their fierce forward rushes were quite a feature of the game.

Returning to the attack clever work between Cockell and Melle ended in Shaw scoring a try in an easy position for Johnstone to convert.

CORRESPONDENCE.

"HEART-STRAIN."

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

SIR,—I trust you will allow me a small space in the JOURNAL to reply to Sir Thomas Horder's criticism of my letter on the above subject, which appeared in the January number. I was, as Sir Thomas Horder says, dealing with the young healthy heart when I stated that—"I was of opinion it could not be damaged by the muscular exertion involved in the training and life of an athlete." I entirely agree with Sir Thomas that the heart of the ordinary sedentary citizen—especially if he is middle-aged—can be damaged by over-strain.

With regard to the question of sinus arrhythmia indicating an impairment of the heart, I am fully aware that both Mackenzie and Lewis differ from me on this point. I cannot, however, believe that an irregularly acting heart, whatever the cause of that irregularity, is as good and stable as a regularly acting one, and I speak from practical experience when I say that the large majority of young men I have seen whose hearts have broken down under strain have had sinus arrhythmia and a history of some heart trouble in the past; whereas, in cases of shell-shock, etc., where there is a regularly acting heart, I have usually found that heart has remained quite sound despite the mental and physical strain. It would be of great interest to get the opinions of those Bart.'s men who have had experience of such cases in military hospitals, with regard to the connection and co-existence of sinus arrhythmia and cardiac and circulatory trouble, and I shall look forward to seeing some letters in the JOURNAL on this subject. I have always regarded Sir Thomas Horder's opinion on points of clinical medicine as exceptionally well-balanced and well-considered, and I have valued it accordingly. I am quite open to altering my opinion if it does not stand the test of time and further research. At present, however, my clinical experience leads me to believe that—other things being equal—a heart exhibiting sinus arrhythmia does not stand unusual strain, and is not so stable as one that has a perfectly regular rhythm.

I am, Sir,

Yours faithfully,

LESLIE THORNE-THORNE.

108, HARLEY STREET;

January 8th, 1919.

MITRAL STENOSIS.

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

SIR,—Mitral stenosis, I believe, is a condition very rarely found in men. But during the last eight months, in the battalion to which I am attached, I have met with something between twelve and twenty cases of what I consider to be mitral stenosis. During that period there has been a large turnover of men arriving on drafts and disappearing as casualties, and I regret that, owing to exigencies of the times, I was unable to collect and make notes on the cases as they cropped up. I mention them now, since it seems to me that, from the point of view of ætiology, there may be some relation between the occurrence of the disease and the conditions of hardship to which soldiers on active service are exposed, involving continual and often prolonged exposure to wet and cold.

I had it frequently drilled into me at Bart.'s that mitral stenosis by itself was a chronic and progressive condition, and not found as the result of acute rheumatic endocarditis. Now none of the men in question gave a history of acute rheumatism or scarlatina. Is it not possible, therefore, that prolonged exposure to conditions of wet and cold favours the production of this chronic, progressive condition, possibly of rheumatic nature, in the same way that it gives rise to myalgia? If so, mitral stenosis would then be another war disease.

Now with regard to the cases themselves. Symptoms were present in some cases and absent in others, the latter were only discovered accidentally. Symptoms, when present, were attacks of giddiness, shortness of breath and præcordial pain. The latter was not constant. There were never any signs of hypertrophy of the left ventricle. A thrill at the apex, presystolic in time, was detected in a few cases, but not in all. In all cases a rough murmur was heard running up to the first sound, which was short and sharp.

I should be glad to know if any other medical officer has noticed anything in this direction or can give me information on this subject.

Yours faithfully,

B.E.F., FRANCE;

January 14th, 1919.

B. B. SHARP,

Lieut., R.A.M.C.

REVIEW.

MUSINGS OF A MEDICO. By KENNETH ROGERS, M.D. (Erskine Macdonald, Ltd.) Pp. 72. Price 3s. 6d. net.

Dr. Rogers is an old Bart.'s man, and we are glad to have the opportunity of bringing his very pleasing little book of verse to the notice of our readers. The volume contains some sixty short poems, which deal with a variety of topics. Some of the verses are suggested by the war, others by travel. But the author is undoubtedly in his happiest vein when his pen leads him to thoughts of the country. Dr. Rogers is an obvious lover of flowers. "On Man, Bees and Flowers" is a delightful effort; equally good is the rhyme of "The Dragon Fly." Lovers of verse will appreciate these musings, and we commend the book to our readers.

APPOINTMENTS.

CLARKE, P. SELWYN, M.C., M.R.C.S., L.R.C.P., appointed House Physician, Royal Victoria Hospital, Dover.

GALSTAUN, G., M.R.C.S., L.R.C.P., appointed R.M.O. at Lord Mayor Treloar Cripples' Hospital and College, Alton.

CHANGES OF ADDRESS.

BOURKE, J. B., c/o Dr. Colmer, Yeovil.

CLARKE, P. SELWYN, Royal Victoria Hospital, Dover.

GALSTAUN, G., Lord Mayor Treloar Cripples' Hospital and College, Alton, Hants.

GURNEY-DIXON, S., Deerhurst, Lyndhurst.

HAMILL, P., 84, Wimpole Street, W. 1. (Tel. Padd. 2452.)

PADWICK, J. C., 154, Oakwood Court, Kensington, W. 14.

DE SEGUNDO, C. S., 39, Howitt Road, Belsize Park, N.W. 3.

WHALE, L., 132, Harley Street, W. 1. (Tel. Padd. 2828.)

BIRTHS.

BOWER.—On December 20th, the wife of Capt. H. J. Bower, R.A.M.C., Netley, of a son.

BURTON.—On December 3rd, at Bethnall House, N.E., Dorrit, the wife of G. E. Burton, Surgeon-Lieut. R.N. (Temp.), of a daughter.

CLEMENTI-SMITH.—On December 12th, at a nursing home in Clifton, the wife of Major H. Clementi-Smith, R.A.M.C.—a daughter.

FOSTER.—On December 11th, at St. Loyes, Exeter, Anita, wife of Major Raymond L. V. Foster, R.A.M.C., of a son.

KITCHING.—On December 6th, at 24, Charleston Road, Eastbourne, the wife of Capt. R. L. Kitching, R.A.M.C., prematurely of a daughter (stillborn).

LYSTER.—On December 7th, at Sandgate, Kent, Ada Erica (*née* Neal), wife of Capt. R. G. Lyster, R.A.F., of a son.

PERKINS.—On January 5th, to Dr. and Mrs. Philip M. Perkins, Tunbridge Wells—a son.

RIVIERE.—On January 5th, at St. Giles' Plain, Norwich, to Veronica, wife of Bernard B. Riviere, F.R.C.S.—a son.

MARRIAGES.

CHAMBERS—ALDERSON.—On November 30th, at St. Mary Abbot's, Kensington, Lieut.-Col. Guy Oldham Chambers, R.A.M.C., son of Dr. and Mrs. H. W. Chambers, 101, Goldhawk Road, W. to Adèle Maude, widow of Lieut. A. R. Alderson, R.E., of Cirencester.

FRANKLIN—CARVER.—On October 17th, at St. Margaret's Church, Ockley, Major George Denne Franklin, B.A., M.B., B.C. (Cantab.), M.R.C.P. (Lond.), Indian Medical Service, to Ethel Janet Carver, formerly Sister Rahere, eldest daughter of the late Rev. H. J. Carver, of Melbury Abbas, and Mrs. Carver, "Hatchlea," Ockley, Surrey.

GURNEY-DIXON—CHAMBERLAIN.—On December 10th, at Essex Church, Notting Hill Gate, Capt. Samuel Gurney-Dixon, M.A., M.D. (Cantab.), M.R.C.S. (Eng.), L.R.C.P. (Lond.), of The Orchard, Lyndhurst, to Hilda, widow of Capt. John Chamberlain, M.C., and daughter of the late Prof. J. H. Poynting, D.Sc., F.R.S., J.P., of Deerhurst, Lyndhurst, Hants.

HADFIELD—IRVINE.—On December 14th, at St. Stephen's Church, Westminster, Geoffrey Hadfield, M.D. (Lond.), Capt., R.A.M.C. (temp.), eldest son of the late J. H. Hadfield, of Plymouth, to Eileen, only daughter of the late W. C. D. Irvine, Irvestown, co. Fermanagh, Ireland.

WHITE-COOPER—TRACEY.—On November 27th, at St. Saviour's, Dartmouth, by the Rev. Stewart Sim, uncle of the bride and Vicar of Lower Brixham, William Ronald White-Cooper, Capt. S.A.M.C., eldest son of Mr. and Mrs. William White-Cooper, of Cradock, S. Africa, to Rosamond Nancy, daughter of Col. H. F. Tracey, C.F., and Mrs. Tracey, of North Ford, Dartmouth, Devon.

DEATH.

JOYNT.—On December 30th, 1918, at 3rd London General Hospital, Wandsworth, Ivor Wm. Joynt, B.A., B.C. Cantab., only surviving son of Lieut.-Col. H. W. Joynt, of Bournemouth.

ACKNOWLEDGMENTS.

A Medical Service for the Genuinely Necessitous Classes of the Community, by V. T. Greenyer, F.R.C.S.

The Cholera Controversy, by A. C. Evarts, M.B.

The Nation's Welfare: The Future of the Medical Profession, by Maj.-Gen. Sir Bertrand Dawson.

The British Journal of Nursing, *St. Mary's Hospital Gazette*, *The Nursing Times*, *The Medical Review*, *London Hospital Gazette*, *Long Island Medical Journal*, *Journal of the Department of Public Health, Hospitals and Charitable Aid*, *New York State Journal of Medicine*, *The Hospital*, *Guy's Hospital Gazette*, *St. Mary's Hospital Gazette*, *The Journal of the American Medical Association*, *Giornale della R. Società Italiana d'Igiene*.

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.

St. Bartholomew's Hospital



"Æquamemento rebus in arduis
Servare mentem."

—Horace, Book ii, Ode iii.

JOURNAL.

VOL. XXVI.—No. 6.]


MARCH 1ST, 1919.

[PRICE SIXPENCE.

CALENDAR.

Fri., Feb.	28.—Dr. Calvert and Mr. D'Arcy Power on duty.
Tues., Mar.	4.—Dr. Fletcher and Mr. Waring on duty.
Wed., "	5.—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri., "	7.—Dr. Drysdale and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Drysdale.
Tues., "	11.—Dr. Tooth and Mr. D'Arcy Power on duty.
Wed., "	12.—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri., "	14.—Dr. Calvert and Mr. Waring on duty.
Tues., "	18.—Dr. Fletcher and Mr. McAdam Eccles on duty.
Fri., "	21.—Dr. Drysdale and Mr. D'Arcy Power on duty.
Tues., "	25.—Dr. Tooth and Mr. Waring on duty.
Fri., "	28.—Dr. Calvert and Mr. McAdam Eccles on duty.
Tues., Apr.	1.—Dr. Fletcher and Mr. D'Arcy Power on duty.

EDITORIAL NOTES.

 WITH the very deepest regret we have to record the death from pneumonia following influenza of Mr. Harry Blakeway, M.S., F.R.C.S., Surgical Registrar to the Hospital. He was taken ill on February 6th and died in Etherington-Smith Ward on February 15th. It is only a few weeks since we had to report the death of Dr. A. E. Stansfeld; to have lost in so short a space of time two of the most brilliant of the younger members of the Hospital Staff is nothing short of a calamity.

Mr. Blakeway had established a reputation which many an older and more experienced surgeon might have envied. As a teacher he was exceptional. For some months he had acted as Resident Assistant Surgeon, and there is no doubt that the strain of his Hospital work had considerably lowered his vitality.

To his widow and children we offer our deepest sympathy.

An obituary notice and appreciation appears elsewhere in this issue.

* * *

It is also with much regret that we have to report the death of two Bart.'s students, namely, Francis Wharton Lemarchand and Lofty Effendi Abdalla Simaika, both of

whom died in Mark Ward, the former on February 12th from pneumonia following influenza, the latter on February 16th from tuberculous peritonitis.

Francis Wharton Lemarchand was perhaps the best-known student Bart.'s has had during recent years. He was the only son of Dr. Arthur Wharton Lemarchand, of Barnstaple, himself an old Bart.'s man, and was born in 1893. He was educated at Mostyn House School, Parkgate, and Malvern College. In his early days he showed promise of becoming a fine athlete, but while at Parkgate he contracted a very severe septic pneumonia with pericarditis and an interlobular empyema. His heart never properly recovered and he had to abandon in a great measure his athletics. He was, however, a fine swimmer and a boxer considerably above the average.

When the war broke out he was at Bart.'s, and after being rejected several times on account of his heart eventually obtained a commission in the Navy as a Surgeon-Probationer. He served six months on H.M.S. "Nessus," and later after a period of study at the Hospital was appointed to H.M.S. "Whirlwind," taking part in the Zeebrugge Expedition. During the action he was transferred to H.M.S. "Phœbe," on which ship he performed gallant service. After serving six months' he returned to the Hospital and quickly passed his Medicine and Midwifery. He was to have taken Surgery in April. Last year before going to Zeebrugge he married.

"Binney," as he was affectionately known to his friends, will be sorely missed at Bart.'s. It was impossible to be dull in his company—he was, in fact, the life of the Hospital, and he leaves a niche which will not be easily filled.

Lofty Effendi Abdalla Simaika was the eldest son of Abdalla Bey Simaika, Legal Adviser to the Egyptian State Railways, and a nephew of Marcos Pasha Simaika, of Cairo. He came to this country about two years ago, and just before his illness was studying for his Final. In his quiet unassuming way he was very popular. His memory was extraordinary, and there is no doubt that had he lived he

would have gone far in the profession of which he was so keen a student.

To the relatives and friends of these Bart.'s men we tender our sincere sympathy.

* * *

Our congratulations to Capt. D. B. Pascall, R.A.M.C., and Capt. H. J. Pickering, R.A.M.C., on being awarded the Military Cross. The following are the official details :

"Temp. Capt. (Act.-Maj.) D. B. Pascall, M.B., No. 11 Field Amb., R.A.M.C.—For conspicuous gallantry and devotion to duty during the operations astride the Arras-Cambrai Road on September 2nd, 1918. He was in charge of the evacuation of casualties from the Front, and repeatedly made journeys over the shell-swept area around Dury and Eteripigny, locating and maintaining touch with R.A.Ps. and bearer posts. Through his disregard of danger the casualties were speedily evacuated."

"Temp. Capt. H. J. Pickering, No. 15 Field Amb., R.A.M.C.—For conspicuous gallantry and devotion to duty from September 25th to 30th, 1918, near Cambrai, especially one night, when, hearing that there was a congestion of wounded at a R.A.P., he went forward through heavy shell-fire and remained all night, collecting bearers from every available source and supervising the clearing of the post. Throughout the whole period he had only one other officer to assist him in the forward area. He inspired his men with his own cheerfulness, energy and endurance."

* * *

We are most pleased to learn that there has been a very generous response to the appeal made in our last issue on behalf of the wife and children of the late Dr. A. E. Stansfeld. It has been suggested that the sum should be devoted to educational purposes, but whatever form the help shall take, it is hoped that a substantial amount will be forthcoming.

May we again remind our readers of the appeal and the desirability of completing this memorial as soon as possible. Dr. Stansfeld was a young man; he was on the threshold of a great career; his all had been put into his advancement in the profession he loved so much. Unfortunately that career was cut short, and we feel sure that many Bart.'s men will wish to honour his name and show their appreciation in a practical form.

To those who have already contributed the Committee tender their sincere thanks.

Subscriptions should be sent to Dr. F. W. Andrewes, the Pathological Department.

* * *

Dr. Norman Moore's book on *The History of St. Bartholomew's Hospital* is a magnificent production, and we desire to congratulate the author most heartily on the completion of a work which must have involved an enormous amount of time, search and patience. The history of London's Senior Hospital is always extraordinarily

fascinating, especially to Bart.'s men, but we must confess that it was not until we came to read Dr. Moore's book that we realised what a large part the old Hospital has contributed to the history of this great city. The author proposes to hand over all profits accruing from the sale of the book to the Hospital funds, and for this reason alone we hope that the first edition will be quickly exhausted. The book is reviewed at some length in this issue.

* * *

Major-General Sir Wilmot Herringham's letter on Medical Education in London, which appeared in the February issue of this JOURNAL, has attracted much attention. The *British Medical Journal* (February 16th, 1919) devotes a column to Sir Wilmot's communication, and fully endorses all he has to say on this most important topic.

The letter we are printing in this issue, if anything, is even more important—in fact we do not remember having read anything more practical on the question of post-graduate study.

There is no reason why London should not become the great universal centre for medical instruction. The opportunity is a unique one, and it is on the lines suggested in Sir Wilmot Herringham's letter that such a desirable end might be attained.

* * *

In view of our comments in the last issue of the JOURNAL, in which we deplored the decadence of the Abernethian Society, we are most pleased to learn that this old and honoured Society has once more been set going. Soon after the publication of our note a meeting was called, over which Mr. Girling Ball was asked to preside. The following officers were elected :

Presidents : G. A. Fisher, G. Lyon Smith.

Vice-Presidents : H. Corsi, C. Dixey.

Extra Committee Men : B. Melle, C. J. Wells.

Secretaries : T. Zerolo, N. B. Vinter.

The first Clinical Evening was held on February 20th and proved highly successful. The enthusiasm and interest which was evident throughout the evening left no doubt that Bart.'s is as alive as ever, and still capable of making its presence felt as a potent factor in the medical life of this great city.

* * *

Major R. C. Elmslie, M.S., F.R.C.S., has been appointed Honorary Surgeon to the Royal National Orthopædic Hospital.

* * *

Sir George Newman, late Lecturer in Public Health at this Hospital, has been appointed Principal Medical Officer to the Local Government Board. Sir George is also retaining his position as Chief Medical Officer of the Board of Education.

The following gentlemen were nominated to the Resident Staff, commencing February 1st, 1919 :

House-Physicians—

Dr. Tooth.	A. Gregson Williams.
Dr. Calvert.	F. T. Burkitt.
Dr. Fletcher.	G. Lyon-Smith.
Dr. Drysdale.	G. A. Fisher.

Medical Receiving Officers—

C. F. Krige.	H. D. Kelf.
H. W. C. Vines.	N. B. Thomas.

House-Surgeons—

Mr. D'Arcy Power.	M. V. Boucaud.
Mr. Waring.	R. L. Williams.
Mr. Eccles.	H. Corsi.

Surgical Receiving Officers—

F. Gray.	H. Barbash.
J. E. A. Boucaud.	

Intern Midwifery Assistant . . . W. B. Heywood-Waddington.

Extern Midwifery Assistant . . . C. W. Bennett.

House-Surgeon to Ophthalmic Department . . . N. J. Macdonald.

House-Surgeon to Throat, Nose and Ear Department . . . J. A. van Heerden.

House-Surgeon to Venereal Department . . . J. J. Gasperine.

Resident Anæsthetists . . . D. A. Blount.

C. H. Thomas.

* * *

It is with much sorrow that we learn of the death of Sir Archibald Garrod's last surviving son, who died of pneumonia on February 4th. Lieut. Basil Rahere Garrod passed out of Sandhurst in December, 1915, and was gazetted to the 1st Loyal North Lancashire Regiment. After serving some time in France he became attached to the R.F.C., and was serving with the squadron at the time of his death. His brothers, Lieut. A. Noel Garrod, R.A.M.C., and 2nd Lieut. Thomas A. Garrod, were both killed in France.

The sympathy of Bart.'s men, both past and present, will go out to Sir Archibald and Lady Garrod in their inexpressibly sad bereavement.

* * *

We regret to learn of the death of Dr. William George Kemp, of Oakhurst, Hastings, which occurred with tragic suddenness while in a tramcar on January 24th. Dr. Kemp was born at Alnwick in 1846, and educated at King's School, Canterbury, and at this Hospital. After qualifying M.R.C.S. and L.R.C.P.(Lond.), he was House-Surgeon at Nelson Hospital, N.Z., and in 1870 began practice in Wellington, N.Z., holding the appointment of Surgeon to the Wellington Hospital, and having a wide consulting general practice. He was the first surgeon to perform ovariectomy in New Zealand, where he was highly esteemed for his skill and sterling character. He returned to England in 1892 and took the M.D.(Durham), but retired from all practice shortly afterwards. Dr. Kemp married Charlotte, daughter of Dr. J. D. Greenwood, and leaves a widow, four

sons, and three daughters. One daughter, a King's College Hospital sister, was killed by a German bomb while working at a Red Cross Hospital in Belgium. One son is Major in the N.Z. Medical Corps, one Captain, R.A.M.C., and a third son is in medical practice in New Zealand.

ON MEDICAL EDUCATION IN LONDON.

(SECOND COMMUNICATION—POST-GRADUATE TEACHING.)

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

SIR,—The reform of our education of medical students by the introduction of the professorial system is not the only improvement in medical education that is needed. Post-graduate instruction is hopelessly deficient and its extension is greatly to be desired. We have not only our own graduates to think of, but we are likely to have, and ought to have, a much larger number of Canadian and American graduates than before the war. What are the needs of such men, and how can they best be met?

One feature of the post-graduate teaching in Germany, which was so marked as to strike all visitors, was the immense prevalence of coaching classes given by teachers of the Privat-dozent type. These men, either utilising in-patients or paying out-patients a few pence for attendance, were able to give courses on special subjects, often well illustrated by living examples, which were just of the kind that we call revision classes, though, by reason of the limited scope of each one, they pursued the subject more deeply. I attended such classes nearly forty years ago at Vienna. Since then Berlin has become a great centre for them.

A second attraction was the provision of clinical facilities. If you wished to learn the use of the laryngoscope, the otoscope, the ophthalmoscope, or of any other instrument of clinical research, there were large classes either of in-patients or out-patients held by the professors or by extra-mural teachers, where you could obtain a considerable facility and experience. It was also possible to obtain an appointment as assistant to a professor of surgery, and thereby a large experience in operations such as in England are never done but by the hospital staff. In Germany they are handed over to the assistant.

The lectures of the professors are sometimes extremely good. They are rather elaborate clinical demonstrations than lectures, and were in my day sometimes combined with question and answer which prevented interest from flagging. Both Germans and French, especially the latter, take great pains to learn to lecture. The French certainly have a greater gift of speech than we. But I should like to know how many English lecturers have really practised themselves in speaking fluently and with expression. I

have heard lecturers in our own school who were not fit to talk to the parish pump. Even it would have gone to sleep—as I always did.

Lastly, many men obtain a place in a professor's laboratory. This is done not so much for the sake of the actual work that they are given to do, which is usually some very uninteresting and monotonous series of tests, but that they may have the run of the laboratory, see all that is being done there, and learn the methodical system of work for which the Germans are justly famed.

Would it be advisable, if we could, to provide some such means of instruction as these I have mentioned, and how far, if advisable, would it be possible?

I have heard it said that we do not want strangers, and strangers have said to me that that fact was made so evident that they retreated to France or Germany with all convenient dispatch. I think that view is both churlish and short-sighted. But the same mechanism would suit both strangers and our own graduates, and in providing for the one we should be supplying the wants of both.

We must start by realising that general hospital schools are not the places for post-graduate teaching. It is impossible to combine undergraduates and graduates, and there is too much to do for the former to allow of separate classes. This difficulty applies both to what I have called coaching classes and to clinical work in the wards or out-patient departments. At St. Bartholomew's we, for several years before the war, organised special long-vacation classes in the summer for such of our own old students as wished. But this was all we could do.

On the other hand, there would be no difficulty in admitting graduates to lectures if they wished to come, and it is conceivable that clinical lectures which rose to the level of those of Müller at Munich would attract. It is also possible for a graduate, even if a stranger, to obtain a place in a pathological laboratory, but the scantiness of our resources usually obliges us to require him to pay his own expenses. If professorial units were established, a place as assistant would probably not be difficult to obtain for a man with good credentials.

It is rather, however, to the special hospitals that those graduates look who come to London to improve their knowledge—to Great Ormond Street, Queen Square, Brompton, Golden Square, Moorfields and similar places.

Coaching classes they can get practically nowhere. They do not perhaps represent a high form of education. But they are extremely useful for men who, finding themselves rusty in a particular subject, wish within a limited time to rub up their knowledge of it. As there is no supply there is now no demand for them. But there soon would be, and it is well worth considering whether opportunity should not be given to resident medical officers, registrars, or even assistant physicians to hold such classes in their hospital buildings. It would be a useful addition to many a scanty

income, and since there is no way of learning so good as teaching, it would improve the teachers themselves.

The out-patient practice and instruction at Queen Square and Moorfields is highly admired, and offers as great facilities—especially if a man takes a clinical post—as any hospital in the world can give. Great Ormond Street, too, is much appreciated. But men have told me that the same does not hold good for others. They feel that the visiting physician is in a hurry and does not want to teach, and, going there with a rather high idea of the standard of knowledge and practice at the place, they come away feeling not only that they have not benefited, but that they have been looked upon as rather a nuisance than otherwise. That seems a great pity. We have an immense wealth of clinical material in London. We have many men whose clinical work is as good as any there is, and it is bad for the reputation of London that so little attempt should be made to allow graduates, whether English or strangers—but my remarks apply especially to the latter—to obtain instruction. We shall probably have a very much larger number of visitors in future than we have had in the past. They are, many of them, honestly anxious to learn what they can, and it is much the better policy to give as much, and not as little as possible.

Any such system would require organisation. Those officers of special hospitals who were willing to take part in it, for the good of the country and also in some measure for their own, should form a committee among themselves and see what they could promise. Some hospitals will be able, by means of their crowds of patients, to give more varied clinical demonstration. Others can give greater facility for personal clinical work because the crowd is less. Some men want the one, some the other. There should be some attempt to provide instruction and clinical facilities in all special branches.

Then arrangements should be in some regular fashion brought to the knowledge of graduates in search of such things. They should be able to apply to someone, not necessarily a doctor, who could tell them where they could get the particular things they want, and who might even make the arrangements for them. A regular list of classes, and of the times and places where clinical demonstrations are given, or clinical appointments can be held, would be kept in print and given to applicants. The expenses could be easily covered, and the benefit would be considerable.

I am ambitious for London. I feel that she does not do herself justice, partly through a natural hatred of self-advertisement, partly out of sheer dislike of trouble, and partly also out of dislike of strangers. That indolent and repellant policy is, in my view, a great mistake. It has prevented us from being known, and therefore valued, as individuals, and it has prevented the excellence of English teaching and practice, which is, in my opinion, very high indeed, from being appreciated. I feel inclined to take the

words out of the Royal mouth, and to reiterate, "Wake up England!"

And let me say finally that I feel such a step as this to be not only of medical, but of national, and even of world-wide importance. I am sure that one of the greatest results of the war has been the creation of closer relations between this country and the Dominions on the one hand, and between the Empire and America on the other. But in France I have been brought into close contact with doctors from Canada, from Australia, and from the United States, and I can say, without the least reserve, that their relations with us have been of the most cordial character. We have indubitably learnt much from them and they from us. I think it has been a great pleasure to all of us. America especially had a feeling that we were insular and somewhat stiff and prejudiced. The cordiality with which they were instantly received, the facilities which they were instantly given, and the co-operation which we were as eager to welcome as they to offer, made, as I have reason to know, as great an impression upon their medical officers as upon the combatants. I feel sure that a great deal of misapprehension has been cleared away, and a great deal of very good will created. To continue that should be the aim of all classes in England, and we doctors, by the means I have indicated, can do our share in that work. I hope that in the International Co-operation of Science, which I see has been formally inaugurated, we shall be drawn into specially close connection with those who speak our tongue. I hope to see medicine and the allied sciences in England systematically acting in combination with those of America, and a continuous intercourse established between the two. Nothing is more likely to strengthen that friendship, which, for the preservation of peace, is of the last importance, than personal intercourse. If we can do something to bring men over here from the Dominions and the States, we shall be advancing the interests not only of English medicine, not only of the British Empire, but of the world.

I am, Sir,

Yours obediently,

G.H.Q., France.

W. P. HERRINGHAM.

MEDICAL NOTES.

By Sir THOMAS HORDER, M.D.

(Continued from p. 54.)

ON PLEURISY.

(70) There are probably few diseases more often diagnosed without adequate reasons than pleurisy; there are probably few diseases that exist more often unsuspected.

(71) The pain of pleurisy is capable of very extensive

reference: it may be felt as high in the body as the cervical vertebræ, and as low as Poupart's ligament. One of the commonest remote points of reference is the extreme tip of the shoulder, and pain in this situation should always lead to careful examination of the chest for pleuritic rub.

(72) Two sounds are at times mistaken by the beginner for pleuritic friction and must be distinguished from it: (i) muscular rumble, especially when exaggerated by shiver, and (ii) rhonchus. (i) is heard all over the chest, and universal pleurisy does not occur; moreover (i) is a continuous sound, whereas pleuritic rub is rhythmical. (ii) is nearly always bilateral, which acute pleurisy uncommonly is; but of much greater differential value is the fact that whereas pleuritic rub is a constant sound, rhonchus is inconstant, being affected by cough and by deep breathing.

(73) The presence of skodaic resonance beneath the clavicle, though highly suggestive of pleural effusion, is not pathognomonic of this; the sign is occasionally present in cases of solid lung (cancer, massive collapse, and pneumonic consolidation).

(74) Rheumatic pleurodynia is a common condition, especially in children, but it is doubtful if true rheumatic pleurisy occurs apart from rheumatic fever.

(75) Primary pleurisy with serous effusion is most often due to infection of the pleura by the tubercle bacillus. The evidence for this statement is as follows: (i) *Clinical evidence.*—(a) Many of the patients develop phthisis later in life. The percentage of cases in which this happens is less nowadays than formerly, for the reason that more of them are treated on the lines of early pulmonary tuberculosis, and consequently the lung infection is more often delayed, or altogether prevented, than was wont to be the case. (b) In a few of the cases there is co-existent early phthisis. (ii) *Cytological evidence.*—The cell-content of the effusion is usually very highly lymphocytic, and this is known to be the case in tuberculous serous effusions. (iii) *Morbid anatomical evidence.*—In the few cases that are fatal, and are subjected to autopsy, tubercles are demonstrable on the pleural membrane. (iv) *Bacteriological evidence.*—If appropriate tests be made, the tubercle bacillus can be demonstrated in the effusion in over 70 per cent. of the cases; rarely by searching the clot (which forms in the effusion) for the bacillus by the simple film method; seldom even if the clot be digested prior to making the films; but more often than not if a considerable quantity of the effusion (not less than 20 c.c.) be centrifuged and the deposit be injected into a guinea-pig.

(76) Pleural effusion complicating nephritis is of two very different kinds: (i) hydrothorax, in most cases part of a general œdema, and (ii) pleuritic exudate, due to acute inflammation of the serous membrane. (ii) is often quite

acute in its onset and course, and is generally accompanied by fever. It is in many cases associated with infection by a streptococcus of low virulence, less often by the pneumococcus.

(77) Pleurisy, usually left-sided, may be the first event drawing attention to the existence of gastric ulcer. The diagnosis, as may be supposed, is not easy. But when the patient is a young woman subject to attacks of dyspepsia of the hyperacid type; when the pleurisy is insidious in its onset; when liquid effusion appears slowly, is purulent in character and contains a mixture of micro-organisms—in the presence of these facts the diagnosis may be made with some confidence.

(78) It is not very uncommon to find pleurisy developing between the third and eighth day after an operation for gastro-enterostomy. Although the event is somewhat alarming, the prognosis is not necessarily bad; most of the cases recover and not a few recover without the aid of further surgical procedures. The occurrence of such cases, and their recovery without serious consequences, remind us how very susceptible the pleura is to infection, and how extremely well equipped it is for dealing with infection.

(79) Pleural effusion discovered to have been latent, or to be much smaller in amount than the physical signs led the observer to anticipate, or the withdrawal of which affects the physical signs and the symptoms but little: consider the possibility of new growth in association with the effusion.

(80) The commonest cause of blood-stained pleural effusion is not malignant disease of the lung or pleura, but the commonest cause of pleural effusion in general—tuberculosis. A third common cause of sanguineous effusion is hæmorrhagic infarct, complicating dilated right heart, and in most cases associated with mitral stenosis. Pleural effusion complicating influenza may also be blood-stained.

(81) Movements of the accessory muscles of respiration, and especially of those connected with the shoulder girdle, are liable to prolong an attack of pleurisy. This may sometimes be demonstrated by the effect on the temperature chart of three or four days during which the patient is allowed free movements of the arms in bed, followed by a similar period during which he is kept strictly at rest. A valuable adjunct to the treatment of pleurisy is to immobilise the arm on the affected side by strapping it to the chest.

(82) The indications for aspiration of a serous pleuritic effusion are three: (i) The effusion is very large: the fluid should be drawn off as soon as the condition is diagnosed. (ii) The effusion is not very large, but there are symptoms of cardiac or of respiratory distress: the effusion should be aspirated in the hope that this procedure may relieve the distress. (iii) The effusion has been present for ten to

fourteen days and shows no signs of being absorbed. Concerning the cases coming into this group two questions may reasonably be asked: (a) Why not aspirate before the tenth day? Because the evolution of the process of exudation is not usually complete before that day, and removal of the fluid before the high tide is reached is likely to lead to recurrence of the effusion. (b) Why aspirate at the end of this particular interval? Because an effusion that is allowed to remain unabsorbed longer than this period of time is liable to cause permanent collapse of lung with associated deformity of the chest.

(83) A very important, though a subsidiary, reason for not aspirating every pleuritic effusion so soon as it is diagnosed, is that the lung on the side of the effusion may be the seat of active tuberculosis. If this is the case the early removal of the fluid may prove an actual danger to the patient, by causing rapid expansion of the collapsed lung and consequent risk of extension of the tuberculous process. Another occasional consequence of such unwise treatment is the occurrence of pneumothorax with its attendant dangers. The presence of the fluid keeps the lung collapsed, and so tends to check an acute tuberculous inflammation. In other words, the incidence of a pleural effusion in association with active phthisis is a "conservative" process, the benefit of which to the patient may be undone by hasty treatment.

(84) The use of respiratory gymnastics and special breathing exercises designed to restore the function of the lung after an attack of pleurisy with liquid effusion requires careful supervision. Graduation is the essence of the treatment; but given an enthusiastic patient, and a demonstrator bent on rapid results, and anything may happen, from mere prolongation of the period of convalescence to a recurrence of the effusion.

INFLUENZAL EMPYEMA.

By GEOFFREY BOURNE, M.B., M.R.C.P.

SINCE the commencement of the present influenza epidemic till the end of January, 1919, thirty-one cases of empyema, associated with influenza, have been treated in the civilian wards of this Hospital. The following remarks are based upon facts observed in connection with these cases.

Many pathologists have studied the bacteriology of the present epidemic: some have claimed Pfeiffer's bacillus, others a Gram-negative diplococcus, others a streptococcus, as the causative organism of the disease.

The very disparity of the claims suggests that none are correct. The truth probably is that the causative organism is unknown, and may be a filter-passer. There is no doubt

however, that the organisms above mentioned, together with the pneumococcus and others, occur in association with the undiscovered virus. It is to this symbiosis that many of the complications are due. Prominent among these stands empyema.

Empyema, as known before the present epidemic, occurred almost entirely in association with pneumonia; and the organism present in 90 per cent. of the cases was the pneumococcus. In the present series of cases, however, although the pneumococcus is not uncommon, the predominating organism is undoubtedly a streptococcus.

Thus the empyema of influenza is radically different from that of lobar pneumonia, and must be considered from all points of view, including that of treatment, from a totally new standpoint.

Etiology.—It is commonest below the age of 30. There seem to be two periods when it is especially common, *i. e.* between the ages of 4 and 7 and between the ages of 17 and 27. Pneumococcal cases are commoner in children and adolescents, streptococcal cases in adults.

Influenzal empyema is apparently commoner in females. In the sixty female beds of this Hospital there have been 22 cases within the above-stated period, and in the 56 civilian male beds there have been 9 cases.

A very marked feature of post-influenzal empyema is its predilection for the left side. It is, according to the figures at present available, three times as common on the left side: of 31 cases 24 have been left-sided.

These figures should be contrasted with records of empyemata occurring previous to the present epidemic. Of 29 empyemata occurring in Luke before the epidemic, 21 were on the right side. The cause for this localisation is a matter for conjecture. Probably the congestion of the bases of the lungs, almost invariably present to some extent in influenza, is increased on the left side by the mechanical presence of the heart. Possibly also this congestion, though inimical to the growth of the more delicate pneumococcus, favours the growth of the harder streptococcus. Pathological evidence on this point would be interesting.

Classification of influenzal empyemata is necessary in order that each case may have appropriate treatment.

The penny-in-the-slot idea, "empyema"—"resection," can only lead to unsatisfactory, if not disastrous treatment. Classification according to bacteriology is most useful and most scientific.

Thus we have:

- (1) Streptococcal.
- (2) Pneumococcal.

(1) STREPTOCOCCAL EMPYEMA.

(a) *Acute Streptococcal Empyema.*

Acute streptococcal empyema occurs within the first fortnight, usually the first ten days of the disease, and is

coexistent with an acute streptococcal infection of the lung, usually a broncho-pneumonia.

On aspiration the fluid is seen to be thin and watery. Its colour varies from that of blood to that of amber. On standing it separates into two layers—a clear, coloured upper layer and a thicker opaque deposit. The deposit, which consists chiefly of pus-cells, reaches only to about a quarter of the height of the fluid in the test-tube. The more acute the infection the redder and thinner is the fluid.

Streptococci, often in chains of considerable length, are found in the film in large numbers, and in the culture in pure growth.

The characteristic clinical features may be said to be:

- (1) Rapidity of collection of the fluid and of re-collection after aspiration.
- (2) The extreme accompanying toxæmia.
- (3) A considerable degree of cyanosis.

Treatment.

Specific treatment, though theoretically the most hopeful of any, seems as yet to be of little use.

Antistreptococcal sera have been tried, but, probably owing to the difficulty of hitting off the exact strain of organism, the results have been disappointing.

Vaccines have been similarly unsatisfactory.

Symptomatic treatment.—Resection of a rib is contra-indicated. It seems almost invariably to be followed by death. Information received from a naval colleague concerning a series of cases in a naval hospital bears out the same point. Of these cases every one treated by resection died. The only cases that did not were treated by repeated aspiration.

The treatment of the toxæmia consists in fresh air, large quantities of fluid, looseness of the bowels. On one occasion venesection was temporarily beneficial.

To recapitulate: In acute streptococcal empyema do not resect. Aspirate repeatedly; try sera; wash out the toxins; treat symptoms.

The terminations are three: Death, absorption of fluid; chronicity.

(b) *Chronic Streptococcal Empyema.*

Chronic streptococcal empyema occurs usually by the infection of the pleura by an organism of a lesser degree of virulence than is found in the acute type. In only a small percentage of cases has the infection started as the above-described acute streptococcal empyema.

Whereas the acute empyema arises during the height of the attack of influenza, the chronic one arises as it were out of its ashes. A usual history is that the patient had influenza four or five weeks ago, being in bed about a week, got up, felt fairly well till a fortnight ago, when she began to notice cough, dyspnoea, and general lassitude. On

examination signs of a large effusion are found. Aspiration gives yellow pus.

So far as can be judged from the history and from the few cases available, the onset of the condition is fairly gradual, the effusion not reaching its maximum size for a fortnight or three weeks. During this period of onset there is fever, rapid pulse, lassitude, some headache, and other symptoms, due to the presence of active streptococcal inflammation of the pleura. As time goes on the acuteness of the inflammation dies down, and with it fall the temperature, and to some extent also the pulse-rate. Now, however, are added the symptoms due to the embarrassment of heart and lungs by the large quantity of fluid. Thus the pulse-rate rises again.

Whereas the toxic signs of an acute inflammation have now died down, there still are present in the effusion a good reservoir of poisons. To the absorption of these are due the wasting and pallor.

For the sake of lucidity it is advisable to describe two types of chronic streptococcal empyema. But it must be remembered that these are merely two stages in the progress of a single pathological condition. Between the two types are many gradations.

Type A.—"Subacute type."

Type B.—"Chronic type."

Type A.—The usual history is that the patient had influenza four weeks ago or less. The signs and symptoms of an active toxic condition—fever, malaise, headache—are present. The pus withdrawn on aspiration is yellow, fairly opaque, but of a thin and watery consistency. A film shows streptococci present in fair numbers. Their chains are usually short. Briefly the organisms present in the pleural cavity are active, parasitic, pathogenic.

Type B.—There is a longer history than four weeks since the attack of influenza. The patient is possibly afebrile. The symptoms are due to the mechanical presence of the effusion. The pus is thicker than in type A.

Microscopically the streptococci are few in number. They are alive, but dormant, passive, saprophytic.

In the above brief sketches of the two types the predominant colours only have been used. There is no intention of suggesting that symptoms of mechanical origin are always absent in the subacute type, or that the large collection of pus often found in the chronic type gives rise to no toxic symptoms.

The first picture is one of a subacute, still progressing infection; the second is one of a condition in which active inflammation has pretty well ceased.

The necessity for recognising these two stages of chronic streptococcal empyema is shown by their different response to treatment.

Treatment of Chronic Streptococcal Empyema.

Resection of a rib in type A is followed by several weeks

of pyrexia, continuous discharge in which streptococci are found, and a condition of œdema and often of brawny induration of the edges of the wound, which ultimately heals.

In type B resection is followed by a rapid disappearance of symptoms and a normal period of healing and convalescence. Thus, to reconsider the evidence, in acute streptococcal empyema resection is followed by death; in type B of chronic streptococcal empyema resection is followed by rapid recovery; and in type A by an unsatisfactory and delayed recovery. In the first of these cases resection is the wrong treatment, and in the second is correct. The treatment of the third case must therefore be considered. Bearing in mind the pathology of the condition, it would seem ideal to transform type A into type B and then to resect. By merely waiting this change will in most cases come about. In the meantime, however, the patient is exposed to certain dangers.

These are—

- (1) Renewed increase in the activity of the streptococcal infection.
- (2) Mechanical embarrassment of the heart.
- (3) Mechanical embarrassment of respiration.
- (4) An intractable cough due to the presence of the large effusion, which adds greatly to the handicap to heart and respiration.

The three last symptoms can be relieved by aspiration, for the pus in these cases is rarely too viscid to pass through the needle.

In addition to this symptomatic treatment, an endeavour should be made to shorten the period of acute inflammation during which resection is inadvisable. This, shortly, consists of bed, plenty of good food, extra fluids, looseness of bowels, and specific treatment with antistreptococcal sera and autogenous vaccines, preferably sensitised.

Resect as soon as the temperature chart and the cessation of increase of fluid show that stage B has been reached.

To recapitulate: In chronic streptococcal empyema first determine whether the streptococcal infection is still active; if so, wait till it subsides before resecting, meanwhile treating symptoms by aspiration and attacking the infection.

(2) *Pneumococcal Empyema.*

The pneumococcal empyema of influenza differs very little, as regards pathology and treatment, from that of lobar pneumonia. The pneumococcus is found. The pus is green, not yellow, as in the streptococcal cases. Resection of a rib in the acute stage is followed by rapid recovery. This latter point must be emphasised in contrast to the streptococcal cases. No further remarks are necessary as regards pneumococcal empyema. Information regarding them is available elsewhere.

It may perhaps be worth mentioning that several cases of acute influenza-pneumococcal empyema have been treated

by incision of the parietes, without resection of a rib, and by insertion of a rigid tube. This treatment, if efficient drainage is kept, and if subsequent rises of temperature are treated by efficient probing for retained loculi of pus, seems to be followed by more rapid healing and convalescence than if a rib had been resected. Chronic pneumococcal empyema, however, must be treated by resection, owing to the fibrinous flakes present in the pus.

CONCLUSIONS.

- (1) Influenzal empyema is chiefly streptococcal.
- (2) It is twice as common in females.
- (3) It has a predilection for the left side.
- (4) Never resect a rib in acute streptococcal empyema.
- (5) In chronic streptococcal empyema wait till the infection has died down, then resect.
- (6) An acute pneumococcal empyema can sometimes be given a more rapid convalescence by incising the parietes between the ribs and by not resecting a rib.
- (7) A chronic pneumococcal empyema is best treated by resection.

[I am indebted to the kindness of the members of the Medical Staff for permission to quote these cases.]

A CASE OF MALFORMATION OF THE TRACHEO-ŒSOPHAGEAL SEPTUM.

By J. A. VAN HEERDEN, M.R.C.S., L.R.C.P.



A MALE full-time child was born on September 8th by forceps delivery for prolonged second stage and distress. It was noticed soon after birth that the child had more than the average amount of mucus in its air-passages; its breathing was accompanied by tracheal rales. When suckled it very soon got blue and distressed, but it would recover after regurgitation of its feed mixed with frothy mucus.

Partly on account of the mother's retracted nipples, and partly because there appeared to be an excess of mucus in the air-passages, thus interfering with breathing when suckling, the child was forthwith fed artificially.

Here, again, after swallowing a drachm or two of milk and water in successive quantities of a few minims at a time, it would invariably become cyanosed and distressed, and it would not settle down until the feed had been slowly regurgitated.

There never occurred any true act of vomiting, and the regurgitated fluid was not acid. No visible peristalsis was observed, and no tumour was seen or felt in the stomach region. The nostrils and nasopharynx were repeatedly cleared with pledgets of wool soaked in bicarbonate of

soda, but, even along with the administration of small doses of atropine, no apparent change was observed, and frothy mucus would repeatedly collect in the mouth and nasopharynx.

On the fourth day, and repeatedly afterwards, a soft nasal tube was passed with the greatest ease for $9\frac{1}{2}$ in. and no obstruction was apparent. All attempts to introduce fluid by this tube failed. The child was never distressed with the tube *in situ*, and the end of the tube was never found coiled in the pharynx.

An attempt to pass an œsophageal tube by mouth failed, as some obstruction was encountered about 3 in. from the epiglottis.

Mr. Rose pointed out that the tube, which was introduced by the nose, might very easily be coiled up in a dilated *cul-de-sac* of the œsophagus.

On the sixth day Mr. Blakeway was asked to see the child. While the diagnosis was regarded as uncertain, it was considered that the condition was probably to be ascribed to a congenital malformation of the œsophagus, but that pyloric stenosis had also to be considered; against the latter were the absence of dilatation of the stomach, visible peristalsis, or any real act of vomiting; against the former only the apparently easy passage of the nasal tube.

In either case laparotomy was necessary without more delay if the child's life was to be saved. It was supposed that such a course would make the diagnosis clear, an empty stomach with a normal pylorus indicating the performance of gastrostomy (if the parents were willing that such a procedure should be carried out), or on the other hand, a thickened pylorus pointing to the necessity of gastro-enterostomy or some form of pyloroplasty.

The operation was immediately carried out through a median epigastric incision. The stomach was at once seen to be somewhat dilated, while the jejunum was contracted, pale and empty. The pylorus was certainly natural, and stomach contents (apparently chiefly wind) could be squeezed through into the duodenum.

Gastro-enterostomy was decided upon, as on the one hand it was possible that, as is not infrequent, a congenital obstruction of the duodenum might be present, but the very poor condition of the child forbade further investigations; while on the other the prospect of permanent gastrostomy in an infant was viewed with the greatest reluctance. The posterior operation was performed in the usual manner, using clamps, and the incision in the abdominal wall was rapidly closed.

Though the operation was completed in less than twenty minutes the child showed few of the signs of life by the time it was over; it responded, however, to the ordinary restorative measures.

After its return to the ward the infant's condition for a time gave ground for hope, and during the first nine hours it had taken 14 drachms of milk and water—a feat it

had never accomplished before. (Where this fluid went to was never subsequently discovered!)

Later, however, regurgitation, not of milk but of what appeared to be bile-stained material, took place after each attempt at feeding, and death finally occurred twenty-nine hours after the operation.

At the post-mortem examination it was found that the upper segment of the œsophagus formed a widely-dilated *cul-de-sac* and reached to the bifurcation of the trachea.

The lower segment of the œsophagus opened in the posterior wall of the trachea, a third of an inch above the bifurcation of that channel. Its orifice was bounded below by a crescentic fold, the lateral margins of which turned upwards over the free ends of the tracheal rings. The *cul-de-sac* of the upper segment of the œsophagus overlapped the origin of the lower segment, to which it was

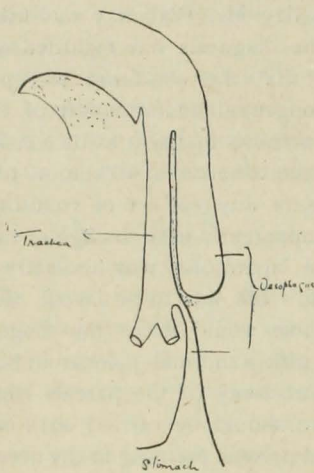


DIAGRAM TO ILLUSTRATE THE CASE.

joined by a strand of muscular tissue; this latter portion of the gullet had no communication with the upper segment. Only meconium and a little blood were present in the intestine.

The family history showed that the parents and their one other child were normally developed.

The mother gave a negative Wassermann reaction.

The case is of interest not only on account of the comparative rarity of the condition, but also in virtue of the symptoms which occurred immediately after birth—regurgitation of its feed following attacks of cyanosis and distress.

No true act of vomiting ever occurred.

It illustrates the deceptive facility with which a soft nasal tube may appear to pass down the gullet while it is in reality coiled up in a dilated upper part of that tube.

To produce this malformation of the tracheo-oesophageal septum Keith says the lateral tracheo-oesophageal ridges and folds, instead of proceeding horizontally backwards so as to meet between the lung buds and œsophagus and so divide the primitive œsophagus into a dorsal and ventral

division, proceed obliquely backwards and dorsalwards so as to meet on the dorsal wall of the foregut.

On referring to reports on other similar cases it was found that in the majority of these malformations there is present a right aortic arch or its representative—a right subclavian artery arising as the last trunk from the aortic arch; other malformations in order of sequence were hare-lip, cleft palate, atresia ani and malformation of the heart.

In this case no other malformation was found.

By courtesy of Dr. Williamson and the late Mr. Blakeway I am permitted to publish the note on this case.

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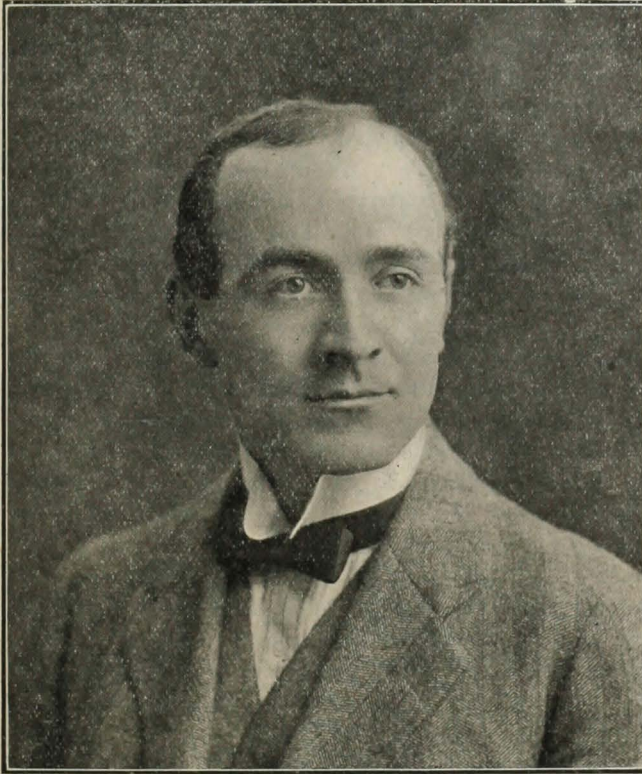
OBITUARY.

HARRY BLAKEWAY, B.Sc., M.S., F.R.C.S.



HARRY Blakeway, Resident Assistant Surgeon to our Hospital, died on February 15th in the Etherington-Smith Ward for Medical Officers, from pneumonia following an attack of influenza. He was the second son of Mr. James Blakeway, veterinary surgeon at Stourbridge, in Worcestershire. He came to our Medical School in 1903 as an undergraduate of the University of London, and throughout had a distinguished student's career, taking a considerable number of our prizes and scholarships, amongst which were the Harvey Prize in Practical Physiology, the Willett Medal in Operative Surgery, the Matthews Duncan Medal in Obstetrics, the Walsham Prize in Surgical Pathology, and the Brackenbury Scholarship in Surgery. He qualified in 1908 as M.R.C.S., L.R.C.P., and soon afterwards was appointed House-Surgeon to Mr. Lockwood. In 1910 he took the Fellowship of the Royal College of Surgeons and the M.S. at the University of London. He was then appointed Demonstrator of Anatomy and held this post for several years, during which period he proved himself to be an excellent teacher, and in addition did good original work in anatomy, publishing papers on congenital absence of gall-bladder, etc., and investigations in the anatomy of the palate. In 1905 he took the degree of B.Sc. (Lond.), with Honours in Physiology. Whilst working in the Anatomical Department he was appointed to the surgical posts of Surgeon to Out-patients at the Victoria Hospital for Children and Assistant Surgeon to the Truss Society. At the Victoria Hospital he

pursued his investigations in connection with the surgical treatment of hare-lip and cleft palate, and in 1915 was Hunterian Professor at the Royal College of Surgeons, where he lectured on the operative treatment of cleft palate. In 1913 he was appointed Surgical Registrar to the Hospital, which appointment he continued to hold until his untimely death. At the commencement of the war in 1914 he desired to place his services at the disposal of the War Office for service abroad, but at the request of the authorities of the School and Hospital he continued to work at the Hospital and Medical School, doing the work



HARRY BLAKEWAY, B.Sc., M.S., F.R.C.S.

at various times of Surgical Registrar, Demonstrator of Morbid Anatomy and Surgical Pathology, Demonstrator of Anatomy, Temporary Assistant Surgeon, and lastly, that of Resident Assistant Surgeon. Without his able assistance and untiring energies in whatever department the authorities of the School or Hospital found desirable, it would have been difficult to have carried on so satisfactorily the teaching of those of our students who remained, or returned to pass their examinations and complete their curriculum. Personally, I feel a great debt of gratitude to him for the help he gave me during the period he acted as my Assistant Surgeon, both as regards the surgical work of the Hospital and the instruction of the dressers and students.

I regarded Blakeway as one of the most promising of our young surgeons, who would without doubt have made his mark in the surgical profession if his career had not been brought to this early termination.

He married Margery Campbell, daughter of Mr. Frank Griffith, of Woking, and leaves one son and two daughters.

H. J. W.

HARRY BLAKEWAY was a man in a thousand—one of those men whom natural ability and intense industry raise high above the average of their day and generation. The long list of successes won by him in his undergraduate days—and he took the B.Sc. Honours Degree in Physiology in the University of London “in his stride”—were indeed the promise of that hunger for work and brilliance of achievement which followed him to the end.

From among the past Demonstrators of Anatomy in this Hospital who have gone to their rest, three stand out of whom it can be said with certainty that had they devoted themselves to Anatomy as their life-work they would have ranked among the foremost names in that science—Walsham, Lockwood, Blakeway.

Blakeway was indeed the anatomist born: he had the technical skill, the patience, the scientific insight and the real *flair* for making and demonstrating a specimen that are given to few. He never undertook a lecture without the most careful preparation, and to his thoughtful, clear delivery was added the charm of a stimulating personality. As a teacher he was a constant inspiration to the willing student and a mirror of shame to the “slacker.” Indeed, when he showed anger it was only when faced by some standard of duty or work which could not withstand the white heat of his own.

His dissections of the pharynx and palate—his most notable anatomical work—were exquisitely done, and find a fitting home in the Museum of the Royal College of Surgeons. In later work, on the intricacies of an abnormal heart, he showed the same genius for dissection and observation. His interest in Anatomy never waned, and ideals which he had long cherished, and had only recently expressed, will be of great use, it is to be hoped, in the reconstruction of the Department.

Others are better qualified to appraise his later record than the writer, but he can say this much with truth—that he has never known a young surgeon of more brilliant promise. Blakeway's mastery of its literature and methods, his consideration for the patient, the deftness of his touch and the skill of his hands all seemed to point to a brilliant future in the Science and Art of Surgery. Something more than admiration had grown out of his steady regard for the great traditions of Paget's life and work: he himself had attained many of the high qualities associated with a name he revered so much.

The heavy toll of war has not been taken in foreign

lands alone. With youth and vigour in his blood Blakeway naturally longed to be on active service somewhere near our fighting men; but thrice over, as in the case of Stansfeld, his services were appealed for as indispensable by the Hospital and Medical School. Both men, thus called on to take a heavy share in the work of our greatly depleted Staff, undoubtedly so undermined their health by tireless energy and incessant work that, when they were stricken, Death laid both low in their prime—

“And straight was a path of gold for them,
And the need of a world of men for us.”

No words can express the loyal friend that Blakeway was. Memories of him in his home are too sacred to touch upon here. Good books he loved, and from the storehouse of an accurate memory he would readily recall much of the best in them; good music he loved, too, and often some tedious dissection would be relieved by whistled fragments of favourite melody. He was always at his best in the open country, in whose sights and sounds he revelled with simple joy. In earlier years a keen horseman to hounds, in later years he took to golf with the same zest with which he tackled everything; his swinging drive was a treat to see. To be with him on these occasions, rare of late, when he sought relaxation in the open was like being in the company of a boy on happy holiday.

Vale! Yet—

“No, at noonday in the bustle of man's work time
Greet the unseen with a cheer!
Bid him forward, breast and back as either should be,
'Strive and thrive!' cry 'Speed,—fight on, fare ever,
There as here!'”

A. M.

LEONARD GEORGE GUTHRIE, M.D.(OXON.),
F.R.C.P.

BY the death of Dr. Leonard Guthrie, which took place on December 24th as the result of a severe accident, St. Bartholomew's Hospital is called upon to mourn the loss of one of her most distinguished students. More than thirty years have elapsed since Leonard Guthrie first began the study of medicine at St. Bartholomew's after having been educated at Magdalen College, Oxford, where his academic career was most successful. Although his professional life was spent away from the Hospital, few men were more widely known and respected by those who had been his fellow students in the past.

Leonard Guthrie belonged to a type of physician—too rarely met with—in which high qualities of mind and character were most happily blended. He was a learned physician, and his well-trained mind contained vast stores of knowledge and erudition which enabled him to throw unusual and interesting lights upon the medical problems with which he came into contact. His medical writings

were, therefore, of a high order, and he had the power of clear and even elegant exposition, which, while it charmed, never left the reader in doubt as to his meaning. In practical medicine the domains of neurology and disease in children claimed his entire attention, and to these subjects he contributed much valuable work. The history of medicine also interested him intensely and gave him opportunities for the exhibition of his undoubted literary skill. In 1907–8 he was appointed to deliver the Fitz-Patrick Lectures in that subject before the Royal College of Physicians, and they were justly admired on account of the learning displayed and their high literary merit. Besides the many papers of a strictly medical nature, Guthrie was the author of that charming work, *Hospital Sketches*, by Galen, which shows him to have been a most capable master of blended humour and pathos.

But the mental attainments of Leonard Guthrie could never have exerted such an influence upon those with whom he came into contact without those personal qualities which endeared him to all. Throughout life he had no thought of self, and was ever ready to sacrifice himself in the cause of others. His conception of the duty of a physician was high, and there is no instance in his career where personal advantage tempted him to swerve a hair's breadth from the path he believed to be right. Guthrie could always be trusted to take the straight road, and for this reason his services were often requisitioned in cases where internal differences had arisen. With many of the views expressed at the present time he had no sympathy, but if he permitted himself a criticism, it was without rancour and left no sting. Indeed, his keen sense of humour rather led him to stand aside from the contest and to be amused while others were breaking lances in the arena. Few men had such a wide circle of friends, and many will feel to-day the poorer for his loss. He has gone, but he has left behind him a memory that any one would be proud to have—a memory of unselfish services faithfully performed, of high purpose, and of sympathy open to all.

A. C.

NOTE ON A NEW PRODUCT.

We have received from Genatosan Ltd. (the British Purchasers of the Sanatogen Co.) a sample of Genaspirin, a brand of acetyl-salicylic acid which they have recently placed on the market. We have no hesitation in describing the sample as excellent. Its purity is unquestioned. The product contains no free salicylic or acetic acid, and even on the addition of 0.2 per cent. hydrochloric acid there was no reaction with ferric chloride.

There is no doubt that many samples of acetyl-salicylic acid on the market are far from being up to B.P. standard. Medical men prescribing Genaspirin may rest assured that their patients are getting a particularly pure form of the drug.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. GUY'S HOSPITAL.

Over a thousand spectators—with strong contingents from both Hospitals, many in gala costume—saw Guy's defeat Bart.'s by a goal and a try (8 points) to a try (3 points) at Queen's Club on January 25th.

Both sides were at full strength, and from the kick-off to "no-side" equally keen to score a win over their rivals.

Guy's, possessing an excellent pack of forwards, were somewhat favoured by the soft and slippery ground, but, if overweighted, the Bart.'s pack put every ounce into their work, and at one period of the game more than held their opponents.

The three-quarters and halves were well matched and equally well marked, and no one was allowed to run far on account of the keen tackling on both sides.

The only score of the first half came through the Bart.'s scrum-half, Llewellyn, who was always to the fore throughout the game, and his try was the result of a clever individual effort and thoroughly deserved. Melle failed to goal from a difficult angle, but almost put the Hospital further ahead from a penalty kick, the ball just falling short. Bart.'s thus crossed over with a well-deserved lead of 3 points.

Early in the second half Guy's attacked vigorously, and Aspenwall, taking advantage of a misunderstanding between the Hospital backs, ran over with a try, which Crook improved upon with an exceptionally fine kick.

Two points down, Bart.'s made desperate efforts to regain the lead, but Guy's defence was sound, their tackling excellent, and their heavier pack now beginning to assert its superiority in the tight scrummages.

The only other score came ten minutes from the end, when P. Krige ran over after a clever combined movement. The kick at goal failed.

It was a great game in every respect, and on their play, especially in the second half, Guy's thoroughly deserved their win.

ST. BARTHOLOMEW'S HOSPITAL v. THE CANADIANS.

Played at Winchmore Hill on Saturday, February 22nd. The ground was in a terrible state after the recent rain and good handling amongst the backs was impossible. The game developed into a struggle between the opposing forwards. The visiting pack was much the heavier, but the Hospital forwards held them and were cleverer in the loose.

In the first half, Krige, picking up and running strongly, scored far out. Mellé converted from a difficult angle. The Canadians attacked after this and had bad luck in not scoring. In the second half Horder scored from a forward rush and Mellé just failed to convert. From a clever cross-kick by Llewellyn Hendley scored, but the try was disallowed. The Canadians scored an unconverted try a few minutes before "no-side." Thus a strenuous game was won by the Hospital by 8 points to 3.

The Hospital was without Shaw, Skaife and Capps from the forwards. Krige and Morlock were the best of the pack, and Thomas and Llewellyn the best of the outsides.

ASSOCIATION FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. GUY'S HOSPITAL.

Played at Winchmore Hill on January 25th. Bart.'s soon took the offensive, and after a bout of passing Morton opened the score with a good shot, and Corfe shortly after increased the lead. The Guy's team rallied, but apart from a few movements initiated by the Guy's centre-half, who was always prominent, play was confined to their half. Just before half-time Frost dribbled through and scored on the left wing with a good shot high up in the corner of the net. Play ruled more even in the second half, and a very pretty piece of work by the Guy's centre-half enabled their centre-forward to score. Another good run by Frost on the left wing resulted in a fourth

point being registered for Bart.'s, the final score being 4—1 in their favour. The Bart.'s defence was very sound; Gray played a very good game at centre-half, while the forwards kept well together.

ST. BARTHOLOMEW'S HOSPITAL v. THE OLD CITIZENS.

Played at Winchmore Hill on February 8th. The ground was frozen and several inches deep in snow. Despite this the game was very fast. Bart.'s opened the score; early taking the offensive they quickly found the net after a corner. Two more goals were added, and then a combined rush by their forwards ended in their scoring. After half-time Bart.'s continued to press, and four more goals were scored. All the attempts of the Old Citizens to break through the defence failed, and Bart.'s were left winners by 7 goals to 3. The goal-getters were Summers 3, Spencer 3, and Samy 1.

ST. BARTHOLOMEW'S HOSPITAL v. LONDON HOSPITAL 1ST XI.

Played at Hale End on February 15th. Bart.'s turned out a rather depleted side, three regular members of the team being down with influenza. The London team had been playing together before Christmas, and their combination and shooting on a very fast and slippery ground were excellent. Bart.'s defence was overwhelmed by the London forwards, who were much heavier and faster, and the score was 11—1 in their favour. Bart.'s were unlucky not to score on several occasions, and the score is not quite a true reflection of the balance of play.

CORRESPONDENCE.

THE LATE DR. L. G. GUTHRIE.

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

DEAR SIR,—I saw a good deal of Leonard Guthrie, whose death was announced early in January, and I took him to his first maternity case. I was leaving "Mackenzie's" when he began his cases. He was always a very sedate student, and one day in the wards, at a time when everyone was reading *Vice Versa* (1883), a probationer said to him: "You always remind me of old Bultitude when he found himself at school." To which Guthrie quietly replied: "Perhaps my brother was thinking of me when he wrote the book." And we knew for the first time that F. Anstey was a Guthrie.

Yours sincerely,
EDMUND F. BINDLOSS.

THE BOLTONS,
S. FARNBOROUGH.

"MITRAL STENOSIS": "HEART-STRAIN."

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

SIR,—The question raised by Lieut. Sharp in the current issue of the JOURNAL is a particularly interesting one. He suggests that his identification of a considerable number of cases of mitral stenosis in soldiers—a number far in excess of that he has learned to expect in the male population as a whole—argues the influence of certain familiar war circumstances in the production of this condition.

I think, however, the majority of medical officers will be inclined to agree with me that this is only one of many instances in which their military experience has changed their ideas as to the relative frequency or infrequency of ailments among the population. I have so often heard a reference in some such terms as—"I had no idea there were so many men in the world with chronic bronchitis, or so much nervous dyspepsia or chronic rheumatism," and so on.

Now in my opinion there has been too great a tendency—pardonable enough, of course, in view of the obvious coincidence—to suppose that the exposure, the hardships, the enforced activity and other circumstances inseparable from a military life are the cause of this frequency. To take one condition for example. The innumerable explanations which even to this day confuse and cloud the ætiology and pathology of "soldier's heart" are very largely due to the attempt so to determine its causation.

The war has had the effect of stirring up sediment and so render

ing turbid a previously clear medium—if I may be permitted the simile. For two reasons a large number of men who before the war never enjoyed the advantage of medical examination are now displaying their lesions before the eyes, fingers and stethoscopes of the Profession.

In the first place the periodical examination of drafts referred to by Lieut. Sharp leads to the recognition of conditions like valvular disease which have caused no symptoms, but are brought to light by the careful examination of such observers as Lieut. Sharp.

Secondly, a large number of conscripts who in civilian life would nurse their trivial ailments without calling upon medical assistance, taking a day off whenever they felt so disposed, naturally find such a proceeding impossible under army conditions; and to escape the irksomeness of duty they report sick, thus swelling the number of "chronics" who haunt the hospitals and medical inspection rooms.

In these ways there is produced a fictitious picture of the incidence of disease contrasting with civilian life. War has been responsible not so much for producing as for unmasking these "war diseases."

Whilst I am writing, may I beg the hospitality of a little space for a further reference to "heart-strain." I had not intended to continue the discussion, since Sir Thomas Horder's kind and most illuminating reply to my original letter seemed to render any addition from my pen unnecessary. But Dr. Thorne-Thorne has raised the question of sinus arrhythmia, and has invited discussion on the subject.

I must confess myself a whole-hearted supporter of Sir James Mackenzie and Dr. Lewis in holding that this form of irregularity is no indication of cardiac impairment.

I have never come across an athlete with sinus arrhythmia. On two or three occasions I have seen very definite valvular disease clearly compatible with extreme physical exertion. I particularly recall one of the finest runners this country ever produced who had well-marked mitral regurgitation and suffered from periodic attacks of typical articular rheumatism. During the summer of 1909 he insisted on competing in the Mile Amateur Championship within three weeks of an attack, in spite of my protestations, and although he did not win the event he put up a magnificent performance by finishing third in a great race. He continued to compete regularly, without, so far as I could see, the slightest cardiac distress up to the day of his death—he was killed very early in the war. And readers of the *British Medical Journal* will recall the remarkable case recently recorded of a Canadian athlete who was able to achieve first-class performances, although the possessor of a much enlarged heart and a pronounced degree of aortic regurgitation! But sinus arrhythmia I have never seen in an athlete, and this is precisely what I should expect, because this condition would seem to denote a nervous instability which accords badly with the stuff of which a good athlete must be made.

I have therefore no hesitation in agreeing with Dr. Thorne-Thorne that "the large majority of young men . . . whose hearts have broken down under strain have had sinus arrhythmia," although my explanation of the coincidence and his are diametrically opposed.

Of course, it is open to anyone to argue that what I stigmatise as want of pluck is really an indication of cardiac disease, and what I dismiss airily as symptoms due to vaso-motor instability are really an indication of "heart-strain." And I do not think we should ever get any further than agreeing to differ, for indeed, as Sir Thomas Horder most appositely sums up the whole matter—"Opinions can only be expressed: they scarcely admit of discussion."

I am, Sir,

Yours faithfully,
ADOLPHE ABRAHAMS.

CONNAUGHT HOSPITAL, ALDERSHOT;
February 10th, 1919.

"HEART-STRAIN."

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

SIR,—The correspondence on "heart-strain" in the recent numbers of the JOURNAL has been very interesting. May I add my little experience out here, which supports Dr. Thorne-Thorne's views in my opinion.

Since the armistice I have had to examine a great number of men with a view to possible claims on the country to compensate them for disabilities attributable to military service.

All that have come before me joined the Army as category A men and were subsequently classified B ii or B iii.

I have been struck by the frequency with which I have found sinus arrhythmia and nothing else abnormal in men who have been put into the lower categories on account of "D.A.H."

I am, Sir,

Yours faithfully,

D. S. PRACY,

Capt., R.A.M.C.

B.E.F., FRANCE;

February 15th, 1919.

REVIEWS.

THE HISTORY OF ST. BARTHOLOMEW'S HOSPITAL. By NORMAN MOORE, M.D. (London: C. Arthur Pearson, Ltd., 1918.) 2 vols., 4to. Pp. 614 and 992. Illustrated. Price £3 3s. net.

The *History of St. Bartholomew's Hospital* "whereof by parcels we have sometime heard but not intently," has at length appeared, and the wonder is, not that it has been delayed so long, but that it has appeared so soon. Dr. Norman Moore is to be congratulated most heartily upon the two fine volumes in which it is enshrined. The long and almost unbroken existence of the Hospital on its original site has allowed of the accumulation of a vast number of documents, whilst the position of the Hospital in regard to the City of London and of the City in relation to England has brought it into touch with the history of our country at many points. Dr. Moore has proved himself a skillful guide and interpreter, for he has stores of knowledge on many subjects, a wide acquaintance with men and their affairs throughout the ages, and above all, the gift of interesting his readers in what he writes. We are thankful, therefore, that he has been spared to bring the work of a lifetime to so successful an issue, for any future historian of the Hospital will merely have to continue his work on the same lines.

The early chapters are based necessarily upon the *liber fundacionis*, with such additional facts as Dr. Moore has been able to obtain about our founder and his immediate successors. The real historical value of the work begins with a series of Bulls, Charters and Chirographa telling of the slow acquisition of privileges and property by the Hospital. These important documents are not only printed *in extenso*, but, thanks to the liberality of Miss Ethel Mary Portal, are skillfully reproduced in facsimile by Mr. Emery Walker. They give a marvellous picture of contemporary life and thought, with occasional hints of the tragedies and other motives which led the donors to bequeath some of the property to the Hospital. They afford opportunities, too, of correcting some traditional mistakes in London nomenclature, as in the case of Wood Street and Basinghall Street. The Hospital should certainly move to have the little blind alley between the Pathological Institute and the Out-patient block in Giltspur Street renamed Vitry Lane—instead of Windmill Court by which it is now known—in memory of William of Viteri, who was a good friend to the Hospital in the reign of Henry II. Dr. Norman Moore has done much to lighten the perusal of these charters by those who are not trained historians. He introduces numerous personal touches and sidelights, and it is clear in many cases that he has visited the places which they mention. In 1249 the Hospital owed £11 to the butcher for meat, and made the following agreement by which the debt would be paid off in eight years and a quarter: "To all the faithful of Christ to whom the present writing happeneth to come, Bartholomew the Chaplain, proctor of the hospital of St. Bartholomew of London and the brethren of the same place health in the Lord. Be it known to you all that we owe Walter of Hendon butcher, eleven pounds sterling for meat received by us from him on loan for the use of our house and of the sick lying therein. Which money we by common agreement have assigned to the said Walter . . . under the form here written namely each year twenty-six shillings and eightpence at the four principal terms of the year, at each term six shillings and eightpence." Such an agreement shows that the Hospital credit was good and the butcher was long-suffering, whilst money, as money, was scarce.

The human, as opposed to the more purely historical, interest begins with John Cok, the first Renter, who lived through the long Mastership of John Wakering or Blakberd. The Hospital is nearly as much indebted to Brother Cok as to Dr. Norman Moore himself.

He wrote a beautiful hand and compiled the Cartulary, thereby preserving nearly all that is known of the early history of the Hospital. Like Dr. Moore, he was fond of asides which shed light upon contemporary occurrences. "'Thanks be to God,' quoth John Cok," he writes frequently, and we may re-echo his sentiment on account of Mrs. Moore, who has provided so excellent and accurate an index to the two volumes of the present history. We learn that Lady Joan Astley lived within the Hospital. She was a nurse to King Henry VI. The brass* in St. Andrew's Church at Cranford, Northamptonshire, tells of another nurse who looked after him when he lived at Cranford Hall. She was the widow of John ffossebrok and received £10 per annum "for decent support of herself about the Royal person." This sum being insufficient she complained, and it was accordingly doubled. Seventeen years afterwards (1444), when she is styled "quondam sicca nutricis nostræ," she had a grant for life of "a dolium of red wine of Gascony per annum." One of her lineal descendants is now the wife of a member of the surgical staff, so that the Hospital has still a link with King Henry VI.

There is not much fresh information to be gathered about the Hospital at the time of the dissolution, for this period has attracted the attention of several previous writers, but there are many interesting facts in the extracts from the ledgers and journals which show how faithfully the various officers have at all times carried out their charges.

The latter half of the second volume is of absorbing interest to everyone educated at St. Bartholomew's Hospital, for it deals largely with those who have made the Hospital famous throughout the world. Beginning with Dr. Caius, who lived in, but was not otherwise of, the Hospital, Dr. Moore writes with the pen of a skilled biographer about the physicians and surgeons. He has produced a charming series of pen portraits. There is nought set down in malice, but each man is weighed carefully and a just estimate is formed of his character and ability. He has fortunately written only of our predecessors: the living are not judged. In the account of the Officials there is a particularly pleasing picture of the old Steward—Mark Morris—whose portrait still looks down upon the scene of his former labours. There are also chapters on the medical school and the present buildings. The last chapter, treating of the patients, contains many good stories told in a style which is curiously reminiscent of George Borrow. Lastly, it should be added that everyone who buys a copy of the history will not only have obtained his money's worth, but will have done an act of charity, for the profits have been generously allocated by the author to the Building Fund of the Hospital.

MANUAL OF BACTERIOLOGY. By ROBERT MUIR and JAMES RITCHIE. Seventh Edition. (Oxford University Press.) Pp. 751. Price, 16s. net.

The present volume has been thoroughly revised as the result of the impetus given to bacteriological research following on the war. Much new matter has been incorporated in the chapters dealing with cerebro-spinal fever, with intestinal infections, with tetanus, and with the grave conditions occurring in wounds; also a number of new methods have been described, and several new illustrations have been added. A working knowledge of bacteriology is absolutely essential to the medical student of to-day, and we know of no better book than the volume under review. The study of microbiology (we prefer the term to bacteriology) bids fair to revolutionise both medicine and surgery, and no medical library is complete without it contains a copy of this most valuable work.

A MANUAL OF CHEMISTRY. By ARTHUR P. LUFF and HUGH C. H. CANDY. (Cassell & Co., Ltd.) Price 12s. net.

This admirably concise volume is excellently suited to the requirements of the first professional examination. The theoretical side of chemistry is explained with thoroughness and lucidity. Both the inorganic and the organic sections are fully dealt with, the organic compounds receiving special attention. Part V is devoted to chemical

* "Hic jacent Johes ffossebrok Armig. qui obiit vii die mensis Octobris anno Dni Millmo ccccviii. Et Matilda uxor ejus que fuit sicca Nutrix Dno. Regi Henrico Sexto. Quor aiabs ppietetur Deus. Amen.

problems, a section of the book which might prove even more valuable if the answers had been separated from the questions. The practical chemistry in the concluding part of the volume contains all and more than is likely to be required for examination purposes.

THE EARLY TREATMENT OF WAR WOUNDS. By Col. H. M. W. GRAY, C.B., C.M.G. (Henry Frowde and Hodder & Stoughton. Oxford Medical Publications.) Pp. 299. Price 10s. net.

Col. Gray's book is one of the most valuable works on war surgery that has yet appeared, but its excellence emphasises the unfortunate fact that it has only been published after the urgent need for it has vanished. It was just some such work as this that was wanted long ago to help the surgeons working in France to co-ordinate their efforts along the best lines, and it would have spread the sphere of Col. Gray's inspiring influence far beyond the limits of the Army in which he worked. Many books and papers have been written on special sections of war surgery, but in no other book can be found so true and vivid a picture of the work in field ambulances and casualty clearing stations, or so sympathetic a view of the difficulties to be overcome. The excellence of the book lies not so much in the detailed descriptions of surgical technique, for Col. Gray has necessarily been brief in attempting to cover almost the whole subject of the treatment of the wounded, but rather in the sound general principles which it enunciates and its realisation of the conditions which limit their application. In matters of detail it might be possible to find points for criticism, and already in the *British Medical Journal* for January 25th Sir Anthony Bowlby has corrected Col. Gray's figures of the percentage mortality due to fractures of the femur; but it is notoriously difficult to collect under war conditions statistics which can truly be called accurate, so that shortcomings in this respect may be readily forgiven. It is not so easy to understand why Col. Gray has dismissed so summarily the whole subject of abdominal wounds, which he refers to only in the preface, and why he has made practically no reference to such important matters as the surgery of blood-vessels and nerves. If he had dealt with these in the same manner as he has with wounds of the thorax and brain and with fractures of the femur, he would have greatly increased the value of the book without making any considerable increase in its size. Nevertheless he has given us an extraordinarily interesting and valuable book which ought to be read by everyone, whether in the medical profession or not, who wants to gain a general knowledge of the principles and practice of surgery at the front. Principles which before the war were generally accepted have been profoundly modified, and Col. Gray has been one of the leaders in an immense surgical undertaking, the results of which will leave an enduring mark on the practice of surgery in the future.

G. L. K.

MATERIA MEDICA AND THERAPEUTICS. By J. MITCHELL BRUCE and WALTER J. DILLING. (Cassell & Co., Ltd.) Pp. 675. Price 9s. net.

The new edition of this well-known work has been revised and brought up-to-date in order to correspond with war conditions. As a text-book on Materia Medica it can be thoroughly recommended. The therapeutical section is well arranged and not too advanced, so that it can be easily understood in conjunction with the study of Materia Medica. It is unfortunate that a higher standard of dispensing has not been set before the student, several of the pharmaceutical details being very lax.

THE WHOLE DUTY OF THE REGIMENTAL MEDICAL OFFICER. By Capt. P. WOOD. (Forster, Groom & Co.) Price 2s. 6d net.

The author, who writes from Salonika, lays stress on an aspect of the medical officer's work which is apt to be overlooked by civilian medical men—the fact that he is an officer as well as doctor. He describes the duty of the R.M.O. under three headings: (1) His duty to the State, (2) his duty to the unit, and (3) his duty to himself. In the appendix he enumerates the points to be attended to in inspecting a camp, and describes some easily improvised sanitary

appliances. The author's description of anti-malarial methods is useful, and is not to be found as a rule in books of a similar nature. The book should prove useful to newly-joined M.Os. and to candidates for Certificates "A" and "B" of the O.T.C.

BY THE WAY.

Overheard in the Operative Surgery Class:

Surgeon: What are the indications for cholecystostomy?

Student: I don't know, Sir.

Surgeon: Come! come! Whom did you dress for?

Student: You, Sir.

(Collapse of the Surgeon.)

Surgeon in Out-patient Department telling dresser to examine patient's foot:

Surgeon: What do you think it is?

Dresser: An adventitious bursa.

Surgeon (in his gruff manner): Yes; well, what is the common name for it?

Dresser: Sometimes known as a bunion.

Surgeon: Why is it called a bunion?

Dresser (somewhat rattled): Because it interferes with the pilgrim's progress!

We are indebted to an old Bart.'s man for the details of the following amusing episode:

Entering my consulting room the other day I found a Belgian examining with interest the "Spy" Cartoons of Celebrated Doctors issued by *Vanity Fair*. He had reached the one of Sir Walter Foster and seemed greatly excited—"Excuse me Mistaire," he said, "Spy—eh?"

I nodded acquiescence.

"And all these other gentlemen. *Spies—eh?*"

Then I had to explain.

EXAMINATIONS, ETC.

CONJOINT EXAMINATION BOARD.

First Examination. January, 1919.

Elementary Biology.—T. M. Marcuse.

Practical Pharmacy.—T. A. Eccles.

Second Examination. January, 1919.

Anatomy and Physiology.—H. S. Bell, L. M. Billingham, H. Shannon, C. G. Martin, S. G. Harrison.

The following have completed the examinations for the M.R.C.S., L.R.C.P.: H. W. C. Vines, H. D. Kelf, R. H. Clarke, H. Barbash, R. L. Williams, F. Gray, R. I. Rhys.

CHANGES OF ADDRESS.

BREWITT, B. J., Estcourt, Natal, S. Africa.

CUNNINGHAM, F. H. L., 13, Marlborough Road, St. John's Wood, N.W.8.

GOW, A. E., 37, Queen Anne Street, W. (after March 18th). (Tel. Mayfair 5011).

JEANS, F., 30, Rodney Street, Liverpool.

SYMONDS, H., Kimberley, S. Africa.

WALLIS, R. L. M., Wooburn, Bucks.

WILLIAMS, F. S., Broome Cottage, Bedlington, Northumberland.

WORBOYS, Capt. T. S., R.A.M.C., Willow Dene, Hassocks, Sussex.

BIRTHS.

BURKITT.—On February 14th, at 24, St. Stephen's Avenue, W. Ealing, to Mary, the wife of Capt. F. T. Burkitt, M.A., M.R.C.S., L.R.C.P., late (S.R.) "The Queen's" Regt.—a daughter.

FRASER.—On Sunday, December 15th, the wife of Forbes Fraser, of 5, The Circus, Bath—a daughter.

ROBERTS.—On January 30th, at Sydney, N.S.W., the wife of Surgeon-Lieut.-Commander W. E. Roberts, Royal Australian Navy, of a daughter.

MARRIAGES.

BLAIR—STEEGE.—On December 27th, at St. Matthias Church, Richmond, Surrey, by the Rev. A. A. Blair, Charles James Longworth Blair, Surgeon, R.N., to Lilian, daughter of Mr. and Mrs. F. W. Steege, of Richmond.

CATFORD—CARASSO.—On January 23rd, at Kasr-el-Nil Garrison Church, Cairo, Capt. Eric Catford, R.A.M.C., only son of Mr. and Mrs. Catford, of Crouch End, N., to Mary, elder daughter of Mrs. Carasso, of Alexandria.

CHANDLER—RAIMES.—On February 4th, at Cavendish, by the Rev. J. D. Barnard, M.A., and the Rev. O. G. Bolton, Frederick George Chandler, M.A., M.D.(Cantab.), to Marjorie, younger daughter of the late Frederick Raimes, J.P., and Mrs. Raimes, of Hartburn Lodge, Stockton-on-Tees.

WATERHOUSE—CONNOR.—On February 11th, at St. Peter's Church, Paddington, Rupert Waterhouse, M.D., M.R.C.P., of 25, The Circus, Bath, to Mabel Dorothy Connor, of 34, Charlton Street, Maidstone.

DEATHS.

ADAMS.—On February 14th, 1919, at his residence, The Lawn, Martock, Somerset, Joseph Dixon Adams, M.D.

BLAKEWAY.—On February 15th, 1919, at St. Bartholomew's Hospital, from pneumonia, Harry Blakeway, B.Sc., M.S., F.R.C.S., of 1, Weymouth Street, W., aged 35.

CORY.—On February 15th, 1919, at Soham, Cambs., Charles George Cory, M.R.C.S., L.R.C.P., youngest son of the late Rev. E. W. Cory, M.A., R.D., Vicar of Meldreth, Cambs., aged 47.

FINCH.—On February 5th, 1919, at his residence, Holmdale, Stoneygate, Leicester, John Edward Montague Finch, M.D.(Cantab.), aged 77.

HAMPTON.—On February 13th, 1919, T. Hampton, M.B.(Lond.), M.R.C.S., of Grosmont, Hereford, from influenza.

HAWES.—On December 15th, 1918, at Stanmer, Bexhill, after a long illness, patiently borne, Colin Sadler Hawes, M.R.C.S., elder son of the late James and Caroline Hawes, and dearly loved husband of Lilian Hawes, aged 42.

ACKNOWLEDGMENTS.

The British Journal of Nursing, St. Mary's Hospital Gazette, The Nursing Times, The Medical Review, London Hospital Gazette, Long Island Medical Journal, Journal of the Department of Public Health, Hospitals and Charitable Aid, New York State Journal of Medicine, The Hospital, Guy's Hospital Gazette, St. Mary's Hospital Gazette, The Journal of the American Medical Association, University of London Military Education Report.

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.

St. Bartholomew's Hospital



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

JOURNAL.

VOL. XXVI.—No. 7.]

APRIL 1ST, 1919.

[PRICE SIXPENCE.

CALENDAR.

Fri., Mar.	28.	—Dr. Calvert and Mr. McAdam Eccles (Mr. Gordon Watson) on duty.
Tues., Apr.	1.	—Dr. Fletcher and Mr. D'Arcy Power on duty.
Fri., "	4.	—Sir Archibald Garrod and Mr. Waring on duty.
Tues., "	8.	—Dr. Tooth and Mr. McAdam Eccles (Mr. Gordon Watson) on duty.
Fri., "	11.	—Dr. Calvert and Mr. D'Arcy Power on duty.
Tues., "	15.	—Dr. Fletcher and Mr. Waring on duty.
Fri., "	18.	—Sir Archibald Garrod and Mr. McAdam Eccles (Mr. Gordon Watson) on duty.
Tues., "	22.	—Dr. Tooth and Mr. D'Arcy Power on duty.
Summer Session begins.		
Fri., "	25.	—Dr. Calvert and Mr. Waring on duty.
Tues., "	29.	—Dr. Fletcher and Mr. McAdam Eccles (Mr. Gordon Watson) on duty.

EDITORIAL NOTES.

BOR several years it has been customary to forward copies of the April issue of the JOURNAL to all St. Bartholomew's men whose addresses could be traced, irrespective of whether they were subscribers or not.

Since 1915 we have also published at intervals a supplement giving details of the Hospital men and their connection with the war. This latter has been held over *pro tem.*, the proposal being to publish a complete souvenir as soon as the necessary details can be got together.

In view of the enormous importance which the Hospital is attaching to reconstruction, the Publication Committee have decided to make the May issue a special Reconstruction Number, a copy of which will be forwarded to all "Bart.'s" men instead of the usual April issue.

* * *

The voting papers for the coming election of Fellows into the Council of the Royal College of Surgeons have just been issued. There are two vacancies, and to fill these six Fellows have been nominated.

We notice with much interest that one of these is a Fellow of the College who is in general practice. This is an innovation as regards candidates for the Council. Dr. John Frederick Jennings, a former House-Surgeon of the late Sir Henry Butlin, and a late Demonstrator of Anatomy in our Medical School, has been duly nominated.

We trust that when St. Bartholomew's Fellows are sending in their voting papers they will consider giving one of their votes to him as a representative of general practitioners on the Council. Dr. Jennings is a distinguished "Bart.'s" student, and we look forward with confidence to his election.

* * *

We note with considerable pleasure that Dr. F. A. Bainbridge, Professor of Physiology in the University of London and Lecturer on Physiology at this Hospital, has been nominated for election as a Fellow of the Royal Society.

Professor Bainbridge fully deserves the honour which has been conferred upon him, and "Bart.'s" men will wish to join with us in offering him our heartiest congratulations.

The two other members of the Hospital Staff who hold this distinction are Sir Archibald Garrod and Prof. F. W. Andrewes.

* * *

Sir Archibald Garrod has resigned his temporary commission in the A.M.S. and is back at work in the Hospital. Sir Archibald has been doing most valuable work in Malta, and we extend a warm welcome to him after his long absence.

* * *

Sir Thomas Horder's "Notes," to which our readers have become somewhat accustomed, but we trust not with any sense of weariness (these words come from the author of the "Notes" and not from ourselves) are held over. Sir Thomas has decided to take his holiday earlier this year, and has availed himself of an invitation to visit Constantinople on H.M.S. "Emperor of India." He expects to be away for about five or six weeks.

With true editorial instinct we scent possible "copy" of a less technical nature than the notes above referred to.

Dr. Gow's paper on "Protein Shock and Intravenous Vaccine Therapy" is one of the most original and illuminating papers read before the Abernethian Society for a long time, and it affords us considerable pleasure to be able to print the paper almost in its entirety. The author is to be congratulated on his handling of a most difficult subject, concerning which very little has as yet appeared in English Medical Literature.

* * *

We are very glad to hear that subscriptions to the Stansfeld Memorial Fund are still coming in. As the Committee is desirous of closing the fund as soon as possible it is hoped that intending subscribers will take the opportunity of forwarding any donation they may intend to make to Prof. F. W. Andrewes as soon as possible.

* * *

Our readers will recall the interesting account we published some months ago of the "capture" of a German gun from the Mall. For some weeks this interesting relic was allowed to remain in the Square, where, needless to say, it was the subject of much interest. A letter was forwarded to the commanding officer of the battalion responsible for the capture of the gun in France asking for permission to retain the trophy, and the following letter was received in return:

"Dear —,

"I was much interested to hear what had happened to one of our guns. I shall be proud to think of it in your Square. Of course I cannot give you any official authority to keep the gun, but bar that I think the best place is the one you suggest.

Speaking on behalf of my Brigade I am only too glad that your Hospital, which has done so much to help us win the war, should keep the trophy.

"Yours sincerely,

"M. CROFTON,

"Lt.-Col. R.F.A.,

"O.C. 317 Bde., R.F.A."

A week or two later the gun was removed, and now we are most pleased to learn that Viscount Sandhurst has received a letter from the War Office granting permission to the Hospital to have the gun back and to keep it as a permanent memento.

* * *

The Bradshaw lecture, which was delivered by Lt.-Col. D'Arcy Power before the Royal College of Surgeons on November 14th of last year, has been published in book form. The subject of the lecture was "Cancer of the Tongue," and we feel sure that many Hospital men will be glad to avail themselves of the opportunity of possessing a copy of Col. Power's most interesting paper. The publishers are Messrs. John Wright & Sons, Ltd., Bristol.

* * *

We owe an apology to the Association Football Club anent our statement in a previous issue of the JOURNAL that with the exception of the Rugby Football Club the social side of the Hospital had been non-existent. We are very pleased to learn that this club has also had a very successful season, especially since the beginning of the year.

We are asked to state that the Annual Meeting of the St. Bartholomew's Hospital Women's Guild will be held on View Day, Wednesday, May 14th, in the Great Hall. Particulars and cards of invitation to the meeting may be obtained from the Hon. Secretary, Mrs. Norman Moore, 67, Gloucester Place, W. 1.

* * *

It is with much regret that we have to record the death of Dr. Thomas Hampton, which occurred on February 13th, from pneumonia, at Grosmont, near Hereford.

An appreciation of Dr. Hampton, with some details of his career, appears elsewhere in this issue.

* * *

We learn with much regret of the death of Dr. Joseph Baldwin Nias, which took place at a nursing home on February 20th. Some details of Dr. Nias's career and an appreciation of his work appear in a later page of this issue.

* * *

We also have to report the death of Dr. R. W. Brigstocke, which occurred at an advanced age at Scole, Norfolk. Dr. Brigstocke received his education at this hospital when Sir James Paget was Warden. He took the diplomas of M.R.C.S. and L.S.A. in 1859, and entered the Navy as surgeon. He served in ships engaged in the suppression of the slave trade, and while thus employed accompanied the expedition which found David Livingstone, with whom he stayed for some time. After leaving the Navy, and having obtained the degree of M.D. in Constantinople, Dr. Brigstocke settled in Beyrout. For forty years he had a very large practice in that cosmopolitan city. He was an accomplished linguist, and when Lecturer on Obstetrics, Gynæcology, and Diseases of Children at the Syrian Protestant College and Medical School, Beyrout (1870-1882), lectured both in Arabic and English. For services rendered during the cholera epidemic in 1896 Dr. Brigstocke received the Order of the Medjidie, third class, and for similar work among the Italian colony in Beyrout was made Chevalier of the Order of St. Maurice and Lazare by the King of Italy. On his return to England he settled at Scole, in Norfolk.

Dr. Brigstocke was a delightful companion and had many friends, not only in this country but also in the Far East. His wife, to whom he had been married fifty-three years, survives him, and he leaves a family of four daughters and two sons.

THE LATE MR. HARRY BLAKEWAY.



It is deeply regretted that the early death of Mr. Blakeway makes it necessary to appeal to the members of our Hospital to help to provide for the needs and future education of his family.

He leaves a widow and three children, the eldest of whom

is five years of age. During the last five years he devoted himself so completely to hospital work that he was unable to take that share of private practice which he might reasonably have expected to obtain in normal times. The position Mr. Blakeway had attained was won entirely by his own ability and hard work, and he was just passing through that critical period of a surgeon's career when, as Sir James Paget said, the work done is largely in excess of the income gained.

We feel sure that all colleagues and students who knew him and appreciate the work he has done for the Hospital and School will gladly help by sending a donation to any of the undersigned :

ANTHONY A. BOWLBY.	H. MORLEY FLETCHER.
D'ARCY POWER.	J. H. DRYSDALE.
H. J. WARING.	A. MACPHAIL, <i>Treasurer,</i>
W. McADAM ECCLES.	<i>Anatomy Department.</i>
JAMES CALVERT.	R. M. VICK, <i>Secretary,</i>
	<i>Pathology Department.</i>

ST. BARTHOLOMEW'S HOSPITAL;
March 20th, 1919.

CONCERNING "PROTEIN SHOCK" AND INTRAVENOUS VACCINE THERAPY.

(An abstract of a Paper read before the Abernethian Society on March 27th, 1919.)

By A. E. Gow, M.D.

THE protein shock reaction, which so far has attracted more attention as a therapeutic measure in America than in this country, is induced by the intravenous injection of a "foreign" protein—that is, a protein not normally present in the tissues of man. Various substances have been employed, mostly in the form of bacterial emulsions, though a similar reaction may follow the intravenous injection of horse-serum, proteose, egg-albumen, red blood-cells of a different species of animal, or certain colloidal metals, though in the latter case it would appear that the protective suspension may be responsible, in part at least, for the resulting phenomena. With regard to bacterial emulsions, it is found that the proteins constituting the *coli-typhoid* group are more efficacious in inducing the shock reaction than are those of other species, and it is therefore a vaccine of typhoid or colon bacilli that is most frequently employed. I have succeeded in producing a modified shock reaction with *Streptococcus pyogenes* in one case, but have found *S. salivarius* and a diphtheroid bacillus to be incapable of inciting the desired reaction. Pfeiffer's influenza bacillus is uncertain, but *Bacillus coli* apparently never fails when given in suitable dosage.

The diseases in which benefit by this form of treatment has been reported fall into four main groups:—

(1) Infective disease in which the causal organism is unknown or not certainly determined. This group includes Rheumatic Fever and Acute Arthritis of toxic origin.

(2) Infective disease in which the causal organism is known, but in which specific vaccine therapy is of little value, *e. g.* Gonorrhoeal Arthritis.

(3) Infective disease in which the causal organism is known, and in which intravenous vaccine is given for both its specific and shock effect, *e. g.* Typhoid and Paratyphoid Fevers, Coliform infections of the urinary tract, etc.

(4) Chronic disorders of unknown ætiology, *e. g.* Psoriasis, Pemphigus, Lupus erythematosus (1), and certain other diseases of the skin.

The vaccine may consist either of a plain or sensitised emulsion.

In the preparation of sensitised vaccine the antiserum employed is commonly derived from the horse, and it is possible that the vaccine may contain a trace of horse-serum protein. As so many patients nowadays have received at some time or other an injection of horse-serum, in the form of antitetanus serum or diphtheria antitoxin for example, which may have served as the sensitising dose, it is well, for safety's sake, to carry out a simple intradermal test as a routine to exclude anaphylaxis to horse-serum before an intravenous injection of serum or sensitised vaccine is undertaken. Further, a few individuals, particularly those with an unstable vasomotor system, may exhibit an idiosyncrasy to the form of protein (*coli* or typhoid vaccine) chosen, and it is therefore advisable that a similar test with the bacillary protein should be performed.

The intradermal test with serum is carried out as follows: Serum is diluted 1 in 10 with normal saline solution. This may be done conveniently in a sterile hypodermic syringe. A very fine and sharp needle is then fitted to the syringe already filled and the air is expelled. The outer aspect of the arm just above the elbow is a suitable site for the injection, and the skin there is well cleansed with ether. The needle is inserted through the skin as though a subcutaneous injection were about to be given; the syringe is then brought parallel to the skin and the point of the needle so manoeuvred that it again pierces the deeper layers of the skin without completely coming through. I have found it easier to get the point of the needle intradermal by this means than by a partial perforation of the skin from outside. That the needle point is in the correct layer is shown by any attempt to depress it causing a small pucker of the skin in the neighbourhood. A small quantity of the fluid—a drop or two is ample—is then injected; it should produce a small white wheal as big as a split-pea. The needle is withdrawn and a control injection made with sterile normal saline in similar fashion in the same neighbourhood. This saline wheal fades rapidly, as also does that produced by the serum if the test is negative. Should the patient show hypersensitiveness however, an urticarial wheal on an ery

thematous base begins to develop within five minutes, reaching its maximum usually in an hour and then fading rapidly. Other forms of foreign protein, *e. g.* vaccine, may be substituted for the serum in appropriate cases. Should the test prove positive "desensitisation" of the patient must be carried out before an intravenous injection is given, or otherwise alarming and even fatal symptoms of anaphylactic shock may ensue.

The protein employed to produce "protein shock" being most frequently a coli or typhoid vaccine, the remarks immediately following apply solely to the reaction induced by that type of antigen.

Dosage.—With fairly wide limits the size of the dose has but little effect on the severity of the reaction. Thus I have experienced a higher temperature response after an initial intravenous dose of 50 million killed *coli* vaccine in one patient than after 200 million of the same vaccine in another, though it must be admitted that the general constitutional disturbance was greater in the latter. So far as my experience goes, and according to American observers, the initial dose for an average adult may with perfect safety lie between 50 and 100 million, though Gay (2) in the treatment of typhoid fever advocates the use of 150 million sensitised typhoid bacilli as the initial dose. Cecil (3) mentions that by a mistake in technique 400 or 500 million killed typhoid bacilli were given as a first dose to three of his patients with arthritis, yet the reaction was little if any more severe than that caused by smaller doses and the therapeutic effect was no better.

In order to effect the desired result it is necessary to produce a moderate reaction. The dosage in successive injections must be progressively slightly increased so that a like train of symptoms may follow after each inoculation.

Technique of the Injection.—The patient is confined to bed for twenty-four hours at least. In order to lessen as far as possible the nausea and liability to vomiting commonly met with, especially after a first injection, a mild aperient is given the evening before. A light breakfast is advisable, and the injection should be made, if possible, before midday, so that the transitory unpleasantness of the reaction may be over before night.

Intravenous injections of one sort or another are of such common occurrence at the present day that these remarks on technique must appear superfluous to many, but I venture to include them as success is so dependent on attention to detail.

The requirements are: (1) Ether and wool to clean the skin. (2) A sterilised needle and syringe of 10 c.c. capacity. (3) The vaccine containing 100 million colon or typhoid bacilli per c.c. (4) Ten c.c. of sterile, warm, normal saline solution. It is more convenient if the total volume of the injection measures 10 c.c. rather than $\frac{1}{2}$ or 1 c.c., as the larger quantity is easier to handle and the dose of protein can be given more slowly. (5) Adrenalin solution

1:1000 or $\frac{1}{100}$ -gr. tabloids of atropine sulphate. An assistant to help in filling the syringe and to constrict the patient's arm and thus render prominent the veins in the ante-cubital fossa is also desirable. Dr. Canti has designed a very simple tourniquet, easy to release, which is admirably suited for the latter purpose.

The skin over the selected vein is cleansed and the desired dose of vaccine, whether $\frac{1}{2}$, $\frac{3}{4}$ or 1 c.c., is drawn up into the syringe and the volume made up to 10 c.c. with normal saline solution. The assistant now applies the tourniquet, or constricts the upper arm, which is lying flat on the bed fully extended, and the patient is told to open and clench the fist several times until the vein on the front of the elbow becomes prominent; in some individuals the veins are more easily felt than seen. The needle of the syringe is inserted into the vein in the usual manner of vein-puncture; a successful puncture is indicated by a flow of blood into the syringe. The assistant now relaxes the tourniquet (or his hold of the arm) and the injection is made very slowly; that the fluid is entering the vein and not the perivascular tissues is shown by complete absence of swelling in the region of the needle-point. When the contents of the syringe have been pushed into the vein the needle is withdrawn and the arm held vertically upwards for a few minutes to prevent extravasation of blood; no dressing is required.

THE REACTION.

General.—In the afebrile human subject the intravenous injection of from 50 to 100 million killed *coli* vaccine is followed by a very definite train of symptoms which comprise the so-called "protein shock reaction." For a period varying from three-quarters of an hour to four hours the patient will experience no abnormal sensations, but after that symptoms will appear somewhat suddenly. The earliest symptom is commonly an involuntary twitching of the muscles of the legs. This may spread to the trunk and become general with or without the patient feeling cold, and last, perhaps intermittently, for from fifteen to forty-five minutes; the onset of this rigor is occasionally preceded by a dull ache in the back or shins. Before the shivering is finished the patient commonly has abdominal discomfort, with nausea, and not infrequently vomits; he has headache, which is usually frontal and sometimes pronounced. In the more severe instances the patient may be very restless; dyspnoea and cyanosis have been reported, but I have never met with any symptoms of respiratory distress. Should such occur it is said a hypodermic injection of 1 c.c. adrenalin or of $\frac{1}{100}$ -gr. atropin sulph., or both, give speedy relief. As the reaction passes off, especially if it be after a second or third injection, general pains in the limbs with marked cutaneous hyperaesthesia may be complained of for a short time and yawning is frequently seen. As a rule the patient is quite free from headache and other

discomfort after the seventh hour, though exceptionally facial herpes may develop two or three days later, with or without tender areas in the skin.

Just prior to the onset of the shivering the temperature begins to rise and continues to do so until about the sixth hour. It commonly reaches 103° or 104° F. before returning to normal at the end of twenty-four hours; defervescence may be interrupted by a short secondary rise of a degree or so.

With succeeding injections of increased dose the fever, though reaching an equal height, is apt to set in earlier and be of shorter duration.

The pulse-frequency is increased during the reaction, and extra systoles may occur during the rigor and for a short time afterwards. The increase of the pulse-frequency is generally of somewhat longer duration than is the raised temperature. The spleen may become enlarged during the reaction; in two cases of coliform infection of the urinary tract the organ was just palpable for a short time twelve hours after the injection.

Blood-pressure changes.—The systolic blood-pressure, in my experience, usually shows a fall of a few millimetres before any symptoms are evident. During the rigor I have met with a small rise on two occasions only, and that either to the pre-injection figure or a few millimetres above it; more generally the fall continues for twelve hours or so, the reading then being about 20 mm. below the initial figure. The systolic blood-pressure is commonly normal again after twenty-four hours.

The diastolic pressure generally rises appreciably within the first half-hour. In three instances it showed an increase of 12, 22 and 20 mm. Hg. respectively during that period. The rise may continue until the end of the rigor, but more frequently this pressure drops rapidly after the first half-hour and may be at its lowest by the end of the second hour—perhaps a drop of 30 mm. in one and a-half hours. It tends to remain at about this level for twelve hours or so, but is normal again in twenty-four hours.

Pulse-pressure is the term applied to the difference between the systolic and diastolic blood-pressures. The fall in systolic pressure coinciding with the rise in diastolic pressure soon after the injection obviously leads to a marked diminution of pulse-pressure. In two instances (in the same patient following a second and third injection) the pulse-pressure at the end of the first half-hour appeared to measure only 6 and 2 mm. respectively. This state of affairs was of very short duration, and fifteen minutes later the pulse-pressure had risen considerably owing to the rapid fall in diastolic pressure. So far as could be determined with the patient lying quietly in bed, this transitory low pulse-pressure was unaccompanied by any symptoms whatever.

Cytological changes in the blood.—The intravenous injection of *B. coli* vaccine causes an almost immediate fall in the white blood-cells, in which polymorphonuclears, lymphocytes,

and large mononuclears are all early involved; eosinophil and basophil cells appear to stand fast until later. Following a first injection the retreat of the Polymorphonuclears from the peripheral circulation is extremely hurried, and at the end of the first hour they may be outnumbered by the lymphocytes. By the second hour signs of a rally may be evident, and at about the fourth hour the pre-injection figure may be reached. A rapid increase then takes place, and the maximum of 20,000 to 30,000 per c.mm. is reached in twenty-four hours. This rise is succeeded by a fall during the next forty-eight hours to the pre-injection figure, or even below it, the whole cycle occupying approximately seventy-two hours. During the leucocytosis neutrophil myelocytes frequently appear, and normoblasts have also been met with.

Though the fall in the Lymphocytes is less abrupt it is a very striking feature, and of far longer duration than the polynuclear leucopænia. For the first half-hour the lymphocytes as a rule show little change, but before the hour is passed the departure of many from the peripheral blood is apparent and the exodus continues for two or three hours, when perhaps not more than a tenth of the original number will remain. By the eleventh hour there will be indications of recovery, and the number of lymphocytes gradually rises till it reaches the normal at about the forty-eighth hour. There is no lymphocytosis.

After second and third injections I have found the polynuclear leucopænia to be of shorter duration, and the leucocytosis more rapid in development, though less sustained. The lymphocytes, however, do not disappear so early from the peripheral circulation, and with later injections may even show signs of an actual increase before the fall sets in.

With smaller doses of coli or mixed typhoid vaccine the reaction is comparatively feeble. Dr. Adamson, who has kindly permitted me to refer to cases under his charge in this Hospital, has been treating successfully certain diseases of the skin with intravenous injections of mixed typhoid vaccine, the initial dose being 10 million killed bacilli. Some hours after the injection the patients commonly complain of slight headache, some general pains, and perhaps a little nausea. The temperature only rises a degree or two, and no chill or shivering results, but with subsequent injections a brisk reaction may take place.

It is obvious from the foregoing description of the clinical symptoms and signs that are wont to follow upon the intravenous injection of a foreign protein in certain doses that the reaction is in no sense a "shock" in the usually accepted surgical application of the term. Following immediately on a surgical operation, if the patient survive, three phases are commonly seen, termed respectively "shock," "reaction," and "traumatic fever." The stage of "shock" is characterised in the main by subnormal temperature, high pulse-frequency, and lowered blood-pressure. This is succeeded by reaction,

in which there is a return of the temperature to normal and a fall in the pulse-frequency. Nor does this reaction come under the heading of the so-called "anaphylactic shock," which is brought about in the animal body by the reinjection of a foreign protein after the lapse of a certain period of time. Following the initial or sensitising injection the animal may become "hypersensitive" to the specific protein,

the injection cannot be ascribed to the short bout of fever produced thereby. A cumbersome but expressive and noncommittal title would be the "Intravenous Protein Reaction," and its practical application "Intravenous Protein (or Vaccine) Therapy.

Cecil (3) reports on forty cases of rheumatic fever, acute toxic arthritis and gonorrhoeal arthritis, which were subjected

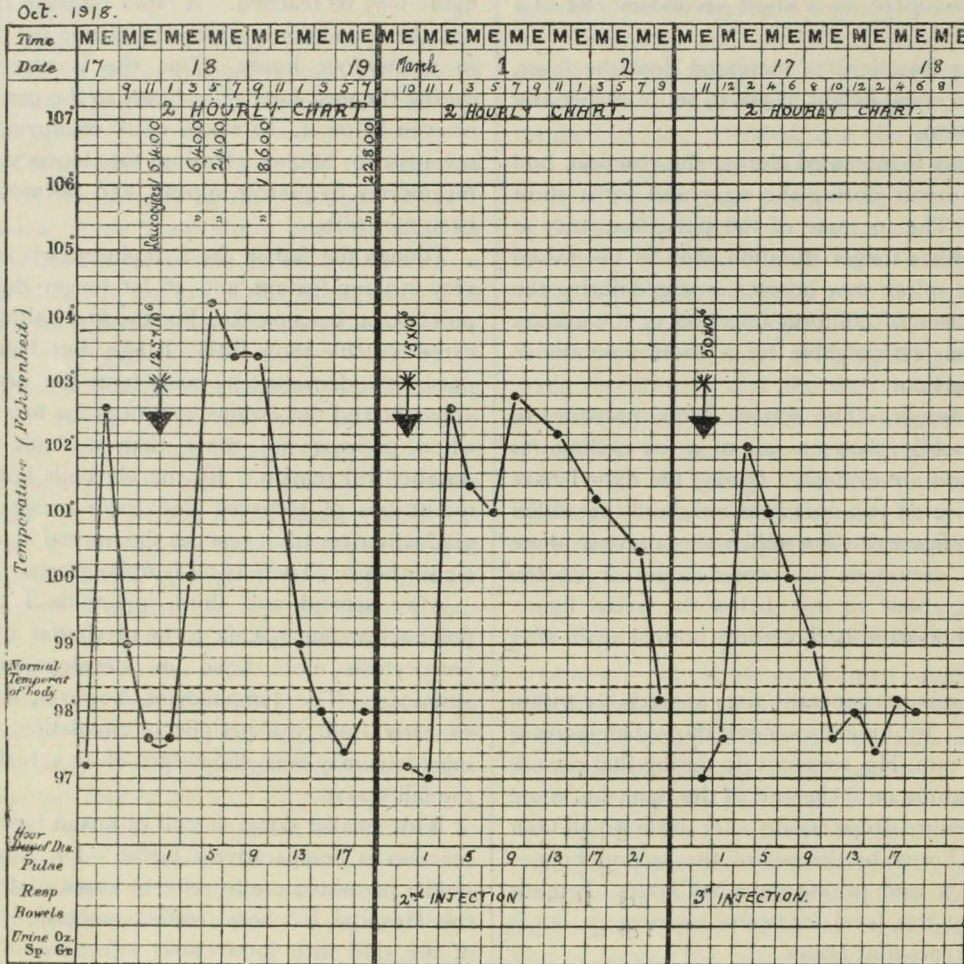


Chart illustrating temperature reaction after the intravenous injection (marked by arrow) of 125 million autogenous *B. coli* vaccine in case of pyelonephritis with pyrexia.

In this case of lupus vulgaris under the care of Dr. H. G. Adamson, the first injection of 10 million mixed typhoid vaccine did not cause the temperature to rise above 100° F. The charts after second and third injections are here reproduced. The temperature following the second injection shows a well-marked secondary rise. The earlier onset of the fever and its shorter duration with succeeding doses are clearly brought out on comparison of the two charts.

so that it reacts in a peculiar fashion to a second or intoxicating dose. Such a reaction may on occasion resemble that of protein shock in certain important features, but it differs in other essentials. To avoid confusion Auld (4) has suggested "pyrogenic" as a distinguishing term, but this also is not without objection. Fever may follow the intravenous injection of a number of substances containing no protein, and further, the clinical improvement consequent on

to this form of treatment. In rheumatic fever and "non-specific" arthritis about 40 per cent. are stated to have recovered completely in two to ten days without salicylate, and most of the others were much improved. In rheumatic fever the average number of injections required was two, the dose varying from 30 to 100 million killed typhoid bacilli. Salicylate was given if one or two doses of vaccine proved incapable of producing recovery. The seven patients with

gonorrhœal arthritis appeared to benefit but little, if at all, by the vaccine; the injection gave relief for twenty-four hours or more, and then the joint pains returned.

In one case of chronic gonorrhœal arthritis marked improvement followed the intravenous injection of a diphtheroid bacillus which I isolated in quantity from the urine after prostatic massage.

Peterson (5) records a case of "acute multiple arthritis" which received at intervals doses of 50 to 75 million typhoid vaccine intravenously on three occasions, and was thereby much improved. The precise nature of the arthritis is not revealed.

Miller and Lusk (6) also report favourable results in the treatment of acute and chronic arthritis by the injection of foreign protein.

Acute disease, other than arthritis, has also been treated—in some cases satisfactorily—by the intravenous injection of typhoid vaccine. In typhoid fever itself both sensitised and unsensitised vaccine has been used by several workers. Gay (2) summarises their results and adds ninety-eight cases of his own, which show a mortality of 6.6 per cent., and thirteen complications. He states that the milder cases of the disease react better to the treatment than the more severe, but even the most severe will in some instances at least be benefited and even aborted. The usual dose of the initial injection was 150 million, and the dosage in successive inoculations was slightly increased in order to produce a similar reaction. He states that in typhoid fever the injection is followed in from fifteen minutes to an hour by a chill, which may last for fifteen minutes, and is accompanied by a rise in temperature of one to three degrees, reaching its maximum within three hours and then falling. With the chill is associated a rise in the pulse-frequency, and there may be slight cyanosis, some respiratory distress, and a sense of discomfort. The temperature reaches normal or subnormal in about twelve hours, with sweating, and usually improvement of such symptoms as headache, delirium, etc. If the temperature again rises over a period of two or three days a slightly increased dose is given; if no striking result follows three or four injections at two or three days' interval, very little good from further treatment on the same lines is to be expected. The disease was aborted in one-third of the cases in his series, benefited in another third, while in the remainder it was unaffected. The liability to complications appeared to be diminished, but as a means of preventing relapse the injections are of little value.

Typhoid vaccine has also been administered intravenously in the treatment of lobar pneumonia (Scully (7)), and other acute infections. I have employed an autogenous coli vaccine intravenously in the treatment of subacute *pyelonephritis* with good result. One case of two months' duration showed a tender swelling in the right renal region, pyrexia, and 10 per cent. of pus in the urine. After four injections the urine became free from cells

and bacilli, and was still sterile when last examined, two months later.

A *traumatic ulcer* of the foot, consequent on a wound sustained in the Zeebrugge raid, resisted ordinary vaccine and antiseptic treatment for five and a-half months. It healed rapidly after one intravenous injection of autogenous sensitised vaccine prepared from the streptococcus which was found to be the predominant organism. The dose of 100 million produced a sharp reaction with shivering and a rise of temperature which lasted for eighty hours, reaching its maximum of 104.2° F. at the twentieth hour.

A case of *broncho-pneumonia following influenza* was treated with vaccine intravenously. A lusty New Zealander, æt. 25, contracted influenza in hospital, and, as he appeared very ill in the first twelve hours, a swab was taken of his nasopharynx and plated out on blood-agar. A small Gram-negative bacillus, morphologically indistinguishable from Pfeiffer's influenza bacillus, was obtained in practically pure culture. An emulsion of this organism was put up with the serum of a patient recently convalescent from a sharp attack of the disease, but otherwise healthy, and in whose nasopharynx a like organism had been demonstrated; sensitisation of the bacillus appeared to take place.

During the third day this patient's temperature fell from 104.8° F. to 99.8° F. and all seemed to be going well, but on the fourth day the temperature shot up again, headache returned, he developed severe pain in the right chest, a frequent painful cough, and brought up a quantity of bright blood-stained sputum, obviously from the lung. Herpetic vesicles rapidly developed on the left lower lip. The same evening movement of the right chest was greatly diminished and percussion much impaired in the axilla and below the right nipple. There was no marked increase of vocal vibrations, but the breath-sounds were very weak in this area, and many fine crepitations were heard with marked increase of voice-sounds.

A film of the sputum showed large numbers of this Gram-negative bacillus and a few organisms resembling pneumococci. As his leucocyte count was only 6560 per c.mm. it was considered that the pneumococcus was not the main infecting organism.

His general condition appearing serious, it was decided, with his permission, to give the vaccine intravenously.

A dose of 75 million sensitised bacilli was given intravenously fourteen hours after the onset of the signs and symptoms suggestive of broncho-pneumonia, his temperature at the time being 103.8° F. An hour later the temperature was unchanged, but at the second hour it had risen to 105.4° F.; yet there had been no chill and he volunteered the statement that his headache had gone, his chest was more comfortable, and that he "felt much better in himself." Four hours after the injection the temperature had returned to 103.8° F.; it continued to fall by lysis, being subnormal in seventy-two hours.

The sputum remained blood-stained for twenty-four hours after the injection, when it became more copious and purulent, and the pneumococcus appeared to be the predominant organism. Cough persisted for several days, and the signs in the chest slowly cleared.

It is regretted that frequent observations on the behaviour of the leucocytes after the injection were not possible, but no leucocytosis was detected, the highest count recorded being 7320 per c.mm. at the tenth hour.

The writer does not for one moment bring this forward as a convincing case of the value of intravenous vaccine, but he believes it can at any rate be said that it was productive of no ill-effect, and the almost immediate improvement in the general condition of the patient was certainly striking. Unfortunately one is rarely in a position to give an autogenous sensitised vaccine at so early a stage of disease.

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- (4) AULD.—“Pyrogenic Therapy,” *Brit. Med. Journ.*, 1918, i, p. 195.
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- (7) SCULLY.—*Fourn. Amer. Med. Ass. c.*, 1917, lxix, p. 20.

SOME POINTS IN THE TREATMENT OF INTRA-OCULAR FOREIGN BODIES IN FRANCE.

By R. FOSTER MOORE, M.A., B.C.(Cantab.), F.R.C.S.

THERE are, of course, a number of points in which military differs from civil eye practice, but there are two which especially strike one.

The most important is the large number of wounds of the eyeball and orbit; the second is the presence of the ubiquitous scrimshanker, a genus almost unknown in ordinary everyday work.

The most interesting part of the work is the treatment of the intra-ocular foreign bodies.

The writer had charge of the ophthalmic work of one of the three areas in France at which a giant magnet for the removal of these was provided, and was very fortunate in

having two most excellent colleagues, one of whom, Mr. H. P. Gibb, was a Bart.'s man.

We drew upon a large area for penetrating wounds, and consequently had exceptional experience in all forms of intra-ocular operations.

In ordinary hospital practice the tale of the man who comes up with an intra-ocular foreign body is usually that he was hammering a chisel or similar tool when a fragment flew off and struck him in the eye. He is probably seen within an hour or two of the accident, the fragment is often clean, smooth, and sharp, and is usually magnetic, and consequently can be removed.

In France, on the other hand, the man was frequently not seen till the second day, the fragments which entered the eye were of various material, *e.g.* stone, bone, wood, copper, aluminium, iron, etc., and of these the last only was capable of removal (with few exceptions), and then only if it was magnetic.

The fragments, too, were often dirty and had rough, fractured surfaces.

It will be gathered that the prognosis in the case of perforation of the eyeball by a foreign body is greatly worse in military than in civil practice.

A new type of giant magnet has recently been introduced, which will, I believe, completely displace the old Haab. Ours was of this new type, and was the only one of its kind in France. We have recently substituted this magnet for the Haab at Moorfields, and as one is shortly to be installed at this Hospital it may be of interest to describe it and the method of its use. The figure on p. 81 gives a good idea of its general appearance.

It consists of an oval of soft iron wound with insulated copper wire. When a continuous current is passed a magnetic field is generated within the ring, which has its greatest saturation at the centre, and soft iron rods, such as those supplied with the instrument, when taken in the hand and brought within this field, become magnets for the time being. If one individual holds the largest rod within the ring on one side, and another individual applies to this the next largest rod from the other side, the two will find themselves unable to pull the rods apart.

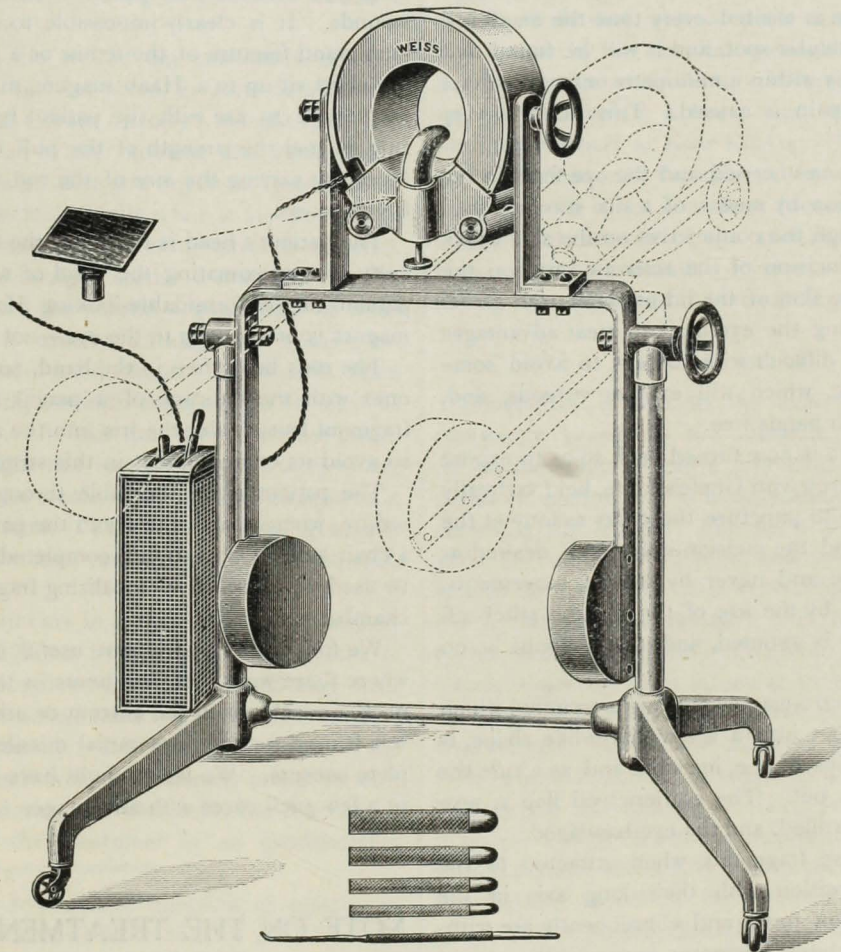
The need for so great power will be realised when it is remembered that many intra-ocular foreign bodies are smaller than a pin's head, that they may be but feebly magnetic, and that it may be impossible to approximate the rod nearer than to within 18 mm. of the foreign body. It should be made clear that the magnet is not used to pull the fragment forcibly out of the eye, but to draw it into some position from which it is easily removed—usually into the anterior chamber.

METHOD OF USE.

The patient is placed on an ordinary operating table, the pupil having been previously fully dilated so as to facilitate

the entry of the foreign body into the anterior chamber, the eye is cocainised and a speculum introduced. The magnet is then brought up behind the patient and the ring swung down into the horizontal position so that it encircles his head. The head and magnet are now manipulated so that the eye to be examined is exactly in the centre of the magnetic field. The smallest rod is now brought up to the centre of the cornea until it actually touches it, and any sort of reaction, whether subjective in the way of pain, or

The reason for applying the magnet always to the centre of the cornea is that by this means a fragment, wherever it may be in the eye, is brought up against the lens, over the highly convex posterior surface of which it glides till it reaches its edge. It then comes through the fibres of the suspensory ligament and presents behind the iris. From this position it is coaxed into the anterior chamber by means of one of the small rods, and left resting on the front of the iris for the time being.



GIANT RING MAGNET.

objective in the way of movement of the iris, etc., is conclusive proof of the presence of a magnetic foreign body.

If no response is elicited the larger rods are used in turn until the largest one of all is applied, taking care always to apply them to the centre of the cornea only. If now, however, the greatest power available has been used with a negative result, the largest rod should be applied to the sclerotic all round as far back as possible, with the idea of getting nearer to a foreign body which may possibly be present, but which has not responded hitherto because it was perhaps too minute, or too far back, or too feebly magnetic.

The giant magnet has now completed its function, and the actual removal is effected by means of a small hand electro-magnet.

A keratome incision is made through the cornea above, taking care in withdrawing the keratome to avoid loss of the aqueous by keeping its point forward. The hand magnet is now applied to the cornea immediately over the foreign body, which can then be guided along the posterior surface of the cornea to the keratome incision, through which it is drawn without introducing the magnet terminal inside the eye or even between the lips of the wound.

It will be evident that the success of this manœuvre wit

the small magnet depends upon avoiding the escape of the aqueous.

The foregoing is an account of what is known as the anterior route for removal, but in a few cases, owing to the minute size of the fragment, to its low magnetic affinity, to its position far back in the globe, to its entanglement in the retina or choroid, or sometimes to its large size, it becomes necessary to incise the sclerotic and effect the removal by this, the posterior route.

The presence of a magnetic foreign body is made sure of by the fact that pain is elicited every time the small rod is brought up to a particular spot, and it will be found that the patient is able to say within a millimetre or two the exact point at which most pain is caused. This point is very carefully noted.

The patient is now anæsthetised and the eye fixed in the most convenient position by means of a silk stitch, passed on the one hand through the conjunctiva on the side opposite to the projected incision of the sclerotic, and on the other hand through the skin of the lid or cheek.

This method of fixing the eye has two great advantages over forceps, first it is difficult with forceps to avoid some pressure on the globe, which will express vitreous, and, secondly, it leaves both hands free.

A flap of conjunctiva is now turned back so as to expose the sclerotic, and a narrow von Græfe's knife, held vertically to the surface, is made to puncture the coats exactly at the predetermined spot, and the incision enlarged if desired *as the knife is withdrawn* and never by see-saw movements. By this expedient and by the use of the fixation stitch all pressure on the globe is avoided, and there should be no loss of vitreous.

The small hand electro-magnet, having a terminal which has been hammered out into a screw-driver-like shape, is now brought to the lips of the incision, and as a rule the fragment at once slips out. The conjunctival flap is now sewn over, atropine instilled, and the eye bandaged.

Fortunately all these fragments when attracted to the magnet take up a position with their long axis in the direction of the lines of force, and consequently are withdrawn with their narrowest diameter engaging the wound and never broad side on.

No mention has been made of X-ray localisation. The most important reason for this is that so far as immediate treatment is concerned the magnet tells everything that is necessary, *i. e.* it demonstrates whether a foreign body which is magnetic is present, and this X rays do not tell; and in times of pressure (I speak of war conditions) the radiographer is sufficiently occupied without having relatively unessential work put upon him. It is true he can localise very accurately the position of the fragment, but this is almost immaterial, for, with few exceptions, an endeavour is made to bring it forward into the anterior chamber from whatever position it may be in the eye. If the magnet

proves negative, the aid of X rays is called in to determine the presence or absence of a non-magnetic foreign body, in this way influencing the ultimate prognosis, and the question as to whether the eye should be removed. It should be stated, however, that the presence of an intra-ocular foreign body does not necessarily render enucleation advisable, for some such eyes recover good vision and retain it.

The advantages of this magnet over the Haab will, I think, be obvious, and they are especially great in war surgery, where so many patients are the subject of multiple wounds. It is clearly impossible to make a patient with a compound fracture of the femur or a penetrating wound of the chest sit up to a Haab magnet, and it is a very clumsy instrument to use with the patient lying down. With the ring magnet the strength of the pull can be graduated to a nicety by varying the size of the rod used and its distance from the eye.

The patient's head is fixed on the table, and so the difficulty of approximating the head of a scared and reluctant patient to the formidable-looking Haab is avoided. The magnet is brought up to the eye—not the eye to the magnet.

The rods being free in the hand, one can use the smaller ones with the delicacy of a pencil and carefully coax a fragment from under the iris into the anterior chamber, and so avoid its entanglement in this structure.

The patient is on the table throughout the whole procedure, whereas with the Haab the patient is first sitting on a chair and the operation is completed on the table. It can be used as described for localising fragments in the vitreous chamber.

We found this instrument useful in a number of cases where there were shell fragments in the tissues of the face, neck, or scalp, or in the antrum or orbit. In one case only was it used for an intracranial missile, but then with complete success. We felt it might have been used more often in a few such cases with advantage.

NOTE ON THE TREATMENT OF CHRONIC AMÆBIC DYSENTERY.

By S. R. PRALL, M.B., B.C.(Cantab.), Capt. R.A.M.C.



THE object of this note is to call attention to a method of treatment which I have found to produce very good results, and which is perhaps deserving of wider use.

The essential factors of treatment are: (1) The combined administration of ipecacuanha by the mouth and emetine by the rectum.

(2) A modified Lenhartz diet; and—

(3) The use of rectal carminatives twenty-four hours after the rectal injection of emetine.

The diet on the first day consists of one egg and eight ounces of milk, which are beaten up together and given every hour in teaspoonfuls from 8 a.m. to 8 p.m. This diet is increased each day by one egg and four ounces of milk until the patient is taking daily eight eggs and two pints of milk, when these quantities are continued.

Ipecacuanha is given in the form of a pill at 11 p.m. on the first day—that is, three hours after the last meal. On the first day 60 grs. is given, and this is decreased by 5 grs. each day until the patient is taking 10 grs., after which he ceases to take any more.

On the morning of the second day one ounce of mag. sulph. is given; when this has acted, emetine is given by the rectum—one half of a grain dissolved in eight ounces of distilled water is injected in the morning and again in the afternoon. It is essential that the injection should reach the cæcum; the patient will usually retain it for two or three hours. On the third day a rectal carminative is injected. I used for this purpose issufgoll seeds—a drachm to a pint of water—and this gives the patient a good deal of relief from the pain which is usually, although not always, experienced after the emetine injections. Emetine is again given on the fifth, eighth, eleventh days, and so on until six grains have been given. By this time the patient has invariably improved, his weight has increased, amœbic cysts are reported absent from the stools, and his usual complaint is that he wants more food. The diet is then gradually increased, scraped raw beef and rusks being the first additions.

To effect a permanent cure in a case of chronic dysentery is undoubtedly very difficult in this country.* Cases of chronic dysentery supposed to have been cured may recur after twelve months—whether from the same infection or a fresh one it is difficult to say. It is impossible to say if the cases with which I dealt were permanently cured, as they passed out of my care during convalescence, but it is certain that they reacted to the treatment in an extraordinary manner.

I observed that the hypodermic injection of emetine in cases of chronic dysentery, whilst it had no effect on the appearance of amœbic cysts in the stools, frequently resulted in disordered action of the heart, especially after patients had had a prolonged treatment. This toxic effect of emetine never resulted after rectal injections as far as I observed, even though some patients continued injections for two or three months whilst waiting for a boat to England.

The value of emetine in dysentery is well known and undoubted, but the points I have emphasised indicate that administering emetine *per rectum* is more rational than the hypodermic method, because the emetine is able to act at once at the seat of the infection, and also because it does not produce any toxic effects on the heart.

* The note was written in India.—Ed.

BILHARZIOSIS.

By S. A. EL DAAB, M.R.C.S., L.R.C.P.



URING my short practice in this country I have already met with a case of bilharziosis. Considering that many Englishmen have been to Egypt and Mesopotamia, where this disease is endemic, it is very likely that more of these cases will be met with in due course by my hospital colleagues who have not given the disease much consideration before. It has thus occurred to me to formulate a few points which I have gathered from my teachers at Kasr El Ainy Hospital who have had a vast experience of the subject.

Bilharziosis is not a modern disease. Certain engravings on the walls of one of the ancient Egyptian temples in Kena, dating thousands of years B.C., give a clue to its having been known to the ancient Egyptians (Madden).

ÆTIOLOGY.

Bilharziosis is due to the *Schistosomum hematobium*, commonly known as the bilharzia worm. It is similar to the liver-fluke of cattle, and lives in the radicles of the portal circulation. It is usually found in couples, the male enclosing the female. The male is cylindrical in shape, white in colour, 11–15 mm., and possesses an oral and a ventral sucker; there is a ventral folding of the two sides which encloses the female. The female is longer and darker in colour, 20 mm. The outer surface of the body is closely beset by small cuticular prominences. The exact method by which the ovum leaves the human body is now understood. The female migrates from larger to smaller veins where it sticks and sheds its ova. The walls of the bladder are the site of election, particularly round the trigone. The ovum with the help of its spine passes through smaller venules and finally pierces their walls and lies in the peri-vascular spaces of the submucous layer, whence by muscular contraction of the bladder during micturition it is expelled with the urine. If the urine gets mixed with fresh water, the ova hatch in from twenty to thirty minutes, letting loose the free larva (miracidium), which swims about by virtue of its cilia; if this meets the intermediate host, which is a small mollusc abounding in the irrigation canals of Egypt, reaching the liver of the intermediate host, it undergoes metamorphosis and migrates as an immature worm (1–2 mm.). These immature worms, and not the miracidia, have the capacity of getting into the human circulation, either through the mucous membrane or skin.

The points of interest are:

- (1) The intermediate host has only recently been discovered by Leiper (1916).
- (2) The miracidium (free larva) can only live in stagnant

water—a point which explains the fact of its rare occurrence in Upper Egypt (there being no stagnant water there).

(3) A hot climate (Egyptian summer) is essential for the completion of the cycle.

PATHOLOGY.

For the sake of convenience I shall confine myself to lesions of the bladder, but the observations hold good for rectum, colon, ureters or kidneys.

The presence of the ova excites an irritating process of the submucous tissue, while hæmorrhages are produced by the action of their spines. The morbid anatomy of the condition is that in the early stages there are hyperæmia and petechial hæmorrhages. The condition known as "sandy patches" is very characteristic. This is due to the collection of numerous ova in patches in the submucous layer of the bladder, which look and feel very much like a thin layer of sand. In the later stages there are papillomatous, ulcerative and gangrenous conditions of the bladder, and in very old cases the walls of the bladder are extremely rough and the lumen is reduced to a minimum.

CLINICAL ACCOUNT.

(1) Frequent painful micturition is sometimes the earliest symptom, but frequent hæmorrhage, which may be microscopical, but as a rule macroscopical, is the first alarming symptom.

(2) Retention of urine is a frequent symptom.

(3) Later on secondary septic cystitis supervenes, and the case takes the form of an ascending infection.

(4) Still later there is a very nasty complication—hydro-pyonephrosis from implication of the ureteric openings.

(5) Bilharzial masses in perinæum or penis or vulva, leading to abscesses and fistulæ.

(6) A bilharzial mass may act as a nucleus for a stone.

(7) A clay pipe is responsible for a cancerous lip in England, and bilharziosis is responsible for a cancerous bladder in Egypt (Ferguson).

TREATMENT.

Prophylactic.—It would be necessary to dry Egypt every five years in order to eradicate the disease. (Ideal but rather drastic!) The following lines of treatment are taken by different surgeons:

Palliative.—Male fern, etc.

Symptomatic.—Hot douches of antiseptics, etc.

Curative.—Intravenous injection of—(1) Emetine, which stops the bleeding and produces negative result by the microscope, but immediately the injection is stopped there is a relapse. (2) Tartar emetic, claimed to be encouraging by Christopherson.

Operative.—Perinæal drainage. In the early stages it is unnecessary; in the late stages it is fatal. Operate on masses and fistulæ.

EPISODES OF WARD-LIFE.

"THE JOLLY RONUKERS."

LOOKING back over that period during which I was a patient, a student, not of medicine, but of hospital technique, I remember at least one item which might claim the epithet "exciting."

Of course, the ordinary commonplace medical student or nurse would see nothing worthy of the term "exciting" in the monthly appearance of two or three men who come to polish the floors. Indeed, to appreciate, and to appreciate fully, is of the sick a privilege; and one consolation awarded to our patients is the thrill to the backbone which they experience when The Jolly Ronukers give their entertainment in the wards.

Monotony tones all colour to a dull grey. Grey indeed was the ward on that dull autumn morning. Monotony was King and Routine his Commander-in-Chief.

The sequence of awakening day had been mechanically waded through as it had been mechanically waded through each morning for past decades—seen, but not realised; the same kind of probationer swept the same floor in the same conscientious way as probationers of 1818 A.D. conscientiously swept the floor. Brasses were cleaned, slabs were cleansed, and a sleepy patient had risen at 6.15 and had rubbed up the electric light switches. The two-year stripes made the same speculations on their chances in the next blue-belt exam. as their predecessors have done back into the dim past. Even the final flourish at the end of a bed-making was in the daily programme, when the curtain is slung up, away from harm, over the half-hoop, and the two nurses marching to the foot end of the bed clutch the bar of the bed *en passant*, and jerk the bed and its occupant to a position fourteen inches further from the wall.

One of the nurses commenced pulling down the curtains, carefully folding each and slapping it in a professional manner against the wall. It was all habit.

Suddenly, as if she had heard a whistle and "Take Cover" from the street below, she stopped, thought one moment, then sharply addressed another nurse on the opposite side of the ward: "Nurse! The Ronukers!"

Immediately the air was electric with bustling and excitement. Involuntary became voluntary; potential became kinetic; no longer the ordinary was received, but the extraordinary was expected. O men of Bartholomew! what a change was there!

Nurses began to run hither and thither, no longer unnoticed by the vulgar crowd, no longer unheeded in their thankless task. Pull out the beds again; sling once more the curtains on the hoops!

Wake, O thou that slumberest ; waken this joyous morning ! Rejoice with the world ! Be glad in your heart for this day of all days the enjoyable and the glad some is not rationed ! No therapeutic doses to-day ; to-day is Free Beer ! Take full measure ! The brim is sparkling with beaded bubbles. Take it now, lest you awake and to-morrow has come—to-morrow with its likeness to the past, to-morrow with its ever-recurring ablutions, meals, ablutions, and the sleepy afternoon droning of the physician's voice as it slowly proceeds from bed to bed, moving only to linger again, lingering only to fade away in your dreaming.

Lunch came and was cleared away. The excitement had developed and had reached a degree of silent tension which was only equalled in the highly-strung nervous state of the febrile.

Solemnly the clock ticked out the minutes till the event of the month should take place. Titterings of nurses in the kitchen seemed irreverent. To cough was to profane the sacred moment, big as it was with the future.

At last the future was born.

Into the ward strode those great men, proud in their power, stout with muscle, slow in their strength, prepared—not to act—but to perform their life-work.

I respected them as, when a boy, I respected an engine-driver ; I envied them as I envied the postmen who drive red-painted Post-office carts. I revered them.

It was calmly that each took off his hat, his coat, and then his waistcoat. It was with calm deliberation that each rolled up his sleeve. But beneath the still surface deep under-currents flowed swiftly.

Thus prepared, the three heroes stood up, glanced around like experienced batsmen to see how their opponents (passive in this game, and helpless) were placed, and then, spitting into their hollowed hands, they leapt to their work.

My memory gives me no clear picture. The atmosphere was that of a futurist cinematograph show. The Ronukers darted in all directions. Clutching on to bed-rails they slung the beds from this side to that, and from one end of the ward to the other. They juggled with stools and chairs. I remember the last nurse dodging a bed and disappearing from view, hoping to evade purgatory at least in this life.

After a second or two, when the beds and other articles of furniture and the patients were all piled in one corner of the ward, these frantic men of herculean strength seized what I remember as large tree-trunks, and ran madly up and down and round about, swinging the tree-trunks and making hideous grimaces—a very fetish of wild movement and savage ecstasy over living.

After this frenzied dance of liberty the beds were again seized and hurled over to another corner of the ward, and another mad frolic commenced.

But I was weak from my continued fever ; I fainted in the fulness of pleasure.

When I revived in the evening the ward had reverted to type : the time for washing came round as usual. But for the absence of a nurse who fell on the slippery floor and sprained her ankle, no trace remained of the spirited antics which had been performed for us that very morning by The Jolly Ronukers.

D. W. W.

OBITUARY.

JOSEPH BALDWIN NIAS, M.D.(OXON.).



JOSEPH Baldwin Nias died on February 20th, 1919. He was born at Bath on December 13th, 1857, the eldest son of Admiral Sir Joseph Nias, K.C.B., whose name was given to that remote island in the Pacific from the folk lore of whose inhabitants Sir James Frazer has gathered so many illustrations in his recently published volumes on *The Folk Lore of the Old Testament*.

After spending five years at Winchester Nias entered Exeter College, Oxford, in 1875, and was elected to an open scholarship in Science in 1876. He thus came under the teaching of Ray Lankester, who was then in residence and was actively engaged in College tuition. In 1879 he obtained a First Class in the Final School of natural Science at a time when candidates were not allowed to specialise. He entered St. Bartholomew's Hospital for his medical training in October, 1879, and in 1882 he was elected Burdett-Coutts scholar in the University of Oxford for proficiency in Geology and Natural Science as bearing on Geology. In the same year he was chosen a Radcliffe Travelling Fellow, and spent the statutable period abroad, chiefly in Paris. He was admitted a Bachelor of Medicine in 1883, and a Member of the Royal College of Physicians. He filled the post of Casualty Physician during the years 1885 and 1886, having Dr. Haig and Dr. Arthur Davies as his colleagues. In 1893 he graduated M.D. at Oxford with a dissertation "On Mastication in Young Children." He then settled in general practice at 5, Rosary Gardens, South Kensington, where he remained until his death.

A very courteous gentleman, and somewhat of the old school, Nias had original ideas upon the subject of medical education. He determined from the beginning of his career that he would practise medicine, and it was popularly believed amongst his contemporaries that he succeeded in obtaining his medical qualifications without having seen more surgery than was visible in an occasional visit to the out-patient room. It is certain that he never became an in-patient dresser. In later life he devoted his attention to bacteriology, and worked in the Laboratory at St. Mary's Hospital. He wrote a report on the Greek manuscripts in the Library of the Medical Society of London, which was published in 1905.

At the International Congress of 1914, in which a section for the history of medicine was formed for the first time, Nias was placed upon the council of the section, and read an excellent paper entitled "Typhoid Fever in the Civil War" (1642-46).

The Clarendon Press issued in 1918 his sketch of the life of Dr. John Radcliffe, with an account of his Fellows and Foundations. This work had occupied much of his spare time for many years, and it was a source of great satisfaction to him that he had lived to complete it. D'A. P.

COLIN SADLER HAWES, M.R.C.S., L.R.C.P.

It was with very great regret that his many friends heard of Colin Hawes's death on December 15th, 1918, from pulmonary hæmorrhage at the age of 42, for he was a man with many close friends, and in spite of being an invalid for so long his interest in his friends never flagged.

His circle of correspondents was exceptionally large. Letter-writing was his *forte*, and he wrote such a good letter that his letters had to be answered if for no worthier reason than to bring a reply again from him. He had a wide acquaintance with Bart.'s men and their movements. A reference to him would infallibly elicit information as to the whereabouts and present occupation of most of his contemporaries and many who were not of his own time.

Colin Hawes was educated at Haileybury and Bart.'s, taking the Conjoint qualification in 1900. As a student he was very keen on games, and played regularly for the Hospital in the 2nd XI at cricket and 2nd XV football, though probably even then his health prevented his attaining more distinction in athletics.

From October, 1900, to October, 1901, he was House-Surgeon to Mr. Walsham, and a great favourite in the residents' quarters and mess.

Shortly after going out of residence the signs of early phthisis were detected. The remainder of his life was spent in searching for a climate and a cure. Having tried South Africa, he journeyed to the Argentine and finally returned to England, becoming assistant to Dr. Thurnam at Nordrach-on-Mendip Sanatorium. Unfortunately, although his disease progressed but slowly its course was never completely arrested, and his work at the Sanatorium was a constant struggle in spite of his intense interest in the problems of tuberculosis.

In 1908 he married Lilian, daughter of the late Robert and Mary Gibson, of Keighley, Yorks.

During the war he braced himself to another effort and undertook medical work again at the South African Hospital in Richmond Park. His heart was thoroughly in this work, and he dearly loved to give his time and his strength to his soldier patients. But his strength was unequal to the call. He was compelled after ten months at this hospital to give up work altogether.

After many months of more complete invalidism he died,

unexpectedly and rapidly, of a hæmoptysis, having lived to his great joy to see the war brought to a successful end.

J. A. N.

THOMAS HAMPTON, M.B.(LOND.), M.R.C.S., L.R.C.P.

Dr. Thomas Hampton, whose death occurred on February 13th, at Grosmont, near Hereford, was a St. Bartholomew's man. After taking the qualification of the Conjoint Board, he was appointed House-Physician to Dr. Philip Hensley. Other appointments he filled in London were House-Physician to the Metropolitan Hospital, and then Resident Medical Officer to the Royal Chest Hospital. He came to me as assistant in my practice in 1898, and stayed until October, 1900, when I persuaded him to go back to London and take the final M.B. This he did with apparently little trouble. He afterwards settled down in practice at Grosmont, where he has made himself universally beloved. He has been a very staunch friend of mine all these years, and I have had an enormous number of opportunities of judging his sterling worth in practice. He was especially shrewd in the diagnosis of surgical emergencies arising out of medical cases, and never lost time—even at the greatest personal trouble and inconvenience to himself—in getting them operated on without delay. When Hampton made a diagnosis it was never very far off the mark. I have never forgotten the clear and definite clinical picture he drew in a case of sub-diaphragmatic abscess following old ulcer of the stomach. It was operated on with perfect result, and the lady has been in good health ever since. (Such cases were not recognised twenty-one years ago as early and satisfactorily as they are at the present day.)

He married a daughter of Albert Estcourt, Esq., of Gloucester. His wife survives him without children, to whom is extended the heartfelt sympathy of all with whom he came in contact.

C. F. C.

ABERNETHIAN SOCIETY.



THE Midsessional meeting of the Abernethian Society was held in the Medical and Surgical Theatre on March 13th, the President, Mr. Lyon-Smith, being in the Chair.

A large audience of members and visitors, including the Nursing Staff, gathered to hear Baron Meyendorff's discourse on "Various Aspects in the Origin and Development of Bolshevism in Russia."

The Baron, who was President of the Russian Duma during the years 1907 to 1908, was introduced by the President.

In fluent English Baron Meyendorff gave a most interesting account of the history, development and psychology of the Russian revolution. Comparing the Russian to the French and other revolutions he discussed the local and general causes, which he divided into physiological and

psychological. In his opinion the war had upset the normal sentiment of certain classes in Russia. When the revolution was initiated the general opinion was that it would not succeed. The Baron had close relations with leading members of all parties, and was therefore in a position to study the feelings of the country.

The garrison of Petrograd, 200,000 men in all, was the first part of the army to join the workmen. The majority of these soldiers had not been to the front. At this time the fighting forces still remained loyal. The workmen's programme was then accepted, although disapproved of by M. Kerenski.

The moderate Socialists, aided by part of the army, wanted a more energetic interference in the war. There is no doubt that these persons were true patriots, but the people were tired of the war and wished to keep on the defensive. Furthermore, they desired to give up all offensive tactics, as well as all ideas of conquering Constantinople. This made an excellent medium for Bolshevism, which started then under Lenin, who preached that the war was waged and kept up by the capitalists merely for commercial purposes.

The triumph of Bolshevism was as unexpected as that of the first revolution. The Bolsheviks were in power in two days, and they themselves were astonished at their success. Symptoms of spontaneous anarchy quickly followed. Soldiers began to steal and shoot at random. Policemen and officers were murdered in cold blood, whilst women looked on and jeered.

New military laws were introduced to moderate the outrages and bloodshed, but, there being no mutual confidence, various new powers sprang up spontaneously. "When the individuals of a race become suspicious," said the Baron, "they give way to cruelty, and this has no limits."

Soldiers returning from the Front were classed as "heroes," and displayed their heroism by committing outrageous crimes.

Baron Meyendorff made an interesting study of the psychology of the feelings of the people. Individual responsibility, he stated, is the result of modern ideas. This fact has been misunderstood in Russia, where the innocent mother of a soldier is shot because she is a militarist, and similarly any German is considered a criminal because he is a German.

The first principles to be lost in a psychological disease of this kind are those of decency.

Bolshevism is a form of Socialism worked by a degenerate crowd. It is a battle of classes, and its aim is to destroy bureaucracy and ownership.

Lenin, the Bolshevik leader, is by birth a Russian nobleman. In 1897 he published a book in Switzerland on Socialism, basing his theories on those of the well-known German Socialist Carl Max. The Socialists were divided into evolutionists, who wished to reach their goal by gradual

innovation, and the revolutionaries, whose means were blood and steel. It was to the latter class that the Bolsheviks belonged, clamouring for the immediate extermination of the *bourgeois* and landowners.

Baron Meyendorff concluded his brilliant and most interesting discourse by saying that Socialism deprives a nation of all the qualities and attributes which lead to progress.

The President called on Col. D'Arcy Power, who, in a brief speech, thanked Baron Meyendorff for his brilliant address. Mr. Harmer seconded the vote of thanks, which was carried unanimously amidst great applause.

Baron Meyendorff expressed his gratitude to the Society and audience, and Mr. Lyon-Smith closed the meeting.

T. F. ZEROLO,
Hon. Sec.

STUDENTS' UNION.



THE Annual General Meeting of the Students' Union Council was held in the Abernethian Room on March 12th, 1919.

Colonel Waring was unanimously re-elected President of the Students' Union and Capt. Girling Ball and Capt. Macphail Treasurers for the ensuing year.

C. SHAW,
Hon. Sec.

RUGBY FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. OXFORD UNIVERSITY.

On March 9th the Hospital visited Oxford and defeated the University XV by 1 goal (5 points) to *nil*. Although the game was keenly contested and the teams equally matched, Bart.'s suffered severely through injuries to players.

Llewellyn had to retire for the greater part of the first half, but fortunately returned at half-time; Melle and Parkes, however, had to leave the field early in the second half, and for the last twenty minutes the Hospital played with thirteen men. The only score of the game came after a quarter of an hour's play. Melle, who played a great game, intercepted a pass, and beating the full-back, scored under the posts for Johnstone to convert.

During the whole of the first half Bart.'s had the most of the game, and were unfortunate in not adding to their score; but the Oxford centres kicked and fielded well, and it was mainly owing to their efforts that the Oxford line remained intact.

Soon after the re-start Melle intercepted again, and it was in the race for the ball that he was injured. Shortly afterwards Parkes, while stopping a dangerous rush, collided with the Oxford wing. For the remainder of the game Bart.'s were kept on the defensive, although on one occasion Krige, who was the most prominent player on the field, might have put Cockell in.

The final whistle went, leaving the Hospital winners by 5 points.

CORRESPONDENCE.

MITRAL STENOSIS.

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

SIR,—Lieut. Sharp's letter in your February number raises several points of great interest. Mitral stenosis is not very uncommon in men; hospital impressions are open to the fallacy that patients do not as a rule come up unless they have symptoms severe enough to warrant their missing a day's work in order to attend. Mild degrees of mitral stenosis are easily missed, especially if the room is not free

from noise during auscultation and if the patient has rested for a few minutes before examination. Slight exertion accentuates the murmur and the thrill. In the earlier days of the war, when large numbers of recruits were being rapidly examined, many men were passed into the Army who should have been rejected. Several of those who were sent to me later for special examination had definite mitral stenosis.

From early 1916 until about the time of the armistice "doubtful" heart cases were sent by the recruiting boards in the London area to the Heart Hospital for special examination. Some 10,000 were examined under this scheme (about 2000 during the six months that I worked there). Detailed histories were taken on a special form, electro-cardiographic and X-ray examinations were made, and, in addition, the response to standard work was investigated in all cases.

The statistical analysis of the mass of data obtained by my colleagues is a formidable undertaking and is not yet complete, though certain brief preliminary reports have already been published. The figures for mitral stenosis are not yet available, but it is clear that the factor of "strain" is negligible. A history of febrile attacks with slight pains and aches was common, but my impression is that frank attacks of rheumatic fever were recorded with less frequency than the accepted teaching would lead one to expect. Lieut. Sharp will doubtless look forward with interest to the publication of the full report.

Many patients with mitral stenosis feel little inconvenience and are capable of considerable exertion. One recruit referred to me had rowed in his college boat, and until war broke out was an active oarsman. He had well-marked aortic regurgitation as well as mitral stenosis and regurgitation. Two of my former patients with the same lesion are active riders. One regularly follows hounds over very difficult country; the other, a lady, has ridden long distances in South Africa, and had no inconvenience during a pregnancy.

I am, Sir,
Yours, etc.,

I, Weymouth Street, W. 1.

P. HAMILL.

A CASE OF SARCOMA OF THE TONGUE.

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

SIR,—I have read with interest the account by Mr. W. E. Heath in the February issue of the JOURNAL of a case of sarcoma of the tongue, and venture to offer my humble criticism of the manner in which the case was managed. It illustrates one or two important points.

The patient came to the Hospital in March with a short history of a lump in the tongue. This was diagnosed correctly by Mr. Blakeway as a sarcoma. In spite of this, time was wasted giving injections of arsenic, and an operation was not performed until September 13th. The tumour was then "shelled out with a certain amount of difficulty." The growth returned quickly and was widely removed on October 14th. This case illustrates in a very striking manner the value of a preliminary microscopic examination of tumours before operation, either by cutting out a piece and having it prepared in the laboratory, or by having a section cut at the time of the operation. This would have avoided the risk of incomplete removal of a malignant growth by "shelling" it out. Also it would have prevented the delay in operating and the unnecessary injections of arsenic. The writer does not state whether the Wassermann test was performed, but even if it were positive I should have had a piece out of this tumour for microscopic examination.

I am, Sir,
Yours faithfully,

355, Camden Road,
Holloway, N.

ERNEST H. SHAW.

CHANGES OF ADDRESS.

- BELL, K. D., Surg.-Commander, R.N., Oakcroft, Fareham, Hants.
CHATER, J. S., Epworth, Bristol Road, Sherborne, Dorset.
FORBES, Capt. J. G., R.A.M.C., Oakridge, Linkfield Lane, Redhill, Surrey.
GRAHAM, G., 12, Ladbroke Gardens, W. 11; tel. Park 2985 (*private address*). 37, Queen Anne Street, W. 1; tel. Mayfair 5011 (*consulting room*).
HAMILL, P., 1, Weymouth Street, W. 1. (Tel. Gerrard 4339.) (*After April 23rd.*)
HUDSON, B., Palace Hotel, Montana-sur-Sierre, Switzerland. (*After May 1st.*)

MORGAN, C. C., 25, White Friars, Chester.

ROPER, F. A., 5, Dix's Field, Exeter.

VINER, G., 27, Queen Anne Street, Cavendish Square, W. 1. (Tel. Mayfair 188.)

APPOINTMENTS.

- BRASH, E. J. Y., M.B., B.C.(Cantab.), appointed Medical Officer to the Exeter Dispensary.
HUTT, C. W., M.B., B.C.(Cantab.), appointed whole-time Medical and School Medical Officer for Dudley.
MAWHOOD, R. H., M.B., B.C.(Cantab.), F.R.C.S.(Eng.), appointed Honorary Assistant Surgeon to King Edward VII Hospital, Windsor.
WATERHOUSE, R., M.D., M.R.C.P.(Lond.), appointed Physician to the Royal United Hospital, Bath.

BIRTHS.

- BURRA.—On January 20th, at Little Kimble, the wife of Dr. L. T. Burra of a daughter.
EDMOND.—On February 15th, at Cruck Meole House, Hanwood, Shropshire, the wife of Major W. S. Edmond, F.R.C.S., R.A.M.C., of a daughter.
LONGSTAFF.—On January 21st, at Thornhill, St. Mary's Road, Ditton Hill, Surbiton, to Capt. E. R. Longstaff, R.A.M.C. (S.R.), and Mrs. Longstaff—a daughter.
RAWLING.—On March 21st, at 11, Wyndham Place, Bryanston Square, the wife of L. Bathe Rawling, F.R.C.S., of a daughter.
STIDSTON.—On March 20th, at 14, Waterloo Road, Wolverhampton, to the wife (*née* Olive Cumberland) of Dr. C. A. Stidston—a daughter.

MARRIAGES.

- DANKS—AIKMAN.—On February 26th, at St. Mary's Parish Church, Wimbledon, by the Rev. H. Monro, Vicar, and the Rev. A. G. M. Mengens, Vicar of Kingston Vale, Walter Seymour Danks, M.D., Sutton (Major, R.A.M.C.), to Isobel Theodora, youngest daughter of Thomson Aikman, Esq., Pendreath, Wimbledon, and Bramley Croft, Hindhead, Surrey.
JONES—THATCHER.—On February 15th, at St. John of Jerusalem, South Hackney, by the Rev. G. T. McLean, M.A., William Henry Jones, M.B., B.S.(Lond.), Temp. Lieut., R.A.M.C., fifth son of the late Mr. J. Jones, of Talybont, Cardiganshire, to Gwendolen Frances Mildred, second daughter of the Rev. and Mrs. W. Romaine Thatcher, of South Hackney.
NICHOLAS—HACKING.—On February 18th, at Holy Trinity, Sloane Street, by the Right Rev. Bishop Bury, D.D., Capt. C. F. Nicholas, R.A.M.C., second son of the late William Nicholas, Esq., Bothwell, Tasmania, and Mrs. Nicholas, of 17, Edwardes Square, Kensington, to Ann Kathleen, fourth daughter of the Ven. Archdeacon and Mrs. Hacking, Hill House, Southwell, Notts.
SOLTAU—WRIGHT.—On March 13th, at St. Mary's Church, Stafford, by the Rev. J. S. D. Rider, M.C., S.C.F., assisted by the Rev. J. E. Jones, Capt. H. K. V. Soltau, R.A.M.C., only son of the late Dr. Henry Soltau, F.R.G.S., and of Mrs. Soltau, to Nora Ramsar, youngest daughter of Mr. Charles H. Wright, of Tillington Hall, Stafford.

DEATHS.

- ANDREWS.—On February 20th, 1919, at Gaisgill, Elstree, Samuel Andrews, M.R.C.S., L.R.C.P., late of Basingstoke, aged 68.
FREEMAN.—On December 24th, 1918, suddenly, at his residence, 30, London Road, Reading, William Thomas Freeman, M.D.(Durh.), F.R.C.S., R.A.M.C.
GUTHRIE.—On December 24th, 1918, at Kensington Infirmary, from injuries received in an accident on the previous evening, Leonard George Guthrie, M.A., M.D.(Oxon.), F.R.C.P., 15, Upper Berkeley Street, W., aged 60.
KEMP.—On January 17th, 1919, suddenly, of heart failure, William George Kemp, M.D.(Durh.), of Oakhurst, Hastings, formerly of Wellington, New Zealand, aged 72.
LE QUESNE.—On January 24th, 1919, at Melbury, Havre des Pas, Jersey, Edwin Joseph Le Quesne, M.R.C.S., L.R.C.P. late of Tring, youngest son of the late Philip Le Quesne, aged 67.
NIAS.—On February 20th, 1919, at a nursing home, Joseph Baldwin Nias, M.D.(Oxon.), of Rosary Gardens, S.W.
SYRETT.—On February 20th, 1919, at his residence, Stour House, Dovercourt, Ernest Frank Syrett, M.D.(Durh.), formerly of Nayland, Suffolk, aged 49.

St. Bartholomew's Hospital



"Æquam memento rebus in arduis
Servare mentem."

—Horace, Book ii, Ode iii.

JOURNAL.

VOL. XXVI.—No. 8.]

MAY 1ST, 1919.

[PRICE SIXPENCE.]

CALENDAR.

Fri., Apr.	25.—	Dr. Calvert and Mr. Waring on duty.
Tues., "	29.—	Dr. Fletcher and Mr. McAdam Eccles on duty.
Wed., "	30.—	Clinical Lecture (Surgery), Sir Anthony Bowlby.
Fri., May	2.—	Sir Wilmot Herringham and Sir Anthony Bowlby on duty. Clinical Lecture (Medicine), Sir Wilmot Herringham.
Tues., "	6.—	Dr. Tooth and Mr. D'Arcy Power on duty.
Wed., "	7.—	Clinical Lecture (Surgery), Mr. D'Arcy Power.
Fri., "	9.—	Sir Archibald Garrod and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Tooth.
Tues., "	13.—	Dr. Calvert and Mr. McAdam Eccles on duty.
Wed., "	14.—	View Day.
Fri., "	16.—	Dr. Fletcher and Mr. Bailey on duty. Clinical Lecture (Medicine), Dr. Calvert.
Tues., "	20.—	Sir Wilmot Herringham and Sir Anthony Bowlby on duty.
Wed., "	21.—	Clinical Lecture (Surgery), Mr. Waring.
Fri., "	23.—	Dr. Tooth and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine), Sir Archibald Garrod.
Tues., "	27.—	Sir Archibald Garrod and Mr. Waring on duty.
Wed., "	28.—	Clinical Lecture (Surgery), Mr. D'Arcy Power.
Fri., "	30.—	Dr. Calvert and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Calvert.
Tues., June	3.—	Dr. Fletcher and Mr. R. C. Bailey on duty.

EDITORIAL NOTES.

IN placing this Reconstruction Number before our readers our first duty must be to thank those members of the Hospital Staff, both past and present, who have so kindly supplied us with such useful, interesting and valuable data. It affords us a considerable amount of satisfaction to be able to state that each particular branch of Hospital work has been handled by an expert.

For some reason or other Bart.'s has had the reputation of being conservative in its ways and methods, and if this issue does nothing else than prove that, far from lagging behind, our Hospital is actually leading in the van of progress, our efforts will not have been in vain.

It would be invidious to single out any one name to whom our thanks are especially due, but we cannot let the occasion pass without expressing our indebtedness to Major McAdam Eccles for the great assistance he has rendered us in preparing this number for the press.

Not the least important of the many departments of the Hospital which are most in need of reconstruction is the Nurses' Home. A scheme to erect a new and thoroughly up-to-date building is definitely in hand, and at least £150,000 is required for the purpose. We are enclosing with this issue a short statement giving some details of the proposed building. Funds are urgently needed in order that the work may be got in hand as soon as possible.

We feel sure that Bart.'s men will gladly avail themselves of the opportunity of subscribing to such a worthy object.

* * *

With the return to the Hospital of Sir Wilmot Herringham and Sir Anthony Bowlby our Senior Staff is complete. We extend a warm welcome to our Senior Physician and Surgeon, and congratulate them on the well-merited honours they have earned and incidentally have conferred upon the Hospital.

We are also glad to welcome back Dr. H. Thursfield and Mr. G. E. Gask, both of whom have carried out important work on the Western Front.

* * *

Our warmest congratulations to Sir Norman Moore on the Baronetcy bestowed upon him by His Majesty so soon after his re-election as President of the Royal College of Physicians of London.

We also heartily congratulate Sir Thomas Jenner Verral on the well-deserved honour of knighthood for his work during the war in securing medical officers for the Services.

* * *

It has been decided to resume the Annual Dance, which this year will be held at the Prince's Restaurant on May 23rd, commencing at 10 o'clock. Tickets, price one guinea, may be obtained from the Secretaries, E. F. Peck and W. B. A. Lewis.

* * *

Seeing that this issue should reach every old St. Bartholomew's man, we desire to state that the Blakeway and the Stansfeld Memorial Funds are still open. For the Blakeway Fund cheques should be sent to Capt. Alex. Macphail, Anatomical Department, and for the Stansfeld Fund to Prof. F. W. Andrewes, Pathological Department.

It is officially announced that another expedition to the Antarctic regions has been formed, and is now in an advanced stage so far as the organisation is concerned.

It will be known as the "British Imperial Antarctic Expedition," its leader being Mr. John L. Cope, F.R.G.S., who accompanied the Imperial Trans-Antarctic Expedition, 1914-17, as surgeon and biologist to the Ross Sea party, and who was one of the party of nine who were left on the Great Ice Barrier to lay depots after the "Aurora" had broken away from her moorings, and when the fate of all the men was almost disastrous.

Until recently Mr. Cope was studying Medicine at this Hospital, and those who attended the most interesting lecture which he gave before the Abernethian Society last year on his experiences in the Antarctic will wish him every success in his new venture.

* * *

Rugby enthusiasts will join with us in congratulating M. G. Thomas, who is completing his last year in Hospital, on being chosen to play for Wales against New Zealand. Mr. Thomas also represented the Principality earlier on in the season.

* * *

It affords us much pleasure to congratulate Lieut.-Col. W. H. Hamilton, D.S.O., I.M.S., and Lieut.-Col. F. E. Swinton, I.M.S., on receiving the Companionship of the Order of the Indian Empire.

* * *

We are pleased to congratulate the following St. Bartholomew's men on being awarded the Military Cross: Capt. E. J. Bradley, R.A.M.C., S.R.; Capt. (Act.-Maj.) Frank Coleman, R.A.M.C.T.; Capt. (Act.-Maj.) H. R. Dive, R.A.M.C.; Temp. Capt. W. B. Gourlay; Temp. Capt. T. Howell, R.A.M.C.; Temp. Capt. C. W. B. Littlejohn, R.A.M.C.; Capt. (Act.-Maj.) H. W. Maltby, R.A.M.C., S.R.; Lieut. A. V. Pegge, R.A.M.C., S.R.

* * *

The King of the Belgians has conferred the Cross of Chevalier of the Order of the Crown on Mr. G. R. Fox and Mr. H. C. Manning in recognition of services to the Belgian civil population in the Yser district 1914-15, while serving with the Friends' Ambulance Unit.

* * *

Our congratulations to the following St. Bartholomew's men whose names have been brought to the notice of the Secretary of State for War for valuable services rendered: Maj. A. Bird, R.A.M.C.; Temp. Lieut.-Col. J. J. G. Blandford, R.A.M.C.; Temp. Maj. R. J. D'A. Irvine, R.A.M.C.; Capt. J. G. F. Hosken, R.A.M.C.T.; Lieut.-Col. F. J. Paley, R.A.M.C.T.; Temp. Capt. F. J. Rawlinson, R.A.M.C.; Surg.-Maj. J. Soutter, R.G.A. (Vol.); Temp. Capt. (Act.-Maj.) A. W. G. Woodforde, R.A.M.C.; Temp. Capt. E. D. Wortley, R.A.M.C.

* * *

We note with much interest that the following have been mentioned in Despatches:

British Salonica Force.—Temp. Capt. J. C. M. Bailey, O.B.E., R.A.M.C.; Capt. T. S. Hele, R.A.M.C.T.; Capt. (Act.-Maj.) H. A. Playfair-Robertson, R.A.M.C.T.; Lieut.-Col. F. E. A. Webb, O.B.E., R.A.M.C.T.

East African Force.—Temp. Capt. S. Mason, S.A.M.C.; Lieut.-Col. R. F. Standage, I.M.S.

Egyptian Expeditionary Force.—Temp. Capt. F. H. Diggle, O.B.E., R.A.M.C.; Maj. (Temp. Lieut.-Col.) E. C. Hodgson, D.S.O., I.M.S.; Lieut.-Col. (Temp. Col.) E. P. Sewell, C.M.G., D.S.O., R.A.M.C.; Temp. Capt. (Act.-Maj.) E. B. Smith, R.A.M.C.; Maj. G. C. Taylor, O.B.E., R.A.M.C.T.

Mesopotamian Expeditionary Force.—Temp. Capt. K. D. Atteridge, R.A.M.C.; Temp. Capt. F. B. Ambler, I.M.S.; Temp. Capt. B. E. A. Batt, R.A.M.C.; Lieut.-Col. W. R. Batty, D.S.O., I.M.S.; Capt. A. M. Dick, I.M.S.; Temp. Capt. A. Feiling, R.A.M.C.; Lieut.-Col. and Bt.-Col. M. H. G. Fell, C.M.G., R.A.M.C.; Col. S. F. St. D. Green, A.M.S.; Maj. and Bt.-Lieut.-Col. W. H. Hamilton, D.S.O., I.M.S.; Temp. Capt. A. R. Jennings, R.A.M.C.; Maj. F. P. Mackie, I.M.S.; Temp. Capt. H. H. Raw, R.A.M.C.; Capt. J. M. Weddell, R.A.M.C.; Capt. P. A. With, R.A.M.C.

* * *

It is with much pleasure that we notice the names of nearly fifty St. Bartholomew's men in civil practice in the list which has recently been brought to the notice of the Secretary of State for War for valuable medical services rendered in the United Kingdom.

The names are too numerous to publish in this issue, but will be included in the next Roll of Honour.

* * *

We regret to have to record the death of the following well-known Bart.'s men:

Dr. Ralph Winnington Leftwich died on March 25th after a short illness. He studied at this Hospital and the University of Aberdeen, and afterwards visited Paris and Vienna. He graduated M.B. with honours and C.M. at the University of Aberdeen in 1873, and took the degree of M.D. in 1875. He was House-Surgeon, and afterwards for a time Assistant Physician, to the Shadwell Children's Hospital. Later on he engaged in general practice in Ebury Street, London, and held various medical appointments in connection with London tramway companies. Dr. Leftwich took a keen interest and showed high capabilities in the practice of medicine. In 1888 he published *An Index of Symptoms*, which reached a seventh edition this year. Of another book, *The Pocket-Book of Treatment*, a third edition appeared in 1917. In 1913 he published a volume entitled *Tabular Diagnosis*, and in 1918 another on *Rational Therapeutics*. Dr. Leftwich was a keen student of Shakespeare's life and time, and to his paper showing that St. Saviour's, Southwark, was the poet's parish church when he lived in London, and presumably his place of worship, was due the erection of the Shakespeare Memorial there. So recently as March 19th Dr. Leftwich read before

Hocū sit uniuersis fidelibus qđ ego raherus sc̄i bartholomei q̄ ē in smethefeld por-
 tator ecclie nre conuenit. ecclia s̄. sepulchri hagnom elegio s̄. regis alii p̄fessionis
 n̄ inuente usq; ad fine dieŕū suor̄ in elemosina concessim̄. Illud autē sc̄tore quod
 idem p̄dicte hagno. singlis annis ad usus canonicor̄ simul & paupum in hospi-
 tali degentiu. quingenta sol̄ nob̄ reddet. In festiuitate sc̄i michaelis. xxv. sol̄. xxv.
 in pascha. Anno incarnationis dñi millesimo. c. xxx. vij. Anno ū sc̄do impij stephani
 regis in anglia. his existencib; test. haco decan. hugo. s̄. martini can. Gualter' ff
 Gwitti archidiaconi. Thold can. Radus' magist. Gulebr' p̄. Ostr' p̄. Radbr' de sc̄a
 maria. Algar' p̄. Godefrid' fili' haldewini sac̄. Rog' mag' Algran' Odo. Gau-
 frid' cunestable. Ric' p̄. Lurco oligic' Gaufrid' de heli.



RAHERUS TO HAGNO, A.D. 1137.

Adlard & Son & West Newman, Ltd.

the Historical Section of the Royal Society of Medicine a paper founded on a detailed study of the authentic signatures of Shakespeare, in which it was shown that in each case there were clear indications, increasing with age, of writer's cramp; it was suggested that to this cause might properly be assigned the fact that during his last years Shakespeare added little or nothing to his earlier plays and poems, a circumstance for which no satisfactory explanation had hitherto been found.

Dr. Ernest Frank Syrett died after a brief but painful illness on February 20th. He was born at Ramsgate in 1869, and was educated at Maidstone. He studied medicine at this Hospital and obtained the London Conjoint diplomas in 1891 and the M.B. and B.S. degrees at Durham University in 1893, proceeding to the M.D. degree two years later. After holding the post of Resident Medical Officer to the Fleming Memorial Hospital for Sick Children at Newcastle-on-Tyne, he served for a short period as a medical officer in the Peninsular and Oriental Line. Subsequently he practised first at Nayland, near Colchester, and later at Dovercourt, where he held most of the public medical appointments, including that of M.O.H. for the borough of Harwich. Dr. Syrett was typically an able country general practitioner. Quick at absorbing knowledge and ready in applying it, he was also very competent in organising his work. In this way he was able to carry on a wide general practice in addition to performing satisfactorily the duties connected with his numerous public appointments. His services in connection with the war hospitals and other military matters at the fortified town of Harwich had obtained for him the friendship and respect of the naval and military authorities. He was extremely popular with his patients, and his popularity was increased in private life by his keenness as a sportsman. He married in 1899 Maude, elder daughter of the Rev. J. D. Gray, M.A., and leaves a widow and three children.

Dr. John Albert Manton, a well-known Sheffield medical practitioner, died on February 4th from pneumonia following influenza. He was born at Wakefield in 1864, and studied medicine at this Hospital and at the medical schools of Leeds and the University of Durham, obtaining the M.R.C.S. and L.R.C.P. diplomas in 1886. Two years later he began practice in the Park district of Sheffield. Among other early appointments he was Demonstrator of Anatomy in the Sheffield School of Medicine. For many years Dr. Manton took a prominent part in municipal life as a member of the city council and a guardian. In addition to the work of a large private practice, he held the appointments of Medical Officer to the Sheffield Post Office and to the Education Department. He spent his holidays in travel and made good use of his experiences, both on the platform and in various literary contributions. He visited Serbia in 1899, and wrote a series of sympathetic articles on life in the Balkans, in recognition of which he was appointed by King

Alexander of Serbia a Chevalier of the Order of St. Sava. He was an enthusiastic cyclist, and was for many years President of the Sheffield Road Club, in this way adding year by year to his knowledge of local roads and of the antiquarian lore of the countryside. Dr. Manton leaves a widow, a son and two daughters.

* * *

We would again draw the attention of those old Bart.'s men who do not subscribe to the JOURNAL to the fact that since the war began it has been most difficult to keep up with the increasing cost of its production. We are naturally proud of the fact that during the whole period of the war the JOURNAL has appeared regularly each month, and we would ask non-subscribers to help us in this matter. The subscription is comparatively small, being 5s. a year, or £1 1s. for five years.

This appeal is made particularly to newly qualified men who may be taking up outside posts or starting in practice, and with whom we would like to keep in touch through the medium of the JOURNAL.

FOUNDATION OF HOSPITAL AND SCHOOL.

ST. Bartholomew's Hospital will in four years attain the eight hundredth year of its existence. Its principal gate occupies the situation in which it was placed in 1123, the year of its foundation. Richard of Beames, Bishop of London, by whose authority it was dedicated to its present purpose—the relief of the poor and the sick—had been consecrated by St. Anselm and was a chosen Councillor of King Henry Beauclerc. His own energy, aided by the secular power of the Conqueror's son, King Henry, and the spiritual power of Bishop Richard of Beames, enabled Rahere, the founder, to whom all London, and, beyond London, all the world of medicine, is so much indebted, to establish the Hospital which, when sick in Italy, he had vowed to build outside the walls of London. One charter sealed by him in the second year of the reign of King Stephen, 1137, remains the single unchanged relic of his time, the one object which he had actually touched. It is a grant of the benefice of the church of St. Sepulchre. Two seals are attached to it—those of the Prior of St. Bartholomew's church and of the Hospital. The Prior's shows the church, the Hospital's the figure of a brother, perhaps Rahere himself, holding an almsbox, and in the margin the words, "*Sigillum hospitalis sancti bartholomei de smethefeld.*"

This ancient document may be taken as typical of the foundation and its time. The Hospital stood outside the

city wall and its ditch and in view of all going in and out of that part of the city.

It became well known to the citizens, and from the twelfth to the fifteenth century received numerous augmentations to its emoluments from inhabitants of the City and of the neighbouring counties. The hungry were fed, the wretched were consoled, and the sick treated in accordance with the teaching of St. Isidore of Seville, of John Mirfield's *Breviarium Bartholomei*, and of some of the authors known to Chaucer's "Doctor of Physik."

"Deiscorides and eke Rufus,
Old Ypocras, Haly and Galien,
Serapyon, Razis and Avycen,
Averrois, Damascien, and Constantyn,
Bernard and Gatesden and Gilbertyn."

Such was the Hospital life and work of the Middle Ages.

Then came King Henry VIII's attempt to seize the lands and revenues of the Hospital, successfully resisted by the citizens of London. The size of the Hospital was increased, and soon after surgeons were appointed who had been trained and examined by members of their guild. Next, physicians trained in universities and belonging to a learned college became chiefs of the staff. On February 1st, 1664, students of medicine appear as apprentices of the surgeons, having clearly been in existence for some time before, and from this the steady development of the School of Medicine progresses. Harvey was Physician to the Hospital, and it is clear that students had definitely appeared in his lifetime. It continued to develop, and in the next century regular lectures, of which the first were those of Nourse, began to be given.

John Freke, a surgeon learned in obstetrics and electricity, took charge of the beginnings of a museum, and after him Percival Pott, one of the greatest of English surgeons, carried on the traditions of teaching, and after him Abernethy appeared, who firmly established the teaching of anatomy in relation to surgery and of surgery in relation to pathology. His teaching was such that the buildings had to be increased, and in a famous memorandum he pointed out to the Governors the advantage of the school to the patients. He said: "The number of students resorting to hospitals may be considered as an evidence of the good medical practice which they have an opportunity of observing, and of the instructions which they receive in them. This attendance forms also a strong incentive to the medical officers to perform their duties diligently and with skill and science, since their conduct is open to the public expression of praise or censure by these vigilant observers."

These remarks of Abernethy cannot be too much dwelt upon and enlarged. The goodness of the hospital depends on the publicity of the work done within it. The teachers in its wards and out-patient rooms work under the critical eyes of students. They teach the students, whether these are working before taking their degrees, or after, not as

infallible authorities, but as men digging in the same mine and walking on the same paths. It is this openness to criticism and invitation to it which makes the teaching in the wards so valuable—valuable at the same time to the teacher, to the student and to the patient.

RECONSTRUCTION.

1. RECONSTRUCTION IN STAFF.



THE articles from the illuminating pen of Sir Wilmot Herringham have shown that matters are moving in relation to the question of clinical units.

Hitherto the units (or "firms" as they were called almost affectionately) have answered well, and the team- or group-work thus exemplified has shown the manner in which an advance can be made.

Take the old unit of physician, assistant physician, pathological clerk, house-physician, junior house-physician and clinical clerks which so many remember so well, and it can be shown that when all were pulling well together excellent work was done. Then came the time when it was found that a chief assistant was desirable, and, although this appointment was not always made, it was tried sufficiently often to show that it ought to and did prove a most valuable addition to the unit.

In spite of this good work there were, however, some grave defects in inter-relation work. For instance, no definite out-patient department was associated with the in-patient wards; the physician or the surgeon did not have a definite time each week in which to see cases which had been in the wards, cases sent up to him for diagnosis, or cases sent from the ordinary out-patient department with a view to admission. There was not a sufficiently close touch between the wards and the pathological department, and there was hardly any association between such departments as those of anatomy or physiology and the clinical departments.

Then came the war, and all the possibilities of improvement had to wait. Now the war is over and these matters have again been taken up promptly and seriously. Possibilities of "professorial units" and good "team clinical units," and of much greater inter-departmental work are foreshadowed, particularly in Sir George Newman's most suggestive *Notes on Medical Education*. All these require men, time and money, and they will no doubt be forthcoming, and that fairly soon.

Why should there not be a thoroughly manned professorial unit in medicine and in surgery, say with a "professor" and "assistant professor," a first assistant and second assistant, a senior and junior house-physician (or surgeon) and clerks (or dressers), making a team of, say, fourteen men?

Why should not the professor and his assistants have adequate time for teaching and research?

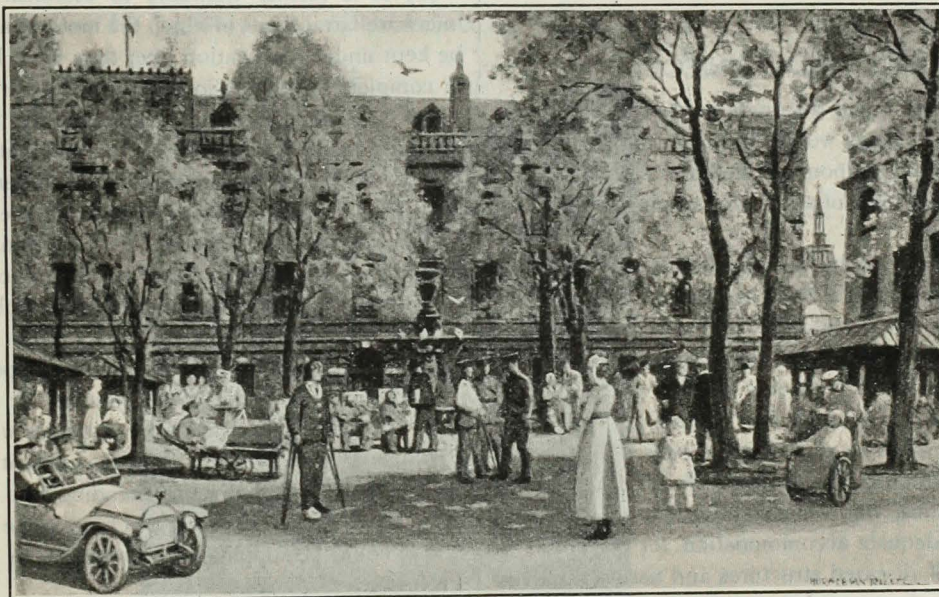
Why should not there be money available to give them opportunities for extra good work?

We believe such will be the group or "firm" of the near future.

A very important question arises in connection with a "clinical professor," or, as he might be called, "director of clinic"—should he be a whole-time man or not? For a physician or a surgeon in London to devote his whole time to teaching and research means he must be paid a real competency. In these days of inflated prices it is difficult to say to what this should amount.

displaced, if ever! The actual contact of the student with the patient is essential, and breeds that type of excellent general practitioner of which we have a right to be proud. But bedside teaching and clinical lectures can be made more thorough even yet.

Take a case, for example, of carcinoma of the rectum—a fairly common disease. The teaching upon such a case, in one or more clinical lectures, might embrace: (1) The development of the rectum and anus; (2) the normal anatomy of the same; (3) the normal histology of the same; (4) a discussion as to the possible causes of carcinoma in this region; (5) the types of carcinoma found here, with museum specimens; (6) the morbid histology



"THE SQUARE," ST. BARTHOLOMEW'S HOSPITAL.

From the original water-colour drawing by Horace Van Ruith (1916).

To debar private practice entirely would deprive him of an important part of his training, and therefore the man appointed to the professorship should preferably have had some years of private work before he takes office.

In addition the ordinary clinical units will have to be elaborated so as to make them the best possible for patients and pupils. Here, again, team-work is highly desirable, and men, and probably money, are required.

2. RECONSTRUCTION IN CLINICAL TEACHING.

It cannot be asserted that the clinical teaching in our School has been bad, or even behind the times. It has been good and fairly up-to-date, but it can be better and quite up-to-date.

Bedside teaching is the bed-rock of British medical education, and may the time be far distant when it is

o. carcinoma recti; (7) methods of examination—digital, proctoscope, sigmoidoscope, barium enema and X-rays, etc.; (8) the spread of carcinoma recti; (9) operative methods of treatment, radical and palliative; (10) prognosis after operation; (11) treatment of advanced cases; (12) conditions causing death of patients suffering from carcinoma recti; (13) post-mortem findings; (14) a discussion as to the prevention of carcinoma recti, and the need for early diagnosis if present.

It is along such lines that a professor would find time and scope for what may be termed super-clinical lectures.

Then, again, the inculcation of a scientific spirit, and the cult of observation, while rightly belonging to all teaching, is apt to be neglected by those whose time for teaching is limited, and whose methods of teaching are, perforce, sometimes hurried.

The teaching also of clinical laboratory procedure in

close connection with the ward is of great value, and by no means adequately provided for.

Education in the after-results of the treatment of disease in in-patients is greatly neglected, chiefly owing to the fact that the ward and the out-patient department are each almost a water-tight compartment.

It must ever be remembered that teaching in a professorial unit is supplementary to that in an ordinary clinical unit, and must never be allowed to take the place of, or allow neglect of, such excellent, though routine teaching.

In a large clinical hospital like St. Bartholomew's it is quite a question as to whether the clinical material is used as fully as it might be for the purpose of the education of the student.

3. OBSTETRICS AND GYNÆCOLOGY.

The establishment of an adequate professorial clinic in obstetrics and gynæcology would, it is felt, afford the best opportunity of improving upon our methods of teaching and of increasing the facilities for advancing original research in these subjects.

The clinic, in order to be adequate, should consist of a Professor or Director, who should be a whole-time man, an Assistant Director, who should devote a certain number of hours each week to the clinic, and two whole-time assistants, in addition to the ordinary resident medical officers. The Professor ought to have under his control at least thirty obstetric and twenty-five gynæcological beds. He should have a clinical pathological laboratory fully equipped for routine examinations, both chemical, bacteriological and histological, and adequate accommodation for the preservation and storage of diseased structures and tissues removed from the operating theatre and post-mortem room, together with a room for housing the notes and records of the Department (with cabinets for a card-index system) and a special library of the clinic.

It will readily be seen that it would not be possible to find room in the Department as it is at present constituted for a professorial clinic on these lines, and that such a clinic is possible only if a special building is provided to house it and if the grant of a considerable sum of money is made.

Until such provision is forthcoming can anything be done meanwhile for the benefit of the patients and students and to facilitate research? The whole question has recently been considered by the Board of Studies in Midwifery and Gynæcology.

OBSTETRICS.

(1) The Obstetrical Department differs from the other departments of the Hospital in that the majority of the patients are not necessarily suffering from disease, but are admitted into hospital for what should be a physiological process. Midwifery is essentially a branch of preventive medicine. It is felt, therefore, that the scope of the *ante-*

natal work of the Department might be enlarged with advantage. One of the four out-patient sessions might be reserved for this work, whereby greater opportunities could be obtained for the study of normal and abnormal pregnancy, and the detection of the earliest manifestations of departure from the normal with a view to the diagnosis and prevention of pathological pregnancy and difficult labour.

At the same time the patients themselves should receive instruction, in order to help them to become good mothers, in the necessity for personal and home hygiene, in the feeding and care of the expected infants, and in the circumstances in which they should consult a doctor during the pregnancy.

(2) It is further desirable to establish a *post-natal* or infant welfare centre, in which the mothers and infants could be kept under observation after they have left the Hospital or completed the lying-in time on the District.

(3) A thorough training of students in the conduct of labour is of great national importance. In order that the material may be used to the best advantage, both to student and instructor, every labour should be conducted in the presence of a senior medical officer of the Department. This opinion found expression at a recent meeting of the Obstetric Section of the Royal Society of Medicine, at which considerable dissatisfaction was felt that this important part of the subject was not taught as a rule by the one most competent to do so. Unfortunately it is not often possible for the visiting physician so to time his visit that it coincides with the arrival of the infant. The remedy lies in the appointment of a whole-time medical officer of senior standing who would always be available. If the professorial clinic came into being such a man could be supplied from among the assistants to the Professor.

But if a professorial clinic is not possible within the Hospital, it has been suggested that separate maternity hospitals should be taken over or established and run on the lines of the professorial clinic.

GYNÆCOLOGY.

(1) A closer association between this Department and others of the Hospital should be established. As an instance, consider the X-ray or radium treatment of uterine hæmorrhage. Each case should be seen in consultation between a member of the X-ray and the Gynæcological Department, the frequency and number of applications and the dosage should be discussed, and the clinical progress of the case watched by both. Similarly, in a pathological investigation the case should be discussed at the bedside by the gynæcologist and pathologist in consultation. When a physiological problem arises the physiologist should be called in consultation.

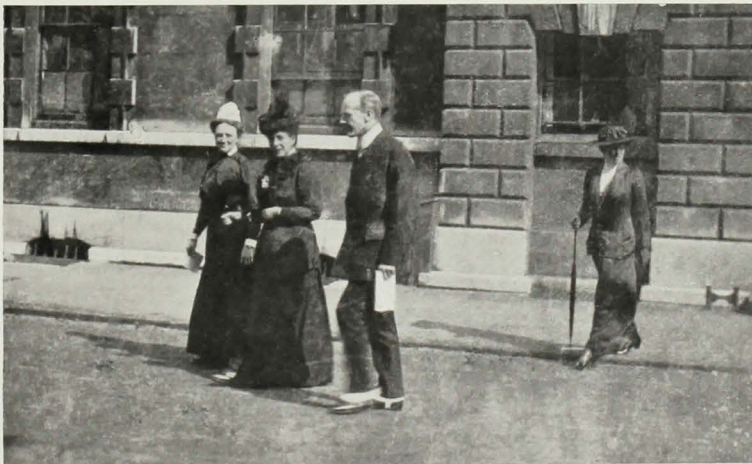
(2) Further, a closer association is called for not only between this and other departments but between the various portions of the Department itself. For example, a patient



H.M. THE QUEEN, H.R.H. PRINCESS MARY, THE TREASURER.



LITTLE BRITAIN GATE, SHOWING SCARS FROM ZEPPELIN BOMB.



H.M. QUEEN ALEXANDRA, H.R.H. PRINCESS VICTORIA, THE MATRON, THE CLERK.

who has been attending as an out-patient should, on entering the ward as an in-patient, be accompanied by her out-patient notes, in which her history is recorded, together with the clinical findings at previous examinations, and a record of what drugs have already been given, with their effects noted.

Similarly, on leaving hospital and transfer to the Out-patient Department these notes should again be available, with a record of the treatment adopted while the patient was in the ward.

(3) It is felt that the present arrangements for carrying on the pathological work of the Department might be still further improved upon by the provision of a special laboratory on the lines indicated for the professorial clinic, or failing this by the setting aside of a portion of the present laboratory if it were possible. It is felt also that the best use is not being made of the material. All structures removed from the operating theatre or the post-mortem room should be preserved entire for investigation in the Department, and a weekly demonstration (both macroscopic and microscopic) be instituted.

(4) Finally, the Department should have its own Registrar as an officer separate from the Midwifery Tutor. When the work of the Department is in full swing the Tutor has so much of his time occupied by routine work that he is unable to carry out original research to the best advantage. Were his duties shared by a Registrar, who, together with the Tutor, should be paid an adequate sum, it would be to the benefit of the Department.

4. RECONSTRUCTION IN PATHOLOGY.

The Pathological Department is a comparatively new feature of the Hospital, having been in existence little more than twenty years. It might hence be thought in little need of reconstruction, and indeed it presents many valuable elements which one would be sorry to see altered. The system of pathological clerkships is one which it would be difficult to improve upon, save perhaps that care might be taken to ensure closer contact on the part of the clerk with the ward case from which his material comes. Again, as a training ground for the man who aspires to a post on the medical or surgical staff the Pathological Department would be hard to beat.

Nevertheless, the progress of the last twenty years has rendered certain changes in the Department advisable and even necessary. Pathology is now a profession in itself, hitherto worse paid than medicine and surgery, but no less honourable, and to men of the requisite bent fully as interesting and agreeable. The time seems now to have come when the Hospital should no longer be content to regard the Pathological Department merely as a transient training-ground for its younger physicians and surgeons, invaluable though such training may be for them, but should also

endeavour to use it for the training of men who wish to make pathology their career in life. To accomplish this two things are necessary. Provision must be made not only for temporary demonstratorships for clinicians, but also for more permanent posts for those who desire to remain pathologists. And these latter posts must be paid on such a scale as to enable men to become pathologists without too great a financial sacrifice.

Again, pathology has developed along many lines. No one man can now hope to become equally competent as a morbid anatomist and histologist, a bacteriologist, an experimental pathologist and a pathological chemist. It has hitherto been a feature of our Pathological Department that these branches have not been divided up into water-tight compartments, but that those in training there have done something in most of the subjects. Up to a point this has doubtless been a good thing; it has preserved a certain unity and perspective in pathology, and it has made the Department a broader and better training-ground. For those who are merely passing through it for a year or two some degree of this absence of specialisation can doubtless be maintained, and it is desirable that those who are teaching clinical pathology should be all-round pathologists. But for those who intend to remain pathologists some degree of specialisation is now imperative, and it is probable that the time has arrived when the more permanent officers of the Department should be men devoting themselves each to a special branch of the subject. In the case of chemical pathology this is already an accomplished fact, but we equally need the specialised bacteriologist and the morbid anatomist and histologist. The latter may well be permanent Curator of the Museum—a post which has long urgently needed filling.

It is certain that such changes as are here indicated, though they will cost more money, will greatly advance the efficiency of the Pathological Department. The clinical material from the wards will receive more expert examination, and the practical teaching of the students will be more satisfactorily carried out. Nor need it be supposed that such increased specialisation in pathology will involve any sacrifice on the part of the clinical curriculum. Pathology, medicine and surgery advance as a whole; and if pathology has been named first of the three it is because it is inseparable from the others, and forms the basis upon which they must rest.

5. RECONSTRUCTION IN INTERMEDIATE TEACHING.

ANATOMY.

The most urgent need of our Anatomy Department is not a matter of local reconstruction, but is one that is shared by all the anatomical schools in the country, namely, the want of an adequate supply of material. Since 1832, when it

became law, the Anatomy Act has for the most part failed to secure the facilities for dissecting and operative surgery work which it was meant to do. Recently many efforts have been made to have the precarious conditions of anatomical supply improved, and it is hoped that they may soon be crowned with success. In these efforts several members of our Hospital have taken a not unimportant part.

The chief function of the Anatomy Department must always be to furnish and direct the students' opportunity of gaining a first-hand knowledge of the details of the human body by dissection. The present inadequate supply of material makes it necessary for two students to share a part; and, while this has certain advantages if they always work systematically together, it has the great disadvantage that half the requisite experience in handling instruments and displaying structures, and half the individual training in accurate observation, is lost, and the laudable "pride in a part" is more difficult to foster.

Important additions to the main work of the Department which are in contemplation are systematic demonstrations of surface anatomy on the living model, and of bones and viscera by means of departmental X-ray apparatus.

While the present Dissecting Room is adequate and excellent in many respects, several improvements are required in the Department: (1) A reading room, with which might be combined a bone room equipped with a full set of well marked human and comparative specimens; (2) a laboratory for practical embryology and elementary histology; (3) a room to serve the double purpose of demonstration on the living model and X-ray demonstrations; while those who have had business in these places know that the Lecturer's and Demonstrators' Rooms lack accommodation. The Lecture Room is in need of a better set of blackboards and an epidiascope.

With regard to staff, at least one whole-time demonstrator is required in addition to the part-time demonstrators, through whom valuable touch is kept with the practical applications of anatomy.

The whirligig of time and experience has exposed some disadvantages in concentrating the teaching and examinations in anatomy on the end of the second year. In former times anatomy was one of the subjects included in the Final examination, and to-day advocates are to be found for the principle of spreading the teaching over the fourth and fifth years in addition to the second and third. But any drastic change in the place of anatomy in the curriculum can only take place if a common plan be agreed on by the Universities and Examining Boards as a whole. Meanwhile the institution of a lectureship on applied anatomy, to be held by an experienced demonstrator, who would conduct a systematic course throughout each term, would effect a valuable *liaison* between junior and senior years.

Much more might be done in the way of using the

Anatomy Rooms and Staff for medical and surgical consultations; given an adequate supply of subjects and reasonable notice, special dissections might be prepared to demonstrate to clinical classes important anatomical points involved in particular cases.

Another important *liaison* which might be carried out in the case of students engaged in the dissection of the thorax and abdomen is that they should be given an opportunity, at least once in the course of that study, to examine and handle the viscera available in a fresh state in the post-mortem room.

PHYSIOLOGY.

The maintenance of health depends not merely on the normal functional capacity of the individual organs of the body, but also on a constant and delicate adjustment and regulation of the functional activity of the different parts of the body; and it is the disturbance or the annulling of one or more of these regulative processes which constitutes the essence of disease. Further, the process of recovery from disease is brought about sometimes by the recovery by an organ of functional power which has been temporarily in abeyance, sometimes by the restoration of regulative adjustments, and sometimes by the compensatory exaggeration of adjustments and adaptations, which, though normally possessed by the body, are usually evoked to a comparatively limited extent. All these changes, when they occur, are brought about by the body itself—the so-called *vis medicatrix naturæ*—and the art of the physician lies, not in restoring the normal functions of the body (for this is beyond his power), but in providing the conditions under which the body can most effectively and rapidly cure itself.

It is evident, therefore, that a wide knowledge, both of the principles underlying the normal working of the body and of the many adjustments which it possesses (in other words, a knowledge of physiology), is necessary if the physician is to understand the significance of the symptoms which he observes, and to profit by his experience in the treatment of disease. Moreover, the physician whose medicine rests upon the sure foundation of scientific knowledge is not only better equipped than the pure empiricist for the treatment of the individual patient, but he possesses the inestimable advantage that his knowledge of medicine is living, progressive and productive instead of being sterile and stagnant. Physiology, in short, lies at the root of medicine, and the advancement of medicine is indissolubly bound up with the progress of physiological knowledge.

The principles just enunciated are so obvious and, except among the backwoodsmen of the medical profession, so generally accepted as almost to have become platitudes; and, from this point of view, the problem which the "reconstructionist" has to face is a purely practical one, namely, in what way can the future medical practitioner be most efficiently taught to apply to the study and treatment

of disease the physiological principles which he learns first, and to build up his knowledge of medicine on a rational basis.

Under the present system the student enters—or should enter—the wards with a fair grasp of the more important adjustments and regulative processes possessed by the body, and of the part which these play in the normal life of the body. In the acquisition of this knowledge the student has to learn a great many facts which are of value only in so far as they assist him to understand fundamental principles, and which he can with advantage forget later. But it is not always sufficiently realised that, without this “spade-work,” the student’s knowledge of principles which are vital to him later would be so vague and shadowy as to be valueless, and that the time now allotted to physiology in the curriculum is all too short for this purpose. At this stage, moreover, it is practically impossible to teach to the student the practical application of the principles which he is learning, because he lacks the clinical training necessary to enable him to understand such teaching.

It is therefore during his clinical training, and as a definite part of this training, that the student must be shown how to correlate his physiological knowledge with his clinical experience. A student, for example, enters the wards knowing that dyspnoea is caused by a change either in the reaction of the blood or in the excitability of the respiratory centre, or in both of these factors, and perhaps knowing also that these changes may originate in some disturbance of the respiratory or circulatory system or of the kidneys. Supposing the student to be confronted with a patient who is dyspnoeic, what is the best means of teaching him to apply this knowledge to the observation and interpretation of this and other symptoms, and to arrive at a rational conclusion as to the real nature of the morbid condition existing in the patient? Although he must of necessity rely primarily on his clinical teacher, there is a growing movement in favour of carrying on the teaching of applied physiology throughout the entire period of clinical training, and of including it in the final examination. The precise form which such teaching should take remains uncertain, but one plan would be a short course for each student dealing first with the adjustments normally at work in, for instance, the circulatory system, and then with the way in which these adjustments are utilised in maintaining the circulation in the face of conditions of disease. The student ought then to be able to adopt the same method in studying other forms of disease. In all probability such a course would be most advantageous if given by the clinician and the physiologist acting in concert, since the physiologist usually lacks clinical experience, and the physician is not always in touch with recent physiology. It may be that other methods may prove more satisfactory, but, whatever the method, the object is to bridge more securely the gap between the principles on which medicine is established and the practical application of those principles.

From this point of view, the most fully equipped teacher is a man who, on the one hand, has the necessary clinical experience, and, on the other hand, is actually engaged in research upon some of the problems which he meets in the wards. Many of these are physiological, and can be most successfully attacked in the laboratory by experiment; and the encouragement of physiological research among the younger qualified men, and especially among those who intend to become clinical teachers, is a most important factor in the advancement of scientific medicine. Research is the most direct road to real knowledge, and a man who spends even a year, not in teaching physiology, but in experimentally applying his physiology to some problem possessing a practical bearing on medicine, gains an insight into the real working of the body which will always be of the utmost value to him. A sufficiency of such men in the wards will gradually leaven the whole lump, and it is from men of this type that our future professors of medicine will be chosen.

Apart from the question of teaching, considerable development has taken place during the last few years in the direct application of purely physiological methods to the diagnosis of disease in the wards. In diabetes, for example, analysis of the patient’s alveolar air may give valuable information as to the imminence of coma, and the same method applied to various types of dyspnoea has thrown light on their causation. The application of such methods constitutes what may be termed clinical physiology, and, although its range is limited, there is no doubt that clinical physiology will play an increasingly larger part in the work of the wards, and that in this way physiology and clinical medicine are gradually being brought into closer touch with each other.

6. RECONSTRUCTION IN EQUIPMENT.

It is proverbial that bad carpenters complain of their tools, but it is equally true that frequently good carpenters are forced to use bad tools.

For teaching, both clinical and theoretical, good equipment is essential for good results.

Instruction is received not only through the ear, but also by the eye, by touch, and even by smelling and tasting, and any apparatus which renders perception by the organs of these senses is most valuable in education. Hence the epidiascope, the cinematograph, X-ray apparatus, cystoscope, œsophagoscope, the electro-cardiograph, and many another instrument of projection or of investigation are not only to be desired, but are essential at the present time in any well-equipped medical school. That our wards, laboratories, out-patient rooms, lecture theatres, and physiological, anatomical and other departments repeatedly require re-furnishing on these lines goes without saying, but apparatus of this type is expensive, and its upkeep and repair an ever-increasing source of expenditure.

In an up-to-date medical school money must be found for this purpose, and it is again with considerable interest that teachers have read Sir George Newman's suggestions and prophecies.

It is possible that a large lecture theatre, often maintaining avoidable waste of space, should be internally reconstructed so as to become much more compact, and often thereby more comfortable and more suitable for lecture purposes. Frequently in a theatre more or less devoted to clinical lectures no proper means of demonstrating patients are provided, and the demonstration is more or less of a farce.

When fresh equipment is determined on, it is of the utmost importance that it should be the best obtainable, for in the end the best is the cheapest, for it serves its proper purpose and lasts longest.

7. RECONSTRUCTION IN NURSES' HOME AND TEACHING.

HOUSING.

It has always been the proud and rightful boast that the training of nurses at St. Bartholomew's has been good.

It cannot, however, be said that the housing of the nurses upon the Hospital site has been other than deplorable for many a long year. The time has come when the quarters occupied by the nurses must be reconstructed, and the need for reconstruction is obvious from the following. At present the nurses are accommodated in scattered buildings which stand within the Hospital precincts. At the south-west angle they live in houses which were once the homes of the vicar of the parish, of the apothecary, and of a clerk of the Hospital. A building at the northern corner of the Smithfield front supplies rooms for a few more. Others are lodged in the eastern end of the old College. A fourth contingent dwells in the houses which extend from near the Little Britain Gate towards the Post Office; while a fifth occupies the lofty buildings of what was the Mathematical School of Christ's Hospital. The mere fact of the irregular distribution of these buildings is a serious interference with their usefulness as residences for persons whose duties require their habitat to be certainly known and easily found. Moreover, they enjoy less light, air and quiet than could be obtained in a building carefully planned for a nurses' home. Such a building should have all the modern appliances for labour-saving, for sanitation, and for health. All parts of a new and thoroughly thought-out building could be kept clean and easily heated, and the cost of running it would be proportionately much less than that of numerous scattered dwellings.

A scheme has been successfully launched for the erection of a home capable of accommodating 400 sisters and nurses and 100 female domestic staff. It will provide the former in a practical way with all the necessities and comforts

which ladies in training to become nurses should have. Such a home must cost a considerable sum, and it is believed that to build wisely and well, but not extravagantly, at least £150,000 will be required. This amount must come from those who believe in the value of nurses, and from those who owe a debt of gratitude to a trained nurse for themselves or others.

TRAINING.

Up till recently a probationer has usually been sent straight into a ward without any preliminary instruction or training. She is at once set to do things and deal with patients without those general principles upon which scientific nursing is based, and is largely at the mercy, to begin with, of other nurses often but little more experienced than herself. Frequently she may pass through a period of "stage-fright." She finds the work hard, possibly uncongenial, and often she has to attend lectures at the end of a day's toil, with little or no pleasure. Further, there is in many hospitals an examination in the preliminary subjects at the end of the first year of practical training. Practical experience is hampered by the constant drag of an examination in view. These drawbacks could be overcome by the following:

(a) A preliminary examination in general knowledge before entrance.

(b) A three months' course at the Hospital, for which a moderate fee should be charged. Such a course would include twelve lectures on anatomy, twelve lectures on physiology, and twelve lectures on hygiene, each series to be given by the heads of these departments in the Medical School; half a dozen lectures on the principles of nursing and of hospital administration, to be given by the Matron or a "sister-tutor"; and a short practical course in bandaging, etc.

(c) At the end of this preliminary course a qualifying examination is needed, and the names of those who pass this should be placed upon a waiting list, from which probationers are chosen as vacancies arise. Those who fail might be allowed to attend a second course without fee, and be given a second examination, but if they fail in this second test they should be dismissed.

(d) The successful candidates would pass into the wards, and, having been already instructed on sound principles, will be concerned henceforth solely in putting them into practice. Later courses of lectures would include more advanced nursing, and those parts of medicine, surgery and special subjects about which a nurse must have a sound knowledge.

(e) At the end of three (or perhaps four) years a final (certificate) examination would be held.

A nurse acts under a medical practitioner, but even so her responsibility in the present day is great. A good nurse, with a good medical practitioner, saves many lives,

and a good nurse implies one who has been thoroughly trained.

The foundation of a "College of Nursing" is a step in the right direction, and the suggested introduction of "sister-tutors" cannot but tend for good.

CONCLUSION.

The possibilities of the future, and chiefly through sound, well thought-out reconstruction, are large, and it is for the Medical School and the Nursing School of St. Bartholomew's Hospital, whilst inheriting such splendid traditions from the past, to be prepared for greater and grander purposes in the future.

Our School mottoes point the way, for, while "Art is long and life is short," much can be accomplished if "Whatsoever thy hand findeth to do" is done with thy might. So be it!

RETURN.

T SUPPOSE that every man who returns from abroad, his war-labour ended, is greeted with the question, "Well, are you *glad* to get back?" The correct *riposte* to this conversational opening is a little difficult. The easy answer, "But of course I am," which for the first few days comes spontaneously and without reflection is true no doubt; but it has a double defect: it damps down effectually that approach to conversation, and it is certainly an economy of truth. For with few exceptions I imagine that most men, at least in our profession, feel a pleasure not unmixed with regret on their return. A friend of mine who himself has felt the difficulty has, I believe, diagnosed correctly the chief cause, when he observed that "We were devilish lucky, you and I, to have had this break in the routine of our lives." That, at any rate for the older among us, is an explanation in part of our inability to feel the unmixed delight which our friends seem to expect. We ought to be overjoyed at the termination of our exile, but even while we tell them that we are glad, we are rather shamed to know that we are not so glad as we would have them believe.

Here at home we live an ordered life, knowing that no day is likely to bring with it new untried experiences, or unusual event. Our work is planned days, weeks, or even months ahead; our pleasures are packed tightly into the crevices of the ordered plan; we shall rise, be surrounded from morning to evening with the arts and also the crafts of civilisation, and when our day is spent go to sleep with the knowledge that "to-morrow and to-morrow creeps in this petty pace from day to day." Whereas "out there"—France, Salonika, Mesopotamia, India, Africa, Asia, it does not matter where in the world—each day had possibilities of surprise, of joy, of pain, of delight, of discomfort,

of the meeting of old friends, the forging of new ties, all in measure pressed down and running over; in fact, Routine, that tyrant of our lives at home, sank into insignificance. So that the honest answer to the question cannot be compressed into a brief acquiescence. We must go back to our school days, or even earlier, to our days of childhood, to find a parallel to these feelings, when life held all its surprises in store, and lavished them day by day—before custom lay upon us "with a weight heavy as frost."

So while we re-enter our ordered life with the pleasure with which we greet an old friend, yet we cast a lingering look to those days when every hour was "a bringer of new things," and we bend to the yoke of custom with a sigh for the past days, in which we old men renewed our youth, and the young men stored memories and experiences which will help them in their turn to bear without too much repining the burden of the years.

H. T.

REVIEWS.

THE INTENSIVE TREATMENT OF SYPHILIS AND LOCOMOTOR ATAXIA BY AACHEN METHODS. By REGINALD HAYES. Third Edition. (Baillière, Tindall & Cox.) Pp. viii + 92. Price 4s. 6d. net.

Now that it is no longer possible—and certainly not desirable even if it were possible—to send patients to Aachen, a detailed account of the methods employed in the treatment of syphilis will be welcome. The author gives a very clear account of the combined treatment of sulphur water internally and the daily inunction of mercury. Such treatment can quite well be carried out in this country, and providing the rubbing is systematically done the results are certainly very striking, especially in cases of syphilis of the central nervous system.

Reference is made to the use of salvarsan, and emphasis laid on the necessity of using mercury for a long period of time as an adjunct.

The four illustrations depicting the correct position of the patient during inunction add considerably to the value of the book.

ESSENTIALS OF MEDICAL ELECTRICITY. By ELKIN P. CUMBERBATCH. Fourth Edition. (Henry Kimpton.) Pp. 368. Price 7s. 6d. net.

The present edition has been thoroughly revised and many parts have been rewritten. The chapter on "Medical Ionisation" has been extended so as to include those diseases of women for which treatment by the ionic method is especially indicated.

An extremely interesting chapter is devoted to "Diathermy"; its uses in both medicine and surgery are dealt with in a most able manner.

Much new matter has been incorporated in the chapter on the "Electrical Testing of Muscle and Nerve," which also includes a note on the physiological and pathological principles underlying the subject.

There are several other additions as well as a number of new illustrations.

The book is very readable, and eminently suited to the needs of both student and practitioner.

ELEMENTS OF SURGICAL DIAGNOSIS. By Sir ALFRED PEARCE GOULD and ERIC PEARCE GOULD. Fifth Edition. (Cassell & Co.) Pp. 722. Price 12s. 6d. net.

In order to keep this work to a size which will conveniently slip into the pocket, and at the same time include much new data, the authors have considerably reduced the introductory matter. This we regard as unfortunate; it is a section of the book which should have been added to rather than curtailed.

Several new radiographic reproductions have been included in this edition, the majority of which are excellent. New matter: such subjects as "Gas Gangrene" and "Causalgia."

While the student will find in this volume much that is of value, we cannot confidently recommend the book for routine work. Diagnosis is most important, treatment equally so, and the object of the student should be to combine the two. It is on these grounds that we justify our statement regarding its value as a text-book.

CORRESPONDENCE.

A STATE MEDICAL SERVICE.

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

SIR,—As an example of what we may all be reduced to one day under a State Medical Service, I send the following extracts from a printed petition sent by the Sub-Assistant Surgeons to the Inspector-General of Civil Hospitals, Burma.

"The Humble Memorial of ———, Sub-Assistant Surgeon,

"Most Respectfully Sheweth:

"That the promise of a favourable consideration that was given to the Memorial submitted by the Members of the Sub-Assistant Surgeons' class in the year 1914, having not been even in the distant vision of fulfilment after a lapse of four years, your Memorialist submitted a reminder in the early part of 1918, the pressing need of which action was then plainly detailed.

"That the reasons adduced for the increment so late as 1914 stand now vivified with unquestionable assertion.

"... That when all the Provinces have generously bestowed the boon of increment spontaneously in the midst of war, and all the increases being a perceptible long jump quite unthought of and unexpected, your Memorialist feels depressed and dejected to find that the Province which was always the first to set examples to others in the granting of boons and in the redress of grievances, has become the last to hear the prayers of your Memorialist's class, keeping the Memorial pending indefinitely for five years.

"That the meagre pay now granted to your Memorialist's class acts detrimental to making the Rangoon Government Medical School popular, with the result that very few are attracted to fall into the miserable lot of your Memorialist.

"... The necessity of revising the old order of things to make the future of the students bright and prospective traces itself in bold relief.

"That while emphasising the fact that the struggle to maintain his life is getting keener and harder, and that his case has to be looked into early, your Memorialist begs the grant of a scale of pay ranging from Rs. 150 to Rs. 350 per mensem, ... which will meet the pressing needs of your Memorialist, and go to make his life worthy of existence in the Medical world.

"For which act of kindness your Memorialist shall ever pray.

"——— L. M. P.,

"Your Humble Memorialist,
"Sub-Assistant-Surgeon."

Under a State Medical Service at home will life be "worthy of existence in the Medical world?"

Yours faithfully,

L. B. CANE,

Capt. R.A.M.C.

O.C. INDIAN STATION HOSPITAL;

MEIKTILA, BURMA.

February 11th, 1919.

EXAMINATIONS, ETC.

UNIVERSITY OF CAMBRIDGE.

The degree of M.D. has been conferred upon G. A. Smythe.

UNIVERSITY OF LONDON.

First Examination for Medical Degrees. March, 1919: Pass List.

Trevor Davies, J. W. Poole, P. Thwaites.

Second Examination for Medical Degrees. March, 1919: Pass List.

Part I: Organic and Applied Chemistry.—R. S. Anderson, R. T. Bannister, G. L. Brocklehurst, C. O. S. B. Brooke, E. A. Coldrey, S. C. Cruden, M. Erfan, P. C. C. Garnham, C. F. Harris, J. P. Hosford, C. M. Jennings, R. Keene, J. H. R. Laptain, A. C. Maconie, G. S. Morgan, D. A. Robertson, B. M. Tracey, A. H. C. Visick, R. H. Wade, A. Walk.*

* Awarded a mark of distinction.

Part II: Anatomy, Physiology and Pharmacology.—F. C. W. Capps, K. H. Doouss, L. M. Jennings, W. E. Lloyd, D. M. Lloyd-Jones, G. J. V. Nelken, F. P. Schofield, G. J. Sophianopoulos, E. W. C. Thomas, R. A. Walsh.

APPOINTMENTS.

CUMBERLIDGE, W. I., M.B.(Cantab.), F.R.C.S., Capt. R.A.M.C., appointed Honorary Surgeon to the Leicester Royal Infirmary.
NUTTALL, W. W., M.D.(Durh.), appointed Certifying Surgeon under the Factory and Workshop Acts for the Folkestone District.

CHANGES OF ADDRESS.

BARRIS, J. D., has returned to 50, Welbeck Street, W. 1. (Tel. Mayfair 1751.)
BURROWS, Col. H., A.M.S., Consulting Surgeon to the Army of Occupation, c/o D.M.S., Cologne.
COUCHMAN, H. J., 4, Downing Street, Farnham, Surrey.
DOWNER, R. L. E., 32a, St. Aubyn's, Hove, Sussex.
EVANS, GEOFFREY, 37, Queen Anne Steet, W. 1. (Tel. Mayfair 5011.)
FRY, A. P., Knightwick, Worcester.
HOLTHUSEN, A. W., 583, London Road, Westcliff-on-Sea.
HOWELL, B. WHITCHURCH, 35, Weymouth Street, W. 1.
HUMPHREY, A. M., Horham Hall, Thaxted, Essex.
LUCAS, ALBERT, 141, Great Charles St. (Newhall Street), Birmingham.
MATTHEWS, Lieut.-Col. E. A. C., D.S.O., V.H.S., I.M.S., No. 5, Indian General Hospital, Port Tewfik, Suez, E.E.F.
SMYTHE, G. A., Buckingham House, Winchester.

BIRTHS.

PHILLIPS.—On March 28th, at Newstead, Waterloo Park, Liverpool, the wife of Lionel L. Phillips (late Capt. R.A.M.C.), grandson of the late Lewis Phillips, of Winchmore Hill, and son of the late Walter J. Phillips, J.P., of Totnes, Devon, of a son (Lewis).
SEWELL.—On March 20th, at Coonoor, India, Dorothy, the wife of Capt. R. B. Seymour Sewell, I.M.S., of a daughter.

DEATHS.

BRIGSTOCKE.—On February 12th, 1919, at a nursing home, Richard Wish Brigstocke, of the Old Rectory, Scole, Norfolk, and formerly of Beyrout, Syria, beloved husband of Elizabeth Brigstocke for fifty-three years, aged 80.
BUTCHER.—On January 10th, 1919, at Holyrood, Cleveland Rd., Ealing, W., W. Deane Butcher, M.R.C.S., aged 71.
GRIFFIN.—On April 1st, 1919, at Mundesley, Norfolk, John Purser Griffin, M.R.C.S., L.R.C.P., late of Baldock, Herts., third son of the late James Griffin, Esq., J.P., and Mrs. Griffin, of Southsea.
LEFTWICH.—On March 25th, 1919, Ralph Winnington Leftwich, M.D., C.M.(Aberd.) of 36, Ebury St., Eaton Square, London, aged 70.
MANTON.—On February 4th, 1919, at Shrewsbury House, Park, Sheffield, from pneumonia following influenza, John Albert Manton, M.R.C.S., L.R.C.P.
NESHAM.—On February 5th, 1919, at Ellison Place, Newcastle-upon-Tyne, Robert Anderson Nesham, M.R.C.S., L.R.C.P.
STOCKER.—On March 27th, 1918, reported "missing," now presumed killed, flying near Dompierre, Flight Sub-Lieut. Edward Cuthbert Stocker, R.N., younger son and only surviving child of Major E. G. Stocker, R.A.M.C.T., and Mrs. Stocker, Carn Brea, Cornwall, aged 18½.

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.

St. Bartholomew's Hospital



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

JOURNAL.

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JUNE 1ST, 1919.

[PRICE SIXPENCE.

CALENDAR.

Fri., May	30.—Dr. Calvert and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Calvert.
Tues., June	3.—Dr. Fletcher and Mr. R. C. Bailey on duty.
Wed., "	4.—Clinical Lecture (Surgery), Mr. Waring.
Fri., "	6.—Sir Wilmot Herringham and Sir Anthony Bowlby on duty. Clinical Lecture (Medicine), Sir A. E. Garrod.
Tues., "	10.—Dr. Tooth and Mr. D'Arcy Power on duty.
Wed., "	11.—Clinical Lecture (Surgery), Sir Anthony Bowlby.
Fri., "	13.—Sir A. Garrod and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Tooth.
Tues., "	17.—Dr. Calvert and Mr. McAdam Eccles on duty.
Wed., "	18.—Clinical Lecture (Surgery), Mr. Girling Ball.
Fri., "	20.—Dr. Fletcher and Mr. Bailey on duty. Clinical Lecture (Medicine), Dr. Fletcher.
Tues., "	24.—Sir Wilmot Herringham and Sir Anthony Bowlby on duty.
Wed., "	25.—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri., "	27.—Dr. Tooth and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine), Sir Wilmot Herringham.
Tues., July	1.—Sir A. Garrod and Mr. H. J. Waring on duty.
Wed., "	2.—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri., "	4.—Dr. Calvert and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Fletcher.

EDITORIAL NOTES.

ITH the very deepest regret we have to record the death of Mr. Arthur Watkins, for twenty-four years Steward to the Hospital.

No officer of the Hospital ever had its welfare more at heart, and if ever a man died in harness it was he.

The amount of work he got through was tremendous. There is no doubt that the strain, especially during the period of the war, hastened his death. By night and day he was ever ready to attend to convoys, and the well-being of our wounded soldiers was always his first consideration. It is no exaggeration to say that the Steward was loved by all, and his memory will linger for many years to come.

By a happy chance we are able to publish a photograph which in a way is historic, showing as it does the Steward seeing the last of the soldiers off from the Hospital.

Mr. Wilfred Watkins, Curator of the Surgery, and his sisters ask us to thank the numerous friends, particularly members of the Staff, who have written expressing their kind sympathy, as they find it quite impossible to acknowledge all the letters individually.

* * *

The Hospital was again favoured with the most perfect weather on the occasion of the Annual View-Day, which was held on May 14th. The attendance was hardly as large as we have seen, but the renewal of so many acquaintances, the revival of the dainty teas in the Wards, and possibly the fact that no longer was the Hospital subject to visits by enemy aircraft, made the afternoon a particularly happy one.

We are publishing elsewhere in this issue a description of the preparations which the Nursing Staff make on these occasions. The time-honoured inspection of the Wards by the Hospital officials also affords copy for our modern Shakespearean contributor.

* * *

It is most pleasing to see the Hospital getting back to pre-war conditions, especially as far as the social side is concerned. The Cricket Club is well under way, and two elevens are playing regularly every week. The Rifle, Swimming, Boxing and Tennis Clubs all show promise of having a successful season. We are very delighted to learn that the Musical Society is again in evidence. Under the energetic secretaryship of Mr. Hilton practices have already begun. This is one of the few—we almost said very few—social functions where the Nursing Staff can co-operate, and we look forward to a really first-rate concert in the not distant future.

* * *

The first Annual Dance since 1914 was held at Prince's Galleries on Friday, May 23rd.

The complete success of the evening was largely due to Mr. E. F. Peck and the two committees, who have worked very hard, and are to be congratulated on the result of their efforts.

The company numbered just over 300, and it is expected that a substantial surplus will be available for the New Nurses' Home. The success of the evening was greatly added to by Mr. Joyce's band, which was ever ready to give encores, and naturally the vivacious music contributed very largely to the pleasure of the dancing.

In the earlier part of the evening Mrs. H. J. Waring, President of the Ladies' Committee, was presented with a bouquet of roses.

* * *

We are asked to state that the Annual Past and Present Cricket and Tennis Matches will be held at Winchmore Hill on Wednesday, June 11th. The Artists Rifles' Band will be in attendance, and tea will be provided. A large gathering of Past and Present Bart.'s men is expected.

* * *

Our congratulations to the following St. Bartholomew's men on their election to the Fellowship of the Royal College of Physicians of London: Dr. G. A. Auden, Dr. A. E. Gow, Dr. P. Hamill, Dr. F. P. Mackie, and Dr. A. E. Naish.

* * *

It gives us much pleasure to congratulate Temp. Capt. (Act.-Major) A. Richmond, M.C., on being awarded a Bar to this decoration, and Lieut. E. R. Batho on receiving the Military Cross.

* * *

We are pleased to see that Lieut.-Col. T. H. Foulkes, I.M.S., has been brought to the notice of the authorities for gallant and distinguished services in connection with operations at Aden.

* * *

Our warmest congratulations to Mr. J. A. C. Forsyth, F.R.C.S., on receiving the Jacksonian Prize for the year 1918 for his dissertation on "Injuries and Diseases of the Pancreas and their Surgical Treatment."

* * *

The Treasurer's report for the year 1918 is just to hand, and contains several interesting items in connection with the Hospital.

It is with very great pleasure that we learn that H.R.H. the Prince of Wales has consented to become President of the Hospital. This office was vacated by His Majesty King George V when he became Patron of the Hospital on his accession to the Throne.

Another most gratifying item of news is that Her Majesty Queen Mary has graciously intimated her willingness to allow her name to be used in connection with the new Nurses' Home which is shortly to be built, and which will be known as "Queen Mary's Home (or Hostel) for St. Bartholomew's Nurses."

One of the first steps in Reconstruction, to which we gave such prominence in our last issue, is the establishment of an Out-patient Department in Psychological Medicine. The Department, which is under the direction of Sir Robert Armstrong-Jones, M.D., was opened on May 1st, and will be conducted on lines similar to those in other special departments.

* * *

We desire to remind old Bart.'s men of the memorial funds on behalf of the dependents of the late Mr. Harry Blakeway. Though suffering an initial disadvantage owing to the previous appeal of a very similar and sad need, the Fund, we are pleased to learn, is making good progress; Capt. A. Macphail, Anatomy Rooms, Treasurer, will gladly receive further donations.

* * *

The Committee of the Stansfeld Fund hope that anyone still intending to subscribe will do so before June 30th, on which date it has been decided to close the list.

Subscriptions may be sent to the Treasurer, Prof. F. W. Andrewes, the Pathological Department.

* * *

We understand that a Committee has been formed for the purpose of considering the question of a memorial to the officers and men of all branches of the R.A.M.C. who have fallen in the war. St. Bartholomew's is to be represented on this Committee by Sir Norman Moore, Bt., P.R.C.P., Major-General Sir Anthony Bowlby, K.C.M.G., K.C.V.O., C.B., A.M.S., and Maj. E. B. Waggett, D.S.O., R.A.M.C.T.

* * *

The following gentlemen were nominated to the Resident Staff commencing May 1st, 1919:

House-Physicians—

Sir Wilmot Herringham.	J. B. Hume.
	G. F. P. Gibbons.
Dr. Tooth.	A. G. Williams.
	C. E. Kindersley.
Sir A. E. Garrod.	H. W. C. Vines.
	H. A. Douglas.
Dr. Calvert.	F. T. Burkitt.
	F. G. Lescher.
Dr. Fletcher.	H. D. Kelf.
	M. V. Boucaud.

House-Surgeons—

Sir Anthony Bowlby.	R. G. Morgan.
	W. S. Sykes.
Mr. D'Arcy Power.	C. F. Beyers.
	P. Kittel.
Mr. Waring.	M. Barbash.
	C. W. Bennett.
Mr. McAdam Eccles.	C. F. Krige.
	G. A. Fisher.
Mr. Bailey.	E. M. Atkinson.
	R. M. Dannatt.

These appointments are made for a period of three months. Juniors will automatically become Seniors.

<i>Intern Midwifery Assistant</i>	W. B. Heywood-Waddington.
<i>House-Surgeon to Ophthalmic Department</i>	J. E. A. Boucaud.
<i>House-Surgeon to Throat, Nose and Ear Department</i>	E. B. Barnes.
<i>House-Surgeon to Venereal and Skin Departments</i>	C. H. Thomas.

These appointments are for six months.

Extern Midwifery Assistant N. B. Thomas.

This appointment is for three months.

* * *

It is with sincere regret that we have received the news of the resignation of Mr. R. Cozens Bailey from the Surgical Staff of the Hospital. We are glad to hear, however, that although he will no longer be amongst us at the Hospital, Bart.'s men outside will still be able to have the advantage of his help in private practice—an asset which would be a great loss if he had decided to deprive us of this also while still in the prime of his surgical career. We wish him a long life and congratulations on his recovery from his illness.

* * *

Our readers will regret to learn of the death of Dr. A. G. Bateman, who for so many years was connected with the Medical Defence Union. It is largely owing to his enthusiasm and capacity for work that the Union has been brought to its present state of usefulness and value, not only to the members themselves, but also to the medical profession at large.

Just prior to his death Dr. Bateman had been made Chevalier of the Order of Leopold.

* * *

ROLL OF HONOUR.

We regret to have to report the death of three more Hospital men while on active service. To their relatives and friends we offer our sincere sympathy.

Temp. Capt. James Connor Maxwell Bailey, O.B.E., R.A.M.C., died in German East Africa on April 13th, aged 40. He was the only son of Mr. L. F. Bailey, of Dulwich, and was educated at this Hospital, taking the M.R.C.S. and L.R.C.P., and also the M.B.(Lond.) in 1901 and the M.D. in 1909. After serving as house-surgeon, gynaecological house-surgeon and senior house-physician at the West London Hospital, he joined the West African Medical Staff and served in South Nigeria. He took a temporary commission as lieutenant in the R.A.M.C. on March 1st, 1916, and was promoted to captain after a year's service. At the time of his death he held the post of principal medical officer in German East Africa. He received the O.B.E. on January 1st, 1919.

Major M. N. Perrin, who died as the result of an accident while flying, qualified in 1913. He held a commission in the R.A.F. Medical Service. Major Perrin, who was to have been demobilised the following week, was the only son of Mr. and Mrs. Perrin, of Kensington and Bushey Heath.

Temp. Capt. A. C. Sturdy, M.C., R.A.M.C., was educated at Cambridge and St. Bartholomew's Hospital, and qualified in 1909. He held appointments at St. Bartholomew's and at the Royal Free Hospitals, London; and prior to joining up was in practice at Horsham, Sussex, where he was public vaccinator to the urban district, and surgeon to the Cottage Hospital. He died at Bombay of dysentery.

MEDICAL NOTES.

By SIR THOMAS HORDER, M.D.

(Continued from p. 62.)

PNEUMONIA.

(85) The most certain differential sign in the diagnosis of pleuritic effusion from pneumonic consolidation of the lung is displacement of the heart. The next most important differential sign is abolition of the vocal thrill. But if the amount of fluid in the pleural sac be not large, or if the heart be fixed by adhesions, there may be no certain displacement of the apex-beat; and if pneumonia be accompanied by a small effusion into the pleura, the vocal vibrations may be absent. Whence it follows that cases are not infrequently met with in which the only method of differential diagnosis is an exploratory puncture of the chest.

(86) If consolidation of the lung be taken as the criterion of pneumonia, then the earliest physical sign of pneumonia to appear is impairment of the percussion note. And the last physical sign to disappear with resolution of the pneumonia is also impairment of the percussion note: indeed this sign may never completely disappear.

(87) A large experience of the post-mortem room shows that pneumonic consolidation confined to the middle lobe of the lung is not only much less common than is often thought, but that it is quite rare. Indeed, if we exclude collapse, to which the middle lobe is very prone, this portion of the lung is frequently found to be unaffected by the lesions that affect the lower and upper lobes.

(88) Apical pneumonia may be easily overlooked if the observer omits to examine the chest carefully in the regions of the suprascapular and infrascapular fossæ.

(89) Apical pneumonia is more common in children than in adults; the prognosis is usually better, and resolution is usually earlier, than in basal pneumonia.

(90) The term "broncho-pneumonia" is often used incorrectly to describe cases of pneumonia of lobar type in which the areas of consolidation are small and multiple. The term should not be used without due regard to patho-

genesis and to the course of the disease-process. Broncho-pneumonia may exist with a single area of consolidation, and lobar pneumonia may exist with several.

(91) Lobar pneumonia not infrequently recrudesces, but rarely relapses; broncho-pneumonia often does both.

(92) The four most serious complications of pneumonia are endocarditis, meningitis, pericarditis and peritonitis. Pneumococcal endocarditis is probably always fatal, because it is of the ulcerating variety. Pneumococcal meningitis and pericarditis are highly purulent, and are not much less grave in regard to their issue. Pneumococcal peritonitis is a less hopeless complication, probably because it is more amenable to surgical treatment.

(93) If rusty sputa are present in pneumonia, the examination of stained films gives fairly accurate information as to the nature of the lung infection. If no rusty sputa are available the only reliable guide to the nature of the infection is by lung puncture. Information derived from examination of mucoid or muco-purulent sputa may only relate to infection of the bronchial tract.

(94) Elderly patients not seldom emerge successfully from a severe lobar pneumonia to die of a bronchitis which complicates or follows it.

(95) Any event which lowers very considerably the general state of the patient during the course of pneumonia may delay resolution; nor must resolution be expected in any patient, quite apart from complications, if the general condition is very serious, nor so long as it remains so. For resolution is not a mechanical, but a vital, process, requiring a definite measure of activity on the part of the tissues concerned in order that it shall take place.

(96) Treat patients suffering from pulmonary tuberculosis with abundance of fresh air whenever practicable; treat patients suffering from pneumonia with abundance of fresh air whether practicable or not.

(97) In the treatment of pneumonia no amount of oxygen inhalation is likely to balance the deleterious effect of shut windows, a gas fire, a crowded room and the patient's bed in a *cul-de-sac*.

(98) Venesection in the cyanosis of pneumonia: the argument from theory, for and against, is immaterial, because in practice the procedure does not help.

(99) Troublesome cough during the early stage of pneumonia is either due to the acutely congested state of the upper respiratory tract or to associated pleurisy. In either case it is purposeless, and in the latter case it is also very painful; it is therefore a mistake to aggravate it by the use of stimulating expectorants such as carbonate of ammonium.

(100) Pending the results of certain promising efforts at specific therapy which are still on trial, the treatment of the

pneumonic patient is "upon expectant lines." This term is regarded by some as an indication of the helplessness of the practitioner in face of this disease. But expectant treatment does not mean a policy of "wait and see." It means the careful oversight of, and an endeavour to assist to the utmost, the various functions by means of which the immune process takes effect. It is the duty of the doctor to provide for a liberal supply of oxygen to the lungs, and therefore to the tissues generally; to facilitate digestion and assimilation; to provide for rapid elimination by the lungs, bowels, kidneys and skin; to control the temperature; to maintain the tone of the heart; to rest the nervous system; to give confidence to the mind. Prompt and persistent attention to these things, or the neglect of them, not seldom makes the difference between life and death—a sufficient justification of the wisdom of not omitting thorough non-specific measures concurrently with any method of immunisation that may be embarked upon.

CERTAIN ASPECTS OF DIABETES.

By W. LANGDON BROWN, M.D., F.R.C.P.

[Reprinted from "The Medical World," by kind permission of the Editor.]



THE glands which control carbohydrate metabolism fall into two antagonistic groups; the first consists of the pancreas, whose internal secretion promotes the utilisation of sugar by the tissues and increases carbohydrate tolerance; the second comprises the thyroid, the pituitary and the suprarenal, the secretion of each of which mobilises the sugar into the blood and diminishes carbohydrate tolerance. The members of the second group have two other features in common besides this effect on carbohydrate metabolism; they are all associated with the activity of the reproductive organs, and they all have their secretion controlled by the sympathetic. It is the correlation between this group and the reproductive glands that accounts for the influence of pregnancy in exciting glycosuria.

The main rôle of carbohydrate in metabolism is to provide fuel for muscular energy and to provide for the complete combustion of other food-stuffs, particularly the fats.

The pancreas comes into activity when food is being prepared for absorption into the body; its external secretion is therefore pre-eminently concerned in the storage of energy; the internal secretion acts in the same direction. The pancreas is anabolic, and, like other anabolic activities, is controlled by the vagus, though not to the same extent as some of them. And as the vagus and the sympathetic are opposite in effect when supplied to the same structure, we should expect that the sympathetic would be inhibitory

to the pancreas as it is to other digestive processes. The antagonistic group, like other structures controlled by the sympathetic, comes into action when preparation is being made for display of energy.

Sympathetic stimulation is in the primitive state a preliminary to fight or flight. "Emotion moves us, hence the name," says Sherrington. Perhaps it would be more correct to say that emotion should lead to movement. But under conditions of civilisation the response to emotion tends to be repressed, while preparations for that response still occur. Among these preparations is the mobilisation of blood sugar, which is required for the anticipated display of muscular energy, since active muscle consumes three and a half times as much sugar as resting muscle.

Nervous energy tends to run in accustomed channels. Hence the influence of training. But this applies equally when the nervous energy is perverted; the emotional stimulus may persist because the natural response does not occur and the increased blood sugar becomes habitual.

It is clear, then, that anything diminishing the secretion of the pancreas or increasing the secretion of its antagonists will lower sugar tolerance and may excite frank glycosuria. Now any of the glands controlling carbohydrate metabolism may, of course, become the seat of organic disease. But in that case there will be other signs besides the effect on carbohydrate metabolism. If the pancreas be defective there will be fatty diarrhoea, and probably muscle nuclei and starch grains will be present in the stools. If its duct be obstructed, excess of its diastatic ferment will pass into the urine, where it can be identified. If its tissue cells are disintegrating, some of the products will also be found in the urine. The effects of hyperthyroidism are far-reaching and easily recognised. Over-activity of the pituitary may show itself in skeletal changes, polyuria and pressure effects on the second and third cranial nerves. Clinically we know less of over-secretion of the adrenals in disease, but we might expect it to be accompanied by general sympathetic irritation and raised blood-tension as well as by glycosuria.

It must be admitted that improved diagnostic methods of recognising signs of disease in these glands have not led to their being found in an increasing proportion of cases of clinical diabetes, although glycosuria may accompany organic disease of these glands. This led to the promulgation of the polyglandular hypothesis to explain diabetes. It was regarded as due to a "loss of balance between internal secretions." But how is such a loss of balance brought about? One can understand a loss of balance on a tripod if one leg is broken off. When one gland is diseased the antagonists will show relatively increased activity, just as a group of muscles will show contracture when their antagonists are paralysed. But when none of the glands are organically diseased, it seems to me that the only way in which a loss of balance can

be produced is through a disturbed innervation. And it is clear that sympathetic irritation will at the same time diminish the activity of the gland which promotes sugar utilisation and increase the activity of the group of glands which throws sugar into the blood. In my Croonian Lectures I attempted to show by a lengthy chain of argument that no explanation of diabetes was adequate which left the sympathetic nervous system out of account.

Allen is one of the most recent and most convinced supporters of the pancreatic origin of diabetes. Yet even he admits that diabetes may proceed to a fatal issue and still leave the pancreas as good as normal. He is therefore obliged to postulate the existence of some nervous action, which is, as he says, more probably irritative than paralytic. Such an irritative action of the sympathetic would, as I have shown, supply the requirements of his postulate. As the effect of the sympathetic is less pronounced in diminishing the activity of the pancreas than in increasing the activity of its antagonists, it does not seem likely that its action would be confined to the pancreas, especially when we remember that the sympathetic nervous system is anatomically designed to produce wide-spread effects. Allen is opposed to the idea of an antagonism between the pancreas and the other group, although his own experiments appear to me to support that hypothesis.

Sympathetic irritation, then, means increased katabolism and diminished anabolism. And the new point we have learned about diabetes is that it is characterised by a wasteful metabolism. Now the quickest method of forcing metabolism to adopt economical lines is to cut off supplies. To realise this, one has only to note the quick fall of nitrogenous output as soon as no food protein is taken. Yet the old method of treatment in diabetes was greatly to increase the amount of protein in the food, thus throwing fuel into the flames. For excess of protein is a great quickener of all metabolic processes. One lesson we have all had to learn from the war is that we can balance our metabolism at a much lower level than we previously thought possible. And what may be but a passing phase for the normal individual must remain a permanent state for the diabetic. He must be permanently underfed. If he can balance his metabolism when the caloric value of his food is adequate to maintain life and a fair display of energy, the outlook is good; if he cannot acquire a balance until the intake is reduced too much for this, the outlook is bad. This is the *rationale* of the fasting treatment of diabetes. It is not difficult temporarily to rid the urine of sugar, but it may be difficult, nay impossible, to keep it free when the diet is increased to anything like the level to maintain life. It will be noted that this treatment does not attack the underlying cause of the disease, nor have we as yet any means of so doing. Indeed, the disease often progresses, though usually more slowly, during the

treatment. The value of intercalated fast days in the treatment of diabetes has been known for some years. It is the special merit of Allen's work that, starting from a fast, he systematically and cautiously re-educates the organism to metabolise more economically. He finds also experimentally that anything which diverts the energy of the pancreas from external secretion increases its capacity for internal secretion; conversely a strain thrown on its external secretory activity diminishes its internal secretory powers. This affords another reason for periods of alimentary rest.

Though Allen has naturally received the credit for the discovery of this method of treatment, we should not forget in this country that it was simultaneously discovered by Graham, while working in Garrod's wards at St. Bartholomew's Hospital. Unfortunately the war prevented any detailed publication by him. In essentials the two methods are the same, though Graham's is the less drastic and in my opinion is the less apt to disturb the general health. Many of us had been fumbling, with an inkling of the truth, along these lines, but to those two men must be accorded the credit for seeing farther into the heart of the problem. The results are shown in Poulton's Goulstonian Lectures. He finds that at Guy's Hospital, whereas formerly the mortality during the first year of the disease was 16.9 per cent., it is now only 5.4 per cent.; the average mortality rate of all cases admitted has been reduced from 23 per cent. to 7.7 per cent.; and whereas only 9.8 per cent. were formerly made free from sugar even for a day, now 73.5 per cent. can be rendered free for longer or shorter periods. Moreover, we have learned that coma is more generally due to faulty dieting with excess of protein and fat than an essential part of the disease.

MODERN METHODS OF TREATING FRACTURED FEMORA.

By W. ETHERINGTON WILSON,

Resident Medical Officer, 1st London General Hospital.

"To look back to Antiquity is one thing,
To go back to it is another."

THIS is written with a hope that those who have already seen a great deal of femur treatment during the war will not consider the subject rather an "ancient" one to bring up now. Much has been written and done in this direction during the last two years; but no doubt there are still many who have not had the opportunity of applying these recent methods, or seeing the results, and I sincerely hope that a few helpful hints and suggestions may be gleaned from this article by the latter.

A knowledge of some good method of treatment is essential to prevent the avoidable disabilities and crippling which otherwise must often result. The H/S D. need no longer think himself unlucky when a fractured femur case falls to his lot, thanks to the excellent results which can be obtained, and can be shown in the special femur wards of the war, such as those at the 1st London General Hospital. Mr. Harold Wilson is responsible for the very good results obtained at the 1st London. Thanks are due to Major Sinclair, R.A.M.C., whose ingenuity and enterprise have been largely responsible for the improved procedure in treating fractured thighs.

I propose to deal in this Journal with the apparatus for, and the treatment of, a straightforward fracture in the middle of the femur.

A discussion will follow in a subsequent issue on points worthy of further consideration.

APPARATUS AND METHOD OF APPLICATION.

(1) *Thomas's knee-splint*, having a ring of sufficient size to easily fit the upper part of the patient's thigh. An average size is one having a circumference of 21 in. The very large sizes, *i. e.* 30 in., etc., used in this war should be abandoned, because they often cause deformity, are cumbersome and insanitary.

(2) *Glue*.—Composition recommended (Sinclair):—

Common glue	50 parts
Water	50 "
Glycerin	4 "
Calcium chloride	4 "
Thymol	1 part

The above when cool should be soft, flexible and elastic. The composition and treatment of the glue and the method of application to the leg is a most important matter, because on this knowledge the avoidance of future trouble depends, *e. g.* pain, blistering and slipping of the extension. The following points should help:

(i) Glue should just be brought to the melting-point by heating in a water-bath; it is then ready for use. The glue is spoilt by rapid melting and boiling.

(ii) The glue extension is applied to the limb between the knee and the ankle. Do not shave the leg. Apply glue all round the leg, upwards to within $\frac{3}{4}$ in. of a line around the limb at the level of the head of the fibula, downwards to a similar line 2 in. above the tip of the internal malleolus. When completely painted, finish off by stroking the hair in an upward direction.

(iii) Light threefold gauze 4 in. by 36 in. is next applied, one on each side of the glued leg, avoiding the crest of the tibia, but parallel to it.

(iv) Bandage to the limits of the glue by figure-of-8 method, commencing below. The first two turns of the bandage should not be tight; thereafter bandage firmly. These points are important.

The bandage itself should have a loose meshwork to allow the glue to settle in the meshes, thus further adding to the security of the extension. Pain and swelling of the foot does not occur because the bandaging is too firm; it is due to the first turn below being tight and cutting into the skin when pull is applied.

Adhesive-plaster strapping is not recommended. If used apply bandage in the same way.

(3) *Sinclair-foot-piece*.—A flat wooden support which fits against the sole of the foot is most useful. It is kept in position as follows: The dorsum, sole and sides of foot are glued completely; flannel strands $\frac{3}{4}$ in. by 8 in. long are stuck on round the foot from the sole round to the dorsum, the ends of each strand not meeting in the mid line by $\frac{3}{4}$ in. Each strand supports two metal rings (size of a shilling), the rings being placed on either side of the sole of the foot—*i. e.* six on each side. Tapes are tied to each ring. The tapes of opposite sides then embrace the foot-piece, which is thus held in position.

The latter is previously padded for the foot to rest comfortably on.

Objects of the foot piece:

- (a) Adds to comfort of patient.
- (b) Foot is steadied.
- (c) Foot can be rotated outwards or inwards by moving the foot-piece.
- (d) It can be converted into an extension when other methods have failed temporarily.
- (e) Dorsi and plantar flexion of the foot are allowed at the will of the patient, thus preventing a stiff ankle.

The foot-piece is supported on the bars of the Thomas by a cross-bar which can be moved up and down, and held in position by a butterfly knot.

(4) *A square extension support* made of metal is tied on to the end of the Thomas, projecting downwards. The gauze extension is tied around this, and it serves to keep the extension off the ankles, thus avoiding discomfort.

(5) *A frame, eight pulleys, four bags* containing sand or shot and weighing six and eight pounds respectively. Lengths of *blind-cord*.

The pulleys and cord suspend the bags, which in turn suspend the Thomas and the limb.

A frame made by Mr. Harold Wilson is used in the wards at Bart.'s. It is a small and useful modification of the Balkan frame.

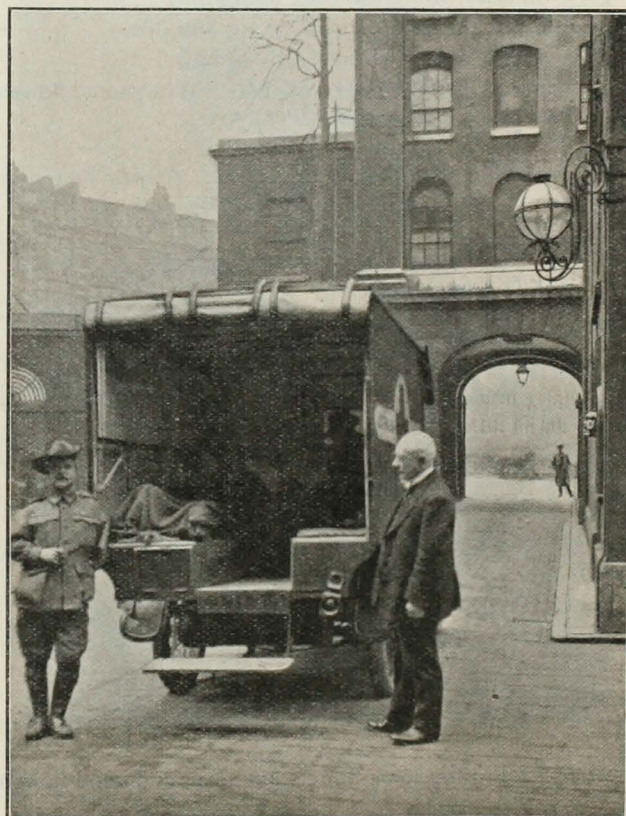
Its objects are: (i) To support the Thomas. (ii) A sling over the middle beam enables the patient to lift himself as much as twelve inches off the bed, the foot of the sound leg being the only part actually touching the bed. Nursing is thus made easy. (iii) The middle vertical beam at the foot of the bed is the fixed point to which the Thomas is tied to get extension, as will be explained later.

(6) *Two blocks* to raise the foot of the bed. The height

required varies with the case, 12 in. being an average amount.

In the special femur ward at the 1st London General Hospital the building is fitted up with overhead apparatus, serving the same purpose as described, except that the frame and other impedimenta are done away with. As a femur-ward is a war-time invention and does not come into civil practice it will not be described. The apparatus described can be seen in the wards at St. Bartholomew's Hospital.

(To be concluded.)



THE LATE STEWARD BIDDING FAREWELL TO THE LAST SOLDIER LEAVING THE HOSPITAL.

GAUDEAMUS IGITUR, OR VIEW DAY.

(*Four Sisters "in the Pink" round fire—first week in May.*)

1st P.S.: When shall we four be relieved,
In winter, summer, or in spring?

2nd P.S.: When the hurly-burly's done,
When the battle's fought and won.

(*Exeunt three P. Sisters. Third P.S. remains alone in room.*)

3rd P.S. : The earth will on itself but twice more turn
 Before the Viscount, and the Governors will,
 According to our ancient customs, come
 And con the list of all the sick and suffering
 Now lying in our ward. I know that some
 Will never see another moon, and some
 Must toss and moan long days and nights. But still
 The Governors we will tell, that all within
 The space of two weeks will be well.

(4th P. Sister meditating in her room.)

4th P.S. : The day is almost here—the dreadful day !
 I will arise before the cock doth crow,
 And risk the foul, contagious air, and, like
 A wraith, with Franlink I will go into
 The world's great mart, and there will buy some flowers
 To decorate our hearth.

(5 a.m.—Meets Staff-nurse in Square. Proceed to Covent
 Garden to buy flowers.)

4th P.S. : 'Tis late. Let's stir ourselves, or soon the sun
 Will find us out.

(They meet colleagues from another ward.)

4th P.S. : Good morning, friend ! In "Faith," I had not
 thought
 To meet, in such a place, a member of
 The Great Retreat of Saint Bartholomew.

Sister "So" : A greeting ! "Mark" my words ! I deeply
 fear
 Our Matron none too pleased will be, that we
 At such an hour have broke our bounds, and can
 Near Covent Mart by all be found.

(They separate and arrive at Covent Garden and buy flowers.)

4th P.S. : Prithee some flowers, my man, and good flowers,
 too !
 Some lilac and forget-me-nots.

S.-N. : These white and tender blossoms sure will make
 A pretty setting for the mauve.

4th P.S. : Let's go. We have enough.

(In Ward—late forenoon. View Day.)

4th P.S. : The Ward is almost done. Two chairs are there
 Before the hearth. Full many times have I
 Been on the "mat" ; but now, in one short hour,
 A Viscount and the Matron too will sit
 Upon my "mat."

th P.S. : Go, Nurse, put on your best attire.

Probationer : Now twice I've changed my stomacher and
 twice

I've changed my cap ! When will it all be o'er ?

4th P.S. : Now wheel this patient from the "front," and fill
 His place with other from the "back." His knees
 Are always up, and do upset the bed.

(All Nurses in a line in Front Ward. Physicians and
 House-Physicians. 1st P.S. at end of Ward waiting
 to receive Governors.)

4th P.S. : Hark ! They come !

(Looks towards screen at end of Ward.)

4th P.S. : I feel an eye is peering from behind that screen !

(Enter Viscount and Governors, preceded by Mace bearers
 Matron, Steward, Clerk to the Governors. FANFARE
 OF TRUMPETS.)

Mace-bearer : The Viscount and the Governors !

(Viscount shakes hand with Sister and Nurses. Viscount
 and Matron seated on hearth "MAT." Physicians
 and Governors grouped around. Physicians read
 out list of sick in Ward.)

Physician : Now "One" has Rheumatoid Arthritis,
 And "Two" has Fibroid Myocarditis, "Three"
 Is suffering from Suppurative Phlebitis,
 And "Four" Gastritis has, while "Five" has got
 A Mórbus Córdis with Auricular Fibrillation.
 Leukæmias and Anæmias, too, are here,
 And Dropsy cases not a few ; but all
 Within ten days we will discharge !

Viscount : Pray, Doctors, do you find the Ward well to
 Your liking !

Doctors : We do.

Viscount : The Sister and the Nurses too—do meet
 With your approval ?

Matron : They do.

Viscount : The patients, too, contented are, so we
 Will go elsewhere ! Adieu.

(Exeunt Omnes.)

FINIS.

G. W. T.

BACK FROM THE WAR.

BACK from the war, boy, and what saw you there?
Blood, death and laughter and men that would dare;
Strong hands of friendship and freedom from care.

What have you thought about, boy, who didst roam?
Food in the belly and love in the home;
Life, love and ale in the days that should come.

What was the war about, boy, after all?
The freedom of each and the freedom of all
To live to the best of us up to our call.

What have you learned, boy, and what do you see?
That the world's full of comrades as diff'rent can be;
And there's duty for them and there's duty for me.

J. R. R. T.

OBITUARY.

ARTHUR WATKINS.

THE Hospital has just lost a very highly valued officer in the death of its Steward, Mr. Arthur Watkins, in his 63rd year. On May 2nd he attended the funeral of Major Perrin, a former prominent member of the Resident Staff, at Weybridge. Upon leaving he had a cerebral seizure and passed away peacefully shortly afterwards.

Watkins was born in December, 1856, and entered the Clerk's Office in January, 1879, after having had some experience in a commercial house in the City. In June, 1887, he was appointed Assistant to the Steward (the late Mr. Mark Morris), and upon that officer's decease in November, 1895, was elected Steward. He had therefore completed forty years' service in the Hospital.

During this long tenure of office he was most devoted to the Hospital, and gave his best ungrudgingly to its service, for his heart was in his work.

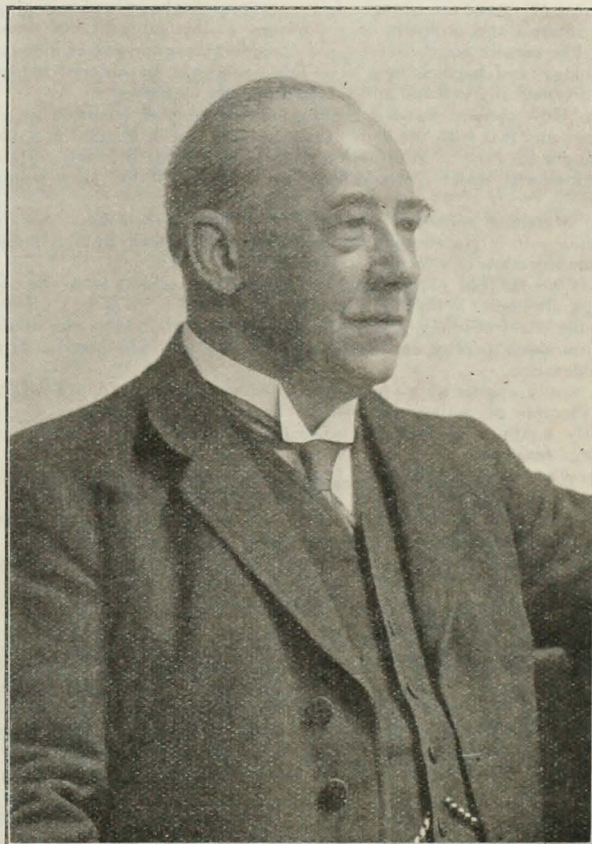
For the period of the war, when no less than 5406 patients were passed through the Military Wing of the Hospital, he was invariably present to receive the convoys of wounded as they arrived, and never failed to think of some means of adding to their comfort. His calm and placid demeanour during the numerous air raids to which London was subjected was of the greatest encouragement to patients and staff alike.

Visitors to the Hospital on our historic annual "View Day" considered it incomplete without a hand-shake and a few words with the popular Steward; and his presence was sadly missed this year in the official tour of the wards.

To those who sought his advice (which was always worth having) it was freely given, and in his quiet and unostentatious way he proved a good friend to many. His genial personality endeared him to everyone, and his loss will be keenly felt by all who knew him.

The writer cannot do better than quote Sir Norman Moore in his recently published *History of the Hospital*.

"And it is pleasant to know that this admirable old Steward (Mark Morris) would have thoroughly approved Mr. Watkins who was elected to succeed him in December 1895, and exactly resembles him in the qualities of invariable beneficence and untiring attention to every detail of his work."



THE STEWARD.

His recreations were foreign travel (when opportunity arose) and music, he having been the founder and Secretary of several choral and orchestral societies. In early life he was a conspicuous figure on the banks of the Lea as the popular and energetic secretary of a well-known rowing club.

He took keen interest in the Incorporated Association of Hospital Officers, having been a member since its foundation in 1902, and its President for the year 1914-15. He was also a member of the Dickens Fellowship Club and the City Temple Literary Society.

The large attendance of Governors and members of the various staffs of our own and other hospitals at the funeral service, held in the Church of St. Bartholomew-the-Great on May 7th, testified to the esteem in which he was held.

J. S. S.

CORRESPONDENCE.

PROTEIN SHOCK AND INTRAVENOUS VACCINE THERAPY.

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

SIR,—Dr. Gow's paper on "Protein Shock and Intravenous Vaccine Therapy" is of such interest that I hope he may be induced to write more upon the same subject.

Those of us who are engaged in general practice have been watching with interest the progress of experience in this subject; but those who, like myself, are conscious of a considerable ignorance of modern pathology and bacteriology have felt somewhat bewildered before the information available and the terminology employed.

Dr. Gow's paper shows a striking marshalling of recorded experience; and it is with the belief that the clinician in general practice is hungry for further information that I venture to indicate certain questions with which it would be of great interest if Dr. Gow would deal.

(1) *Material employed for inducing the intravenous protein reaction.*—It is stated that the reaction is "induced by the intravenous injection of a foreign protein."

May we be told of the observed effects consequent upon the use of egg-albumen? In this way a simpler issue is involved; for the possible effect of other bodies contained in bacterial emulsions would be eliminated thereby, and one thing at a time would be presented for consideration.

It would appear by no means impossible that much (if not all) of the theories of active and passive immunisation may have to be greatly modified as further knowledge is gained in the subject of protein reaction.

(2) *The words "sensitised" and "desensitised."*—Is there any explanation of the processes of "sensitisation" and "desensitisation"? The application of the former word both to the patient and to the agent introduced into him is to me a puzzling use of words.

(3) *Intravenous and intradermal.*—(a) What is the explanation of the difference in reaction caused by "intravenous" and "intradermal" injections of sera and vaccines? (It would appear to be unconnected with dosage.)

(b) In the case of anti tetanus serum, a very small proportion of patients have exhibited a reaction which has been often described. Is this anaphylactic? Is it a protein reaction? I have many times given it to patients who have had previous injections after intervals of two years and upwards, and have seen no reaction. This serum is not given intravenously. What is the essential difference in the disposal by the body of intravenously and intradermally given sera respectively?

(c) In the case of "anti-typhoid vaccine" (T.V. and T.A.B.), the reaction for the most part bears no resemblance to the clinical picture of intravenous protein reaction; one would not expect it. On the other hand, I have seen two cases (of which I was one) having a very striking resemblance thereto—extreme suddenness of onset, rigor, nausea, vomiting, headache. These injections were not intravenous. Were they cases of protein reaction?

(4) The difference in the behaviour of the body to intravenous and to intradermal injections of sera respectively seems to be a subject of the greatest interest, and may lead to the advancement of our knowledge as to the causation of certain obscure diseases, and of our knowledge of the behaviour of injured tissues.

(5) A most interesting and suggestive article by Dr. Clive Riviere appeared (I think in the *Brit. Med. Journ.* in 1908 or 1909) on "Auto-inoculation in Medicine"; some of the theories put forward therein may come into contact with this knowledge of protein reaction now being gained.

(6) The subject appears to me to be of the greatest interest and importance to medicine, and my gratitude to Dr. Gow for his paper includes a hopeful anticipation of further papers to come.

I am, Sir,

Your obedient servant,

J. R. R. TRIST,
Lieut.-Col., R.A.M.C. (S.R.),
commanding 2/2 Wessex Field Amb.,
B.E.F., France.

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

SIR,—You have kindly allowed me to see Col. Rigden Trist's letter in advance so that there may be less delay in reply. But it needs a far abler pen than mine to furnish explanation of the various and interesting phenomena to which he refers, and the rôle I have tried to fulfil so far is that of a recorder only, and it is unwise for me to attempt to overstep that at present.

With regard to his first point, I have no personal experience of the intravenous injection of egg-albumen. To obtain a satisfactory therapeutic effect when a foreign, non-specific protein is employed, *i.e.* when an autogenous vaccine is not used, it appears to be essential to produce a brisk reaction with a temperature of 104° F. or so. This result is obtained with great constancy by the use of an emulsion of *B. coli* or *B. typhosus*, and as either is easy to procure and simple to handle it is most frequently employed.

(2) It is indeed unfortunate that the terms *sensitisation* and *desensitisation* have been applied to both patient and vaccine, for the meaning in each case is entirely different. A *patient* is said to be *sensitised* to a particular protein when he has been rendered *hypersensitive* to it by an injection of that protein, that is, when a second small dose of that same protein causes him to react in a certain peculiar fashion—the so-called "anaphylactic shock." *Desensitisation of a patient* is the process whereby this state of anaphylaxis is rendered of no account and the patient become "anti-anaphylactic." A *sensitised vaccine* is an emulsion of the organism which has been in contact with specific anti-serum, whereby union of antigen (bacterium) and antibody (in the serum) has been brought about. A sensitised vaccine has the advantage over a plain emulsion in that it is less toxic, can be given in larger doses, the production of immunity is accelerated, and the "negative phase" is eliminated or greatly diminished.

3. (a) It is possible that the difference in reaction caused by the *intravenous* and *subcutaneous* injection of sera and vaccines depends in the main on the rapidity with which these substances reach the blood-stream. In the former it is instantaneous, producing a relatively brisk response; in the latter absorption takes place slowly, and the effects are relatively mild and spread over a longer period. The *intradermal* route is employed as a test for anaphylaxis only, as it yields a visible result.

(b) A reaction following second doses of anti-tetanus serum may be either serum sickness or anaphylactic shock. The majority of patients, fortunately, is not rendered anaphylactic by one subcutaneous injection of serum.

(c) When giving what is intended to be a subcutaneous injection of vaccine it is possible that on rare occasions the needle may pierce a small vein in the tissues, with the result that all, or part, of the dose enters the vein. This seems to me a likely explanation of Col. Trist's experience, for the sequence he describes is typical of the intravenous protein reaction.

I am grateful to Col. Trist for his letter, and wish I could more satisfactorily answer his questions. It seems my remarks may have stimulated an interest in this subject, and I hope others may be induced to work at it and record their experiences.

I am, Sir,

Yours faithfully,

A. E. Gow.

37, QUEEN ANNE STREET, W. 1;
May 12th, 1919.

RECONSTRUCTION.

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

SIR,—Having read with much interest the articles on reconstruction appearing in your last issue, I would like to draw attention to what seems a deficiency in the Hospital's present organisation. To my mind there is required a proper "Follow-up" Department—such as exists in most American clinics, and which could be readily instituted at "Bart's," and this at very little expense.

All that is needed is a card-index system, and a clerk to send letters to ex-patients, or their doctors, inquiring about their progress, etc., or inviting them to attend and interview the physician or surgeon who treated them. Such a department might be controlled by one of the Medical or Surgical Registrars, who would note down the results of inquiries and interviews on special "follow-up" forms.

These could then be bound with the case-notes or in a separate volume.

At present final results are unknown, for as it is the student sees very few complete cases, excepting those in a room on the top floor of the Pathological Block. Others are probably forgotten; for example, he never knows if the man whose semilunar cartilage he saw removed, or the subject who underwent a gastro-enterostomy, remained cured of his symptoms a year or two later.

In the wards one learns much diagnosis but very little prognosis, —the latter a much more difficult subject and one of supreme importance to the general practitioner.

I am, Sir,
Yours faithfully,
A. D. WALL,
Temp. Surgeon-Lieut., R.N.

May 16th, 1919.

THE TREATMENT OF AMŒBIC DYSENTERY.

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

SIR,—I have read with considerable surprise a paper in your current issue by Capt. Prall, R.A.M.C., on the treatment of amœbic dysentery.

The treatment of dysentery by heroic doses of ipecacuanha was a horrible one even in the days when such a course was necessary; now that more efficient drugs are at hand it is positively barbarous. If the drug must be given by the mouth, it is surely better in the form of the double iodide of bismuth and emetine in, say, gr. ij doses. This, if given as a pill coated with salol, seldom causes vomiting, and never seriously interferes with the nutrition of the patient.

In regard to the question of hypodermic injection of emetine, I have used the drug since it was first introduced, and have given several thousand injections. I have never seen a patient upset by it, and I believe this only occurs when excessive doses are used or the administration of the drug is continued too long without a break. I think Capt. Prall must seek some other cause for the D.A.H.

Capt. Prall says that "it is essential that the injection should reach the cæcum," but, apart from the fact that dysenteric ulcers may be found post-mortem in the lower part of the ileum, one fails to see how an enema of 8 oz. is ever going to reach the cæcum. If Capt. Prall will, on the X-ray table, inject an enema of this amount containing a radio-opaque substance, I think he will convince himself of the difficulty.

There is no proof brought forward in this paper that any case of a dysentery carrier can be cured by this method, and these are the only cases that really cause any difficulty to the physician.

My own experience is that gr. iij of the double iodide of bismuth and emetine given for a period of twenty-one days, then omitted for fourteen, and subsequently repeated if required, will cure all but a very small number of carriers, the results having been checked over a considerable number of weeks. Possibly Lambert's method—double iodide gr. ij at night and emetine hypodermic gr. j in the morning—is better still.

I am, yours, etc.,
JAMES L. MAXWELL,
Major, R.A.M.C.

GRAYLINGWELL WAR HOSPITAL,
CHICHESTER;
April 12th, 1919.

REVIEWS.

PYE'S SURGICAL HANDICRAFT. Enlarged and largely re-written by W. H. CLAYTON-GREENE. Eighth Edition. (John Wright & Sons, Ltd.) Pp. 639. Price 21s. net.

We have always regarded this work as one of the most practical and useful compilations from the point of view of the dresser, and

particularly the house-surgeon. The book is extremely well printed and illustrated, and constitutes a veritable store of practical information. Several sections of the book are written by specialists in that particular subject; thus, the chapter on "Poisoning" is in the capable hands of Dr. W. H. Willcox, while Dr. Joseph Blomfield is responsible for the short chapter on "Anæsthesia."

The present edition has been thoroughly revised and includes much new matter, a notable addition being the details for the treatment of orthopædic cases.

We have every confidence in recommending the volume under review; it is a book which should be in the hands of every student.

AIDS TO SURGERY. By JOSEPH CUNNING and CECIL A. JOLL. Fourth Edition. (Baillière, Tindall & Cox.) Pp. viii + 420. Price 4s. 6d. net.

This most excellent little volume is deservedly one of the most popular of the "Aid" Series. It may be described as an admirable epitome of surgery. The present edition has been almost entirely revised by Cecil A. Joll, who is to be congratulated on his efforts to include the latest advances in military surgery.

The R.A.M.C. officer returning from the Front will find this little volume most useful in enabling him to review rapidly a subject which in a great number of cases unfortunately has had to be neglected. From the point of view of the student the book will prove equally valuable for revision purposes.

THE AFTER-TREATMENT OF WOUNDS AND INJURIES. By R. C. ELMSLIE, M.S., F.R.C.S. (J. & A. Churchill.) Pp. 319. Price 15s. net.

The author of this illuminating work needs no introduction to our readers. Mr. Elmslie for several years has done most valuable work in charge of the Orthopædic Department of this Hospital. During the war he has also been connected with a special military orthopædic hospital, and it is largely the results of the experience acquired during two and a-half years in this latter establishment which go to make up the volume.

Three principles underlie orthopædic surgery: a knowledge of pathology, a clear appreciation of mechanics, and the realisation that the surgeon's aim is to restore function; and while many new methods have appeared in military orthopædics the principles are the same in civil practice.

The book is divided into nineteen chapters and embraces every branch of this most important aspect of surgery. An interesting chapter is devoted to the rational treatment of chronic sinuses of bone, the author strongly advocating the radical operation as performed by Prof. Broca. The chapters devoted to methods of splinting, physical methods of treatment and plaster-of-Paris work are exceptionally valuable, representing as they do the results of a unique experience. Other chapters deal with injuries to specific regions, and contain many examples of actual cases.

The book contains a large number of illustrations, some of which, we regret to say, appear to have suffered somewhat in reproduction. Otherwise the book is excellently done, and both author and publishers are to be congratulated on the production of a work of the very highest order.

LEWIS'S MEDICAL AND SCIENTIFIC LIBRARY. (H. K. Lewis & Co., Ltd.) Pp. 492. Price 12s. 6d. net. To subscribers 6s. net.

Lewis's Library is one of those valuable institutions which the medical student soon learns to regard as a practical necessity. This excellently bound catalogue gives a complete list of books available, the present edition having been revised to the end of 1917. A classified index of subjects with the names of those authors who have treated upon them has also been included, and adds considerably to its usefulness.

AIDS TO HISTOLOGY. By A. GOODALL. (Baillière, Tindall & Cox.)
Second Edition. Pp. viii + 135. Price 3s.

While this book may prove of value in revising the histology of the various tissues and organs of the body, we cannot say that we are greatly impressed. It does not differ materially from the first edition published in 1911. Obviously in a book of this size it is not possible to include many illustrations, which in a book on this subject would appear to be an essential feature, and we think the student would be well advised to concentrate on some of the larger books dealing with this branch of microscopical work.

EXAMINATIONS, ETC.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

May, 1919.

W. D'Este Emery has passed the Examination for Membership.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

Final F.R.C.S. Examination, May, 1919.

T. H. Just, R. E. T. Tatlow, H. B. G. Russell, L. G. Phillips,
R. O. Ward, M. W. K. Bird.

Primary F.R.C.S. Examination, May, 1919.

Special Examination.—W. Briggs, E. I. Lloyd, J. Mc.L. Pinkerton,
Ordinary Examination.—F. C. W. Capps, H. L. Sackett, S. R. Saimaika, W. E. M. Wardill, E. H. Weatherall.

CONJOINT EXAMINING BOARD.

First Examination, March, 1919.

Part I. Chemistry.—H. C. M. Williams, A. Jephcott.

Part II. Physics.—H. C. M. Williams, A. Jephcott, D. H. Cockell,
W. M. Jones.

Part III. Elementary Biology.—H. C. M. Williams, S. Jenkinson,
H. V. R. T. Lauder, M. H. Mehliss, H. H. D. Sutherland, G. Elliot.

Second Examination, March, 1919.

Anatomy and Physiology.—G. Kinneir, S. Gordon, T. J. D. Atteridge.

Final Examination, March, 1919.

The following have completed the Examination for the Diplomas
of M.R.C.S. & L.R.C.P.:

J. N. Leitch, P. B. Kittel, C. W. Bennett, W. S. Sykes, J. L.
Nisbet, E. D. Macmillan.

CHANGES OF ADDRESS.

BECKTON, H., 57, Goldington Road, Bedford.

CANE, L. B., Capt. R.A.M.C., Burma Mines Ltd., Namtu, Northern
Shan States, Burma.

CARVER, A., 35, Paradise Street, Birmingham.

DRAWBRIDGE, W. R. L., Lancing College, near Worthing, Sussex.

GRIFFITH, H. K., Roydon, Ashelton Road, Torquay.

HAMILL, J. M., 5, Avonmore Mansions, Avonmore Road, West
Kensington, W. 19.

HAMILTON, W. G., Maj. I.M.S., Presidency Jail, Alipore, Calcutta.

HARKER, T. H., 18, Queen's Road, Southport, Lancs.

HAY, K. R., 47, Hill Street, Berkeley Square, W. 1. (Tel. Mayfair
5768.)

HUDSON, B., Palace Hotel, Montana s. Sierre. (Valais.)

HUGHES, G. S., 6, St. Leonards, York.

LEGG, J. WICKHAM, 82, Woodstock Road, Oxford.

OLIVER, M. W. B., 128, Harley Street, W. 1. (Tel. Mayfair 4188.)

PARKER, H. F., The Turret House, Guildford.

ROBINSON, C. A., Brookside, Beaufort Road, Llandrindod Wells.

ROXBURGH, A. C., 31, New Cavendish Street, W. 1. (Tel. Mayfair
4764.)

SHAW, H. C. C., Charleville, Queensland, Australia.

SLOMAN, H., c/o 39, West Street, Farnham.

WHARRY, H. M., 54, Beaumont Street, W. 1.

Dr. OSKAR TEICHMANN, of "Sitka," Chislehurst, has by deed
poll, dated the 12th day of May, 1919, changed his name to Dr.
OSKAR TEICHMAN.

APPOINTMENTS.

BROCKMAN, R. St. L., M.R.C.S., L.R.C.P.(Lond.), appointed R.S.O.,
The Royal Infirmary, Sheffield.

EVANS, D. B., M.R.C.S., L.R.C.P., appointed Medical Superintendent,
North Wales Sanatorium, Llangyfan, near Denbigh.

MAXWELL, J. P., M.D.(Lond.), F.R.C.S., appointed Professor and Head
of the Department of Gynæcology and Obstetrics at Union Medical
College, Rockefeller Foundation, Peking.

BIRTHS.

HAY.—On May 25th, at 47, Hill Street, Berkeley Square, W. 1, the
wife of Kenneth R. Hay, M.B., of a daughter.

QUICK.—On May 12th, at 137, Walter Road, Swansea, to Ruth (*née*
Hellins), wife of Dr. Hamilton Quick—a daughter.

SQUIRE.—On May 11th, at Firbank, Hythe, to Dorothy (*née* Walter),
wife of Lieut. H. F. Squire, R.A.F., M.S., the gift of a son.

RAMSAY.—On May 13th, at 4, Bryanston Street, W., the wife of
Robert A. Ramsay, of a son.

WATERFIELD.—On April 4th, at Port Sudan, to Noël E. Waterfield,
M.B., B.S.(Lond.), F.R.C.S., and Mrs. Waterfield—a daughter.

WHITE.—On May 10th, at 1, Albemarle Road, Withington, Man-
chester, the wife of Dr. C. Powell White—a son.

MARRIAGES.

BACKUS—ELSON.—On May 14th, at Savoy Chapel, Dr. C. H. Backus,
R.A.M.C., to Gertrud Marion Elson.

SHAH—SHAH.—At Poona (India), on February 27th, 1919, while on
leave from Palestine, Capt. J. M. Shah, I.M.S., E.E.F., with
Shahunshah Begum, daughter of Capt. Cassem Shah, 3rd Skinner's
Horse, Indian Army.

DEATHS.

BAILEY.—On April 13th, 1919, in German East Africa, James Connor
Maxwell Bailey, O.B.E., M.D.(Lond.), Principal Medical Officer
in German East Africa, aged 40.

BATEMAN.—On April 9th, 1919, after a short illness, Alfred George
Bateman, M.B., C.M.(Aberd.), Secretary of the Medical Defence
Union.

STURDY.—On May 1st, 1919, at the Colabar Hospital, Bombay, of
dysentery, while on active service, Arthur Carlile, M.C., F.R.C.S.
(Eng.), Temp. Capt. R.A.M.C., and practising at Horsham, second
son of Rev. H. C. Sturdy, aged 36.

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. Bartholo-
mew'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.

St. Bartholomew's Hospital



"Æquam memento rebus in arduis
Servare mentem."

—Horace, Book ii, Ode iii.

JOURNAL.

VOL. XXVI.—No. 10.]


JULY 1ST, 1919.

[PRICE SIXPENCE.

CALENDAR.

Fri., June	27.—Dr. Tooth and Sir D'Arcy Power on duty.
Tues., July	1.—Sir Archibald Garrod and Mr. Waring on duty.
Fri., „	4.—Dr. Calvert and Mr. McAdam Eccles on duty.
Tues., „	8.—Dr. Fletcher and Mr. Bailey on duty.
Fri., „	11.—Sir Wilmot Herringham and Sir Anthony Bowlby on duty.
Tues., „	15.—Dr. Tooth and Sir D'Arcy Power on duty.
Wed., „	16.— Summer Session ends.
Fri., „	18.—Sir Archibald Garrod and Mr. Waring on duty.
Tues., „	22.—Dr. Calvert and Mr. McAdam Eccles on duty.
Fri., „	25.—Dr. Fletcher and Mr. Bailey on duty.
Tues., „	29.—Sir Wilmot Herringham and Sir Anthony Bowlby on duty.
Fri., Aug.,	1.—Dr. Tooth and Sir D'Arcy Power on duty.

EDITORIAL NOTES.

E are indeed sorry to hear that Sir Anthony Bowlby, K.C.B., K.C.M.G., K.C.V.O., is about to retire from the active service of the Hospital.

There are many old St. Bartholomew's men who owe a great deal to Sir Anthony, both as his pupils and as practitioners afterwards, and we are glad to see by a letter which will be found in this JOURNAL that an opportunity has been given to all Hospital men to subscribe towards a portrait of him, which shall be hung in the Great Hall of the Hospital.

It is some long time since a member of the Staff has been honoured in this way, and we are quite sure there is no more outstanding figure in the life of the Hospital during late years who deserves the honour more than Sir Anthony.

We wish the scheme every success.

* * *

The occasion of the Mid-Sessional Address before the Abernethian Society on June 19th was in every way reminiscent of pre-war days.

Sir Anthony Bowlby had consented to speak on "The

Development of Front-line Surgery in France," and the result was one of the best addresses we have been privileged to hear in our familiar lecture theatre.

For over an hour Sir Anthony spoke without notes, his delivery and diction being perfect. Many of us realised for the first time how much the country really owes to the organising efforts of our Senior Surgeon, and never has the Hospital been more proud of its distinguished representative.

We hope to publish a report of Sir Anthony's address in our next issue.

* * *

The results in the Final London M.B. Examinations as usual are very complimentary to the Hospital. We cannot let the occasion pass, however, without specially congratulating Mr. R. J. Perkins on his magnificent effort. Not only has he gained the Gold Medal, but in addition is distinguished in Forensic Medicine, Medicine and Surgery. With one possible exception, we believe, this constitutes a record for the Hospital.

The results in the Final Examination for the Fellowship of the Royal College of Surgeons are also creditable, six out of the fifteen successful candidates being Bart.'s men.

* * *

The revival of the Past and Present Cricket and Tennis Matches at Winchmore Hill was a success in every way. We are publishing elsewhere the scores, although, to be perfectly frank, the cricket was quite a secondary feature compared with the most excellent tea and the delightful music of the Artists' Rifles' band.

We were very pleased to see so many members of the Senior Staff present.

* * *

It will no doubt interest our readers to learn that Dr. C. S. Myers, F.R.S., Director of the Cambridge University Laboratory of Experimental Psychology, has been elected a Fellow of Caius College.

* * *

As a result of the Hospital Dance, we understand that exactly £100 will be handed over to the Fund for the

New Home for the Nurses. We congratulate all concerned on this very pleasing effort.

* * *

Lieut.-Col. W. McAdam Eccles has been appointed Surgical Adviser to the Headquarters (A.M.S.) Appeal Board, War Office.

* * *

Our heartiest congratulations to the following members of our Hospital Staff whose names appear in the Birthday Honours. The awards are as follows:

K.C.B.—Temp. Maj.-Gen. Sir A. A. Bowlby.

K.C.M.G.—Temp. Maj.-Gen. Sir W. P. Herringham.

K.B.E.—Lieut.-Col. D'Arcy Power.

„ Temp. Col. C. Gordon Watson.

C.B.E.—Temp. Lieut.-Col. Sir Robert Armstrong-Jones.

„ Lieut.-Col. J. Calvert.

„ Temp. Hon. Lieut.-Col. M. H. Gordon,

„ Capt. (Act.-Maj.) R. M. Vick.

O.B.E.—Maj. F. W. Andrewes.

„ Capt. and Brevet-Maj. R. C. Elmslie.

„ Temp. Capt. (Act.-Maj.) J. E. H. Roberts.

To be Brevet Lieut.-Col.—Maj. W. McAdam Eccles.

In addition to the members of the Staff, a very large number of Bart.'s men are included in the Birthday Honours. Owing to the lack of space it is not possible to include the list in this issue, but we hope to do so in the August number.

* * *

The Blakeway Memorial Fund is making steady progress, and donations now arriving from abroad show that the appeals which have appeared in these pages are gradually reaching out-lying friends keen to testify their admiration for the man and his work. Poignancy is now given to these appeals by the notice, appearing in another column, of the birth of a posthumous child. Further contributions to the Fund will be welcomed by Capt. A. Macphail, Treasurer, Anatomy Department, or Mr. R. M. Vick, Secretary, Pathology Department.

* * *

We regret to hear of the death of Mr. Edgar Duncan Macmillan, M.R.C.S., L.R.C.P., who was a student here for the past three years, having qualified quite recently. He was taken ill with cerebro-spinal meningitis on May 2nd, just a fortnight after passing his final examination, and died three weeks later on May 23rd in York Military Hospital.

Macmillan was in his twenty-fifth year and the only son of Major J. M. Macmillan, R.A.M.C. Headquarters, Northern Command, York, and was educated at the High School, Glasgow, his father being in practice in that city at the time.

He intended to take a degree in science before proceeding to his medical course, but over-study leading to ill-health

he accompanied his parents to British Columbia, Canada, in 1910. They returned to England after five years of an open-air life which put him on his feet again. Macmillan became a medical student at this Hospital early in 1916, and by dint of hard study he passed the Conjoint Examination in the minimum regulation period. While at Bart.'s he made several friends, was respected by all his colleagues, and his conscientious work in his clinical appointments was far above the average. So keen was he in his desire for knowledge and experience that during his vacations from Bart.'s he acted as house-surgeon at the County Hospital, and assisted at the Military Hospital, York.

He was buried at Berkswich, Stafford, near the residence of his fiancée, Miss Burton, to whom, as well as his parents and sister, we extend the sincerest sympathy in their bereavement.

THE BOWLBY PORTRAIT FUND.

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

DEAR SIR,

Sir Anthony Bowlby will shortly retire from the Staff of the Hospital. It is proposed to present him with a portrait of himself, painted by a well-known artist, as a recognition not only of his services to the Hospital and Medical School of St. Bartholomew, but also as an appreciation, which all Bart.'s men must feel, for the great work that he has done in connection with the A.M.S. during the war. It is felt that all those who have come in contact with him either directly or indirectly would like to subscribe towards such an object, and therefore the notice has been circulated to all old Bart.'s men and students inviting them to do so.

A certain number of these notices have been returned to me owing to the fact that we have some incorrect addresses. I should not like to feel that there may be some who would wish to subscribe and have not received this notice, and am therefore asking you whether you would be as good as to place this letter in the JOURNAL.

It is hoped that all those who are intending to subscribe will do so as soon as possible so that arrangements may be made in selecting the artist who is to make the portrait, as this will largely depend upon the amount of money obtained. It is hoped that we shall be able to employ the services of the best artist possible.

When the portrait is painted it is intended that a meeting should be held to present the portrait to Sir Anthony, together with a list of the subscribers. The permission of the Treasurer and Almoners has been given that the portrait should be hung in the Great Hall of the Hospital amongst those of his illustrious predecessors which already adorn it.

Subscriptions, which should not exceed two guineas,

should be sent to Mr. R. Cozens Bailey at the accompanying address, who will act as Hon. Treasurer of the Fund.

Yours sincerely,

W. GIRLING BALL,

Hon. Sec.

Bowlby Portrait Fund.

WARDEN'S HOUSE,

ST. BARTHOLOMEW'S HOSPITAL AND COLLEGE,

LONDON, E.C.;

June 12th, 1919.

MEDICAL NOTES.

By SIR THOMAS HORDER, M.D.

(Continued from p. 104.)

DISEASES OF THE STOMACH.

(101) Dilatation of the stomach is not in itself an indication for gastro-enterostomy. The indication for this procedure in a case of dilated stomach is pyloric obstruction, and in proportion to the degree of this defect which is present in any particular case will benefit follow the operation. If the case is one of primary "atonic" dilatation with ptosis, the result of short-circuiting the pylorus is nearly always disappointing, and not infrequently harmful.

(102) Pain is sometimes the sole symptom in a case of duodenal ulcer, and yet, if the pain have certain characters, a diagnosis may be made with considerable confidence. Much more hesitation is called for in the diagnosis of cholecystitis in similar circumstances. *In appendicitis it is doubtful if a diagnosis based upon pain alone is ever justified.*

(103) Cardiospasm occurs under three different conditions: (i) in association with gastric "hyperacidity" and flatulence; (ii) as a neurosis; and (iii) in association with cancer of the cardiac end of the stomach. (i) is quite common; a point of importance in connection with it is that, if the pain be severe, which it not seldom is, and if the symptoms referable to the stomach be not very apparent, which they may not be, the source of the pain may be considered to be the aorta, and the pain may be thought to be anginal in character. (ii) occurs in women, usually about middle age; it leads eventually to loss of flesh, even to emaciation, and eventually to dilatation of the œsophagus; the patient often finds that she can swallow her food with relative comfort if she takes her meals alone. In (iii) the pain is usually much less severe than in (ii) and (i), and its occurrence is less erratic.

(104) Peptic ulcer is not cured by an operation performed to short-circuit it, and the surgeon who allows his patient to think so is either careless of the latter's welfare in the future,

or learns nothing from experience. A short-circuit drains the stomach, allows physiological rest to the organ, facilitates healing of the ulcerated surface, and enables the patient to get much better results from appropriate changes in his diet and habits than he can do without these helps. *The operation should be regarded as being the first step in treatment, and not the last.*

(105) Anorexia is an important, and often a very early, symptom in cancer of the stomach. It is also an important symptom in the differential diagnosis of this disease from simple ulcer, in which disease, though the appetite is often capricious (and sometimes excessive) it is rarely absent.

(106) A helpful point in the differential diagnosis of simple as against malignant pyloric obstruction is the condition of the blood: in simple obstruction, whatever the degree of emaciation—and this may be considerable—anæmia does not occur, whereas in obstruction due to cancer anæmia is almost invariable and may be very marked.

(107) It is commonly taught that cancer of the stomach is usually preceded by such predisposing causes as gastritis, simple ulcer, etc., and that cancer of the colon is preceded by constipation. The doctrine would seem to be based upon pure supposition, for though it is certain that in a few cases carcinoma supervenes upon chronic gastric ulcer, it happens much more frequently that the subjects of cancer of the stomach have been free from all forms of dyspepsia until the time the growth develops. The disease comes, as it were, "out of the blue." Similarly with cancer of the colon, more often than not the patient's first experience of troublesome constipation synchronises with the development of the carcinoma. Moreover, both gastric dyspepsia and (especially) constipation are more common in females than in males, whereas the reverse is the case with cancer of the stomach and with cancer of the colon.

(108) Cancer of the stomach developing in a woman who is the subject of marked gastroptosis may yield a mass which is felt in the neighbourhood of the umbilicus. In these circumstances, despite the apparently bad prognosis indicated by the presence of a tumour, and by its size, an exploratory laparotomy should be undertaken, because this position of the growth is relatively favourable for complete removal. Such cases provide some of the few radical cures that have followed surgical treatment in this disease.

(109) *The only hope of radical cure in cancer of the stomach is afforded by very early diagnosis.* On no account should the observer wait for the development of a tumour. If a case of gastric dyspepsia, on the evidence available, is considered to be of this nature, and if the patient continues to lose weight after fourteen days of observation in bed, with careful feeding, it is a sound proceeding to explore the stomach with a view to excision of the growth.

DISEASES OF THE LIVER.

(110) In palpation of the liver it is well to adopt a definite method. Perhaps the following is as good as any:

(i) *Find the lower border and trace its outline.* In doing this, care should be taken to begin the palpation sufficiently low down to ensure not missing the edge of an organ that is larger than was anticipated. If this precaution be not adopted, and the surface of the liver happen to be smooth, it is not unlikely that the observer will report that the lower border of the liver cannot be felt. This error is avoided by beginning to palpate in the right iliac fossa and proceeding gradually upwards. (ii) *Ascertain the characters of the lower border*—? thin or thick, ? regular or irregular, ? normal consistency or hard, ? everted. (iii) *Explore the anterior surface* of the organ for uniformity or lack of it, and for the number and size of any irregularities, with any special feature these may possess, e. g., umbilication. (iv) *Judge of the massiveness of the organ*, using the bimanual method, which has also been employed in (i) and (ii). (v) *Judge also of the degree of fixation of the organ* by bimanual palpation when the patient is in the genu-pectoral position.

(111) There are three stages in the course of alcoholic cirrhosis of the liver: portal congestion, portal pressure, and cholæmia. In the first stage the symptoms are chiefly those of chronic gastritis, and physical signs are, for the most part, absent. The symptoms and signs during the second stage are chiefly referable to the collateral portal circulation. The symptoms of the third stage are toxic, and are analogous to those met with in icterus gravis. But in most cases this third stage never arrives, because the patient succumbs to one or other of the serious complications of the second stage (hæmatemesis, portal thrombosis, heart failure), or to one of those infective processes to which the patient is specially liable (tuberculosis, streptococcus and pneumococcus infection).

(112) Hæmatemesis in cirrhosis of the liver may occur during the stage of portal congestion, in which case the bleeding is due to more or less general oozing from the congested gastric mucosa and is not of serious consequence; or it may occur during the stage of portal pressure (collateral portal circulation), when the blood usually comes from an ulcerated varicose vein at the lower end of the œsophagus and is of very serious significance. If this distinction can be made clearly in any particular case, the treatment is considerably helped. In the early type of hæmorrhage portal depletives may be used freely with advantage; in the later type the treatment should be on the lines adopted in the hæmatemesis of gastric ulcer.

(113) The state of compensation which is seen in many cases of cirrhosis of the liver during the second stage may be maintained at a fairly good level for several years, provided the patient gives up all or most of his alcohol and

adopts a simple dietary. This condition of things is rarely seen in hospital practice—a fact which explains the bad prognosis in respect of time given by many authors in this disease.

(114) The distinction which has been made between cirrhosis of the liver and perihepatitis in regard to ascites—namely, that when ascites recurs several times after paracentesis the pathological condition present is perihepatitis and not cirrhosis—is probably much too arbitrary. It is doubtless true that, *ceteris paribus*, perihepatitis is more constantly followed by ascites than is cirrhosis of the liver; but it is also true that recurring ascites not seldom complicates cirrhosis in the absence of perihepatitis.

(115) *Fever is common in cirrhosis of the liver, but the cause of it is by no means always apparent.* Serious causes that should be passed in review are pleural, pulmonary and peritoneal tuberculosis, septic pylephlebitis and cholecystitis. When the cause is obscure and the degree of pyrexia slight, the fever is probably related to subinfection of the peritoneum by micro-organisms of low virulence. Chemical and cytological examination of the ascitic fluid and post-mortem examination of the peritoneum yield evidence that chronic peritonitis is common in cirrhosis of the liver.

MODERN METHODS OF TREATING FRACTURED FEMORA.

By W. ETHERINGTON WILSON,
Resident Medical Officer, 1st London General Hospital.

“To look back to Antiquity is one thing,
To go back to it is another.”

(Continued from p. 107.)

PUTTING UP A FRACTURED FEMUR INTO THE FIRST POSITION (Fig. 1).

It is better to give a general anæsthetic; gas ought not to be used, and gas and oxygen in the hands of experts only. Complete relaxation is necessary.

The Thomas having been fitted, the leg and thigh are supported by four-inch-wide slings, clipped on the outer bar. The glue extension is applied, having first scrubbed the leg with a solution of sodium bicarbonate to get the grease out of the skin, thus enabling the glue to do its part better. The extension support is attached, the Sinclair foot-piece applied, and the Thomas with the fractured limb slung from the frame. As a routine, the bars of the splint should be bent slightly at the knee so that the latter lies flexed in the Thomas.

The nearer the fracture to the knee the more the splint is bent, and the further away the fracture from the knee the

straighter the splint. A middle-third fracture of the femur requires the knee flexed about ten degrees. The sling just above the knee and the one actually controlling the site of fracture are kept pulled up taut. If the leg now be pulled in this semiflexed position, leverage is obtained, enabling the lower fragment to be kept from sagging backwards. This backward sagging is one of the most common and serious disabilities resulting; more will be said about it later. It is necessary here to bear this in mind. The natural forward curve of the femur is aimed at, hence the sling at the site of the fracture is heaved up until the thigh presents this gentle curve forwards.

The ring of the Thomas is pulled up the thigh as far

The cord and extension should be gently untied, the splint pulled up, and then the former tied again. The amount of pull going on can be gathered by feeling whether the cord tying the splint to the frame is taut or not. It must be kept pulled tight.

As regards discomfort, this only lasts two or three days, and is due to some extent to the patient's unusual position. Morphia gr. $\frac{1}{4}$ is given at once if there are any complaints of pain the first day. Patients soon get used to having their "legs pulled," and even like it—obviously so.

Pain is often due to spasm or traction on some particular muscle of the thigh; the adductors offend particularly. Massage and morphia tide this over the first day or two.

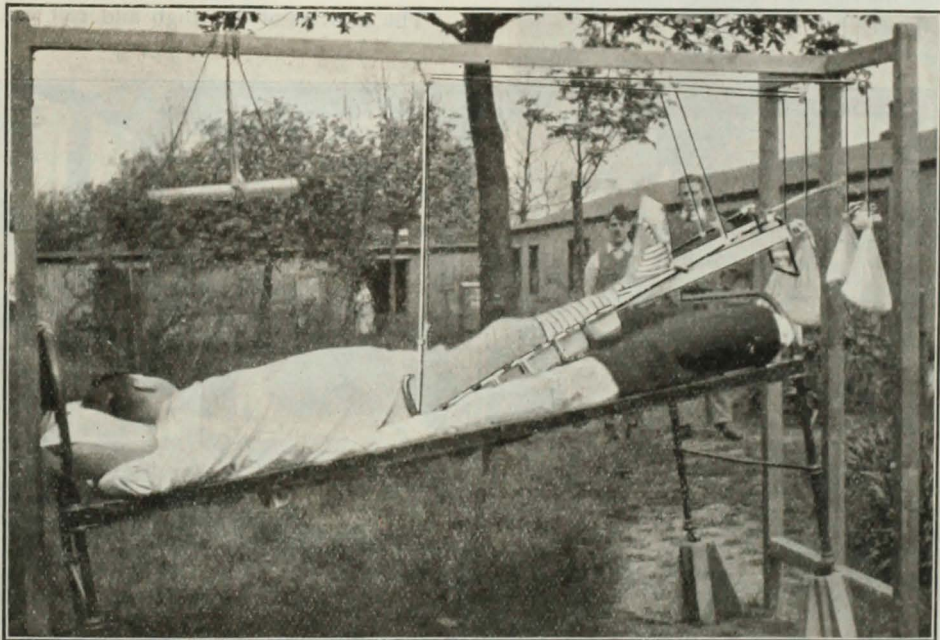


FIG. 1.—FIRST POSITION OF A FRACTURED FEMUR.

as anatomy will allow, and the extension is tied round the support. The foot of the bed is raised on the 12-in. blocks, the patient is brought well down the bed, and the end of the splint is tied with cord as near as possible to the vertical beam of the frame. The patient is only allowed one flat pillow, except at meal-times. The foot-piece is rotated so that the foot rests with the toes turned out in the walking position.

The patient is now "hanging by his leg," *i. e.* the body-weight is pulling on the cord; the cord is pulling the end of the splint, which causes the extension on the leg to pull the thigh. Thus the pull is obtained by body-weight, the amount depending on the slope of the bed.

Next day it may be found that the ring of the Thomas has been pulled downwards for an inch or more, this being due to the stretching of structures concerned in the pull.

Skiagrams are taken two or three days after putting the case up: an anterior and a lateral view are necessary, except in upper third fractures, where lateral views are difficult to obtain. If the position is not satisfactory and adjusting of slings has to be done the skiagrams will need repeating to see the corrected position.

The first position lasts for eight weeks in an average simple fracture; the time, however, varies in some cases, and the following three points help to decide.

- (A) *Amount of callus* and its quality shown in X-ray after 8 weeks. This varies very much in some cases.
- (B) *Position of fractured ends.*—The following rough rules will be found useful as a guide:
 - (i) Perfect end-to-end apposition with visible and palpable callus around site of fracture: 9 weeks.

- (ii) End-to-end junction with good, visible and easily palpable callus, when the fractured surfaces are only partially apposed: 8 weeks.
- (iii) Cases with side-to-side apposition, *i. e.* with overlap and union with visible palpable callus: 10 weeks.
- (c) The patient can raise the whole thigh in one piece quite painlessly, and he will say it feels very firm.
- To recapitulate. The objects of the first position in femur treatment are:

- (i) To obtain correct alignment of the fragments.
- (ii) To keep the corrected position until the callus formed is sufficient in amount and quality to hold the fracture in position without the pull of the body-weight.

SECOND POSITION (Fig. 2).

The extension cord tying the splint to the frame is removed; the foot of the bed is lowered by removing the blocks; the bars of the Thomas are straightened with irons, or if these are not available the splint should be changed for a straight Thomas. It is necessary to have the knee fully extended now to prepare for the third position of walking. The foot-piece is removed and the foot supported at right angles by a sling across the sole clipped in position between two uprights.

The limb now lies passively in the splint, being held there by the glue extension in the ordinary way; the extension by body-weight has done its work.

The muscles of the thigh and calf can now be brought

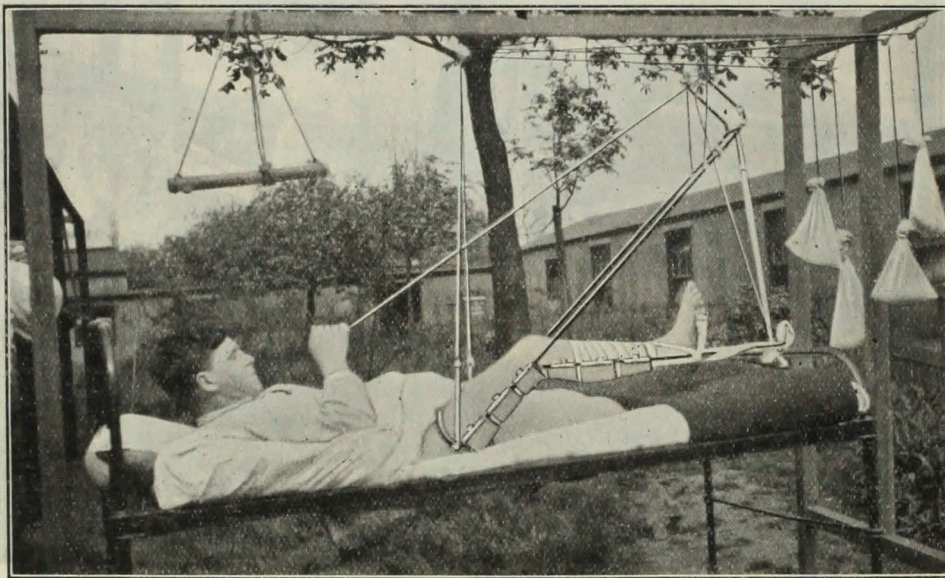


FIG. 2.—SECOND POSITION OF A FRACTURED FEMUR WITH KNEE-FLEXING PIECE.

- (iii) To prevent mal-union, causing disabilities.
- (iv) To prevent shortening.

Obviously, then, the first stage in the treatment is the most important, because on it depends the result to be obtained.

Massage and Electrical Treatment.

Massage of the knee and patella, the quadriceps extensor muscles and the site of fracture should be commenced about six weeks after the fracture.

Electrical stimulation of the quadriceps by the Faradic current should be done for fifteen minutes daily, beginning after three weeks in the favourable cases.

The objects of massage and stimulation are to stimulate the formation of callus, to prevent muscular wasting, to prevent adhesions, especially about the patella and knee, resulting in stiffness of the joint.

into action and the foot can be moved as desired by the patient—in other words, a certain amount of stress is thrown on the site of fracture, and this is a most important factor in the hardening of callus. This stage, then, is one of passive hardening. The position described above is maintained for about seven days and then a knee-flexing arm is added to the apparatus (Fig. 2). The flexing-piece resembles the lower half of a Thomas splint, being less wide so as to fit inside the bars of the latter, to which it is attached by two screws $\frac{3}{4}$ in. above the line of the joint. The leg is transferred to this flexing splint, and by means of a pulley, etc., the patient is able to flex and extend his own knee by pulling a cord (see Fig. 2). The ends of the splints are tied by a long piece of tape limiting the range of flexion. The range of movement of the knee can be daily increased by letting out the tape as far as the patient will allow. When exercising

the joint the leg should always be pulled up into the completely extended position.

Early movement of the knee is very necessary and the result in simple fractures is very good. In compound fractures of the femur, especially where septic processes are still at work among the muscles, resulting in adhesions and scarring, the early movement of the knee is unavoidably delayed.

The second position, including the flexing splint, is maintained for three to four weeks, but this again depends on the progress of the case.

To repeat once again: The second stage in the treatment of a fractured femur is a process of passive hardening of the flexible callus formed in the first stage, and is preparatory to the third stage of active hardening.

THIRD POSITION (Fig. 3).

All apparatus is removed, the limb is measured for a walking caliper, and while the latter is being made the leg lies in bed between sandbags, a pad being placed under the site of fracture.

Method of fitting a walking caliper.—An ordinary Thomas splint with a smaller sized ring is tried on the thigh. The ring is pulled and eased up the thigh as high up as anatomy will allow and must fit the thigh accurately in this position, so that no gap exists between it and the skin. The posterior and inner part of the ring must abut against the tuber ischii when the splint is pushed upwards; it is most important that the tuberosity should not slip through the ring, as the whole idea is that when upright the patient should sit on the ring of the caliper.

The splint is now jammed up against the ischial tuberosity and the length of the limb recorded on the inner bar at the level of the sole of the foot at right angles, a scratch with a file being made. Another mark is made $\frac{3}{4}$ in. below the former. The splint is then sent to be made into a caliper, with instructions that the bend is to be made beyond the second mark, the cut horizontal ends fitting into a hole made on each side of the heel of the boot, the outer hole being placed about 1 in. further forward on the heel than the inner one. The object of this oblique fixation of the ends of the caliper is to keep the foot turned slightly outwards, as in walking. It will be seen now that when the walking caliper is worn it is too long for the patient, so that his heel does not touch the bottom of his boot by $\frac{3}{4}$ in. Thus the patient "sits" on his caliper when walking, and only a very small portion of the body-weight is thrown on the fracture through walking on the ball of the foot.

It is emphasised that the heel should not reach the bottom of the boot when walking; disregard of this point may lead to bending of the fracture, with deformity and shortening.

It is necessary to support the knee in the caliper and to this end a trough splint is used, which can be moulded

to fit the back of the limb accurately from the upper part of the thigh to the top of the boot. This is bandaged on, the same bandage also taking in the bars of the caliper from top to bottom, making the splint and leg secure and preventing the ends of the caliper from springing out of the boot when walking.

Correction of shortening and lengthening.—In the proper treatment of a fracture of the femur obtained within a week of the smash, it is just as easy to finish up with the limb a quarter of an inch too long as it is a quarter of an inch



FIG. 3.—THIRD POSITION WITH THE WALKING CALIPER.

too short. The tendency of over-pulling with consequent lengthening has to be guarded against.

Each limb is measured from the anterior superior iliac spine to the tip of the internal malleolus, the patient lying quite square in the bed with legs outstretched. The same points are chosen on these bony landmarks, otherwise it is quite easy to make a mistake of an inch. Another less accurate measurement is from the anterior superior iliac spine to the upper border of the patella.

- (a) If both limbs are of *equal length* add $\frac{3}{4}$ in. thickness to the heel of the sound boot (because the caliper on the other leg is $\frac{3}{4}$ in. too long), and $\frac{3}{8}$ in. bars (like football boots) to the sole.
- (b) If the injured limb is, say, $\frac{1}{2}$ in. *short*, then the sound side must be raised $\frac{1}{4}$ in. ($\frac{3}{4} - \frac{1}{2}$) to make the lengths equal.
- (c) If the injured limb is $\frac{1}{2}$ in. too *long*, then the sound side must be raised $1\frac{1}{4}$ in. ($\frac{3}{4} + \frac{1}{2}$).

Only half the difference in length is required to be put on the sole of the boot in these cases.

The caliper and boots being fitted and the Jones's trough splint bandaged into position, the patient is helped to walk a few yards the first day and then treated to a brandy and soda if necessary. Our experience with soldiers on the second day is that many walk out of the ward and round the hospital grounds with the help of two sticks. Crutches ought not to be encouraged. After a few days one stick alone is used.

A webbing strap attached to the front and back of the ring of the caliper and passing over the opposite shoulder keeps the ring up in the crutch and this completes the outfit.

The meaning of the third position may be briefly expressed as follows: It is a process of active hardening of the callus already partially prepared by the second position, in order to bring it gradually into the bony condition essential to the patient if he is to walk without a splint, or the fear of further deformity gradually arising by the give of the not too well consolidated "cement." The results of recent experience have led to the suggestion that the walking calipers ought not to be discarded for six months. The length of time, however, ought to vary with the case in question. Four to six months would be a better rule to adopt, and no patient should be advised to wear it for less than four months to be on the safe side.

FURTHER TREATMENT.

Daily massage and active and passive movements of the knee-joint should be carried out during the third stage.

Much can be done by the patient himself, night and morning, while the splint is not worn.

Great care is necessary during passive movements of the knee lest bending occur at the site of the fracture. This is particularly liable to occur in fractures of the lower third of the femur adjacent to the joint, in which cases vigorous methods will result in backward bending at the site of fracture.

In obstinate knee-joints following compound fractures a larger range of movement will be obtained when the patient is able to throw away his caliper and begin to use the knee by walking.

A STATE MEDICAL SERVICE.

REPORTS AND RETURNS.

By A CAPTAIN IN THE R.A.M.C.

THE following is an example of what much of the work consists of in a State Medical Service:

Reports and Returns.

2626/29(D.M.S.5).

ARMY HEADQUARTERS, INDIA,
MEDICAL BRANCH,

SIMLA;

October 19th, 1918.

From

THE DIRECTOR, MEDICAL SERVICES IN INDIA,

To

THE MEDICAL OFFICER

IN CHARGE OF PRISONERS OF WAR CAMP,
HOSPITAL, ———.

Memorandum.

With reference to the monthly return of sick for Turkish Prisoners of War for September, 1918, it is pointed out that the causes of deaths shown marginally is not considered sufficiently explanatory for statistical purposes.

Attention is invited to this Office letter No. 17243-15 (D.M.S.5) dated the 26th February, 1918.

(Signed) ———,

Lieut.-Colonel, R.A.M.C.

For Director of Medical Services in India.

Reply.

No. —, Civilian, ———. Drowning (accidental).

Kindly note that this death should be returned as No. 1030 (a) Suffocation from submersion.

Kindly correct your office copy accordingly.

THE PAST AND PRESENT CRICKET MATCH.

BY ONE OF THE "OLD 'UNS."



WHAT a pity it is that the "old 'uns" cannot both bat and field in the afternoon. We batted as usual after lunch, walked to the wickets 'midst sympathetic murmurs and encouraging glances from the bright eyes of our feminine admirers—and we rejoined them very shortly to explain what we would have done with that

bowling in the olden days and how we got out to the only good ball of the match. It is true that a surgeon, who was called away in the nick of time immediately previous to his going in, has emphatically declared that the bowling was poor and that he would probably have made a century. The fact remains, however, that the others did not often succeed in hitting the ball where they wished it to go.

On the other hand, our fielding was really admirable considering. Our wicket-keeper was in great form, a distinguished anaesthetist bowled a wicket to his evident surprise and delight, the aforesaid surgeon caught a catch in the slips 'midst the plaudits and congratulations of his colleagues, a neurologist of renown bowled three overs, and, being rather an expensive physician, was then removed from his office, and the team as a whole placed itself with great bravery directly in the way of the ball and dashed to the boundary—after the ball—time and again, oblivious of the fact that they would bitterly regret their unusual agility on the morrow. Altogether we felt quite pleased with ourselves, but this was all unseen by those whom we desired to impress.

Anyhow, we had an excellent lunch and tea, a delightful day, and a few hours in which to renew old friendships. Also we hope to be asked to play again next year. We were not downhearted, though some of us were stiff and sore for days afterwards.

PRESENT.		PAST.	
S. Orchard, b Dalton.....	12	S. G. Etheridge, c Parkes, b	
J. Parrish, c Last, b Dalton	5	Parrish	6
A. E. Parkes, c and b Dalton	68	H. M. Williams, run out.....	12
P. C. Collyns, c Gibson, b		C. M. Hinds Howell, b	
Etheridge.....	18	Parrish	6
C. H. Bracewell, c Gibson, b		C. W. O'Brien, st Bracewell,	
Last	34	b McCall	2
H. D. McCall, b Dalton ...	15	H. A. Dalton, not out	23
M. G. Thomas, not out.....	33	H. E. S. Boyle, b Parrish ...	11
R. S. Coldrey, c Rawling,		L. B. Rawling, absent	0
b Dalton	4	H. J. Churchill, b McCall ...	1
H. V. Morlock, st Gibson, b		F. H. Robbins, c and b	
Dalton	0	Parrish	7
T. E. Moody - Jones, b		R. W. B. Gibson, b Parrish	1
Etheridge	15	Last, b McCall	0
S. Mahmoud, b Boyle	0		
Extras	27	Extras	4
Total	231	Total.....	73

OBITUARY

ARTHUR CARLILE STURDY, M.C., F.R.C.S.

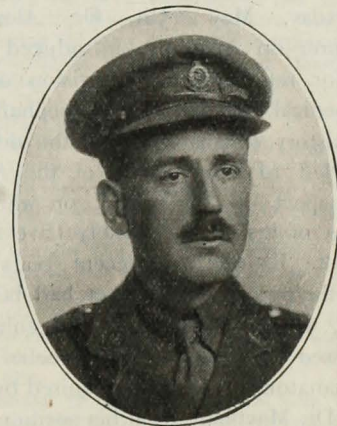


CAPTAIN Arthur Carlile Sturdy, M.C., F.R.C.S., died of dysentery in the Colaba Military Hospital, Bombay, on May 1st, at the age of 36. He was the second son of the Rev. H. C. Sturdy, formerly Vicar of St. Paul's, Dorking. He was educated at St. Paul's School, whence he went to Cambridge and afterwards to St. Bart.'s, where he held the posts of House-Surgeon and Intern

Midwifery Assistant. After leaving the Hospital he became Senior Resident Medical Officer at the Royal Free Hospital. For a time he was practising at Baldock, and in 1913 he entered into partnership with Messrs. Vernon, Kinneir, Jukes, Stevens & Jamison at Horsham. He became a member of the staff of the Horsham Cottage Hospital, and in that capacity did a considerable amount of surgical work.

Early in the summer of 1915 he volunteered for service in the R.A.M.C., and served in France until June, 1917. During the latter part of this time he was attached as M.O. to the 2nd Hampshires, and while with that regiment he gained the Military Cross. The official account says that "he attended the wounded for many hours under heavy fire. He showed a complete disregard for danger in organising search parties, and recovered wounded who had been left for several days."

He returned home in June, 1917, after completing two



THE LATE CAPT. ARTHUR CARLILE STURDY.

years' service with the rank of captain. On the demand for more medical officers in October, 1917, he rejoined the R.A.M.C., and was soon sent to Mesopotamia, serving in a casualty clearing station, and latterly as Surgeon-Specialist in the 33rd Base General Hospital in Basra, where he remained until April of the present year, when he started to come home. On reaching Bombay he found that he could not get a ship for some weeks, and went to Naini Tal to see a brother who was suffering from dysentery. In Naini Tal Captain Sturdy himself suffered from dysentery, and was admitted into hospital; after a short stay there he appeared to have quite recovered, and returned to Bombay, expecting to embark for home. On the journey by rail he had a recurrence of his illness, and was removed from Bombay station in an ambulance to the Colaba Hospital, where he died the following night. His unexpected death after three and a-half years of hard and faithful service comes as a very hard blow to his many friends, who have been eagerly hoping to welcome him home. He knew his

work well, and always did it thoroughly. As a colleague he was always reliable in all things, and he knew how to gain the confidence and affection of his patients. Those who knew him best liked and respected him most. Though his place knows him no more, his memory will live with his friends of all classes. He had a charming personality, and he worked hard without stint and without jealousy. His professional attainments were high, and he was ever eager to learn. He seemed to have a bright future. He was a keen lover of music and an enthusiastic mountaineer.

St. Bart.'s has lost a devoted son of whom she may be proud. May he rest in peace. M. H. H. V.

ABERNETHIAN SOCIETY.



At a meeting of the Abernethian Society held on Thursday, May 15th, Dr. Alex Macphail, Lecturer on Anatomy, introduced a discussion on the need for reform in the provision of anatomical material for medical schools. Dr. Macphail first briefly reviewed the history of anatomy and the difficulties and crimes which led to the passing of the Anatomy Act in 1834—an aspect of the subject on which two previous addresses of his to the Society have already been published in the JOURNAL in recent years. He then explained how the purpose of the Act had been frustrated in many ways, ways unforeseen by the enlightened politicians who passed it into law in the full belief that it would provide all the anatomical material required by the schools for all time. Dr. Macphail, from his position as Secretary of an International Committee of Licensed Teachers of Anatomy and Operative Surgery, was able to say something of the steps which had been taken to get the present Government to deal with the problem on lines suited to the needs of the present time, and was hopeful that a marked improvement in the supply might be attained in the near future. But he pointed out that the "subjects" on which teaching and research in anatomy and operative surgery are dependent, the bodies of the unclaimed dead, are becoming a vanishing quantity owing to the steadily increasing success of many measures which are tending to reduce the ranks of pauperism in this country. Thus the time must soon come, in no very distant future, he said, when other means of providing "subjects" must be found if the only sure foundation of medicine and surgery is to be secured, viz. the dissection of and operative practice on the the dead. The lecturer dwelt on the possibility of history having to repeat itself through medical students being forced through lack of human subjects to learn anatomy solely by dissecting lower animals; but this would mean a return to the dark ages of medical study, and the problem must be solved, if possible, in other ways. Pointing out to

the younger members of the Society that the problem will be theirs to solve, Dr. Macphail advocated frank dealing with the public, rich and poor alike, in whose best interest it is, in the long run, that the practitioners to whom they entrust their health in life should be adequately provided with the necessary training in anatomy and operative surgery during their student career.

At Dr. Macphail's suggestion a discussion was then opened by the President, Mr. Fisher, in which various members took part, and several important points were raised and considered.

The vote of thanks proposed by the Secretary, Mr. Zerolo, was seconded by Mr. Hume, both of whom referred to the great interest and initiative taken by Dr. Macphail in a matter of such vital importance to the medical profession. The vote was carried with acclamation.

T. F. ZEROLO } *Hon. Secs.*
N. S. B. VINTER }

RAHERE LODGE.



THE Installation Meeting of the Rahere Lodge, No. 2546, was held in the Great Hall of St. Bartholomew's Hospital on Tuesday, June 17th, 1919. Three candidates, G. W. Stone, W. B. Heywood-Waddington, and C. H. Thomas, were initiated by the W.M., W. Bro. Hepburn. W. Bro. Ernest Clarke delivered the charge to the Initiates. W. Bro. Hepburn then installed W. Bro. Swinford Edwards as Worshipful Master for the ensuing year. The charges were delivered by W. Bro. Hepburn, W. Bro. Laming Evans and W. Bro. Perram. The following officers were appointed:

W. Bro. F. SWINFORD EDWARDS	W. M.
W. Bro. A. HEPBURN	I. P. M.
Bro. E. W. BREWERTON	S. W.
Bro. H. PRITCHARD	J. W.
Bro. The Rev. DAND	Chaplain.
W. Bro. ERNEST CLARKE, P.M., P.G.D.	Treasurer.
W. Bro. E. LAMING EVANS, P.M., L.R.	Secretary.
W. Bro. M. L. TRECHMAN, P.M., L.R.	D. C.
Bro. A. S. WOODWARK	S. D.
Bro. GIRLING BALL	J. D.
W. Bro. H. MORLEY FLETCHER, P.M., P.G.D.	1st Asst. D. C.
W. Bro. FRANCIS CLARK, P.G.D.	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. R. M. VICK	Asst. Secretary.
W. Bro. G. H. WHITAKER, L.R.	I. G.
W. Bro. E. P. FURBER, P.P.G.J.W., Surrey	Sen. Steward.
Bro. J. CUNNING	Steward.
Bro. F. A. ROSE	Steward.
W. Bro. A. H. COUGHTREY	Tyler.
Bro. E. W. HALLETT	Asst. Tyler.

After the ceremony in the Great Hall, seventy-seven members and guests met at the banquet at the Imperial Restaurant. Many brethren resumed their masonic duties after a lapse of five years. The evening was marked at an

early stage by a spontaneous outburst of joyous congratulation to the Father of the Lodge, W.Bro. Sir D'Arcy Power, upon the recent honour of Knight Commander of the Most Excellent Order of the British Empire conferred upon him. Wild enthusiasm was followed by the singing of "He's a jolly good fellow."

The Sheriff of the City of London, W.Bro. Banister Fletcher, responded to the toast of the "Grand Officers," and W.Bro. Sir John Cockburn, K.C.M.G., himself a medical man, and latterly Agent-General for South Australia, responded for the visitors.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

AT the Annual General Meeting held in March for the election of officers, the following were elected:

Captain 1st XV	C. Shaw.
Vice-Captain	M. G. Thomas.
Secretary	S. Orchard.
Captain 2nd XV	N. G. Thomson.
Secretary	E. F. Peck.
Captain 3rd XV	Not elected.
Secretary	

Full fixture lists for three XV's have been arranged. The 1st XV fixtures include matches with Harlequins, Richmond, Roslyn Park, London Welsh, London Irish, Oxford University, Cambridge University, United Services Portsmouth, Rugby, Coventry, and all the "Old Boys" teams.

University College Hospital will be met in the 1st Round of the Hospital Cup.

CRICKET CLUB.

Up to the present the Hospital have only won two matches. We have been unlucky in not being able to put our whole strength into the field for the majority of matches, the absence of Melle and McCall especially being severely felt. The batting has been disappointing, chiefly owing to lack of nets. Most of the runs have come from the first three or four. Against the Cryptics, however, we gave our best batting display of the season, everybody batting well to make a creditable draw. We have had a good number of runs scored against us. The bowlers have had no assistance from the wickets, but too many loose balls are sent down, and no one can be relied on to keep a good length. The ground fielding has been good, and the catching moderate.

v. WINCHMORE HILL. Lost.

Winchmore Hill, 136. Bart.'s, 125 (Melle, 56).

v. SOUTHGATE. Lost.

Southgate, 144. Bart.'s, 98 (Melle, 26).

v. HORNSEY. Drawn.

Bart.'s, 233 (Melle, 109; Orchard, 73; Parkes, 33 not out). Hornsey, 230 for 6 wickets.

v. OLD CITIZENS. Won.

Old Citizens, 27 (Melle, 6 for 9; McCall, 4 for 14). Bart.'s, 294 (McCall, 61; Melle, 50; Orchard, 57).

v. GUY'S (1st ROUND, CUP). Lost.

Bart.'s, 187 (Melle, 92). Guy's, 232.

v. WELLINGBORO' MASTERS. Lost.

Wellingboro', 336 for 4; declared. Bart.'s, 128 (Parkes, 38, Bracewell, 24).

v. Dr. CALVERT'S XI. Lost.

Dr. Calvert's XI, 139. Bart.'s, 129 (Bracewell, 36; Orchard, 34).

v. R.A.M.C., ALDERSHOT. Lost.

R.A.M.C., 209. Bart.'s, 127 (Parkes, 52; Orchard, 30).

v. PAST. Won.

Present, 231. Past, 73.

v. CRYPTICS. Drawn.

Cryptics, 311 for 8, declared. Bart.'s, 191 for 6 (Bracewell, 69 not out; Orchard, 33).

v. ALEXANDRA PARK. Lost.

Bart.'s, 180 for 6, declared (Orchard, 67; Bracewell, 29). Alexandra Park, 181 for 6.

v. INDIAN GYMKHANA. Lost.

Indian Gymkhana, 301 for 8, declared. Bart.'s, 84 (E. Coldy, 32).

v. CHESHUNT. Lost.

Bart.'s, 139 (Parkes, 53). Cheshunt, 140 for 4.

LAWN TENNIS CLUB.

Great difficulty has been experienced this year in discovering the best talent in the Hospital as no lawn tennis to speak of has been played during the war; but by the inauguration of a Hospital tournament, and thanks to the energies of Messrs. J. G. Johnstone and H. T. Hendley, it was possible to select a representative team to play against Guy's Hospital on June 13th in the First Round of the Inter-Hospital Cup Tie.

Of the four matches played so far the Hospital has won three and lost one, viz. against Chiswick Park "B." Krige and Johnstone did well to win all their three matches against Chiswick "B."

The match against the Gentlemen of Winchmore Hill proved an easy win for the Hospital, the first and second pairs experiencing no difficulty in winning all three of their matches.

The match against the Past on June 11th was played under ideal conditions. The Past were obviously out of practice, showing great knowledge of the game, but not bringing off their strokes with precision till the end of the afternoon, when it was evident that the Present would have had their work cut out to win had the Past been in form at the first.

The First Round of the Inter-Hospital Cup Tie against Guy's Hospital saw the Hospital at its full strength for the first time, and resulted in a win for Bart.'s by eleven matches to three. St. Bartholomew's won five Singles out of the six, despite their lack of practice in Singles, so it was only necessary for them to win three of the "Doubles" matches in the afternoon to win. This they soon did, the first two pairs of the Hospital again winning all three matches.

RESULTS.

St. Bartholomew's Hospital *v.* Chiswick Park "B" was played at Winchmore Hill on June 4th, 1919, the result being a win for the visitors by 5 matches to 4.

St. Bartholomew's Hospital *v.* Gentlemen of Winchmore Hill, June 7th, 1919, at Winchmore Hill, resulted in a win for the Hospital by 7 matches to 2 and 106 to 62 games.

The Present *v.* the Past—played at Winchmore Hill June 11th, 1919—resulted in a win for the Present by 7 matches to 2 and 107 games to 68.

St. Bartholomew's Hospital *v.* Guy's Hospital (Inter-Hospital Cup Tie), played at Winchmore Hill on June 13th, 1919, resulted in a win for St. Bartholomew's Hospital by 11 matches to 3 and 183 games to 131.

CORRESPONDENCE.

THE TREATMENT OF AMŒBIC DYSENTERY.

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

SIR,—In recent issues of the JOURNAL I have read with interest Capt. Prall's paper and Major Maxwell's letter on the treatment of amœbic dysentery.

Capt. Prall did not have his cases long enough under observation to know if his treatment had really brought about cure.

It is true, as Major Maxwell writes, that heroic doses of ipecacuanha are no longer necessary. It was always a difficult—to put it mildly—form of treatment. Natives of India "put up with it" more readily than Europeans. However, it was often completely effective, as careful microscopic investigation of stools over lengthy periods, following on treatment, showed.

A lively memory of that form of treatment, both as administrator—of necessity forceful if not bullying—and, in due turn, revolting patient and receiver, compels agreement with Major Maxwell that, with emetine at hand, it is a barbarous treatment. In quite small doses, however, ipecacuanha is still useful and effective in certain cases.

The "cure" of carrier cases by bismuth emetine iodide is probably just as satisfactory as Major Maxwell claims; it is not wise, perhaps, yet to make any too definite statements about the permanency of these cures. However this may be, all experience of the disease to-day leaves no doubt at all that the B.E.I. treatment of chronic cases and carriers is a great improvement on the method of hypodermic injection of emetine hydrochloride by itself.

While not daring the attempt to define "excessive" or "too long" in relation to the use of emetine and/or bismuth emetine iodide, I may be allowed to state that, like Major Maxwell, I have never been able to convict emetine or B.E.I. of any ill-effects following its use. Consideration is due to the facts that—

(1) Some cases of chronic amœbic dysentery undergoing emetine and/or B.E.I. treatment show D.A.H.

(2) Some cases after apparent cure of dysentery by one or more courses of emetine and/or B.E.I. show D.A.H.

(3) Some cases of D.A.H.—their only objective or subjective symptom—are found to be infected with *Entamoeba histolytica*.

In all these cases (1, 2, 3) *E. histolytica* can be demonstrated.

In most of these cases (1, 2, 3) D.A.H. disappears after *E. histolytica* disappears.

In most of the cases (3) *E. histolytica* disappears on treatment with B.E.I. or B.E.I. and emetine hydrochloride combined.

There is surely excuse for the proposition that the D.A.H. in emetine hydrochloride and/or B.E.I. treated amœbiasis may be caused by the entamœbæ and not by the emetine.

I am, Sir,
Yours faithfully,
H. M. HANSCHHELL.

LONDON SCHOOL OF TROPICAL MEDICINE
(UNIVERSITY OF LONDON),
ROYAL ALBERT DOCK, E.;
June 10th, 1919.

EXAMINATIONS, ETC.

UNIVERSITY OF LONDON.

Third (M.B.B.S.) Examination for Medical Degrees, May, 1919.

Honours.—R. J. Perkins, Distinguished in Medicine, Forensic Medicine and Surgery. University Medal.

Pass.—J. E. A. Boucaud, J. Capell, P. Selwyn Clarke, G. F. Cooke, J. N. Leitch, B. H. Pidcock.

Supplementary Pass List, May, 1919.

Group I.—R. G. Lyster, C. H. Thomas, W. R. White-Cooper.

CHANGES OF ADDRESS.

ANDREW, JOHN, 5a, Penywern Road, Earl's Court, S.W. 5.
DALLY, J. F. HALLS, 93, Harley Street, W. 1. (Tel. Mayfair 2697, unchanged.)
DRAKE, E. C., 23, Park Square, Regent's Park, N.W. 1 (After July 12th.)
FIDDIAN, J. V., 76, Dunham Terrace, Ashton-under-Lyne.
HOWELL, B. W., 35, Weymouth Street, W. 1; and 55, Cornwall Gardens, S.W. 7. (Tells Western 4141 and 361.)
JOHNSON, H. J., Heathgate Corner, N.W. 4.
KING, H. H., Capt. I.M.S., c/o Cox & Co., Bombay.
MILNER, S. W., Caprera, Cleveland Road, Torquay.
PAYNE, J. E., 57, Carlisle Road, Eastbourne.
PRANCE, C. H. G., Ashtead, Surrey.
QUICK, H. E., 137, Walter Road, Swansea.

ROBERTS, J. E. H., (Residence) 1k, Montagu Mansions, Portman Square, W. 1. (Tel. Mayfair 4818.)

ROBERTSON, J. F., Ullesthorpe Grange, near Lutterworth.

SMITH, N. F., 6, Queen's Road, Hertford.

WALLER, H. M., Oakfield, Ellesmere Port.

WARD, R. OZIER, St. Peter's Hospital, Henrietta Street, W.C. 2.

WRANGHAM, J. M., Stones House, Ripponden, near Halifax.

YOUNG, F. P., Dilkusha, Newquay, Cornwall.

APPOINTMENTS.

BOURNE, GEOFFREY, M.B., B.S. (Lond.), M.R.C.P., appointed Assistant Physician to the Queen's Hospital for Children.

RIVIERE, B. B., F.R.C.S., appointed Honorary Surgeon to the Jenny Lind Children's Hospital, Norwich.

SCOTT, W. H., M.R.C.S., L.R.C.P., appointed Resident Medical Officer at the Western Dispensary, Rochester Row.

SHAH, J. M., Capt. I.M.S., M.R.C.S., L.R.C.P., appointed M.O. i/c Troops and O.C. Military Detention Hospital, Jaffa, Palestine, E.E.F.

SMITH, N. F., M.R.C.S., L.R.C.P., appointed Assistant Honorary Medical Officer to the County Hospital, Hertford.

WARD, R. OZIER, D.S.O., M.C., F.R.C.S., appointed Junior House-Surgeon to St. Peter's Hospital, London.

BIRTHS.

BLAKEWAY—On June 29th, at the Cottage, Poplar Grove, Woking, the wife of the late Harry Blakeway, F.R.C.S., of a daughter.

RIVIERE—On January 5th, 1919, at St. Giles Plain, Norwich, to Veronica, wife of Bernard B. Riviere, F.R.C.S. (Eng.)—a son.

SCHOLTZ—On May 4th, at Secunderabad, India, the wife of Capt. Claude J. Scholtz, R.A.M.C., of a son.

WALKER—On June 1st, at St. John's Wood, the wife of L. A. Walker, M.D., Capt., R.A.F., of 37, Piccadilly—a son.

MARRIAGES.

ACKLAND—MARLOW.—On May 18th, 1919, at St. Dionis Church, Kensington, by the Rev. Dr. Carter, J. G. Ackland, Capt., R.A.M.C., to Dorothy, daughter of Mrs. Marlow, of Arundell Mansions, Kensington, W.

GRAY—FULLER.—On May 28th, at Fletton Parish Church, Peterborough, Frank Gray, M.B., B.Ch., B.A. (Cantab.), Surg.-Lieut., R.N., to Mary, eldest daughter of the late Mr. G. Fuller and of Mrs. Fuller, of Peterborough.

HINE—LILLYWHITE.—On June 4th, at St. Gabriel's, Warwick Square, by the Rev. Cecil Image, cousin of the bride, T. G. Macaulay Hine, M.D., Major, R.A.M.C., to Margaret Ellen, only daughter of Mr. and Mrs. Herbert Lillywhite, of Broadfield, Guildford.

DEATHS.

CARTWRIGHT.—On June 23rd, 1919, at Oswestry, John Peplow Cartwright, M.R.C.S. (Eng.), aged 70.

EARLE.—On June 5th, 1919, at his residence, East Hayes House, Bath, Walter George Earle, M.R.C.S., L.R.C.P., aged 64.

MACMILLAN.—On May 23rd, 1919, at the Military Hospital, York, Edgar Duncan Macmillan, M.R.C.S., L.R.C.P., only son of Major J. M. Macmillan, R.A.M.C., York, and dearly loved fiancé of Miss Millicent H. Burton, Walton, Stafford, aged 24.

WAY.—On June 14th, at Chale, Isle of Wight, Gladys Elizabeth Mary, the beloved wife of Capt. Leslie F. K. Way, D.S.O., R.A.M.C.

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.

St. Bartholomew's Hospital



"Æquam memento rebus in arduis
Servare mentem."

—Horace, Book ii, Ode iii.

JOURNAL.

VOL. XXVI.—No. 11.]

AUGUST 1ST, 1919.

[PRICE SIXPENCE.

CALENDAR.

Tues., July 29.—Dr. Drysdale and Sir Anthony Bowlby on duty.
Fri., Aug. 1.—Dr. Tooth and Sir D'Arcy Power on duty.
Tues., " 5.—Sir Archibald Garrod and Mr. Waring on duty.
Fri., " 8.—Dr. Calvert and Mr. McAdam Eccles on duty.
Tues., " 12.—Dr. Fletcher and Mr. Gask on duty.
Fri., " 15.—Dr. Drysdale and Sir Anthony Bowlby on duty.
Tues., " 19.—Dr. Tooth and Sir D'Arcy Power on duty.
Fri., " 22.—Sir Archibald Garrod and Mr. Waring on duty.
Tues., " 26.—Dr. Calvert and Mr. McAdam Eccles on duty.
Fri., " 29.—Dr. Fletcher and Mr. Gask on duty.
Tues., Sept. 2.—Dr. Drysdale and Sir Anthony Bowlby on duty.

EDITORIAL NOTES.

IN addition to the list of the members of our Staff who were included in the Birthday Honours, it gives us very great pleasure to publish the names of so many other Bart.'s men who were similarly honoured, and to one and all we offer our warmest congratulations.

C.B.—Lieut.-Col. (Act.-Col.) R. Pickard.

Knight Bachelor.—J. C. Verco.

K.B.E. (Military Division).—Surg.-Capt. A. S. Nance, R.N.

C.B.E.—Lieut.-Col. (Temp. Col.) H. G. Barling, Lieut.-Col. and Brevet-Col. L. K. Harrison, Temp. Maj. (Temp. Lieut.-Col.) W. de M. Hill, Maj.-Gen. O. R. A. Julian, Lieut.-Col. and Brevet-Col. C. W. M. Moullin, Temp. Col. J. H. Parsons, Lieut.-Col. L. W. Rolleston, Lieut.-Col. (Temp. Col.) A. S. Woodwark, Col. F. W. Begbie, Temp. Maj. and Act.-Lieut.-Col. W. P. S. Branson, Capt. (Temp. Col.) H. Burrows, Temp. Capt. (Act.-Lieut.-Col.) F. Fraser, Lieut.-Col. E. C. Hayes, Col. H. S. Thurston, Capt. (Temp. Maj.) A. S. Cane, Capt. T. S. Hele.

O.B.E.—Capt. (Act.-Maj.) A. Abrahams, Lieut.-Col. H. A. Berryman, Maj. R. H. Bremridge, Maj. M. A. Cooke, Temp. Capt. P. W. Dove, Capt. and Brevet-Maj. A. G. R. Foulerton, Temp. Hon. Maj. T. G. M. Hine, Maj. (Act.-Lieut.-Col.) E. B. Lathbury, Temp. Capt. E. G. D. Murray, Temp. Capt. W. A. Murray, Lieut.-Col. C. T. Parsons, Maj. W. G. Spencer, Lieut.-Col. R. M. West, Temp. Capt. E. D. Wortley, Temp. Lieut.-Col. W. Wrangham, Temp. Maj. W. P. Yetts, Maj. G. E. O. Fenwick, Maj. A. W. Izard, Capt. R. D. Parker, Maj. J. C. A. Rigby, Maj. A. H. Hogarth, Maj. J. Everedge, Capt. (Act.-Maj.) G. F. P. Gibbons, Temp. Capt. E. T. C. Milligan, Temp. Capt. R. F. Moore, Temp. Maj. M. W. B. Oliver, Temp. Capt. (Act.-Maj.) H. W. Scawin, Lieut.-Col. G. C. E. Simpson, Lieut.-Col. G. N. Stephen, Capt. (Act.-Maj.) L. R. Tosswill, Temp. Capt. (Act.-Maj.) M. Bates, Capt. (Act.-Maj.) M. J. Holgate, Capt. H. S. C. Starkey, Temp. Capt. (Act. Maj.) R. H. Strong, Maj. (Act.-Lieut.-Col.) J. J. Urwin, Maj. (Temp. Lieut.-Col. H. M. Cruddas, Lieut.-Col. F. E. Fremantle, Capt. J. C. John, Temp. Capt. C. R. Taylor.

M.B.E.—Capt. C. R. Woodruff, Capt. E. P. Carmody.

D.S.O.—Capt. (Act.-Lieut.-Col.) H. N. Burroughes, Lieut.-Col. A. D. Ducat, Capt. (Act.-Lieut.-Col.) I. R. Hudleston, Capt. (Act.-Lieut.-Col.) L. F. K. Way, Capt. (Act.-Maj.) R. O. Ward, Maj. and Brevet-Lieut.-Col. (Act.-Lieut.-Col.) H. M. H. Melhuish, Maj. (Act.-Lieut.-Col.) H. T. Samuel.

M.C.—Capt. G. H. H. Waylen.

To be Brevet-Colonel.—Lieut.-Col. (Temp. Col.) L. Humphry.

To be Brevet-Lieutenant-Colonel.—Maj. H. Skelding, Maj. M. G. Pearson, Maj. (Act.-Lieut.-Col.) F. P. Connor, Maj. (Act.-Lieut.-Col.) R. A. Lloyd.

To be Brevet-Major.—Capt. H. S. Dickson, Capt. R. A. Peters, Capt. E. S. Winter.

Croce de Guerra.—Temp. Capt. H. E. M. Baylis, Lieut.-Col. (Temp. Col.) R. Pickard, Capt. O. Teichman.

Order of the Rising Sun, Fourth Class.—Col. W. R. Smith.

Mentioned in Despatches.

Italy.—R.A.M.C.: Capt. (Act.-Lieut.-Col.) J. J. H. Beckton, Capt. W. Broughton-Alcock (S.R.), Temp. Capt. C. H. G. Prance, Capt. C. C. Robinson (T.F.). *A.M.S.:* Col. R. Pickard, C.M.G., T.D.; Temp. Col. C. G. Watson, C.M.G.

Egypt.—A.M.S. and R.A.M.C.: Lieut.-Col. (Temp. Col.) E. P. Sewell, C.M.G., D.S.O.; Temp. Capt. (Act.-Maj.) M. Bates, Temp. Capt. J. B. Binns, Temp. Capt. F. Brickwell, Capt. E. A. P. Brock, Capt. E. Catford, Temp. Capt. (Act.-Maj.) R. H. Strong. *R.A.M.C.T.:* Capt. (Act.-Lieut.-Col.) H. S. Beadles, Capt. M. T. G. Clegg, Capt. H. M. McC. Coombs, Maj. (Act.-Lieut.-Col.) H. T. Samuel, Capt. (Act.-Maj.) A. L. Sharpin, Capt. W. S. Soden, Capt. H. S. C. Starkey. *I.M.S.:* Capt. F. J. Anderson, M.C.; Capt. T. L. Bomford; Maj. and Brevet-Lieut.-Col. (Temp. Col.) G. Browse, D.S.O.; Capt. (Act.-Maj.) M. J. Holgate, Maj. and Brevet-Lieut.-Col. (Act.-Lieut.-Col.) H. M. H. Melhuish, Maj. (Act.-Lieut.-Col.) J. J. Urwin.

Salonika.—R.A.M.C.: Capt. (Act.-Maj.) A. S. Cane, Temp. Capt. H. H. L. Ellison, Temp. Capt. J. K. Willis. *R.A.M.C.T.:* Capt. T. S. Hele, Capt. (Act.-Maj.) H. A. Playfair-Robertson, Capt. (Act.-Maj.) R. M. Vick.

Mesopotamia.—R.A.M.C.: Temp. Capt. H. G. Baynes, Temp. Capt. C. R. Taylor, Capt. J. M. Weddell. *R.A.M.C.T.:* Lieut.-Col. F. E. Fremantle. *A.M.S.:* Temp. Col. T. P. Legg, C.M.G.; Col. A. H. Morris; Col. W. H. Starr, C.B., C.M.G. *I.M.S.:* Maj. (Act.-Lieut.-Col.) F. P. Connor, D.S.O.; Lieut.-Col. H. M. Cruddas, C.M.G.; Maj. and Brevet-Lieut.-Col. W. H. Hamilton, D.S.O.; Capt. J. C. John.

* * *

The following gentlemen have been nominated to House Appointments commencing August 1st, 1919:

House-Physicians—

Dr. Tooth.	C. E. Kindersley.	Senior.
	H. A. Bell.	Junior.
Sir A. Garrod.	H. A. Douglas.	Senior.
	G. S. Trower.	Junior.
Dr. Calvert.	F. G. Lescher.	Senior.
	C. Herington.	Junior.
Dr. Fletcher.	M. V. Boucaud.	Senior.
	S. M. Cohen.	Junior.
Dr. Drysdale.	G. F. P. Gibbons.	Senior.
	E. I. Lloyd.	Junior.

House-Surgeons—

Sir D'Arcy Power.	P. Kittel.	Senior.
	G. B. Richardson.	Junior.
Mr. Waring.	C. W. Bennett.	Senior.
	F. D. Marsh.	Junior.
Mr. Eccles.	G. A. Fisher.	Senior.
	C. Dunscombe.	Junior.
Mr. Rawling.	W. S. Sykes.	Senior.
	T. G. Evans.	Junior.
Mr. Gask.	R. M. Dannatt.	Senior.
	E. Coyte.	Junior.

These appointments are made for a period of three months. Juniors will automatically become Seniors at the end of the three-months' period.

House-Surgeon to Venereal and Skin

Department H. J. Levy.
Extern Midwifery Assistant P. C. Collyns.

These appointments are for a period of three months.

* * *

At a meeting of the Council of the Royal College of Surgeons of England held on July 10th, Sir Anthony Bowlby was elected a Vice-President.

Sir D'Arcy Power was re-elected a member of the Executive Committee of the Imperial Cancer Research Fund.

* * *

We learn with much interest that Dr. A. R. Neligan has been appointed to the Persian Government Hospital with instructions to re-organise it on modern lines. Until recently the hospital was in German hands.

* * *

Sir George Newman, K.C.B., late lecturer on Public Health at this Hospital, has been appointed Chief Medical Officer of the newly formed Ministry of Health, with a position in the Government service which corresponds to that of the Secretary of a Ministry. By special arrangement Sir George also retains his position as Chief Medical Officer of the Board of Education.

* * *

We have received several letters from our readers requesting that a list of the times of attendance of physicians and surgeons at the various departments should be published at intervals. These times are still somewhat unsettled, but it is hoped by October to have the arrangements completed, and, in any case, we propose to publish in that issue as complete a list as possible.

* * *

With much regret we have to record the death of Dr. George Wilks, a well-known resident of Ashford. Born in 1840, he commenced his studies at Cambridge, taking his degree in the Classical Tripos in 1863, and subsequently studied at this Hospital, where he was a pupil of Sir James Paget. After qualifying he returned to Ashford and started in practice with his father in 1868. After the death of his father in 1878 Dr. Wilks carried on the practice alone until 1886, when he was joined in partnership by Mr. E. Colville, who still carries on the practice.

Dr. Wilks was well known amongst medical practitioners outside his native country, and in 1907 became Master of the Worshipful Society of Apothecaries. He was a prominent Freemason and for many years a county Justice of the Peace.

A SKETCH OF THE GROWTH OF THE SURGERY OF THE FRONT IN FRANCE.

An Address to the Abernethian Society of St. Bartholomew's Hospital.

By SIR ANTHONY BOWLEY, K.C.B., K.C.M.G., K.C.V.O.,
Lately Consulting Surgeon, British Armies in France.

IT is about eighteen years since I addressed the Abernethian Society after my return from the South African War, where I had been in surgical charge of the "Portland Hospital."

I had at that time got to know much of the work of the Army Medical Service, and subsequently, as Consulting Surgeon to Millbank Military Hospital and in other ways, I had kept in touch with this branch of our profession. It was probably partly in consequence of this that, when the war was about a week old, I was offered by Sir Arthur Sloggett the appointment of Consulting Surgeon in France, and my friend Sir George Makins was also selected. I have never been able to learn why the B.E.F. did not require our services at once, but the fact is that it was past the middle of September before they allowed us to leave England, and it was the 23rd of that month before I sailed for Havre.

I lost no time in going to Paris, for it was there that the headquarters of the L. of C. was situated, and I was soon visiting various hospitals in or near that city. The Battle of the Aisne was drawing to a close, and our casualty clearing stations were engaged in field ambulance work and in entraining wounded. During the fighting at Mons, in the retreat, and at the Marne they had not been employed, and at the Aisne also most of their kit and stores were not being utilised. We had as yet no motor ambulance cars. Many of the wounded came into Paris, but most of them were being sent to Rouen, so after a few days I also went there, and spent my time in the two general hospitals which were at work.

Everything I saw pointed to great difficulties in dealing with the wounded at the front, and I was deeply impressed by the condition of the patients on their arrival at the base hospitals. It seemed to me that I might be of more use further forward than at Rouen, and this feeling was very much accentuated when I learnt that the British Army was leaving the Aisne and moving northwards. I therefore asked if I could not be of more service in that direction, and was much gratified to receive an order on October 12th telling me to report at general headquarters. I lost no time in obeying, and left early next morning for Abbeville. Beyond that town the roads were crowded with army transport of every kind, and I did not arrive at St. Omer till 5.30 p.m. on October 13th. It was getting dusk, but inside the town I met Major Poe, R.A.M.C., whom I had

last seen at Rouen, and who had arrived in charge of our first motor ambulance convoy. He told me that he was just off "to a place called Hazebrouck," that there had been fighting on a large front that day, and that he expected to bring in 420 wounded. Little did he or I think that this was the opening day of what would ever after be known as the "First Battle of Ypres"!

I had arrived at the nick of time. Early next morning I was at the office of the Medical Department, and found that Col. (later Major-General) Tuckey O'Donnell had recently been appointed to be "D.M.S. Front," and was the senior officer at G.H.Q. at that time. I soon saw him and the A.G., Lieutenant-General Macready, and explained that I had been sent out as Consulting Surgeon, and that I wanted to stay at the front. It seemed to have been generally accepted that the only proper place for all consulting surgeons was the base, but as there were only two of us, and as Sir G. Makins was working hard at Boulogne, I did not have much difficulty in obtaining permission to stay and help with the 420 wounded who had arrived, or were arriving, at No. 1 C.C.S. in the "College de St. Joseph." I was then supposed to have come to G.H.Q. temporarily, but, as it turned out, my stay lasted for the rest of the war.

I have only a few words more to say by way of introduction, but it is necessary to mention that I found the "D.M.S. Front" most helpful in every way and most sympathetic towards my proposals or suggestions. Later on he became the D.D.G. under Sir Arthur Sloggett, and was replaced in 1916 by Sir W. Macpherson when he left us to take up the chief administrative appointment in India. From all these officers I received every assistance and encouragement throughout the war, as I also did from their successors, Sir Charles Burtchaell and Major-General J. Thomson.

I think that my work was all the easier because my previous experience in South Africa enabled me to realise from the beginning that the Army Medical Service was essentially an integral part of the whole Army, and that it must be considered always as a part which was intimately related to various other parts, and could not be considered as if it were a detached unit.

Thus, it was the considered policy of the Army before the war that no wounded should be retained near the front longer than was absolutely necessary, and that consequently they must be evacuated to the L. of C. on the first opportunity. The Army had decided to get the wounded out of its way as soon as it could, and it did not wish to have large hospitals near the front, which would require the transport of food and ordnance supplies on railway lines or roads urgently needed for military stores of every description. It had further to be realised that the "military situation" always dominated everything, and that one must not expect to be always furnished with a reason for decisions opposed to one's own opinions. It is necessary to keep these facts in view in order to realise that radical changes in the

surgery of the front could not be made by the Army Medical Service with a stroke of the pen, and that the decision on many matters did not rest with the Director-General alone, but was a concern of the General Staff also. It is not appreciated by many, for example, that the site of a C.C.S. and the arrangements for the transport of wounded are matters which can only be settled in conjunction with the "Q Branch" of an army, or that the alteration of the whole policy of evacuation of sick and wounded was a matter which interested the General Staff.

Now we come to the ever-famous "First Battle of Ypres." During this fight our army had only a comparatively small number of men in the field, namely, six depleted infantry divisions and three cavalry divisions. I am not going to describe the battle; it would take a great deal more than the time at my disposal, but it began at Hazebrouck on October 13th, and it was continued by the gradual advance of our troops until, in the north, we passed beyond Ypres. The country was at that time very pretty, with sloping hill-sides and woods, and it may interest you to know that at a place called Polygon Wood a number of horses used to be trained for the "International Horse Show" at Olympia. What happened during the next few weeks was that we and the French, and north of us the French Marines at Dixmude, and north of them the Belgians, were fighting very hard to stop an overwhelming mass of Germans, with an equally overwhelming mass of artillery, who attacked on the whole front from Bethune to the sea, and the casualties that we suffered were in no way represented by the number of the wounded. In those days it happened over and over again that whole companies were practically annihilated. They stood their ground, they returned the fire of the enemy, they fought until they died, and that is why there were comparatively few wounded in proportion to the dead. But before they laid down their lives they killed by accurate and rapid rifle fire a sufficient number of Germans to ultimately stop the onset.

We had six clearing stations at work. One was in Ypres, but it was shelled out the first week, and had to be taken to Hazebrouck, which was twenty miles back, and where there was already another. One was at St. Omer, about thirty miles back, and was used as a sort of base hospital. One was at Poperinghe, which is behind Ypres. One was at Bailleul; one was at Bethune. The last three were our only C.C.S. units close to the battle, and the one in Bethune was shelled out before the year ended.

Now let us just look at the situation for one moment, and think of what the C.C.S.'s could do for the 13,000 men who were wounded in this fight. They each consisted of a staff of only six medical officers, a commanding officer, and a quartermaster, and they each had altogether eighty orderlies. They were equipped on plans made during peace, merely with the intention that they should act as places through which the wounded could be passed from

the field ambulances into a train, and they were never intended to do operative surgery. They had no beds and only 200 stretchers; they had hardly any instruments; they had each one operating table; they had no sterilising apparatus and very few towels, there were no gloves, there were no gowns. So when I arrived at the front on October 13th I realised that the more numerous field ambulances must do most of the emergency operations, and that anything on a large scale in the way of front-line surgery was impossible for the moment. But it was very evident that as soon as the opportunity came there was much which might be done.

Officially, the first battle of Ypres lasted until November 17th, but it went on for a little longer than that. Towards the middle of November it was suggested that some beds might be got for the worst cases in the C.C.S.'s and we got twenty beds to start with. That was a beginning, but when we got the beds we said—"It is no good having beds for sick patients unless you have nursing sisters"! The latter were not supposed to go to the C.C.S.'s, but when we got the beds we asked for them and said: "Until you have sisters you will not get a sufficiently high ideal of work." We wanted to do things as well as they did them at any great civil hospital; so we got twenty beds to begin with, and we got five nurses to each C.C.S. That was in November, and at Christmas I came back for a few days to London, partly for leave, but I also came back with authority to obtain considerably more equipment for the C.C.S.'s.

So ended 1914, but, although the obvious changes in front-line surgery were but small, the all-important principle had been conceded, namely, that the C.C.S.'s no longer existed merely for the purpose of evacuation, but were allowed to treat, operate upon, and retain wounded men. A small beginning, it is true, but one that contained great possibilities for the future.

1915.

I returned to France early in January, and from that time onwards we began to do regular operating work in C.C.S.'s and to train surgical staffs. At this stage also we had to come to some definite decision as to the lines on which we were going to work. Were we going to ask that a large number of experienced operating surgeons should be sent out from England to take front-line work at the C.C.S.'s, or were we not? I knew that there were many operating surgeons in England who were doing very hard work, and I knew that some of them who could do first-rate work at home were not young enough to stand the racket of C.C.S.'s work night and day, and, if we did get them out to France, others would have to be found to take on their work, so my impression was that we ought to train our own staffs at the front. But I pointed out that it was no good training the staffs unless it was arranged that they should, as far as

possible, not be changed. There is a tendency in all armies to move people about, and you might go to a unit one day and find so and so there; go the next, and find somebody else in his place. Well, from that time onwards we started training some men and casting out others whom we did not find good enough, until we had a satisfactory, capable, energetic lot of young surgeons, and I can never sufficiently express my admiration for the way in which the front-line surgery was done by them.

The next event was that, on March 10th, there came the crowds of wounded from the Battle of Neuve Chapelle. Up to this time the British Army had expected daily to move forwards; the idea always was that we were going to advance, and the consequence was that, because of this idea, the supply of additional equipment to C.C.S.'s was postponed. The main object of the Army was, of course, to beat the Germans, and everything was subservient to that, for the wounded man necessarily takes a secondary place in war. Supplies of munitions and food for the fighting men—that is the first consideration. I did not grumble, but I only tell you the fact that, as far as front-line surgery was concerned, we were necessarily handicapped by the idea that we were going to advance. The next thing that handicapped me personally was that the General Staff had not yet learnt how far it could trust us civilians or our proposals to do operations at the front. When events were leading towards the Neuve Chapelle fight, I knew beforehand that there was going to be a battle, but I was not told anything officially until the battle had actually begun. The fact was that in March, 1915, we had not yet got to the stage when those in authority turned to us and said to the consulting surgeons: "There is going to be a fight; it is going to take place on such a day and in such a place. Make the necessary surgical arrangements, and be ready for the treatment of so many wounded." That all came a little later, when the Ds.M.S. of armies worked with the active co-operation of their respective consultants. So "Neuve Chapelle" arrived, and with it 12,000 wounded for whom there were very few C.C.S.'s. It was impossible, of course, for the latter to deal with the majority of the wounded, nor were they intended to do so, for at that time the policy of the British Army was still the same as that of all the other armies when the war began, *i. e.* "We will not in battle deal with wounded men at the front; operating work has got to be done at the base." And it must be recognised that evacuation to the base was very good and rapid in this battle.

On April 22nd the "Second Battle of Ypres" began. On May 9th our attack on "Festubert" began, and those fights overlapped. There were 60,000 wounded during April and May. During that time we had ten C.C.S.'s at work, and I felt myself that the strain on them was greater than it had been even in the First Battle of Ypres, while the surgeons at the base were no more than sufficient in

numbers for their own work. And so we went on during the spring and summer of 1915, training staffs of C.C.S.'s to do the surgical work, putting the C.C.S.'s into huts or tents instead of in houses, increasing accommodation for operations, adding to the equipment, and, as a result, accomplishing all that was surgically necessary during times of comparative calm, but always overwhelmed when there was a great battle.

And then after a short rest came the next battle—"Loos," on September 25th, an attack by the First Army. Before that time my friend Col. Wallace had come out, and he took one section of the front, which was in the area of the First Army, while I carried on in the Ypres section, in the Second Army. Just before the battle of Loos, an "advanced operating centre," as it was called, was created near Bethune, and that deserves to be mentioned because this was the first time an advanced operating centre was pitched in front of existing C.C.S.'s for a battle. Unfortunately it was swamped by the number of cases brought in, and the few C.C.S.'s could not do more work for the wounded than had been accomplished by the C.C.S.'s in previous battles.

During the year 1915 we had had altogether 196,000 wounded, and of these about 50,000 were wounded at Loos, and 60,000 were wounded in April and May at Ypres and Festubert.

After the battle of Loos Col. Wallace and I felt that the time was ripe for a more definite recognition of the value of the front-line surgery, and we therefore asked for an increase of the surgeons in the C.C.S.'s, and especially for reinforcements before heavy fighting began. We pointed out that the C.C.S.'s were now able to do very valuable work at the front so long as we were not overwhelmed, and our proposals were very cordially received by the Director-General.

So the year 1915 closed. It had been a time of disappointment for the Army, because all our expectations of a general advance had come to naught, and now a period of trench warfare had become established. But as far as surgery was concerned the change was advantageous, for we had been enabled to further increase the equipment of the C.C.S.'s since Neuve Chapelle, and to make them into real front-line hospitals. The combatants themselves looked to us for help, and no one actually at the battle front questioned any longer the policy of providing the wounded with prompt surgical treatment. The C.C.S.'s had indeed already won the confidence of the Army, and now they were bound to progress yet further.

1916.

The year 1916 opened very quietly. A Third Army had been formed in the Albert region, with Col. Alexis Thomson as its Consulting Surgeon, and a Fourth Army was in process of creation. It was this increase of the Army

that brought about in April my appointment as "Advising Consulting Surgeon" at G.H.Q., and I was given a sort of roving commission along the whole front, with the duty of advising in all surgical matters. I had already the rank of Surgeon-General, and this was of very great assistance in my new post.

Preparations were beginning for our attack in the Somme region, and I accordingly spent a good deal of time in the area occupied by the Fourth Army, on whose front the fight was to take place. Here I enjoyed the fullest opportunity of hearing from the D.M.S., Surgeon-General O'Keeffe, the arrangements which were being made for the C.C.S. work, and I now had also the advantage of discussing the proposals at first hand.

The chief difficulty was that the railway communications were as yet quite insufficient for all the requirements of the army, and, as supplies and munitions had first claim, it was difficult to get sanction for as many C.C.S.'s as seemed to be necessary. But we were going into a very big fight and the wounded were certain to be very numerous, so the Director-General ultimately arranged for the provision of fourteen C.C.S.'s to hold not less than one thousand men each; some of them could take nearly two thousand, and we provided in addition a very good advanced operating centre for abdominal cases, with about forty beds, near to Albert.

Further, and most important of all, we were able to increase all the surgical staffs before the battle began, and were also allowed to bring to our help the surgical specialists from other C.C.S.'s further north, arrangements which greatly assisted the work of Cols. T. Sinclair and Maynard Smith, who were associated with me as consultants, for it should be mentioned that soon after the fight began our Fifth Army came into being. During this battle I lived at a C.C.S. near to Albert, and took charge of certain areas as a consulting surgeon.

It was well we had made large provision in the C.C.S.'s, for on the first day there were 22,500 wounded, the next day there were 16,000, the next day there were 9000. After that matters eased off, yet the total number of casualties during the battle was over 300,000. It was fortunate also that during this fight we had fourteen medical officers instead of six in each C.C.S., and instead of five nurses we had fifteen; and as the result of the increased staffs, and in spite of the pressure of battle, I had the satisfaction of reporting to the Director-General that we had done 30,000 essential operations under anæsthetics at the front during a period of three and a half months. That brings us to the end of 1916—a year in which front-line surgery made a very great advance and established itself on a sound footing.

1917.

Now we come to 1917. Great encouragement was given to us by the Director-General to materially increase the staffs of C.C.S.'s; but in consequence of the German Army

retiring over a large portion of the front, arrangements had to be made in addition for an advanced operating centre behind Arras. The scene of battle had now shifted northwards to the areas of the Third and First Armies, whose consultants were Cols. H. M. Gray and C. Wallace, and whose Ds.M.S. were Surgeon-Generals Murray-Irwin and W. Pike. The surgery had already become everywhere very much more efficient than it had ever been before. The "Thomas" splint, which formed such an important feature in our work was now being universally used by the C.C.S.'s and field ambulances of every army, and it had even gone as far forward as the regimental aid posts in some areas. The best methods of applying it had been thoroughly taught during the winter by all the consulting surgeons, and its use and the use of other new first-aid splints had been demonstrated in every field ambulance as well as in the C.C.S.'s on the whole front. This personal education very soon proved of the greatest possible value.

The battle at Vimy and Arras, which began on April 9th, was fought by our First and Third Armies, and many new C.C.S.'s were provided before it began. It had to be unduly prolonged in order to help the French, who had got into great difficulties on the Aisne, and our prolonged attacking under very unfavourable conditions gave rise to many more casualties than would have occurred if we had only required to do as much as we ourselves wished. But the surgeons of the C.C.S.'s were reinforced by "surgical teams" from other units, comprising a surgeon, a sister and an anæsthetist, and good work was done everywhere.

Then came the "Messines" fight on June 7th, further north still, and when I returned to the Second Army I was glad to find that Col. Gordon Watson was the Consulting Surgeon, and he and I arranged, under Major-General Porter, the D.M.S., for the treatment of the wounded. Well, that was a most completely successful fight. The arrangements of the D.M.S. for bringing the wounded into the "corps dressing stations" and the C.C.S.'s worked most smoothly, and 18,000 men were treated very thoroughly in three days. Most of the C.C.S.'s held as many as 1000 patients and had fifteen nursing sisters. In no previous fight had the wounded done so well.

And then arrangements had to be made with the Ds.M.S. of the Second and Fifth Armies (Surgeon-Generals Porter and Skinner) for the "Third Battle of Ypres"—the "Passchendaele fight"—which began on July 31st, and we were very fortunate in being able to provide for yet larger reinforcements of surgeons than formerly. There had recently arrived a number of American surgeons, and some of them were amongst the very best surgeons in the whole of America. They were not yet required for their own army, and by getting them and a number of our own colonial surgeons—

Australians, Canadians, New Zealanders, and South Africans—we created enlarged and most efficient staffs for the C.C.S.'s, so that each of these had at least twenty-four medical officers, and we were also enabled to double the operating equipment. Each C.C.S. kept eight operating tables at work, and no less than 60,000 wounded were treated under anæsthetics during the fight. That was the best thing that we had yet done, because, as the total wounded in the three and a half months amounted to 196,000, those 60,000 represented about 30 per cent of the whole of the wounded who passed through the C.C.S.'s. It should also be noted that it was during this fight that blood-transfusion was first employed on a large scale. Almost the whole of the necessary operations were done at the front on this occasion, and the result was that never before had the wounded in the general hospitals done so well.

Before this battle had well finished another attack of ours blazed up at Cambrai on November 20th. The Germans replied by an attack on November 30th, and our C.C.S.'s, although they were very near the line of fire at one time, managed to hold on to their sites, and practically all the wounded were adequately treated.

The year 1917 came to an end soon after this battle, and the Army Medical Service could look back on its front-line work with a good deal of satisfaction. The wounded had reached a total of nearly 500,000 in the year, but in spite of such great numbers a far larger proportion of them than in any previous year had been thoroughly treated at the front. The equipment of the C.C.S.'s had become very complete, and the arrangements for reinforcing hard-worked units had been fully tried and not found wanting.

1918.

We entered next upon what proved to be the last year of the war—1918. It began very peaceably; there was nothing doing. I wandered over the front to see that all was in readiness, and found but few wounded anywhere, although we all knew that this was really the calm before the storm. There was subsequently a lot of talk about our being surprised by the German attack, but there was not a word of truth in this statement, for all C.C.S. commanders of the Fifth Army had been warned by the D.M.S., Surgeon-General Skinner, that the attack was impending, and later we got definite information that it would take place on March 21st.

On the morning of that day I started early, and from twenty-five miles away I could hear the roar of battle. I went down to the headquarters of the Fifth Army, and even after eleven o'clock there was so dense a mist on the hills that you could not see 100 yards. It was in that mist that at dawn the Germans had managed to push their way between our outposts, where our line was very thin, for the Fifth Army covered about forty miles of line with only

fourteen divisions. I got down to headquarters of the D.M.S. at Nesle, and afterwards went on further forward with the Consulting Surgeon, Col. Maynard-Smith, to a place called Ham. There I found the most advanced of our C.C.S.'s working splendidly, but there had been a fire in the medical stores in the village, and the railway line between this C.C.S. and the next one at Cugny was broken by shell fire. We heard, however, that the patients had been got away to Compiègne, so I went on to a group of C.C.S.'s further north. Here also everyone was working hard, for they were close to the main road leading from St. Quentin, and great numbers of wounded were arriving. On this day and early on the next practically all the wounded were satisfactorily treated in the C.C.S.'s. Afterwards there were many who could not be brought in, because, for one reason, the roads got so blocked with traffic, retiring guns, and innumerable lorries that the ambulance cars which took patients to the C.C.S.'s from the field ambulances could not always get back to the field ambulances to pick up the next load. The result was that a certain number of wounded were necessarily left behind, although not before many of them had been carefully dressed and splinted by the field ambulance staffs. Some Units lost their all, but others saved a great deal of their kit and equipment. Every C.C.S. of the Third and Fifth Armies had to retire, but many of them were reconstituted in the neighbourhood of Amiens and within a day or two were again at work.

The Germans claimed 93,000 unwounded prisoners, but the actual number was, I believe, about 46,000 wounded and unwounded put together, and not a single patient once in a C.C.S. was captured. Wonderful stories went round the base, and even to England, as to the number of people who had been captured, and one rumour said "the whole of No. 00 C.C.S. has been captured with all the staff and the nurses," etc. It was all invention, yet, considering what had happened, it was surprising that there were not more reports of disasters. But then there was a complete absence of anything like a panic.

In only one instance were a few patients left behind, and then they were left in charge of a medical officer and some orderlies. It was the right thing to do at the time, for the capture of the whole staff would not have helped matters. But even in that case some cars and lorries were sent back, and everyone was evacuated before the Germans arrived. Meantime the train service to the base had been first-rate, and the general hospitals received the wounded with but little delay. Fortunately, we had anticipated that the latter would be heavily worked, and more operating theatres and more surgeons were waiting in readiness before the call for action came. The Ds.M.S. and the consulting surgeons of the Third and Fifth Armies, Cols. Gray and Maynard-Smith, had had a very anxious time, but the worst of the pressure was all over within a week, for by the 28th the

retreat had stopped and the German attack had already failed.

The real cause of the failure was the complete defeat of the German assault on the Arras sector on March 28th. After having rushed the south of our line they made a very determined effort to get through further north, at the junction of the First and Third Armies, but there was no mist as there was on March 21st, and our artillerymen were able to get on to their troops where they were massing behind the line, and machine gunners and rifles fired into them as they came nearer. We heard afterwards, what we did not know at the time, that after the attack had failed with tremendous losses Ludendorff abandoned the main offensive, and you will remember that the further German advance towards Amiens never came off.

Fighting continued, however, in April and May in the northern part of the line which we called the "Kemmel area," and also on the Armentières-Bethuné front in the region of the Lys, but although some of the C.C.S.'s had to retire, the front-line surgery continued without much interruption in all three armies, and while the people in England were still full of anxiety, we in France were confident that before the summer was out our turn would come to advance ourselves.

You will remember that on May 27th the Germans attacked the French on the Aisne. We also had some divisions down there—divisions which were not up to strength and which suffered very severely, although they held on, and by holding on they helped to prevent Rheims from being taken. But the French were defeated and were driven back beyond the Aisne, and in consequence one of our C.C.S.'s in this region was captured, and as the staff remained so as to care for the wounded, they were captured also.

We now come to July, the month in which the tide of battle began to turn, although the full flood did not run till August. On July 4th—Independence Day—the Americans came into the battle line for the first time near Villers Bretonneux. They had been ordered by their own people to be under our command for the attack, and then at the last moment for some reason the order for them to join in the attack was countermanded. This caused great disappointment, and one section of the Americans behaved as Nelson did when he put his blind eye to the telescope, and "did not hear the counter-orders." The attack was a very successful one; there were not many wounded, and all were easily dealt with by our surgeons.

On July 15th came the last attack of the Germans. They crossed the Marne, but were violently counter-attacked by French, British and Americans on July 18th, and at that time and subsequently some of our C.C.S.'s had very heavy work near the Marne, and were so overfilled with wounded that many of the latter had to be passed on to American and French units for treatment.

It was early in August that I became aware of movements of large numbers of cavalry and guns, all very mysteriously done at night, and I realised that there was something big on foot. But it was only twenty-four hours before it actually took place that I and Col. Gask, the consulting surgeon of the Fourth Army, were told officially that there was to be a big attack by us in the area of the Fourth Army on August 8th.

The warning was short, but the C.C.S.'s were ready in every way, and ample reinforcements of surgical teams arrived in plenty of time, so that when the battle did begin on the morning of August 8th we were quite prepared for it, with plenty of C.C.S.'s and plenty of surgeons. In four days we had about 18,000 wounded.

The attack of August 8th was a complete surprise, as you may remember. It was a surprise to you over here; it was a surprise even to some of the troops who took part in it, and it was a very great surprise to the Germans. That day marked the beginning of our own great offensive, the opening of the greatest battle that has ever been fought, and the beginning of a British advance which ran the Germans to a standstill, and which practically never stopped until the enemy were completely defeated and the armistice was signed.

During the earlier part of the battle the fighting was mostly in the south, but after a short time it spread over the whole line. There was a brief interval after the end of August, and then in September we got back once more to the old position of the Hindenburg Line. When we got as far as that inquiries were set on foot to ascertain whether our troops were over-tired, now that they had fought continuously for six weeks, but all the information pointed to the fact that they were still full of go and keen to attack, so Sir Douglas Haig decided to press home the advance and to attack at all points.

The consequence was that on September 27th, 28th and 29th our great assault took place on the Hindenburg Line, and in the north the Belgians joined in with the Second Army. On the 27th and 28th the Second, Third and First Armies attacked, and finally, on the 29th, the Fourth Army. The result was a universal advance, heavy losses, but a complete destruction of the German *morale*; for now that they were driven back from what they had believed to be an impregnable position the fighting spirit was knocked out of them, although the First, Third and Fourth Armies had some strenuous opposition in very difficult country early in October.

I need hardly remind you that these advances of ours always meant a constant moving and re-pitching of our C.C.S.'s, which had now to leave their huts and some of their equipment behind them and do their work in tents. But before each fresh advance there was generally a little breathing time, and, as everything was planned and thought out beforehand by the various Ds.M.S. and their consulting

surgeons, the C.C.S.'s were generally all well placed and well equipped before the fighting of the next stage began. During the earlier part of our advance the stress of the work fell successively on the Fourth, Third and First Armies, and then on the Second Army. The Fifth Army had not been in the line since the great German attack, and was only just being reinstated when our own attack opened on August 8th. It became engaged in September.

As far as the surgery was concerned there was increasing difficulty in supplying sufficient staffs as more and more of the whole Army became engaged, but almost everywhere the high standard which had been reached was maintained in spite of the difficulties.

A greater trouble was that the C.C.S.'s had often to send some patients to the base before operation or else to evacuate others sooner than was surgically advisable because of the constantly recurring calls to pack up and move on with the victorious troops. It was a penalty of success, and this evacuation to the base was really urgently necessary, because the devastated country and the destroyed railways quite prevented, at the time, the moving forward of the general hospitals.

The Great War was now drawing towards a close, but it was destined not to end until we had crowned our success by an advance in the old "Ypres salient," and here, on October 14th, the Second Army fought for the last time over the old battle-field. The D.M.S., Major-General Guise Moores, pushed up our clearing stations in preparation for this fight, now not only as far as they had been before the previous March retreat, but this time as far as Ypres itself, and we established a group of three at Brielen, just outside Ypres.

I told you that I originally arrived at the Ypres front on October 13th, 1914, and here we were back again on October 14th, 1918, after an interval of just four years. I had heard the first shells come into Ypres, and that day I heard the last. It was interesting to realise that, whereas in 1914 there was no attempt to perform surgical operations at the front on a large scale, in 1918 no less than 40 per cent. of the whole of the patients who were brought to the Brielen C.C.S.'s of the Second Army were anæsthetised and passed through the operating theatres during heavy fighting.

Extraordinary changes had taken place in the treatment of wounded men between the first battle of Ypres in 1914 and the "Last Battle of Ypres" in 1918.

You will remember that when Napoleon returned from Elba there was a campaign which was called "The Hundred Days." The great battle that the British Army began on August 8th and finished on November 11th, and which resulted in the defeat of the Germans and the ending of the war in 1918 instead of continuing through the winter, lasted just about the same time. It will very likely be known in future as "The Hundred Days' Battle of the Great War."

During this period we had more than 300,000 wounded to deal with, but the accumulated experience of many battles and the systematised methods developed by constant practice enabled the work to be done with comparatively little difficulty. It is of course true that at times the C.C.S.'s were overworked, and that the quality of the surgery suffered. This must always occur in great battles because of events beyond the control of the Medical Service. Yet, even when this is admitted, it may still be claimed that the British surgery of the Front showed a continuous improvement in each successive year of the Great War.

THREE CASES FROM LUCAS AND HENRY WARDS.

By C. F. BEYERS, M.R.C.S., L.R.C.P.

(1) CASE OF FIBRO-SARCOMA OF MUSCULO-SPIRAL NERVE.

SARCOMATA of peripheral nerves are comparatively rare, and this case is of interest in that a nerve of the upper extremity is affected. These tumours are most commonly found in the nerves of the lower extremity, more than half the recorded cases being sarcomata of the great sciatic nerve.

Frances J—, æt. 19, a book-folder, was admitted to Hospital on June 6th, 1919, complaining of a swelling of the left arm and wrist-drop. She noticed the swelling when she was twelve years old, and suffered no pain or inconvenience from it until a month before admission, when it became painful. It increased in size and she developed wrist-drop. On examination an ovoid swelling as large as a hen's egg was discovered in the left arm at the junction of its middle and lower thirds. It was situated on the outer side of the external inter-muscular septum and beneath the outer head of the triceps. The swelling was solid, and possessed a smooth surface and a clearly defined outline. It was not attached to the bone and was freely moveable from side to side but not in the long axis of the arm. The forearm was not wasted. Marked wrist-drop was present. The electrical reactions of the muscles were as follows: The triceps was normal, the extensor carpi ulnaris and the extensor communis digitorum showed partial R.D., while the other extensors of the wrist and fingers and the supinator showed complete R.D. The musculo-spiral and posterior interosseous nerves were inexcitable.

An incision was made over the swelling and a soft encapsulated tumour connected with the musculo-spiral nerve was discovered. The nerve-sheath was seen proximally to spread out over the tumour and some of the nerve-fibres could be traced into its substance. The tumour was excised

and on section proved to be a fibro-sarcoma. No nerve-fibres were observed in the section.

As the continuity of the nerve was preserved as much as possible, and owing to the fact that the tumour has probably only a local malignancy, the prognosis may be regarded as favourable.

(2) CASE OF CHRONIC INTESTINAL OBSTRUCTION DUE TO CICATRISATION OF AN OLD ULCER OF THE ILEUM.

Albert D—, æt. 26, an international footballer, was admitted to the Hospital on June 7th, 1919.

He was quite well until February, 1919, when he contracted a sore on the penis in Lagos, Nigeria. After an intravenous injection of salvarsan he became very ill, with continuous vomiting, abdominal pain and mæna. From that time he began to lose weight very rapidly. He referred his pain to the lower part of his abdomen, coming on about eight hours after meals, and accompanied by rumbling and gurgling noises. He came to England, and attended at the London School of Tropical Medicine, where an exhaustive examination of his stools, blood and urine was made, but no evidence of tropical disease was discovered. He was given salvarsan again without any ill-results. A Wassermann examination proved to be negative.

On admission to this Hospital he was found to be very emaciated, and suffering from pain and nausea after food with occasional vomiting. His abdomen was distended, and visible peristalsis with borborygmi was present. An X-ray examination was made, and showed considerable delay in the passage from the ileum to the cæcum.

A laparotomy was performed. The ileum was found to be much distended, and on tracing it downwards a constriction was discovered about 12 in. from the ileo-cæcal valve. A lateral entero-enterostomy was performed. The structure was evidently the result of the cicatrization of an intestinal ulcer, single, circular in outline, and situated on the side of the intestine which is furthest away from the mesentery. The ileum was much distended, and for some inches on the proximal side of the ulcer it was greatly thickened and inflamed. The operation wound was closed without drainage. There was a slight fæcal discharge on the second day, but this ceased on the twelfth day, and the general condition of the patient has improved steadily.

(3) GALL-STONES OR RENAL COLIC.

The following case of repeated attacks of colic associated with a large right-sided abdominal tumour is interesting from the point of view of diagnosis. The question that had to be decided was whether the colic was renal or biliary in origin.

Mrs. Hannah J—, æt. 74, was admitted to hospital on June 26th, 1919. She has always had "bilious attacks," which consisted of headaches and discomfort after meals, but without pain or vomiting. She was slightly jaundiced

on one occasion in 1916. She has had increased frequency of micturition for some years. The attacks of colic began three months before admission. The pain was felt in the right side of the abdomen and in the small of the back. There was no jaundice and no vomiting and she says that her stools appeared natural. On the other hand she found that during an attack she would at first pass very small quantities of urine and then a large amount, which appeared to relieve her pain very greatly. She says that her urine became "gritty" during the last week.

On admission her temperature was normal and her pulse 88. She was not jaundiced. Her abdomen was slightly rigid, and a large, tender, moveable tumour could be felt to the right of and slightly above the umbilicus. The tumour could be moved in an upward and side-to-side direction, but not downwards. The outline was rounded and well defined and the surface quite smooth. On palpating the right lumbar region pressure appeared to be communicated to the tumour and *vice versa*. On percussion the tumour was dull and the dullness was found to be continuous with the liver dullness. A tentative diagnosis of floating kidney with hydronephrosis or less probably of biliary colic was made. On operating through a lumbar incision the right kidney was found to be normal in size and not displaced. The patient was therefore turned over on her back and the usual gall-bladder incision made. A much-distended and inflamed mucocoele was discovered, and after evacuating the contents of the bladder a single large stone was found impacted in the cystic duct. Cholecystectomy was performed and the patient made a rapid recovery.

I am indebted to Sir D'Arcy Power, K.B.E., for permission to publish these cases, and to the dresser, Mr. L. M. Billingham, for taking the careful notes which are here summarised.

TWO CASES OF ACUTE INTESTINAL OBSTRUCTION.

By SAMUEL GREEN, F.R.C.S.(Edin.), Waimate, N.Z.

IT is almost necessary to apologise for publishing two cases of such a relatively common catastrophe as "acute intestinal obstruction." The two cases are very similar, in so far as the cause of the obstruction was situated at the terminal portion of the ileum; furthermore the actual lesions found are comparatively uncommon.

Negative signs and symptoms are not mentioned.

Mrs. W—, æt. 44, awoke suddenly at 3 a.m. with a gripping abdominal pain. Seen at 6.30 a.m., by which time there had been a second attack.

She seemed to be anxious about herself. Careful examination revealed nothing except slight rigidity of the right

rectus and tenderness down the right side. Temperature and pulse normal.

The idea of operation was not well received, but another attack of pain decided the matter, and the abdomen was opened. The diagnosis was (?) acute intestinal obstruction, Dr. A. G. Pitts assisted.

The abdomen was opened below the umbilicus by pulling the right rectus outwards. Clear fluid escaped, and collapsed intestine noticed. The cæcum was collapsed. The appendix was found tightly bound down by old adhesions; it was removed with difficulty. The collapsed coil of ileum was traced backwards until it disappeared in a fossa behind the cæcum. This fossa contained 18 in. of intestine, which was easily freed. The fossa ran upward behind the ascending colon for about 5 in.; its mouth was obliterated by catgut sutures; whilst this was being done a large vein was pricked. The operation took $2\frac{1}{2}$ hours—far too long! The patient made an uninterrupted recovery.

Mrs. B—, æt. 37, the victim of double inguinal hernia and complete prolapse of the uterus, was suddenly afflicted by a severe pain in the abdomen. This occurred at 7 p.m. At 8 p.m. she vomited. Attacks of pain recurred with vomiting, and continued hourly until 12 mid-day on the following day, when her husband was sufficiently alarmed to send for me.

She was very ill. Temperature 97° F.; pulse 64. The only physical sign she presented was slight tenderness in the R.I.F.; no distension; left hernia down, but reducible right hernia not down. No impulse over the inguinal canal.

She was brought into the hospital and given an enema with a good result of fæces and flatus. This I neglected. Shortly afterwards she vomited about a pint of brownish fluid.

Diagnosis: high obstruction of small intestine.

Owing to unforeseen delays the abdomen was not opened until 8 p.m. Dr. E. C. Hayes assisted me. Right paramedian incision 7 in. long, the rectus pulled outwards. Free fluid, straw-coloured. The cæcum was collapsed. The ileum was traced backwards and was found to enter the right inguinal sac, where it formed a Richter's hernia which had been reduced *en masse*. The neck of the sac was thick and fibrous; a small nick in this enabled the gut to escape, together with dark fluid. The gut was dark in colour but soon recovered. The sac was obliterated as much as possible. I was so elated at having found and successfully dealt with the cause of the obstruction that I forgot my diagnosis and closed the abdomen. No flatus was passed for 24 hours and then only a little. Shock was marked. Calomel, pituitrin, eserine and enemata eventually produced bowel movements. The patient recovered.

The ileum between the ileo-cæcal valve and the site of obstruction was marked by fibrous rings, evidently the result of previous strangulations.

It is not meant for one so inexperienced as I am to draw conclusions from cases, but the above have given me three rules for my own guidance.

(1) Don't start fiddling with a chronic appendix when there is obvious intestinal obstruction.

(2) If you make a diagnosis of "obstruction high up" and find "obstruction low down" make certain that the diagnosis was wrong. It saves much worry when the patient passes nothing for 24 hours.

(3) In cases of sudden colicky pains in the abdomen that seem localised and do not suggest renal or biliary colic I shall open the abdomen as quickly as possible and shall hope thereby to save a few lives. The mistakes will be borne with fortitude.

Of course this statement is too broad to be accepted literally.

THE BOWLBY PORTRAIT FUND.

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

DEAR SIR,

Sir Anthony Bowlby will shortly retire from the Staff of the Hospital. It is proposed to present him with a portrait of himself, painted by a well-known artist, as a recognition not only of his services to the Hospital and Medical School of St. Bartholomew, but also as an appreciation, which all Bart.'s men must feel, for the great work that he has done in connection with the A.M.S. during the war. It is felt that all those who have come in contact with him either directly or indirectly would like to subscribe towards such an object, and therefore the notice has been circulated to all old Bart.'s men and students inviting them to do so.

A certain number of these notices have been returned to me owing to the fact that we have some incorrect addresses. I should not like to feel that there may be some who would wish to subscribe and have not received this notice, and am therefore asking you whether you would be as good as to place this letter in the JOURNAL.

It is hoped that all those who are intending to subscribe will do so as soon as possible so that arrangements may be made in selecting the artist who is to make the portrait, as this will largely depend upon the amount of money obtained. It is hoped that we shall be able to employ the services of the best artist possible.

When the portrait is painted it is intended that a meeting should be held to present the portrait to Sir Anthony, together with a list of the subscribers. The permission of the Treasurer and Almoners has been given that the portrait should be hung in the Great Hall of the Hospital amongst those of his illustrious predecessors which already adorn it.

Subscriptions, which should not exceed two guineas,

should be sent to Mr. R. Cozens Bailey at the accompanying address, who will act as Hon. Treasurer of the Fund.

Yours sincerely,

W. GIRLING BALL,

Hon. Sec.

Bowlby Portrait Fund.

WARDEN'S HOUSE,

ST. BARTHOLOMEW'S HOSPITAL AND COLLEGE,

LONDON, E.C.;

June 12th, 1919.

[We understand that the above Fund will shortly be closed.—ED.]

STUDENTS' UNION.

ST. BARTHOLOMEW'S HOSPITAL ROWING CLUB.

A meeting was held on June 13th, 1919, Sir A. A. Bowlby, K.C.M.G., in the chair.

(1) It was decided to revive the Club in 1919, with a view to holding, if possible, an inter-hospital race in September or October, 1919.

St. Bart.'s is the present holder of the challenge cup.

(2) The following officers were elected for the ensuing season:—

President	Sir A. A. Bowlby, K.C.M.G.
Vice-President	Mr. L. Bathe-Rawling.
Captain	Mr. Kindersley.
Hon. Sec.	Mr. D. C. Fairbairn.
	D. C. FAIRBAIRN, <i>Hon. Sec.</i>

LAWN TENNIS CLUB.

THE HOSPITAL QUALIFIES FOR THE FINALS OF THE SENIOR AND JUNIOR CUPS.

The Hospital had to meet the Middlesex on June 26th in the Second Round of the Senior Inter-Hospital Cup. The latter's team had a weak tail, though their first pair, Gunasekara and Van Geysel, was probably the strongest the Hospital has had to encounter.

St. Bartholomew's started well by winning all six Singles, the most even of these being between C. H. Gunasekara and W. D. Urwick, in which the latter just pulled through in the final set by 6-4. Score: 7-5, 5-7, 6-4.

Despite the fact that J. G. Johnstone, had disposed of Van Geysel (7-5, 5-2), Johnstone and Urwick lost to Gunasekara and Van Geysel in the Doubles after an exciting three-set match; but the Hospital second pair, C. F. Krige and H. D. McCall, after losing the first set (9-11) against this Middlesex first pair, won the second and third sets easily, Gunasekara being tired out by the final set and rarely getting to the net.

Owing to King's College Hospital scratching, the Hospital has now to play St. Thomas's in the Final.

The Second tennis six, captained by H. A. Douglas, have beaten St. Thomas's and the U.C.H. in the First and Semi-final Rounds of the Junior Inter-Hospital Cup, and so have qualified to meet Guy's in the Final.

RESULTS.

June 21st: St. Bartholomew's lost to Guy's by 4 Matches to 5 in a friendly match played at Honor Oak.

June 25th—First Round of Junior Inter-Hospital Cup: Played at Chiswick. St. Bartholomew's beat St. Thomas's by 4 matches to 2 in the Singles and 4 matches to 2 also in the Doubles.

June 26th—Second Round Senior Inter-Hospital Cup: Played at Winchmore. St. Bartholomew's beat the Middlesex by 6 Singles to love and by 6 Doubles to 1.

June 28th: St. Bartholomew's beat the Cumberland Club "B" by 5 matches to 4.

July 10th—Semi-final Round Junior Cup-tie: At Perivale. St. Bartholomew's beat U.C.H. by 3 Singles to 2 and 5 Doubles to 2.

Semi-final Round Senior Inter-Hospital Cup: King's College Hospital scratched.

EXAMINATIONS, ETC.

UNIVERSITY OF OXFORD.

M.S.—R. O. Ward.

CONJOINT EXAMINATION BOARD.

Final Examination. July, 1919.

The following have completed the examination for the Diplomas of M.R.C.S. and L.R.C.P.: S. M. Cohen, P. C. Collyns, J. C. Davies, C. Dunscombe, T. G. Evans, H. J. Levy, G. J. Sophianopoulos, B. M. G. Thomas.

APPOINTMENTS.

HARRIS, H. G., M.D., B.S.(Durham), M.R.C.S., L.R.C.P., appointed Medical Officer to the Ordnance Survey Office, Southampton.

LISTER, A. E. J., M.B., B.S.(Lond.), F.R.C.S.(Eng.), Major I.M.S., appointed an Honorary Surgeon to His Excellency the Viceroy and Governor-General of India.

ROBERTS, A. H., M.R.C.S., L.R.C.P., appointed Certifying Surgeon, under the Factory and Workshop Acts, for Malling.

SLADDEN, A. F., M.D., B.Ch.(Oxon.), appointed Pathologist to the Swansea General Hospital.

SMYTHE, G. A., M.D.(Cantab.), appointed Obstetric Physician to the Royal Hants County Hospital.

WADE, R., M.R.C.S., L.R.C.P., appointed Assistant Administrator of Anæsthetics, St. Bartholomew's Hospital.

CHANGES OF ADDRESS.

BOODLE, G. A., The Cottage, Pearcroft Road, Stonehouse, Glos.

CLARKE, A. J., 25, Caversham Road, Kentish Town, N.W. 5.

FISON, J., 9, North Park Road, Harrogate.

GIBSON, R. W. B., Crown Mines, Johannesburg, South Africa.

GRANGE, C. D'O., 104, Station Parade, Harrogate.

HUMPHRY, A. M., St. Aubin, Jersey.

MARTIN, E. L., 127, Prince's Avenue, Hull.

PAIN, B. H., Fairlawn, Park Road, Southborough, Kent.

RAIL, W. A., 272, Wightman Road, Hornsey, N. 8.

SLADDEN, A. F., Cheltenham House, Eaton Grove, Swansea.

SMYTHE, G. A., 41, Southgate Street, Winchester.

WHITE, C. P., 3, Draycott Place, Cadogan Gardens, W.

BIRTHS.

FERGUSON.—On July 23rd, at Saxstead, Marshall's Road, Sutton, the wife of John Ferguson, M.B., B.S.(Lond.), Park Road, Cheam, Surrey, of a son.

WILLIAMS.—On July 2nd, at Broome Cottage, Bedlington, to the wife (*née* Joan O'Callaghan) of F. S. Williams, M.B., B.S.(Lond.)—a daughter.

MARRIAGES.

BATTEN—TURNBULL.—On July 23rd, at Essex Church, Notting Hill Gate, W., by the Rev. J. H. Weatherall, Capt. Lindsey Willett Batten, R.A.M.C., elder son of Dr. and Mrs. Rayner Batten, of Campden Lodge, Campden Hill Road, W., and 9, Wimpole Street, W., to Ellen Mary, elder daughter of Dr. and Mrs. G. Lindsay Turnbull, of 47, Ladbroke Square, W., and granddaughter of the late James Freeman, of Norwich.

ORR-EWING—ROSS.—On July 16th, at Parbold, by Rev. W. Seaman, Archibald Orr-Ewing, M.B., B.C.(Cantab.), elder son of Mr. and Mrs. Archibald Orr-Ewing, of Weston-super-Mare, to Gladys Mary, second daughter of Mr. and Mrs. Alex. Ross, Parbold.

DEATHS.

CARTWRIGHT.—On June 23rd, 1919, at Oswestry, John Peplow Cartwright, M.R.C.S.(Eng.), aged 70.

PENNY.—On April 25th, 1919, George Town Penny, of 9, Alexander Road, Ulverston, Lancs.

RANDALL.—At 54, Park Street, Bridgend, Wyndham Randall, L.R.C.P.(Edin.), M.R.C.S.(Eng.), aged 72.

St. Bartholomew's Hospital



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

JOURNAL.

VOL. XXVI.—No. 12.]


SEPTEMBER 1ST, 1919.

[PRICE SIXPENCE.

CALENDAR.

Fri., Aug. 29.—Dr. Morley Fletcher and Mr. Rawling on duty.
Tues., Sept. 2.—Dr. Drysdale and Mr. Gask on duty.
Fri., „ 5.—Dr. Tooth and Sir D'Arcy Power on duty.
Tues., „ 9.—Sir A. Garrod and Mr. Waring on duty.
Fri., „ 12.—Dr. Calvert and Mr. McAdam Eccles on duty.
Tues., „ 16.—Dr. Morley Fletcher and Mr. Rawling on duty.
Fri., „ 19.—Dr. Drysdale and Mr. Gask on duty.
Tues., „ 23.—Dr. Tooth and Sir D'Arcy Power on duty.
Fri., „ 26.—Sir A. Garrod and Mr. Waring on duty.
Tues., „ 30.—Dr. Calvert and Mr. McAdam Eccles on duty.
Old Students' Dinner.
Wed., Oct. 1.—**Winter Session begins.**
Fri., „ 3.—Dr. Morley Fletcher and Mr. Rawling on duty.
Tues., „ 7.—Dr. Drysdale and Mr. Gask on duty.

EDITORIAL NOTES.

 WITH the publication of this issue we come to the end of another Hospital year, and, as on previous occasions, we have recounted briefly in our retrospect some of the outstanding events during this period. The war is over, and peace is definitely signed. The part played by the Hospital has been a great and glorious one, and some day we hope to tell the full story. But it is the immediate future which concerns us at the moment. During the past few months the Hospital has been gradually getting back to its pre-war condition, but, curiously, the process has not been a rapid one. Perhaps it is that men are tired after their exertions of five years' war, but with the advent of the new academic year we have every confidence that Bart.'s will once more get into its stride.

* * *

We wish to take this opportunity of again thanking the several Bart.'s men who during the past year have favoured us with contributions to these pages. It is no light task to run a journal even on the modest lines of this publication. Unfortunately the Editorial department is by no means alone in its responsibilities. The increased cost of labour is a

very serious problem indeed, and more than makes up for any decrease in the cost of materials.

We do wish to appeal for support, financially and otherwise. In our editorial capacity we shall be most grateful for any contribution. The Publication Committee will be equally grateful for financial support. The success of the Hospital JOURNAL largely rests with past and present Hospital men, and we confidently believe they will not fail us.

* * *

It is with great regret that we learn that Sir Wilmot Herringham, K.C.M.G., C.B., has resigned his position as Senior Physician to the Hospital. Sir Wilmot is entitled to a rather special token of memory on the part of old St. Bartholomew's men in that he was the first President of the reconstructed Students' Union, and it is largely owing to him that the clubs have reached the very highly efficient state which they do at the present time.

He was also at one time in charge of the Officers' Training Corps, in which he took a very special interest. Outside the Hospital he attained the high office of Vice-Chancellor of the University of London and consulting Physician to the armies in France. In the early days of the war he commanded the First London General Hospital.

We feel that Sir Wilmot has always been a students' man, and we wish him long life and happiness.

* * *

Our warmest congratulations to Lieut.-Col. H. Gilbert Barling on the baronetcy bestowed upon him in connection with the Birthday Honours. Col. Barling is Vice-Chancellor of Birmingham University, where he has been Ingleby Lecturer and Dean of the Medical Faculty. He has also been Examiner in Surgery at the University of Cambridge, and has done very good work in connection with the war.

* * *

Fleet-Surgeon Alfred T. Corrie, R.N., has been elected a Governor of this Hospital.

* * *

We are pleased to congratulate Col. E. M. Hassard, A.M.S., and Col. H. S. Thurston, C.B., C.M.G., R.A.M.C., on being awarded the Military Order of Avis (Portuguese).

* * *

The following Bart.'s men have been mentioned in Despatches from the Commander-in-Chief in India: Lieut.-Col. H. G. Winter, R.A.M.C., Major F. A. H. Clarke, R.A.M.C.

* * *

We owe an apology to Temp. Capt. R. Foster Moore, who was awarded the O.B.E. in the recent Birthday Honours. Mr. Foster Moore as Assistant Ophthalmic Surgeon should, of course, have been included in the list of names of members of the Hospital Staff which appeared in the July issue, and we much regret the omission.

* * *

Sir Robert Armstrong-Jones, M.D., C.B.E., Lecturer on Psychological Medicine at this Hospital, has been appointed a Deputy Lieutenant of the County of Carnarvon.

* * *

We are pleased to see the Old Students' Dinner is again to hold its meeting on September 30th.

We are very sorry to learn that it is to be held at Princes' Restaurant and not in the Great Hall of the Hospital as usual, but we understand there is some difficulty in arranging for the provision of food within the Hospital precincts.

Dr. W. S. A. Griffith is to be the Chairman on this occasion, and we trust that the meeting will be a "bumper" one—in fact, a re-union of all the Bart.'s men after the war.

* * *

At a recent meeting of the Royal College of Physicians of London the following appointments were made:

Censors.—Sir Wilmot P. Herringham, Sir Humphry D. Rolleston.

Treasurer.—Sir Dyce Duckworth.

Registrar.—Dr. J. A. Ormerod.

Harveian Librarian.—Dr. T. H. A. Chaplin.

Curator of the Museum.—Dr. A. T. Davies.

Examiners:

Chemistry.—Dr. W. H. Hurtley.

Medical Anatomy and Principles and Practice of Medicine.

—Dr. J. Calvert, Dr. W. A. Turner, Dr. A. J. Hall.

Tropical Medicine.—Dr. J. B. Christopherson.

Dr. F. W. Andrewes was re-elected a member of the Executive Committee of the Imperial Cancer Research Fund.

Sir W. Church was reappointed a member of this Fund.

* * *

The following appointments have been made in connection with the Hospital:

Demonstrators of Practical Surgery: W. Girling Ball, F.R.C.S., and J. E. H. Roberts, O.B.E., M.B., F.R.C.S.

Demonstrator of Operative Surgery: Sir Charles Gordon Watson, K.B.E., F.R.C.S.

Demonstrator of Midwifery: M. Donaldson, M.B., F.R.C.S.

Demonstrator of Biology: W. A. Cunnington, M.A., Ph.D.

Demonstrator of Chemistry: J. H. Johnston, M.Sc.

Demonstrator of Physics: F. Ll. Hopwood, D.Sc.

Senior Demonstrator of Anatomy: J. L. Shellshear, D.S.O., M.B., Ch.M.(Sydney).

Demonstrators of Anatomy: R. A. Ramsay, M.Ch., M.B., F.R.C.S., H. E. Griffiths, M.B., B.S., F.R.C.S., J. B. Hume, M.R.C.S., L.R.C.P.

Senior Demonstrator of Physiology: J. Trevan, M.B., B.S., M.R.C.P.

Demonstrators of Physiology: N. B. Dreyer, R. Hilton.

Demonstrators of Pathology: R. G. Canti, M.B., B.C., T. Joekes, M.B., E. G. D. Murray, O.B.E.

Curator of the Museum: T. H. G. Shore, M.D., B.C.

* * *

We regret to announce the death, in his 73rd year, of Dr. Wyndham Randall, Bridgend, which occurred on July 17th. He was educated at Cheltenham and at this Hospital. Dr. Randall was the *doyen* of the profession in the district; he spent nearly the whole of his professional life in his native town, and by his many sterling qualities won the confidence of his colleagues. To within a few years of his death he was medical officer to the Bridgend and Cowbridge Board of Guardians, and medical officer of health to the Bridgend Urban District Council and also to the Penybont Rural District Council. The loss of a son—a captain in the R.A.M.C.—in the war was a blow from which he never recovered.

Dr. Randall was deeply interested in all matters appertaining to his profession, a thoughtful and regular reader of current medical literature. Though he held strong and decided views on many controversial questions, both political and otherwise, views not always accepted by his friends, yet however much they differed from him none doubted his sincerity and all loved his companionship.

* * *

We also regret to have to record the death of Dr. Lovell Drage, which took place at Hatfield on August 15th, after a brief illness. Born in 1859, he was educated at Winchester, and, going up to Christ Church, took a science degree in 1881. At Winchester he was a distinguished rifle shot, and was one of the team that won the Ashburton Shield in 1875. From Oxford Dr. Drage proceeded to Owen's College for a course of pure science. His career at this Hospital procured for him the appointment of House-Surgeon, under the late Sir Thomas Smith, and another appointment under the celebrated obstetrician, Dr. J. Matthews Duncan. He was medical officer of Health for the Hatfield Rural District and coroner for Mid Herts, staff surgeon of the Herts Constabulary, and medical officer of the Herts Yeomanry. He was the author of *Chemical Treatment of Cancer* and other medical works.

OUR RETROSPECT.

ON the occasion of our last retrospect war was still raging, although at the time of writing the Allies were carrying all before them and victory appeared to be well in sight. Soon after the Armistice was signed, men began to come back to the Hospital, but it was not until the New Year that there was any marked ingress of students. The commencement of the Summer Session showed a very large entry, in spite of the fact that the Medical School Committee decided not to admit women as Hospital students.

Quite a feature of the Summer Session was the large number of Overseas Post-graduates. So numerous were they at times that some of the departments were quite crowded out, and we are afraid that in more than one instance students had to take a back seat. Nevertheless we welcomed them at the Hospital, especially the Colonial and American "medicos," and trust they will carry back to their native lands pleasant memories of London's Senior Hospital.

Towards the end of May practically all the Staff had returned, much to the satisfaction, and perhaps we might add, relief of the very hard-worked members who had carried on so admirably during their absence.

Major-General Sir Wilmot Herringham lectured on two occasions during the Summer Session, his subjects being "Trench Fever" and "Gas Poisoning."

Major-General Sir Anthony Bowlby's reappearance when he delivered his first lecture since the outbreak of war was also a notable occasion, and was undoubtedly the best-attended lecture at the Hospital during the year.

We much regret that both Sir Wilmot and Sir Anthony have since tendered their resignations as members of the Hospital Staff.

The Hospital has also lost another valuable teacher in the resignation of Mr. R. Cozens Bailey from the Surgical Staff.

Unfortunately the cessation of hostilities in November did not see the close of the Roll of Honour, and several deaths whilst on active service occurred after that date.

The decorations in connection with the war have been very numerous, and most of them have been referred to in our editorial columns. The list includes the following: K.C.B., 1; K.C.M.G., 2; K.B.E., 3; Knight Bachelor, 1; C.B., 4; C.M.G., 3; C.I.E., 3; C.B.E., 21; M.B.E., 4; O.B.E., 56; D.S.O., 8; Bar to the M.C., 4; M.C., 19; Mentioned in Despatches, 127; Board of Trade Bronze Medal for Saving Life at Sea, 1; Promotion, 11; Chevalier of Legion of Honour, 1; Chevalier Ordre de Leopold, 2; Croix de Chevalier of Legion of Honour, 1; Croix de Guerre, 7; Cross of Chevalier of the Order of the Crown, 2; Order of the Rising Sun (Fourth Class), 1; Order of St.

Sava, 1; Italian Bronze Medal, 1; Associate of the Order of St. John of Jerusalem, 1; Civil Honours, 50.

Reconstruction has been very much in the air since the beginning of the year. The May issue of the JOURNAL was entirely devoted to this most important part of the future of the Hospital, and while no actual details can yet be published, we have reason to know that many sound schemes have been formulated and will shortly be launched. It is, indeed, very satisfactory to know that Bart.'s again takes a first place in the advancement of medicine in the world's greatest city.

We have already referred to the large entry of students, and naturally this has meant a revival of the social side of the Hospital. The Rugby team had an exceptionally successful season. The Cricket, Tennis, Rowing, Boxing and other clubs have also demonstrated that the Hospital is getting back to pre-war conditions. Other social functions which have been revived to the delight of everyone have been the Annual Dance and the Past and Present Cricket Match, both of which were a great success.

A notable event of the year has been the very determined effort which the Hospital has made and is making to build a new Home for the Nurses. This has long been a very serious need, but thanks very largely to the energies of Lieut.-Col. W. McAdam Eccles the prospect of a new building in the near future is definitely assured.

It is with much regret that we have to record the death of several past students. We would especially mention the death of two of the most brilliant of the younger members of the Hospital Staff—Dr. A. E. Stansfeld and Mr. Harry Blakeway. There is no doubt that the highest which medicine and surgery had to offer was at their command, and both the Hospital and the medical profession at large are the poorer by their loss.

Another very sad loss to the Hospital has been the death of Mr. Arthur Watkins, who for twenty-four years had acted as Steward to the Hospital. No public institution ever had a more faithful servant. The crowded gathering at the memorial service which was held at St. Bartholomew's-the-Great bore eloquent testimony to the esteem in which he was held.

Many honours, recognitions and appointments have been conferred upon Bart.'s men during the year which add credit to the Hospital. Amongst these we may mention the following:

Major R. C. Elmslie has been appointed Honorary Surgeon to the National Orthopædic Hospital.

Prof. F. A. Bainbridge has been elected a Fellow of the Royal Society.

Sir Norman Moore has been re-elected President of the Royal College of Physicians of London and has also had a Baronetcy bestowed upon him.

Dr. A. E. Gow and Dr. P. Hamill have been elected Fellows of the Royal College of Physicians of London.

Major-Gen. Sir Anthony Bowlby has been awarded the K.C.B.

Major-Gen. Sir Wilmot Herrington has been awarded the K.C.M.G.

The K.B.E. has been conferred upon Lieut.-Col. D'Arcy Power and Col. Gordon Watson.

The C.B.E. has been awarded to Lieut.-Col. J. Calvert, Lieut.-Col. Sir Robert Armstrong-Jones, Lieut.-Col. M. H. Gordon and Major R. M. Vick.

Major F. W. Andrewes, Major R. C. Elmslie, Major J. E. H. Roberts and Capt. R. Foster Moore have been awarded the O.B.E.

Sir Anthony Bowlby has been elected a Vice-President of the Royal College of Surgeons of England.

Sir George Newman has been appointed Chief Medical Officer of the newly-formed Ministry of Health.

The Hospital has again been very successful in regard to the various examinations.

At the University of Oxford one has taken the degree of M.D. and one the degree of M.Ch.

At the University of London one has taken the degree of M.D., and eight have taken the degree of M.B., B.S., one gaining the Gold Medal. At the Royal College of Physicians five have been elected Fellows, and two have obtained the M.R.C.P.

At the Royal College of Surgeons of England seven have obtained the F.R.C.S., while eight have passed the examination for the Primary F.R.C.S. Two members have obtained the D.P.H. One has obtained the Diploma in Tropical Medicine.

Of the Conjoint Board Examinations thirty-two have obtained the Diplomas of M.R.C.S., L.R.C.P.

The Scholarships and Prizes during the year 1918-1919 have been awarded as follows :

- Lawrence Scholarship*.—G. Bourne.
Luther Holden Scholarship.—No award.
Brackenbury Medical Scholarship.—S. M. Cohen.
Brackenbury Surgical Scholarship.—W. E. H. Banks.
Kirkes Scholarship and Gold Medal.—Not awarded.
Matthews Duncan Prize.—W. S. Sykes.
Willett Medal.—S. M. Cohen.
Walsham Prize.—W. E. H. Banks.
Bentley Prize.—Not awarded.
Hichens Prize.—Not awarded.
Wix Prize.—Not awarded.
Sir George Burrows Prize.—J. V. Landau.
Skyner Prize.—G. Slot.
Shuter Scholarship.—R. Hilton.
Junior Scholarships: Biology, Chemistry, and Physics.—(1) H. Burt-White, (2) N. E. Laurence.
Junior Scholarships: Anatomy and Physiology.—(1) A. Walk, (2) A. C. Maconie.
Harvey Prize.—(1) W. M. Mitchell (prize), (2) F. C. Capps, (3) H. Shannon.
Senior Scholarship in Anatomy, Physiology, and Chemistry.—W. E. Lloyd.

Junior Practical Anatomy (Treasurer's Prize).—(1) A. H. C. Visick (prize), (2) A. Q. Wells, (3) A. W. Hart-Perry, (4) S. J. Davies and E. Coldrey æq.

Senior Practical Anatomy (Foster Prize).—(1) F. C. W. Capps (prize), (2) D. M. Lloyd Jones, (3) B. L. Jeaffreson and W. E. Cloyd æq.

Senior Entrance Scholarship in Science.—C. L. Pasricha.

Junior Entrance Scholarship in Science.—B. M. Tracey.

Entrance Scholarship in Arts.—J. Maxwell.

Jeaffreson Exhibition.—N. E. Laurence.

MEDICAL NOTES.

By Sir THOMAS HORDER, M.D.,

(Continued from page 116.)

DISEASES OF THE KIDNEY.

(116) *Pace* physiology one is tempted to say that there is no such thing as "normal" urine. It is certainly wisdom in the beginner to accept this axiom in the routine examination and description of his patients.

(117) The disposition of "renal" œdema is determined in the first place by looseness of the cellular tissues, and in the second place by gravity; the disposition of "cardiac" œdema is determined in the first place by gravity, and in the second place by looseness of the cellular tissues. "Renal" œdema is first apparent, or is more marked, in the early morning; "cardiac" œdema is first apparent, or is more marked, in the evening.

(118) It is quite common to find concurrence of chronic nephritis and dilatation of the heart. Even so, it is important to determine which factor is the more dominant one in the case, because, if such determination is possible, the appropriate treatment can be more readily undertaken.

(119) Both chronic nephritis and dilatation of the heart may lead to a scanty, albuminous urine. But in the case of chronic nephritis the scanty urine is usually pale—pigment elimination being diminished,—is free from, or has but a small, deposit, the amount of albumen is considerable, and renal casts are present. Whereas in dilatation of the heart the scanty urine is generally high coloured, contains a large uratic deposit, the amount of albumin is usually low, and renal casts are absent.

(120) In nephritis arterial tension rises before albuminuria appears, and for some time before arteriosclerosis shows itself—a clinical observation that preceded the introduction of the sphygmomanometer by many years. Similarly, in nephritis the heart is affected before there are any signs of cardiac hypertrophy. This heart "irritability" shows itself by shortness of breath, palpitation, præcordial distress and night starts on the subjective side, and by arrhythmia on the objective side. These are functional disturbances, and they subside before any structural changes take place if renal adequacy is restored within reasonable time.

(121) It is a common practice to attempt to "flush the kidneys" in certain cases of nephritis in which the secretion of urine is diminished. But experience does not justify this measure. Nor does theory, for in acute nephritis the use of copious drinks contravenes the main indication, which is to secure physiological rest of the inflamed organ, and the renal elimination of water is a vital, and not a mechanical, process; whilst in chronic nephritis such treatment tends to increase existing œdema, or to induce it if not already present. *The time to increase the fluid ingested is when diuresis begins, not before it has commenced.*

(122) The French have a maxim by which they express the urgent necessity of strict adherence to a diet of milk in any case of nephritis in which there is the least suggestion of acute uræmia: *lait ou mort*. The fear of starvation is so deeply rooted in the English mind that it is sometimes necessary, in order to secure co-operation, to meet this fear by arousing another of a worse contingency. Even when the decision to confine the diet to milk is agreed upon the whole question is not settled: the matter of quantity is equally important; 30 oz. *per diem* should be the limit in an adult, and half that quantity in a child. The total amount of fluid allowed should not exceed twice these amounts (*vide* § 120).

(123) The use of a saltless diet in cases of renal œdema, though it has not justified the enthusiasm with which French physicians originally advocated it, is yet a helpful adjunct in treatment.

(124) Decapsulation of the kidneys in the treatment of nephritis has fallen almost entirely, but probably quite undeservedly, into disrepute. Like many another therapeutic measure it was killed by its friends, who advocated it without sufficient forbearance. Its success turns upon the careful choice of suitable cases. Given a case of sub-acute nephritis, or a case of acute nephritis which is tending to become chronic, in which dropsy is persistent, in which structural cardio-vascular changes are absent or are present only in slight degree, and in which thorough treatment on general lines has failed to establish a cure in three months—in such a case the operation should be seriously entertained. The mortality of the operation in such a case is negligible, and the results more than justify the procedure.

(125) The known presence of a calculus in the kidney or in the urinary tract is not in itself an indication for surgical treatment. But if, in spite of general measures, (i) chronic pain or attacks of colic persist, (ii) hæmaturia recurs, or (iii) the urine becomes infected, operation should be advised.

(126) Tuberculosis of the kidney most often begins in the apex of a pyramid. This accounts for the frequency with which hæmaturia is the first sign, or one of the earliest signs, of the disease. The hæmaturia often intermits, and

the urine may be quite healthy between the attacks. The hæmorrhage may be induced by exercise and may be checked by rest. The analogy with calculus in these respects is sometimes very striking, and occasionally they may be rendered even closer by the occurrence in renal tuberculosis of pain of a colicky nature.

(127) The key to many intractable cases of *B. coli* infection of the urinary tract is often to be found in the state of the bowel.

(128) The occurrence of epididymitis as the result of *B. coli* infection is not widely known; the affection is therefore often attributed erroneously to gonorrhœa or to tuberculosis.

A CASE OF AURICULAR FLUTTER: THE EFFECT OF TREATMENT BY DIGITALIS.

By I. DE BURGH DALY, M.A., M.B., B.Ch.(Cantab.),
Captain, R.A.F. Medical Service.

IN a paper published by G. Bourne in the *St. Bartholomew's Hospital Journal* for May, 1918, a case of auricular flutter was described and an account given of the result of treatment by digitalis.

The patient was discharged from hospital in December, 1917, and readmitted in September, 1918, when further treatment was carried out, the effect of which forms the subject of this paper. A *résumé* of the paper by G. Bourne has been added to allow of a clearer conception of his condition which led up to readmission.

[*Résumé*.—J. B—, æt. 60, cigarette maker, had suffered from chronic bronchitis for twelve years. In May, 1916, he had a sudden sensation of weakness in both legs, associated with pain in the upper part of the chest. The pain was of maximum intensity behind the angle of Ludovici of the sternum, but radiated to the left shoulder and down the back of the left arm. He recovered in a few minutes, and the pain disappeared. Similar attacks occurred, until one more severe than the others brought him to hospital on November 1st, 1917. On admission his pulse was uncountable; he was cyanosed and very short of breath. A day later his pulse was 140, regular, and did not vary with posture or exercise. The chest was emphysematous in shape; examination of the lungs revealed the presence of scattered *râles*. The area of cardiac dulness was increased both to the right and the left; there was no ascites or œdema. The liver was not enlarged, and the urine was free from albumen. Sixty minims of tincture digitalis *per diem* were administered, but the failure of this drug to reduce the pulse-rate led to the suspicion of the presence of an abnormal auricular rhythm. An electro-cardiogram showed auricular flutter; the auricular and ventricular rates were 280 and 140 respectively. The P-R interval was 26 of a second. An attempt to produce auricular fibrillation by larger doses of digitalis was successful, but on the withdrawal of the drug the auricular flutter returned. A second attempt, made with still larger doses of digitalis, again produced fibrillation of the auricles, and was followed by the normal sequence of cardiac events. Details are given in Chart A 1, II. The patient was discharged on December 15th, 1917, feeling much improved in general health.]

In March, 1918, he had another attack of weakness and pain—the first since he left hospital in December, 1917. He complained that the slightest exertion made him very short of breath and easily tired. On clinical evidence alone it was thought that a recurrence of auricular flutter was the cause of his symptoms. Unfortunately it was not possible to take an electro-cardiogram at this date, but in the following June and August two records were obtained by G. Bourne, both of which showed auricular flutter.

From March to September, 1917, the attacks of weakness took place at intervals of about one month. Treatment during this period was confined to tincture digitalis, 45 minims *per diem* being taken. Owing to domestic difficulties he was unable to enter hospital as an in-patient until September 18th, 1918.

On admission he was slightly cyanosed; the veins of the neck were full and appeared to be "fluttering." The area of cardiac dulness extended 4 in. from the mid-line in the fifth space to the left and $1\frac{1}{2}$ in. in the fourth space to the right. The heart-sounds were distant; no bruits were heard. The pulse was 72 per minute and almost regular; rarely "dropped beats" occurred, but premature beats were absent.

He had a troublesome cough, and was expectorating a small amount of muco-purulent material. Scattered *râles* were heard all over the chest. There was no œdema, ascites or albuminuria. There was no orthopnoea.

On the evening of admission polygraph tracings were taken. The effect of respirations and pressure upon the vagus in the neck were observed. Auricular flutter was present with varying 3:1 and 4:1 heart-block. The auricular rate was approximately 270 per minute (i).

On September 19th an electro-cardiogram (ii) showed auricular flutter with 4:1 heart-block, 2:1 heart-block occurring at irregular intervals. The auricular rate was 300, and the P-R interval .25 of a second.

On September 20th 60 minims of tincture digitalis were given, the dose being increased to 90 minims on the following day. The chart (iii) represents the amount of digitalis taken *per diem* with the resulting changes of rhythm. Auricular fibrillation appears to have been produced on the fifth day from the commencement of digitalis administration, lasted approximately eleven days, and was followed by the normal sino-auricular rhythm.

It was uncertain as to the exact time auricular fibrillation supervened. On the fourth day of the digitalis course the pulse was irregular and 65 per minute; all the beats were coming through to the wrist and there was no change in rhythm after exercise. The irregularity was presumed to be due to varying degrees of heart-block. On the following day exercise increased the irregularity; the rate also rose from 62 to 74 per minute. A few of the beats were not coming through to the wrist and auricular fibrillation was presumed to have occurred. The difficulty of accurately ascertaining the time of change of rhythm is discussed later.

Clinically, auricular flutter associated with varying grades of auriculo-ventricular block closely simulates auricular fibrillation, especially when large doses of digitalis are being taken. There is some reason to believe that the explanation is partly to be found in the comparatively slight ventricular irregularity present during the earlier periods of fibrillation, when large doses of digitalis are being taken, as compared with the later periods when digitalis has been discontinued. Again, the reaction to exercise when auricular fibrillation is present is less marked if digitalis is being taken in large doses.

On September 27th an electro-cardiogram confirmed the change to auricular fibrillation (iii).

The return to normal sino-auricular rhythm took place on October 4th. At 11.30 a.m. on that date the pulse at the wrist was irregularly irregular, but at 4.30 p.m. it was evident that a dominant rhythm had set in although there were a few irregular periods; respiratory arrhythmia was well marked. The following day an electro-cardiogram showed normal cardiac events (iv).

From October 11th to 21st 90 minims of tincture digitalis *per diem* were given to discover if a further course would enable him to remain free from auricular flutter for a longer period than three months. During the administration the pulse was always quite regular and never fell below 55; very few subjective symptoms were experienced. He was discharged on October 25th feeling very much improved.

DIGITALIS.

It is of interest to note the relationship between the amount of digitalis, the period over which it was given, and the consequent changes in the auricular rhythm. The onset of a different rhythm was estimated clinically.

The total quantity of digitalis taken before the onset of auricular fibrillation at the second and third attempts (A ii, B iii) was between 300 and 400 minims of the tincture. In the first attempt (A i) between 400 and 500 minims were taken, the larger amount probably being necessary because of the inadequate doses administered on the first three days.

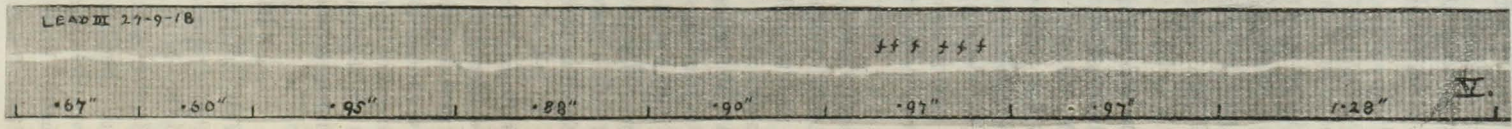
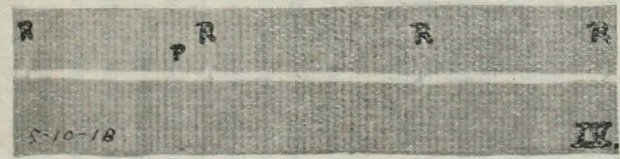
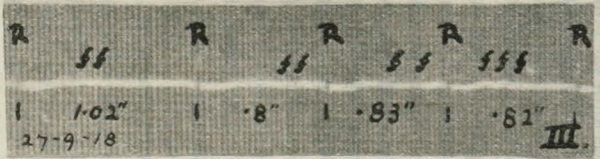
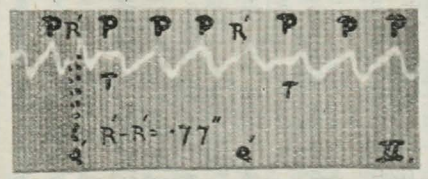
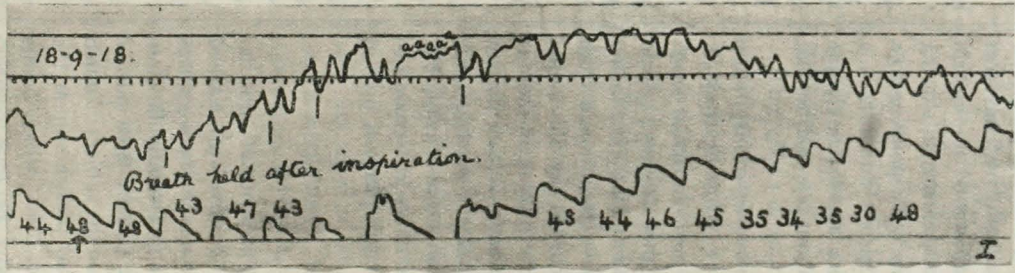
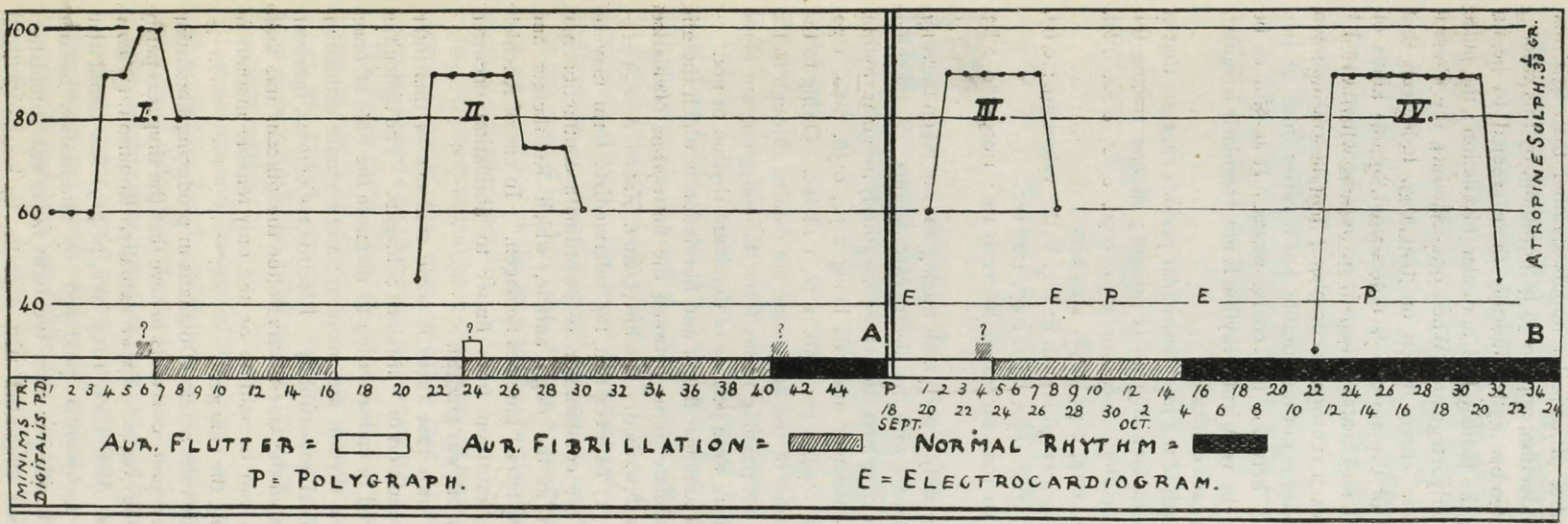
Failure to produce the normal rhythm the first time (A i) appears to have been due to the premature withdrawal of the drug after auricular fibrillation had occurred.

THE EFFECT OF ATROPINE SULPHATE.

On October 23rd, two days after the digitalis had been omitted, $\frac{1}{3}$ gr. atropine sulphate was given subcutaneously. The ventricular rate increased from 76 to 108 in 38 minutes. The time taken to reach the maximum rate was longer than had been experienced in other cases. Preliminary slowing was well marked, the pulse falling to 64 per minute in 13 minutes.

EFFECT OF PRESSURE UPON THE VAGI.

September 18th.—Compression of the *left* vagus in the neck sometimes resulted in ventricular inhibition as



evidenced by absence of the heart-sounds and carotid pulsations on the opposite side of the neck; the longest pause noticed was about three seconds. Compression of the *right* vagus failed to produce any obvious change of rhythm in spite of frequent attempts.

Satisfactory tracings of ventricular inhibition following pressure upon the *left* vagus were not procured. The difficulty of manipulating the jugular receiver-cup and the discomfort caused to the patient by pressure on the vagus produced too much movement to allow of a readable jugular curve being recorded, but it is hoped that further trials will be possible, using the string galvanometer for recording purposes.

EFFECT OF RESPIRATIONS.

On September 18th a deep inspiration followed by fixation of the chest in the full inspiratory position with the breath held produced "dropped beats."

A polygraph tracing illustrating the respiratory effect is seen in Fig. 1; it has been re-drawn for the sake of clearness.

The superimposition of the "a," "c" and "v" waves at the commencement of the tracing allows of no certain interpretation, but during the period of ventricular slowing five "a" waves are isolated, each one corresponding to a division of the time marker, which registers one-fifth of a second. The auricular rate is therefore approximately 300 per minute, and the ventricular rate about one-quarter that number.

About five seconds after the commencement of inspiration the rhythm appears to change from 4:1 to 8:1 heart-block, the higher grade of block lasting for two ventricular beats only. Subsequently it seems probable that varying 4:1 and 5:1 block takes place. The jugular tracing only being readable in places, the calculations have been made from the length of ventricular cycles recorded by the radial pulsations. This method is open to criticism as there is no evidence of regular auricular contractions other than at the period of ventricular inhibition, but electro-cardiographic curves the following day render the conclusions justifiable. The ordinates marked on the jugular curve correspond to the radial impulse. The radial tracing in places is marred by muscular movements.

ELECTRO-CARDIOGRAPHIC CURVES.

The ventricular complex during the presence of auricular flutter is represented by a large electro-positive wave marked "Q" in Fig. 11, but there is probably no relation between this deflection and the "Q" of the normal supra-ventricular complex. The path taken by the impulse passing from auricle to ventricle in auricular flutter has been the subject of much debate. Both respiratory changes and pressure upon the vagus in the neck increase the grade of block, which points to the path of conduction being under nervous control; therefore, the view held by Lewis, that the aberrant com-

plex is due to increased junctional activity owing to the larger number of auricular impulses rather than to a new path of conduction, appears to be borne out by this case.

On September 27th, clinically there seemed to be no doubt that the patient had auricular fibrillation; the pulse was irregularly irregular. When one examines the electro-cardiographic curves taken on that day, it is seen that fibrillation of the auricles is represented by two kinds of waves—fine and coarse; there is no representative of "P" preceding each ventricular complex. The interval between the fine waves is not measurable, but it varies from .08 sec. to .12 sec. between the coarse waves. It is also to be noted that the ventricular rhythm is not irregularly irregular, as was the case clinically.

The length of the interventricular periods suggests that at times a dominant rhythm is present; in one tracing the successive periods measure 1.30, 0.90, 0.82, 0.82, 0.85, 0.73, 0.80, 1.15, 0.73, 0.98, 1.43 sec.

In another, which is seen in Fig. V, the values are: 0.67, 0.60, 0.95, 0.88, 0.90, 0.97, 0.97, 1.28 sec.

In Fig. III four successive intervals are: 1.02, 0.80, 0.83, 0.82 sec.

Unfortunately a polygraph tracing was not taken the same day to compare with the electro-cardiograms. A sphygmogram three days later showed an irregularly irregular rhythm, the interventricular intervals being 0.72, 0.56, 0.70, 1.30, 1.52, 0.70, 0.94, 0.76, 0.56, 1.38, 1.16 sec. Owing to the fact that some of the beats were not coming through to the wrist it is not possible to say from the sphygmogram alone whether there were periods of dominant rhythm or not.

Cases of auricular flutter and fibrillation in which there is an intermediate form between the flutter and fibrillation have been described. Ritchie (*Quart. Journ. Med.*, 1913-14, vii, p. 1) believes that the intermediate form may be similar to the combination of co-ordinate contraction and fibrillation in the dog's auricle, which Rothberger and Winterberg term "unreines Schlagen." In one of Ritchie's cases the transition from flutter to fibrillation occurred repeatedly but was gradual.

In our own case there is some evidence of this intermediate condition or "unreines Schlagen." The difficulties encountered in endeavouring to diagnose the time of onset of the new rhythm are manifest; any accurate estimation was a clinical impossibility. Electro-cardiograms, however, demonstrated the true nature of the arrhythmia, and their exhibition can be said to be the only reliable method of determining the changes.

As regards the action of digitalis in producing fibrillation after flutter, some observers believe that the drug acts partly through the vagus. Experimentally, Robinson (*Journ. Exp. Med. New York*, 1913, xvii, p. 429) has found that auricular tachycardia produced by faradisation became auricular fibrillation when the right vagus was stimulated; it has been suggested that digitalis, by reason of vagal

stimulation, converts flutter to fibrillation in the same manner. This theory is not incompatible with the knowledge that the vast majority, if not all, the cases of auricular flutter are the result of a carditis.

In a letter received from the patient, dated April 28th, 1919, he states: "As far as I am able to judge my pulse beats regularly but often. . . . the bad attacks from which I used to suffer such agony have stopped. . . . I am practically in the same condition now as when I left the hospital."

I am greatly indebted to Dr. Drysdale for the privilege of describing this case, and to G. Bourne for permission to publish a *résumé* of his paper.

THE FACIAL HOSPITAL,

78, BROOK STREET, W. 1.

By R. C. ACKLAND, M.R.C.S., L.R.C.P., L.D.S.



EARLY in the war and partially as the outcome of visits to France it was apparent to the writer of this article that the trench warfare then existing would mean a large percentage of head and face wounds.

The surgery of wounds of the face was forthcoming, but treatment of wounds of the face involving fracture of the jaw called for the co-operation of the dental surgeon, who in turn needed the help of the dental mechanic.

The Hon. Sir Arthur Stanley, acting on behalf of the Joint Committee of the Red Cross and Order of St. John, with the consent of the War Office, established a Hospital for Facial Injuries at 78, Brook Street, W. 1, of which the writer had charge. The house selected needed practically no alteration to make it a capital hospital of 40 beds.

It was opened in May, 1916, first as an auxiliary to and then as a Section of the 1st London General Hospital, by whom it was administered.

Its usefulness was at once demonstrated inasmuch as the parent Hospital was soon asked to take its overflow of patients, who at one time were more than 100 in number.

The Brook Street Hospital soon after acquired a second house as hostel for some of its patients, and 24, Norfolk Street, was rapidly furnished and equipped (also by the Joint Committee), the total number of beds in the two Hospitals being 77.

Instruments and fittings for the theatre as well as tools and appliances for the laboratory were obtained at once and without difficulty. Requests to 83, Pall Mall, brought prompt results, this being in marked contrast to what happened when similar appeals were made to the War Office when the writer was working at the 1st London Hospital before the establishment of the Red Cross Hospital.

To procure an Albee Saw quickly Sir Arthur Stanley himself sent a cable to Mr. Pierpont Morgan in American with the result that the saw was dispatched at once.

In all about 500 in-patients were attended. The major number of these needed mechanism of the most accurate and delicate type, first to reduce deformity, and secondly to immobilise the fractured jaws. Finally dentures carrying artificial teeth had to be made in the major number of cases. Special apparatus was designed to replace the bony framework of the face and so restore its contour.

The aim of the splint proper was not only to secure union of the bony fragments but also the proper occlusion of the teeth for masticating purposes. Nearly £300 worth of old gold jewellery was collected and assayed to be used in making the different mechanism. Some of this was transferred to other centres of the same kind which subsequently sprang up. Instruments were designed, and made in the laboratory, for measuring degrees of trismus and the strength of the "bite." An electrically driven air pump supplying pressure to points opposite each of the three chairs enabled the V.A.D. staff to throw "wash" into sinuses and wounds. This apparatus was used after each meal and especially just before the patients went to bed as a matter of routine treatment.

Wounds of the interior of the mouth cavity were thus rapidly got under control and absorption brought to its minimum.

The splints in general were of cast silver covered by gold electrically deposited. All sorts of attachments in the way of springs, screws and wires were brought into use as the special need of the case demanded.

Messrs. Meyer, and Melzter of Great Portland Street, by the direction of the writer, made an electrically driven saw carried at the end of a flexible metal arm (a stronger copy of the ordinary dental drill arm).

Various patterns of saws, twin and single, burrs and drills could be used. A special feature was an auxiliary handpiece, which could be used in the left hand to help steady the hold of the right hand and so prevent the saw or saws "chattering" or "running" away.

This saw with the Albee and all the other surgical fittings and furniture of the Hospital have been transferred to St. Bartholomew's Hospital as a gift from the Joint Committee of the Red Cross and Order of St. John.

The following members of the Surgical Staff of St. Bartholomew's were kind enough to undertake the surgery needed: Mr. Gask, C.M.G., D.S.O., Mr. Girling Ball, Mr. Sydney Scott, and again Mr. Girling Ball, as in turn these gentlemen undertook service in the expeditionary forces.

On the Dental Staff of St. Bartholomew's Hospital, Dr. Fairbank, Mr. Huddart, Mr. Bruce Stevenson and the writer were at work throughout, except that the first-named was "called up" for service in the Navy.

About the surgery of this class of injury so much has been written to the JOURNAL and so much has been said at special demonstrations on the subject that the writer will do no more than state a few of his opinions as the outcome of over three and a-half years of observation and treatment of these cases.

The skin and soft tissues in which the lower jaw is suspended form a pouch which tends by gravity to become a trap for pus. Even when pendant drainage exists it is difficult to maintain. Pus around the ends of fractured bone causes more or less necrosis. It is this coalition of things rather than a poor blood-supply—which is claimed to be the causes by most text-books—that handicaps all surgery of these parts. Therefore cleanliness by means of a stream of wash forced into the wounds under pressure at frequent intervals proved to be a necessity. Temperatures came down, and the patients attended more regularly for this treatment because of the sense of well-being and comfort it invariably brought about. Carbolic acid solution of 1:60 to 1:80 used hot was found to be the most effective wash. Merely "swabbing" the mouth out failed to empty the pus and food out of the wounds, and liquids used as a mouth-wash failed for the same reason.

Stereoscopic radiography (taken as a matter of routine of all patients) proved a necessity, as of course one would expect.

Strips or fragments of alveolar process, with teeth embedded, to which the splint could be cemented so as to keep it in position, seem to act as scaffolding for new bone growth, although the piece or strip with teeth was itself thrown off later. The strictest cleanliness by syringing was all-essential in dealing with these fragments.

When the fracture was such that healing by splinting alone could bring about union, teeth at the fractured ends or in their vicinity "killed" by the original injury—(the radiograph could not tell one which were dead—would prevent union, and splints often had to come off and these renewed before union would take place on re-splinting.

Of these fractures which splinting alone would not heal because the gap caused by loss of bone was too great, grafting was resorted to. The earlier grafts were from bone taken from a rib; the next was a series taken from the tibia, and those later from the crest of the ilium. The last-named were the most successful, and gaps which at the beginning of the war it seemed hopeless to attempt to graft were tackled most successfully towards the end of the war.

Small shavings of bone, with pedicles of soft tissue cut by the saw from the vicinity of a medium-sized gap and sewn into the gap by means of the soft tissues, was a means of obtaining union in two cases operated upon by the writer. Of course the usual splinting of the fragments preceded the above operation.

Although the results obtained by plastic surgery were more spectacular, the real difficulty was generally to obtain

union of the bony fragments and to obtain it so that the natural occlusion of the teeth was not lost. However, in a large number of cases respect for the teeth and their occlusion did not complicate matters, for the teeth were either absent or were so inferior in type that the patient was better off for masticating purposes when well-made artificial teeth were supplied later.

The first four in-patients consisted of two men from the Southern, one from the Western and one from the Northern Commands, all of whom had not been treated for fractured jaws. One, whose whole chin was blown away, was on his admittance into St. Bartholomew's in his *eighth* hospital, and two others, also temporarily admitted under Capt. Girling Ball, were in three or four hospitals previously. So that it will be seen that there was an urgent need for special jaw work seeing that these men had been wounded six months to eighteen months previously. It was chance that discovered these cases to the writer, and his reasonable deduction that there were other like cases led to the establishment of this special hospital, which supposition was justified, for many other untreated cases were sent there for treatment.

The Facial Hospital was in existence from May 1st, 1916, to June 12th, 1919. In addition to its 500 in-patients it had a large number of out-patients attending from the surrounding private hospitals in the vicinity.

THE DRESSER'S VADE MECUM.

- (1) A dresser has position but no magnitude.
- (2) The sleeves of an operating gown and the wrists of the gloves (as supplied to dressers), produced ever so far in either direction, will not meet.
- (3) Let A and B be two dressers in the box at 9 a.m. (their firm being on duty and the other dressers being away for the week-end). Let x represent the number of patients outside. Then the time taken to finish the lot = $T = \frac{x}{2}$ minutes = not $< 2\frac{1}{2}$ hours. Give a short account of sister's remarks to A and B when they arrive in the ward at 11.45 a.m. to do dressings.
- (4) Let there be four dressers on a firm. Let that firm be on duty. Explain why the senior dresser only does one afternoon in the box. If not, why not!
- (5) Explain the term "septic dresser." Is he more septic than the others? Is this possible?
- (6) A junior house-surgeon is one who is somewhere else when wanted.
- (7) A senior house-surgeon is one who allots cases to dressers at 12.30 on full day and at 1.30 tells you off for not writing notes on them.

W.S.S.

STUDENTS' UNION.

LAWN TENNIS CLUB.

SENIOR INTER-HOSPITAL CUP WON BY THE HOSPITAL.

Any misgivings felt by the team in not having J. G. Johnstone present in this final against St. Thomas's Hospital were quickly dispelled when Urwick, McCall and Cody quickly defeated their opponents in the Singles, and Krige, Summers and Orchard had each won a set.

As it turned out the Hospital won nine matches straight off without the loss of a set, and thus secured the Cup. Scores:

Singles.—W. D. Urwick beat C. Nicory, 6-3, 6-2; C. F. Krige beat F. B. Hobbs, 6-3, 8-6; H. D. McCall beat G. H. Poole, 6-3, 6-2; H. Summers beat Dalais, 9-7, 6-4; W. E. Cody beat Humfreys, 6-1, 6-4; S. Orchard beat Hoschild, 6-2, 6-4.

Doubles.—C. F. Krige and H. D. McCall beat C. Nicory and G. H. Poole, 6-0, 6-3; W. D. Urwick and H. Summers beat F. B. Hobbs and Humfreys, 8-6, 6-4; W. E. Cody and S. Orchard beat Dalais and Hoschild, 6-1, 6-2.

The second team failed against Guy's in the final for the Junior Cup, the latter hospital putting up a team which was nearly as good as their first team.

It is expected that Johnstone, Urwick, Summers, Orchard and Cody will all be available next year, and therefore we may hope for another successful season.

Colours have been awarded to J. G. Johnstone, W. D. Urwick, C. F. Krige and H. D. McCall.

CORRESPONDENCE.

THE TREATMENT OF AMEBIC DYSENTERY.

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

SIR,—I should like to reply to the sharp criticism aimed at me by Major Maxwell, R.A.M.C., on the subject of amebic dysentery.

The treatment of dysentery by the so-called heroic doses of ipecacuanha is still upheld by so eminent an authority on tropical diseases as Sir Patrick Manson, so I consider myself in good company. To describe the method as "positively barbarous" is hardly tactful.

If Major Maxwell has never seen a patient upset by hypodermic injections of emetine he must have been very lucky, for it is a well-known fact that in a considerable proportion of cases it gives rise to diarrhoea, and, in a few, to degrees of peripheral neuritis characterised by feelings of weakness, sometimes amounting to paresis of the extremities and impairment of deglutition. As regards the D.A.H., an extraordinary large percentage of troops invalided with dysentery from Gallipoli and Mesopotamia have developed D.A.H., as many M.O.'s of my acquaintance have also noted, and we attributed this to the use (? abuse) of emetine.

I found that in making a rectal injection the patient was able to locate the fluid, therefore I consider the X-ray experiment suggested unnecessary. Dysenteric ulcers, it is true, may occur in the lower ileum, but they are most frequent in the cæcum and the flexures.

I did not mention dysenteric "carriers" and would never attempt to prove that they could be cured. It is curious that there should have been 1342 deaths from dysentery out of a total of 38,108 cases in the South African campaign, if "the dysenteric carrier is the only case that really causes any difficulty to the physician." Turning to more recent times, I am sure Major Maxwell cannot have seen many of the human wrecks that have returned and are returning from Mesopotamia suffering from chronic dysentery. The treatment of dysentery by emetine bismuth iodide was the first I tried out here and I consider it over-rated.

Apologising for encroaching upon so much of your valuable space.

I am, Sir,
Yours faithfully,
S. R. PRALL,
Capt. R.A.M.C.

BRITISH STATION HOSPITAL,
AHMEDNAGAR (DECCAN);
July 9th, 1919.

REVIEWS.

PRACTICAL VACCINE TREATMENT. By R. W. ALLEN, M.A., M.D., B.S. (H. K. Lewis & Co., Ltd.) Pp. xii + 308. Price 7s. 6d. net.

The author of this volume is a well-known advocate of vaccine therapy, his book on this subject having already run to a fourth edition. The present work is mainly written for the general practitioner, who can be forgiven if the present position of this enormously interesting but highly confusing branch of therapeutics is not quite clear to him. All phases of vaccine therapy are touched upon, the taking of the specimen, the preparation of the vaccine, its administration and the indications for same. Special chapters are devoted to diseases of the respiratory and circulatory systems, the skin and connective tissues, bones and joints, the intestinal tract, and the genito-urinary system. Quite the most interesting—and, from the point of view of the general practitioner, perhaps the most useful—part of the book is the concluding chapter, which deals with a series of questions on vaccine treatment which have been actually put to the author by medical men.

IRISH ETHNO-BOTANY AND THE EVOLUTION OF MEDICINE IN IRELAND. By MICHAEL P. MALONEY, M.B., Ch.B. (M. H. Gill & Son, Ltd.) Pp. 96. Price 4s. 6d. net.

This little work aims at giving in outline the evolution of medicine in Ireland and at indicating the comprehensive characters of Irish ethno-botany. The first part comprises a list of the native medicinal Irish herbs; the second the evolution of medicine in Ireland. To the native medicinal herbs are attached their Irish names, and in some cases indications of their medicinal properties. The latter part of the book deals in a very sketchy way with the history of medicine in Ireland from Druidical to modern times, but we should be very sorry to regard it as a contribution to the evolution of medicine in that part of the world.

DISEASES OF WOMEN. By THOMAS G. STEVENS, M.D., F.R.C.S. (Hodder & Stoughton & Henry Frowde. London Medical Publications.) Pp. 431. Price 15s. net.

We reviewed this volume when it was first published in 1912 and need only reiterate what we said on that occasion, namely, that it is probably one of the best books available on the subject from the point of view of the student.

The edition has now been reprinted, and in spite of rival works should still command a ready sale.

A SHORT PRACTICE OF MEDICINE. By ROBERT A. FLEMING, M.A., M.D., F.R.C.P.E., F.R.S.E. (J. & A. Churchill.) Third Edition. Pp. 675. Price 21s. net.

For nearly two years the last edition of this work has been out of print, and we are glad to see this well-written and excellently arranged book making its reappearance. As the author says, there are many excellent text-books on medicine but few small-sized manuals. This is not to suggest that the volume under review is any way in the nature of a revision book: the essential details are given in every case, but such details as qualitative and quantitative testing of normal and abnormal constituents of urine and stomach contents are omitted, and pulse-tracings with their diagnostic significance have not been described.

It is rather to be regretted that in a book of this description no attempt has been made to group together clinical features in tabulated form. Such tables are most helpful for examination purposes.

The present volume contains some useful notes on trench fever and trench nephritis, and several new illustrations have been added to those in the previous edition.

We can with confidence recommend the book to our readers. It is larger than most manuals, it is smaller than most text-books, and should prove a valuable help to the student as well as of considerable service to the busy practitioner.

ESSENTIALS OF PHYSIOLOGY. By F. A. BAINBRIDGE and J. ACKWORTH MENZIES. (Longmans, Green & Co.) Third Edition. Pp. 484. Price 12s. 6d. net.

The first edition of this book was published in 1914, and the fact that a third volume is already being called for is sufficient evidence of its popularity. We do not think we should be far wrong in saying that it is probably the most-popular book on physiology which has been published during recent years. For examination purposes the book is admirable. Although small and compact, no essential details have been omitted, and while for the higher examinations larger volumes on the subject may have to be consulted, especially from the experimental side, the book may be relied upon as a sound working basis.

The present volume has been thoroughly revised and brought up to date, and now contains 179 illustrations. The sections dealing with the constitution of proteins and with the chemical changes accompanying muscular contraction have been re-written. The authors have also thought it advisable to re-write the section on the functions of the renal tubules.

EXAMINATIONS, ETC.

UNIVERSITY OF LONDON.

Examination for M.D. Degree, July, 1919.

Branch I. Medicine.—C. Cooke.

First Examination for Medical Degrees, July, 1919.

E. J. Blackaby, D. A. Brigg, R. K. Cannan, L. I. M. Castleden, R. S. Coldrey, F. S. Coleman, J. R. Collacott, E. R. Cullinan, J. Elgood, D. B. Fraser, F. H. K. Green, C. C. Hentschel, N. A. Jory, R. A. E. Klaber, N. E. Laurence, † J. Maxwell, H. V. Morlock, R. D. Reid,* A. J. D. Smith, H. B. White, L. A. Willmott.

* Awarded a mark of distinction in Inorganic Chemistry.

† Awarded a mark of distinction in Physics and in Biology.

Second Examination for Medical Degrees, August, 1919.

Part I.—J. R. Hamerton, R. H. Cooke, N. A. Jory, I. Kinsler, H. L. Oldershaw, C. M. Pearce, R. W. H. Tincker.

CONJOINT EXAMINATION BOARD.

First Examination, July, 1919.

Part I. Chemistry.—V. Barkin, G. Elliot, W. R. E. Harrison, B. A. J. Mayo, M. H. Samy, R. W. Savage, H. H. D. Sutherland.

Part II. Physics.—V. Barkin, G. Elliot, W. R. E. Harrison, C. de W. Kiteat, T. M. Marcuse, M. H. Samy, R. W. Savage, H. H. D. Sutherland, T. B. Thomas.

Part III. Elementary Biology.—V. Barkin, G. R. Nicholls, R. W. Savage.

Part IV. Practical Pharmacy.—F. Asker, S. J. Davies, E. Savage, H. C. M. Williams.

Second Examination, June, 1919.

Anatomy and Physiology.—N. L. Capener, B. J. Hallowes.

DIPLOMA IN PUBLIC HEALTH.

The Diploma in Public Health was conferred upon C. D. Day, and Major H. Falk, I.M.S.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

The following having passed the required examination was admitted a Member: A. C. Roxburgh.

LONDON SCHOOL OF TROPICAL MEDICINE.

The following candidate was successful at the examination held at the end of the sixth session (May–July, 1919): Capt. W. C. Spackman, I.M.S.

APPOINTMENTS.

ALLEN, Temp. Major W. G. E., R.A.M.C. (retired), M.R.C.S., L.R.C.P., appointed to Board of Assessors, Ministry of Pensions, Burton Court, Chelsea.

BUTTERY, H. R., M.R.C.S., L.R.C.P., appointed House Physician at the Royal Chest Hospital, City Road.

COOMBS, H. M. McC., M.R.C.S., L.R.C.P., appointed Certifying Surgeon under the Factory and Workshop Acts for the Bedford District of the County of Bedford.

FORSYTH, J. A. CAIRNS, M.Sc., M.B., F.R.C.S., appointed Surgeon to the French Hospital, London.

LISTER, Major A. E. J., I.M.S., M.B., B.S. (Lond.), F.R.C.S., appointed an Honorary Surgeon to H.E. the Viceroy and Governor-General of India.

QUINE, A. E., M.B., Ch.B. (Vict., Manchester), F.R.C.S. Eng., appointed Joint Venereal Diseases Medical Officer for the Cumberland and Carlisle City County Councils.

RAMSAY, J., O.B.E., M.D. (Lond.), appointed Medical Referee, Ministry of Pensions, Blackburn area.

STRONG, R. H., M.R.C.S., L.R.C.P. (Edin.), appointed Assistant School Medical Officer to the Edmonton Education Committee.

WOODMAN, MUSGRAVE, M.S. (Lond.), F.R.C.S. (Eng.), appointed Hon. Aural Surgeon and Laryngologist, General Hospital, Birmingham.

WYLLYS, WILLIAM, M.R.C.S., L.R.C.P., L.S.A., appointed Honorary Ophthalmic Surgeon to the Great Yarmouth General Hospital.

CHANGES OF ADDRESS.

ALLEN, Temp. Major W. G. E., R.A.M.C. (retired), 28, Westbourne Gardens, Folkestone.

ARCHER, CHARLES W., 7, North Park Road, Harrogate.

ARMSTRONG, R. R., 28, Wimpole Street, W. 1.

BOURKE, J. B., Market Street, Crewkerne.

BURKE, Major G. T., I.M.S., 48th Indian General Hospital, Army of the Black Sea, Constantinople.

CONNOR, Lt.-Col. F. P., D.S.O., I.M.S., 2, Upper Wood Street, Calcutta.

GREY, Capt. H. MARTIN, R.A.M.C., Officers' Mess, Delhi Barracks, Tidworth, Salisbury Plain.

HARTILL, S., Bucklands, East Cowes.

HATTERSLEY, Capt. S. M., R.A.M.C., Pink House, Tigné, Malta.

LAVAN, L. T., 5, Grosvenor Street, W. 1.

MANLOVE, J. E., 10, Wyndham Place, W. 1.

MAXWELL, Major J. L., R.A.M.C., Shinro, Tainan, Formosa.

POWELL, J. C., 22, Welbeck Street, Cavendish Square, W. 1.

SALE, J. C., Weeumbah, Longreach, Queensland, Australia.

TRIPP, C. L. H., 11, East Grove Road, St. Leonards, Exeter.

WILLIAMS, CYRIL, Ardmore, New Place, New Town, Uckfield, Sussex.

BIRTHS.

HILL.—On August 7th, at Dalestead, Caterham Valley, Surrey, the wife of Fred T. Hill, M.R.C.S., L.R.C.P., of a son (Anthony).

KEMP.—On July 24th, at Caversham, Lemsford Road, St. Albans, the wife of C. Gordon Kemp, M.D., of a daughter.

KEYNES.—On August 14th, at Grove House, Hollywood Road, S.W., the wife of Geoffrey Keynes, M.D., of a son.

TURTON.—On July 30th, at 21, Brunswick Place, Hove, the wife of J. R. H. Turton, M.B., B.S., F.R.C.S., of a daughter.

MARRIAGES.

COWAN—SNELL.—On August 23rd, at Brixton Independent Church, S.W., Capt. David John Cowan, 5th Bn. Connaught Rangers, only son of Mr. and Mrs. E. W. Cowan, to Katharine Mary, younger daughter of Rev. Bernard J. Snell.

LOWE—WALTERS.—At Inkpen, Hungerford, on July 30th, by the Rev. H. D. Butler, Rector, Major Godfrey J. R. Lowe, R.A.M.C. (T.), Registrar, 4th Northern General Hospital, Lincoln, to Miss Olive Walters, R.R.C. (late T.F.N.S.), only daughter of Mr. and Mrs. J. W. Walters, of Sadlers, Inkpen.

VON BERGEN—ALLEN.—On August 19th, at St. John's, Limehouse Fields, Carl W. von Bergen, M.D., of Devon House, Leatherhead, to Mary Barbara Satow, only daughter of Edward Satow Allen, of Crampshaw Cottage, Ashted.

DEATHS.

DRAGE.—On August 14th, 1919, at North Place, Hatfield, Lovell Drage, M.D.

POWER.—Formerly reported wounded and missing during the second battle of Ypres, now known to have died in German hands on May 9th, 1915, Lieut. George Henry Fosbroke Power, 6th Battr. Middlesex Regiment, Commoner of New College, Oxford, and President of the Oxford University Fencing Club, aged 21, the dearly loved younger son of D'Arcy and Eleanor Power.

WILKS.—On June 11th, 1919, at his residence, Ashford, Kent, George Wilks, M.C. (Cantab.), M.R.C.S., L.S.A.

