

A MANUAL OF FEVERS. By C. B. KER, M.D. (Ed.), F.R.C.P. (Ed.). Second Edition. (London: Henry Frowde & Hodder & Stoughton.) Pp. x + 334. Price 12s. 6d. net.

The second edition of this book has been thoroughly revised and brought up to date. The manual is intended for the student attending a fever hospital course, and admirably attains its object. The information is presented in a concise and in a usefully dogmatic manner, though the teaching differs in some minor details from that prevalent in the south of England. We are sorry that the author uses "hyperpyrexia" in the old and unscientific sense as the equivalent of very high fever, "usually over 106°." There are many useful diagrams of temperature charts, and six (not very useful) black-and-white photographs of rashes.

EXAMINATIONS, ETC.

UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:
M.B., B.Ch.—D. D. Evans.
B.Ch.—R. S. Corbett.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

The following has been admitted a Member:
T. K. Bouey.

CONJOINT BOARD.

The following have completed the examinations for the Diplomas of M.R.C.S., L.R.C.P.:

S. Bloom, B. D. Hughes, E. Mervyn Jones, J. N. Kerr, A. H. Kretchmar, H. D. Llewellyn, W. H. Nettelheld, T. R. Rees, K. E. Shellshear, S. Suvansa, H. Tothill, E. H. Weatherall.

First Examination, January, 1922.

Chemistry.—O. H. Bellerby, A. S. Edwards, J. D. R. Games, H. C. Hermon, N. F. Kendall, E. F. D. Owen, J. Spencer, E. O. Watson.

Physics.—A. S. Edwards, J. D. B. Games, D. Imber, P. B. P. Mellows, J. Spencer.

Elementary Biology.—C. H. A. Carty-Salmon, W. W. Darley, A. S. Edwards, R. Fison, J. T. C. Gray, H. C. Hermon, H. Hillaby, A. Liberis, C. T. P. Powell, E. O. Watson.

Second Examination.

Part I: Anatomy and Physiology.—H. C. J. Ball, R. J. I. Bell, J. H. H. Chataway, J. Currie, G. D. Drury, A. J. Enzer, J. L. B. Marais, B. Press, A. D. H. Simpson, Z. M. Yusuf.

Anatomy.—H. F. Chillingworth, D. T. Lloyd, K. C. L. Paddle, H. A. M. Whitby.

Physiology.—D. R. Reynolds.

Part II: Pharmacology and Materia Medica.—J. D. Allen, S. Brest, N. L. Capener, D. Imber, J. L. B. Marais, A. E. Ross, R. Stuart, Z. M. Yusuf.

CHANGES OF ADDRESS.

BRADLEY, E. J., 21, Foregate Street, Stafford. (Tel. 50.)
DANNATT, R. MALCOLM, Senior Assistant Medical Officer, City of Westminster Infirmary, Fulham Road, S.W. 10.
EBERLE, W. F., Ravenscroft, Dunstable Road, Luton.
STONE, G. K., 6, Stanley Gardens, W. 11.
WELLER, C. A., Thaxted, Essex.

APPOINTMENTS.

BRADLEY, E. J., M.D. (Cantab.), appointed Assistant Hon. Surgeon to the Stafford General Infirmary.
DANNATT, R. MALCOLM, M.B., B.S. (Lond.), appointed Senior Assistant Medical Officer, City of Westminster Infirmary, Fulham Road.

FEILDEN, Major F. E., R.A.M.C., appointed Embarkation Medical Officer for Evacuation of Troops, Waterford, Ireland.
GAUVAIN, Sir H. J., M.D., M.Ch. (Cantab.), appointed Consulting Surgeon (Tuberculosis), London County Council, and Consulting Orthopaedic Surgeon to the Heatherwood (United Services Fund) Hospital for Crippled Children, Ascot.
HICKS, E. P., M.B. (Cantab.), D.T.M., D.P.H., R.C.P.S., appointed Demonstrator at the London School of Tropical Medicine.
NETTELFIELD, W. H., M.R.C.S., L.R.C.P., appointed House-Surgeon to the Southend Victoria Hospital, Southend-on-Sea.

BIRTHS.

CANE.—On February 13th, at Homewood, Peterston-super-Fly, Glamorganshire, to Dr. and Mrs. Maurice H. Cane—a daughter.
DAVIS.—On January 31st, at 24, Upper Berkeley Street, to Vera, wife of K. J. Acton Davis, M.Ch., F.R.C.S.—a daughter.
SREGGOS.—On January 26th, at 9, High Street, Stevingage, Herts, to Gladys Jessie, the wife of B. Lynden Sreggos—a son.
VICK.—On February 17th, at the Warden's House, St. Bartholomew's Hospital, to the wife of Reginald M. Vick—a daughter (Sarah Douglas).
WATERHOUSE.—On February 7th, at 25, The Circus, Bath, the wife of Rupert Waterhouse, M.D., M.R.C.P., of a son.
WOODMAN.—On January 26th, at 132, Hagley Road, Edgbaston, Birmingham, the wife of E. Musgrave Woodman, M.S., F.R.C.S.—a son.

MARRIAGES.

FORSYTH—BARNEY.—On February 8th, at Alderney, John Andrew Cairns Forsyth, M.Sc., M.B., F.R.C.S., of 56, Harley Street and 1A, Portman Mansions, W. 1, to Phyllis Honor, daughter of the Rev. John Le Brun and Mrs. Le Brun, The Rectory, Alderney, and widow of Lieutenant M. Middleton Barney, R.E.
STONE—POLAND.—On February 1st, at St. Saviour's, Walton Street, by the Rev. H. E. Trask, Gerald William Stone, M.R.C.S., L.R.C.P., of Cumnor, Dyke-road, Brighton, to Celina Violet Travers, younger daughter of the late Vice-Admiral J. A. Poland and of Mrs. Poland, 4, Cresswell Gardens, South Kensington.

DEATHS.

PALMER.—On February 8th, 1922, at a nursing home in London, William Pitt Palmer, M.D., late of Torquay.
WILLAN.—On January 27th, 1922, at Littlehampton, Thomas Henry Willan, M.R.C.S., L.S.A., aged 82 years.
WOLFEERSTAN.—On February 2nd, 1922, suddenly, at 1, Alton Terrace, Plymouth, Dr. Sedley Wolfeerstan, aged 79.

NOTICE.

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

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

St. Bartholomew's Hospital



JOURNAL.

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

VOL. XXIX.—No. 7.]

APRIL 1ST, 1922.

PRICE NINEPENCE.

CALENDAR.

Fri., Mar. 31.—Sir Thomas Horder and Sir Charles Gordon-Watson on duty.
Mon., April 3.—2nd Conjoint (Part II) examination begins.
Tues., " 4.—Prof. Fraser and Prof. Gask on duty.
Final Conjoint Examination begins.
Fri., " 7.—Dr. Morley Fletcher and Mr. Waring on duty.
Tues., " 11.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Fri., " 14.—Good Friday. Sir Percival H.-S. Hartley and Mr. Rawling on duty.
Mon., " 17.—Easter Monday.
Tues., " 18.—Sir Thomas Horder and Sir Charles Gordon-Watson on duty.
Thurs., " 20.—Last date for receiving matter for the May issue of the JOURNAL.
Fri., " 21.—Prof. Fraser and Prof. Gask on duty.
Tues., " 25.—Dr. Morley Fletcher and Mr. Waring on duty.
Fri., " 28.—Dr. Drysdale and Mr. McAdam Eccles on duty.

EDITORIAL.

HOSPITAL finance has become since the war a question of such urgent public importance that even the layman recognises its difficulty and complexity. To us who live in the medical atmosphere it has become so frequent a matter for discussion as to be hackneyed before it is settled, dull before it is decided.

Some time ago there came a change in the ancient custom of this Hospital. Patients were required to pay for their maintenance whilst under our roof. We believe that this departure, necessary as indeed it was, has been generally disliked by the medical and nursing staff. Stephen Paget wrote of our Quadrangle, " . . . and a visitor loitering here will see that we are a brotherhood and the patients are our guests." "Paying guests" they must now be called—a different and a doubtful term. Nor has the change been without its active evils. How often have the Sisters noticed the worry caused by the weekly payments to a

patient already finding it difficult enough to meet the exigencies of health. The tendency has been for the baser type of patient to conceive his treatment a return on strict commercial lines for cash payment, with consequent discontent, and we believe, though we cannot now prove it, that a third unfortunate result is the increasing difficulty in obtaining permission for that post-mortem examination which is so urgently necessary for the advance of knowledge. Before payment began this permission—often a very painful and worrying concession to a bereaved relative—could be represented as some return for Hospital care.

We are not advocating a return to the old system. That is impossible. Modern science is too expensive. It is an unfortunate fact that a man or institution—yes, even St. Bartholomew's Hospital—must live within income or go bankrupt. We cannot rely upon the spasmodic offerings of the grateful, nor Micawber-like can we wait much longer for something to turn up. We, in common with all hospitals, must make sure of a reasonable income or submit to the humiliation of cramping limitations and constant importunity.

During the past few months several schemes have been suggested to solve the difficulty. At last one, called The London Hospitals Contributory Scheme and under the auspices of the King Edward's Hospital Fund for London, has been tentatively accepted by the Hospital authorities.

The chief points in the scheme, as we understand it, are:

(1) "In order to avoid abuse by those who can afford to pay for treatment outside the hospital, it is necessary to fix a strict income-limit. Accordingly the scheme is confined to persons whose individual income does not exceed £4 a week for a single man or woman, £5 a week for a man and wife with no children under sixteen, £6 a week for a man and wife with children under sixteen. Such persons being employees in a factory or other unit of employment, or members of societies established for mutual benefit, will join in groups."

(2) "Regular contributors of 12s. per annum paid in one sum in advance, or 13s. per annum paid in weekly instal-

ments of 3d., will, together with their wives and children under sixteen, when accepted for treatment by a hospital, be relieved, by payments made on their behalf by the central organisation, from contributing to their cost of maintenance as in-patients and from any charge in all out-patient departments."

(3) The scheme will be worked by a central organisation, distinct from King Edward's Fund and any individual hospital. Money will be paid to the central organisation, and by it be disbursed to the various hospitals participating in the scheme.

(4) It will be for us to decide, as before, whether any hospital treatment is necessary or wise for a patient, and if so, whether in-patient or out-patient treatment is best, and for patients so treated, if coming within the scheme, payment will be made by the organisation and not by the patient. "The scheme has nothing to do with National Health Insurance, and leaves untouched the position and responsibility of the general practitioner; it does not cover ordinary maternity cases, or any treatment for which provision is made by the State or local authorities."

These are a few of the essentials of the scheme in which Bart.'s has agreed to participate. The central organisation has not yet been instituted, although we suppose it soon will be. The position of the general practitioner—always important in such proposals—seems assured. We thoroughly believe in the necessity for a contributory scheme and a voluntary contributory scheme. Our only point of criticism is that the scheme may not go far enough, and that there may be competition between the central organisation and those varied approved and friendly societies to which the best type of working man so often belongs. It may not go far enough in providing benefits—for instance the London Ambulance facilities are at present a disgrace to the Metropolis. The friendly societies may be able to provide similar benefits at a cheaper rate. Moreover it seems difficult to work out at all accurately how much new money will be brought in this way to the Hospital.

However, it is a step in the right direction, and Micawber may find his feet in the New World.

The Annual General Meeting of the Students' Union took place on March 10th. An outstanding feature of the proceeding was the retirement of Mr. H. J. Waring from the Presidential Chair. Mr. Waring has for twelve years in his official capacity—and not less unofficially—helped the students in very many ways. For this long-continued and most valuable work the meeting expressed its deep gratitude. In Dr. Drysdale Mr. Waring will have a worthy successor.

The report presented at the meeting was excellent and hopeful. The erection of a stand at Winchmore Hill, the re-establishment of the Boxing Club on a sound basis,

general improvements to the Athletic Ground and in the Catering Company, and the marked increase in the power and influence of the Students' Union Council, stand out to our mind as the most important work of the past year. It would be improper not to mention, what all men know, that the general improvement suggested above has been, to a very large measure, due to the energy and determination of the retiring secretary, Mr. G. B. Tait.

As we go to press we hear that C. Lovatt Evans, Esq., D.Sc.(Lond.), M.R.C.S., L.R.C.P., has been appointed to the Chair of Physiology in our Medical College. We congratulate Dr. Evans upon his appointment and wish him happiness and success in his work. We shall refer to the matter again next month.

It is proposed to hold a Special Post-graduate Vacation Course this year on lines somewhat similar to that given in 1921. The dates chosen are from July 13th to the 29th. Early application for admission to this Course should be made to the Dean, as the numbers will necessarily have to be limited. In order to avoid the congestion occasioned last year the Course is to be prolonged by three days. The programme will be distributed to all old Bart.'s men within the next few weeks.

We have before us the tenth annual report of the St. Bartholomew's Hospital Women's Guild, whose work is done so silently (we speak metaphorically), efficiently and altogether admirably that its results, although appreciated, may not always be credited to the right quarter. Its chief object is to provide clothes for poor patients, and a very large number of garments were made and distributed last year. In the Orthopaedic Department alone 600 cases have been helped. Many a harassed mother has received not only a well child back to her care, but a warmly-clothed child too. The work of the Guild requires not only monetary gifts, but the time and work of friends of the Hospital.

We understand that Mrs. Harmer, who is now Honorary Secretary, will be pleased to send cards of invitation to the Annual Meeting on View Day, May 10th, at the Hospital, to any desiring them.

A small movable stand will shortly be placed in the Post-mortem Room to allow students to see the autopsies more clearly. How often have we waited at the back of the crowd at an interesting post-mortem trying hard to catch a glimpse of the proceedings. We hope that some system of dishes may be arranged, so that parts as soon as they are removed from the body and discussed by the demonstrator may be handed round for inspection.

With our own eight hundredth centenary celebrations

next year it is with special interest that we commend to our readers' notice a little monograph dedicated to the medical students of St. Bartholomew's Hospital, London, on the staff of which William Harvey served as Physician 1609-1643, and called *A Century of Medicine at Padua*, by Sir George Newman, K.C.B., M.D., D.C.L. It is published at one shilling by The British Periodicals, Ltd., 170, Fleet Street, and is most interesting and instructive. Padua this year celebrates its seven hundredth anniversary, and amongst famous names associated with it are Linacre, John Collet, Sir Thomas More, Erasmus, John Caius, Harvey, Vesalius and Galileo. These men lit lamps which are burning still.

Our heartiest congratulations to the Soccer Club, which has finished a highly successful season by winning both the Hospital Cup and the Junior Hospital Cup. In both cases Guy's were our opponents in the Finals. The Hospital Cup was won after two replays, and in the first replay two periods of extra time were allowed. After such efforts we are particularly proud of the team's victory.

There recently passed away in Herefordshire Dr. Charles Drage, æt. 97, for many years resident in Hatfield. Dr. Drage was an old Bart.'s man, and admirably represented all that was best in the older school of practitioner. One of his earliest patients was the great Duke of Wellington, and he was medical attendant to three Prime Ministers—Lord Melbourne, Lord Palmerston and the late Lord Salisbury. He retired in 1912 and went to live with his daughter at Rodd Court, Herefordshire. He had three sons: one of them, Dr. Lovell Drage, who died in 1919, was associated in practice with his father, and was also coroner for Hertfordshire; another is a clergyman in Yorkshire; and the third, Mr. Geoffrey Drage, is the well-known writer on economics and politics, who was formerly M.P. for Derby.

STUDENTS' UNION.

ANNUAL GENERAL MEETING.

THE Annual General Meeting of the Students' Union was held on March 10th, 1922. There was a crowded attendance, and great enthusiasm was displayed at the two chief features of the meeting, viz. the election of Dr. Drysdale as President, and the reading by Mr. Tait of the Council's Annual Report. This report embodied an account of a great deal of successful work done by the Council for the past year, in the processes of reconstruction and reorganisation made necessary by post-war conditions. Nowhere was this better demonstrated than in the great improvements made to the very unsatisfactory conditions at Winchmore Hill. Under the guidance of their President, Mr. Waring, and inspired by the uncon-

querable energy of the Secretaries of the Union, the sub-committee appointed for this purpose have now brought about a condition of affairs at Winchmore Hill which is a triumph of successful organisation. The performances of the individual clubs showed a period of marked activity, the most successful probably being the Rugby, Association, Rifle and Amateur Dramatic Clubs. The statement that the Catering Company—a subject of much heated discussion—had "at last found its feet" was received in a somewhat dubious silence; and the report finished with the words: "In conclusion, we may regard our efforts at reconstruction with justifiable satisfaction, feeling that, at the close of our term of office, we hand over to those who may be elected to succeed us a Union larger in numbers and far more powerful and united than at any previous time in its long history."

In announcing his resignation to the meeting, Mr. Waring explained that this step was necessary owing to the new responsibilities devolving upon him in the reorganisation of the Medical School; and in submitting the nomination of Dr. J. H. Drysdale as his successor, he felt sure that the choice was in every way a happy one. Amid great acclamation Dr. Drysdale was then unanimously elected, and took his place in the Chair.

In proposing a vote of thanks to the retiring President, Messrs. Tait and Sackett expressed their deep gratitude to him for his ungrudging help during his twelve years of office, and welcomed Dr. Drysdale to the Chair.

The Treasurers' report for the year, presented by Mr. Vick, showed the Union to be in a sound financial state, and prepared to meet any reasonable calls made upon it in the interests of the students and their clubs.

W. H.

THE PRIVATE CLINIC IN GREAT BRITAIN.

The Mid Sessional Address to the Abernethian Society, delivered on January 26th, 1922.

By SIR THOMAS HORDER, M.D.,
Physician to St. Bartholomew's Hospital.

(Continued from p. 94.)

Dr. Hawthorne's second proposition reads as follows: "That there is no objection to combination in medical practice so long as the welfare of the individual patient remains the commanding consideration, and provided the authority and responsibility of the practitioner in charge are neither confused by a crowd of competing councillors nor concealed behind the name of an organisation or institute." With which proposition I cordially agree. If I did not think "the welfare of the individual patient" remained the prime consideration in this suggested variation

upon current methods of practice, I would certainly not consider it in any sense a progressive, but rather a retrogressive step. I have looked very closely indeed at this particular objection—I refer to the possible sacrifice of the individual patient's interest—and, believing it to be a bogey, I decline to be frightened by it. I fully admit that there may be a danger in any very large clinic that the organisation may absorb the personal interest, and the patient may find himself the mere butterfly upon the wheel of the machine. But I am no advocate of very large clinics. One or two of the institutions at present in existence in the States are, in my judgment, much too large—certainly too large for this country. The whole process becomes mechanical, and it is not an exaggeration when one hears these institutions scoffed at as places where the patient is sent upon a "circular tour," emerging with a voluminous and expensive dossier, but with no considered judgment as to the essential nature of his malady. Like a good many others, I not infrequently have these lengthy reports brought to me by bewildered patients, who sometimes ask pathetically if I will read them through and tell them what is the matter with them. It is alleged by a friend of mine that one of his patients had had his circular tour, even to the inclusion of a cystoscopic examination, but that by some mischance no one had thought to examine his urine! All this is to be regarded as the abuse of the idea of group practice, not as its fulfilment. A great temptation will confront any small but successful group to pander to its *clientèle* by duplicating its members, by enlarging its sphere, and, as an inevitable result, sacrificing its efficiency by loss of personal interest in its patients. This temptation should be resisted just as strenuously as should be the identical temptation which sooner or later faces every successful doctor who is engaged in a purely individual practice. Either he yields to the increasing pressure, converts himself into a machine and grinds out ill-digested opinions about the patients who come to him; or he resists, declines to accept more obligations than he can meet with the standard he has set himself, and continues to do good and satisfactory work. Most often he yields, but this is not due to the exigencies of medical practice so much as to the weakness of human nature. The same principle applies to group clinics. This consideration need not depress us, however. The cure is a simple one. Already in America a number of small and successful groups have arisen in different centres, and these serve to protect the large and unwieldy groups from a worse reputation than they would otherwise earn by supplying the growing demand for group-medicine.

I am dwelling somewhat at length upon this objection that the group clinic system tends to eliminate the personal factor in practice because, as already mentioned, I regard the close contact of patient and doctor as a point of great importance, and one which it is essential at all costs to preserve. Having said that, I shall not perhaps be lightly

accused of possessing a callous disposition if I also say that there is not seldom a tendency to lose sight of a doctor's responsibility in view of his manifestations of sympathy. "How kind you are, doctor!" say our patients to us, and which of us does not say to himself, if not to them, "Yes, I know, but am I by chance a little *competent*?" What is it exactly that they require of us? Do they want to get well of their disease as the result of scientific investigation and treatment, or do they only want to die in the odour of kindliness?

In the minds of some it is thought that those who advocate group-medicine have in view the elimination of the general practitioner, or that this will result from such an innovation, whether it be intended or not. This is surely a fallacy. It is clear to me that the general practitioner must always be the backbone of medical practice. Upon his shoulders there will still be the onus of the diagnosis and the treatment of the great bulk of sick persons. He will remain their confidant, and it will be his duty still to act as responsible agent for interpreting in individual cases the latest and best knowledge that medicine can offer. But he can do this all the more, and all the better, in proportion as he is freed from the burden, sometimes nearly as intolerable as it is unfair, of knowing that in many cases he is not giving all the help that can be given because he, individually, has not had the expert training necessary for the investigations required for the diagnosis, or the facilities necessary for the scheme of treatment indicated. The best men realise this quite clearly, and they would welcome in private, what they readily avail themselves of in hospital practice—the existence of groups of men working together under one roof, capable of undertaking the complete investigation of an obscure case, and able to return any patient sent to them with a report of their findings and a suggested scheme of treatment based upon it.

Another objection to the group clinic is that it must inevitably lead to the unnecessary duplication of examinations. But if we may assume honesty of purpose on the part of the members of the group and some sense of the nature of pathological processes—and we are as dependent upon these two things in individuals working alone as working together—I do not see why this objection need apply. I have already referred to the gibe of the circular tour and how to avoid this stigma. Incidentally, I think that those who urge this particular objection forget how numerous and how wildly devised are the expert investigations of a needless sort at present undertaken in large numbers of obscure cases.

Perhaps a sounder objection to group practice is the charge that it leads to *cliques*, and this seems a danger that must be warded off by any set of men engaging in this particular type of work. I suggested just now that the members of a group might advisedly be drawn from different schools. Supposing this to be done, and that the members

kept their hospital work going at the same time that they were engaged in the work of a group, these two facts would go far to neutralise the risk of forming a mere coterie. But there are other safeguards that might possibly be taken. Groups might overlap, one or more members belonging to more than one group. It should be always possible for any patient to obtain the opinion of an expert outside the group if he wishes it, and it should be equally possible for any member of the group to get an outside opinion for his patient, to confirm or not to confirm the opinion given by his colleague in the group. These safeguards should suffice to counter a tendency to cliquism.

If we assume that the principle of the private group clinic is sound and that it seems desirable to test it in actual practice in this country, how would it be well to begin? The form of the group would necessarily differ according to the locality, but for the time being we need not discuss rural districts, where the conditions are not so amenable. I suggest that in the first place the group clinic confine itself almost entirely to diagnosis; it would be pre-eminently a diagnostic clinic.

As all the expert members of this supposed group are of the status of consultants no patients would be seen at the clinic unless sent by their general practitioner, and no second visits would be possible except by the request of the practitioner. The latter would be as free to accompany his patient to the clinic, and himself suggest personally the opinions he desires, as now he visits the individual consultant of his choice and discusses the case with him.

I have gone much more fully into a discussion of this third form of private clinic because, though I think there is room for both of the others, there is evidently a great deal more inertia to overcome in regard to the group clinic in Great Britain. And yet I feel sure that the experiment is well worth trying, and will, I am confident, prove successful. To those who say the idea is American, and that there is no need to change the present British system, I would reply that I think we can do this thing, like a lot of other things, in a way more suited to our own conditions than the way we see it done in America. As to the need for closer collaboration in the investigation and treatment of obscure disease-processes, both for efficiency in diagnosis and for the saving of valuable time, I consider the case is amply proven.

Certain desiderata in connection with group practice, some of which I have already hinted at, may perhaps be summarised before I close.

(1) Groups should not be too large. (2) The individual members of a group should be carefully chosen, both on account of their personal ability to work easily with others, and on account of their possessing expert knowledge and skill in particular directions. (3) Members of a group should have complete freedom to go outside their number for further opinions concerning their patients, and patients

coming to the group clinic should also be allowed free choice of opinions outside the *personnel* of the group. (4) Frequent discussions should take place between all the members of the group concerning difficult cases, and interested practitioners should be invited to attend. (5) Joint reports on particular types of case dealt with in the clinic should be published from time to time after open conference between the members of the group specially interested.

I have been, I fear, all too sketchy in my address this evening. The subject is one which lends itself at this juncture more to suggestions than to detailed consideration. The enormous progress in various branches of medical science, the large number of new methods calling for more critical exploitation, the great changes in social and economic conditions, the financial straits of our great general hospitals, the existence of the "new poor"—all these things seem to me to point to the urgent desirability of great and even drastic changes in medical practice. And our profession should, I think, take the lead, rather than be forced by the public to follow a less wise lead taken by itself, in the direction of making our art more efficient, more rational and more attractive.

THE DOCTORS OF DICKENS.

By T. H. G. SHORE, M.D., M.R.C.P.



CHARLES DICKENS was a keen observer of human nature and mannerisms, and he surveyed his doctors, we may imagine, with the same penetrating scrutiny that he bestowed upon all sorts and conditions of men, and his subtle wit led him to be no sparer of persons. Doubtless, therefore, his descriptions of doctors are true to the types he sought to portray, though in some instances it would please their pride to think that he had caricatured them severely. Medical practice in the times of which Dickens wrote, generally some years before the actual date of the publication of the books, had really only just begun to advance from empirical mediævalism to the scientific height to which it is now gradually attaining, and to a man of his intelligence and powers of observation the hollow sham that lay beneath much of the professional veneer must have been only too patent, and he does not hesitate to lay it bare, but so delicately clothed the facts he exposed in a cloak of humour that not even the most sensitive can take offence.

To most it will come as a surprise to learn that upwards of fifty doctors are mentioned in the various works of Dickens, but curiously enough no apothecary, in a time when that calling was more important than it is to-day. Some of the doctors, it is true, are no more than mentioned, but some are important characters; some figure prominently though their professional position really matters nothing to

the story, while others make a fleeting appearance strictly as medical men in the practice of their profession. Dickens' doctors may then be classified to simplify the survey, and those which do not concern us as medical men dismissed after brief reference only. It must be understood, however, that by such treatment there is no intention to detract from the importance of these worthy men as characters essential to the books in which they occur.

First those not appearing in a professional capacity. In *Martin Chuzzlewit* three such doctors are introduced. Dr. Bevan was an outspoken American who befriended Martin Chuzzlewit. "He hardly ever practised." Dr. Quinary Dunkle was one of a deputation which interviewed the Hon. Elijah Pogram, and Dr. Lewsome appears in an unprofessional manner in that he supplied drugs to Jonas Chuzzlewit with which to poison his father Anthony Chuzzlewit.

Mr. Bayham Badger (*Bleak House*) was in practice in Chelsea, but only interests us by having taken Richard Carstone as an apprentice, which arrangement did not last long, for Carstone was an unsettled youth and finally joined the army.

In the *Pickwick Papers* are two army surgeons, attached to line regiments as was the custom prior to the formation of the R.A.M.C. Dr. Slammer of the 97th, a short, pompous, irascible man with a fringe of bristly hair round his otherwise bald head, challenged Mr. Winkle, in mistake for Mr. Jingle, who had worn the former's clothes at the Rochester Charity Ball. The duel fell through. Dr. Payne of the 43rd was present.

Alan Woodcourt (*Bleak House*) is a character of importance to the book, but his professional abilities are hardly mentioned. When introduced he had been qualified but three or four years, though already a capable practitioner, for he was "well thought of by some of the greatest men in the profession." He was a thoughtful man, with powers of observation, and considerable energy and resource. Dr. Joe Specks (*The Uncommercial Traveller*) was the friend of the Uncommercial Traveller, upon whom he called when he revisited the place of his birth, and whom he had not met since his boyhood. Dr. Manette (*A Tale of Two Cities*) was the white-haired and prematurely aged shoemaker, who was "recalled to life" after his long confinement which terminated in the year 1775; he is not mentioned professionally.

In the "Battle of Life" (*Christmas Stories*) are Dr. Jedler and Dr. Heathfield. Dr. Jedler had retired from practice and was the father of two daughters, of whom Grace, the elder, married Dr. Heathfield, Marion, the younger, having run away to make the match possible, though she was really in love with the doctor. Dr. Dundey ("Detective Police," *Reprinted Pieces*) committed a bank robbery in Ireland, and after getting away to America was hunted down and incarcerated in the Tombs, a prison in New York.

Only one titled practitioner is mentioned by Dickens. He was medical adviser to Mrs. Witterterley in *Nicholas Nickleby*, and was called Sir Tumley Snuffin. We know nothing more about him.

In the second group of our classification are a number of medical men, whom Dickens introduces because of his love of thoroughness and attention to detail. They were professionally engaged at the births of some of his more important characters, but, that accomplished, have no further part in the story.

Oliver Twist was born in a workhouse, his mother being attended by an old woman, Mrs. Thingummy, and the parish doctor, whose name does not appear. As Oliver's mother died at his birth difficulty in feeding the child was anticipated, and an excellent start was made towards the production of a delicate child. "It is very likely the child will be troublesome; give it a little gruel if it is." Little Dorrit also was born in poor circumstances, in the Marshalsea Debtors' Prison. The medical attendant on that occasion was Dr. Haggage, who "had been the experienced surgeon of a passenger ship." His occupation of the Marshalsea was doubtless attributable to alcohol, for twice in the course of the confinement he sent the nurse away to obtain stimulant for herself, but he took his share.

When David Copperfield was born, the labour being precipitated by the arrival on the scene of Miss Betsy Trotwood, Dr. Chillip was in attendance. He was a nervous, self-effacing little man, much in awe of Miss Trotwood. As the labour advanced he reported progress, "We are, we are progressing favourably," thereby displaying reasonable caution. It may be remembered that David Copperfield was born with a caul, a circumstance which afforded Dickens an opportunity of ridiculing a superstition not yet dead. The caul was offered for sale at fifteen guineas, but not sold. Ten years later it was raffled and won by an old lady, who at the age of 92 died in her bed, without being drowned.

Mr. Pilkins was the family doctor of the Dombey's, and was consumed with his own importance on account of his association, at the birth of Paul Dombey, with the great Dr. Parker Peps. So proud was he that he is said to have talked about the forthcoming event for six weeks before, not professionally a very tactful practice. Dr. Parker Peps was "one of the court physicians and a man of immense reputation for assisting at the increase of great families," and is portrayed "walking up and down the drawing-room with his hands behind him, to the unspeakable admiration of the family surgeon." So frequently did his practice lead him into titled circles that on three occasions in referring to his patient a title crept into her name; he called her "Her grace the Duchess," "Lady Cankerby" and "the Countess of Dombey" flattery under the guise of absent mindedness.

Mrs. Kenwigs (*Nicholas Nickleby*) was attended in her confinement by Dr. Lumbeys, a popular practitioner

in a prolific neighbourhood, whose practice so filled his time that on the occasion in question he had had no time to shave. He declared that each baby he delivered was finer than the last, and speaking to Mr. Kenwigs he said, "Well, Mr. Kenwigs, this makes six; you'll have a fine family in time, sir."

One other doctor appears in obstetric practice, Mr. Dawson, who confined Mrs. Robinson ("Our Parish" in *Sketches by Boz*). He is chiefly known for displaying "a large light, with a different colour in every pane of glass."

The remaining group of doctors includes all those in medical practice, of whose methods and abilities something can be learnt. Dr. Jobbling (*Martin Chuzzlewit*) is an instance of a medical officer to an insurance company—the Anglo-Bengalese Assurance Company. He was fond of his food and drank deeply, especially of what the company provided. This must not, however, be read as an unduly adverse criticism of the profession, for Dickens writes of a time when the pleasures of the table were more generally indulged than now, and drinking of the right sort was rather a guarantee of comfortable circumstances than an opprobrium. The best people did it, and Dr. Jobbling was no exception. His method of examination of proposers for insurance consisted of "feeling their pulses, looking at their tongues, listening at their ribs, poking them in the chest and so forth; though . . . he well knew beforehand that whatever kind of lives they were, the Anglo-Bengalese would accept them readily."

Dr. Losberne (*Oliver Twist*) "had grown fat more from good humour than from good living." He was called to treat Oliver Twist's arm, which had been injured by a gunshot wound after the attempted burglary at Mrs. Malies' house. He succeeded in putting the authorities off the scent of Oliver Twist, and also cured his patient.

Dr. Wosky ("The Boarding House" in *Sketches by Boz*) was medical attendant to Mrs. Bloss. "He had a very good practice, and plenty of money, which he had amassed by invariably humouring the worst fancies of all the females of all the families he had ever been introduced into," a practice which is not unknown to-day. Mr. Slasher (*Pickwick Papers*) was referred to in a story by Jack Hopkins, a medical student, and must therefore be taken with reserve. He was surgeon to Bartholomew's Hospital, and was the "best operator alive—took a boy's leg out of the socket last week—exactly two minutes after it was all over the boy said he wouldn't lie there to be made game of, and would tell his mother if they didn't begin. Dear me, said Mr. Pickwick, astonished." Such was operative speed in pre-anæsthetic days!

Our Bore ("Our Bore"—*Reprinted Pieces*) was evidently a hypochondriac; he consulted no less than five doctors in a single page. Dr. Callow, "one of the most eminent physicians in London . . . said 'liver!' and prescribed

rhubarb and calomel, low diet, and moderate exercise." He only got worse, so he went to Dr. Moon, "whom half the town was then mad about. Moon was interested in the case; to do him justice he was very much interested in the case; and he said 'kidneys!' He . . . gave strong acids, cupped, and blistered." Our Bore then saw Dr. Clatter and Dr. Snugglewood together. Dr. Clatter said "accumulation of fat about the heart!" the moment he saw him. Snugglewood said "brain!" but agreed "to lay Our Bore upon his back, to shave his head, to leech him, to administer enormous quantities of medicine, and to keep him low." At last Mr. Jilkins was consulted. He had a very small practice in Great Portland Street, and said "You have been humbugged. This is a case of indigestion, occasioned by deficiency of power in the stomach." He prescribed mutton chops and sherry, and "in a week Our Bore was on his legs, and Jilkins's success dates from that period."

In the *American Notes* Dickens records his meetings with two doctors. The first, Dr. Crocus, he met at Belleville. He was evidently an itinerant practitioner, travelling from town to town as a show might, lecturing on Phrenology, and treating what patients came to him after the lecture. The second, Dr. S. G. Howe, of Boston, is famous the world over for having achieved the exceedingly difficult task he set himself of educating the blind deaf-mute girl Laura Bridgman, and so giving a tremendous stimulus to the education of mentally defective children. A direction in which the United States preceded this country by some years. A considerable account of the earlier stages in the education of the girl is given by Dickens in Dr. Howe's own words, and makes extremely interesting reading.

In the *Mudfog Sketches*, a descent from the sublime to the ridiculous, occurs a grotesque account of two meetings of the Medical Section of the Mudfog Association. The chief features of the characters are their names, but one or two of the subjects under discussion are worth repetition. The first meeting took place in the coach-house of the "Pig and Tinderbox," the chair being taken by Dr. Toorell, with as vice-presidents Professors Muff and Nogo. Present were Dr. Kntankumagen (of Moscow), Dr. Neeshawts, Dr. Fee, and Mr. Knight Bell, M.R.C.S. The latter "showed a wax preparation of the interior of a gentleman who in early life had inadvertently swallowed a door key." At the autopsy the portion of the stomach which bore the impression of the key was removed by a student, who had made from it a duplicate with which he burglariously entered the house of the deceased. He was tried and executed. At the second meeting, in the bar room of the "Black Boy and Stomach-ache," the chair was taken by Dr. Soemup, with Messrs. Pessell and Mortair as vice-presidents. Communications were made by Dr. Grummidge, and Mr. Pipkin, a homœopath. The latter reported a case of a gentleman who was

shot; he maintained that the administration of minute doses of powder and shot would have been followed by recovery.

The remaining medical personages who concern us are the three students in *Pickwick Papers*, Bob Sawyer and his two friends Benjamin Allen and Jack Hopkins, who were in the habit of meeting together in the former's rooms, in Lant Street, Borough. There they entertained the Pickwickians to a somewhat boisterous evening, in the early part of which Jack Hopkins, who was a Bart.'s man, told the story, narrated above, of the surgical skill of Mr. Slasher. Benjamin Allen was a Guy's man and, of the two, the closer friend of Bob Sawyer, who had hopes of marrying Allen's sister. There is no record of either Ben Allen or Jack Hopkins getting qualified.

The average man, if asked to enumerate the doctors mentioned by Dickens, would probably put Bob Sawyer first, or at any rate second, for he is certainly one of the most popular and best known of his characters. As a student he is described as having "about him that sort of slovenly smartness and swaggering gait, which is peculiar to young gentlemen who smoke in the streets by day, shout and scream in them by night, call waiters by their christian names, and do various other acts and deeds of an equally facetious description. He wore a pair of plaid trousers, and a large rough double-breasted waistcoat; out of doors he carried a thick stick with a big top. He eschewed gloves, and looked on the whole something like a dissipated Robinson Crusoe."

Later on he got qualified, and was discovered by Mr. Winkle in Bristol, having taken over the practice of one Dr. Nockemorf, and established himself under the painted sign "Sawyer late Nockemorf." The devices resorted to by this genius in advertising are proverbial. The drawers in his surgery, all brilliantly labelled, were either empty or dummies, but gave the impression of a well-stocked dispensary. He wore dark glasses and pored over a musty volume when anyone came in. At night the lamplighter pulled vigorously at his bell and attracted attention of the neighbours, for a consideration. His boy was sent round with a bottle of medicine and a powder, which he left at some house each day, calling the next with apologies for the mistake, and he arranged to be called out of church on Sundays just before the Psalms. Nowadays he would have had a message flashed upon the screen at the local cinema between two reels, requesting his attendance urgently at a certain address.

Although Dickens ridicules the medical profession severely, on the whole he shows more mercy than he does to some others, for instance the legal, and he does it in a manner which can hardly damage its reputation. The nursing branch, except for a number of midwives, is only represented by Sairey Gamp and her friend Betsy Prig, for there is no evidence that the mythical Mrs. Arris was a

nurse. The characters of his nurses are no doubt somewhat overpainted, but he probably intended to throw some light upon what was one of the disgraces of the period. In his preface to *Martin Chuzzlewit*, Dickens says that these characters are not much exaggerated as descriptions of the nurses of twenty years before. That being so the nursing of the early Victorian era had best be left untouched, beyond the remark that there is scarcely a branch of medicine in which greater progress has been made.

A MEDICAL SCHOOL IN CHINA.

By S. D. STURTON, B.A., M.B., B.Ch.(Cantab.), M.R.C.S., L.R.C.P.

IT may perhaps interest the readers of the JOURNAL to hear something of a modern medical school in China. It is known as the "Hangchow Hospital and Medical Training College," and is situated at Hangchow, the capital of the province of Chekiang.

The Hospital, which is the property of the Church Missionary Society, was founded about forty years ago from a pre-existing opium refuge. The Medical School has been in existence for about thirty-five years.

The Hospital itself contains 386 beds—220 being in the Hospital in the city, the remainder are in the Tuberculosis and Leper Sanatoria, the Isolation Hospital, and the Convalescent Home, all of which are situated on the hills outside the ancient city wall.

The General Hospital has separate buildings for male and female patients, with a maternity department, and a building for in-patient venereal treatment.

In addition to the Medical School we have training schools for pharmacy students, male nurses, female nurses, and maternity students.

The medical curriculum is five years in length, and attempts to cover the same ground as an English medical school. The subjects are arranged rather differently, physiology being commenced during the first year to encourage the students while they are plodding through inorganic chemistry, physics and biology.

Anatomy is studied during the second and third years, clinical methods and pathology being studied in the third year. The students also commence their practical clinical work during the third year: although it is a disadvantage to have it overlapping with anatomy, it is an advantage for them to spend at least three years over their clinical work.

In addition to medical work every student is required to take a course of Bible study, Chinese composition, and English. The two former subjects are required by our own institution, the latter by the Chinese Government before they will stamp the diplomas granted to graduates.

There are great difficulties in the way of teaching medicine out here. The greatest has been removed now that the

Chinese Government has granted permission for the dissection of the human body. Hitherto anatomy has been taught with the aid of charts and models, but next term we hope to have a "meat shop" in full swing.

We have also acquired new X-ray apparatus, and some new apparatus for the Pathological and Physics Laboratories.

Our second great difficulty is lack of funds. The grant from the Society is only 7000 dollars per annum, and most of the patients are too poor to contribute anything like the cost of their maintenance. Very few students can afford their own microscopes, and we have only six for teaching purposes in all departments; even second-hand ones would be exceedingly useful.

The College badly needs rebuilding at a cost of £10,000. There are rooms for fifty students where we need rooms for seventy. The students' dining room with its rice bowls and chopsticks would give the most strong-stomached Bart.'s man indigestion, while the ablution places are certainly no inducement to wash when there is a keen wind sweeping across China from the Gobi Desert.

Our third difficulty is lack of skilled staff. At present we have four British practitioners working full time, with part-time help from an American practitioner. The resident staff consists of seven Chinese doctors, all of them graduates of this College. They hold resident posts much longer than is usual at home, and combine their hospital work with teaching the students. Just imagine a hospital more than half the size of Bart.'s with only this staff! We wish that some fairy godmother or keen friends at home would provide us with the necessary men, money and microscopes to give our students a better chance. During the past year we have had 2500 in-patients and about 30,000 out-patients. A thousand operations have been performed under general anaesthetics.

TWO CASES OF ENTERO-SPASM OF THE SIGMOID COLON SIMULATING NEW GROWTH.

By R. W. TAYLOR.

THE two cases described below were admitted to this hospital with symptoms which justified a provisional diagnosis of a new growth in the sigmoid colon.

CASE 1.—A. D. B.—, *act.* 59, housewife, was admitted to Darker Ward, October 13th, 1921, complaining of severe abdominal pain and passage of blood with stools.

History.—She had suffered from indigestion and constipation for years, and was in the habit of taking purgatives. For a month she had abdominal pain, which commenced in the left inferior fossa, travelled upwards and across to the right side. This pain was not related in any way to meals. She became very constipated and took castor oil 5 j on

September 13th. This was followed by a very-painful defecation and the passage of a pint of blood after the stool. Since then she has kept her bowels open by castor oil and enemata, losing some blood at the end of every stool. She had occasionally noticed "slime" with the motion. She did not complain of rectal prolapse and had not lost weight.

On admission she was a healthy-looking woman. The teeth in the lower jaw were carious, with pyorrhoea alveolaris, and the tongue was furred. The abdomen was moderately distended but no tumour could be felt, and *per rectum* nothing could be detected digitally. Her stools were dark and not formed.

On October 17th, 1921, she was given a bismuth enema. The X-ray report was as follows:

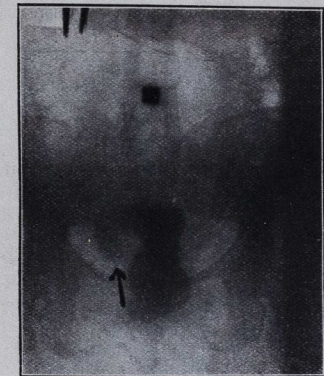


FIG. 1.—CASE 1: "THERE IS PROBABLY AN OBSTRUCTION IN THE SIGMOID COLON (AT ARROW)."

"It was found possible to inject only one pint of the enema. Repeated attempts were made to inject more without success. There is probably an obstruction in the sigmoid colon (at arrow). The irregular edge of the shadow at arrow is in favour of a diagnosis of malignant new growth."

Diagnosis.—Obstruction in sigmoid.

This was followed on October 25th, 1921, by a bismuth meal, and X-ray plates were taken up to 101 hours.

The X-ray conclusions were:

"The appearances suggest there is some obstruction in the pelvic colon. Comparison with the enema plates confirms this, but there is no evidence of a persisting irregularity of outline."

Laparotomy was performed by Mr. McAdam Eccles on November 1st, 1921, by a mid-line incision below the umbilicus. No evidence of obstruction was discovered anywhere, but the pelvic colon was long with a considerable mesentery. The abdomen was closed.

She made a good recovery and was discharged on November 12th, 1921, without recurrence of pain or of blood and mucus in stools.

CASE 2.—R. M.—, stores foreman, æt. 42, admitted to Sitwell Ward on November 21st, 1921, complaining of pain on defecation and blood in stools.

History.—He was in good health until six months ago, when he noticed blood with stools. He complained of a feeling of fullness in the rectum after defecation. On straining that was followed by the passage of flatus and a little bright blood, which dripped into, or sometimes spattered around the pan. A dull aching pain in the anal region occurred after each defecation, lasting about half an hour. He said he was not constipated but always took a pinch of Epsom salts in the morning. For three weeks this pain had been worse and the bleeding more marked.

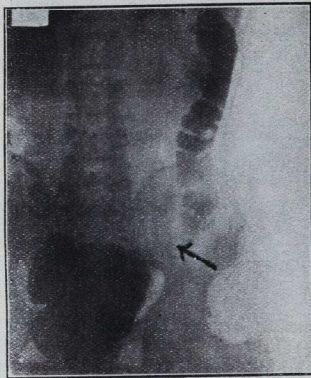


FIG. 2.—CASE 2: AN OBSTRUCTION IS SUGGESTED IN THE PELVIC COLON.

He had not noticed any rectal prolapse or "slime" in stools. During the last six months he had lost 14 lbs. in weight and now felt weak and was short of breath.

On admission he appeared to be quite healthy, but a cylindrical hard mass 3 inches long and half an inch wide could be palpated in the left iliac fossa, its long axis lying downwards and inwards. Its surface was smooth and the edges round. The upper limit was definite but the lower seemed to dip into the pelvis. It could be rolled freely at right angles to, but was fixed in the direction of the long axis. It was not tender.

Per rectum.—N.A.D.

There was some red blood mixed with each stool.

Sigmoidoscopy was performed on November 22nd, 1921. The instrument passed easily at first but stopped in the region of the sigmoid colon. A hand placed on the

abdomen could palpate the end of the sigmoidoscope in the region of the mass described above. The mucous membrane at this spot was inflamed, but no neoplasm was visible. On withdrawal two small internal hemorrhoids were seen.

A bismuth enema was given on November 29th, 1921, and the report was:

"An obstruction is present in the pelvic colon near the brim of the pelvis. The enema trickled through it slowly and filled the descending colon."

X-ray diagnosis.—Obstruction in pelvic colon probably due to a new growth.

Laparotomy performed by Mr. McAdam Eccles, on December 3rd, 1921, revealed no signs of obstruction in the large bowel; but the sigmoid colon was long with a long mesentery. It was abnormally irritable and contracted segmentally on digital pressure. Diverticulitis? The abdomen was closed.

Both these cases had very long sigmoid colons, a condition recognised by Jordan (1) as predisposing to intestinal stasis and subsequent ulceration of the bowel wall, which would explain the presence of blood in the stool. Harrison Cripps (2) recognised a condition of muscular spasm of the colon following ulceration, causing an otherwise slight narrowing to assume the characteristics of a tight stricture.

Entero-spasm of the sigmoid colon may be so persistent as to be mistaken for a true organic stricture, either simple or malignant.

Swinford Edwards (3) described a case somewhat similar to Case 2, in which a rounded swelling could be palpated in the left iliac fossa. Per rectum digitally nothing abnormal could be discovered, but a proctoscopic examination did not permit the passage of the instrument for more than 6 inches.

A colostomy incision was made in the left iliac region, and when brought out of the wound the sigmoid colon was observed to contract for a length of 3 inches to the size of one's little finger, becoming quite white and hard. After a while it resumed its normal appearance.

He performed colostomy to relieve the condition.

Entero-spasm is sometimes amenable to belladonna given in as large doses as the patient can tolerate, (4) and it would have been interesting to have repeated the X-ray bismuth enema examinations of these two patients after an injection of atropine.

I am indebted to Mr. McAdam Eccles for permission to publish these notes.

REFERENCES.

- (1) ARBUTHNOT LANE.—*The Operative Treatment of Chronic Intestinal Stasis*, p. 393.
- (2) HARRISON CRIPPS.—*Diseases of Rectum and Anus*.
- (3) SWINFORD EDWARDS.—*Diseases of Rectum and Anus*.
- (4) WILLIAM RUSSELL.—*Stomach and Abdomen*.

PROFESSIONAL OPPORTUNITIES.

By W. F. ROPER SAUNDERS, M.R.C.S., L.R.C.P., D.P.H.

(7) THE DUTIES OF PART-TIME MEDICAL OFFICERS OF HEALTH.

ANY general practitioners, especially in rural areas, hold appointments as part-time medical officers of health. The work involved is extremely interesting and does not make great demands on the time of the doctor, as most of the actual sanitary work is done by the sanitary inspector.

An order of the Local Government Board lays down the duties of a medical officer of health. Among them may be mentioned: investigation of outbreaks of epidemic disease; to make systematic inspections of his district and to "direct" the sanitary inspector (as a matter of fact the part-time M.O.H. occasionally accompanies his sanitary inspector in his inspections, especially when it is likely that the matter in hand may be the subject of legal proceedings, but does not "direct" his work, the inspector asking for his advice when necessary); to advise the local authority on sanitary matters; to inspect foods suspected to be unsound; to make periodical reports, particularly an annual report; to make the required returns to the county M.O.H. and to the Ministry of Health and to keep certain records.

In actual practice the work of a part-time M.O.H. is:—

1. To keep certain books:

(a) A record of the notifications of births received by him. (In some areas these notifications do not pass through his hands, being sent direct to the county M.O.H.)

(b) A list of the notifications of infectious diseases received by him.

(c) A record of the deaths which have been registered in his district and of their causation. (This information is supplied by the registrar of births and deaths.)

Various other books, e.g. records of housing and sanitary inspections, are kept by the sanitary inspector and should be occasionally inspected by the M.O.H.

2. Practical work:

(a) Occasional housing and sanitary inspections with the sanitary inspector.

(b) It is customary for the sanitary inspector, if he suspects food to be unsound, to ask the M.O.H. to examine it with him.

(c) If any serious infectious disease, e.g. smallpox, breaks out, the M.O.H. pays personal visits to cases in order to investigate the origin of the outbreak. This is also done if there is an extensive outbreak of a less dangerous disease, e.g. scarlet fever, but sporadic cases of infectious diseases are usually visited by the sanitary inspector alone; he records various particulars, and disinfects the premises when the patient is removed to hospital or is no longer infectious, as the case may be.

(d) Special inspections, e.g. of a piece of land proposed to be used for sewage disposal. Such inspections are usually carried out at the request of the local authority.

(e) He may be asked by general practitioners to consult with them in cases of infectious disease where the diagnosis is doubtful.

3. Reports:

(a) In most instances the M.O.H. presents a monthly report to his council. This includes the number of births notified in the month, the birth-rate, the number of deaths and death-rate, the number of deaths of infants under one year of age and the infantile mortality rate, the zymotic death-rate, the number of notifications of infectious diseases in the month, any special prevalence of a particular infectious disease and reports of any special work done. If the district is divided into "wards," it is customary to give the above statistics for each ward separately as well as for the whole district.

(b) Every Saturday he must fill in and post to the county M.O.H. and the Ministry of Health postcards summarising the number of cases of infectious diseases notified during the week.

(c) Any special report required by the council or the Ministry of Health.

(d) The annual report. The Ministry of Health issues an annual memorandum as to its contents and the M.O.H. is expected to arrange his report on the lines laid down in this document. It is usual to include in annual reports particulars of the physical features, etc. of the district and of the occupations of the inhabitants, notes as to water supply, drainage, etc., and removal of refuse. The M.O.H. also reports on milk and dairies, food inspections, and on the prevalence of infectious diseases. Notes should be included of any action taken to remedy insanitary conditions mentioned in previous reports, and attention should be drawn to such defects as still remain unremedied.

Reference must be made to inspections of workshops made under the Factory and Workshops Act, and copies of the annual report must be sent to the Ministry of Health, the Home Secretary and the county M.O.H.

At the end of the annual report certain tables of statistics required by the Ministry of Health are included, together with the sanitary inspector's annual report.

Other duties are often performed by part-time medical officers of health, e.g. medical superintendence of isolation hospitals, but such duties are entirely independent of their duties as M.O.H.

It is hoped that this short article may serve to stimulate interest in this work among senior students.

OUR PRIZE COMPETITION.

THE grass is never allowed to grow under the Editorial feet, and this month we are offering a ONE SHILLING PRIZE

in the hope of discovering another Poet Laureate at this Hospital. There is an elevating form of poem known as the limerick; this particularly lends itself to the use of medical terminology. You merely have to submit limericks containing rhymes to any of the following words:

- Haematomolpos Pneumonia Syringomyelia Diabetes Actinomycosis Haemoptysis Dysentery Ascites Purpura Acromegaly Typhus Whitlow

One competitor may send in any number of poems. The shilling prize will be awarded to the best poem on any of the above subjects. The Editor is at liberty to publish poems other than that winning the prize if he so pleases. In case any reader is not clear what a limerick is, we append one or two to indicate what a high standard must be attained to stand any chance of earning THE MAGNIFICENT PRIZE.

"There was an old man of Etruria, Who had haematoporphyrimuria, The surgeon said 'Quite, We'll soon put you right, We'll take out both kidneys and cure yer!'"

"A youth was gestating a thesis, On dysidiadochokinesis, Exams drawing near, He murmured 'I fear It's nothing but pseudo-cyosis.'"

Any reader of the JOURNAL, male or female, from 9 to 90, may compete. Address letter "Competition," Journal Office, St. Bartholomew's Hospital, E.C. 1, before April 20th.

THE EDITOR'S DECISION WILL BE FINAL, and no remarks must be passed on his judgment.

UNITED HOSPITALS HARE AND HOUNDS.

INTER-HOSPITAL CUP.

The competition for the "Kent Hughes" cup was held at Blackheath on Wednesday, March 8th, over a 7 1/2-mile course. Four Hospitals were represented, there being 32 runners in all, with five a side counting. Guy's (the holders), who showed great form, retained the cup, beating King's by 20 points. Bart's and London shared third place with 72 points each. R. C. Lightwood (King's) was first man home, beating M. E. M. Jago (Guy's) by about 50 yards. J. G. S. Thomas (Guy's) came third, with W. W. Darley (Bart's) fourth.

Places.—W. W. Darley, 4th; J. D. Allen, 22nd; J. A. Hickinbotham, 25th; W. P. Greenwood, 27th; E. S. Evans, 28th; also ran H. E. McLaughlin, 29th.

Team places:

Table with 2 columns: Hospital Name and Points. Rows: Guy's (2, 3, 5, 6, 7 = 23), King's (1, 9, 10, 11, 12 = 43), Bart's (4, 15, 16, 18, 19 = 72), London (8, 13, 14, 17, 20 = 72)

This is our first year at cross-country running, and with only a scratch team we did very well to keep on a level with London. Next year with proper training we ought to be on a level with Guy's.

STUDENTS' UNION.

ELECTION OF OFFICERS, 1922.

President.—J. H. Drysdale, Esq., M.D. Vice-President.—G. B. Tait. Treasurers.—W. Girding Ball, F.R.C.S., Reginald M. Vick, F.R.C.S. Secretaries.—H. S. Gordon, W. Holdsworth. Constituency A.—E. Coldrey, R. W. Savage, J. P. W. Jamie, H. L. Oldershaw, E. Liston. Constituency B.—W. Holdsworth, H. C. J. Ball. Constituency C.—A. D. Wall, F.R.C.S. Finance Committee.—J. H. Drysdale, M.D., W. Girding Ball, F.R.C.S., Reginald M. Vick, F.R.C.S., G. B. Tait, H. S. Gordon, W. Holdsworth, H. C. J. Ball, E. Liston (Financial Secretary). Representatives on Council.—G. B. Tait, W. Holdsworth.

RUGBY FOOTBALL.

ST. BARTHOLOMEW'S HOSPITAL v. O.M.T.'S.

On February 18th the Hospital side vied in contest with the O.M.T.'s at the Old Deer Park.

The Taylors had more of the game than the Hospital, but were compelled to retire defeated through the superior cleverness of the Hospital three-quarters. The Hospital forwards were no match for the home side, but the defence was very sound. In the initial stages the Taylors pressed, and Burrell was forced into touch in goal when apparently sure of scoring. After a quarter of an hour Bart's attacked, and a smart opening by Davies sent Thomas, who had cleverly backed up Moody-Jones, over for a fine try. Just before the interval Davies and Neville, profiting by some bad passing by the Taylors, snapped up the ball and Davies crossed the try line. In the second half Gordon kicked a penalty goal. Cove-Smith played a great if rather a robust game for the O.M.T.'s. The remainder of the play was mostly in the visitors' territory. Bryant scored for the Taylors from a melleé just outside the line.

Bart's: 2 tries, 1 penalty goal (9 pts.). O.M.T.'s: 3 pts. Bart's: W. Gaisford, back; W. Moody-Jones, P. O. Davies, M. G. Thomas (Capt.), L. C. Neville, three-quarters; T. P. Williams, D. H. Cockell, halves; A. Beith, A. B. Cooper, G. Parker, H. G. Anderson, E. Vergette, H. Gordon, H. Morlock, T. D. Allen, forwards.

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

On Tuesday, February 21st, the Hospital met St. Thomas's Hospital in the Second Round of the United Hospitals' Cup. There was no change in the Bart's fifteen. St. Thomas's started very promisingly and promptly rushed to the Bart's twenty-five. It was not long, however, before Bart's opened the scoring, by a fine bout of passing, which ended in Thomas running nearly half the length of the field to score a try. A short time afterwards Neville, receiving a well-judged pass by Davies, sprinted for thirty yards along the touch-line and brushed aside the full-back to score a fine try. Bart's flattered to deceive. After this the Thomas's forwards kept the ball close. The dash, quick following up, their extra "push" in the tight did much to cramp the superior style of the Bart's outsiders. To this must be added the fact that the Bart's scrum-half twisted his knee very badly, which, of course, militated against mobility round the scrums. Thomas's were well served at half by Cooper and Malley, though the latter was inclined to be off-side at times. Just before the interval Thomas's scored after a nice "blind" side movement. Good combination by Davies and Neville led to a third try for Bart's after the interval.

The Bart's pack were better in the scrums than in the loose. The Bart's three-quarters combined well but were rarely allowed to display their powers of attack. The Thomas's forwards were superior on the day's form. Parker worked very hard and saved the Hospital repeatedly by good kicks into touch. Howell scored for St. Thomas's. Bart's: 3 tries (9 pts.). St. Thomas's: 1 goal (5 pts.).

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

It was unfortunate that Bart's should have had to field their side without two of the best forwards.

G. W. Parker had been assailed by a super-mystic type of pneumococci, and C. Shaw had the misfortune to break a fibula. A Carnegie-Brown, who had been on the injured list for some time, pluckily turned out.

Bart's started well by carrying the play into the Guy's territory, where Moody-Jones, P. O. Davies and Thomas made stubborn efforts to get through, but the Guy's defence was sound. In ten minutes Daneel scored for Guy's after a "blind" side movement by Spring and Schalkwijk.

About ten minutes later a judicious cross-kick by Albertijn, after a perfect "dummy" was well taken by Fouraker, who scored the second try for Guy's. Daneel added the extra points. Watson scored a third before the interval. Bart's made intermittent attacks on the Guy's territory, but they were vying with one of the best teams in the country. During the second half two more tries were scored through Daneel and Steyn. St. Bart's defended well throughout, and in the loose Morlock, Beith, Carnegie-Brown and Cooper were often prominent. In the tight Vergette often put thousands of foot-lbs. into good efforts to the delight of the spectators. Orchard at times put in some neat dribbles. Anderson, as usual, was always to the fore, and Allen, though outweighted, to be content with loose passes and defensive work. Neville made one thrilling run and Thomas and Davies defended stoutly. Guy's Hospital are to be congratulated on the all-round brilliancy of their team. Albertijn kicked, passed and gave "dummies" as no other man can do in the four countries. Bart's made a stubborn fight against the best team any hospital has ever had. Comfort is derived from the fact that Bart's can easily claim second place amongst the hospital teams of to-day.

Guy's: 17 pts. Bart's: Nil. Bart's: W. T. Gaisford, back; W. Moody-Jones, M. G. Thomas (Capt.), P. O. Davies, L. C. Neville, three-quarters; D. H. Cockell, T. P. Williams, halves; H. G. Anderson, A. E. Beith, A. B. Cooper, H. Morlock, S. Orchard, J. Allen, A. Carnegie-Brown, E. S. Vergette, forwards.

ST. BARTHOLOMEW'S HOSPITAL v. ROSSLYN PARK.

On March 4th the Hospital fielded a very weak side against Rosslyn Park.

After having slightly the better of the argument in the first half—during which neither side scored—the Hospital ultimately demonstrated their superiority outside the scrum and won by 1 goal, 2 tries (11 pts.) to nil.

The ground was very greasy and attempts at passing continually broke down.

Late in the second half Johnstone intercepted a pass, and beating Winton, scored for Gaisford to convert. Later Penitreath scored an unconverted try, as the result of clever passing. Then Robertson, a speedy runner, scored after a good dash along the touch-line. Wall and Bell were the most conspicuous on the Park side.

ASSOCIATION FOOTBALL.

ST. BARTHOLOMEW'S HOSPITAL v. R.M.C., CAMBERLEY.

The match against Sandhurst at Camberley, on February 26th, provided an opportunity of trying out the team in preparation for the Cup-final, and served to disclose the fact that it is among the forwards where our chief weakness lies.

The defence was very sound, particularly noticeable being the work of Coldrey and Caiger at back and Oldershaw at right half. Dick at centre-half, too, was a great worker, as he always is, but an inclination to hang on to the ball a little too long often forced his forwards into an off-side position, and so many a good opening was spoiled. Ward could not be blamed for the goal scored against him, and saved splendidly on several occasions. Savage was the pick of the forwards, and was responsible for the equalising goal. Lloyd had few opportunities of showing his fine speed and shooting capabilities, chiefly on account of getting off-side.

The result, a draw of one goal each, was a fair reflex of the play, but it should be noted that until half-time the Hospital side were without the services of Lorenzen and Nicholls, who had missed their train at Waterloo.

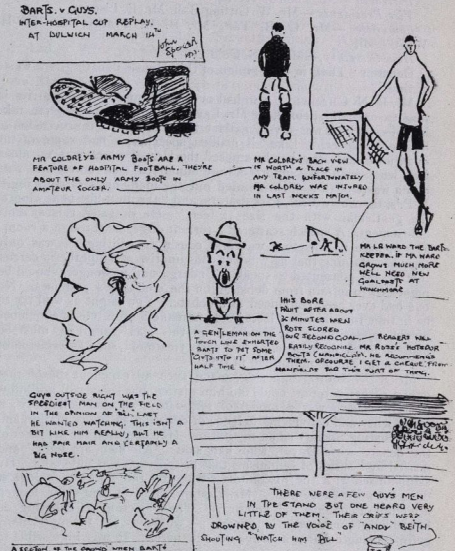
Bart's: L. B. Ward, goal; E. Coldrey, G. H. Caiger, backs;

H. L. Oldershaw, A. C. Dick, A. E. Lorenzen, half-backs; G. R. Nicholls, A. Ross, E. I. Lloyd, R. W. Savage, J. A. Morton, forwards.

HOSPITAL CUP: FINAL TRIAL.

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

Played on the ground of the London Hospital at Hale End on March 9th, and resulted in a draw of two goals each. An unfortunate accident to Coldrey after only a few minutes' play considerably spoiled our chances of winning this game, but so well did our ten remaining men play throughout that until quite near the end it seemed that we might just pull it off. The Guy's forwards, however, were not to be denied, and saved themselves from defeat by



BART'S v. GUY'S. INTER-HOSPITAL CUP REPLAY AT DULWICH, MARCH 14TH.

scoring an equalising goal close on time. The game was an excellent one to watch, and, if one may judge by the amount of noise, quite to the taste of the spectators.

Although playing one man short, Bart's were the first to score, and retained this advantage until half-time. In the second half Guy's equalised, and then Bart's got one in front again, only to lose the lead as stated above.

The early misfortune to Coldrey threw a great deal of extra work on to Caiger at back, but so well did he perform that one hardly realised that we were a back short. He was undoubtedly the best player on the field, and deserving of the highest praise. Oldershaw gave him excellent assistance and was the best of a very good line of half-backs. The only weakness was among the forwards, a lack of co-ordinated action being evident throughout; yet each man tried individually so hard that one is bound to congratulate them all on such a good showing. Savage, perhaps, pleased most, some of his passes to Parrish were models of what passes on the run should be. Parrish scored both goals for us, and although aided on each occasion by an error of judgment on the part of Guy's goalkeeper he must be credited with two very good long shots. He and Savage made by far the most effective wing. Lloyd was at times a very thrushful centre, and once or twice it seemed that he must get through, but he had no luck. The right wing were badly handicapped by the absence of Coldrey behind them.

Playing splendidly robust football, it would have been bad luck for either side to have lost, and a draw was the fairest result.

A report of the replay will be given in the next issue of the JOURNAL.
Bart's: L. B. Ward, goal; E. Coldrey, G. H. Caiger, backs; H. L. Oldershaw, A. C. Dick, A. E. Lorenzen, half-backs; G. R. Nicholls, A. Ross, E. I. Lloyd, R. W. Savage, J. Parrish, forwards.

DEBATING SOCIETY.

Annual General Meeting, held on March 14th, 1922, in the Abernethian Room, at 4.45 p.m., Sir Thomas Horder in the chair.

Business: The following officers were elected for 1922-23:

President.—Sir Thomas Horder.

Vice-Presidents.—Mr. W. Girling Ball, Mr. E. Liston.

Committee.—Mr. G. B. Tait, Mr. B. M. Tracey, Mr. E. H. Weatherall.

Hon. Secretary.—Mr. R. S. Coldrey.

Debate: "That, in the opinion of this House, debating is a waste of time."

Mr. R. N. CHADWICK, who had overslept himself, did not arrive in time to open the debate, so Mr. LAPTAIN kindly consented to take his place, which was a very gallant thing to do on the occasion of his maiden speech. Like all maiden speeches, it had some of the qualities of an essay, but he amused the House, which was no mean feat, when even his supporters were bound to look bored and vote him a waste of time. He pointed out the many evils of debating—M.P.'s, the *Daily Mail*, park orators, and "the bull like bellowing of the gentleman with the size 12 feet." He despised this anæmic amusement. A speech scattered a torrent of germs through a room; as a menace to society it was first cousin to spitting. It was only after ascertaining that he was not consumptive or a diphtheria carrier that he had consented to speak. Underground passengers should be requested to refrain from debating on the company's premises. No one had ever been convinced at a debate. You might as well try to be in time for midwifery lectures as to make a proselyte of a member of the opposition. "This debating, this 'gas'-gangrene, must be made a notifiable disease, so that early treatment, such as excision of the mouth, can be performed in time."

Mr. A. E. ROCHE, opposing, made such an excellent speech that only a *verbalim* report could do him justice, but space will not allow it. His speech was a model of seriousness without solemnity; it was a witty and convincing defence of debating as an occupation and the Debating Society as an institution. He compared the proposer of the debate with David, who had said, "All men are liars," and proved by a series of syllogisms that his position was untenable. He sympathised with the discomfort sitting on the horns of a logical dilemma must cause him. (Mr. Laptain, in a soft arm-chair, looked a picture of content and comfort.) The objection to debating on hygienic grounds was unfounded; "we have sat through many germ-spitting debates and we are still here." It was impossible to avoid questions of a reproductive nature in the Debating Society. Michael Foster had said "that all the toil and turmoil of human existence may be regarded simply as the by-play of an ovum-bearing organism." "I rather fancy that in him zoology has gained what psycho-analysis has lost." Man holds his supremacy by virtue of his brain, and he preferred to look upon human behaviour as the by-play of a brain-bearing organism. That was why one did not find a specimen of *Homo sapiens* at the Zoo. "No ape has written *The Decline and Fall of the Simian Empire*" as the great Gibbon had written of Rome. "Why, gentlemen, have you come here? Perhaps the quality of the speeches is making you wonder why." You have come here to breathe in the "atmosphere of intellect, which is so much more stimulating than alcohol. The Debating Society is a recent sprout or hernia of the Hospital, and if you denounce debating you denounce the Hospital."

This is not even a *résumé* of Mr. Roche's speech, as those who heard it will realise. Trying to condense such a speech is certainly a waste of time, because it is quite an impossible task.

Mr. R. N. CHADWICK apologised for being late; he thought the debate was to commence at 5.30. "This is the first time I have attended a meeting of this Society. (Cries of 'Shame!') I admit it is the honourable and learned members' loss." He gave us a detailed autobiography, which included the startling admission that he had been to school. (Prolonged applause.) "I am glad the House approves of my having done so." He had belonged to many debating societies, but his only happy memories were of a few occasions when the liquid stimulation, provided free, had rendered him oblivious of the tortures which the institutions provided under the name of mental stimulation. He pointed out to everyone what a dull life they must expect during

debates, but none would suffer worse than he. "Mine is indeed the most unfortunate position. (Hear, Hear.) I shall have a heavy bill for the oil I have used in preparing arguments which will not convince anyone." (Hear, Hear.)

Mr. F. ALLEN seconded Mr. Roche. He said he had nothing new to add; he could only reiterate, in feeble tones and feeble English, arguments already used. The power of speech was unique to man, and the ability to debate was only found in the highest civilisations. "No animal but man has the power of debate, except woman, and that is debatable." A doctor should be able to debate, because he was occasionally a public character, he frequently had patients to deal with, and he was always in the coroner's court. The supporters of the motion should have burnt down the A.R. if they believed in "deeds, not words."

Sir THOMAS HORDER, from the chair, asked for fairness to the proposers of the motion. Men fought that wars might cease; their attitude was something similar and was not necessarily illogical.

Mr. R. S. COLDREY, as next year's Hon. Sec., felt bound to expound his belief that debating was not a waste of time (it may not be, but we can assure him it occupies an uncanon amount of it), so he bounced up and denounced three of the speakers for living up to the traditions of the Society by not speaking to the point. Mr. Chadwick's long and thrilling account of his life-history had been amusing; was amusement a waste of time? Debating was a means of increasing our already feeble intellects (it is strange how one member assumes the other members are a collection of imbeciles, while the next addresses them as if each could add F.R.S. to his name—such is the difference between truth and flattery). To say debating was a waste of time was a statement of unutterable conceit. "Have we nothing to learn by hearing the opinions of others?"

Mr. HOWELL was in a pugnacious mood; he disagreed with everybody; he did not suffer from nightmares; Mr. Laptain's arguments were feeble; Mr. Chadwick's speech was his own damnation, and he hoped he would make many more speeches (a most unchristian sentiment). Finally, he hurled anathemas on the Committee for choosing such a ridiculous subject (the Committee are not a "press-gang").

Mr. EDWARD also disagreed with everybody: coupled with his flushed countenance, this statement made one suspect that he, too, had reached the quarrelsome stage; but he went on very pleasantly and amused the House, so perhaps it was only modesty. As often happens with these attempts to make a three-cornered fight out of a two-sided debate, Mr. Edward's views were not succinct.

Mr. A. C. VISICK had read an article on how to debate without abdominal pain; the only symptom he had ever suffered during debates was perineal discomfort; if only the Chairman would give his expert opinion on this abdominal pain, Mr. Visick would sleep undisturbed.

Mr. C. H. ANDREWES, "hands clasped behind, as if to balance the prone brow oppressive with its mind," explained that he had come to waste his time. Wasting time was one of the necessities of existence, and debating was one of the most enjoyable ways of doing it; busy men such as he needed relaxation after the sweat and toil of the day. He always measured his cranial circumference before and after debates, but had not noticed any appreciable change; therefore he concluded that debating did not improve the mind.

Mr. G. B. TAIT agreed with Mr. Andrewes that a thing might be a waste of time and yet be worth doing. He illustrated this fact with military reminiscences. Mr. Roche had referred to the Debating Society as a sprout or hernia of the Hospital. It was a hernia for which medical treatment was eminently suitable, it should be supported. The proposers of the motion had the virtual support of all members of the Hospital, who proved, by their absence from the debate, that they thought it was a waste of time.

Mr. E. R. CULLINAN made some remarks about seaweed. People should come to debates to hear things they did not hear in ordinary life (a doubtful compliment).

Sir THOMAS HORDER rose from the chair to defend the Committee in their choice of the subject of the debate; he thought the choice had justified itself by the high level of the speeches. He would remind that serious-minded youth who had objected to it that this was the last debate of the year; there was still some truth in the old saying, "Decipere in loco." As regards the abdominal pain, he would need further facts before he could pronounce judgment. Was it the speaker who had the pain or those who listened? Was it epigastric, due perhaps to "Dutch courage" imbibed too late, or was it lower down and due to other possible causes?

The House decided that debating was not a waste of time by 21 votes to 17.

ABERNETHIAN SOCIETY.

ON February 17th Mr. Reginald M. Vick, M.Ch., F.R.C.S., gave an address before the Society on "Malaria in the Struma Valley." He carried his audience back to the lurid days of war, and described the gallant advance of the Salonika Force up the Struma Valley into the jaws of malarial death. The clinical aspect of that epidemic, the utter unpreparedness with which it was faced, despite the notoriety of the Valley as a stronghold of malaria, and the means by which it was at long length held in check, were described by the lecturer—a grim but stirring story, eloquently told.

On February 23rd a discussion was held on the subject "Empyema," with special reference to treatment. The discussion was opened by Mr. C. S. Prance.

On March 3rd a clinical evening was held.

On March 9th the Society was addressed by Dr. John Adams, F.R.C.S., on "The Treatment of Antenatal and Post-natal Syphilis." Dr. Adams said he had first addressed the Society in 1873. He described the work of the Thavies Inn Venereal Centre for Pregnant Women, of which he is in charge, and laid great emphasis upon the value of early treatment—within a few hours of birth—by both mercurial and arsenical preparations. His results speak for themselves. The Society is indebted to Dr. John Adams for his great kindness in coming to address it, and for showing a series of cases of cured congenital syphilis.

On March 16th the ANNUAL GENERAL MEETING was held. The Annual Report of the Committee was presented.

In this report the Committee emphasised the fact that an attempt had been made to carry out an old tradition of the Society by encouraging members, whether unqualified or recently qualified, to take an active part in the reading of papers and cutting into discussions, it being one of the chief aims of the Society to enable younger members to come forward and express their views with confidence.

The result of the election of officers for the session 1922-23 was announced as follows:

President.—Mr. E. H. Weatherall, M.A., C. Visick.

Vice-Presidents.—Mr. A. C. Macdonald, Mr. W. E. M. Mitchell.

Secretary.—Mr. E. Coldrey, Mr. J. P. Hosford.

Committee-men.—Mr. H. G. Anderson, Mr. R. Bolton.

REVIEWS.

THE STOMACH AND ABDOMEN FROM THE PHYSICIAN'S STAND-POINT. By WILLIAM RUSSELL, M.D., LL.D. (London: Baillière, Tindall & Cox.) Demy 8vo. Pp. xii + 329. Price 15s. net.

This book embodies the author's teachings on various abdominal conditions, especially the common disorders of the stomach. Many of these teachings are unorthodox; the unorthodoxies are based upon the author's own clinical experience, but do not appear to us to be backed up sufficiently by scientific arguments. Tea, for instance, is alleged to diminish gastric secretion; and much stress is laid on the importance of congenital stenosis of the pylorus in causing stomach troubles in the adult. Many of the author's own cases are quoted throughout the book. There is no index.

A SYNOPSIS OF MEDICINE. By H. LETHEBY TIDY, M.A., M.D., B.Ch., F.R.C.P. Second edition, revised. (Bristol: John Wright & Sons, Ltd.) Pp. xv + 956. Price 21s. net.

We have before us the second edition of this "synopsis." We hardly dare call it a cram-book, for there are 34 pages on typhoid fever alone, and the student who could cram all its 956 pages into his cranium before a Final examination would be a marvellous phenomenon. Its arrangement is, of course, tabular throughout; and the information given is sound and up to date. Some things, such as cardiac failure and renal function, do not lend themselves to tabulation; but we cannot do other than admire the courage of attempting to "tabulate" normal carbohydrate metabolism in four pages. In our opinion this book is more useful to one who wishes rapidly to revise the outlines of his knowledge of one particular disease than to one who urgently requires to learn "something about everything" for his Final examination. The present edition

has not been much altered, except for the section on encephalitis lethargica, which has been rewritten.

MEDICAL SCIENCE ABSTRACTS AND REVIEWS. Vol. v, Nos. 5 and 6 (February and March, 1922). (Oxford University Press: Humphrey Milford. Price 3s. net.)

The February issue of this journal contains reviews of cardiovascular diseases, diabetes insipidus and the nature of antigens, while the March number deals with tuberculosis, measles, pachymeningitis interna haemorrhagica, and the relation of blood coagulation to purpura and hæmophilia.

TUMOURS, INNOCENT AND MALIGNANT. By Sir JOHN BLAND-SUTTON, LL.D., F.R.C.S. Seventh Edition. (Cassell & Co., Ltd.) With 383 wood engravings. Pp. 806. Price 30s. net.

There is little necessity to commend the seventh edition of Sir John Bland-Sutton's classic work on tumours, since the book is known and approved by all. The present edition is the richer for some new knowledge in the relation of ductless glands to tumours and other kindred matters. There are also twenty-three more of the excellent engravings which have always been a feature of the work. Surely never was a scientific volume written with such evident relish as this—indeed we feel that sometimes the author has allowed his diffuse and almost garrulous style to run away with him. However, for the benefit of men newly engaged in clinical work we may assert that this is the book on tumours.

A GUIDE TO URINARY DISEASES. By ADOLPHE ABRAHAM, O.B.E., M.D. (Cantab.), M.R.C.S. (London), and A. CLIFFORD MORSON, O.B.E., F.R.C.S. (Eng.). (London: Edward Arnold & Co.) Pp. 120. Price 9s. net.

This little book is written by a physician and a surgeon for the general practitioner with the aim of helping him to diagnose urinary diseases from the symptoms present. With this end in view the modern pathological methods, though generally mentioned, are put second to investigations which the medical man can carry out for himself.

We believe this is sound policy, for the student trained at a great hospital and surrounded by elaborate pathological help often finds himself completely lost when forced to rely in the country on his own scanty resources.

The subject-matter of this book is good and the judgment of the writer well balanced. The following sentences end the chapter on renal function tests: "It cannot be too often emphasised that these tests *per se* must not be the only guide to the condition of the kidneys. The feature is only complete when chemical tests, changes in the urine, and the general condition of the patient are placed in their proper perspective."

We do not agree with all the author's statements. "Patients suffering from malignant disease of the prostate universally complain of pain—a symptom absent in simple enlargement—in the region of the perineum, specially on pressure, such as when sitting on a hard seat," seems to us to be exaggerated, but on the whole we can heartily commend the book to senior student and practitioner.

A SYNOPSIS OF MIDWIFERY. By ALECK W. BOURNE, B.A., M.B., B.Ch. (Camb.), F.R.C.S. (Eng.). Second Edition. (Bristol: John Wright & Sons, Ltd.) Pp. 211. Price 15s. net.

This work cannot be called a cram-book, although it is written in the usual tabulated form. Everything which the senior student can want in the theoretical part of obstetrics may be found here quickly and easily.

New work in the rapidly developing subject of the toxæmias of pregnancy and the hæmorrhages of pregnancy and labour has been added in this edition.

We believe that the study of obstetrics is one well suited to tabulation, and we think that the work will be a help to many.

SURGERY. (Complete volume. Catechism Series.) By CHARLES R. WHITTAKER, F.R.C.S. (Edin.), etc. Fourth Edition. (Edinburgh: E. & S. Livingstone.) Pp. 402. Price 9s. net.

This volume contains the catechism series in surgery. The contents of the book cover such ground in theoretical surgery as may be necessary—combined with clinical knowledge—for pass examinations, and are arranged in the form of questions and answers. It is valuable for those wishing to test their knowledge immediately before an examination.

RECENT BOOKS AND PAPERS BY
ST. BARTHOLOMEW'S MEN.

- ADAMSON, H. G., M.D. "Case for Diagnosis." *Proceedings Royal Society of Medicine*, February, 1922.
- BARRIS, J., F.R.C.S. (and J. McCURRICH). "Case of Hematoma of the Vulva following Labour." *Ibid.*, December, 1921.
- BOYLE, H. EDMUND G., O.B.E. "Report on Visit as Official Representative of the Section of Anesthetics to the First Meeting of the Canadian Society of Anesthetists at Niagara, and to the Meeting of the American Society of Anesthetists at Boston, in June, 1921." *Ibid.*, January, 1922.
- BROUGHTON-ALCOCK, W., M.B. (and J. GORDON THOMSON, M.B., Ch.B.). "Ziemer's cystitis, Dublin, 1898 found in a Specimen of Human Faces in England." *Ibid.*, February, 1922.
- "*Embryomas intestinalis* (Wenyon and O'Connor), 1917: Description of the Cysts and Free Forms found in a Case in England." *Ibid.*
- BROWS, W. LEWIS, M.A., M.D., F.R.C.P. "The Position of the Thyroid Gland in the Endocrine System." *British Medical Journal*, January 21st, 1922.
- BURNSLAW, M. M., M.B., M.R.C.S., L.R.C.P., F.R.Anthrop.Inst. "The Subconscious Element in Long Fasting." *Medical World*, December, 1921.
- CLARES, ENRIQUE, M.D., F.R.C.S. "Milestones in Retraction Work." *Practitioner*, February, 1922.
- COCKAYNE, E. A., M.D. "Case of Dwarfism." *Proceedings Royal Society of Medicine*, February, 1922.
- CUMBERBATCH, E. P., M.D. "The Importance of Physics, Anatomy and Physiology for the Practice and Progress of Electricity and Radiology." (Presidential Address of Electro-Therapeutics, Royal Society of Medicine.) *Ibid.*, December, 1921.
- DAVE, HAZEL, M.B. "Case of Tuberculosis of the Skin following a Cat Bite." *Ibid.*, January, 1922.
- "A Resistant Case of Secondary Syphilis." *Ibid.*, February, 1922.
- DONALDSON, MACDONALD, M.D. "Cancer of Cervix associated with Sarcoma of Omentum." *Ibid.*, December, 1921.
- DUNN-GRANT, SIR JAMES, K.B.E., M.D. "Case of Vertigo, due to Cholesteatoma of Middle Ear, cured by Osmoticotomy." *Ibid.*
- "Paralysis of the Left Recurrent Laryngeal Nerve due to Pressure of Mediastinal Glands." *Ibid.*, January, 1922.
- "Former Paralysis of Left Recurrent Nerve: Tracheal Tugging; Suspected Aneurysm." *Ibid.*
- (and C. C. WOESTER-DROUGHT, M.D.). "Case of Unilateral Deafness with Anaesthesia of the Same Side of the Face." *Ibid.*, December, 1921.
- ELMSLIE, R. C., O.B.E., M.S. "Contracture from Burn treated by Plastic Operation." *Ibid.*
- "Case of Congenital Absence of Sacrum with Associated Dislocation of the Hip and Talipes Calcaneovalgus." *Ibid.*, January, 1922.
- EVANS, E. LAMING, C.B.S., F.R.C.S. "Case of Charcot's Arthropathy of the Tarsus with Normal Knee-jerks and Normal Pupil Reflexes." *Ibid.*
- "Case of After-Result of Tendon Transplantation in Foot in a Case of Infantile Paralysis." *Ibid.*
- FEILING, A., M.D. (and W. L. HOLYOAK, M.D.). "Case of Renal Dwarfism with Optic Atrophy." *Ibid.*
- GARDNER-MENNIES, F. M., M.R.C.S. (and J. GRAHAM WILLMORE, M.R.C.S.). "Influenza: Treatment by Direct Stimulation of Leucopoiesis." *Lancet*, January 21st, 1922.
- GROVES, E. W. HEY, M.S., F.R.C.S. "The Long Fox Lecture: The Repair of Bone Injuries." *British Medical-Chirurgical Journal*, December, 1921.
- HAYNES, G. S., M.D., M.R.C.P. (and J. F. GASKELL, M.D., F.R.C.P.). "A Case of Primary Carcinoma of the Lung." *British Medical Journal*, February 11th, 1922.
- HICKS, E. P., M.B., M.R.C.S., D.I.M.M.H. "Hereditary Perforating Ulcer of the Foot." *Lancet*, February 18th, 1922.
- HOWELL, B. WHITCOMB, F.R.C.S. "Case of Arthritis of Both Hips." *Proceedings Royal Society of Medicine*, January, 1922.
- "Case of Fracture at the Elbow Joint." *Ibid.*, February, 1922.
- HURRY, JAMESON, B., M.A., M.D. "Exophthalmic Goitre and the 'Vicious Circle.'" *Clinical Journal*, January 25th, 1922.
- JEST, T. H., M.B. "Case of Ossification of the Membrane around a Perforation." *Proceedings Royal Society of Medicine*, December, 1921.
- "Lithium in External Auditory Meatus." *Ibid.*
- MCDONAGH, J. E. R., F.R.C.S. "Early Syphilis of the Prostate." *British Medical Journal*, February 11th, 1922.
- "The Rationale of the Wassermann Reaction" (abstract). *Proceedings Royal Society of Medicine*, January, 1922.
- MYERS, BERNARD, C.M.G., M.D., M.R.C.P. "Some Points on Certain Gastro-Intestinal Affections in Infants." *Clinical Journal*, February 18th, 1922.
- "Case of Adiposis Dolosa." *Proceedings Royal Society of Medicine*, January, 1922.
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- PARAMON, R. H., F.R.C.S. "Eclampsia and its Incidence." *Ibid.*
- PYBES, F. C., M.S., F.R.C.S. "Remarks on Intussusception." *Clinical Journal*, February 1st and 8th, 1922.
- SCULL, STUART, M.S. "A Pigeon Sixteen Months after a Single Application of Alcohol to the Membranous Labyrinth (Left Side)." *Proceedings Royal Society of Medicine*, December, 1921.
- "Remarks on the Comparative Effects, Immediate and Remote, of Introducing Absolute Alcohol into the Labyrinth of Birds and Human Subjects" (Cinematograph Demonstration). *Ibid.*, February, 1922.
- SPENCE, W. G., M.S., F.R.C.S. "Some Local Results of Dental Infection." *British Medical Journal*, January 28th, 1922.
- THORNS-THORNE, LESLIE, M.D. "A Clinical Aspect of Hypertension." *Clinical Journal*, February, 1922.
- TWEEDIE, A. R., F.R.C.S. "A Short Account (Demonstration) of the Research Work being conducted at Utrecht on the Saccular, Utricular and Allied Reflexes." *Proceedings Royal Society of Medicine*, February, 1922.
- WEBER, F. PANKAS, M.A., M.D., F.R.C.P. "Leuco-Sarcoma, Lympho-Sarcoma, Lymphadenoma and Infectious Mononucleosis." *British Journal of Children's Diseases*, October-December, 1921.
- WHALE, H. LAWSON, F.R.C.S. "A Large Exostosis removed from the External Auditory Meatus of an Adult Male." *Proceedings Royal Society of Medicine*, December, 1921.

EXAMINATIONS, ETC.
UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:
M.Ch.—R. StL. Brockman.
M.B., D.Ch.—E. L. Dobson, E. I. Lloyd.
M.B.—A. J. Copeland.
B.Ch.—E. Donaldson.

CHANGES OF ADDRESS.

ADAMS, J. WROTH, East London, Cape Colony.
BHAT, K. S., 99, New North Road, N.
BULL, L. J. F., St. Ronan's, Gloucester Road, Kingston-on-Thames.
CLARK, FRANCIS, Medical College, Mourden, Manchuria.
EVANS, GEOFFREY, 23, Park Square, N.W. 1. (Tel. Museum 56.)
LADELL, E. W. J., 17, Western Road, Port Elizabeth, South Africa.
PATRICK, N. C., Ulster Club, Belfast.
TREWBY, J. F., 1, Park Square West, Portland Place, N.W. (Tels. Langham 2310, 2311.)
WILSON, CYRIL, 7, Beaumont Street, Portland Place, W. 1.

APPOINTMENTS.

BOWLEY, Major-General Sir ANTHONY A., K.C.B., K.C.M.G., K.C.V.O., F.R.C.S. (ret'd.), appointed Hon. Col. of the 48th (South Midland) Division R.A.M.C. T.A. Units.
GRANT-JOHNSTON, Capt. J., R.A.M.C. (T.A.), appointed D.A.D.M.S., 48th (South Midland) Division, T.A. Units.
PHILLIPS, L. L., M.R.C.S., I.R.C.P., appointed Medical Officer in Charge of X-Ray Department, Royal Berkshire Hospital, Reading.

BIRTHS.

BULCOCK.—On March 15th, to the wife of Dr. J. Henderson Bulcock, Foxley Lane, Purley—a son.
ELGOOD.—On March 10th, at 19, Greencroft Gardens, Hampstead N.W., Ethel Helen, wife of Cyril Lloyd Elgood, of a son.
GORDON WATSON.—On February 21st, at Baldock, Herts, Lucy (née Colman-Platten), wife of F. E. Gordon Watson, M.R.C.S., of a daughter. (East Anglian papers, please copy.)
HANBURY.—On February 21st, at Foxbury, Woldingham, to Margaret, wife of Reginald J. Hanbury—a daughter.
HILL.—On March 14th, at Dalestead, Caterham Valley, Surrey, to Ruth, the wife of P. T. Hill, M.C., M.R.C.S., L.R.C.P.—a son.
KINDERSLEY.—On February 21st, at Ulster Lodge, Warminster, to Peggy (née Carlisle), wife of Charles E. Kindersley—a son.
POWER.—On February 23rd, at Alexandria, the wife of Squadron Leader D'Atcy Power, M.C., R.A.F. Med. Serv., of a son (stillborn).
SIMPSON.—On February 9th, at 83, Brown Street, Salisbury, the wife of A. D. H. Simpson—a son.

MARRIAGES.

FRASER—THOMSON.—On February 8th, at St. Mark's, North Audley Street, W., by the Rev. W. G. Pennyman, Duncan Beaufort, younger son of Dr. and Mrs. Fraser, of Lyghe, Kent, to Gladys Couper, daughter of the late Mr. Frederick Thomson and of Mrs. Thomson, Arnhall, Dundee.
MITCHELL—HAMILTON.—On March 11th, at St. John's Church, Hampstead, by the Rev. L. S. Hunter, M.A., Canon-Designate of Newcastle, William Eric Marcus, eldest son of Dr. J. F. Mitchell, of Bangor, Ireland, to Catherine, younger daughter of W. F. Hamilton, Esq., of Fairlie, New Zealand.

DEATHS.

HICKS.—On February 27th, 1922, at 11, Clarendon Square, Leamington, Dr. Philip Hicks, the beloved husband of Beatrice Hicks, aged 55.
PICKETT.—On March 3rd, 1922, at 18, Worthing Road, Southsea, Jacob Pickett, M.D., Past P.G. Steward, Staffordshire, founder Æsculapian Lodge, No. 2,410, aged 87.
STEVENS.—On March 6th, 1922, at Plumstead, suddenly, Reginald Charles Jeremie Stevens, M.B., husband of Kathleen Stevens, of 75, Upper Grosvenor Road, Tunbridge Wells.

St. Bartholomew's Hospital



JOURNAL.

VOL. XXIX.—No. 8.]

MAY 1ST, 1922.

PRICE NINEPENCE.

CALENDAR.

- Mon., May 1.—Clinical Lecture (Special Subject), Mr. Harmer. Final M.B. (London) begins. Royal Society of Medicine, Lecture by Sir Humphry Rolleston (5 p.m.), "Recent Physiology of the Liver."
- Tues., " 2.—Sir P. Horton-Smith Hartley and Mr. Rawling on duty.
- Fri., " 5.—Sir Thomas Horder and Sir C. Gordon-Watson on duty. Clinical Lecture (Medicine), Sir T. Horder. Professorial Lecture, Dr. Thursfield, "Jaundice in Children." Rugby Football Club Dinner, Holborn Restaurant, 7 p.m.
- Sat., " 6.—Lawn Tennis Match at Chiswick Park (home).
- Mon., " 8.—Clinical Lecture (Special Subject), Mr. Rose.
- Tues., " 9.—Prof. Fraser and Prof. Gask on duty.
- Wed., " 10.—View Day. Clinical Lecture (Surgery), Mr. Waring. Lawn Tennis Match v. R.M.A. (away).
- Fri., " 12.—Dr. Morley Fletcher and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Morley Fletcher. Professorial Lecture, Dr. Langdon Brown, "Diseases of the Pancreas."
- Sat., " 13.—Cricket Match v. Southgate.
- Mon., " 15.—Clinical Lecture (Special Subject), Mr. Elmslie. Royal Society of Medicine, Lecture by Sir Thomas Horder (5 p.m.), "The Clinical Significance of Hemoptysis."
- Wed., " 17.—Clinical Lecture (Surgery), Mr. Waring. Lawn Tennis Match v. Highgate (away).
- Fri., " 19.—Sir P. Horton-Smith Hartley and Mr. Rawling on duty. Clinical Lecture (Medicine), Dr. Drysdale. Professorial Lecture, Mr. Waring, "Cholelithiasis"
- Sat., " 20.—Cricket Match v. King's College. Lawn Tennis Match v. H.C.H. (home).
- Mon., " 22.—Clinical Lecture (Special Subject), Dr. Cumberbatch.
- Tues., " 23.—Sir Thomas Horder and Sir C. Gordon-Watson on duty.
- Wed., " 24.—Clinical Lecture (Surgery), Mr. McAdam Eccles. Lawn Tennis Match v. Gallery I. T.C. (home).
- Fri., " 26.—Prof. Fraser and Prof. Gask on duty. Clinical Lecture (Medicine), Dr. Drysdale. Professorial Lecture, Mr. Waring, "Cholelithiasis" (continued).
- Sat., " 27.—Cricket Match v. Wanderers. Lawn Tennis Match v. Trinity College, Cambridge (home).
- Mon., " 29.—Clinical Lecture (Special Subject), Mr. Scott.
- Tues., " 30.—Dr. Morley Fletcher and Mr. Waring on duty.
- Wed., " 31.—Clinical Lecture (Surgery), Mr. McAdam Eccles. Lawn Tennis Match v. Highgate (home).

EDITORIAL.



O-OPERATION has some manifest advantages over competition, and we therefore welcome the combined hospital appeal which is being launched under the auspices of King Edward's Hospital Fund for London. The Prince of Wales has signified his approval of this combined appeal, and the campaign seriously began on Easter Tuesday, when 950 banks throughout the country opened donation accounts. Where so many charities are simultaneously appealing for funds, the potential giver does not know which way to turn and may end by giving nowhere. An appeal like this should make him hesitate no longer.

We all of us hate change; but the most conservative of us will feel that Mark Ward will be honoured by its new name of Sandhurst Ward. An inscription is shortly to be set up in the Ward to place on record the great services which our late Treasurer rendered to the Hospital during his thirteen years of office. But we fear that Matthew, Luke and John will feel lonely without their colleague. We may also mention that as part of the outcome of the recent "Fleet Street Week" for Bart.'s a "Fleet Street" Bed has been endowed in Mark—we should say, Sandhurst—Ward.

The Nurses' Home is at last under way. Plans have been prepared for the immediate erection of a block of buildings on the eastern boundary of the Hospital fronting on Little Britain and providing bedroom accommodation for 165 persons. It is hoped that it will be ready for occupation by the spring of 1923.

On the afternoon of Saturday, April 22nd, the Lady Mayoress held a reception at the Mansion House for St. Bartholomew's Nurses. It will be recollected that the Lady Mayoress was herself trained at this Hospital. And

now the demolition of the old Nurses' Home has actually begun, as our readers can see (and hear) for themselves if their way to the Hospital lies along Little Britain.

An interesting ceremony took place at 11 a.m. on Tuesday, April 25th. The Lord Mayor and Lady Mayoress arrived at the Hospital, accompanied by awe-inspiring officials; they were received and conducted by the Treasurer and the Matron to the top of the Nurses' Home, and by means of a steep and narrow stairway debouched upon the roof, followed by about thirty on-lookers, including some enterprising sisters. At a given signal the Lady Mayoress pulled a lever, thus hurling a large chimney on to the ground beneath, amidst the applause of the spectators. The chimney having been well and truly laid low, the party descended. Our readers will note a picture of the crucial moment on p. 129. We are in a position to deny the rumour that the ceremony was completed by an onslaught by the nurses with bricks upon the windows of the Home. We should like to express the gratitude of the Hospital to the Lord Mayor and Lady Mayoress for their interest in Bart.'s, and our satisfaction (which the nurses doubtless share) at this sign of real progress towards the new Home.

We are indeed glad to hear that Sir Humphry Davy Rolleston has been elected President of the Royal College of Physicians. Sir Norman Moore, after four years of office, was no longer seeking re-election, and no doubt vacated the chair the more willingly on knowing that his place might be taken by another Bart.'s man. Sir Humphry was installed in office by Sir William Church, under whom he had served as House-Physician at this Hospital—we dare not think how long ago. Sir Humphry was also elected the representative of the College at the celebrations in honour of the foundation of the University of Padua, to which we referred in our last issue.

The interchanges of lectures now going on between different countries are a significant sign of the desire for a true international spirit in medicine. Several eminent French scientists are lecturing in London this summer; and at the Grand Amphitheatre of the Faculty of Medicine in Paris we see that Sir Wilmot Herringham is lecturing on "Trench Fever" on May 11th, and that Mr. H. J. Waring is discoursing on "Acute Pancreatitis" on May 20th. Between England and Holland this interchange is even simpler, in that most Dutch students readily understand English. Sir Frederick Andrewes is lecturing on "Arterial Degenerations" at the Universities of Utrecht and Amsterdam on May 5th and 8th respectively.

Last month we were able briefly to welcome Dr. C.

Lovatt Evans to the Chair of Physiology at this Hospital. That he is a worthy addition to our teaching staff may be seen from the further details we are able to give of his earlier achievements.

Dr. Evans was born on July 9th, 1884, and was educated at the University of Birmingham and at University College and University College Hospital, London. He obtained the B.Sc. Pass Degree as an external student in 1910 and was then appointed Sharpey Scholar and Assistant in Physiology at University College. He obtained the D.Sc. degree in Physiology as an internal student in 1913. From December, 1913, to November, 1917, he was a recognised teacher of physiology at University College. In 1914 he was awarded the Schafer Prize in Physiology at University College. In January, 1916, he qualified M.R.C.S., L.R.C.P., and then joined the Army. In 1917 he was appointed Professor of Experimental Physiology and Experimental Pharmacology in the University of Leeds, and took up his duties there on demobilisation in May, 1918. In July, 1919, he left Leeds to undertake research work at the National Institute for Medical Research. He has also carried out research work at Freiburg im Breisgau and at Cambridge. He has published a number of papers on experimental and chemical physiology in the *Journal of Physiology* (1912-21), the *Proceedings of the Physiological Society* (1915-20) and other scientific journals, English and foreign.

The following are the appointments to the Junior Staff for the next six months:

House-Physicians to—	
Dr. H. Morley Fletcher	Mr. E. W. C. Thomas (sen.). Mr. E. Gallop (jun.).
Dr. J. H. Drysdale	Mr. J. G. Johnstone (sen.). Mr. J. N. Kerr (jun.).
Sir P. H. S. Hartley	Mr. F. Allen (sen.). Mr. L. S. Morgan (jun.).
Sir Thomas Horder	Mr. D. M. Lloyd-Jones (sen.). Mr. H. Tothill (jun.).
House Surgeons to—	
Mr. H. J. Waring	Mr. F. C. W. Capps (sen.). Mr. G. F. Abercrombie (jun.). Mr. C. A. Horder (sen.).
Mr. McAdam Eccles	Mr. W. E. M. Mitchell (jun.). Mr. B. L. Jeaffreson (sen.).
Mr. L. B. Rawling	Mr. F. T. Evans (jun.). Mr. H. N. Andrews (sen.).
Sir C. Gordon-Watson	Mr. W. Shaw (jun.).
Professional Units:	
Medical	Mr. W. E. Lloyd (sen.). Mr. E. H. Weatherall (jun.). Mr. R. W. P. Hosford (sen.). Mr. H. C. Killingback (jun.).
Surgical	Mr. H. L. Sackett.
Intern Midwifery Assistant	
Non-resident Midwifery Assistant	Mr. E. Catford.
Extern Midwifery Assistant	Mr. H. Shannon.
House-Surgeon to—	
Throat, Nose and Ear Department	Mr. C. S. Prance.
Eye Department	Mr. J. Conway Davies.
Orthopaedic Department	Mr. L. M. Jennings.
Skin and V.D. Department	Mr. J. L. Fotts.

Newly qualified men may be interested to learn that the Royal Society of Medicine is now prepared to admit "Associates." Any qualified man or woman is eligible as an associate up to five years from qualification. Associates have somewhat fewer privileges than Fellows—they do not receive the *Proceedings* gratis and may take only one book from the Library at a time; but the subscriptions are correspondingly less—a concession which should prove valuable to many.

We congratulate our new Treasurer, Lord Stanmore, who has been made a Knight of Justice of the Order of St. John of Jerusalem.

Dr. W. S. A. Griffith has been re-appointed representative of the Royal College of Surgeons to the Central Midwives Board.

We trust it is not impertinent of us to congratulate our eminent Lecturer on Morbid Anatomy on the unsolicited testimonials he has been receiving (*vide* the Public Press), not only from one of his Majesty's Judges but also from the foreman of the jury in a recent criminal case.

The First Dinner of the Tenth Decennial Club will take place on Thursday, June 29th, 1922. All men who entered the Hospital in the years 1905-1915, and subsequently qualified, are members of this decennial and will receive notice of the dinner.

Mr. David G. T. K. Cross, B.M., M.A., has been elected by the Radcliffe Trustees, at Oxford, to a Travelling Fellowship, tenable for three years.

We take this opportunity of welcoming a new contemporary. The University of London Union Society is publishing a magazine on May 3rd. We wish it every success.

OBITUARY.

We regret to announce the death of Dr. W. A. Hollis, M.D., F.R.C.P., who died at Hove on March 26th, 1922, aged 82. Dr. Hollis was educated at Brighton College, Trinity College, Cambridge, and St. Bartholomew's, where he held the post of House-Physician. He was at one time President of the British Medical Association, and was Consulting Physician to the Royal Sussex County Hospital.

THE RESULTS OF THE RECENT SCHICK TESTS AMONG STUDENTS.

By Sir Frederick Andrewes, F.R.S.

IN a recent article in this JOURNAL Dr. Okell has dealt with the subject of the Schick test, and immunisation against diphtheria. There is, therefore, no need to go into the matter again further than to recall the fact that the Schick test is one for demonstrating the presence of diphtheria antitoxin in the blood. A very small fraction of an antitoxin unit, per c.cm. of blood, neutralises the minute dose of toxin injected into the skin, so that no effect is produced by the latter, and experience has shown that even this small amount of antitoxin in the blood suffices to protect against an attack of diphtheria. Thus a person with a negative Schick reaction may be regarded as immune. The matter is, however, complicated by what are termed "pseudo-reactions." A person may have antitoxin in his blood and be immune, and yet be sensitive to some element in the toxin injected other than the toxin itself, and so give a skin reaction very hard to distinguish from a true positive. The difficulty is overcome by making use of the fact that the true toxin is easily destroyed by heat, whereas the substance to which the pseudo-reaction is due, usually assumed to be some other constituent of the bacillary body, is heat-stable. Unheated toxin is injected in one place and heated toxin in another. Pseudo-reactions are rare in children, but comparatively common in adults: they are usually associated with immunity, but combined pseudo- and true positive-reactions occur.

There is now a large amount of evidence as to immunity against diphtheria at different periods of life. This was first studied by Römer's method, in which the serum of the human case is injected into a guinea-pig, mixed with a known dose of toxin. This is a more accurate method than the Schick test because it is not confused by pseudo-reactions, and also because it can be made strictly quantitative. The two methods have, however, given reasonably concordant results. It is shown that infants at birth are immune in more than 80 per cent. of all cases. This is passive immunity by transfer of antitoxin from the maternal blood, and is hence transient, though kept up for a while by breast-feeding. By the time children have reached $2\frac{1}{2}$ to $3\frac{1}{2}$ years the number of immunes has fallen to 28 per cent. (v. Groer and Kassowitz)—the lowest point reached. Thenceforward the proportion of immunes rises gradually, till by the end of adolescence the percentage of immunes is again over 80; and now it is active, not passive, immunity, and therefore enduring.

It is now generally accepted that this acquired immunity depends on infection by the diphtheria bacillus—not

necessarily on a declared attack of diphtheria, but often on slight, and perhaps repeated, infections, not enough to set up manifest disease, or by rhinitis without constitutional symptoms—such conditions, in fact, as we know are common in children. If this is so, we should expect to find the proportion of immunes higher in the lower than in the middle or upper classes, because the former, owing to overcrowding, more defective sanitation, and massing in elementary schools, are far more exposed to infection by the bacillus. Children of the middle and upper classes are largely shielded from such infection, and thus have less chance of becoming immune. Now, the data upon which the age-curve of immunity has been based are chiefly derived from the lower strata of society—from elementary school children, orphanages and out-patient departments. We must not therefore assume that the proportion of immunes is the same in all social strata. Last year Zingher, who tested 52,000 children in New York schools, published the results grouped according to the degree of crowding in the several areas. In good-class schools in sparsely inhabited areas he found only 33 per cent. of immunes, while in poor districts the proportion was as high as 80–84 per cent. In a rural school only 15 per cent. were immune.

No observations bearing on this point have so far been carried out in this country, and this was the reason for asking the students at St. Bartholomew's to volunteer for the Schick test in numbers sufficient to give a good idea of the proportion of those immune against diphtheria in a representative middle-class population of young English adults. Thanks are due to the 157 men who volunteered (and turned up for subsequent readings), and we owe a great debt to the energy and enthusiasm of Dr. O'Brien and his colleagues who carried out the tests. Of the 157 men tested, 103 gave a positive result—65.6 per cent.,—leaving only 34.4 per cent. immunes. Blood was taken from a good number of the volunteers, and was tested on guinea pigs: the immunes had from 1.0–5 units of anti-toxin per c.cm., the non-immunes had none (or less than 1.0/100 unit) in 27 cases out of 30; the remaining 3 appeared to have small amounts on the first test, but are being re-investigated. Of 21 men who said they had previously had diphtheria, 15 were positive and 6 negative, illustrating the well-known fact that an attack of clinical diphtheria confers little protection. Pseudo-reactions were fairly common.

It will be apparent that these observations are of considerable value, for they are the first in this country which bear on the question of immunity in relation to environment. They support Zingher's observations in America, and strengthen the hypothesis that immunity against diphtheria is associated with exposure to infection during childhood. In place of the 84 per cent. of immunes found

by v. Groer and Kassowitz amongst out-patients at Vienna, the students at Bart.'s show only 34.4 per cent. It may be added that of 23 nurses who were also tested, 13 were positive and 10 negative—43.4 per cent. immune. Those of us—and I am among the number—who react positively to the Schick test, may perhaps console ourselves for our lack of immunity by the reflection that at least "we ain't been brought up common."

SOME NOTES ON DUODENAL ULCER.*

By GODFREY LOWE, M.R.C.S., L.R.C.P.

A long personal experience of this condition renders one capable of describing its mode of onset, symptoms, and the various methods of treatment which have been adopted, whether successful or otherwise. Being interested personally one has naturally read with avidity all the accessible literature of the subject, but I do not propose to bore you by detailing the various authorities beyond saying that one owes a very great deal to Sir Berkeley Moynihan, who was the first to publish (*Lancet*, 1905, i, p. 34) a complete account of the symptoms, although two cases of chronic duodenal ulcer had been operated on by Codivella in 1893 and 1898, and the first successful closure of a perforation was performed by H. P. Dean in 1893. It was, however, Sir Berkeley Moynihan who made the operation of gastro-enterostomy what it is to-day, and it may be taken as a conservative estimate that 90 per cent. of the cases of chronic duodenal ulcer that have failed to be cured by medical means can be cured by surgical measures. Naturally there are differences of opinion. Dr. Hurst of Guy's, says (*British Medical Journal*, April 24th, 1921); "Everyone must agree that the surgical treatment of gastric and duodenal ulcer is a confession of failure," and he gives a most elaborate scale of dietary and medication for the treatment of these conditions. It is not for me to judge between the surgeon and the physician. I am inclined to agree with a surgeon who said to me: "The operation of gastro-enterostomy is the most successful in surgery in suitable cases." I leave it at that.

The condition is seasonal in its incidence. My first attack was one early summer: epigastric pain, a pain as of hunger, a warm sort of pain. I did not know what it was. That was fifteen or sixteen years ago, before I and probably a good many others were as well informed on the subject as we are now. The pain came on about 6 p.m. and was relieved by food. It returned each evening for a few days about the same time and then disappeared till the following year. This time it was not quelled till I went on a holiday, when I lost it at once. And so I went on from year to year. One year it lasted from

* A Paper read before the Lincoln Medical Society, December 1st, 1921.

June to October; another year I felt nothing of it. During the war, when I was exceedingly busy and had a lot of cold night work, it was no worse than usual, the attacks lasting three or four weeks at intervals of six months or so. From June, 1920, to July of this year it hardly ever left me. The attacks of pain were characteristic. After a meal like breakfast the pain came on in about two hours. After the midday meal when meat was taken it would appear in about 2½ to 3 hours; after a light meal like afternoon tea, especially if the tea was at all strong, in 1½ to 2 hours and in the evening about 2½ hours after dinner. The 3 o'clock in the morning pain, though frequent, was not a constant feature. I soon found that taking a boiled egg, for instance, at tea time, prolonged the interval, and reducing the carbohydrate intake at breakfast and indeed at other meals acted in like manner. Strong tea on one occasion initiated an attack. Porridge, pastry, new bread, new potatoes, pickles, vinegar, acid fruits were all productive of early trouble. The pain was always relieved by food and I used to arrange to carry bananas or little sandwiches wherever possible, but of course there were times when it was not convenient to eat and I suffered much torture. The discovery of the soda-mint tablet was a great occasion, and I never afterwards was without a supply loose in my waistcoat pocket or by my bedside at night, which I could surreptitiously nibble when occasion arose; two or three or four of these would always give relief. Such is the history many a patient could give you. On the other hand, some people have duodenal ulcers which give no sign of their presence until the patient has a severe, even fatal hæmorrhage, or until they burst into the peritoneal cavity.

Of course I consulted various kind medical friends, who advised various remedies more or less useful. One thing I noticed, however—each different kind of treatment had a good effect for a time. This led me almost to hope that the whole thing was really a neurosis, as was more than hinted by one amiable being, who thought a course of active service in France would best suit the complaint. I tried to delude myself, too, with the idea of hyperchlorhydria. I believe that this is a myth in spite of chemical analyses of stomach-contents. I don't believe an excess of acid in the stomach will hurt the normal mucous membrane of a stomach or duodenum, but if there is a sore place the normal amount of acid will cause pain in exactly the same way as the juice of an orange will make your finger smart only if there is a cut in it. I tried all the recognised stunts—emulsion of magnesia, large doses of bismuth and bicarbonate of sodium, etc. All these things neutralise the acid in the stomach, but they do not cure the patient. The pain is caused by the acid chyme as it leaves the stomach passing over a sore place in the duodenum. Render the chyme alkaline and you relieve the symptoms, but you do not heal the ulcer. The theory of the medical treatment of the condition is that the chyme is rendered and kept alkaline, and that if the ulcer is never

worried by acid it will heal. Dr. Hurst's treatment, which is by far the most elaborate, is based on this theory.

Before dealing with this I should like to say a word about diagnosis and prophylaxis. The site of the pain to the right of the epigastrium close to the costal margin, the onset of the pain two to three hours after a meal, the periodicity of the attacks (early summer and autumn), the relief of the pain by the ingestion of food or alkalies, are all characteristic and well-known symptoms. In the later stages one gets evidence of septic absorption as shown by an unhealthy complexion and loss of flesh, symptoms of adhesions shown by a dragging pain up the œsophagus on twisting the body round, also an aching pain produced by riding a bicycle on bad roads. One may differentiate from gastric ulcer by the absence of vomiting, and the fact that the pain is relieved, not intensified, by food. Other conditions to be kept in mind are appendicitis—a common accompaniment, by the way, of duodenal ulcer—cholecystitis and pancreatitis. There is, as a rule, no jaundice with duodenal ulcer. As regards appendicitis, many cases of duodenal ulcer have been cured by the removal of the appendix, and any operation for the cure of the ulcer should be accompanied by an examination of the appendix and its removal if it is in the slightest degree abnormal. I will not enter into the details of X-ray examination, by which the rate at which the bismuth meal passes through the pylorus and the peristaltic movements throw additional light on the condition. Hæmorrhage, of course, may occur, and may indeed be the first symptom. A careful examination of the stools in a doubtful case may reveal occult blood: there may be distinct melæna or there may be violent hæmatemesis. On the other hand, perforation, with its grave abdominal symptoms, may be the first sign of a duodenal or gastric ulcer.

Prophylaxis between the attacks is easier to talk about than to carry out. One feels perfectly well, one hopes that the last attack will really be the last, and it is difficult for a healthy man to be strictly dieted. But one can exclude septic foci such as the teeth and nasal sinuses, and see that constipation is avoided. Such articles of food and drink as pastry, new bread, new potatoes, coarse vegetables, raw fruit, fruit containing seeds, strong tea or coffee, aerated drinks, preferably all alcohol are best avoided. The less starchy food taken the better. Curries, vinegar and things which strongly stimulate the formation of gastric juice are particularly to be cut out. One should eat slowly and thoroughly masticate, and avoid long intervals between meals. And, lastly, never go out without a supply of soda-mint tablets.

Coming to the question of treatment, we are up against the old problem as to whether medical or surgical measures are to be taken. Although I have myself been most successfully treated surgically, I can remember many cases of undoubted duodenal ulcer which have healed without

any drastic treatment, and I am in no hurry to advocate operation except in cases such as I shall enumerate later. Some cases, however, go on until they either burst or bleed, or are operated on, in spite of all you can do. I think every ulcer ought to be given a chance to heal, but there is very often a difficulty about treatment. Energetic medical treatment means rest in bed on a very careful diet for several weeks. Discussing this with a medical friend, he said: "If you are going to bed for several weeks you might as well have a laparotomy done; it won't take any longer than medical treatment, and is far more certain of cure." That is the surgeon speaking of the well-established case where you have to take energetic measures of some sort, but there are lots of mild cases where the man keeps at work—his work is generally of a sedentary character; he cannot afford the time or money for energetic medical or surgical treatment, and, in fact, he does not feel bad enough for either. But that man is always in danger. Don't let him go for a holiday where he is out of reach of expert surgical help should that be necessary. What can we do for this man? He can be dieted on the lines already indicated, he can avoid cold and fatigue, he can have his teeth, nose and throat examined and sterilised. He can have a mid-morning meal of milk and a night-cap of, more milk containing magnesia, or a cup of Bengel. You treat him medically on the lines, as far as possible, that I am about to indicate. He must live hygienically and we must hope for the best. All this is quite easy and the man may get a lot better, but he is not necessarily cured. He may come back again next year and you then have to decide on something more energetic. You can't go on treating this man in an ambulatory fashion indefinitely, and simply relieving his pain with large doses of alkalies. Has anybody here ever tried the effect on his own system of the prolonged ingestion of large doses of alkalies? Few things I imagine make you feel more miserable. Another drawback I soon discovered was that the excess of alkali delays gastric digestion and I got the most frantic dyspepsia. The pylorus opens when the stomach contents get acid. If they do not get acid the pylorus remains shut or only partially open, and you get stasis of the stomach contents. They call that pyloric spasm. I do not think it is a spasm but simply a lack of the natural call. At any rate I found that if the pain came on as the time for a meal approached, I dared not take the alkali for fear of the resulting dyspepsia. Hence my irritation if I was late for a meal or a meal was late in appearance. Apart from the depression caused by the alkali treatment and the resulting dyspepsia, the victim of a duodenal ulcer feels fairly well, and between the attacks quite well. If one can ward off the pain by taking nourishment at the proper times, I see no reason in theory why one should not go on indefinitely. The appetite is good—too good in fact, because in this condition the stomach contents seem to pass on too quickly. There is no vomiting or nausea, and until one gets dyspepsia, as I

say, one is pretty fit. But, especially in our profession, where one's work is so irregular, one cannot go on with this sort of thing indefinitely. It is, moreover, a very harassing condition. One may think—if I can keep off the pain for a week or two by taking food at the proper time I shall heal up; but one is haunted by the fear that if one of these meals be missed the whole programme will be spoiled. All this is the experience of an ambulatory case—the case of the man who hopes that he can get to the bottom of his trouble without sacrificing his time and means of livelihood.

All this fails: the case recurs; further treatment is called for. The alternatives are, active medical or active surgical treatment. The decision in each case has to be come to on its merits.

The medical treatment laid down by Dr. Sippey as quoted by Dr. Hurst (*British Medical Journal*, April 24th, 1921) is put as briefly as possible as follows: Rest in bed except for a daily bath and the use of the night stool. Five oz. milk and cream together with gr. x sodium citrate dissolved in dr. ij emulsiō magnesiæ are given every hour from 8 a.m. to 8 p.m. Immediately before alternate feeds beginning at 7.30 a.m. $\frac{1}{2}$ oz. of olive oil is given. This inhibits the formation of gastric juice and is a highly nutritive food into the bargain. Immediately before the remaining feeds tr. belladonna \mathfrak{m} v, which has the same effect, is given. Half-an-hour after each feed and at 9, 9.30 and 10 p.m. a powder of gr. x calcium carbonate and gr. xxx bismuth carbonate are given in water. At 6 a.m. $\frac{1}{2}$ oz. of bismuth carbonate shaken up in 5 to 10 oz. of water is swallowed, and the patient lies on his right side or in such a position that the powder is likely to come in contact with the ulcer. This forms a protective covering to the ulcer, and at the same time neutralises any acid present and calls forth a local secretion of protective mucus. Thus the contents of the stomach are kept neutral or alkaline from 6 a.m. to 10 p.m. But you must prevent hyper-secretion of gastric juice during the night; otherwise the ulcer cannot heal. So at 11 p.m. you completely empty the stomach by Senoian's evacuator; if not more than 2 oz. of fluid are present on two consecutive nights this can be discontinued. If half a pint or more is removed at 11 p.m. the stomach should be evacuated again at 1 a.m. At 11 p.m. atropine sulphate is injected subcutaneously in order to inhibit the further secretion of gastric juice; the largest dose which does not produce unpleasant dryness of the mouth should be given, beginning with gr. $\frac{1}{10}$. The alkaline powder should be given at the same time, and if more than 2 oz. of fluid were evacuated it should be repeated every two hours through the night. In most cases the continued nocturnal secretion is rapidly controlled by this treatment. The bowels are regulated by the magnesia and an enema given if required. If diarrhoea occurs some of the magnesia is replaced by an equal quantity of bismuth. This treatment is continued until the patient has had no symptoms for three weeks, when the diet can be rapidly increased within

the limits laid down under prophylaxis. For at least six months the patient should be instructed to take the alkaline powder or a small feed as nearly as possible at hourly intervals between meals.

Such is the active medical treatment of duodenal ulcer, and you will agree, I think, that it requires a vast amount of patience and attention to details, and could, of course, only be carried out effectually by trained hands or in a hospital or nursing home.

What is the result of all this? The ulcer is healed, but it is not safe to assume that the patient is cured. Some indiscretion in diet, some exposure to cold or fatigue, may produce a recurrence of the symptoms. In such a case the only remedy is surgical. Operative treatment is not to be undertaken lightly. Curiously the cases which do the worst after operation—that is, where there are unpleasant symptoms such as vomiting, regurgitation of bile, etc., are those where the operation has revealed the fact that no ulcer has been present. The chief indications for operation are: (1) perforation; (2) cases of pyloric obstruction or duodenal stenosis from scarring of healed ulcers; (3) when the symptoms recur after one or more courses of medical treatment. This category depends very largely on the patient's circumstances, mode of living, etc., the man of leisure being able to afford the time and money for further medical treatment. (4) When hæmorrhage has occurred more than once, especially in cases over middle age; (5) when there is a possibility of a malignant growth being present. No. 3 category includes those cases where you have a patient who, like myself, is unable to submit to a long course of medical treatment at all, where there are definite signs of an ulcer being present and of long standing, symptoms also of some septic absorption, as shown by an unhealthy complexion, dirty tongue and loss of flesh; signs of adhesions forming, as shown by a sickening dragging pain on the stomach and œsophagus when turning suddenly round, and, in fact, a general feeling of "fed-up-ness."

I do not propose to enter into the details of the operation of posterior gastro-jejunostomy; suffice it to say that I went through it at Mansfield at the hands of Dr. Houfton on July 3rd, 1921. An ulcer about $\frac{1}{2}$ in. in diameter with thickened edges was found on the lower border of the duodenum close to the pylorus. There were sundry adhesions on the anterior surface opposite the ulcer. There was no apparent dilatation of the stomach or thickening of the pylorus. There was some vomiting of blood within the first twelve hours, but after that there were no untoward symptoms beyond on two occasions some regurgitation of bile. Nothing was taken by the mouth for 24 hours. Washing the mouth frequently with cold water relieved the thirst, care being taken of course to avoid swallowing any. Next day I was given two-hourly feeds of 1 oz. of milk and water and in the evening a cup of tea. Next day and the following day some fish was given, and on the fourth day I was treated to a lamb chop and some peas and a new potato. I mention

these details because I think patients are sometimes kept too long without solid food after operation. Of course a good deal depends on the quality of the cooking and the skill and reliability of the nursing. I was particularly lucky in this respect. The patient is allowed out of bed within a fortnight if all goes well and in less than a month he is back at home weak but happy. The greatest care must be taken with the food at first. The stomach should not be overloaded, particularly by fluids. It is best to keep the meals as dry as possible and avoid rich foods of all descriptions. Gradually a return may be made to ordinary but reasonable diet. Cold and fatigue must be avoided and the patient should not attempt serious work for at least three months. We do not nowadays anticipate peptic ulcers and the other horrors that used to follow the anterior operation. The ulcer should heal and remain healed now that the outflow from the stomach is diverted to another channel. Unless the stomach is unduly distended there does not seem to be any passing of the stomach contents through the pylorus, which of course might happen in those cases where there was no stricture of the pylorus. Another precaution is that the patient should not lie on his right side in bed for at any rate the first half of the night.

A lot more might be said on this very interesting subject. I hope I have not wearied you in my effort to provide a topic for what I am sure will prove a most interesting discussion.

A discussion followed the reading of the paper.

Dr. HOUFTON (Mansfield) said that from his experience of a large number of cases, very few of the chronic typical cases of duodenal ulcer either perforated or bled. Many which did so had been diagnosed and treated as cases of chronic dyspepsia. An interesting point was—what happens to the ulcer when the symptoms disappear between the attacks? It certainly does not heal. Discussion had taken place as to whether it was necessary to close the pylorus at the time of operation. His opinion was that this is not necessary, as the attachment of the jejunum to the stomach made the point of attachment in time the lowest point, and very little if any of the stomach contents passed through the pylorus.

Dr. STANLEY GREEN, who had suffered from duodenal ulcer for years and had a gastro-ostomy done twelve years ago, pointed out that the disease seemed to affect those who were as a rule large bread-eaters. He quoted a case where the symptoms, which were of long standing, disappeared after the removal of a particularly septic tooth. The results of the operation in his own case had been good except for occasional attacks of heart-burn after taking tea or beef. He attributed this to the fact that in those days the stoma was not made as large as it is now. He referred also to the X-ray diagnosis, which in doubtful cases was of the utmost

value. Other points raised were the best position for the patient after operation, the necessity for enfolding the ulcer, the formation of adhesions, unpleasant after-symptoms, etc.

Mr. Lowe, in replying on the discussion, referred to most of the above points. As regards after-symptoms, the chief one immediately was the intense pain felt during the first week or two, whenever any tension was put upon the rectus muscle in the process of nursing. This could be obviated if the operation could be performed without splitting the rectus. Two other after-effects were (1) considerable difficulty in regulating the bowels, and (2) occasional dragging pains in the epigastrium. He attributed the first to the fact that he duodenum and a certain portion of the jejunum, the most useful portions of the small intestine from the point of view of digestion, had ceased to function, and there must naturally be some disturbance for a time at any rate with the natural process of assimilation. The second symptom he attributed to the fact that the stomach now was being pulled upon by a moveable portion of the intestine being attached to its lower border (which itself was liable to be pulled upon) as well as a more or less fixed structure, the duodenum. He had no fear of adhesions, which were well guarded against at the time of operation. As regards the post-operative position, he had found the sitting-up position quite comfortable except in very hot weather.

P.G.C.'S FOR G.P.'S.

THE recent helpful criticism of the Post-Graduate Classes raises once more what should be a hardy annual in the JOURNAL, under the Dog-day title, "Can Post-Graduate Classes be made valuable to the men for whom they are arranged?"

The beknighted teaching staff is yearning to shower blessings on the benighted provincials, only partly aware perhaps of the complicated culture (learned in historic schools, but quickly becoming prehistoric) which they adapt to the needs of the blacker heathen amongst whom they work.

As a vestigial coccygeal terminal, I venture to assert that the members practising in the provinces form the backbone of the profession.

What shall the skull teach to the backbone, the brain to the cord—wherein the vital centres lie?

Can any truth wreathe out of this bubbling cauldron of false similes and mixed metaphors? Surely the analogy of the upper neuron appears at once before our eyes—the Post-Graduate Course materialises.

The condition in need of treatment is the wasting of knowledge from disuse following loss of communication with the higher centres. Is it possible successfully to graft

in the upper neuron area, and re-vitalise limbs grown rigid, or enlarge pupils inelastic through senility?

Those seeking knowledge are many—too many, but presumably classifiable.

Here are a few types.

The man appointed to the staff of a cottage hospital, with its vast responsibility, needs to review the possibilities of surgery, and to be inoculated (confound these buzzing metaphors!) with the confidence which is needful for efficiency.

The trend of national treatment is driving some men into specialities; they need a concentrated course of suitable animal extract—eye of newt or tongue of dog, nose of Turk or Tartar's lip, or liver of blaspheming Jew, or any other anatomical detail for which they intend to cultivate—or assume—expert enthusiasm.

Then there is the man of some leisure and sufficient means who can afford to spend a fortnight renewing old friendships, and taking mental delight in the fluctuations of thought amongst the leaders of medicine.

Occasionally practitioners are found who realise that they are out of date; others keep too much up to date, and their minds are lit chiefly by the flashlights of infallible cures set ablaze by commercial enthusiasm or by unjustified scientific optimism. Their dilemma is at least three-horned and monstrous: wholesale scepticism, which is improper; wholesale acceptance, which is impossible; or practice without belief, which is immoral. They need guidance to find the alternative, composed of knowledge and prophesy, caution and daring—of each equal parts.

Others are troubled with the eternally bicornual problem, recalled by the words mind and matter, hyperæsthesia and pain, inability and disability. Mental conditions have been grouped for generations under inaccurate and misleading terms—the shackles of progressive thought—neuritis, rheumatism and neurasthenia, and so forth.

Shall all be treated in our ignorance by suggestion, quackery, hypnotism, semi-demi-science, dream-dissection, etc., or shall the old soothing and easy alternative be continued, that of licking our readily adhesive labels, or shall someone discover, and then boldly teach us how to estimate the mental factor in real disease, in functional counterfeits, and in the common conglomerates?

Practitioners as a whole, I believe, do not care a pre-war tuppence how vaccines are made. They want to see cases cured, and to be enabled to go and do likewise. They have no desire to make pretty sparks in an X-ray room, but they want actually to see such a number of X-ray pictures as will convince them of the far-reaching accomplishments and possibilities of the sixth sense. They do not hanker to agitate peaceful streptococcal colonies with platinum needles, but want to know when to call in the aid of sera, and of surgery.

American *confrères*, and others from Europe, seek a com-

prehensive display which shall reveal the apparent progress of theory and the apparent progress of practice in this comparatively speaking sober old country.

All men in the practice of medicine need recurrent visits to that invaluable adjunct of the teaching hospital—the school of humility, which we used to dub the P.M. room. There death-certificates are treated as scraps of paper, confidence is judiciously shaken, and physician, surgeon and pathologist meet as allies in the face of overwhelming and victorious death, still wielding world-dominion.

The sight of a series of autopsies restores the power of

surgeon before April 1st." "I am up for a special appointment in a provincial hospital in three weeks—prepare me." "I wish to become acquainted with all the latest in bacteriology, or radiography, or cardiography during my ten days' holiday." In twenty minutes a scheme has been planned out for each, embracing visits to half the hospitals in the metropolis, special evening grinds by enthusiasts, a course of reading, and a learned guardian angel, warranted angelic for the full fortnight. A cheque then passes, and when it is honoured the course begins, and the victim soon returns to practice satisfied and sated but not fed up. I



THE BEGINNING OF THE END. CHIMNEY PRECIPITATED BY THE LADY MAYORESS ON APRIL 25TH.

By courtesy of the Tropical Press Agency and the 'Daily Sketch.'

penetrative diagnosis and reiterates the enlightening suspicion that "W. I." is not yet the hall-mark of infallibility.

The budding surgeon needs his course, the isolated specialist must have his personally conducted tour, the foreign visitors would welcome a third variety, the general practitioners a very elastic fourth.

I doubt if any one hospital can run successfully a series of courses. The plan of a post-graduate hospital of the American type is hampered by difficulties amongst our jealous schools of teaching and of practice.

In one's dreams there is a central bureau furnished with a heavy pile carpet, a counter, a telephone, a pile of reference books, and three benevolent Fellows—an F.R.C.P., an F.R.C.S., and a Pathological Fellow. They receive politely strange requests: "Make me an efficient general

psycho-analyst would interpret this dream another fashionable cure of a common complaint might come to pass. The Editor will doubtless assure such interpreter that he will not be thrust into a pit or sold to Ishmaelites as was the pioneer dream analyst.

The coccyx has again shown itself to be of little practical use, and will doubtless fail to wag the dog since it must describe and subscribe itself. VESTIGIAL.

TERPSICHORANIA.

[Synonyms: CEREBROCRURALEXAGGEREXIA: DANCING-MADNESS.]

Definition.—A nervous disorder of unknown origin which attacks both sexes equally and simultaneously, and is characterised by rhythmical spasto-ataxic movements of the legs. It is thought to have no connection with chorea.

History.—The disease was well known to the ancients, in whom it was frequently associated with excessive alcoholism. The best English account is that given by Addison in 1744. (See the *Spectator*, vol. i.)

Etiology.—It is a disease of comparatively early life. The commonest age is from 6 to 90. It is highly contagious, and occurs in pandemic form, especially during the winter months. The medical profession is particularly susceptible. Even hospital nurses are—rarely—infected. The church is said, by some authorities, to enjoy a certain degree of immunity. But Woffler claims to have produced dansiform movements by injecting 10 c.c. of strong sulphuric acid into the sole of a bishop.

Pathology.—The disease is obviously an infection, but up to the present the causative organism has not been isolated. It is therefore regarded as a "filter-passer."

There are no characteristic morbid changes, but in cases of extreme chronicity Shoeliss has noted ulceration of the feet.

Symptoms.—The attacks usually come on suddenly, but their onset may be insidious. They may be preceded by twitchings of the toes. An important point is their relationship to music. Many patients in whom the disease runs a chronic course will develop severe exacerbations on listening to a jazzical band or gramophone. Some persons are only attacked when under the influence of music, and in many cases the primary infection is directly attributable to the lowering of resistance produced by listening to a barrel-organ or concertina.

A typical attack occurs as follows:

The patient, if he be a man, approaches a woman similarly affected, and speaks a few quiet words to her. Usually they have, previously, been introduced, but (in certain circles) this is not invariable. He gently places his right hand upon her back and his left upon her right hand or wrist, "as though palpating for vocal fremitus and feeling her pulse simultaneously" (Krazi).

They then stroll off together, their movements exhibiting the characteristic gait—sometimes sliding, sometimes tripping, sometimes whirling in a wheeliform manner. After about ten minutes (at a point usually coinciding with the cessation of a particular piece of music) the attack subsides, and both parties retire to seek rest and refreshment. This apparent recovery is, unfortunately, but temporary.

In a surprisingly short space of time each patient is liable to suffer a severe relapse in which the whole painful process is repeated. Pyrexia is noted, as a rule, at the conclusion of about eight or ten relapses.

Diagnosis.—In advanced cases this presents no difficulty. In the early stages it is not so easy. The suspicion of the medical man should be aroused by any tendency to "beat time with the feet" when listening to music, or any marked propensity for "late nights" exhibited by his patients.

Prognosis.—On the whole this is very unsatisfactory. Some cases make a good recovery under proper treatment, but a vast majority remain hopelessly incurable, and dance themselves into matrimony or the grave.

Treatment.—(1) *Surgical:* Amputation of both legs is said, in a few instances, to have proved beneficial.

(2) *Medical:* Since music has been shown to have so definite a bearing on the onset of the disease, it is obviously necessary that patients should be segregated together in strict silence. They should be housed in special wards (male and female respectively), of which the floors are covered with sandpaper or a thin layer of glue. Any polished ground-surface is exceedingly likely to give rise to symptoms in susceptible persons.

The diet should be plain and wholesome. Alcohol and vice should be strictly forbidden.


No drugs are of any real value. Even salicylates are apparently useless. Large doses of ol. ric. are said to have produced a temporary inability to enjoy an attack.

Above all things, the doctor must remember that terpsichorania is a contagious disease.

It is only by rigid isolation of suspected persons and exhaustive bacteriological research (in his leisure hours) in the near future that he can hope to combat successfully what has been rightly called "the bane of puritanical society."

F. GREEN.

OUR PRIZE COMPETITION: RESULT.

E have learnt a lot. We have been overwhelmed with entries for our competition. We little knew how badly most of our readers needed a shilling; nor how many of them were potential Poet Laureates; nor how many sufferers from syringomyelia were called Amelia or Ophelia or Celia or lived in Roumelia. The incidence of pneumonia on young ladies named Sonia is also very high. It cuts us to the heart not to give the shilling to dozens of competitors (but we won't).

The Prize—the Magnificent Prize of One Shilling—has been won by a doctor from the North of England, who has sent two excellent efforts, but who wishes to conceal his identity under the initials "W.W." (No, suspicious

reader, we haven't kept the shilling ourselves. There really is such a person.)

His first poem is truly educational:

"A lady whose name was Ophelia
Had the signs of syringomyelia.
So they tested her skin
To heat, cold, and a pin,
But each time she declared, 'I don't feel yer!'"

And what can beat this for dramatic effect?

"A professor whose playful delight is
To tap every case of ascites,
Had a horrible qualm
When he heard with alarm
A pop—it was just tympanites."

So we have sent W.W. a postal order.

We end by congratulating ourselves that such easy words were set. Three was the minimum number of entries for any word. And we congratulate the two enterprising people (one was a nurse) who submitted limericks for every word.

DISRESPECTFUL DITTIES.

I. THE FACIES HIPPOCRATICA.

Hippocrates, the Grecian sage,
Adored the verdant young greengage.
Alas, one day our sage was seen
To eat no less than seventeen.
Appalling must his pains have been;
His face no longer calm, serene,
Assumed a simply ghastly green;
And his expression symptomatic,
Has since been known as Hippocratic.

II. SYDENHAM'S CHOREA.

Sydenham felt so spry and hearty;
Sydenham held a children's party;
Gave them cakes and crackers, and
Let them dance to his nice jazz band.
The tunes are gay; the tunes are bright;
Sydenham's children dance all night,
Make queer faces as round they go,
Wiggle a finger and waggle a toe.
Wild was the dance: as there had to be a
Technical term, it was called "Chorca,"
And soon he wished that he never had bidden 'em;
Far less spry felt poor old Sydenham.

GEMINI.

SAMPLES.

(Taken from letters of sailors' and soldiers' wives written to the authorities concerned with the payment of separation allowances.)

Supplied by CECIL TERRY, M.A., M.B., B.Ch.(Oxon.), M.R.C.S.

(1) "My Bill has been put in charge of a spittoon, shall I get any more pay?"

(2) "We have received your letter. I am the grandfather and grandmother. He was born and brought up in this house in answer to your letter."

(3) "My husband has been away Crystal Palace and got four days' furlong and has gone away to the mind sweepers."

(4) "I write these few lines for Mrs. Morgan who can't write herself, she is expecting to be confined and can do with it."

(5) "In accordance with instructions ring paper I have given birth to a daughter 1st of April."

(6) "You have changed my little boy into a little girl, will it make any difference?"

(7) "I am expecting to be confined next month will you please let me know what I am to do about it?"

(8) "Unless I receive my husband's pay at once I shall be compelled to lead an immortal life."

(9) "In answer to your letter I was ill in bed with Happendesittis it will be useful now."

(10) "I have not received no pay since my husband has gone from nowhere."

(11) "Mrs. Haynes has been put to bed with a little lad, wife of Peter Haynes."

(12) "Will you please send my money as soon as possible as I am walking about Boston like a pauper, and oblige?"

ORAL SEPSIS AMONG THE ROMANS.

(*Martial:* Epigrams V, 43.)

Læcania's teeth are snowy, Thais' brown:
—Læcania bought hers, Thais has her own!

ALEX. E. ROCHE.

STUDENTS' UNION.

ASSOCIATION FOOTBALL.

SENIOR INTER-HOSPITAL CUP. FINAL TIE.

ST. BARTHOLOMEW'S HOSPITAL v. GUY'S—1ST REPLAY.

Through the kindness of the Dulwich Hamlet F.C. this match was played on the ground of that Club at Clampton Hill on March 14th, and in spite of the fact that two periods of extra time were played it had again to be left drawn with two goals apiece.

Excellent conditions prevailed, and a thoroughly interesting game resulted. Bart's were represented by the same team which drew the previous week, except that Morton replaced the injured Coldrey at back.

The opening exchanges were all in favour of Guy's, who played like a winning side. Our men, on the other hand, indulged in far too much wild kicking and could not seem to settle down.

This depressing period passed, fortunately, after Lloyd scored one of his typical goals—a good first time long shot which had the Guy's custodian beaten all the way. From this point until half-time we quite held our own.

It was immediately following the breather that we had our worst shock. Guy's attacked strongly and quickly scored a goal to equalise, following it immediately with another while our men were suffering from the discomfort of the first. This second goal was due to a misunderstanding between Ward and Lorenzen, the latter player going for the man instead of the ball, and so allowing another Guy's forward to slip through and score easily. These two reverses temporarily threw our side out of gear, but they quickly pulled themselves together under the stimulus of wild entreaties from their followers (ably led by Bill Last), and were rewarded for their great efforts with a goal scored just on time by Ross from a splendid centre by Parrish. Full time arrived with two goals each.

During the extra time, fifteen minutes each way, Bart's were by far the better side, yet Guy's missed one chance of scoring, the best they had had during the whole match. In spite of our superiority we were unable to get the vital goal, and extra time ended with the score unaltered. Ten minutes extra each way was decided upon, and the game continued all in favour of Bart's. One great individual burst by Lloyd nearly brought the winning goal, but he had no luck with his shot. Lorenzen, Dick and Oldershaw had by this time completely mastered the opposing forwards, and the end came just in time to save Guy's from almost certain defeat.

Ward was good in goal. Caiger and Morton at back were sterling defenders; the latter must be congratulated upon making such an excellent show in an unusual position, and proved worthy of the honour of deputising for Coldrey. Dick was the best man on the field, while Lorenzen and Oldershaw were great in defence. All the half-backs, in the early stages of the game, failed to give the forwards the passes they needed. On the whole the defence was very sound.

The forwards were not so impressive. As a line they lacked cohesion, and we looked in vain for anything like combination; this may have been due partly perhaps to the above-mentioned fault of the half-back. Lloyd and Parrish did most of the good things, though all must be praised for their strenuous work. It speaks well for the fitness and training of each one that they held and subsequently subdued such a good side as we know Guy's to be.

Bart's: L. B. Ward, *goal*; J. A. Morton, G. H. Caiger, *backs*; H. L. Oldershaw, A. C. Dick, A. E. Lorenzen, *half-backs*; G. K. Nicholls, A. Ross, E. I. Lloyd, R. W. Savage, J. Parrish, *forwards*.

SENIOR INTER-HOSPITAL CUP. FINAL TIE.

ST. BARTHOLOMEW'S HOSPITAL v. GUY'S—2ND REPLAY.

The third and last meeting of these two teams in this year's contest took place on March 21st at New Beckenham on the Lloyd's Bank Athletic Ground, when Bart's proved victorious by two goals to one. The same team turned out as in the last replay.

A strong wind, a light ball and a bumpy ground combined to defeat both sides in their endeavour to play football, yet we won because we had three men who could use other parts of their anatomy

to very good purpose. These were Lloyd (inside of head), Morton (outside of head), and Ward (both fists). It was brainy work on Lloyd's part almost to sit on the Guy's goalkeeper during the first half when we had the wind in our favour, for he was then able to get back a short pass for Ross to score the first goal, and was later in a position to take the ball from the custodian's hands and score the second one himself. Morton's headwork (usual football kind) was the sensation of the match, and because of it, together with some splendid tackling in the second half, he must be given place of honour as best man on our side. Ward runs him pretty close, for he gave a first-class exhibition of big punching under most difficult conditions.

Of the rest of the side all did well. The defence, as usual, showed to much greater advantage, our half-backs, in my humble opinion, being good enough to hold most amateur forward lines, and they have been throughout the competition the great strength of our side.

A good following of supporters cheered the victory of Bart's, among whom we were glad to see Sir Charles and Lady Gordon-Watson, Dr. Drysdale, Mr. Foster Moore, Dr. Gow, and two distinguished members of the Nursing Staff.

Lorenzen received the cup at the conclusion of the game, and it has been rumoured that this highly-prized bauble (not Lorenzen, of course) had something of an adventurous career during the subsequent few hours of its existence. However, it eventually came to rest on the Library table, where it should stay for many seasons if we can retain the services of this year's gallant cup team.

JUNIOR INTER-HOSPITAL CUP. SEMI-FINAL.

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

Played on Tuesday, March 14th, at Winchmore Hill. During the first half the Hospital second string, aided by a strong wind and three capable halves, penned in their opponents. The forward line was very weak and lacked cohesion, and except for an occasional shot by Clark never looked really dangerous. In the second half matters were more even, and after Morton had scored there was a distinct improvement in the play. Thomas's soon equalised, however, but later a well-directed shot by Anderson put Bart's ahead again, and just before the finish Morton sent us further ahead. E.W.C. Thomas at centre half was the pick of the defence, and in the second half Morton did excellently at forward. Result: St. Bart's II, 3; St. Thomas's II, 1.

Bart's: R. W. H. Tincker, *goal*; J. S. H. Wilson, D. Diamond, *backs*; E. S. Evans, E. W. C. Thomas, J. G. McMenamin (Capt.), *half-backs*; B. L. Jeaffreson, J. A. Morton, A. Clark, R. S. Anderson, F. Asker, *forwards*.

JUNIOR INTER-HOSPITAL CUP. FINAL.

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

Played on Saturday, March 25th, at Winchmore Hill. Early efforts by Guy's were successfully checked by the home backs. Play was then transferred to the other end, where neat work on the right wing ended in Maingot almost bundling the ball through. Just before half-time, Guy's, taking advantage of a miskick, opened the scoring. Soon after the restart an admirably placed pass by Maingot enabled Clark to chase through and equalise. A little later, following an excellent centre from Asker, McMenamin found himself with an open goal, and, making no mistake, placed Bart's ahead. Guy's were not to be denied, however, and had soon levelled matters once again. A quarter of an hour from the finish an individual effort by Clark resulted in a third goal to Bart's. No further scoring took place, but the Guy's left wing caused much trouble and showed excellent understanding. Tincker, in goal, played brilliantly, running out with great effect. Clark was on top form, and his two goals came as a fitting reward. Result: St. Bart's II, 3; Guy's II, 2. Bart's: R. W. H. Tincker, *goal*; J. S. H. Wilson, D. R. Diamond, *backs*; E. S. Evans, E. W. C. Thomas, R. S. Anderson, *half-backs*; B. L. Jeaffreson, J. G. McMenamin (Capt.), A. Clark, R. H. Maingot, F. Asker, *forwards*.

The following gentlemen have been awarded honours for the past season, 1921-2: A. E. Lorenzen (Capt.), G. R. Nicholls (Vice-Capt.), E. A. Coldrey, E. I. Lloyd, H. L. Oldershaw, G. H. Caiger, A. C. Dick, J. A. Morton, A. E. Ross, R. W. Savage, L. B. Ward.

THE ASSOCIATION FOOTBALL CLUB DINNER.

The Dinner of the Association Football Club was held at Oddeno's Imperial Restaurant on April 7th. Sir Charles Gordon-Watson, President of the Club, was in the Chair, and the company included Mr. Foster Moore, Vice-President, Sir Thomas Horder, Dr. A. E. Gow, and the Rev. R. J. Craggs.

After the loyal toasts has been honoured Sir Charles submitted the toast of "The Soccer teams." He said that this year two records had been set up, for never before had Bart's held both Senior and Junior Inter-Hospital Cups at the same time; also he believed that the three meetings which were necessary to decide the Final made another record.

Mr. A. E. Lorenzen (Capt.) responded to the toast with his characteristic modesty.

Both Mr. Foster Moore and Dr. A. E. Gow, speaking in humorous vein, created some considerable amusement, while later in the evening Mr. S. Jenkinson proved himself an after-dinner speaker of the first water.

Throughout the evening Dr. Stanley White and the Bart's Jazz Band provided musical interludes, which were exceedingly well received and greatly appreciated.

At the Annual General Meeting of the Association Football Club the following gentlemen were elected officers of the Club for the forthcoming season, 1922-3:

President.—Sir C. Gordon-Watson, K.C.B., C.M.G., F.R.C.S.
Vice-Presidents.—Mr. Holmes Spicer, F.R.C.S., Mr. Foster Moore, F.R.C.S., Dr. A. E. Gow.

Capt., 1st XI.—A. E. Lorenzen.
Vice-Capt., 1st XI.—H. L. Oldershaw.
Hon. Sec., 1st XI.—A. C. Dick.
Capt., 2nd XI.—J. A. Morton.
Hon. Sec., 2nd XI.—R. W. H. Tincker.
Capt., 3rd XI.—S. Jenkinson.
Hon. Sec., 3rd XI.—C. M. Jennings.
Three extra Committee men.—E. Coldrey, G. R. Nicholls, G. H. Caiger.

CRICKET CLUB.

Cricket, although played in a casual manner on the sea shore, is a game which above all others demands serious and constant practice, especially if the players are to attain that great skill which is desirable in a team representing this ancient institution.

Since this is so the Committee would like to impress upon all old supporters of the Club and others desirous of taking part in the fielding practice afforded by our opponents, that the nets are now available for use.

The first match will be played on May 6th at Winchmore Hill. For other fixtures see Calendar.

J. PARKINSH,
Hon. Sec., C.C.

REVIEWS.

THE PRACTITIONER'S MANUAL OF GYNÆCOLOGY. By A. C. MAGIAN, M.D. (London: Wm. Heinemann [Medical Books], Ltd.) Pp. 436. Price 21s. net.

THE TREATMENT OF COMMON FEMALE AILMENTS. By FREDERICK JOHN MCCANN, M.D. (Edin.), M.R.C.P. (Lond.), F.R.C.S. (Eng.). (London: Edward Arnold & Co.) Pp. 152. Price 8s. 6d. net.

We group these two works together because they are both addressed to the general practitioner, and both deal with the same subject, though Dr. Magian's work is materially fuller and is illustrated. There are few cases more troublesome to the general practitioner than some of the patients suffering from the disorders of women.

So much of this work is empirical, and will be ill the correlation of the endocrine glands is more fully known.

Dr. Magian's book is well produced. It contains little, if any, new

knowledge, but will serve as a compendium of facts on this subject. We feel that he is over-estimating the amount of operative technique that the practitioner will need to know, and recommend him to use his scissors towards the end of the work in the next edition. The chapter on diagnosis is especially good.

Dr. McCann's shorter book is, we think, more suitable for the intended purpose. We like his style. It is unpretentious and yet contains the facts, and it is quite delightfully and unashamedly intimate. "Now, with regard to inevitable abortions. What is to be done for them? Supposing you are called to a case where an abortion is inevitable, where there has been free hemorrhage and the cervix is protruding, what is to be done? You, of course, cannot wait there all night, and you must do something. The best treatment is . . . and so on. Dr. McCann tells you what to do. We thank him for an excellent and helpful little book.

BLOOD TRANSFUSION. By GREGORY KEVNES, M.D., F.R.C.S. (London: Henry Frowde & Hodder & Stoughton.) Pp. 166. Price 8s. 6d. net.

It is a pleasure to be able to review a book by yet another member of the Editorial Staff of the JOURNAL. (So many editors of this JOURNAL take to writing books in after-life that we are beginning to be afraid for ourselves.) This book, which is in the well-known binding of the Oxford Medical Publications, not only describes clearly the indications for and technique of blood transfusion, but discusses at some length the history of the subject and the physiology and pathology of shock and of blood-groups. The author describes in most detail the technique he is accustomed to use himself; he does not mention one of its main disadvantages—the necessity for starting with a given calculated amount of sodium citrate, when unforeseen circumstances may cause less than the corresponding quantity of blood to be withdrawn from the donor. The book is a notable achievement, and may be confidently recommended to those interested in the subject; the bibliography at the end is presumably the fullest in existence and contains over 300 references.

THE RELATIONS OF TUBERCULOSIS TO GENERAL BODILY CONDITIONS. By F. PARKES WEBER, M.A., M.D., F.R.C.P. (London: H. K. Lewis & Co.) Pp. 27. Demy 8vo. Price 2s. 6d. net. Paper covers.

This pamphlet contains the First Mitchell Lecture of the Royal College of Physicians. It deals with the portal of entry of tubercle into the body and with the effect on tuberculosis of diabetes, gout, heart-disease and various other ailments. An appendix gives the literature of "spontaneous idiopathic pneumothorax."

MEDICAL OPHTHALMOLOGY. By R. FOSTER MOORE, O.B.E., M.A., B.Ch., F.R.C.S. (London: J. & A. Churchill.) Pp. viii + 300. 80 illustrations. Price 15s. net.

This is a book, excellently got up, which contains all that the physician or student needs to know about ophthalmology in connection with general medical diseases; and, as our readers are aware, Mr. Foster Moore is an authority on this subject. The first chapter deals with certain general eye symptoms without special reference to any disease in particular. In later chapters medical diseases are roughly grouped and the ocular findings described. While most attention is given to ophthalmoscopic findings, the reader will find excellent accounts of other eye signs and symptoms, such as ocular palsies, nystagmus and the various signs in Graves's disease. There are full references and the figures are lucid, though there are no coloured plates. We hope that the book will blossom out into colours in the later editions which are sure to be called for presently.

INTERNAL SECRETION AND THE DUCTLESS GLANDS. By SWALE VINCENT, LL.D., D.Sc., M.D., etc. Second Edition. (London: Edward Arnold & Co.) Pp. 442. Price 25s. net.

It is ten years since Dr. Swale Vincent's work on the ductless glands was published. At that time endocrinology was not as popular as it is now, when every practitioner is conversant with some of the main developments in this department of medicine. The present edition contains much new matter, but the book is not enlarged. Each of the glands is discussed in great detail, and at the

conclusion of the book there is a chapter on the inter-relationship of the organs of internal secretion. We could wish that this had been longer, for in our opinion the glands can only be adequately studied as they are related to one another.

The book is well illustrated, and the format is good. It should be read by students after they have passed their first professional examination and after they have graduated. We expect that in future editions the author will be compelled to leave out some of the comparative anatomy in which he evidently delights.

INTRINSIC CANCER OF THE LARYNX AND THE OPERATION OF LARYNGO-FISSURE. By IRWIN MOORE, M.B., C.M. (Edin.). (London: University of London Press.) 46 Illustrations. Pp. 147. Price £1 net.

A monograph dealing with one operation necessarily appeals to a limited number of surgeons. In this case the appeal is to laryngologists particularly; and the author has dealt so carefully and minutely with the details of an elaborate operation that all beginning to specialise in this branch must needs now read his book before attempting it.

It is not likely that the monograph will fall into the hands of many general practitioners. This is a pity, for the author quotes a leading authority who, referring to twenty-three cases of cancer of the larynx which he had seen, states that only one was in its early stage; and his advice is that "anyone of cancer age complaining of hoarseness, which lasts for more than six weeks, should be kept under careful observation."

CORRESPONDENCE.

GROUP CLINICS.

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

SIR,—Through the courtesy of a friend my attention has to-day been directed to the March issue of your JOURNAL, and to Sir Thomas Horder's suggestion—included in his address to the Abernethian Society—that, as a generous concession, I may perhaps be allowed "decently to bury" some words I am reported to have spoken at the discussion on "Group Clinics" at the Royal Society of Medicine in June, 1921. Now had such a course of conduct been necessary for me, or even advisable, I should be far from reluctant to be beholden to Sir Thos. Horder's generosity. On the present occasion, however, I do not feel the need of this gracious shelter; nor do I propose to seek it. The material facts are very simple. It appears that my remarks, made at the discussion in question, were reported in the *Lancet*, and that the reporter there records under my name the sentence, "The aim of scientific research is the discovery of truth; the aim of medical practice is to cure the patient." I do not for one moment question the accuracy of the report, though at this distance of time I cannot pretend to remember the exact words employed. Some days after the discussion I wrote out my speech from memory (aided by some rough notes), and this writing was published in the *Medical Press and Circular*. In these circumstances it is hardly surprising that the two records do not agree in detail, and I gather from Sir Thos. Horder's address that the latter record does not contain the above-quoted phrase, and that, in its place as it were, I write, "The aim and spirit of scientific research are not identical with the aim and spirit of medical practice."

Upon this difference, such as it is, Sir Thos. Horder advances the innuendo that I am anxious "to bury" my spoken proposition, or to withdraw it from observation under a cloud of words of other and different meaning; and he proposes that by a stretch of generosity I may perhaps be graciously allowed so to do. Will you permit me, Sir, to assure him that, so far as I am concerned, his capacity for generous consideration may remain unstrained? The incriminated sentences, at least as I read them, contain no conflict in the same thing, and though the words differ there is no conflict in the sense. Indeed, on re-reading them, I am inclined to express a paternal preference for the more epigrammatic phrasing, and to regret that this form of words did not revive in my memory when I was writing my

personal contribution for the press. So far, therefore, from soliciting from Sir Thos. Horder a charitable funeral for my spoken phrase, I am obliged to him for conferring upon it a vitality and distinction which, but for his intervention, it could never have hoped to enjoy. My one regret is that he should have been so ready to translate a difference—surely hardly more than verbal—between two accounts of one and the same speech into a suggestion either that I have not sufficient courage to defend my spoken word, or, alternatively, that I have failed in the grace of open confession of error.

On the merits of the doctrine which the phrases affirm—whether the one or the other—I remain quite impotent. What is generally, though perhaps somewhat loosely, called pure science or scientific research, pursues truth by methods which know no limitation other than those prescribed by municipal or moral law; the fate of the individual test-tube or of the individual guinea-pig is not even dust in the balance, and utilitarian values are largely or entirely out of the reckoning. But medical practice is first and foremost, and all the time, the care of living men and women, and while fulness and accuracy of knowledge are doubtless highly to be desired, they are to be pursued here only in so far as they conduce to the patient's personal welfare. In the one case the aim is truth at all hazards; in the other truth in so far as it is compatible with the interests of the patient—with the interests, that is, of the individual unit who is the central point of the inquiry.

Sir Thos. Horder writes, "I regard every obscure case of illness as a problem for scientific research," and provided he will omit the word "obscure" (I suggest no funeral) and will translate "scientific research" as the orderly and accurate collection of facts, and the study of these with a view to the patient's welfare, I am in entire agreement with him, as are doubtless all other practitioners of the medical art. If in addition to this main aim, and in harmony with it, the practitioner can add to the body of pathological or therapeutic truth, so much the better. But this latter enterprise, at least as I read the rules, must stand in a secondary, subordinate and postponed position; and it is, I submit, on such an understanding that the patient commits himself to the care of the physician, and the physician in turn accepts responsibility and takes his fee. If Sir Thos. Horder cares to apply to these well-established and generally-adopted medical methods the term "scientific research," the effect as sound may be impressive, but substantially nothing is changed. In the examination of a patient's excretions, etc., in a laboratory there is no more "research," and no less, than there is in the classical methods of physical diagnosis, or in the use of various instrumental aids to exact clinical observation and record. All these modes of investigation are universally acknowledged, and the application of them to individual sick men and women is medical practice. On the other hand, "scientific research," at least as I understand the term, is directed, not to the detection or verification of a fact or a series of facts in an individual or personal problem, but rather to an ordered attempt by observations, by experiments and by allied methods, to establish some new fact or doctrine, and I should be surprised to hear that practising physicians in any number would be willing to dub themselves research scholars or workers. In one sense, everyone engaged in an attempt to discover truth is engaged in research. But it is not in this loose and general meaning that the phrase "scientific research" is commonly employed, nor are endowments for such a purpose directed by so catholic an interpretation.

The phrase which Sir Thos. Horder, in the exercise of his good-will, imagines I am anxious "to bury," expresses in brief form the distinctions I have here endeavoured to emphasise, and while I am nothing loath to accept generosity when (as well may be the case) I need it, I am little inclined to welcome it when imposed on me in the form of a superfluous and unsolicited recommendation to mercy. I am, Sir,

Yours faithfully,
C. O. HAWTHORNE.
63, HARLEY STREET, W. 1.;
March 30th, 1922.

DRUGS AND THE CURE OF DISEASE.

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

DEAR SIR,—The progress of modern medicine has confronted the general practitioner with a situation which is almost tragical.

The general public used to believe, and a good many still believe, that the medical practitioner was able to cure diseases; indeed years ago the medical practitioner might have thought so himself. But since the discovery of germs as a causative agent in diseases it has become quite clear that medicines in the ordinary sense have no part in the cure of disease. The patient, in fact, gets well in spite of the medicine, and so the practitioner had to be recognised by the public, and so the patient would consider that he was not properly treated. It was even found that the taking of coloured water had a distinctly good effect on the patient, acting apparently by suggestion. Drugs which relieve pain of course are placed in a different category, and are most useful for that purpose.

The cure of a purely medical disease has, I believe, never been accomplished, unless pediculosis, scabies, and some of the grosser parasites, such as tapeworm or ringworm, can be counted as medical diseases.

The bacteriologists and pathologists supplied the medical practitioner with antitoxins and vaccines, but these were found to be almost useless in the cure of disease, though some were very powerful protective agents in such diseases as tetanus and enteric. The study of organo-therapy gave some help in a case like myxoedema, but it cannot be considered a cure, for the treatment has to be continued indefinitely.

The psycho-analysts have recently come forward to treat our neurotics—those patients whom we had almost considered hopeless. These new psychologists start by telling us that everyone is a little mad (I suppose they include themselves), and that neuroses are caused by "repressed complexes," and that if these are brought to light and the patient convinced that they have been the cause of his disease then he gets well at once. But in my experience, if you can convince a neurotic patient of anything relating to his health he may get rapidly well, unless, as sometimes happens, he gets much worse. When I found that it had taken three years to discover one patient's "repressed complexes" I had my doubts as to the success of the treatment in general practice.

A French gentleman has recently introduced a new method of treatment, or at least a modification of one of the oldest therapeutic agents, and that is the treatment by "prayer." But he informs us that for two thousand years we have been saying the wrong prayers, and saying them in the wrong way. The new prayer is, "Every day in every respect I get better and better," and not, "Lord have mercy upon me a sinner"; and this should be repeated, not thoughtfully and fervently, but thoughtlessly and listlessly. I wonder which of these methods will survive?

We have, of course, learnt much as to the nursing and feeding of patients in disease, but the chief use of the medical practitioner seems to be making the diagnosis and giving the prognosis.

The relief to the patient and his friends when the medical practitioner can give a favourable prognosis is the one thing where his skill can be demonstrated and proved.

In 999 cases out of 1000 he is right, but these cases which should redound to his credit are not counted to him for righteousness, and the one case in which he may have been wrong is remembered to his discredit. This is one of the trials he has to bear with patience, and it is perhaps to some extent discounted by the undisguised belief of the public that he is responsible for the cure of the disease.

The prospect of "curing a disease" seems to be as far off as ever. Yours truly,

49, ALMA ROAD, WINDSOR; W. F. LLOYD.
March 30th, 1922.

FRESH-AIR TREATMENT AMONG THE ROMANS.

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

DEAR SIR,—It is commonly believed that there is nothing new under the sun, and evidently not in medicine. I have lately had my attention drawn to a passage from the Letters of the Younger Pliny, which shows that the Romans knew about as much about the treatment of pulmonary tuberculosis as we do. Perhaps you could find space for the passage, as it may be unfamiliar to some of your readers.

"Some years ago he (i.e. my freedman Zosimus) strained himself so much by too strong exertion of his voice that he spit blood, upon which account I sent him into Egypt, from whence, after a long

absence, he lately returned with great benefit to his health. But having again exerted himself for several days together, he was reminded of his former malady by a slight return of his cough, and a spitting of blood. For this reason I intend to send him to your farm at Forum Julii, having frequently heard you mention it as a healthy air, and recommend the milk of that place as very salutary in disorders of this nature."

I am yours faithfully,
ST. BARTHOLOMEW'S HOSPITAL;
April 20th, 1922. CONSTANT READER.

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- "Spleno-megaly with Progressive Ascites and Loud Venous Hum: Spontaneous Cure of Ascites by Leakage through Abdominal Wall." *British Medical Journal*, April 15th, 1922.
- HARDWICK SMITH, H. M.B., F.R.C.S. "Peritonitis." *New Zealand Medical Journal*, February, 1922.
- HAYWARD, JOHN A., M.D., F.R.C.S. (and MCCARTHY, T., M.R.C.S., L.R.C.P.). "Haemorrhagic Colitis." *British Medical Journal*, April 8th, 1922.
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- "A Femoral Hernia of Unusual Size." *Lancet*, March 4th, 1922.
- MCDONAGH, J. E. R., F.R.C.S. "Venereal Diseases as we see them To-day." *Practitioner*, March, 1922.
- MYERS, BERNARD, C.M.G., M.D., M.R.C.P. "Some Points on Certain Gastro-intestinal Affections in Infants." *Clinical Journal*, February 1st and 8th, 1922.
- OKELL, C. C., M.R.C.P. (R. A. O'BRIEN, M.D., A. J. BAGLETON, M.D., M.R.C.P., C.C.P., A. T. GLENNY, B.Sc., and E. M. BAXTER, M.Sc.). "Further Experiments with the Schick's Test." *Lancet*, April 15th, 1922.
- PAVEY SMITH, A. B., M.C., M.B., F.R.C.S. "Some Remote Effects of Tonsillitis." *Practitioner*, April, 1922.
- PERVIS, FREDERICK E., M.S., F.R.C.S. "Some Cysts of Childhood." *Clinical Journal*, February, 1922.
- "Some Tumours of Childhood." *Ibid.*, March 1st and 8th, 1922.
- "Some Surgical Aspects of Congenital Syphilis." *Ibid.*, April 5th, 1922.

- ROPER, ARTHUR C., F.R.C.S. "Two Series of Cases of Cataract." *Lancet*, April 1st, 1922.
- SHAW, ERNEST H., M.R.C.P. (E. BELLINGHAM SMITH, M.D., B.S., M.R.C.P. and E. H. S.). "Two Cases of Malformation of the Kidney in Infancy." *Ibid.*, April 15th, 1922.
- SPECKER, W. G., M.S. "Some Local Results of Dental Infection." *British Dental Journal*, March 1st, 1922.
- WALKER, KENNETH M., M.B., B.Ch., F.R.C.S. "Ascending Infections of the Kidney." *Lancet*, April 8th, 1922.
- "Historical Lecture on the Nature and Cause of Old age Enlargement of the Prostate." *British Medical Journal*, February 25th, 1922.
- "Diathermy in Genito-Urinary Surgery." *Practitioner*, March, 1922.
- WHITE, CHARLES POWELL, M.D., F.R.C.S. "The Application of the Methods of Correlation to the Study of the Urine." *Lancet*, February 25th, 1922.

EXAMINATIONS, ETC.

UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:

M.Ch.—R. StL. Brockman.

M.B., B.Ch.—E. L. Dobson, E. I. Lloyd.

M.B.—A. J. Copeland.

B.Ch.—E. Donaldson.

UNIVERSITY OF LONDON.

Second Examination, March, 1922.

Part I.—H. S. Box, H. C. Boyde, M. Bryer, P. E. J. Cutting, D. A. Dewhurst, P. H. Flockton, A. E. Fraser-Smith, E. A. Freeman, W. L. Gillbard, F. G. Greenwood, E. Holmes, R. H. Knight, J. R. Macdonnell, W. Ogden, H. J. Seddon, L. G. Smith, R. K. Smith, E. A. White, F. E. C. Williams.

Part II.—H. G. Anderson, F. A. Bevan, R. Bolton, W. R. W. Bonner-Morgan, S. Brest, E. E. Claxton, F. R. Corfe, R. N. Currow, C. S. Drawmer, F. G. France, P. Garson, G. S. Hals, C. E. Harries, F. Heckford, D. V. Hubble, J. T. Hunter, R. S. Johnson, D. E. Lawrence, L. M. P. Maillard, D. G. Martin, B. A. J. Mayo, G. W. C. Parker, F. D. S. Poole, B. Press, D. C. Price, J. A. F. Storrs, A. F. Taylor, W. R. Thrower, H. Treisman, L. B. Ward, W. Wilkinson.

UNIVERSITY OF LIVERPOOL.

Diploma in Tropical Medicine.

A. R. Jennings, M.B., B.Ch.

CONJOINT EXAMINING BOARD.

First Examination, April, 1922.

Chemistry.—C. H. C. Carty-Salmon, W. W. Darley, B. H. Gibson, H. Hillaby, S. B. S. Smith, R. E. Waugh.

Physics.—W. W. Darley, J. L. T. Davies, B. H. Gibson, H. C. Hermon, H. Hillaby, E. F. D. Owen, S. B. S. Smith.

Biology.—J. D. B. Games, H. E. Houtton, C. P. Madden, W. T. Mills, W. V. Roache, S. Smith, J. E. Snow, W. A. Wood.

Second Examination.

Anatomy and Physiology.—G. H. Buncombe, S. M. Coleman, P. H. Diemer, H. B. Howell, A. H. Kynaston, J. B. Lloyd, J. G. McManamin, G. G. Stewart.

Physiology.—H. F. Chillingworth, J. E. C. Morton, K. C. L. Paddle, H. A. M. Widdly.

Pharmacology and Materia Medica.—W. F. D. Benton, J. H. H. Chataway, J. E. Elam, C. R. Steel, H. K. Tucker.

LONDON SCHOOL OF TROPICAL MEDICINE.

At an examination held recently the following candidates passed:

With Distinction.—D. G. F. Moore.

Pass.—E. F. Peck.

CHANGES OF ADDRESS.

BOKENHAM, T. B., Heathcote, 141, Otley Road, Headingley, Leeds.

DRAKE, E. C., 46, Devonshire Street, W. 1. (Tel. Langham 2415.)

MOORE, D. FITZGERALD, West African Medical Service, Nigeria.

POWELL, R. R., Earlsridge, Woodlands Road, Redhill.

SAUNDERS, W. E. R., Mountsorrel, near Loughborough.

VALERIE, Squad. Leader, J., R.A.F.M.S., Gothic House, Vine Road, E. Molesey.

WINTER, E. S., 9, Minster Yard, Lincoln.

WRIGHT, Lt.-Col. A., R.A.M.C., Gordon Road, Camberley, Surrey.

BIRTHS.

BOWES.—On March 29th, at 3, De Vaux Place, Salisbury, to Dorothea, the wife of G. K. Bowes, M.D., M.R.C.P.—a son.

CANE.—On March 25th, at Bungay, to Dr. and Mrs. Leonard B. Cane—a son.

FAIRLIE-CLARKE.—On March 27th, at 11, Waterloo Crescent, Dover, Gwendolen (*née* Balmer), wife of A. J. Fairlie-Clarke, F.R.C.S., of a daughter.

MARRIAGES.

GARROD—PIERCE.—On April 22nd, at the Old Jordans Meeting House, Lawrence P. Garrod, M.B., B.Ch., son of Mr. and Mrs. Cubitt Garrod, of Bournemouth, to Marjorie, daughter of Dr. and Mrs. Bedford Pierce, of Malton, formerly of York.

JUST—MAGTAGGART.—On April 10th, at St. Martin-in-the-Fields, by Rev. W. K. L. Sheppard, Theodore H. Just, only son of Sir H. W. Just, K.C.M.G., C.B., of Chesham, to Alice Marie, second daughter of the late H. B. Mactaggart, of Campbelltown, and Mrs. Mactaggart, of 95, Barkston Gardens.

WELLS—DUNLOP.—On February 23rd, at All Saints' Church, Compton, Winchester, by the Rev. J. C. Blackett, and assisted by the Rev. A. C. Lowth, Philip Hower Wells, M.R.C.P., M.C., son of Dr. and Mrs. Poulett Wells, of Hampstead, N.W., to Doris Joan, youngest daughter of Mr. and Mrs. J. M. Dunlop, "Fair oak," Hants.

DEATHS.

HOLLIS.—On March 26th, 1922, at Hove, William Ainslie Hollis, M.D., F.R.C.P., ex-President of the British Medical Association, aged 82.

MCLEAN.—On March 11th, 1922, at 12, Furzedown Road, Highfield, Southampton, W. W. L. McLean, M.R.C.S., L.R.C.P., D.P.H., Senior Medical Inspector, Board of Trade, aged 57.

MOORE.—On March 27th, 1922, at 3, Starkie Street, Preston, Lancs. (suddenly), W. F. Moore, M.R.C.S., L.R.C.P.

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 7s. 6d., 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.

Vol. XXIX.—No. 9.]

JUNE 1ST, 1922.

PRICE NINEPENCE.

CALENDAR.

- Fri., June 2.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Clinical Lecture (Medicine), Dr. Morley Fletcher.
Annual Hospital Sports at Winchmore Hill, 2 p.m.
- Sat., „ 3.—Cricket Match v. Hampstead (away).
Lawn Tennis Match v. Cumberland L.T.C. (home).
- Mon., „ 5.—**Whit Monday.**
Annual Cricket Week begins.
Cricket Match v. Croydon (home).
- Tues., „ 6.—Sir P. Horton-Smith Hartley and Mr. Rawling on duty.
Cricket Match v. Winchmore Hill (home).
- Wed., „ 7.—Clinical Lecture (Surgery), Mr. Rawling.
Cricket Match v. Uxbridge (home).
- Thurs., „ 8.—**Abenethian Society. Midsummer Address, 8.30 p.m. Mr. George Bernard Shaw on "The Advantages of being Unregistered."**
Cricket Match v. R.A.M.C. (Aldershot) (home).
- Fri., „ 9.—Sir Thomas Horder and Sir C. Gordon-Watson on duty.
Clinical Lecture (Medicine), Sir P. H.-S. Hartley.
Professorial Lecture, Dr. Morley Fletcher, "Cirrhosis of the Liver."
Cricket Match v. Mr. Rawling's XI (home).
- Sat., „ 10.—**Inter-Hospital Sports at Queen's Club, 2.30 p.m.**
Cricket Match v. Streatham (home).
- Mon., „ 12.—Clinical Lecture (Special Subject), Mr. Elmslie.
- Tues., „ 13.—Prof. Fraser and Prof. Gask on duty.
- Wed., „ 14.—Clinical Lecture (Surgery), Mr. Rawling.
Lawn Tennis Match v. Cumberland (away).
- Fri., „ 16.—Dr. Morley Fletcher and Mr. Waring on duty.
Clinical Lecture (Medicine), Sir Thomas Horder.
Professorial Lecture, Mr. Waring, "Cholelithiasis."
- Sat., „ 17.—Cricket Match v. Edgware (home).
- Mon., „ 19.—Clinical Lecture (Special Subject), Mr. Just.
- Tues., „ 20.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Last day for receiving matter for July issue of the JOURNAL.
- Wed., „ 21.—Clinical Lecture (Surgery), Sir C. Gordon-Watson.
Lawn Tennis Match. Past v. Present (home).
- Thurs., „ 22.—Annual Dinner of Eighth Decennial Club. Odd-evening's, 7.30 p.m.
- Fri., „ 23.—Sir P. Horton-Smith Hartley and Mr. Rawling on duty.
Clinical Lecture (Medicine), Sir P. H.-S. Hartley.
Professorial Lecture, Mr. Waring, "Cholelithiasis" (cont.).
- Sat., „ 24.—Cricket Match v. Mr. R. Maingot's XI (home).
Lawn Tennis Match v. Chiswick Park (away).
- Sun., „ 25.—Lawn Tennis Match v. Gallery L.T.C. (away).
- Mon., „ 26.—Clinical Lecture (Special Subject), Mr. Rose.
- Tues., „ 27.—Sir Thomas Horder and Sir C. Gordon-Watson on duty.
- Wed., „ 28.—Clinical Lecture (Surgery), Sir C. Gordon-Watson.
- Fri., „ 30.—Prof. Fraser and Prof. Gask on duty.

EDITORIAL.

ALL those of our readers who live in London will have seen the numerous placards and other evidences of the activity of the organisers of the combined appeal for London hospitals. By the time we go to press we—and we hope all other Londoners—will be a little lighter in pocket as a result of the flag day on May 24th in aid of the hospitals. Further details of this and other activities will be found elsewhere in this issue. There may be many amongst us who do not like flag days and similar schemes for raising money. But most of us have a wholesome prejudice in favour of the voluntary hospital system. Even those who have no longer any faith that the voluntary system can last for long will admit that it is worth making some effort to help carry our own and other hospitals over the difficult post-war period in hopes of a brighter future beyond.

* * *

View Day passed off on May 10th with its customary success, although the weather was not quite up to the traditional standard. Many of the wards were charmingly decorated, particularly —, but, no! our correspondence columns will be overflowing with protesting letters from infuriated Sisters if we attempt any unwise discrimination.

* * *

There has been some difficulty in filling the posts of resident anaesthetists for the ensuing six months. The authorities have now reverted to the old system of having one senior resident anaesthetist at a higher salary and two juniors, instead of three of equal standing. While it is obviously undesirable to change more often than is necessary, we cannot help thinking that more men would apply for these posts if they were for three months only. Relatively few men take up anaesthetics as a career, and the others may not feel disposed to spend six whole months in acquiring proficiency in what will occupy a comparatively small proportion of their time in the future.

It gives us great pleasure to congratulate the following Bart.'s men on their election as Fellows of the Royal College of Physicians: Dr. Geoffrey Evans, Assistant Director of the Medical Unit, Dr. H. H. Dale, and Major A. H. Hayes, R.A.M.C.

* * *

We are very glad to be able to welcome Prof. Harvey Cushing, who is arriving on June 4th to take over the directorship of the Surgical Unit for a period of ten days, at the special invitation of the Governors and Medical School. Prof. Harvey Cushing was educated at Yale University. He was for some time Surgeon at the Johns Hopkins Hospital under Prof. Halstead; here he became a great friend of the late Sir William Osler. Later he was made Professor of Surgery at Harvard with control of the Peter Brigham Bent Hospital at Boston. During the war he was attached for some time to the British Forces, and worked in close collaboration with them at casualty clearing stations on head injuries. He was made a C.B. and an honorary F.R.C.S.(Eng.). He is well known over here for his work on cerebral surgery and for his skill as a technician. His interests are wide—in education as well as in surgery. Mr. Gask was invited last year to act as temporary chief of the Peter Brigham Bent Hospital, and this is, as it were, a return visit. We are glad to welcome Prof. Cushing, not only because of the honour his visit does us, and because of what we hope to learn from him, but because his visit is a sign of a welcome and ever-increasing tendency for the two great English-speaking nations to draw closer together in science as in other interests.

* * *

On May 11th, at a meeting of the Council of the Royal College of Surgeons, Mr. Charles Brook, of Lincoln, whose diploma of membership was dated April 19th, 1861, received the honour of F.R.C.S. Mr. Brook was a dresser to Mr. Lawrence and House-Surgeon to Mr. Skey. Messrs. Willett, Langton and Morratt Baker were his fellow house-surgeons. Having to return to Lincoln owing to the illness of his father, the remainder of his house-surgeoncy—in those days house-surgeons had to pay for the office—was bought by Mr. Howard Marsh. During the war Mr. Brook, although then seventy-five years of age, did good service as Lieut.-Colonel in charge of the Surgical Division of the 4th Northern General Hospital at Lincoln. We congratulate Mr. Brook on his honour, which fittingly recognises a lifetime of hard and valuable work.

* * *

We are able to give some more details of the Special Post-Graduate Vacation Course, which this year will begin on Thursday, July 13th, and be carried on until Saturday, July 29th.

An attempt has been made on this occasion to confine the classes to dealing with methods of treatment as far as possible.

The subjects dealt with by the Physicians include the "General Management of Heart Failure," "Treatment of Pulmonary Tuberculosis by Artificial Pneumo-thorax," "Treatment by Diuretics," "Clinical Types of Anaemia, with Special Reference to Treatment," and "Arteriosclerosis." On the Surgical side the "Treatment of Hernia" and "Imperfectly Migrated Testicle," "Treatment of Simple Ailments of the Rectum," "Cholelithiasis," and "Head Injuries." In the Department of Diseases of Women the "Relation of Endocrine Glands to Gynaecology and Obstetrics" together with the management of an Ante-natal Clinic are to be dealt with. In each of the Special Departments the treatment of minor ailments plays a most important part in the course. Certain special demonstrations have been set forth, including the methods of carrying out a post-mortem examination, skin-grafting, the diagnosis and treatment of gastric ulcer, the treatment of diabetes mellitus, and the modern treatment of fractures of the upper limb. The Clinical Pathology course has been arranged so as to include all the simple methods of examination which can be carried out by the practitioner himself. The whole of the course is purely practical and should prove of great use to the practitioner.

The period over which the course extends as compared with last year has been increased so as to avoid the long days' work which were so tiring, so that there are now intervals which will allow those attending the course to indulge in any forms of recreation they may desire.

In order to avoid the overcrowding which occurred last year in the clinical classes, these will on this occasion be held in one of the large out-patient departments, which should prove of convenience to those attending the course.

As the numbers to be admitted to the course are limited, it is extremely desirable that those wishing to attend should send their names at once to the Dean of the Medical School.

* * *

On Thursday, June 8th, the Midsummer Address of the Abernethian Society will be delivered in the Medical and Surgical Theatre by Mr. George Bernard Shaw on "The Advantages of being Unregistered." Most of his hearers will, we imagine, have a prejudice in favour of being registered, and for the sake of the Medical School we hope that Mr. Bernard Shaw will not succeed in convincing such of our members as are not yet qualified.

* * *

The Annual Dinner of the Eighth Decennial Club, of which Mr. Waring and Dr. Drysdale are the secretaries, will be held at Oddenino's Imperial Restaurant, Regent Street, on Thursday, June 22nd, at 7.30 p.m.

THE OCTOCENTENARY OF THE FOUNDATION.

I. THE PATIENTS.

By SIR D'ARCY POWER, K.B.E.



THE approach of the eight hundredth anniversary of the foundation of the Hospital reminds us of the persistence of type in human nature. Surroundings are changed, habits are different, but the sick man remains as he has always been, giving praise where it is least deserved and blaming where he should have given thanks. The patient has always been the first consideration in the Hospital from its very beginning. For him the Hospital was founded, for him house, food, bed and fire were provided. Then, as now, he came from far distances, as well as from the immediate neighbourhood. Walking most often, sometimes on a mule, rarely on horseback, occasionally by barge, which would bring him up the Thames, along the Fleet and land him at the bottom of Hosier Lane, a stone's throw from the Hospital. Arrived at his journey's end, he and the little company of friends who accompanied him would go to the great Priory Church to give thanks for his escape from the perils of the war, and would there ask help of the Canons. Many times the change of air and scene and food during the many days' journey had produced so great an improvement that two or three nights' rest in the Convent would complete the cure, and he would start home again announcing the miracle in every alehouse where he rested. The very sick died on the way, the moderately sick were cured by natural processes and auto-suggestion; there remained a third group, and these the Canons, with knowledge born of long experience, sent over to the Hospital, which was then, as now, opposite their doors.

Thus recommended, the patient would ring at the Hospital gate, which stood on its present site, and would be interviewed by the porter, would be admitted, and would be seen by the Master or by one of the eight Brethren. Being found suitable, he would be admitted into the Hospital, then a hall with an altar at one end of it. A sister would bring him water to wash his face and his hands and his feet, but, in the early days at least, he would find but rough accommodation and poor food, though it would be no worse than he was accustomed to at home. The Brethren themselves slept on a rug upon the floor, with a pillow as a concession to human weakness, and one or more rugs to cover them; the Sisters fared no better, so it is probable that the patients were accommodated in like manner. Later the beds were raised from the ground; later still they had curtains, and a man was provided at an annual charge to keep them free from

bugs. It was not until 1815 that iron bedsteads were provided.

At first the food was got by begging with the addition of a tithe of their rations, which were given daily by the Canons of the Convent. The Brethren of the Hospital, with the novices, were expected to go into the markets with a bowl and gather such meat as the charitable butchers were disposed to give. By preaching and personal solicitation, too, they obtained gifts more often in kind than in money, and thus for many years the Hospital lived from hand to mouth, paying its way for the most part, but sometimes deeply in debt. Little is known of the treatment adopted, but amongst a series of fabulous stories told to enhance the sanctity of the Church there are occasional glimpses of the earlier methods. The most interesting is that of a man who had been apprenticed to a carpenter, for it shows that in very early times the value of graduated exercises was well understood. The patient was so crippled that his fingers were contracted and he could not put meat into his mouth, whilst his legs were cleaving to the hinder parts of his thighs. Being maintained in the Hospital at the expense of the Convent, "the desired health gradually began to come again, First in his hands though they were crooked; he made small distaffs and weights and other things used by women and then, as he gained strength, he began to hew wood with an axe and square logs with an adze and finally he became a carpenter as he had been bred up in his youth and followed his trade in the Church and in the City of London," and by him the Church and the Hospital gained great renown.


Most of the patients did not come from afar. They were admitted from the immediate neighbourhood and many died. They were buried in the Convent grounds, until after much wrangling the Hospital obtained permission to bury in its own cemetery. The privilege was highly prized, for it secured the burial fees, and many wealthy citizens chose to be buried with the poor in token of humility. The Hospital probably maintained from fifty to one hundred beds during the first four hundred years of its existence. When it was re-founded provision was made for one hundred patients, although it was some time before that number was reached. It progressed steadily except in 1666, when the City was rendered so desolate by the Great Fire of London that the wards were nearly empty for a time and the nursing staff was reduced.

Minor ailments were always treated at the Hospital. The Fair in Smithfield and the horse races and jousts held there must have produced a plentiful crop of accidents; the constant use of clubs and knives, too, by the undisciplined apprentices throughout the middle ages must have caused many emergency cases. There is no

reference to out-patients until 1664, but, as they are then mentioned casually, the custom of their attendance probably arose much earlier. In 1678 it was considered that their numbers had become burdensome, and it was ordered that only eight should be admitted in a week—a very different state of affairs from that which had arisen two hundred years later, when Dr. Bridges, the present Poet Laureate, calculated that as Casualty Physician 7730 patients had passed before him in three months, of whom 5330 were new cases. His amusing and outspoken paper published in the Hospital Reports for 1878 drew attention to an abuse which was soon afterwards remedied.

THE INVESTIGATION OF CANCER.

By M. H. GORDON, C.M.G., C.B.E., M.D.

ANCER consists of normal tissue-cells which have taken to growing rapidly, and have acquired a "malignant" capacity to infiltrate the surrounding tissues, and to penetrate and colonise organs at a distance. This invasive character is the chief property that distinguishes a cancer-cell from that of an innocent tumour. The active multiplication of cancer-cells is often accompanied by a high mortality amongst them, and the dead cells tend to break down and form ulcers, especially when the growth is situated in the tongue, throat, stomach, intestine, bladder, or cervix uteri. Broken-down cancer-cells frequently become infected with bacteria, which gradually wear the patient down and bring about his death, but cancer also kills often by its mechanical effects, notably by producing obstruction.

Scientific researches devoted to cancer have been directed to determining its distribution in the animal kingdom, its comparative morphology, and its natural history, but chiefly to studying the problem of its causation by experiments on rats and mice.

While these investigations have resulted in important advances in our knowledge of the pathology of the disease, there little of practical value has yet emerged from them, and there is no denying the fact that to-day cancer is at least as prevalent and probably quite as fatal to the community at large as it was before these researches began about twenty years ago.

Admittedly the chief object hitherto of scientific research on cancer has been to define the cause of the disease. It is well to bear in mind, however, that even if success should eventually be attained in defining the cause or causes of cancer, there is no certainty that we shall then be in a position either to prevent or cure it. For instance there is evidence that irritation or injury may predispose to cancer, but the knowledge of such causes offers little either for prevention or treatment. Even if—as now seems improbable—the cause of cancer should ultimately prove to be a

specific agent, though the prospect of ultimate success would be enormously improved, we should not necessarily be in a position to take effective action to control the disease. We have known the specific cause of tuberculosis for a number of years, but tubercle is still an important factor in the annual mortality. On the other hand, in the case of both malaria and syphilis, valuable remedies were available long before the causes of these diseases were known.

The vital question now arises—Is it possible that the suffering and mortality from cancer can be reduced, and if so, what are the lines of action and observation that seem likely to bring about such improvement other than, and supplementary to, those measures already in progress?

Before attempting to answer this question it may be stated that in case of researches carried out for the purpose of controlling a particular disease, a necessary condition of success is first to formulate the problem correctly for investigation, and then to subdivide it into its component parts so that each can be studied separately as parts of the whole in the order of their relative importance. A further point to bear in mind is that when, as so often happens, an attempt to solve a problem by frontal attack fails, the obstacle can often be passed by finding a way round it. But however carefully an investigation is planned beforehand, progress ultimately depends on the capacity of the individual investigator to overcome the difficulties that continually arise, for many of these difficulties cannot be foreseen and therefore are not realised until the work is in actual progress.

The following is an outline of the investigations proposed.

Scheme of Investigation.

- (1) Accurate definition of the present incidence and severity of cancer:
 - (a) General and local incidence in the United Kingdom.
 - (b) Degree of prevalence of each kind of cancer.
 - (c) Relative virulence of each kind (duration of life of patient).
- (2) Determination of the exact degree of efficacy of present methods of treatment:
 - (a) Comparison of the fate of patients treated and untreated respectively.
 - (b) Comparison of the value of various methods of treatment.
 - (c) Do cancer cases treated early recover permanently? If so, how can such early diagnosis and treatment best be promoted?
- (3) Further standpoints from which the cancer problem can be attacked:
 - (a) To what extent is cancer an immunity problem?
 - (b) Can the condition of the patient be improved by application of the information obtained under (a)?

- (c) Other ideas that are bound to arise when a systematic study of the disease in man with modern methods is undertaken and persevered with.

It will be observed that all of the investigations proposed refer to cancer in the human subject, and therefore do not overlap with, but are supplementary to, the researches already in progress in the cancer research laboratories on mice, rats, etc.

The first two headings refer to information that is essential for progress in the future control of cancer. Without this knowledge it is difficult to see how we can hope to check the disease. With it we shall be able to define the cancer problem with a degree of accuracy at present not possible, and this is the first step towards its practical control.

The difficulties in the way of private individuals who may have the tenacity to attempt to study cancer at present with a view to contributing to progress are considerable. The disease for practical purposes is either operable or inoperable. If of the former category the patient is taken into hospital, operated on, and then sent home to make room for another, but if of the latter he is sent home or to an institution or infirmary. It is almost hopeless to expect progress under these circumstances, and should progress be made possible, and, for instance, a simple method of immunisation obtained that appears to relieve the local pain and cachexia of cancer, it would take years for a private individual even to get such procedure tried on a large enough scale to be able to speak with certainty as to its exact value.

On the other hand, if some central department were organised to deal with cancer, such organisation would include not only means of collecting information with regard to the incidence and fatality of this disease, but also means of testing, and, if satisfactory, of applying on a wide scale more effectual methods for its treatment and control.

The grounds for suspecting cancer to be at any rate in part a problem in immunity are as follows:


(1) Patients with apparently similar growths vary considerably as regards the length of time that elapses before they succumb. This difference in the resistance suggests the possible operation of some factor that checks the growth of the cancer-cell.

(2) Present methods of treatment aim at the destruction of the cancer-cell by physical agency, *e.g.* by removing it with the knife, or by destroying it with X-rays, radium, etc. The body has far more effective methods than these of removing a noxious foreign cell with invasive tendencies. These defensive methods of the body have been extensively studied in relation to bacterial infection with remarkable success, and the practical application of this knowledge has resulted in some of the chief advances made by practical medicine during recent years. Looked at broadly, cancer has many analogies with a bacterial invasion, and several serological studies have been made with a view to defining the mechanism of the resistance, but the work in question

has been too sporadic and fragmentary as yet to enable us to be certain as to the extent of this form of resistance, or as to the precise mechanism involved. Enough, however, has been found out about it already to indicate that further work on this subject is eminently desirable, and systematic observations should be carried out on cancer patients from this point of view instead of surrendering to the disease in the manner now followed when the case is declared inoperable.

THREE CASES OF ADDISON'S DISEASE.

By E. W. G. MASTERMAN, M.D., F.R.C.S.,
Medical Superintendent, Camberwell Infirmary.

"DDISON'S disease" is reputed to be rare. This may be in part because unless a post-mortem be made it may easily be overlooked. Each of the cases recorded below was sent to Camberwell Infirmary by her own medical attendant with a different diagnosis, yet each one was, as the post-mortem proved, at the last stage of Addison's disease. Had they died outside, undoubtedly the chief cause of their death would never have been discovered.

CASE 1.—E. S. H., *æt.* 27, a female, admitted August 23rd, 1919, suffering from the presumed malady of a "rectal ulcerated growth." She had had rectal symptoms for four months blood-stained discharge, increasing constipation and some vomiting. She had a malignant ulcer, proved subsequently to be carcinomatous, in the rectum, but this probably would not have killed her for many months.

On admission patient was described as "sunburnt," and her lips were pigmented; she was emaciated, with a feeble heart-beat and pulse of 120. There was no distension of the abdomen, but the large intestine was full of scybala. On August 22nd I did a colostomy, but, to my dismay, she utterly collapsed and died in twenty-four hours.

At the post-mortem both suprarenals were found enlarged and their normal structure was replaced by what looked like a "whitish growth." This under the microscope proved to be "largely caseous, with a few calcareous granules, and in places giant-cell systems." Both glands were tuberculous. The heart was flabby; kidneys slightly granular; the thyroid slightly hypertrophied. There were deposits of old tubercle at apices of both lungs.

CASE 2.—E. K., *æt.* 38, a female, admitted February 3rd, 1922, with the presumed malady "bladder calculus." She was said to have had hæmaturia off and on for fourteen months. We never saw any sign of this. She had had amenorrhœa one year.

On admission she was very ill. She had marked pigmentation on the lips, cheeks and tongue, also on the face,

flexures of the arms and legs, the hands, and the "linea alba."

In view of the outside diagnosis we proposed to cystoscope her, but she commenced vomiting on February 20th and became rapidly increasingly weak and apathetic, passing gradually into a drowsy state. Heart somewhat weak—84. A faint trace of albumen in the urine; no sugar. Blood examination: no leucocytosis; no abnormal cells. The last three days her temperature rose to about 102° F. She died quietly on the morning of February 27th.

Post-mortem examination showed the left suprarenal full of tubercles in a caseous condition. Right suprarenal also full of tubercles, but not so extensively caseous. Kidneys enlarged, but not macroscopically diseased. Bladder normal. Many adhesions between upper surface of liver and diaphragm; also between spleen, which was enlarged, and diaphragm. Lungs normal. Heart muscle brownish and soft. Stomach, multiple small hæmorrhages into the mucous membrane. Left Fallopian tube puckered, and containing at one point a mass of caseous tuberculous material.

CASE 3.—E. P., æt. 30, a female, admitted March 23rd, 1922, with the presumed malady "neurasthenia."

The history she gave was that during the last two or three months she had had an "awful feeling" inside, which she could not explain. She had been rapidly losing all bodily energy, and lately had not been able to dress herself. She had a slight cough. On admission temperature was 96° F.; pulse very poor indeed—104. There were numerous pigmented spots, like freckles, scattered over her face, and a few small more darkly pigmented spots on the lower part of her body. The fingers were also pigmented at the knuckles. She had sordes on her lips. There was pus and albumen in her urine. The temperature rose the next morning to 99.6° F. At 11 p.m. the same evening she died quite suddenly.

At the post-mortem examination we found that both suprarenal glands were greatly enlarged and were full of caseating tuberculous material, which on the right side had broken down in the centre of the gland into a mass of creamy pus. The right kidney contained a well-defined rounded caseating tuberculous mass, about the size of a cherry; the pelvis was dilated and the secreting substance greatly reduced. The corresponding ureter was greatly thickened all the way to the bladder, which did not itself appear to be diseased. The left kidney was hypertrophied and congested, but not obviously diseased. There were extensive old tuberculous lesions at the apices of both lungs. There were also evidences of old pelvic peritonitis, probably gonorrhœal. She had had appendicectomy done a few years ago.

These three cases are very characteristic of the later stages of this disease. The age corresponds with the

usual. *Allbutt's System* gives thirty-one as the average age, which is practically what we have here. All three cases showed evidence of old tuberculous mischief elsewhere, but in all the most progressive tuberculous disease was in the suprarenals. The pigmentation could very easily have been overlooked, but when looked for was quite evident. It is exceptional that all the cases were females.

I have notes of three other cases, but all incomplete. In one case, a man, æt. 78, the patient was brought in here *in articulo mortis* from a common lodging-house, where he had suddenly collapsed. Post-mortem we found both suprarenals tuberculous, but he also had a dilated heart and atheroma of the aortic valves—conditions much more clearly the cause of death than the "Addison's disease." In this case some slight pigmentation of the skin was noted. In a second case, though the clinical notes made "Addison's disease" probable, a post-mortem was refused, so we cannot be sure. In a third, although one suprarenal was diffused and the other apparently tuberculous, the whole clinical history favoured "pernicious anæmia" as the main cause of death.

It is probable that the records of other Metropolitan infirmaries would show many similar cases, as a chronic condition of this sort, unless diagnosed in the earlier stages, would more probably lead to admission to an infirmary than to a teaching hospital.

THE DIAGNOSIS OF MENTAL DEFICIENCY IN CHILDREN.

By W. E. ROPER SAUNDERS, M.R.C.S., L.R.C.P., D.P.H.

THIS article is intended to draw attention to a subject which usually receives very little consideration in the medical curriculum. The student learns to recognise cretinism, mongolism and one or two other definite types of mental deficiency, but the fact is not impressed upon him that the great majority of such children do not conform to any of these types.

Under the Mental Deficiency Act, 1913, any medical practitioner is assumed to be competent to diagnose mental deficiency, and one of the two certificates required under this Act for the admission of a patient to a registered institution should, whenever practicable, be signed by the usual medical attendant.

The general practitioner is likely to be consulted as regards idiots and imbeciles, and may have school-children brought to him by their parents when the medical officers of the local education authority have examined them and reported them to be dull, backward or mentally defective. In the latter case the parents wish for the opinion of their own doctor as a confirmation or as regards the possibility of treatment. It is therefore necessary to

have some idea of how to make a systematic examination of a child suspected of being mentally defective.

The examination should commence with a note of the total time the child has attended school, together with the total loss of school attendance. This is obviously important, as the mental backwardness of a child may be entirely explained by poor attendance.

The family history as regards insanity, mental deficiency, epilepsy, etc., should be noted. Where there is such a family history, it is probable that the mental defect found will be permanent and not merely a condition of backwardness. It is advisable to inquire for miscarriages and still-born children as evidence of a syphilitic taint.

The personal history should be taken. Special notes should be made as to whether there was any injury at birth (instrumental labour) or asphyxia neonatorum and as to whether the child was breast fed. Injury at birth or asphyxia point to an organic brain lesion, with a serious prognosis as regards mental attainments. The diseases from which the child has suffered should be recorded; meningitis, in particular, appears to be a potent cause of mental defect. The same remark applies to encephalitis lethargica, but this has only recently been recognised.

A general physical examination should now be made and any heart, lung, etc., disease noted. Any marked lesion naturally tends to produce mental backwardness, which will probably improve if the causative defect is treated.

The child should be asked to repeat a few words and any defect of speech noted. Markedly defective speech is associated with pronounced mental deficiency. The vision should be tested by Snellen's test types (idiots and imbeciles will seldom be able to recognise the letters) and the hearing by the forced whisper test, and the results recorded. The testing of the acuity of the senses is one of the most important parts of the whole examination, as many children are backward as a result of defective vision or hearing. If such defects can be improved, there may be a great improvement in the child's progress in school. If it is possible to decide at once what treatment is necessary, so much the better.

A special examination of the nose and throat is made to detect enlarged tonsils and (or) adenoids, both of which are common causes of mental backwardness, curable by their operative removal.

Inquiry should be made as to enuresis, incontinence of urine or fæces. The smell of the child's clothes is often suggestive. If the control of the sphincters is poor, the fact points to irremediable mental defect.

The so-called "stigmata of degeneration" are next noted, if present. The more important of them are mongoloid eyes, epicanthic folds, webbed fingers and abnormal lobes of ears. During this part of the examination the well-known mongolian, etc., types will be recognised, if the child is an example of one of them. It should be clearly under-

stood that "stigmata" are not diagnostic of mental deficiency, and a child may possess several and yet be perfectly normal. The presence of two or three of such stigmata in a backward child renders it probable that the defect is permanent.

The maximum circumference of the head should be measured and compared with a table of normal measurements. A measurement of 1 or 2 in. less than normal is strongly indicative of mental defect.

This completes the physical examination, which is essential, as otherwise weakly, partially-blind, deaf, deaf and dumb, etc., children may be regarded as mentally deficient.

It is best to commence the mental examination by noting if the child is able to carry out a simple command, e.g. to open a door. It should be asked to walk across the room and any peculiarities of attitude and gait noted. Habits such as biting the nails or rocking the body must be observed, as their presence points to lower grades of mentality, e.g. imbeciles or idiots.

A simple question, such as "What did you have for your breakfast?" serves as a rough test of memory. Association of ideas is tested by such a question as "What do you get from cows?"

The parents should be asked whether the child knows what belongs to it (possession), and is able to avoid common dangers, e.g. fires (self-protection). Deficiency in these qualities indicates idiocy.

Any immoral traits, e.g. masturbation, will be similarly ascertained. The parents should also be asked whether the child can be sent on an errand without a note; if it can, it is probably of higher grade than imbecile.

The next step is the application of "intelligence tests." It is impossible in an article of this length to describe these tests except to say that they consist of graduated tests, which can be normally performed at various ages from three to sixteen. The tests are varied in nature, and include repetition of sentences and numbers, description of pictures, counting, copying simple figures and so forth. The responses are recorded and the child's "mental age" as thus estimated is calculated. This, when divided by the child's actual age and multiplied by 100, gives the "intelligence quotient." For example, a child æt. 10 can only answer the questions normally answered by a child æt. 7; its "intelligence quotient" is $\frac{7}{10} \times 100 = 70$. Those who wish to know more about these tests are referred to Jermain's *Measurement of Intelligence*, the standard work on the subject.

The "intelligence quotient" or IQ is the best guide we possess at present in the diagnosis of the higher grades of mental deficiency. A value of 100 is theoretically indicative of average mental development, but for practical purposes anything over 90 may be taken as normal. Values from 70 to 90 indicate "dull" or "backward" children, from 40 to 70 "mentally deficient" children, from 40 to 20

imbeciles, and below 20 idiots. The distinction between "dull," and "backward" children is rather subtle, but a child whose IQ is between 70 and 90, and who has no physical or sensory defects or loss of school attendance to account for the low IQ, is to be regarded as "dull," whereas a child with a similar IQ, but with some ascertainable cause for it, can be regarded as "backward." "Dull" and "backward" children are usually placed in special classes in ordinary elementary schools, "mentally deficient" children in special schools, and "idiots" and "imbeciles" in special institutions.

The IQ is not of itself a complete guide to the mental classification of a child; it must be considered together with the other evidence derived from the systematic physical and mental examination.



BEFORE OPERATION.

AFTER FIRST OPERATION.

AFTER SECOND OPERATION.

A rough test of the child's educational attainments should be made; easy reading, writing, counting and arithmetical questions should be asked. Idiots and imbeciles cannot, as a rule, answer any such questions.

The Mental Deficiency Act, 1913, defines an idiot as "a person . . . unable to guard himself against common physical dangers," imbeciles as "incapable of managing themselves or their affairs, or in the case of children of being taught to do so," and mentally defective children as "not being imbecile, and not being merely dull and backward . . . and incapable of receiving proper benefit from the instruction in the ordinary public elementary schools, but are not incapable by reason of such defect of receiving benefit from instruction in such special classes and schools as are in this Act mentioned."

A CASE OF CIRSOID ANEURYSM OF THE LEFT SUPERFICIAL TEMPORAL VESSELS.

By H. BURT-WHITE.

FA—, æt. 30, canteen steward, admitted to Sitwell Ward October 13th, 1921, complaining of a painless swelling of the left side of face and head.

History.—Seventeen years ago patient noticed small soft swelling in region of left frontal eminence. No pain experienced. No record of trauma. Since that date the swelling has progressively enlarged, spreading downwards in front of left ear along the course of superficial temporal vessels and backwards in the middle line of the scalp.

Past history.—Nil ad rem.

Local condition.—A soft, sinuously curved swelling was evident, about 12 in. long and 2 in. broad, extending from the left parotid region below, passing upwards along the course of the anterior branch of the left superficial temporal artery to the sagittal suture and extending back to a point 3 in. anterior to the external occipital protuberance.

The positions of greatest prominence were in the parotid and temporal regions. The surface was smooth except for a few scattered nodular enlargements. The skin was purple with minute engorged vessels, while larger vessels were seen entering from all sides. Although not easily moveable over deeper structures, except in the parotid region, it seemed unattached to the bones of the skull and easily compressible. On palpation a definite expansive impulse and thrill could be felt. A continuous bruit was heard on auscultation.

First operation by Mr. McAdam Eccles, October 18th, 1921.—A curved incision was made in the left parotid region and a skin flap dissected backwards. The parotid

gland was exposed and the facial nerve isolated. The enlarged superficial temporal artery was ligatured in this position. This had the effect of diminishing the pulsation distal to the ligature, but as it did not entirely obliterate it deep connection was assumed to exist.

A second incision was made about 2½ in. above and parallel to the left supraorbital ridge. The scalp was very vascular and many enlarged vessels were ligatured in the region of the supra-orbital and frontal arteries.

After this operation the swelling was generally decreased. The pulsation was less marked and the bruit just audible.

The patient was shown at Surgical Consultations, November 17th, 1921, when the decision was unanimous that further surgical treatment would be beneficial. It was suggested that a large skin flap should be turned forwards containing the sac, which could be dissected out at a later stage of the operation.

Following this advice a *second operation* was performed by Mr. McAdam Eccles, November 20th, 1921. A semi-circular incision was made, starting on the medial side of the aneurysm in the frontal region, curving backwards and laterally to end above the upper extremity of the left ear. In this procedure many large vessels were encountered and ligatured.

A large flap embodying the sac and all structures to the pericranium was turned downwards. The number of vessels coming through the skull was very small. All vessels entering the aneurysmal sac were ligatured; a particularly large one, about ½ in. diameter, was noticed in the frontal region.

The sac was incised, and after expressing the contained blood was not observed to refill. The sac was not dissected out and the scalp incision was closed.

The patient made a quick recovery, and three weeks after the latter operation the whole aneurysm was greatly diminished in size, except for a rather prominent swelling in the frontal region. This was thought to be due to a collection of blood which had partially clotted in the sac. There was no pain, pulsation or bruit at any point.

The three photographs taken before operation, at the intermediate stage and the final result, demonstrate better than any description the beneficial effect of the treatment.

By courtesy of Mr. McAdam Eccles I am permitted to publish the note on this case.

MEDICINE IN KOREA.

By HENRY MORRISON, M.A., M.B.(Cantab.).

KOREA is a peninsula, situated in the middle of the very extensive seaboard of Eastern Asia. She is, owing to her position, an independent country; and although she has refused to admit any foreigners into her confines until a comparatively recent

date, she has nevertheless had to bow down to China as her sovereign mistress, and from her draw from time to time knowledge in all things pertaining to the administration of her affairs of state. Chinese influence is in evidence everywhere, and although Korea may claim to have been independent and individualistic as a nation, there is only one sign of any initiative in that direction, viz. the grotesque native dress of both men and women; and, although it is certainly original, it is not a style that would be tolerated in any other country than Korea!

The literature of Korea is very scanty, and I can find none in which is given any description of attempted colonisation by the English or any other western nation prior to the year 1824, when a British naval frigate anchored off Chemulpo on the Western coast. All attempts were made to conciliate the natives but were totally unavailing, and bonds of friendship were impossible owing to the stupid self-pride of the Korean and his mistrust placed in the English. Thus were the doors of the "Hermit Kingdom" closed to western civilisation, and commercial enterprise debarred for some years to come.

It is only in the last fifty years that the thick hide of Korean aloofness has been penetrated, and this has been due to a great extent to the invasion of the country by the Chinese or the Japanese in their international disagreements, and, one may add, too, of the Russians through the medium of Siberia. Korea has had to allow and suffer the hand of the invader and the inevitable man of commerce and speculation (as an aftermath) to see her land; and when the appalling state of her administration had been exposed, when her politics were so corrupt as even to make other Oriental nations shiver, when her helplessness was so patent to all eyes, then had she to undergo another humiliation, and become assimilated and controlled by Japan.

In spite of the many beneficial changes wrought by Japan, Korea maintains a firm and dogged resistance towards the hand of the invader. 'Tis a passive resistance, due to being too proud to fight, and being totally ignorant of her complete inability to rule herself successfully. This being the present state of affairs in Korea, it can readily be comprehended how impossible it is for the lamp of learning to shine brightly in Korea, and how medicine, *inter alia*, suffers in its progress.

Just as China has influenced Korea in religion, art and architecture, so we can assume that in Korean medicine we find evidence on every hand of the Chinese alchemist, astrologer and physician.

We may laugh at Korean native medicine now (and, incidentally, Chinese medicine, too), but let us remember that in the time of Confucius the art of medicine had most probably reached the standard in which it is practised

to-day, and in that era (which is 2500 years ago) some of the Chinese teachings were more ingenious than those evolved by Hippocrates. What teaching could the latter promulgate which could possibly compare with that of the Chinese in relation to plague? Over 2000 years ago it was customary for the Chinese of all classes in the event of an epidemic of plague to plaster on the doors of their houses large black cats cut out of paper. And this was not done as being emblematical of good luck, but to prevent rats from entering the house and thereby introducing infection! The association of rats and the plague bacillus in Confucius' day is rather wonderful in the days when microscopes were not, and one has to regard the incident as a prodigious form of empirical preventive medicine.

What influence Chinese medicine had on the countries in the near East it is difficult to ascertain. But when one remembers that Confucius and his colleagues spread their doctrines from one end of Cathay to the other, it is only a mere step from Thibet into Arabia, and once there only a comparatively short and possible journey into Asia Minor. In the thirteenth century, with precisely the same means of travel as in the year 500 B.C., Marco Polo and his sons accomplished the distance from Venice to Peking and back in three years. In many medical orations we are repeatedly told of the influence the teachings of Hippocrates had on English medicine. I think one might go further, and suggest that it is quite possible when more of ancient China is known to view in the work of Hippocrates the influence of some great Oriental physician. If China ethnologically is the "racial centre," as it is believed to be in certain schools to-day, then Chinese influence directly and indirectly ought to be felt in all things—medicine not excepted.

In the country parts of Korea and Korea is essentially agricultural) the local medicine man still holds sway, until a missionary passing through adds what little medical knowledge he has. Even then Korean mistrust in anything foreign has to be overcome; and let it be remembered that the mutation of medical treatment which has existed for centuries, and which has remained unchanged during that period, cannot be accomplished in a day. Yet the Korean, even in his obstinacy, is but human, and, like the westerner, likes occasionally to flit from one doctor to another until he finds that peace of mind which is a panacea for all his ailments.

In certain Korean towns, foreigners (chiefly Americans) have built hospitals and are gradually teaching the native the advantages of modern medicine and surgery.

This side of medicine in Korea I do not wish to deal with. I want to introduce you to the medicine man in the midst of his superstitious practices and relate briefly only a few of the wonders which are to be seen in the

Korean Pharmacopœia. Also shall I usher in a few patients who came to me with their troubles during the leisure moments of a shooting expedition.

In rural Korea, as in many other countries where the light of modern civilisation has only just penetrated, the lamp of western medicine shines but dimly; and dimly enough for the Korean still to place his assurance in the efficiency of his own native doctor, but without totally disregarding the beneficial possibilities of English and American therapy. With true Oriental disregard of time, and with the extreme apathy that marks every Korean, he will subject himself and his family to months of useless treatment, and, being an atheist, buoys himself with hope born of superstition and necromancy.

The Korean doctors, following the medical precepts of their forefathers, have incepted unto themselves those doctrines—inseparable from mediæval medicine in all parts of the world—of submitting their patients, not only to decoctions from herbs, but to mixtures of dried flies, snails, mice, crabs, and even worms, all gathered at a particular time when the medicinal value of the medication is highest, and when the Korean "dæmons" can be invoked with the most favourable results to the patient during the swallowing of the draught. In Korean medical practice, as well as in Chinese, evil spirits play a most important part. The earth is supposed to be full of evil spirits ready to pounce upon the unwary whenever opportunity offers. All diseases are attributed to their work. They have great power, and can disguise themselves by every conceivable means. I will only mention four of the multitude of spirits who are supposed to live in Korea.

(a) The devil of neuralgia, who, with fiendish delight, claps an iron band tightly on your head, and with automatic precision tightens it and slackens it at regular intervals.

(b) The three spirits of ague. The first has a bucket of cold water with which to discomfort you with rigors; the second has a stove in which he lights a fire to give you "the fever"; and the third has a hammer to wield upon the unfortunate patient's head and give him headaches.

Thus is one afflicted in Korea.

For four days I lived in a Korean hut, twenty-five miles from the nearest station on the Mukden-Seoul railway; and one day, when I was not engaged in pheasant-shooting, I was introduced to the local medicine-man by the Padre with whom I was staying. At the door of his "surgery" were burning joss sticks of all sizes, and there were many hideous pictures plastered here and there on the walls of the hut, depicting in a very crude manner some of the diseases to which the Korean is subject. Inside the hut the odour was unbearable; but when you looked around

and saw flies, crabs and worms "cooking" in the same crucible, one's imagination as to the cause of the offence needed no further stimulation.

This medicine-man eyed me with considerable distrust, as if, in one fell moment, I were about to expose his awful ignorance and rob him of his whole practice in the village. When, however, he heard I was only remaining for four days he became slightly more amicable, but would on no consideration of bribery and corruption divulge the mystical secrets of his personal associations with astrology and the dæmons of all his drugs. He maintained almost a perverse aloofness throughout the whole of our short interview, and was adamant in his decision of refusing to impart to me the ways and means by which he cured his patients. As a last resort I murmured something about the personal fellowship associated with the League of Nations; but he was without understanding on this subject, became more sullen and silent, so that in the end I thought I had better leave him.

After this unsatisfactory and very brief conference, the Padre let it be known throughout the village that a foreign doctor was at hand, and in a very short time the small compound of our dwelling was filled with the sick and maimed. The Padre acted as interpreter, and by this means I realised the shortcomings of the Korean medicine-man.

I shall now digress, and after a brief survey of only a few of the wonderful medicaments in the Korean Pharmacopœia will revert to my clinic.

All Eastern pharmacopœias are prodigious in their size, and the Korean work is in bulk not very far behind that of China.

Although many are the drugs which are used in the East, one cannot be in the confines of the Orient many days without hearing of ginseng, to whose omnipotency every other flower, fruit or root bows down in proud obeisance. No drug in the British Pharmacopœia rivals with us the estimation in which ginseng is held by the Oriental. It is a tonic, a febrifuge, a stomachic, the very elixir of life, taken spasmodically or regularly in Korean wine by most Koreans who can afford it. And Korea is the home of ginseng, and even in this small country the cultivation of the root is almost limited within the boundaries of one town—Song Do. So important did Song Do become owing to its large exports of ginseng that five centuries ago it was raised to the important position of being the capital of Korea. To-day it is the second city in the country.

Ginseng is rarely found growing under natural conditions, and the search for it so often ends in failure that the common people credit it with magical properties and believe that only men of pure lives can find it. A single

specimen has been sold for \$400 (£40), and it is of considerably more value than the cultivated root.

The cultivation of ginseng is a most laborious and tedious process. Just as the ordinary farm is dependent upon climatic conditions for the success of its annual crops, much more so is the ginseng farm dependent upon good weather, for only once in seven years is there a "ginseng season." Mrs. Bishop, in her masterly work on Korea, describes the growth of ginseng as follows:

"All round Song Do are carefully fenced farms on which ginseng is grown with great care and exquisite neatness on beds 18 inches wide, 2 feet high, and neatly bordered with slates. It is sown in April, transplanted in the following spring, and again in three years into specially prepared ground, not recently cultivated, and which has not been used for ginseng culture for seven years. Up to the second year the plant has only two leaves. In the fourth year it is six inches high, with four leaves standing out at right angles from the stalk. It reaches maturity in the sixth or seventh year. During its growth it is sheltered from both wind and sun by well-made reed roofs with blinds, which are raised or lowered as may be required. When the root is taken up it is known as 'white ginseng,' and is bought by merchants, who get it 'manufactured' into red ginseng, and as such does it reach the medicine-man."

Ginseng has a very special "dæmon," who is invoked in all probability more than any other dæmon in Korea.

There is no known disease for which ginseng is not a cure. It is the perfect panacea.

The manufacture and uses of other drugs in the Korean Pharmacopœia is comparatively uninteresting, so let us view the manner in which insects and such-like creatures are employed for medicinal purposes.

"For a painful eye" use tape-worms. "Only tape-worms which are vomited are used. These worms are carefully collected, dried and reduced to powder. The nature of the powder is very cold. If a few drops of a solution of it be applied to inflamed or painful eyes, it will exert a soothing influence at once!"

For boils and allied cutaneous affections our antidote is the grey spider, prepared in the following manner: "For medicinal purposes the head and feet are discarded, and the remainder of the animal dried and rubbed up into a powder. No heat should be applied, as this agent causes it to lose its virtues as a medicine. This drug is slightly cold by nature and somewhat poisonous. It is used for pimples or boils."

For nervous afflictions, with or without paralysis, use scorpions! "Scorpions are imported from China for medicinal purposes. The small ones are the best, and for medicine they can be caught at any season. Formerly these creatures were found within the palace enclosure,

but these were all carefully killed to be used for medicine, and now there are none found in all Korea. The entire body is used in medicine, but the tail, which contains the sting, is the best for this use. The sting is very poisonous. When prepared for use, the insect should be washed thoroughly and roasted. The nature is tranquillising, the taste both bitter and sweet, and it is decidedly poisonous. It is used for all forms of paralysis, or partial paralysis, and for convulsions in children."

The inebriate is not forgotten and is advised to take freshwater snails. "Freshwater snails have a long pointed head, and are of a yellowish-green colour. They should be collected in the summer and autumn, and washed in rice water until all the earth is washed off, and then boiled. These creatures are difficult to kill. They are known to have been motionless in a wall for thirty years, and when exposed to the air and dew to have revived. Their nature is cold, the taste sweet, and they are non-poisonous. They reduce fever, aid the liver and quench thirst. They also sober drunkenness."

Even the surgeon is aided in his treatment of injuries by the use of cockchafer grubs. "These are found in plenty about decaying vegetable matter. When lying on their backs they are capable of locomotion, and when on their feet, they move with wonderful rapidity. Those which are found on the mulberry, or willow trees, and are of a pure white colour, are the best for use in medicine. They can be gathered at any time, and after being dried in the shade should be heated with rice or glutinous rice. Before preparing them for use in medicine, the dust and dirt should be carefully brushed off the back of the insect. Those which are not able to crawl on their backs are not true cockchafer grubs. The nature of this medicine is slightly cold, the taste salt, and it possesses poisonous properties. It is used for rheumatism, for cataract, for corneal opacity, for fractures and sprains, for wounds caused by edged weapons, and for extravasations of blood."

Still more wonderful in the realms of surgery is the startling effect produced when the brain of the mole cricket is used. "This," we are told, "if applied to such punctured wounds as have been caused by a wooden weapon, will cause them to heal, and it will also cause splinters of wood to come to the surface!"

For the more epicurean of our patients, "take hornets' nests, which are found in the forests as well as near the houses of the people. For medicine those found on the hills are the best. They should be collected from the seventh day of the seventh moon, until the eleventh or twelfth moon, boiled, dried and reduced to powder. Hornets' nests are tranquillising in nature and can be taken before meals to increase the appetite."

To aid prognosis the following paragraph should be

studied carefully! "Lice: These insects leave the body of a dying man. To tell whether an invalid will recover or not, place some of these insects on a table before him. If the insects go to the chest of the invalid he will recover, but if they go to his back, he will die."

Thus are medicines administered in Korea, and I should imagine with very varying effects.

To revert to my clinic.

The first patient was a girl of about 15, who for the past three years suffered from fits. She had undergone long periods of treatment, when the only hope of cure on the medicine-man's part was the successful invocation of certain of the many little devils with whom he was supposed to be in league. Later she was subjected to a favourite and specific remedy—that of needling. A needle, four inches long, was put in a flame until red-hot, and then stuck repeatedly into the ball of the thumb. This was a perfect panacea in Korean therapy, and was resorted to when all other means failed. She had six months of this, and, being not one bit the better, her medicine-man pronounced she had devils of such quantity inside her that all his means of driving them away were totally inadequate!

Among many other patients, whose complaints varied from schistosomiasis to blepharitis, was a little child aged 5, who, one year ago, drank from a bottle containing Korean wine. He became deeply intoxicated, and for the whole of the next two days existed in a soundly unconscious condition. He recovered in a short time, and for the following twelve months was in excellent health. To put it into the words of the child's mother, "He then had nine abscesses, which all appeared within a short time of each other, and which were situated in various parts of the body." The Korean interpretation of this misfortune was, that with the advent of each abscess there came part of "the fire of the wine" out of his body. A native medicine-man was seen, and he prescribed that a swallow be caught in the early part of the morning, killed, and pressed to the affected area. One swallow was necessary for each abscess. In reality the unfortunate child had suppurating tuberculous glands as well as tuberculous peritonitis with considerable effusion. He had been undergoing the "swallow treatment" for some time, and as there was no improvement even the patience of the Korean parents reached its limitations, and their faith in the necromantic physician changed to hatred and suspicion. I gave what little advice I could under the prevailing conditions. But how can one advocate open-air treatment when the principles of Korean sanitation and hygiene are the complete reverse of our own, and when their one main idea of nursing inside their miserable squalid huts is to place the patient in the guest room, under which is built a brick area for

a fire? The fire is lit and the patient stoked back to health. The more they think of the patient, the more fuel will they heap on the fire, and with the small air entry to the room almost (as the old lady said) "grammatically sealed," the unfortunate patient must pass through stages of "heads" far worse than those produced by any number of drugs.

To-day, however, Korea, like all other Oriental countries, is rising out of her lethargy of countless generations. She is tolerating the advent of the stranger within her gates, and slowly realising the many advantages which western civilisation bring to her. The Americans are building hospitals in most of the large towns, and these serve large areas of the countryside. The native, having had frequent "ocular demonstration" of the efficiency of civilised medicine, is rapidly brushing aside the medicine-man, and is slowly, very slowly, becoming obedient to the sanitary principles enforced by the Japanese. But there is still much to do in Korea. Yet the foundations of constructive principles have been laid, and it only requires a satisfactory ending to the Washington Conference in order that political and anti-racial barriers be overcome, and, after that, the successful erection of constitutional ideals be commenced.

Korea will have to suffer much western "leaven" in her system of politics, in order that flagrant corruption—inseparable from all forms of Oriental Government—be ever banished. And in medicine, too, is the same amount of leaven necessary, so that the "demons" may be finally expelled from the minds of the people, and allow the needs of scientific medicine to take root and flourish eternally.

EX SCRIPTIS.

(2ND INSTALMENT.)

Dr. Womack has kindly sent us a second instalment of examination "howlers," which we print below.

PHYSICS.

(The questions in most cases have not been given; they can be inferred.)

Gravity was discovered by Izaak Walton. It is chiefly noticeable in the autumn when the apples are falling from the trees.

Specific gravity keeps us on the earth, if not we should roll off.

Q. How would you remove air from a flask?

A. Fill the flask with water, tip the water out, and put the cork in quick.

Q. Distinguish between mass and weight.

A. . . . thus, if one went into a shop and asked

for 1 lb. of cheese the mass would be the cheese, but the weight namely the 1 lb. would not be worth the money.

Velocity may be defined as "what a man drops a hot plate with."

A pound weighs more at London than at Paris because theoretically speaking Paris is nearer the equator than London and therefore hotter.

A pound weighs less at Paris than at London because of the adverse rate of exchange.

Mass is the term given to the volume of any substance. This is due to the atmospheric pressure. London lies lower than Paris in its geographical situation, therefore the lower the body the greater the atmospheric pressure becomes, and *vice versa*.

The note in a closed pipe can be compared to that of a concertina when only one end is pushed in, whilst that in an open pipe when both ends of the concertina are pushed in at once.

A double fugue is a stop on the organ which makes a loud noise.

Asked to define a "diatonic interval" one candidate wrote thus: "Some people think that when you die you go for a time to a place of preparation. This is called the diatonic interval."

Q. What is a "second" of time? Explain carefully how it is connected with the time of revolution of the earth on its axis.

A. 1. By a second of time is meant the time which a body takes to fall the distance of 32 feet per second. This is known as the uniform acceleration of time per second.

A. 2. Time is something that everybody understands, but nobody can define.

A. 3. A second is the smallest portion of time conceivable to human beings without artificial means.

A. 4. The time the earth takes to make a revolution on its axis is a little over 24 hours, but as it is much more convenient to have an exact number of hours, the time over is not counted.

A. 5. The earth rotates more slowly now than it used to because there are more people living on it. This partly accounts also for the greater ages of the patriarchs.

Q. How would you determine the amount of heat given out by a rabbit in six hours?

A. 1. Wrap the rabbit in flannel for 6 hours, and quickly removing the flannel wrap it round a metal vessel full of water. Find the heat thus imparted to the water.

A. 2. Put the rabbit into a vessel containing broken ice for 6 hours, and determine how much ice is melted.

A. 3. Shave the rabbit and apply a thermopile at different parts of the body, and take the average reading.

The ohm is the current maintained at the ends of 18 feet of wire (.034 diameter), the size of the cell being 1 quart.

The Leclanché cell is charged with sal volatile.
Daniell's cell was a pit in the earth about 24 feet across and 20 feet deep, and full of roaring lions.
The capacity of a Leyden jar is the quantity of electricity it can receive without the glass being broken.
The longer spark will give you the higher jar.

UNSEEN TRANSLATIONS.

Arma virumque cano.—Arms and poison for the dog.
Cave canem.—Beware lest I sing.
Poeta nascitur non fit.—A nasty poet is fit for nothing.
Vis consilii expers mole ruit sua.—The unexpected weight of the consul fell on the soft pig.
Ceruleae puppes.—Skye terriers.
Vide peius consultat, doctor etiam.—Is your eyesight bad, consult a doctor.
Odora canum vis.—A strong doggy smell—on which the schoolmaster's comment was, "In this form, Jones, we canum for 'dog Latin.'"

GRAMMAR.

What is the masculine of Regina?—Reginald.
Compare Caesar and Alexander.—Caesar, caeserior, caeserimus. Alexander, Alexandrior, Alexanderimus.
Decline the present indicative of *esse* and *posse*.—Sum, es, est, sumus, estis, sunt. Pum, pes, pest, pumus, pestis, punt.

DISRESPECTFUL DITTIES.

III. BRIGHT'S DISEASE.

Doctor Richard Bright of Guy's
Had several patients large in size.
Their legs were swollen as could be;
Their eyes so puffed they could not see.
To this oedema Bright objected,
And so he had them venesected.
He took a teaspoon by the handle,
Held it above a tallow candle,
And boiled some urine o'er the flame
(As you or I might do the same).
To his surprise, we find it stated,
The urine was coagulated.
Alas, his dropsied patients died.
Our thoughtful doctor looked inside:
He found their kidneys large and white,
The capsules were adherent quite.
So that is why the name of Bright is
Associated with nephritis.

IV. PARKINSON'S DISEASE.

Poor Pa Parkinson very seldom smiled;
Always apathetic and never really riled,
Vacuous his features as any in Debre'tt's,
Poor Pa Parkinson, rolling cigarettes.

Wags delight to push him, find he never stops,
Kuns because he has to, runs until he drops,
Festinant his gait, like a tipsy marmoset's,
Poor Pa Parkinson, rolling cigarettes.
Now he's in the text-book (where curios belong),
They say his mesencephalon had hopelessly gone wrong.
Here's to his health then! . . . Another one? . . . Yes, let's!
Poor Pa Parkinson, rolling cigarettes. GEMINI.

THE COMBINED HOSPITALS APPEAL.

THE great appeal on behalf of the combined hospitals of London, organised by a Central Committee under the Director-Generalship of Sir Shrapnell Smith, promises to be the unqualified success which it was hoped and believed it would be. Among the many "stunts" which this able committee has evolved are a collection on the Epsom course on Derby Day, in which 2000 students will take part; a procession before H.M. the King, of the staff, nurses and students of the London hospitals; and an affair on June 25th, known as "Balloon Sunday," the plans of which appear, at the moment, to be somewhat in the air. In addition to these, there are the Albert Hall Ball, the inter-Hospital Sports at Queen's Club, a River Regatta, and several other matinées and sporting events—the proceeds from which will all go towards the half million pounds which it is expected will be raised as a result of these combined efforts.

Bart's, under the auspices of the Students' Union, is taking part on every occasion, her efforts being organised by the Secretaries of the Union together with a special committee appointed for this purpose.

The appeal was launched with great energy on Empire Day, about 300 students from this Hospital taking part. Seldom has a response been more enthusiastic and spontaneous. When people were asked to help, they did so in every way they could.

Somewhat at an advantage in having the entire City at their disposal, Bart's worked tooth and nail to get money. With barrel-organs, 'bus-jumping parties, jazz-bands and lorries, they entertained the public and made them pay for it. The response was great. Money poured in from every quarter. From the ragged urchin with his "eres a'apenny, gunvor," to the multi-millionaire whose words were inarticulate, all gave and gave willingly. It was a terribly hot day for this sort of work, and a terribly dry one. That, however, deterred nobody. One noticed Mr. J. Elgood, with perspiration pouring from his face, lifting his voice in a hearty stave to the crowd who followed his organ from place to place. Mr. Elgood was a great source of amusement to the crowd, and when he began auctioneering things, they readily responded with both "back-chat" and money.

Mr. F. A. Bryan was an early success as a 'bus-jumper,

being the first person of the day to require a new box. At the Stock Exchange Mr. L. C. Neville, with a party of first year youths, collected quite a large amount of money. These youths, with amazing coolness, invaded office after office in which were seated the mighty ones of the financial world, and seldom did they come away unrewarded. Something is rumoured about a certain gentleman having danced in front of the Stock Exchange with an actress or actresses. It is only on hearing that this incident produced several pounds that we can forgive that gentleman! At Anderton's Hotel, Mr. G. B. Tait and his party were very successful, and were well supported by members of the Fleet Street Club. The collecting station at the Royal Exchange was quite a busy spot. Throughout the day a large crowd gathered round the table, and, with the sun's heat pouring right down on them, Messrs. Storrs, Mellows, Cross and Mayo spent many heated hours exchanging boxes, looking after ladies who were selling flags, and dealing with people who imagined the place was a general information bureau. Towards the end of the afternoon, Mr. Moonan and his Jazz Band arrived; the crowd thickened, and money literally flowed in, and was almost as quickly transported to Bart's in taxis. Although obviously unpractised, this band gave quite a creditable performance, Mr. Pembrey's efforts with a wind instrument being especially brave. It was soon after this that the thing happened. It must have been that a fairy godmother, somewhere, suddenly decided to get to work. She appeared in the useful form of the director of Messrs. Vines, who offered to send to the collecting station two cases of champagne. The offer, after a brief consultation among those concerned, was accepted. A room near-by was borrowed; the champagne duly arrived, and . . .

A rather unfortunate, but to some extent amusing, incident occurred with the Ashwell troupe. This was a troupe of ex-service men who had very kindly offered their services to the Hospital, and were accepted. They had not been out long, before Bart's were rung up to say that they had been detained at Row Street Police Station, owing to some query about their permit cards. This being satisfactorily cleared up, they were released, and all was apparently well. The next that was heard of them, however, was that they had been locked up in Vine Street Police Station, where they spent the night. The whole thing arose out of these men collecting in the wrong area—their permits being confined to the City. They were eventually released and all ended happily. Their appearance in the Court in the morning, however, still clad in the most startling fancy-dress, and with faces still daubed with running grease-paints, must have evoked a considerable amount of mirth.

Besides what has been mentioned, there were many other "side-shows" going on all over the City. One's general observations, however, rather lead one to think that

the simpler methods of collecting money are far more productive than the highly elaborate means which some students employed. As an instance of this, the mere holding out of a blanket by a couple of students was quite sufficient for the public to rain money into it, from the tops of 'buses and elsewhere.

While, for obvious reasons, it is quite impossible to mention all those who did good work, or even those who did more than that, it should be recorded that the entire arrangements for the barrel-organ part of the programme were carried out by Mr. B. A. J. Mayo, who is once again to be congratulated on his careful handling of a difficult and intricate matter. On previous occasions Mr. Mayo has shown us what he can do about barrel-organs, and he fully deserves the title bestowed upon him later in the evening of the "Barrel-Organ King"!

The triumph of the whole day bears excellent testimony to the truth that complete organisation is necessary to ensure success. A large measure of the credit for this must go to Mr. H. S. Gordon, who, with the sub-committee appointed to deal with this day, worked out a careful scheme by which precise information was supplied for every individual who took part in the collection. Bridle, who worked hard, was a considerable help, in many ways, to the committee.

We have, indeed, every reason to be proud of our efforts on Empire Day, on which men of every year set out, with unity of purpose, to fulfil a duty which is undoubtedly the privilege of each and all who have the interests of their Mother Hospital at heart.

W. H.

REVIEWS.

REPORTS OF THE ST. ANDREW'S INSTITUTE FOR CLINICAL RESEARCH. (London: Henry Frowde and Hodder & Stoughton.) Vol. I. Pp. 208. Price 10s. 6d. net.

This volume represents "a part of the outcome of the first year of work of the St. Andrew's Institute for Clinical Research." The papers which it contains mainly lay forth the principles on which the Staff of the Institute are tackling the problem of clinical research. Three of the twelve papers are by Sir James Mackenzie, the Honorary Director of the Institute, and the other papers reflect Sir James's ideas very closely. The Institute has been much criticised; but it is obviously unfair to condemn an attempt to advance medical knowledge by a new method of attack until that attempt has been given a fair trial. The last paper, on Cutaneous Sensation, is perhaps the most interesting in the volume. A great merit of this report is that it is likely to cause the reader to indulge in a little analysis of his own ideas on clinical research and his own methods of medical practice.

AIDS TO MEDICINE. By BERNARD HUDSON, M.D., M.R.C.P. (London: Baillière, Tindall & Cox.) Fcap. 8vo. Pp. x + 370. Price 4s. 6d. net.

AIDS TO ORGANOTHERAPY. By I. G. COBB, M.D., M.R.C.S. (London: Baillière, Tindall & Cox.) Fcap. 8vo. Pp. viii + 183. Price 5s. net.

The volume on Medicine in the "Aids" series is now in its third edition; it has been revised, and a chapter on common skin diseases has been added.

The volume on organotherapy fills us with alarm. Where are

"Aids" to end? Why not aids to cardio-therapy? or aids to typhoid fever? And then why not buy a text-book? Full of interest as the book is, it seems to us quite unsuited for an "Aids" series. It contains much practical advice, but the author does not discriminate sufficiently clearly between remedies of proved value and those whose worth is highly problematical. But he does utter a warning, though not a very strong one, against the indiscriminate use of the diagnosis of "hypo-endocrinism." But let him not administer his thyroid *per oram (sic)*. It is not Latin.

EMILE COUÉ: THE MAN AND HIS WORK. By HUGH MACNAGHTEN. (London: Methuen & Co., Ltd.) Paper Covers. Price 2s. net.

This is a short account of M. Coué and his work, written by one who is obviously a hero-worshipper. The writer emphasises the effect of M. Coué's personality, and does not insist that there is anything strikingly new or original in his teaching about auto-suggestion.

STUDENTS' UNION.

CRICKET CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. WINCHMORE HILL C.C.

Played away on May 6th. Result: Won.
This game was distinguished by the very low scores of both sides. The Hospital were dismissed rapidly for 69, 25 of which were scored by D. T. Brims, but Winchmore Hill were even less successful owing to the bowling of A. B. Cooper, which permitted them to score but 27 (Cooper 7 for 13).
The second innings, played by both sides very rapidly and very badly, left the Hospital victorious by the narrow margin of 8 runs.

ST. BARTHOLOMEW'S HOSPITAL v. SOUTHGATE.

Played at Winchmore Hill on May 20th. Result: Won.
This result was again due chiefly to the bowling of A. B. Cooper and the sound batting of E. H. Watkins.
Scores: Hospital 139 (Watkins 41, Parrish 20); Southgate 65 (Cooper 7 for 18).

THE CRICKET WEEK.

The Annual Cricket Week commences on Whit Monday, June 3th. For matches to be played in this week and for other fixtures, see the Calendar.

The first round of the Inter-Hospital Cup Tie is to be played before May 31st, v. Middlesex Hospital.

EXAMINATIONS, ETC.

UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:
M.B., B.Ch.—W. B. A. Lewis, G. S. Trower.
M.B.—E. Donaldson, A. O. Courtis.

Second Examination for Medical and Surgical Degrees, Easter Term, 1922.

Part II: Pharmacology and General Pathology.—H. R. B. Dearden, A. W. C. Mellor.

ROYAL COLLEGE OF PHYSICIANS OF ENGLAND.

At a meeting held in April the following degrees were conferred:
Fellows.—H. H. Dale, C.B.E., F.R.S., M.D.(Cantab.), A. G. Evans, M.D.(Cantab.), A. H. Hayes, Major R.A.M.C.
Members.—N. H. Hill, M.B.(Lond.), M.R.C.S., L.R.C.P., C. T. Maitland, M.D.(Lond.), W. G. Wyllie, M.D.(Edin.).

CONJOINT EXAMINING BOARD.

The Diploma in Public Health has been conferred on H. W. Toms, M.B., B.Ch.(Oxon.).

The following have completed the examination for the Diplomas of M.R.C.S.(Eng.), L.R.C.P.(Lond.):

B. Homa, H. C. Killingback, W. Laing, K. W. Leon, F. R. L. Miller, W. E. M. Mitchell, J. G. V. Nelken, A. E. Roche, S. J. Woodall.

CHANGES OF ADDRESS.

BONEY, T. K., Major R.A.M.C., R.A.M.C. Mess, Aldershot.
CRAWFORD, C. R., Milton Lodge, Goldsmith Avenue, Southsea. (Tel. Portsmouth 2578.)
GIBBINS, H. B., 4, Station Road, Maidstone.
HANCOCK, F. T., Clovelly, Hounslow.
HEALD, C. B., 25, Park Crescent, Portland Place, W. 1. (Tel. Langham 1221.)
HICKS, E. P., c/o Messrs. Minet, May & Co., 5, Dowgate Hill, Cannon Street, E.C. 4.

APPOINTMENTS.

BONEY, T. K., M.D.(Lond.), Major R.A.M.C., appointed Medical Specialist, Aldershot Command.
HICKS, E. P., M.B.(Cantab.), D.T.M., appointed Assistant Pathologist to the Municipal Council, Shanghai.
LISTER, A. E. J., Lieut.-Col. I.M.S., M.B., B.S.(Lond.), F.R.C.S., appointed Hon. Assistant Surgeon to the Western Ophthalmic Hospital.
ORCHARD, S., M.R.C.S., L.R.C.P., appointed House-Physician at the East London Hospital for Children.

BIRTHS.

BATT.—On Tuesday, May 16th, at Denston, near Newmarket, to Olive, wife of John Dorrington Batt—a son.
DALY.—On May 7th, at Shelley, Yorks, to Molly (*nee* Leatham), wife of I. De Burgh Daly, of 11, Templar's-avenue, N.W.—a son.
FAWSSETT.—On April 13th, at Clarence House, Rhyl, North Wales, the wife of R. Shirley Fawcett, M.R.C.S., L.R.C.P., of a son.
GRIFFITH.—On April 26th, at Roydon, Torquay, to Helena and Harold K. Griffith, F.R.C.S.—a son.
OULTON.—On May 4th, at Port Said, the wife of E. V. Oulton, M.B., B.C., Medical Officer of Health for Port Said, of a daughter.

MARRIAGES.

BRIDGEMAN—KLEINWORT.—On May 11th, at St. Peter's, Eaton Square, by the Right Rev. the Lord Bishop of Kingston, assisted by the Rev. T. Barton Milton, Vicar of Boughton Monchelsea, Lieut.-Commander Paul Bridgeman, Royal Navy (retired), son of the late Brig.-General the Honorable Francis Bridgeman and the late Mrs. Bridgeman, to Alice Dorothy, fifth daughter of Mr. and Mrs. Kleinwort, 45, Belgrave-square, S.W. 1.

MARSHALL—HIBBERT.—On April 27th, at the Parish Church, Marylebone, by the Rev. F. R. Pinhorn, uncle of the bride, Eric Stewart Marshall, C.B.E., M.C., to Enid, younger daughter of the late Sir William Treacher, K.C.M.G., and of Lady Treacher, of Parkstone, Dorset.

WELLER—HARRIS.—On April 20th, at St. Matthias', Richmond, Dr. Charles A. Weller, of Thaxted, Essex, to Jane Drew Harris, of Kilmallock, Co. Limerick.

DEATHS.

BEGBIE.—On April 25th, 1922, at 1, Carlton Hill, Exmouth, after a long illness, Col. Francis Warburton Begbie, C.B.E., A.M.S. (retired), eldest son of the late James Warburton Begbie, M.D., LL.D., of Edinburgh, aged 57.

CRESSEY.—On April 19th, 1922, at Bournemouth, after many years' illness, George Henry Cressey, late of Tonbridge, aged 67.

HAMEL.—On May 3rd, 1922, at Westfield House, Surbiton, Gust. Hamel, M.D., M.V.O., of 1, Stratford Place, W. 1.

NEWSTEAD.—On May 9th, 1922, James Newstead, of Great Haywards, Haywards Heath, late of West Ashby, Lincolnshire.

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 7s. 6d., 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. XXIX.—No. 10.]

JULY 1ST, 1922.

PRICE NINEPENCE.

CALENDAR.

Sat., July 1.—Lawn Tennis Match v. R.M.A. (home).
Mon., „ 3.—Clinical Lecture (Special Subject), Mr. Elmslie.
Second M.B.(Lond.), Part II, Examination begins.
Tues., „ 4.—Dr. Morley Fletcher and Mr. Waring on duty.
Final Conjoint Board Examination begins.
Wed., „ 5.—7th Decennial Club Dinner; Trocadero Restaurant, 7 p.m.
Lawn Tennis Match v. U.C.H. (away).
Fri., „ 7.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Mon., „ 10.—First M.B.(Lond.) Examination begins.
Tues., „ 11.—Sir P. Horton-Smith Hartley and Mr. Rawling on duty.
Thurs., „ 13.—Post-Graduate Course begins.
Second M.B.(Lond.), Part I, Examination begins.
Fri., „ 14.—Sir T. Horder and Sir C. Gordon-Watson on duty.
9th Decennial Club Dinner; Langham Hotel, 7.30 p.m.
Tues., „ 18.—Prof. Fraser and Prof. Gask on duty.
First Conjoint Board Examination begins.
Thurs., „ 20.—Last day for receiving matter for August issue of the JOURNAL.
Fri., „ 21.—Dr. Morley Fletcher and Mr. Waring on duty.
Tues., „ 25.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Fri., „ 28.—Sir P. Horton-Smith Hartley and Mr. Rawling on duty.
Sat., „ 29.—Post-Graduate Course ends.

EDITORIAL.

ALL Bart's men will join in congratulating Mr. H. J. Waring upon his election as Vice-Chancellor of the University of London. We at this Hospital well know that through this appointment the University will gain in manliness of tone, in teaching efficiency, and in public esteem.

As we write these notes Prof. Harvey Cushing is again crossing the Atlantic after a visit which must have been, even for an American citizen, a particularly crowded and bustling ten days. He came here at the invitation of the Governors

and the Medical College of the Hospital to direct for a short time our Surgical Professorial Unit. Last year it will be remembered that Mr. Gask visited in a similar fashion the Peter Bent Brigham Hospital in Boston.

It was a happy thought to follow up in this fashion the rapprochement between British and American surgeons formed in France. The practice of medicine is in the truest sense international. In helping the suffering we are neither British nor American, but merely men upon whom is laid the duty and privilege of pooling in one common stock such knowledge and experience as we possess for the relief of the sick. This is fundamentally why we welcome such an interchange as this. Necessarily it has other results. It helps in some small degree to bind together two great nations. Certainly there are enough interested persons who would desire to see it otherwise.

We may say that Mr. Cushing's visit was a personal triumph. He was made a perpetual student of the Hospital and his signature is now in the book which every Bart's man signs on entering the Hospital. He lectured to us, talked to us "round the Fountain," and generally became one of us. One thing remains: we should have liked to have seen him operating. The British are an insular and reserved people not given to demonstration. These traits we share at Bart's, but we can whole-heartedly tell Mr. Cushing that we liked him. We hope he will come again.

A change in the point of view, a knowledge that there are other methods besides our own (a fact particularly difficult for Bart's men to appreciate), is of such utmost value in keeping alive the true spirit of science, that one wonders if in the future it may not be possible for selected senior students and young qualified men of different countries and universities to interchange for a brief period. This will come, but how long will it take to come?

Mr. George Bernard Shaw lectured before the Abernethian Society in June on the subject of "The Advantages of being Unregistered." A report will be found elsewhere.

The Medical and Surgical Theatre was full to overflowing, and the upper gallery had finally to be opened. It goes without saying that Mr. Shaw's lecture scintillated with wit and caustic comment. It was, however, destructive without being constructive, and seemed brilliant for the sake of brilliance; but let it be remembered that he was lecturing in a hot-bed of registration, for it was very largely through this Hospital that nurses' registration became legal.

Mr. Shaw tried, like the fat boy in *Pickwick*, to make our flesh creep. He told us that the medical profession was losing the confidence of the public. We don't think it is; we believe that the average man (and the average man has a large amount of shrewd common sense) would rather consult a registered than an unregistered practitioner—yea, even than an osteopath. It would, we suppose, sound incredible to Mr. Shaw, but the awful fact remains that probably a majority of his audience did not know what an osteopath was.

One point we missed. We should dearly like to have heard some praise of the cheiro-practics, who, we imagine, must be a particularly deadly form of unregistered practitioner.

We can safely say that every member of the audience enjoyed Mr. Shaw's delightful lecture. The Abernethian Society are to be congratulated on the success of the meeting.

* * *

Official permission has been granted for the establishment of a department long needed in the Hospital. A method of maintaining touch with patients after treatment will soon be established. At present Mrs. Smith, after receiving the fullest treatment, often passes to pastures new beyond our ken. This, so far as we can prevent it, will no longer happen. She will be "followed up." Business methods will be joined to science, and from the alliance will, we suppose, come forth a progeny of statistics.

We welcome this latest piece of practical common-sense. Below is an official memorandum explaining the scheme.

"FOLLOW UP" DEPARTMENT.

The reasons why such a Department is considered desirable are as follows:

1. At the present time the Medical Officers have no means of ascertaining the ultimate value of the treatment which they administer to the patients.
2. Accurate statistics are wanted. These statistics would form valuable material for investigation by those in charge of the patients as to the individual differences in treatment or technique which had given the best results.
3. The knowledge of the condition of patients after leaving the Hospital would form a valuable aid to prognosis of disease.

The method suggested to carry out this design is as follows:

1. The Medical Council shall determine the diseases to be investigated by the "Follow Up" Department.
2. The Medical Officer in charge of the patient shall indicate to the Registration Bureau by arranged signal (red wafer or stamp) attached to the notes which patient is to be followed up.
3. The Lady Interviewer will keep a card index showing the names, addresses and diseases of such patients.
4. The Lady Interviewer will send a postcard at a given time (say every three months) asking the patient to attend at the Hospital at a certain time.
5. The patient will be examined by a member of the "Firm" who had charge of the patient and the result of the examination will be entered on the notes.
6. It is hoped that the Women's Guild will undertake to visit the homes of those patients who do not reply to the postcards.
7. An annual summary and analysis of the results shall be prepared by the Medical Officers appropriate to each series.

* * *

A Congress of Electrology and Physio-Therapeutics was held recently in London, under the auspices of the Section of Electro-Therapeutics of the Royal Society of Medicine and of the British Society for the Advancement of Radiology and Physio-Therapeutics. The Congress was chiefly attended by British, French and Belgian delegates the North Sea allies. Several important meetings were held in this Hospital. Our early participation in such events is very satisfactory, for who dare predict to what mighty strength in the cure of malignant disease this infant amongst the special departments may yet attain?

* * *

Our best congratulations to Dr. Porter Phillips, whom we inadvertently omitted last month from our list of Bart.'s men receiving the honour of the Fellowship of the Royal College of Physicians of London.

* * *

The Decennial Clubs are now holding their annual dinners. The Eighth and Tenth Clubs have already done so, the latter Club being launched recently with great goodwill and much success.

The Ninth Decennial will dine on Friday, July 14th, at 7.30, in the Langham Hotel, the day after the commencement of the Post-Graduate Class. All students entering the Hospital between 1895 and 1905 are eligible.

The Seventh Decennial Club Dinner will be held at the Trocadero Restaurant on July 5th at 7 p.m.

* * *

In our recent remarks on the Associateship of the Royal Society of Medicine we omitted to mention a further reason

for young graduates joining the Society under the scheme. Provided that an Associate has made three yearly subscriptions, he is excused the customary entrance fee if within five years of qualification he desires to become a Fellow.

Mr. W. Girling Ball, one of the two secretaries of the Society, will be pleased to give further details to any Bart.'s man desiring to become an Associate.

* * *

We heartily welcome the Rev. William Vassall, M.A. (Oxon.), who comes to us in the capacity of Assistant Hospitalier. In bidding "good-bye" to Mr. Craggs we should like to say how much the Hospital will miss his kindly and cheery personality.

* * *

The following Bart.'s men, to whom we offer our sincere congratulations, were in the list of Birthday Honours: Dr. H. K. Anderson, of Cambridge, received a knighthood; Dr. A. R. Cook was made a C.M.G.; and the M.V.O. (4th Class) was awarded to Surg.-Comdr. F. H. Nimmo, R.N.

* * *

The recent results of the Final Fellowship Examination of the Royal College of Surgeons of England were particularly successful from this Hospital. Of ninety-two candidates twenty-five passed, and of these nine came from this College—a highly satisfactory result.

* * *

Sir Frederick Andrewes has been appointed a representative of the Royal College of Physicians of London on the Lister Institute of Preventative Medicine.

* * *

The Empire Day collections, an account of which appeared in our last issue, were eminently successful. £1702 19s. 11d. was collected by students of this Hospital.

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Capt. J. M. Shah, F.R.C.S., has been awarded the M.B.E. (Mil. Div.) for services rendered during operations in N. and N.E. Persia from 1917 to 1921.

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OBITUARY.

Dr. William Halse R. Rivers, Fellow and Prælector in Natural Sciences, St. John's College, Cambridge, died on June 4th at Cambridge.

Dr. Rivers was President of the Royal Anthropological Institute and the Folk-Lore Society. During the war he served as a captain in the R.A.M.C., and amongst other duties was Psychologist to the Central Hospital, R.A.F. Born in 1864, he was educated at Tonbridge and St. Bartholomew's Hospital. He was Croonian Lecturer to the Royal College of Physicians in 1906, FitzPatrick Lecturer

from 1915-16, President of the Section for Anthropology, British Association, in 1911, and he was awarded the Royal Society's Royal Medal in 1915. He was formerly Lecturer on Psychology at Guy's Hospital, and Lecturer on Physiological and Experimental Psychology at Cambridge. Amongst his publications were *The History of Melanesian Society, Kinship and Social Organisation, Mind and Medicine, Dreams and Primitive Culture, The Influence of Alcohol and other Drugs on Fatigue*, and *The Todas*, and he contributed various papers in *Reports of the Cambridge Expedition to the Torres Straits* and in scientific journals. Dr. Rivers held the degrees of M.A., M.D. and Hon. LL.D. of St. Andrews, and was a Doctor of Science of Manchester University, a Fellow of the Royal College of Physicians, and a Fellow of the Royal Society. He was a brilliant anthropologist and a man of great personal charm. His writings have gained in interest as the years have passed by, and perhaps of all his books the latest, *Instinct and the Unconscious*, was the most suggestive. It was Freudianism with important differences, for the English anthropologist, seeking a biological theory of the troubles of the mind and fresh from his work among soldiers who had failed to stand the stress of battle, discarded or amplified many of the conclusions of the Viennese professor. Through Dr. Rivers' death the world loses a thinker of the first rank.

* * *

Colonel Francis Warburton Begbie, whose death is announced at the age of 58, was the son of an Edinburgh M.D., and was educated at Fettes, Oxford Military College, Cowley, and St. Bartholomew's Hospital. He had a distinguished career in the Army Medical Service, mostly in India, but he also served through the South African War. At the beginning of the Great War he was in Burma. Later he served at the base hospital of the Mesopotamia Field Force. After being Commandant of the R.A.M.C. training centres at Eastbourne, Ripon and Blackpool, he got his wish and went to France, where he did fine work. He had recently been acting as medical member of the Pensions Board for the Exeter District. A man of exceptional charm and magnificent physique, he had done much big game shooting in India, Burma and Ceylon.

* * *

We regret to announce the death of Dr. Gust. Hamel, M.D., M.V.O., who died recently at Surbiton. Dr. Hamel qualified in Switzerland and later re-qualified from St. Bartholomew's Hospital. He was particularly interested in treatment by mechanical exercises. He was the father of the airman, Gustav Hamel, who was lost in a cross-channel flight shortly before the war.

RAHERE LODGE NO. 2546.

THE Installation Meeting of the Rahere Lodge was held in the Great Hall, St. Bartholomew's Hospital, on Wednesday, June 21st, at 5.30 p.m. Previous to the installation Victor A. Spang was initiated by W. Bro. C. H. Perram. The charge was given by W. Bro. H. J. Johnson. W. Bro. Harold Pritchard was installed as Worshipful Master for the ensuing year. The following officers were appointed:

W. Bro. C. H. PERRAM	Acting I.P.M.
Bro. GIRLING BALL	S.W.
Bro. A. W. STOTT	J.W.
Bro. The Rev. R. B. DAND	Chaplain.
W. Bro. ERNEST CLARKE, P.M., P.G.D.	Treasurer.
Bro. GEOFFREY EVANS	Secretary.
W. Bro. M. L. TRECHMAN, P.M., L.R.	D.C.
Bro. WALTON READ	S.D.
Bro. H. D. GILLES	J.D.
W. Bro. H. MORLEY FLETCHER, P.M., P.G.D.	Deputy D.C.
W. Bro. H. E. G. BOYLE, P.M.	Asst. D.C.
W. Bro. LAMING EVANS, P.M., L.R.	Almoner.
W. Bro. L. W. BATHURST, P.M., I.R.	Organist.
Bro. G. L. LYON-SMITH	Asst. Secretary.
Bro. LANGFORD MOORE	I.G.
W. Bro. E. P. FURBER, P.P.G.J.W., Surrey	Sen. Steward.
Bro. B. H. SPILLSBURY	Steward.
Bro. DE BURGH DALY	Tyler.
W. Bro. A. H. COUGHTRY, P.P.G.S.B., Heris	Tyler.
Bro. E. W. HALLETT	Asst. Tyler.

A P.M. Jewel was awarded by ballot at the previous meeting of the Lodge to W. Bro. Francis Clark at the end of his term of office. It could not be presented to him, however, owing to his absence in China.

Ninety-two brethren and guests dined subsequently at the Imperial Restaurant.

THE OCTOCENTENARY OF THE FOUNDATION.

2. THE SISTERS.

By Sir D'ARCY POWER, K.B.E.

THE patients and the Sisters alone have come down to us from the most ancient time with the least change. At the beginning the Sisters tended the sick poor as an act of charity and to the best of their ability without special training. The religious motive may now be less conspicuous and is in part obscured by the professional aspect, but it nevertheless exists. No nurse worthy of the name can take upon herself the manifold cares and responsibilities of a Sister without having in her heart those feelings which actuated her early predecessors. The four Sisters formed an integral part of the original foundation of the Hospital. They were professed Nuns—probably of the Order of St. Augustine, for the Saint gave his rule to women before he placed it on men. They were chosen by the Prior of the Convent on the recommendation of the Master and Brethren of the Hospital, and swore fidelity to the Prior and Convent and obedience to the Master. They lived in a common refectory and slept together in a

dormitory. They received daily four loaves of white bread, three loaves of second quality bread, half a flagon of ale and the better of the two dishes of cooked food supplied to the Brethren. They wore tunics and overtunics of grey cloth, and it is expressly stated that the tunic was not to reach lower than their ankles. But this was at a time when long trailing skirts were in fashion.

One of the four was detailed to take charge of and to issue to the inmates of the Hospital all articles of clothing and other necessaries from the common stock. No doubt with the intention of making her position easier, it was a part of the rule that no one should grumble if he did not get as good a suit as he expected, or if the garments he received had been already worn by someone else. But there is no mention that one Sister was before another though all were under the Master. Their work was life long, and in some cases they held good social positions, and were able to make substantial bequests to the Hospital which had been their home.

In the course of ages some must have become specially skilled in midwifery, for many women were delivered in the Hospital; others must have made that tradition of skilled but unscientific nursing which still exists as the hallmark of the best type of St. Bartholomew's nurse. The patient first and always, gentleness, courtesy, and the numberless minute tricks and details which have been learnt and carried on from generation to generation by observation and not by precept. The numbers remained unaltered for four hundred years, and although the duties were nominally unchanged, it is manifest that four persons could not have nursed from 60 to 100 patients, even where many could help themselves, and all were made to do more for themselves than is now required of them. There must have been subordinates, but of these we hear nothing.

There was no break in the tradition when King Henry VIII took the revenues of the Hospital into his own hands, but there was a great reorganisation. A few patients remained in the Hospital, and the Sisters must have been there to attend upon them. In 1544 five Sisters were appointed, and in 1551 the number was increased to twelve. One of the twelve was chosen to act as Matron, and to her was attached "a fool." Sir Norman Moore, in his history of the Hospital, rather unkindly counts the fool as a Sister, and thus makes the number thirteen, although in reality there were but twelve. The Hospital is so conservative, however, that in the opinion of some the type still recurs at long intervals, though it is no longer a professional office. Under the new constitution the Matron and Sisters had duties and perquisites which have now lapsed. The Matron had personal charge of all the bedding in the Hospital, and she was enjoined to see that the Sisters did their duty in spinning, and did not enter their wards after seven o'clock in winter or nine in the summer, except to attend to patients in danger of immediate death or suffering

from extreme sickness. She was allowed as a perquisite to sell ale, and receive a shilling for the use of a pall when a patient died. The Sisters, on their side, had to wash the patients' linen as well as to scrub the floors, but they took half a crown from every patient who was operated upon and one shilling from each patient admitted into their ward.

The appointment of Sister carried with it a habit or uniform just as in the pre-Reformation days when the Sisters were nuns. Six yards of cloth were allowed yearly at 22s. 6d. The cloth was at first brown, but was soon changed to light blue, and blue in various shades has remained the colour of the Sisters' uniform since 1555. The common dormitory remained until 1787, when the Sisters began to sleep and live, as they now do, in the little room partitioned off from the ward. The change was probably for the better, as there are several orders for the Sisters' wards to be cleared of bugs by the Hospital bug-catcher. They appear to have been a strong and self-reliant body of women, for on one occasion they made a determined attack upon a Sheriff's officer, and obliged him to relinquish a patient whom he had captured in one of the wards. As early as 1647 women helpers had been introduced, who sometimes claimed the reversion to the place of Sister. They represent the original of the Staff Nurse. A regular nursing staff was in existence in 1818, for the Physicians and Surgeons in that year represented to the Governors that one Sister and two Nurses were not sufficient for a double ward. In 1821 the Nurses were ordered to wear a brown uniform, and in 1868 scrubbers were appointed to undertake the drudgery of scrubbing the floors and passages—a duty which had hitherto devolved on the Nurses under the supervision of the Sisters. In 1877 an institution was opened for the training of Nurses in connection with the Hospital, and from this time onwards nursing in the Hospital has become more and more a skilled profession.

TYPES OF MENINGITIS IN CHILDREN: CLINICAL LECTURE.

By HUGH THURSFIELD, M.D., F.R.C.P.

THE accurate recognition of the nature of a disease must always be the first step towards the efficient treatment, so I propose to devote the present lecture to a consideration of the problems of diagnosis presented to us by the various types of meningitis. Even in this sentence I have been betrayed into an inaccuracy, for the disease to which we habitually give the name of meningitis is usually far more than an inflammation of the coverings of the brain, and it would be more accurate, but certainly more cumbersome, if we spoke of leptomeningo-encephalitis; for the greater number of the symptoms which indicate its presence owe their origin to the effects of

inflammation not merely of the pia-arachnoid, but in the cells of the brain itself.

It is probable that there are recorded instances of meningitis due to infection with every known type of pathogenic organism, but in children there are three groups which predominate—the meningococcus, the tubercle bacillus and the pyogenic cocci; and these give rise to three distinct types of clinical phenomena.

MENINGISM.

But before I begin to consider these I must first clear the ground by discussing the use of two terms which are fairly common—meningism and serous meningitis. If we take as the chief criterion of the existence of a meningitis the alterations in pressure, in the albuminous content, and in the character and number of the cells of the cerebro-spinal fluid, then meningism can be said to be present where with a normal fluid the clinical signs of a meningitis are found. But it is questionable how far we are justified in relying absolutely on this criterion. It is established that there is an early stage in epidemic cerebro-spinal fever where, if we relied solely on the evidence afforded by the fluid, we should be obliged to deny the existence of meningitis. It appears therefore to me that it is more in accordance with the facts to regard meningism with its normal cerebro-spinal fluid as an early stage in the development of the inflammation of the meninges, and to believe that it is possible at this early stage for the defensive mechanisms of the body to prevent the further spread of the inflammation and to restore the meninges to a normal state. Meningism thus considered will be the slightest and most recoverable type of inflammation of the meninges. It accords with this view that we find that meningism is most frequently met with in the acute febrile affections. A child with a pneumonia may exhibit the screaming, the vomiting, the retraction of the head, the squints, and the rigidity of the limbs of an advanced stage of meningitis. If with these signs there is a normal cerebro-spinal fluid, even where the fluid is under increased pressure, and if the symptoms have come on early in the attack, the diagnosis of meningism can be safely made. It is rare—indeed I do not know of a case—that such symptoms present early in the disease point to the existence of a frank meningitis.

SEROUS MENINGITIS.

From time to time we meet with cases in which the clinical phenomena of meningitis are present and the C.S.F. shows slight increase of pressure, a moderate leucocytosis and an increase in the albuminous content, yet is neither frankly purulent nor can any organisms be found either in films or by cultivation. Such cases occur perhaps most frequently in connection with middle-ear disease when the mastoid cells are involved in a suppurative process. It is not usually the herald of a more

serious inflammation, and, when the cause has been properly dealt with, rapidly subsides, leaving no sequelæ behind. It is common to speak of such instances as serous meningitis, and it appears to me to be reasonable to regard serous meningitis as a further but still recoverable stage than meningismus in the development of meningitis proper.

MENINGOCOCCUS MENINGITIS.

Passing now to the recognised forms of meningitis, I will first speak of meningococcus meningitis. You are, of course, familiar with the fact that during the war there occurred outbreaks of epidemic cerebro-spinal fever due to this organism, both in this country and, to a less extent, in the armies abroad; but it is perhaps less well recognised that a sporadic form of the disease, due to an organism which in nearly all essential respects is identical with that of the epidemic disease, is fairly common in children, especially in children below two years of age. This disease was for many years known under the name of posterior basic meningitis, so-called from the distribution mainly in the posterior fossa of the skull and the posterior surface of the spinal cord. Dr. Still was the first accurately to describe and isolate the organism of this disease, and to point out the close resemblance which it bore to the organism described by Weichselbaum in the epidemic disease. The bacteriological side of the disease is full of interesting points on which I have not space to dilate, but for our present purpose I think that we may assume that the two diseases, the epidemic and the sporadic, are identical, and that they are caused by an organism which is found to vary in its characteristics in different cases. Dr. Gordon has separated four different types of the organism, finding that Types 1 and 2 are much the more frequent, at any rate in the epidemic disease. In the sporadic disease of infants the differentiation into types has not been so completely studied.

Clinically we meet with both the epidemic and the sporadic forms of the disease in children. The illness may begin insidiously or with an acute onset. If it begins insidiously the baby does not at first appear to be very ill. There is slight fever and often some diarrhoea, and the distinctive features of meningitis do not show themselves for several days. These distinctive signs are the retraction of the head, and the bulging of the anterior fontanelle. If the onset is more acute these signs are usually present from the beginning. The fever is often continued in type, but sometimes is intermittent and may be scarcely noticeable. Unlike other forms of meningitis there is usually no photophobia; the child lies with widely staring eyes, often with a ring of sclerotic visible, and there is no doubt that he is often quite blind. As a rule, however, the pupils remain active to light and there is little or no alteration to be seen in the fundus. In some few cases there is a definite papillitis. Squints are comparatively uncommon. Rashes occur; usually a patchy erythema, but in some cases, just as

in the epidemic disease, the rash is purpuric or herpetic in character. Kernig's sign and Brudzinsky's sign are usually present, both of these being merely a means of eliciting the hypertonicity of the trunk and leg muscles. In some few cases there is effusion into the joints, and if the fluid is withdrawn it is found to be purulent, with the meningococcus demonstrable in the pus-cells. The C.S.F. is turbid, even frankly purulent, with abundance of pus-cells containing the characteristic biscuit-shaped coccus. The course of the disease varies. Below two years of age recovery was rare before the use of serum was introduced. Above two years a fair proportion of the cases recovered after an illness of some days to some weeks. The use of serum has undoubtedly increased the chances of recovery, but it remains a disease with a high mortality. When recovery occurs it is usually complete and sequelæ are uncommon. Yet there are cases in which a spastic paralysis of one or more limbs persists or more rarely wasting of a limb. The only common sequel is hydrocephalus, due to the shutting off of the spinal theca from the sub-arachnoid cerebral space. Acquired hydrocephalus is most often due to this disease. When it occurs it is nearly always progressive and leads to death. The surgical attempts to deal with it have not often succeeded. If it becomes spontaneously stationary, it is usually only after so much damage has been done to the brain that idiocy results.

The diagnosis depends of course on the examination of the C.S.F., but unfortunately this is not always decisive. The specific organism may not be found, and though by the use of suitable media it may be cultivated, this method also fails. From the clinical point of view, it is right to assume that a purulent C.S.F. in the absence of definite organisms is evidence of meningococcal meningitis, since this is by far the commonest type of meningitis in infants under two years of age. I have in these remarks left out much of interest: the curious incidence of the disease; the manner in which the cases occur, none coming under observation for many months, and then ten or a dozen in as many weeks—a fact suggestive of small local epidemics; the curious blindness, without optic atrophy or papillitis, and with such rapid and as a rule permanent recovery. Recently I discharged one infant as permanently blind after three months, but within a fortnight it was brought up seeing perfectly and has had no further trouble. This was one of the uncommon cases which showed a marked papillitis during the acute stage. There are also many points about the treatment deserving of consideration, which may here be summarised as consisting in the early, frequent, and copious administration of serum. If there is opportunity for differentiating the types of the organism it is best to give a serum prepared from that type, but since time is of the first importance, a mixed serum should be employed at once without waiting for the differentiation. In the later stages of the disease

vaccines have been employed with some success. It is best to use a sensitised vaccine and inject it every day in doses beginning with 200–300 millions of the organism. In the most severe cases the serum injections should be given not only intrathecally and subcutaneously, but intravenously, and even into the cerebral cavity through the anterior fontanelle.

TUBERCULOUS MENINGITIS.

The next type of meningitis is certainly the most dreaded, for the physician is absolutely powerless to arrest its progress. It is a disputed point whether tuberculous meningitis which has once given symptoms and signs of its existence can pass on to either temporary or permanent recovery. From time to time cases are published of recovery. Few of these will bear the test of critical examination, but there are a few which appear to be unquestionable. We may admit the possibility and credit the fact, and yet be obliged to confess that such instances are of the nature of miracles, so certain is it that the invasion of the meninges by the tubercle bacillus means death. But even so the disease remains a most interesting problem; its onset is so varied, its course so unexpected, and its recognition often so difficult.

First as to the age at which it is common. There is no age wholly exempt, but its greatest incidence is among children between the ages of two and six years. Many instances are found among the younger infants, the youngest of whom I have a record being four months of age, but speaking generally a meningitis in a child of less than two years is more likely to be due to the meningococcus than to the tubercle bacillus.

The children affected are more usually healthy than otherwise; indeed it is an old observation that tuberculous meningitis picks out the fat, robust child rather than the delicate. Usually there is no warning of the disease, which begins with a certain degree of drowsiness or irritability, slight fever and obstinate constipation. I should like to lay stress on this last, for though not an uncommon complaint, yet the onset of unwonted constipation with some general decline of health is so characteristic a beginning of tuberculous meningitis that it should at once excite suspicion. In other instances the disease begins, so to speak, full-fledged, with fever, unconsciousness, and convulsions. Others, again, though this is much less common, have a period of indefinite malaise which is a source of puzzle to parents and doctors, especially as it is often intermittent, and for several days the patient may seem to have recovered completely only to relapse.

The problems are extremely difficult to solve. I propose to give one or two examples. A child, æt. 2, became extremely ill with consolidation of the left upper lobe of the lung. A fortnight after the onset of the lung trouble he was very drowsy, but irritable when aroused; with a

marked squint and difficult breathing and attacks of cyanosis. He had no Kernig's sign, and no retraction of the head. A few days later he became quite blind, with a failure of the pupils to react to light; and three weeks after the beginning of his illness he had a "fit." His father had died three months previously of pulmonary tuberculosis. The C.S.F. was under pressure, but quite normal in its constituents. For a month he remained blind and then recovered his health completely. This was an example of meningismus, which in the absence of an examination of the C.S.F. could easily have been mistaken for tuberculous or, indeed, meningococcus meningitis.

A child exhibited great irritability with attacks of vomiting at the end of the month of July. Her age was 18 months. When first seen twelve days after the onset, she had well-marked paralysis of the left arm, leg, and face, with constant myoclonic movements of the right arm and leg. She had no squint, and her knee-jerks were not obtained. So far she presented signs which would have suggested the diagnosis of an encephalitis, but the C.S.F. was clear, under pressure, and contained 18 per cent. albumen. No tubercle bacilli were demonstrated. The palsy of the face improved, and then about a month after the beginning of the illness it was observed that the muscles of the arm and leg were wasting. This suggested that the diagnosis was, in reality, a poliomyelitis. A few days later she died somewhat unexpectedly, and at the autopsy typical tuberculous meningitis was found. In this case an accurate diagnosis was not made during life. Encephalitis, poliomyelitis and tuberculous meningitis were discussed, with a leaning towards the last, but so far as the examination of the C.S.F. is concerned the findings are compatible with either of the others.

In the later stages of the disease the diagnosis is usually easy, in spite of the case I have just quoted. In the earlier stages I have myself made or seen made by others the diagnosis of tumour, middle-ear disease, thrombosis of the cerebral sinuses, pyelitis due to the *Bacillus coli communis*, and, of course, poliomyelitis and encephalitis. The only means of accurate diagnosis in a difficult case is the careful examination of the C.S.F. In cases of tuberculous meningitis a fine clot forms in the fluid at the end of a few hours, and if this clot be examined a surprisingly large number will be found to contain tubercle bacilli entangled in the meshes. One of my colleagues has so found them in over 90 per cent. of the cases of tuberculous meningitis with which he has had to deal. Failing the demonstration of the bacilli, a clear fluid with an excess of albumen, the absence of the normal sugar and an excess of lymphocyte cells is so strongly in favour of tuberculous meningitis, that unless there is abundant clinical reason to think otherwise such findings may be regarded as decisive. There are, it is true, exceptions. A child of three was taken ill with headache, vomiting, and constipation. She

had slight fever and marked retraction of the head. Her C.S.F. on three different occasions contained an excess of albumen and an excess of mononuclear cells. Her symptoms disappeared in a few days and she made an uninterrupted recovery. This patient certainly had a meningitis, but there is no clue to its nature. It is hardly likely to have been meningococci, for in the acute stage at least the cells would almost certainly have been polymorphonuclear. Such a case might be called, if we care to use the term, "Serous meningitis," but as I explained earlier it is a bad name, and I prefer to speak of meningitis simply. I quote it merely to draw attention to the difficulties of interpretation of the C.S.F.

MENINGITIS DUE TO THE PYOGENIC COCCI.

The third type to which I call your attention is that which arises as a result of infection with the pyogenic cocci, streptococci, staphylococci and pneumococci. I class these together, because of the striking similarity in their clinical course. Given the infection of the meninges, the usual course of the disease is death within three days with high fever—a striking difference from the prolonged course of the meningococci and tuberculous cases. The chief source of infection with streptococci is of course the ear, and the majority of the children affected are older in years than those we have considered previously; in infants it is generally the result of sepsis in the umbilical cord, but almost any streptococcal or staphylococcal infection may terminate in a meningitis. Usually there is no difficulty about the diagnosis since the infective organism is present in abundance in the C.S.F. The chief difficulty is to distinguish between the cases due to a diffuse infection and those caused by localised infection arising in connection with mastoid disease. The clinical symptoms have nothing to distinguish them from those present in any other form of meningitis.

Pneumococci meningitis is most often found as a sequel to broncho-pneumonia and empyema in babies.

I do not pretend to have covered the ground in this lecture; I have said nothing, for instance, about the cases of influenzal meningitis. They are rare and have striking points in common with meningococci meningitis, but of course the organism is very different. An interesting question is whether this organism is Pfeiffer's bacillus or something resembling it. Nor have I said anything about the rarer organisms which are found in the meninges. My purpose has been to concentrate your attention on the three types which are the most often met with among children, and on the variations in the clinical phenomena and on the difficulties of diagnosis often presented by these cases in an extreme degree even when the C.S.F. is most carefully examined. My last remark is to warn you that syphilitic meningitis, though it does occur, is rather a pathological than a clinical curiosity, and that it very rarely enters into the question of diagnosis.

NOTES ON A CASE OF ACUTE OSTEO-MYELITIS OF THE FEMUR: DIAPHYSECTOMY.

By ROSEVE MAINGOT, F.R.C.S.,
Chief Assistant to a Surgical Unit, St. Bartholomew's Hospital;
Surgical Registrar, West London Hospital.

IN looking through the Hospital records covering a period of many years, I find that the operation of diaphysectomy, either partial or complete, for acute osteomyelitis has rarely been performed.

This case is published, as it embodies several points of interest, both practical and theoretical, and also because it exemplifies the excellent results that so frequently obtain after a diaphysectomy for acute osteomyelitis of the bones of the upper and lower extremities.

The following account is a *résumé* of the dresser's notes:

(1) *History*.—S. C., æt. 13, schoolboy, on August 10th, 1921, sustained a severe fall on his right side. He was able to walk home, but complained of severe pain in his right thigh.

During the next two days he felt ill, and said that his right thigh was painful and "throbbing." On August 14th, 1921, he consulted his doctor, who immediately sent him to the hospital diagnosed as "acute osteomyelitis of the right femur."

(2) *Examination*.—On admission the patient looked ill and was in great pain. The first record of his temperature chart read as follows: T. 101°, P. 104, R. 24. The right thigh was swollen, inflamed and very tender. Fluctuation could be detected in the lower third of the thigh, particularly on the inner side about the region of the adductor tubercle.

The right knee was held flexed; it was swollen, and no movements of the joint could be tolerated by the patient.

White blood cells = 13,000 per c.mm.

(3) *Operation*.—The patient was anaesthetised with gas and oxygen, and a partial diaphysectomy of the right femur was performed by Mr. Rawling. Through a large incision on the outer aspect of the thigh a quantity of foul-smelling greenish pus was evacuated. The periosteum was stripped by pus from the lower epiphysis to within (approximately) three inches of the small trochanter.

Three and a quarter inches of the shaft of the femur was excised sub-periosteally in its lower third, leaving behind 1½ in. of the bone attached to the diseased lower epiphysis. The wound was irrigated with hydrogen peroxide and saline, and then packed with flavine and paraffin.

The limb was temporarily fixed in a Thomas's splint in an extended position.

(4) *After-treatment*.—The wound was dressed next day under an anaesthetic, and the limb was "put up" on a Thomas's extension apparatus.

During the next week the wound was dressed four times, and an anaesthetic was required on each occasion. After this the wound was dressed twice daily.

As there was some backward tilting of the lower portion of the femur the splint was bent through an angle of 40° at

the knee. The limb was kept in this extended position for three months, and subsequently a Thomas's walking calliper splint was applied to the right leg.

A skiagram of the right femur was taken every month to ascertain the amount of new bone-formation, the alignment and the fate of the distal 1½ in. of the shaft.

The X-ray reports are copied verbatim and read as follows:

"September: There is a 3-in. gap in the right femur. The upper end of the lower fragment is slightly tilted backwards. A line of new periosteal bone is forming in the gap." (This skiagram was taken about one month after the operation.)

"October: Considerable new bone-formation bridging the gap between the upper and lower portions of the shaft. New bone is mostly on the outer and anterior region. No evidence of sequestrum."

"November: There is a considerable increase in the amount of new bone-formation since previous plates. Position of fragments is apparently unaltered; alignment is good."

"December: The bridge between the ends of the bone is similar to the condition of a month ago. There is, however, evidence of increased density of the bone in several places. Alignment good; no sequestra."

The patient had a long course of massage and movements, and in April of this year he discarded his calliper.

(5) *Present condition*.—The patient can walk about in absolute comfort without the aid of a stick. He can also run short distances.

There is no shortening, no angulation, and no deformity. The 6-in. line or scar on outer aspect of thigh is firm and healthy. The movements of the right hip and right knee are normal, except that flexion at the knee is limited by one-fifth. It is fair to presume that in a short while this disability will entirely disappear.

(6) *Points of interest*.—(a) The temperature and pulse, displaying small fluctuations, returned to normal, and remained normal five days after the operation. This, as a rule, does not take place so soon after the more stereotyped "gutter operation." The probable explanation is that after a diaphysectomy better drainage has been effected.

(b) After the operation the patient never complained of pain, except when the wound was dressed, after the use of an anaesthetic had been discontinued. Between his dressings he was quite comfortable.

(c) Although the disease apparently commenced in the lower epiphysis, the 1½ in. of the shaft of the bone adherent to it was not cast off as a sequestrum. It recovered and entered into the formation of the new diaphysis.

(d) Only one operation was necessary in this case. The too frequent sequel of the "gutter" operation is sequestrectomy.

(e) There was no shortening of the affected femur after the new bone was laid down. Shortening and deformity were obviated by efficient splinting and extension.

I am indebted to Mr. Rawling for his kindness in allowing me to publish the notes of his case.

PITUITARY TUMOURS.*

PROF. CUSHING first showed two cases. One was a boy, æt. 11. He was fat, intellectually bright, had broad hips and showed evidence of sexual retardation; he had been noticed to be slow in convalescing after an appendix operation and his skin had been seen to be blotchy. He had no headaches and no visual disturbances. Prof. Cushing deplored the tendency of "so-called endocrinologists" to classify mankind according to excessive or deficient secretion of one or another endocrine organ; he thought there was no justification for asserting that this boy's condition was due to pituitary defect without more definite evidence.

The second case shown was a boy, æt. 14, who, besides a similar adiposity associated with precocious sexual development, showed spasticity of the legs, a large head (pointing to hydrocephalus) and strabismus. There was, however, no primary optic atrophy nor changes in the visual fields. These facts pointed to something pressing on the pyramidal tracts, having a mesial position elsewhere than near the optic chiasma. A pineal tumour was suggested, particularly in view of the evidence of hydrocephalus; such a tumour might readily block the iter. It was pointed out that retrogressive changes normally occurred in the pineal at the time of adolescence. Removal of the pineal in animals permitted unusually rapid development of secondary sexual characters, while a tumour of the gland might have a similar effect. The X rays in this case showed a distorted sella turcica, which was not necessarily due to a tumour of the pituitary itself. The adiposity might be accounted for by a secondary pressure on the pituitary; adiposity sometimes followed increased intracranial pressure due to hydrocephalus in infants or associated with a cerebellar tumour.

As regards the treatment of these cases, Prof. Cushing suggested that the first boy should be given pituitary by mouth, in spite of the very little evidence that feeding with ductless glands other than thyroid was of much value; he hoped no one would impress on the boy that he was in any way abnormal. In the second case operative measures were indicated. An osteoplastic resection of the skull would be necessary; puncturing the ventricle would allow the brain to collapse and fairly good access to the region of the fornix could thus be obtained.

The lecturer here gave a warning—"Ductless glands have run away with themselves; we must keep our feet on the ground." He reminded his hearers that adrenal tumours might be associated with adiposity; thyroid tumours with hyperthyroidism; pituitary tumours with failure of reproductive development on the one hand and with acromegaly on the other. The features of Addison's disease and tetany

* A report of a lecture by Prof. Harvey Cushing, delivered in the Medical and Surgical Theatre on June 12th, 1922.

were also familiar, but there were many "bizarre, interlocking conditions" which were very difficult. It was unwise to diagnose a ductless gland defect unless there was a definite recognisable organic lesion.

A number of excellent lantern-slides were shown, portraying patients with various endocrine defects, particularly of the pituitary—all the cases being ones confirmed by autopsy or other means. Of particular interest were some of a type of pituitary defect associated with a thin face and with a peculiar wrinkling of the skin; of pituitary defects occurring in three generations of one family; and of another case which was greatly benefited by feeding with pituitary. Many diagrams of defects of the visual fields were demonstrated, showing the first defect in the upper temporal field, going on to hemianopsia, loss of vision in the macula and finally complete blindness. Other more cheerful diagrams showed the gradual enlargement of the visual fields after operation. Prof. Cushing also showed X rays of the skull with abnormalities of the sella turcica; another plate showed a curious mottling associated with hydrocephalus such as might be produced by a pineal tumour. In other slides the line of approach to the pituitary in both nasal and transfrontal operations was seen. As the lecturer pointed out, in cases of acromegaly where the sella was obviously enlarged, the tumour could be attacked by the nasal route, pressure relieved and the vision improved—and the saving of sight was the most that could usually be hoped for by operation. Whereas if no enlargement of the sella was visible, the tumour was probably small and high up; and an osteo-plastic resection and transfrontal operation were indicated. In many cases the patient, his skiagrams, his visual fields at different stages and microscopical sections of his tumour were seen in a most instructive manner, all on one slide.

Prof. Harvey Cushing concluded a most interesting lecture by expressing his satisfaction at having been made a perpetual student of St. Bartholomew's Hospital and the pleasure which his visit here had given him.

A SHIP'S SURGEON THROUGH THE PANAMA CANAL.

By T. B. CARLYON, M.R.C.S., L.R.C.P.



HAVE lately returned from a voyage to New Zealand, and think that it may be of interest to those who have not been through the Panama Canal to get a few details of that wonderful engineering work.

As a voyage it probably differs little from any others, including as it does the usual sports, cosy corners and ponderous, if not highly enlightening discussions. The Canal zone is a strip of land 10 miles wide with Christobal

and Balboa at either end. From Christobal to the first lock, Gatun, is 6 miles. Here the ship is lifted 85 feet in three lifts. The chambers are each 1000 feet long and 110 feet wide and are worked by electricity, the ship being towed through by electric motors on rails. After leaving the lock the ship enters the great artificial lake, formed by damming up the River Chagress, its size being 164 square miles and 85 feet above sea-level. The conception of making this dam is why the Americans succeeded where Mr. Lesseps failed. The water level is regulated by spillways through the dam. By raising the water level in this way the impossible alternative of making the Culebra Cut sufficiently deep was obviated—the French scheme. The high level of the lake has also provided the whole of the electric power, and incidentally has flooded the previously malaria-infested marshes, the district being now quite healthy.

After crossing the lake you enter the famous Culebra Cut, which is 7 miles long, 300 feet wide and 45 feet deep—unfortunately still liable to land slides.

At the two last locks the ship is lowered 55 feet and proceeds to the western entrance at Balboa—7 miles' distance—having previously been lowered 30 feet at Pedro Miguel lock. At this end the hills to be cut through are over 500 feet high—a barrier to the original sea-level canal scheme. The total cost of the canal was about £80,000,000.

Our next call was at Pitcairn Island, situated in the South Pacific, 1½ miles long by ¼ miles wide. It is the oldest British Colony after Sydney and Norfolk Island. In 1790 Fletcher Christian and eight others, the relics of the mutiny of H.M.S. "Bounty", with six Polynesians and a dozen women, ran the "Bounty" ashore at Pitcairn and burnt her, their retreat being unknown for eighteen years. In 1806 they were taken to Norfolk Island; some returned, and now number 174. They depend on passing steamers for money, with which they buy the necessary articles from New Zealand. A governor is chosen from among themselves, who exercises complete authority and administers the various rites. Fruit and fish, which are abundant, are the main articles of food. A very quaint custom is for the crews of all the shore boats to sing several hymns as the steamer departs. By continuity of marriage and other causes it is conceivable that in time the inhabitants will degenerate; they are already far from being a healthy-looking race. One wonders how they have so long remained contented with their lot.

New Zealand was reached after a pleasant voyage, but only to find that "times" were if anything worse than at home, farm produce and stock being almost unsaleable, though the general view was inclined to be optimistic.

On our return voyage, in one of the Canal locks, we were all very amused over the capture of a small crocodile. Word was passed for the ship surgeon to *skin him*, but

evidently master "Croc" had an inkling of this, as, after exhibiting himself to the passengers, he wriggled out of the bosun's hands and took a header off the ship's side. I heard he had gone through this same performance on several occasions!

As regards the post of ship surgeon, I advise any applicant, before "signing on," to make sure that his cabin accommodation and surgery are what they should reasonably be expected to be, and if he wants modern drugs, to take them with him.

BELINDA ON BIRTHDAY HONOURS.



I CALLED on Belinda Treherne the other afternoon and we had a talk about old days at Bart.'s. It is many years since she gave a hand with the Christmas entertainment, but she still has a warm corner in her heart for the old place, and I was pleased to see that she has kept her good looks and even now shows something of the high spirits that used to enliven us.

A so-called ex-service brass band was making a hash of the National Anthem in the street, and that reminded me that it was the King's birthday. I offered my sympathy on the continued omission of Belinda's name from the Honours List. It is common knowledge that for three years she was the life of every V.A.D. fancy-dress supper party at Wimeraples, and was recommended over and over again by the dear D.C. for a decoration; but nothing came of it and she is still untitled and a spinster.

"They might at least have given you a medal bar for every engagement you were in," I said, "and an oakleaf for breaking it off with the brigadier."

"You'll live and die a cat, my dear," she answered, "and a cat without a ribbon round your neck. Thetrouble about you, Nathaniel, is you're much too regular in all your ways."

"Always a man of regular habits," I murmured into my tumbler.

"Nonsense. What I mean is that you would have done far better not to be such a regular kind of doctor. Now if you had gone in for setting bones or manipulating surgeons (or whatever it is they do) instead of wasting seven years over exams, you might be Sir Nathaniel to-day with a little bit put by in the savings bank."

"Well, if you hadn't been such a regular jilt you'd be Dame Belinda or even a Duchess by now."

When I was saying good-bye to her mother, Belinda pushed a slip of paper into my hand. The light is not very good in my attic and Belinda's writing is abominable, but this is what I make of her communication:

BIRTHDAY TREATS.

The particulars appended to the names are those officially supplied by the Government Departments issuing the List.

O.M. (Fifth Class).

MR. BOOSTUS SMILES. For his efforts to combine Higher Thought with Purin-free Nut-outlets at strictly competitive prices.

M.D. Lambeth (Honoris Coud).

M. EMILE DAYBYDAY. For his services, in every respect, to the neurasthenic pensioners at Tooting on a memorable occasion.

Home Service Medal (in Brass).

Prof. NANNY GOATS. Author of "Radiant Tosh" and kindred works on sale everywhere. For unostentatious services to domestic economy.

DISRESPECTFUL DITTIES.

V. POIT'S FRACTURE AND POIT'S PUFFY TUMOUR.

Is it forgot how Percy Pott
Attained to text-book fame?
He slid his heel on orange peel
And crashing down he came.
He cried "I'm dashed! My ankle's smashed.
This fall shall make my name."

His fracture well, he itched to tell
His fellows how it happened:
How ligament in twain was rent;
How fibula was snapped.
And all inclined to praise a mind
So singularly apt.

Immense his pride, as far and wide
His fame was swelled by rumour.
And, sad but true, his head swelled too.
With well-intentioned humour,
His colleagues said, "That swollen head
Is Percy's puffy tumour!"

VI. YO HO HO! PULV. IPECAC. CO. I (Dover's Powder.)

Oh, Dover was a pirate and he sailed the Spanish Main.
A hacking cough convulsed him; he had agonising pain.
So he mixed himself a powder, which he liked it more and more.
Ipecac. and opium and K₂SO₄.

Oh, dram by dram was Dover's way (and wash it down
with rum!)
He grew so balmy that the crew rose up and swore, "You
scum,
You've doped and soaked until you've gone completely off
your rocker:
So now you'll walk the blinking plank to Davy Jones's
locker!"

Oh, Dover was a pirate and they made him walk the plank.
He walked along for half a yard, then toppled off and sank.
Down dropped Dover; not a trace of him remains:
But the dose of Dover's powder, it is five to fifteen grains.

With a Yo ho ho! Pulv. ipecac. co. I
And a Yo heave ho for Dover!

GEMINI.

HOSPITAL DEFINITIONS.

(This was found by a Bart.'s man in an old army hut and seems to us worthy of insertion.)

A hospital is a collection of corridors covered by a roof and supported by its foundations and contributions.

A ward is a room attached to the side of a corridor. It contains fresh air in large quantities, nurses, beds, and patients.

A bed has position, but no magnitude. Its real duty is to glorify the ward. To disarrange a bed is a criminal offence. It is a far, far better thing to have a tidy bed than a comfortable patient.

A patient is the victim of circumstances and of a conspiracy between the doctor and the hospital authorities. When the meal-time arrives he understands why he is called a patient.

A nurse is essential for the proper running of a hospital. Her chief duties are to wake the patients when asleep.

A meal is a long, thin thing about three inches in diameter and about two hours long. It is incomplete without rice pudding. This is supplied either as a pleasant surprise or to annoy the patients, who thereafter faint at the mere mention of it.

A clinical thermometer is a morbid, cold-blooded instrument which requires warming up twice a day. This it is the duty of the patient to do.

A doctor is a member of the medical profession, who is usually to be found at the other end of a stethoscope. His greatest joy is to push a shoe-horn down one's throat, coupled with the request to say "Ah!"

A chart is a scrap of paper hanging on to a board at the head of your bed. It has often been mistaken for a tube map, but is really the life-story of a clinical thermometer set to music.

ANNUAL SPORTS.

THE Annual Sports were held at Winchmore Hill at 2 p.m. on Friday, June 2nd.

Not for many years, if ever, has the Athletic Club been honoured by the presence of the Treasurer of the Hospital at its Annual Sports Meeting. We appreciate Lord Stanmore's interest in this and other affairs connected with the Medical School.

The general attendance at the meeting was poor. Possibly the proximity of Whitsuntide and the threatening appearance of the weather were, in part, responsible.

Our thanks are due to Mrs. Harmer for the charming way in which she presented the prizes. Mr. Harmer, on her behalf, replied to a vote of thanks in an interesting and witty speech.

The members of the Senior Staff, who kindly acted as officials, carried out their duties with their usual efficiency and despatch. They were only prevented from keeping events up to scheduled time by the lateness or absence of a considerable proportion of prospective competitors.

The laying out of the ground was in every way satisfactory, thanks to the energy and experience of the groundsman.

RESULTS.

Throwing the Hammer: 1, R. D. Reid; 2, J. C. A. Davis. Distance, 76 ft. 1½ in.

1 Mile Handicap: 1, J. R. Deagley; 2, W. W. Darley. Time, 4 min. 45 sec.

High Jump: 1, J. D. Allen; 2, H. G. Anderson. Height, 5 ft. 7 in.

Putting the Shot: 1, R. D. Reid; 2, E. S. Vergette. Distance, 31 ft. 6¼ in.

100 Yards: 1, J. C. A. Davis; 2, P. R. Viviers. Time, 10½ sec.

½ Mile Handicap: 1, H. C. J. Ball; 2, J. R. Deagley. Time, 2 min. 6½ sec.

Long Jump: 1, J. D. Allen; 2, L. C. Neville. Distance, 18 ft. 7 in.

120 Yards Handicap: 1, H. Royle (5 yards); 2, P. R. Rainey (10 yards). Time, 12½ sec.

220 Yards: 1, J. C. A. Davis; 2, L. C. Neville. Time, 24½ sec.

120 Yards Hurdles: 1, L. C. Neville; 2, E. I. Lloyd. Time, 17½ sec.

Obstacle Race: 1, J. P. Hosford; 2, M. Pentreath.

¾ Mile: 1, J. C. A. Davis; 2, E. Bacon. Time, 54½ sec.

Inter-Year Tug-of-War: Third Year.

Inter-Year Relay Race: First Year and Third Year—dead-heat.

THERAPEUTICS AND THE THEATRE.

DO not even find it necessary to plunge my hands deep into my trouser pockets in order to realise that I am hard up. I feel it in every nerve and viscus. Inspection, palpation, percussion and auscultation all demonstrate the same phenomenon. When I am poor, poverty oozes from my pores.

But every casual observer must have noted the recent change in my financial position. I can now afford to lunch with the Catering Company. I smoke my Abdulla in the Square. It has even been reported that I drink tea at 3.30.

Those who know me but little have correlated these facts with the proximity of equestrian events in the sporting world. Nay brother! not so. Far less blatant is my method of reaping shekels.

Have you ever stood for long hours in a theatre queue, suffering costal abrasions from the elbow on the right, suffocation from the peppermint behind—enduring the secondary manifestations of a suppression neurosis caused by the certainty that after all you will not get a seat—with a sharp cramp in your gemellus inferior and a dull dragging pain about the left gastrocnemius? Have you never envied with an envy that deserves a place in the front rank of the seven deadly sins, the rubber-jointed gentlemen who play at being frogs, the goitrous tenor who wants you to "let him be there"? Would you not even change

STUDENTS' UNION.

ABERNETHIAN SOCIETY.

The Advantages of Being Unregistered. Lecture by G. B. S.

THE Mid-Sessional Address of the Abernethian Society was delivered on Thursday, June 8th, in the Medical and Surgical Theatre, by Mr. George Bernard Shaw, his subject being—"The Advantages of being Unregistered."

It is questionable whether any other person would have had the moral courage necessary to address a gathering so representative of all that is orthodox in medicine upon such a heretical theme. But it is a testimony to the genius and eloquence of Mr. Shaw that, not only was his address received with acclamation as a marvel of wit, but that on all sides was a lot of truth in what he had said!

The large theatre was for the first time for many years filled to its gallery, by an audience consisting of members of the Society (staff and students), Nursing Staff and visitors.

Mr. Shaw, in opening, stated that when asked by its Secretary to address the Society, he had replied that he would do so on "The Disadvantages of being Registered."

That was some time ago. Since then had come the news of Mr. Barker's knighthood, which afforded a very evident example of the great advantages of being un-registered. Hence the change in title.

It must, he said, be taken as a serious blow to medical prestige that this honour, which, in medicine, was usually reserved for the heads of the profession, had been conferred on a man who was not only unregistered, but also unqualified.

Sir Herbert Barker had had no recognised medical training. He was a "bone-setter," who had "learned his business" from another bone setter. The medical faculty was inclined to regard Sir Herbert Barker, the bone-setters and the osteopaths as ignorant persons who "did not know the difference between a tuberculous joint and a traumatic dislocation." (Applause.) Unfortunately such persons, with all their ignorance, got relatively as many cures as the qualified practitioners themselves, and often got their best results where the others had failed.

As an instance of such a case, Mr. Shaw referred to a well-known actress whose dislocated "haunch-bone" (applause), having baffled London's surgeons, was instantaneously replaced by an unqualified osteopath.

To the public there had always been a kind of glamour about the unqualified man—probably because he dared to charge more than his qualified rival. But this, of late, had increased to a degree of popularity which seriously challenged that of the medical profession. So pronounced was this tendency that patients nowadays would frequently run the whole gamut of osteopaths, masseurs, Christian scientists and psychotherapists before turning to the qualified doctor for advice. This, said the speaker, was a deplorable state of affairs.

Mr. Shaw then related the story of his uncle, an Irish practitioner of the old school, whom the stress of more modern conditions had reduced from the comparative luxury of a flourishing practice to a condition of complete insolvency. It was a really tragic story, but we ventured to think it a trifle irrelevant, though its narration was marked by sallies of the most brilliant wit.

What was the cause of this waning of public faith in the doctors? According to Mr. Shaw, it was the narrow-mindedness of the General Medical Council.

If the present system continued, and unless the Council began to put its house in order, the day would come when each brass-plate in Harley Street, in addition to the doctor's qualifications, would bear the legend, "No connection with the General Medical Council."

The main failing of the Council, as at present constituted, was that it consisted entirely of doctors. Such a system tended to a medical autocracy, and the community for whom the doctors worked had thus no opportunity of expressing its views on medical organisation and conduct.

The remedy for this lay in so constituting the General Medical Council that it consisted mainly of members of the informed public—other than doctors—with a committee of doctors as assessors. Such a body would then be in a better position to effect several much-needed reforms in medical practice and education.

First among these reforms came the question of admission into the profession: it was absurd, said Mr. Shaw, for any body of men, whether doctors or bottle-washers, to say to an individual, "You

places (for the time being) with the asthmatic organ-grinder who "joined up at his country's call"? And have you not craned your aching neck to look at them, and strained your retrahens auriculorum to catch the sympathetic hush-notes of the singer, and finally have you not emptied your copper coins into the verminous cap?

Now I will tell you how I hauled my ship into harbour.

I have an ancient trench coat—too bespattered with castrol and grease to be pawnable—with a selection of pockets which would delight the heart of a Hackney lady with chronic rummage sale septicaemia. The cap was a difficulty, but my landlady tipped the dustman and he produced one from a neighbouring bin. We sterilised it in the copper and then poured ink and picric acid over it, and tore the lining just a little more. Then we pinned a Serbian flag in one corner of the peak and performed a traumatic dislocation of the vertical button, and suspended it by three-quarters of an inch of black thread. Shod in plimsolls with toes emerging I make my way each night to the West End theatre district.

This is how I start: "Good evenin', ladies and gents, I want to crave your kind intention for a short time this evenin'. You knows as well as I does, nobody better, that doctors nowadays don't believe in drugs. They says, 'Drugs is what quacks kill people with, while we do it 'andsome with knives and thyroids.' Now ladies and gentlemen, that is because of the 'orrid ignorance of the medical profession, which, as Mr. Bernard Shaw says, doesn't know how to dislocate a haunch bone. Now Hi know something about drugs—I 'as to—it's me livin'. I've studied um for years and years. I've taken um all meself and don't I look a fine figure of a man. Now sir, you're lookin' run down—try a sample box of my arsenic pills—they'll make a giant of you. They stimulate the bone marrow to renewed activity. How much sir?—Only 9½d.—and you can meet me here next week and get a full size box. Thank you sir, thank you! Now you sir—what's the trouble, you look worried; out of sorts?—sore throat, I thought so sir—Now don't waste time—there's nothing like thymol for garglin'—rather expensive sir, 1s. 6d. a small box but worth twenty times that. Gargle night and morning—thank you sir."

Trade, on the whole, is good. I often make two guineas in an evening. Of course, in this, as in every other worthy profession, there are pitfalls. I found myself waxing eloquent over pil. aloes c̄ asafetida to a young doctor queuing up for Cairo the other evening. He was not polite. I spotted my house physician outside Prince's three nights ago. I remembered I had an urgent appointment at St. James', and missed the only decent chance I've had to sell digitalis.

I am wondering if I will worry to get qualified. What does an L.R.C.P. mean to a pit queue? R. B.

shall not enter our profession!" It was for the general public to say whether a person were fit or no to be a doctor. They only could do it in a manner free from prejudice. Next came the problem of medical education: the most needed reform was a lengthening of the student's curriculum (Groans), but this could be compensated by the cutting out of certain unnecessary subjects which were taught at present. (Cheers.)

The smattering of science, for instance, with which the medical student was "grounded" was, in Mr. Shaw's opinion, unnecessary. He considered that medicine was not a scientific profession, yet such was the effect of the so-called "scientific training" that the surgeon tended to regard all disease problems as mechanical, the physician to regard them as chemical, whereas, in reality, such problems were vital. In what direction, then, should the curriculum be lengthened? At present the student had no training in either Swedish massage or osteopathy, both of which forms of treatment had been tried and found of value. As the doctor was supposed to understand and practise all forms of treatment, the study of such subjects should form an important part of medical education.

When these reforms were instituted, then, and then only, would the medical profession attain that position which it ought to hold in our public life, that is, "the top of the tree."

Mr. Shaw then sat down amidst great applause.

A vote of thanks was proposed by Mr. McCADAM ECCLES and seconded by Mr. VICK.

In replying, Mr. SHAW stated that if any advanced thinkers among his audience found themselves "up against" the General Medical Council in their future careers, they should come to him and he "would put it right!"

GOLF CLUB.

The annual match between the St. Bartholomew's Hospital Golf Club and the Staff was played at Hanger Hill on Wednesday, May 24th, 1922. The Staff very kindly entertained us to dinner after the match, which in every way was a great success.

SINGLES.

STAFF.	ST. BART'S GOLF CLUB.
Dr. Hinds Howell	0 J. H. T. Davies (6 & 5) 1
Mr. Rose (2 & 1)	1 J. Ness Walker 0
Dr. Graham	1 N. F. Kendall 1
Mr. Wade (2 & 1)	1 C. H. C. Dalton 0
Mr. Spicer	0 H. F. Chillingworth (6 & 5) 1
Mr. Corbett (8 & 6)	1 A. V. Mackenzie 0
Mr. Girling Ball	0 A. W. Brown (6 & 5) 1
Mr. Foster Moore	0 J. L. Potts (7 & 6) 1
	3½ 4½

FOURSBOMES.

Rose and Wade (5 & 4)	1 Walker and Davies 0
Howell and Graham (2)	1 Dalton and Kendall 0
Ball and Spicer	0 Chillingworth and Mackenzie (8 & 7) 1
Moore and Corbett	0 Brown and Potts (2 & 1) 1
	2 2

SWIMMING CLUB.

The First Round of the Inter-Hospital Competitions was decided on June 1st at Fitzroy Street Baths, when we met Guy's Hospital.

In the swimming we were rather unfortunate to lose by 1 point after a very close contest, the 1st, 2nd and 3rd men in both 1 and 2 lengths events being separated by a touch only.

Points were scored for Bart's by the following:

One length.—G. D. Drury, 2nd; N. A. Jory, 3rd.

Two lengths.—N. A. Jory, 3rd.

Three lengths.—M. Harker, 2nd; J. Attwood, 3rd.

Team race (Bart's won by 5 yards).—G. D. Drury, B. Hodze, M. Harker, N. Jory, P. King, M. Pentreath.

Total: Guy's 23 points; Bart's 22 points.

The Water Polo was won by Guy's, 6-1; and in the Diving Guy's secured both 1st and 2nd places.

CRICKET CLUB.

The results of the Cricket season have up to the present moment been satisfactory. Of the 12 matches played, 5 have been won, 4 lost and 3 drawn. Of the 3 matches drawn, 2 have been in our favour, the third even. Of the individual matches those of K.A.M.C. Aldershot, Mr. Rawling's XI and the Cup Ties call for comment. The K.A.M.C., who quickly dismissed our first 4 men for 19, were ultimately mastered by E. H. Watkins, who reached 107 before leaving. The Hospital were able to defeat them after some trouble by about 30 runs.

Mr. Rawling's XI was again victorious, owing to the all-round talent shown by two visitors from Croydon. We regret the sudden spell of good bowling which so summarily dismissed our President.

The Cup Ties have been won easily. Middlesex Hospital were defeated by over 100 runs, and Charing Cross were even less fortunate, since they could only make 26 (Cooper 4 for 7, Parish 6 for 11) in reply to our 301 for 8 (A. E. Parkes 129, Parish 93). The next round (Semi-Final) will be played before June 30th.

REVIEWS.

THE NURSES' "ENQUIRE WITHIN." By E. M. CLARKE. Revised and Corrected by P. B. BENTLEY, M.R.C.S. (Eng.), etc. (London: The Scientific Press, Ltd.) Pp. 328. Price 4s. net.

If you are going to write a book for nurses, make it small by all means, but let the little which it contains be concise, precise and accurate. It is not the quantity, it is the quality which matters.

It is not enough for an intelligent woman to know that Pott's fracture is one "just above the ankle." Nor do we think it sufficient to say of a symptom concerning which a nurse must be constantly on the alert: "rigors, or severe shivering, indicates the commencement of some acute disease." With children convulsions take the place of rigors. These are samples from a book which, containing much wisdom, seems to us still to need careful revision.

NOTES ON GYNÆCOLOGICAL NURSING. By FELICIE NORTON. (London: The Scientific Press, Ltd.) Pp. 96. Price 1s. 3d. net.

This is an excellent little book. It contains much that the nurse needs to know in this special branch of nursing. We have found no mistakes. An index and a few illustrations of the various forms of specula, etc., would improve the value of the handbook.

SEX PROBLEMS IN WOMEN. By S. C. MAGIAN, M.D. (London: William Heinemann [Medical Books], Ltd.) Pp. 219. Price 12s. 6d.

We cannot recommend this book. It contains little that the average doctor does not know. It contains much that he need not know and which might be omitted.

RICKETS. By J. LAWSON DICK, M.D. (Edin.), F.R.C.S. (Eng.). (William Heinemann [Medical Books], Ltd.) Pp. 468. Price 25s. net.

Dr. Lawson Dick's special knowledge of housing problems has produced in this book an unusual mixture of sociology and medicine. Perhaps this is wise. Certainly it is necessary if you believe with the author that the field of inquiry on the cause of rickets "can almost certainly be narrowed down to the conditions of vicious environment which prevail at their worst in slum areas. These are—confinement and the breathing of a vitiated atmosphere in overcrowded and badly ventilated rooms, lack of sunlight, and loss of the opportunities for proper exercise."

Interesting investigations into the frequency of rickets in slum areas are described. Of 1000 Hackney children, 798 showed signs of present or past rickets. The pathology of the condition is extensively dealt with. The book is a treat to thinking men.

ARTIFICIAL LIMBS AND AMPUTATION STUMPS: A PRACTICAL HANDBOOK. By E. MUIRHEAD LITTLE, F.R.C.S. (Eng.). (London: H. K. Lewis & Co., Ltd.) Pp. viii + 319, 207 illustrations. Price 18s. net.

This will form a valuable book to medical men called in to advise on the subject of the choice and getting of artificial limbs. Every variety from the simple page-leg to the most complicated artificial arm is described in detail, with helpful advice on its suitability in special cases. But this becomes work of a highly technical character, and we doubt if many practitioners will find time to make themselves competent on these lines. This book will, however, show the possibilities. For the specialist it provides a highly interesting piece of technical literature.

SURGICAL PATHOLOGY. By ERIC PEARCE GOULD, M.D., M.Ch. (Oxon.), F.R.C.S. (Eng.). (London: J. & A. Churchill.) Pp. 169. Price 6s.

This résumé of surgical pathology may be useful to men who have already learnt their work, and who, on the eve of the Conjoint Surgery Examination, desire to refresh their memory. But pathology is not learnt thus.

TREATMENT OF INJURIES OF THE PERIPHERAL SPINAL NERVES. By SIR HAROLD STILES, K.B.E., F.R.C.S., and MISS M. F. FORRESTER BROWN, M.S., M.D. (Oxford Medical Publications.) Illustrated. Pp. 180. Price 15s. net.

The surgical results of the war remain with us; and now, following the huge mass of incompletely prepared books published during and immediately after the war, there are beginning to appear more important and better produced volumes. The book before us is a clear account of our present knowledge of peripheral nerve surgery. It contains nothing specially new. There seems in nerve surgery little room for that difference of opinion on important points which characterises other branches of the subject. The book is well produced and the illustrations excellent. We can confidently recommend it to all interested in nerve surgery.

A CLINICAL TREATISE ON DIABETES MELLITUS. By MARCEL LARRÉ, M.D. Translated, revised and edited by C. G. CUMSTON, M.D. Pp. viii + 375. (London: William Heinemann [Medical Books], Ltd.) Price 18s. net.

Most of the chapters in this book are lectures or papers of Prof. Larré's written at various times after 1908. Many of them, particularly the purely clinical studies, are very helpful. But a good deal seems strange to modern English ears. Diabetes is divided into rather definite compartments—diabetes with and diabetes without denutrition. Allen's work is mentioned but briefly, and "fast cures" receive but faint praise. There is plentiful evidence that the book is a translation; several words used are not English, and many English words are used in a wrong sense. What (p. 63) is a "cubic gramme"? Renal and cardiac oedemas are not commonly referred to in this country as "brightic or systolic hydropsies" (p. 115). From a sentence on p. 257 the reader must infer that the only cure way for patients to remain free from glycosuria is to "form the habit of exceeding their tolerance for carbohydrates!"

INFLUENZA: ESSAYS BY SEVERAL AUTHORS. Edited by F. G. CROOKSHANK, M.D., F.R.C.P. (London: William Heinemann [Medical Books], Ltd.) Pp. xii + 529. Price 30s. net.

Throughout these seventeen essays by some eleven authors there run these motifs: (i) Influenza is no new disease, but one of immense antiquity; (ii) it has a close epidemiological connection with encephalitis lethargica, Heine-Medin disease, cerebrospinal fever, and possibly dengue, Malta fever and other diseases, (iii) there may be an even closer ætiological connection; (iv) the solution of the influenza problem lies, perhaps, not in finding a specific virus, but in studying other vague extra- or intra-corporal factors, at present little understood. The chapter on the "Bacteriology of Influenza" is the longest in the book, in it Dr. Robert Donaldson spends nearly one hundred pages in denying to Pfeiffer's bacillus any causal relationship to the disease. Here many will agree with him; but his statement that "there is not the slightest shred of evidence that the disease is due to a so-called filter-passing virus" seems hardly warranted even by the facts he himself quotes. In a collection of essays by independent writers some are bound to be better than others. Particularly suggestive and interesting are two by Bart's men—that by Dr. W. H. Hauser on the "Phases of Influenza," and that by Dr. Adolphe Abrahams on "Clinical and Therapeutical Considerations."

RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEWS MEN.

BERRY, JAMES, B.S., F.R.C.S. "Thyroid Surgery." *Medical Annual*, 1922. (Bristol: John Wright & Sons, Ltd.)
BROWN, W. LANGDON, M.A., M.D., F.R.C.P. "Endocrinology." *Ibid.*
COOPER, PERRY R., M.D., B.Sc. (Lond.), F.R.C.S. (Eng.). "On Operations for Appendicitis." *Clinical Journal*, May 3rd, 1922.
DILL, H. H., C.R.E., M.D., F.R.S. (and Major C. F. WHITE, O.B.E., M.D.). "Report on an Experimental and Clinical Comparison of the Therapeutic Properties of Different Preparations of 914 (Neosalvarsan)." *Lancet*, April, 22nd, 1922.

DURAN, ALBAN H. G., F.R.C.S. "Valentine Mott's Aneurysm Needle for Ligation of the Innominate and Subclavian Arteries." *British Medical Journal*, April 22nd, 1922.

EVANS, E. LAMING, C.B.E., M.A., M.D., B.C., F.R.C.S. "Some Recent Advances in Orthopaedic Surgery." *Lancet*, May 6th, 1922.

FEILING, ANTHONY, M.D., F.R.C.P. "The Goutaloxin Lectures on the Interpretation of Symptoms in Disease of the Central Nervous System." Lecture I. *Ibid.*, April 22nd, 1922.

— *Ibid.*, Lecture II. *Ibid.*, April 29th, 1922.

— *Ibid.*, Lecture III. *Ibid.*, May 6th, 1922.

GROVES, E. W. HEY, M.S., M.D., F.R.C.P. "Orthopaedic Surgery." *Medical Annual*, 1922. (Bristol: John Wright & Sons, Ltd.)

KEYES, GEORGE. "Duplication of the Ureter." *British Journal of Surgery*, April, 1922.

LISTER, A. E. J., Lt.-Col., I.M.S. (ret.), M.B., B.S., F.R.C.S. "Eye Diseases." *Medical Annual*, 1922. (Bristol: John Wright & Sons, Ltd.)

MACKENZIE, WALLIS R. L., M.A., M.D. (and EVERARD WILLIAMS, H. G., M.D.). "An Experimental Investigation of the Corpus Luteum in its Relation to the Toxæmia of Pregnancy." *Lancet*, April 22nd, 1922.

MOORE, R. FOSTER, O.B.E., M.A., F.R.C.S. (Cantab.), F.R.C.S. *Medical Ophthalmology*. (London: J. & A. Churchill.)

NATHAN, L. E., M.R.C.S., L.R.C.P. "A New Serum Test for Kala-Asar." *Indian Journal of Medical Research*, April, 1922.

NOON, CHARLES, F.R.C.S. "An Arterio-venous Aneurysm Treated by Ligation of the Left Subclavian Artery." *British Medical Journal*, May 6th, 1922.

POWELL, SIR DAVID. "Eponyms—IV. Williams Hey, of Leeds." *British Journal of Surgery*, April, 1922.

SPENCER, W. G. "Exophthalmic Goitre; Death from Bilateral Femoral Thrombosis and Gangrene." *Ibid.*, April, 1922.

WATSON, SIR C. GOODEN, K.B.E., C.M.E., F.R.C.S. "Bone-setting and Manipulation of Joints." *Clinical Journal*, May 10th, 1922.

CORRESPONDENCE.

THE CURE OF DISEASE.

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

DEAR SIR,—Without venturing upon the "repressed complexes" of Dr. W. F. Lloyd, may I submit that the position of modern medicine is not so tragical after all?

Surely medical practitioners did not think that they cured disease even "years ago"; certainly the surgeon (was it Ambrose Paré?) did not, who said, "I dressed him: God healed him."

Have we thought to do more by counsel and therapy than so to affect mind and body as to remove such hindrances as exist by reason of injury (by violence or poison) or of the unwise habits of the patient?

Most of us have repressed complexes, but we are not all neurotics; yet a convalescence from influenza may so parade them before our jangled minds that we may enter into the feelings of one such; and the more, could we not think it reasonable that "every day we shall grow better and better," saying it a little "thoughtlessly and even listlessly."

Yet a patient's habits of thought may be as unwise as his habits of eating or of drinking, and sorely need counsel to remove a hindrance to cure; not less would the subject of an early phthisis in the depths of depression lose his prospect of cure did the physician (forgetting that his patient had a body) fail to diagnose the condition and order a regimen therefor.

Nor is the use of drugs vain in removing a hindrance to cure (even though all "specifics" be excluded from the consideration).

For, what shall we say of nux vomica for the wearied sleepless bronchitic; of garlic in whooping cough; of digitalis, of calcium lactate, of potassium iodide, of the many drugs of value for external application in diseases of the skin? And is not modern medicine offering a new field of usefulness for the acids in the recent work upon the P₁ problems?

We treat our patients, and, if wisely, cure may follow.

And surely the more "thoughtlessly"—or at least the more lightly—heardly and, if it may be, merrily—a man shall say this or that of

his body, the better then for him and it, and the more practically shall he cry, "Lord have mercy upon me, a sinner," as he orders his body to march behind him on the highway of life.

Yours truly,
12, ALMA ROAD,
CLIFTON, BRISTOL. J. R. R. TRIST.

"HARVEY" WARD.

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

SIR,—Now that Mark Ward has been renamed "Sandhurst," I would like to take this opportunity of asking the reason why no ward of St. Bartholomew's has been honoured with the great name of William Harvey. Ever since I was a student at the Hospital I have been astonished at this strange omission.

Harvey was Physician at the Hospital for over thirty years (1609-1643), and Sir Norman Moore relates that in 1633 he drew up sixteen regulations for the administration of the Hospital which with one exception were adopted by the Governors. I believe most of Harvey's regulations, with slight modifications, are still in force.

Yours faithfully,
UNITED SERVICE CLUB, W. HAMILTON.
CALCUTTA;
May 31st, 1922.

SAMPLES.

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

DEAR SIR,—In the May number under the heading "Samples" you might have entered the following:

(1) In answer to your letter I have given birth to twins. Hoping this will be satisfactory.

(2) Just a line to say that owing to your delay in sending me the money, we have not a morsel of food in the house, hoping you are the same.

(3) I have received no money since my husband has been put in a conscription camp in Germany.

Yours very truly,
KHAGAU P.O., E.I. RAILWAY, INDIA; B. W. HOLMES.
May 21st, 1922.

A QUERY.

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

SIR,—Can any member of St. Bartholomew's inform me why the peace of the Hospital is being disturbed by an army of navvies in Smithfield who seem to be molesting a perfectly good piece of road, leaving undisturbed Holborn and Oxford Street, which bump the motor-cyclist worse than examiners?

Yours, etc.,
ST. BARTHOLOMEW'S HOSPITAL, E.C. 1.; EARNEST STUDENT.
7 June 28th, 1922.

EXAMINATIONS, ETC.

UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:
M.D.—N. G. Homer, H. W. C. Vines.
M.B., B.Ch.—W. F. Eberlie.
B.Ch.—G. C. Wells-Cole.

UNIVERSITY OF LONDON.

Third (M.B., B.S.) Examination for Medical Degrees, May, 1922.

Honours.—C. M. Gwillim (Distinguished in Midwifery), E. H. Weatherall (Distinguished in Medicine, Forensic Medicine and Midwifery).

Pass.—K. N. G. Bailey, F. T. Evans, J. N. Kerr, H. J. McCurrah, M. H. Renall (B.Sc.), H. Shannon, H. Tothill.

Supplementary Pass List.

Group I.—S. Bloom, F. P. Schofield.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

The following were successful at the Final Fellowship Examination held in June:

F. J. Anderson, R. S. Corbett, E. A. Crook, A. R. Dingley, S. L. Higgs, B. H. Pidcock, J. P. Ross, H. M. Wharry, W. E. Wilson.

The following were successful at the Primary Fellowship Examination held in June:
D. J. Batterham, D. A. Brigg, G. O. Chambers, R. L. Williams.

CHANGES OF ADDRESS.

ARCHER, C. W., 29, Albion Street, Hull. (Tel. Central 6803.)
CODY, W. E., 31, St. James' Road, Kingston-on-Thames.
COURTIS, A. O., "Beeley," Oxted, Surrey.
GRAHAM, G., 1, Devonshire Place, W. I. (Mayfair 6407.)
HUMPHRY, A. MURCHISON, 50, Don Road, St. Helier, Jersey. (Tel. St. Helier 850.)
JUST, T. H., 16, Oxford and Cambridge Mansions, Marylebone Road, W. 1. (Tel. Padd. 2678.)
MILNER, S. W., "Meesyllan," Boncath, Pembrokeshire, S. Wales.
SQUARE, W. RUSSELL, c/o The Pahang Consolidated Co., Ltd., Sungli Lembing, Kuantan, Pahang, F.M.S.
WHARRY, H. M., 136, Harley Street, W. 1.

APPOINTMENTS.

HEWER, C. LANGTON, M.B., B.S., appointed Anaesthetist to the Seamen's Hospital, Royal Albert Dock.
HILL, N. H., M.B., B.S. (Lond.), M.R.C.P., appointed Assistant Physician to the Belgrave Hospital for Children, S.W.
LOYD, G. W., M.D. (Lond.), appointed Medical Superintendent of Croydon Union Infirmary.
MARSH, F. D., M.C., M.B., F.R.C.S., appointed Hon. Aural Surgeon and Laryngologist to the Children's Hospital, Birmingham.
WHARRY, H. M., F.R.C.S., appointed Surgical Registrar to the Throat Hospital, Golden Square.

BIRTHS.

ATTLEE.—On June 16th, at 24, High Street, Eton, the wife of Dr. Wilfred Attlee—a son and a daughter.
GERARD-PEARSE.—On June 17th, at 14, Royal Terrace, Weymouth, to Joyce (née Anderson), the wife of John Gerard-Pearse, F.R.C.S.—a son.
NICHOLSON.—On June 7th, at Wokingham, the wife of C. John Nicholson, M.R.C.S.—a daughter.

MARRIAGE.

POYNDEY-BERINGER.—On June 17th, at West Chittington, Sussex, by the Rev. A. Caldecott, Rector of the Parish, Frederick Cecil Poyndey, M.B. (Oxon.), of East Grinstead, only son of the late Rev. Frederick Poyndey, formerly Second Master of Charterhouse, to Lucy Maria, daughter of the late John Harley, M.D., of Beeding, near Pulborough, and widow of O. L. Beringer.

DEATHS.

BRODRIBB.—On May 30th, 1922, at St. Leonards-on-Sea, Charles Aiken Brodrigg, M.R.C.S., L.S.A., aged 70.
RIVERS.—On June 4th, 1922, at Cambridge, William Halse Rivers, Rivers, M.D., F.R.S., F.R.C.P.

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 7s. 6d., 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.

VOL. XXIX.—No. 11.]

AUGUST 1ST, 1922.

PRICE NINEPENCE.

CALENDAR.

Tues., Aug. 1.—Sir T. Horder and Sir C. Gordon-Watson on duty.
Fri., „ 4.—Prof. Fraser and Prof. Gask on duty.
Mon., „ 7.—Bank Holiday.
Tues., „ 8.—Dr. Morley Fletcher and Mr. Waring on duty.
Fri., „ 11.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Tues., „ 15.—Sir P. Horton-Smith Hartley and Mr. Rawling on duty.
Fri., „ 18.—Sir T. Horder and Sir C. Gordon-Watson on duty.
Sat., „ 19.—Last day for receiving matter for September issue of the JOURNAL.
Tues., „ 22.—Prof. Fraser and Prof. Gask on duty.
Fri., „ 25.—Dr. Morley Fletcher and Mr. Waring on duty.
Tues., „ 29.—Dr. Drysdale and Mr. McAdam Eccles on duty.

EDITORIAL.

WE offer no apology for making this month's Editorial Notes as short as possible. We would make them shorter if we could. For this is the holiday month when our seniors are absent from wards and consultations and laboratories, gaining health and strength to grapple with another year's teaching. There is, however, a bright side to the sombre picture for us who remain. The Chief Assistants now come into their own. They walk across the Square with an added weight—we might almost say the droop of premature age—about their shoulders. Great and terrible is their responsibility these summer days, and well they bear the strain.

To all our readers we wish a very happy holiday, well knowing that after a year's work at Bart.'s none can deserve it better nor enjoy it more.

We are delighted once again to see the post-graduates with us. They represent not only past generations of Bart.'s men (and therefore command our respect and affection), but the most enlightened and progressive type of general practitioner. We welcome them back to the place whose traditions they maintain and which we in our turn inherit. We wish that one of them might lecture to us on the difficulties of general practice.

* * *

The recent inaugural dinner of the Tenth Decennial Club was a very great success. Over seventy members were present. We congratulate Dr. Stott and Mr. Reginald M. Vick upon the event.

* * *

The latest sister society of our own Abernethian Society is the recently established Cambridge University Medical Society. Dr. Langdon Brown delivered the inaugural address. We hope and predict great success for the Cambridge enterprise.

* * *

Our heartiest congratulations to Mr. Elgood in securing the third place in the King's Hundred at Bisley. This is brilliantly better than his place last year of thirtieth.

* * *

We have recently seen a set of engravings, produced by Messrs. Beynon, of Cheltenham, and now on sale in the Library. The drawings are of Hospital subjects well known to Bart.'s men and nurses, to whom we commend them. They are of great artistic charm and merit, and one or more should be on the walls of every student, past or present, of the Hospital.

THE OCTOCENTENARY OF THE FOUNDATION.

3. THE BEADLES.

By SIR D'ARCY POWER, K.B.E.

FTEN in the Hospital Square, sometimes in Cheapside, more rarely in Oxford Street, a pleasant-looking official may be seen in a wide-skirted black coat with a silver badge on his right breast bearing the Hospital arms and wearing the regulation cap of black with a narrow white piping—the Hospital colours. He is one of the Hospital beadles, and he takes us straight back to the re-foundation of the Hospital, and to the days of Henry VIII. He is as much a part of the Hospital as the Clerk or the Surgeons and even more so, because he is a parish officer as well as a Hospital servant, and he came into existence when the parish of St. Bartholomew's-the-Less was established in 1547. His duties both as a Hospital official and as a parish beadle were clearly defined from the very beginning. His charge as a beadle was that—"Your office and charge is to give attendance from time to time upon the Governors of this House, and to do such business as they shall assign to you. On all such days as the Governors of this House shall not sit in this Hospital for the affairs of the same ye shall separate and divide yourselves into the sundry parts and liberties thereof every man taking his several walk. And if in any of your walks ye shall happen to spy any person infected with any loathly grief or disease, which shall fortune to lie in any notable place of this City to the noyance and infection of the passers by and slander of this House, ye shall then give knowledge thereof to the Almoners of this Hospital that they may take such order therein as to them shall be thought meet.

"Ye shall also have a special eye and regard unto all such persons as have been cured and healed in this House that none of them counterfeit any grief or disease, neither beg within the City and liberties thereof. And if ye shall fortune to find any so doing, ye shall immediately commit him, or them, to some cage and give knowledge thereof to the Governors of this House, that they may take further order as they shall think best.

"Ye shall not haunt nor frequent the company of any poor and beggarly persons (that is to say) to drink or eat with them in any victualling house or other place, neither shall ye receive any bribe or reward of any of them, lest by occasion thereof you should wink at them, and so lewdly licence them to beg, upon pain to be dismissed this House.

"Also ye shall not suffer any sturdy or idle beggar or vagabond to beg or ask alms within this City of London or the suburbs of the same, but ye shall forthwith commit all such to ward and immediately signify the name and surname

of him or them to the Alderman of that ward where ye shall apprehend any such beggar or else to the Lord Mayor that execution may be done as the law in that case provideth. This is your charge."

In addition to this charge relating to the main duties of the beadles there exist the more detailed orders for the beadles, which are of equal interest. They are:

"First, you shall every day, two and two together, walk through your wards appointed with your staffs in your hands; and all such vagrant and idle persons as you shall find in your walks or in any place abroad, you shall apprehend and convey to the Bridewell. And if you chance to be resisted by way of the said vagrants and evil persons you shall call for aid to every constable next adjoining to assist you. And if he refuse to do so, to take his name and go to the Lord Mayor and deliver unto him the disobedience of the said constable. And if the Lord Mayor do not presently cause such constable to be punished, then at the next Court of Aldermen you to attend and make your complaint, whereby the law may be executed accordingly.

"Item, if any of your citizens die within your walks you are to give your attendance at the houses of them so deceased and to see that no rogues or idle persons resort thither to trouble the street. And if anything be given you of benevolence for your travail to take it thankfully without calling aught of duty. And if you be not of yourselves able to clear the streets of such; then you shall call to your aid such beadles whose walks are next adjoining to aid and assist you therein. And you shall distribute to them part of such money as shall be given unto you. And you shall not intrude yourselves to none other burials out of your wards or walks but unto such as you shall be called by your fellow beadles.

"Item, one of you every Sunday with the rest of the beadles of the other houses shall give your attendance at Paul's Cross at the sermon time; to visit all the streets and lanes adjoining and there to apprehend all such vagrant and idle persons as shall be there found by you, and to carry them as well men as women and children to Bridewell; whereby there may be order taken according to the law prescribed.

"And if any of you shall be found negligent in performing these orders above said or any other orders hereafter made and devised, upon every fault found your staffs shall be taken from you and to be secluded for evermore for serving in those rooms. Whereof assure yourselves without any favour or otherwise to be punished according to the Governors' discretion."

It is clear therefore that the beadles of the Hospital were persons of importance in the City, that they had ample authority to maintain order, apprehend rogues and compel the sick who were a menace to public health to come to the Hospital for treatment. They are now reduced to two, and are to be clearly distinguished from the "box carriers"

who used to attend the surgeon as he went his rounds in the wards, one being attached to each. The box carrier derived his name from the heavy brass-bound box of instruments which he carried when minor operations in the wards were performed on the spur of the moment without an anæsthetic. He was at once a terror to the dresser and a help to the house-surgeon. His heavy step slowly ascending the stairs in the middle of the night was a warning to the house-surgeon of a loud knock on his bedroom door, followed by "A case in the Surgery, Sir, but you needn't 'urry for it ain't hurgent," or else "I think you'd better come quick for 'e seems pretty bad."

THE PITUITARY GLAND IN ITS RELATION TO OBSTETRICS AND GYNÆCOLOGY.*

By DR. HERBERT WILLIAMSON, F.R.C.P.

GENTLEMEN,—When I was asked to give two lectures in the Post-Graduate Course, I asked myself in what direction the greatest advances had been made in obstetrics and gynæcology during the last few years. I came to the conclusion that it was in the recognition of the part played by the ductless glands in causing derangements of the reproductive functions.

Let us, as an example, consider the question of menorrhagia. Until recently we recognised two groups of cases—those associated with general diseases, and of these, perhaps, the anæmias and lesions of the mitral valve were the two commonest, and those found in connection with local pelvic conditions. But there were many cases in which we found neither local nor general cause for the symptoms. We then tried drugs, and if these failed, as they very frequently did, we curetted and made a microscopic examination of the curettings. And in time the report came back to us with the blessed word "endometritis." May I here make a remark about endometritis. The uterine mucous membrane is not the same in appearance on any two days of the menstrual cycle. Look at this, and this, and this [here three plates were shown on the epidiascope]. All these are from a normal uterus, and yet the microscopic appearances are entirely different. If you send a specimen of curettings to a pathologist you should tell him upon what day of the menstrual cycle it was taken.

We now recognise that the cause of menorrhagia must often be sought in the ductless glands, the ovary, the thyroid, the pituitary—each or all may be responsible. Curetting is seldom done now save for diagnostic purposes. If you cannot find any other cause for menorrhagia think of the ductless glands.

The profuse menorrhagia of puberty is frequently due to hyperthyroidism, and in these cases the basal metabolic

* An account of two lectures in the Post-Graduate Course.

rate is usually raised. Let me here give you a word of warning. Some would have us treat this condition of the thyroid with X rays. I regard this as dangerous. Certainly the menorrhagia is stopped, but I have known two cases in which permanent amenorrhœa resulted.

Other types of menorrhagia are associated with excessive production of lutein tissue or of excessive secretion of the anterior lobe of the pituitary body.

Menstruation is entirely dependent upon ovulation. A hyperactivity of the lutein-tissue produces menorrhagia; a hypoactivity will give scanty menstruation or amenorrhœa. But let us go further back. What excites ovarian activity? We cannot give a complete answer to this question, but we do know that the thymus, the internal secretion of the mammary gland, the suprarenals, all inhibit ovarian activity. It is at puberty, when the thymus atrophies, that ovulation commences; during lactation there is amenorrhœa: the suprarenal tends toward the male characteristics. The thyroid and the anterior lobe of the pituitary stimulate the ovary to activity.

There is an old saying that a woman is a woman because of her ovaries. This statement requires modification, for that combination of attributes, physical, psychic, and mental, which in their sum total constitute "femininity," depends not merely upon the presence of ovaries, but upon the whole system of inter-related and inter-acting endocrine glands.

Let me quote two cases in proof of this. This appears to be the picture of an attractive young woman. The body contour, the rounded limbs, the well-developed breasts, the distribution of hair upon the body, the very poise of her head as she is being photographed, are typically feminine. The external genitals were well formed, but the vagina was short and ended blindly. Because of certain vague symptoms the abdomen was opened by Dr. Russell Andrews. There was no trace of a uterus or Fallopian tubes, but two gland-like bodies were found attached by thick bands to the posterior abdominal wall. One was removed, the other left. I show you a picture of the microscopic section of this gland; it is composed, as you see, of seminiferous tubules with numbers of interstitial cells. It is a testicle.

The other case was described by Dr. Gordon Holmes at a meeting of the Association of Physicians in May, 1921:

Dr. Gordon Holmes related a case of tumour of the suprarenal cortex in a young woman. Her development was normal until the age of 19. Then menstruation ceased suddenly and the secondary sexual characteristics underwent very marked changes—atrophy of the mammae and appearance of coarse hair on the lips, chin and body. Her configuration became essentially male. The clitoris enlarged and the uterus was very small. Sugar tolerance was considerably raised. A tumour was felt in the right side of the abdomen which gradually increased in size. It was removed, and was found to be encapsulated with a structure micro-

scopically resembling normal suprarenal tissue. The patient menstruated twenty-six days after its removal for the first time for some years, and the male characteristics rapidly disappeared. She now appeared to be quite normal. Photographs were shown illustrating her appearance before and after the removal of the tumour.

Before proceeding to discuss the pituitary gland more fully let me give you a word of warning. The study of endocrinology is yet in its infancy. The experimental evidence is often contradictory. Clinical facts do not always fit in with laboratory conclusions. There is at present much unfounded speculation. Great caution is therefore necessary in accepting conclusions.

The pituitary body lies in the sella turcica, and the situation furnishes us with one method—the X-rays—of confirming diagnosis of pituitary enlargement. Its weight is $1\frac{1}{2}$ grm. and it is one of the most vascular organs in the body, for twenty to twenty-six arterioles supply it. It is composed of three parts—the pars anterior or glandularis, the pars intermedia and the pars nervosa, the latter two together forming the posterior lobe. The pars anterior, developed from Rathke's pouch, discharges its internal secretion direct into the blood and lymph-spaces. During pregnancy a new type of cell is found in the anterior lobe, so that a competent pathologist on examining a pituitary gland can tell you whether the patient from whom it was taken was pregnant or not. The pars intermedia manufactures a secretion which passes through the pars nervosa into the cerebro-spinal fluid contained in the third ventricle. As is well known, each of the parts of the pituitary exhibits marked microscopic differences.

When we study the physiology the problem is a complicated one, and we are soon forced to the conclusion that the anterior and posterior lobes have different functions. The anterior lobe is intimately associated with the process of growth and with the development of the sex-glands.

From the posterior lobe an active extract can be obtained which—

- (1) Raises the blood-pressure and strengthens the heart's beat.
- (2) Constricts the coronary artery.
- (3) Causes contraction of unstriated muscle, of the uterus, the bladder, the intestines.
- (4) Stimulates the secretory activity of the renal cells.
- (5) Dilates the renal vessels.
- (6) Causes a temporary (but not permanent) increase in the flow of milk.
- (7) Produces glycosuria by causing disappearance of glycogen from the liver and diminishing carbohydrate tolerance.

If the anterior lobe be partially removed in a young animal we find—

- (1) Deficiency of growth.
- (2) Imperfect ossification of bones.

- (3) Failure of development of the sexual organs.

If removed in an adult animal we find atrophy of the sexual organs.

If young animals are fed on the anterior lobe of the gland we find—

- (1) Very early functional activity of both ovaries and testes, with early manifestations of sexual maturity.
- (2) Early oögenesis and spermatogenesis.

A remarkable experiment was recently performed to ascertain the effects of feeding laying hens on pituitary substance: 655 hens were kept under observation upon a fixed diet and under constant conditions. They laid 233 eggs per diem; after adding pituitary gland substance to their food for four days the daily average rose to 352 eggs per day.

No active extract has ever been prepared from the anterior lobe. No graft of the anterior lobe has ever lived long enough to permit of observations of any value, but from the evidence I have quoted and from other evidence I might quote if time permitted, these functions of the anterior lobe have been firmly established.

In practice instances of anterior lobe deficiency often come under the observation of the gynaecologist. The patients are brought because they have passed the usual age of puberty, but they have failed to develop sexually and the periods have not been established.

Here is a remarkable instance of such a condition. This girl, at the time the photograph was taken, was 19 years of age; she measured 4 ft. 3 in. in height and had never menstruated. As you see, the secondary sexual characters are lacking: the female configuration, development of the mammary gland and of pubic hair are not present.

Minor degrees of this same deficiency are common in practice, and many cases of late puberty, imperfect development of the uterus with its attendant painful menstruation and menstrual irregularities are due to this cause. It is of great importance to detect them early, for by timely treatment years of mental and bodily suffering may be averted from these unfortunate girls.

The clinical manifestations of deficiency of the anterior lobe of the pituitary body are, then, in the severer grades pituitary infantilism, and in the milder grades delayed puberty, with an ill-developed uterus with dysmenorrhoea. Therefore, to girls with late menstruation, with scanty, painful periods and with a small, ill-developed uterus I give the following extract of ductless glands: 2 gr. of the whole pituitary gland and 5 gr. of extract of whole ovarian gland twice daily, with 1 gr. of extract of thyroid gland at night. These may be combined in capsules for convenience. With regard to ovarian extract, it should be recognised that there are three forms: one is extract of corpus luteum, another is extract of the whole gland, and another is extract of ovarian residue. I give, in these cases, extract of the whole gland.

Anterior lobe deficiency in adults may be manifested as Fröhlich's syndrome or dystrophia adiposo-genitalis. The chief symptoms of the condition are the deposit of fat, especially in those places where fat is normally plentiful in the female, such as the abdomen, the buttocks, and the proximal portions of the limbs. Associated with the fat, and apparently in the subcutaneous fat, are painful hard swellings, transitory in nature. There is amenorrhoea and a high sugar tolerance. The treatment is by administration of extract of pituitary.

Excess of the anterior lobe brings about giantism before the ossification of the epiphyses is completed; afterwards, acromegaly.

In the early stages of each there is increased sexual activity; later, as degeneration occurs, sexual inactivity. Therefore, just as with the thyroid gland we have hyperthyroidism associated with Graves's disease and hypothyroidism leading to myxedema, so we have hyper- and hypo-pituitarism. But the problem of the pituitary is more complicated than that of the thyroid, because as degenerative changes occur in the gland hyperpituitarism passes into hypopituitarism, and in an organ with two lobes, each having a separate function, one may be over-active and the other under-active. For instance, a tumour of the anterior lobe may press on the posterior lobe and we may get hypopituitarism—that is, a group of manifestations which are not those of either hyper- or hypo-pituitarism.

Now let us consider the use of posterior lobe extracts. First, you must know what preparation you are using, for the product of one leading firm of manufacturing chemists is double the strength of another.

My advice to you is, if you use pituitary use it in small doses—never stronger than 1 c.c. of 10 per cent. in labour. I regard 1 c.c. of 20 per cent. as a dangerous dose. If, therefore, you use a 20 per cent. solution, use not more than half a cubic centimetre, for we know that the result of the injection of pituitary extract may be uterine tetanus or tonic uterine contraction. Now let us consider the use of pituitary extract in pregnancy—and I should like to mention that the discovery of the effect of pituitary extract on uterine contraction is due to an old Bart's man, an old house-physician of Dr. Gee's—Dr. Dale.

Primary uterine inertia may occur in successive pregnancies, and it has been suggested that it is a preventable condition. If, late in pregnancy, the uterus tends to remain flaccid under your hand, the probability of the condition is suggested. Give calcium lactate together with 3 or 4 minims of 2.5 per cent. solution of pituitary as a prophylactic during the last few weeks of pregnancy. Here is another point: It is known that the fetal pituitary becomes active shortly before birth. Does the pituitary cause the onset of labour? This is pure speculation.

We all meet with instances of protracted pregnancy; even when the date of the last menstrual period is known beyond

possibility of error, there is no sign of the onset of labour at the end of the calculated 280 days. The longer the child remains in the uterus the larger it becomes and the harder is the head; pregnancy protracted beyond the normal period therefore brings danger of lacerations and injuries to the mother, and of intra-cranial hæmorrhages to the child. What are we to do in these cases? My own practice is to give an ounce of castor oil, and to order, as soon as the castor oil has acted, three doses of 10 gr. of quinine (30 gr. in all) to be given at intervals of two hours. Some obstetricians advise that this should be combined with intra-muscular injections of $\frac{1}{4}$ iv of a 10 per cent. solution of pituitary extract repeated if necessary at intervals of an hour for four or five doses. Personally, I believe the castor oil and quinine to be quite as effective without the pituitary, and the pituitary without the castor oil and quinine is certainly of very little value.

Never use pituitary after inducing with bougies or a bag. I was once called to a case where two bougies had been inserted, and later $7\frac{1}{2}$ $\frac{1}{4}$ of 20 per cent. solution of pituitary had been exhibited. Rupture of the uterus resulted.

Now with regard to pituitary in the first stage of labour, save in one or two very exceptional cases, don't use it. Suppose you give the drug with the cervix three-quarters dilated, the child may be born after three or four severe pains, but it will tear through the cervix, not stretch it open. In certain cases of accidental hæmorrhage and in placenta prævia it is useful. Never give it in cases of concealed accidental hæmorrhage with albuminuria. This is essentially a toxæmia with necrosis of uterine muscle. If you prescribe it you may easily get a rupture of the uterus.

In the second stage there must be four indications before exhibiting the drug:

- (i) The head must be low in the pelvis.
- (ii) There must be no obstruction at the vulval orifice.
- (iii) The patient must be a multipara.
- (iv) Forceps must be ready boiled.

Never give more than 1 c.c. of 10 per cent. solution. This should be the maximum dose. After giving the drug watch the fetal heart. After fifteen minutes if the baby is not born, put on forceps and deliver. If before fifteen minutes there are variations in the fetal heart-rate, put on forceps immediately. I am in complete agreement with the writer who said: "To the mother who has borne children with an inability to deliver the child when the head is on the perineum it is a boon; to the primipara in the first stage of labour a menace."

Eclampsia with a high blood-pressure is apparently not a contra-indication of pituitary.

One other question we must ask: Does pituitary affect the child? Dr. Ernest Holt has investigated the question. There is more danger of asphyxia livida or pallida after pituitary has been given. The proportion of stillbirths is larger after pituitary has been used. At autopsies on fatal

cases there are often meningeal and cerebral hæmorrhages. If these had not killed, they might easily have caused idiocy or epilepsy.

In the third stage of labour do not give the drug till the placenta has come away, or you may get hour-glass contraction. After delivery of the placenta, and especially with post partum hæmorrhage, its effects are excellent. It acts quicker if injected into the uterus direct. After-pains are often relieved by pituitary.

Turning now to another function of the pituitary gland, we will study its rôle in the production of what is known as the "transient glycosuria of pregnancy."

We recognise three main types of cases in which sugar appears in the urine during pregnancy:

(1) *The alimentary type.* The urine contains glucose but there are no symptoms of polyuria, thirst or pruritus. The blood-sugar is scarcely if at all above the normal, and when the patient is dieted the glucose disappears from the urine.

(2) *True diabetes in pregnancy.* Here we have symptoms of polyuria, thirst, hunger and pruritus. The blood-sugar is high, and the urine-glucose is influenced by diet. The prognosis is very grave: diabetic coma often follows delivery.

(3) *The transient glycosuria of pregnancy.* There is glucose in the urine but there are no symptoms as in diabetes. The sugar is present in varying amount during the pregnancy; it disappears within a few days of delivery and recurs in subsequent pregnancies. Its amount is often increased by placing the patient on a carbohydrate-free diet. The blood-sugar is very little if at all higher than that of a normal pregnant woman. The condition need cause no anxiety.

Let me quote you a typical case of this last condition: A lady, æt 21, was married in January, 1921. The last period was from July 28th to August 3rd, 1921, and she then became pregnant. On January 4th, 1922, glucose was found in her urine. There was no polyuria, no thirst, no hunger, no pruritus, and she felt well. On that date the sugar in the urine was 32 per cent.

She was dieted, and allowed only two small pieces of bread per diem; all sugar, cakes, sweets and potatoes were eliminated. In spite of this dieting, by February 10th the urine-sugar had increased to 3 per cent. I saw her at this time, and asked Dr. Mackenzie Wallis to estimate her blood-sugar. He found it only 12 per cent.—scarcely above the normal for a pregnant woman. We therefore put her back on a full carbohydrate diet, and in four days the urine-sugar had fallen to 0.7 per cent. Sugar persisted in her urine in varying amount throughout the pregnancy, and within a few days of delivery had disappeared completely. I have no doubt that, should she again become pregnant, it will reappear.

I need not point out to you the importance of diagnosis between these conditions when we remember the good

prognosis of the first and third and the grave prognosis of the second. You will gather further from what I have said that the crux of the matter lies in the estimation of the blood-sugar.

We believe that these transient glycosurias—symptomless, uninfluenced by diet, recurring in pregnancy after pregnancy, and associated with a normal blood-sugar—are the result of an increased activity of the pituitary body. This opinion is confirmed by the recent experimental work of Dr. Mackenzie Wallis. By his sugar-tolerance tests he has shown that after the administration of glucose the blood-sugar curves obtained in the transient glycosuria of pregnancy are identical with that obtained in the glycosuria of acromegaly.

I had hoped to touch on other effects of the pituitary upon pregnancy, such as its rôle in milk secretion, the limiting of the bitemporal visual fields by pressure of the enlarged anterior lobe on the optic chiasma, its relation to calcium retention to build up the fetal bones, and other points, but our time is gone.

I have tried to outline some of the relationships between the pituitary body and the reproductive system, in the hope that this may be of use to you in your practice. There is much to be said of the thyroid, the supra-renal, the thymus and the para-thyroids, and above all of the ovary itself when considered as an organ of internal secretion.

CHRONIC SCLEROSIS.

By GEOFFREY EVANS, M.D., F.R.C.P.

THE regular advance in medical knowledge is largely the result of accurate observation and analysis of the complex problems that disease presents. A familiar example of achievement by this method (which has left its mark on the nomenclature of disease) was the separation of typhoid from typhus fever by Gerhard, of Philadelphia, in 1837. In 1896 Achard identified paratyphoid infections; later two forms of paratyphoid infection, A and B, were recognised by their serological and cultural differences, and more recently our knowledge has been extended by the identification of paratyphoid C.

Medicine advances most surely by regular short steps such as these, but occasionally in a hundred years a great discovery is made that throws a flood of light on problems unconnected with the immediate object of the original research. The work of Louis Pasteur, for instance, opened up a new vista in the causation of disease; the greatness of his achievement almost masks the method by which he gained success, but a study of his work shows him subjecting the most complex problems to acute analysis, and one of the results of this method was the discovery of the microbic origin of disease. It is rather remarkable that when the

greatest biologist of all time was still working on the problems of acute disease, a Russian savant of almost equal eminence, Elie Metchnikoff, was engaged on a problem of even greater magnitude in the study of chronic disease and senility. The two men are a striking contrast: Pasteur's mind was so centred on life that he became a protagonist in the controversy on spontaneous generation; Metchnikoff was so obsessed by the idea of the fear of death that he was led to apply the results of his investigations into the phenomena of inflammation to the elucidation of senility and premature death. Metchnikoff had his master's power of acute observation and analysis, but his imagination led him on to synthesis, and a truly grand obsession made him blame the large intestine for the disharmonies that he found in man. These two giants in biology appear as the prototypes of the analytic and synthetic mind; the one succeeded while the other in a measure failed.

The humblest worker among us who spends an hour at practical work or an hour in reflection must necessarily follow in the footsteps of Pasteur or Metchnikoff in exploring the fields of medicine. I sometimes think it is a strain of indolence that makes me welcome the synthetic idea. I well remember in my student days the joy of discovery that the treatment of arteriosclerosis and chronic interstitial nephritis detailed in different chapters of my text-book of medicine was almost identically the same. We all know very well the sense of bewilderment and fatigue when parties to a discussion on chronic kidney disease individually make use of such terms as large white, small white, contracting, contracted, granular, red granular, true red granular, arteriosclerotic and senile kidneys, chronic parenchymatous, mixed, diffuse and interstitial nephritis. Nor does this exhaust the possibilities, for there are types of chronic disease to which the names of distinguished physicians are attached, and the discovery of the "reine schrumpfniere" shows that future possibilities will not be curtailed by the limitations imposed by the English language. This confusion of terms is an incidental and temporary result of the application of the method of analysis, for each phrase or term has its own peculiar connotation, and signifies some particular clinical or pathological type that workers have attempted to isolate. Mere words lose their meaning in such an atmosphere of phrase, and if one of the parties to the discussion were to speak of chronic nephritis it is almost certain that he would be asked what he meant.

The subject presents an irresistible temptation to correlation or synthesis. It is tempting to class together in a single group all those forms of chronic kidney disease which show under the microscope the ordinary histological signs of chronic inflammation; so long as words retain their meaning it is tempting to call all these varieties of chronic kidney disease chronic nephritis simply. If this is accepted it follows that all these varieties of kidneys named are included in the term "chronic nephritis," excepting the

arteriosclerotic and the senile kidneys. This forms a simple basis from which to start, and the two exceptions to the common designation named above may be transferred from the realm of kidney to arterial disease.

It is impossible to escape from the close association of arterial and renal disease. Changes in the size and activity of the heart and variations in the blood-pressure are among the cardinal clinical signs of acute nephritis; the earliest pathological changes in the kidney in acute nephritis appear to be in the capillary nexus of the glomerular tufts (Herxheimer); arteriosclerosis is a common accompaniment of chronic nephritis; the connection, in fact, is so intimate that chronic nephritis cannot be considered without relation to arteriosclerosis. As in the case of chronic kidney disease, the understanding of chronic arterial disease owes much of its difficulty to the obscurity and diversity of its nomenclature. The problem of its causation is still obscure, but the nature of the affection of the arterial wall is one of inflammation. "Chronic arteritis" will displace the term "arteriosclerosis" when it is established to general satisfaction that the nature of the pathological process in arteriosclerosis is one of inflammation. Prof. Virchow was the first to propound the inflammatory theory of arteriosclerosis, and one of the difficulties in its acceptance has been the fact that the lesion differs in certain important respects from chronic inflammatory lesions in other tissues of the body. Thus small-cell infiltration is conspicuous by its absence, and degenerative changes often eclipse inflammatory reaction in the affected parts of the vessel-wall. This is, however, a possible explanation for this and other differences in the relatively poor blood supply of arterial walls, and the degree to which arteries are avascular structures must be settled by anatomists when the blood supply of these tissues is more accurately known. For the present I would accept the inflammatory theory of arteriosclerosis, and suggest that the simultaneous appearance of cellular proliferation, replacement fibrosis and degeneration is dependent on the adequacy of the supply of oxygen to the affected tissue-cells; those cells, such as the endothelial cells, which have a sufficient supply of oxygen have the power of responding to insult by proliferation while those cells, such as the deep tissue-cells of the intima, undergo degeneration because they exist in an avascular environment. Another important condition which may determine the type of lesion in a particular case may be the inherited or acquired vitality of the affected tissues; on such a theory the difference between diffuse hyperplastic sclerosis with its cardiac hypertrophy and raised blood-pressure on the one hand and senile arteriosclerosis on the other hand becomes one of tissue vitality varying with age.

On the hypothesis, then, that arteriosclerosis is chronic arteritis—and some would acknowledge the statement as a fact—the arteriosclerotic and senile kidney are seen to be forms of chronic inflammatory disease. In these two types

of kidney disease the chief affection is of the intimate vasculature of the kidney, and the renal parenchyma is held to suffer secondary degeneration and atrophy by starvation of its proper supply of blood. The same explanation has been given of the relation of arteriosclerosis to chronic nephritis—that is to say it has been held that arteriosclerosis causes chronic nephritis, while others hold that in certain cases chronic nephritis causes arteriosclerosis. There is a confused argument for and against both these views, and it cannot be said that the accumulation of accurate observation on the problem that these conflicting views present has led to any advance in our knowledge of the disease. On the other hand, there is some evidence for the opinion that both chronic arteritis and chronic nephritis are the result of the activity of the same pathogenic agents—that they are, in fact, alternative expressions of the same disease. Thus, when the kidneys bear the brunt of the affection the disease is chronic nephritis, and it may be noted that there are rare cases of death from kidney disease in which the kidneys are small, shrivelled and fibrotic, but without any appreciable arteriosclerosis in either the kidneys or other organs of the body; when the arteries bear the brunt of the affection the disease is arteriosclerosis—diffuse hyperplastic sclerosis or senile arteriosclerosis according to the vitality of the tissues of the arterial wall. The circumstances which determine the affection of the kidneys in one case, the arteries in another case and both arteries and kidneys in a third case is an interesting matter for speculation, but it does not affect the present postulate that chronic nephritis and arteriosclerosis are coincident or varying expressions of the same disease.

It is a clinical fact that some affection of the heart is a common accompaniment of arteriosclerosis and chronic nephritis. With a persistently raised systolic pressure there is cardiac hypertrophy particularly affecting the left ventricle; by taking a number of cases and plotting the systolic blood-pressure taken during life and the heart weight as measured after death, it can be shown that there is a definite relation between the height of the blood-pressure and the weight of the heart. It may be concluded that the cardiac hypertrophy is a compensatory phenomenon, secondary to a persistently raised blood-pressure. There is another familiar group of cases in which the cardiac affection is secondary to disease of the coronary arteries or their branches. Recent anatomical researches by Dr. Louis Gross have thrown new light on the vasculature of the heart, and emphasised the dependence of the conducting tissues on the integrity of the particular vessels that supply them. In some cases, which form a third group of interest in connection with the present thesis, there is a greater degree of cardiac hypertrophy than can be accounted for by the rise in systolic pressure—cases in which disease of the coronary circulation appears insufficient to account for the degree of cardiac affection that is present. In these cases it is suggested that the heart has suffered

simultaneously with the vessels, and that cardiosclerosis and arteriosclerosis have occurred coincidentally as the result of the action of the same pathogenic agents.

It seems that in these lesions found post mortem and in such cases seen during life we are dealing with a disease of the cardio-vasculo-renal system, which may have its chief incidence on the pump, the hose or the nozzle in any particular case, while frequently the whole system is affected by the chronic inflammatory process. The cardio-vasculo-renal system is not, however, the only system affected in the morbid process of this disease. Osteoarthritis is a common accompaniment of arteriosclerosis, and the vascular lesion is so commonly present on post-mortem examination that it has been suggested, as in the case of chronic nephritis, that the chronic arthritis is secondary to chronic arteritis. Mr. A. G. Timbrell Fisher, in his recent Hunterian Lectures, describes the results of most interesting observations on the subject of osteoarthritis. He discards the view that the joint changes are secondary to arterial changes, and he explains the joint changes in terms of a chronic inflammatory process. His explanation of coincident proliferative and degenerative changes in terms of adequacy of oxygen supply to the affected tissue is well supported by anatomical and histological evidence, and the general similarity of the microscopical appearances of the joint lesion in osteoarthritis and the vascular lesion in arteriosclerosis provides additional evidence in favour of the inflammatory theory of arteriosclerosis.

In addition to chronic arthritis the frequent occurrence of glycosuria in arteriosclerosis seems to introduce the pancreas to the complex already described, and doubtless the same arguments as to the causal sequence of arteriosclerosis and pancreatic sclerosis have been or will be brought forward as has been done in discussing the relation of chronic nephritis to arteriosclerosis. The relation of emphysema to this complex needs discussion, but sufficient perhaps has been said to indicate the identity of a chronic inflammatory process called chronic sclerosis—a disease which is rarely limited to a single organ, and most often affects more than a single system. The centre of its attack most often falls on the cardio-vasculo-renal system, and this system may be affected in its entire extent or with a major incidence on the cardio-vascular or vasculo-renal parts. It seems at present that the process of disease is by no means general, and that the liver and brain for instance commonly escape attack. In order to give chronic sclerosis identity as a disease it may be compared to gout, which it resembles in so many respects that the differential diagnosis may be difficult when the characteristic joint lesions and tophi of gout are not manifest. The recognition of chronic sclerosis has the advantage of focussing the attention of the clinician on the whole group of organs and systems commonly affected when attention has been drawn by signs or symptoms to any one of them. It also helps to place

arteriosclerosis in proper proportion to sclerosis elsewhere in the body. Arteriosclerosis appears as the centre of the complex as a whole, as it is the centre of cardio-vasculo-renal sclerosis; this suggestion, however, may be prejudiced, for, as Fielding said, "Every physician, almost, hath his favourite disease." Finally chronic sclerosis, in whatever form it may appear, determines a general line of treatment in respect of environment, work, habits, diet and elimination and a certain attitude in prognosis which is a good foundation on which to build the special course of therapy that the case requires.

STUDENTS' UNION.

LAWN TENNIS CLUB.

Results of the 2nd VI.

v. GALLERV L.T.C.

Lost, 0-9. G. K. Loveday and A. V. Mackenzie lost to Bailey and Bartlett, 2-6, 10-12; lost to Atwell and Bowers, 3-6, 6-3, 3-6; lost to Patience and Brumwell, 0-6, 6-2, 1-6. W. J. J. and B. W. Brown lost to Bailey and Bartlett, 4-6, 4-6; lost to Atwell and Bowers, 1-6, 1-6; lost to Patience and Brumwell, 0-6, 5-7. R. A. P. Corkery and A. Q. Wells lost to Bailey and Bartlett, 1-6, 0-6; lost to Atwell and Bowers, 1-6, 1-6; lost to Patience and Brumwell, 1-6, 1-6.

v. MIDDLESEX HOSPITAL.

Won 9-0. G. K. Loveday and A. V. Mackenzie beat Nicholson and Sladen, 6-0, 6-2; beat Scarff and Escourt, 6-2, 6-2; beat Grey and Chissell, 6-2, 6-0. J. D. M. Stewart and W. Brown beat Nicholson and Sladen, 7-5, 9-7; beat Scarff and Escourt, 4-6, 6-2, 6-3; beat Grey and Chissell, 6-1, 6-1. G. H. Caiger and A. Davenport beat Nicholson and Sladen, 6-3, 6-0; beat Scarff and Escourt, 6-2, 6-1; beat Grey and Chissell, 6-2, 6-1.

v. UNIVERSITY COLLEGE HOSPITAL.

Won, 5-4. W. J. J. and W. Brown lost to Pair No. 1, 1-6, 8-6, 1-6; beat Pair No. 2, 6-4, 6-3; beat Pair No. 3, 6-4, 6-8, 7-5. A. Q. Wells and G. S. Morgan lost to Pair No. 1, 4-6, 4-6; lost to Pair No. 2, 5-7, 5-7; lost to Pair No. 3, 0-6, 6-4, 4-6. J. A. Macfadyen and R. H. Knight beat Pair No. 1, 4-6, 6-2, 6-4; beat Pair No. 2, 6-3, 8-6; beat Pair No. 3, 6-3, 6-4.

v. HIGHGATE L.T.C.

Lost, 7-1, two matches drawn. A. V. Mackenzie and A. C. Cusop lost to Hepworth and Murphy, 4-6, 5-7; beat Read and Cusop, 6-4, 6-1; drew with Bush and Bush, 4-6, 7-5. G. S. Morgan and R. H. Knight lost to Hepworth and Murphy, 3-6, 3-6; lost to Reed and Cusop, 1-6, 4-6; lost to Bush and Bush, 4-6, 6-4, 3-6. A. C. Liesching and R. Green lost to Reed and Cusop, 6-1, 6-3; lost to Bush and Bush, 2-6, 6-3, 2-6.

v. LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE.

Won, 5-0. K. Loveday and W. J. J. beat Hornsby and Markini, 6-4, 6-4; beat Stanton and Nicholls, 6-1, 6-1. G. S. Morgan and J. A. Macfadyen beat Hornsby and Markini, 6-4, 4-6, 6-4; beat Stanton and Nicholls, 6-1, 6-1. R. Green and N. A. Jory beat Stanton and Nicholls, 6-4, 6-0.

Inter-Hospital Cup.

v. KING'S COLLEGE HOSPITAL.

The 2nd VI met King's College Hospital in the first round of the Inter-Hospital Cup and won by 8 matches to 6. As the score indicates it was most keenly fought, and had it not been for the slight advantage we held in the doubles matches we should most certainly have failed.

Singles.—K. Loveday v. Kohnstann, 2-6, 3-6; A. V. Mackenzie v. Collins, 6-3, 6-2; G. H. Caiger v. Porter, 1-6, 3-6; B. W. Brown v. Rice, 4-6, 1-6; J. D. M. Stewart v. Dyer, 6-4, 6-1; A. C. Davenport v. Morgan, not played. Bart.'s 2 matches; King's 3.
Doubles.—G. K. Loveday and A. V. Mackenzie beat Kohnstann and Porter, 6-2, 6-3; beat Collins and Dyer, 6-2, 6-2; beat Rice and Morgan, 6-1, 6-4. W. Brown and J. D. Stewart lost to Kohnstann and Porter, 3-6, 2-6; beat Collins and Dyer, 6-2, 8-6; lost to Rice and Morgan, 3-6, 0-6. A. C. Davenport and G. H. Caiger lost to Kohnstann and Porter, 3-6, 4-6; beat Collins and Dyer, 6-1, 6-4; beat Rice and Morgan, 6-3, 6-4. Bart.'s 6 matches; King's, 3.

v. GUY'S HOSPITAL.

In the second round we met Guy's Hospital and were beaten to matches to 2. It was a most disappointing result because as a team we were capable of better things. Guy's are not unbeatable, and it should have been a very close match, not that one wishes to depreciate the value of our opponents, who were a better team both in singles and doubles.

Singles.—G. K. Loveday v. Phillips, 0-6, 1-6; A. V. Mackenzie v. Morgan, 4-6, 6-8; G. H. Caiger v. Potts, 2-6, 0-6; B. W. Brown v. Sharpey, 2-6, 0-6; W. J. J. v. Laver, 2-6, 2-6; J. D. M. Stewart v. Gordon, 4-6, 6-3, 6-4. Bart.'s 5 matches; Guy's 5 matches.
Doubles.—K. Loveday and A. V. Mackenzie lost to Phillips and Morgan, 1-6, 6-3, 4-6; lost to Potts and Sharp, 7-5, 6-8, 3-6. S. A. Macfadyen and G. Caiger lost to Potts and Sharp, 1-6, 0-6; beat Gordon and Laver, 7-5, 5-7, 6-4. W. J. J. and B. W. Brown lost to Phillips and Morgan, 1-6, 2-6; lost to Gordon and Laver, 5-7, 2-6.

This season was not altogether a crowning success. More matches were arranged but the elements were against us. Then the general enthusiasm which reigned at the commencement of the season was not kept up. Why? We don't know, except that it simply died a natural death. It was never general except for a few energetic ones who did their best to keep things going. We therefore strongly urge that all members of clubs should take a more active and livelier interest in their games to help in an endeavour to place "Bart.'s" where she should be, and not where she is as compared with the other hospitals of London.

GOLF CLUB.

The match *versus* the London Hospital in the Semi-final of the Inter-Hospital Golf, which was played off at Sandy Lodge on July 11th, 1922, resulted in a win for Bart.'s.

ST. BARTHOLOMEW'S HOSPITAL.	LONDON HOSPITAL.
C. H. Prall	0 A. R. Lister (1 up)
J. H. T. Davies (5 & 3)	1 F. Valentine
J. Ness Walker (4 & 2)	1 B. Thompson
H. F. Chillingworth	0 W. G. Lister (7 & 6)
J. L. Potts (4 & 3)	1 J. Burrell
R. Stuart Low (3 & 1)	1 J. Trevor

Prall and Davies	0 A. R. Lister and Valentine
Walker and Potts (1 up)	1 W. G. Lister and Thompson
Chillingworth and Stuart Low	½ Trevor and Burrell

STUDENTS' CHRISTIAN UNION.

A WEEK-END camp was held at Addington, near Croydon, from July 22nd-25th.
Mr. J. B. Hume, F.R.C.S., was kind enough to come down as Camp Commandant, and the Assistant Hospitaler came as Chaplain. We numbered fourteen Bart.'s men in all.
The weather was kind, and everyone had a thoroughly enjoyable time.

REVIEWS.

MEDICAL SCIENCE: ABSTRACTS AND REVIEWS. May, June, July, 1922. (The Medical Research Council: Humphrey Milford, Oxford University Press.) Each 3s. net, or annual subscription 30s. post free.

Three numbers of this admirable periodical lie before us. It will be sufficient to mention the chief contents.

In the May number are articles on "Acute Rheumatism and Rheumatoid Affections," "Cerebro-spinal Fever," "Chancroid"; in June there is a masterly *synopsis* of the recent literature on syphilis; and in July "Diseases of the Liver," "Intestinal Parasites," and "Some Recent Work on the Corpus Striatum" are found.

In each issue there are the usual very full abstracts of recent work on all medical subjects.

THE THRESHOLD OF MOTHERHOOD: HANDBOOK FOR THE PREGNANT WOMAN. By R. DOUGLAS HOWAT, L.R.C.P.(Edin.), L.R.C.S.(Edin.). (Glasgow: Maclehose, Jackson & Co.) Pp. 49. Price 3s. 6d.

Any book talking sense to the pregnant woman about her condition, and not costing too much, is to be welcomed, especially if, as in the present volume, there is a refreshing absence of that sentimentalism which often spoils such works. There are, however, two serious criticisms—one of commission, the other of omission. We do not think that a medical man should advise a woman only to engage a doctor for her confinement who will promise to give her chloroform during labour. Medical men must not be under the dictation of patients with regard to treatment. Often enough chloroform is not indicated; sometimes it is contra-indicated. There is no mention of that thorough medical examination at least once during pregnancy upon which modern obstetricians should insist, and upon the need of which the public is so badly educated.

Apart from these faults the book is good.

OTO-RHINO-LARYNGOLOGY FOR THE STUDENT AND PRACTITIONER. By Dr. GEORGES LAURENS. Translated by H. CLAYTON FOX, F.R.C.S.(Irel.). (John Wright & Sons, Ltd.) 2nd English edition. 589 illustrations. Pp. 350. Price 17s. 6d. net.

The French mind seems particularly able to set forth scientific facts with absolute clearness. This clarity of thought and of expression, the exactness of detail in applying the simplest piece of technique, the extraordinary wealth of illuminating illustrations, are the dominating features of a very excellent book. The writer covers the ground in an extensive fashion, only stopping at the point where proceedings should be taken in hand by a consultant, where work has to be performed which only years of experience can justify. Till this point is reached the book is a valuable mine of information for student or practitioner. It must be of extraordinary value to the house-surgeon in this department.

Particularly do we like the author's method of stating, after he has told the reader what to advise and do in any given circumstance, what to avoid. It is difficult in a book so uniformly good to point out special excellences. The chapters on the larynx make a difficult subject easy. Interesting and sometimes forgotten is his differentiation between Ménière's disease (vertigo caused by hemorrhage into the labyrinth, and very rare) and Ménière's syndrome (vertigo, deafness, and tinnitus caused by any irritation of the labyrinth). We think that perhaps a little more pathology might be helpful, and surely the treatment of dysphagia due to tuberculosis of the larynx by anaesthetisation of the superior laryngeal nerve is a specialised manoeuvre? But these are small points in a remarkably able book. We congratulate the translator on his success.

A TREATISE ON GLAUCOMA. By ROBERT HENRY ELLIOT, M.D., B.S.(Lond.), Sc.D.(Edin.), F.R.C.S.(Eng.). (London: Henry Frowde and Hodder & Stoughton.) With 213 illustrations. Pp. 650. Price 30s. net.

This great work on a special disease of a special department must command respect and interest, not only because it is obvious that no effort has been spared by author or publisher to render it as complete

as possible, but also because the name of the writer will always be associated with the operation of corneo-scleral trephining for the cure of the condition. Col. Elliot's experience in India (surely a paradise for the ophthalmologist) has given him an immense opportunity for research in eye conditions, and the wisdom of many years is found in the book before us.

The length of the volume will indicate its scope. It aims at being a full and complete account of glaucoma. Many points of an historical nature are added. Its very completeness, whilst rendering it invaluable to the ophthalmologist, makes it unsuitable for the student.

Where all is good, full, well written, and dictated by the actual practice and belief of the writer, it is difficult to pick out any section for special praise, but probably the 144 pages devoted to operative treatment will be specially valuable to the surgeon. The smaller points of technique are admirably elucidated, and the emphatic points of technique early in spite of risks is a lesson which cannot be too well learnt. There are many dangers in operating. A bad result, often in spite of, and not because of, the surgeon, brings blame upon him; non-interference and slowly progressing blindness may be forgiven. But glaucoma is a disease in which often professional risks must be undertaken for the patient's good.

CATARACT AND ITS TREATMENT. By HENRY KIRKPATRICK, M.B. (London: Henry Frowde and Hodder & Stoughton.) Illustrated. Pp. 201. Price 12s. 6d.

This volume, also by a retired I.M.S. colonel, is a less ambitious attempt to write a complete account of one ophthalmic condition. The book is well prepared, and is not too large to be outside the range of the keen student or ophthalmic house-surgeon. It contains little that is new, but is a good, clear and careful account of the subject. It excels in the description of treatment before operation—although advice is modelled on the practice in an Indian hospital—and the after-treatment, with an account of the complications occurring after operation.

THE OPHTHALMOLOGY OF GENERAL PRACTICE. By MALCOLM L. HEBBURN, M.D.(Lond.), F.R.C.S.(Eng.). (Cassell & Co., Ltd.) With 40 colour and 9 half-tone illustrations. Pp. 183. Price 12s. 6d. net.

This is a very good book indeed. The object of the writer is to enable the general practitioner to distinguish between cases which he should be able to treat himself with success and those which must be referred to a specialist. We think that the writer has admirably succeeded in his aim.

The volume commences with preliminary chapters on "The Examination of the Eye," "Urgent Cases in General Practice," "Drugs in Ocular Diseases," and "Operations," which will repay careful and repeated attention. Hence he proceeds on the usual anatomical basis of classification.

There is one chapter which we hope in future editions may be amplified—that on "Errors of Refraction and Accommodation, and Eye-strain." Those who have ever been in general practice will well realise what a source of income must often be neglected through sheer ignorance, and will desire more information on this subject.

The illustrations are excellent.

PHYSICAL EXAMINATION OF THE CHEST, WITH SPECIAL REFERENCE TO PULMONARY TUBERCULOSIS, INCLUDING A CHAPTER ON TUBERCULOSIS OF THE LARYNX. By JAMES CROCKET, M.D., D.P.H. (London: H. K. Lewis & Co., Ltd.) Cr. 8vo. Pp. viii + 254. 56 illustrations, including 14 plates. Price 9s. net.

Though the title of this book implies that the whole chest is considered, the subject matter deals only with the lungs, pleura, and such changes in the rest of the chest as are secondary to pulmonary disease. There are many useful hints in the detailed account given, particularly in the chapter on inspection. It is well known that no two teachers employ the same nomenclature, and it is therefore useless to criticise this. We must, however, protest against the statement, apropos of *adles*, that "the term 'subcrepitant' is quite expressive of what is meant"; to most students, we feel sure, this

adjective is meaningless. From what must surely be an extraordinary oversight, the discussion of vocal resonance is completely omitted (though vocal fremitus is considered fully); the word "bronchophony" is not to be found anywhere. Nor does the author give any hint that he disapproves of this method of physical examination. There is a useful chapter on X-ray diagnosis, and a particularly good one (with 17 figures) on the larynx in tuberculosis.

TAYLOR'S PRACTICE OF MEDICINE. By E. P. POULTON, M.D., F.R.C.P., with the assistance of C. P. SYMONDS, M.D., M.R.C.P., and H. W. BARBER, B.A., M.B., F.R.C.P. Twelfth Edition. (London: J. & A. Churchill.) Pp. xiv + 980, 24 plates and 87 text-figures. Price 30s. net.

A great deal of careful work has evidently been put into the revision of this book by Dr. Poulton and his colleagues. The fact

that two colleagues had to be called in perhaps indicates, as is suggested in the preface, that a text-book on medicine can never again be tackled by one man. There is little which has not had to be revised or added to since the last edition in 1918. As we read each section we keep noticing additions which have been incorporated from the most recent literature. There is an appendix dealing with the Schick test, van den Bergh's test in jaundice, and rapid treatment with digitalis.

In contrast to the general excellence, two sections struck us as very inadequate, those on the treatment of empyema and the pathology of purpura (where blood-platelets are never mentioned). The value of clubbed fingers in the diagnosis of malignant endocarditis is not referred to; on p. 612 "Planorbis boissoyi" should read "boissy"; if asked to draw invidious comparisons between "Taylor" and the equally well-known "Osler," we should advise the student, in view of the rapidity with which medical knowledge grows, to buy whichever of the two has the more recent edition.

HOURS OF ATTENDANCE AT THE HOSPITAL OUT-PATIENT DEPARTMENTS.

	Monday.	Tuesday.	Wednesday.	Thursday.	Friday.	Saturday.
General Medical	Dr. Hinds Howell 10 a.m.	Dr. Geoffrey Evans 10 a.m.	Dr. Langdon Brown 10 a.m.	Dr. Gow 10 a.m.	Prof. Fraser 10 a.m.	Dr. Thursfield 10 a.m.
General Surgical	Prof. Gask 10 a.m.	Mr. Vick 10 a.m.	Mr. Wilson 10 a.m.	Mr. Dunhill 10 a.m.	Mr. Roberts 10 a.m.	Mr. Girdling Ball 10 a.m.
Gynæcology	Dr. Barris 9 a.m.	—	Dr. Donaldson 1.30 p.m.	Dr. Barris (Ante-natal Clinic) 1.30 p.m.	—	Dr. Donaldson 9 a.m.
Ophthalmology	Mr. Holmes Spicer 1 p.m.	Mr. Foster Moore 1 p.m.	—	Mr. Holmes Spicer 1 p.m.	Mr. Foster Moore 1 p.m.	—
Laryngology	Mr. Harmer 1 p.m.	Mr. Rose 9 a.m.	—	Mr. Harmer 9 a.m.	Mr. Rose 1 p.m.	—
Otology	Mr. Scott 1 p.m.	Mr. Just 9 a.m.	—	Mr. Scott 9 a.m.	Mr. Just 1 p.m.	—
Orthopedics	Mr. Elmslie 1 p.m.	—	—	Mr. Elmslie 1 p.m.	—	—
Dermatology	—	Dr. Adamson 9 a.m.	Dr. Adamson 9 a.m.	—	Dr. Adamson 9 a.m.	—
Diseases of Children	Dr. Thursfield 1.30 p.m.	—	Dr. Morley Fletcher 1.30 p.m.	—	—	—
Electrical Therapeutics	Dr. Cumberbatch (Men) 1 p.m.	Dr. Cumberbatch (Women) 1 p.m.	—	Dr. Cumberbatch (Men) 1 p.m.	Dr. Cumberbatch (Women) 1 p.m.	—
Dentistry	Mr. Fairbank 9 a.m.	Mr. Fairbank 9 a.m.	Mr. Coleman 9 a.m.	Mr. Fairbank 9 a.m.	Mr. Coleman 9 a.m.	Mr. Coleman 9 a.m.
Psychological Medicine	—	—	—	—	Dr. Austen 10 a.m.	—
Veneral Diseases (Golden Lane)	Women and children 12 to 2 p.m.	—	Men 12 to 2 p.m.	Women and children 12 to 2 p.m.	Men 5 p.m. to 7 p.m.	—
Tuberculosis Dispensary	6 p.m.	12.30 p.m.	—	6 p.m.	12.30 p.m.	—
X-Rays	9.30 a.m. and 1.30 p.m.	9.30 a.m. and 1.30 p.m.	9.30 a.m.	9.30 a.m. and 1.30 p.m.	9.30 a.m. and 1.30 p.m.	9.30 a.m.
Exercises and Massage	9 a.m. and 1.30 p.m.	9 a.m. and 1.30 p.m.	9 a.m. to 1 p.m.	9 a.m. and 1.30 p.m.	9 a.m. and 1.30 p.m.	9 a.m. to 1 p.m.

EXAMINATIONS, ETC.

UNIVERSITY OF OXFORD.

The following degrees have been conferred:
D.M.—G. H. Rosedale.
M.S.—E. A. Crook.
B.M.—W. Champneys.

UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:
M.D.—I. de B. Daly, A. B. Appleton.

UNIVERSITY OF LONDON.

M.D. Examination, July, 1922.

Branch I: Medicine.—F. E. S. Willis.
Branch IV: Midwifery and Diseases of Women.—G. F. Cooke.
Branch VI: Tropical Medicine.—C. V. Boland.

Second Examination for Medical Degrees. Part II.

(For Internal and External Students.)

J. S. Aldridge, H. G. Anderson, H. I. C. Balfour, C. F. J. Baron, J. R. Bengley, F. P. O. Bridgeman, E. Büchler, J. B. Crabtree, M. Fishman, F. G. Greenwood, A. Gross, H. F. Hiscocks, W. Holdsworth, A. C. Liesching, G. K. Loveday, I. S. Moscow, C. E. Pearsons, M. D. Rawkins, D. E. Thomas, R. W. H. Tincker.

LONDON SCHOOL OF TROPICAL MEDICINE.

The following candidates passed the examination held at the termination of the Sixty-ninth (April-July, 1922) Session:
 Lieut.-Col. S. Hunt, I.M.S., C. Dunscombe.

ROYAL COLLEGES OF PHYSICIANS AND SURGEONS.

D.P.H.

The *Diploma in Public Health* has been conferred upon:
 H. Toms, D. S. Brachman, A. M. Eikirdany.

D.P.M.

The *Diploma in Psychological Medicine* has been conferred upon:
 J. J. Gasperine.

SOCIETY OF APOTHECARIES.

The Diploma of the Society was conferred on:
 T. Adam.

APPOINTMENTS.

BARNES, E. B., M.R.C.S., L.R.C.P., appointed Medical Officer to the Throat and Ear Ward, Ministry of Pensions Hospital, Orpington.
 COURT, E. P., M.R.C.S., L.R.C.P., appointed Deputy Medical Superintendent, Borough Mental Hospital, Rowditch, Derby.
 DANNATT, M., M.B., B.S.(Lond.), appointed Deputy Medical Superintendent, Camberwell Infirmary.
 EVANS, D. B., M.R.C.S., L.R.C.P., appointed Medical Superintendent to the Standish House Sanatorium for Tuberculosis, Stonehouse.
 GRAY, A., F.R.C.S.(Eng.), M.R.C.P.(Edin.), appointed Assistant Physician for Diseases of Women, London Homeopathic Hospital, Great Ormond Street, and Queen Square.
 MATTHEWS, E. A. C., Lt.-Col. I.M.S., D.S.O., M.B., B.Ch.(Cantab.), appointed to the Command of Palestine General Hospital, Ludd, Palestine.
 WHITEHEAD, F. E., M.R.C.S., L.R.C.P., appointed Senior Medical Officer, Nyasaland, British Central Africa.
 WOODFORDE, A. W. G., M.B., B.S.(Lond.), appointed Hon. Assistant Surgeon, and Hon. Assistant Orthopaedic Surgeon, to St. Bartholomew's Hospital, Rochester.

CHANGES OF ADDRESS.

BARNES, E. B., Ministry of Pensions Hospital, Orpington.
 BURSTAL, E., 46, Lansdowne Road, Bournemouth.
 COOK, A. R., Melrose, 8, South Park Hill Road, S. Croydon (temporary).

COURT, E. P., Borough Mental Hospital, Rowditch, Derby.
 CROOK, E. A., 136, Harley Street, W. 1. (Tel. Mayfair 6397.)
 CROWLEY, R. H., New Town Hostel, Welwyn Garden City, Herts.
 DANNATT, M., Camberwell Infirmary, Brunswick Square, Camberwell, S.E. 5.
 DAVIES, S. TREVOR, Tuberculosis Dispensary, 140, West Green Road, Tottenham, N. 15.
 DUPRÉ, W. H., St. Just. nr. Penzance, Cornwall.
 EVANS, D. B., Standish House, Stonehouse, Glos. (Tel. Stonehouse 176.)
 FOOKS, G. E., Lt.-Col. I.M.S., Upton, Bangalore, India.
 GRAHAM, G., 1, Devonshire Place, W. 1. (Tel. Mayfair 6407.)
 LEE, W. F., 17, Prince's Avenue, Muswell Hill, N.
 MACKENZIE, K. A. I., Surg.-Lt. R.N., Lansdowne House, Ryde, Isle of Wight.
 MATTHEWS, E. A. C., Lt.-Col. I.M.S., D.S.O., Palestine General Hospital, Ludd, Palestine.
 VINTER, N. S. B., c/o Post Office, Charlestown, Nevis, B.W.I.
 WHITEHEAD, F. E., Medical Department, Nyasaland, British Central Africa.

BIRTHS.

BARNES.—On June 26th, at Wiltshire House, Wiltshire Road, S.W. 9, Frances (*née* Norman), wife of Howell Wood Barnes, B.A., M.B., B.Ch.(Cantab.), M.O.H., Metropolitan Borough of Camberwell—of a daughter (Sybil Mary).
 BROUGHTON-ALCOCK.—On June 28th, at 20, Grosvenor Street, W. 1, to Dr. and Mrs. W. Broughton-Alcock—a daughter.
 GILBERTSON.—On June 26th, at Bancroft, Hitchin, Herts, the wife of Dr. H. Marshall Gilbertson—of a daughter.
 MATHER.—On June 18th, at 79, Linden Road, Bournville, Birmingham, to Alice, the wife of Edward E. Mather, M.B.—a son.
 PRENTICE.—On July 9th, at Seacliffe, Kingsgate, Kent, to Margaret, wife of H. Ridley Prentice, M.B., M.R.C.P.—twin sons.
 ROSSDALE.—On June 26th, to Kate, wife of Dr. George Rosedale, of 57, Upper Berkeley Street—a daughter.

MARRIAGES.

BALLINGALL—CHANDLER.—On May 3rd, 1922, at St. George's Cathedral, Jerusalem, Palestine, by the Right Reverend the Bishop of Jerusalem, Captain David Charles Gordon Ballingall, M.C., R.A.M.C., eldest son of the late Charles Gulland Ballingall and Mrs. C. G. Ballingall, Hampstead, London, and Rosa Beatrice Chandler, eldest daughter of Mr. and Mrs. A. B. Chandler, formerly of Seagry, Chippenham, Wilts.
 CHAMBERLAIN—CLEMENTS.—On July 22nd, at St. Giles' Registry Office, W., Arthur George Chamberlain to Mary Eileen Emélie Clements.
 EMMERSON—PETO.—On July 1st, at St. Mary Abbot's, Kensington, by the Rev. R. W. Bell, Cuthbert Lindsay Emmerson (Capt., R.A.M.C.), only son of the late Dr. Emmerson, of Biggleswade, Beds, to Gladys Emma, only daughter of the late Mr. William Peto and Mrs. Peto, of Canon Court, Maidenhead.

DEATH.

TOSSWILL.—On July 7th, 1922, at 5, Clifton Hill, Exeter, Louis Henry Tosswill, M.B.(Cantab.), aged 79.

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 7s. 6d., 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. XXIX.—No. 12.]

SEPTEMBER 1ST, 1922.

PRICE NINEPENCE.

CALENDAR.

Tues., Aug. 29.—Dr. Drysdale and Mr. McAdam Eccles on duty.
 Fri., Sept. 1.—Sir P. Horton-Smith Hartley and Mr. Rawling on duty.
 Tues., „ 5.—Sir T. Horder and Sir C. Gordon-Watson on duty.
 Fri., „ 8.—Prof. Fraser and Prof. Gask on duty.
 Tues., „ 12.—Dr. H. Morley Fletcher and Mr. Waring on duty.
 Fri., „ 15.—Dr. Drysdale and Mr. McAdam Eccles on duty.
 Tues., „ 19.—Sir P. Horton-Smith Hartley and Mr. Rawling on duty.
 Fri., „ 22.—Sir T. Horder and Sir C. Gordon-Watson on duty.
 Tues., „ 26.—Prof. Fraser and Prof. Gask on duty.
 Fri., „ 29.—Dr. H. Morley Fletcher and Mr. Waring on duty.

EDITORIAL.



THE Professorial Units have been in the past seriously hampered by the lack of adequate accommodation for their pathological work. We hope that soon this will be remedied, for the Council to the Trustees of the late Sir William Dunn has recently granted (under certain conditions) £10,000 to the Hospital for the purpose of establishing and maintaining suitable laboratory accommodation. The whole of the present Isolation Block will be devoted to the Professorial Units, and a bridge will be built between the first floor and Sandhurst Ward.

Thus should two thoroughly alive Hospital departments be able to extend their influence. They have so far necessarily devoted themselves in a very large measure to becoming valuable teaching units. It now remains to be seen whether, with their new accommodation, the fruits of this teaching and its inspiration, may be demonstrated in the production of sound research.

* * *

The Sub-Committees appointed in connection with the Eight Hundredth Centenary Celebrations have now issued their reports.

The Religious Services Sub-Committee recommends that the Festival should begin with a celebration of the Holy Communion, followed by two special services, one in St. Paul's Cathedral, the other in the Church of St. Bartholomew the Great, one at the beginning, the other at the end of the Festival; and that there should be a procession from the Hospital to St. Bartholomew the Great or possibly to St. Paul's.

The Exhibitions Sub-Committee has prepared a provisional grouping of books, prints, maps, etc., which will be exhibited in the Great Hall.

The Scientific Sub-Committee will publish a Commemorative Volume containing an historical account of the Hospital by Sir D'Arcy Power, and a statement of its future needs by Mr. Waring. It is proposed in the report that a competition be held under the direction of the President of the Institute of British Architects to provide architectural plans for rebuilding the Hospital, with prizes not exceeding £1000 in amount. We understand, however, that this scheme will very probably be found unworkable, and that a single architect may be asked to furnish plans instead.

The Entertainment Sub-Committee proposes to reproduce the Bartholomew Fair (as held in Elizabethan days), in the Square, together with various luncheons, dinners, and a conversazione.

The chief points of interest about the report of the Reception Sub-Committee are its determination to invite delegates from English-speaking universities only, and the fact that there will be no expenses in connection with their work.

Regarding these proposals as a whole there can be no doubt that this important anniversary will be adequately celebrated.

* * *

The pleas for the gradual reconstruction of the Hospital should perhaps be as interesting and instructive as anything

in the programme; for which of us has not conjectured upon what plan the Bart.'s of the future will be built? On the one hand is the urgent necessity of advancing with advancing science. To stand still in this case is to go back. An ancient institution tends always to rest upon its laurels. We must expand in all directions or fail to maintain our position.

On the other hand is the real affection felt by all Bart.'s men for these old buildings which have seen so much of hope and suffering, recovery and death, success and failure. There is no doubt, however, that in the direct issue sentiment would have to go. It is the healing of the sick with the maximum efficiency which is all important, and the vital problem is the wisest possible use of existing ground space.

We imagine that the present suggestions for reconstruction are an attempt to combine the ideas of modern ward hygiene with the advantages, sentimental and real, of a great teaching centre in London. This rebuilding, if it comes, will be a huge business. Possibly yet another way may be found. It may be that, since we cannot expand in area, we may have to go higher. The top wards in each block might well be demolished, several stories of new wards with up-to-date and elaborate hygienic and pathological arrangements instituted, and on the top, high above the dust and roar of the London streets, a flat roof, connecting block to block by bridges, and providing roof gardens for the patients and tennis courts for nurses and students.

We who are at Bart.'s now cannot but feel that the Hospital is at the very crest of a great wave of prosperity and of public esteem. There are many reasons for this, but the first and most important, for which we should be profoundly thankful, is the wise, cautious, and yet bold administration of those at the head of the Medical College and Hospital during and immediately after the trying war years. They who met those problems will be able to meet the extraordinary difficulties suggested by the Octocentenary Prize.

* * *

We are relieved that the memorandum proposes the Bartholomew Fair is to be "as it was held in the Elizabethan Period." There will be about twenty-five side-shows, some resembling those which took place at Bartholomew Fair and some "of a more modern character." To brighten up Queen Elizabeth, we presume.

We believe that it was in the days of Good Queen Bess that Bartholomew Fair was visited by the first man who took the trouble to describe it—one Paul Hentzner—who, after visiting Germany, France, Italy and England, wrote an "Itinerarium," after translated by Bentley for Horace Walpole:

"It is worthy of observation that every year upon St. Bartholomew's Day, when the Fair is held, it is usual for

the Mayor, attended by the twelve principal aldermen, to walk in a neighbouring field dressed in his scarlet gown, and about his neck a golden chain to which is hung a golden fleece, and, besides that particular ornament which distinguishes the most noble Order of the Garter, when the Mayor goes out of the precincts of the City a sceptre and sword and a cap are borne before him, and he is followed by the principal aldermen in scarlet gowns with gold chains, himself and they on horseback. Upon their arrival at a place appointed for that purpose, where a tent is pitched, the mob begin to wrestle before them, two at a time; the conquerors receive rewards from the magistrates. After this is over a parcel of live rabbits are turned loose among the crowd, which are pursued by a number of boys who endeavour to catch them with all the noise they can make. While we were at this show one of our company, Tobias Salander, Doctor of Physic, had his pocket picked of his purse, with nine crowns, which, without doubt, was so cleverly taken from him by an Englishman who always kept very close to him that the Doctor did not perceive it."

There was, however, a darker side. Five years before this visit the Fair was forbidden because of plague; five years later it was closed again. Hentzner's description of Queen Elizabeth is interesting: "In the fifty-sixth year of her age (as we are told), very majestic; her face oblong, fair but wrinkled; her eyes small, but black and pleasant; her nose a little hooked, her lips narrow, and her teeth black (a defect the English seem subject to from their too great use of sugar). . . . She wore false hair, and that red; her bosom was uncovered, as all the English ladies have it till they marry; her hands were small, her fingers long, and her stature neither tall nor low; her air was stately; her manner of speaking mild and obliging."

Yes, Elizabeth's time is the period for the Fair!

* * *

Early in August the Hospital was shocked to hear of the tragic death of Estlin Hugh Weatherall, an obituary of whom will be found elsewhere. A man of great promise, of a gentle spirit and surveying life with level eyes, his was a personality which can ill be spared. Readers of the Journal will miss in him one of the writers of the witty articles signed "Gemini." We extend our deepest sympathy to his sorrowing family.

* * *

At the adjourned inquest held on August 16th last a verdict of "death from misadventure" was returned. Weatherall was riding pillion fashion when the accident occurred. Any practising surgeon well knows the danger of this form of riding, whilst the motor-cyclist is compelled to realise it by the greatly increased premium demanded when insuring a machine if a pillion-passenger is to be

carried. We believe that pillion riding should be made illegal. Several times already the question has been raised in Parliament. Each time no action has been taken.

* * *

Our congratulations upon the following honours: Lt.-Col. F. O'Kinealy, C.I.E., I.M.S., Chief Medical Officer to the Prince of Wales during his recent tour, has been made a C.V.O.

Sir Anthony Bowlby has been elected President and Sir D'Arcy Power Vice-President of the Royal College of Surgeons of England during the ensuing year.

Messrs. H. E. Griffiths, G. L. Keynes, L. B. Rawling and E. M. Woodman have been appointed Hunterian Professors.

* * *

Our congratulations to the following Bart.'s men who have been elected to Junior Beit Fellowships:—*Ernest Basil Verney*: Proposed research, "The Physiology and Pathology of Urinary Secretion," at the Institute of Physiology, University College, London. *Reginald Hilton*: Proposed research, "The Study of the Blood Gases in various stages of Pulmonary Collapse produced by Artificial Pneumothorax; the Condition of the Circulation in the Collapsed Lung." Place of research, the Laboratory and Wards of the Professorial Unit of St. Bartholomew's Hospital.

* * *

Ivan de Burgh Daly was elected to a fourth year fellowship for his research on "Auriculo-Ventricular Block."

* * *

Amid the congratulations of many friends, Dr. F. J. Waldo has just completed twenty-one years' service as Coroner of the City of London and Southwark.

Dr. Waldo's public work dates back long before he went to the City. For many years he was the first Medical Officer of Health to the Two Temples and in the old Borough of Southwark, and had to face some of the hard problems presented by slumdom in its worst phases. The old Tabard Street area—one of the very worst in London—was "on his beat," and it was largely due to his efforts that clearance was at last made.

Through his action, too, the sewage-sodden "cellar" bakehouses of Southwark and other low-lying districts and insanitary underground bakeries were legislated for, and the Salvation Army shelters placed under the Common Lodging Houses Act.

To us at Bart.'s he is well known as an old friend and an old Lecturer to the Hospital.

* * *

It is an Englishman's privilege to grumble at his food, but we are glad that never yet have we discussed in the Journal the affairs of the Catering Company; partly because we have noticed that almost every hospital journal in

London has its recurring grumble at its own restaurant, and chiefly because we believe that on the whole the Catering Company does very well indeed. It is, however, a pleasure to be able to praise whole-heartedly an innovation. In place of a particularly monotonous tea menu there is now such luxury as an epicure could desire. Some great mind has done this thing. Lest, however, the Catering Company should vaunt itself we would tactfully suggest that the same mind will have considerable scope in considering our breakfast diet.

* * *

Few events in the Hospital have recently been so generally acclaimed with approval as the proposal of the Vicar to hold a Parish Festival on Bartholomew's Day, August 24th. It is to us a matter of pride that the Hospital is a parish in itself, and his parishioners will be glad indeed to meet their Vicar and each other "in some other place besides the Church and the wards"—a touch in his invitation which has led to many a quiet chuckle.

We congratulate Mr. Dunkley on the wisdom and inspiration of this move, and, writing some days before the meeting, look forward "with sure and certain hope" to a pleasant evening.

* * *

As we go to press we are able to express our thanks to the Vicar for a delightful evening, wholly free from constraint and stiffness. Where all who performed were good, Mr. Catford's singing requires special mention.

May we hope that Mr. Dunkley will organise other "parish festivals"? Such an opportunity for the meeting together of all resident in the Hospital fills a long-felt lack in our social life.

THE QUESTION.

What is life but a flower that's blown,
And proud its colours doth wear;
Whose fragrance awhile fills the air,
Then is gone?

What is life but a comet alight
In the darkness of Time; that doth boast
An effulgence supreme, then is lost
In the night?

What is life but a song that is sung,
And with sweetness enchanteth the ear;
Whose passionate rapture we hear
Not for long?

What is life but a vision soon fled,
That appeareth to us in a dream;
Whose transient glory doth gleam,
Then is sped?

OBITUARY.

ESTLIN HUGH WEATHERALL, M.B., B.S.(Lond.),
M.R.C.S., L.R.C.P.

IT is with more than ordinary sorrow that we record the death, at the age of 24, of Estlin Weatherall, Junior House-Physician to the Medical Unit. Many at the Hospital will feel not only the tragedy of it, but also a deeper sense of personal loss. Weatherall was spending his fortnight's holiday as M.O. of a Boys' Own Brigade Camp at Deal. He was killed on August 1st, in a motor-cycle accident at Ramsgate. The motor cycle on which he was riding pillion collided with a char-à-banc at a blind corner, and he was thrown off and killed instantly. He was the son of the Rev. J. H. Weatherall, of Notting Hill Gate, was educated at Bolton Grammar School, and joined this Hospital in January, 1916. He was undoubtedly one of the most brilliant men of his year: he gained an Entrance Scholarship in Arts, a Senior Scholarship in Anatomy and Physiology, the Wix Prize and the Burrows and Skynner Prizes. He qualified M.R.C.S., L.R.C.P. in January of this year, and took his London M.B. in May, obtaining distinctions in Medicine, Forensic Medicine and Midwifery. Inclining at first to surgery, he took the Primary Fellowship "in his stride"; but later he turned to medicine and was appointed last April as Junior House-Physician to the Medical Professorial Unit. During the war he served for six months as a surgeon-probationer, and found his feet at once, having a natural love for the sea and ships. The success of the Abernethian Society last session was very largely due to his energy as Secretary; he was elected President in March, but only once took the Chair, when his excellent speech in introducing Mr. Bernard Shaw will be remembered by all who heard it. He was Vice-President of the Debating Society, where he not infrequently spoke with sound sense and humour. A sense of humour was, indeed, one of his characteristics, as were a modest and gentle nature and a rigid sense of honesty. We can never know what Medicine and the Hospital have missed by his death; we only know what his colleagues on the Junior Staff and other friends at the Hospital have lost, and above all our sympathy goes out to his family. Those of us who knew him best feel that we are the better for having known him, and that his life, though short, has not been in vain.

C. H. A.

THE OCTOCENTENARY OF THE
FOUNDATION.

4. PITCAIRN WARD.

By SIR D'ARCY POWER, K.B.E.

TO the many who enter our Wards the names denote only their position in the block; they connote nothing at all. For them Pitcairn, Abernethy, Lawrence and Stanley are as much abstractions as Faith, Hope and Charity, yet each should remind us of those great men who helped to bring the Hospital and the School to its present position in the world of Medicine. The Pitcairns, uncle and nephew, were successively Physicians to the Hospital, and both by their occasional lectures on medicine began systematic teaching on the medical side at a time when Pott and Abernethy were developing it surgically. By mere perversity Pitcairn is a surgical rather than a medical ward, although neither of its namesakes had any use or experience in this branch of their art.

There is but little to be said of William Pitcairn, the uncle. Born in 1711, he studied under Boerhaave at Leyden, graduated M.D. at Rheims, acted as private tutor to the Duke of Hamilton at Oxford, made the grand tour with him, received the M.D. of Oxford when the Radcliffe Camera was opened in 1749, and then settled in London. He was elected Physician to the Hospital in 1750, rose rapidly to eminence and fortune, and was President of the College of Physicians from 1775 until 1785. He resigned his office of Physician in 1780 and was appointed Treasurer of the Hospital in 1784. He lived in Upper Street, Islington, where he had a garden of five acres, which was only surpassed in London by that of Dr. John Fothergill at Upton near Stratford-by-Bow in Essex. He died in 1791, and was buried in our Hospital Church. We think of him as a learned and successful physician of a type which was then not uncommon.

It is far otherwise with his nephew—David Pitcairn—who still lives for us as a man as well as a doctor. A loveable man, we are told, tall, erect, and strikingly handsome in his youth, and retaining his good looks to his life's end: one of those to whom his friends and colleagues always turned for help and advice in time of sorrow, need, sickness, or any other adversity. His manner was simple, gentle and dignified; from his kindness of heart he was frequently led to give more attention to his patients than could well be demanded from a physician, and as this evidently sprung from no interested motive, he often acquired considerable influence over those whom he attended during sickness. No medical man indeed of his eminence in London perhaps ever exercised his profession to such a degree gratuitously, says one who knew him personally. Besides, few physicians

CHRONIC GASTRO-INTESTINAL CATARRH
IN CHILDREN.

By T. H. G. SHORE, M.D., M.R.C.P.

OUT-PATIENT experience must sooner or later lead to the conviction that the common diseases are the most important, and in children of all ages the commonest are probably the minor disorders of the gastro-intestinal tract. Unfortunately the symptoms of which the parents complain are most varied, and often their bearing is not obvious, so that the underlying condition shared by a large group of patients is apt to be overlooked, and treatment meted out rather to the symptoms than to the disease.

Such diverse complaints as fidgeting, lassitude, lack of interest in meals, especially breakfast, wasting, sleep-walking, cough, worms, pallor, jaundice and nocturnal enuresis, to mention only a few, may ultimately be referable to catarrhal disorders of the gastro-intestinal tract.

Chronic gastro-intestinal catarrh probably has its origin in improper and irregular feeding in the earlier years of life, though it is between the ages of four and twelve that it is most often met, when it is kept up by the parental ignorance and carelessness which started it. Children who have irregular meals, with odds and ends between meals, and sweets to keep them quiet, are the sort which have chronic catarrh. The mode of life is partly the cause of the trouble and partly the result. The catarrhal child is peevish and irritable, and will not eat at the proper times, and is then given cakes, biscuits or sweets between meals, under the belief that food is needed to overcome the common symptom of wasting. The result is quite otherwise, for the child continues to waste, and we hear that his food does him no good. Such irregular feeding with carbohydrates only keeps up the condition, which passes from bad to worse. Chronic gastro-intestinal catarrh often seems to start as a legacy from some other state of catarrh such as whooping-cough or measles; hence the advisability of a proper restoration of health by a change of air after such diseases.

In its simplest form "the derangement consists in an increased secretion of mucus from the whole internal surface of the alimentary canal; it is a mucus flux which interferes mechanically with digestion and absorption of food, and by its influence impedes general nutrition," to quote Eustace Smith. The immediate result of this is to lower functional activity throughout the alimentary canal; digestive juices are poured out in smaller amount, muscular tone is diminished and peristalsis less effectual. The presence of mucus is often to be demonstrated in the vomit or in the stool. From this simple but general catarrh extension occurs to neighbouring organs in communication with the alimentary tract, the bile-ducts and pancreatic duct, and its reflection is seen—a pale, flabby, indented

ever gained so extensive an acquaintance with the various orders of society. He associated much with gentlemen of the law, had a taste for the fine arts, was a fellow of the Royal Society as well as of the Society of Antiquaries.

Born in Fife in 1749, he was the younger son of John Pitcairn, a major of marines, who was killed at the Battle of Bunker's Hill, though his body is buried in our Hospital Church. His elder brother Robert, as by an accident, gave his name to Pitcairn Island, where the crew of the "Bounty" afterwards made a home.

David was educated at the High School, Edinburgh, and at Glasgow, before his uncle sent him to graduate in medicine at Corpus Christi College, Cambridge. He obtained his M.B. degree in 1779, and was elected Physician to the Hospital in the following year, a post he resigned, says Sir Norman Moore, in 1793. He was admitted a Fellow of the College of Physicians in 1785, and was five times Censor. Whilst he was at the Hospital he continued and improved the medical teaching, and brought it into line with the reformed methods introduced by John Abernethy on the surgical side. It is reported traditionally that in the course of these lectures he first drew attention to the fact that valvular disease of the heart was a frequent result of rheumatic fever. Subject to repeated attacks of quinsy and suffering from hæmoptysis, he left England in 1798, and spent eighteen months in Portugal, where he so far recovered his health that he returned to England, took a house in Lincoln's Inn Fields, then a fashionable neighbourhood, and continued to practise. On April 13th, 1809, he had an acute attack of œdematous laryngitis, which appeared to present unusual characters to his friend Dr. Matthew Baillie, who was called in to attend him. Reading Dr. Baillie's account by the light of modern knowledge, it would appear to have been an acute streptococcal infection of the nature of Ludwig's or Vincent's angina. He died at his house in Craig's Court, Charing Cross, three days later, and is buried with his father and uncle in the Church of St. Bartholomew's the Less.

Pitcairn was one of the distinguished line of physicians who carried the gold-headed cane which is now a treasured possession of the Royal College of Physicians. Belonging originally to Radcliffe, it passed to Mead, Askew, for a short time to William Pitcairn, to David Pitcairn, who gave it to Matthew Baillie, Hunter's nephew, who bequeathed it in turn to Sir Henry Hallford. Becoming garrulous in its old age the cane wrote the story of its experiences when it was in the possession of its successive masters. The book proved to be so entertaining that it was several times reprinted.

tongue, with pharyngitis and perhaps chronic bronchitis as well.

After such a prefatory description the commoner symptoms are easy to explain. The mucous coating over the interior of the stomach leads to imperfect gastric digestion and allows of fermentation; the result is discomfort after food due to wind, and consequent refusal to take much at a time. This is often construed as a lack of appetite, but sometimes parents will say that the child is ravenous but soon satisfied. He is, however, ravenous again before the next meal is due. This type of gastric dyspepsia causes pain "under the heart," and some children suffer from nausea and occasional vomiting or "bilious attacks"—not to be confused with cyclic vomiting. Catarrh in the duodenum produces discomfort from flatulence, often leads to jaundice from catarrhal involvement of the bile-passages, and doubtless also to pancreatitis, though this is not so easily detected. From the small intestine flatulence and gurgling are the chief symptoms, and abdominal distension may be pointed out by the child's mother.

Among the most characteristic symptoms of the condition are those due to chronic catarrh of the colon. The cæcum may become distended with gas, and colic arises from spasm or irregular peristalsis further on. Constipation is common, as also is looseness of the bowels, and the two states often alternate. The stools contain quantities of mucus, either mixed up with faecal material or occurring separately as masses of jelly: slimy mucous coats over the surface of small, hard, dark-coloured scybala, which may be retained for days owing to the slippery surface interfering with the muscular propulsion. Such faecal masses sooner or later lead to local irritation in the rectum or higher up, which is relieved by an attack of diarrhoea, during which much mucus is passed with perhaps a little blood. Undigested food, such as portions of vegetable matter, raisins, currants, carrot, fragments of orange and so on, often pass practically unchanged. They have gradually worked their way through the intestine, and have been protected by an envelope of mucus from the action of the digestive juices. Prolapse of the rectum is not uncommon in these patients, and appendicitis is often seen.

Malnutrition naturally results from the "mucous disease," as Eustace Smith called this condition. Younger children get labelled "consumptive bowels," though the factor of tuberculosis does not exist; in older children it is often erroneously suspected. The patients become pale, complain of abdominal discomfort, lose weight and appetite, and may sweat at night, though not to the extent that is seen in the head sweating of rickets, or the more general sweating of tuberculosis or sepsis. The presence of some bronchitis may lend support to the graver diagnosis, but pyrexia is not commonly present. Fainting at school is common in such children. It is in these patients that pica, or a perverted appetite, is sometimes met. Some children

will eat dirt, coal, orange-peel, garden worms, or even brown paper. In any case the appetite is uncertain, and often difficult to accommodate. Usually such children prefer carbohydrates, and in some the dietary consists of little else.

Another common manifestation of the mucous state is the presence of threadworms, or less often of the round worm or whip-worm. Worms are not in themselves to be regarded as a disease and treated as such, but only as a sign of disease. They do not find lodgment in a healthy bowel, but the layer of mucus coating over the lining of the colon in these children forms an ideal nidus for their existence; it adds greatly to the difficulty of their complete removal. The life-history of these worms is as yet only imperfectly understood. How they enter the body, whether or not there is an intermediate host, and if so what it is, and consequently the rational prophylactic treatment, are at present unknown. It is easy to suppose, as is commonly taught, that children reinfest themselves by ova lodged under the finger-nails by scratching to relieve pruritus ani, but recent work shows that the larval stage has to be far advanced if the young worm is to survive the gastric juice after it has been swallowed. Some believe that the larvæ of ascaris pass through the lung, just as those of ankylostoma, the miner's worm, do. The same may be the method adopted by the thread-worm, though the balance of opinion seems to be against it. At any rate one cannot believe that irritation of the nose is provided by Nature at the psychological moment in order that the child may scratch and reinfest itself. It seems much more likely that there is something in the noses of infected children to produce irritation, and that may well be larvæ at some stage of their migration. Children infested with worms frequently suffer from a cough, which becomes worse when increases in the number of worms occur. Other symptoms due to the irritation of worms are restlessness at night, which may amount to somnambulism, vulvo-vaginitis, and even fits or a mild choreic condition.

From what has been said it is evident that chronic gastro-intestinal catarrh is responsible for a great deal of minor illness of a very diverse nature. The effects of the condition on the health of a growing child are, however, farther reaching than this. A child so afflicted grows up to be "delicate" and peevish, and later may become a nuisance to himself and others by his fads and fancies with regard to food; he may grow up a hypochondriac. A constipated habit often has its origin in this condition. Catarrh in the colon may lead to chronic colitis, with changes in the mucous membrane and musculature of the bowel, to the formation of piles, and more remotely to infections of the urinary tract, which may be extremely difficult to eradicate. Pyelitis in children frequently arises in this way, and may persist into adult life. Oöphoritis and some forms of dysmenorrhœa in later life may well have their beginnings in chronic gastro-enteritis of childhood.

INSANITY IN ITS RELATION TO CRIMINAL LAW.

By J. G. PORTER PHILLIPS, M.D.(Lond.), F.R.C.P.

SOCIETY throughout all its evolutionary stages, in order to keep law and order within its pale, has been compelled to adopt punitive measures of varying severity and thus protect itself from chaos and dissolution.

For centuries past our legal system, founded upon the wisdom of Roman law, has steadily developed and improved, with the result that law, as taught and practised in England at the present day, has attracted the admiration of all nations.

As a peace-loving citizen one has to accept the rulings of those responsible for the framing and administration of the law, knowing full well that any deviation from the ordinary paths can only be obtained by alteration of the law as it stands upon our Statute Book by recognised constitutional methods.

The recent outburst of public opinion, incensed with emotional feeling, but lacking true technical perspective, regarding the alleged mal-administration of the criminal law in the case of murder, has resuscitated an old bone of contention between medicine and law.

The responsibility which devolves upon the shoulders of every citizen may be considered either from the civil or criminal point of view.

Responsibility as a term is a purely legal one and means liability to punishment. Criminal responsibility furthermore may be interpreted as the liability to punishment for crime, and the legal test of the latter rests on the question of the knowledge of right and wrong.

One can discuss the question of insanity in any particular case only when the mental health of an individual is queried. A conflict of opinion must necessarily result, as the test of responsibility in the legal sense does not harmonise with that formulated by psychologists. Unfortunately both the legal and medical experts are constantly juggling with the word "insanity," and yet have failed so far to define exactly this fluctuating and nebulous state of mind.

In the first instance, reviewing these complex problems, it is well to differentiate between mental disorder and insanity, as both terms are not infrequently wrongly used by the uninitiated.

Insanity cannot manifest itself without the existence of mental disorder, whereas mental disorder can exist in no small measure without the incidence of insanity. Many men and women carry out their civil duties of life whilst suffering from a disordered mind, and continue to do so

The treatment in an early case is comparatively easy, but when the condition has been established for some years it is by no means so simple, and considerable ingenuity may be needed to make the child submit to a radical change of diet. The diet, of course, is the most important consideration. The chief change consists in great reduction in the amount of carbohydrate taken, for this is the main cause of fermentation and production of flatulence. It would do no harm if all carbohydrate but bread were cut off, and even that were restricted in amount. More protein, in the form of milk, meat, and eggs is needed. Fat is probably not being taken in excess, for these children are "hilians." "What we have ourselves," though doubtfully suitable as an adult dietary, is certainly not suitable to a young child. As important as the nature of the food is the regularity with which it is taken. Meals should be at regular times, three or four a day according to the age of the child, and nothing should be allowed between meals. A potent source of trouble is the carbohydrate meal in the middle of the morning at school. One's popularity with the patient must suffer by forbidding the consumption of sweets. A point to remember, at any rate in the hospital class of child, is a regular warm bath at night, for this helps to restore the functional activity of the skin, which becomes dry and harsh in these cases. General health picks up more rapidly if this is attended to. A proper amount of exercise and plenty of fresh air are essential.

Medicinal treatment is begun by giving alkali (sodium bicarbonate) in fair doses before each meal, and this may well be combined with a bitter such as calumba or gentian (haust. calumbæ alk., St. B. H.). This mixture should be given 10 or 15 minutes before food, three or four times a day, according to the number of meals thought advisable. Alkali given in this way tends to detach or dissolve mucus from the gastric mucosa, and perhaps from further down the alimentary tract. A regular mild aperient at night will help by removing periodically the mucus so detached. A suitable powder or tablet is one containing equal parts of powdered rhubarb and hydrarg. cum creta, the dose being adjusted to particular requirements (pil. hyd. c. cret. et rhei, St. B. H.). In some cases aloes or senna are suitable.

Other than the simple manifestations require treatment on their merits. Worms need santonin, or rectal injections of quassia or common salt. Bromide is indicated in certain nervous states, and so on, but no expectation of cure must be entertained unless the underlying condition has been dealt with along the lines indicated.

A tonic, such as iron or cinchona, may be needed later on, but by far the best is a change of air to a bracing seaside place.

without arousing much, if any, suspicion as to their abnormal mental mechanism. On the other hand, insanity, being essentially based upon the disorder of conduct (and language), very soon manifests its presence by the individual concerned entering into conflict with his or her social surroundings.

This is undoubtedly the juncture at which interest, criticism and often aimless discussion are aroused when we have to consider the question of responsibility in relation to crime. Here we are faced with a difficult and controversial matter in having to differentiate between the legal and medical interpretation of the question, whether the accused was capable of knowing what was morally right from what was morally wrong, and *not* whether the individual was in a condition to know whether that which he was doing was legally wrong.

At once we find ourselves insidiously involved with the problem of defining moral sense and moral discrimination. These two latter terms, each having its respective definition and value, cannot be discussed in detail, but suffice it to say the former is an inherited or instinctive quality, whereas the latter is that attribute which is evolved and further elaborated from the innate moral sense by means of environment and education, with its corrective influences in the form of punishment.

The relation of insanity to criminal law has always been unsatisfactory, the medical or psychological views being opposed to those held by the Legislature.

Judicial opinion as existing to-day has been the outcome of controversy and discussion, which resulted from the well-known MacNaughton case which attracted so much public attention in 1843.

In this case the question of insanity and its bearing on the administration of the criminal law was raised.

One named MacNaughton, who had apparently been suffering from mental disorder for some little time with prominence of persecutory delusions, was arrested for murder. He imagined that a system of persecution instigated by the Home Secretary of that time was directed against him and endangered his very existence. Filled with morbid suspicion and apprehension he lay in wait for Sir Robert Peel, but mistaking the identity of his secretary, Mr. Drummond, he shot at and killed him instead, in the full belief that he was the Home Secretary, and thus the person responsible for the plot against him.

The prisoner was found to be insane and acquitted, which resulted in an outburst of public feeling.

The case was then considered by the House of Lords and judicial opinion was sought. After much deliberation and discussion, the now famous MacNaughton dictum or ruling was framed. This judicial ruling may be summarised as follows:

If a person suffers from a delusion but is *not* otherwise insane, he is held to be responsible for his offence *unless* he

has acted in such a way as would have been permissible had the facts about which his delusion exists been true. Thus, should a person, suffering from a delusion that another is about to kill him, kill the other individual (in self-defence), the former is *not* held to be responsible.

On the other hand, should the delusion be that he is being simply robbed, then in this case the deluded person is deemed responsible.

Generally speaking, when a plea of insanity is urged it has been laid down that if at the time of committing the offence the accused, labouring under such defect of reason from disease of the mind, did not know the nature and quality of the act he was committing, he cannot be deemed responsible for that act, and if he did know and did not understand he was doing what was wrong, again he is *not* deemed responsible for that crime.

The concept of crime in a general sense must necessarily be a social rather than a biological one.

In order to study this accurately and thus be able to formulate appropriate and efficient measures for its check, one must, wherever possible, scrutinise very carefully the past as well as the present stock-in-trade of the unfortunate culprit, such as total inheritance, his mental make-up, environment and impelling influences at work.

Thus when the problem of criminal responsibility arises the whole "worldly" setting of the case should be ascertained, carefully analysed, and considered judgment given in each individual case.

In view of the fact that public attention has been strongly focussed on a recent murder trial it may be interesting to some readers to review the case.

It will be seen that the law, usually so clear, definite and just, in this instance is entirely responsible for the paradoxical state of affairs which has unfortunately arisen.

Public opinion in many instances is the outcome of calm, deliberate and logical reasoning based on practical experiences of life, but more often the judgment formed is coloured by sentimental tone, which, stimulated by indignation, may assume a state of emotional ebullition.

In this instance hostile criticism and scathing comments were directed against the various individuals responsible for the proper conduct of the case subsequent to the sentence of death being passed on the accused man.

This particular case has certainly proved a paradox owing to the inflexible and adamant attitude of the law. By the existence of a law which was enacted as far back as the reign of Henry VIII it has been ordered "that an insane man shall not go to execution."

At the trial the plea of insanity was rejected by judge and jury, perhaps due no doubt to the fact that the accused *did* understand the nature and quality of the act for which he was indicted. Later the Court of Criminal Appeal firmly upheld the verdict. According to the dictates of common sense and morality nothing now remained but for

the law to proceed with its capital punishment, but unfortunately for public opinion the law was compelled to intervene in favour of the convicted, and thus stultify its previous carefully considered judgment.

According to the Section 2 (4) of the Criminal Lunatics Act, 1884, the Home Secretary is forced to institute an inquiry into the state of mind of the condemned man, *i.e.*, after sentence has been passed, should the question of insanity be brought to his notice.

It is obvious, then, as far as this particular case is concerned, the law provides a paradoxical state of affairs, and one which is not only opposed to the teachings of common-sense, but also deletes its own ruling.

As far as medical witnesses at the trial are concerned it is their simple duty to give an unbiassed and honest opinion as to the mental state of the accused at the moment he committed the crime, *i.e.*, whether the prisoner understood the nature and quality of the crime, and, if he did, did he understand that what he was doing was morally wrong.

Although the question of the prisoner's previous history does not actually count, yet it usually influences the verdict of the jury.

As pointed out above the medical practitioners specially appointed by the Home Secretary to inquire into the state of mind of the condemned man (after sentence) did so and made a report thereon.

After carefully reviewing all the above facts it would appear that the law is wrong as at present constituted.

Although it is obvious in such a case that medical views must be seriously considered, yet the Legislature cannot justly state that "crime will not abate if the infliction of the penalties of the law is left to the experts of Harley Street."

The time has now arrived when there must be a definite *rapprochement* between the medical and legal authorities regarding the interpretation of insanity in its relation to criminal law.

Since the above lines were penned the Lord Chancellor has appointed a Committee of Inquiry, composed of prominent members of the legal profession, to investigate what changes, if any, should be made in the administration of criminal law.

NOTES ON THE NURSING OF PNEUMONIA.

PNEUMONIA is one of the diseases in which nursing is somewhat more important than medicine in aiding the patient towards recovery. It often happens that when the recently qualified man goes either to a small hospital to become a house-physician, or enters the strenuous profession of a private practitioner, it

becomes necessary for him to order the nursing as well as the medical treatment; hence these notes on the nursing of this common complaint.

Position. Keep lying flat, with one pillow, unless the patient wishes to sit up.

Clothing. Let the patient wear a cotton garment, open down the back (to avoid difficulty in changing it when necessary), a light blanket over the feet, sheet and quilt, till the temperature has fallen.

Washing. The patient should be gently rolled into a blanket morning and evening, and thoroughly sponged all over, taking about 10 minutes over the process. It is much more comfortable and soothing to use very hot (about 110° F.) rather than tepid water.

Owing to distress caused to a pneumonia patient by moving him, it is often only possible to attend to his back morning and evening when he is being sponged, and as it is a short illness the back rarely gives rise to any real anxiety. It should be washed with plenty of soap and water, well dried, rubbed with hazeline solution or methylated spirit, and powdered with starch powder. An air ring will add to the patient's comfort if it can be obtained.

The mouth must be attended to before and after every feed. If the patient is able he may rinse it out with some warm mouth-wash such as listerine or glycothymoline and water. Usually it is necessary for the nurse to cleanse it with wisps of wool wound round a bit of stick; the best solution for this purpose is sod. bicarb. ʒj dissolved in water ʒv. Listerine may be added if the mouth is offensive or the patient dislikes the taste. A little ung. hydrarg. nit. dil. rubbed over the lips will keep them from becoming uncomfortably dry.

The patient must be fed regularly every 2 hours by day and as nearly every 4 hours by night as can be done without waking him. He should be given citrated milk ʒij (sod. citrate gr. j to every ʒj of milk), with glucose or sugar ʒj and ʒij of coffee, tea, water, soda-water, or chocolate (1 oz. of chocolate dissolved in ʒij boiling water), or one egg beaten (two in 24 hours), arranging the feeds so as to get variety in flavour, and water, lemonade, or soda-water ʒvj every 2 hours, alternately with milk feeds. As much more fluid should be given as the patient will take, but milk feeds must *not* be increased in either time or quantity, or digestive troubles will arise. A little custard, jelly, or thin bread and butter is permissible if the patient will take it. Feeds may be cold or hot as desired.

The times of medicines, stimulants and **Medicines.** hypodermic injections should be arranged so that they do not come together. If brandy and strychnine are being ordered, give them 4-hourly alternately so as to keep up the stimulant effect. Never

put brandy into a feed, as, if all food is not taken, the patient has not had the amount of stimulant ordered.

A pneumonia patient should never be awakened for *any* treatment; nothing is so important as sleep. Have feeds, medicines, injections, etc., absolutely ready so that the moment he wakes whatever is due may be given and he may go to sleep again as quickly as possible. A pneumonia patient rarely sleeps for more than 2 hours without waking, so that a good nurse will get nourishment as well as treatment given.

If the temperature reaches 105° F. it is advisable to cradle, leaving the patient in a cotton shirt, with a light blanket over the feet as far up as the knees. Put two large body cradles over him and cover him over with a sheet, leaving both ends open, and tucking the sides under the mattress firmly, as most patients will pull the sheet over them if left untucked. If the feet are cold put on sleeping-socks. Outside hospital cradling is not possible on account of opposition of relatives; then only one sheet must be left covering him. If the temperature reaches 104° F. sponging must be carried out, proceeding as for the morning and evening process, but continuing for twenty minutes. The very hot water will bring the temperature down just as well as tepid and will not cause discomfort to the patient. The patient should be dabbed dry with a soft towel, not rubbed, and left cradled, his temperature being taken half an hour after sponging is finished to see how much it has fallen.

A rectal tube will sometimes relieve this condition, but usually an enema gives more relief; it should be given without turning patient, so that as little disturbance as possible is caused.

Though helpful to some patients, others are terrified by it, considering it the signing of their death-warrant. Should it worry the patient, discontinue it at once; *any* treatment which worries a patient is harmful.

Nothing relieves the pain of pleurisy so rapidly as leeches. Should it be necessary to apply them, place a piece of lint with small holes cut in it over the painful area, seeing that the apertures are over ribs, so that pressure can be applied later. Put each leech into a test-tube that has been blocked about 1 in. from the top with a plug of cotton-wool; invert the tube over the hole in the lint and hold fairly firmly till the leech has become attached; draw the test-tube gently away, and the leech will rest on the lint, so that the patient will not feel its clamminess. If it will not bite, put a little sweet milk on the skin. Should this fail to attract the beast, lightly scratch the skin with a sharp needle; should this fail, discard the refractory leeches and try others. When they have dropped off (it usually takes about three-quarters

of an hour for them to dine) put on a fomentation of four-fold lint, renew in 20 minutes, then firmly strap on leech pads. Bleeding will rarely occur; if it should do so, soak the first layer of the pad in 1-1000 adrenalin and strap a halfpenny firmly over the outside of pads. (A leech pad is made of four layers of double lint in graduated circles, the smallest about the size of a threepenny-bit, largest the size of a halfpenny, inside the smallest layer of lint a wisp of gauze, as the blood clots more easily by this device.) If it be necessary to remove the leeches, put some salt on their heads and they will drop off. Do not let the patient see the leeches; arrange a curtain or towel to obstruct the view.

As the time comes when the crisis is likely, the patient must be watched very carefully for the first sign of sweating. Usually this occurs first over the chest; less often on the forehead. Put on two blankets, a hot bottle to the feet if weather be cold, and give hot drinks—coffee is very useful, or some hot brandy and water may be advisable. When the patient has ceased to sweat, rub down quickly with a hot towel, and put on a warm dry shirt, and fresh sheets if required. Frequently the temperature drops considerably below normal, and the pulse is infrequent; no anxiety need be felt, provided the patient seems comfortable; it will soon recover the normal level when more nourishment is taken. As soon as the crisis is over, let the patient take any digestible solid food that he will, and discontinue 2 hourly feeds.

CHILDREN UNDER THE AGE OF ABOUT 10 YEARS.

The nursing of young children differs considerably from that required for adults.

A child can always lie down, and should be tied down to prevent it throwing a strain on the heart by sitting up and moving about. Light cotton garments, bedsocks if feet tend to become cold, or a light blanket over feet, sheet and quilt. Sponging night and morning as for adult, but only 5 minutes is necessary for a small child.

It is always necessary for the nurse to cleanse the mouth, as even the older children cannot usually be made to rinse out their mouths properly.

Give the same type of food as for adults, the quantity being modified to suit the child's age; it is often not possible to get it to take the whole of the feed at the proper time; try then to get the quantity taken in small drinks during the 2 hours. A child should always be awakened for feeds (4-hourly by night) as it will sleep again at once, and will very quickly get into regular habits. If feeds are persistently vomited as soon as taken, give the child a drink of water, the same

quantity as its feed, which will be vomited, then give feed *immediately*; it will nearly always be retained.

Cradling can be carried out as for adults, but if the temperature reaches 104° it is easier in infants and little ones up to three years or so to put them into a bath at the bedside at a temperature of 100° F. and reduce to about 95° for 10 minutes. The child should be supported on nurse's arm, and water sponged over chest; submerging the chest might embarrass respiration, besides being liable to frighten child. Small children are often marvellously soothed by a hot bath. Proceed as above, but keep temperature of water at 100° F.

Infants whose chests sound full of "rattles," who are intensely cyanosed and seem absolutely overwhelmed with their disease, are often much relieved by a mustard bath (mustard 2 tablespoonfuls, well mixed into a thin paste with cold water and added to 2 gallons of water) at a temperature of 100° F., gently increasing to 105°. Usually 5 or 6 minutes is long enough to keep them in it.

Children should be awakened for feeds and necessary treatment.

Treat on the same lines as for adult patients; little children rarely sweat, and often sleep through the actual fall of temperature, which may be very rapid—from 104° to 96° F. in 3 or 4 hours. It is only rarely that anything more than extra clothing and hot drinks are required.

Never cradle *any* patient, either adult or child, no matter what the temperature may be, if sweating is present.

THE PERSIAN GOVERNMENT HOSPITAL, TEHRAN.

By A. R. NELIGAN, M.D. (Lond.), M.R.C.S., L.R.C.P.,
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Physician to the British Legation and Medical Officer to the Hospital.



NOTE appeared in the Journal during 1919 to the effect that the British Government had undertaken to assist the Persian Government to reorganise this Hospital, and to that end had placed the services of Dr. J. Scott, Medical Superintendent of the Indo-European Telegraph Department, and of myself, at its disposal. We entered on our duties on June 1st, 1919, and as my colleague left Tehran on leave six weeks later, I was the only permanent medical officer at work during most of the first nine months of the reorganisation, and think that a short account of what has been done may interest St. Bartholomew's men.

The Hospital was opened in 1869 and had a Persian

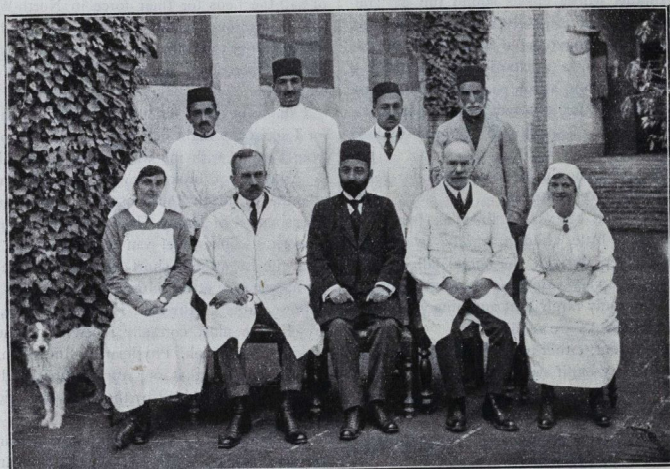
staff until 1896, when the doctor of the German Legation was put in charge of it. Later a second German was appointed as his assistant. This arrangement lasted until November, 1915, when the Turkish Embassy and the German and Austrian Legations left Tehran in the expectation that the Shah would follow them, and thus bring Persia into the war against us. After an anxious day for the Allies in Tehran, His Majesty decided to take the *advice* of the British and Russian Ministers, and sent away his travelling carriage. The German Legation did not return, and the Hospital passed into Persian hands again, and a Persian Director, the senior of the court physicians, was appointed. For a time the Russian Red Cross had the use of half the beds for their force in North-West Persia, but the institution steadily deteriorated, and in 1919 was taking in not more than thirty in-patients, and this in a city of over 200,000 people with hundreds of villages in the environs.

I shall not easily forget the day on which we took over, for I spent the night before in the desert, some thirty miles from Tehran, with my wife, two friends, half the sand-flies in Asia and a broken-down Ford car, the result of an attempt to reach the Caspian Gates, the scene of the assassination of Darius III during his pursuit by Alexander (330 B.C.). The relief van which came to find us landed us at the Legation a short hour before the time fixed for my appearance at the Hospital, white with dust and quite unrepresentable. However, I arrived in time, and Scott and myself were most cordially received by the Director, Dr. Hakim ed Dowleh, Physician to the Shah, and the staff. It may be said that our appointment had been received very favourably indeed by the local profession and Persians in general.

The Hospital is situated in a main thoroughfare, and the tramway passes the door—a fact of importance for the poor in a city which covers some sixteen square miles. It used to stand in large grounds but most of these have been sold, and the area covered by the institution to-day is about two hundred yards long by sixty yards wide, about half of which is garden. There is a handsome covered entrance, which, like that of another hospital, bears the name of a King, Nasr ed Din Shah. Rooms on either side accommodate the gate-keeper, the armed guard and the gardener. From it a straight drive leads through the garden to the building. On the right is a bungalow which was later fitted up for the English matron, and, nearer the Hospital on the other side, is a construction which holds the steam disinfecter. The Hospital proper is built, like most Persian houses, round a paved courtyard. It is entered from the garden by a handsome portico, on the domed ceiling of which is carved in plaster the Prussian Eagles, as well as the "Lion and the Sun." In the centre of the court is the usual large tank (no fountain with restful rim!), and round it are sunk beds with trees and shrubs. The general effect

is most pleasing. The buildings are on one floor raised about four feet from the level of the court. They have domed roofs (a common thing in Persia, where timber for rafters is scarce) and immensely thick walls, and consist of a series of small rooms, no one of which takes more than eight beds. They were lighted by low windows on the side towards the court, and there was a huge dead air space in each dome. One of our first improvements was to make top lighting and ventilation. Between the wards on the north side of the court and the boundary wall is a smaller compound, in which were eight small rooms for paying patients at one end, and next them two large storerooms.

The clean operating theatre is on the south side of the courtyard and is exceedingly good for Persia. It is very well lit and lofty. The floor and the walls for five feet up are tiled with white tiles, and the corners are rounded off with specially made tiles. There were locally made glazed basins and sinks, with a hot and cold tap for each, operated by the elbow, but unconnected, and the cold water not sterilised. We subsequently altered the boilers so as to sterilise the cold water, and connected the taps so as to be able to wash in running water of any desired temperature. It should be stated that there is no piped water supply at Tehran, and that therefore the water of the Hospital has to



Back row :
DR. ANAYATULLAH KHAN (Out patients and Anaesthetist). DR. HUSSEIN KHAN MOGADDAM (In-patients). DR. HUSSEIN KHAN SAIFI (Pathologist). DR. ITIMAD ED DOWLEH (Accountant).
Front row :
MISS S. E. OXLEY (Matron). DR. A. R. NELIGAN. DR. HAKIM ED DOWLEH (Director). DR. J. SCOTT. MISS L. A. HEATH

These last we converted into excellent wards, and later on we set aside the compound for women patients.

The out-patient department occupied part of the west side of the courtyard, and consisted of waiting rooms for men and for women, a consulting room, and a fine large room used for dressings and septic operations, with a tiled floor and wash basins with taps. It was unventilated, however, and the heat and smell in summer were most trying. The out-patients entered at the main gate and traversed the whole Hospital before reaching the department—an obvious nuisance.

be distributed by hand. Think, O reader, what this means! We could, as a matter of fact, arrange our own supply had we pipes, but we have not, and we are some five hundred miles from the nearest railway station. I have actually seen an enthusiastic European laying down old rifle barrels, which he had had "threaded," after removing the cartridge chamber, and then screwed one into the other. The use of steel piping on a large scale presented financial difficulties, however, with which we were not able to deal! The theatre is entered through an anaesthetic room tiled in the same way.

There were forty-two beds and twenty-five patients, most of them chronic cases. Two rooms were given up to V.D., and there were the lunatics. I cannot omit a description of their cells. There were eight of them, each nine feet by five, opening on a long narrow corridor, closed at one end by a huge iron gate, and close to the general wards. The cells again had each a heavy iron barred gate, which gave them the appearance of a row of dens for wild animals. In two of them we found immensely heavy wood and iron stocks, one of them made to take several people—apparently the only means of restraint. The mental case is a very serious difficulty here, and no doubt these cells had helped

Augean stables, etc. I can only mention a few of the problems which faced us. Reference has been made to the nursing question. Conservancy: No system of refuse disposal, the principal latrine soaking into the water supply of a whole quarter of the town (I had often heard Persians say that they never drank that water!); an open pit beneath the kitchen window received the *dejecta* of the operating rooms and surgery. Drinking water: Source obviously polluted; patients frequently contracted dysentery while in, and one of the staff nearly died of dysentery shortly after we took over. Instruments: Not enough for the smallest operation; eight rusty Spencer-Wells forceps, for



THE COURTYARD.

to solve many a problem in a rough and ready way. An asylum had recently been opened, however, and their unfortunate occupants were removed to it by our advice, and the cells put to other uses.

Strangely enough there was no separate section for women, and we found that very few consented to enter the Hospital as in-patients.

The staff consisted of the Director, whose duties at Court apparently allowed him little time for the Hospital; two young Persian doctors, trained at Tehran, who, with the assistance of two resident medical students, did all the clinical work; an elderly accountant; a number of male "nurses" and one female "nurse," who knew nothing of nursing, but several of whom were adepts at preparing an opium pipe! and servants.

Our first inspection of the institution left us talking of

instance, did duty for all kinds of work; bowls, trays, ligature and suture material, splints, etc., almost non-existent. Linen room practically empty. No laboratory, dispensary or mortuary. Laundry and bathroom quite inadequate. At the time too, of which I am writing—the summer of 1919—war conditions still held at Tehran, extremely high prices, no imports, and articles of European origin therefore fantastically expensive, transport from abroad very slow and costly. However, the Persian Government, when we entered on our duties, had substantially increased the Hospital budget so as to make it more nearly conform with the increased cost of living; our Government was ready to help with *matériel*, and "supplies" at Bagdad and Kazvin allowed us to purchase some urgently needed stores.

As regards the structure, we reported to the Persian

Government that it would be unwise to incur the heavy expenditure necessary to make the best of it, and advised that only necessary and urgent works should be carried out, and that a modern hospital should be built on another site. This view was accepted, as were, indeed, all our proposals, but the new hospital, alas! has still to be begun. And so we cleaned, painted, ventilated and repaired; made new latrines, a bathroom, a laundry and a dispensary; out-patient entrance and exit, laboratory, shelter for open-air treatment and a mortuary. A cart to bring water from the British Legation was started. A sewing-machine under the Colony's trained nurse made sheets, garments, etc. The bazaars fell to and turned out Hospital furniture, from instrument tables to spittoons, sterilisers to stretchers, temperature charts to squeegees made from old motor tyres. Instrument stores and apparatus were ordered from home (they arrived two years later!). Dr. Woollatt, who was acting for Scott, and I composed a pharmacopoeia (in French by the way!), in which figure not a few old friends from Bart's, in company with strange companions such as "Injection intraveineuse de quinine" and "Pommade d'antimoine" (for oriental sore). Special departments were also started—"Eyes," "V.D." and "Throat and Ear." Among our first clinical assistants was one from Moorfields, another was M.D. Loudon and a third was a Prince!

Most important of all, the Persian Government gave permission to engage a Matron. The Overseas Nursing Association sent us Miss S. E. Oxley, late of Westminster Hospital. She has trained orderlies, and two Persian girls who wear correct uniform and work unveiled—a triumph indeed! We have a women's section now with twenty beds, and they are always full. Further, it was arranged that the nurse of the British Colony should live with the matron and help in the work and teaching.

One of our duties is to give clinical teaching to the student of the Persian Medical School. This is a state school (education free), and is now the only licence-giving authority in the country. The lecturers are nearly all Persians (some of whom have studied in France), but include two French doctors. The teaching is entirely theoretical, and the school has next to no equipment. There is no compulsory programme of clinical instruction, and until last year the French doctors had no hospital for teaching purposes. We hope with them to yet make clinical work obligatory. It is a most unfortunate position in a country where practical men are so badly needed as they are in Persia. We very early started out-patient dresserships and drew up a regular programme of clinical work but the authorities have failed to enforce it. One of the chief difficulties is that the bulk of the students are poor, many come from distant towns, and they have to work for their living in the morning and attend lectures in the afternoon. This does not leave much time for hospital practice. Instruction is given in Persian or French.

Our work is exceedingly varied. My colleague and I share it, but he does all the eye work and I run the laboratory (now well fitted up and the proud possessor of the only guinea-pigs in Tehran) with a Persian assistant. On the medical side we rarely see rheumatic fever or its effects, though rheumatic affections, in spite of the dry climate, are very common; and while syphilis is wide-spread, it attacks the nervous and vascular systems much less frequently than in Europe. But malaria, pneumonia, dysentery and enteric fever keep us busy, and our admission list last year included typhus fever, relapsing fever, anthrax, tetanus, acute glanders and leprosy.

On the surgical side hernia, stone in the bladder (for which we crush), bone disease and cataract, or the results of trachoma, provide most of the operative work. Tuberculosis is rampant, especially of the bones and joints. The Persian has very poor resistance, and most of our cases reach us in the late stages with deformity and sinuses. Fortunately the climate is ideal for open-air and sun treatment. I saw two tuberculous joints in a wandering tribe while I was fishing in the mountains last summer. Malignant disease, except carcinoma of the breast and sarcoma of the jaws, is rare. This fact, and the rareness of appendicitis and of ulcers of the stomach and duodenum among Mohammedans and of industrial accidents (absence of machinery) cuts down the operation list as compared with London. On the other hand, accidents with firearms and bites from animals (panthers, wolves, camels and so on) help to keep the sterilisers going. I had forgotten hepatic abscess; it is a common disease here but we seldom have to do an open operation: aspiration followed by the injection of emetine or quinine is better for both patient and doctor. A hod-carrier, whose liver held six pints of pus at the first aspiration, has been treated recently and has returned to his work.

Rickets is almost non-existent here, and so we have few obstetric operations to do. Diseases of the ovaries and Fallopian tubes are the most common reasons for abdominal section.

We can now take in eighty patients. Our work suffered much last year for the same reasons that hospitals at home suffered, namely, lack of funds. This is a poor country and has been hard hit by the depression in trade. A fund started by Lady Cox, when her husband, Sir Percy Cox, was British Minister, has enabled us to tide over a bad time and to help many poor patients on their discharge.

Our great need is X-ray and electro-therapeutic apparatus, and only the local political and financial situation has prevented our bringing them out. Recently our chief difficulty has been solved by the generosity of H.H. Prince Farman Farma, who has offered to put up and maintain the necessary buildings at his own expense. We hope, therefore, to have an up-to-date department before long, with a Persian who has specialised in Paris in charge of it.

The Prince, who is known in Persia for his generosity to hospitals, has also offered to build and maintain a V.D. clinic and ward. He is setting a shining example which we hope will be followed by many of his countrymen, both here in the capital and in the provinces in the case of other hospitals.

This hospital is not the only one in Tehran. The American Mission has a well-built hospital with forty-five beds for men and ten for women, two doctors, one of them a lady, and a trained nurse. A hospital with thirty beds was started last year for the French professors. There is also a hospital for women and children under a French lady doctor, but it is badly equipped and is practically an out-patient department. The Bahais have a small hospital, and there are the military and police hospitals. Recently the Tehran municipality started a hospital which is to have eventually a hundred beds, as well as a series of treatment centres for the poor scattered about the city. The British Government has maintained for very many years a well-equipped dispensary in both the Tehran and the summer Legations, which is very largely attended by the poor, who receive free treatment and medicine.

ROUND THE FOUNTAIN.

STUDENT: "Well, we'll just give you a whiff of gas . . ."

PATIENT: "No you won't, guv'nor; I've got gastritis as it is."

* * *

"I'd been examining the case and the Examiner came along.

"Well, what is it?" says he.

"Varicocele," says I.

"Why?" says he.

"Bag o' worms," says I.

"What sort o' worms?" says he.

"And the only sort I could think of was *Ankylostoma duodenale*."

* * *

A medical man in Russia was recently called out to a case at night, was knocked on the head and eaten. Well, well! A doctor's lot is not a happy one.

REVIEWS.

ANATOMY AND PHYSIOLOGY FOR JUNIOR NURSES. By FELICIE NORTON. (London Scientific Press, Ltd.) Illustrated. Pp. 73. Price 2s. 6d.

This is a book for the probationer nurse. It contains sound but extremely elementary teaching. One wonders whether it is not too condensed to be interesting to one just beginning the study of anatomy and physiology. The illustrations are, on the whole, good, but we strongly advise the inclusion of a diagram of the renal tubules and circulation in any further edition.

HINTS TO PROBATIONER NURSES IN MENTAL HOSPITALS. By RICHARD EAGER, O.B.E., M.D. (London: H. K. Lewis & Co., Ltd.) Pp. 80. Price 1s. 6d.

An excellent little book dealing with the duties of nurses in this special department and with its emergencies. Half the book is an elementary account of modern psychology.

DE ARTE PHYSICALI ET DE CIRURGIA OF MASTER JOHN ARDERNE, SURGEON OF NEWARK. Dated 1412; translated by Sir D'Acely POWER, K.B.E., M.B.(Oxon.), F.R.C.S., from a transcript made by ERIC MILLAR, M.A.(Oxon.). (London: John Bale, Sons & Danielsson, Ltd.) Coloured Frontispiece and 13 Plates. Pp. 57. Price 10s. 6d. net.

This book is published under the auspices of Mr. Henry S. Wellcome, of the well-known firm of Messrs. Burroughes & Wellcome, and is the first of their volumes of research studies in medical history. It gives us the very greatest pleasure to see a great business house in this country contributing to literature and science.

John Arderne was an operating surgeon of Newark between 1349 and 1370, and his practice lay amongst the nobility, wealthy landowners and the higher clergy. He was himself well educated though a layman, and he met his patients on terms of equality. He was perfectly honest, and kept so open a mind that he says more than once, after stating his own practice, "never the less do another man as him thinketh better." He had sufficient originality to invent the operation for the cure of fistula, which, after falling into disuse for nearly five hundred years, is now universally employed. The present volume is largely composed of translations of his prescriptions, always quaint and often horrible: "*Against matted glands*: Ground ivy ground up and infused with oil of cummin plastered on. Also goats' dung with vinegar is useful if it is employed as a plaister."

In his instructions in midwifery he shows himself well ahead of his time. There is little which he advises which may not be done to this day.

The illustrations of the original documents are admirable. The book is a delight.

AIDS TO BACTERIOLOGY. By WILLIAM PARTRIDGE, F.I.C. (London: Baillière, Tindall & Cox.) Pp. viii + 276. Price 5s. net.

It is a curious fact in the ever-popular "Aids" series that while the volume in one subject may with difficulty be sufficient for, say, the college examinations, another volume—and such a one is this before us—may be sufficient for a much more advanced test.

Mr. Partridge has done his work well, as the fourth edition of his book testifies. In the present volume such recent work as Petroff's medium, the egg-broth, Gordon and Han's pea-flour agar are described. It is a book we can heartily commend to students reading for an examination in which bacteriology is a subsidiary subject.

RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

ADAMSON, H. G., M.D. "Sporotrichosis (with Cultures)." *Proceedings Royal Society of Medicine*, March, 1922.

BLAIR, C. J., LONDON. "Lobulated White Mass at Macula." *Ibid.*

BOURN, GRIFFITH, M.D. "A Simple Portable Apparatus for Continuous Oxygen Administration." *British Medical Journal*, July 8th, 1922.

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CAMMIDGE, P. J., M.D. "The Source of the Amyolytic Ferment of the Urine." *Ibid.*, June, 1922.

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CAUTLEY, EDMUND, M.D., F.R.C.P. "Proprietary Food and Milks." *Ibid.*, July, 1922.

CHANDLER, F. G., M.D. "The History of the Diagnosis and Treatment of Empyema." *Proceedings Royal Society of Medicine*, February, 1922.

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COCKayne, E. A., M.D. "Case of Defective Ossification of Skull." *Ibid.*, May, 1922.

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* * * Examinations, etc., are unavoidably held over.

CHANGES OF ADDRESS.

- BEADLES, Lt.-Col. H. S., R.A.M.C., P.M.O. Gendarmerie, Surafend Camp, Ludd, Palestine.
- DURAND, T. W. H., The General Hospital, Johore Bahru, Malay States.
- GRIFFITH-JONES, C., 38, Finedar Road, Wellingborough.
- HODGSON, G. HAMILTON, Charing Cross Hospital, S.W. 1.
- HOLGATE, Major M. J., I.M.S., 55, Fellows Road, Hampstead, N.W. 3. (Temporary.)
- KELF, H. D., 71, Trafalgar Road, Greenwich, S.E. (Tel. Greenwich, 686).

- TOMS, H. W., Assistant to M.O.H., Local Sanitary Office, Bangkok.
- WHITBY, F. Dymchurch, Kent.
- WHITE, F. NORMAN, Chief Commissioner, Epidemic Commission, League of Nations, Geneva, Switzerland.
- WILLIAMS, R. HARVEY, "Lisnamee," The Avenue, Hitchin.

APPOINTMENTS.

- COLE, B. H., M.R.C.S., L.R.C.P., appointed House-Physician at the Royal Berkshire Hospital, Reading.
- ILLI, N. H., M.B., B.S. (Lond.), M.R.C.P., appointed Assistant Physician to the Metropolitan Hospital.
- HODGEN, G. HAMILTON, M.R.C.S., L.R.C.P., appointed House Surgeon at Charing Cross Hospital.
- STURTON, C., M.R.C.S., L.R.C.P., appointed House Surgeon to Salisbury General Infirmary.
- THOMAS, C. HAMBLEN, M.B., B.S. (Lond.), appointed Chief Assistant, Ear, Nose and Throat Department, West London Hospital, and Aural Specialist to the Ministry of Pensions.
- TOMS, H. W., M.D., B.Ch. (Oxon.), appointed Assistant to Medical Officer of Health, Bangkok.

BIRTH.

- WILLIAMS.—On April 20th, 1922, at Lisnamee, The Avenue, Hitchin, to the wife of R. Harvey Williams—a daughter.

MARRIAGES.

- BATTERHAM—RUNDLE.—On August 3rd, at St. Mary's, Rolvenden, by the Rev. G. Andrew (Vicar) and the Rev. Canon Beale (Vicar of Sandhurst and Newenden), Capt. Douglas John Batterham, son of Dr. Batterham, of Beechfields, Northiam, to Ethel Thelma Rundle, only daughter of Dr. and Mrs. F. Carlyon Rundle, of the Old Parsonage, Rolvenden.
- GRIFFITH-JONES—GOODING.—On August 2nd, at Mount View Congregational Church, Stroud Green, N., by the Rev. Dr. E. Griffith-Jones, father of the bridegroom, assisted by the Rev. W. E. Cloutman, Dr. Cyril Griffith-Jones to Dorothy May, daughter of Mr. and Mrs. E. R. Gooding.

DEATHS.

- CROSS.—On August 28th, at 49, West Heath Drive, N.W. 11, in his 57th year, William Henry Cross, B.A., J.P., for 38 years Clerk to the Governors of St. Bartholomew's Hospital.
- JENKINS.—On August 6th, 1922, at 11, Hills Place, Oxford Street, W., Dr. T. J. Price Jenkins, aged 58.
- PLETTS.—On August 5th, 1922, at his residence, Bedford, John Menham Pletts, M.D., etc., formerly of Ryde, Isle of Wight, aged 72.
- RAWLING.—On July 24th, 1922, Sarah Bathe Rawling, of 16, Montagu Street, Portman Square, aged 74.
- STACK.—On August 3rd, 1922, at King's College Hospital, London, Edward Hugh Edwards Stack, M.B., F.R.C.S., of Clifton, Bristol, aged 55.
- STEVENS.—On August 20th, 1922, at Gaya, India, from cholera, Lt.-Col. Algernon Francis Stevens, I.M.S., third son of the late Sir Charles Cecil Stevens, K.C.S.I., and Lady Stevens.
- VINCENT.—On July 21st, 1922, at 32, Seymour Street, Ralph Vincent, M.D., eldest son of Ralph Vincent, of Leytonstone.
- WEATHERALL.—On August 1st, 1922, killed in motor cycle accident, Estlin Hugh Weatherall, M.B., B.S. (Lond.), House-Physician, St. Bartholomew's Hospital, and of Essex House, Kensington, aged 24.
- WILCOX.—On August 14th, 1922, of heart disease, Ernest Wilcox, M.D., M.R.C.S., C.M., Hambrook Court, Glos., beloved husband of Minnie Wilcox (née Husler).

NOTICE.

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

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