JUNIOR NURSING MANUAL No. 2. BRITISH RED CROSS SOCIETY. By BEATRICE AGAR. (Cassell & Co.)

Most girls' schools now teach first aid and hygiene, and for such class work this book is admirably suited. The language is clear and simple, and the book deals only with subjects likely to be needed by the amateur.

THE NURSING MIRROR POCKET ENCYCLOPÆDIA AND DIARY, 1925.

The fact that this is the eighteenth issue of this book proves its usefulness. The alphabetical arrangement greatly facilitates reference, and there are numerous tables, while the book does not contain much unnecessary information.

Erratum.—The name of F. W. Robertson, M.D., should have been mentioned in connection with the case of transverse presentation which we published in our last issue.—ED.

EXAMINATIONS, ETC.

UNIVERSITY OF OXFORD.

The following degrees have been conferred:
B.M.—M. J. W. Minshull, A. W. L. Row.

CONJOINT EXAMINING BOARD.

First Examination. January, 1925.

Chemistry.—H. V. Burt.
Physics.—H. V. Burt.
Elementary Biology.—H. V. Burt, M. W. Gonin, H. G. Hind.

Pre-Medical Examination.

Chemistry.—R. H. Leaver.
Physics.—H. L. Hodgkinson, R. H. Leaver.

Second Examination.

Part I. Anatomy and Physiology.—A. N. Hobbs, E. ap I. Rosser, J. E. Snow.
Anatomy only.—W. A. Wood.
Physiology only. N. B. Colman, E. C. T. Foot, J. T. C. Gray, C. J. Sanderson, J. L. Smith, R. Zeitlin.
Part II. Pharmacology and Materia Medica.—J. G. Cox, A. P. Gaston, B. Kettle, K. Knowles, C. D. de Labilliere, E. G. Laurence, A. Myerson, C. P. Nixon, L. G. M. Page, A. de la C. Russian, J. M. Taylor, H. A. Tracey, C. J. Sanderson.

Final Examination.

The following have completed the examination for the Diplomas of M.R.C.S. and L.R.C.P., and have had the Diplomas conferred on them:

J. D. Allen, C. E. G. Beveridge, W. A. Bourne, S. Brest, H. F. Brewer, D. A. Digg, D. J. Brims, R. J. Brocklehurst, H. F. Chillingworth, H. A. Clegg, C. P. Craggs, J. Currie, G. E. Ellis, M. G. Fitzgerald, H. Levy, A. C. Liesching, A. W. C. Mellor, W. R. Nash, G. W. C. Parker, A. E. Parkes, M. D. Rawkins, A. F. Taylor, W. R. Thrower, R. A. Walsh, L. B. Ward.

CHANGES OF ADDRESS.

CORBETT, R. S., Department of Surgery, University Hospital, Ann Arbor, Michigan, U.S.A.
HALL, P., 146, Harley Street, W. 1. (Tel. Langham 2338.)
HILL, N., 136, Harley Street, W. 1. (Tel. Mayfair 6397.)
IRVING, J. B., 2, Oak Hill, Dawlish, Devon.
KENNEDY, W. W., Sherwood House, Coombe Martin, Devon.
LEITCH, J. N., Moran P.O., Assam, India.
MCCURRICH, H. J., 67, Dyke Road, Brighton.
MORFORD, A., Southwood, Grand Avenue, Worthing, Sussex; *and* 12, Buckingham Palace Road, S.W. 1.
NANKIVELL, A. T., Duke of Cornwall Hotel, Plymouth.
STEEL, C. R., Tanganyika, British East Africa.
TUNBRIDGE, W. S., Oxted, Surrey.
YEATMAN, J. W., Old Beach Road, Brighton, S. Australia.

APPOINTMENTS.

ALLEN, J. D., M.R.C.S., L.R.C.P., appointed House-Surgeon to the Royal Gwent Hospital, Newport, Mon.
DAVIES, J. CONWAY, M.R.C.P.(Lond.), appointed Physician to the Seamen's Hospital.
FRANCE, F. G., M.R.C.S., L.R.C.P., appointed House-Physician to the Hospital for Consumption and Diseases of the Chest, Brompton Road, S.W.
GALSTAUN, S. G., M.R.C.S., L.R.C.P., appointed Hon. Radiologist in Charge of the Radiology Department of the Medical College Hospitals, Calcutta.
MCCURRICH, H. J., M.S.(Lond.), F.R.C.S., appointed Medical Officer, Poor Law Institute, Brighton.
NANKIVELL, A. T., M.D.(Lond.), D.P.H.(Cantab.), appointed Medical Officer of Health, Port Medical Officer, Chief Tuberculosis Officer and School Medical Officer to the County Borough of Plymouth.
PADDLE, K., M.R.C.S., L.R.C.P., appointed Assistant Medical Officer, West Riding Asylum, Wakefield.
PIDCOCK, B. H., M.B., B.S.(Lond.), appointed Assistant Surgeon to the Royal Hants County Hospital, Winchester.
SAXBY-WILLIS, F. E., M.D.(Lond.), M.R.C.P., appointed Consulting Physician to the Weir Hospital, Clapham Park, S.W.
SMITH, A. W. H., M.R.C.S., L.R.C.P., appointed House-Surgeon to the Huddersfield Royal Infirmary.
TREISSMAN, H., M.R.C.S., L.R.C.P., appointed Resident Medical Officer to the Jenny Lind Hospital, Norwich.

BIRTHS.

MITCHELL.—On February 18th, at 129, Wigmore Street, to Kitty, wife of W. E. M. Mitchell, M.C., F.R.C.S.—a daughter.

MARRIAGES.

HENSHALL—SHORE.—On February 18th, at the Priory Church of St. Bartholomew-the-Great, E.C., by the Rev. Tilden Smith, Edward, son of the late William Henshall and Mrs. Henshall, of Colwyn Bay, to Marjory Amelia, elder daughter of Dr. and Mrs. T. W. Shore, of Upper Norwood.
HORDER—GIVEN.—On January 28th, at Mossley Hill, Liverpool, Cecil A. Horder, M.A., F.R.C.S., son of the late E. G. Horder, F.R.C.S.(Ed.), and Mrs. Horder, to Jessie, daughter of J. C. M. Given, M.D., M.R.C.P., and Mrs. Given, of Liverpool.
LAPTAIN—PEATE.—On February 9th, 1925, at the Parish Church, Newton Ferrers, Devon, Jonathan Henry Rich Laptain, of Yealmpton, Devon, to Hilda, younger daughter of Mrs. and the late Mr. Peate.

GOLDEN WEDDING.

STEVENS—FERGUSSON.—On February 18th, 1875, at Aberdeen, Alfred Felix Stevens, M.D., of Stoke Newington, N. (later The Hawthorns, Stamford Hill), to Jane Armstrong, eldest daughter of Mr. and Mrs. Robert Fergusson, of Aberdeen. Present address: Longville, Cheltenham.

DEATHS.

KLEIN.—On February 9th, 1925, at 13, Wilbury Villas, Hove, Prof. E. E. Klein, M.D., F.R.S., aged 80.
STEEDMAN.—On February 14th, 1925, suddenly, of heart failure, John Francis Steedman, F.R.C.S., of "Arcall," Prentis Road, Streatham.

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. 1.

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. XXXII.—No. 7.] APRIL 1ST, 1925. PRICE NINEPENCE.

CALENDAR.

Fri., April 3.—Sir Thomas Horder and Mr. Rawling on duty.
Tues., „ 7. Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Fri., „ 10.—Prof. Fraser and Prof. Gask on duty.
Tues., „ 14.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Fri., „ 17.—Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.
Mon., „ 20.—**Summer Session Commences.**
Tues., „ 21.—Sir Thomas Horder and Mr. Rawling on duty.
Last day for receiving matter for May issue of Journal.
Fri., „ 24.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Tues., „ 28.—Prof. Fraser and Prof. Gask on duty.

EDITORIAL.

SEVERAL Bart.'s men who had been associated with Mr. Cross as anæsthetists wished, on his retirement, to give him some tangible mark of their respect for his character and ability. Some members of the Surgical Staff expressed a desire to associate themselves with this suggestion, and under the direction of Dr. Hadfield a subscription list was opened, a gift was chosen, and has now been received by Mr. Cross, who has written the following letter:

MY DEAR HADFIELD,—It is with feelings of great pleasure that I write to you acknowledging the receipt to-day of the very handsome present of Waterford glass, conveying as it does the mark of regard felt by the many subscribers with whom I have been associated for the last twenty-five years.

During this long period my relationship with them has been of the happiest.

May I ask you to add to your kindness in the matter by conveying to them my deepest gratitude and most kindly remembrances.

Yours very sincerely,
W. FOSTER CROSS.

* * *

We offer our heartiest congratulations to the Association Football Club who have won the Inter-Hospital Cup for the second year in succession. They beat St. Thomas's Hospital by one goal to *nil* in the Final Round after a hard game.

* * *

On June 26th, 1657, the remains of the great William Harvey were deposited in the vault of the historic old church at Hempstead in Essex. In the year 1882 the tower of this church was destroyed, and still lies as a heap of stones in the graveyard. In the following year the body was placed in a handsome sarcophagus subscribed for by the Royal College of Physicians and deposited inside the church. It is now proposed to restore the tower as a memorial to William Harvey. The Treasurer of the Hospital, Lord Stanmore, is the chairman of the Committee, and Sir D'Arcy Power is on the Executive.

St. Bartholomew's is proud of Harvey, and we hope that many Bart.'s men will subscribe to this memorial. Subscriptions should be sent to Dr. Sidney Phillips, at the Royal College of Physicians, Pall Mall East.

* * *

We offer our hearty congratulations to Sir Humphry Rolleston on his appointment as Regius Professor of Physic in the University of Cambridge. We realize with pride that the Regius Professors of both Universities are now Bart.'s men, Sir Archibald Garrod holding this honoured position at Oxford.

We offer hearty, if somewhat tardy, congratulations to Professor Lovat-Evans, who has recently been made a Fellow of the Royal Society.

Also we are pleased to mention Mr. Kenneth Franklin, who has been made a Fellow of Oriel College and appointed Demonstrator in the Department of Pharmacology at the University of Cambridge.

* * *

It is with great regret that we record the death of Dr. Joseph Ardeine Ormerod, Registrar of the Royal College of Physicians of London, an honoured member of the Medical Consulting Staff of the Hospital, and Consulting Physician to the National Hospital for Paralysis and Epilepsy.

From Rugby Ormerod went to Oxford in 1867, having gained a classical scholarship to Corpus Christi. At the 'Varsity his progress was brilliant. He won the Chancellor's Prize for Latin verse, and was elected a Fellow of Jesus College. He came to Bart.'s in 1871, and throughout his long connection with this Hospital showed himself to be a great scholar and a great clinician.

A memorial service was held at the Church of St. Bartholomew-the-Less.

* * *

In our February issue we recorded the death of Dr. Attfield, the oldest Bart.'s man. By his death this proud title passed to Dr. Arthur E. T. Longhurst, of Chandler's Ford, Hants. On March 20th Dr. Longhurst died. He qualified from this Hospital in 1853, and spent long and eventful years as a practitioner. He was in Turkey and the Crimea from 1854 to 1855, was present at the siege of Sebastopol, and suffered in the Indian Mutiny. The JOURNAL published an article by him as late as 1915, and but for an attack of influenza he would have written for us again two months ago.

We are anxious to know who is now "the oldest Bart.'s man."

* * *

It has been found impossible to arrange the next Dinner of the Tenth Decennial Contemporary Club on the first Friday in May this year, the date decided upon at the last Dinner.

There are several reasons for this decision, but the chief one is the difficulty of arranging two dinners of the Club so close together as December 12th and May 1st.

The next dinner will, therefore, be held on the first Friday in May, 1926 (May 7th).

THIRTY CASES OF ARTIFICIAL PNEUMOTHORAX IN ADVANCED PULMONARY TUBERCULOSIS.

By BERNARD HUDSON, M.D., M.R.C.P., Swiss Federal Diploma.

Victoria Sanatorium, Davos-Platz.

I HAVE thought it worth while to record these thirty cases inasmuch as they were all of advancing, extensive and severe disease, and there is no doubt that in many of them, if not all of them, had they been left alone, the disease would by now have progressed to a fatal termination. They all unfortunately arrived in an advanced and active state of the disease, coming to Switzerland, as I am sorry to say occurs in many cases, as a last hope, all other means of treatment having failed. In each case the attempts at inducing an artificial pneumothorax were decided upon when it became obvious that the condition was not going to settle down with rest and the ordinary treatments available—in other words it was attempted in order to save life. This group of cases recorded does not include any of the more favourable ones, but only the severe ones, and covers a period from the years 1920 to 1923 inclusive in nearly all the cases. In almost all these patients there was some disease in the good lung, which in the favourable instances has become quite inactive.

The analysis of results up to the present time is as follows: Twenty are in good health and able to get about, but none of them are yet working at any employment, although there are three who intend to make an attempt next summer. Out of all the cases only twelve have escaped the complication of fluid, and in four cases a cold abscess containing pus with tubercle bacilli formed. However, these four cases are all doing well, the fluid being removed as required and replaced with air. All the others which have had fluid are doing well. There were two instances in the group of spontaneous pneumothorax. Luckily the cavity did not become seriously infected, and the pneumothorax was kept up artificially. Here again in each of these cases a cold abscess eventually formed, which was dealt with by aspiration when required and replacement with air. These patients are doing well and are in excellent general health. Of the patients, six are dead, two died of spontaneous pneumothorax occurring in the artificial one, probably due to rupture of a cortical cavity, a pleuro-bronchial fistula being formed in each case, the patient eventually dying of sepsis. In one case death was due directly to hæmorrhage; the pneumothorax was done originally to attempt to control a big hæmorrhage, but did not succeed, owing probably to a very thick-walled incompressible cavity from which the bleeding occurred. In two others death was due to an acute spread of tuberculosis in the good lung.

Examining these results we have at least the satisfaction of knowing that out of thirty desperate cases, all of whom would in all probability either be dead or near it at the present time, twenty have been saved and are able to get about feeling well, and more or less enjoying life. Two are at present ill; one of them is in the stages of acute effusion, almost certainly forming a cold abscess of the pleura, the other has developed a dry pleurisy and a pleuro-pericarditis in the left lung, the right one being the pneumothoraxed one. The fillings are being discontinued for the time in this case, and the condition is passing off, the patient improving. In three of the patients a small pocket of gas only was obtainable owing to the presence of adhesions, and the results are insufficient. During this period, 1920–1923, there were several other severe cases attempted, but found quite impossible to do, owing to the presence of extensive adhesions.

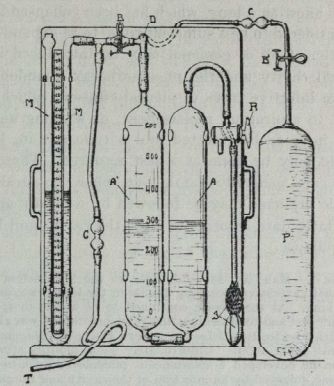
Total number of cases, 30: *Well at present*, 20, of which twelve have or have had effusions, four of which effusions being purulent, containing tubercle bacilli, but not infected with secondary organisms.

Ill at present, 2; one with an acute effusion, and one with pleurisy and pleuro-pericarditis of the opposite (left) lung. These will almost certainly settle down and improve.

Partially successful only, 3. A small pocket only being produced owing to adhesions.

Dead, 6; two from spontaneous pneumothorax occurring in the artificial one, two from spread in the opposite lung, one from hæmorrhage, one from infection of the cavity with pneumococcus.

The apparatus used for many of these cases has been the one illustrated below, which was designed by my colleague, Dr. J. Mamie, of Lausanne. Another apparatus which has also been employed was Dr. Frey's modification of Von Muralt's, which is very similar in many ways to the above. The advantages of this type of machine are many. It is portable, and may be carried about during the physician's visits to various clinics, houses, etc. It may be employed quite easily by one person, and does not require an assistant. The whole apparatus is not more than 50 cm. high; it is light and easily transportable. The tubes are smaller than is usually the case and contain only 500 or 600 cc., but if more gas is necessary it can be easily introduced without removing the needle or disturbing the apparatus or the patient in any way.



APPARATUS ACCORDING TO THE DESIGN OF DR. MAMIE.*

A and *A'*, tubes containing the gas and solution of perchloride of mercury. *A'*, graduated from 0 to 600 c.c. *B*, a clamp control: the communication between the tube of gas and the needle. *B'*, a clamp control: the communication between the graduated tube and the reserve of gas *P*, which is situated behind the apparatus. *C*, a filter placed in the exit tube of the gas. *C'*, a filter placed in the entrance tube of the gas. *M*, water thermometer graduated up to 40 c.c. *P*, reserve of gas (generally nitrogen). *R*, tap for the pressure bulb *S*. *S*, pressure bulb. *T*, tube to which is attached the needle.

In order to charge apparatus with gas, take away the forceps *B'*, turn the tap *R* so that it communicates with the outside air, and press upon the tube *P*, which is generally a rubber bag containing nitrogen or air, so that the gas is forced into *A'*, which is filled to the point 0; then shut the clamp *B'*, and the apparatus is ready for use. Once the needle is in the pleural space, it is only necessary to remove the clamp *B*, and there is now communication between the gas-containing tube and the pleural cavity. The gas is thus forced into the pleural cavity by the pressure exerted by the tube *A*, which, of course, is full of the solution of perchloride of mercury.

As regards the removal of fluid, I generally merely replace it with air, introducing the gas through the same needle with which the aspiration was carried out. The pleural cavity, in our opinion, should not be washed out, except in cases of grave infection; in these cases the cavity may be washed out, either through the same needle, by means of an ordinary funnel, or it may be washed out through two needles, the fluid being introduced through one and escaping by another one at a lower level. Sterile water, saline, or some weak antiseptic may be used. In some cases where there has been a pleural effusion, good results have been obtained by aspirating the effusion, washing the pleural cavity

* The Mamie apparatus is manufactured by Messrs. Hausmann & Co., of St. Gallen.

out, and replacing the fluid with an inert oil, such as oil of gomenol, 10 per cent. This method is also useful when allowing a lung, which has been collapsed for what is considered to be a sufficient time, to re-expand. About 200 c.c. of oil of gomenol may be introduced into the pleural cavity and the pneumothorax abandoned. In severe infective cases of pleural effusions which do not react to aspiration, replacement, or washing out, a rib may have to be resected and a tube put in, but this should only be done as a last resource. These severe cases are generally fatal, but when favourable, the simple drainage may be followed by a plastic operation at a later date, in order to close the cavity and keep up the collapse.

CASE 1.—Male, æt. 21. Admitted to the Sanatorium in June, 1919, with extensive spreading disease in the lower two lobes of the right lung. As the disease continued to be active in spite of all ordinary rest and treatment, artificial pneumothorax was attempted, and with a perfectly satisfactory result. The patient became afebrile and was going about. Unfortunately some months after the induction he developed a spontaneous pneumothorax into the artificial one, followed by an infection of the cavity and the production of a pyo-pneumothorax. This was washed out many times, but eventually had to be drained. A thoracoplasty was attempted later to close the cavity, but unfortunately the patient went downhill from a spread of tuberculosis in the opposite lung, and died about a year later.

CASE 4.—Female, æt. 26, was rapidly going downhill with extensive spreading disease in the left lung, and commencing in the right also. Artificial pneumothorax induced as a last resort in 1920 with a partially successful result, the top of the left lung being adherent. This was followed by arrest of the disease in the right lung and recovery of the patient. In this case complications have occurred—a serous effusion four months after induction, which absorbed. In February, 1924, the patient contracted an attack of acute pleurisy on the left side with effusion, which subsequently developed into a cold abscess of the pleura containing tubercle bacilli but no secondary infection. The present state of this case is that she is really in very good health and afebrile, but every six weeks the pus is removed from the pleural cavity and replaced by air, but gradually fills up again each time.

CASE 5.—Male, æt. 30, with exceedingly active disease in the right lung, with softening and cavity formation, and some commencing tubercle in the left, patient going downhill very rapidly, and artificial pneumothorax was attempted to save life in the summer of 1923. The result was highly gratifying and very successful: the whole process became inactive, and the patient was getting about and looking well and afebrile with suppression of cough and sputum. In December, 1924, this patient suddenly collapsed and very nearly died. It was found that he had ruptured his collapsed lung and there was a fistula between the pneumothorax and his mouth. Fluid subsequently formed, and the patient for some weeks was extremely ill, but the present position is that the fluid has re-absorbed, the fistula appears to have closed, and the pneumothorax is now being carried on again perfectly successfully, and the patient looks like recovering his health once more. This has been a very remarkable case.

CASE 9. Female, æt. 33, with very acute infiltration of the left lung, with rapid formation of a large cavity in the upper part of the lower lobe. This patient was going downhill very rapidly and artificial pneumothorax was performed in the summer of 1920. There were no complications of any kind. The pneumothorax has now been discontinued for nearly a year, the cavity is quite healed and represented by a linear scar, and the patient is quite well and leading a normal life.

CASE 11.—Male, æt. 39, came under observation with an infiltration of the whole of the right lung, the disease being probably of some considerable standing. There was a good deal of cough and sputum, and he was febrile every night. I was on the point of proposing an attempt at artificial pneumothorax when he developed a spontaneous one. He very nearly died from shock; the collapse of the lung was complete and sudden, and was followed by an effusion. Very luckily the hole must have closed quickly, and the effusion did not become badly infected. It was removed and replaced by air, and gradually changed its character from a serous effusion to thick tuberculous pus. The present state is that (fifteen months after the occurrence of the spontaneous pneumothorax) there is no fluid, the patient takes 500 c.c. of air comfortably every three weeks, and is extremely well in every way; there is no cough or sputum, and never any rise of temperature.

CASE 13.—This case is almost exactly identical with Case 12, the patient being a female, æt. 22, artificial pneumothorax being performed for the same reason. This patient is now quite well in her general health, but has a cold abscess of the pleura, the fluid being removed in intervals of about six weeks and being replaced by air. Up to the present it has always slowly re-accumulated.

CASE 14.—Male, æt. 29, came under observation in August, 1921, with disease in the right upper lobe and left apex. He did very well under ordinary *regime* and treatment for a year. He then had a severe hæmorrhage, followed by renewed activity and spreading in the right lung. Artificial pneumothorax was then attempted in order to save life, and in order to stop the bleeding. A partial result only was obtained owing to the presence of adhesions, but it was sufficient to arrest the hæmorrhage and to restore the patient to a measure of health. He became afebrile and the cough and sputum diminished considerably, and the disease in the left lung was apparently arrested. The refills were kept up every three weeks, about 300 c.c. of air being as much as could be comfortably got in at a time. There were no complications in the pneumothorax at all, and the patient did really astonishingly well considering for a year, but unfortunately developed cerebral symptoms and died.

CASE 15.—Male, æt. 34, a case of long standing, probably six or seven years, came under observation about eight months ago, with extensive active disease in both lungs, the left lung being the worst. As this patient was obviously going downhill I thought it advisable to attempt to collapse the worst lung, and accordingly a small pneumothorax was induced on the left side. This patient is certainly improved, his cough and sputum have lessened, his temperature is lower, and he is better than he was. A small quantity of air—only about 400 c.c.—is injected about every eight days. There have been no complications up to date, and if things go well I propose in a few months to leave the pneumothorax on the left side alone, and do a similar procedure on the right lung, so as to give that a rest as well.

CASE 16.—A lady, æt. 51, came into the Sanatorium with active and extensive disease in the left lung of considerable standing. The ordinary rest and *régime* had no effect, and the activity did not settle down. Accordingly a pneumothorax was successfully induced in December, 1923. She developed a serous effusion two months later, which became absorbed. This patient is now perfectly well and is living at home in England, the pneumothorax being still kept up.

CASE 17.—A man, æt. 30, came under observation with active trouble in the left lung, with softening and cavity formation. This patient had recurrent hæmorrhage, and a pneumothorax was performed to control this and was quite successful. He has now had a pneumothorax for eighteen months, which is still being kept up, and he is in very fair health, with no cough, fever or sputum.

CASE 23.—Man, æt. 41, was gassed during the war. No definite evidence of tuberculosis ever found, no cough, temperature generally normal, and never any tuberculosis found in the sputum, but he was having recurrent hæmorrhages about every fourteen days, which were getting bigger and bigger. X-ray photograph showed a dark shadow at the right hilus. Accordingly this lung was collapsed on the chance of controlling the hæmorrhage, and with complete success. The pneumothorax has been left off and the lung is now perfectly well again, and the patient is in very good health.

CASE 28.—Man, æt. 43, with extensive spreading disease with softening and cavity formation in the left lung and involvement of the right apex, with much cough and sputum, and violent auto-inoculation. A pneumothorax was successfully induced eighteen months ago, and is still being kept up without the slightest complication. The lesion in the right lung has become completely inactive, the patient has no cough or sputum, and is in extremely good health in every way.

CASE 29.—Young woman, æt. 23, with very severe disease in the right lung and recurrent hæmorrhages. When she came under observation here she had been ill for about two years, had been in other sanatoria, and had steadily got worse and worse. A pneumothorax was successfully induced, with the very greatest benefit to this patient. She developed an effusion later on, which persisted and re-accumulated when removed. This patient remained perfectly well for eighteen months, until a short time ago she got a violent infection on the pneumothorax side with pneumococcus. The fluid increased rapidly in amount and quickly became purulent. Washing out of the cavity was done on several occasions, but without the slightest beneficial result, and eventually, owing to this very severe toxæmia and fever, a rib was resected and the cavity drained. She temporarily improved very much, and a month later an attempt was made to close the cavity by a thoracoplasty, which was successfully performed, but unfortunately was too much for the patient, who died a day or two later from shock.

THE INFLUENCE OF INFECTIONS UPON DIABETES MELLITUS.

FOR many years it has been known that infections occurring in diabetic patients are less amenable to treatment than they are in those who suffer from other chronic diseases—a fact to which attention has again been directed during the recently prevalent epidemic of sore throats and influenza. The infection, which may be acute or chronic, may vary from a few small boils to a gangrene of the lung, and its usual effect is to aggravate the course of the original disease. A vicious circle is thus set up, which, commencing with an apparently slight and innocent condition, may progress rapidly, with the result that the patient sinks into coma before the nature or even the existence of the exciting cause is suspected. Nevertheless, in cases of diabetic coma or of severe diabetes which tend to lose ground in spite of treatment, an underlying infection is usually present and must be sought for, the treatment of this complication being as essential as the treatment of the diabetes itself.

In general it may be stated that if a diabetic patient has a normal blood-sugar under treatment, the effect of even a mild acute infection, such as an ordinary sore throat or a common cold, will be an immediate rise in the blood sugar and very probably glycosuria. In dealing with such cases we were, until quite recently, faced with two definite indications for treatment, each pointing in a direction contrary to the other. On the one hand it was necessary to bring down the blood-sugar and to render the urine sugar-free, this being accomplished by what was literally a starvation diet. On the other hand, if the underlying infection were to be dealt with by the body, food had to be supplied to compensate for the increased tissue destruction. In actual practice the food intake was cut down almost to *nil*, so that the patient had no power of resistance to even a mild infection, with the result that coma and death were of all too frequent occurrence. In other words, no matter what line of treatment was adopted, the vicious circle remained unbroken, and it is only since the introduction of insulin that we have been able to meet both indications at once—to lower the blood sugar and at the same time to supply the patient with a diet of adequate caloric value. The type of foodstuff which is ordered is also of importance, for it is necessary to provide a small quantity of carbohydrate for the febrile tissues to burn, and this must be supplied in a form which can be easily assimilated by the patient. The food which suits this purpose best is milk, and it is useful to remember that, for every 100 c.cs. of milk taken, 4 grm. of lactose are being metabolized as glucose within the body, and that 1 unit of insulin is needed for the utilization of every 2 grm. of glucose absorbed.

The following three cases, recently in the wards of the Medical Unit, illustrate some of the different types of infection which may be encountered, and, as they provide typical examples of the condition in question, it may be of interest to record their mode of response to the infection, and the steps found necessary to combat its effects in each case.

CASE 1.—E. H—, æt. 12, a schoolboy, was admitted to Sandhurst Ward on November 24th, 1924, in a very drowsy state. The history was that he had been "off colour" for several weeks and had been losing weight, beyond which facts there was nothing to suggest the onset of diabetes. During the two days previous to admission he had been constipated and had commenced to vomit, while later he developed acute pain beneath the lower end of the sternum, not related to respiration nor to the taking of food. On the day of admission he had become very drowsy, and large quantities of sugar and acetone bodies were found in his urine. On examination he was not completely unconscious and could be made to answer questions, but he was obviously very ill, with temperature 97° F., pulse 110, and respirations 10. The respirations were slow and deep, and the eye-ball tension was low, while the blood-sugar, taken before treatment commenced, showed 0·34 per cent. During the first twelve hours he was given water only by the mouth and 80 units of insulin, by which time his urine, tested every three hours, was free from sugar and contained considerably less acetone bodies, but the remarkable fact was that clinically his condition was very little improved. He was then given 1 litre of milk within the next twenty-four hours in addition to an egg and vegetable diet and 40 units of insulin in four equal doses: of this insulin 20 units would be needed to metabolize the carbohydrate given in the milk, while the remainder was available for the reduction of the blood-sugar. During the day the clinical condition of the patient improved markedly, and by the following morning he appeared to be almost normal. His blood-sugar at noon on November 26th showed 0·085 per cent., but at 1 p.m. had risen to 0·17 per cent., showing

that the regulation of sugar metabolism was still very unstable. After this date the patient made rapid progress, and within four weeks was taking a diet containing protein 75 grm., fat 132 grm. and carbohydrate 25 grm., making a daily caloric value of 1586, while he was kept sugar-free, with a blood-sugar of about 0·1 per cent., with 4 units of insulin. Even with this dose he began to manifest symptoms of hypoglycæmia, so that it had eventually to be reduced to 3 units daily for a short time.

While he was in this satisfactory state he suddenly developed a sore throat and his blood-sugar rose to 0·2 per cent., while sugar reappeared in his urine. The course of the infection is seen in Chart I, and the treatment consisted in the addition of 10 units of insulin

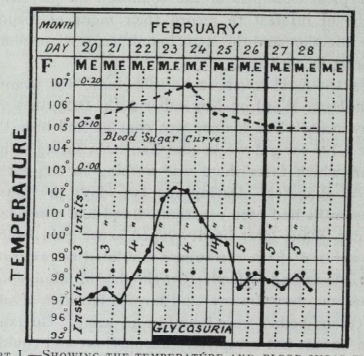


CHART I.—SHOWING THE TEMPERATURE AND BLOOD-SUGAR FIGURES DURING AN ATTACK OF TONSILLITIS.

for one day and an increase in the milk to 300 c.c. The urine again became sugar-free and subsequently remained so on 5 units of insulin daily; of course vigorous local treatment was carried out in addition.

In this case the main points of interest are the treatment of the initial coma, and the fact that, although the urine rapidly became sugar-free, his clinical condition did not improve until carbohydrate had been supplied. The infection which determined the onset of coma was not very obvious, but the condition described above points to an acute gastritis; the blood-count on admission showed 11,800 white blood-cells, of which 8140 were polymorphonuclear cells. It is also worthy of note that a diabetic may be suffering from a severe infection with a subnormal temperature, in which case the pulse-rate may often be relatively raised.

The potency of insulin is demonstrated in this case in a remarkable way, as 4 units of insulin caused symptoms of hypoglycæmia, while 3 units permitted a very slow rise of blood-sugar. In this connection it may be useful to recapitulate the main manifestations of hypoglycæmia observed up to the present.

Perhaps the very first indication in children is a gradual increase in the pulse-rate occurring over a period of several days (see Chart II). In slightly more severe cases the patient begins to sweat and has tremors of the hands, perhaps accompanied by numbness and paræsthesia usually of the face or tongue. Later the patient complains of hunger pains or limpness and asthenia with diplopia and sometimes aphasia. Another symptom is lack of concentration, which may proceed to delirium and delusions, or complete inco-ordination; in children fits may be observed, while in the most severe cases there may be a sudden onset of coma—a condition which must be carefully distinguished from the coma associated with hyperglycæmia. The treatment of hypoglycæmia is, of

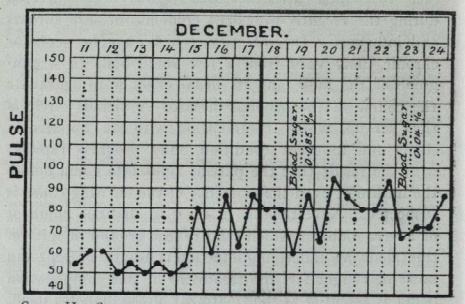


CHART II.—SHOWING THE INCREASED PULSE RATE WHICH PRECEDED THE DEVELOPMENT OF HYPERGLYCÆMIA.

course, to provide sugar by giving a few lumps in strong coffee, or alternatively to mobilize the carbohydrate stored in the body by the injection of liq. adrenalin 1 : 1000 mv, followed by some sugar.

CASE 2.—Mrs. F—, æt. 37, was admitted to President Ward on October 27th, 1924, complaining of weakness and thirst. The total duration of symptoms had been only six weeks, and her local medical adviser had given a grave prognosis on account of her weak state and the large quantity of sugar in her urine, as well as her lack of response to ordinary dietetic measures. On admission she appeared to be very weak although not near coma, and her urine contained a large amount of sugar and acetone bodies. Detailed examination did not reveal any acute septic focus, and the only sign of chronic infection was some gingivitis and apparently slight pyorrhœa in the region of the lower incisor teeth. Treatment was commenced with a hunger day and two egg and vegetable days, but insulin was not given. The sugar in the urine diminished markedly, but four days after admission on the above very spare diet the

blood-sugar was still 0·175 per cent. It was therefore decided to deal with the only apparent source of infection, and accordingly all her remaining teeth were extracted on November 4th. After this operation had been performed the patient steadily improved, and her blood-sugar did not rise above 0·095 per cent. although the diet was rapidly increased, so that a week later she was taking 62 grm. of protein, 122 grm. of fat and 20 grm. of sugar daily. The addition of bread, however, did cause her to pass a trace of sugar on one occasion.

She was discharged from hospital in very good health four weeks after admission, and subsequent progress notes show that she has remained well at home, except for a slight attack of influenza, from which she made a good recovery.

The points of interest about this patient are that she was admitted as a grave and rapidly progressive case; that the focus of infection was very slight and one which is present in a large number of cases, and that as a result of the elimination of the septic focus she did not require a single unit of insulin to enable her to attain a condition of equilibrium on an adequate diet.

CASE 3.—Mrs. E—, æt. 46, was admitted to President Ward on October 3rd, 1924, in coma. The patient was gravely ill, with a temperature of 95° F., a large quantity of sugar and acetone bodies in her urine, and a blood-sugar of over 0·36 per cent. In this case no infection was discovered at first, and treatment was carried out by giving 85 units of insulin and 1 litre of milk in the first twenty-four hours. The patient improved slowly but the blood-sugar fluctuated, at times reaching 0·36 per cent., and the temperature steadily rose, reaching 99° F. in the evenings, rendering the existence of some hidden focus probable. This was discovered on the fifth day after admission, and two small abscesses just inside the vagina were opened and drained, with corresponding improvement on the part of the patient. Glycosuria still continued, however, and the blood sugar persisted above 0·20 per cent., when further investigation revealed a few pus-cells and many coliform organisms in a catheter specimen of urine. Treatment with potassium citrate quickly cleared the urine of this infection, and the improvement of the patient clinically was reflected in a fall of the blood-sugar to 0·13 per cent., around which figure it remained, although the daily dose of insulin was gradually lowered to 17 units with the top of the ladder diet, a diet containing 60 grm. of protein, 122 grm. of fat, and 20 grm. of carbohydrate.

This case illustrates doubly the importance of search for a septic focus, and shows that if the blood-sugar does not drop to normal after dealing with one infection, search should be instituted for a second. The patient also showed symptoms of the aphasic type of hypoglycæmia on two occasions, but responded quickly to treatment, and afterwards stated that she could remember events which occurred during her attack "as if she had been dreaming," showing that she could not have been completely unconscious.

SUMMARY.

Any acute infection will raise the blood-sugar of a diabetic patient, and unless careful treatment is carried out by rest, food and, if necessary, insulin, coma may result quite quickly. In any diabetic who is acutely ill an infection is almost certain to be found, and the commonest places to be affected are the throat and ears, the respiratory and genito-urinary systems. The fact that a diabetic patient is afebrile by no means excludes the presence of any sort of infection, and the temperature chart may be misleading in this condition, the most valuable guides being the pulse-rate and the white blood-count.

A word of warning might be added against the use of ether as a general anæsthetic in these patients; in addition to the grave risk of post-anæsthetic bronchitis, ether has been found to have a direct action in neutralizing the effect of insulin, so that it is safer to use gas and oxygen, or some such type of anæsthesia.

In conclusion my thanks are due to Dr. Geoffrey Evans for permission to publish the notes of these cases, and to Dr. George Graham for his assistance and advice in their elaboration.

JAMES MAXWELL.

TWO UNUSUAL ABDOMINAL ACCIDENTS.

THE diagnosis of intra-abdominal accidents is too frequently a matter of extreme difficulty; thus there is born a period of hesitation while conservative treatment is weighed up against what may seem a rash activity. Admitting diagnosis to be difficult, the notes of two uncommon accidents may prove of some interest. In the first, one of rupture of the small intestine, the diagnosis was obscured by rather anomalous signs. Exploration of the abdomen proved our delay to be unwarranted, yet the result was favourable. In the second case the external evidences of injury were not extensive, and merely served to conceal the actual damage. But any surgeon who had explored this abdomen would have been faced with a ruptured kidney, a lacerated spleen and a traumatic diaphragmatic hernia. His efforts would have been unavailing.

CASE 1: *Rupture of the small intestine.—History.*—C. S—, æt. 13, female. February 6th, 1925, while crossing a road patient was knocked over by a motor

lorry, a wheel of which was said to have passed over her abdomen.

On admission.—The child was cold, pale, and suffering from shock. Temperature, 98°; pulse, 110; respirations, 40. There was no evidence of injury above the diaphragm.

An examination of the abdomen revealed the following points: A small area of bruising was apparent in the region of the left anterior superior iliac spine. Slight rigidity of the whole anterior abdominal wall was present, this being most marked in the upper left quadrant. Tenderness was generalized. The area of liver dullness was within normal limits and no evidence of free intraperitoneal fluid could be elicited. The pelvis was intact.

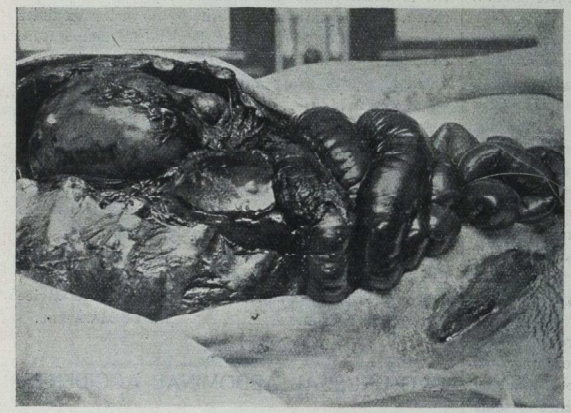


FIG. 1.—ON THE LEFT SIDE CAN BE SEEN THE STOMACH AND SPLEEN LYING ABOVE THE DIAPHRAGM. THE WOUND IN THE RIGHT ILIAC FOSSA IS PRESENT IN THE LOWER RIGHT CORNER.

Urine analysis: No blood nor other abnormal constituent was present.

The patient was admitted and kept under observation.

During the first two hours the general condition improved, the temperature rising to 99°, while the pulse-frequency remained stationary at 110. Abdominal rigidity passed off, but tenderness was still present over the upper left rectus.

Twelve hours after admission the temperature rose to 100·8°; the pulse-frequency showed a corresponding rise to 152. Vomiting of bile-stained fluid commenced.

Sixteen hours after admission.—The abdomen became distended and slight rigidity over upper left rectus was perceptible. The area of liver dullness was unchanged and any evidence of intraperitoneal free fluid was not forthcoming.

The patient volunteered that thirst was her main trouble. There was no pain, nor had there been any except on abdominal palpation.

Twenty hours after accident.—Exploration of the abdomen was considered necessary, and carried out by Mr. McAdam Eccles. The abdomen was opened, under a general anæsthetic, by a 5-in. left paramedian incision, two-thirds of which were above and one-third below the umbilicus. There was a slight increase of clear peritoneal fluid. A coil of jejunum was found completely divided, from the cut ends of which very little intestinal contents had escaped. An end-to-end anastomosis was performed. Previous to suture of the abdominal parietes the peritoneal cavity was irrigated with warm saline. The abdomen was closed with a large tube draining the pelvis.

The total time of operation was twenty minutes. At the termination of the operation the radial pulses could not be felt and respiration became embarrassed. An intravenous saline of ʒxx was given, this was followed by a return of the radial pulses, but the actual frequency could not be ascertained.

One and a half hours after operation strychnine gr. $\frac{1}{30}$ and a further ʒxx of saline were administered intravenously.

During the night continuous subcutaneous saline was given. The bowels were opened on the following morning.

Recovery was uneventful except for occasional attacks of colicky pain. Five weeks after the accident the patient was able to leave hospital on a full diet.

CASE 2: *Traumatic diaphragmatic hernia.—History.*—S. C—, male, æt. 20. On February 25th, 1925, the patient was engaged in cleaning the outside of a window, when, overbalancing, he fell headlong on to a metal spike about 20 feet below. This spike entered the abdomen in the right iliac fossa, and the patient remained impaled till the arrival of assistance about five minutes later.

On admission to hospital at 3.35 p.m. the patient was obviously in great pain; temperature 96°, pulse perceptible but impossible to count and respirations 40.

There was a lacerated wound about one and a half inches in length through all the layers of the abdominal wall in the right iliac fossa, and through this coils of small intestine could be seen. The anterior abdominal wall was generally rigid and tender, the area

of liver-dullness was within normal limits and there was no evidence of free fluid in the peritoneal cavity.

His condition of shock was treated by warmth, morphia gr $\frac{1}{6}$ and an intravenous saline of ʒxxx. Three-quarters of an hour after admission his general condition was slightly improved, the pulse-frequency had decreased to 120 and the volume had improved. Abdominal pain as the chief symptom was now replaced by dyspnœa and a feeling of tightness over the lower thorax.

At 5 p.m. ʒxx of gum saline were administered intravenously, but the patient gradually became worse and died at 8.20 p.m.

A post-mortem examination revealed multiple injuries of an uncommon nature. External examination showed the wound described previously in the right iliac fossa, just below which the skin presented a peculiar striation due to stretching. This is well shown in Fig 1. The lesion of paramount importance was a tear about 3 in. long, running transversely in front of the left leaflet of the diaphragm (Fig. 3). Through this tear a hernial protrusion of the stomach and spleen had taken place into the left pleural cavity. The spleen was ruptured, but the stomach, which was intact and remarkably dilated, had caused an almost complete collapse of the left lung. The heart was displaced, and occupied a position just to the right of the middle line.

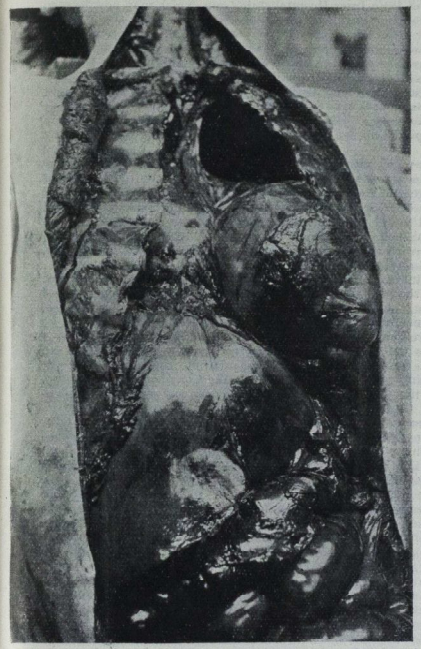


FIG. 2.

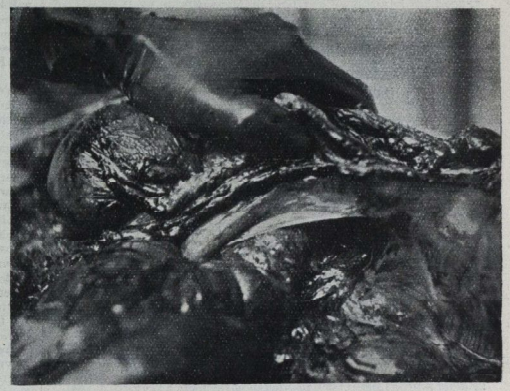


FIG. 3.

FIG. 2.—THE DARK AREA IN THE UPPER RIGHT CORNER IS THE COLLAPSED LEFT LUNG, IMMEDIATELY BELOW WHICH LIES THE DILATED STOMACH.

FIG. 3.—RUNNING TRANSVERSELY ACROSS IS THE TEAR IN THE DIAPHRAGM THROUGH WHICH THE STOMACH AND SPLEEN HAVE PASSED.

The right kidney had undergone extensive laceration. The escaping blood from this viscus had caused a large retro-peritoneal hæmatoma extending across the middle line just below the third part of the duodenum. The serous covering of the third part of the duodenum was torn, but the other coats had escaped. The eighth, ninth and tenth left ribs were fractured.

I wish to thank Mr. McAdam Eccles for permission to publish these notes, while I am indebted to Mr. H. B. Howell for the excellent photographs.

HAROLD BURT-WHITE.

THE BROWN-SEQUARD SYNDROME.

Said B. to S., "Come, let's contrive
A syndrome new and clever.
Your spinal cord, while you're alive,
I'm going to semi-sever."

He did; his colleague soon descried
(To his eternal cost)
That he, *on the affected side*,
The following had lost:—

All power, his position-sense,
Discriminating touch,
His vasomotor tone—and hence
It grieved him very much.

These other woes he had to bear
(Which briefly may be told):
Gone *from the other side* there were
Pain, touch, and heat and cold.

MORAL.

The Moral which these lines afford
Exceedingly immense is;
Don't fiddle with your spinal cord
For fear you lose your senses!

F. G.

STUDENTS' UNION.

ANNUAL REPORT OF STUDENTS' UNION COUNCIL, 1925.

GENTLEMEN,—We have much pleasure in presenting to you our twenty-first Annual Report. 1923 was a most eventful year, bringing with it both the Octocentenary Celebrations and the second Fleet Street Week, and it is perhaps by way of being in the nature of reaction after this that the year now ending has been so devoid of interest as far as the activities of the Students' Union are concerned. At one time, it is true, we were stirred to our depths by the rumour that a team was to be raised to represent Bart.'s in a great Inter-Hospital Crossword puzzle competition, but rumour proved again a baseless knave, and the hope, once throbbing in our hearts, had perforce to fade again.

However, one event is worthy of report: the Students' Union now possesses a cloak room worthy of the name, increased space, better ventilation, attendance and telephoning facilities—all matters which we appreciate all the more for their having been needed for so long. It is perhaps annoying to be unable to see for oneself whether the correspondence rack contains anything of personal interest, but this defect will be remedied, we hope, at an early date, and we should like to take this opportunity of thanking the School authorities and all those responsible for their successful efforts to improve the accommodation and facilities of the students.

During the year the increasing number of complaints respecting the quality of goods supplied by Messrs. Paget, and more especially with regard to their attitude towards customers, rendered it necessary to take official notice of the matter, and the response made to our complaints proving unsatisfactory, estimates were obtained from other firms, and resulted in Messrs. George Lewin, of Crooked Lane, Cannon Street, being appointed Hospital Outfitters. The quality and price of their goods compare very favourably with anything we have experienced, and their attitude towards us as customers is a decided improvement on what has gone before.

Special mention should be made of the Dance this year, which proved quite the most successful we remember. We congratulate the Secretaries, G. P. Roxburgh and J. W. D. Buttery, and all others connected with the organization, on the excellent results of their efforts. We should like to congratulate a very keen old Bart.'s man, Capt. Batterham, of the R.A.M.C., on winning from Guy's the Dawson of Penn Inter-Hospital skiing cup, which may now be seen in the Library.

Of our new President—Mr. W. Girling Ball—we need say no more than that he has proved all that we hoped. We thank him for all he has done this year, and trust that for many years to come he will be as closely associated with the Students' Union.

To turn to the Clubs, that of *Rugby Football* comes first by right of seniority, but it is to be regretted not by the right of achievement it had last season. Far from repeating the success of last year in the Hospital Cup, we were beaten by Guy's in the first round by 8–3.

We may say with certain justification that we have not had the best of luck this season. Before Xmas we were continually having to change our team through injury or exams., and when we had won one or two good matches in January, the hope that we had managed to get together quite a good side was dashed by the loss of several men, including our captain, A. W. L. Row, whose place, together with that of a much improved player, J. W. D. Buttery, we were quite unable to fill.

Even taking all these things into consideration we were not the side we should have been; there was a certain deplorable lack of the team spirit which is essential for success. W. F. Gaisford, whose knee made him another notable absentee, will, we hope, be fit and well next season.

It was unfortunate that two of our leading forwards spoilt an otherwise fine record by a childish attitude towards the Rugger side, owing to a quarrel with which the Club had nothing to do. We feel that their action of refusing to play was most unsportsmanlike.

We were sorry to have to say good-bye to our Treasurer, J. L. T. Davies, early in the season, and we fully appreciate the work he so ungrudgingly put in on behalf of the Club. Another man to whom the thanks of the club are due is P. H. Flockton, upon whose shoulders has fallen the whole of the organizing below the A team, and the good records and increasing demand for fixtures among the three junior teams bear good witness to his keenness and efficiency. The "A" team did well in the early part of the season, but came down in most lamentable fashion against Guy's.

We hope that our efforts next year will result in our building up a better and more successful side.

To date the *Hockey Club* has had a successful season, although several of the best fixtures have had to be scratched, especially the mid-week matches of the 2nd and 3rd XI's, owing to the bad drainage of the ground at Winchmore Hill. The first eleven have only lost 3 of their 14 matches, and have done so well as to beat Shoeburyness Garrison, and draw with Sandhurst and Royal Corps of Signals, whilst the 2nd have lost only one of their 15 matches, and have scored 108 goals against 19.

In the senior division of the Inter-Hospital Cup they met and defeated King's in the second round 6–0. Against Guy's in the semi final they were unexpectedly beaten by 3–1, a surprising result when the records of the two clubs are compared.

Special mention should be made of J. E. Church, who has played in the Southern Counties trial, and who with J. G. Milner has played regularly for Middlesex.

The *Association Football Club* has enjoyed a fairly successful season. Three elevens have been placed regularly in the field, and have lost an aggregate of 12 matches out of 37 played.

Both teams are to be congratulated on reaching the final of the Inter-Hospital Cup ties, and we extend to them our best wishes for their success.

The season of the *Cricket Club* was badly interfered with by the weather, the cricket week being quite spoiled, and altogether 10 matches had to be scratched; of those played, 6 were won and 6 lost, 5 being drawn. Considering the difficulty in obtaining practice last year owing to inclement weather, the side did well.

In the Inter-Hospital Cup we easily beat King's, but St. Thomas's defeated us in the next round. Increased keenness was shown in the 2nd XI, and there was no difficulty in turning out a side regularly. They unfortunately were unable to overcome King's in the Junior Cup.

Prospects for 1925 are good, with plenty of last season's talent still available under the captaincy of R. H. Bettington.

It is hoped that more interest will be taken in the Past *v.* Present match, and in the Cricket Week which starts on June 1st.

Unfortunately for the *Athletic Club* rain marred their annual sports, but in spite of the heavy going, some good racing and times were recorded.

It is gratifying to notice the support given to athletics by the Staff, and it is to be deplored that more students do not follow their example.

Rain again interfered with the United Hospitals Sports, when we were second to Guy's.

H. B. Stallard is to be congratulated on equalling the record time for the half-mile and the relay team on winning their event.

M. R. Sinclair from Cambridge, and Lakshmanan, the Indian Olympic Games hurdler, should help Bart.'s to regain the Cup in 1925.

We were unlucky to lose the Kent-Hughes Cup in the cross-country race on March 11th. Guy's won it with 31 points, we were second with only one more point.

The *Boxing Club* established a long attempted precedent last year by winning the Inter-Hospital Boxing Cup. We congratulate Messrs. Marcuse, Colenso-Jones and Chalke on winning their weights.

On December 5th, 1924, T. M. Marcuse and G. Colenso-Jones reached the finals in the Universities, Cadets and Hospitals Competitions. The same two boxers were chosen as first strings in their respective weights to represent London University *v.* Oxford.

Bart.'s put up a strong team in the Inter-Hospitals contests at N.S.C. on March 11th, and the keenness which has prevailed throughout the term was rewarded when we won the Cup for another year. J. L. Colenso-Jones especially is to be congratulated on boxing in two weights, winning the heavies, and only just being beaten on points in the light-heavies. To T. M. Marcuse, too, we must extend our congratulations for adding another to his list of victories. Three more of our representatives reached the finals, and so gained points for the Hospital, and we were left winners with St. Thomas's and Guy's close behind.

The *Boat Club* has lost a number of its most experienced oarsmen during the last year. The remainder, however, have been turning out regularly during the winter and taking advantage of the coaching available at the L.R.C.

The list of new members is very satisfactory, and one or more fours are going out regularly twice a week for coaching as well as Saturday's work.

The activities of the *Tennis Club* were considerably curtailed by the persistently bad weather of 1924.

With practically reconstructed teams the 1st and 2nd VI's were fortunate to win more than 50 per cent. of their remaining engagements, and the experience gained should stand them in good stead for the coming season.

We have to welcome the advent of Sir Charles Gordon-Watson, K.B.E., as President in place of Dr. Morley Fletcher, who has so ably guided us during the past few years. It is hoped to revive the annual match against the Staff this year, which has not been played for two years.

A word to those who wish to help Bart.'s to capture the Inter-Hospital Cup once again: "Practise now, and don't wait until May 1st to take out your rackets." The first round will be played before May 31st.

In the season 1924–25 the *Fives Club* has played 9 matches and won 4. It has taken part in the Fives Association competitions, and the usual singles and doubles competitions have been played.

Improvements in the lighting of the court have made play possible at all hours.

The *Golf Club* had a very successful season last year. For the first time in their records they won the Inter-Hospital Golf Club, beating Guy's by 10 matches to 2 and St. Thomas's in the final by 8 to 4.

Three club matches were played, in which we won against St. Albans and Broxbourne, but were badly beaten by Sudbury.

The match *v.* the Staff was drawn at 10 all. Perhaps it should be added that the students gave the staff a lead of 3 up in each match.

R. H. Bettington won the Girling Ball Challenge Cup and W. S. Maclay the Hospital Cup.

200 members of the Hospital were found to have played at Sandy Lodge during the year.

The *Swimming Club* did not have a very successful season as regards winning their matches. We lost 7 out of 12, to some extent owing to illness.

In spite of having a very weak team out we ran Guy's to 2–5, losing the swimming event only by the team race.

A great improvement was the keenness shown and the inauguration of a second team which showed considerable promise and keenness.

After a period of some quietude the *Debating Society* has again been able to fill a need in providing a non-academic form of entertainment, and it is hoped instruction for those for whom the more prosaic side of life occupies a large amount of time.

One more debate will be held before the end of the session.

The attendance at all the debates has been quite good, and the number of those taking part has been a distinct advance on former years.

The Society has been fortunate in discovering hidden talent which it is hoped will be available in the future.

The standard of debating has been high, as shown particularly by two or three notable speeches, and two members of the Society have been invited by and have spoken at the University Union Society.

The continuance of the process of organization and advancement of the Union we pass on to those elected to succeed us, with every confidence that they will successfully carry on the work of gaining for students the full privileges of their membership of the Union.

Finally we should like on behalf of all members of the Students' Union to thank the Treasurer and Almoners, the Dean, the College Committee, Mr. Hayes, and the representatives of the Staff on the Students' Union for their invariable courtesy in considering all matters referred to them by the Council, and for their untiring and unselfish efforts on behalf of the Union.

We remain, Gentlemen,
Your obedient servants,
E. S. VERCETTE,
M. J. HARKER,
Hon. Secs.

DEBATING SOCIETY.

A debate was held on February 19th, Mr. E. R. Cullinan (Vice-President) in the Chair.

The motion was "That unqualified practice is of service in medical progress."

Mr. J. J. SAVAGE opened the debate, and said that the first medical practice recorded was that of Adam and Eve, who treated each other for apples impacted in the throat and snake-bite. Experience was gained by treating such minor ailments, and in time men became specialized in medical treatment through the practice thus obtained, and after a while segregated themselves into what is the closed profession we know to-day. The evils of closed professions were ever obvious, but how obvious, as for example the daily press, is the freedom and freshness of journalism, which admits any worthy of the name to its ranks. In the past, new ideas, whether medical or purely scientific, were mocked at, and we were doing the same to day if any new idea or theory were advanced by a non-medical man. Pasteur was not a doctor, but who will deny the greatness of the work he did, and moreover, though unqualified, he successfully treated diseases which baffled the medical skill of his time? Vaccination was introduced by a lady, certainly unqualified in our sense of the word, but who will deny the advance made thereby?

Mr. PICKUP GREENWOOD, opposing the motion, said that no one ought to ignore progress, and if unqualified people have ideas, those skilled in practice should be the ones to try them out. He enumerated cases where quackery came to grief, especially cases which only anyone with a medical training could possibly diagnose with certainty. Qualifications as we know them are to protect the public, not the holder, and if certain men have inborn manipulative skill, they should be controlled just as much as those who undergo a long course to arrive at a more advanced condition of fitness for treating the public.

If uncontrolled quackery were sanctioned officially, the art of medicine would be divided into the camp of those who used scientific means, and those who worked by rule of thumb.

Mr. F. F. IMIANITOFF, supporting the motion, said that the aim of medical science is not to cure, but to eradicate disease, and if a layman can produce a theory or plan assisting in the latter, then no man should hesitate to give it a careful trial.

Mr. R. W. RAVEN, speaking against the motion, showed how

unqualified practitioners were always above learning the fundamentals of medical science—they thought there was a short cut. Quackery was realized to be a public danger in the days of Henry VIII, who founded the Royal College of Physicians to combat their ravages, and surely the general features of quackery are the same to-day.

The motion was then declared open for debate, and the following members took part: Messrs. C. W. Brook, R. Bolton, E. A. Freeman, J. Scovell, P. Mellows, F. Malony and W. R. Thrower.

Mr. SAVAGE then replied and the House divided; ayes 18, noes 15, the motion being carried.

RUGBY FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL *v.* H.A.C.

Played at Winchmore Hill on March 7th. After a pleasant game, in which our opponents extended us fully, we won by 10–3 (2 goals to a penalty goal).

The conditions were good, but faulty handling spoilt most of the passing movements. The forwards were evenly matched, and up to half-time the only score was a penalty goal by the H.A.C. After the interval, however, our team, whose condition was none too good, pulled themselves together, and began to press consistently. F. O. Davies picked up in the loose, cut through at great speed, and on reaching the full back gave Neville a perfectly timed pass, resulting in a score behind the posts. Edwards converted. Soon afterwards A. MacGregor cut through brilliantly, and swerving infield, completely beat the full back and scored between the posts. Edwards converted.

ST. BARTHOLOMEW'S HOSPITAL *v.* BLACKHEATH.

Played at Rectory Field, on March 14th. Our first fixture with "The Club" yielded a fine game, which we ultimately lost by 21 points to 5, though the actual play was much more even than the score indicated. At half-time Blackheath led by a goal and a penalty goal. Maley went off with concussion, and Williams was evidently feeling his injured shoulder the whole game.

The second half saw the Hospital start off with a rush, and a fine dribble led by Morgan ended up with Fitzgerald's picking up on the run and dashing over, Bettington converting.

After this Blackheath began to rule the game, and Strong, their scrum half, played brilliantly, his long passes from the base of the scrum completely demoralizing our back division, where Pentreath obviously found Wynne too big a handful.

Bettington, Beagley and Morgan were the best of the pack, and F. O. Davies at centre showed flashes of brilliance and tackled most determinedly.

ST. BARTHOLOMEW'S HOSPITAL *v.* LONDON SCOTTISH.

Played at Winchmore Hill on March 21st. Our first post-war match with the Scottish resulted in a win for the Hospital by 2 goals (one penalty) to 1. It was a scrappy game, containing little good football, and plenty of roughness amongst the forwards.

A brilliant try by Neville and two good place kicks by Bettington enabled us to win, just on time. We were beaten in every department forward except in loose rushes, where Bettington and Morgan excelled. At scrum-half Underwood played pluckily and well in the face of persistent off-side tactics.

The backs were very evenly matched, though the Scottish did most of the attacking, by virtue of their success in controlling all the tight scrums.

ST. BARTHOLOMEW'S HOSPITAL *v.* LOWESTOFT.

Played at Lowestoft on February 28th before a large crowd. During the first quarter of an hour the Hospital were kept in their "25," but good tackling prevented any score. Then the forwards carried play to the opponents' line, and from a round of passing T. P. Williams scored a try which was not converted. The Hospital now had most of the game, the forwards continually getting the ball in the loose and scrummages. Fetts played well at stand-off half, and was ably supported in attack by Royle and Petty. Grace and Golville ran strongly on the wing, the latter scoring two very good tries. Amongst the forwards T. Colenso-Jones and T. P. Pittard were prominent. The end came with the score St. Bart.'s, 1 goal, 4 tries; Lowestoft, *nil*.

ST. BARTHOLOMEW'S HOSPITAL 2ND XV *v.* R.A.F.

On March 2nd the 2nd XV met a strong side at Shotley, composed of players from combined services, including some prominent Navy forwards.

A crowd numbering 3000 turned up at the Services Ground at Shotley, and witnessed the last game there this season. The play was fast throughout; tackling was vigorous. There was plenty of open play, and many of the passing movements were excellent to watch. T. Colenso-Jones made an excellent skipper. Apart from his play in the open, and being much in evidence in scrummages, the tactics he adopted for his side were mainly responsible for the victory. Beagley was prominent with some fine dribbles and following up. The half-backs, Underwood and Fells, played with great success, while the quartette were excellent in defence, Grace in particular saving at least two certain tries by cutting across the corner flag. Levick kicked well and was very safe.

The game was much enjoyed by the large crowd and was the best game seen there this season. Tries were scored by Grace, Colville and T. R. Beagley.

Score: St. Bart.'s, 9 pts.; R.A.F., *nil*.

ASSOCIATION FOOTBALL CLUB.

The 1st XI defeated St. Thomas's Hospital in the Senior Cup Final by 1 goal to *nil*. This is the second year in succession that the Club have won the Cup.

Previously the records of this season, although not strikingly good, show a certain consistency which is gratifying, especially when one considers that all teams have had to be built up of men who, till this year, have not played with one another. The number of games played by all elevens show that there is a decided increase in the enthusiasm, at least in the playing members of the Club. Let us hope that there is sufficient increase in the number of playing members to enable a third eleven to be run regularly next season.

Unfortunately the 2nd XI, after fighting two stout battles, were defeated in the Junior Inter-Hospital Cup Final *v.* Guy's Hospital by 2–1.

HOCKEY CLUB.

INTER-HOSPITAL HOCKEY CUP.

Semi-Final.

The Hospital were beaten by Guy's 3–1 in the semi-final at Richmond on Monday, March 9th.

The first half of the game was very even with the Hospital having slightly the better of the game, though neither side was able to score.

Early in the second half Guy's scored from a scrimmage in front of goal. The Hospital continued to attack, and later Church equalized with a good flick shot. The game continued very evenly, and about half-way through the second half Guy's gained the lead. The Hospital tried hard to draw level, but Guy's defence was sound and prevented further scoring. In the last few minutes of the game Guy's scored their third goal, their inside-left taking a centre from the right wing and scoring with a good "first-time" shot.

Mention must be made of S. B. Benton, who played an extremely sound game at left back, tackling and clearing with good judgment.

Team.—R. W. Windle; B. E. T. Mosse, S. B. Benton; J. H. Attwood, W. A. Briggs, V. P. Robinson; M. R. Sinclair, G. W. S. Foster, A. W. Guinness, J. E. Church, J. G. Milner.

ST. BARTHOLOMEW'S HOSPITAL *v.* ST. ALBANS H.C.

Playing away, the Hospital beat St. Albans on March 9th by 3–2. From the start the Hospital pressed, but failed to score, chiefly due to the good defence of the St. Albans' goalkeeper, who played well throughout the game. St. Albans then carried out a series of rushes, and after about fifteen minutes' play scored through their inside-left, who was unmarked. The Hospital continued to press, and just before half-time Guinness scored with a flick shot from a *mêlée* in front of goal. Early in the second half Church scored, and a few minutes later added the Hospital's third goal. The Hospital continued to press, but failed to score again. Towards the end of the game St. Albans' forwards carried out a rush which led to their inside-right scoring.

Team.—R. W. Windle; B. E. T. Mosse, R. A. Walsh; J. H. Attwood, W. A. Briggs, S. B. Benton; M. R. Sinclair, G. W. S. Foster, H. W. Guinness, J. E. Church, J. G. Milner.

ST. BARTHOLOMEW'S HOSPITAL *v.* WOOLWICH GARRISON.

The Hospital beat Woolwich Garrison at Woolwich on Saturday, March 14th, by 4–0. The ground was somewhat bumpy, which made ball control difficult. From the bully-off the Hospital ran through and scored from a shot by Church. No further score was made in the first half, the game being very even.

In the second half the Hospital added three more goals through Milner, Church and Foster. The game was not as uneven as the score implies. The Garrison made repeated attempts to score, but found the defence of Benton at left back and Windle in goal too sound.

Team.—R. W. Windle; W. A. Briggs, S. B. Benton; J. H. Attwood, T. S. Goodwin, V. P. Robinson; M. R. Sinclair, G. W. S. Foster, J. G. Milner, J. E. Church, G. H. Tanner.

The Hockey 2nd XI may justly claim to be the most successful team in the Hospital this season. In spite of a fixture list considerably in advance of that of last year, the team has built up the following excellent record:

Played 20 games, won 17, drawn 2, lost 1. Goals: For, 147; against, 29.

All second teams played have been beaten, as well as the first teams of Barnet (twice), R.A.F., Uxbridge and the Air Ministry. The solitary defeat was by Radlett I (3–5), and the two drawn games were with the R.A.F. Uxbridge (3–3) and U.C.H. I (5–5). Double figures were scored on six occasions, the highest being 14–0 against London Hospital II.

In the first round of the Junior Cup Bart.'s II walked over; in the second they defeated Westminster I by 7–0, and in the semi-final King's II were beaten by 9–4. It is expected that Bart.'s II will shortly meet St. Thomas's II in the final.

C. G. Sinclair has played very well in goal, although he has not been overworked. P. M. Wright is a very sound full back; R. A. Walsh has been his partner in most of the matches, his place at other times being ably taken by R. J. Armstrong. S. B. Benton played a few games at the beginning of the season, when he was taken by the 1st for playing too well. M. S. R. Broadbent, V. P. Robinson and K. W. D. Hartley have been a half-back line combining the excellent qualities of vigour and intelligence, and they have been equally good in both attack and defence. The forwards have combined excellently and shot well. The wings have remained fairly constant—H. B. Stallard and F. C. Roles on the right, and A. C. Bell and G. M. Tanner on the left. W. G. Scott-Brown has been an excellent centre when the call of duty has not prevented him from playing, while A. I. Pagan and C. Simon have been very useful deputies in various positions.

UNITED HOSPITALS HARE AND HOUNDS.

Inter-Hospital Race.

Run at West Wickham on Wednesday, March 11th, over a 7½-mile course, and resulted in a win for Guy's by a single point in spite of the sporting appearance of H. B. Stallard and J. R. Beagley for us. Four hospitals competed, but University College Hospital was unable to turn out a full team, and so were not allowed to score. G. F. McCormick (U.C.H.) took the lead soon after the start, but after covering about half a mile he was attacked by a dog, which removed part of his calf. This gave the lead to M. E. M. Jago, who was running strongly, followed by Simpson (King's), Darley, Stallard and Walker (Bart.'s). McCormick, when he had recovered from his shock, went up into second place, and these positions were held till one mile from home, when H. B. Stallard showed a fine burst of speed and went up into 3rd place. Simpson beat Darley on the run home. Next came H. N. Walker, who ran in excellent form throughout the race, followed by a string of Guy's men, with J. R. Beagley and O. H. Bellerby, who finished 4th and 5th for Bart.'s, close behind. Both ran very plucky races. The Hospital was also supported by F. C. Roles (15th), A. H. Grace (19th), J. E. Snow (20th), and M. D. Young (23rd). C. S. Wise laid the trail. Our only supporter was W. S. Hinton, whose vocal encouragement was greatly appreciated. Scoring 5 a-side on the 'Varsity system, the result was as follows:

	min.	sec.		min.	sec.
1. M. E. M. Jago (Guy's)	45	8⅘	13. R. P. Ross (King's)	48	39
— G. F. C. McCormick (U.C.H.)	45	44	14. D. C. Drake (Guy's)	49	8
2. H. B. Stallard (Bart.'s)	46	1	15. F. C. Roles (Bart.'s)	49	48
3. A. Simpson (King's)	46	15	16. R. H. Yelf (King's)	50	41
4. W. W. Darley (Bart.'s)	46	18	17. N. F. Pearson ,,	50	48
5. H. N. Walker ,,	46	55	— J. W. Storey (U.C.H.)	51	20
6. L. K. Wills (Guy's)	47	36	18. T. M. Colhaem (Guy's)	52	3
7. G. W. Rake ,,	47	43	— R. M. Walker (U.C.H.)	52	51
8. J. G. S. Thomas (Guy's)	47	50	19. A. H. Grace (Bart.'s)	53	24
9. J. H. Chitty (Guy's)	48	1	20. J. E. Snow ,,	53	27
10. G. R. S. Stewart (Guy's)	48	17	21. M. Baillie (King's)	53	29
11. J. R. Beagley (Bart.'s)	48	34	22. C. Perkins ,,	54	54
12. O. H. Bellerby ,,	48	37	— G. H. Buttle (U.C.H.)	55	9
			23. M. D. Young (Bart.'s)	56	17
			24. M. P. Way (Guy's)	56	41
			25. A. B. Hewlett (King's)	62	0

Guy's, 1, 6, 7, 8, 9 = 31.
Bart.'s, 2, 4, 5, 10, 11 = 32.
King's, 3, 12, 13, 14, 15 = 57.
U.C.H.—Did not score.

FIVES.

Further results of fives matches are as follows:

Sat., Jan. 31st	*v.*	King's College—away	Lost.
,, Feb. 7th	*v.*	Old Paulines—home	Won.
,, ,, 14th	*v.*	Clare College, Cambridge—away	Lost.
,, ,, 21st	*v.*	University College—home	Won.
,, ,, 28th	*v.*	Clare College, Cambridge—home	Won.
,, March 7th	*v.*	King's College—home	Won.

MUSICAL SOCIETY.

Of late the attendance of members at meetings has not been encouraging; and as it is hoped that a combined choral and orchestral concert may be given in the summer, an appeal is made to all those in the Hospital who sing or who play orchestral instruments to come to the Society's assistance in their various capacities.

Considering the size of our Medical School, Bart.'s should be able to hold her own amongst the hospital musical societies. Guy's gave an excellent concert a short while ago, and it goes without saying that we should be able to do at least as well.

Old Bart.'s men, in addition to present members of the Medical School, will be very welcome at meetings of the Society. Expert talent, though needed, is not by any means essential for membership.

Practices are held on Thursdays in the Great Hall, at 5.30 p.m. for the orchestra and at 8.30 p.m. for the chorus. The Hon. Secs. are F. H. A. Walker (orchestral) and R. N. Curnow (choral).

CORRESPONDENCE.

THE MUSEUM.

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

DEAR SIR,—May I, through the medium of your columns, draw attention to certain minor matters which would facilitate the work in the Museum.

First I would mention the Catalogue. Many doubtless consider the copies of the Catalogue to be in a bad way, and so they are, but please remember that the new copies have taken some years to prepare, and are the last that can be prepared before an entirely new catalogue involving re-arrangement and re-numbering of the specimens can be undertaken.

Therefore may I suggest as follows:

(1) Don't scribble.

(2) When an error is discovered report it to the Curator or one of the attendants.

(3) Don't criticize the old descriptions. They may be out of date, and will be adjusted in the next edition, but they at least have attained a respectable age—far greater than those who read them.

(4) Close the book when you have finished, and so prevent more of the smuts of London collecting on the pages.

Next as to new specimens:

I wonder how many realize the additional work (and vexation of spirit) that is entailed when specimens arrive with no name or other means of identification. I believe the provision of a history or other particulars appears in the charges of the Chief Assistants. Would they mind reading those charges.

Lastly, the return of specimens to the Museum after use elsewhere. It is difficult to collect all bottles from lecture theatres if they are pushed under the seats. If they are taken to remote corners of the Hospital they may not be found for months, thereby causing great inconvenience, and some of the Catalogue errors are due to this cause. Finally, bottles used in the Museum itself might easily be returned to the shelf by the user, and so save what amounts daily to a considerable expenditure of time by the Museum attendants.

I apologize, Sir, for trespassing on your space, but I do not often do so.

I am, etc.,

T. H. G. SHORE.

REVIEWS.

THE BLOOD: A GUIDE TO ITS EXAMINATION AND TO THE DIAGNOSIS AND TREATMENT OF ITS DISEASES. By G. L. GULLAND and A. GOODALL. (W. Green & Son, Edinburgh, 1925.)

The third edition of this well-known book, which has been compiled for the student and practitioner, retains the high standard of previous editions. It is divided into five parts. Part I deals with methods of examination of the blood, and no clearer exposition of the subject could be wished for. It is a pity that one or two new methods have been omitted, otherwise this section is very complete and concise. Part II is devoted to a description of the formed elements of the blood, the sources of the blood-cells and their development. Herein is included a chapter on the blood of certain animals, and a valuable table is given of the average blood-counts of animals obtained by different authors, including those of the writers themselves. We note that some of the figures do not agree very closely with those obtained by ourselves. Diseases of the blood, bone-marrow, etc., are dealt with in an excellent manner in Part III. The difficult question as to nomenclature and classification of the diseases again comes up for discussion, and that given in the text is perhaps as good as any for practical purposes. Part IV is devoted to a description of the blood in special diseases, while the last part treats of diseases due to animal parasites. The book contains 424 pages, including an adequate index. There are 29 figures in the text, and 16 coloured plates. One or two of the coloured drawings in Plate III and Plate XV are, in our opinion, not good, although, generally speaking, the plates are admirable. The paper and printing are good and altogether the book can be thoroughly recommended.

C. C. T.

HANDBOOK OF BACTERIOLOGY. By J. W. BIGGER. (Baillière Tindall & Cox.) Price 12s. 6d.

The course of a reviewer is a somewhat delicate one: upon his one hand is the stony Editorial glance, upon the other is the whirlpool of fulsome dishonesty; between these two terrors safe steering is sometimes a difficult matter.

Great joy therefore assails his heart when he sees before him a broad, deep channel. Such is the case in dealing with the present work. It is described as a handbook of bacteriology. The title is a modest one, for the knowledge so clearly set out within its covers would equip a student for any of his examinations in pathological bacteriology. The commonest and most frequent pathological experiences are set out and explained at the greatest length, the less common ones more briefly, and the extreme rarities are omitted.

The excellent chapters on sterilization, preparation of media and the making of cultures are sufficiently short not to be boring, and sufficiently full to be of real service to a practising bacteriologist. Other good points are the chapter on the obtaining of material from patients and that on the bacteriology of water and milk.

The theories upon immunity are clearly expounded, with perhaps rather a dash of dogmatism—a quality that, however, may for students contain more virtue than vice. Toxins and antitoxins and their actions and qualities are well explained. Anaphylaxis and hyper-sensitiveness are reasonably and clearly set forth.

After this excellent series of theoretical chapters come individual descriptions of the commoner organisms, their habitat, morphology and cultural characteristics. These are lucid, adequate, and to the point.

This book is exactly what is required by the medical pathological clerk: with its aid his work is likely to take on a double interest and its examination value will be impressed more deeply into his mind.

The student who wishes to revise his bacteriology for a final examination will find it very clearly written, not too long, but sufficiently comprehensive.

The general practitioner attached as honorary pathologist to a cottage hospital will find it invaluable.

Even the hospital pathologist himself is likely to find it a clear and concise book of reference.

Not the least of its many virtues are five excellent coloured plates and a series of clear photographs and figures.

It can be confidently recommended to those wishing to obtain a well-written sound book of bacteriology of a reasonable length. It is likely to have the success it deserves.

HANDBOOK OF OPERATIVE SURGERY. By Sir WILLIAM J. DE C. WHEELER. Fourth edition. (Baillière, Tindall & Cox.) Price 15s.

To write a small book of operative surgery suitable for the medical student and for those who are doing a certain amount of surgery in practice is not an easy task, but in this case it has been admirably done.

The operations are briefly described, many practical hints are given, and there are numerous illustrations.

The fourth edition of this work, besides dealing with the commoner operations, contains also an outline of some of the more elaborate procedures which belong to the realm of the specialist. This has been done, and we think rightly so, in order to give an intelligent insight into methods which the reader himself may never use, but of which he may often hear mention.

MODERN METHODS IN THE DIAGNOSIS AND TREATMENT OF RENAL DISEASE. By HUGH MACLEAN, M.D., D.Sc. Second edition. (Constable & Co., Ltd.) Price 12s.

The secretion of the kidney is easily obtained for examination, the histological structure has been thoroughly investigated, and the organ lends itself for purposes of animal experimentation, but its workings in health and disease still present many problems for solution.

The author gives an interesting summary of the present state of our knowledge. He points out that "albuminuria, even when accompanied by casts, is no proof that the patient is suffering from defective kidneys."

The various kidney tests now available for use by the general practitioner—albeit a not too busy one—are described and discussed in relation to typical cases.

The book is full of valuable information and observations, and will very well repay for careful reading.

ESSAYS AND ADDRESSES ON DIGESTIVE AND NERVOUS DISEASES AND ON ADDISON'S ANÆMIA AND ASTHMA. By ARTHUR F. HURST, M.A., M.D., F.R.C.P. Pp. 320. 15 plates. (William Heinemann [Medical Books] Ltd.) Price 21s.

The author states that in this volume his object is to put on record his present views on various subjects which have specially interested him during the last ten years, by revising and expanding his addresses and articles to scientific journals. The result is a volume of unique interest.

Throughout one hears the voice of one who speaks with a personal authority. Take this quotation from the first chapter. "Concerning muco-membranous colic (the author will not have it called "colitis"), he says, "I know of few sadder spectacles than the bedridden young woman, the only child of a widow whose life is devoted to keeping up her daughter's reputation as an intestinal martyr. But get her away from her parents, her purges and her Plombières, and she will soon be free from her psycho-neurosis: the muco-membranous colic, the pure neurosis, may still be present, though it requires but little treatment beyond wholesome neglect.

Great importance is laid upon the X-ray investigations in cases of chronic appendicitis, as also in suspected cases of gall-stones.

The chapter on asthma is particularly convincing, perhaps because, as the author states at the commencement, he himself suffers from asthma, and has had the opportunity of "thirty years of observation on a single case."

The very interesting section on the hysterical element in organic disease and injury of the central nervous system is of great interest and strikes the reader as being singularly well balanced, which can be claimed for so few treatises expounding psychotherapy. This is a book to be read and re-read.

FUNDAMENTAL PRINCIPLES IN TREATMENT. By HARRY CAMPBELL, M.D., B.S., F.R.C.P. (Baillière, Tindall & Cox.) Pp. 477. Price 10s. 6d.

This book, which has so hopeful a title, is very disappointing. Well written and well produced, it seems always to be near the point at issue, but never to get there. It tells the student a great deal that he knows already if he is a person of normal common sense and has read his standard text books, and it tells him very little that is new and almost nothing that is useful.

PYE'S SURGICAL HANDICRAFT. Edited and largely rewritten by W. H. CLAYTON-GREENE, C.B.E., F.R.C.S. (Bristol: John Wright & Sons, Ltd.) Pp. 595. Price 21s.

This work has far outgrown the original intention of Walter Pye to describe details of surgical work as it appears from the view of house-surgeons and dressers in surgical wards, and if we had any adverse criticism it is that the book has become too big, and tends to approach to the confines of the text-book of surgery, without attempting its completeness.

Otherwise we have nothing but praise for the book. It has been brought thoroughly up to date, is well illustrated, and advice is succinct and clear.

Particularly to be mentioned are the useful hints on methods of examination and the facts to be gathered from them, the chapter on the examination of the rectum being a good example of this point. There is a very useful chapter on the treatment of the teeth, with illustrations of the various types of dental forceps and the methods of extraction for individual teeth.

We heartily recommend this most useful book to students and such junior members of the profession who are called upon to carry out surgical procedures.

ORAL TESTS, BASED ON THE SYLLABUS FOR THE PRELIMINARY STATE EXAMINATIONS IN NURSING. (The Scientific Press, Ltd.) Pp. 77.

This little book contains questions and answers arranged under the headings Anatomy, Physiology, Hygiene and Theory of Nursing. The book should be useful to nurses studying for examinations, and, within its narrow limits, appears well prepared. We are, however, not conversant with the posterior femoral as the chief muscle at the back of the thigh, nor did we think that the inner attachment of Poupart's ligament was the symphysis pubis.

AN X-RAY ATLAS OF THE NORMAL AND ABNORMAL STRUCTURES OF THE BODY. By ARCHIBALD M'KENDRICK and CHARLES WHITTAKER. (E. & S. Livingstone.) Price 25s.

The first 37 pages of this book are devoted to normal radiograms. The author seems to have adopted a new plan of taking radiograms of joints from five arbitrary points. The first is termed "the normal focus point," the significance of which is not explained. The other points are 4" internal, external, above and below. The radiograms of this part of the book are good, and adequately supplemented with diagrams.

The remainder of the book is divided into three sections:

1. Injuries and diseases of limbs.
2. Head, neck, thorax and spine.
3. Abdomen.

Strangely enough the radiograms in these last three sections are accompanied by few diagrams, and little or no attempt is made to explain upon what appearances diagnoses are based. The commonest lesions are still the commonest. Yet in the abdominal section diverticula of the duodenum, diverticulitis of small intestine and the effects of pressure on the stomach by retro-peritoneal tumours find a place, while carcinoma of the large intestine is entirely ignored. The reproductions are good and the study of so many radiograms cannot fail to be fascinating.

INTERNAL DERANGEMENTS OF THE KNEE-JOINT: THEIR PATHOLOGY AND TREATMENT BY MODERN METHODS. By A. G. TIMBRELL FISHER, M.C., F.R.C.S.(Eng.). (London: H. K. Lewis & Co., Ltd., 1924) Demy 8vo. Pp. xii + 144. 80 Figures on 40 plates. Price 12s. 6d. net.

We apologize for the delay in reviewing this book by Mr. Timbrell Fisher, who is an old Bart.'s man. Apparently it was overlooked during changes in the Editorial Staff last year; we are therefore very pleased to have another opportunity of commending it to those starting out into general practice. As Sir Arthur Keith says in his foreword, the treatment of joint diseases is now much before the lay mind, being associated with some sort of manipulative magic and secrecy on the part of bone-setters, and he emphasizes the importance of the accurate knowledge of structure, function, disease and treatment, and of exposing this knowledge to the full light of day.

The present work, besides being a summary of the general state of our knowledge at the present time, gives details of Mr. Fisher's own original work, including very careful researches into the anatomy and pathology of the knee, and a new operation for exploring the knee-joint—the so-called patellar-displacing operation.

In Part I the author deals with the pathology and surgery of the semilunar cartilages. Actually he does more than this, as he works out very carefully the anatomy and physiology of the knee-joint, and makes a fascinating and live subject out of what is usually dealt with in a very dull way by most text-books of anatomy. Part II deals with other causes of derangement, including loose bodies, osteo-arthritis, hypertrophied synovial fringes, ruptured cruciate ligaments, etc.

Besides the foreword by Sir Arthur Keith, there are a number of footnotes by Sir Robert Jones. The book is well illustrated by photographs and drawings, but we think that it would save confusion if the side of the body to which the joint belonged was indicated below figures, such as No. 6 and No. 10. We find a small misprint on p. 18: where the "screw home" action of the joint at the end of full extension is being referred to, the word "flexion" is used at one point.

Mr. Fisher is able to speak with authority on the anatomy, physiology and pathology of the knee, and here the book is entirely satisfactory, but on the clinical side we must confess to being rather irritated by the annotations of Sir Robert Jones, which, although excellent in themselves, can be found elsewhere. We would have preferred to have had Mr. Fisher's views and summaries undiluted. Altogether we found the book very stimulating.

REJUVENATION BY GRAFTING. By Dr. SERGE VORONOFF. Translation by F. F. IMIANITOFF, B.A. (George Allen & Unwin.) Price 15s. net.

The evidence for the rejuvenation of man by testicular grafts from the chimpanzee is presented in a complete manner, the method being to implant thin slices on or within the tunica vaginalis.

Though animal experiments have convinced the author that the hetero-graft is useless, yet he claims that the ape is in such close relationship to man that the graft is not destroyed.

Histological evidence shows that the graft is gradually replaced by connective tissue, and that spermatogenesis is lost. The benefit from the operation is stated to be due to absorption of the testicular hormone, which he ascribes to the supporting cells of Sertoli, those cells remaining unchanged in the connective tissue.

The clinical evidence claims improvement of health and renewal of physical and sexual vigour.

The book is very readable, and Mr. Imianitoff is to be congratulated on his translation. An important book which may be fundamental.

A MANUAL OF MEDICINE. By Prof. T. K. MONRO. (Baillière, Tindall & Cox.) Pp. xviii + 1033. Price 25s.

The latest edition of Prof. T. K. Monro's *Manual of Medicine* remains substantially the same text-book that has been used by generations of students, especially north of the Border. There are, necessarily, several alterations and additions as a result of the advances which have taken place in medicine within the last few years, but the general arrangement of the subject-matter remains unaltered.

The section on diabetes mellitus has been considerably altered and the subject of blood-sugar curves is more fully discussed, while the treatment by insulin is summarized rather briefly. The statement made on p. 248 that "febrile attacks and other intercurrent illnesses often cause the sugar to diminish greatly" is not in accordance with the teaching of most authorities, and is hardly borne out by general experience.

The subject of cardiac irregularities has been brought up to date, but might with advantage have been even more fully discussed in view of the importance of the subject. Only one page is devoted to auricular fibrillation and digitalis therapy, and there is no mention of rapid digitalization. Another omission in treatment occurs in the discussion of chronic gout, where no mention is made of atophan.

On the whole the author expresses himself clearly and succinctly; he succeeds in conveying a reasonably adequate idea of typhoid fever and its complications in only twelve pages!

The typing and spacing are such that the book can be read easily and without fatigue.

THE INSULIN TREATMENT OF DIABETES MELLITUS. By P. J. CAMMIDGE, M.D.(Lond.), D.P.H.(Camb.). (Edinburgh: E. & S. Livingstone.) Second edition. Pp. 212.

The rapid exhaustion of the first edition of this little book is proof of its deserved popularity among medical men. All the writings of Dr. Cammidge on diabetes mellitus and its concomitant problems are, to say the least, always interesting and well presented. The lucidity with which he presents his arguments and demonstrates his hypotheses is well known.

In this book the insulin treatment is explained and put before the reader in its simplest form. The difficulties so often experienced in manipulating the diet and the dosage of insulin are reduced to a minimum; the methods adopted by different authorities are discussed, and good reasons are given for the methods of the author himself.

The reprint of Kellogg's table is particularly valuable, and will save many hours of mathematical calculations to those who use it.

This is a book which we heartily recommend to medical practitioners, house-physicians, and the more advanced medical students.

EXAMINATIONS, ETC.

UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:

M.D.—C. R. Crowther.

M.B., B.Chir.—B. Broadbent.

M.B.—J. C. Ainsworth-Davis, A. H. Johns.

ROYAL COLLEGE OF PHYSICIANS.

The following have been elected Members:

W. H. W. Attlee, C. M. Gwillim, D. M. Lloyd-Jones, H. V. Morlock, G. K. Stone, J. A. Struthers.

ROYAL COLLEGES OF PHYSICIANS AND SURGEONS.

The Diploma of Public Health has been conferred on the following candidates:

E. B. Brooke, E. A. Coldrey, W. E. M. Mitchell, L. R. Shore, R. G. R. West.

CHANGES OF ADDRESS.

BRASH, J. B., The Mill House, Bassingbourn, near Royston, Herts.

GRANGE, C. D'OYLEY, 3, Clarence Drive, Harrogate.

HUMPHRY, A. M., The Cap House, Pontrilas, near Hereford.

LONGFORD, W. U. D., High Street, Holywood, co. Down, Ireland. Tel. Holywood 187.

MCKINNEY, H. G., Fairymount, St. Austell, Cornwall.

STRUGNELL, L. P., Surg. Lt. Comdr. R.N., R.N. Hospital, Plymouth.

WALL, A. D., c/o Dr. Marshall, Hong-Kong & Shanghai Bank Buildings, Shanghai, China. Cables: Viewall, Shanghai.

WHITE, C. F. O., 117, Park Street, W. 1. Tel. Mayfair 4840.

APPOINTMENTS.

ANDERSON, D. D., M.R.C.S., L.R.C.P., appointed Medical Officer of Health for Chilpancingo, Mexico.

BRIMS, D. J., M.R.C.S., L.R.C.P., appointed House-Surgeon, Croydon General Hospital.

FOOTE, R. R., M.R.C.S., L.R.C.P., appointed Assistant Medical Officer at Queen Charlotte's Maternity Hospital.

GRANGE, C. D'OYLEY, F.R.C.S., appointed Surgeon to the Harrogate Infirmary.

MACFADYEN, J. A., M.B., B.Ch.(Oxf.), appointed Medical Officer at the Addington Hospital, Durban, South Africa.

SMITH, H., M.R.C.S., L.R.C.P., appointed Junior Resident Medical Officer at the Hospital of St. Cross, Rugby.

BIRTHS.

COVENTON.—On February 23rd, to Dr. A. W. Duncan and H. Muriel Coventon, The Chantry, Aylesbury, Bucks—a daughter.

LEATHART.—On February 1st, at 11, Tollemache Road, Birkenhead, to the wife of P. W. Leathart, M.B., B.Ch.—a daughter.

RIDOUT.—On March 14th, at St. Elmo, Southsea, to the wife of C. A. Scott Ridout, M.S., F.R.C.S.—a son.

WELLS.—On February 21st, at Banbury, to Vera (*née* Grantham-Hill) and Clement J. L. Wells, B.M.—a son.

SILVER WEDDING.

COOK—TIMPSON.—On March 20th, 1900, at Namirembe Cathedral, Kampala, Uganda, by the late Bishop Tucker, Albert Ruskin Cook, M.D., to Katharine Timpson.

DEATHS.

BURROWS.—On March 8th, 1925, at Devonshire House, Southsea, Lucy Mary Elizabeth, the beloved wife of Harold Burrows.

CASTLE.—On March 11th, 1925, Richard Field Castle, M.B., B.Ch. (Cantab.), of Thornhill House, Darfield, Yorks, aged 64 years.

COMPTON.—On March 2nd, 1925, at midnight, Thomas Armetriding Compton, M.D.(Trinity College, Dublin), of Journey's End, Parkstone, aged 87.

FOWELL.—On March 1st, 1925, Hugh, only child of Dr. and Mrs. Patrick Fowell, of Welshpool.

HIND.—On February 26th, 1925, at Harrogate, Henry Hind, F.R.C.S., of Sharon, Ripon, and formerly of Harrogate and Stockton-on-Tees, aged 77.

LONGHURST.—On March 20th, 1925, at The Homestead, Chandler's Ford, Hampshire, Arthur E. I. Longhurst, M.D., late 60th Rifles, aged 94.

MALDEN.—On March 19th, 1925, at 2, Clarendon Place, Leamington Spa, Frank James Malden, M.D., aged 63 years.

MOORE.—On March 7th, 1925, Col. E. J. Moore, C.B., V.D., M.B., B.Ch.(Oxon.), of Park End, Blackheath Park, elder son of the late Thomas Moore, F.R.C.S., of Blackheath, aged 62.

ORMEROD.—On March 5th, 1925, Joseph Arderne Ormerod, M.D., F.R.C.P., of 25, Upper Wimpole Street, W., and Greenhill, Upham, Hants, eldest surviving son of the late Venerable Archdeacon T. J. Ormerod.

WHITELEY.—On March 7th, 1925, Daniel Flockton Whiteley, M.R.C.S., L.R.C.P.(Lond)., of 29, Colcherne Court, S.W. 5, and 48, Britannia Road, Fulham.

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. 1.*

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. XXXII.—NO. 8.] MAY 1ST, 1925. PRICE NINEPENCE.

CALENDAR.

Fri.,	May 1.	—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Sat.,	,, 2.	—**Annual Athletic Sports, Winchmore Hill.**
Mon.,	,, 4.	—Special Subject Lecture, Dr. Cumberbatch.
Tues.,	,, 5.	—Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.
Wed.,	,, 6.	—Clinical Lecture (Surgery), Sir Holburt Waring.
Fri.,	,, 8.	—Sir Thomas Horder and Mr. Rawling on duty. Clinical Lecture (Medicine), Sir Thomas Horder.
Mon.,	,, 11.	—Special Subject Lecture, Mr. Harmer.
Tues.,	,, 12.	—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Wed.,	,, 13.	—**Annual View Day.**
Fri.,	,, 15.	—Prof. Fraser and Prof. Gask on duty. Clinical Lecture (Medicine), Sir P. Horton-Smith Hartley.
Mon.,	,, 18.	—Special Subject Lecture, Mr. Elmslie.
Tues.,	,, 19.	—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Wed.,	,, 20.	—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri.,	,, 22.	Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. H. Morley Fletcher. **Last day for receiving matter for June issue of Journal.**
Mon.,	,, 25.	—Special Subject Lecture, Mr. Scott.
Tues.,	,, 26.	—Sir Thomas Horder and Mr. Rawling on duty.
Wed.,	,, 27.	—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri.,	,, 29.	—Dr. Langdon Brown and Sir C. Gordon Watson on duty. Clinical Lecture (Medicine), Sir P. Horton-Smith Hartley.

EDITORIAL.

AT no time in the year can our Hospital be described in the terms of Lamb's famous picture of the South Sea House as exhibiting "an indolence almost cloistral," but at this time of the year we demonstrate a more than usually vigorous activity. Flowers surround the roots of each of the trees in the Square, and as if hating to be outdone by these importations, the trees themselves are bursting into leaf. The dreadful period of "wall washing" has passed. With tremendous activity and with the production of a quite revolting odour, the ancient paint and plaster has been removed from the walls of the archway through the north block, ready for the reception of the war memorial tablets. Aspiring auscultators in the east block are finding bronchial breathing even harder to hear while the British workman outside does his best with a sledge-hammer on the rising pillars of the nurse's new home. Soon we shall see the procession with pots of green paint for the seats in the Square. Then, truly, View Day will be near.

* * *

We wish to comment on two significant new arrivals with the early spring. The first, verdant as the season itself, is the new set of teapots that has appeared in a wondering refectory. With great care we have examined their strange spouts, and feel convinced that the committee of the catering company is going to insist on a periodical bacteriological examination. With the edge of a knife (tell it not in Gath) we have successfully analysed one physical property of the metallic part of them. Much as we like them they do not help us much in solving the great problem of this beverage—Is China tea a distinct and individual entity, or is it merely Indian tea made insufferably weak?

The second arrival is a far more ponderous matter, and no subject for flippant jest. It is P.P. 2776. Since our extreme youth there has been no London terminus like St. Pancras, for there and only there could one see a quiet, tired sounding electric motor that pulled along the most perfect toy train in the world. But since the advent of P.P. 2776 we live in daily proximity to the dream of our childhood. P.P. 2776 is perfect. When you grow frightened at the comet-like speed that you have attained thereon you step off in as dignified a manner as possible, and P.P. 2776, realizing that you have gone as far as you intended, promptly stops dead. It has the most penetrating of head-lights, the most twinkling of tail-lights, the most tactful of hooters. We have offered the whole of our princely editorial salary for permission to make one trip to Winchmore and back on this stately steed.

We are sad to see that in the general refurbishing, a certain lamp-post has not been replaced in the north-east corner of the Square. A report, so far receiving no support from any official quarter, says that the Christian Union has offered to give financial assistance to this deserving cause.

* * *

We had feared that a certain member of the Staff had sustained an acute attack of "Spring" when we observed on the notice-board that he would "lecture in the anatomical theatre until further notice." We can confidently assure our readers that he occasionally stops for meals, so we assume that the attack is only subacute.

* * *

The publication of the *Reports* has been taken over by a new committee, consisting of Sir Thomas Horder, Dr. Langdon Brown (Honorary Treasurer), Mr. McAdam Eccles, and Sir Bernard Spilsbury; Mr. Girling Ball and Dr. Geoffrey Evans are the Joint Editors. It is intended to publish the *Reports* in their original form. Every effort is being made to increase their circulation, and the principal object in the choice of material for the *Reports* is to reflect the work being done in the Hospital. The Committee earnestly hope that the *Reports* will continue to be well supported by old Bart.'s men, and that those now leaving the Hospital will become subscribers.

* * *

The Warden of the College has asked us to insert the following notice with reference to alterations which will be made in the dates of the nomination of members to the Resident Staff:

> "It has been decided that the meeting for consideration of nominations for May in each year will be held on the *first Wednesday in March*, and that the nominations for November in each year be considered at a meeting to be held on the *first Wednesday in October*.
>
> **This means that in future the notices of vacancies on the Resident Staff will be posted at the end of January and August in each year.**

* * *

Our hearty congratulations go to Kenneth Franklin on the commendation he has received on his work for the Radcliffe Prize, and on his being awarded the Radcliffe Travelling Scholarship for 1925. At the same time we should like to correct an error made in our last issue. Mr. Franklin's demonstratorship is at Oxford, and not at Cambridge as was stated.

* * *

The Annual "Past *v.* Present" Cricket Match will take place at Winchmore Hill, on Friday, June 5th, at 11.30 a.m. Will anyone who wishes to play for the "Past" XI communicate with Mr. Rodney Maingot.

HOUSE APPOINTMENTS.

THE following gentlemen have been nominated to House Appointments from May 1st, 1925:

Junior House-Physicians—	
Dr. Morley Fletcher.	J. Currie.
Sir Percival Hartley.	B. A. J. Mayo.
Prof. F. R. Fraser.	P. H. Martin.
Sir Thomas Horder, Bart.	R. S. Johnson.
Dr. Langdon Brown.	D. V. Hubble.
Junior House-Surgeons—	
Sir Holburt Waring.	D. A. Brigg.
Mr. McAdam Eccles.	T. Dodd.
Mr. L. Bathe Rawling.	H. B. Savage.
Prof. G. E. Gask.	A. W. L. Rowe.
Sir C. Gordon-Watson.	J. G. Milner.
Intern Midwifery Assistant (Resident)	H. Burt-White.
Intern Midwifery Assistant (Non-Resident)	W. A. Bourne.
Extern Midwifery Assistant	A. B. Cowley.*
H.-S. to Throat Department	R. T. Payne.
H.-S. to Ophthalmic Department	F. Heckford.
H.-S. to Venereal and Skin Department	F. H. K. Green.† / J. P. W. Jamie.‡
H.-S. to Orthopædic Department	W. R. Thrower.
Junior Resident Anæsthetists	A. Barnsley. / M. G. Fitzgerald.

* 3 months. † 3 months, May. ‡ 3 months, August.
All others for 6 months.

ST. BARTHOLOMEW'S HOSPITAL REPORTS.

IN the year 1864, sixty-one years ago, the Staff of St. Bartholomew's Hospital decided to issue a yearly volume embodying papers dealing with the work of the Hospital during the preceding twelve months. This venture proved to be of interest to many, and not least to old St. Bartholomew's men.

The preface to the first volume contains the following: "It has been their (the Staff's) object to give to these essays a thoroughly practical character, admitting, however, scientific contributions connected with subjects taught in the School," and it was because of these lines that the *Reports* became justly famous.

Sir James Paget wrote the first paper in this volume on "Cases of Pyæmia." Amongst the other papers of 1865 were one by Sir William S. Church, and one by Sir Dyce Duckworth, both of whom are happily still with us, sixty years after their early authorship.

Succeeding numbers contained many papers which have become classics. Some deserving of special mention are, 'A Case of Œsophagotomy" in 1867; "Protoxide of Nitrogen as an Anæsthetic" in 1869; "Ipecacuanha in Dysentery" in 1871; "Hyperpyrexia in Rheumatic Fever" in 1874; "Complete Intraperitoneal Ligature in Ovariotomy" in 1877; and "An Historical Case of Typhoid Fever (1612)" in 1881.

On the completion of the first twenty volumes, Sir William Church, who still takes much interest in the *Reports*, made an exhaustive index of their contents—a labour of love for which perhaps few have given him his due.

In 1904 a further twenty volumes were completed, and with the issue for 1905 another index, compiled by Mr. McAdam Eccles, was incorporated. This index was very full, with excellent cross references—in fact a model of what a useful index should be. It occupies no less than 120 pages, and a reference to it will show the extraordinary variety of subjects with which these *Reports* had dealt in these two decades.

Therein is recorded where may be found an instance of tabes dorsalis in husband and wife, an account of Theophilus Philanthropos and his six gifts, Gee's tripod of life, the suggestion that the persistence of fœtal veins in the spermatic cord may be a cause of varicocele, and the beginning of the use of warm baths in cases of long-standing suppuration.

Again twenty years have nearly elapsed, and it will be for someone else to bring into being a third and similar useful compilation.

The Great War upset the regularity of these yearly volumes as it disturbed many other publications.

Since the war, changes, some good, and some perhaps not so good, have been made. There cannot, however, be any doubt that the interest in the *Reports* has somewhat waned. There are fewer subscribers, and some of these subscribers have not been paying their subscriptions so regularly as heretofore, consequently those responsible for the management of the *Reports* have been so greatly handicapped that the suspension of the volumes was at one time seriously contemplated. It has been decided, however, to continue them, with contents much on the original lines, and it is hoped and believed that old Bartholomew's men will rally to their support as in the past. Attention is drawn to the announcement which appears in this issue of the JOURNAL.

SAMUEL COLLINS, DOCTOR IN PHYSIC.

SAMUEL COLLINS figures in the list of the Fellows of the Royal College of Physicians for the year 1677, a contemporary of Glisson and Sir Charles Scarborough. He published in 1685 a work on Anatomy, one volume of which it is my good fortune to possess.

Collins' *Anatomy* is not, as modern books dry tomes, full of facts the accuracy of which it is useless to question, facts that the average student can only retain by the use of mnemonics, facts that may safely be forgotten once the nightmare epoch of examinations is safely past. No! Collins describes the human body joyfully, inaccurately, but with such a choice of ornate diction as makes his work a solace and a pleasure after toilsome years of Gray and Cunningham. Thus he speaks of the heart:

"The Heart is the most noble piece of Household Stuff belonging to the Middle Apartiment of the Body and may be truly entitled the Sun of its Microcosm, from which the rays of Life seated in the Blood are displayed by Arteries into all parts of this little World."

Again: "The Face being a handsome Frontispiece (embellishing the anterior region of the highest apartiment relating to the elegant frame of a Mans body) doth present the prospect of a rare Landscip, drawn with Nature's curious pencil in excellent perspective, made up of many lights and shades, rendering the graceful frontispiece round and soft. . . . In the middle of this delightful prospect is situated the nose. . . . The sides of the Face are graced with Cheeks shaded with groves of hair and beset with Roses and Lilies, as painted with white and red (rarely intermixed) and melted into each other by a sweet softness making a delightful harmony. The lower region of this frontispiece is adorned with two lips shutting and opening the small apartiment of the mouth, as with folding doors, to treat ourselves with the reception of dainties (endued with variety of delicious tastes) and with pleasant discourse, the amiable expression of the mind."

Dr. Collins is most methodical; in every case after his descriptions he goes on to discuss the uses of organs and structures.

"The use of the Pleura is, I humbly conceive, by encircling the inward circumference of the Thorax with a soft vail, to secure the viscera of the middle story of the body—the heart and lungs, from dashing in their motion against the more hard walls of the Sternum, Ribs and Vertebres of the Back."

Better still, he does not confine himself to his title subject, but breaks out delightfully into clinical stories, pathology and treatment, and further into wider realms of comparative anatomy, on which last subject it must be confessed he proves unconscionably dull.

Here is a good example of his method of relating a case:

"Of an Empyema." "I shall take the boldness to give an instance in Mr. Echins, a gentleman of Northamptonshire (related to a person of Honour, Colonel Stroade, Governor of Dovor Castle) who was oppressed with a great cough, a high difficulty of breathing accompanied by a slow putrid fever, and many other diagnostics which follow an ulcer of the lungs and an empyema, flowing from a source of purulent matter (entertained from the

confines of the lungs into the capacity of the breast) falling down upon the Diaphragm.

"In order to evacuate the matter of this disease and to relieve the aggrieved lungs and midriff, an apertion was made in the Intercostal Muscles between the ribs by Mr Pierce, a skilful Chirurgeon relating to the Hospital of St. Thomas; whereupon, the Thorax being opened a quantity of sanious and purulent matter was discharged through the wound; and he also excerned it by coughing, vomiting, by stool and by urine. All these excavations were plain to sense but the great difficulty remaineth how nature could expel the peccant matter by these several ways; which I humbly conceive may be accomplished after this manner. Some part of the pus was transmitted into the bronchia and thrown up by coughing, and some other portion was entertained out of the substance of the Bronchia and Sinus only (apostemated not ulcered) into the extremities of the Pulmonary Veins and carried through the left Ventricle of the Heart (causing great faintness and dejection of spirit attended with fever) and Descendent trunk of the Aorta, into the Coeliac Artery and its terminations into the cavity of the Stomach, whence it was expelled by vomiting; and afterwards some part of the pus was conveyed further by the Descendent trunk into the branches and extremities of the upper and lower mesenteric arteries, into the cavity of the intestines and thrown off by stool.

"And the reliques of the purulent excretion not carried off did descend lower by the said trunk into the Emulgent arteries and the Capillaries implanted in the glands of the Kidneys in which a secretion was made of the purulent material from the Blood and embodied with serous Recrements, whereupon they were received into the Urinary Ducts and carried through the Pelvis and Ureters and thence excerned through the Urethra.

"The patient was perfectly restored to health and strength many years ago and is yet alive and healthy as a monument of God's Wonderful Mercy."

A rather bold conception of pyæmia perhaps, but his imagination has run away with him altogether in "The Manner how to discover a Fracture of the Skull": "In order to discover whether both Tables are broken the Patient may stop his Nostrils and shut his Mouth and make a strong expiration, whereupon the detained breath will have recourse to the Brain and swell up its substance and Membranes, whereupon will ensue an exudation of a frothy mixture and some loss of blood and sanious matter so that the manner of the Fracture may be discerned when the skull is laid bare which is necessary in wounds of the skull."

With such a wealth of material it is difficult to know where to stop, but I will conclude with a quotation of "The Cure of a Pleurisie":

"Attenuating Medecines made of Apozemes prepared with Dog Grass, Wild Asparagus, and Mild Pectorals; and in a Peripneumonia which is often a companion of this disease Testaceous Powders, full of Volatil Salt as Crabs' Claws, Pearl, the Mandible of a Pike, the Bone of the Heart of a Stag; as also Sal Prunella, Salt of Coral, Urine, Infusion of Horse Dung made in Red Poppy Water and White Wine are very useful."

APPOINTMENTS ANALYSED.

[By way of apology for the views expressed, the writer begs humbly to say that they have been acquired during the holding of five years' resident appointments in a dozen responsible London and Provincial hospitals.]

WHEN the son of Rahere rises reverently from sacerdotal Blessing and chirurgical Confirmation, a book of Exhortations in his hands and a Diploma under his arm, it behoves him—like a true knight of Æsculapius—to pass his vigil before the altar in Contemplation and Meditation.

Facilis descensus Averni. So sweetly glides the flower-strewn path of Ease with *dolce far niente* as the maid, that we tend to pass unobtrusively into that Limbo of Mediocrity, where Ichabod is written against our name. It is for this reason, then, that the article is written, that the neophyte may temper his footsteps with wisdom as he treads his way to the stars.

The most disappointing post in the whole of the hospital calendar is that of house-surgeon. Its possession tends ofttimes to pride and superciliousness (*mea culpa!*—I also have "possessed"), and to an exaggerated importance over and beyond its deserts. In this it is helped by Press and Public, who profess to see in the house-surgeon the sum total of hospital efficiency. It "shouts" like Sir Edward Marshall Hall, and the duped layman gazes, awe-struck, in open-mouthed, adenoid wonder.

Disillusion however is at hand. On May 1st—dire omen—Labour Day, the great Hospital change-over takes place, and the exodus begins. "The shouting and the tumult dies, the captains and the kings depart." Our house-surgeon packs up his trunks. Shorn of the trappings of office Prestige dwindles; gone, now, is the Glory that was his, like the passing of a summer's day. Truly does the Magnificat proclaim *Exaltavit humiles, et deposuit potentes a sede.*

Perspective restored him, he strikes now for the Rough Road of Reality. He is equipped with a knowledge highly technical and applicable mainly to the narrow field of Specialism, and he receives a welcome from the fraternity, of a quality so meagre, that, compared to which, Balfour's reception by Damascus Arabs seems boisterous and exuberant in the extreme.

To that great and honourable body who uphold the highest of medical traditions throughout the country, and to which most of us will belong (I refer to the family practitioner) the modifications of Bilroth II and Polya and the details of a Rammstedt will be as nebulous and as misty as a dissertation on advanced mathematics to a horned and be-spangled Zulu. But—the relief of colic, the coming of a baby's tooth, the knowledge of infant feeding, the cure of constipation, the pain-relieving drugs for cough, headache, neuralgia, lumbago, rheumatism and myositis—*these* are the things that bring gladness to the patient and treasured delight to the doctor; yet they are but sketchily taught in schools.

The experience of a house-surgeon is of little use in the busy round of the general practitioner. The greatest surgical emergency is Appendicitis, representing more than 50 per cent. of all abdominal cases, and a knowledge of this, together with the data of Intestinal Obstruction—indispensable in the medical armamentarium—form a working basis for the busy doctor at once sound, sufficient and logical. His primary duty is not to "*diagnose*," but to *recognize*, and the "acute abdomen" is like the picture page of the *Daily Mail*, it shrieks and screams in its own advertisement.

When the gravity of the condition is recognized the doctor's task is easy—admission to hospital. Not so for the physician. The public insist that surgical cases shall go to hospital, while medical cases are treated at home. There is no ordeal in medicine demanding Courage, Self-reliance and Character to such an extent as a doctor face to face with, say, a case of acute pneumonia in a favourite son, gasping in the anguish of dyspnœa, while rusty sputum hangs on livid lips, the mounting pulse proclaiming the maddened heart; and hour by hour suspicion swells in volume and the watchers' trust and confidence grow less.

Relatives easily forgive a surgeon. To them, Death is the natural sequence of serious operative procedure, and great is their joy on recovery. Surgeons, like plumbers, may bury their mistakes and live at peace, but the unlucky physician is shown no such consideration. *Cure the patient or take the blame.* In a prolonged experience of fever hospitals I have seen many deaths from diphtheria, but hardly one in which the doctor, nurse or ambulance man was not ultimately consigned to perdition or cursed to coroner's court.

The great preponderance of work in general practice is *medical*, and on that the practitioner rises or falls. Ethics differ; we have ours, the patients theirs, and they judge a man (*a*) by his sympathy and consideration, (*b*) by his capacity to relieve pain. Degrees are nothing to an invalid, in whom the junior resident takes precedence to a member of the visiting staff.

Ask a man lately discharged from hospital *who* did his operation, and the odds are he will name the house-surgeon. *Sic transit gloria chirurgica.* Knowledge? They have no means of discrimination. In the eyes of the sick, an L.M.S.S.A. is of equal importance to an F.R.C.S., probably more so—it contains *more letters!*

The post ranking next in importance to the house-physician is that of O.P. Casualty, for here is wisdom and experience in abundance—the type of case that he will meet in hundreds in his after life—surely the great garden of knowledge wherein the aspirant may browse at will. Tell a woman how "*sweetly*" to work a colostomy and you have a friend for life. Tell a man how hæmorrhoids will disappear under massage and ointment, *and show him how*, and he will shout your praises down the street. Give the possessor of a distressing cough *linctus heroin*, and he will come across the road to shake you by the hand.

Our knowledge, unfortunately, is but ill-matured. We are all trained in colostomy and the fitting of belts, but few, in the necessary toilet and regulation of the bowel itself, yet disorder and uncleanness here, in a sensitive patient, make life a very hell upon earth. Yet salol, care, and morning wash-outs will work a miracle. We all give ung. galli c opio—knowing that opium is not absorbed—and forget the rectal massage, yet the very essence of alleviation is in this—and, *to the second finger-joint.* So on and on; did we but grace our work, we would have the nobler reward.

It is in the Casualty more than anywhere else that knowledge of value beyond ruby or pearl is to be acquired. In fractures, bruises, cuts, sprains, dislocations, fevers, coughs, pneumonia and malaise we have a record of living history, and an ardent student in *that* book has never yet been sued successfully in Court for mal praxis or incompetence.

Midwifery is the Cinderella of medicine, yet she shows great favours, and the man who courts her with diligence marries a fairy princess. Practical midwifery can never be written; like the dogmas of Catholicism, it is based on tradition. It lives by word of mouth. We talk of Champetier de Ribes' bags as dependable instruments in emergency. Yet, endeavour to use them and they collapse like a Woolworth balloon. Show me a hospital that can produce a trio of bags that will not leak, or collapse, or come undone, and I will add another to the nine wonders of the world.

How few can detect with certainty the fœtal heart. Spend an hour in diligent search, "tune in" to murmur

and bruit, and it will stand out like a Greenwich time-signal. The undilated cervix is the greatest trap in obstetrics. The *thin-shelved os out-spun on fœtal head* requires a cultured finger for its recognition, and the application of forceps without that knowledge has landed men ere this in prison for manslaughter. To the gentle aspirant in midwifery, a little chloroform, a drachm of ergot, and a lot of patience, make a compendium for the treatment of labour in all its stages not lightly to be disregarded nor despised, while a clean shirt daily, a rigid regard for antisepsis and a short second stage form the basis of his success. "The best advice I can give a young accoucheur on the conduct of labour," said a celebrated obstetrician, "is to keep his hands in his pockets and leave his midwifery bag at home."

Fevers and anæsthetics are the twin graces of medical practice, bedecking with laurel all those who therein seek; yet the equipment of the average student in these important branches of our course is as far removed from the basic requirements of Practice, as the wheeze of a broken-down Southern asthmatic from the speed of a Scottish express!

Yet ether is foolproof. It is chloroform that kills. To the unskilled and inexperienced it is more deadly than smallpox, more disastrous than gas gangrene. Yet every practitioner uses it, aye, flies to its aid in every way, as the coroners' records tell. Thus do we enlarge our cemeteries, thus populate the City of the Dead.

Fevers can be learned on the fingers of the hand—bleary eyes, blotches and sneezing mean measles, and tongue, temperature, faucial injection and body flush mean scarlatina; but above all, the *tongue*, white coated, richly papillated; while a creamy patch on the throat, thick, mosaic, widespread, a musty odour and a listless child proclaim the Klebs-Loeffler bacillus. Adults rarely get fevers excepting diphtheria, which alone of all the exanthemata can be contracted again and again. Measles and chickenpox spread among children like a fire in Tussaud's. Scarlet fever is somewhat contagious, and diphtheria scarcely at all.

All knowledge has value, and as such may be expressed in abstract terms. Our aspiring practitioner was worried and consulted that famous craniologist—Dr. Abernethy Gee—who replied with the appended, *A Chart on Medical Worth:*

H.-P. experience	. . .	65 points.
Casualty experience	. .	55 ,,
Midwifery experience	. .	45 ,,
H.-S. experience	. . .	40 ,,
Fever experience	. . .	25 ,,
Anæsthetics experience	. .	20 ,,
Total	. . . .	250 ,,

"In the experience of them all," he says, in his delightful old-world manner, "the candidate approacheth the FULL man." So be it. Knowledge, as Mr. Selfridge tells us, engenders Confidence, Confidence begets Enthusiasm, and with Enthusiasm you may conquer the world.

J. J. SAVAGE.

TURPENTINE AS A THERAPEUTIC AGENT.

By JOHN WHITTINGDALE, M.A., M.B., F.R.C.S., D.O.(Oxon).

TURPENTINE, the oleum terebinthæ rectificatæ of the Pharmacopœia, is a substance that is readily obtainable and often of great service in an emergency.

It is a matter of common knowledge that turpentine applied externally on hot flannel, or rubbed in as a liniment, will relieve the pain of colic, fibrositis and sprains, but it has other properties even more valuable.

As a cleansing agent turpentine will remove tar and grease from the skin preparatory to dressing wounds caused by machinery, etc.

Hæmostasis.—Applied locally, turpentine is useful in checking bleeding from tooth-sockets after the extraction of teeth. The practitioner is frequently called late at night to a patient who has had teeth extracted under local anæsthesia, and is becoming frightened by the persistent ooze of blood from the lacerated and inflamed sockets. The patient should be seated and the light arranged to illuminate the mouth. The tooth-cavities should be washed out with warm water and pieces of clot removed. Some ribbon gauze lightly wrung out of turpentine is packed into the cavities with the aid of a probe; the redundant gauze is folded upon itself to form a pad.

Placing the forefinger or thumb upon the pad and making counter-pressure with the other fingers upon the jaw, steady pressure is made for 14 minutes by the clock. If the patient is supported with the head raised, the lowering of the intracranial arterial pressure may lead to fainting, which is an aid to hæmostasis.

After the bleeding has stopped, the patient should be put to bed and given a quarter of a grain of morphia hypodermically.

During hæmoptysis, the inhalation of the vapour of turpentine from a sponge or cotton-wool saturated with the liquid tends to lessen the cough, and may be of some value in promoting the cessation of bleeding. The patient finds it comforting and feels that something is being done.

External application.—Turpentine is frequently applied to the skin as a hot stupe to relieve pain, but it should be remembered that some skins are very intolerant to this application, and react by developing a widespread and acutely irritating eruption similar to that produced by the *Rhus toxicodendron*.

To promote intestinal peristalsis.—For the relief of the agonizing flatulent distension so commonly present after abdominal section many remedies are in vogue, and of these the most popular are the subcutaneous or intramuscular injection of eserine sulphate and pituitary extract. It will be found that the action of these drugs is aided and intensified if their administration is followed within three-quarters of an hour by an enema containing half an ounce of turpentine and of castor in one pint of soap and water.

This injection is given as a rule about twenty-four hours after an operation for appendectomy or strangulated hernia, but should be postponed for thirty-six hours after an intestinal anastomosis.

Promotion of leucocytosis.—Fochier, in 1891, was the first to advocate the subcutaneous injection of turpentine to produce a fixation abscess in cases of sepsis. When the patient is overwhelmed by an infection and the reaction of the leucoblastic tissues is apparently inefficient, the promotion of a fixation abscess by the subcutaneous injection of 1 c.c. of turpentine is occasionally dramatic in its results.

The following case history is of interest:

R. N—, a domestic servant, æt. 17, was admitted to hospital in July, 1922, suffering from mastoid suppuration following acute infection of the left ear. The mastoid cells were opened up, and a track through the tegmen tympani was enlarged and found to lead through the dura to an abscess in the temporal lobe of the brain. Drainage was established, and for a week the patient was apparently doing well. A spreading meningo-encephalitis developed, and the patient became unconscious, wildly delirious, and completely incontinent. The wound was opened up and drained freely, but the general condition deteriorated. The temperature remained subnormal, and nutrition was maintained by daily subcutaneous infusion of two pints of 4 per cent. glucose in normal saline.

At this stage 1 c.c. of turpentine was injected subcutaneously at the outer side of the left thigh. The same evening the temperature rose to 104° F., and the skin became reddened at the site of the injection. It was fomented four-hourly and subcutaneous infusion maintained by continuous drip. The temperature became hectic in type, and a subcutaneous abscess in the thigh at the site of the injection was opened three days later. One week after the injection the patient suddenly became conscious and asked for milk. Thereafter she improved steadily, and left the hospital six weeks after the date of the injection. She is now quite well and has resumed her employment.

Recently (*Surgery, Gynæcology and Obstetrics*, October, 1924) Wren and Tenenbaum, of the Vanderbilt Clinic, have reported success from the use of a modification of this method in the treatment of acute gonorrhœal epididymitis. They follow a technique described by Klingmueller, and use a 20 per cent. emulsion of rectified turpentine in sterile olive oil. Half to 1 c.c. of this emulsion is injected at the level of the periosteum, two fingers'-breadth below the iliac crest. They report that, six to twelve hours after the injection, the pain was stopped or was alleviated, and the tenderness of the epididymis was diminished.

The injections were repeated, if necessary, every other day. In about half the cases only one injection was required; others were given up to seven injections before the epididymitis and pain subsided.

The authors report complete relief in 83 per cent. of cases. These results demand that the method should have further trial, and its use might be extended to the treatment of obscure infections, *e.g.* rheumatoid arthritis.

ANATOMY OF A DIGITAL EXAMINATION OF THE RECTUM.

THE first time that a finger is put in the rectum is usually in the dissecting rooms, at the stage when the perinæum is being dissected. The guide-book recommends this procedure to help the passage of a staff along the membranous and prostatic portions of the urethra, then requires the rectum to be "moderately" distended with tow and the anus stitched up. Later in considering the relations of the pelvic viscera, the student is told to "repeatedly introduce" his right index finger into the rectum, but in a dead subject it is difficult to appreciate the structure and relations, especially if the organ had been "immoderately" distended with tow.

As a dresser one seldom examines a rectum unless it be one's own case, and then only if the region is known to be abnormal. There is a tendency to introduce the finger to its full extent, feel the lesion expected, and withdraw rejoicing. In examining an abdomen one is taught to go over region by region systematically, but in the rectum method is not always insisted on.

If the finger is introduced in three stages, and the relations of the tip of the finger at each stage

considered, each structure is examined in turn and any abnormality will be detected. The lowest inch is explored in the first stage, when the finger is only inserted to the first joint; the second inch when the finger is inserted to the second joint; the third inch when the whole finger is inserted, slight pressure giving an extra half-inch. At each stage it is important to rotate the finger to examine the whole circumference of the rectum.

First stage.—The sphincter muscles are felt, and if the patient voluntarily contracts, they are reinforced by the levatores ani muscles, making this last inch of rectum (or anal canal) feel like "a broad muscular band" (Cripps). The mucous membrane is very sensitive and lies in longitudinal folds, which cannot normally be felt. The anterior relations are the base of the triangular ligament, the membranous urethra and bulb, and Cowper's glands.

Second stage.—The tip of the finger has passed above the anal valves and is in relation to the columns of Morgagni. Here the mucous membrane is less sensitive.

Anteriorly lies the prostate, posteriorly the coccyx, and laterally the levatores ani muscles, the ischio-rectal fossæ, offering no resistance, and the inner surface of the tuber ischii.

Third stage.—Anteriorly the triangular area of the base of the bladder is felt (if full), along the two sides of which lie the seminal vesicles and ends of vasa, meeting below in the prostate at the apex of the triangle. Along the base of the triangle the lowest edge of the recto-vesical pouch of peritoneum can just be reached if the bladder is empty.

Posteriorly the sacrum is felt; and laterally the levatores ani and ischio-rectal fossæ.

In the female rectum the perinæal body is an anterior relation in the first stage, the posterior wall of the vagina in the second and third, and in the latter the cervix uteri can always be felt, resembling a hard umbrella ring.

E. A. CROOK.

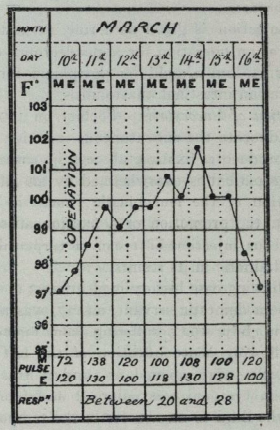
A CASE OF OPEN FRACTURE OF THE SKULL; HERNIA CEREBRI; MENINGITIS; RECOVERY.

THE notes of the following case should be of interest in that they show (i) the doubtful advantage of skull-plating in old septic cases, on account of the possibility of lighting up old sepsis by the introduction of a foreign body, and (ii) the advantages of repeated lumbar puncture in meningitis.

A. P—, boy, æt. 6, in February, 1923, whilst returning from school was knocked down by a motor-car. He was admitted to the Mansfield Hospital, and was found to have fractures of the left humerus and right tibia and fibula, and a compound fracture of the frontal bone.

Several depressed fragments of bone were removed from the frontal region. The wound suppurated and five weeks later there began to be a protrusion. He remained in hospital 18 weeks.

When seen by me a month later the fractures to the arm and leg were firmly united in good position. There was, in the upper part of the forehead, a transversely oval pulsating mass 3 in. wide, 1½ in. from above down and standing out ¾ in., covered by granulations and discharging pus. It increased in size on coughing. There



was no headache or other symptom, and his intellect was quite normal.

Attempts to harden the tumour with spirit caused considerable reaction. Normal saline dressings were applied night and morning for some weeks. The epithelium gradually commenced to grow over the tumour, which retracted into the skull to some extent. The child was admitted to St. Bartholomew's in August, 1923, under the care of Mr. Rawling. The wound was dressed with Dakin's solution. The granulating surface gradually became covered with the ingrowth of the epithelium and the pulsating mass became somewhat decreased in size.

During his stay in hospital the temperature, pulse and respirations remained normal; no symptoms or signs were observed. He was discharged in November, 1923, and advised to return in 6 months.

He returned in February, 1924. The surface of the old wound was covered with epithelium, there being a thick scab in the centre. This was removed and a small quantity of pus welled up. Tincture of iodine was applied, and within a few days the wound became dry.

Operation March 10th, 1924, by Mr. L. B. Rawling, under a general anæsthetic, the patient being propped up in a sitting position.

An incision 4½ in. long was made transversely across the skull, so as to encircle the scar-tissue. The scar and surrounding skin were carefully dissected away from the underlying brain-tissue and bone. An attempt was made to separate the dura mater from the bone with the object of drawing it over the wound, but it was found impossible. It was found that on drawing the two edges of the scalp together the skin of the forehead became tense, causing elevation of the eyebrows and altering the expression. An incision was then made transversely over the mid-temporal region about 6 in. long and parallel to the first incision, passing down to the loose areolar tissue under the epicranium. The scalp anterior to this was separated from the precranium and drawn forwards. The edges of the anterior wound were sutured.

A further incision was made 4 in. behind the previous one and parallel to the other two, 3½ in. long. The scalp was loosened in a similar manner and drawn forward, and the middle wound closed. The posterior flap of the posterior wound was undercut and the edges of the wound brought together. Gauze was applied over the incisions and the head very firmly bandaged, the ears being first thickly coated with vaseline.

Two days after the operation he complained of a little pain in the front of the head, was sleeping badly and there was some rise of temperature.

The fifth day after the operation he was very drowsy and a swelling was noticed over the anterior wound. This was opened and a small quantity of blood and pus evacuated.

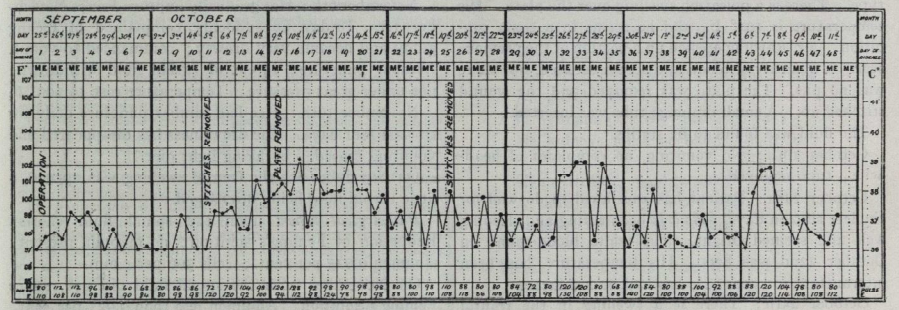
Eusol dressings were applied for the next ten days and the wound gradually healed up, the temperature being normal after the seventh day and the drowsiness disappeared.

Patient was discharged on April 19th, 1924, and advised to return in six months for plating.

He was quite well during the five months at home, had no headache or drowsiness, and wore an aluminium plate under his cap to protect the parts.

Readmitted September 24th.

Operation, September 25th, 1924, by Mr L. B. Rawling under a general anæsthetic, the patient being again propped up.



It was noticed that the brain was bulging through the skull opening. A lumbar puncture was performed. The cerebrospinal fluid ran very freely out of the cannula; 38 c.c. of fluid was drained away before the brain became level with the skull. The operation was then proceeded with.

A horseshoe-shaped incision was made down to the skull and about 1 in. outside the opening in the skull. The flap was raised from the skull and adherent brain-tissue, and thrown downwards, all bleeding from the cut edges being controlled with hæmostatic forceps.

A thin, circular silver plate about ½ in. larger in diameter than the skull opening was inserted and left in position to cover the opening in the skull. The skin-flap was replaced, all extravasated blood being squeezed out from the wound before the last stitch was inserted. The wound was dressed with strips of dry gauze and bandaged firmly with a roll of gauze.

The accompanying chart shows the temperature and pulse-rates following the operation.

The progress of the patient after the operation was as follows:

September 26th: Patient complains of no pain, but there is persistent vomiting, which is projectile in character.

September 29th: Seems rather sleepy; lies curled up on his left side; has no pain in the head. Still vomiting.

September 30th: The wound appears healthy. $\frac{1}{6}$ gr. of morphia was given and the vomiting has ceased. He is having light food.

October 3rd: He seems very well; is eating and sleeping well, and shows no signs of drowsiness.

October 5th: Stitches removed. The wound is completely healed and looks healthy.

October 8th: Patient is a little sleepy and has vomited once, projectile in character.

October 9th: Vomiting every half hour, projectile in type. There is a pulsating swelling over the plate. His temperature is 101° F., and he seems in a toxic condition. Mr. Rawling opened up a portion of the previous scar. A quantity of blood and serum escaped, but there was no pus. The plate was removed and the wound stitched up. A small drainage-tube was inserted.

The fluid was found to be sterile.

October 10th: No vomiting, no complaint of head ache; tube removed.

October 24th: Patient has continued to do well for the last sixteen days. He has been eating and sleeping well and seemed bright. His white blood-count on October 22nd was 8200. His temperature has been intermittent in type. He has had no headache.

October 25th: There is a swelling in the frontal region. He does not seem sleepy, and has no headache. Fluid drawn off from the swelling was found to be sterile. *Microscopically* blood-cells were seen, but no pus-cells.

October 26th: Vomiting everything taken. He is very drowsy. The swelling in the frontal region has rather increased in size.

October 27th: Still very drowsy, lying curled up on his left side. The swelling is decidedly bigger; turbid fluid has been aspirated from it.

October 28th: The vomiting continues. He has no pain in the head or neck, and no stiffness. White blood-count 20,600.

About 6 p.m. he complained of pain in his head and neck, and was lying on his back with his head thrown backwards. The neck was stiff and could not be flexed. No spasmodic movements were seen. Kernig's sign well marked. Pupils were equal and dilated; no strabismus. Abdominal reflexes absent. Lumbar puncture showed turbid cerebrospinal fluid under pressure. Pathological examination showed the turbid fluid contained a definite clot and an opaque white deposit; also contained many polymorphonuclear leucocytes and Gram-positive cocci arranged in pairs and singly, chiefly intracellular.

October 29th: He has no headache. Vomited till 12 noon. Mental condition was quite normal. Neck still stiff. 5 c.c. of antistreptococcal serum injected subcutaneously. Lumbar puncture again done; 40 c.c. of turbid fluid withdrawn under pressure.

October 30th: 7·5 c.c. of antistreptococcal serum injected this morning. Seems brighter; all stiffness gone. 40 c.c. of cerebrospinal fluid withdrawn; fluid less turbid.

He has been very constipated during the whole attack.

October 31st: Lumbar puncture.

November 1st; Fluid from lumbar puncture only slightly turbid, not under pressure. Eating and sleeping well, but is very thin.

November 6th: Has gradually improved since November 1st. To-day he suddenly complained of feeling giddy and became very drowsy; commenced to vomit. Lumbar puncture: 15 c.c. of turbid fluid withdrawn; not under great pressure. Temperature rose to 100° F.

November 10th: Has had lumbar puncture daily for the last four days. The drowsiness has disappeared and vomiting ceased. Is taking light diet.

On November 8th the frontal swelling was opened, a little turbid fluid being discharged.

Pathological report upon the spinal fluid shows: Reduction of Fehling's solution; no globulin present; albumen 0·025 per cent.; cells 306 per c.mm.

On November 10th the spinal fluid did not reduce Fehling's solution. Albumen less than 0·025 per cent., cells 170 per c.mm., culture sterile; white blood-count 8,800.

November 18th: Lumbar puncture has been done every other day. Patient has much improved, is gaining weight. The temperature and pulse normal.

He was discharged on November 6th, the wounds healed and mental condition normal, and since that date his general condition has gradually improved, and he remains well.

I am indebted to Mr. L. B. Rawling for permission to publish this case. I desire to take this opportunity of thanking both Mr. Rawling and Mr. J. R. Hamerton for the assistance they have given me.

H. E. HOUFTON.

A CASE OF GALL-STONES.

MRS. D—, female, æt. 40, was admitted to hospital complaining of abdominal pain after meals, which had troubled her for the past twelve years. For the past year she had also suffered from vomiting after meals, usually about 1–1½ hours after taking food.

Previous history.—She stated that she was operated upon elsewhere for gall-stones twelve years ago. I was, unfortunately, not able to trace her previous notes and so do not know what operation was performed.

On examination patient was of a peculiarly dark tint of skin, though not jaundiced. Temperature 98·4° F.; pulse 68 and of good volume. Sclerotics clear, mucous membranes not pale. Tongue coated with a thick fur.

Abdomen poorly covered. Old operation scar on right side of abdomen above umbilicus, about 5½ in. long. The right hypochondrium was definitely tender and somewhat rigid. No tumour was palpable.

The urine was normal.

X-ray examination.—Duodenal cap poorly shown. Marked delay in emptying of stomach, some bismuth being present eight hours after meal. Constriction visible at pylorus; no evidence of ulcer. Condition probably due to adhesions.

Exploratory laparotomy.—Right para-median incision just outside old scar. An adhesive band was found passing from the peritoneum of the anterior abdominal wall and the right side of the peritoneum covering the ligamentum teres, to the upper margin of the duodenum about 1½ in. from the pyloric sphincter. This was divided, and several smaller adhesions around the pylorus freed.

The gall-bladder was found to contain stones, and was incised. Seven stones were removed from the gall-bladder and three were extracted from the cystic duct. An attempt was made to remove the gall-bladder, but the condition of the patient being poor, the fundus and body were removed and the stump stitched to the parietal incision. A further gall-stone was palpated in the cystic duct, but time did not allow of its extraction.

Subsequent progress.—(1) For the first eight days after operation no drainage through the abdominal wound occurred. The urine and stools were normal.

(2) On the ninth day the patient had a slight attack of colic. The stools became clay-coloured and the urine contained bile. Drainage from the wound now became free. Traces of jaundice became evident in the sclerotics and conjunctiva.

(3) On the fifteenth day the patient had a very severe attack of colic. After this the drainage of bile ceased immediately. The stools and urine quickly returned to normal. The former were searched for four days for a stone, but none could be found. The patient made an uninterrupted recovery.

Conclusions.

The striking feature of the case is the excellent demonstration afforded of the effects of a stone at different points of the biliary system—(1) in the cystic duct; (2) in the common bile-duct; (3) passed.

It is also interesting that the stone should be discharged, presumably, by the intestine rather than by the drainage wound in the neck of the gall-bladder.

I am indebted to Mr. S. K. Hutton for permission to publish this case.

FRANK G. GREENWOOD.

TEMPORA MUTANTUR
(OR 45—50).

FULL fifty fair and feckless folks,
With frills and funny hats,
Come, bearing in their arms a host
Of bawling brainless brats;
And some of them are lachrymose,
And querulous as cats.

A tattered paper one displays,
Bearing the grime of weeks;
"Digestion's very bad," she says,
And gurgles as she speaks,
Diffusing to the atmosphere
The peppermint she reeks.

"Pain in me back," another cries
(Dropping a chubby lad),
"And when I've stooped to wash 'is face
An awful time I've 'ad;
And William ('e's my husband) says,
Me kidneys must be bad!"

"Them dreadful palpitations," cries
A third one, "get's my goat,
And gives me such a terrible
Dry feeling in the throat.
Please, is it for the 'eart, that long
Perscription wot you wrote?"

"I suffers faints and flushes,
Dreadful rheumatism too,
Me nerves is all atwitter,
Doctor, what am I to do,
With squawlin' kids around me,
Like the monkeys at the Zoo?"

Thus dolefully "*les miserables*"
Describe each pain and ache,
And leave with liniment to rub,
And medicine to take,
And an awe-inspiring confidence
Which nothing seems to shake.

And the Doctor? Tackles symptoms,
But alas, he knows too well
That tho' they cling to him
Like any winkle to its shell,
In "*tempora mutantur*"
Time alone can work the spell.

F. G.

THE LIGHTER SIDE.

THE more lasting of the impressions that one carries away from a year of hospital experience are not always of one's most instructive cases. Often the best remembered lessons are those which have their lighter side, though I may add this may not always be apparent at the time. The following incidents taught me more of the art of self-control than many an emergency operation.

The first concerns a case which arrived one crowded evening, preceded by a frantic telephone message and accompanied by this letter:

The Casualty Officer, ——— Hospital.

DEAR SIR,—I called to see the bearer, Mr. C—, æt. 51, at 3 p.m. to-day, and found him suffering from a severe pain in the abdomen. My diagnosis was ? renal colic, and I gave him heroin gr. $\frac{1}{12}$ hypodermically to relieve the pain. Soon afterwards he began to perspire and became drowsy, with contracted pupils, and seemed to be going in for toxic symptoms. I therefore gave him apomorphine gr. $\frac{1}{60}$ *and he vomited profusely.*

Then I administered tinct. belladonna mxxx by mouth and gave inject. strychnine gr. $\frac{1}{15}$ hypodermically. Since then I have washed his stomach out twice with pot. permang. *and have left some in.*

However, as he is still drowsy I should be greatly indebted if you could kindly admit him and continue treatment and oblige,—Yours faithfully, ——— M.B., B.S.(Honrs.)Lond.

The patient appeared a trifle exhausted, but having been put to bed and warmed up, revived sufficiently to discharge himself next morning. For the benefit of posterity and the Registrar, and for the lack of any clinical evidence of disease, his notes were headed "intestinal colic."

The second case is an instance of the pitfalls into which circumstantial evidence, an obvious result and a hasty diagnosis, without due consideration of inconsistent details, may lead.

The patient, a burly, muscular navvy, æt. 56, was rushed in by the police, with this story:

Half an hour previously his neighbours in the next room heard a crash. They rushed in to find the patient lying in one corner of his quarters, the air being full of "narsty smoke from a bad chimbley doctor." A bottle labelled "oxalic acid" lay on the mantelshelf near by.

Police—ambulance—hospital, a vigorous Robert pouring calx saccharatus from a first-aid chest through a rapidly swelling buccal vacity and pharynx despite energetic protests from the patient. Then on arrival I fell upon him after hearing the circumstances, etc., and rapidly consulting my Bart.'s Pharmacopœia (in the passage), produced a stomach-pump and got to work. Finally we desisted, and a rather woebegone, very dysarthric voice, which previously had had no chance, was heard to utter, "Gawd, doctor! I ain't swallered nothink." Then we got the true facts.

The patient, in an endeavour to blow off the top of his head, had emptied several fireworks, filled his mouth with the powder, and set light to it. From his point of view the result was distinctly disappointing; from ours, very chastening. A closer attention to detail revealed—

(1) The bottle had not been recently opened.

(2) The patient's moustache was singed and contained specks of unburnt powder.

(3) The "lidy friend" suddenly remembered his fire wasn't alight, etc.

There is a very obvious moral here. Think it out.

THE LOTUS-EATER.

Tænia Saginata speaks:

Some folks regret their lives are set
In sempiternal furrow:
The earl his seat; the "cop" his beat;
The *acarus* her burrow.
But from *my* groove I never move;
I'm very well content
With what you all perhaps would call
A crude environment.
And I submit that I'm more fit
Than any man alive;
I just hold tight—a parasite—
Absorb *your* food, and thrive.
The H.-P. sees, and Ma agrees,
That Tommy's getting thinner.
The silly ass gives *filix mas*,
And tries to spoil my dinner.
Then I enact what is in fact
A pretty brainy wheeze—
Pretend I'm dead, and forthwith shed
My ripe proglottides.
(That same H.-P. would hate to be
The clerks round Tommy's bed;
Some of that mob will have the job
Of hunting for my head!)
But once I'm set, you'll seldom get
My suckers to relax;
I do not care to budge from where
They don't charge Income-Tax!

A. B.

ROMANCE.

["They tend to get remarkably precocious for their age . . . and to acquire an abnormal interest in their own signs and symptoms!"—R. Hutchison on cœliac disease.]

WE found them flirting in the Square;
They were a priceless little pair:
He was a "cœliac" of Gee,
And she
A wee abdominal T.B.

He led the way along Love's bowery road,
Whispering symptoms in a way which showed
Intense
Omniscience,
Suggestive of a too-precocious sense.

Saying "he led" a metaphor implies;
It takes a pair of legs of decent size
To guide
Even one's hide,
Along a Square as broad as it is wide.

For O, his legs were wobbly when he stood;
His legs were wobbly, but his heart was good;
He said "'Oo sees,
In my disease
One often has no *jerks* about the knees!"

And when she, rather coy,
Feigned to despise the boy,
Seizing her hands
He cried, "Me understands,
And blames it on your mesenteric glands!"

Meanwhile the maid,
Bashful but unafraid,
Sits very square;
Dark eyes and hair,
Long lashes, body rather like a pear. . . .

Budding Romance?
Someday perchance,
When the great sun
Its healing work has done
Two little specimens may yet be one!

F. G.

STUDENTS' UNION.

THE ATHLETIC CLUB.

THE Annual Athletic Sports are to be held this year at Winchmore Hill on Saturday, May 2nd, at 2 p.m. Mrs. Gask has kindly consented to present the prizes. Everybody and their friends are asked to turn up and make the meeting a success. Teas will be provided on the ground at a small charge.

This year, in addition to the Inter-Club Relay event, there is to be an Inter-Firm Tug-of-War. It is hoped that this will stimulate enthusiasm and interest for a greater number of men. Come along and support your firm.

The 3 Miles race and the preliminary round of the Tug-of-War are to take place on Thursday, April 30th.

Other Fixtures.

On Tuesday, May 12th, the Athletic Club is holding the first of its friendly contests in preparation for the all-important United Hospitals Athletic Meeting (provisional date, June 10th). Venue Paddington Recreation Ground; opponents, University College and Hospital A.C. Programmes, price 6*d.* to defray expenses, can be obtained from the Hon. Secs. at an early date. A little support will be very welcome.

We are considering sending in a team for the University of London Athletic Meeting at Stamford Bridge on Wednesday, May 20th. If this materializes we shall have a good chance of winning the University Cup. Once again enthusiasm and support will make all the difference to our chances. W. S. H.

CRICKET CLUB.

THE season commences on Wednesday, May 6th, with a match against the Wanderers Cricket Club at Winchmore Hill, and on the following Saturday there is a game against Southgate Cricket Club.

The 1st and 2nd XI's are meeting St. Mary's Hospital in the second round of the Hospital Cups on Wednesday, May 20th.

REVIEWS.

AN INTRODUCTION TO DERMATOLOGY. By Sir NORMAN WALKER. Eighth edition. (Edinburgh: W. Green & Son, Ltd.) Price 20*s.* net.

This is now undoubtedly the best of the smaller books on dermatology in the English language, the fact that eight editions have been called for since it was first published in 1899 being an index to its popularity. In this edition, which has been largely re-written, a good deal of new matter has been included without increasing the size of the book, by omitting reference to certain rare conditions.

It is the most readable text-book on any subject with which the reviewer is acquainted, being written in a very easy style, and liberally interspersed with amusing anecdotes and dry remarks which greatly assist the student to appreciate and to remember the points which the author makes.

The standpoint of the whole work is essentially practical, and one feels that the author is drawing from his own experience throughout the book. A sentence on p. 19 gives a clue to the character of the whole work: "There is great scope for the exercise of common sense in the practice of dermatology."

A special feature is the number and excellence of the illustrations. Although there are only 362 pages of text, there are no less than 92 plates and 80 smaller illustrations. The vast majority of the plates are coloured and most lifelike (although a few are rather too bright), so that the book almost forms an atlas of the commoner skin diseases. The coloured plate of urticaria appears to be upside down, so that by an optical illusion the lesions appear depressed instead of elevated.

One or two points may be mentioned on which the author's views are opposed to those generally accepted, viz. his contention that alopecia areata is a contagious disease, that psoriasis is only a dry form of seborrhœa, and that there is no such disease as eczema. These are, however, minor points, and to a student who is aware of the views generally held they only add to the interest of the work, which is one that can be thoroughly recommended.

AIDS TO PSYCHIATRY. By W. S. DAWSON, M.A., M.D.(Oxon.), M.R.C.P.(Lond.), D.P.M. (Baillière, Tindall & Cox.) Pp. 309. Price 4s. 6d. net.

A knowledge of normal and abnormal psychology cannot possibly be obtained by the perusal of a condensed or elementary account of the subject; for in no subject is a complete and leisurely description more necessary than in psychiatry. An abbreviated account must therefore be either thickly obscure, or so simple that what it has to tell is known already by everyone. This book—certainly not obscure—presents, however, the subject in an orderly fashion, which will serve to render less nebulous and more concrete the ideas of a reader new to the study of mental diseases, while to the man up for his Finals it may prove of assistance as a rapid mode of revision.

Diagnosis and treatment are very much in evidence, unlike the cursory fashion in which these all-important divisions are treated in the larger books. There is a useful chapter on the mental disorders associated with physical disease, and there are some welcome paragraphs on tests for mental deficiency. In an early part of the book is traced the gradual development of psychological thought to its culmination in the theories of Freud and Jung, and this knowledge is applied to all the problems of psychiatry, from the beginning of the book to the end—a great change from the ordinary text-book, where these theories are strictly confined to one short chapter or paragraph, or even omitted entirely. The insertion of statements such as the following may, however, drive some people back to the old conventional text books on insanity: Chapter XI—"the sublimation of sadistic impulses leads to a career as soldier, surgeon or butcher!"

REPORTS OF THE ST. ANDREWS INSTITUTE FOR CLINICAL RESEARCH. Vol. II.

So much has been written recently concerning the late Sir James Mackenzie and his work at the St. Andrews Institute by the most eminent men in the profession that it would be almost impertinent for us to express any opinion on this little volume, which records some of the work of the Institute.

We feel, however, that we have a right to say that no man so captivated and stimulated the student mind as the late Director of the St. Andrews Institute. The intelligent student always wishes to know the why and the wherefore of symptoms and physical signs; the only real attempt that we know of that has been made so far to answer these questions has been the work carried out at St. Andrews.

The late Sir James Mackenzie always realized the tremendous importance of the general practitioner in the elucidation of the problems of disease processes, and his constant reiteration of this truth did much to counteract the mania for specializing, which is so rife at the present time.

This volume consists of eleven articles, of which six have already appeared in different medical journals. Each one is well written, and the illustrations are excellent. We refrain from any detailed comments, as we feel that it is the duty of every man who is really interested in medicine to read the articles for himself. If, after so doing, any man can say that he has not been stimulated and encouraged to go on with his work, the sooner the better he realizes that he is a drone in the profession.

The future will show the value of this work. Unless we are greatly mistaken it will be an imperishable monument to the memory of one of the great benefactors of the human race.

ACUTE INFECTIOUS DISEASES. By J. D. ROLLESTON, M.A., M.D. (William Heinemann [Medical Books] Ltd.) Pp. 376. Price 12s. 6d. net.

Anything that such an authority as Dr. J. D. Rolleston may write on infectious diseases is bound to be interesting. On receiving this book we wondered whether, at the present time, when most text-books of general medicine devoted so much space to the acute infectious diseases, there was really much justification for writing a special text-book on those conditions. Having read the book our doubts are no longer present. The author gives a more vivid and real picture of the various diseases with which he deals than any that we have hitherto seen. He is to be congratulated on having given a short historical note on each disease—what a lot can be learnt about a disease by knowing the story of how it was first recognized and described! But Dr. Rolleston is not content with the story of the past: he gives an excellent account of all the more recent advances in knowledge. He states in the preface that the work is chiefly clinical in character, but we can safely say that his account of the bacteriology of the different diseases is of extraordinary merit—concise and well set out.

We agree entirely with him as to the absence of any illustrations in the book, for as he says, the cutaneous lesions of these diseases can only be studied properly at the bedside.

If we may venture on a criticism of such an excellent book, it would be that the incubation period and the quarantine period of the different diseases be set out more prominently. This book will be used extensively, and it would be greatly to the convenience of its readers were this small matter attended to in the next edition.

It is almost superfluous to recommend this book to all medical men—students as well as qualified men.

THE MEDICAL YEAR-BOOK AND CLASSIFIED DIRECTORY, 1925. (London: William Heinemann (Medical Books) Ltd.)

It is quite impossible to "review" a publication such as this. Perhaps nothing better can be said of this second annual issue than that, if it is possible, it is even better than the first issue. It is a veritable mine of information on medical matters; there is scarcely anything appertaining to the profession which it does not contain. It is, indeed, a "Medical A.B.C.," "Whitaker" and "Who's Who" combined. We strongly recommend it to all practitioners and consultants; if they buy this year's issue there will be no need to recommend next year's to them, for they will have ordered their copy in advance.

THE ROUTINE EXAMINATION OF THE EYE. By BASIL LANG. (Edward Arnold & Co.) 6s. net.

This small book forms a most complete and careful account of the necessary steps whereby the eyes may be fully and accurately examined. It is lucidly written and well illustrated, the many small but important details both of practice and theory which are embodied adding to its value.

Thorough examination is essential that all the facts required for sound diagnosis and treatment may be obtained, and these are only to be had by a complete and methodical system of procedure.

By such means the examination is fuller and yet shorter, and this book provides a very good plan on which such examination should be made. The printing and general outlay are well in keeping with the soundness of the text.

CORRESPONDENCE.

ROYAL MEDICAL BENEVOLENT FUND.

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

DEAR SIR, Whilst fully recognizing the claims of Epsom College referred to in "Third Chip's" valuable notes on General Practice in the March number of the JOURNAL, will you allow me to remind your readers that there is another great medical charity both deserving and requiring their support.

I refer to the Royal Medical Benevolent Fund, which makes grants of money to distressed members of the profession, their widows or orphans, and also provides annuities for many of them after they have reached the age of 60. In 1922—I have mislaid copies of more recent reports—£4433 was voted to 305 applicants and the annuitants numbered 168. The applications for help are most carefully and sympathetically considered by the Case Committee, which meets every month for the purpose, but the funds at their disposal only allow grants which are as a rule quite inadequate. The accounts are strictly audited by chartered accountants, and the expenses only just exceed 10 per cent.

The work of the Fund is supplemented by the Royal Medical Benevolent Fund Guild, the Ladies' Branch, which does splendid service by visiting the beneficiaries, providing clothing, assisting in sickness, etc.

Recently qualified men who think of marrying and are not unduly rich should certainly, if eligible, join the Society for the Relief of the Widows and Orphans of Medical Men. This is a provident society which, owing to its accumulated funds and the fact that comparatively few of its members leave any dependents in poverty, is able to give help when it is required on a scale which is out of all proportion to the small annual subscription.

Although not connected, both the Fund and the Widows' Society have offices at 11, Chandos Street, Cavendish Square, W.

Yours faithfully,
W. E. SARGANT,
Late Hon. Secretary,
Royal Medical Benevolent Fund.

A REVIEW.

To the Editor, "St. Bartholomew's Hospital Journal."

SIR,—I am wondering who the Olympian individual may be who writes of my *Fundamental Principles of Treatment*, that it tells the student *very little that is new and almost nothing that is useful*. This is a serious statement to make in the journal of a medical school, and if not accurate the writer of it incurs a grave responsibility.

I venture to hope that some of the readers of our JOURNAL may have sufficient curiosity to dip into the book so contemptuously condemned—I have had a copy of it sent to the College Librarian—and judge for themselves as to the justice of your reviewer's pronouncement.

I am, yours, etc.,
HARRY CAMPBELL.

Harley Street;
April 18th, 1925.

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

BARNES, E. BROUCHTON, F.R.C.S.(Edin.). "A Diathermy Snare for the Removal of Post-Nasal Growths." *British Medical Journal*, January 31st, 1925.

BREWERTON, E. W., F.R.C.S. "Operations on the Eye" (*Modern Operative Surgery*, edited by H. W. CARSON, F.R.C.S. London: Cassell & Co., Ltd.)

BULL, L. J. FORMAN, M.B., B.S. "Bilateral Cystic Embryoma of Ovary with Torsion of Pedicle of One Cyst." *British Medical Journal*, January 31st, 1925.

CARSON, H. W., F.R.C.S. Editor of *Modern Operative Surgery*, 2 vols. London: Cassell & Co., Ltd. And author of chapters on "Operations for Abdominal Injuries"; "Operations on the Stomach"; "Operations for Diseases of the Pancreas"; "Splenectomy"; "Operations for Intestinal Obstruction"; "Enterectomy and Intestinal Anastomosis"; "Operations for Cancer of the Large Intestine"; "Operations for Appendicitis and Peritonitis"; "Operations for Hernia"; "Operations for Cancer of the Rectum."

——— "Specimen of Scirrhus Carcinoma of Stomach (Localized Leather-bottle Type)." *Proceedings of the Royal Society of Medicine*, October, 1924.

——— "Specimen of Leio-myo-sarcoma of Fallopian Tube." *Ibid.*, October, 1924.

——— "Specimen from Case of Adenoma of Thyroid." *Ibid.*, October, 1924.

DUNDAS-GRANT, Sir JAMES, K.B.E., M.D. "Larynx Removed for Basal-celled Epithelioma; Patient still under Treatment." *Ibid.*, October, 1924.

——— "Case of Distortion of the Larynx Producing Tracheal Obstruction due to Cicatricial Contraction following an Abscess." *Ibid.*, October, 1924.

——— "Case of Tuberculosis of the Larynx with an Unusual Degree of Involvement of the Base of the Tongue." *Ibid.*, January, 1925.

——— "Case of Hyperplastic Laryngitis." *Ibid.*, January, 1925.

——— "Case of Nævoid Angioma of the Tympanum (? Endothelioma)." *Ibid.*, January, 1925.

EDWARDS, F. SWINFORD, F.R.C.S. Discussion on Prolapse of the Rectum. *Ibid.*, October, 1924.

——— Discussion on the Treatment of Carcinoma of the Rectum. *Ibid.*, October, 1924.

——— Discussion on the Treatment of Hæmorrhoids by Injection. *Ibid.*, October, 1924.

ELMSLIE, R. C., O.B.E., M.S., F.R.C.S. "General Orthopædics: Operations on Tendons; Amputations." (*Modern Operative Surgery*, edited by H. W. CARSON, F.R.C.S. London: Cassell & Co., Ltd.)

EVANS, E. LAMING, C.B.E., F.R.C.S. "Case of Left Unilateral Complete Absence of Tibia." *Proceedings of the Royal Society of Medicine*, September, 1924.

——— "Case of Aneurysm Occurring Eight Years after Gunshot Wound." *Ibid.*, September, 1924.

FORBES, J. GRAHAM, M.D., F.R.C.P., D.P.H. Discussion on Polycystic Disease of the Kidneys. *Ibid.*, October, 1924.

GAUVAIN, Sir HENRY J., M.A., M.D., M.Ch. "Conservative Treatment in Surgical Tuberculosis." (*Modern Operative Surgery*, edited by H. W. CARSON. London: Cassell & Co., Ltd.)

GILLIES, H. D., C.B.E., K.C.M.G., F.R.C.S. "Plastic Surgery" (*Ibid.*)

GORDON-WATSON, Sir CHARLES, K.B.E., C.M.G., F.R.C.S. "Discussion on Prolapse of the Rectum." *Proceedings of the Royal Society of Medicine*, October, 1924.

——— Discussion on the Treatment of Carcinoma of the Rectum. *Ibid.*, October, 1924.

HADFIELD, GEOFFREY, M.D. "Juxta-ampullary Carcinoma of Wirsung's Duct." *British Journal of Surgery*, January, 1925.

HARMER, W. DOUGLAS, M.A., M.B., M.C., F.R.C.S. "Operations on the Nose and Pharynx." (*Modern Operative Surgery*, edited by H. W. CARSON, F.R.C.S. London: Cassell & Co., Ltd.)

HEWER, C. LANGTON, M.B., B.S., M.R.C.S., L.R.C.P. "Ethylene Anæsthesia, with Observations upon 120 Administrations." *Lancet*, January 24th, 1925.

HEY GROVES, ERNEST W., B.Sc., M.D., M.S., F.R.C.S. "Fracture Operations." (*Modern Operative Surgery*, edited by H. W. CARSON, F.R.C.S. London: Cassell & Co., Ltd.)

HORDER, Sir THOMAS, Bart., M.D., F.R.C.P. "The Influence of Radiology upon our Conceptions of Disease." *Proceedings of the Royal Society of Medicine*, October, 1924.

——— Discussion on Polycystic Disease of the Kidneys. *Ibid.*, October, 1924.

——— "The Electronic Reactions of Abrams." *British Medical Journal*, January 24th, 1925.

JONES, W. HOWARD, M.D. "The Use of Chloroform and the Misuse of Ether." *Proceedings of the Royal Society of Medicine*, October, 1924.

JUST, T. H., M.B., B.Ch., F.R.C.S. "Operations on the Œsophagus." (*Modern Operative Surgery*, edited by H. W. CARSON, F.R.C.S. London: Cassell & Co., Ltd.)

LEATHART, P. W., B.A., M.B., Ch.B., M.R.C.S., L.R.C.P. "The Lymphoid Apparatus as a Culture Centre for Septic Organisms." *Proceedings of the Royal Society of Medicine*, November, 1924.

LYSTER, R. A., M.D., B.Sc., D.P.H. Discussion on The Notification of Puerperal Sepsis. *Ibid.*, January, 1925.

MCDONAGH, J. E. R., F.R.C.S. "Case of Diabetic Xanthoma treated with a Sulphur Compound of Histidine (Thiol-amino-methyl-glycoxaline)." (Abstract.) *Ibid.*, December, 1924.

MILES, W. ERNEST, F.R.C.S. Discussion on Prolapse of the Rectum. *Ibid.*, October, 1924.

——— Discussion on the Treatment of Carcinoma of the Rectum. *Ibid.*, October, 1924.

PAPADOPOULOS, S. G., M.B., B.S. "A Case of Tonsillectomy in a Boy with Congenital Heart Disease." *Lancet*, January 24th, 1925.

POWER, Sir D'ARCY, K.B.E., F.R.C.S. "Eponyms: Macewen's Osteotomy." *British Journal of Surgery*, January, 1925.

RAWLING, L. BATHE, B.A., M.B., B.Ch., F.R.C.S. "Operations on the Skull and Brain." (*Modern Operative Surgery*, edited by H. W. CARSON, F.R.C.S. London: Cassell & Co., Ltd.)

RUSSELL, H. G. BEDFORD, M.A., B.Ch., F.R.C.S. "Operations on the Larynx and Trachea." *Ibid.*

SCOTT, SYDNEY, M.S., F.R.C.S. "Operations on the Ear." (*Ibid.*

——— Discussion on "Naso-Pharyngeal Growths." *Proceedings of the Royal Society of Medicine*, October, 1924.

——— Discussion on Otological and Rhinological Problems in Scarlet Fever and Measles. *Ibid.*, October, 1924.

SPICER, FREDERICK, M.D. "Branchial Cyst in Fauces." *Ibid.*, October, 1924.

SPILSBURY, Sir BERNARD, M.B. Discussion on Polycystic Disease of the Kidneys. *Ibid.*, October, 1924.

TWEEDIE, A. R., F.R.C.S. "Vertigo in Relation to the 'Otolith' and 'Neck' Reflexes." *Ibid.*, October, 1924.

VERRALL, P. JENNER, F.R.C.S. "Operations on Joints." (*Modern Operative Surgery*, edited by H. W. CARSON, F.R.C.S. London: Cassell & Co., Ltd.)

WALKER, KENNETH M., F.R.C.S., M.A., M.B., B.C. "Specimen of a Kidney Removed Five Months after Decapsulation." *Proceedings of the Royal Society of Medicine*, October, 1924.

WALKER, KENNETH M., F.R.C.S., M.A., M.B., B.C. "Per-Urethral Operations for Prostatic Obstruction." *British Medical Journal*, January 31st, 1925.

WEBER, F. PARKES, M.D. "Developmental Telangiectatic Hæmorrhage and so-called 'Telangiectasia'—Familial and Non-Familial." *British Journal of Children's Diseases*, July–September, 1924.

——— "A Law Regarding the Distribution of the Depigmented Leucodermic Patches of Vitiligo when they are superadded to Mole-like Nævi." *Ibid.*, July–September, 1924.

——— "Pemphigus Limited to Mouth and Larynx." *Proceedings of the Royal Society of Medicine*, October, 1924.

——— Discussion on Polycystic Disease of the Kidneys. *Ibid.*, October, 1924.

——— "Xanthosis of Hands and Feet in Diabetes Mellitus ('Ochrodermatosis' of Castellani, 'Xanthochromia cutis' of French Authors)." (Abstract.) *Ibid.*, December, 1924.

——— "A Case of Cutaneous Neurofibromatosis (Recklinghausen's Disease) with a Left Lateral (Suprazygomata) Meningocele simulating a Soft Fibromatous Fold of Skin." *Ibid.*, January, 1925.

WHITEFORD, HAMILTON, M.R.C.S., L.R.C.P. "Some Unusual Surgical Cases." *Medical Press and Circular*, January 14th and 21st, 1925.

WOODMAN, E. MUSGRAVE, M.S. Discussion on Naso-Pharyngeal Growths. *Proceedings of the Royal Society of Medicine*, October, 1924.

YATES, A. LOWNDES, M.D., F.R.C.S. "Methods of Estimating the Activity of the Ciliary Epithelium within the Sinuses." (Abstract.) *Ibid.*, October, 1924.

——— Discussion on Naso-Pharyngeal Growths. *Ibid.*, October, 1924.

EXAMINATIONS, ETC.

UNIVERSITY OF LONDON.

Second Examination for Medical Degrees. March, 1925.

Part I.—A. M. Boyd, W. R. Burrows, S. G. Collingwood, D. L. Croft, F. A. Edwards, A. D. Everett, A. P. Gaston, R. L. W. Harris, K. W. D. Hartley, L. Newblatt, A. W. Patton, I. Preiskel, R. K. Price, R. A. C. Rice, H. L. Rogerson, J. D. Scott, J. Marshall Scott,* E. M. Sharples, D. Warshawsky, J. O. Williams, T. C. Yip.

* Awarded a mark of distinction.

Part II.—H. L. W. Beach, A. C. H. Bell, N. E. Cook, W. P. M. Davidson, G. A. S. Harris, D. A. Langhorne, B. J. Lovely, A. M. McMaster, C. P. Moore, M. Mundy, K. F. Phillips, I. M. Robertson.

CONJOINT EXAMINING BOARD.

First Examinations. April, 1925.

Chemistry.—D. H. Edwards, E. N. Jenkinson, B. F. Powell.
Physics.—E. N. Jenkinson.
Elementary Biology.—E. N. Jenkinson, P. J. StH. L. Maudesley.

Pre-Medical Examination.

Chemistry.—T. H. N. Whitehurst, H. L. Hodgkinson.
Physics.—J. A. Mansi.

Second Examination.

Part I. Anatomy and Physiology.—D. W. Cooke, D. Kettle, K. Knowles, E. G. Laurence, A. Liberis, F. W. Linton-Bogle, P. I. Peltz A. de la C. Russeau, C. Wroth.
Anatomy only.—J. T. C. Gray, S. Kaul, N. F. Kendall, C. P. Madden, C. J. Sanderson, D. Stephens, R. Zeitlin.
Physiology only.—L. G. M. Page.
Part II. Pharmacology and Materia Medica.—H. H. Boyden, I. Byer, A. L. Climer, M. Gamboa, H. W. Guinness, F. R. I. B. H. Kennedy, J. E. Phelps, F. G. V. Scovell.

CHANGES OF ADDRESS.

AINSWORTH-DAVIS, J. C., Oakfields, Kingsbury, N.W. 10.
ENZER, A. J., c/o P.M.O., Kenya, East Africa.
HIGGINS, A. G., Willingham, Cambridge.
LEWIS, I. C., c/o Dr. Grove, St. Ives, Huntingdon.
MAXWELL, J. P., 69, Melbury Gardens, Raynes Park, Wimbledon, S.W.
ROCHE, A. E., St. Peter's Hospital, Henrietta Street, Covent Garden, W.C. 2.
WOOD, J. H., Thornton Rust, Aysgarth, North Yorkshire.

APPOINTMENTS.

BOKENHAM, T. J., M.R.C.S., L.R.C.P., appointed Assistant Radiologist to the Middlesex Hospital.

CHALKE, H. D., M.R.C.S., L.R.C.P., appointed House-Surgeon to the Devonshire Hospital, Buxton.

CHAMBERS, H., M.R.C.S., appointed Anæsthetist to the Freemasons' Hospital and Nursing Home.

CHESTER-WILLIAMS, F. E. M.R.C.S., L.R.C.P., appointed House-Surgeon to the Royal Albert Dock Hospital (Seamen's Society).

CHRISTOPHERSON, J. B., M.B., B.Ch.(Cantab.), appointed Physician for Tropical Diseases at the Freemasons' Hospital and Nursing Home.

FERENCH, F. G., M.D., F.R.C.S.(Eng.), M.R.C.P., appointed Dermatologist to London Temperance Hospital.

FRENCH, J. G., F.R.C.S., appointed Surgeon for Diseases of the Throat and Ear to the Freemasons' Hospital and Nursing Home.

GASPERINE, J. J., M.R.C.S., L.R.C.P., D.P.H., D.P.M., appointed Medical Superintendent at Rendlesham Hall, Woodbridge.

HALL, PERCY, M.R.C.S., L.R.C.P., appointed Hon. Actino-Therapist to Mount Vernon Hospital.

RIVETT, L. C., F.R.C.S., appointed Gynæcologist to the Freemasons' Hospital and Nursing Home.

ROBERTS, W. E., Surg.-Comdr. R. Australian Navy, reappointed P.M.O., H.M. Australian Naval Hospital, Westernport, Victoria, Australia.

BIRTHS.

BROUGHTON-ALCOCK.—On April 12th, at 20, Grosvenor Street, W. 1, to Marion, wife of Dr. W. Broughton-Alcock—a daughter.

CHURCHILL.—On March 24th, at 16, Devonport Street, Hyde Park, to Kathleen, wife of Henry J. Churchill—a son.

HAYMAN.—On March 26th, at 52, Caister Road, Great Yarmouth, to Mary (*née* Edwards), wife of F. Keith Hayman, F.R.C.S.—a son.

ILOTT.—On March 28th, at 1, Garden Road, Bromley, Kent, to the wife of Cyril H. Ilott, M.B.—a daughter.

LYSTER.—On April 4th, at Great Baddow, Essex, to Erica (*née* Neal), wife of Ronald Guy Lyster, M.B., B.S.—a son.

RIVIERE.—On March 28th, at St. Giles Plain, Norwich, to Veronica, wife of Bernard B. Riviere, F.R.C.S.—a son.

ROSSDALE.—On March 31st, at 57, Upper Berkeley Street, to Kate, wife of Dr. George Rossdale—a son.

MARRIAGE.

THURSTON—CARRINGTON.—On Tuesday, March 31st, 1925, at the Chapel of the Savoy, Colonel Hugh Stanley Thurston, C.B., C.M.G., C.B.E., to Angela Doreen, daughter of Brigadier-General H. E. H. Bland, C.B., C.M.G.

DEATHS.

DUDFIELD.—On April 10th, 1925, from appendicitis, in London, Samuel Reginald Orme Dudfield, O.B.E. (Mil.), late Capt. R.A.M.C., M.A., M.B., D.P.H., F.S.S., M.O.H. for Paddington for 30 years, aged 64.

HUSBAND.—On March 26th, 1925, at May Bank, Clevedon, Somerset, Walter Edward Husband, M.R.C.S., L.R.C.P.(Lond.), eldest surviving son of the late William Dalla Husband, F.R.C.S., J.P., D.L., of York, aged 69.

ROBINSON.—On February 17th, 1925, Alfred Robinson, M.D.(Durh.), of Rotherham.

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. 1.*

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.*

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St. Bartholomew's Hospital Journal.

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

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CALENDAR.

Mon., June 1. Cricket Week Commences at Winchmore Hill *v.* Croydon C. C. 11.30.
Tues., ,, 2.—Prof. Fraser and Prof. Gask on duty.
Cricket Match *v.* M.C.C. Home. 11.30.
Wed., ,, 3.—Clinical Surgery Lecture, Sir C. Gordon-Watson.
Cricket Match *v.* R.A.M.C. (Aldershot). Home. 11.30.
Tennis Match *v.* Kings College Hospital. Home.
Thurs., ,, 4.—Cricket Match *v.* Old Cholmelians. Home. 11.30.
Fri., ,, 5.—Medicine Lecture, Sir Thomas Horder.
Dr. Morley Fletcher and Sir Holburt Waring on duty.
Cricket Match, Past *v.* Present. Home. 11.30.
Sat., ,, 6.—Cricket Match *v.* St. Albans C.C. Home. 11.30.
Mon., ,, 8.—Special Subject Lecture, Mr. Elmslie.
Tues., ,, 9.—Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.
Wed., ,, 10.—Clinical Surgery Lecture, Sir C. Gordon-Watson.
Tennis Match *v.* U.C.H. Away.
Fri., ,, 12.—Sir Thomas Horder and Mr. Rawling on duty.
Clinical Medicine Lecture, Dr. H. Morley Fletcher.
Sat., ,, 13.—Cricket Match *v.* Streatham C.C. Home. 2.0.
Mon., ,, 15.—Special Subject Lecture, Mr. Just.
Tues., ,, 16.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Wed., ,, 17.—Tennis Match *v.* Guys Hospital. Home.
Thurs., ,, 18.—**Abernethian Society. Mid-Sessional Lecture. Sir Arthur Keith: "Something Ancient."**
Fri., ,, 19.—Prof. Fraser and Prof. Gask on duty.
Clinical Medicine Lecture, Dr. Langdon Brown.
Sat., ,, 20. Cricket Match *v.* U.C.S. Old Boys. Home. 11.30.
Mon., ,, 22.—Special Subject Lecture, Mr. Harmer.
Tues., ,, 23.—**Last day for receiving matter for July issue of Journal.**
Dr. Morley Fletcher and Sir Holburt Waring on duty.
Wed., ,, 24.—Clinical Surgery Lecture, Mr. L. Bathe Rawling.
Tennis Match *v.* Cumberland L.T.C. Away.
Fri., ,, 26.—Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.
Clinical Medicine Lecture, Dr. Langdon Brown.
Sat., ,, 27.—Cricket Match *v.* Hornsey C.C. Home.
Tennis Match *v.* R.M.A. Home.
Mon., ,, 29.—Special Subject Lecture, Mr. Elmslie.
Tues., ,, 30.—Sir Thomas Horder and Mr. Rawling on duty.

EDITORIAL.

WE do not wish to belittle the virtue of punctuality. We are two days late in our appearance this month, and we should be flattered to hear of a riot in the cloak-room. Had we appeared on the first of the month no one would have been there to receive us, it being bank-holiday. Had we appeared two days earlier our readers would have lost at least one interesting article.

We suggest that adequate amends have been made by the addition of an extra eight columns over our usual length.

* * *

We believe that it is not a mere pious hope to say that we expect our readers do not confine their literary browsings exclusively to medical writings. So we expect that a certain sixpenny weekly that has recently burst its brilliance on the journalistic horizon is not unknown to them. We wish to express the sincerity of our flattery by the path of imitation. Would that we had the ability of the large Editor of the weekly and could express our dearest thoughts to the public under such a heading as "Found Squandering," but although this is beyond our powers we feel that a column headed the "Cockpit" would be both useful and entertaining.

Let us amplify our suggestion. In an edition of the JOURNAL published some months ago there was an exceedingly interesting article on the treatment of whooping-cough by means of intra-muscular and rectal injections of ether. We happen to know that behind the scenes quite a considerable correspondence has been carried on upon this line of treatment. But the JOURNAL has not had the opportunity of passing on these subsequent ideas to its readers. Again, we know that the highly provocative article in our last issue giving the writer's opinions on the relative values of appointments has led to much comment, but so far only one dissentient mind has become articulate. We do not wish to wave

red flags at bulls, but we ask you, gentlemen, to fight us and each other in our "Cockpit."

* * *

We wish to congratulate the Warden, Mr. R. M. Vick, on receiving the Territorial Decoration.

* * *

We offer our congratulations to the following Bartholomew's men upon their election as Fellows of the Royal College of Physicians: Dr. J. D. Barris, Dr. F. G. Chandler, Dr. L. J. Davies, Dr. H. H. Scott.

* * *

Also, our hearty congratulations go to Mr. R. S. Johnson on winning the Gold Medal in the London M.B. examination. It was high time that this trophy returned to Bart.'s, our last winner being Dr. C. H. Andrewes. * * *

We wish to congratulate Mr. F. F. Imianitoff on winning the British Medical Associations' prize for this area with an essay on "Chronic Intestinal Obstruction." In a slightly abridged form and robbed of most of its illustrations and addenda we publish it in this number. We are proud to remember that for the last three years a Bart.'s man won this prize and we hope that the honour will be "kept in the family."

* * *

We are profoundly impressed with the possibilities of the amusement park at Wembley as therapeutic agents. The well-known passion of the surgical unit for blue toes has, we hear, led one of its members to take a man so afflicted to the flying boats. After being centrifugalized for two hours, observations (so says our report) were made on the extremities. They were found to be distinctly warmer than before, so a second experiment was made in which the patient was placed in the inner car and in the outer car was a dresser with a thermopile. The failure of the second experiment was put down to the fact that, being in the inner car the peripheral velocity was much less than in the first case. One member of the unit then "thought" while another looked down a microscope, and a third did a blood count. Despite the fact that nothing more dramatic than increased eosinophiles was discovered, pathology has been brought to Wembley and the Dunn lab. sleeps more happily.

* * *

Bertie, the Brontosarus, is a weird animal of doubtful genus, constructed under the guidance of Mr. Pickup Greenwood. He was conducted by Mr. Imianitoff to the Botanic Gardens Old English Fête, where he so stimulated the visitors that £37 10s. was handed over to the contribution department. Mrs. Rosita Forbes, the well-known explorer, was patron of the show and very kindly turned up to see "Bertie" perform.

This is the month of the great invasion. We are to welcome to our midst a number of members of the Interstate Post-Graduate Association of the United States of America. A garden party is to take place in the Square on Thursday, June 4th, for which invitations have been sent by the Treasurer of the Hospital and the President and Council of the Medical College. We hope that the heavens will be as kind as they were on View Day, and that the seats will by then have been painted. Then America should see Bart.'s at its best.

There has been some considerable searching of hearts among the more junior men who have received invitations as to what will be the appropriate attire. We are tempted to suggest that nothing from a morning coat to "plus fours" will be considered out of place.

* * *

The Annual Dinner of the 9th Decennial Contemporary Club will be held at Oddenino's Imperial Restaurant on Wednesday, July 1st. The Secretaries are Dr. Hinds Howell and Mr. R. C. Elmslie.

* * *

It is with deep regret that we record the death of Dr. Howard Tooth, Consulting Physician to this Hospital. An appreciation of his great services to the Hospital and Medical College will be found elsewhere in this issue.

THE POST-SANATORIUM TREATMENT OF PULMONARY TUBERCULOSIS.

AMONG all the problems which meet a man going into practice for the first time, that of the treatment of cases of pulmonary tuberculosis who have newly returned from a period of sanatorium treatment, is one for which his previous experience will help him least. It is also one of the greatest importance, as it is upon the way the post-sanatorium treatment is conducted that the final result will depend. Cases returning from an adequate period of sanatorium treatment may be roughly divided into those in which quiescence of the disease has been established, and those in which it has not. The latter will not be considered here, as it is unlikely that, if at a good sanatorium, the establishment of quiescence has not been achieved, it will be possible to do so by ordinary methods at home.

The first essential is to get an accurate idea of the patient's condition. I want at this stage to emphasize the need for estimation of the condition from two completely different standpoints:

1. That of the amount of toxæmia that is present.
2. That of the condition of the local lesion in the lungs.

1. The average case will be found on examination at this stage to be afebrile, and to have little or no increase of pulse-rate at rest or moderate exertion, to have no malaise, and feel well, a slight or no cough, and little or no sputum, and be at about normal weight; that is to say, have little or no evidence of toxæmia.

2. This will vary enormously with extent of the lesion. Make a careful diagram of the physical signs, especially the amount of retraction of the chest and local wasting. Do not, because you heard added sounds, jump to the conclusion that the medical superintendent of the sanatorium does not know his business: without entering into controversial points, the presence of *râles* is compatible with a healing lesion. Pay particular attention to the undiseased parts of the lungs, and put down accurately in what parts of the lungs the physical signs are normal.

Having thus got as accurate an idea as possible what the condition of the patient is, draw out a complete plan of life for him, keeping as near your ideals as the economic situation permits. There are three factors which will influence the progress of any given patient, and his success in maintaining the quiescence he has achieved, and consolidating it into the arrest that you hope for finally (do not talk about cure, it only creates wrong impressions in your patient).

(1) The patient's economic position: this is outside your control, naturally the better his position the more nearly he can follow your directions.

(2) The character of the patient; the firmer the control he keeps on himself, the more nearly he will follow your directions. "You cannot hope to arrest pulmonary tuberculosis in a fool."

(3) Medical treatment; the patient ought to be under the care of one physician, his general practitioner, who can call in the specialist as difficulties arise, or if special forms of treatment are thought necessary, but the knowledge of his response to work, temperament and type of disease will be much more exact in the man who sees the patient constantly than in the man who is called in occasionally.

The patient should be seen monthly for three years, after apparent arrest three monthly, and his condition reviewed in the light of previous examinations, and his life adjusted in accordance with the estimate formed.

The point should be impressed on the patient that his treatment has only just started, and that his life routine should follow as closely as possible that which he has learnt in the sanatorium.

The axis round which all our treatment revolves, is, that the only real remedy we have at present against the disease is rest in one form or another. Accordingly go carefully into the following points:

*

1. *Work.*—If there is no need for the patient to work, this does not apply. If, as in the majority of cases, there is, study his occupation from the point of the amount of strain on the patient. The work to which a man is accustomed will probably be far less exacting for him than a new occupation at which he is a beginner, and therefore which he will be able to do only with a greater expenditure of mental and physical energy. He will also earn less and therefore probably take more out of himself by worry as to prospects, etc.

The ideal form of work is one at a fixed salary and fixed hours; no form of work on which the patient's earnings are dependent on results or on commission is advisable. The hours should be short, and if possible should provide for a rest in the middle of the day. The surroundings should be light and airy: if possible in a room or office by himself, so that he is the arbitrator of the window question.

2. *Recreation and rest time.*—If the amount of work is higher than is suitable, the leisure time must make up for it by more rest. If the work is very light, more liberty can be allowed in the way of exercise. Very early bed and not too early rising, avoidance of social engagements involving crowds, are the rule. Walking, quiet riding on a quiet horse, if the patient has been previously accustomed to it, bowls, half rounds of golf with a caddy, and light gardening, are suitable types of exercise. No form of exercise that cannot be quickly knocked off if tiredness comes on, is allowed.

If the work is at all strenuous the week-end should be devoted to resting, not exercise; "a good tramp in the open" is not usually as good as a good rest in the open.

Do not allow your patient to start by doing too much at first. He may tell you that at sanatorium he has been doing really hard digging; he may have been, but he probably will not tell you that it was for four hours only, and that fourteen were spent in rest.

3. *Food.*—Do not worry about this, let him eat what he finds suitable within reason, provided that he eats well. He must not neglect or hurry his meals.

4. *Place of residence.*—A dry place in the country, with a large amount of sun, sheltered from very cold winds is the ideal; but do not achieve this at the cost of long and tiring travelling night and morning. Make sure that the patient has an airy room to himself with sufficiently convenient heating arrangements to encourage the window to be kept open, and if he has not a study which is his entirely, and in which he can rest undisturbed, have his bedroom fitted partially as a sitting-room, with a couch so that he can retire there and rest.

5. Look very carefully into the precautions that your patient takes to prevent infecting others, remember that children and young adults are much more susceptible

to infection than the middle aged. Arrangements should be made to overhaul the former periodically, and not merely when the original case is diagnosed.

6. *Symptoms.*—Treat them as they arise. Never forget that it is the symptoms that you are treating and that patients suffering from phthisis can have the illnesses that normal people have.

Having in detail laid down the life that your patient is to lead, watch him carefully for evidence of the failure of the quiescence to be maintained and consolidated, as judged by the criteria given later. If you are not satisfied that all is well, ascertain by careful enquiry and inspection (if necessary) that the *régime* advised is being carried out. If not, try and get the faults rectified. If the *régime* ordered is being followed, the amount of rest is too small and must be increased at the expense of exercise or work. This, if carried out sufficiently and soon enough, will probably be successful. If this fails, the question of other special forms of treatment or of a further period of sanatorium must be considered, but remember that the second period of sanatorium is seldom as efficient as the first in obtaining quiescence. Refrain from being too ambitious in your programme of work and exercise. It can easily be increased. It is discouraging to the patient to decrease it, although it may be necessary if the progress is not satisfactory.

The estimation of the progress of the disease is based:

1. On the symptoms indicating toxæmia.

2. On the symptoms and signs indicating the condition of the local lesion.

The former is by far the more important.

1. (*a*) *Malaise.* There is apt to be at first an increase of tiredness on getting back to work, especially if the change has been rather abrupt and if there is a general lack of tone, but this should quickly pass off. If it persists, or listlessness or tiredness appear as a fresh symptom, it is an indication that more rest should be insisted on.

(*b*) *Temperature.*—A morning and evening record is very useful and should be used, unless the patient is unduly introspective. A chart is more valuable than a simple record, as an increase in the difference between morning and evening records may appear before actual pyrexia. The record can be regarded as accurate in contradistinction to the temperatures taken in the diagnosis stage, as the patient will have learnt to keep accurate records at sanatorium. A definite evening pyrexia above 99° must never be disregarded.

(*c*) *Weight.*—An accurate weekly record must be kept; the patient weighed on the same scale and in the same clothes. On return from sanatorium there is usually a fall of a few pounds, but the weight should quickly settle, and if a persistent fall occurs after this, it is the precursor of re-activity.

2. The symptoms referable to the local lesion which require notice are:

(*a*) *Dyspnœa.*—This is of little or no importance. With the increase of fibrosis, which is our object, there may be a slow increase of dyspnœa. This may be regarded as favourable rather than the reverse, and should occasion no anxiety.

(*b*) *Cough.*—The conditions of open-air life tend to reduce the cough, apart from the condition of the disease and its reappearance on return need not cause undue anxiety. The reappearance later of a cough which cannot be accounted for by condition of the throat and nose or bronchitis, or if thought to be due to these conditions does not disappear on suitable treatment, should lead to redoubled vigilance on the points already mentioned.

(*c*) *Sputum.*—The recurrence of a little morning mucoid sputum is usual on return from sanatorium, but having appeared it should not increase persistently or become more purulent.

(*d*) *Pleurisy.*—Undoubted pleurisy especially if recurrent, should be looked on as definite evidence of reactivity.

(*e*) *Hæmoptysis.*—An isolated slight hæmoptysis, or repeated, if at long intervals may quite well come from a healing lesion and need not in itself give rise to alarm. If repeated frequently, however, they give much anxiety and disability to the patient, and the advice of a specialist on the suitability for pneumothorax should be taken.

The physical signs of a breakdown of quiescence are very equivocal even to the expert. As fibrosis proceeds the signs in the diseased area may become more pronounced; concentrate therefore on the part of the lungs which you have previously found to be clear. Any extension of the lesion must receive prompt treatment. A single radiographic examination of a patient's lungs seldom will be of much help in deciding on the progress of the disease in a difficult case. The greater the experience of the radiologist, the greater will be his diffidence in expressing a definite opinion. If cases in which it can be afforded, it is worth while to have a film taken by a radiologist who specialises in lung work when the patient returns home, and filing it for comparison later if occasion arises. From the difference very much more useful information can be obtained, but if possible have both films taken by the same man.

The post-sanatorium treatment of cases is a long business, but surprisingly good results will be obtained if the patient's medical attendant is persevering and continuously watchful.

There are three main points in the treatment of pulmonary tuberculosis till the day arises when a specific cure is discovered.

1. Early diagnosis. 2. Efficient post-sanatorium treatment. 3. Efficient sanatorium treatment; in this order of importance, and it is thus the general practitioner who can do the most in combating the disease.

F. H. YOUNG.

THE DIAGNOSIS AND TREATMENT OF CHRONIC INTESTINAL OBSTRUCTION:

WITH THREE ILLUSTRATIVE CASES.

[Being the major part of the Prize Essay in the British Medical Association's competition for this year.]

IT is reported that Laennec the immortal founder of modern medicine, once prefaced a clinical lecture with the following apparent paradox: "The description or explanation of a symptom, if it is to be methodical and scientific, must needs be built up on a classification based on the anatomy and the physiology of the parts in question." The full force of this truism was very vividly brought back to us in our preliminary reflections on the subject-matter of this essay.

For we are of opinion that—whatever he said or done by practitioners, unfortunately too often and too easily satisfied when they have pigeon-holed a "case" under that very unsatisfactory label of Chronic Intestinal Obstruction—that in chronic obstruction we have to deal with a very definite aggregate of symptoms, one which always recurs as a complete and well-defined syndrome, however much the causes thereof may vary, and however much its recognition may be obscured by superimposed signs that are peculiar to some of these causes. And it was our original purpose, in planning this essay out, to adopt the following modification of Russell Howard's classification (2), and to deal successively with chronic obstruction due to—

A. Conditions, outside the lumen of the gut, that cause hindrance to the passage of food or fæces.

B. Conditions, within the walls of the gut, that cause hindrance to the passage of food or fæces.

C. Conditions, within the lumen of the gut, that cause hindrance to the passage of food or fæces.

D. Displacements of the gut or of portions of the gut that cause hindrance to the passage of food or fæces.

E. Changes in the peristaltic movements of the gut that cause hindrance to the passage of food or fæces.

But difficulties loomed large on considering the limits imposed to the size of this essay, and we then thought of finding some table or statistics which, based on the figures of occurrence, would provide us with a smaller division of this, our subject, and also enable us to cover the whole ground with only three illustrative cases.

Here, again, we were to be disappointed, for we were unable to find any such statistics.

We then collected cases from the wards of this Hospital, in order to draw up the table we needed, taking care to include in our list only such cases as presented a clear picture of chronic obstruction, either on admission, or at some time previous to it. The following are the figures for the years 1922–1924:

Total number of cases.—71.

Chronic obstruction due to—

A.	*Conditions outside the lumen of the gut:*		
	1. Post-operative adhesions and kinks	8 = 13·33	per cent.
	2. Lumbar abscess	3 = 5	,,
	3. Extra-peritoneal growths (sarcoma)	1 = 1·66	,,
B.	*Conditions within the wall of gut:*		
	1. Diverticulitis	5 = 8·33	,,
	2. Carcinoma: 27 = 70 per cent. — Small intestine	1 = 1·66	,,
	Ascending colon	6 = 10	,,
	Transverse ,,	7 = 6·66	,,
	Descending ,,	13 = 21·66	,,
C.	*Conditions within lumen of gut:*		
	1. Foreign objects (gall-stone and safety-pin)	2 = 3·33	,,
	2. Intra-tubal growth (polyp in sigmoid colon)	1 = 1·66	,,
D.	*Displacements of the gut:*		
	1. Strangulation through old wound	1 = 1·66	,,
	2. Visceroptosis	17 = 23·33	,,
E.	*Changes in peristalsis:*		
	1. Intestinal stasis	3 = 5	,,
	2. Hirschsprung's disease	1 = 1·66	,,
F.	*Undiagnosed:*	2 = 3·33	,,

After careful consideration we decided to present the following three cases: (1) A case of carcinoma of the sigmoid colon; (2) a case of diverticulitis; and (3) a case of visceroptosis.

We foresee the following objections to our choice: (*a*) "Why have you left out of your classification all cases of obstruction in the rectum?" and (*b*) "Why, if choosing cases typical of the more frequent causes of chronic obstruction, do you not quote such a case as might be due to kinking or partial obstruction of bands; rather than presenting two patients suffering from affections of the *wall* of the gut, as are Cases I and II?"

To the first objection we can reply as follows: Although all cases of rectal obstruction have, at some time or other, the symptoms of chronic obstruction, yet

the clinical picture is but very rarely clear. Either the dyschezia becomes, soon after its onset, completely hidden by the more striking and severe symptoms of malignancy (the most frequent cause), *e. g.* the passage of blood or pus; or else, what we should like to call "the tripod of cardinal symptoms of chronic intestinal obstruction" is lost sight of by both doctor and patient in the face of severe local pain, the condition of neighbouring organs, or of the symptoms caused by an early-occurring attack of acute obstruction.

The nature of the cases we have had under our immediate supervision also influenced us greatly in our choice of the conditions hereafter reported, and the frequency of errors in the differential diagnosis between the very serious condition of malignant new growth and such comparatively benign affections as chronic diverticulitis also seemed a powerful argument in favour of our giving an example of each disease, so as to emphasize, if possible, the various pitfalls into which one may be led.

As to cases of kinks and strangulation by bands, these, for the most part, only came under medical attention when the condition had become acute, and in numerous other cases pain was the only symptom complained of by the patient (5). This distortion of the "tripod of symptoms," we thought, was another good reason not to emphasize too much this cause of chronic intestinal obstruction.

CASE 1.—*A case of carcinoma of the sigmoid colon.*

Mrs. Phoebe H—, æt. 31. Early 1921, periods of constipation.
Early 1922, suffers from diarrhœa, sickness, abdominal pain and constipation.
Early 1923, patient noticed tumour in left side. Continuous epigastric pain.
Late June, 1923, increasing difficulty with bowels. Diarrhœa ceased. Tumour enlarges and is diagnosed as carcinoma.
August 1st, 1923, exploratory laparotomy; partial excision of colon with lateral anastomosis; cæcostomy.
September 10th, 1923, patient discharged.
November 23rd, 1924, patient followed up: well; no recurrence.

INTERPRETATION.

The above is a perfectly simple and straightforward case. It is one of early carcinoma properly diagnosed, satisfactorily excised and free from recurrence. Several points are well illustrated by it and are worthy of notice. We wish to draw attention to the very early onset of symptoms a point which we shall develop later. The only other point worth mentioning here is the relatively unsatisfactory result of cæcostomy as a means of draining the alimentary tract. In 29 cases in which this operation was recently performed at this Hospital, 19 proved to be unsatisfactory, 3 cases gave but moderately good results, while the remaining 7 proved to be useful, functioning artificial ani.

Having established by the table given in the introduction that carcinoma of the large intestine is one of the frequent causes of chronic intestinal obstruction, there still remain for us to decide exactly in which part of the bowel it was of commonest occurrence. The table gave a percentage of 58·3 for the descending colon and of 25 for the ascending colon. But firstly, as these 27 cases were only those in which a clear picture of chronic obstruction was present, and secondly, as that number was so very small, it was thought wise to find some more authoritative statistics to help in our choice of the case.

J. R. Tuttle gives the following classification of 2431 malignant tumours of the intestine:

Carcinoma of the rectum, 1690.
" of cæcum and ascending colon, 283.
" of the sigmoid colon, 182.
" of the transverse and descending colon, 160.
" of the appendix, 60.
Neoplasms of the ileum, 37 (22 cases of sarcoma).
" " jejunum, 14 (12 cases of sarcoma).
" " duodenum, 5 (1 case of sarcoma).

From other sources in the literature we get the following figures for 1404 cases of carcinoma of the large intestine (rectum excluded):

Carcinoma of the ascending colon and hepatic flexure, 566 = 40·3 per cent.
Carcinoma of the pelvic and descending colon (including splenic flexure), 577 = 40·6 per cent.
Carcinoma of the transverse colon, 267 = 19 per cent.

The sigmoid colon, together with the cæco-colon, form the two sites of normal stagnation of the intestinal contents, and are also the sites of greatest sensitiveness.

A word must be said of the macroscopic aspects of malignant growths, as they have a distinct bearing on chronic obstruction. There are two types of carcinoma that affect the bowel. The one is the scirrhus and the other the encephaloid tumour. The appearance they present is very constant; while the harder tumour mostly adopts the annular, laterally expanding type, the softer form of the disease projects into the lumen of the bowel in the form of friable vegetations. The obstruction to the passage of food and fæces is obvious in the case of vegetating growth. Its nature is also easily understandable; a progressively growing tumour projecting into the lumen of the tube must bring about progressive retardation of the flow of contents. This retardation, from the fact that it is slowly increasing and constantly present, gives rise to the symptoms of chronic obstruction.

Similarly in the scirrhus type of growth, the lateral infiltration of the wall of the bowel first produces a hardening of a segment of the gut-tube. This in itself is sufficient to bring about a certain amount of obstruction, for if local induration takes place in a tube having actively contracting walls, retardation of the transit of the contents always takes place. It was very clearly brought home to us by a simple little experiment we tried, namely, of interposing a segment of glass tubing in the middle of an indiarubber pipe, along which we forced pultaceous matter by manually compressing the rubber. Marked arrest of the flow took place at the site of the glass segment, which represented the annular type of growth.

The reason why we should expect chronic obstruction in all cases of carcinoma seems very clear to us from a consideration of the above-mentioned facts; and if these are true we ought to be able to recognize the symptoms of this condition from the very earliest onset of the disease.

The recognition of malignancy has now become one of the cardinal landmarks in the Science of Healing, and much has been written on the subject of diagnosis. We wish to stress the necessity for X ray investigation in all cases, and the importance of *visual* evidence of the nature of the tumour when laparotomies are performed.

As to treatment, the claims of X-ray therapy, radium-therapy and Curie-therapy (the excellent name now used in France for deep X-ray treatment) are not yet sufficiently supported to merit more than a mere mention and an expectant watchfulness. Purely medical means have proved to be of no avail, and even the quasi-Maskelynian magic boxes of recent repute have failed to give results worthy of serious consideration. At the present moment we must still fall back on the surgeon's knife as the sole panacea in this dilemma of science.

CASE 2.—*A case of chronic diverticulitis.*

Mrs. Elizabeth D—, æt. 65. 1895–1915, patient suffered from biliousness.
1922, patient has henceforth been chronically constipated.
November, 1923, attack of coffee-ground vomiting.
December, 1923, attack of distension. Treated at Metropolitan Hospital with enemata.
May, 1924, patient noticed a "lump in stomach." This grew more and more painful.
June 10th, 1924, twisting pain in site of tumour. Patient came up to hospital. Recommended for admission.
June 21st, 1924, exploratory laparotomy and transverse colostomy. Tumour diagnosed by hand as carcinoma.
July 2nd, 1924, retraction of colostomy. Operation to pull it out and colostomy opened.
July 17th, 1924, colostomy under tension again. Operation to relieve tension.
August 1st, 1924, patient discharged, to come in again for removal of tumour.
October 1st, 1924, *Operation:* Resection of iliac colon and end-to-end anastomosis. Tumour found to be chronic diverticulitis.
November 2nd, 1924, patient discharged. To come up toward latter part of January to have colostomy closed.

INTERPRETATION.

Although, as is shown by the figures quoted in the introduction, diverticulitis is not one of the most frequent causes of chronic intestinal obstruction, yet the above-mentioned case is very instructive. First of all it shows how much the clinical picture of diverticulitis may resemble that of a malignant neoplasm, and then, much can be learnt from the error of diagnosis which was made—one which happily proved to be of but little consequence to the patient. X-ray examination of the gut was omitted in view of what was considered a sure, true clinical diagnosis.

We have here a striking illustration of how very closely a diverticulitis can simulate a carcinoma. Luckily for the patient, the condition was ultimately recognized and successfully treated.

We base our conception of diverticulitis on Jordan's masterly exposition of the pathology of this condition. He says: " . . . Colitis always precedes diverticulitis. This condition is found in those who lead strenuous lives and seldom among those born to wealth and ease. The catarrhal state of the mucous membrane induces tight haustral constrictions of the bowel, with exaggerated sacculations between the haustra—in fact the condition known as 'false diverticulitis.' After this condition has persisted for some time it becomes permanent, the haustra never relax, and the lumen of the bowel never opens fully. The bowel forces its contents through the narrow lumen in small amounts suspended in mucus.

"The iliac colon is the part of the large intestine where bands form first (Lane's 'first and last kink'), and, from long-continued catarrh, becomes tightly and persistently contracted. Hence the iliac colon is by far the most frequent seat of diverticulitis. After a time small-cell infiltration takes place, which leads to a palpable tumour. The saccules lose their muscle coats at this stage, for—

"1. The whole bowel is sodden.
"2. The circular muscle, owing to spasm, contracts down to the bowel wall at the base of the saccule, leaving its side bare of muscle.
"3. The muscle-layer which covers the saccule is attenuated by pressure from within the bowel, and is gradually absorbed. . . ."

This, we think, is a rational, true and complete explanation of the origin of diverticulitis, of its pathology, and accounts for its most usual situation. Jordan goes on to say:

" . . . The catarrh which leads to colitis is very obstinate, and it takes all the resources of the physician to cure or lessen it. The catarrh itself is due primarily to stasis of the large intestine, and secondarily to microbic infection. Diverticulitis is therefore a special manifestation of stasis. . . ."

Here, however, we cease to agree with him, arguing

that his explanation of the original catarrh is dogmatic and empirical. This condition may be due to several other causes, *e. g.* to irritation of the mucous membrane by solid, undigested particles of food, and other slight mechanical injuries; to a local toxæmia; to weakening of the resistance of segments of the bowel by minute infarctions; to microbic infection *per se*, etc. And generally, we think that the deductions he draws to arrive at the conclusion that "diverticulitis is a special manifestation of stasis" is a misinterpretation of cause and effect. Why should not diverticulitis

FIG. 18. SKIAGRAM OF BARIUM MEAL IN AN UNUSUAL CASE OF DIVERTICULITIS.

develop quite independently from a pre-existing stasis? And then, if this is possible, once that diverticulitis is established, stasis and chronic obstruction would follow as a result of this condition.

It would be difficult to conceive of normal peristalsis in a bowel, a fairly large segment of which is thickened, infiltrated and often sclerosed. This is a deduction one is forced to arrive at after glancing at Specimen 1952A in the Museum of this Hospital—even after making most generous allowances for the after-effects of the exteriorization of that particular tumour. Retardation of fæcal transit is brought about by causes similar to those present in annular carcinoma, and by the presence of solid concretions filling up the diverticula and projecting into the lumen of the bowel. This retardation at the site of the tumour is tantamount, and gives rise to, the symptoms of chronic obstruction.

Diagnosis.

Although suspicions may be aroused as to the nature of the tumour that is present by the history and the clinical examination of the case, laparotomy and a positive skiagram are the only certain ways of diagnosing diverticulitis.

Differentiation has to be made from the following affections of the bowel: Carcinoma, actinomycosis, tuberculous peritonitis, chronic sigmoiditis, left-sided appendicitis, and in the female, from adnexal disease. The typical small oval patches of shadow that remain after evacuation of the greater part of a barium meal are almost pathognomonic. Yet a certain amount of care has to be exercised in the interpretation of the skiagrams (see Fig. 18). According to John Muir, these small shadows must be differentiated from calculi, phleboliths and calcified glands. This is easily accomplished by exposing a plate before administering the opaque meal. Incidentally Muir also finds that diverticulitis is most commonly found distally to the splenic flexure.

As regards treatment, there is but little to say. Medical means are, apparently, useless, and Rotter, the authority we are quoting here, always advises some form of extirpation. The less formidable types of operation are naturally to be used, and these practically amount to local resection. Preliminary colostomy is not necessary, as there is usually no trouble in the healing of the anastomosis, a constipating mixture such as M. catechu. co. being sufficiently efficacious to prevent stress taking place too early at the site of the gut-junction.

CASE 3.—*A case of visceroptosis and of intestinal stasis.*

Miss Emily M—, æt. 38. 1905, attack of "gastric ulcer" lasting nine weeks.
1909, attack of "gastric ulcer" lasting 8 weeks.
1913, attack of "gastric ulcer" lasting 3 months.
1916, attack of appendicitis—no operation.
1916–1921, attacks of vomiting and epigastric pain.
Early 1921, these attacks get more severe and more frequent.
June, 1921, appendicectomy.
September, 1921, operation for piles and fistula *in ano*.
November, 1921, recurrence of vomiting and epigastric pain.
December 3rd, 1921, cæcopexy.
January 17th, 1922, no improvement; transferred to Medical Ward.
February 12th, 1922, transferred to sanatorium, slightly improved.
August 2nd, 1922, operation for femoral hernia.
February 12th, 1923, readmitted for pain in epigastrium an hæmatemesis. No attack while in ward. Discharged.

INTERPRETATION.

This patient belongs to and forms a very good example of a class that has raised much discussion during the last few years. We refer to what has so aptly been called "the abdominal woman." These unfortunate people seem to be born only to spend the greater part of their lives either in the beds of nursing homes and infirmaries, or else to drag their ever-ailing, worn-out bodies through the consulting-rooms of specialists. Each one of these is able to find some cause of the trouble, and to recommend some form of "unfailing" treatment, and yet,

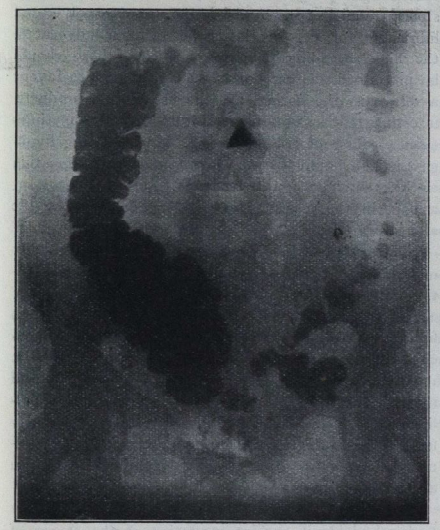


FIG. 20.—CASE 3.—MISS EMILY M—. VISCEROPTOSIS BEFORE OPERATION (21 : 11 : 21).

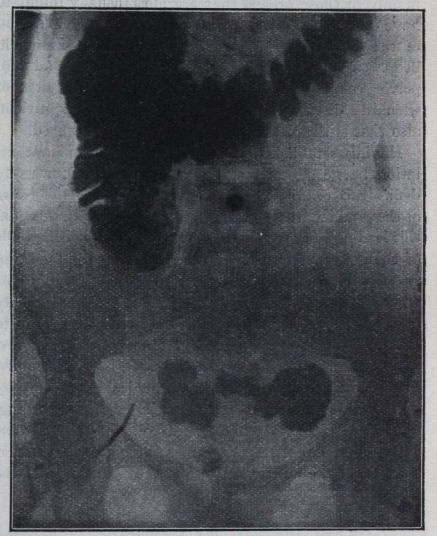


FIG. 21.—CASE 3.—MISS EMILY M—. VISCEROPTOSIS AFTER OPERATION (23 : 2 : 23).

they are ever unable definitely to cure the patient from symptoms which are undoubtedly very real, and which cause the sufferers infinite misery. This weary, dragged-out helplessness, sooner or later—and this in every case—reduces the patient to a bundle of worn-out nerves, either to a neurasthenia of the worst degree, or else to an extreme hypochondria. Of this last class Miss Emily M— was a very good example. In all cases, the symptoms of chronic intestinal obstruction are predominant.

Victor Pauchet, speaking of the surgical treatment of intestinal stasis, emphatically dissociates Glenard's disease from what he terms "Lane's disease," and which he defines as "visceroptosis combined with chronic intestinal stasis." This, in our opinion, is an erroneous exposition of the clinical and pathological findings. J. C. Roux, in his magnificent treatise on gastro-intestinal pathology, clearly points out that stasis always accompanies ptosis of the viscera. And, indeed, it would be difficult to believe that normal peristaltic movements are present in gut that is always found to be enlarged proportionally to its descent and that is ever sluggish (as evidenced by *all* X-ray findings in *all* cases of enteroptosis). In our opinion, the term "Lane's disease" should be strictly restricted to the state of intestinal stasis resultant on the presence of kinks and adhesions of the bowel, this, in fact, being the theme of Sir Arbuthnot Lane's well-known treatise.

Symptoms nearly always accompany ptosis. These are usually constipation, dyspepsia and dragging pain in the back and abdomen—in other words a clear picture of chronic obstruction. Sometimes, but only rarely, pronounced symptoms of stercoræmia are present. This, we think, is another good proof to back our divergence from Pauchet's view, for although stasis is

undoubtedly present in the absorptive part of the large intestine, yet it is not sufficiently acute in cases of enteroptosis to produce any marked degree of stercorœmia, the delay in transit not being so great as in cases due to kinks and adhesions the fæces pass on, and only accumulate to any great extent in the ballooned pelvic colon and rectum.

That stasis is a symptom often caused by kinks and adhesions of the gut cannot be doubted, but the very diagram given by Pauchet to illustrate this point brings forth a strange coincidence in favour of the views expressed in this essay, namely that stasis occurs mainly in those organs that are most usually found to have dropped, and then in the immediate neighbourhood of the situation of the flexure of the gut. Stomach, ileo-cæcal junction, cæcum, transverse colon and iliopelvic colon—these are the most common sites of Glenard's disease of the alimentary tract. It is in them also that stasis of the contents is most pronounced.

Having established the existence of a constant relation between ptosis and stasis, it remains for us to define this relationship. Whether ptosis be the cause of the gradual arrest of the intestinal hæmic circulation, this leading to progressive anæmia and atony of the walls of the gut, thereby slowing the transit of the food and fæces, and then followed by a passive dilatation, or whether, on the contrary, a pre-existing stasis, possibly even physiological in origin (as it is so closely related to the anatomical situation of places of constriction, *i. e.* flexures and junctions), when increased by slack habits, brings about, either by purely mechanical or possibly by stercorœmic means, a gradual dropping, fat-absorbing, elongation of the mesentery we are unable to say. The latter explanation seems the most favourable, however, because of the undoubted results of re-education of the bowel.

Diagnosis and Treatment.

The distinction drawn by Frank Glenard between the strong and the weak abdominal-walled cases should not, in our opinion, be emphasized overmuch, as we think that they are but two stages of one same slowly working process. X-ray examination of a baryta meal usually confirms a diagnosis previously arrived at by the clinical examination. A long, complex history often gives the first clue to this condition. The symptoms of chronic obstruction are always present, and, if recognized, should always bring to mind the possiblity of enteroptosis.

If the contentions put forth in this paper are correct, and visceroptosis be due to an inherent tendency aggravated by the appallingly lax method of living that the patients have got accustomed to—and this has been confirmed in every case we have seen: age, sex, occupation, histories of irregular and irrational meals, irregular training of the bowels, lack of methodical exercise, abuse of ill-fitting stays and compressing belts, these are features that can always be elicited—then clearly our first purpose should be a re-modelling of the patient's life and the re-education of her bowels. This can usually be brought about if the case is seen early, by a complete change of life, of which Regularity must be the keynote. Regular hours, a rational proportion of sleep, daily exercises, massage, mechano-therapy, an out-of-doors existence, Lebon's reptation treatment of the spine if need be, regular and easily digested meals not containing any ingredients likely to cause solid, weighty stools, training of the bowel by the use of laxatives and lubricants, or, as has lastly been much advocated, the high ascending douches of Vichy—these should be prescribed. Other points which are said to favour a return to the normal are the use of bile products, intestinal antiseptics, agars, pituitrin, and sometimes even a course of organotherapy. A well-fitting hypogastric belt should always be worn, and the re-education of the mental state must be made to play as important a part in the treatment as the re-education of the alimentary tract.

If, however, several months of well-carried-out efforts on the lines indicated above fail to bring about amelioration surgical measures must be considered.

The operations used for the relief of visceroptosis are as follows: Colo- and cæcopexies, cæcoplications, short-circuiting operations and partial or complete colectomies.

We have taken some care to find out the results of the suspension operations. These are simply appalling, and their complete abandonment is ardently urged. In no single case has the writer known of a permanent cure; in most cases the condition has been aggravated.

Cæcoplication has the same effect—one that is clearly understandable if our interpretation of the causes of the chronic obstruction be true. Remedying the position or the volume of a viscus that has become atonic and dilated cannot bring back its normal functioning powers.

As to the short-circuiting operations and the colectomies, they seem to meet the demands, but they are of so drastic a nature that even Sir Arbuthnot Lane's well-arranged arguments cannot convince us of their use on any but the most extreme cases.

In conclusion we desire to urge the medical treatment of visceroptosis in preference to surgical interference. Even in the worst cases medical re-education (though necessarily very abridged and imperfect in the hospital cases analysed) appears to give slightly better results than the operative measures.

DISCUSSION AND THEME.

(1) *What is Chronic Intestinal Obstruction?*

By chronic intestinal obstruction we mean a finite aggregate of symptoms due to slow and progressive interference with the transit of the meal-products from the stomach to the rectum. Of the multiplicity of causes some act by directly setting up intra-luminal obstacles to the passage of the food-bolus, some by passively and locally resisting its passage, as in annular carcinoma, others by presenting such atony of the propelling powers of the gut as to practically abolish all intra-tubal circulation. We desire to say an additional word on the subject of intestinal adhesions and kinks. It has already been suggested that these cases do not constitute a class typical of chronic obstruction, for not only is there a distortion of the "tripod of symptoms" and a more frequent picture of acute obstruction, but there are a great number of patients in whom adhesions, or kinks, or both, are present, and who complain of no symptoms whatever of obstruction. We have permission to quote the verbal authority of Sir Bernard Spilsbury, who declares having seen a great number of cases in which the post-mortem examination revealed the presence of adhesions—kinks being much rarer—although there had been no history of any abdominal discomfort. If it is possible for this condition to be present in a great number of people without causing discomfort, we suggest that chronic obstruction cannot be said to be caused by kinks and adhesions. The few cases where the presence of these happens to coincide with the symptoms of obstruction, and the plea of inability to find any other cause to account for it, must, we think, be replaced by the accusations of inexhaustive examination and search.

The symptoms of chronic obstruction, we have said, form a finite and constant aggregate. These symptoms are: *Progressive constipation* of long duration alternating with occasional attacks of diarrhœa (caused by a transient colitis resulting from excessive purgation); *nausea* accompanied by vomiting; and *pain*, of a sickening "colicky" and "twisting" nature, either felt at the site of the lesion, or generally distributed over the whole abdomen. So constant is the nature of this group that we have ventured to give it the name of "the tripod of cardinal symptoms of chronic intestinal obstruction." Although these symptoms are not all present at the same time throughout the existence of the underlying cause, yet they are always elicited by a careful investigation of the case, and are usually present, alternating with periods of quiescence, over epochs that may last for months or years. Very often the appearance of the "tripod" is heralded by another symptom. This is the "explosive" passage of flatus, the patient feeling discomfort due to accumulation of flatus, which suddenly seems to overcome local obstructions and is passed, thus bringing about immediate relief.

It follows from these remarks that chronic intestinal obstruction is not a disease. Nor yet is it the real cause of the patient's illness. *Per se*, it is nothing but one of the shared-out manifestations of a group of conditions which bring about opposition to the passage of the food-bolus. It is composed of symptoms that are always grouped together and that are pathognomonic for this condition to the same degree as headache, vomiting and optic neuritis form a group characteristic of raised intra-cranial pressure, whatever the underlying cause might be. It follows that there can be no method of diagnosis or of treatment of chronic obstruction which will be appropriate for all cases.

But the detection of chronic obstruction, especially in its early stages, is of the greatest importance. If the deductions drawn in this essay are true, then obstruction must be present in every case of malignancy from the very onset, and its early recognition should form one of the most valuable means of early and radical cure. If only the attention of medical men were trained more fully to appreciate the importance of chronic obstruction, and more thoroughly to understand that it is but a cloak under which the most variable and important diseases may lie hidden, cures from cancer would occupy a much nobler place in our statistics, and many would be the cases where relief, due to a proper understanding of the conditions, would replace lengthy and unavailing treatment of "dyspepsias" and "chronic tummys."

(2) *The Diagnosis of Chronic Intestinal Obstruction.*

The diagnosis of chronic intestinal obstruction depends mainly upon the recognition of the symptoms mentioned above. In addition most authors dwell at length upon some minor point or other which is ever found to be denied by a subsequent writer. Thus Carless insists on early dilatation of the abdomen and on visible peristaltic movements, which Cabot declares are only present in 17 per cent. of cases. Pearce Gould attributes great importance to progressive diminution of the size of the motions, while Taylor does not even deign to mention this point. These are undoubtedly all true observations, and they form occasional adjuncts to diagnosis. The clinical history must be made the main foundation. To this a very useful superstructure is added by the routine examination of the patient, the digital, proctoscopic and sigmoidoscopic examination of the rectum and the lower part of the sigmoid colon, and by the radioscopic

examination of the behaviour of a baryta meal and enema. If this surgical crescendo has been carefully followed, there is usually no difficulty in establishing the existence or non-existence of chronic obstruction.

But this must by no means be considered as sufficient. The main task in all cases must ever be the recognition of the causal lesion. If the diagnosis is still obscure one must have recourse to other means; but on no account is the case to be abandoned when labelled "chronic intestinal obstruction." There must be no hesitation in deciding to explore the abdomen, for surely even a needless operation is much preferable to the possible existence of an overlooked cancer!

(3) *The Treatment of Chronic Intestinal Obstruction.*

We feel compelled to urge once again that all efficient treatment must be based on a correct diagnosis of the underlying disease, and that the *curative* treatment of chronic intestinal obstruction is the appropriate treatment of the symptom-producing cause.

Palliative treatment for the relief of the obstructive symptoms may be started as soon as the patient comes under observation, provided once more that efforts do not rest at that. The keynote of all palliative treatment must be rest, purgation, massage and diet, repeated wash-outs of the lower bowel—these in order to remove obstructive fæces and impactions—the treatment of any accompanying colitis and a serious attempt to re-educate the bowel.

To sum up, chronic intestinal obstruction must be regarded as a picture evoked by several conditions. Its cardinal symptoms are constant in their occurrence, and must be considered as a clue to the existence of some underlying cause. If that cause be a neoplasm, chronic obstruction of some degree is present from the very onset, and early recognition should lead to radical cure. The treatment is that of the underlying disease; if cancer, excision; if diverticulitis, local resection; if visceroptosis, medical re-education. In addition, palliative treatment should be resorted to from the very first admission of the patient.

We wish to express our thanks to Messrs. L. Bathe Rawling and J. F. H. Roberts for permission to publish the cases reported; to the Chief Assistants of the various units for their courtesy in giving us access to their files and indexes; and to the Staff of the X-ray Department for their help in reproducing the illustrative photographs.

FRED. F. IMIANITOFF.

This is followed by a considerable addenda, in which is included a fuller history of each of the three cases, a chart of the varieties of surgical colectomies, an analysis of 14 cases of visceroptosis and bibliography.

DYSID-ROW-SIS.

OLD Charon rowing 'cross the Styx
Was seized with Cheiropompholyx,
His Cheiropompholygian paws
Made the poor man to drop his oars . . .
A wail of warning rent the air
"No thoroughfare! No thoroughfare!"

Soon there appeared from out the mist
Wraith of a Dermatologist;
"Amnesia soon sets in," he cried
On this inhospitable tide,
In spite of which, I rather think,
Our panacea *was* Cream of Zinc!"

The old man paid his fee and bought a lot,
Two shillings—and a penny for the pot . . .

* * *

It's nice to think there still remain
Some themes for Mr. Sutton Vane!

F. G.

SUPRAPUBIC PROSTATECTOMY OPERATIONS.

IT was in 1901 at St. Peter's Hospital, Covent Garden, that Sir Peter Freyer did his first operation for removal of the enlarged prostate by the suprapubic route, the patient being a Mr. John Thomas.

This brilliant operative procedure only received, after a fierce struggle, the world-wide recognition which it so well deserved, but Sir Peter Freyer, with his Irish blood, was one who relished a fight. Prior to the introduction of this operation the treatment of the enlarged prostate was by such measures as vasectomy, castration, passing sounds, giving various drugs, etc.

All these procedures were of little avail, and the patient was condemned to the daily and nocturnal use of a catheter, which meant the added complication of chronic cystitis.

Modifications and improvements of Freyer's original operation were bound to come, and below are briefly described the methods now in use by the surgeons of St. Peter's Hospital, where some 120 suprapubic prostatectomies are performed during the year.

The Freyer Operation.

With the patient in the dorsal position a catheter is passed and the bladder fully distended with lotion. A 3-in. median incision is made extending upwards from the symphysis pubis; the portion of the anterior aspect of the bladder thus exposed is freed of peritoneum, which is displaced upwards by the finger, and the bladder is opened by a stab incision. The prostate is enucleated by the forefinger of one hand introduced into the bladder, during which process the gland is supported and pressed forwards by the forefinger of the other hand which is inserted into the rectum. When freed, the prostate is delivered from the bladder; if the gland is a very large one this is sometimes rather difficult to do through the small incision.

The bleeding resulting from the enucleation may be slight or severe; it is dealt with by irrigating the bladder through the catheter with several pints of silver nitrate solution at a temperature of 115° F. A large bore tube is introduced into the bladder, and a small one into the cave of Retzius, one or two stitches are inserted to repair the incision and the patient is returned to bed.

This, the original operation, is now seldom done; its great merit is that it is speedy, for the whole procedure only takes a few minutes; its disadvantages, however, are several. Thus, unless a preliminary cystoscopy has been done, it is quite easy to miss any of the commoner complications which may be present, such as a small bladder stone, a growth, or a diverticulum; for during the operation no inspection of the bladder is carried out, everything being done by touch.

Again, the state in which the bladder is left as regards the opening into the prostatic cavity, the presence of tags or flaps of mucous membrane which may later obstruct this opening, the possibility of the incomplete removal of the prostate, are not considered.

Further, owing to the quantity of fluid used in irrigation, it is difficult to appreciate how much blood has been lost, and in some cases the irrigation is not effective, and the patient is returned to bed still bleeding.

The Modified Freyer or "Closed" Operation.

The procedure is similar to the above up to the stage at which the prostate is enucleated, except that the incision is a little larger; also until the prostate has been freed two gloves are worn on the hand which is used to give support from the rectum, but in cases where the gland comes away easily no finger is passed into the rectum.

After the prostate has been lifted out of the bladder, the finger is introduced to feel for tags and flaps of mucous membrane; these are seized with a long pair of Spencer Wells forceps and cut off with scissors.

The prostatic cavity is now explored with the finger, and it will usually be found that separating it from the bladder posteriorly is a more or less prominent shelf or "overhang," which contains bladder mucous membrane, the posterior part of the internal vesical sphincter, and part of the prostatic capsule and sheath. A long pair of Spencer Wells forceps is guided by the finger to this shelf in the mid-line posteriorly, a firm hold is taken, and with scissors a cut is made on either side of the forceps back to the rectal wall, so that a wedge-shaped piece is thus removed.

The importance of this procedure is that it makes a wide opening from the bladder into the prostatic cavity and thus helps to prevent any undue contraction of the bladder outlet with possible onset of obstruction later.

The prostatic cavity and also the bladder base are now firmly packed with a long strip of vaselined gauze which has been soaked in flavine solution, a Marion's tube is inserted into the bladder and the wound repaired. The gauze, as a rule, checks the bleeding satisfactorily and can be removed in 48 hours.

The Thomson-Walker or "Open Operation."(1)

The bladder is opened by a much larger incision, so that the hand which has been passed through between the recti muscles can the more readily reach and enucleate the prostate; no supporting finger in the rectum is required.

After removal of the gland a Thomson Walker bladder retractor is used and the remainder of the operation carried out under direct vision, the patient being in the Trendelenburg position. Any tags or flaps of mucous membrane observed are cut away. Blood can sometimes be seen spurting from arteries in the lateral walls of the prostatic cavity; these are secured and ligatured.

The projecting posterior lip of the prostatic cavity is now divided in the mid-line, and in some cases a wedge-shaped piece removed back to the anterior rectal wall; this is always seen to cause some bleeding.

A continuous suture is inserted to include the posterior two-thirds of the rim of the prostatic cavity, the stitch passing through from the bladder mucous membrane to obtain a bite on the bed from which the prostate has been enucleated.

At the conclusion of this operation inspection shows that the bladder and prostatic cavities have been thrown into one, and thus any risk of post-prostatectomy obstruction practically eliminated. No tags or flaps remain to slough away, the surface being smooth, and such that it will facilitate rapid healing.

Furthermore the bleeding has been stopped, and the patient leaves the table dry, which is a source of great comfort to all concerned, and especially to the house-surgeon.

The incision, being a large one, must be carefully repaired, after the insertion of a tube of medium size

into the bladder and a small one into the cave of Retzius. Experience shows that the incision heals by first intention down to the drainage-tube, and any risk of hernia developing is slight.

The Modified Thomson-Walker Operation.

The operation is similar to the one last described, except that little or no suturing is done of the edge of the prostatic cavity, it being argued that this step is not always necessary, prolongs the operation, is sometimes very difficult to do, and the stitching itself may cause bleeding.

The results of the two operations must decide as to which is the better. A comparison of a series of cases shows that those in which the suturing is not done undoubtedly bleed much more. For although there may be little bleeding to see at the conclusion of the operation, when the patient is shocked and under the influence of the anæsthetic, yet there is often considerable bleeding during the next few days.

It has been stated that it does good to a number of these elderly men to let them bleed. But that this is an undoubted fallacy can readily be seen by comparing the convalescence of those patients treated by the Thomson-Walker operation and those left to bleed.

Bilateral vasectomy is carried out just below the external abdominal ring. This operation is easily done, takes very little time, and is a certain guarantee against that troublesome after-complication of epididymo-orchitis.

It seems a great pity that this very satisfactory procedure has not obtained in this country the widespread popularity which it enjoys in France.

No reference has been made to one- and two-stage operations; the general rule at St. Peter's Hospital being to do a one-stage whenever possible, the chief guides being the patient's clinical condition and a urine yielding at least 1 per cent. of urea in the Maclean urea concentration test.

Operation for Carcinoma of the Prostate.(2)

This operation has been recently elaborated for early cases. As a rule the patients are only seen in the later stages, when the choice of treatment lies between catheter life or permanent suprapubic drainage.

Briefly the operation may be described as follows: The bladder is opened and a Thomson-Walker retractor inserted. With a knife an incision is made through the bladder mucous membrane round the internal meatus, and corresponding to the anterior and lateral borders of the prostate, but extending in the mid-line back to the interureteric bar. The prostate is now enucleated by dissection and partly by the finger, but posteriorly it is left hinged to the seminal vesicles. A dissection is now done of the seminal vesicles, which are then removed intact with their sheaths along with the attached prostate, and the bladder mucous membrane overlying it.

Two of the routes of the direct spread of carcinoma of the prostate are to the overlying bladder mucous membrane and to the sheaths of the seminal vesicles.

Hence it is hoped by this more radical operation to obtain better results in early cases.

I wish to acknowledge my great indebtedness to the surgeons of St. Peter's Hospital, also to express my thanks to them for permission to publish this paper.

REFERENCES.

(1) *Brit. Med. Journ.*, Aug. 27th, 1921; *Lancet*, 1921, p. 1008.

(2) For fuller account of more extensive operation, see Clifford Morson, *Proc. Roy. Soc. Med.*, 1924, vol. xvii (Section of Urology), pp. 43–52.

See also Thomson-Walker, "Transvesical Vesiculectomy and Vesiculotomy," Second Congress of Internat. Soc. Urology (1st vol.), Rome, April 24th–26th, 1924.

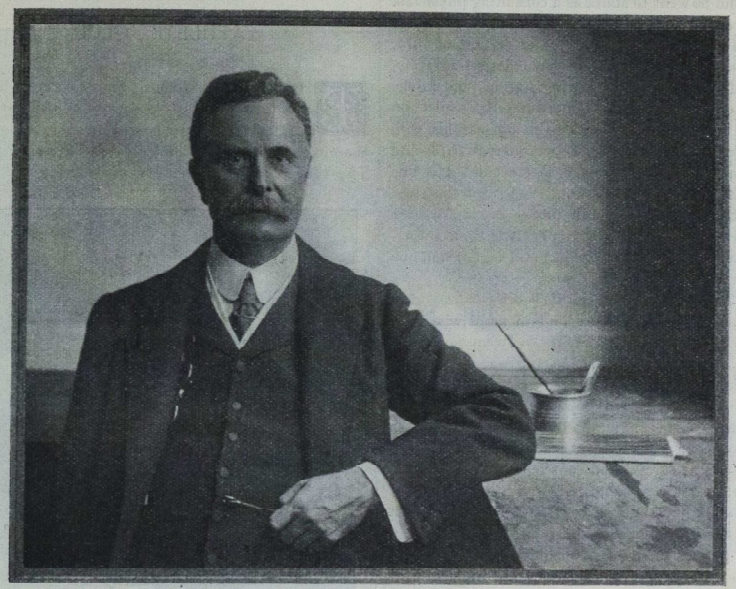
J. LLEWELLYN DAVIES.

OBITUARY.

DR. HOWARD TOOTH.

DR. HOWARD TOOTH was born at Brighton in 1856 and was at Rugby School and St. John's College, Cambridge, before he came to St. Bartholomew's. He qualified in 1880, and, after serving as House-Physician, he became Casualty Physician and Demonstrator of Physiology. After finishing these appointments he was for a time without any post at St. Bartholomew's, but, as soon as an opportunity served, he was appointed Demonstrator of Morbid Anatomy, and subsequently, in 1897, Assistant Physician, becoming full Physician in 1906. It was during the period before he became Assistant Physician that he was attracted to the study of diseases of the nervous system, and became a physician to the Queen Square Hospital; and it was in this period also that he was elected a Fellow of the Royal College of Physicians in the year 1888, and gave the Goulstonian Lectures on "Secondary Degenerations of the Spinal Cord." It was, indeed, very largely due to the reputation he had acquired as a most capable investigator of nervous diseases that he was gladly welcomed as a member of the permanent staff of our School, and it is very certain that we were fortunate in securing his services for a long period of years.

The characteristic qualities of Tooth's work were the extraordinary patience and thoroughness with which he investigated all his cases, and the sympathy and desire to help which were always in evidence. It was these qualities which made him so successful both as a general physician and as a consultant in nervous diseases.



THE LATE DR. HOWARD TOOTH, C.B., F.R.C.P.

It is not necessary to enumerate his various medical writings, but mention must be made of his address on "The Growth and Survival Period of Intracranial Tumours," delivered when he was President of the Neurological Society in 1912. This is justly looked upon as the most authorative contribution yet made to this difficult subject, and the investigation of the records of 500 cases occupied all his spare time for two years or more.

A very important part of Tooth's life work was to be found in his association with the Army, which began with the Boer War in 1899. The first Civilian Hospital to serve in the Field was named the "Portland Hospital," and three of its medical and surgical staff (including the writer) were drawn from St. Bartholomew's. It came into being very soon after the war began, and when it arrived at the Cape it was found that Tooth was the only "consulting physician" attached to the Forces; and as a result his services were in constant demand. The Hospital was first pitched ten miles from Cape Town, but soon moved up to a camp outside Bloemfontein, and Tooth was almost swamped by the enteric cases under his own care as well as by those he saw in consultation in many other units. But in spite of the sickness in the Army, and, especially when the health of the troops improved, Tooth thoroughly enjoyed the open-air life of a tented camp and the constant sunshine of the veld. He was also *persona grata* to all the officers of the R.A.M.C., and very popular wherever he went.

After the Boer War he joined the London University O.T.C., and was called upon to serve on a committee for the re-organization of the Army Medical Service; and the R.A.M.C. would all acknowledge that the

recommendations of this committee proved the basis of the most important reforms and improvements in this branch of the service.

It very naturally resulted that when the Great War broke out Tooth was again called upon to serve, and was very soon appointed to command our own War Hospital, namely, the "First London General Hospital," at Camberwell. In this position he was a conspicuous success, but, nevertheless, was not satisfied unless he could serve overseas, and, before long, his wish was gratified, and he went to Malta as a consulting physician. Here he remained to the great advantage of a large number of soldier patients till the latter part of 1917, when he was transferred, at his own desire, to Italy, and served in the casualty clearing stations and in the hospitals on the Riviera. Unfortunately, whilst on duty here, he became ill, and, much against his will, was invalided to England in the summer of 1918, and so was unable to see the war to its end. His fine service was recognized by three mentions in despatches, the award of the "C.B." and the conferring by the University of Malta of the degree of "M.D.Hon.Causa," whilst many of his friends felt that still higher honours might well have been accorded him.

At St. Bartholomew's Hospital Tooth was an ideal colleague and one who always kept in mind what was best for the Hospital and School. Twenty or more years ago, when the Hospital entered upon its career of expansion, it was he who acted as secretary to the Medical Council and served on every one of the various sub-committees and in numberless consultations with the Hospital Governors. As a teacher in the Medical School he was as careful and conscientious as in everything that he did. He loved to be with young people, and his pupils quickly realized that he was a lenient critic of their clinical efforts and their guide and friend in the out-patient room or the medical ward.

He was always fond of teaching, and from the time that he taught physiology he was popular with all his pupils and was always most good-tempered and patient in explaining and smoothing over difficulties. As a consultant he was so transparently honest and keen to get to the bottom of things that he quickly won the confidence of his patients, both in hospital and in private practice, and was universally recognized as one of the very best opinions on diseases of the nervous system.

For many years he was an enthusiastic cyclist, and on several occasions rode to the north of Scotland and back during his summer holidays. He was also fond of fishing as an out-door pursuit, and played the violin, and was one of the founders of the Hospital Musical Society. At home he spent much of his spare time in his carpenter's shop, and he became a very skilled worker both in wood and in metal.

After leaving London for Hadleigh, in Suffolk, he accepted an appointment at Ipswich of a Clinic for Nervous Diseases under the Pensions Ministry, and took the keenest interest in his work in spite of failing health. He led a most active and useful life and was always happiest when fully occupied, for he was one of those men who are never idle.

ATHLETIC CLUB.

THE Annual Athletic Sports were held on Saturday, May 2nd, at Winchmore Hill. Entries on the whole were more encouraging than in past years, and some good racing was witnessed. The times and performances, considering the sodden

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"THE LAST OF THE BARONS."

nature of the track, were excellent. Some useful new talent was unearthed, and the team this year should be much stronger than for the past few years.

In the absence of the President, Dr. Morley Fletcher, who was away examining for the Conjoint Board, Sir C. Gordon Watson presided, and Mrs. Gask kindly consented to give away the prizes.

The attendance towards the close of the afternoon was certainly larger than usual.

RESULTS.

3 Miles: run on Thursday, April 30th. 1, J. R. Beagley; 2, H. N. Walker. Time, 17 min. 3⅘ sec.

100 Yards: 1, T. R. Griffiths: 2. W. S. Hinton; 3, M. R. Sinclair. Time, 10⅘ sec.

120 Yards Handicap: 1, T. R. Griffiths (4 yds.); 2, J. E. Church (8 yds.). Time 12¼ secs.

This was a new event and created much amusement and enthusiasm, seven firms and the second year put in teams. In some cases the Chiefs were much in evidence cheering their teams (which in many cases included Clinical Assistants) to greater efforts.

W. S. H.

Athletic Contest versus *University College and Hospital A. C.*

The first of the friendly contests arranged for the season took place on Tuesday, May 12th at Paddington. Blessed with the first fine evening of the season, a very pleasant and close contest of seven events took place. In order to keep enthusiasm high to the last place two men from each side were included in each event, the

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100 YARDS FINAL.

1 mile Handicap: 1, H. B. Stallard (scr.); 2, A. H. Grace (25 yds.); 3, J. R. Beagley (scr.). Time 4 min. 49 sec.

220 Yards: 1, T. R. Griffiths, 2, M. R. Sinclair, 3, W. S. Hinton. Time, 23⅘ sec.

440 Yards: 1, M. R. Sinclair, 2, B. B. Hosford, 3, E. V. H. Pentreath. Time 51⅘ sec.

880 Yards Handicap: 1, H. B. Stallard (scr.), 2, J. R. Beagley (40 yds.). Time, 2 min. 3¼ sec.

Long Jump: 1, M. R. Sinclair; 2, A. Clark; 3, J. H. Pierre. Distance, 20 ft. 10 in.

High Jump: 1, C. K. Lakshmanan; 2, W. A. Briggs; 3, N. E. Cook. Height, 5 ft. 5 in.

Throwing the Hammer: 1, G. H. Day; 2, H. E. Houghton. Distance, 72 feet.

Putting the Shot: 1, J. W. D. Buttery; 2, G. H. Day. Distance 33 feet.

120 Yards Hurdles: 1, C. K. Lakshmanan; 2, W. A. Briggs; 3, H. Royle. Time, 18 sec.

Inter-Club Relay: 1, C XV Rugger; 2, Soccer.

Inter-Firm Tug-of-War: Final won by Mr. Rawlings' Firm.

points were 4, 3, 2, 1 for the four competitors. Four points were given to the winnning relay team.

The following Bart.'s men gained points:

100 Yards: 1, T. R. Griffiths; 2, W. S. Hinton. Time, 10⅘ sec. 7 points.

1 Mile: 1, H. B. Stallard; 4, A. H. Grace. 5 points.

440 Yards: 2, M. R. Sinclair; 3, B. B. Hosford. 5 points.

High Jump: 1, C. K. Lakshmanan; 2. W. A. Briggs. Height, 5 ft. 5 in. 7 points.

Long Jump: 2. A. Clark; 3. M. R. Sinclair. 5 points.

3 Miles: 3, J. R. Beagley; 4, H. N. Walker. 3 points.

Relay: 1, Bart.'s A. C. (440, E. V. H. Pentreath; 220, T. R. Griffiths; 220, W. S. Hinton; 880, H. B. Stallard). Won easily in 3 min. 43 sec. 4 points.

Result: Won, 36 points to 28 points.

Invitation Relay.

On Thursday, May 14th, the Hospital Relay Team, consisting of Messrs. Sinclair, Griffiths, Hinton and Stallard competed in the

Annual Invitation Relay organized by the S.L.H. Against some good teams, such as Sandhurst, R.N.C., Guy's, etc., the Bart.'s four kept their unbeaten record intact, easily finishing first in the excellent time of 3 min. 40⅗ sec.

The Relay team (although only containing two of its original members) is in its third season without having been beaten by any other side.

W. S. H.

Inter-Varsity Athletic Meeting.

The following men are to be congratulated on having been selected to represent the University of London in the Inter-Varsity Meeting at Nottingham on Friday and Saturday, May 15th and 16th.

T. R. Griffiths (100 and 220 yds.), W. S. Hinton (100 yds.), C. K. Lakshmanan (120 yds. hurdles), M. R. Sinclair (440 yds.), J. R. Beagley (half-mile), and H. B. Stallard (one mile).

Griffiths won both the 100 and 220 yds. for London, with Hinton second to him in the 100 yds. Lakshmanan, Sinclair and Stallard all succeeded in winning their events.

The Bart.'s representatives were thus mainly responsible for London University's easy victory, scoring no less than 28 of London's 46 points, Manchester being placed second with only 20 points.

J. R. B.

STUDENTS' UNION.

GOLF CLUB.

ST. BARTHOLOMEW'S HOSPITAL *v.* MIDDLESEX HOSPITAL.

Played at Sandy Lodge on March 5th, 1925.

R. H. Bettington	1	Thornton	0
H. O. White	0	Morton	1
H. E. Houfton	1	Nicholas	0
H. Smith	1	Gray	0
J. Milner	0	Dockstay	1
C. E. Woodrow	1	Charlton	0
L. H. T. Davies	1	Allen	0
W. Beattie	0	Puckridge	1
H. Stanton	1	Lipscombe	0
G. C. Woods-Brown	1	Winter	0
Bart.'s won by 7–3.	7		3

ST. BARTHOLOMEW'S HOSPITAL *v.* SUDBURY.

Played at Sudbury on April 22nd, 1925.

C. P. Chater	0	R. H. Bettington	1
C. W. Clarke	0	W. A. Barnes	1
P. H. Neal	1	H. O. White	0
A. W. Meacock	0	C. E. Woodrow	1
H. Tomlins	0	H. E. Houfton	1
G. Brown	½	W. S. Maclay	½
F. C. Thompson	0	J. Cox	1
A. H. Nisbet	1	S. Burt	0
J. R. Mullings	1	W. Briggs	0
H. Roberts	1	H. Stanton	0
	4½		5½
Chater and Clarke	1	Bettington and Barnes	0
Neal and Meacock	1	White and Woodrow	0
Tomlins and Thompson	1	Houfton and Cox	0
Brown and Nisbet	1	Maclay and Burt	0
Mullings and Roberts	1	Briggs and Stanton	0

Sudbury won by 9½—5½.

ST. BARTHOLOMEW'S HOSPITAL *v.* WIMBLEDON PARK.

Played at Wimbledon Park on May 12th, 1925.

Col. Balfour	0	C. E. Woodrow	1
G. B. Brand	1	J. Cox	0
H. E. Comings	0	H. O. White	1
F. A. Odell	1	H. E. Houfton	0
Maj. Wosley	0	N. F. Kendall	1
C. Seymour	0	W. S. Maclay	1
J. W. MacBride	0	S. Burt	1
D. O. Thornton	0	C. A. Francis	1
	2		6
Brand and Odell	1	White and Houfton	0
Baltour and Comings	1	Cox and Woodrow	0
Seymour and Wolsey	1	Maclay and Francis	0
MacBride and Thornton	0	Kendall and Burt	1
	3		1

Bart.'s won by 7—5.

ST. BARTHOLOMEW'S HOSPITAL *v.* BROXBOURNE.

Played at Broxbourne on May 17th, 1925.

L. A. Speakman	1	R. H. Bettington	0
J. Writord Brown	1	W. A. Barnes	0
G. F. Hamilton	0	C. E. Woodrow	1
C. B. Yule	1	H. O. White	0
N. H. Hole	1	J. Cox	0
E. R. Speyer	0	W. S. Maclay	1
C. A. Chase	0	S. Burt	1
J. P. Rochfort	0	A. H. Roberts	1
Dr. Cobbledick	1	R. G. Moir	0
Dr. Sturge	1	J. G. Milner	0
C. H. Vox	0	F. Heckford	1
Maj. Drake	0	G. C. Woods-Brown	1
	6		6
Speakman and Dawes	0	Bettington and Barnes	1
Hamilton and Hole	0	Woodrow and White	1
Hill and Speyer	0	Cox and Maclay	1
Chase and Tennant	0	Burt and Moir	1
Rochfort and Drake	0	Milner and Woods-Brown	1
Cobbledick and Sturge	0	Roberts and Heckford	1
	0		6

Bart.'s won by 12—6.

CRICKET CLUB.

THE Cricket Club has started the season well. The 1st XI won the first three matches and the 2nd XI, after losing the first game of the season against Southgate 11, beat Winchmore Hill II in the next game—a feat which has not been accomplished within memory!

RESULTS.

1ST XI.

May 9th, v. Southgate C.C.—Southgate 57 (Meeser 4 for 18). St. Bartholomew's scored the requisite number of runs for the loss of 4 wickets.

May 16th, v. Winchmore Hill C.C.—Bart.'s again won by 6 wickets. Winchmore Hill made 81 (Bettington 6 for 24). For Bart.'s Bettington scored 62 runs.

May 20th, v. St. Mary's Hospital (Inter-Hospital Cup-Tie, 2nd Round).—St. Bartholomew's 210 for 9 wkts. (declared), (Woods-Brown 57, Mackie 44, Bettington 38). St. Mary's, 117 (T. C. Hunt 73); (Bettington 4 for 29). We congratulate Mr. T. C. Hunt on a splendid batting performance.

2ND XI.

May 9th, v. Southgate II.—Southgate 173 (Stokes 5 for 31). St. Bartholomew's, 79.

May 16th, v. Winchmore Hill II.—Winchmore Hill. Bart.'s won by 3 wickets (Pierre 55, Stokes 35).

May 21st, v. St. Mary's Hospital II (Cup-Tie, 2nd Round).—Bart.'s won by 3 wickets. St. Mary's batted first and scored 105 (Stanton 4 for 29). For Bart.'s Parker made 31 runs and T. P. Williams made 27.

In the next round (semi-final) we meet the winner of the Charing Cross and K.C.H. tie.

Dr. C. M. Hinds Howell is captaining the Past side on Friday, June 5th.

The Cricket Week begins on June 1st.

REVIEWS.

MEDICAL ELECTRICITY FOR NURSES. By HAROLD WIGG. Price 6s. net.

An instructing and interesting little book, moderately priced.

Presumably written for the nurse working under medical supervision and with a definite knowledge of the subject. There are many helpful chapters. It should also appeal to the qualified worker and the student of medical electricity, to whom the diagrams and plates will prove very useful.

A HANDBOOK OF MIDWIFERY (6th Edition). By COMYNS BERKELEY, M.A., M.C., M.D.(Cantab.), F.R.C.P.(Lond.), M.R.C.S.(Eng.). (London: Cassell & Co. Ltd.) Pp. 578. Price 8s.

The new and sixth edition of this well-known and valuable Handbook on Midwifery will be welcomed by midwives and students alike, forming as it does a concise, well-tabulated and easily read guide to the subject.

The original work has been revised and several chapters rewritten. Notably those dealing with infant-feeding and the care of premature children, which are now brought into line with the most modern ideas on the subject. Many excellent illustrations have also been added.

The ground covered in this Handbook is enormous, including as it does, elementary physiology and anatomy, pregnancy, labour, the puerperium, infant-feeding and the care of babies, etc., and there are some useful chapters on the preparation for various operations, Cæsarean section, etc., which will be much appreciated.

SYNOPSIS OF MIDWIFERY AND GYNÆCOLOGY. By ALECK W. BOURNE, D.A., M.B., B.Ch., F.R.C.S. (Bristol: John Wright & Sons, Ltd.) Third Edition. Revised and Enlarged. Pp. 434. Price 15s. net.

The third edition of this volume of the Synopsis Series has been enlarged, but without making it unwieldy, by the addition of a section on gynæcology. The general features of the Synopsis Series are retained. The revision of the Obstetric Section might have been more drastic. The old method of dividing puerperal sepsis into the sapræmic and septicæmic varieties has been retained although it is obsolete, and no mention is made of the frequent incidence of streptococci in the condition formerly classed as sapræmia. When dealing with contracted pelvis the author has not emphasized ante-natal examinations sufficiently. Far too much stress has been placed upon pelvic measurements, and the use of forceps in cases of contracted pelvis, as elsewhere in the book, is too strongly indicated. In the chapter on post-partum hæmorrhage we think that mismanagement of the third stage of labour should be made more prominent in the ætiology of this complication, and we do not agree that manual removal of the placenta is to be advocated as the first method of treatment adopted in cases where hæmorrhage occurs before the placenta is born.

The new section on Gynæcology is very well written, and for this the author deserves the highest praise. Great skill is displayed in summing up the methods of treatment, and students will gladly welcome this branch of the work. Perhaps more attention could be paid to differential diagnosis. Students are inclined to know lists of causes of symptoms, but to be unable to differentiate one from another. In the chapter on endometritis the author has shown courage, but his achievement is still far from the ideal.

ESSENTIALS OF INFANT FEEDING. By F. A. BARLOW. (London: H. K. Lewis & Co.) Crown 8vo. Pp. viii + 80. Price 3s. 6d. net.

This book is intended to help students in acquiring the principles of infant feeding. Its basis is physiological, and a truly scientific atmosphere can be detected throughout. The main points of this subject are brought out concisely and with good judgment. The book is full of useful practical details which must be of very great help to students.

A thorough knowledge of infant feeding is essential for any general practitioner, and for its acquirement the student can have no better guide than this small volume.

THE BOOK OF BREAST-FEEDING. By HESTER VINEY. (George Routledge & Sons, Ltd.) Pp. 73. Price 1s. net.

The attention being paid to infant feeding at the present time has been responsible for the production of a large amount of literature on the question of bottle-feeding, but little notice has been drawn to breast-feeding. This book brings out the details of breast-feeding in an admirable manner and should be useful to midwives and nurses. It might easily have been condensed to half its size, however, and the subject-matter could be better arranged.

A SYNOPSIS OF GYNÆCOLOGY. By ARTHUR GRAY, F.R.C.S., M.R.C.P. (Edward Arnold & Co.) Pp. 352. Price 10s. 6d.

This synopsis is very complete, and few subjects, even the most modern advances in the investigation of endometriomata, escape attention. The book is probably the most valuable yet published for candidates offering themselves for the higher examinations in gynæcology. The arrangement of the material is excellent and the descriptions are lucid and concise. The short chapter on Forensic Gynæcology is welcomed, for it will help students to realise their legal responsibilities after qualification. Perhaps the author has gone into too great detail over rare tumours and abnormalities, and the attention given to treatment is not quite as much as is desired.

Improvement might be made in the spacing of the sections. Important divisions, such as the one on Fibroids, are worthy of more prominent notice. The book is rather large for a synopsis, but it is doubtful if, with the high standard adopted, any omissions can be suggested.

The book can be highly recommended, for it covers as wide a field as any synopsis can do, and no objections can be made to the views expressed.

AN INTRODUCTION TO PRACTICAL BACTERIOLOGY. By T. J. MACKIE, M.D., D.P.H., and J. E. MCCARTNEY, M.D., D.Sc. (Edinburgh: E. & S. Livingstone, 1925.) Pp. 298. Price unstated.

This text-book is intended primarily for the use of students, and, as its title implies, is concerned with the practical aspect of its subject rather than with theory. Thus only five pages are devoted to the very large subject of immunity. Since the average student dislikes buying two text books where one will serve, it might perhaps have been better (although this would admittedly alter the aim of the work) to amplify this part of the text at the expense of the chapters on the preparation of the more uncommon media, the methods employed in animal experiments and the recognition of sundry tropical parasites. There is also far too little space devoted to the collection of specimens, and the selection and preparation of material for examination. Many of the difficulties in bacteriological work, in hospital as well as in private practice, are due to ignorance of these elementary facts. Only one detail calls for comment: The instructions given for paraffin embedding are calculated to produce a block before which any razor would shudder.

A novel and valuable feature of the book is a chapter on the filtrable viruses, and an admirable practice followed probably for the first time in a work of this size is the inclusion of brief descriptions of non-pathogenic bacteria with which such organisms as, for instance, the anthrax bacillus may be confused.

THE BACTERIOLOGY OF FOOD. By CUTHBERT DUKES, M.D., M.Sc., D.P.H. (London: H. K. Lewis, Ltd., 1925) Pp. 180. 29 Illustrations. Price 7s. 6d.

It is very properly observed in the preface to this book that industrial, medical, veterinary and other branches of bacteriology have hitherto been pursued as individual sciences, the workers in each branch often having little knowledge of the others. Very much is to be hoped from a proper co-ordination of all this work, and although this has little to do with Dr. Dukes's subject, it may be remarked that nowhere is this more necessary than in the present very distant relations of animal and human pathology.

The proper discussion of the bacteriology of food involves both the industrial and medical branches of the science, and in this volume is combined a variety of information which hitherto was only to be

found scattered among several books. The main articles of food concerned are, of course, water, milk and its derivatives, various liquors, and everything susceptible of being canned or bottled. The author has been remarkably successful in preserving all essential technical detail, and at the same time providing a highly readable volume. The more picturesque aspects of cheese manufacturing and the brewing of fermented liquors afford a fascinating story which could hardly be bettered. Apart from its practical value, this book has the unusual merit in medical works of being so written as to be capable of interesting the layman.

EXAMINATIONS, ETC.

UNIVERSITY OF OXFORD.

The following degree has been conferred:
D.M.—H. D. Haldin-Davis.

UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:
M.D.—H. J. Paterson.
M.B., B.Chir.—J. Ness-Walker, C. A. Horder.
M.B.—E. G. Holmes.
B.Chir.—G. B. Tait.
The following candidate has satisfied the Examiners in both parts of the examination for the *Diploma in Public Health*:
S. M. Hattersley.

Diploma in Medical Radiology and Electrology.

C. J. K. O'Malley, R. S. Topham.

CONJOINT EXAMINING BOARD.

The Diplomas of *M.R.C.S., L.R.C.P.*, have been conferred on the following:
W. A. Barnes, J. R. Beagley, A. T. Bettinson, W. R. W. Bonner-Morgan, C. W. Brook, L. I. M. Castleden, J. E. Church, R. N. Curnow, H. E. Daniel, J. D. Dillon, J. I. C. Doyle, C. A. Francis, D. B. Fraser, A. W. Gardner, R. Green, G. S. Hale, A. R. Hill, H. F. Hiscocks, H. B. Howell, J. T. Hunter, C. K. Lakshmanan, J. C. C. Langford, E. F. Maloney, J. G. Milner, A. J. Moody, C. A. Moody, I. S. Moscow, W. Ogden, B. Press, P. E. Pym, T. Rees, A. E. Ross, T. W. E. Royden, D. G. Shields, J. R. Smith, J. S. Spickett, Y. S. Wan, R. M. Windeyer.

ROYAL COLLEGE OF PHYSICIANS.

The following have been admitted *Members*:
M. J. Cohen, M.D.(Liverp.), R. Hunt Cooke, M.B.(Lond.) C. F. Harris, M.B.(Lond.)., D. J. Prendergast, M.B.(Toronto), J. R. Ramsay, M.D.(Lond.).

ROYAL COLLEGES OF PHYSICIANS AND SURGEONS.

The *Diploma in Public Health* has been conferred on:
H. L. Oldershaw.
The *Diploma in Tropical Medicine and Hygiene* has been conferred on:
T. S. Goodwin, R. A. E. Klaber.

CHANGES OF ADDRESS.

ANDREWES, Sir FREDERICK, Windy Gap, Merton Lane, Highgate, N. 6. (Tel. Mountview 182.)
ASTON, R. N., The Bungalow, Sea View, Isle of Wight.
CHAPMAN, E. F., Wingmore Lodge, Wokingham, Berks.
DOYLE, J. L. C., 130, Old Bromley Road, Bromley, Kent.
HILL, R. A. P., Prospect Villa, Downderry, Cornwall.
HUDSON, BERNARD, The Victoria Sanatorium, Davos-Platz, Grisons, Switzerland.
TRAPNELL, F. C., 20, Copers Cope Road, Beckenham.

APPOINTMENTS.

ALEXANDER, G. L., M.R.C.S., L.R.C.P., appointed House Surgeon, Wolverhampton and Staffordshire General Hospital.
BROOKE, C. O. S. B., M.R.C.S., L.R.C.P., appointed Resident Medical Officer at the Royal Chest Hospital, City Road, E.C.
DALTON, C. H. C., M.R.C.S., L.R.C.P., appointed Casualty House Surgeon, St. Bartholomew's Hospital, Rochester.
EAST, C. J., M.R.C.S., L.R.C.P., appointed House Surgeon at the Royal Victoria Hospital, Dover.
ELLIS, G. E., M.R.C.S., L.R.C.P., appointed Junior House Physician at the Belgrave Hospital for Children.
HEWER, C. LANGTON, M.B., B.S.(Lond.), appointed Anæsthetist to the Hospital for Tropical Diseases, Endsleigh Gardens.
LYON-SMITH, G. L., M.B., B.Ch.(Cantab.), appointed Assistant Physician to the Royal Sussex County Hospital, Brighton.
PHILLIPS, L. G., F.R.C.S., M.S.(Lond.), appointed Obstetric Surgeon to In-Patients, Queen Charlotte's Maternity Hospital.
ROBERTS, C. H., F.R.C.P., F.R.C.S., appointed Consulting Obstetric Surgeon, Queen Charlotte's Maternity Hospital.
SMITH, H. G., M.D.(Lond.), D.P.H.(Camb.), appointed Medical Officer of Health, School Medical Officer and Police Surgeon, Lincoln.
WEST, R. G. R., M.B., B.S.(Lond.), D.P.H., R.C.P.S., appointed House Physician to the Royal Northern Hospital.

BIRTHS.

GRIFFITH.—On April 19th, at 13, Brunswick Square, Hove, to Elsie Maud (*née* Visick), wife of John R. Griffith, F.R.C.S.—a daughter.
HARVEY-WILLIAMS.—On May 21st, at Lisnamoe, Hitchin, Herts, to Doris, wife of Robert Harvey-Williams, F.R.C.S.E.—a son.

MARRIAGE.

COOPER COURT.—On May 2nd, at St. Bartholomew's-the-Great, Smithfield, London, by the Rev. Ivor Farrar, Arthur Basil, youngest son of the late Chas. Henry Cooper and Mrs. Cooper, of Whetstone, and Sarah Anne (Sally), second daughter of Mr. and Mrs. J. H. Court, of Swansea. Australian papers please copy.

DEATHS.

CHRISTOPHERSON.—On May 11th, 1925, Cecil Christopherson, Surgeon, of St. Leonards-on-Sea, son of the late Derman Christopherson, of Kidbrook, Blackheath.
HUME.—On Wednesday, May 6th, 1925, at Fircroft, St. Mary Church, Torquay, Walter Augustas Hume, M.R.C.S., L.S.A., aged 68.
MAW.—On April 23rd, 1925, suddenly, at The Old House, Westcott, Surrey, Henry Trentham Maw, M.D., M.A.(Cantab.), beloved husband of E. Gertrude Maw, and eldest surviving son of the late Charles Maw, of Nutfield, Surrey, in his 50th year.
TOOTH.—On May 13th, 1925, at the Moat, Hadleigh, Suffolk, Henry Howard Tooth, C.B., C.M.G., M.D., F.R.C.P., late of 34, Harley Street, aged 69.

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. 1.*

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 310.*

St. Bartholomew's Hospital JOURNAL.

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

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CALENDAR.

Fri., July 3.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Tues., „ 7.—Prof. Fraser and Prof. Gask on duty.
Fri., „ 10.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Tues., „ 14.—Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.
Fri., „ 17.—Sir Thomas Horder and Mr. Rawling on duty.
Tues., „ 21.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.

Last day for receiving matter for August issue of the Journal.

Fri., „ 24.—Prof. Fraser and Prof. Gask on duty.
Tues., „ 28.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Fri., „ 31.—Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.

EDITORIAL.

WE have for long cherished a delusion that provided one searched hard enough and with sufficient care one will find a logical basis for all phenomena—even for the ptyalin in saliva, for the hour of 9 a.m. for a lecture, or the abolition of the half-crown day at Wembley. But we have been presented with a circumstance which has so far baffled us. Why, after the final break-up of the heat wave and the onset of chilly evenings, does the Catering Company suddenly spring upon us ices for dinner.

* * *

The Fourth of July might have seemed a far more appropriate date for an American reception than the Fourth of June, but deeper analysis will show that Independence Day might not have been a happy omen. These visits from other medical schools do tend to emphasize the fact that no school of thought or school of technique is "independent."

Dr. Charles Mayo, the head of the delegation, was kind enough to send the following message to Bart.'s men:

> "On behalf of the American visitors I wish to say to the members of this Hospital that we have felt as we have viewed this ancient building and its historic old church, and as we have listened to its long record in the glorious old Hall, that we have been brought into intimate and personal contact with the history of this Hospital. In so doing we have been brought into touch with 800 years of the history of English medicine, which is the history of the medicine of the world.
>
> "We shall take back to the States a feeling of intimacy which we shall value throughout the length of our lives."

We have one bone to pick with the Delegation. We were promised an article by one of the leading surgeons of the party, but, sad to say, it is not yet with us.

* * *

Four Bart.'s men were honoured by being made Honorary Members of the Inter-State Post-Graduate Assembly of America: Sir Humphry Rolleston, Sir Holburt Waring, Sir James Berry and Mr. Girling Ball.

* * *

We wish to offer our most hearty congratulations to Sir James Berry on his honour of Knighthood, an honour which will be greatly appreciated by all Bart.'s men who knew him, and with whom he was most deservedly popular.

Mr. Girling Ball has relinquished the office of Sub-Dean to the Medical College, a post which he has held for the last four years since his retirement as Warden of the College, he having held the latter post for eight years. He has also resigned his post as Demonstrator of Operative Surgery, which he has held for twelve years.

We are sure that these resignations will not lessen the deep interest that Mr. Ball has always taken in the student life of the Hospital, an interest that has been greatly valued by a generation of Bartholomew's men.

* * *

The Clubs have started the season well; the Athletic Club has won the Inter-Hospital Challenge Shield with twenty-four points to spare; the Rifle Club were over 100 points to the good at the end of the last round of the Inter-Hospital Competition, and thus won the Armitage Cup comfortably. It only remains for the Cricket Club to follow suit.

* * *

This Hospital has reason to be pleased with recent examination results. Out of twenty-seven candidates who passed the final F.R.C.S. no less than ten were Bart.'s men.

Among them was the Senior Resident Anæsthetist, Mr. C. M. Pearce, to whom we offer our hearty congratulations. As we noted in the last issue, Mr. R. S. Johnson won the Gold Medal in the London M.D.; he also was awarded distinctions in medicine. Mr. F. D. S. Poole also gained distinctions in medicine, and Mr. C. P. Craggs in surgery.

* * *

The Annual Old Students' Dinner will be held in the Great Hall on Thursday evening, October 1st. The Secretaries for the Dinner are Sir C. Gordon-Watson and Mr. R. M. Vick, to whom all inquiries should be addressed.

* * *

The Fourth Annual Charity Athletic Contest between the Banks (holders), United Hospitals, Insurance Offices and Stock Exchange, for the *Financial Times* Challenge Shield, takes place at the Crystal Palace on Saturday, July 11th, when the Lady Mayoress (Lady Bower) will attend to present the trophy to the winners. For the past three years, or since the inception of the contest, the Shield has rested with the Banks, the United Hospitals on each occasion being close runners-up.

The programme of the meeting provides the most attractive form of athletics, consisting of twelve scratch events. This year the United Hospitals will be very strongly represented, and should possess a sporting chance of "lifting" the trophy. In any case the contest is of the finest, while the cause speaks for itself.

In order that the entire proceeds may be divided between Bart.'s and the other hospitals belonging to the U.H.A.C., the *Financial Times* is again contributing a sum of money to cover all expenses of the meeting.

Tickets, 1*s.* 6*d.* (including admission to the covered stands), may be obtained from the Hon. Secretary, Mr. R. A. Lyons, Contributions Department, St. Bartholomew's Hospital, E.C. 1.

* * *

We offer our congratulations to the following prize-winners:

Brackenbury Medical Scholarship	H. V. DICKS.
,, Surgical Scholarship	H. J. SEDDON.
Burrows Prize	H. V. DICKS.
Skynner ,,	H. L. WILSON.
Walsham ,,	H. J. SEDDON.
Willett Medal	H. J. SEDDON.
Harvey Prize	W. P. M. DAVIDSON.
Prox. acces.	B. J. LOVELY.
Treasurer's Prize	J. R. J. BEDDARD.
Certificates to	H. H. BOYDEN.
	C. K. MCKEE.
Foster Prize	A. M. MCMASTER.
Certificates to	B. KETTLE.
	R. F. PHILLIPS.
Bentley Prize	H. L. WILSON.
Wix Prize	W. R. BETT.
Kirkes Scholarship and Gold Medal	H. V. DICKS.

* * *

The hand-book of the Special Vacation Post-Graduate Course is before us. The Course lasts from September 7th till September 18th, and a most attractive programme has been arranged.

In the afternoons there will be four demonstrations on Medical and four on Surgical Practice, four demonstrations on Diseases of Women, and in each of the special departments demonstrations for post-graduates only have also been organized.

A series of ten special demonstrations will show certain methods of technique and other points of interest.

ECONOMY.

A medical student, visiting a country practitioner, was very surprised at the following conversation between doctor and patient:

"Now, go home and take this bottle of medicine, and when it is finished bring me back a sample of your water."

The student cautiously inquired if the practitioner really took the trouble to test the urine of all his patients.

"Gracious, no," replied the doctor, "but it's an excellent way of getting back your medicine bottles."

RAHERE LODGE NO. 2546.

THE Installation Meeting of the Rahere Lodge was held in the Great Hall at St. Bartholomew's Hospital on Tuesday, June 16th, at 5.15 p.m.

Prior to the Installation, Dr. John Davis Barris and Mr. William Byron Webster were initiated by W. Bro. Arnold Stott, the charge being given by W. Bro. Girling Ball.

W. Bro. Reginald M. Vick was then installed as the Worshipful Master for the ensuing year.

The following officers were appointed:

W. Bro. Arnold Stott	I.P.M.
Bro. Geoffrey Evans	S.W.
W. Bro. H. D. Gillies	J.W.
Bro. R. B. Dand	Chaplain.
W. Bro. Ernest Clarke	Treasurer.
W. Bro. Girling Ball	Secretary.
W. Bro. C. H. Perram	D.C.
Bro. T. H. Just	S.D.
Bro. Howard Jones	J.D.
W. Bro. H. E. G. Boyle	Asst. D.C.
W. Bro. E. Laming Evans	Almoner.
W. Bro. L. W. Bathurst	Organist.
Bro. C. Hamblen Thomas	Asst. Secretary.
Bro. Sir Bernard Spilsbury	I.G.
W. Bro. E. P. Furber	Senior Steward.
Bro. Frank Coleman	Steward.
Bro. M. W. B. Oliver	Steward.
W. Bro. A. H. Coughtrey	Tyler
Bro. E. W. Hallett	Asst. Tyler.

The Past Master's Jewel was awarded to W. Bro. Arnold Stott for the excellent manner in which he had carried out the work of the Lodge during his year of office.

One hundred and twenty-four brethren and guests dined at the Imperial Restaurant.

A REMISSION IN A CASE OF CHRONIC MYELOCYTIC LEUKÆMIA IN A CHILD.

By GEOFFREY BOURNE, M.D., M.R.C.P.

THE following case of myelocytic leukæmia is worthy of record for two reasons: a remission occurred during which the blood picture became normal both in numbers and in kind, as a result of treatment; the case has now been under observation for fifteen months.

Although in adults a temporary return to the normal leucocyte count is a common sequel to radiotherapy, it is rare for the component figures of that count to reassume their normal proportions. Almost invariably myelocytes are, in such cases, still present. Rare as this is in adults, it is an even rarer event in children. With regard to the duration of the disease most writers are dogmatic as to its limitation to a matter of months. Thursfield (1) states: "In children the reported cases have all been of brief duration, at most six to eight months." Still (2) writes: "The average duration seems to be about three months from the time when pallor first attracts attention." Thomson (3) gives the same figures as Thursfield. The references are, of course, to the much commoner chronic form of the disease.

T. C—, æt. 9, was first seen in March, 1924.

Fourteen months previously he had begun to suffer from a cough, started to lose weight and perspired at night.

He was not confined to bed, but remained up and about and played with other children.

Twelve months previously, as the symptoms persisted his trouble was, apparently, diagnosed as tuberculosis, for which he was treated at the local county dispensary.

Seven weeks previously a lump was discovered in the abdomen and he was admitted to the local hospital.

A blood-count done there showed him to have a leucocytosis of 250,000.

There was no history of hæmorrhage from any point, no history of purpuric rash or bruising. The appetite had remained good and the bowels had been open regularly. For the previous few weeks he had had some difficulty in retaining his water.

On March 24th, 1924, he was admitted under the writer's care to the East London Hospital for Children, Shadwell.

Past history.—Measles at the age of 2, pertussis at 4.

Family history.—Mother died of phthisis.

On examination he was a fairly healthy but rather undersized boy. There was no pallor, œdema or purpuric rash.

The temperature was normal, the pulse was 120, falling in four days to 90, and the respiration-rate was normal.

There were no retinal hæmorrhages, the tongue was slightly coated and the breath foul. The gums showed a very severe gingivitis, and the teeth were badly discoloured by a yellowish irregular soft-looking surface.

There were no enlarged submaxillary or cervical glands.

The chest was normal to inspection, palpation and percussion. On auscultation a systolic murmur was heard over the pulmonary base and the air-entry at the left base was deficient.

The abdomen, except for the presence of the large

spleen, was normal. The urine was highly coloured and contained urates, but no albumen.

The spleen reached to the level of the anterior superior iliac spines, at a point 1 in. to the left of the mid-line—a distance of 7½ in. from the costal margin—and, at the level of the umbilicus, to a point 1½ in. to the right of the mid-line.

The blood-count was:

Hæmoglobin	45 per cent.
Red cells	2,784,000
White cells	384,000

The differential count was:

Polymorphs	168,960
Eosinophiles	11,520
Basophiles	11,520
Lymphocytes	3,840
Neutrophile myelocytes	149,760
Eosinophile myelocytes	11,520
Basophile myelocytes	26,880

Two normoblasts were seen in counting 200 cells.

Treatment.—The two main factors that seemed to claim notice were the unusual chronicity of the condition and the youth of the patient. It was felt that the conjunction of these gave the best prospects of success, if indeed success were ever to attend the treatment of leukæmia.

With this object in view an attack was made upon the disease by three methods—X rays, naphthalene tetrachloride and transfusion. In addition the condition of the teeth and gums was treated. The X rays were given in six doses of 3II, 5II, 2½II, 5II, 5H, and 5H, at weekly intervals, the size of the dose varying according to the rapidity of change in the white blood-count.

Naphthalene tetrachloride was given in 5-grain doses three times a day by mouth for eight weeks.

Three transfusions of uncitrated whole blood (40 c.c., 20 c.c. and 40 c.c.) were given at 14-day intervals.

It was known that none of these measures alone had ever influenced leukæmia sufficiently to produce a cure, but, in view of the chronicity of the case and the youth of the patient, it was felt that a combination of all three methods might be worth trying.

The result produced by any one of the therapeutic measures is unfortunately here not analysable, but either *post* or *propter hoc*, a rapid and progressive improvement occurred.

By June 19th the red cells were 5,216,000, the hæmoglobin was 80 per cent. and the white count was 6,700.

The differential count was:

Polymorphs	5065
Basophiles	107
Eosinophiles	0
Large mononuclears	67
Lymphocytes	1273
Neutrophile myelocytes	107
Basophile myelocytes	40
Eosinophile myelocytes	0

On July 7th the count was: Red cells, 5,184,000; white cells, 7500.

The differential count was:

Polymorphs	5550
Eosinophiles	112
Basophiles	75
Large mononuclears	263
Lymphocytes	1500

No myelocytes seen.

The boy returned to his home and has been at school until April, 1925.

On being sent for to ascertain his progress it was found that the spleen had enlarged to a distance of 2½ in. below the costal margin in the left nipple line, and the white count was again increased, the cells numbering 217,000. He is now undergoing further treatment.

Conclusions.—A case of myelocytic leukæmia in a child is reported. The length of history is now fifteen months from the time when the enlarged spleen was first felt.

A remission followed treatment by X rays, naphthalene tetrachloride and transfusion.

I am much indebted to the Pathologist and to the Radiologist of the East London Hospital for Children—Drs. Crawford and Leggett—for their assistance in investigating and treating the patient.

REFERENCES.

(1) THURSFIELD.—*Diseases of Children*, Garrod, Batten and Thursfield, p. 519.

(2) STILL.—*Common Disorders of Childhood*, p. 663.

(3) THOMSON.—*Clinical Study and Treatment of Sick Children.*

NON-CONGESTIVE, ACUTE INTUSSUSCEPTION.

By D. W. WINNICOTT, M.R.C.P.,

Assistant Physician, Paddington Green Children's Hospital and Queen's Hospital for Children.

THE diagnosis of intussusception as it typically occurs in a small child is not always difficult. Indeed, it may be extremely easy when an infant or young child, otherwise healthy, suddenly suffers from acute pain in the abdomen, which causes him to scream and to develop a certain amount of shock, and passes mucus, coloured pink with blood, instead of fæces, and when, on palpation, one finds a sausage-shaped tumour lying deep across the abdomen below the liver margin combined with an emptiness in the right iliac fossa. But there are all degrees of difficulty to be encountered in the diagnosis of individual, non typical cases.

The very fact that a fair proportion of cases are quite typical is in itself a source of danger. The disease-picture is easy to teach to beginners, and the medical student is likely to gain the impression that departures from the typical symptoms and signs can be used as strong arguments against a diagnosis of intussusception.

The following two cases, which came within two days of each other to the Queen's Hospital for Children, do not show any new point. But they may serve to emphasize the importance of diagnosing each case on its own merits and not in relation to a supposed standard case.

CASE 1.—Edna M—, æt. 2 years 10 months, only child of healthy parents, is a slightly-built little girl, but on the whole healthy. She had been under treatment since November last with a persisting *B. coli* infection of the urinary tract. Since January of this year this infection had been only occasionally found, but for minor ailments the child had been kept under observation. Towards the end of April there was a definite improvement in her general health, so that she was discharged from the Out-Patient Department.

May 1st: The patient became suddenly ill and complained of pain in the abdomen. This pain was very severe and came on every quarter of an hour. It caused sweating, absolutely preventing sleep. There was almost complete loss of appetite and retching, but no vomiting. The motion was normal.

This condition lasted for four days before the parents brought the child for advice. During the four days there was some degree of constipation, but at no time was there any blood or slime in the motion. The child persistently said: "I have fallen and hurt my tummy," but the parents had no knowledge of any fall.

May 4th: On the fourth day the parents brought the child to hospital because she was getting very thin from lack of food and drink, and also exhausted from lack of sleep.

When the child was seen in Out Patient's she appeared thin and worn out, but she had a good colour and did not look toxic. Temperature 100° F.; pulse rate about 120. On palpation of the abdomen a resistance was felt in the region of the right upper half rectus muscle. The history of severe spasmodic pain led one to suspect intussusception, and therefore resistance here was known to have special significance. However, the continued normal motions and the absence of vomiting on the fourth day made one hesitate in making such a diagnosis. Moreover, T.B. infection had all along been suspected in this patient, and the swelling which was felt after prolonged palpation would have done excellently for rolled-up omentum. *Per rectum* examination revealed nothing abnormal and was followed by normal fæces.

The child was admitted, and observed until the next day. White blood-count 13,000; temperature 99°; pulse 150.

May 5th: Condition unchanged. Temperature 100°–102°, pulse 160. Taking only lemonade. No vomiting, two normal motions. Operation performed (by Mr. A. W. Mackay, the R.M.O.).

CASE 2.—Zena B—, æt. 11 months, was a healthy child and had never been ill.

May 4th: Suddenly ill, apparently with pain in the abdomen. Loss of appetite. Vomiting. Bowels not open.

May 5th: Vomiting continued. Pain. Bowels not open.

May 6th: Brought to Casualty because of symptoms continuing. Crying made palpation without an anæsthetic very difficult, but "? tumour" was recorded. *Per rectum* a mass was felt, probably fæces. No slime or blood or fæces followed. A saline enema was given, with a constipated result, no blood and a trace of mucus. Temperature normal, pulse 140–150. The child was admitted and examined under an anæsthetic. A tumour was palpated and an operation performed by Mr. Mackay, the R.M.O.

In each case the operation was successful, and in each case Mr. Mackay found an intussusception of the ileo-cæcal variety. There was some œdema, but no marked congestion. Lymph-glands were easily palpable in the mesentery in each case, and in the older child some of these were apparently tuberculous. In neither case was any local condition discovered in the bowel-wall which might have started an intussusception, although some local abnormality is said nearly always to occur in the chronic, secondary intussusception of adults.

The comment on Case 1 would be that the intussusception undoubtedly was present for 100 hours, and that in spite of that there were passed, naturally, just before the operation, two normal stools. There was no vomiting.

In the second case the intussusception lasted about 50 hours before operation, and yet the saline enema produced the ordinary fæcal masses of a constipated patient. There was no blood, and there was a very small quantity of clear mucus, which, presumably, was no more than a common result of the presence of hard fæcal masses on the lumen of the gut.

(I am indebted to Dr. Helen Mackay for permission to publish the second case, which was under her care.)

This condition is usually described as a form of "chronic" intussusception, but it would seem likely that ætiologically there is no relationship between this kind and the secondary, chronic intussusception of adults. Certainly it would be dangerous to regard the disease as a chronic one, not requiring surgical treatment at the earliest possible moment.

On the other hand, it is difficult not to find more in the difference between this variety and the acute typical intussusception with early congestion in the part of the bowel involved than simply a difference of degree. One of these two cases was not at all the robust type of child that one comes to associate with the more usual

acute intussusception picture. She was a puny child with a low-grade tubercle bacillus infection.

The length of the mesentery is thought to be greater in these cases by some observers (5).

There are recorded cases in the literature in which it is pretty certain there was an intussusception which became reduced spontaneously. One wonders whether they were cases of the type illustrated by the two here described.

SUMMARY

(1) Two cases of intussusception are described with, in each case, an unusually long interval between onset of symptoms and urgent need for operation, and an absence of the signs of congestion in the part of the bowel involved.

(2) It is suggested that the name "chronic" intussusception commonly given to this type of case is misleading.

REFERENCES.

(1) HUTCHINSON.—*Diseases of Children*, 1925, p. 393.

(2) STILL.—*Clinical Journal*, 1922, p. 37.

(3) JONES, J. G.—*Brit. Journ. of Surg.*, xii, p. 378 (October, 1924).

(4) MARSH, H. E.—*Ann. Surg.*, lxxix, p. 244.

(5) WAUGH.—*Lancet*, 1911, i, p. 1492.

(6) OWEN, A. W.—*Brit. Med. Journ.*, 1924, i, pp. 904–906.

(7) BERGSTROM.—*Amer. Journ. Diseases of Children*, xxvii, p. 444.

LUPUS VULGARIS TREATED BY LUNDIE'S TUBERCULIN.

THE *British Medical Journal* on February 28th, 1925, published an article, "A New Tuberculin," by Dr. Lundie, in which he comments very favourably on the treatment of lupus vulgaris and lupus erythematosus.

During the last few months we have had the opportunity of treating a case of lupus vulgaris by "tuberculin L" with excellent results.

Miss T—, æt. 30, domestic servant, first came under observation during August, 1924. She was then thin, pale, nervous and obviously ill, but refused examination until November 27th, 1924, when the condition was found.

She stated a small "sore" on her back commenced two years ago and had gradually increased to its present size. She sought advice, but was told it was probably of venereal origin, and had been ashamed to accept treatment. She had lost several situations when her fellow servants had discovered its existence. The case was therefore one of neglected lupus which had received no treatment of any description.

On examination a large patch of lupus vulgaris was seen in the interscapular region, roughly rectangular in shape, measuring 6 in. by 4 in. The surface was rough and nodular, discharging freely, with large incrustations. Typical apple-jelly nodules could be demonstrated, and the whole area looked thoroughly septic. It was surrounded by a red raw advancing edge. The centre was occupied by a white scar.

To exclude the possibility of syphilitic infection, a blood Wassermann was taken and proved to be negative. There was a history of four months' amenorrhœa.

Treatment was commenced with tuberculin L on December 10th, 1924, obtained from Dr. Lundie, made from Bovine Strain No. 1, National Collection of Type Cultures.

Three strengths were used:

No. 1. 100 millions to 1 c.c.
No. 2. 1000 ,, ,, ,,
No. 3. 5000 ,, ,, ,,

Throughout the treatment there was no febrile reaction, and she remained at work.

Below are given the dates of each injection and the weight of the patient.

10.12.24	. mij	No. 1 T.L. .	6 st. 10 lb.
10.12.24	. miv	,,	
14.12.24	. mvj	,,	
19.12.24	. mviij	,, .	6 st. 11 lb.
24.12.24	. mx	,,	
29.12.24	. mxv	,, .	7 st. 0 lb.
	(Menstruated two days.)		
3.1.25	. mij	No. 2 T.L.	
7.1.25	. miv	,, .	7 st. 1¼ lb.
12.1.25	. mviij	,, .	7 st. 2½ lb.
17.1.25	. mx	,, .	7 st. 3½ lb.
23.1.25	. mxij	,, .	7 st. 3¾ lb.
30.1.25	. mxv	,,	
6.2.25	. mxx	,, .	7 st. 4½ lb.
13.2.25	. mv	No. 3 T.L. .	7 st. 6 lb.
Advancing at weekly intervals to—			
3.4.25	. mxv	No. 3 T.L. .	7 st. 8 lb.

The chart shows clearly the gradual increase in weight, which corresponded to a great improvement in the health, appearance and mentality of the patient. She became plump, rosy of cheek and cheerful of mien. Menstruation became regular at four-weekly intervals.

The local condition also rapidly improved. After one month the advancing edge had disappeared and the surface became quite dry.

To-day the whole area is pale and smooth. The apple-jelly nodules are no longer visible. The central scar has been replaced by normal skin and the surrounding skin is growing in from all directions. There is hope of eventual complete cure.

This case was demonstrated before the Lecicester Medical Society on March 25th, 1925.

We have also used this tuberculin in cases of chronic afebrile pulmonary tuberculosis, employing the same system of dosage, using the evening temperature and the weight as a control.

TWO CASES OF SPONTANEOUS FRACTURE WITH SUBSEQUENT UNION OCCURRING IN OSTEITIS DEFORMANS.

IT is well known that osteitis deformans or Paget's disease is characterized by a progressive hypertrophy of the bony skeleton, in which there is much modification in the structure of the bones, so that they yield to pressure. The marked curvature of the weight-bearing bones so produced gives rise in the advanced stage to a typical waddling gait. These changes are often accompanied by rheumatic pains in the bones affected. Sometimes, the disease is localized to one bone, *e. g.* the skull or tibia, but generally the disease is progressive and symmetrical.

Sir James Paget saw his first case of the disease in 1856 but did not publish it until 1876, when he reported five cases.

Wrany described one of these cases in 1867.

Paget named the disease osteitis deformans, not knowing at the time that Czerny in 1873 had described a typical case and suggested the name "ostitis deformans."

In 1697, Malpighii described a condition in which there was a porous hypertrophy of the cranial bones. Later, Virchow called this condition leontiasis ossea, and some modern authorities consider the latter a modification of the typical Paget's disease.

PATHOLOGY.

The disease attacks chiefly the long bones, the spine and skull.

The compact bone is rarefied and thickened, and there is considerable subperiosteal new bone-formation.

The bones are light, soft and porous, with irregular arrangement of the trabeculæ and rarefaction of the cancellous tissue, and often with enlargement of the Haversian canals.

Unlike osteomalacia, the condition is not associated with halisteresis, for Da Costa, Bergain and Hawke found retention of calcium, magnesium and phosphorus, and excess excretion of sulphur. They suggest these results can be explained if the first step in the new formation of bone or osteoid tissue be the production of the organic matrix of bone which is known to be rich in sulphur. Later Ca, Mg and P are deposited in this matrix with the elimination of sulphur. The difficulty to surmount is that the nitrogen excretion does not increase to the same extent as should be the case if all the sulphur had origin in the organic bone matrix. They offer the suggestion that the nitrogen may be conserved in the body and re-utilized.

Pinney has studied the bloods of five cases of the disease, and finds no anæmia and no alteration in the total number of leucocytes, but a definite eosinophilia and a slight basophilia.

ÆTIOLOGY.

The disease seems to begin in middle life in most cases; up to 1901 the average age of incidence was 49. In the 251 cases reported up to 1923, males tended to predominate in the ratio of six males to five females. Heredity appears to be a factor in 7 per cent. of cases.

Nothing is known of the actual cause of the disease.

Paget himself thought it was a chronic inflammation, and this view was supported by Bulton, Clutton, Silcock and many others.

Lunn, in 1885, suggested that it was a constitutional disease producing atrophy and absorption of a large part of the osseous system, with consequent weakening of the bones so that they yielded to strain; this was followed by a compensatory strengthening by the growth of a variety of callus. Silcock severely criticized this view, and asked, "Why atrophy, when the first sign was thickening and enlargement?" Further, if compensatory thickening occurred, this would be of the nature of a buttress, whereas the mass of hypertrophied tissue was deposited on the convexity of the bone and not on the concavity. Also, the cranium was generally affected and there was no strain exerted on the skull.

Von Recklinghausen thought that the exciting cause was of the nature of a true osteomalacia, associated with an inflammatory process which converted the medulla into fibrous tissue. This view appears untenable, especially in the light of modern evidence, which shows that there is retention of calcium and excess excretion of sulphur in Paget's disease, and McCrudden has found

just the opposite conditions in osteomalacia. It may be, however, that calcium retention occurs after a preliminary osteomalacia.

De la Tourette, Prince and others have suggested that it is due to a nerve lesion and have found nerve-changes post mortem. Prince draws a parallel between it and tabes and other nerve lesions where cord degeneration occurs, where often the first symptoms are severe rheumatic pains. The latter are frequently noticed in the beginning of Paget's disease, and he suggests that just as lesions of certain parts of the spinal cord cause myopathies, so lesions of definite groups of nerve-cells might be the cause of osteopathies without any other spinal symptoms.

Again, Fournier and Lannelongue attribute the disease to a late manifestation of a syphilitic or para-syphilitic lesion.

Finally, Keith and others put forward the view that the disease is a result of a loss of balance between the constituents of the endocrine system. Perhaps, it may be due to some disturbance of parathyroid function which is known to be bound up with calcium metabolism, or to lesions of the thyroid or pituitary body, which glands have been found pathological in many cases post mortem.

Statistics have shown that nearly 10 per cent. of all cases of the disease develop sarcoma, *i. e.* the disease predisposes to the development of sarcoma. It has been thought that malignant disease may result from the "ill-regulated cellular activity which attends abnormal bone-destruction and bone-formation."

According to the records of 251 cases, only 15 cases of pathologic fracture are reported.

Le Wald found spontaneous fractures in 4 out of 14 cases. He believes that they are not unusual, and if they occur will probably unite.

Hurwitz, on the other hand, states that the occurrence of spontaneous fractures is almost pathognomonic of osteitis fibrosa, and he believes that a number of cases have been incorrectly described as Paget's disease.

Lewin recently reported the third case on record of a pathologic fracture with bony union in a bone with osteitis deformans.

In the light of these rather contradictory statements, the report of the two following cases is warranted.

In both these cases, diagnosed as osteitis deformans, a spontaneous fracture occurred, which was followed by good union.

G. W—, male, æt. 46, labourer.

Past history.—August, 1924: Patient tripped upon some loose chalk whilst carrying a heavy stone. He felt something snap in his left leg. He was taken to a cottage hospital in a conveyance, was told he had no fracture and was taken back to his home. Patient stayed in bed for three months. Then he got about on two sticks, for he still had considerable pain of a dull aching character. He says he noticed "bowing" of his left leg after getting up and about.

Patient was sent to hospital by an insurance agency and was admitted on March 13th, 1925.

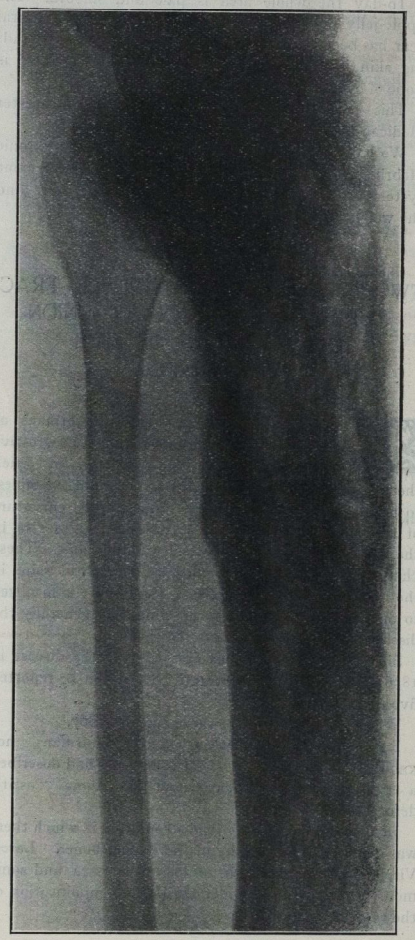

FIG. 1.—G. W—. X-RAY PHOTOGRAPH ON ADMISSION.

Condition on admission.—Healthy-looking man; eyes equal, react to light and accommodation. Skull: No signs of enlargement of cranial bones. Femora: There is slight exaggeration of the anterior curve of the femora.

Tibiæ—Left: This bone is bowed outwards and forwards; the skin over the shin is shiny and far more brown in colour than the right leg. Two scars are to be seen just below the patella due to an old injury, five or six years ago, in a bicycle accident. The whole bone is enlarged, especially at about the junction of the middle and upper thirds. On palpation, the anterior surface is rough and uneven throughout and the skin is hotter to the touch than that on the right. There is no sign of fracture, and movements are normal. Six inches below the patella the left leg is 1½ in. wider in circumference than the right. Just above the malleoli the left is ½ in. broader. On standing the knees are wide apart with the heels together.

Right: There is a slight accentuation of the anterior curve of the right tibia.

Head: This is 22 in. in circumference, and 12½ in. from the meatus of one ear to the other. There is an old scar on the penis. Remainder of skeleton appears normal.

Special examinations.—Wassermann and Sigma reactions positive.

Blood-count: Red blood-corpuscles, 6,000,000; white blood-corpuscles, 3200; hæmoglobin, 74 per cent.; colour index, .62.

X-ray examination.—The upper three-quarters of the tibia shows: (1) Transverse, united fracture about 12 cm. from the knee-joint; (2) the whole of the bone is rarefied and the compact tissue is thickened. The Haversian canals are greatly enlarged (Fig. 1).

F. R—, male, æt. 36, commercial traveller.

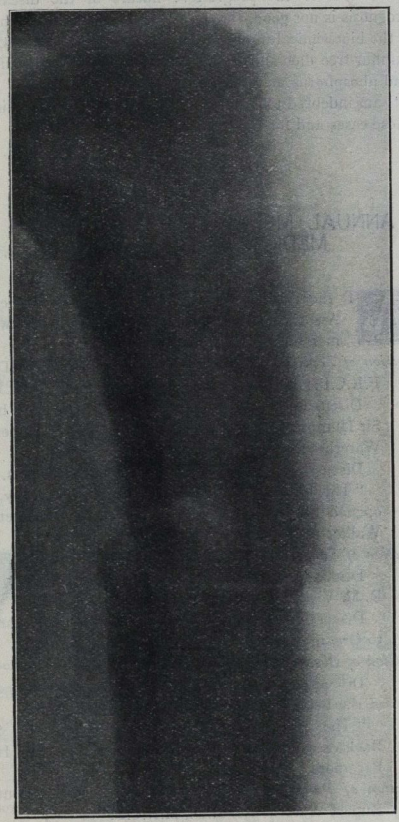

FIG. 2.—F. R—. X-RAY TAKEN IMMEDIATELY AFTER FRACTURE.

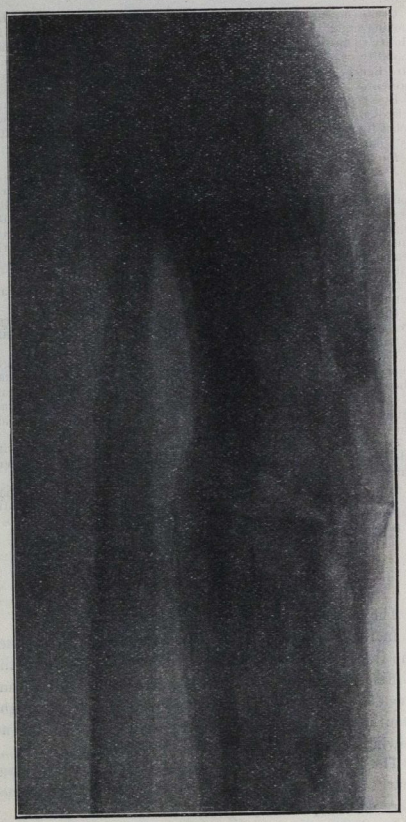

FIG. 3.—F. R—. X-RAY TAKEN FOUR MONTHS LATER SHOWING UNION.

Past history.—Spring, 1918: Patient struck left tibia (shin) on step of 'bus.

Autumn, 1918: He noticed a diffuse, brawny swelling on the front of the left leg.

July, 1919: His left leg felt very hot, but was not red. Patient visited his doctor, who advised X-ray.

July 22nd, 1919: To-day the leg was X-rayed privately.

July 28th, 1919: Patient tripped up whilst walking down escalator and fractured his left tibia, and was admitted to St. Mary's Hospital

same day. Six weeks later he left hospital with leg in plaster; the latter he wore only for two days. Patient says that from this time the leg seemed to bend forwards and to be swollen.

June, 1924: He had another X-ray taken of this leg, for leg was much swollen and very painful at intervals.

January 30th, 1925: While hurrying around a corner patient suddenly felt his leg give way under him. He supported himself against a wall and did not fall or slip. He then realized he could not walk.

Condition on admission.—Lying on a stretcher. Very healthy-looking man. Swelling and forward bowing of left tibia, with inability to move it. Covering skin is pigmented (brown). Abnormal mobility of lower three-quarters on upper quarter of tibia. Urine: no Bence-Jones protein. Wassermann: negative. Knee-jerks present.

Eyes equal, react to light and accommodation. Arteries not sclerosed. Neck: thyroid normal size. History of neuralgic headaches frequently. Head: circumference 56 cm.; meatus to meatus 35·5 cm. No abnormal distance between femora on standing.

Family history.—No evidence of inherited disease of bone.

X-ray report.—(Fig. 2.) There is a horizontal fracture about 10 cm. from the knee-joint, with little displacement. The tibia is considerably enlarged. The compact tissue is much thickened, but its density is less than the more normal region of the head of the bone. The cancellous bone is irregular in density and the Haversian canals have practically disappeared in the lower part, but in the head of the bone they can still be seen. The disease extends to within 5 cm. of the ankle-joint.

Diagnosis.—Osteitis deformans, although the Haversian canals are not enlarged, as is the rule.

The whole osseous system was then investigated. There has been no increase noticed in the size of the head or any other bones (size in hats at present 6¾; patient's height 5ft. 6½ in.).

X-ray examination.—The left humerus, both femora, the right tibia, the bones of the forearms, hands and right foot appear normal. The right humerus shows increased density of the shaft and increase in width, mainly of the compact bone, and general loss of internal detail, with some enlargement of the Haversian canals. There are similar changes seen round both acetabula.

Treatment.—The leg was splinted on a Neville's back splint with side pieces, and patient was discharged in plaster with apparent union on February 26th.

April 8th: Patient's leg was again X-rayed to see if union had taken place. The plate showed that the line of fracture was still visible, but there was a fair amount of callus formation.

June 3rd: Union is progressing satisfactorily (Fig. 3).

CONCLUSIONS.

The age of onset of the disease is characteristic.

In the case of G. W—, it is difficult to say whether the fracture was the result or the exciting cause of the diseased condition, although the skiagram suggests that the disease had been present for longer than eight months. Nevertheless, the patient states that no bowing was noticed until after the fracture.

The fracture has united well and the disease is apparently localized to the one bone, though the other bones were not examined by X-ray.

In the case of F. R— the history is much more complete. It is apparent that—

(1) The disease was present in 1919, before the first fracture.

(2) There was complete bony union after, as is shown by skiagram dated June, 1924.

(3) The spontaneous fracture, January, 1925, was definitely due to the disease in the bone.

(4) A syphilitic origin is unlikely.

(5) The disease is not localized in the one bone, but has affected also the acetabula and the right humerus.

(6) As yet, the cranium is not apparently affected.

(7) There is good union of the fracture by callus, though union has been slow.

In view of the progressive nature of the disease, prognosis is not good, though it has been suggested that if the biochemical findings be accepted, then, perhaps, a sulphur-free diet and feeding with calcium, magnesium and phosphorus may improve the condition.

I am indebted to Prof. Gask for permission to publish these cases and for helpful criticism.

L. R. JANES.

ANNUAL MEETING OF THE BRITISH MEDICAL ASSOCIATION.

AT the Annual Meeting of the British Medical Association the following St. Bartholomew's men among others will take part:

Section of Medicine.—Vice-President, E. J. Cave, M.D., F.R.C.P.; Hon. Sec., F. G. Chandler, M.D., F.R.C.P.

Discussion on Rheumatoid Arthritis, opened by Sir Humphry Rolleston, Bt., followed by Dr. Rupert Waterhouse.

Discussion on Hyperpiesis, Dr. Geoffrey Evans.

"The Uses and Abuses of Endocrine Therapy," opened by Dr. W. Langdon Brown; Mr. Kenneth Walker to take part.

Section of Surgery.—Hon. Sec., Mr. R. M. Vick, O.B.E.

Discussion on Acute Intestinal Obstruction, Mr. R. M. Vick.

Discussion on Fractures, with Special Reference to Organization and Teaching, Mr. G. E. Gask.

Section of Obstetrics and Gynæcology.—

Discussion on the Treatment of Inoperable Cancer of the Pelvic Organs, Mr. Malcolm Donaldson.

"The *rôle* of Surgery in the Treatment of Backward Displacement of the Uterus," Mr. R. H. Paramore.

Section of Pathology and Bacteriology.—Vice-President, Rupert Waterhouse, M.D., M.R.C.P.

Discussion on Filter-passing Viruses, Dr. Mervyn H. Gordon.

Discussion on the Pathological Basis of Treatment by Radium, Dr. T. S. P. Strangeways and Dr. Canti.

Section of Neurology and Psychological Medicine.

Discussion on the Treatment of Insomnia, Dr. Harry Campbell.

Discussion on Prophylaxis in Mental Disorders Sir Humphry Rolleston.

Section of Therapeutics.

Discussion on the Treatment of Asthma, opened by Dr. W. Langdon Brown; Dr. P. Hamill to take part.

"Treatment of Chronic Arthritis," opened by Sir Thomas Horder, Bt.; Dr. C. B. Heald to take part.

Section of Laryngology, Otology and Rhinology.—Vice-President, Sydney R. Scott, M.S., F.R.C.S.

Discussion on Overlooked Cases of Foreign Bodies in the Air-passages, Mr. E. B. Waggett to take part.

"Operative Treatment of Chronic Middle-ear Suppuration," Mr. Sydney R. Scott.

Discussion on Occupational Diseases of Ear, Nose and Throat, and their Prevention, opened by Mr. T. Jefferson Faulder, Mr. C. A. Scott Ridout.

Section of Diseases of Children.—Hon. Sec., R. A. Ramsay, M.Ch., F.R.C.S.

"Treatment of Empyema," Dr. F. G. Chandler.

Section of Ophthalmology.

Discussion on Eye Injuries and Interstitial Keratitis, opened by Mr. T. Holmes Spicer.

Section of Orthopædics.—President, Prof. E. W. Hey Groves, M.S., F.R.C.S.

A CASE OF PROCIDENTIA.

THE notes of the following case may be of interest, as they are concerned with a case of complete procidentia of a size rarely seen nowadays.

On May 23rd, 1925, E. E—, æt. 49, was admitted to this hospital suffering from prolapse. Her last period occurred in November, 1924.

In 1901 she was admitted to this hospital because of a slight prolapse, which was treated in a satisfactory manner.

About two years ago the patient noticed her womb was coming down a little, but as it went back when she lay down no notice was taken of it; since then the descent had become irreplaceable.

On May 23rd she came up to hospital and was admitted. That night she had some incontinence of urine.

On examination a tumour protruding from the vulva was noticed, which was about 12 in. in length and had a diameter of 6 in. At the lower end an opening, apparently the external os, could be seen.

On the anterior surface there was an area of ulceration about 2 in. by 1 in., while laterally there were many smaller ulcerated areas. The surface was dry and scaly elsewhere, and the cervix very large and œdematous.

On further examination it was decided that the tumour was composed of (i) the vagina completely everted; (ii) the bladder (when a catheter was passed into the urethra it went vertically downwards for 0½ in.), (iii) the cervix and uterine body, which was retroflexed within the inverted vagina—a uterine sound passed in for 3¾ in., (iv) ? coils of small intestine. No other abnormalities were discovered.

An operation was performed on May 29th under a general anæsthetic, with the patient in the lithotomy position. The tumour was thoroughly cleaned up and an attempt was made to replace the swelling. Pressure was applied by the operator, aided by his house-surgeon, and many manipulations were made to reduce it. Although the œdema had been considerably lessened by treatment, the vagina was not able to be returned to its normal condition.

The patient was then returned to the ward. She suffered to some extent that evening from shock—her temperature fell to 96·2° and her pulse to 64. By the next evening, however, she had recovered considerably.

On June 8th the patient was again operated on, and this time, after due antiseptic precautions had been taken, the abdomen was opened in the mid-line below the umbilicus by an incision 6 in. in length. The intestine was found to extend downwards into the upper part of the prolapse and it was noticed that there were no adhesions present.

The vagina, however, defied all attempts made by bimanual manipulations to replace it in its normal position. This was due to the enormous size of the os uteri, which was hardened, and was as large as, if not larger, than the pelvic outlet. An incision was then made in the os to allow the two portions of it to overlap, but even this was of no avail, it was then decided to amputate the os.

The abdominal cavity was therefore closed and the prolapsed portion cleaned up, and after the patient had been put in the lithotomy position, was surrounded with sterilised towels in the usual way. An incision was made around the cervix, and a sound passed into the uterus through the os to act as a guide. The uterine arteries and veins were ligatured carefully as the dissection proceeded, but it soon became evident that owing to the enormous hypertrophy of the cervix and the abnormal displacement of the peritoneal pouches, the cervix could not be removed cleanly without performing a vaginal hysterectomy. The Fallopian tubes were therefore cut and ligatured, and the uterus, with the os, was removed. The two edges of the peritoneum were then sewn together, as were also the parametric stumps and the cut vaginal edges. The vagina was inverted into its normal position, after which it was packed with gauze soaked in flavine; a bandage was applied and the patient returned to the ward. About two hours later it was discovered that the vagina had prolapsed again.

After the operation the temperature was 96·6° and the pulse 124. The patient was given a rectal saline, which was retained for about three hours; later, however, the temperature rose to 98°, while the pulse remained the same. The patient was taking abundant fluids, but further salines were not retained.

The next day the temperature gradually rose to 99·5° and the pulse fell to 96. The patient was vomiting slightly, but the abdomen did not seem to be at all rigid.

On the following day the temperature was 100° and the pulse 132, and with this other signs of peritonitis were present. There was some impairment of note on percussion in the right flank and some tenderness in the left iliac fossa. A blood transfusion was then done and 350 c.c. of blood were used. The pulse dropped a little in speed and became fuller at once. Closely after this the patient had a rigor, when the temperature rose to 104·2° and the pulse to 140; the former, however, soon dropped back to 100°.

Unfortunately death soon followed this state of affairs, and the post-mortem examination revealed, as was expected, a general peritonitis, which had spread from the hysterectomy scar.

One interesting feature of this case is that the patient had had only two pregnancies—one in 1898, when the child was stillborn, and when instruments were used, and another in 1899. Following the birth of the first child the patient was in bed with puerperal fever for six weeks.

I am indebted to Dr Barris and Dr. Donaldson for permission to publish this case, and to Dr. W. Shaw for various suggestions.

H. P. LEHMANN.

SOME SUGGESTIONS FOR THE ADVERTISEMENT OF A NEW PATENT MEDICINE.

COLLOL cured the huge carbuncle
That so cursed our aged Uncle.

COLLOL given for half a year
Completely cures "main d'accoucheur."

COLLOL as a nasal spray
Drives hay fever far away.

COLLOL, t.d.s., p.c.—
Bid farewell to B.C.C.

COLLOL by the venous route
Slays Neisser's parasitic brute.

It is whispered—though still rumour—
COLLOL cures Pott's Puffy Tumour.

Give her COLLOL—no more dithering,
See her toxic goitre withering.

COLLOL given twice a day
Turns R.O.P. to L.O.A.

COLLOL cures that wretched chest tickle
And arrests malignant testicle.

COLLOL dropped into her ear
Cured the maid's dysmenorrhœa.

COLLOL rubbed into the tummy
Turns the corpse into a mummy.

ABERNETHIAN SOCIETY.

THE SUMMER SESSIONAL ADDRESS was delivered on Thursday, June 18th, at 8.30 p.m. in the Medical and Surgical Theatre by Sir Arthur Keith, F.R.S., on "Something Ancient." The lecture was illustrated by lantern-slides. Mr. F. H. K. Green was in the Chair. A large audience of members of the Staff, visitors, nurses and students was present.

The lecturer began by saying that he proposed to show how family trees are built up. As a concrete instance he would take the Taungs skull and endeavour to show the part it played in man's family tree. He then showed a map of Africa and pointed out the position of Taungs, where the skull was found; it was in the Kalahari Desert, about 1000 miles north-east of Cape Town. He then pointed out and showed slides of Broken Hill, further north, where the Rhodesian skull was found; this was undoubtedly human, with the face of a gorilla. It belonged to the early Pleistocene period.

The lecturer then showed a diagram representing the human family tree, and showing how the various skulls found from time to time fitted in, and how all the different races were sprung from a common stock. "Pithecanthropus" was the oldest and was entirely on a branch of its own. It most nearly of all represented the "missing link" of the theory of evolution.

The Taungs skull, which was discovered by Prof. Port, was in no sense to be described as a "missing link," and was of a comparatively recent date. It was probably between 50,000 and 100,000 years old. It was undoubtedly the skull of an anthropoid ape. Proofs of this were to be found in the character of the teeth, the shape of the face, and the size of the head. Slides were shown which fully illustrated these points. At birth the brain of a gorilla was nearly the same size as that of a newborn child, but the gorilla's brain grew very little afterwards, so that the brain of an adult man was very much larger than that of an adult gorilla. The fact that the bones of the face of a gorilla grow very much more than the bones of the skull leads to a great change in the shape of the head as it grows up. The shape of the Taungs skull pointed to its belonging to an animal about four years old.

The region where Taungs is situated was originally a green and fertile land, and it was due to the fact that it was now a desert that the race of apes to which the Taungs ape belonged had become extinct.

The skull was now to be seen in the South African Pavilion at Wembley. It was there described as the bedrock of the human family tree, and plaster casts had been made of the original owner, showing him as a man of about sixty, complete with bushy eyebrows, long grey hair, and a nose suggestive of syphilis. All of this was, of course, quite ridiculous.

Prof. GASK proposed a vote of thanks, Mr. BOLTON seconded, and the motion was carried unanimously.

The meeting was then adjourned.

UNITED HOSPITALS SPORTS.

THE 54th Annual United Hospitals Sports Meeting took place at Stamford Bridge on Tuesday, June 9th, in glorious weather.

May we congratulate the Hospital, and particularly those who represented us, on a magnificent performance in winning the Sports? This realization is all the more gratifying in view of Dr. Morley Fletcher's very apt speech, in which he said that there had never been better all-round performances than at this meeting.

The Hospital were fortunate in having Mr. H. B. Stallard as captain; he alone annexed 30 points and the Victor Ludorum Cup—the first time this has been won by a Bart.'s man. He won the ¼ Mile, Mile and 3 Miles, and ran a very good ¼ mile in the relay. His efforts cannot be too highly appreciated.

Mr. W. S. Hinton has been secretary this year; it is safe to say that the office could not have been more efficiently filled. He has worked tremendously hard to get the team together and has been successful in the most tangible way.

There were a number of the Staff present, which was much appreciated, and gave added encouragement to our competitors.

There was an unfortunate occurrence in the 220 yards, both Griffiths and Hinton falling, Griffiths being badly spiked.

Two records were broken and two equalled.

T. R. Griffiths equalled record in the 100 yards by doing 10 secs., while C. K. Lakshmanan equalled the hurdles record of 16⅗ secs.; both are to be congratulated.

The Bart.'s relay team, despite the absence of Griffiths, knocked 1½ secs. off the record. Hinton ran a very good 220 despite being in obvious pain; Sinclair did a fast 440.

A. Honner, of London, jumped magnificently in the Long Jump, and knocked nearly 6 in. off the record; he cleared 23 ft. 10¼ in.

Ten points were scored for a win and six points for a second.

Results:

Three Miles: 1, H. B. Stallard (Bart.'s); 2, J. R. Beagley (Bart.'s); 3, G. W. Rake (Guy's). 10 yards; 40 yards.

100 Yards: 1, T. R. Griffiths (Bart.'s); 2, C. S. Steyn (Guy's); 3, W. Hinton (Bart.'s). Time, 10 secs. Won by 2 yards; 1 yard.

Half-mile: 1, H. B. Stallard (Bart.'s); 2, F. Ta'Bois (London); 3, L. Wills (Guy's). 12 yards; 6 yards. Time, 2 min. 3⅘ secs.

Putting the Shot: 1, E. W. Hutchinson (Guy's), 37 ft. 8 in.; 2, J. D. Buttery (Bart.'s), 36 ft. 4 in.; 3, W. Hertzog (Guy's), 35 ft. 3in.

220 Yards: 1, C. W. Harrison (Guy's); 2, W. S. Hinton (Bart.'s). 12 yards. Time, 23⅘ secs.

Throwing the Hammer: 1, R. Kennedy (St. Thomas's), 90 ft. 8 in.; 2, R. W. Hutchinson (Guy's), 88 ft. 7 in.; 3, G. H. Day (Bart.'s).

120 Hurdles: 1, C. K. Lakshmanan (Bart.'s); 2, C. W. Harrison (Guy's); 3, E. C. Marsh (St. Thomas's). Inches; 5 yards. Time, 16⅘ secs.

1 Mile: 1, H. R. Stallard (Bart.'s); 2, F. W. Ta'Bois (London), 3, E. W. Skiffer (London). 8 yards; 12 yards. Time, 4 min 53 secs.

Long Jump: 1, A. Honner (London), 23 ft. 10¼ in.; 2, W. Hertzog (Guy's), 22 ft. 8½ in.; 3, C. L. Steyn (Guy's), 22 ft. 5½ in.

440 Yards: 1, A. Honner (London); 2, C. W. Harrison (Guy's); 3, D. B. Smallshaw (Guy's). 2 yards; 8 yards. Time, 51 secs.

High Jump: 1, E. C. Marsh, 5 ft. 0½ in.; 2, C. K. Lakshmanan (Bart.'s), 5 ft. 7 in.; 3, S. Howard (London), 5 ft. 6 in.

Tug-of-War: Guy's beat Middlesex 2 pulls to 0.

Relay Race (220, 220, 440, 880); 1, Bart.'s (P. R. Viviers, W. S. Hinton, M. R. Sinclair, H. B. Stallard); 2, London; 3, Guy's. 20 yards; 20 yards. Time, 3 min. 43½ secs.

Bart.'s won the following challenge cups: 100 Yards, T. R. Griffiths; Half mile, 1 Mile, 3 Miles and Victor Ludorum—H. B. Stallard; Relay and the Inter-Hospital Challenge Shield.

Points: Bart.'s 84, Guy's 60, London 38, St. Thomas's 20 Middlesex 6, King's 0.

P. H. F.

STUDENTS' UNION.

GOLF.

STAFF *v.* STUDENTS.

Played at Denham on Wednesday, May 20th, 1925.

Mr. Rose	1	W. A. Barnes	0
Mr. Roxburgh	0	H. O. White	1
Dr. Hinds Howell	1	H. E. Houfton	0
Dr. Graham	1	C. E. Woodrow	0
Mr. Wade	1	J. H. T. Davis	0
Dr. Hill	1	J. Cox	0
Mr. Just	1	S. Burt	0
Mr. Scott	½	C. A. Francis	½
Mr. Bedford Russell	0	W. S. Maclay	1
Sir Charles Gordon Watson	½	J. G. Milner	½
Mr. Griffiths	1	A. H. Roberts	0
Mr. Foster Moore	0	A. F. Wallace	1
Dr. Garrod	1	W. A. Briggs	0
Mr. Holmes Spicer	0	J. Spencer	1
	8		4

Dr. Hill and Mr. Wade	0	Woodrow and Cox	1
Mr. Roxburgh and Mr. Just	0	White and Houfton	1
Dr. Hinds Howell and Dr. Graham	1	Barnes and Francis	0
Mr. Scott and Mr. Russell	0	Maclay and Davis	1
Sir C. Gordon Watson and Mr. Foster Moore	1	Burt and Roberts	0
Mr. Griffiths and Mr. Spicer	0	Milner and Briggs	1
Dr. Garrod and Mr. Rose	0	Wallace and Spencer	1
	2		5

The result was a win for the Staff, who started 3 up on each round, by 10 matches to 9.

The day was perfect as regards weather, and a vote of thanks was proposed to the Staff, who treated the students to an excellent supper in the Clubhouse.

CRICKET CLUB.

AN enjoyable Cricket Week was spent during the glorious first week of June. Results were quite satisfactory, although it was not always possible to put a strong side in the field. A very pleasant game was played against Dr. Hinds Howell's XI; at one time the Hospital team nearly collapsed, and it is hoped that next year—when the match will be played on a Saturday—this Past *v.* Present Match will revert to its former glory.

As a result of our win over Charing Cross Hospital we are in the final tie, and have hopes of winning the Cup for the first time since 1907.

The 2nd XI have been doing well under F. P. Guilfoyle, and should enter the final tie at the expense of King's College Hospital 2nd XI.

RESULTS.

Whit-Monday, June 1st (won by an innings). Croydon C.C. 35 and 101 (Bettington 6 for 15, Meeser 4 for 13). Bart.'s 161 (Bettington 77).

June 2nd (drawn). M.C.C. 289 for 9 (dec.) (Cook 5 for 58). Bart.'s 149 for 7 (Mackie 57, Tannet 38).

June 3rd (won by 8 wkts.). R.A.M.C. (Aldershot) 51 (Bettington 8 for 13, Cook 2 for 1). Bart.'s 303 (Bettington 166).

June 4th (lost). Old Cholmeleians 278 for 7 (dec.). Bart.'s 91.

June 5th (won by 4 wkts.). Dr. Hinds Howell's XI 94 (T. Owen 21; Bettington 3 for 14, Cook 4 for 38). Bart.'s 146 (Maley 47 not out).

June 6th (lost by 6 wkts.). Bart.'s 101. St. Albans 163 (Maley 7 for 48).

June 13th (lost by 3 wkts.). Bart.'s 132 (Guinness 39). Streatham 181 (Maley 6 for 56).

June 19th.—Semi-final, Inter-Hospital Cup (won by 249 runs). Bart.'s 373 for 4 wkts. (dec.). (Bettington 147, Cook 106, Sinclair 51 not out). Charing Cross Hospital 124 (Bettington 6 for 48).

June 20th (lost by 104 runs). U.C.S. Old Boys 202 (Cook 5 for 51). Bart.'s 98 (Cook 29).

2ND XI.

May 23rd (lost). U.C.S. Old Boys 2nd 95 (Guilfoyle 6 for 36). Bart.'s 80.

THE UNIVERSITY OF LONDON ATHLETIC SPORTS.

THE Annual Meeting of the U.L.A.C. was held at Stamford Bridge on Wednesday, May 27th. Owing to exams., etc., the Hospital were not able to enter a full team (as had been hoped) in order to compete for the "Rosebery Bowl."

The following gentlemen, however, entered individually: Messrs. Beagley, Buttery, Hinton, Hosford, Lakshmanan and Griffiths.

RESULTS.

100 Yards: 1, T. R. Griffiths, 2, W. S. Hinton.
220 Yards: 1, T. R. Griffiths; 2, W. S. Hinton.
120 Yards Hurdles: 1, C. K. Lakshmanan.
Putting the Shot: 2, J. W. D. Buttery.
B. B. Hosford and J. R. Beagley qualified for the finals of the 440 and 880 Yards respectively, but failed to gain places in the final.

CORRESPONDENCE.

INSURANCE.

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

DEAR SIR,—In the March number of the JOURNAL appeared some very sound advice by "Third Chip" to those about to enter general practice on the subject of insurance. I should like to cordially endorse his remarks and to add a few words on this subject. I wish most strongly to urge on those who will be practically dependent on their professional earnings to most seriously reflect on what might be the fate of those nearest and dearest to them in the event of their early death. The tragedies to be read in the reports of such societies as The Royal Medical Benevolent Fund should be enough to frighten the most thoughtless, and to make one reflect how culpable it is for any young medical man who is unfortunately without private means to marry without seriously considering future possibilities. The object of this letter is to point out to those in this situation how considerable provision can be made for those dependent on them for practically no expense. The Society for the Relief of the Widows and Orphans of Medical Men, 11, Chandos Street, Cavendish Square, W. 1, was founded in 1788 to relieve the widows and orphans of its members who are left with an income of under £125 a year. This society is so strong financially that last year it was able to grant £65 to the widows of its members and a similar amount to each orphan under 16, and to obtain these advantages the annual subscription is only 2 guineas for those who at the time of their election are under 40 years of age. I need hardly point out what a large premium would be required by an ordinary insurance society for this—forty times as much I dare say in the case of those insuring when not young and leaving several children. I should like to add that the good work carried on for the last 137 years by this Society has only been made possible by the generous help of the more fortunate members of our profession, and to appeal to them by becoming members to help the widows and orphans of the less fortunate.

Yours faithfully,

June 22nd, 1925. A. M. WARE.

REVIEWS.

SURGICAL OPERATIONS: A TEXT-BOOK FOR NURSES. By E. W. HEY GROVES. (Oxford Medical Press.)

The decision to publish a book giving a simple account of surgical operations and technique was a timely one. The recently instituted State Registration examinations for nurses call for a wider theoretical knowledge than has hitherto been necessary, and for this reason alone nurses should find *Surgical Operations*, by E. W. Hey Groves, a welcome addition to their bookshelves.

The nurse entering an operation theatre for the first time will appreciate the author's well known gift for presenting facts in their most rapidly assimilated form.

In a busy operation theatre a nurse has few opportunities of observing cases from A to Z; reference to this work should enable her to fill in the gaps, and therefore perform her duties more intelligently.

The ward nurse also should benefit by it. It must be of immense advantage to her in the post-operative treatment of her patients if she has some knowledge of the steps of the operation performed.

The student who enters in trembling and fearfulness into the operating theatre, will find himself able to take an intelligent interest in procedures that are complicated and confusing if he has read certain parts of the book, which explain lucidly the details which it is essential he should understand.

Moreover, when the day for the final reckoning approaches, he will find the appendix, which contains illustrations of surgical instruments, extremely useful.

Good type, excellent paper and numerous illustrations combine to make a useful text-book, which we can recommend to both students and nurses.

CANCER AND THE PUBLIC. By CHARLES P. CHILDE, B.A., F.R.C.S. (Methuen & Co.) Pp. 250. Price 10*s*. 6*d*.

This book, which is written in language suitable for the layman, has a very definite end in view. The author believes that certain facts about cancer ought to be known by the public, and that the broadcasting of these facts would enormously improve general outlook in this condition.

He demonstrates by his statistics the curability of cancer in certain regions of the body, and by a further set the immensely improved prognosis if the patient comes early to the surgeon.

He then describes the danger signals of cancer in various regions and adds a rather unconvincing chapter on prevention.

The book ought to prove of great value by stimulating the profession to spread necessary knowledge along well-chosen channels, and by acquainting public-spirited people with facts to pass on to the public which matters but which will not read this book.

The volume is not easy reading: there are far too many lists of statistics and far too much repetition. But the medical man should be aware of its existence, and time will be well repaid which is spent in observing the authors' method of presenting an argument which is to him already a truism, but which to his patient is tragically unknown.

MINOR SURGERY. By LIONEL R. FIFIELD, F.R.C.S. (London: H. K. Lewis & Co., Ltd., 1925.)

We think that there are already too many books of this type. It is impossible to separate "minor" from "major" surgery; and when, as in the present case, attempts are made to do so, the result is a work which just dabbles in clinical and applied surgery. Even the beginner would do better to go straight to the text-books on the subject. The house-surgeon and other young practitioners would often be grateful for a book which deals sympathetically with the difficulties they may be up against—difficulties in the way of after-treatment of major and minor operations, for example the after-care of prostatectomy, about which there is very little in the books.

THE STATICS OF THE FEMALE PELVIC VISCERA. Vol. II. By R. H. PARAMORE, M.D., F.R.C.S. (London: H. K. Lewis & Co., Ltd.)

The author is to be congratulated on the very able and thorough account he has given of the historical side of the treatment of the forms of prolapse. This part of the book makes very interesting reading, and excellent material has been chosen to indicate the author's ideas. An enormous amount of literature has been consulted and the author must be complimented for his industry. Perhaps the historical *résumé* has not a perfect sequence, but this is but a small point. The critical survey of the old plastic operations is very good, and the explanations of their failures are carefully analysed. In this way, mainly by a process of exclusion, the criticism becomes constructive. The term "pudendal hernia" is advocated to cover all forms of prolapse and the term "prolapse" is condemned. A good deal can be said for the author's point of view, but the modern tendency is to describe the condition in its individual form rather than to use a general term. The book is very well written and the diagrams and plates excellently produced. Perhaps a third volume is in preparation, for the brief allusions to the suspensory operation seem insufficient, and the recent operations of vaginal fixation and interposition are not considered.

MIDWIFERY. Catechism Series. Third Edition. Part I. (Edinburgh: E. & S. Livingstone.)

It is often useful for a student before his examination to obtain a compact classification of the branches of the subject for which he presents himself. He can then bring together the impressions he has somewhat diffusely acquired in reading the standard text-books. In this respect this volume is of considerable value. The material is well arranged, facts are stated concisely and only important points are indicated. The print is good, but mistakes in the letterpress are numerous and require revision.

TEXT-BOOK FOR NURSES, SURGICAL AND MEDICAL. By HEY GROVES AND BRICKDALE. (Oxford University Press.) Price 2*6s*.

The authors of this work have been too ambitious. It is not possible to cover the whole ground of anatomy and physiology, medical and surgical nursing and hygiene in a volume of some 600 pages of large print. It is not the nurse's duty to do operations, therefore she does not need illustrations of removal of the breast, etc. It *is* her duty to see that everything the surgeon needs is correctly set forth for his use; she will not find any help in this direction. It is useless to say ice poultices or leeches may be needed for the treatment of a patient unless a description of how to make or apply them is given. A text-book should contain detailed descriptions of articles to be used and methods of preparing and using them; this could be done without enlarging this book by deleting the unnecessary matter, and concentrating on real nursing methods which can have a ground-work in written description, although practical work is necessary to acquire useful skill.

We wonder why the work has a different name on the cover and title-page to its subsequent title on each page!

A MANUAL OF MIDWIFERY. By T. W. EDEN and EARDLEY HOLLAND. (Messrs. J. & A. Churchill.) Pp. 704. Price 21*s*.

The sixth edition of this well-known book is edited by Dr. Eardley Holland, to whom certain changes are due.

The section on toxæmiæ of pregnancy has been carefully and lucidly re-written and it is easy to see that Dr. Holland is no mean supporter of the placental theory.

The new part dealing with "Diseases, Injuries and Death of the Fœtus" is a real addition, and worthy of the book. A plea is made for recognition of pulmonary respiration as a sign of "live-birth"; dead-birth is used where the fœtus dies without breathing, even if the fœtal heart be heard at birth; while "still-birth" is used synonymously with asphyxia neonatorum. These definitions we feel should be adopted generally.

One disagrees with certain statements and opinions put forward.

The treatment of pulmonary embolism with cardiac stimulants and oxygen can hardly find universal support. And again, in the treatment of a persistent occipito-posterior in a multipara with the head above the brim, we find the authors advocate version in preference to manual rotation. This book, as a whole, is good, for it is sufficiently academic and yet of great practical help.

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

ADAMSON, H. G., M.D., F.R.C.P. "The Treatment of Two Chronic Skin Diseases: (1) Chronic Eczema." *Lancet*, February 14th, 1925.

——— *Idem.*, (2) "Acne Vulgaris." *Ibid.*, February 21st, 1925.

ARCHER, H. E., M.R.C.S., L.R.C.P. (and ROBB, G. D.). "The Tolerance of the Body for Urea in Health and Disease." *Quarterly Journal of Medicine*, April, 1925.

ARMSTRONG-JONES, Sir ROBERT, M.D., D.Sc., F.R.C.P. An Address on "Suggestion in Social Life." April 4th, 1925.

BERRY, JAMES, F.R.C.S. Discussion on the Diagnosis of Malignant Disease of the Thyroid Gland. *Proceedings of the Royal Society of Medicine*, March, 1925.

BROCKMAN, R. STLEGER, M.A., M.Ch., F.R.C.S. "Acute Intestinal Obstruction: Some Points in its Early Diagnosis." *Practitioner*, March, 1925.

BROWN, W. LANGDON, M.A., M.D., F.R.C.P. "On the Treatment of Pneumonia." *Clinical Journal*, February 11th, 1925.

CARSON, H. W., F.R.C.S. "Cancer of the Colon." *Ibid.*, April 29th, 1925.

CLARKE, ERNEST, M.D., F.R.C.S. "The Eye as an Index of Age." *Practitioner*, April, 1925.

COOPER, P. R., M.D., B.Sc., F.R.C.S. "Labour with Vulval Anus: Prevention of Vulvo-anal Rupture." *Clinical Journal*, April 1st, 1925.

CRONK, H. LESLIE, M.A., M.D., D.P.H. *An Introduction to School Medicine*. London: H. K. Lewis & Co.

DALTON, C. H. C., M.A., M.R.C.S. "Successful Collapse of Lung by Artificial Pneumothorax in Advanced Fibroid Phthisis." *Lancet*, May 9th, 1925.

DAVIES, IVOR J., M.D., M.R.C.P. "Cardio-Vascular Cases." *Clinical Journal*, March 11th, 1925.

DONALDSON, MALCOLM, F.R.C.S. *Obstetrics and Diseases of Women*. (Synopsis of Special Subjects.) London: H. K. Lewis & Co.

——— "Treatment of Inoperable Carcinoma of the Cervix Uteri with Radium." *British Medical Journal*, May 9th, 1925.

DUNDAS-GRANT, Sir JAMES, K.B.E., M.D. "Case of Laryngeal Syncope in a Patient with Carcinoma of the Larynx." *Proceedings of the Royal Society of Medicine*, February, 1925.

——— "A Case of Syringo-bulbo-myelia with Unilateral Nerve-deafness and Immobility of the Opposite Vocal Cord." *Ibid.*, February, 1925.

DUNHILL, T. P., C.M.G., M.D., Ch.B. Discussion on the Diagnosis of Malignant Disease of the Thyroid Gland. *Ibid.*, March, 1925.

EVANS, E. LAMING, C.B.E., F.R.C.S. "A Case of Destruction of the Os Calcis, with Deformity of the Foot." *Ibid.*, February, 1925.

GASK, GEORGE E., F.R.C.S. "Remarks on the Possibilities of Exploratory Tracheotomy." *British Medical Journal*, February 21st, 1925.

GRAHAM, GEORGE, M.D. "The Relation of Infection to Diabetic Coma." *Quarterly Journal of Medicine*, April, 1925.

HALL, PERCY, M.R.C.S., L.R.C.P. *Ultra Violet Rays in the Treatment and Cure of Disease*. 2nd Edition. With Introduction by Sir HENRY GAUVAIN, M.A., M.D., M.C.(Camb.), and LEONARD E. HILL, M.B., F.R.S. London: William Heinemann.

HAMERTON, JAMES R., M.B., B.S., M.R.C.S. "Acute Cholecystitis at the Age of Three." *British Medical Journal*, April 25th, 1925.

HAMMOND, T. E., F.R.C.S. "Pre-Urethral Operations for Prostatic Obstruction." *Ibid.*, March 28th, 1925.

HEY GROVES, ERNEST W., B.Sc., M.S.(Lond.), F.R.C.S. *Surgical Operations*. 2nd Edition. London: Oxford University Press.

HOSFORD, R. W. P., M.B., B.S., F.R.C.S. "Rupture of Abdominal Wall with Protrusion of Uninjured Intestine." *British Medical Journal*, February 14th, 1925.

HOWELL, C. M. HINDS, M.D. An Address on "Encephalitis Lethargica." *Ibid.*, March 7th, 1925.

HUME, J. BASIL, M.B., F.R.C.S. "The Technique of Suprapubic Prostatectomy." From the Clinic of Prof. Hugh Cabot, University of Michigan, Ann Arbor, U.S.A. *Lancet*, May 9th, 1925.

——— "The Anatomy of the Chest." *Tubercle*, May, 1925.

HURRY, JAMIESON B., M.A., M.D. (and ORMSBY, MARY E., M.R.C.S., L.R.C.P.). "Nervous Functional Disorders in Children and the Vicious Circle." *The Child*, February, 1925.

IMIANITOFF, FRED F., B.A.(Lond.). Translator of *Rejuvenation by Grafting*, by Dr. Serge Voronoff. London: George Allen & Unwin.

JEAFFRESON, D. L., M.D., B.S. (T. W. PRESTON, M.R.C.S., and B. L. J.). "Mikulicz's Disease associated with Arrested Miliary Tuberculosis." *British Medical Journal*, February 14th, 1925.

JUET, T. H., M.B., B.Ch., F.R.C.S. "Case of Deafness, with Loss of High Tones, (2) Congenital." *Proceedings of the Royal Society of Medicine*, March, 1925.

JUET, T. H., M.B., B.Ch., F.R.C.S. "Chronic Suppurative Otitis Media; Left Temporo Sphenoidal Abscess; Naming Aphasia." *Ibid.*, March, 1925.

——— "Chronic Suppurative Otitis Media; Right Temporo-Sphenoidal Abscess; Lateral Sinus Thrombosis; Fistula of External Semicircular Canal." *Ibid.*, March, 1925.

KEYNES, GEOFFREY, M.D., F.R.C.S. "A Case of Fat Necrosis of the Breast." *British Journal of Surgery*, April, 1925.

LANG, BASIL, F.R.C.S. *The Routine Examination of the Eye*. London: E. Arnold & Co.

LATHBURY, E. B., O.B.E., R.A.M.C. "A Case of Snake Bite in a Dog Treated with Antivenine Serum." *Journal Royal Army Medical Corps*, April, 1925.

LESCHER, F. GRAHAM, M.C., M.A., M.D. (F. L. A. GREAVES, O.B.E., F.R.C.S., and F. G. L.). "Fibro-Chondroma of the Cauda Equina." *British Medical Journal*, March 28th, 1925.

MCDONAGH, J. E. R., F.R.C.S. "Case of Poradéno-lymphite or Lymphogranulomatose Inguinale Subaiguë." *Proceedings of the Royal Society of Medicine*, March, 1925.

——— "The Chemotherapeutic Treatment of Gonorrhœa and its Complications." *British Medical Journal*, April 4th, 1925.

MACMAHON, CORTLANDT, M.A. "A Method of Treatment of Visceroptosis." *Lancet*, January 10th, 1925.

MARSH, F. D., M.B., B.Ch., F.R.C.S. "Nasal Diphtheria." *British Medical Journal*, March 7th, 1925.

MORTIMER, J. D., M.B., F.R.C.S. "Post-Anæsthetic Vomiting." *Lancet*, February 14th, 1925.

MORTON, CHARLES A., F.R.C.S. "The Pathology and Treatment of Genu Valgum." *British Medical Journal*, February 21st, 1925.

MURRAY, E. G. D., O.B.E. (and R. AYRTON). "Observations on the Growth of Meningococci *in vitro* in Relation to Virulence." *Journal Royal Army Medical Corps*, March, April and May, 1925.

MYERS, CHARLES S., C.B.E., M.D., Sc.D., F.R.S. The Harveian Lecture on "Industrial Fatigue." *Lancet*, May 2nd, 1925.

NAISH, A. E., M.A., M.D., D.Ch., F.R.C.P. "Points in the Diagnosis and Prognosis of Cretinism." *Clinical Journal*, April 8th, 1925.

NOON, CHARLES, F.R.C.S. "Dislocation of the Semi-lunar Bone, with Notes of a Case." *Lancet*, February 28th, 1925.

OKELL, C. C., M.C., M.B., B.Ch. (and H. J. PARISH, M.D., M.R.C.P.). "The Dick Test in Scarlet Fever." *Ibid.*, April 4th, 1925.

PATERSON, HERBERT J., C.B.E., M.C., F.R.C.S. "The Lure of the New." *Proceedings of the Royal Society of Medicine*, February, 1925.

POWER, Sir D'ARCY, K.B.E., F.R.C.S. The Hunterian Oration, entitled "John Hunter as a Man." *Lancet*, February 21st, 1925.

——— "The Scamnum Hippocrates." *Proceedings of the Royal Society of Medicine*, February, 1925.

——— "Whitehead's Operations." *British Journal of Surgery*, April, 1925.

RAWLING, L. BATHE, B.A., M.B., B.Ch., F.R.C.S. "Surgical Aspects of Oxaluria." *Clinical Journal*, May 13th, 1925.

ROXBURGH, A. C., M.D. "Case of Schamberg's Disease." *Proceedings of the Royal Society of Medicine*, March, 1925.

RYLAND, ARCHER, F.R.C.S.(Ed.). *Ear, Nose and Throat*. (Synopsis of Special Subjects.) London: H. K. Lewis & Co.

SCOTT, H. HAROLD, M.D., M.R.C.P., D.T.M.&H.(Camb.), F.R.S. (Edin.). "The Treatment of Sprue." *Lancet*, March 21st, 1925.

SCOTT, SYDNEY, M.S., F.R.C.S. Discussion on the Causes, Early Recognition and Treatment of Non-Tuberculous Meningitis. *Proceedings of the Royal Society of Medicine*, February, 1925.

——— "Skiagrams from a Patient with Malignant Disease of the Ear." *Ibid.*, March, 1925.

SKIPITURE, E. W., M.D., M.R.C.S. "Cases of Epilepsy, General Paralysis and Disseminated Sclerosis to illustrate Speech Defects." *Ibid.*, February, 1925.

SEDGWICK, H. C., O.B.E., R.A.M.C. "A Case of Laceration of Enlarged Malarial Spleen, with Rupture of the Vessels at the Hilum." *Journal Royal Army Medical Corps*, April, 1925.

SOUTHAM, A. H., M.D., M.Ch.(Oxon.), F.R.C.S. (HUGH T. ASHBY, M.D., F.R.C.P., and A. H. S.). "The Early Diagnosis and Treatment of Pyloric Stenosis in Infants." *British Medical Journal*, February 28th, 1925.

SPILSBURY, Sir BERNARD. Lettsomian Lectures on "Wounds and Other Injuries in their Medico-Legal Aspect." *Lancet*, February 28th, March 7th and April 11th, 1925.

TEICHMAN, O., D.S.O., M.C., R.A.M.C.(T.A.). "Suvoroff's Catechism." *Journal Royal Army Medical Corps*, February, 1925.

THURSFIELD, HUGH, M.D., F.R.C.P. Discussion on the Causes, Early Recognition and Treatment of Non-tuberculous Meningitis. *Proceedings of the Royal Society of Medicine*, February, 1925.

——— "Splenomegaly." *Clinical Journal*, March 18th, 1925.

WHITE, C. POWELL, M.D. "A Note on the Association of Cancer with Tuberculosis." *Lancet*, March 14th, 1925.

EXAMINATIONS, ETC.

UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:

M.B., B.Ch.—J. P. W. Jamie, T. S. Goodwin.

M.B.—G. B. Tait. H. E. Harris.

The *Diploma in Medical Radiology and Electrology* has been granted to—

E. P. Cumberbatch, M.B., B.Ch.(Oxon.), F.R.C.P.

G. H. Orton, M.D.(Camb.).

UNIVERSITY OF LONDON.

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

Honours.—C. P. Craggs (*d*), R. S. Johnson (*a*) (University Medal), F. D. S. Poole (*a*).

(*a*) Distinction in Medicine; (*d*) distinction in Surgery.

Pass.—H. G. Anderson, S. Bloom, L. J. M. Castledeu, F. G. France, D. A. J. Mayo, V. A. T. Spong, W. R. Thomet.

Supplementary Pass List, Group I.—A. B. Cowley.

Group II.—S. Brest, R. N. Curnow, G. E. Ellis, G. K. Loveday, G. J. V. Nelken, M. D. Rawkins, L. B. Ward.

ROYAL COLLEGE OF SURGEONS.

The *Diploma of Fellow* has been conferred on the following:

N. F. Adeney, C. M. Brophy, G. O. Chambers, C. C. Coghlan, W. M. Cotter, V. R. Mirajkar, C. M. Pearce, M. M. Riad, R. C. Shaw, M. P. Susman.

ROYAL COLLEGE OF SURGEONS, EDINBURGH.

The following have been admitted Fellows:

C. H. Terry, G. W. Theobald.

CHANGES OF ADDRESS.

CHAMBERS, G. O., 101, Goldhawk Road, W. 12.

DRAWMER, C. S., Ivor Villa, Thwaite Gate, Hunslet, Leeds. (Leeds 23204.)

HEWER, C. LANGTON, 32, Park Village East, Regent's Park, N.W. 1. (Museum 2117.)

HORNER, N. G., B.M.A. House, Tavistock Square, W.C. 1. (Museum 9864.)

KENDREW, A. J., The White House, Myland, Colchester, Essex.

MATHER, E. E., 40, Hawthorne Road, King's Norton, Birmingham.

POLLARD, E. B., Surg.-Lt. R.N., Royal Naval Hospital, Haslar.

RUTTER, G. H., 20, Southfields Road, Eastbourne.

SHANNON, H., c/o J. L. Jona, Esq., M.D., 104, Wattletree Road, Malvern, Melbourne, Victoria, Australia.

TAIT, G. B., Archpool, Handcross, Sussex.

APPOINTMENTS.

CASPER, W. M., M.R.C.S., L.R.C.P., appointed Certifying Surgeon under the Factory and Workshops Acts for Overton, Flint.

FISHER, H. H., M.R.C.S., L.R.C.P., appointed Junior House-Surgeon at the Metropolitan Hospital.

HARTSILVER, J., M.R.C.S., L.R.C.P., appointed House-Surgeon at the East Suffolk and Ipswich Hospital, Ipswich.

HORSBURGH, P. G., M.R.C.S., L.R.C.P., D.P.H., appointed Medical Officer of Health, Nuneaton.

KING, J. F. L., M.R.C.S., L.R.C.P., appointed Casualty Officer at the Metropolitan Hospital.

KLABER, R. A. E., M.B., B.S.(Lond.), D.P.H., D.T.M., appointed Casualty Officer at the Royal Northern Hospital.

KNIGHT, H. E., M.D.(Lond.), appointed Honorary Physician to Rotherham Hospital.

LANE-ROBERTS, C. S., appointed Obstetric Surgeon (with Charge of Out-Patients) to the Royal Northern Hospital.

ORR-EWING, A., M.B., B.Ch.(Cantab.), appointed Certifying Surgeon under the Factory and Workshops Acts for Silverton, Devon.

BIRTHS.

COOMBS.—On May 26th, at Bedford, to Ismay, wife of Martin Coombs, M.B.—a son.

DOUGLAS.—On May 25th, to Dr. and Mrs. H. A. Douglas—a daughter.

FULLER.—On June 9th, at 17, Park Road, Southborough, Tunbridge Wells, to Dr. and Mrs. Fuller—a son.

HORSBURGH.—On May 19th, at Scunthorpe, Lincs, to Dr. and Mrs. Percy G. Horsburgh—a son.

MARRIAGES.

ASTON—ALLEN.—On May 5th, at the Wesleyan Methodist Church, Golders Green, Richard Norman, son of the late Mr. and Mrs. Walter Aston, of Worthing, to Doris Muriel, youngest daughter of the late Rev. W. H. Allen and Mrs. Allen, of Golders Green.

BENNETT—GRAHAM.—On June 2nd, at Westminster, Major William Edward Bennett, T.D., M.B., F.R.C.S., of Birch Tree, Keresley, Coventry, to Alice Graham, widow of Captain Noel Francis Graham, 7th Battalion Royal Warwickshire Regiment, Whitley, Coventry.

HEWER—CHAMPNEY.—On June 10th, at Bristol, Christopher Langton, M.B., B.S.(Lond.), son of J. Langton Hewer, M.D., F.R.C.S., and Mrs. Hewer, of York Terrace, N.W. 1, to Doris Phœbe, youngest daughter of H. D'Arcy Champney, M.A.(Cantab.), and Mrs. Champney, of Bristol.

STRUTHERS—LANGFORD.—On June 6th, at St. Bartholomew-the-Great, Dr. I. A. Struthers, son of Mr. John Struthers, of Paddington, and of the late Mrs. Struthers, to Edith Mary, elder daughter of Dr. and Mrs. C. H. Langford, of Golders Green.

TAIT—ALFORD.—On June 20th, at St. Matthias's, Richmond Hill, by the Rev. J. F. Kendall, M.A., Vicar of Richmond, Greville Brend Tait, M.B., B.Ch., elder son of Mr. Henry Tait, F.R.C.S., and Mrs. Tait, of Highgate, to Elizabeth Joan, elder daughter of Mr. J. S. Alford, M.Inst.C.E., and Mrs. Alford, of Richmond, Surrey.

DEATHS.

ADAMS.—On June 15th, 1925, at 117, Cazenove Road, Stamford Hill, N. 16, Josiah Oake Adams, M.D., J.P., aged 82.

GRAHAM.—On May 20th, 1925, after a short and sudden illness, John Thomas Graham, M.D., C.M.(Glasg.), M.R.C.S.(Eng.), aged 72.

GREEN.—On March 26th, 1925, at a nursing home at Biarritz, Col. R. C. Green, of Warren Grange, Crowborough, Sussex.

LEWIS.—On June 8th, 1925, at 74, Hamilton Terrace, St. John's Wood, N.W., after a very brief illness, Edward John Lewis, M.B., F.R.C.S., aged 65.

THOMAS.—On June 3rd, 1925, Lt.-Col. George T. Thomas, I.M.S. (retired), of 23, Rugby Mansions, W. 14.

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. 1.*

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.*

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St. Bartholomew's Hospital Journal.

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

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CALENDAR.

Mon., August	3.—	August Bank Holiday.
Tues.,	4.—	Sir Thomas Horder and Mr. Rawling on duty.
Fri.,	7.—	Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Tues.,	11.—	Prof. Fraser and Prof. Gask on duty.
Fri.,	14.—	Dr. Morley Fletcher and Sir Holburt Waring on duty.
Tues.,	18.—	Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.
Fri.,	21.—	Sir Thomas Horder and Mr. Rawling on duty.
		Last day for receiving matter for September issue of the Journal.
Tues.,	25.—	Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Fri.,	28.—	Prof. Fraser and Prof. Gask on duty.

EDITORIAL.

IF had firmly made up our mind that the Editorial should contain no reference to August as a "wounded snake," that we would not limply wish our readers a happy holiday, nor tell sad stories about the death of summers. But perusal of Sir John Bland-Sutton's lecture before the American delegates stimulates us to request one who has the pen of a ready writer to produce an article entitled "The Psychology of Students Melted Alive."

* * *

The annals of Hospital cricket can hardly show a more exciting finish than that of the Bart.'s *v.* Guy's match. An account of this dramatic game will be found elsewhere in this issue. We offer our hearty congratulations to the team.

* * *

It is with great pleasure that we offer our congratulations to Sir Thomas Horder upon his most recent honour of being invested a Knight Commander of the Victorian Order.

In our last number we were boasting of recent examination successes. The Hospital sweeps on with triumphant tread. W. E. Lloyd has been awarded the University Gold Medal in the London M.D. examination and J. P. Hosford the Gold Medal in the London M.S. We have thus been awarded this summer the University's gold medals in the M.B., the M.D. and the M.S., a record of which our Hospital and College have every reason to be proud.

* * *

We also wish to congratulate another Bart.'s M.S gold medallist, Mr. Musgrave Woodman, on being awarded the special Certificate for the Jacksonian Essay on "The Pathology, Diagnosis and Treatment of Œsophageal Obstruction."

* * *

By an unfortunate oversight the article in last month's issue on the treatment of lupus vulgaris by Lundie's tuberculin was unsigned. The author was Mr. R. W. Taylor, to whom we offer our apologies for this error.

MEMORIAL TO THE LATE DR. HERBERT WILLIAMSON.

IT is proposed, with the approval of the Medical Council, that a memorial to the late Dr. Williamson be established at St. Bartholomew's Hospital. The form which the memorial shall take must depend upon the sum subscribed, but it is hoped that at least a sufficient amount may be secured to endow a bed in the Department in which he worked. Subscriptions from Dr. Williamson's former colleagues, students and friends should be sent to Dr. Barris, 50, Welbeck Street, London, W. 1.

HUMOUR AND THE SURGEON.

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

THERE seems to be great doubt whether the surgeon had much sense of humour. In early days he led a strenuous life, apt to be killed by the surviving relatives if his patient died, often dealing with bad payers, so that "*Accipe dum dolet*" became an axiom with him; usually at the beck and call of a physician and cleric, his life was not a happy one.

Henri de Mondeville, who wrote his book on surgery between 1306 and 1320, was an exception to the rule. Speaking of the difference between an honest surgeon and one who is less conscientious, he says: "One of these second rate surgeons will come to a sick man who is wealthy and will say to him, with the voice of an archangel—taking care that no witnesses are present—'Seigneur, you must remember that you are the one in pain. It is not your son or your nephew. It is you who are kept awake whilst your friends and servants sleep. Others won't take care of you if you don't take care of yourself. You are rich enough to get advice and to buy health. Have you not made the greater part of your money yourself, so that if you are not a miser you can spend it on yourself. Would to God that those who look after you so badly had your complaint. But this is between ourselves, and what I tell you is only out of pity for you and for your own good.' Then in the absence of the patient he speaks to the relatives and says, 'Seigneurs, this man has the greatest confidence in you, and truly, if you lose him you will lose an excellent friend. It is not to your credit either to let him go without advice, for if he died without advice you would be blamed everlastingly even if it made him as poor as Job. He is really in great danger and it is a serious case, but Nature sometimes does better than we have any right to expect. He is sure to die if no one treats him, but if he is properly treated it is just possible that he will escape and not die. If he dies it won't be the result of the treatment because he is nearly dead already; his only chance is to have a consultation, etc. I am speaking to you as a friend and not as a doctor.'

"But it is quite another matter when this same surgeon has to treat a poor man, for he says, 'I am really sorry for you and I would gladly help you for the love of God only. But I am very busy just now with a lot of difficult cases, and besides the season is not very favourable for an operation. You can't afford to buy what is necessary for your ease, such as drugs and dressings, so I would put it off until the summer if I were you. You will then be able to get the herbs and whatever else is wanted and so save expense. The summer, too, is the best time for the poor.' When the same pauper comes back in the summer the surgeon says to him, 'I am very sorry that I put you off in the winter and told you to wait until the summer, because winter is really the best time. Summer is too hot and there is a fear of stirring up the disease. I should advise you to wait until the hot weather is over." And this goes on everlastingly, for this kind of surgeon never finds time to operate upon a pauper."

De Mondeville classifies his own patients according to their ability to pay fees. The first class, he says, are poor men who must be treated for nothing; the second class is a little better off, and they pay in kind, for they send presents of fowls and ducks. The third class are friends and relations, who pay no fixed fee. They send victuals or presents out of gratitude, but no money. Our assistants ought to suggest to them, saying behind our backs and as if we knew nothing about it when anything is said about money, "No, indeed, the Master would not like it, and you would do much better to make him a little present though I am sure he does not expect anything." Indeed a sharp assistant sometimes makes more by such suggestions than the Master does by his operation. It is just like doubling the fee on account of the horse when the Master makes his visits on horseback. Then there is a class who are notoriously bad payers, such as our nobility and their households, government officials, judges and others whom we are obliged to treat because we dare not offend them. In fact the longer we treat them the more we lose, so it is best to cure them as quickly as possible and to give them the best medicines. De Mondeville also thinks that it is better on the whole for the surgeon to be paid for what he does rather than by a retaining fee, because a salary is apt to make him so hopeful that he will think the blind can certainly see and the lame can walk or even run. The surgeon, too, must beware of those who will make infamous proposals to him because from time immemorial it has been an article of faith with the common people that every surgeon is a thief, a murderer or a swindler. The chief object of the patient is to get cured, and when once he is cured he forgets his obligation and omits to pay. The object of the surgeon, on the other hand, is to obtain money, and he should therefore never be satisfied with a promise or even a pledge, but should take the fee in advance or have a bond for it. As the poet says: "*Sæpe fides data fallit, plegius plaidit, vadium valet*"—"The promise is often broken, the security is worthless, the bond alone holds good."

It is interesting to notice how little customs and ideas have changed in the course of six hundred years.

Infamous proposals are still made to reputable surgeons, fees are not paid without recourse to law, the same classes of patients exist and the second-rate surgeon flourishes by the same arts.

Samuel Butler wrote some witty lines in *Hudibras* which have become classical, though, for some reason, plastic surgeons have not adopted them, and with a strange lack of humour even appear to be offended when they are recited in their presence. They run:

> "So learned Taliacotius from
> The brawny part of Porter's Bum,
> Cut supplemental Noses, which
> Would last as long as Parent Breech;
> But when the date of Nock was out
> Off dropt the Sympathetic Snout."

The reference, of course, is to Van Helmont's story that a nobleman, fearing the operation, but wanting a new nose, hired a labourer to allow the nose to be fashioned from his arm. Thirteen months afterwards the new nose suddenly became cold, and after a few days putrefied and dropped off. Inquiries were made, and it was discovered that the labourer had died at the moment when the nose went cold.

There are various stories, some where the surgeon came off second best, others where he scored. Thus, keeping at home, there is the tale of Percival Pott after the separation of the Barbers from the Surgeons. The United Company had, as the Barbers still have, the right to vote in City elections. Pott, forgetful of the separation, went to record his vote for a Sheriff as a Barber Surgeon Liveryman and was told by the Scrutineer, "No, no, Mr. Pott, you may still be a young shaver, but you haven't been a barber these five years."

Then there is the well-known story told of Abernethy, but also attributed to Dr. Barrowby (Physician to the Hospital 1750–1751), when he was calling upon the Governors to solicit their votes as a candidate for the Assistant Surgeoncy. He went into a grocer's shop on Snowhill. The grocer saw him coming and, putting on his hat and spectacles, came forward and said: "Well, young man, I suppose you want my vote and interest?" "Your vote and interest be damned," said Abernethy: "I want a pound of dips, and please to wrap them up."

Mr. Wheeler, the Surgeon-Apothecary to the Hospital, a great botanist and beloved by everyone, was noted for the abstemiousness of his life. One evening, sitting over the surgery fire, he was descanting on the virtues of a simple life and on the advantages of doing away with everything that was superfluous. Sir William Lawrence, then a student, was sitting behind the old gentleman, who wore the tailed periwig of the time. He seized the tail and said: "But, Mr. Wheeler, you don't practise what you preach; surely this is a superfluity." Mr. Wheeler was taken aback for a moment, and then replied, "So it is, Mr. Lawrence, so it is; pray cut it off," which Lawrence did at once.

There is the standing warning to dressers and self-opiniated house-surgeons in regard to Sir James Paget. It was before the time of the First Aid classes. A man slipped and got a Pott's fracture in Piccadilly. He was taken to St. George's Hospital, where it was found that an umbrella, with a couple of pocket handkerchiefs, had been used to tie up the leg. Next day a gentleman called at the hospital, sent in his card, saw the house-surgeon on duty and inquired how the man was doing who came in yesterday with a broken leg. "Oh," said the house-surgeon, "The man whom some old fool had tied up with his umbrella?" "Yes," said Paget, "I am the old fool and I have called for my umbrella." This may be apocryphal, but the story about Sir George Humphry is literally true. He was not very careful about his dress, looked ill for the most part, and wore a shaggy beard. One evening he was resting in the Hall of the College of Surgeons, having just come up from Cambridge, when an examinee came in, took him by the beard and said, "Well, old chap, I am just going in for the examination. What's the matter with you?"

DIET FROM A PHYSIOLOGIST'S POINT OF VIEW.

By J. M. DUNCAN SCOTT.

IT is the province of the physiologist to study the phenomena of life. The methods available to him are those which are common to all the physical sciences, namely, description and, in particular, measurement. A further variant of the method of description is experiment, by which we mean in the most general terms that we fix all the factors concerned in a phenomenon except one which we alter, and we observe and describe how the phenomenon varies, thus being able to deduce the inter-relationship between factor and phenomenon. The scientist aims at the device and performance of crucial experiments. A line of reasoning leads to the suspicion that a certain proposition is probably true. In order to test it this proposition, or working hypothesis as it is called at this stage, is assumed to be true. An experiment is devised which, if it be true, will give a certain result. Thus the working hypothesis stands or falls by the result, and, if it stands, it is accepted as a theory. Opinions may differ as to whether the test to which it has been

subjected is stringent enough, and whether all the conditions have been adequately fixed. Such a theory is always a cocoanut in a dish of sawdust—fair game for anyone who has a shy; at any time the theory may be upset, or more usually, modified. The prudent man, therefore, distinguishes carefully between facts which have been precisely observed and theory which, current at the moment, is always subject to revision in the future. Why bother about theories at all then? Theories are usually advanced as an explanation of the facts, and the mind of man always hankers after such an explanation. Physiology is, then, attempting to explain certain facts which have been common knowledge for many years, and to find out other facts.

This general introduction is necessary for comprehension of the attitude which the physiologist takes up with regard to diet (or indeed to any of his problems). Every intelligent medical student (and none of my readers is any other) thinks he knows what a physiologist will say about diet. Listen! He will start talking about the caloric value of the proximate food-stuffs:

1 grm. of protein will produce . . 4·1 Calories.
1 grm. of fat will produce . . . 9·3 ,,
1 grm. of carbohydrate will produce . 4·1 ,,

He will then go on to state the necessary amounts of these food-substances in the diet of an average man:

Protein, 100 grm.; fat, 100 grm.; carbohydrate, 500 grm.

From that he will go on to the construction of a diet table, such as this:

—	Grm.	Percentage composition			Total grm.		
		Protein.	Fat.	CHO.	Protein.	Fat.	CHO.
Bread .	600	6·5	—	50	39	—	300
Meat .	200	25	25	—	50	50	—
Butter .	50	—	80	—	—	40	—
Potatoes .	700	—	—	20	—	—	140
Oatmeal .	100	12·5	10	66	12·5	10	66
Total grm. . . .					101·5	100	506

Finally he will talk about the energy value of the diet being about 3000 Calories *per diem* for an average adult man.

This appears to me to be tackling the matter the wrong way round. Since we emerged from the bonds of authority and asked ourselves whether Galen was right after all, medical science has been an inductive one, leading up to theory from facts—not a deductive one, deducing notions from a preconceived theory. The outline above has been set down because it summarizes some necessary data, and because setting it down in this way gives an opportunity of emphasizing the error of the method. Theory should not precede facts; to begin with the general statement and deduce the facts turns the science into a dead one, making everything into a dull process of memorization. The student who crams his physiology in this way loses the romance of the subject. When the physiologist of the last century first "discovered" calories, it was the average menu which he analysed to see what it contained, and what was its energy value; a general statement followed after the collation of numerous data. It enables us to enter into the spirit of those workers if we follow the process which they went through. Let us measure for ourselves, or, if we have not time or inclination for that, let us do what is sometimes more entrancing and less trouble—watch other people measure. Now what is a normal diet from the physiologist's point of view? It may be defined as one which will maintain a normal man in trim for the work (if any) he has to do. That is a definition which any sensible man could give, and a very different definition from that which the intelligent medical student thought the physiologist was going to give. We begin with the menu, analyse it, and then deduce its heat value. If he is wise the physiologist does not perform these complicated processes in front of his subject, for the average man has a horror of order and a love of mess which might make him turn from such a scrupulously analysed diet in disgust; an additional mental factor would then enter into the problem. That way lies valetudinarianism and other fads. Does the diet value vary in different cases? Why of course it does. One man's food is another man's poison. One man requires an enormous amount of stoking to keep him fit; another lives on air.

The next requisite is that the diet must be appetizing and digestible. That is common sense, but it is physiology also, for physiology largely consists in giving reasons for certain things which common sense dictates. Pawlow first put the study of appetite on a firm basis by showing the part played by "appetite juice" in normal digestion. It is to stimulate our appetite juice that we, if lucky, have a room for breakfast and one for dinner and paper them appropriately, that the table is laid with a clean cloth and polished silver, that on state occasions we have a printed menu, that we begin with *hors d'œuvres*, have currant jelly with mutton and mint sauce with lamb. Further, it is for a physiological reason, as everyone knows—the stimulation of gastric secretion by chemical substances—that we begin our meals with soup. Experiment has also demonstrated the truth of the common opinion

that some foods are more easily digested than others, and has provided a table of digestibilities to which the curious may refer. You see that we have now passed from the measuring to the experimental stage of our science.

Turn to the vitamins. Our knowledge of them has also followed the later experimental study of diet. Well, the common man will tell you that it is common sense which tells him that natural foods are better than artificial ones, or perhaps if he is of the contrary habit of thought, he may tell you that he has no instincts in the matter of food, that he has no natural inclination for fruits and lettuce, and that he is, therefore, inclined to disbelieve in vitamins. In the latter case I always suspect that he is suffering from a too thorough education in the so-called principles of diet enunciated by over-dogmatic physiologists of the calorie school. In the former case our subject has the satisfaction of knowing that we can now number and provisionally describe the vitamins, and indeed have gone a long way to discovering their chemical constitution. The evidence so far goes to show that vitamin A is a cholesterol-like substance, the conformation of whose molecule has been altered by the action of ultra-violet light, while vitamin B is possibly a nitrogenous base. Man is a creature whose instincts have been lost by domestication, and it is to be hoped that the family physician of the future will add largely to his income by instructing his *clientèle* in the principles of right living, to the mutual benefit of himself and his patients.

The question of alcohol is also to be considered. You object that we are going outside the subject. Not a bit of it—it is impossible to consider diet without facing this problem. Hunger is the best sauce—at least we are told so. Possibly in a world where there are no insidious toxins derived from septic foci, no other sauce may be needed, but in this work-a-day world, where men grow old and tired, physiologists are, on the whole, inclined to agree that there are times when Heaven-born priniciples must be broken, and the judicious use of a stimulant may rouse the body so that it is in a fit condition to deal with a meal.

Experiment has demonstrated that all proteins have not an equal food value, and a table of the "biological values of proteins" is likewise available for those who wish. It is particularly to be commended to vegetarians for study, for they will find that animal proteins stand enormously higher than vegetable proteins in the scale. Did I hear it whispered that the results of animal experiments are not applicable to man? Nevertheless, we can learn a great deal from them. Experiment has also demonstrated that, amongst the amino-acids of which protein is built up, a sufficient supply of certain essential ones must be included—phenyl-alanine, tyrosin, tryptophane, histidine, cystine and arginin, while lysin is essential for growth, though not for life. Pellagra, which crowds the asylums of Egypt, has often been attributed to the lack of an essential amino-acid, and the problem assumes catastrophic proportions in that country, just as other food deficiency diseases—beri-beri, scurvy and anæmia—do in others. Rickets, while partly due to an unhygienic environment, is also partly due to a vitamin deficiency.

Discussion formerly raged round the question as to what was the absolute minimal protein intake which would sustain life, and it was demonstrated that it could be fairly effectively maintained on half that which has been set down above as the average normal. I have yet to meet the rock climber who carefully calculates the strains to which his rope may be subject, and provides himself with one which is only just sufficient to meet the calculated and, it may even be, experimentally demonstrated desiderata. The demonstration as to what is the minimum of effective protein nutrition is interesting. The minimum is not necessarily the optimum, and a further logical fallacy in suggesting that this minimal protein diet should become universal is that a general law is not proved except by advancing a multiplicity of instances. I know a man who professed himself quite comfortable while living through a blizzard in British Columbia on a handful of raisins which he happened to have in his pocket; I also know others who jibbed at being compelled to live on the more adequate diet of a biscuit and a quarter a day and a pound of beef "on the hoof."

This question as to the minimum of protein nutrition raises the large general question whether the science of physiology is entitled to lay down laws as to what men are to do in the matter of diet—laws of health in general. That it is entitled to study the conditions of health and to promulgate knowledge of them is indisputable. But if that knowledge is taught at all we must also teach what we know very well ourselves—that observations may be inaccurate and interpretation may err; we must claim no infallibility for our dogma, and persuade our public only of the fact that we ourselves have a genuine desire to progress. Thus we started to discuss the question of diet, and find ourselves unable to talk about it without embarking on the most general topics, and having to decide our attitude on certain social questions. Indeed, without these great general problems physiology would lose much of its interest.

Side by side with the minimum of protein nutrition the specific dynamic function of protein must be discussed. Briefly this means that the ingestion of protein stimulates metabolism. Consider what, but for this

action, might happen to the clerk who sat on an office stool all day and had no opportunities of taking exercise after he went home at night. His eight hours in bed are passed at basal metabolism—the metabolism of a man resting and fasting; eight hours in the office show a metabolic rate only 33 per cent. above this; he has no opportunity of bringing his metabolism up to the normal 3000 Calories by adding the 1000 Calories which the small amount of exercise involved in light work adds. His metabolism, in popular language, his vitality, is extremely low. The taking of carbohydrate or fatty food exerts a slight stimulating action on his metabolism, but protein does very much more than either in this direction. In plain words an adequate supply of protein food raises the vitality of such a man. Indeed to such an extent does it raise it that an average mixed diet, in order to maintain the resting body in equilibrium, must have a caloric value 13 to 14 per cent. higher than the sum total of the calories given off during fasting. Space precludes going further into this very large question here, nor would it be very satisfactory to do so, for it cannot yet be said that this problem is completely elucidated.

Other food constituents have a special food value of their own. Fat is of special value as a source of energy. I know an Antarctic explorer who has the valuable accomplishment of being able to eat fat by the pound. In normal life the ingestion of fat diminishes the amount of carbohydrate which must be eaten; otherwise the intestine would be overloaded by having to take in enough carbohydrate to make up the energy requirements of the body, could not digest it, and there would be an increase in intestinal putrefaction. Further, fat is digested late and therefore gives "staying power"; it is for this reason that we usually take bacon for breakfast. Porridge is, as is well known, a very filling diet (owing to its large bulk), but not one that takes a man satisfactorily through a long morning. Carbohydrate, again, is of value, as it is a very "easily digestible" foodstuff. It is of special use in the production of muscular energy. Further, owing to the fact that each molecule of fat requires for its complete combustion the linked oxidation of a molecule of glucose, it is absolutely essential that carbohydrate should be included in the diet, as otherwise ketosis would result; *i. e.* the body would be flooded with the acids which result from the incomplete oxidation of fats.

In finishing, the importance of salts may be alluded to; the fact that they are merely alluded to is not intended to diminish, but rather to emphasize their importance and the inadequacy of our knowledge about them. We know quite a lot about the importance of iron in oxidative processes. We know that an inadequate supply of inorganic iron salts in the diet leads to a deficiency anæmia, as has been abundantly shown by experimental studies. As regards other inorganic radicals, especially calcium, considerable work has lately been done upon them; but it cannot yet be said that our knowledge of them has crystallized in anything approaching a final shape. Much of intense interest might be said about them (it is always the disputable problems which are most interesting); but here nothing more will be done than to indicate their importance, and to suggest that probably in the future, when vitamins have been disposed of satisfactorily, the "food merchants" will turn more and more attention to the absorption, metabolism and function of the inorganic constituents of diet.

Thus we reach the end of our necessarily brief summary. Only adult diet has been touched on, for the question of infant feeding is one which well deserves an article to itself, and I understand that other articles will follow dealing with diet in disease. Indeed our knowledge of diet would only be very partial were it not for the light which is thrown on it by studies relating to disease.

OBITUARY.

HUBERT NICHOLLS, M.A., M.D.(CANTAB.), M.R.C.S.

WE regret to record the death on July 1st at Cranleigh, Longton, Staffordshire, of Dr. Hubert Nicholls.

Dr. Nicholl's career, both as a physician and as an athlete, has been a conspicuous success.

After leaving St. John's College, Cambridge, he came to Bart.'s in 1882. He was appointed Honorary Assistant Physician to the North Staffordshire Infirmary in 1891, and full Physician in 1906.

He was awarded a half blue for cycling at Cambridge, was captain of the St. Bartholomew's Hospital Soccer Club in 1884, and also captained the United Hospitals and Surrey. He also played for the Corinthians on their first tour.

We extend our sincere sympathies to his widow and two sons.

THE GENERAL PRACTITIONER-SPECIALIST.

I HAVE heard men who have tried both declare that they preferred the easy humanities of general practice to the austere and rather arid heights of Harley Street, where patients were nearly always strangers, objects of scientific and pecuniary interest only, and not amenable to friendly gossip. To other men doubtless the trivialities of the general practitioner's round would be abhorrent. However this may be, there is a great deal to be said for a life that combines some of the best features of both types of practice.

The general practitioner-specialist exists *par excelsis* in the industrial towns of the North, places with from forty to a hundred thousand inhabitants, and draining a surrounding area supporting perhaps an equal number. The one I have in mind has a well-equipped hospital of 200 beds. There are admirable operating theatres, ophthalmic, gynæcological, radiological, pathological and medico-electric special departments, all, except the ophthalmic department, staffed by general practitioner-specialists with panel practices. The surgical staff comprises five senior surgeons, four of whom are Fellows of the Edinburgh and London Colleges, and two juniors. These again all have panel practices. There are three house-surgeons, the senior man quite frequently holding a Fellowship. The clinical material is magnificent, and nothing is ever turned away. These surgeons with panel practices find time to travel. This year one has been round the principal clinics in America, and another to Berlin, Vienna and Paris. Three or four will go off together to spend a day with Moynihan or Robert Jones. The theatres are kept busy and the standard of technique is astonishing. Gastrectomies, cholecystectomies, abdomino-perinæal excisions, spinal grafting occur quite frequently on the operation lists, and the mortality rates compare quite well with those of better-known clinics. The lay governors take a great pride in their institution, and no article of equipment is denied to the medical and surgical staff. The theatres contain the latest ideas in lighting, in gas and oxygen plants, electrically operated burrs and saws and a diathermy apparatus, and the theatre sister has been "pinched" from a famous clinic.

The rules of the hospital allow of the admission of two grades of paying patients—(*a*) tariff patients, who are admitted to the general wards and pay two pounds a week, and (*b*) private patients who have a room each and pay five guineas a week. Both these categories pay their surgeons a separate fee, which is a matter of arrangement. There is, besides, a staff fund into which flow monies from education authorities for tonsil and adenoid operations and from the Ministry of Pensions, and this fund is divided up periodically. The most successful of the surgeons augments his outside practice by about £1,000 a year by the work he does in the hospital, and the juniors net perhaps £200 or £300. Appointments on the staff are naturally much sought after, and are made by the lay governors on the recommendation of the medical staff, an essential condition being residence in the area. A typical day's work for a general practitioner-surgeon of the type I have sketched begins at 9, with a surgery lasting till 10.30, during which he will see perhaps a dozen panel patients and three or four private ones. The majority of such men keep a nurse, who saves them much time over dressing, and very often a clerk-dispenser-book-keeper as well, who may be a typist and shorthand writer, very useful in keeping the panel record cards up to date. When the expenses of such a staff are shared by two or three partners they are not a heavy drain. At 10.30 he will probably go to the hospital, see his cases, perhaps operate from 11 to 12.30, and then put in an hour visiting. The panel work tends to concentrate at the surgery, the visiting being mostly to private patients. In the winter the afternoon will be spent in more visiting, and a busy evening surgery lasting three hours will finish the day. There is very little night work in the practice I am describing. Once in two or three months is about the average for night calls. The ordinary midwifery is in the hands of midwives, and there is accommodation in the hospital for difficult cases. The surgeons during their take-in weeks of course have night work—sometimes a whole night of it. In the summer the panel work falls away and there is time for golf and tennis. One splendid feature of the panel is the effect it has had of minimizing professional jealousy and in drawing the profession together.

Every practitioner in this neighbourhood, and there are about sixty in the area served by the hospital—is on the panel. Half-a-dozen of them rent a small shoot with fishing on one of the famous Derbyshire rivers.

Important patients are few and far between, and one is consequently not nearly so tied to the post as one's friends in southern practices. Incomes range rather higher, I imagine, up here too. Personality counts for more than degrees (excepting for hospital appointments). The more popular and efficient men make from two to three thousand a year gross, and the average is perhaps in the 'teens of hundreds. Operation fees are ridiculously small judged by London standards, but when instruments, dressings and all assistance are provided by the hospital, the fifteen or twenty guineas for a major operation is quite remunerative. The great majority of the practitioners in this neighbourhood are hardy

Scots; then come the products of provincial universities, then a handful of Londoners. There are two Cambridge men amongst the sixty, and I think only one solitary representative of Bart.'s. What are the disadvantages of practice in these industrial communities? They are all on the surface. I can imagine the southerner passing through our dingy streets with a shudder and deciding that a pittance in the pleasant towns of the South is better than wealth in such surroundings as these. It is certainly true that life is ugly in its superficial aspect here. The long wet, smoky, grimy winters produce a cumulative depression of the spirits which has to be countered by much social gaiety and frequent holidays. In the partnership I write of each partner gets a week in the spring, a week in the autumn, and three weeks in the summer. Each has also three nights a week free. Manchester, with good music and plays, is only half-an-hour away by car. In spite of these distractions I must confess that towards the end of each winter there is a tendency to be turning up New Zealand and South Africa in the *Encyclopædia*, and that one dreams of long days in the sun just as famished explorers dream of heavy plum puddings. The curious thing is that children grow up sturdy and vigorous in spite of numerous colds, and when the family moves south in the summer and comparisons can be made with southern cousins the balance seems in favour of the North. Life is very enjoyable in the summer here, and in spite of the compassion and frequent exhortations of southern friends, one stays.

OVERHEARD IN THE ACCIDENT BOY.

H.S.: Well, Daddy, what's the trouble?
Patient: Blood in the water, Sir.
H.S.: When did you see the blood, Daddy?
Patient: Yesterday, Sir.
H.S.: Ever noticed it before?
Patient: I bled a lot a month ago, Sir.
H.S.: Ever before?
Patient: Yes, Sir, about four weeks before that, and for two or three days about three months ago.

On examination an enlarged prostate was found, and the H.S. proceeded to write out a casualty form.

H.S.: What's your name, Daddy?
Patient: Menstrual, Sir.

[Collapse of H.S.]

Our well-known love of truth compels us to admit that on close questioning the name was found to be Minstral and not Menstrual, but why spoil a good story?

THE FIRE-EATER.

Plasmodium falciparum replies to *Tænia saginata*. (*Vide* "The Lotus-Eater," ST. BARTHOLOMEW'S HOSPITAL JOURNAL, May, 1925.)

Laud, if you like, the Lotus life
In odes of ardent admiration,
But give to me the stress and strife
I find within the circulation;
The joy of battle as I hustle
Hard upon a doomed corpuscle.

What time you batten on the weak,
Do you never really feel you
Want to lash your tail and seek
Some more sanitary *milieu*?
Do *you* inspire poetic pens
On your confounded Connivens?

I occupy a proper host,
A most inflammatory Colonel,
Who served in India and the Coast
With language lurid and infernal.
You ought to hear how mad he gets
When I start bursting my rosettes.

And when, with lashings of quinine
He seeks my doom, it is my wont
To live *en garçon* in the spleen
(My club—The Senior Schizont).
In human hosts, at any rate,
I'm always strictly celibate.

But should the call of sex prevail,
Ignoring his cinchonic veto,
A gay gametocyte, I hail
A circumambient mosquito.
A most attractive combination
Of love's young dream and aviation.

So keep your cows and strumous brats
For decadent young lotus-browsers;
Give me my Colonel's snowy spats,
His purple face, his spongebag trousers,
The bellow of his morning hate
When I begin to sporulate.

And should I end my fighting days
A martyr in the cause of Science,
Upon a glassy bier I'll raise
My crescent banner in defiance.
Such an end will well become
A bellicose Plasmodium.

E. B.

TEN TOO MANY DOCTORS!

ONE little doctor
Looks you through and through,
Can't diagnose your case;
Then there are two.

Two little doctors
Failing to agree
Call a consultation;
Then there are three.

Three little doctors
Poke you o'er and o'er,
Send for a Specialist;
Then there are four.

Four little doctors
Wonder you're alive,
Another brings the stomach pump,
Then there are five.

Five little doctors
Trying fancy tricks
Order an anæsthetist;
Then there are six.

Six little doctors
Preparing you for heaven,
Call in a D.D.;
Then there are seven.

Seven little doctors
Decide to operate,
Call in a surgeon;
Then there are eight.

Eight little doctors
Think it is your spine,
Send for a neurologist;
Then there are nine.

Nine little doctors
All of them men,
Send for Nurse Williamson;
Then there are ten.

Ten little doctors
Standing by your bed
Come to a decision:
Find you are dead.

—R. W., in *Life*.

SUCCESS.

VAST experience forces me to suppose that the student entering upon any career must greedily grope after success. Especially is this so in the medical profession, where the ideals to be shattered are so many and the aggregate of brain-power is so enormous.

The very term "success" is indefinite and misleading. All boys are going to be successful—naturally every old man must have been. The man unable to define a term, but who nevertheless gives examples, possesses the subtle of discussing that of which he is entirely ignorant. This is an innate quality which examiners cannot fail to appreciate. But I would not encourage it, for it seems to pertain more really—that is on an intellectual basis—to a Dorcas discussion between two deaf ladies (infection with drum $-^{ve}$ bacillus).

Rockefeller, I assume, is financially successful to a moderate degree, perhaps even more so than a post-war dustman; but my admiration is totally sapped when I think that a man should possess an alimentary tract of such a dominant strain that all food appeared to have acquired a violent negative chemiotaxis for it.

King Midas in his little line was a great success. His lightest touch converting tinned haddock, peach Melba and regal birds (κογκυβιτες) into gold must have deprived life of some of the more epicritic sensations, while taste both of the lingual and æsthetic varieties becomes hard to define.

If I cite the above gentlemen as being concrete examples, it remains my sincere wish that I should not be misunderstood. I am casting no aspersion on the hardness of their characters.

What of abstract success? Harley Street, that fading flower; the talented Whitechapel practitioner (I use "talented" in its original Greek sense) and discreet advertisement with imperfect migration into the realms of professional vulgarity.

The majority of medical students are fatalists, that is, those who have entertained sufficient modesty temporarily to prevent their names appearing on the lists of successful candidates. To them perhaps the poet appeals.

"Some are born great" (of course to the Socialist this implies a laborious if not difficult labour on somebody's part); "others become great"—the physical propensity of the profiteer; while legion are those who have had greatness thrust upon them by admiring and ever-generous medical colleagues.

Auto-suggestion, yclept Couéism, will not every time

double the income or treble the patients (volume or number), but as a pastime is quite unrivalled for harmlessness. Apart from the humour of a student repeating many times every morning, "I am a great success," the possibility of his convincing himself is not altogether remote. As an evening exercise it is more euphonious and less likely to be misunderstood than "British Constitution."

Does not this recall a student whose breakfast appetite waxed and waned so curiously that every night before retiring he repeated slowly after his wife the mystic words, "Jejuno-jejunostomy." So inspiring was his success that in a few weeks his articulation was perfect, even with the higher centres depressed.

A feeling that I have discussed success so relevantly and upon such a broad basis leads me to end by quoting the famous Sir Bert Bow-wowker:

"One day when I was about ten years old I was lunching with my uncle. His efforts to remove the leg of a grilled hedge-sparrow culminating in the subluxation of the whole beast into my lap set my whole brain agog. In a flash I realized the great possibilities in joint manipulation. I left his house enveloped in great thoughts and gravy. I would enter one of the great professions and become an osteopath, a carver at Pims', or at the worst a qualified medical practitioner. With my brilliant career I will not bore you, but such is my fame that cabinet ministers and archbishops would heap more degrees upon me, while last night in between the courses of my dinner I reduced a dislocated haunch bone under alcohol (anæsthetic), and started a course of lucrative treatment for displacement of one of the small bones of the shoulder joint, the latter case being a well-known duke's third wife. I mention all this as an example of how lofty ideals stimulated in youth may lead not only to success but to notoriety."

H. R.-W.

THE DOCTOR'S CERTIFICATE.

DEPUTY (*to hewer, who has handed in a doctor's note*): "What's been the mettor wi' ye, Geordie?"

GEORDIE: "It tells ye on that note, dissen't it?"

DEPUTY: "Thor's nowt but a stroke on it."

GEORDIE: "Aw wey, it must have been a 'stroke' Aa hed."

BART.'S AND THE BEGGAR'S OPERA.

THE "Beggar's Opera" is probably familiar to most people in these days of excellent revivals, but in one respect it will, perhaps, be of special interest to readers of this JOURNAL, namely that almost the whole of the action of "The Beggar's Opera" takes place within a stone's throw of the gates of this Hospital—in fact, on the site now occupied by the Old Bailey, and formerly the site of Newgate Prison.

Indeed, these are historic paths to tread! If we could place an ear to the ground and catch, perhaps, the last faint echo of these old associations, coming dimly across two centuries of time, what should we hear? Perhaps the drunken chorus of the prisoners in Newgate; or the rumbling of the fatal cart, as it carried some poor wretch to his dismal end on Tyburn Tree. Perhaps we should hear the clattering hoofs of Macheath's horse, or the steady tramp of his gang of disreputable stalwarts as they marched out to ply their nefarious trade; or the sound of their stirring battle-song:

> ". . . See the Ball I hold!
> Let the Chymists toil like Asses,
> Our Fire their Fire Surpasses,
> And turns all our Lead to Gold."

For, in "The Beggar's Opera," Gay portrays faithfully, if a trifle embitteredly, the conditions of his time. Even his characters are not entirely fictitious, but have their prototypes in actual living persons. Thus, Macheath is identified with an actual notorious highwayman of the day; Peachum is easily recognizable as the ill-famed Jonathan Swift, a notorious receiver of stolen goods who was later hanged at Tyburn; while Jenny Diver was the real name of a dangerous "confidence trickster" of the period.

It seems, then, impossible that Bart.'s, existing in such close proximity to Newgate, could have failed to enter very considerably into the life of that institution. The latter in the early eighteenth century was a hotbed of crime, corruption and disease. Broils were of frequent occurrence among the prisoners, entailing of necessity many casualties, while "gaol fever" and other epidemics were constantly raging. It is recorded in Sir Norman Moore's *History of St. Bartholomew's Hospital* that on January 5th, 1758, "A committee considered the subject of visiting prisoners in Newgate. The physicians attended and said that the visiting of sick persons there cannot be attended with much success or benefit in the present state of the gaol, as on attending there, they have found such prisoners entirely destitute of clothes, bedding, and all sorts of conveniences necessary for the sick." It is also recorded in the same work that as long ago as 1596 the Hospital was in the habit of sending an official Visitor to Newgate to inspect the prisoners. It is stated that on March 13th, 1596, "David Doo was reported for unkindness towards the poor prisoners of Newgate. He was dismissed and William Tompson was appointed Visitor of Newgate in his place."

Newgate, in "The Beggar's Opera" era, was indeed a black spot on the face of London. Its exterior was black and forbidding. It is interesting to note that it was built by George Dance, who was also the architect of St. Bartholomew's Hospital. In the journals of the meetings of the Governors occurs the passage: "The outward walls of his gaol must have impressed many of those passing with feelings of horror and terror, fitly associated with crimes and their punishment." Owing to its nature Newgate became the Mecca of thieves, rogues and beggars of every description, who traded illicitly with the prisoners, and provided them with drink and other commodities which, owing to their confinement, they were unable to obtain. Naturally these rascals and beggars overflowed into surrounding parts, and became a menace to the populace; and the streets were made hideous with their raucous cries. They even invaded the Hospital precincts, which became, according to Sir D'Arcy Power's *History of St. Bartholomew's Hospital*, "the resort of idle and disorderly persons, beggars and others, crying and selling all manner of commodities, very improper for the patients, in and about the staircase and wards of the second and third piles of buildings, to the great discredit of the good government of the house."

"The Beggar's Opera" is of further interest, however, in that it contains many amusing medical references. At the beginning of the Tavern scene, the following dialogue occurs between two members of the gang:

BEN: "But pr'ythee, Matt, what is become of thy brother Tom?"

MATT: "Poor Brother Tom had an accident this time twelvemonth, and so clever a made fellow he was, that I could not save him from those fleaing Rascals the Surgeons; and now, poor man, he is among the Otamys at Surgeons Hall."

Many have been the excuses offered for tippling. Some drink to keep the "flu" away, others to cure insomnia. Here is something fresh:

JENNY DIVER: "Indeed, Sir, I never drink Strong Waters but when I have the Cholic." To which Macheath neatly retorts, "Why, a Lady of Quality is never without the Cholic."

We next meet Macheath in straitened circumstances in a cell in Newgate, having been betrayed by his numerous fair admirers. He leans his head heavily in his hands and sings:

> "Man may escape from Rope and Gun;
> Nay, some have outlived the Doctor's Pill,
> Who takes a woman must be undone . . ."

Apparently Gay regarded the pill as a lethal weapon of the very first magnitude!

This final quotation shows that surgical practice in those days, as in these, had its little compensations. The speaker is a receiver of stolen goods, one Mrs. Trapes: "Then too, allowing for Accidents—I have eleven fine Customers now down under the Surgeon's Hands—what with Fees and other Expenses, there are great Goings-out, and no Comings-in, and not a Farthing to pay for at least a Month's Clothing . . ."

I. L.

A "DYSPEPSIA'S" LIFE.

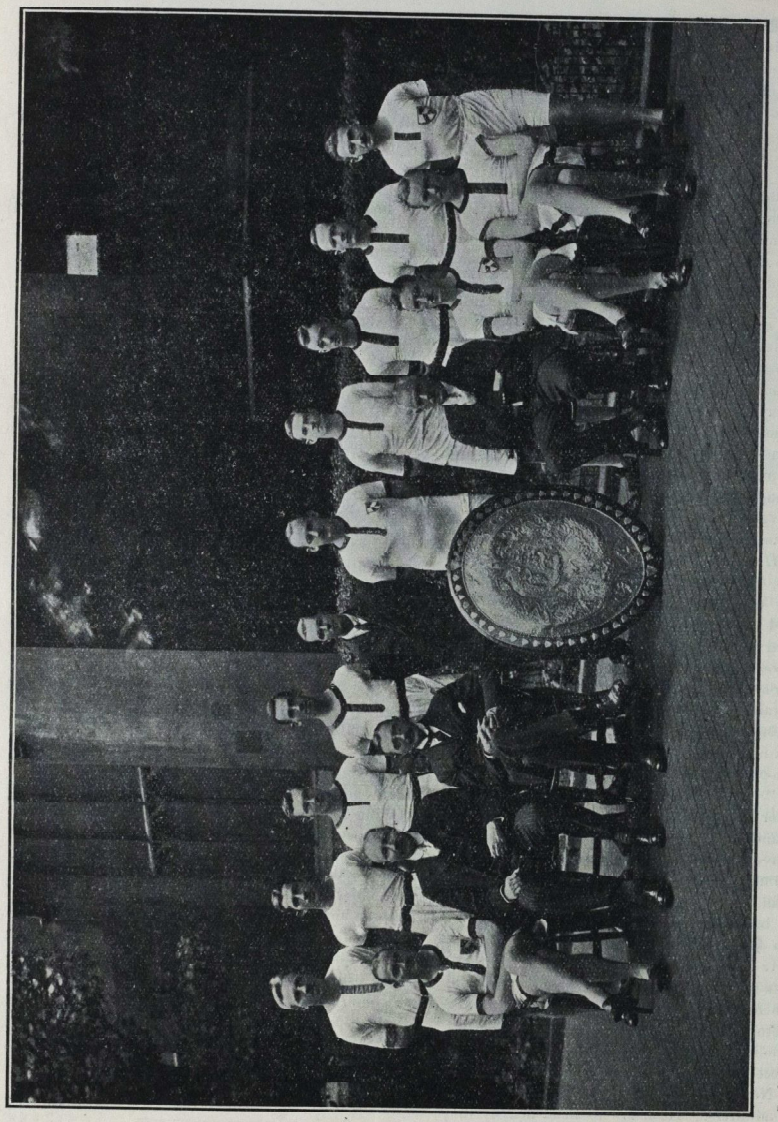
(*Adapted from a well-known song.*)

WHEN the enterprising surgeon's not a-surging,
Or physician contemplating deeds of crime,
They love to think of drastic ways of purging,
Or of estimating stomach-emptying time.
Though his yells of consternation he may smother
When the clerk palpates his kidneys just for fun,
Taking one examination with another
A "dyspepsia's" life is not a happy one.

Though the path. clerk's for the moment in abeyance,
He will soon arrive to take his drop of blood;
And the dentist too is bound to have his *séance*,
But why, it's never clearly understood.
Now vaccine treatment's really not a bother
When once the first injections have begun,
But taking one new form of treatment with another
A "dyspepsia's" life is not a happy one.

Though the night nurse doesn't get much honorarium,
She hurries long before the break of day
To prepare him for his meal of bread and barium
When he faces the ordeal of the X ray.
Though the blue belt come to love him as a brother,
Or the sister as a long-forgotten son,
Taking one consideration with another
A "dyspepsia's" life is not a happy one.

D. McI. J.



THE ATHLETIC CLUB.

Back Row: H. E. Houlton, C. K. Lakshmanan, J. R. Beagley, B. B Hosford, M. R. Sinclair, J. W. D. Buttery, W. W. Darley (*Asst. Hon. Sec.*), A. N. Walker, P. R. Viters, A. Clark.

Front Row: W. S. Hinton (*Hon. Sec.*), Prof. G. E. Gask, C.M.G., D.S.O., F.R.C.S. (*Vice-President*), Dr. H. Morley Fletcher, M.D., F.R.C.P. (*President*), Sir C. Gordon Watson, F.R.C.S., H. B. Stallard (*Capt.*), T. R. Griffiths.

STUDENTS' UNION.

CRICKET CLUB.

THE Cricket Club continued to have a successful season, and though some of the matches have been lost, this has usually been due to inability to place strong teams in the field on these occasions.

Congratulations to our captain, R. H. Bettington, on playing for the Gentlemen *v.* Players at the Oval and at Lord's.

A most thrilling match was played against Guy's Hospital in the final of the "Cup" on July 20th and 21st. Guy's won the toss and batted first. They started well, scoring 70 for 3 wickets. The remaining batsmen were only able to bring the total up to 117, Bettington taking 6 wickets and Maley 4. Bart.'s reply to this was only 107, of which Woods-Brown made 32 and Bettington 28. Guy's started off well again in the second innings, being 63 before the second wicket fell. The remaining batsmen did poorly against Bettington, who took 7 for 43, and the total reached 119. Bart.'s started off fairly well and when play stopped on the first day needed 87 runs to win with 7 wickets to fall. On the following day, rain having fallen overnight, the start was delayed until after lunch. At first the bowlers had difficulty in obtaining a foothold, and runs came steadily though very slowly. As the sun got on the wicket the latter became more difficult. Mackie batted very well and carefully for 28, staying in for 2 hours. The score was 116 with 6 wickets down when Van Schalkwijk performed the hat-trick. When Fells went in, the last man to bat, 14 runs were required to win. 13 of these were obtained when Guinness was out to a splendid catch by Garland at second slip, and the match ended amid tremendous excitement as a tie. Van Schalkwijk bowled well in the second innings, talking 8 wickets for 49 runs.

RESULTS.

June 24th: R.A.F. (Uxbridge) 214 for 7 (dec.) (Meeser 7 for 70). Bart.'s 80 for 6 (Mackie 28). Match drawn.

June 25th: Bart.'s 54 and 100 for 4 (Bettington 59). St. Alban's 288 for 6 (Bettington 3 for 123, Hodgkinson 3 for 55).

June 27th: Bart.'s 235 for 9 (dec.) (Gaisford 109, Mackie 49). Hornsey 112 (Cook 6 for 52).

July 1st: Bart.'s 225 (Fells not out 42, King 33, Cook 61). Nomads 171 (Maley 5 for 52).

July 4th: Finchley 207 for 7. Bart.'s 175 for 6 (Woods-Brown 60, Cook 42).

July 11th: Bart.'s 316 for 6 (Maley 103, Woods-Brown 88). "H" Div. Metropolitan Police 158 (Cook 5 for 40).

July 18th: Bart.'s 255 (Mackie 60, Maley 56). Hampstead 161 (Bettington 5 for 67).

July 20th and 21st:

GUY'S HOSPITAL.

	1st Innings.	*2nd Innings.*	
E. J. Pye-Smith, b Bettington	9	b Bettington	14
T. C. Garland, b Maley	32	b Maley	29
L. Catchpole, b Maley	19	c Mackie, b Maley	14
L. S. Williams, b Maley	12	run out	13
A. H. Curtis, b Maley	2	c Hodgkinson, b Bettington	1
G. Fellows-Smith, b Bettington	0	lbw, b Bettington	20
J. G. van Schalywijk, b Bettington	7	c Fells, b Bettington	4
V. Preen, st Guinness, b Bettington	13	b Bettington	1
G. F. Clark, not out	14	b Bettington	2
W. H. North, c Woods-Brown, b Bettington	0	not out	5
J. White c & b Bettington	0	b Bettington	1
Extras	3	Extras	15
Total	117	Total	119

BOWLING.

	1st Innings.				2nd Innings.			
	o.	m.	w.	r.	o.	m.	w.	r.
Maley	14	1	4	52	13	0	2	61
Bettington	16	2	6	44	12.2	3	7	43
Cook	3	0	0	18	—	—	—	—

ST. BARTHOLOMEW'S HOSPITAL.

	1st Innings.	*2nd Innings.*	
G. C. Woods-Brown, c Preen, b White	32	c Fellows-Smith, b Van Schalkwijk	14
N. E. Cook, c Catchpole, b Van Schalkwijk	0	c Pye-Smith, b Van Schalkwijk	13
K. W. Mackie, c Van Schalkwijk, b Garland	6	c Garland, b Van Schalkwijk	28
R. H. Bettington, c Clark, b Van Schalkwijk	28	b White	3
M. R. Sinclair, c Pye-Smith, b Van Schalkwijk	1	c Pye-Smith, b Van Schalkwijk	22
W. F. Gaisford c & b White	10	c Fellows-Smith, b Clark	17
M. L. Maley, c Van Schalkwijk, b White	1	c North, b Van Schalkwijk	17
H. W. Guinness, b North	5	c Garland, b Van Schalkwijk	5
H. L. Hodgkinson, b North	4	c White, b Van Schalkwijk	0
N.A. King, b Van Schalkwijk	5	c Garland, b Van Schalkwijk	0
R. R. Fells, not out	10	not out	8
Extras	5	Extras	2
Total	107	Total	129

BOWLING.

	1st Innings.				2nd Innings.			
	o.	m.	w.	r.	o.	m.	w.	r.
Van Schalkwijk	17	2	4	52	25.4	5	8	49
T. Garland	5	1	1	7	3	1	0	5
J. White	15	2	3	37	21	3	1	51
W. H. North	5	2	2	6	6	1	0	10
G. T. Clark	—	—	—	—	5	1	1	12

CORRESPONDENCE.

ADDITION TO LIBRARY.

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

There has recently been presented to the Library by the widow of Dr. F. V. Elkington, of Leamington, a folio copy of Remmelin's *Catoptrum Microcosmicum*, published at Ulmæ Suevorum by Johannis Görlini in 1639. The book lacks covers, but is otherwise in fairly good condition. It contains 28 pages and 3 superimposed plates engraved by Stephan Michelspacher. The ornamental title-page was designed by Philip Heinhofer.

The book is interesting in that it was one of the earliest anatomical atlases with superimposed pictures, although the idea was suggested by Vesalius, and was utilized in one or two books before 1613, when the earliest edition of Remmelin's *Catoptrum* was published. In the Surgeon-General's Library at Washington there is a copy of the *Catoptrum* with 2 plates published in 1619, another written in German with 3 plates, published in 1639, and another with 3 plates published in 1660.

Johann Remmelin was born in 1583. A. H. COUGHTREY.

EPSOM COLLEGE.

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

DEAR SIR,—You were recently good enough to publish an appeal from us to your readers to support the candidature of the son of an old Bart.'s man for a Foundation Scholarship. We are pleased to report that this boy was fourth on the list of successful candidates, and we wish to thank all those who generously gave us their support.

Yours faithfully,

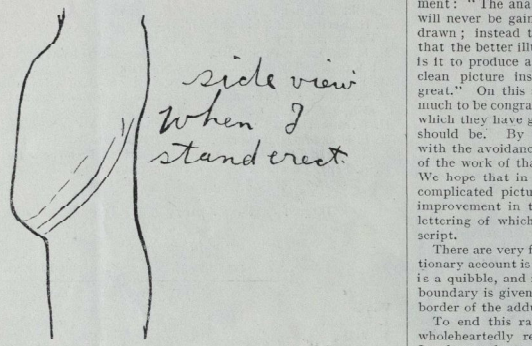
GEO. E. GASK,
GEOFFREY EVANS,
Hon. Local Secretaries.

July 6th, 1925.

DEAR SIR,—Will you kindly let me know whether an operation will put me right.

The lower part of my chest including the floating ribs have pushed themselfs, forward making my appearance ungainly so that I am ashamed to go out. I have been like it since I was 17 yrs, now 31. I put It down to a strain.

Your faithfully,



[Once again our proverbial honesty compels us to admit that this letter was not sent to us, but to the R.M.O. of another London hospital.]

REVIEWS.

BUCHANAN'S MANUAL OF ANATOMY. Edited by E. BARCLAY-SMITH, M.D., J. E. FRAZER, F.R.C.S., F. G. PARSONS, F.R.C.S., and W. WRIGHT, F.R.C.S. 5th Edition. (London: Baillière, Tindall & Cox, 1925.) Pp. vii and 1702, with 810 figures. Price 35s. net.

It is with pleasure that we note a new edition of this, which may be called the Text-book of the London School of Anatomists. It is not meant to be a treatise upon the subject, but has been written for the use of the student during the course of his dissections as an amplification of the knowledge to be obtained from the dissecting-room manuals, and is therefore arranged on a regional basis. It contains more than enough to get a man through any of the ordinary medical examinations in anatomy, and has as well a pleasant "atmosphere." The word "skeleton" it tells us comes from the Greek and means *dry*, and it is true that most text-books succeed in making the whole of anatomy excessively "dry." They seem to have become ultra-scientific, and have forgotten that the medical student is a human being who learns best if he is at the same time amused—a fact that was certainly realized by such teachers of the past as Luther Holden.

Again, it is very unfortunate that the teaching of anatomy should still remain under the curse of a dual nomenclature. Officially students are told to learn both sets of names; they are taught in the old terminology, and the result is that men are sometimes found using out of date books of as many as 35 years of age. It is therefore no doubt to the advantage both of the publishers and to the teaching of anatomy that the book at present under review retains the old nomenclature. Nevertheless we feel that the Basle nomenclature has got to come, although possibly in some anglicized form; and no doubt this change will have to come by a process of evolution, as was suggested by a writer in the *Lancet*, vol. i, 1923. We are therefore sorry to find that the editors of Buchanan have not taken such a simple step in this direction by the use of the terms "medial" and "lateral," instead of the obviously unsuitable "internal" and "external." They might also have dispensed with a large number of the eponymous terms which they keep. We have no use for the "Schneiderian membrane," "Whitnall's tubercle," the "ligaments of Humphrey and Wrisberg," and many another. Nevertheless we should hate to lose sight of the canal of Hunter and the tubes of Fallopius and Eustace. We think that the editors would, in the next edition, do well to include in their admirable Glossary at the end of the book a brief note about each of the more popular Fathers of Anatomy.

In the introduction to the section on osteology there is this statement: "The anatomist's sense is a study of three dimensions, and will never be gained from looking at pictures, however beautifully drawn; instead the paradox is not without a good deal of truth, that the better illustrated a text-book of anatomy is, the less likely is it to produce a good anatomist, since the temptation to use the clean picture instead of the possibly unattractive 'part' is so great." On this score we think that the editors of Buchanan are much to be congratulated in the new illustrations of regional anatomy which they have given us. They are a model of what such pictures should be. By their attainment of simplicity and definiteness with the avoidance of unnecessary line, they remind us in principle of the work of that great artist in another field, the late Phil May. We hope that in future editions the rest of the old cramped and complicated pictures will be removed, and that there will be an improvement in the "finish" of the embryological diagrams, the lettering of which is often of rather clumsily arranged typewriter script.

There are very few mistakes in the book, although a rather revolutionary account is given of the boundaries of Scarpa's triangle, which is a quibble, and introduces an unnecessary complication (the inner boundary is given, with various reasons appended, as the "outer" border of the adductor longus muscle.)

To end this rather rambling review, we have no hesitation in wholeheartedly recommending the fifth edition of Buchanan to London students, and in wishing it every success. N. L. C.

SLIT-LAMP MICROSCOPY OF THE LIVING EYE. By Dr. F. ED. KOBY. Translated by CHARLES GOULDEN, O.B.E., F.R.C.S.(Eng.), and CLARA LOMAS HARRIS, M.B. (London: J. & A. Churchill, 1925.) Pp. xiv and 221. Price 10s. 6d.

Professor Vogt elaborated a new method of examining some of the anterior parts of the globe, and his atlas is well known to most ophthalmologists. Many previously undiscovered phenomena had to be dealt with, and new German words had to be coined to meet the occasion. The exact shades of meaning of such words were unknown to those who had not had the opportunity of working with the Professor. Koby suffered from no such disability, since he had been the Professor's assistant for some time and his translation into French is almost comparable to the "Rosetta Stone."

Now Koby himself has written a book on the subject, naturally in French. He covers the whole ground so well that anyone interested in this branch of ophthalmology had to know what Koby had said. But some find English so much easier than French that this translation has appeared. If a translation is to be any good, not only must the translator know the language, but he must know the subject-matter, else nuances in the original text are lost on him, and the book he is writing fails to interpret the author's meaning. Neither of these disabilities exist in the case of these translators, and the book under review appears faithfully to interpret Koby's views, and everyone possessing a slit-lamp should have a copy of it in his library.

The book is well printed and well bound—a further reason for buying the English rather than the French edition.

TUBERCULOSIS. By JOHN LAIRD.

It is difficult to decide for whom Dr. Laird intended his book. The first part of the book consists of a very strong advocacy for the use of calcium salts in the treatment of tuberculosis, but the evidence he produces for their value is, however, very sketchy, and will not bear critical analysis. The remainder of the book consists of short articles, some of which are apparently intended for the laity and some of which are intended for the medical profession. He is extremely enthusiastic about forms of treatment which have, in the hands of other observers, produced little or no good results. The book appears to be written in a very unbalanced way, and it is to be feared that its perusal will be apt to leave the students with an incorrect idea of the value of the different methods of treatment.

THE FIRST FIVE THOUSAND. By Dr. MARIE STOPES. (London: John Bale, Sons & Danielsson.) Pp. 66.

This little book is the first report of the first birth-control Clinic in the British Empire.

In the introduction, which explains how the Clinic came into being, the writer says: "Only motherhood which is in the control of the mother can now truly advance our race." She states that in addition to the impulse to help the poor, the Clinic had three main intellectual ideals: To see if it was true that the working classes were hostile to the birth-control idea, to obtain first-hand facts about the practical aspect of contraception, and to collect and record facts about the utilization of contraceptive methods by the poor and data about the co-ordinated details of the sex life of women.

Of the first 5000 cases only 54 were unmarried, and the rule now is that only women who have borne at least one child are given the Clinic's fullest help.

Illuminating statistics are quoted showing the rapid rise in death-rate with increase of pregnancy rate.

There is a description of the methods generally recommended, and an analysis of the methods tried before coming to the Clinic.

In the analysis of failures, the Clinic found that in almost every case the cervix was abnormal or that the patient had failed accurately to carry out instructions.

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

ADAMS, JOHN, F.R.C.S. *Ante-Natal and Post-Natal Syphilis.* London: John Murray, 1925.

ADAMSON, H. G., M.D. "? Lichen Obtusus." *Proceedings of the Royal Society of Medicine*, July, 1925.

ATTLEE, W., M.D., B.Ch., M.R.C.P. "Diseases of Adolescence in Boys." *Practitioner*, July, 1925.

BATTEN, RAYNER D., M.D. "The Eye, from Infancy to Old Age." *Ibid.*, July, 1925.

BROCKMAN, R. STILEGER, M.A., M.Ch., F.R.C.S. "The Complications of Gallstones." *Clinical Journal*, May 27th, 1925.

BUKKA, L. T., M.D. "A Case of Recurrent Pneumothorax." *Lancet*, June 6th, 1925.

CHANDLER, F. G., M.A., M.D., M.R.C.P. "Skin Tests: Asthma and Idiosyncrasy." *Ibid.*, June 6th, 1925.

——— (and PRESTON, T. W., M.R.C.S., L.R.C.P.). "Pulmonary Tuberculosis in Childhood." *British Journal of Children's Diseases*, January–March, 1925.

DUNDAS GRANT, Sir JAMES, K.B.E., M.D. "The Relief of Catarrhal Deafness." *Practitioner*, June, 1925.

ELGOOD, C., B.M.(Oxon.). "Rectal Injection of Ether in Whooping-Cough." *British Medical Journal*, May 23rd, 1925.

GASK, GEORGE E., C.M.G., D.S.O., F.R.C.S. "Remarks on the Possibilities of Exploratory Thoracotomy." *Ibid.*, February 21st, 1925.

GAUVAIN, Sir HENRY J., M.A., M.D., M.C. "Organization and Work of a Light Department in a Hospital for Surgical Tuberculosis." *Lancet*, July 4th, 1925.

GRAHAM, GEORGE, M.D. "The Treatment of Diabetes Mellitus in Young Children." *Clinical Journal*, July 8th, 1925.

HAMMOND, T. E., F.R.C.S. "The Diagnosis of Hæmaturia." *Ibid.*, June 24th, 1925.

HEY GROVES, ERNEST W., B.Sc., M.D., M.S., F.R.C.S. "The Treatment of Infantile Paralysis: With a Plea for the Re-organization of our Hospital System." *British Medical Journal*, March 14th, 1925.

——— *A Synopsis of Surgery*, 7th edition. Bristol: John Wright & Sons, 1925.

——— (and the late J. M. FORTESCUE-BRICKDALE, M.D.). *Text-book for Nurses: Anatomy, Physiology, Surgery and Medicine.* London: Oxford University Press, 1925.

HORDER, Sir THOMAS, Bart., M.D., F.R.C.P. "Diseases of Adult Life." *Practitioner*, July, 1925.

HUDSON, BERNARD, M.D., M.R.C.P. "Treatment of Effusions in Artificial Pneumothorax." *British Medical Journal*, June 20th, 1925.

JOHNSTON, J. H., M.Sc., F.I.C. "Sanitation and Water Purification." *Reports of the Progress of Applied Chemistry*, vol. ix, 1924.

LANE-ROBERTS, C. S., M.S., F.R.C.S. "Constipation and Pregnancy." *Practitioner*, June, 1925.

MURRAY, E. G. D., O.B.E. (and AYRTON, R.). "Observations on the Growth of Meningococci *in vitro* in Relation to Virulence." *Journal Royal Army Medical Corps*, July, 1925.

MYERS, BERNARD, C.M.G., M.D. "Male Twins, one of which is a Mongol." *Proceedings of the Royal Society of Medicine*, July, 1925.

——— "Case of Chorea." *Ibid.*, July, 1926.

——— "Absence of Anus: Rectum opening into Posterior Vaginal Wall." *Ibid.*, July, 1925.

NANKIVELL, A. T., M.D., D.P.H. (and KETTLEWELL, G. D., M.R.C.S., L.R.C.P.). "An Outbreak of 308 Cases of Food Poisoning at Greenbank Infirmary and Workhouse, Plymouth." *Medical Officer*, June 6th, 1925.

NAPIER, L. EVERARD, M.R.C.S., L.R.C.P. "A Comparative Study of the Environment Associated with Kala-Azar Prevalence in Calcutta." *Indian Journal Medical Research*, April, 1925.

——— (R. B. LLOYD, L.E.N., and K. G. A. SMITH). "The 'Blood Meal' of *Phlebotomus argentipes* identified by Precipitation Antisera." *Ibid.*, April, 1925.

NIXON, J. A., C.M.G., M.D., F.R.C.P. "Focal Sepsis as a Factor in the Causation of Neurasthenia and Insanity." *British Medical Journal*, July 4th, 1925.

ROCHE, ALEX E., M.A., M.B., M.Ch., F.R.C.S. "Shoulder Pain in Ruptured Ectopic Gestation." *Clinical Journal*, June 3rd, 1925.

ROLLESTON, Sir HUMPHRY, Bart., K.C.B., M.D., Hon. D.Sc.(Oxon.), D.C.L., LL.D., F.R.C.P. "Diseases of Old Age." *Practitioner*, July, 1925.

——— "Some Medical Aspects of Holidays." *British Medical Journal*, July 18th, 1925.

ROXBURGH, A. C., M.D. "? Schamberg's Disease, or Angioma Serpiginosum." *Proceedings of the Royal Society of Medicine*, July, 1925.

RYLAND, ARCHER, F.R.C.S. "Natural Cure similar in Result to that following a Radical Mastoid Operation. Cavity Completely Dry and Epithelialized." *Ibid.*, July, 1925.

SHAW, WILFRED, M.B., B.Ch.(Cantab.), F.R.C.S. "The Relation of Ovarian Function to Menstruation." *Journal of Physiology*, vol. lx, No. 3, July 14th, 1925.

VERRALL, P. JENNER, F.R.C.S. "Bow Legs and Knock-Knee in Young Children." *Clinical Journal*, July 8th, 1925.

WEBER, F. PARKES, M.D. "Two Diseases due to Fashion in Clothing: Chlorosis and Chronic Erythema of the Legs." *British Medical Journal*, May 23rd, 1925.

——— "A Case of Thrombo-Angiitis Obliterans of Twenty-two Years' Duration." *Lancet*, July 4th, 1925.

——— "Case of 'Polycythæmia Hypertonica.'" *Proceedings of the Royal Society of Medicine*, July, 1925.

WHALE, H. LAWSON, M.D., F.R.C.S. "Otitic Intracranial Infection." *British Medical Journal*, May 16th, 1925.

WILLOUGHBY, W. M., M.D. "Port of London Sanitary Authority. The New Motor Launch." *Lancet*, June 27th, 1925.

YATES, A. LOWNDES, M.D., F.R.C.S.(Edin.) (and DARNES, STANLEY, M.D., D.Sc., F.R.C.P.). "The Nasal Sinuses as a Route of Infection in Encephalitis Lethargica." *Ibid.*, July 18th, 1925.

EXAMINATIONS, ETC.

UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:

M.B., B.Chir.—F. C. Cozens, F. A. H. Simmonds.

First Examination for Medical Degrees, June, 1925.

Part I. Chemistry.—F. R. T. Hancock.

Second Examination for Medical Degrees, June, 1925.

Part II. Human Anatomy and Physiology.—J. R. A. Reynolds.

Third Examination for Medical and Surgical Degrees.

Part I. Surgery, Midwifery and Gynæcology.—W. A. Barnes, J. W. D. Buttery, R. T. Chadwick, J. E. Church, J. H. T. Davies, C. A. Francis, J. H. Hannan, J. C. Hogg, E. F. Molony, L. V. Pearson, K. G. Salmon, D. G. Shields, H. B. Stallard, R. S. Tooth.

Part II. Principles and Practice of Physic, Pathology and Pharmacology.—W. A. Bourne, H. F. Brewer, C. H. C. Dalton, J. H. T. Davies, P. O. Davies, G. S. W. Evans, J. Holmes, G. L. F. Rowell, J. R. Smith, H. A. Ware.

UNIVERSITY OF LONDON.

Second Examination for Medical Degrees, July, 1925.

Part II. Anatomy, Physiology and Pharmacology.—J. H. Attwood, S. W. Barber, C. H. Dale, T. G. Davies, A. P. Gaston, W. L. Hurn, W. A. Hutton, D. C. R. R. Jenkins, S. McGladdery, K. W. Mackie, J. Miller, W. T. Mills, P. M. Oxley, D. Preiskel, R. W. Raven, E. ap I. Rosser, C. J. Sanderson, C. G. Sinclair, E. J. J. Smith, K. G. Sugden.

M.D. Examinations, July, 1925.

Branch I. Medicine.—E. Gallop, C. F. Harris, W. E. Lloyd (University Medal), R. H. Wade.

M.S. Examination, July, 1925.

Branch I. Surgery.—J. P. Hosford (University Medal).

B.Sc. Examination.

Honours: Physiology.—(Second Class) D. Stanley Jones; (Third Class) S. Behrman.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

The following have passed the Primary Examination for the Diploma of Fellow:

W. J. H. M. Beattie, B.A.(Cantab.), B. L. Jeaffreson, M.D., B.S.(Lond.).

CHANGES OF ADDRESS.

ATKINSON, E. MILES, 29, Welbeck Street, W. 1. (Tel. Langham 2063.)
BOYLE, H. E. G., 36, Montagu Mansions, Portman Square, W. 1. (Tel. Mayfair 5784.)
DONELAN, C. J., The Hermitage Sanatorium, Whitwell, Ventnor, I.-o.-W.
DUPRE, W. H., Warthen, near Shrewsbury.
GERARD-PEARSE, J. E., Somerset House, Greenhill, Weymouth. (Tel. 190.)
HAYES, A. H., Kilberry, Claygate, Surrey.
HEWER, J. LANGTON, 64, Finchley Road, N.W. 8. (Tel. Hamp. 4561.)
MCCURRICH, H. J., 9A, Palmeira Avenue, Hove, Sussex. (Tel. Hove 6688.)
MILLER, T. M., 18, Grosvenor Road, Tunbridge Wells. (Tel. Tunb. Wells 1481.)
MILNER, S. W., Wells, Norfolk.
MILSOM, E. G. D., 87, Eccleston Square, S.W. 1.
PALMER, C. SPENCER, 4, Gwydyr Mansions, Hove, Sussex.
SIMMONDS, F. A. H., 36, Onslow Gardens, Muswell Hill, N. 10.
WOOD, J. H., Thornton Cottage, Aysgarth, North Yorkshire.

APPOINTMENTS.

ANDERSON, H. G., M.B., B.S.(Lond.), appointed Clinical Assistant, East London Hospital for Children, Shadwell.
ATKINSON, E. MILES, M.B., B.S.(Lond.), F.R.C.S., appointed Assistant Surgeon to the Ear, Nose and Throat Department of the Prince of Wales's Hospital, Tottenham.
CLEGG, H. A., B.A., M.R.C.S., L.R.C.P., appointed House-Physician, Brompton Hospital for Consumption, Fulham Road.
DONELAN, C. J., M.R.C.S., L.R.C.P., appointed Resident Medical Officer, The Hermitage Sanatorium, Ventnor.
DOTTRIDGE, C. A., M.D.(Camb.), D.P.H., appointed Certifying Surgeon under the Factory and Workshops Act for the Lyndhurst District of the County of Hampshire.
ELGOOD, C., M.B., B.Ch.(Oxon.), appointed House-Physician, West London Hospital.
MOLONY, E. F., M.R.C.S., L.R.C.P., appointed House-Surgeon, Addenbrooke's Hospital, Cambridge.
OGDEN, W., M.R.C.S., L.R.C.P., appointed House-Physician at the Hull Royal Infirmary, Hull.
PRESS, B., M.R.C.S., L.R.C.P., appointed House-Surgeon at the Wrexham Infirmary, Denbighshire.
WILSON, A. CYRIL, M.R.C.S., L.R.C.P., appointed Clinical Psychologist (unpaid) to the West End Hospital for Nervous Diseases, Welbeck Street.

BIRTHS.

ANDREWS.—On July 19th, at 152, Harley Street, W. 1, to Helen, wife of J. Alban Andrews, M.C., F.R.C.S.—a daughter.
BATTERHAM.—On July 5th, at the Military Families Hospital, Cologne, to Thelma, wife of Captain D. J. Batterham, F.R.C.S., R.A.M.C.—a son.
CHAPMAN.—On July 23rd, at Wingmore Lodge, Wokingham, Berks, to Dr. and Mrs. E. F. Chapman—a daughter.
RIVETT.—On July 12th, at a nursing home, to Mary, wife of Louis Carnac Rivett, of 118, Harley Street, and 3, Hanover Terrace—a daughter.
ROSS.—On July 22nd, at 32, Loudoun Road, N.W. 8, Marjorie, the wife of J. Paterson Ross, M.B., F.R.C.S.—a son.
SMITH.—At "Stone Field" Maternity Nursing Home, Kidbrook Grove, Blackheath, on July 15th, to Molly (*née* Terraine), wife of Dr. Norman F. Smith (Khartoum)—a daughter.
VICK.—On July 18th, at St. Clere's Hall, Danbury, Essex, to Reginald and Mary Vick—a daughter.

MARRIAGES.

CLAXTON—ERVINE.—On June 30th, at St. Saviour's Church, Denmark Hill, S.E. 5, by the Rev. Canon Hay Aitken, M.A., Dr. Ernest Claxton to Muriel, daughter of Mr. and Mrs. W. J. Ervine, of Denmark Hill.
COLLYNS—PRESTON.—On June 30th, at Edgbaston Parish Church, by the Rev. Canon Bloteld, Vicar, Percival Charles, younger son of Dr. R. J. Collyns, of Dulverton, Somerset, to Rachel Caroline, daughter of Henry W. Preston, of Oakleigh, Alderley Edge, Cheshire.
LINDER—MARSHALL.—On July 23rd, by the Vicar at the Parish Church, Rickmansworth, Dr. Geoffry Challen Linder, only son of Mr. and Mrs. William Linder, to Ruby Esther, daughter of Mr. James and the late Mrs. Marshall, of Dubois, Pennsylvania, U.S.A.
MAWER—JONES.—On July 18th, at Holy Trinity Church, Brompton, by the Rev. Prebendary Gough, assisted by the Rev. Harold Godefroy, uncle of the bride, Percy Uvedale Mawer, younger son of the late Mr. Mawer and of Mrs. Mawr, Folkestone, to Phyllis Florence Jones, younger daughter of Mr. and Mrs. Arthur H. Jones, Friary Hill, Weybridge.
PULFORD—THOMAS.—On June 20th, at the Presbyterian Church, Roath Park, Cardiff, Herbert Pulford, M.A., M.B., B.C.(Cantab.), L.D.S.(Eng.), to Gertrude Thomas, of Cardiff.

DEATHS.

DALBY.—On June 23rd, 1925, at Brighton, John Lyttleton Dalby, M.R.C.S., L.R.C.P., only son of the late Major Dalby, of Ealing, aged 55.
ELKINGTON.—On June 26th, 1925 (suddenly), at Fenny Compton, Warwickshire, Dr. Frederick Victor Elkington, beloved husband of Annie Elkington, aged 61.
NIGHTINGALE.—On Saturday, June 20th, 1925, at Buskelts Woodlands, near Southampton, after a short illness, Samuel Shore Nightingale, M.R.C.S., L.R.C.P., D.P.H., elder son of the late William Shore Nightingale, of Embley, Hants, and Lea Hurst, Derbyshire, aged 64.

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. 1.*

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St. Bartholomew's Hospital JOURNAL.

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

VOL. XXXII.—No. 12.] SEPTEMBER 1ST, 1925. PRICE NINEPENCE.

CALENDAR.

Tues., Sept. 1.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Fri., „ 4.—Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.
Tues., „ 8.—Sir Thomas Horder and Mr. Rawling on duty.
Fri., „ 11.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Tues., „ 15.—Prof. Fraser and Prof. Gask on duty.
Fri., „ 18.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Sat., „ 19.—**Last day for application for House Appointments.**
Tues., „ 22.—Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.
Last day for receiving matter for October issue of the Journal.
Fri., „ 25.—Sir Thomas Horder and Mr. Rawling on duty.
Tues., „ 29.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.

EDITORIAL.

HISTORY relates that when a Royal Personage was presented by the author of the *Decline and Fall of the Roman Empire* with the sixth volume of that masterly treatise, he muttered rebelliously: "Another d——d heavy, thick book. Always scribble, scribble, scribble, eh, Mr. Gibbon?" Our real sympathies are with the overburdened monarch; and consequently we make no apology for the fact that, this month, the JOURNAL is smaller than usual.

* * *

We hope that our readers did not miss the reports of the Osteopaths' Conference which was held at the Savoy Hotel during the first week of August.

In view of the fact that the osteopaths intend to bring a Bill before the House of Commons next session to provide an osteopathic register, which will be comparable in all respects to the Medical Register, it is a pity that the Conference was not given even wider publicity in the Press.

We are aware that here we are on delicate ground. When medical men take counsel together there is a good deal of what Carlyle called "windy blether" talked, but the following quotations from the *Times* reports should be sufficient to acquit us of any bias when we say that we prefer our foolishness to the osteopathic variety.

Dr. Dawes, of Montana, urging the use of uncooked foods, said that "his heart-beat after partaking of cooked foods was 72 to the minute, after uncooked food it was 62. In a year this was a saving of 3,607,200 beats, or a rest of two months for the heart."

The same day Dr. Geddes explained that in order to inhibit the growth of cancer, "the spine and other parts should be adjusted, natural foods should be fed, the patient should live in the open air, do upside-down exercises, and walk on all fours."

It is interesting to observe that this modern work was anticipated by Babylonian royalty thousands of years ago. Nebuchadnezzar, when he ate grass with the oxen, was merely "obviating the growth of ulcers, tumours and cancers."

The next day, a Man from Toronto (land of Banting and Best) lectured on diabetes. "Osteopaths," he said, "had found the cause of diabetes to be in the middle of the back, between the tenth and twelfth dorsal. They could produce sugar by forcible injury in that area, and could correct it by adjusting the structure. They had with them Dr. Fred Ashton, of Manchester, who had made this discovery on the human frame. In order to

maintain this correction human beings must learn to walk on their toes."

This, of course, would account for the fact that we have never heard of a single case of diabetes among the Russian dancers; but Mr. Ashton went further and said that "he did not think any Greek or Roman wrestler could suffer from diabetes because of the posture of the body."

However, we suppose it is a good thing that orthodox medicine should be challenged on a fresh front in each generation. Homeopathy, Christian Science, Anti-vivisection, Anti-vaccination, Osteopathy and Chiropraxy have each, in turn, provided a new assault.

The osteopaths claim to have a large backing of M.P.'s for their Bill, but we hope that the large and active group of medical men in Parliament will see to it that it does not get beyond a First Reading.

* * *

We remind men who intend to apply for House Appointments that they must leave their applications with the Warden on or before Saturday, September 19th.

OBITUARY.

THOMAS PALMER DANIEL, M.R.C.S.

THE death occurred on August 2nd, 1925, at Beaminster, Dorset, of Thomas Palmer Daniel, in his 89th year. Born in 1836, he studied medicine at St. Bartholomew's Hospital from 1854–1858, taking the M.R.C.S. and L.S.A. in the latter year. After qualifying he was for some years assistant to Dr. Lovell Drage, of Hatfield. In 1863 he entered into partnership with his cousin, William Daniel, in his native town of Beaminster, in the practice held jointly by their respective fathers. Here he continued in active practice until 1924, when he had a serious illness.

He was Vice-President of the Dorset Branch of the British Medical Association, in which he took an active part.

It is an interesting fact that he carried on a practice which had been in the family for 225 years, on property which had belonged to the family since before the reign of Henry VIII. He actually died in the same room in which he was born.

He married Caroline, daughter of Cyrus Croft, of Plymouth, and leaves one son, of Detroit, U.S.A., and two daughters, the elder the wife of W. M. Willoughby, M.D., Medical Officer of Health, Port of London, and the younger the wife of A. A. Pim, F.R.C.S.(Edin.), who carries on the practice in Beaminster.

HUMOUR AND THE CONSULTANT:
I. THE DOCTOR.

I AM not sure if some, or indeed any, of the incidents I am about to recall, or the reflections I am about to make, deserve to be regarded as humorous, but that they have seemed to me to breathe a little of the Comic Spirit, "to touch and kindle the mind through laughter," is all the excuse I can offer for setting them down. When all is said, there can, in the nature of things, be but little in any doctor's professional life that may be regarded as rollicking; of the quieter, more subtle, and perhaps more grim sort of comedy, however, there is not a little. Some of the best things cannot, alas, be told, since "doctors do not tell,"—at least they do not tell during the patient's lifetime, and to suppress names would by no means suffice for anonymity in the best instances in view of the internal evidence of the anecdotes.

There is the story of "Why the Cabinet broke up suddenly," for example. It would not be fair to one of our most prominent law-givers to tell that story during his lifetime. And perhaps the doctor who could tell it will die first! Then, again, it would be unfair to myself to tell the story of "The Mayor of Banbury" in the columns of a journal so widely read as this. Full of the idea of comedy though the tale may be, and instructive to myself, too, in that it explains quite adequately why I never go to that important centre of the manufacture of confectionery for a consultation, and so preaching a warning to the young consultant who naturally desires that all places, and especially all manufacturing places, shall be open to him. Our reputations, my young friend, however safe we may think them, are never proof against wagging tongues, and to risk seeing my own tender plant wilt as the result of such cruel exposure would be comedy indeed! No. "The Mayor of Banbury" must wait awhile.

But if some stories are never told because the doctor dies before his patient, and others cannot be told because no doctor's reputation would stand against the telling, then it is clear that some of the best stories are lost to the world. That is all too true; by a generous calculation I estimate that no less then six good stories are lost per doctor per annum in this country. That gives a total of rather less than a quarter of a million spread over the whole profession in twelve months! When we consider what this means in relation to the health of the nation, it becomes a problem of great importance how it may be possible to avoid this loss. But I must confess I am myself unable to suggest a solution. Things are even worse, in a way, than I have painted them, because there are still other stories that may not be told, and those are stories about other doctors. If those doctors were not Bart.'s men, and therefore not regular readers of the JOURNAL, or were they to be trusted to have so nice a sense of the comic spirit that their appreciation of the comedy outweighed their chagrin that the story was about themselves, then perhaps the step might be taken. But I cannot risk the best part of my *clientèle* in this way; I have a wife and family and large expenses. . . . But provided I exercise due care and some degree of generalization, it may be permissible to make a few references.

. . . . .

The practice of sending a patient to the consultant with only the practitioner's visiting card, though it may be evidence of the confidence imposed in him, admits of neither humour nor of pathos. There is often a grim humour, however, in the not uncommon note of introduction which says of an extremely verbose patient of the neurasthenic type, "Mrs. S— can tell you her story so graphically that I need not write to you about her; please tell me exactly what you advise as regards treatment." Nor is the humour lessened when the patient observes, "I think you have already heard fully from my doctor." The reply is necessarily more loyal than veracious. But the consultant also scores occasionally—I mean in the matter of saving his time. It was a patient concerning whom I received exactly this sort of letter who returned to her doctor full of enthusiasm: at long last she had been to a consultant who listened patiently to her story. I received a letter from the doctor complimenting me on giving his patient so satisfactory an interview, and I had not the courage to reply that when his patient thought I was taking careful notes of her many and varied symptoms, I was really writing my opinion to their respective practitioners concerning the last two patients I had seen. It is usually the same type of doctor who says, at the end of a consultation, "I am sure it will have a much better result if *you* write out the *régime* we have agreed upon," and, though he may be correct in his estimate, one cannot but admire the consistency with which he pursues the time-saving device.

There are still to be met a few doctors of the old school who note a suggested prescription on their shirt-cuffs. I met one of these recently, and he took his wooden stethoscope out of his top-hat to listen to the heart. I could not help wondering if his test for glycosuria was the same that was current in Thomas Willis's day. I need scarcely say he practiced in the heart of the country. Doctors "up from the country" sometimes demonstrate that they are unfamiliar with the jig-saw puzzle type of day which falls to the lot of a busy consultant. This unfamiliarity, though embarrassing, has its comic side. Tired by an early morning drive to the station and a long railway journey—and often tired, too, poor fellow, of the egoism of his patient, who has travelled with him—he drifts into the easy chair (unless I have been wary, and have loaded it up with books and things, so as to force him into one of the straight-backed affairs), and does not mind very much if the consultation proceeds somewhat leisurely. Indeed, he does his best to ensure that it shall; is not this *the* event of the day? I have even suffered a very healthy cold douche to my dignity by finding him dropping off to sleep during my careful statement of the diagnosis. But the machine is not, so far, seriously dislocated. A recovery can usually be effected by saving time over the prognosis or the treatment. It is when—the patient disposed of that dread query comes, "And now, doctor, will you just look over *me* for a minute; I promised my wife . . . I don't think there's much wrong, but . . ," there arrives a situation in which one risks offence to a colleague, who is also a good fellow, by declining on the ground that his health is far too important a matter to be disposed of in a "wayside consultation," or risks making a mistake through mental stress born of the knowledge that the jig-saw will be irretrievably upset. So far it is hard going whichever alternative one chooses, and the serious business is unrelieved by any humour. But when, having yielded to the doctor's wish, the second consultation is followed by a leisurely request for an opinion about a daughter who has come up with him, and who is at that moment in the waiting-room, the fun really begins. But does not end, for when the girl has been disposed of—thank heaven for a stroke of luck, the facial diagnosis was quite conclusive—the dear man asks finally for a suggestion about the treatment of a valuable cook, who, by another beneficent dispensation of Providence, has been left at home. All the same, the most subtle part of the comedy is contributed by the man who says to his friend, as they watch the lunch-less consultant's arrival at hospital for his "round," "There's X, late again, I bet he's been piling up the guineas!"

X.

(To be concluded.)

ANATOMY IN RELATION TO SUPPURATIVE TENO-SYNOVITIS.

Anatomy.

THE gross anatomy of the tendon sheaths of the hand is best explained by reference to Diagram 1. It will be seen that there are five separate sheaths, called respectively—

(1) Ulnar bursa, which may be continuous with the little finger sheath.
(2) Sheath to index finger.
(3) Sheath to middle finger.
(4) Sheath to ring finger.
(5) Radial bursa or thumb sheath.

By dissection the relations of these sheaths can be made out. In order to assist in applying this knowledge clinically to cases of suppuration in the tendon-sheaths, a series of experiments has been conducted, in which each sheath was injected with coloured gelatine. When the pressure was raised sufficiently the sheath was ruptured and the dye was forced into the tissues. This extension did not occur in any haphazard manner, but only along certain definite lines in each case. By comparing these results with clinical data it was found that the points of experimental rupture correspond exactly with the points at which pus will rupture. Thus for each particular sheath we can determine the points to which pus is likely to extend, and on this we can base the actual treatment of any case of tendon-sheath suppuration.

From clinical and experimental data it has been found that the little finger sheath may rupture and involve—

(1) Ulnar bursa.
(2) Radial bursa.
(3) Forearm.
(4) Fascial spaces—mid-palmar space, lumbrical space.
(5) Osteomyelitis of middle phalanx.
(6) Suppurative arthritis of proximal interphalangeal and wrist-joints.
(7) Rupture to surface.

It is found that when pus ruptures into the forearm, it always passes to the deep aspect of the mass of flexor muscles and lies between them and the pronator quadratus. This explains the difficulty that is often experienced when searching for pus through an anterior incision. An incision in the front of the forearm should never be made. In order to drain the pus in the forearm an incision is made along the line of the ulna, commencing 1 in. proximal to the styloid process. A pair of Spencer-Wells is then pushed boldly deep to the flexor tendons and made to present on the radial side, where counter-opening is made. This incision will drain the upper ends of the radial and ulnar bursæ and any pus that has ruptured into the forearm. It will be found to be quite unnecessary to introduce any form of drainage-tube, for this will merely cause continued suppuration and pressure necrosis of the tendons. If the incisions are sufficiently free there will be early cessation of discharge and rapid healing in about five days. If the incisions are inadequate or if a tube is introduced, suppuration is continued and permanent impairment of function favoured.

When the radial bursa ruptures the pus passes into the forearm. From the index sheath it may pass to the thenar space or into the lumbrical canal. From the middle and ring fingers the pus passes into the mid-palmar space on the deep aspect of the flexor tendons, anterior to the transversus adductor pollicis. It is of the greatest importance to appreciate these possible sites of extension in order to be able to drain the affected space by a correctly placed incision.

Treatment.

The main principles of treatment of suppurative teno-synovitis are :

I. Exact diagnosis.
II. Adequate incision in correct position.

I. *Exact Diagnosis.*

This can usually be effected by a careful clinical examination before the patient is anæsthetized. The most important part of this is the elicitation of the exact site of maximum tenderness. The sides of the finger may be somewhat tender, but along the line of the tendon there is exquisite and localized tenderness. The main signs on which a diagnosis is made may be summarized :

(1) Localized tenderness.
(2) Rigidity of finger.
(3) Pain felt at the web on passive extension of the finger.

The conditions which have to be differentiated from suppurative teno-synovitis are :

(*a*) Localized tissue-space suppuration.
(*b*) Lymphangitis.

In neither condition are the three cardinal signs of sheath infection found in sufficient degree to indicate teno-synovitis.

It may be wise to note certain points to avoid before considering the actual technique of the operation.

NEVER incise a septic finger under ethyl chloride. It blanches the skin and makes tissues and pus alike solid, thereby rendering accurate localization impossible. Moreover it hurts most powerfully.

NEVER incise a septic finger in the middle line. A mid-line scar is exposed to pressure and is painful. It tends to contract and cause permanent contracture, and if the sheath is opened there is danger of prolapse of the tendon.

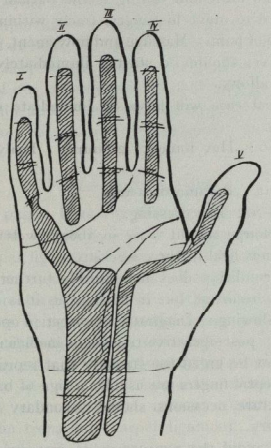

FIG. 1.—DIAGRAM TO SHOW RELATION OF SHEATHS TO CREASES IN HAND.

NEVER incise on the dorsum of the hand or fingers unless you are certain the main collection of pus is there. Though the dorsum is the site of greatest swelling the pus is nearly always on the palmar aspect, and we must use the site of greatest tenderness as our guide.

NEVER incise blindly in a hurry, thinking that "It may be a tendon-sheath." Use a tourniquet, and in a bloodless field under G. & O. (never gas alone) make certain if the pus is outside the sheath. If not incise under observation.

NEVER squeeze a wound in the subsequent dressings. The pernicious habit of the daily squeeze cannot be too heartily condemned. It spreads infection and hurts. If pus does pocket it is an indication that the incision is inadequate and must be enlarged.

II. *Operative Technique.*

A. *Index Finger. Middle Finger. Ring Finger.*

We will assume that an exact diagnosis of suppurative teno-synovitis of index finger has been made and preparation for prolonged G. & O. are completed.

The whole arm is cleansed. It is quite insufficient merely to clean the affected finger and its neighbours. The whole arm will go into the bath subsequently and the whole arm must be rendered aseptic.

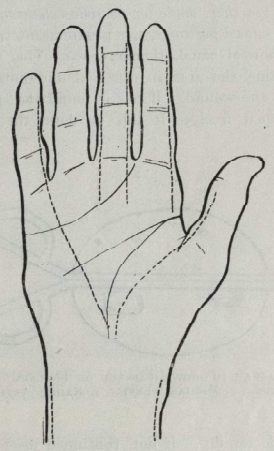

FIG. 2.—DIAGRAM TO SHOW LINE OF INCISIONS USED TO DRAIN SHEATHS.

A tourniquet is applied. Much has been spoken about the danger of Volkmann's ischæmic contracture after the use of a tourniquet. It must be admitted that this is a very real danger if the anchor type is used, consisting of a thick rubber tube. The danger is avoided by using the bag of a sphygmomanometer. It is easily adjusted and causes no damage.

As soon as the patient is under, towels are arranged and the bag is pumped up.

The incision is made to the radial side of the finger, extending from the distal crease of the finger to a thumb-breadth proximal to the web. As there is no bleeding the tissues can be recognized as they are divided, and the sheath is exposed before it is opened. If the diagnosis was in doubt and pus is found outside the sheath, it is best in most cases to refrain from exploring further lest an intact sheath be infected. If no pus has been

discovered the sheath is deliberately opened. In an early case only oily turbid fluid will escape. Sometimes frank pus exudes. The sheath is cautiously explored, and if the pus extends from end to end it is laid open to this extent. On lifting up the tendon from its bed it will often be noted that on the dorsal aspect the evidences of suppuration are more marked than on the volar.

In an early case incision on one side only is needed. If the infection is severe counter-openings are made on the ulnar side also. If the tendon is sloughing it is best excised, thus providing very efficient drainage.

Finally search is made for possible extension of pus in any of the known positions, e.g. proximal interphalangeal joint, lumbrical canal, thenar space. This is effected by squeezing the area in question and noting if pus wells into the wound. If pus is found the space must be laid open freely. If this is done the condition

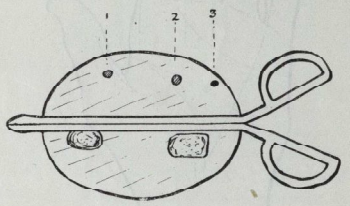

FIG. 3.—DIAGRAM TO SHOW DRAINAGE OF FOREARM. 1. ULNAR NERVE. 2. MEDIAN NERVE. 3. RADIAL ARTERY.

will subside rapidly. If not, continued discharge, persistent œdema, infiltration of muscles and adhesions of joints and tendons will cause permanent impairment of function.

If the incision is adequate and correctly placed no drainage tube is necessary. NEVER USE ANY KIND OF DRAINAGE-TUBE IN A SEPTIC HAND. To this rule there is no exception. Tubes in the hand cause pressure, and pressure causes necrosis. The lips of the wound may be kept open for forty-eight hours by inserting a fold of rubber glove, but never allow a tube to be passed into the deep spaces of the hand, under the carpal ligament or between the metacarpals.

The dressing used on the first occasion is usually dry gauze to assist in the arrest of hæmorrhage. Later gauze soaked in paraffin will prevent dressings sticking. Hot foments for four to five days may be used to ease pain and reduce œdema: but unless they are six thicknesses thick and are changed two-hourly they lose their heat very rapidly.

The hand is then bandaged to a suitable splint to give temporary immobilization. The best position is the tumbler position, with dorsi-extension of the carpus, the fingers assuming the position they take when holding a glass tumbler in the hand.

AFTER-TREATMENT.

We must avoid the boggy, œdematous and sodden hand. Baths, therefore, must be limited to two hours' duration daily for five to six days, and should consist of hypertonic saline as hot as can be borne by the healthy hand.

After the bath and during it the patient should be encouraged to move his fingers freely within the limits of absence of pain. Massage and movement, both active and passive, should be started immediately the local condition allows.

A typical case will have an immediate dressing of dry gauze.

Day 2–6: Hot foments 2-hourly. Daily baths—2 hours.

Day 7–12: Paraffin dressing.

Day 13–20: Dry dressing.

All discharge should cease in about twelve days and most wounds heal in three weeks.

If the condition does not subside further extension may have occurred, but in most cases it is due to one of the following: Diagnosis incorrect; operation inadequate; post-operative treatment inefficient.

It cannot be urged too strongly that repeated operations on septic fingers are usually a sign of bad surgery. Only on rare occasions should secondary operations be necessary.

Always avoid the temptation to incise the point of maximum swelling on the dorsum. With rare exceptions no incision should ever be made on the dorsum of the hand or fingers. Incise over the point of maximum tenderness; in 99 per cent. of cases the pus is on the volar aspect.

There is no class of case in surgery where careful diagnosis, radical treatment and meticulous after-treatment will give more striking results than septic fingers. Inefficiently treated, ankylosis and claw-hand are inevitable. Promptly diagnosed and treated, the ultimate prognosis is excellent. Full flexion of all joints, save the terminal interphalangeal, can be expected in 80 per cent. of cases, while such complications as involvement of the joints and rupture into the forearm are met only on the rarest occasions in cases where the initial treatment was inefficient.

B. *Little Finger or Ulnar Bursa.*

Incision passes on ulnar side of hand from the distal crease of the little-finger to a point just distal to the line of the transverse carpal ligament. In a severe case the carpal ligament is divided and the whole carpal tunnel freely opened up.

In order to drain the proximal part of the sheath an incision is made on the ulnar border of the forearm 1 in. proximal to the ulnar styloid process extending proximally for 3 in. A pair of artery forceps is then pushed into the wound deep to all the mass of tendons, between the flexor profundus and pronator quadratus muscles. It is in this position that the pus will always be found to collect. If necessary a counter-opening is made on the radial border of the forearm.

It is important to remember that although the œdema and swelling are found on the front of the wrist, the pus is deep to the tendons. Occasionally a small collection of pus is found quite superficially at the wrist, but the main mass is nevertheless deep to the tendons and must not be approached through the tendons from the front.

C. *Thumb or Radial Bursa.*

Incision passes from the distal crease on the radial border of the thumb to a point a finger-breadth distal to the carpal ligament. This will avoid injury to the nerve to the thenar eminence. Extension proximally into the forearm is opened as for the ulnar bursa, the incision here being on the radial aspect with counter-opening on the ulnar side if necessary.

In certain cases of very advanced suppuration in the ulnar bursa and the radial bursa the sheath may be opened by continuing the incision proximally and dividing the transverse carpal ligament. But on no account must any tube be inserted into the carpal tunnel for fear of causing pressure necrosis.

A. C. VISICK.

SOME CLINICAL NOTES ON CARDIAC LESIONS.

THESE few notes have been put together for the benefit of those who, having bought a stethoscope, are about to listen for the first time to sounds produced by the human heart.

The writer disclaims any originality for these observations, but it is hoped that of the commoner failings of the heart will bring into focus and make clearer the teaching at the bedside and in the lecture theatre.

With no more ado let us plunge *in medias res*, and consider in the first place the significance of murmurs, and in the second place the estimation of myocardial damage.

As in everything, so in the examination of the heart, are there golden rules. Of these there are three:

1. Examine the patient standing up.
2. Examine the patient lying down.
3. Examine the patient after exercise.

THE SYSTOLIC MURMUR.

A systolic murmur over any area may be either (1) extra-cardiac, or (2) intra-cardiac in origin.

(1) *Extra-cardiac murmurs.*—The commonest of these is the cardio-respiratory murmur produced by a roughened pleura rubbing against the pericardium; it is usually heard at the base of the heart and varies with respiration. Jerky or cog-wheel inspiration will produce a systolic murmur at the apex which is plainly heard in inspiration and fades away with expiration. A mediastinal tumour pressing on the aorta will produce a systolic murmur at the aortic base.

(2) *Intra-cardiac murmurs.*—These may be functional or organic in origin. A valvular orifice is surrounded by a muscular ring, which, if weakened by ill-health or anæmia, will lose tone and relax, with the result that the valve-cusps will then not properly fit the valvular orifice—and so a functional murmur.

This type of murmur is commonly heard at the pulmonary base and disappears after exercise. A systolic murmur at the pulmonary base in association with an accentuated pulmonary second sound is very common in phthisis.

Let us consider the systolic murmur due to organic disease.

At the apex.—One may say that a systolic murmur at the apex without enlargement of the heart is functional in origin. If the heart is enlarged, if the pulmonary second sound is accentuated, and if a systolic murmur is heard at the apex, which is conducted to the axilla and to the inferior angle of the left scapula, then there is present mitral regurgitation due to damage of the mitral valves.

Organic lesions giving rise to a systolic murmur at the pulmonary area are usually of congenital origin (congenital pulmonary stenosis and patent ductus arteriosus), and will not be considered here. The rarest cause of an aortic systolic murmur is aortic stenosis, which should not be diagnosed in the absence of:

1. Enlargement of heart to the left.
2. A slow heaving out-thrust of the apex-beat.
3. A systolic thrill over the aortic base.
4. A rough aortic systolic murmur over the aortic base, conducted into the vessels of the neck.
5. A diminished aortic second sound.
6. A pulse having a slow oblique up-stroke.

Commoner causes of an aortic systolic murmur are syphilitic aortitis and atheroma of the aortic arch.

The Diastolic Murmur.

A diastolic murmur heard anywhere over the præcordium may be taken as evidence of valvular disease.

We shall now consider the late diastolic or presystolic murmur of *mitral stenosis*.

The diagnosis of a fully developed mitral stenosis is not difficult; the pre-systolic thrill, the pre-systolic crescendo murmur, within or at the apex, leading up to a short sharp slapping first sound, together with the accentuated pulmonary second sound, present an unmistakable syndrome. (The Austin Flint murmur of aortic regurgitation is not a crescendo murmur.) But the diagnosis of an early mitral stenosis is not always easy. One may confuse three conditions with an early mitral stenosis.

(1) A reduplicated first sound at the apex with a forcibly acting heart.
(2) A pericardial adhesion at the apex giving rise to a "pericardial kick"—heard close to the stethoscope.
(3) A rapidly acting excitable heart.

How to decide?

Firstly, feel the apex-beat, for in mitral stenosis it has a tapping character.

Secondly, feel the pulse, which is small in volume, but gives one the impression of being firm between beats.

Thirdly, listen for a short sharp first sound at the apex and an accentuated second sound at the pulmonary base.

If you hear no murmur when the patient stands or after he has exercised himself, then make him lie on a couch on his *left side*, and you may then hear a presystolic murmur. In a fully developed mitral stenosis remember to listen just to the left of the sternum in the third, fourth and fifth spaces, where you may hear the diastolic murmur of aortic regurgitation, which is not uncommonly associated with mitral stenosis. If you hear a diastolic murmur at the apex, as you will in a fully developed mitral stenosis, and you are not certain whether the murmur at the lower end of the sternum is aortic or mitral in origin, then notice at which point the murmur has its maximum intensity. If at the lower end of the sternum it is due to aortic regurgitation. If the diastolic murmur is loud at the lower end of the sternum, then quieter as one approaches the apex-beat, where it again becomes loud, you have two points of maximum intensity (*i. e.* maximum relatively to the quiet area in between), and therefore two causes of the murmur, viz. an advanced stage of mitral stenosis in association with aortic regurgitation.

The third stage of mitral stenosis or auricular fibrillation.—Mitral stenosis is the commonest cause of auricular fibrillation, which may, however, follow aortic disease, chronic myocarditis, or it may be toxic in origin. While auricular fibrillation with a rapid pulse is an easy condition to diagnose, yet when, as is sometimes the case, the pulse is slow, it may not be easy to distinguish auricular fibrillation from groups of extra systoles thrown in at irregular intervals.

The irregular irregularity is complete in auricular fibrillation. Notice that a long pause may be followed by a feeble pulse-beat; that a short pause may be followed by a strong pulse-beat; that no two pulse-beats are similar in volume; that no two intervals are the same.

Count the frequency of the heart, and at the same time get someone to count the pulse. there will be a pulse deficit. Apply a sphygmomanometer to the upper arm and listen to the brachial artery at the elbow.

Increase the pressure in the bag till no sound is heard, then slowly release the pressure 5 mm. of Hg. at a time. At first a few sounds will come through, and as the pressure is released, a few more, progressing in number with the release of pressure. The sounds will also vary in intensity, for the ventricle contracts not only at irregular intervals, but also with an irregularity of force.

The pre-systolic murmur, caused by the contracting auricle forcing blood through a stenosed mitral orifice, now gives place to a diastolic murmur, caused by the diastolic suction of the left ventricle. In most cases the pre-systolic thrill disappears. You may, however, feel a thrill and hear a murmur pre systolic in time, but it is not a crescendo murmur, and if you wait for a long, diastolic pause, you will notice an interval between the murmur and the sound. The explanation of the pre-systolic murmur in auricular fibrillation is that you have combined a long diastolic murmur with a short diastolic pause.

Aortic Regurgitation.

If you see a patient with a heart enlarged to left, with a forcible apex-beat, with visible pulsation of carotid and subclavian vessels, with a collapsing pulse, and you cannot at first hear a diastolic murmur either at the aortic base or at the lower end of the sternum, you will be able to bring out the murmur in this way.

Tell the patient to expire forcibly and at the end of expiration make him hold his breath; this brings the aorta closer to the sternum, the sounds become louder, and the absence of breath-sounds makes the detection of a faint diastolic murmur possible.

If you hear Duroziez's murmur—a diastolic murmur in the femoral artery—the diagnosis is confirmed beyond doubt.

Take the blood-pressure and you will find a high systolic and a low diastolic reading.

Estimation of Myocardial Damage.

Enlargement of the heart is better evidence of heart disease than any murmur heard anywhere over the præcordium. It is therefore of the greatest importance to define exactly the position of the left border of the heart. The position of the apex-beat, as felt, is a more certain indication of the position of the left border of the heart than that given by percussion; this has been demonstrated by X rays. The one exception to this rule is pericarditis with effusion.

If unable to feel the apex-beat, stand behind the patient, ask him to lean forward, and then put your left arm through his left axilla; you will often be able to feel a faint apex-beat or slight thrill by this means.

Percussion, the patient standing, may show the heart to be out to the left; percussion, the patient lying down, may prove this observation to be wrong; therefore, if in doubt, always percuss with the patient in both positions.

The patient will give you most of the information about his myocardium. He has dysnpœa, præcordial pain, or palpitation on exertion; he can't do as much as he used to; he feels tired at the end of the day, and does not feel refreshed after a night's rest. Find out how much exertion is necessary to cause dyspnœa, pain or fatigue; this is a rough measure of his myocardial deficiency.

Enlargement of the heart, weakening of the first sound at the apex (for one element in the production of the first sound is the contraction of heart muscle) and atonicity of murmurs are further indications of myocardial disease. Remember also to look for cyanosis of the lips and finger-nails, for fullness or pulsation of the jugular veins, for slight œdema over the tibiæ, for ascites, and listen for *râles* at the bases of the lungs.

If there is stasis of blood in the splanchnic vessels, and if you exert steady pressure on the right hypochondrium, the jugular veins become prominent.

Modern teaching rightly emphasizes the importance of an accurate knowledge of the state of the heart muscle, and in the estimation of this, symptoms are more useful than signs; but only a full knowledge of the signs *and* symptoms can enable one to form a true picture of the state of the heart, and to give a prognosis.

H. A. Clegg.

ANATOMY IN REGARD TO THE TREATMENT OF PILES.

A PILE is a bunch of dilated veins surrounding one of the terminal branches of the superior hæmorrhoidal artery, supported by a stroma of connective tissue, which varies in amount with the age of the pile and the degree of inflammation it has suffered.

The various types of piles, *e. g.* "bleeding," "prolapsing," should be considered stages rather than different varieties of the same condition. In the earlier cases where the pile cannot be felt by the examining finger bleeding is often a prominent feature, whereas in the later cases the pile can be felt by the finger and prolapse occurs.

Most commonly three piles only are present—generally one on the left side and two on the right side of the anal canal.

An explanation of this fact is found in the distribution of the superior hæmorrhoidal artery. This is the principal artery of the rectum, and is the prolongation of the inferior mesenteric artery. It divides into two branches, which run downwards on either side of the rectum; the right is usually larger than the left and lies more posteriorly, and when it has pierced the muscular coat and entered the lax submucous tissue it divides into two main branches; the left artery, on the other hand, remains single till near its termination.

The veins have a similar arrangement to the arteries, starting in the submucous tissue of the anal canal above the level of Hilton's white line.

The three main branches of the artery, two right and one left, explain the position of the commonest piles, but the superior hæmorrhoidal artery is generally found to have seven or eight terminal branches in all, one running beneath each of the columns of Morgagni as far as the anal valves, thus explaining the fact that the maximum crop of piles is seven or occasionally eight.

When the three main piles have been completely removed no recurrence can occur, but there are still four or occasionally five that may form.

The ligature operation is the method that is now almost universally adopted in the treatment of piles. The external sphincter is not divided, nor need this muscle be stretched in order to make the piles come down. Gentle dilatation is all that is necessary, and Mr. Ernest Miles has shown how well the piles are brought down by division, at one point, of the band of fibrous tissue which lies in the submucosa of the pecten (or region between the valves of Morgagni above and

the white line of Hilton below). Mr. Miles has called this deposit of fibrous tissue the pecten band, explaining its presence as due to passive congestion, which is known to produce similar induration in other positions, such, for example, as round a varicose ulcer in the leg.

When the piles have been grasped by pile-forceps, a V-shaped piece of skin is cut at the base of each. The base of the V is at the muco-cutaneous junction, and the skin only is cut, whereby bloodshed is greatly diminished. A deeper cut would divide the branches of the middle and inferior hæmorrhoidal arteries, which run to join the plexus in the submucosa formed by the superior hæmorrhoidal artery.

The strongest plaited silk is used for the ligatures, a maximum of three being necessary, and the strangled piles and their ligatures are tucked into the anal canal, and come away together about the tenth day. No bleeding can occur from ligatures slipping, and no rise of temperature or other adverse symptoms occur from leaving the pile to come away on its own.

E. A. CROOK.

SODIUM THIOSULPHATE IN EXTRA-VENOUS LEAKAGE OF N.A.B.

THE use of sodium thiosulphate in the treatment of arsenical dermatitis was first reported by P. Ravaut (1) in 1920. A more detailed account was given in 1922 by McBride and Dennis (2), who used it successfully in seven cases of severe arsphenamin dermatitis. Their results show that the course of the dermatitis is checked, and that intravenous administration of the salt is an advantage over oral administration. A most interesting case is reported by them of an eight months pregnant woman, who took 7½ gr. of mercuric chloride with suicidal intent. She was seen four hours later with acute abdominal pain and hæmaturia. 15 grm. of thiosulphate of sodium were given by mouth and 0·45 grm. intravenously. Abdominal pain and tenesmus were checked. Further intravenous doses of 0·9 and 0·45 grm. were given in the next twenty-four hours. The patient completely recovered and did not abort. The urine ceased to show any signs of nephritis in a week. Sodium thiosulphate has also been used in arsenical jaundice following N.A.B. and in bismuth and mercurial stomatitis.

Semon (3) also records a case in which, during the intravenous injection of 0·6 grm. novarsenobillon dissolved in 10 c.c. of distilled water, the needle slipped through the posterior wall of the vein and about 2 c.c. of the arsenical solution escaped into the subcutaneous tissues and formed a distinct swelling. The patient complained of severe burning pain and fainted. The needle was left in *situ* and 0·75 grm. sodium thiosulphate dissolved in 8 c.c. distilled water was injected so as to mix with the novarsenobillon solution. A week later no sign of local infiltration was to be seen and no pain was elicited on deep pressure over the site of injection. He records that "this is the first case in my clinic that an extravenous leak of novarsenobillon has escaped the sequelæ of painful subcutaneous infiltration."

The following case occurring in the wards of the hospital is of interest in showing the value of sodium thiosulphate in preventing the evil effects of an escape of N.A.B. into the subcutaneous tissues. A male patient, æt. 56, suffering from an aneurysm of the ascending aorta, was given 0·6 grm. N.A.B. dissolved in 6 c.c. of distilled water into a left antecubital vein. During the injection the patient complained of severe local pain, and a small globular swelling appeared over the site of the injection. The needle was withdrawn and the remainder of the solution was injected into another vein; a small leak of the arsenical solution occurred from this vein also, as evidenced by local pain and swelling. It was clear that a leakage of at least 0·5 c.c. of the solution had escaped into the subcutaneous tissues. 0·45 grm. sodium thiosulphate was dissolved in 5 c.c. distilled water, and within ten minutes of the extravenous leak the swelling was infiltrated with the thiosulphate solution. The patient shortly afterwards experienced relief of the pain. Two hours later the tissues at the site of the injection presented a firm diffuse swelling about 2 in. in diameter. No heat or redness was present. A further infiltration of the swollen area was carried out, 0·45 grm. sodium thiosulphate in 5 c.c. distilled water being used. Twelve hours later the swelling had not increased in size, and flexion of the elbow, though not quite complete, caused no pain. Twenty-four hours later the swelling had begun to subside, and by the following day was scarcely visible, though on palpation an area of thickening could be felt subcutaneously. The usual sequelæ of pain and slow tissue destruction were almost completely prevented. This experience confirms that of Semon, and suggests that it is advisable to have chemically pure sodium thiosulphate at hand in doses of 0·45 grm. This amount should be dissolved in 5 c.c. distilled water, so that it may be used to prevent the unpleasant sequelæ due to novarsenobillon in the subcutaneous tissues. Should the leakage of the arsenical solution into the subcutaneous tissues be considerable a dose of 0·6 to 0·9 grm. sodium thiosulphate may be employed.

It is by the courtesy of Dr. Graham that I publish this case.

REFERENCES.

(1) RAVAUT, P.—*Presse Médicale*, January, 1920, xxviii, p. 73.

(2) MCBRIDE AND DENNIS.—*Arch. Derm. and Syph.*, January, 1923, vol. vii, No. 1.

(3) SEMON.—*Brit. Med. Journ.*, April 12th, 1924, p. 662.

W. AUSTIN ROBB.

A BULL-FIGHT AT TARRAGONA.

POSSIBLY many of your readers have seen a Spanish bull-fight; but in case it may interest any of those who have not, I am giving the best account I can of it below.

On Sunday, June 21st of this year, whilst on our summer cruise, there happened to be a bull-fight taking place in Tarragona, at which port we were stopping. One had heard various accounts of it, varying from "nauseating" to "thrilling," so I determined to go and see one for myself.

A bull-fight is always held either upon a Sunday or a saints' day, and causes as much excitement as a cup tie in England, the season lasting from November until the end of June. It is the only thing in Spain which is punctual, everything else working upon the principle of "Manana."

About an hour and a half before the fight is due to commence a large crowd has assembled, mostly merely to stand outside and listen. The bull-ring itself is a sandy arena, circular in shape, and surrounded by tier after tier of seats, the whole being a miniature representation of a Roman coliseum. About half an hour before the "corrida" is due to commence the crowd of spectators begin to arrive in earnest. It is a picturesque sight, the women all wearing the national dress—high combs in their hair, mantillas and shawls, the latter being wonderfully embroidered in many and various colours and designs. The shawls are hung over the fronts of the boxes and seats, giving a gay and bizarre effect of colour.

Punctually at the time announced the president of the fight arrives in his box amidst cheers from the crowd. A mounted official then enters the arena and makes a long speech of welcome and praise to the president, who then throws him the key of the house in which the bulls are kept. This is caught in his hat, and he then retires and leads in a procession of the various people concerned in playing and killing the bull, each one taking off his hat and bowing to the president, after which all retire except a half-dozen or so who commence to play the bull which is then let into the ring, and tire him out by making him charge at the gaily coloured cloaks. These men are known as "chulos," and display an extraordinary amount of skill and pluck, the bull missing them sometimes by a fraction of an inch or so only. The later they leave their side-step and the less the bull misses them by, the more they are applauded. On the other hand the crowd is impartial, and if the bull should toss one of the chulos, he gets well applauded too.

After some five to seven minutes of this the "picadors" enter. These are men mounted on horses, fit only for the knackers, each being armed with a lance. Their object is to further enrage the bull by pricking it with the lance, and to tire it further by the subsequent loss of blood, and by making it toss the horse. This is the horrible part of the proceedings. The bull often has no wish to charge the horse, but is finally forced to by "chulos" waving their cloaks between the horse and the bull, or any other means. The horse is blindfolded too, and so has no chance of avoiding the charge, even if it was not in most cases too weak. Further, they have their vocal cords cut so that they cannot scream—at least so I was told, and I certainly never heard a horse make a sound; but one ought to be thankful for that I suppose. The cruelty to the horses surpasses anything I've ever seen. They are usually ripped up the belly and disembowelled in varying degrees. If only slightly protruding the guts are stuffed back with straw, the wound sewn up, and the wretched horse brought into the ring again. But some of the injuries are terrible. One horse was treading upon its own guts as it was being led away, whilst broken legs and punctured lungs are common; but so long as the horse can stand it is flogged to its feet and the bull is made to charge it again. After five minutes or so of this the "banderillas" are placed between the shoulders of the bull. The "banderillas" are darts about 2 feet long with barbed points. The "banderillero" takes one in each hand and places them with extraordinary skill and daring. Sometimes it seems impossible that they should get away with it, but their skill is marvellous. To my mind this is the best part of the whole fight. Six "banderillas" are commonly used, and this takes up another five minutes. The final act now takes place. The "espada," with a sword in one hand and a "muleta" in the other, makes a speech to the president (the "muleta" is a red cloth about 3 feet square on a cane). He then approaches the bull, making the bull charge at the "muleta," but himself getting out of the way of its charges. By now the bull is very exhausted and its rushes are slower, and blood is dripping from the many wounds it has had. After some clever passes and footwork the "espada" stands

up to a rush from the bull, and plunges the sword up to the hilt between its shoulders-blades and the bull drops dead at his feet. Then, after the "espada" has made further obeisance and speeches to the president, gaily decked out teams of horses enter the ring and drag out the dead bull and horses. The average time to kill a bull is twenty minutes, and usually six to ten bulls are killed in each "corrida." It is said that during each season about 2500 bulls and 3500 horses are killed.

There is no getting over the fact that a bull-fight is cruel, but to my mind to the horses only, and that exceptionally so. The bull, after all, is in a mad fury; he dies fighting, and at the end death is instantaneous. The men taking part run a considerable risk, and it is by no means uncommon for them to get seriously hurt or even killed. I should go and see another bull-fight to-morrow if it was not for the horses, and that, I think, is the reason why the sport is condemned by English people, and nowadays even by the better classes in Spain.

C. H. SAVORY.

EXAMINATIONS, ETC.

UNIVERSITY OF OXFORD.

Final Examination for the Degree of B.M., C.Bh, July, 1925.

Materia Medica and Pharmacology.—K. A. Hamilton, K. Okell.

Pathology.—L. W. H. Bertie, Noel Chilton, T. B. Hodgson, J. H. Kennedy.

Forensic Medicine and Public Health.—D. A. Abernethy, E. N. Allott, F. J. Bach, J. N. C. Ford, T. B. Hodgson, O. R. Tindall.

Medicine, Surgery and Midwifery.—D. A. Abernethy, E. N. Allott, V. P. Robinson, R. A. Walsh.

UNIVERSITY OF CAMBRIDGE.

The following degrees have been conferred:

M.B., B.Chir.—C. H. C. Dalton.

UNIVERSITY OF LONDON.

First Examination for Medical Degrees, July, 1925.

D. A. Beattie, A. Caplan, W. W. Dewar, I. F. Fisher, L. Freeman, A. H. Grace, G. G. Hanna, D. S. Hayes, G. W. Kirk, G. C. Knight, J. S. MacVine, I. W. Matheson, J. H. Pierre, E. Renbom*, J. I. Rerrie, R. S. Risk, M. Schlaff.

* Awarded a mark of distinction in Physics.

Second Examination for Medical Degrees, July, 1925.

Part I.—E. F. D. Baker, R. C. Bennett, W. R. Candler, J. R. Crumbie†, A. M. Gibb, I. Huntley, I. M. Lamont, H. M. List, C. T. E. Parsons, E. S. Pope, A. C. Riley, R. D. Robinson.

† Awarded a mark of distinction.

ROYAL COLLEGE OF PHYSICIANS.

The following have been admitted Members:

E. Gallop, M.D.(Lond.), G. L. Lyon-Smith, M.B.(Cantab.), H. L. Stokes, M.B.(Melbourne).

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS.

Diploma in Tropical Medicine and Hygiene.

The Diploma has been conferred on the following:

D. D. Anderson, G. H. Dive, T. E. Sheehan, C. Sturton, W. Wilkinson.

Diploma in Psychological Medicine.

The Diploma has been conferred on:

R. G. Riches.

CONJOINT EXAMINING BOARD.

Pre-Medical Examination, July, 1925.

Chemistry.—A. F. Davy, R. L. Mansi.
Physics.—A. F. Davy, R. L. Mansi, J. S. Knox, J. T. Rowe.

First Examination (Old Regulations), July, 1925.

Chemistry.—P. J. StH. L. Maudsley.
Physics.—P. J. StH. L. Maudsley, D. F. Powell.
Biology.—B. F. Powell.

Second Examination, July, 1925.

Part I. Anatomy.—H. H. Boyden, M. Gamboa, G. P. Nixon, H. G. M. Page, D. Preiskel, F. G. V. Scovell, J. L. Smith.

Physiology.—H. H. Boyden, F. W. Crossley-Holland, J. G. Galt, M. Gamboa, A. P. Gaston, H. W. Guinness, P. N. Hanson, F. G. V. Scovell.

Part II. Pharmacology and Materia Medica.—J. R. J. Beddard, W. A. Bellamy, L. G. Byrde, C. R. Todd.

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

J. S. Aldridge, R. G. Anderson, E. Bacon, H. I. C. Balfour, H. C. Boyde, J. W. D. Buttery, G. H. Day, M. Fishman, E. A. Freeman, W. F. Gaisford, S. J. P. Gray, M. J. Harker, L. F. A. Harrison, B. L. Hodge, C. L. Hunt, A. K. Kerr, M. L. Maley, J. B. W. Roberton, G. L. F. Rowell, H. J. Seddon, R. K. Smith, R. Stuart, D. E. Thomas, P. R. Viviers, J. S. Whitton.

CHANGES OF ADDRESS.

ARCHER, C. W., The Sycamores, Cottingham, E. Yorks.
BARNSLEY, R. E., Maj. R.A.M.C., c/o Messrs. Grindlay & Co., Bombay.
ECCLES, T. A., Park House, 47, St. John Street, Ashbourne, Derbyshire.
GREY, H. M., 26, Park Crescent, Portland Place, W. 1. (Tel. Langham 1715.)
KHAMBATA, R. B., School of Tropical Medicine and Hygiene, Central Avenue, Calcutta.
MAXWELL, J. P., Union Medical College, Peking, China.
STORER, R. V., 159, South Terrace, Adelaide, Australia.
TRIPP, C. L. H., Woldingham Chace, Woldingham, Surrey.
WILLIAMS, R. LESTER, 14, Oxford Terrace, Hyde Park, W. 2.

APPOINTMENTS.

BROOK, C. W., M.R.C.S., L.R.C.P., appointed Casualty Officer, Royal Waterloo Hospital.
KHAMBATA, R. B., M.R.C.S., L.R.C.P., D.P.H.(Camb.), appointed Director of Bengal Public Health Laboratory, School of Tropical Medicine and Hygiene, Calcutta.
KLIONSKY, K., M.B., B.S.(Lond.), appointed Resident Medical Officer at the Worcester General Infirmary.
POOLE, J. W., M.B., B.S.(Lond.), appointed Resident Medical Officer, Royal Buckinghamshire Hospital, Aylesbury.
SAVAGE, J. J., M.B.(Oxon.), appointed Casualty Officer, St. Mary's Hospital.
WILLIAMS, R. LESTER, M.B., B.Ch.(Camb.), F.R.C.S.(Eng.), appointed Assistant Surgical Officer, Royal Northern Hospital, Holloway.
WOODFORDE, A. W. G., M.B., B.S.(Lond.), appointed Surgeon to In-Patients, St. Bartholomew's Hospital, Rochester, and Surgeon to Ear, Nose and Throat Department, St. Bartholomew's Hospital, Rochester.

DEATHS.

DANIEL.—On August 2nd, 1925, at Beaminster, Dorset, Thomas Palmer Daniel, M.R.C.S., aged 88.
ODELL.—On August 21st, 1925, at Ferndale, Torquay, William Odell, M.D., F.R.C.S., aged 74.
SHARMAN.—On August 20th, 1925, at Brighton, Dr. J. S. Sharman, of Norwood.

The Editor regrets that the Notices of Births and Marriages are unavoidably held over until next month.

St. Bartholomew's Hospital Journal.

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

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CALENDAR.

Thurs., Oct. 1.—Old Students' Dinner in the Great Hall.
Fri., „ 2.—Prof. Fraser and Prof. Gask on duty.
Sat., „ 3.—Rugby Match *v.* Moseley. Away.
Mon., „ 5.—Special Subject Lecture. Mr. Elmslie.
Tues., „ 6.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Wed., „ 7.—Clinical Surgery Lecture. Sir Holburt Waring.
Fri., „ 9.—Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.
Clinical Medicine Lecture. Dr. Langdon Brown.
Sat., „ 10.—Rugby Match *v.* Richmond. Away.
Mon., „ 12.—Special Subject Lecture. Mr. Harmer.
Tues., „ 13.—Sir Thomas Horder and Mr. Rawling on duty.
Wed., „ 14.—Clinical Surgery Lecture. Mr. McAdam Eccles.
Fri., „ 16.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Clinical Medicine Lecture. Dr. Morley Fletcher.
Sat., „ 17.—Rugby Match *v.* Northampton. Away.
Mon., „ 19.—Special Subject Lecture. Mr. Just.
Tues., „ 20.—Prof. Fraser and Prof. Gask on duty.
Wed., „ 21.—Clinical Surgery Lecture. Sir Holburt Waring.
Rugby Match *v.* Cambridge University. Home.

Last day for receiving matter for November issue of the Journal.

Fri., „ 23.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Clinical Medicine Lecture. Dr. Langdon Brown.
Sat., „ 24.—Rugby Match *v.* R.M.A. Away.
Mon., „ 26.—Special Subject Lecture. Mr. Harmer.
Tues., „ 27.—Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.
Wed., „ 28.—Clinical Surgery Lecture. Mr. McAdam Eccles.
Rugby Match *v.* Cardiff. Away.
Fri., „ 30.—Sir Thomas Horder and Mr. Rawling on duty.
Clinical Medicine Lecture. Sir Thomas Horder.
Sat., „ 31.—Rugby Match *v.* Old Leysians. Away.

EDITORIAL.

EVERY profession which is dear to the heart of its exponents tends to produce a specific series of metaphors. Merely to emphasize that a particular statement is correct a carpenter will say, "You have hit the nail on the head;" a soccer forward will say, "You've scored," and possibly a signalman would say, "You are on the right line," and a jockey, "You've backed a winner." Surely no one can criticize a Hospital journal for discussing its "circulation." As for our fleshy temples, so for any literary effort, life depends upon circulation.

Recently we have been troubled by quite a few letters of this order:

"DEAR SIR,—Since leaving the Hospital after qualifying I have not received my copy of the JOURNAL. [Here follow a few remarks which modesty compels us to omit concerning the excellence of our periodical, its powerful linking with the hub of medical thought, etc., etc. It continues:] On commencing my medical studies my benevolent parent paid a large sum of money on my behalf as my subscription for life membership of the Students' Union. If I am a life member why am I not receiving my JOURNAL, for, contrary to metropolitan opinion, medical practitioners, even if resident in Blankshire, are still living?"

We are desirous to clear up any little misunderstanding. The JOURNAL is supplied free of charge to all members of the Students' Union *until they are qualified*. On qualification all members are asked to become subscribers. No JOURNALS are posted to men who have not registered as subscribers, and the JOURNALS supplied on demand in the Cloak Room are for non-qualified men only. An exception is made to members of the Junior Staff, who have a right, during their term of office, to obtain copies free of charge.